Integrated Care System Board
Meeting held in public

Thursday 9 May 2019, 13:30 – 16:30
Rufford Suite, County Hall, Nottingham

AGENDA

	Time	Agenda Items	Paper	Lead	Action
1.	13:30	Welcome and introductions	Verbal	Chair	To note
2.	13:35	Conflicts of interest	Verbal	Chair	To note
3.	13:40	Minutes of 11 April ICS Board meeting and action log	Paper A1-2	Chair	To agree
4.	13:50	Patient story on smoking in pregnancy	Presentation	Elaine Moss	To discuss
Outcomes Framework, Prevention and Inequalities					
No items on the workplan					
Strategy and System Planning					
5.	14:10	Local Workforce Action Board – update	Paper B1 – 2	Lyn Bacon / Nicky Hill	To discuss
6.	14:40	ICS approach to Best Value Decision Making	Paper C	Lucy Dadge	To agree
Short break					
7.	15:10	ICS Strategy / 5 Year Plan - Outputs of ICS Board Strategy Session 24th April 2019	Paper D	Tom Diamond	To discuss
8.	15:30	Local priorities for inclusion in the 19/20 MoU with NHS England & Improvement	Paper E	Tom Diamond	To agree
9.	15:45	NHS Long Term Plan engagement plan and system narrative	Paper F1 – 2	Alex Ball	To discuss

	Time	Agenda Items	Paper	Lead	Action
10.	16:00	Developing the roles and functions at ICS, ICP and PCN level	Paper G	Deborah Jaines	To agree
11.	16:15	Development of the Model for Primary Care Networks	Paper H	Nicole Atkinson	To agree
Oversight of System Resources and Performance Issues (including MoU)					
12.	16:30	ICS Integrated Performance Report - Finance, Performance & Quality. Escalated issues: • Finance • A&E • Mental health	Paper I1-2	Helen Pledger	To discuss
13.	16:50	Mid Nottinghamshire ICP	Paper J	Richard Mitchell	To discuss
Governance					
No items on the workplan					
17:00 Close					

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

Item 3. Enc A1

Integrated Care System Board meeting
Thursday 11 April 2019 – 09:00 – 12:00
Rufford Suite, County Hall, Nottingham
Meeting held in public

Draft minutes

Present:

ICS Board members	ORGANISATION
Alison Wynne	Director of Strategy and Transformation, Nottingham University Hospitals NHS Trust
Amanda Sullivan	Accountable Officer, Nottinghamshire CCGs
Anthony May *from item 4*	Chief Executive, Nottinghamshire County Council
David Pearson	ICS Chair
Dean Fathers	Chair, Nottinghamshire Healthcare NHS FT
Eric Morton	Chair, Nottingham University Hospitals NHS Trust
John Doddy	Councillor and Chair of the Nottinghamshire Health and Well Being Board, Nottinghamshire County Council
John MacDonald	Chair, Sherwood Forest Hospitals NHS FT
Jon Towler	Lay Member, Nottinghamshire CCGs
Richard Henderson	Chief Executive, East Midlands Ambulance Service
Simon Crowther	Director of Finance, Nottinghamshire Healthcare NHS FT
Stuart Wallace	Councillor and Chair of the Adult Social Care and Health Committee, Nottinghamshire County Council

In Attendance:

Alex Ball	Director of Communications and Engagement, Nottinghamshire ICS
Andy Haynes	Clinical Director, Nottinghamshire ICS
Elaine Moss	Chief Nurse, Nottinghamshire CCGs and ICS
Gavin Lunn	Clinical Lead from Mid Nottinghamshire Clinical Chair, Mansfield and Ashfield CCG
Helen Pledger	Finance Director, Nottinghamshire ICS
Hugh Porter	Clinical Lead from Greater Nottingham Clinical Chair, Nottingham City CCG
Joanna Cooper	Assistant Director, Nottinghamshire ICS
Richard Stratton	Clinical Lead from Greater Nottingham GP, Belvoir Health Group
Thilan Bartholomeuz	Clinical Lead from Mid Nottinghamshire Clinical Chair, Newark and Sherwood CCG
Wendy Saviour	Managing Director, Nottinghamshire ICS

Apologies:

John Brewin	Chief Executive, Nottinghamshire Healthcare NHS FT

Nicole Atkinson	Clinical Lead from Greater Nottingham Clinical Chair, Nottingham West CCG
Richard Mitchell	Chief Executive, Sherwood Forest Hospitals NHS FT
Tracy Taylor	Chief Executive, Nottingham University Hospitals Trust

1. Welcome and introductions – Chairs vision and ambition for the ICS

Apologies received as noted above.

DP welcomed colleagues and members of the public to the first ICS Board meeting to be held in public.

DP highlighted the *What Matters To You* consultation launched March 2019. Further details are available from AB.

DP presented the circulated paper. As part of induction, DP is meeting with Board members individually.

2. Conflicts of Interest

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

3. Minutes of 15 March and 1 April 2019 and Action log

Minutes of ICS Board meeting on 15 March and 1 April 2019 were agreed as an accurate record of the meeting by those present. The action log was noted.

DP informed the Board that the City Council are due to consider its suspension of ICS membership on 16 April. City Council published paper on 9 April with the recommendation that the suspension be lifted. The report that was published demonstrates how we have made progress as an ICS Board through better acknowledgement of the specific needs of the City and its geography and improved democratic accountability through the inclusion of elected members in the ICS Board membership. It is likely that concerns remain about approaches to procurement across the ICS, which a number of partners may be interested in. A paper will be presented to the 9 May meeting on best value decision making for the ICS Board to consider.

4. Patient Story from ICS Cancer Workstream

Simon Castle attended the Board meeting to present the circulated paper and share two patient stories demonstrating the progress to date with cancer transformation. National funding has been secured to expand on the pilot in the City for lung cancer screening to Mansfield and Ashfield.

DP thanked Simon for the presentation on behalf of the Board. The Board discussed the following key points:

- AH advised that the CRG have considered cancer pathways and the issues raised. AH emphasised the importance of monitoring the stage shift in cancers being detected earlier.
- HPo highlighted that the FIT should be celebrated as a local innovation based on research which is now being adopted nationally.
- TB raised concerns about inequalities arising due to differential access to services based on CCG areas and proposed that consideration be given to initiatives being rolled out at PCN level in the future. TB also highlighted the rising burden of treating cancers.
- DF highlighted that more joined up thinking on research agenda. ICSB to consider wider system to improve productivity. AB updated that AHSN will be attending a future ICSB meeting to discuss these issues.
- JM acknowledged the demand on diagnostic services and asked for clarity on where workforce implications are being considered. Simon advised that the East Midlands Cancer Alliance considers workforce issues across the region.
- JD highlighted the depth of information available in the JSNA to inform these decisions.
- EM asked that as a system consideration should be given to the totality of pathways.

Outcomes Framework, Prevention and Inequalities

5. ICS MOU prevention priority – alcohol

Alison Challenger and Chris Packham attended the meeting to provide an update to the ICS Board on the ICS MOU prevention priority.

Following the identification of alcohol as the ICS prevention priority and related work, the Board noted a decline in alcohol related hospital admissions. Additional funding has been secured to improve access to brief advice and alcohol related projects. A national visit was coordinated on 2 April which was well received.

The Board noted the very good progress made and the ongoing work on the implementation plan. The Board agreed to provide ongoing support for this prevention priority.

AS clarified that the prevention priority has been incorporated into the commissioning intentions of all CCGs with resources committed to support this work.

6. ICS Outcomes Framework

Chris Packham attended the meeting to provide an update on the refinement and development of the ICS Outcomes Framework following feedback from the Board at the 15 March meeting.

The Board endorsed the next steps and agreed the updated ambitions and outcomes, recognising that the framework will continue to be developed. The Board will be updated on progress and situated in the context of the local system strategy response to the Long Term Plan.

WS highlighted to the Board that the analytical capacity and capabilities needed to proceed with this work should not be underestimated. Whilst a short term solution is in place, consideration needs to be given to longer term resources for this work.

7. Embedding Personalised Care in Nottinghamshire

Jane North and Roz Howie attended the meeting to present the circulated paper on personalised care for the Board to note progress against the 2018/19 Memorandum of Understanding (MOU) with NHSE. The following key points were made during the discussion:

- JT encouraged the Board to endorse the approach in table 3 of the report in support of developing plans at ICS, ICP and PCN level.
- AS welcomed the report and advised the Board that resources have been embedded within the CCG structure to take this work forward.
- AB advised that early results from the engagement on the Long Term Plan are supportive of the personalised care approach.

The Board agreed a further one-year MOU with NHSE as an advanced Personalised Care Demonstrator site for 2019/20. The Board agreed the next steps set out in the report to jointly develop a plan between the ICS, ICP and PCNs for 2019/20 on universal personalised care and support a resource plan on future funding to deliver commitments under the NHS Long Term Plan.

DP thanked JN and RH for the presentation, and Rosa Waddingham for work on this agenda.

Strategy and System Planning

8. Agree the approach to June 2019 NHSI/E Estates Strategy

HP presented the circulated paper on the approach to developing the Estates Strategy based on the process put in place for 2018/19. HP highlighted that a new SRO has been appointed – Simon Crowther (SC) – and that new processes are in place with the Planning Group making connections to five-year plan including the Clinical Services Strategy, IM&T, and the wider public estates through the One Public Estate (OPE) programme. Estates is now a key agenda item on Financial Sustainability Group.

The Board agreed that the Planning Group would have delegated authority to approve the draft ICS estates strategy submission for submission in June, which was a feedback and review process. The ICS Board will consider the final estates strategy as part of the approval of the five year plan and will get regular updates from the Planning Group.

AS asked for estate and utilisation to be considered across the system recognising that there is good and inadequate estate across acute, community and primary care.

WS highlighted that a more strategic approach needs to be taken for 19/20 to support the development of a coherent estates strategy underpinned by the clinical strategy. DP asked Board members to commit leadership time to support this work led by SC.

ACTIONS:
Board members to support the delegation of the June 19 submission to the Planning Group. All system partners to engage in the development of the estates strategy, in line with five-year plan (including clinical services strategy).

9. Receive an overview of the 2019/20 operational plan submission

HP provided a verbal update on 2019/20 NHS operational plan submission. Following detailed discussions at the meeting on 1 April, organisations and ICPs have been working to further develop plans. Organisational plans were submitted on 4 April and system plan to be submitted 11 April with delegated authority agreed for DP, WS and HP at the 1 April meeting.

HP updated the board on the key changes from the 1 April discussion:

- System control total – the system plan does not currently meet the system control total due to a shortfall of £1.9 million. This relates to a technical issue on the NUH financial plan in relation to MRET funding and the calculation of the organisational control total. NUH have raised this issue directly with NHS Improvement and are awaiting a response.
- A letter has been received on the national ICS financial framework which outlines how the incentive scheme will work for 2019/20. Systems are eligible for the scheme if the plan delivers the system control total and the key elements are the linking of provider sustainability funding to the delivery of the system control total, transformational funding and agreement of freedoms and flexibilities with NHS England and Improvement. The ICS is required to respond by the 26th April to confirm whether it will participate in the scheme. There is a Financial Sustainability meeting on the 24th April, this group will review scenarios and agree the ICS response.
- Transformational Plans – work is continuing in organisations and ICPs, and the actions discussed on 1 April are underway. A further update will be provided to the May Board.
- Activity Plans – there is an error on the Mid Nottinghamshire CCGs outpatient activity plan submission, this has been flagged with NHS England and Improvement.
- The 2019/20 operational plan will be restated across the 3 ICPs by the end of May.

ACTIONS:
Financial Sustainability Group to consider scenarios for ICS financial framework and agree ICS response by 26th April.

Oversight of System Resources and Performance Issues (including MoU)

10. ICS Integrated Performance Report – Finance, Performance & Quality.

WS presented the circulated performance report which is a summary report following feedback from the Board at the 15 March meeting. Further work is underway with CCG colleagues to improve further and develop a dashboard for the ICS Board.

The Board noted the contents of the ICS Integrated Performance Report. Key areas of concern are highlighted in the report summary along with actions being taken to address the performance issues. The red-rated performance areas remain urgent and emergency care, mental health transformation delivery and financial sustainability. WS additionally highlighted risk of delivery in relation to cancer, transforming care and maternity.

EM welcomed summary version and asked that further attention be given by the ICS Board to the red-rated performance areas.

EIM asked that areas with sustained issues are reported into the Governance Group to ensure that risks are captured and managed through the ICS risk register.

ACTIONS:
JC to incorporate red-rated performance areas into the forward workplan for the Board.
EIM and JC to ensure that red-rated performance issues are reported into the Governance Group.

11. Receive a report on the delivery of MOU National and Local priorities and deliverables

WS presented the circulated year end report on the ICS MOU. The Board noted the progress to date and year end position on ICS MOU priorities and deliverables. WS highlighted the areas to progress in 2019/20 outlined in the report.

JT asked for clarity on next steps. WS advised that there has been no recent information from the national team in respect of the MOU for 2019/20. The Board requested that a proposal be produced for the 9 May Board meeting highlighting the ICS team's suggested priorities for the system to be used to inform and shape the 19/20 MOU.

ACTIONS:
WS to oversee the development of a report to the 9 May ICS Board meeting on the system priorities to shape the ICS MOU for 2019/20.

12. Update from the Mid Nottinghamshire ICP

JM presented the circulated paper providing an update on the Mid Nottinghamshire ICP. JM highlighted two critical areas for the ICP on access to transformation funding and access to information.

JM welcomed ICS Board members to attend the visit to Wigan on 26 April. Colleagues to contact RM if they are interested in attending.

JD welcomed representative from ICPs to make use of existing forums to foster working relationships such as the County Health and Wellbeing Board Healthy and Sustainable Communities Group.

Governance

13. ICS Board Terms of Reference

DP presented the circulated paper providing an overview of the legal advice sought on the ICS Board Terms of Reference following the discussion at the 15 March meeting.

The Board discussed the proposed review of the Board in July. AM proposed that a review of the Board should be deferred to allow the Board to form over the next 12 months, which was agreed by the Board.

The Board raised issues that need to be addressed in the short-term ahead of the review:

- Indemnity
- Voting arrangements for clinical members of the group
- Membership and representation on the Board, which could be fulfilled by existing Board members, including public health, workforce and Information/digital.

DP asked that the issues to be considered be collated. The Board agreed that bilateral discussions take place and for a report to be presented to the 13 June meeting.

ACTIONS:
DP to oversee the collation of issues to be considered further to support the development of the ICS Board TOR.

Time and place of next meeting:
9 May 2019, 13:30pm – 16:30pm
Rufford Suite, County Hall

ICS Board membership

Role	John Brewin	Dean Fathers	Richard Mitchell	John Macdonald	Tracy Taylor	Eric Morton	Amanda Sullivan	Anthony May	Stuart Wallace	John Doddy	Wendy Saviour	David Pearson	Jon Towler	Richard Henderson	Simon Crowther	Alison Wynne	Not represented at this meeting
ICS Chair												X					
Chief Executive Nottinghamshire Healthcare NHS FT															X		
Chair or nominee Nottinghamshire Healthcare NHS FT		X															
Chief Executive Sherwood Forest NHS FT																	X
Chair or nominee Sherwood Forest NHS FT				X													
Chief Executive Nottingham University Hospitals NHS Trust																X	
Chair or nominee Nottingham University Hospitals NHS Trust						X											
Chief/Accountable Officer, CCGs							X										

Role	John Brewin	Dean Fathers	Richard Mitchell	John Macdonald	Tracy Taylor	Eric Morton	Amanda Sullivan	Anthony May	Stuart Wallace	John Doddy	Wendy Saviour	David Pearson	Jon Towler	Richard Henderson	Simon Crowther	Alison Wynne	Not represented at this meeting
CCG Chair													X				
EMAS Chief Executive														X			
Nottinghamshire County Council CEO or nominee								X									X
Nottinghamshire County Council elected member									X	X							
NHSE/I representative											X						

In attendance:

	Wendy Saviour	Helen Pledger	Alex Ball	Richard Mitchell	Nicole Atkinson	Richard Stratton	Hugh Porter	Gavin Lunn	Thilan Bartholomeuz	Andy Haynes	Elaine Moss	Alex Ball	Not represented at this meeting
ICS Managing Director	X												
The ICP lead from Greater Nottingham ICP						X	X						
The ICP lead from Mid Nottinghamshire ICP													
Two clinical leads from Greater Nottingham ICP with one to represent primary care providers													
Two clinical leads from Mid Nottinghamshire ICP with one to represent primary care providers								X	X				
ICS Officer - finance director lead		X											
ICS Officer - Clinical director										X			
ICS Officer - Nursing/Quality director											X		
ICS Officer – Public Health Director													X
ICS Officer - Director of Communications and Engagement			X									X	

Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

Item No 3. Enc. B3

ICS Board Action Log (May 2019)

ID	Action	Action owner	Date Added	Deadline	Action update
B142	To provide a brief biographical summary and photograph for the 'Who Are the Board Members' pack	ALL Members	15 March 2019	03 April 2019	A draft pack has been produced with further work needed to collate outstanding information.
B137	To identify resources available to support the development of the implementation plans to deliver the Mental Health Strategy.	John Brewin and Lucy Dadge	15 March 2019	30 April 2019	Resource has been identified to develop the implementation plans to deliver the Mental Health Strategy. Development of the plans is well underway with a first iteration planned for completion by the third week in May.
B145	To ensure that CIP / QIPP opportunities are being fully exploited to contribute to the delivery of system plans by end of April	Organisational Leads	01 April 2019	30 April 2019	Ongoing and being monitored through Financial Sustainability Group
B149	To incorporate red-rated performance areas into the forward workplan for the Board	Joanna Cooper	11 April 2019	31 May 2019	The ICS Board workplan is being reviewed following feedback from board members. Red rated performance areas will be incorporated.
B121	To provide an update at the 13 June 2019 meeting on what lessons have been learnt from the You Know Your Mind Project and how sustainability can be addressed longer term linked to the wider use of PHBs	Amanda Sullivan/Wendy Saviour	15 February 2019	13 June 2019	

ID	Action	Action owner	Date Added	Deadline	Action update
B148	To support the delegation of the 19 June submission to the Planning Group. All system partners to engage in the development of the estates strategy, in line with five-year plan (including clinical services strategy)	ALL Members	11 April 2019	19 June 2019	
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	30 June 2019	
B152	To oversee the collation of issues to be considered further to support the development of the ICS Board TOR	David Pearson	11 April 2019	30 June 2019	
B140	To present a review of the resource available for ICP and PCN development at the 9 May 2019 meeting.	Wendy Saviour and ICP Leads	15 March 2019	31 July 2019	

ENC. B1

Meeting:	ICS Board
Report Title:	Local Workforce Action Board - update
Date of meeting:	Thursday 9 May 2019
Agenda Item Number:	5
Work-stream SRO:	Lyn Bacon
Report Author:	Lyn Bacon/ Nicky Hill
Attachments/Appendices:	Enc B2: Nottinghamshire ICS People and Culture Strategy

Report Summary:

This report provides the ICS Board with an update on the work of the Nottinghamshire Local Workforce Action Board (LWAB) which is the workforce programme board for the ICS.

1. The NHS Long Term Plan highlights workforce as one of the top issues facing the NHS. A national Chief People Officer has been appointed to lead the development of the workforce implementation plan which is due to be published. We have revised the Nottinghamshire People and Culture Strategy which was initially approved by the STP Leadership Board in 2016. Our operational plan will be completed in alignment with the national process.

2. The oversight of the Workforce Strategy requires greater alignment with the ICS to ensure successful delivery of ICS outcomes. The National LWAB maturity matrix highlights an opportunity to strengthen the connection between the Nottinghamshire LWAB and ICS Leadership.

3. As in all parts of the country, there are significant workforce challenges in Nottinghamshire – if no action is taken and based on current projections of demand this could including a shortfall of 1500 clinical staff by 2024. Workforce planning is in the early stages of triangulation with finance and activity plans and the emerging plans to manage demand will help to close this gap. The LWAB has created a system wide database to support future planning.

4. Finance and Capacity

   - Work stream resources need to be reconfirmed to ensure progress continues to be made with the workforce plans;
   - Changes to HEE funding processes have moved system resources to individual Trusts and so this requires further work to ensure and the delivery of future system-wide initiatives.

Action:

☒ To receive
☐ To approve the recommendations

Recommendations:	
1.	To agree the process for the revised People and Culture Strategy approval and oversight and how it will link to the ICS
2.	To support the activity of the LWAB
3.	To consider how the Nottinghamshire LWAB links to the ICS
4.	To consider resource implications

Key implications considered in the report:		
Financial	☒	Loss of key posts and implications for the funding of system wide initiatives
Value for Money	☐	Details to be inserted as appropriate
Risk	☒	Risk to the delivery of the people and culture strategy
Legal	☐	Details to be inserted as appropriate
Workforce	☒	Key pieces of work outlined for delivery of the strategy
Citizen engagement	☐	Details to be inserted as appropriate
Clinical engagement	☒	Importance of linking to the ICS workstreams and the emerging clinical services strategy
Equality impact assessment	☐	Details to be inserted as appropriate

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

Nottingham and Nottinghamshire Integrated Care System (ICS)

People and Culture Strategy 2019 - 2029

Contents Page

Foreword

It's no secret that the health and care workforce is facing more challenging times ahead, with difficulties attracting and retaining high quality staff to deliver the care needs of our population, against a backdrop of increasing demands, efficiency targets and reduced investment. Our local estimates indicate that, based on current demand trajectories, we will have a shortage of at least 1500 clinical staff over the next five years. It is clear that we need to change our approach to workforce planning if we are to have a sustainable workforce to deliver care and support to our population.

The Nottinghamshire Sustainability and Transformation Plan (STP) in October 2016 identified that we need to make some quite fundamental changes to be able to deliver care in a more joined up way, working across organisational boundaries and thinking less in terms of where care is delivered and more on how it is delivered. The success of this depends on having the right people with the right capacity and capability to deliver that care and to support people to stay well and independent for as long as possible.

Nottinghamshire is now one of eight Integrated Care Systems (ICS) in England, leading the development of whole system partnership working to achieve integrated strategic commissioning and delivery of care to our population. We are also a Demonstrator Site for Personalised Care and one of three other ICSs that are paving the way for the introduction of integrated health and social care assessments through our Integrated Care Accelerator Teams. We therefore have some significant strengths to build on and we are proud of what we have achieved so far, with a number of innovative workforce models in Nottinghamshire but there is a lot more to do.

This strategy sets out the challenges as identified by the system, and what we are doing – and will do – to meet those challenges. Success will require the system to work together to maximise resources and opportunities, I hope this paper will encourage them to do that.

The challenges are huge but so are the rewards.

Lyn Bacon
Chief Executive Nottingham Citycare Partnership CIC & Senior Responsible Officer, Workforce & OD, Nottinghamshire ICS

1. Context

Our People and Culture Vision for the Future

Our aim is to deliver an integrated people and culture strategy to support the sustainable delivery of the redesigned models of care in the Nottinghamshire ICS, working through the Local Workforce Action Board to build the capacity and capability to lead workforce change.

The strategy will take account of the development needs of the whole workforce including enhancing the skills of patients, families, carers and communities for self-care and prevention, volunteers and the third sector, staff employed by organisations commissioned to deliver health and care services in the private and public sector.

We aim to align our planning to the aims and ambitions of the Department of Health and Social Care national Long Term Plan (LTP) and the Nottinghamshire Clinical Services Strategy. In this document we will include our five year response to those strategies and a more detailed two year delivery plan taking us to the conclusion of the Five Year Forward View (FYFV) delivery period. As the longer term strategies are developed and emerge, our work plans and priorities will need to be flexible enough to respond to those changing demands and population health needs.

Our long term people and culture vision is to have in place:

1. A sustainable, affordable workforce with the right skills, knowledge and capacity working in partnership to deliver new models of care designed around the needs of our citizens
2. Teams with the confidence and capability to work in partnership with others and lead and deliver service improvement and change
3. Teams with positive attitudes and behaviours to deliver and sustain transformed services, improve outcomes and outstanding patient and service user experience
4. Citizens and communities as partners in care and support, building resilient, supportive neighbourhoods
5. Teams with the skills and knowledge to identify self-care needs and take a flexible, holistic approach to people's needs with a strong prevention focus, encompassing person-centred approaches
6. Teams that are capable of and comfortable with taking forward digitalised care and working with new technologies and artificial intelligence
7. Teams that are diverse and inclusive of and drawn from the populations they serve

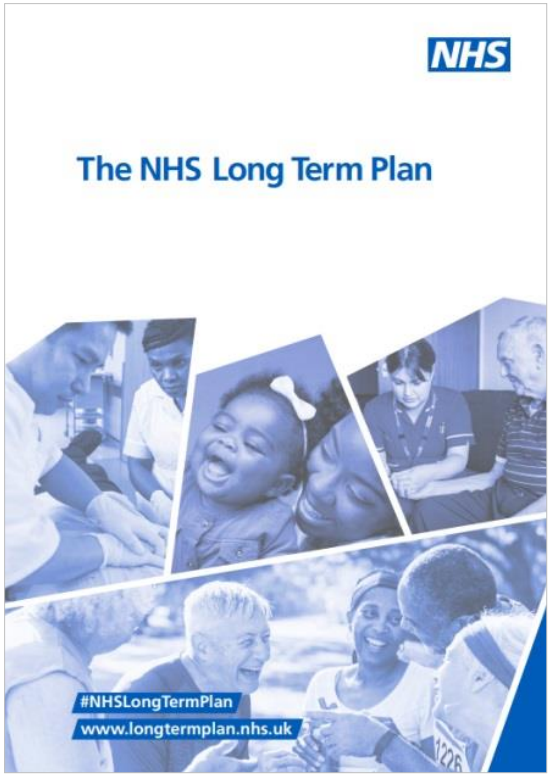
The NHS Long Term Plan

The Long Term Plan (LTP) sets out five practical changes to achieve the its ambitions:

1. We will **boost 'out-of-hospital' care**, and finally dissolve the historic divide between primary and community health services
2. The NHS will **redesign and reduce pressure on emergency hospital services**
3. People will get more control over their own health, and **more personalised care** when they need it
4. **Digitally-enabled primary and outpatient care** will go mainstream across the NHS
5. Local NHS organisations will increasingly **focus on population health** and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere

The LTP sets out the objective to develop and deliver a national workforce implementation plan to deliver the following three strategic aims regarding people and culture that this Nottinghamshire strategy will support:

- Ensure we have enough people, with the right skills and experience, so that staff have the time they need to care for patients well
- Ensure our people have rewarding jobs, work in a positive culture, with opportunities to develop their skills and use state of the art equipment, and have support to manage the complex and often stressful nature of delivering healthcare
- Strengthen and support good, compassionate and diverse leadership at all levels – managerial and clinical – to meet the complex practical, financial and cultural challenges a successful workforce plan and Long Term Plan will demand.



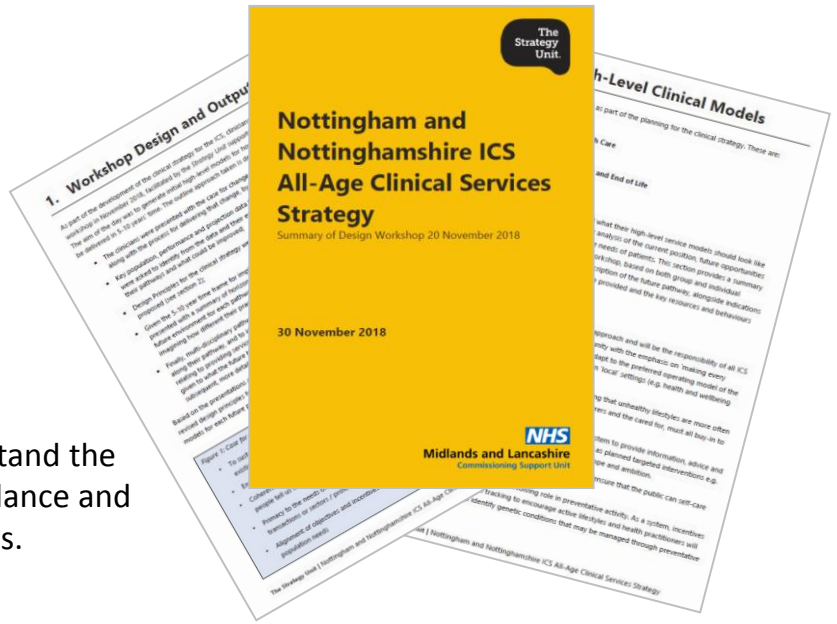
Source: DOH, 2019

Available from: https://www.longtermplan.nhs.uk/

Nottinghamshire Clinical Services Strategy

The ICS is developing the long term strategy with the following objectives:

1. Define a place based model of care
2. Define the levels of standardisation or autonomy at different levels of the system
3. Provide a long term sustainable healthcare model for Nottingham and Nottinghamshire
4. Embed personalised care, prevention and early intervention
5. Provide a strategy in sufficient quality to enable a Pre-Consultation Business Case for any service change that emerges



We are working in partnership with the Clinical Services Strategy team to understand the people and culture implications of the emerging models of care and to offer guidance and expertise on the tools and solutions available to support the transformation goals.

The design principles for the Clinical Services Strategy are:

- Care will provided as close to home as is both clinically effective and most appropriate for the patient, promoting equality of access
- Prevention and early intervention will be supported through a system commitment to make every contact count
- Mental health and wellbeing will be considered alongside physical health and wellbeing
- The clinical strategy's operating model will assume high levels of inter and intra-system engagement
- The Care Models and pathways we develop will ensure pathways are aligned, avoid unnecessary duplication and are based on evidence-based best practice. The will be designed in partnership with patients and the public. They will operate across the whole healthcare system to deliver consistent outcomes for patients through standardised models of care except where variation is clinically justified.

Initial models of care will be developed by March 2019 from which we will develop our work plan for the next two years and beyond.

2. About Our Workforce

Our Current Workforce Profile

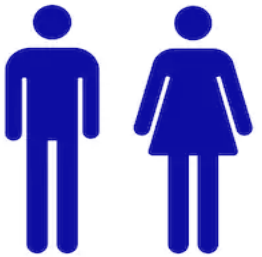
35,436

Full time equivalent members of staff are employed across the Nottinghamshire system*

Where do we work?

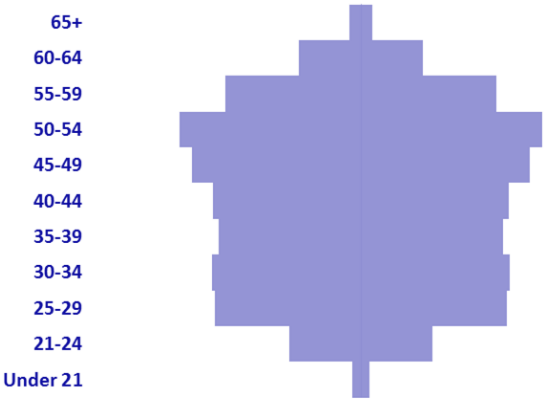
- 18,318 of our staff are based in a **hospital**
- 11,949 of our staff are based within a **community setting**
- 2,171 of our staff are based **out of hospital but system wide**
- 2,965 of our staff are based **out of the ICS**

Gender Split



28% 72%

Our Age Profile



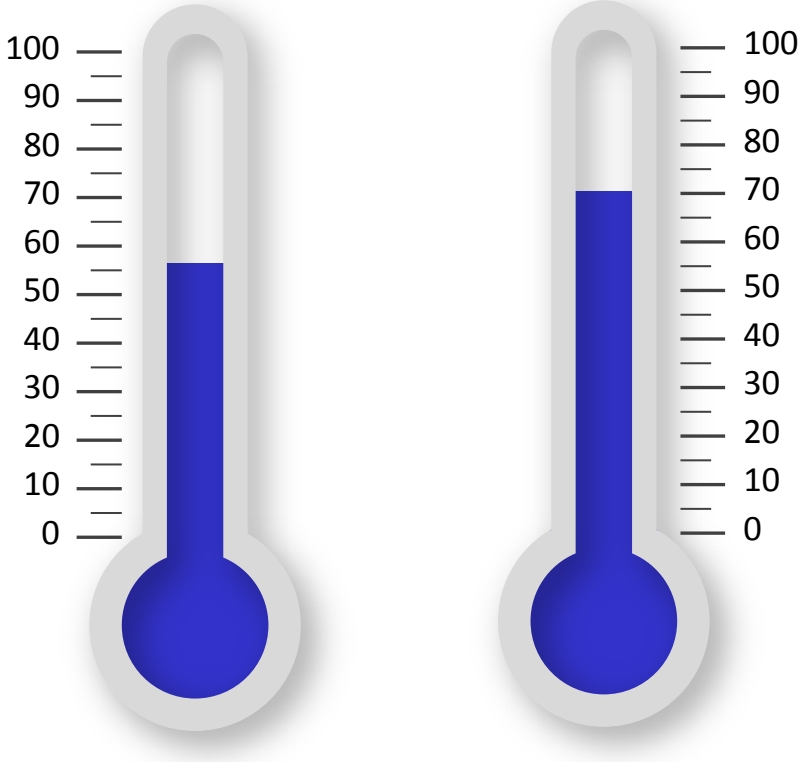
*Data taken from the September 2018 figures and includes Primary, Secondary and Social Care organisations (does not include DHU or other non-NHS providers of MH care)

What it Feels Like to Work in Nottinghamshire

PLACE TO WORK

The percentage of the workforce who agreed / strongly agreed that they would recommend their organisation as a place to work

57%



PLACE TO TREAT

The percentage of the workforce who agreed / strongly agreed that if a friend or relative needed treatment they would be happy with the standard of care provided by their organisation

72%

Data taken from the September 2018 figures and is an average of the responses from the four Provider Organisations

Our People and Culture Challenges

An overview of some of our current people challenges is provided below:

Workforce Supply

Workforce shortages and a decrease in the number of training places has led to an increase in vacancy figures across the system. Highest vacancy rates are currently across the LD (23.9%) and MH (20.95%) workstreams

Health and Wellbeing

Focus needs to be given to staff health and wellbeing as a means of reducing sickness, turnover and improving staff motivation and engagement across the system

Ageing Workforce

Over a quarter of the current Nottingham and Nottinghamshire ICS workforce are over 50 years of age.

Finance and Sustainability

A workforce that works flexibly to respond to individual needs and how people live locally, ensuring that the right skills and services are present in the right place and the right time. Drive to reduce reliance on agency provision.

High Turnover

The overall turnover for Nottingham and Nottinghamshire ICS is 12.44%, and the voluntary turnover is 7.45%. The highest turnover is across the Planned Care workstream (17.77%)

Organisational Development

As new care models emerge there is a need to drive culture change towards collaborative working across organisational and sector boundaries. System leadership skills are key to the achievement of ICS transformation ambitions.

3. Achieving Success

Our Approach

A System Focussed Strategy

The People and Culture Strategy has been developed with the needs our system, our local population and our current and future workforce at the core of our thinking.

We have taken an inclusive approach to the development of the strategy and have focussed our stakeholder engagement, communication and consultation activities around the following areas:

1 **Alignment to the ICS Clinical Services Strategy**
We are working in partnership with the Clinical Services Strategy team to understand the people and culture implications of the emerging models of care and to offer guidance and expertise on the tools and solutions available to support the transformation goals.

2 **Responding to the Needs of the ICS Workstreams**
Throughout the strategy development process we have considered how the people and culture agenda can support the wider transformation ambitions of the ICS Workstreams.

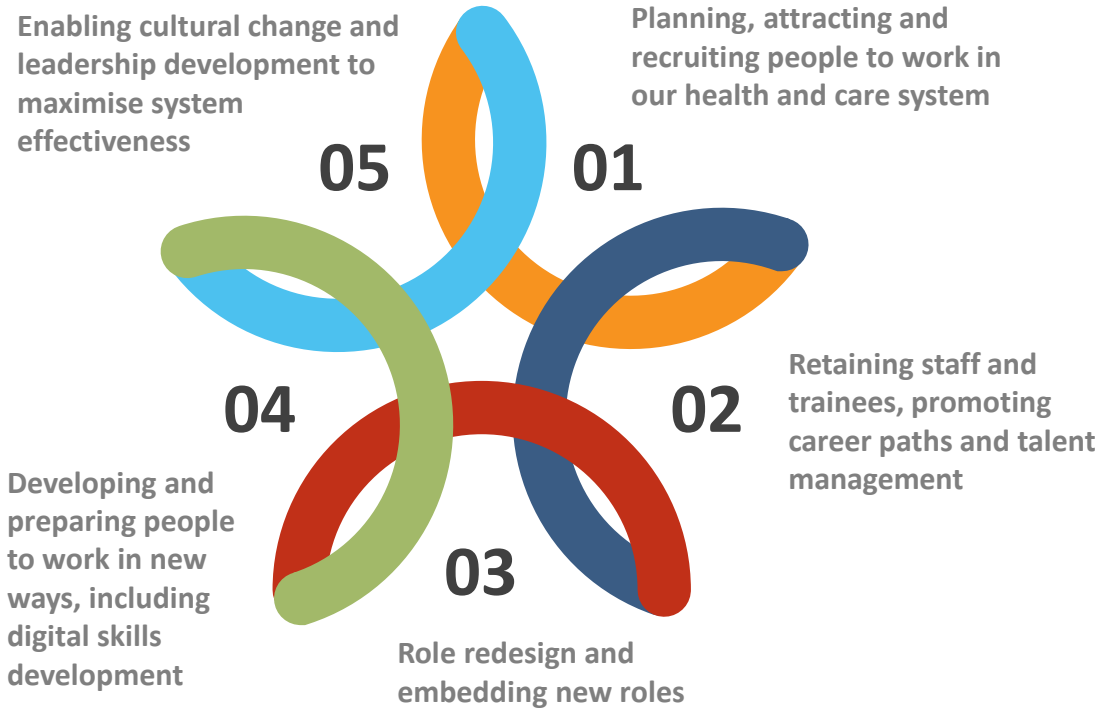
3 **Stakeholder Consultation and Engagement**
The development of this strategy involved stakeholders attending a series of workshops in order to analyse system requirements and identify solutions. The process has been supported by a robust governance structure which includes clinical and system representation including Trade Union colleagues.

People and Culture Priority Areas

As a result of our development journey we have agreed five key priority areas and associated key activities which will enable transformation of our people and culture.

Our Five Strategic Priorities

We will develop a flexible delivery options appraisal and roadmap to take us from our current position to the future shape and skill mix based on our five priority areas.



Key Fact…..

Our work programme will be based on the following principles:

- Securing supply
- Enabling flexibility
- Providing broad pathways for careers
- Widening Participation
- Inclusive, modern, attractive employers
- Integration of financial, service and workforce planning around population need
- Active focus on diversity and inclusion and teams that represent the make up of our local population

A summary of the project and programme activities underway or planned under each of the five priority areas can be found in section 4.

Our People and Culture Ambition

The People and Culture Workstream has developed the system-level outcomes detailed below. These will form part of the ICS System Level Outcomes Framework to provide a clear view of our success as an ICS in improving the health, wellbeing and independence of our residents and transforming the way the health and care system operates (quality and efficiency).

Ambition	System Level Outcomes	EXAMPLE Measures (long list of some example proxy system level measures)
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.	Our system has 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 • Relevant staff survey measures & CQC for non NHS employers • Teams representative of the population we serve (diversity measures, impact of widening participation measures via Talent Academy) • Availability & take up of flexible employment options
	Our people have the skills, knowledge and confidence to take every opportunity to support people to self-care and take a flexible, holistic approach to people's needs with a strong focus on prevention and personalised care	• MECC & personalisation embedded in HR processes: recruitment, induction, essential learning, appraisal • Number of people trained in relevant skills & knowledge & evidence of impact from appraisal • Referrals to lifestyle & support services
	Our people have a positive and rewarding experience working and training in the Nottinghamshire health and care system	• Relevant Staff Survey measures & CQC for non NHS employers: job satisfaction, access to learning & development, health, wellbeing & safety • Health & Wellbeing measures including sickness absence due to anxiety & stress (SS Q11c) • Retention of staff & trainees/students in Nottinghamshire (flow tool) • Trainee & student survey outcomes (learning environment)

Measuring and Monitoring Success

We have developed a system-wide workforce information database that captures and analyses intelligence on our current staff across health and social care providers. Future activity projections have been applied to this baseline to assess the impact of service demand on the future size and shape of our workforce (the 'do nothing' position). Our workforce intelligence system also contains data on the future supply of newly qualified staff from the education system against which to assess demand and understand potential shortages.

In addition to the baseline of current staff in post, we have initiated a twice-yearly collection of information to support the identification of workforce related risk areas including vacancies, turnover, absence levels and agency/bank usage. This will enable us to understand in more detail where our key shortages are and prioritise action in those service areas or staff groups.

We are also developing a population health-led approach to shape the future skills that we will need to deliver future models of care using system dynamics modelling. This approach engages clinicians and managers across the system in developing a range of scenarios to bridge the gap between supply and future demand for skills and provides the opportunity to test the impact of new ways of working and new and innovative roles.

All staff will need the skills and confidence to support people to manage their own health and wellbeing through a systematic approach to prevention, promoting independence and personalisation.

Performance Dashboard

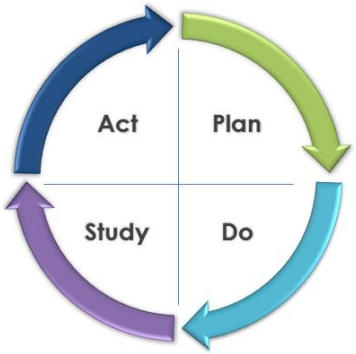
The People and Culture metrics will be incorporated into the ICS Performance Dashboard. This will ensure that our programme of work is fully aligned and supportive of the wider transformation ambitions of the ICS and ICP.

The dashboard is still in development but will include a range of performance metrics, including:

- Retention rates
- Changes in staffing numbers against the plan
- Sickness levels
- Vacancies figures
- Turnover
- Health and well-being of our workforce
- Equality, diversity and inclusion

We will use the PDSA model as a framework to our transformation approach and will:

Plan	Plan our programme of work to deliver maximum benefits to our workforce and our local population
Do	Ensure that projects are delivered in line with workstream and wider system needs
Study	Monitor and evaluate project and programme effectiveness against our original measures of success
Act	Ensure that we embed learning across the ICS / ICP and share lessons learnt



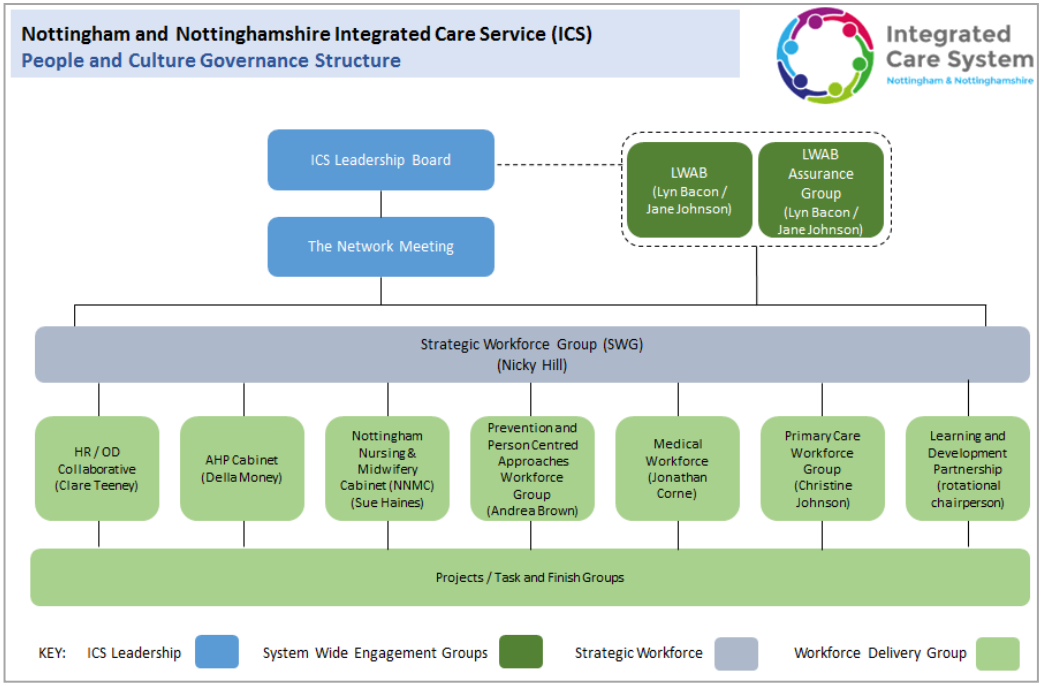
4. Our Work Programme

Workforce Governance for Delivery

We have established a system-wide **Local Workforce Action Board** (LWAB) that is the recognised workforce programme board for the ICS. The Board is co-chaired by a provider CEO and HEE Local Director. Nottinghamshire benefits from a long history of effective joint working with regard to workforce development planning and the board has active representation from health and social care across the system.

The Board provides strategic leadership for workforce development and planning for Nottinghamshire and has four key objectives in its remit:

1. A comprehensive baseline of the NHS and social care workforce and the key issues within the STP footprint
2. A scenario based, high level workforce strategy setting out the workforce implications of the STP's ambitions
3. A workforce transformation plan focused on what is needed to deliver the service ambitions
4. An action plan that proposes the necessary investment in workforce required to support STP delivery, identifying sources of funds to enable its implementation



We have established a Strategic Workforce Group (SWG), chaired by a provider Director of HR that will translate the integrated workforce strategy into a work programme and oversee delivery, drawing on skills, capacity and expertise from across the system. Delivery will be supported through close partnership working with our strategic partnership organisations including HEE, EM Strategic Clinical Networks and East Midlands Academic Health Science Network.

Equality, Diversity and Inclusion

As individual organisations we are passionate about championing a culture of Equality, Diversity and Inclusion where people are able to be themselves in the workplace and in our services should they choose to do so. We acknowledge that this is more powerful when working collaboratively as a system and with this comes increased responsibility to maximise opportunities and have a greater impact in tackling health inequalities.

As part of our delivery programme our ambition is to not only meet but surpass our legal duties through strong partnership working. Our current and future workforce is key to this, reinforcing our need to ensure that our staff and our diverse communities are actively engaged and that we provide a culture of acceptance without exclusion. Together we determine our priorities, which we then action and report to our stakeholders so that we are held accountable.

Within this Strategy our main people priorities are therefore to:

- recruit and retain a diverse workforce which is inclusive of and reflects the diverse communities we serve
- ensure that Equality, Diversity and Inclusion is integral to everything we do and that difference is not only embraced but actively celebrated.

Delivery Plan 2019 - 21

Attracting and Recruiting People to Work in our Health and Care System	
Work Plan / Activity 2019 - 2021	
Increasing and broadening our supply through the Talent Academy approach	• Increasing capacity and diversity in our Work Experience offer • Joint Schools Engagement, Careers Activities, Ambassador Networks(System wide recruitment campaigns) • Apprenticeship routes into employment • Creating attracting career development frameworks • Widening participation activities to ensure diversity & inclusion • Upskilling under-represented groups – disability, service users/people with lived experience • Volunteer workforce & routes into employment including pre-employment preparation
Targeted recruitment from outside Notts – added value through joint activity	• Employers taking joint action to promote the benefits of living and working in Notts to other geographical areas, e.g. London and overseas • Joint campaigns using social media and other methods • Joint recruitment fairs or processes for groups of staff where employers would traditionally be competing • Collaborative approach to international recruitment • Attracting workers with the right skills from other sectors, e.g. digital, scientific, engineering • Partnerships with other sectors to share resource & skills e.g. Biocity, independent sector • Partnerships with education providers to offer real world projects to undergraduate and postgraduate students as part of their programmes of study • Supporting and promoting Return to Practice opportunities across all professional groups

Delivery Plan 2019 - 21

Retaining Staff and Trainees

Work Plan / Activity 2019 - 2021

- Retaining experienced staff by offers of project work, flexible working, education & development opportunities – examples from legacy mentor programme, frailty specialist postgraduate course to retain and develop skills in care of older people
- Promoting and supporting good employment practices across the health and care system
- Work collaboratively to redeploy staff who are at risk within the Health and Care system
- Improving equality of access to career development opportunities for Black and Minority Ethnic and other staff with protected characteristics to retain diversity in our teams
- Support with health and wellbeing – physical and mental health
- Creating supportive team environments & opportunities for experienced staff to transfer skills and mentor other team members
- Well designed and supportive appraisal systems to ensure individual's career aspirations are understood and efforts made to meet them
- Proactive working to woo students and trainees and develop bespoke incentives to remain in Nottinghamshire at the end of training
- Supporting medical staff to achieve Consultant status through alternative routes (CESR)
- Succession planning in Social care relation to an ageing workforce
- Integrated training pathways
- Integrated workforce intelligence information
- Strategic & collaborative approach to commissioning and delivery of education and training through the Learning & Development Partnership (see below)
- Fellowships, sabbaticals, etc.
- Improving our student and learner experience – quality, protected time and learning environment

Delivery Plan 2019 - 21

Role Redesign and Embedding New Roles

Work Plan / Activity 2019 - 2021

- Attractive roles with development opportunities in a range of settings, e.g. rotations, secondments, project work, buddying, learning networks, integrated teams
- Consultant and Advanced Clinical Practice – Nottinghamshire model and implementation plan to support all professions and settings
- Implementing and embedding a Population Health-led approach to the redesign of future teams and skill mix using system dynamics modelling
- Apprenticeship routes into clinical and non-clinical roles
- Apprenticeship Leadership and Management role development
- Integrated graduate schemes
- Nursing Associates roll out and embed – succession planning and sustainable development opportunities
- Career development pathways and succession planning for Care Navigators at all levels (clinical and non-clinical
- Medical Administration Assistants/GP Assistants to release clinical capacity
- Creating attractive schemes with career pathways for medical staff
- Portfolio career options and flexible contracts to remove barriers
- Promoting and developing clinical academic careers (CAC) for nurses, midwives, allied health professionals and health care scientists, establishing a Notts strategic plan working towards achieving the AUKUH target of 1% CAC by 2030

Developing and Preparing People to Work in New Ways, Including Digital Skills Development

Work Plan / Activity 2019 - 2021

- Train and equip staff involved in the delivery of all people's care to work in a person centred way , identify self-care needs and taking e a flexible, holistic approach to people's needs with a strong prevention focus, and focussing on 'what matters' to people and their personal life circumstance
- Ensuring that nursing, midwifery, medical schools, social care courses and any other basic training all systematically address the knowledge and skills required to focus on prevention
- Roll out of holistic competences to reduce hand offs and support continuity of care
- Flexible employment models to enable people to follow a patient/service user pathway between organisations and care settings
- Developing and enabling increased rotational posts and shared learning opportunities, to enable staff to develop skills and confidence working across health and social care sectors
- Broadening and enhancing skills to enable people to work at the top of their licence, e.g. non-medical prescribing. (Imminent publication of nursing careers framework – renewed focus on specialist and specialty practice, progression through to advanced specialist and NMAHP consultant posts – in tandem with "ACP".)
- Enhancing the social care practitioners skills to enable them to be knowledgeable on the availability of Health and Social care services and intervention
- Clinical Pharmacists working in new settings with enhanced skills
- Social Prescribing link worker and community pharmacy roles within primary care settings (PCNs) – preparation for, quality assurance and training – ICS wide
- Proactively shaping our offer to new allied health professionals to work in new ways to take advantage of increasing supply (e.g. physiotherapists and Occupational Therapists)
- Reviewing opportunities for new ways of working for AHPs (AHPs into Action: https://www.england.nhs.uk/wp-content/uploads/2017/01/ahp-action-transform-hlth.pdf)
- Supporting and training Carers and Personal Assistants
- Understanding the impact of technology on practice and its use in streamlining how we work across sector boundaries – ensuring people have the skills to optimise what is available
- Considering portfolio career opportunities for clinical and medical staff to support their development in management, education, service improvement and other opportunities
- Ensuring staff are supported to develop their careers in a safe and supportive environment with access to mentorship and coaching
- Embedding quality improvement skills across teams and providing opportunities for people to lead improvement projects

Delivery Plan 2019 - 21

Enabling Cultural Change and Leadership Development to Maximise System Effectiveness

Work Plan / Activity 2019 - 2021

- Developing and sustaining systems leaders; guiding and aligning collaborative leadership development interventions wherever possible including the development of an ICS leadership offer
- Mapping talent across the ICS and supporting career development opportunities
- Building a culture of continuous quality improvement
- Establishing facilitative support for the ICS Leadership Board; building strong, supportive and trusting relationships among very senior leaders across the ICS and ICP footprints
- Authentic engagement with multi-professional leaders and teams across health and care across the ICS footprint
- Facilitative OD support for the change programmes across the Nottinghamshire ICS Nottinghamshire ICS Learning and Development Partnership
- Embedding community centred approaches and the personalisation agenda across the Nottinghamshire ICS
- Practical OD facilitation to enable HR colleagues and Trades Union colleagues to achieve their vision

PLAN ON A PAGE

2019 - 2021

Integrated Care System
Nottingham & Nottinghamshire

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.

STRATEGIC PRIORITIES

1. **Planning, attracting and recruiting people to work in our health and care system**
2. **Retaining staff and trainees, promoting career paths and talent management**
3. **Role redesign and embedding new roles**
4. **Developing and preparing people to work in new ways, including digital skills development**
5. **Enabling cultural change and leadership development to maximise system effectiveness**

OUR KEY SYSTEM IMPACTS

We will support the transformation ambitions of Nottingham and Nottinghamshire ICS through the delivery of:

1. **A Talent Academy**
   Building capacity through widening participating and the development of new roles
2. **Innovative HR Solutions**
   Providing a toolkit to support flexible employment models and portability of our workforce across the system
3. **Workforce Intelligence**
   Supporting transformation leads to make informed decisions about the workforce required to deliver new models of care
4. **Culture Change**
   Supporting collaborative working across the Nottinghamshire system through a culture of continuous quality improvement and system leadership
5. **A Happier Workforce**
   Ensuring that the health, well-being and happiness of our workforce is at the heart of our programme of work
6. **Equality, Diversity and Inclusion**
   Recruit and retain a diverse workforce which is inclusive of and reflects the diverse communities we serve
7. **Improved Retention**
   Retaining experienced staff by offers of project work, flexible working, education & development opportunities
8. **Strategic Workforce Modelling**
   Implementing and embedding a Population Health-led approach to the redesign of future teams and skill mix using system dynamics modelling

ENC. C

Meeting:	ICS Board
Report Title:	ICS approach to Best Value Decision Making
Date of meeting:	Thursday 9 May 2019
Agenda Item Number:	6
Work-stream SRO:	Amanda Sullivan, Accountable Officer, Nottingham and Nottinghamshire CCGs
Report Author:	Lucy Dadge, Director of Commissioning
Attachments/Appendices:	None

Report Summary:

At the 18 January 2019 meeting of the ICS Board, the Board considered a number of issues raised by Nottingham City Council; including that of Best Value Decision Making when securing sustainable services. The purpose of this short paper is to propose a consistent approach across all parts of the ICS, which can be applied to service changes as appropriate - from major service improvement, through to local supply chain decision-making. The principles sit within the current legislative framework and include criteria such as reducing transactional costs.

Approval is requested for this approach, which sets out the expectations of the Strategic Commissioner and the relationship with the ICS to support decision making. The report also asks for agreement for an annual report of major commissioning intentions across the ICS.

This approval is subject to the agreed approach being adopted by the CCGs and incorporated into procurement policy.

Action:

☐ To receive
☒ To approve the recommendations

Recommendations:

1.	Approve the approach to Best Value Decision Making and support the guiding best practice principles set out in paragraph 7 (subject to consideration by the Governing Bodies of the CCGs).
2.	Note the legal requirements on statutory bodies in respect of fairness and competition.
3.	Agree that the Board should receive an annual report to consider in detail the commissioning intentions for the following financial year.

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 approach for Best Value Decision Making

9 May 2019

Introduction

1. There are a range of different approaches currently deployed across the ICS to ensure Best Value Decision Making when securing sustainable services; including the use of the Social Charter, and other approaches taken by the Local Authorities and CCGs. The NHS Long Term Plan published in January 2019 proposes that the regulations made under section 75 of the Health and Social Care 2012 should be revoked and the power in primary legislation under which they are made should be repealed and replaced by a best value test. This would allow NHS commissioners to choose either to award a contract directly to an NHS provider or to undertake a procurement process, with the aim of ensuring good quality care and value for money.

2. The purpose of this report is to recommend a consistent approach to commissioning decision-making across the health and care system; to seek the ICS Board's approval to adopt the principles; and commit to holding the system to account for delivery against these principles at each level of decision making in the ICS.

3. The approach requires that:

    a. Benchmarking against Best Value Decision Making is undertaken to determine the most appropriate route to awarding contracts for new services. This will be set in the context of the current legislative framework.
    b. Specifications, describing the way services are to be provided and the outcomes required, are to include enhanced aspects relating to social value
    c. The ICS Board will ensure that strategic commissioning decisions in health and care are consistently set in the context of these principles for the delivery against both these elements.

General Approach

4. The Strategic Commissioners will develop and agree the desired population health and care outcomes for the system (and associated commissioning intentions) with the ICS Board on a periodic basis. The purpose of this report is to establish the role of the ICS Board in setting the parameters through which decisions are made, with specific reference to ensuring a more consistent approach to Best Value Decision Making. There are two components to this, delivered through the Strategic Commissioner:

5. Firstly, for significant service change the Strategic Commissioner will develop a process for undertaking benchmarking and best value assessment exercises in advance of deciding whether a procurement process is the optimal approach to deliver the desired population health outcomes. This will then be reviewed in the context of the prevailing legislation. This will be

adapted for any changes to the outcomes required. This benchmarking will assess the market provider landscape, innovation, the nature of need in the area and the volume of need, as well as the performance of the provider as compared to others in the marketplace.

6. The outcome of the benchmarking and legislative review will inform whether an open-market procurement route is required, or whether there are opportunities to vary current arrangements with an existing NHS or Local Authority provider to deliver.

7. Secondly, it is proposed that there is an enhancement to the range of best practice principles considered for inclusion into new service specifications as appropriate. These will be used consistently across the health and care system. The areas that may be included are listed below and there is no intended hierarchy. Possible weightings will be applied on a case by case basis to suit the desired population health outcomes:

Guiding Best Practice Principles

ECONOMIC: Supporting the local economy

- Increase spend within the local economy
- Create employment and training opportunities for citizens
- A strong and diverse local market

SOCIAL: Citizens at the heart of what we do

- Deliver safe, quality and innovative services that meet citizens' needs
- Secure social and community benefits
- Inclusive growth - Tackling deprivation, promoting social inclusion and improving health and wellbeing

ENVIRONMENTAL: Sustainable and responsible

- Air quality and climate change
- Resource efficiency, waste reduction and recycling
- Biodiversity, nature conservation and greening
- Source innovative and sustainable green solutions

Decision-making and Transparency

8. In terms of the ICS Board, there is an expectation that the ICS will guide the strategic direction of the system and where necessary make recommendations to the constituent organisations where this improves outcomes for the population. There are areas where collective agreement is already required (for example the System Control Total for NHS bodies) but it not anticipated that individual decisions around commissioning activities will be subject to that unanimous process.

9. It is appropriate that the ICS Board oversees and confirms commissioning intentions across the Nottingham and Nottinghamshire whilst respecting the role of the CCGs and the local authorities who have the statutory

responsibility for commissioning for their respective populations. It is also the case that the Health and Social Care Act 2012 gave Health and Wellbeing Boards (HWBs) a statutory role in reviewing CCG commissioning plans. This means that CCGs must liaise with the HWBs when preparing or making significant revisions to their commissioning plans, and to provide Boards with a draft plan. The HWB opinion on the final plan must be published with the commissioning plan. The HWB can refer the plan to NHS England if it thinks the Joint Health and Wellbeing Strategy is not being taken account of properly and must be consulted by NHS England when the annual performance of each CCG is drawn up. This is an area where the ICS and HWBs need to work closely together.

10. In addition to the Best Practice Principles above it is important to be aware of the constraints to any collective decision-making. The recent report to the City Council (16th April) spells out some of the legal constraints.

11. It is currently not legally possible to prevent any organisation from tendering for services. The CCGs and other entities who commission in the health sector are subject to the same procurement rules as the local authorities. Those rules are set out in the Public Contracts Regulations 2015 (the 'Regulations'). Health services are subject to the 'light touch regime' within the Regulations which gives greater flexibility to commissioners however there is an overriding principle in the Regulations that all suppliers must be treated equally. That prevents the ability to discriminate on the basis of legal status. It would not be possible to exclude from a procurement process suppliers on the basis that they are private companies.

12. The City Council report (16th April) goes on to say: -

    "it is not possible to have an absolute veto on privatisation …there is some flexibility in the Regulations. The financial threshold at which a contract for services is caught by the light touch regime and requires a competitive tender process is currently £615,278. Below that threshold level a contract for services does not have to be competitively tendered and can be the subject of a direct award. In addition the Regulations provide for the ability to reserve some contracts to qualifying organisations - essentially social enterprise but the scope is limited and subject to restrictions on duration of the contract.

    Proposals to give greater flexibility for commissioners in the NHS are being considered which could give the ability to make direct awards which would assist in the selection of providers, although this seems to only apply to NHS providers not social enterprises and other entities that provide NHS services. (Ref: "Implementing the NHS Long Term Plan – proposals for possible changes to legislation", February 2019)."

13. The intention on the part of the ICS is to be transparent about the decision-making process that determines what needs to be commissioned on behalf of the population, what process is being followed to determine how it is being commissioned and the outcome and impact of commissioning decisions and

the award to contracts. For the ICS Board this must be at the level of the system rather than individual organisations or at a local level. A legal review of the Terms of Reference of the ICS Board is underway and this will provide clarity on the scope of powers that can be exercised.

14. In order to enhance transparency in this area it is proposed, that on an annual basis the Board receives a report on the major commissioning intentions across the system and the estimated value and the impact of any changes. The initial report to should provide a summary of the balance of spend on different services across the health and social care system. This will help to provide clarity across the constituent organisations and greater confidence amongst stakeholders and the public. It would be the intention to align this report with the consideration and agreement of the system control total and operational plans for the NHS so that there is agreement across the whole system to these crucial plans.

Benefits of the Proposed Approach

15. Moving towards a more holistic, best value, approach for commissioning new services will drive a number of benefits e.g.

    a) Consistency of approach across the ICS and ICPs

    b) Alignment with the future developments indicated in the NHS forward plan

    c) Clarify the decision-making oversight of the approach to commissioning and procurement that will be provided by the ICS Board

    d) Support stability and quality of provision for our local population, both public and private

Next steps

16. If agreed, the CCGs will take due consideration of the proposals and how when they can be incorporated in to Commissioning policies. A further report to the Board will confirm the implementation date.

Recommendations

The Board are asked to

1. Approve the approach to Best Value Decision Making and support the guiding best practice principles set out in paragraph 7 (subject to consideration by the Governing Bodies of the CCGs).
2. Note the legal requirements on statutory bodies in respect of fairness and competition.
3. Agree that the Board should receive an annual report to consider in detail the commissioning intentions for the following financial year.

Lucy Dadge
Director of Commissioning, Greater Nottingham
1 May 2019
lucy.dadge@nhs.net

ENC. D

Meeting:	ICS Board
Report Title:	ICS Strategy / 5 Year Plan - Outputs of ICS Board Strategy Session 24 April 2019
Date of meeting:	Thursday 9 May 2019
Agenda Item Number:	7
Work-stream SRO:	Wendy Saviour
Report Author:	Tom Diamond
Attachments/Appendices:	None

Report Summary:

At the ICS Board in March a strategic planning approach based around two workshops with the Board was agreed:

a. Workshop one: to focus on the ICS's vision, ambitions, outcomes and priorities

b. Workshop two: to focus on the actions, milestones and implementation plans to deliver the system's priorities

The first of these workshops was held on 24 April 2019.This paper describes the key discussion points and agreements from the session.

Key outcomes from the workshop were:

- Agreement to the revised vision for the ICS
- Support for the emerging system-level outcomes was reaffirmed
- Support to the emerging system priorities and enablers was given
- Identification of priorities for urgent and emergency care
- Identification of priorities for proactive care

Five actions were proposed at the end of the workshop to take the discussions forward:

a. 'First cut' 19/20 winter plans to be discussed at the July ICS Board development session and then again at the August ICS Board meeting

b. The June and July ICS Board development sessions to focus on the development of the system strategic priorities and Long Term Plan.

c. Time at the Board development session in July to be dedicated to the outputs of the options appraisal to consider alternative care models for same day urgent care

d. Amanda Sullivan to lead a piece of work to further consider the priorities identified during the day in terms of which 'level' of the system (ICS, ICP, PCN) is progressing them, or should progress

them, to identify worked examples to act as proof points for joined up system working and transformation

e. Individual leaders to give consideration to what next steps they might want to take from the session and work on themselves with their system partners to develop relationships and trust, and hold each other to account.

Action:

☐ To receive
☒ To approve the recommendations

Recommendations:

1.	The Board are asked to consider the priorities identified in the Board development session and the next steps for taking them forward.

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

Nottingham City Council | Nottinghamshire County Council | NHS

ICS Strategy / 5 Year Plan
Outputs of ICS Board Strategy Session 24th April 2019

9th May 2019

Introduction

1. Following discussions at the February ICS Board and subsequent follow up conversations with system leaders, a paper was presented to the ICS Board in March that set out a proposed strategic planning approach for the Nottingham and Nottinghamshire Integrated Care System.
2. The strategic planning approach presented was based around two workshops with the ICS Board:
    a. Workshop one: to focus on the ICS's vision, ambitions, outcomes and priorities
    b. Workshop two: to focus on the actions, milestones and implementation plans to deliver the system's priorities
3. The ICS Board agreed the proposed strategic planning approach and the first Board workshop was held on 24 April 2019. This paper sets out the key discussion points and actions from this workshop.

Current position

4. A facilitated development session took place with ICS Board members and key leaders from across the system on 24 April 2019. The purpose of the workshop was to reaffirm the vision, ambitions and outcomes of the ICS and identify and agree strategic priorities to deliver these. A short session just for ICS Board members followed, this session built on the 11 February development session principles of working together to build collective leadership for system transformation.

Vision, ambitions, outcomes and system priorities

5. Workshop attendees agreed the revised vision for the Nottingham and Nottinghamshire ICS contained within the ICS Narrative agreed at the February 2019 ICS Board, and reaffirmed support for the ambitions and outcomes set out in the emerging System-Level Outcomes Framework.
6. Workshop attendees also supported the five emerging system priorities for the Nottingham and Nottinghamshire ICS – all of which received strong support from the early respondents to the public engagement on the Long Term Plan and the local system plan:
    i. Redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting (97% or respondents rated as Important or Very Important in initial engagement responses)

ii. Improve the care of people with single and multiple long term conditions through greater proactive management and self-management to reduce crises (100% rated as Important or Very Important)

iii. Re-shape and transform services and other interventions so they better respond to the mental health and care needs of the population (94% rated as Important or Very Important)

iv. Reduce waste and improve efficiency and value across the system (including estates) (80% rated as Important or Very Important)

v. More action on and improvements in the upstream prevention of avoidable illness and its exacerbations (95% rated as Important or Very Important)

As well as the emerging system enablers:

i. Workforce

ii. Digitalisation, IM&T and analytics

iii. System financial management and innovative payment models

iv. System governance and oversight (including programme delivery)

7. It was agreed the words for the system priorities and enablers would continue to be refined. Specific amendments identified by attendees were:
   a. The need to explicitly identify personalisation in System Priority ii
   b. Put greater emphasis on delivering value, resilience and sustainability for the next 70 years in System Priority iv
   c. Reflect the requirement for system leadership in System Enabler iv

Urgent and emergency care – ambitions and priorities

8. The workshop also focussed detailed discussions specifically on the ambition and priorities for improving urgent and emergency care. In terms of ambition there was broad recognition that attendance at A&E and reduced admissions needed to happen at pace. On the whole there was agreement that this needed to be quantified, working to the long term ambition of safe, effective and sustainable care.

9. Some participants defined an ambition to reduce attendance for A&E minors by 10% over the next two years (i.e. reducing inappropriate attendances through access to suitable alternatives). However, other participants were more cautious about quantifying an ambition as felt there was not a good enough understanding of the data.

10. There was consensus that the activities and interventions to address the demand pressures currently experienced need to be defined, building on local experience such as the Vanguards, and this needs to be done through a focus on system working rather than individual organisations.

11. Workshop attendees identified the following priorities for urgent and emergency care:
    a. Identify and engage an academic research partner to support the ICS to better understand the population's use of services and the drivers of demand and use of services
    b. Conduct a system diagnostic of what is currently working and what isn't to share learning and drive improvements
    c. Define protocols to safely redirect people to more suitable services if they can be treated faster and more efficiently outside of A&E, based on educating and managing the need of defined patient cohorts – any redirection will need to be on the basis of a referral to an alternative service
    d. The ICS Board to review the first draft of winter plans at the July Board development session and then at the ICS Board in August
    e. Ensure the right capacity exists in Primary Care Networks (PCNs)/community based services that can provide alternatives to hospital admissions and support earlier discharge from hospital (and that incentives are aligned)
    f. Hospital discharge services and processes
    g. GPs separate out on the day urgent care provision to enable more time to be spent supporting long term condition management – complete options appraisal to consider alternative models for providing on the day urgent care provision (collaboration by practices within PCNs vs. developing 'health villages' on acute hospital sites) to be completed by the Clinical Services Strategy programme and presented back to the ICS Board
    h. Nationally directed Urgent Treatment Centre Programme
    i. Direct booking and referral into GP practices and other community services
    j. A local review of NHS 111 provision
    k. Establish a population health lead system to reduce need for emergency and urgent care services

Proactive care – ambitions and priorities

12. It was widely agreed by workshop attendees that the local health and care system is faced with an ever growing proportion of the population experiencing a preventable or treatable long term condition. It was agreed there needs to be a greater 'up-stream' focus on prevention and for those living with such conditions, individuals need to be supported to be as independent as possible, ensuring they feel equipped to manage their condition. It was also acknowledged that the scope and definition of long term conditions needed to be defined further.

13. Across the workshop attendees there was strong support for a greater focus on the proactive, coordinated care of specific cohorts of the population to give people as much control and quality to their life as possible. Ensuring they are supported by a care plan, received evidence based interventions from multi-disciplinary teams working across health and social care (including the voluntary sector) and ultimately avoid crisis.
14. Cohorts identified as currently not being as well served as they could be were those with physical and MH conditions, long term conditions, frailty, living in care homes and those at end of life. Better management of data, case finding, joining up health and social care and utilising technology were all seen as key to improving care to these cohorts and other cohorts more widely.
15. It was also widely acknowledged that greater proactive care could drive improvements in system outcomes measures, however the system needed to be cognisant of the impact of enacting such changes i.e. the cost of optimising treatment in the short term vs. system benefits to ascertain if it is manageable.
16. Attendees identified the following priorities for proactive care:
    a. Getting PCNs up and running
    b. Resource model of Multi-disciplinary teams in each PCN
    c. Information and data to risk stratify population and support population health management
    d. Programme of workforce development to support new ways of working
    e. Aligned incentives across providers

Working together

17. Attendees discussed the system's approach to collective leadership. It was agreed relationships had developed well over past months and there was more transparency between organisations. However a number of challenges were identified that the system still needs to overcome, including:
    a. No agreed consensus on collective responsibility at ICS, ICP and PCN level
    b. Full commitment to a system control
    c. Having the headroom to give more time to system working to further develop trust
    d. Delivering transformation at the required pace
    e. Areas that need traction at an ICS level e.g. workforce
    f. How the collective representation of c.22 PCNs is managed?
    g. Identifying proofs of concept to drive transformation
18. It was agreed that giving further consideration to the priorities identified during the day in terms of which ''level' of the ICS should progress them and getting on with doing them would act as good 'proof points' for joined up system working and transformation.

Next steps

19. The following next steps were agreed:

    a. 'First cut' 19/20 winter plans to be discussed at the July ICS Board development session and then again at the August ICS Board meeting

    b. The June and July ICS Board development sessions to focus on the development of the strategic priorities and Long Term Plan.

    c. Time at the Board development session in July to be dedicated to the outputs of the options appraisal to consider alternative care models for same day urgent care – this appraisal is to be led by the Clinical Services Strategy (CSS) programme and all outputs will be received by the CSS Programme Board first

    d. Amanda Sullivan to lead a piece of work to further consider the priorities identified during the day in terms of which 'level' of the system (ICS, ICP, PCN) is progressing them, or should progress them, to identify worked examples to act as proof points for joined up system working and transformation

    e. Individual leaders to give consideration to what next steps they might want to take from the session and work on themselves with their system partners to develop relationships and trust, and hold each other to account.

Recommendations

20. The Board are asked to consider the priorities identified in the Board development session and the next steps for taking them forward.

ENC. E

Meeting:	ICS Board
Report Title:	Local priorities for inclusion in the 19/20 MoU with NHS England & Improvement
Date of meeting:	Thursday 9 May 2019
Agenda Item Number:	8
Work-stream SRO:	Wendy Saviour
Report Author:	Tom Diamond
Attachments/Appendices:	None

Report Summary:

A Memorandum of Understanding (MOU) between the Nottingham and Nottinghamshire Integrated Care System (ICS) and NHS England & Improvement was agreed for 2018/19. This agreement outlined the key objectives and deliverables for the ICS.

These objectives and deliverables were largely set centrally in line with national policy and guidance and the ICS's local system operating plan to deliver them. However there was an opportunity for a small number of local deliverables to be set that were specific to the Nottingham and Nottinghamshire ICS. For 2018/19 a total of eight local objectives were agreed.

It is anticipated there will be an MOU for 2019/20, once again with the majority of objectives and deliverables being set centrally in line with national policy and guidance (the NHS Long Term Plan in particular) with the opportunity to agree a small number of local priorities.

The purpose of this paper is to provide an initial consideration of local priorities for inclusion in the 2019/20 MOU.

Based on the expectation that centrally set objectives will reflect deliverables and performance levels set through national policy (including, for example, urgent and emergency care, mental health and financial performance), four local ICS objectives and deliverables are initially proposed for inclusion in the 2019/20 MOU:

a. Embed the ICS System-Level Outcomes Framework by developing a coherent approach to measuring and reporting the outcomes within the framework at both an ICS Board level and Integrated Care Provider (ICP) level

b. Commence implementation of agreed service changes identified in the outputs of the initial phases of the ICS Clinical Services Strategy

c. Reduce alcohol related harm across the ICS through continue delivery of the agreed eight point plan developed by the Nottinghamshire Alcohol Pathways Group.

d. Further develop the ICS organisational and governance architecture, including:

    i. Integrated oversight;

    ii. Integrated Care Provider structures;

    iii. Integrated planning and delivery by ICPs and PCNs; and

iv. A final form for the strategic commissioning

In addition to the local deliverables and objectives set out above, it is proposed that each of the three ICPs identifies a local priority for inclusion in the 2019/20 MOU that is linked to how they will use the Flexible Transformational Funding (£5 million) available to the ICS for participating in the incentive scheme and allocating provider sustainability funding (PSF) to the delivery of the system control total.

Action:

☐ To receive
☒ To approve the recommendations

Recommendations:

1.	The Board are asked to consider the suggested local deliverables and objectives for inclusion in the 2019/20 ICS MOU together with the proposal that each ICP identifies a local priority linked to how they will use the Flexible Transformation Funding available to the ICS.

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.

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

9 May 2019

Introduction

1. A Memorandum of Understanding (MOU) between the Nottingham and Nottinghamshire ICS and NHS England and NHS Improvement (NHSE&I) was agreed for 2018/19. The agreement outlines key objectives and deliverables for the Integrated Care System (ICS).

2. On the whole these objectives and deliverables were set centrally in line with national policy and guidance, however there was an opportunity for a small number to be set locally that were specific to the Nottingham and Nottinghamshire ICS. For 2018/19 a total of eight local objectives were agreed.

3. These objectives and deliverables were largely set centrally in line with national policy and guidance and the ICS's local system operating plan to deliver them. However there was an opportunity for a small number of local deliverables to be set that were specific to the Nottingham and Nottinghamshire ICS. For 2018/19 a total of eight local objectives were agreed.

4. It is anticipated there will be an MOU for 2019/20, once again with the majority of objectives and deliverables being set centrally in line with national policy and guidance (the NHS Long Term Plan in particular) with the opportunity to agree a small number of local priorities.

Current position

5. As well as delivering the priorities outlined in the system operating plan, the ICS leadership committed to delivering the following high priority deliverables in 2018/19:

    a. Develop a Nottinghamshire Clinical Services Strategy focused on acute, primary and community services. This work will lead to a reduction in unwarranted variation, improve the use of the estate and improve workforce resilience.

    b. Develop a comprehensive mental health services strategy ensuring delivery of service planning requirements including Out of Area Placements reductions, and alignment to physical health strategies.

    c. Finalise the ICS organisational and governance architecture, to provide clarity on integrated oversight, integrated system strategy partnerships, integrated commissioning and integrated provider structures, with early actions to bring CCGs together across the system including committees in common and integrated management teams with a view to having a final

form for the strategic commissioning function by 2020. The ICS will develop its governance structures to enable effective clinical and non-executive strategic input and scrutiny.

d. Remedial action related to core national priorities. A step-change in improvements to the urgent care pathway to bring A&E waiting times back in line with NHS Constitution standards by the end of 2018/19. This will require system wide working between all relevant partners.

e. Scaling up and wide scale adoption of specific care pathways and referral management protocols to implement best practice on a Nottinghamshire wide level in order to maximise efficiencies and service improvement, as well as mitigating service pressures across the system (including the objectives delivered by the current schemes, MSK pathway, Call for Care and care homes support).

f. In support of the ICS Prevention and Wellbeing plan, the ICS will agree a key short term priority for 2018/19 for preventing ill-health across Nottinghamshire.

g. To continue to develop local integrated care partnerships (LICPs) with general practice so that all localities within Nottinghamshire can reach a consistent baseline of maturity to enable integrated primary care at scale across Nottinghamshire, and that the more advanced LICPs are enabled to go further to test Nottinghamshire's ambitions for further transformation of primary care in 2019-20

h. To implement the integrated MDT model that includes social care, mental health, community pharmacy and self-care, and supported by the revised risk stratification and population health approaches being developed across Nottinghamshire, with early focus across Greater Nottingham.

6. The process to develop an MOU for 2019/20 is yet to be initiated by NHSE&I.

7. An overview of progress made in 2018/19 against the key deliverables was considered by the ICS Board at the 11 April meeting. The Board considered the following key areas to accelerate progress:

   a. Whilst the resilience of the system was improved, challenges remain with the overall system priority of achieving the 4 hour target in Greater Nottingham.

   b. At the 15 March ICS Board meeting the ICS mental health strategy was agreed. Commissioners and ICPs have now commenced the development of delivery plans to implement the strategy.

   c. An interim oversight model has been agreed between the ICS and Regional Team for 2018/19. However, further consideration will need to be given to this in 2019/20 as the ICS, ICP and PCN structures become more established. A progression model and oversight framework is in development, by the ICS and regulators, which will include transitional progression steps for integrating oversight as the system matures and develops, under the combined joint regulatory processes.

Issues

8. Based on the expectation that centrally set objectives will reflect deliverables and performance levels set through national policy (including, for example, urgent and emergency care, mental health and financial performance) and the requirement for any local recovery plans and remedial actions, the Board is asked to consider four proposals for local priorities be incorporated into the 2019/20 MOU:
    a. Embed the ICS System-Level Outcomes Framework by developing a coherent approach to measuring and reporting the outcomes within the framework at both an ICS Board level and Integrated Care Provider (ICP) level.
    b. Commence implementation of agreed service changes identified in the outputs of the initial phases of the ICS Clinical Services Strategy
    c. Reduce alcohol related harm across the ICS through continue delivery of the agreed eight point plan developed by the Nottinghamshire Alcohol Pathways Group.
    d. Deliver key actions that support further development of the ICS organisational and governance architecture, including:
        i. Integrated oversight;
        ii. Integrated provider structures;
        iii. Integrated planning and delivery by ICPs and PCNs; and
        iv. A final form for the strategic commissioning
9. In addition to the local deliverables and objectives set out above, it is proposed that each of the three ICPs identifies a local priority for inclusion in the 2019/20 MOU that is linked to how they will use the Flexible Transformational Funding (£5 million) available to the ICS for participating in the incentive scheme and allocating provider sustainability funding (PSF) to the delivery of the system control total.

Recommendations

10. The Board are asked to consider the suggested local deliverables and objectives set out above for inclusion in the 2019/20 ICS MOU together with the proposal that each ICP identifies a local priority linked to how they will use the Flexible Transformation Funding.

ENC. F1

Meeting:	ICS Board
Report Title:	Update on NHS Long Term Plan Engagement and System Narrative
Date of meeting:	Thursday 9 May 2019
Agenda Item Number:	9
Work-stream SRO:	David Pearson
Report Author:	Alex Ball
Attachments/Appendices:	Enc. F2. PowerPoint: Update on NHS Long Term Plan Engagement and System Narrative

Report Summary:

Following the discussion and approval at the February 2019 meeting of the ICS Board of (i) the ICS System Narrative and (ii) the approach to Engagement on the NHS Long Term Plan, this report delivers;

1. An update on the progress to date on the Engagement activities regarding the NHS Long Term Plan
2. An update on the deployment of the ICS System Narrative
3. A summary of the insights regarding the priorities and attitudes of the citizens and staff in Nottingham and Nottinghamshire that can be used to inform the development of the local system strategy
4. An outline of the further engagement activities due to be delivered over the coming weeks.

It is recommended that the Board notes the results of the engagement activities so far; further notes the activities planned over the coming weeks and also commits to supporting those activities wherever possible.

Action:

☐ To receive
☒ To approve the recommendations

Recommendations:

1.	That the Board notes the results so far from the Engagement on the NHS Long Term Plan
2.	That the Board notes the further planned activities to drive Engagement on the Long Term Plan
3.	That the Board commits to promote and enhance those activities through their own organisations' networks and channels

Key implications considered in the report:

Financial	☐	
Value for Money	☐	
Risk	☒	The Engagement on the Long Term Plan and deployment of the System Narrative will help mitigate the risk that stakeholders feel uninformed or disengaged with proposed changes.
Legal	☐	
Workforce	☐	

Citizen engagement	☒	The Engagement will ensure that the voice of citizens, patients and staff is strongly reflected in the development of the local system response to the Long Term Plan
Clinical engagement	☒	The Engagement will ensure that the voice of citizens, patients and staff is strongly reflected in the development of the local system response to the Long Term Plan
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

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Update on NHS Long Term Plan Engagement and System Narrative

9 May 2019

Background

1. At the 15 February 2019 meeting of the ICS Board, two papers were presented and approved, outlining the approach to Engagement on the NHS Long Term Plan (LTP) and also setting out the "system narrative" – a proposed common description of the work of the ICS for use with various audiences.
2. The overall purpose of the Engagement for the Long Term Plan as outlined in the paper from February is to;
    a. Support the development of the system strategic plan due for publication in the Autumn through the production of insights and intelligence from patients, public and staff in Nottingham and Nottinghamshire.
    b. Ensure that the system strategic plan has widespread support when published through building confidence in the way that has been developed and tested with patients, public and staff.
3. The system narrative was approved in simple written form only at the February meeting along with a description of how it would be deployed. This deployment plan included;
    a. Digital content for websites and social media
    b. A set of standard slides and material for internal and external briefings
    c. Creation of a new visual identity
    d. A set of animations and videos explaining the work of the system
4. This paper updates on both of these pieces of work, in particular sharing the activities and results of the Engagement work and describing the ways in which the approved system narrative has been used since approval.

Activities to Date

5. The Engagement activities regarding the LTP commenced on 29 March 2019 and so far have included
    a. The launch of a new microsite website at https://nottswhatmatterstoyou.co.uk/ which introduces the Long Term Plan to a local audience and asks them to contribute to the development of the local system response through completing a short survey.
    b. Promotion of this website through the system's social media channels (Twitter and Facebook) and the CCG websites.
    c. Close working with Healthwatch as they also engage with the public to align activities and ensure that the same questions are used.
    d. Sharing of the promotional materials with system partners (NHS, Local Authority (including Councillors), VCS and others) for amplification through their own channels.
    e. Sharing of information about this activity with the Nottinghamshire Members of Parliament and inviting them to a briefing and discussion in Westminster.
    f. Promotion of the activity through press release and other media activity.

g. Significant levels of face-to-face engagement with the public delivered by the in-house and Healthwatch teams, including;
    i. Large local employers including Experian and EoN.
    ii. Blood Glucose testing of public for Diabetes Awareness Week including promotion of the survey.
    iii. Meeting with social groups including local "Community Gardens"
    iv. Discussions and promotions of survey at health interest groups and public forums across Nottinghamshire including: Hucknall Carers, Arnold Mental Health Drop-In, The Hive in Mansfield, outBurst in Nottingham and many others.
h. Initial stages of market research by Britain Thinks started in late April with in-depth at-home discussions and focus groups with patients to measure their attitude to and experience of the services provided in Nottinghamshire.

6. The system narrative has been used in the following ways to support the engagement activities;
    a. Overall approach and style used to inform the development of the survey questions and approach.
    b. Core language used to create copy for What Matters To You website
    c. Core language used to create copy for social media messages
    d. Tone, style and content used to inform press releases and media briefings
    e. Tone, style and content used to develop partner and stakeholder briefings including for MPs and Councillors.

Results to Date

7. The initial outputs from the Engagement activity are very encouraging with nearly 600 responses to the survey being captured. In summary;
    a. The campaign website has attracted 2,215 visitors and captured over 300 responses to the survey.
    b. The social media activity across 200 posts has reached 65,206 people and generated 170 clicks through to the website.
    c. Colleagues at Healthwatch have secured approximately 250 of their targeted 500 survey responses including a mixture of online and offline responses and reaching groups across all parts of the ICS area.
    d. System partners across the area have promoted the campaign through their channels and we have further activities planned (see below)
    e. Briefing and discussion with Members of Parliament confirmed for 14th May with nine out of the ten relevant MPs accepting the invitation.
    f. Media coverage has been secured in the Nottingham Post, Mansfield Chad and West Bridgford Wire.
8. The use of the System Narrative has enabled a coherent thread to run through all the activities and also helped to shape the choice of topics included in the survey. We will also use the initial insights secured to refine the narrative, in particular ensuring that the public's unprompted reflections on health and care services are included.

Insights Secured

9. Further detail is in the attached presentation, but in summary;
    a. Framing the local system strategy when published as protecting the free-at-the-point-of-need model and underpinning the contributions of and support for staff will maximise its chance of landing well with external audiences.
    b. There is support for the proposed top three priorities but describing the strategy solely through the lens of financial efficiency would risk it being received poorly.
    c. Workforce is a critically important theme that needs to be front and centre.
    d. There is less support for digital transformation – will need to consider the use of persuasion tactics on this theme and ensure that it isn't seen as being about reducing access but instead about "joining up".
    e. There is some support for the prevention agenda but needs to be balanced with messages around treatment improvements too and reassurance around effectiveness.
    f. Patients like the idea of being in control of their health but want professional medical guidance to underpin that too.

Forward Schedule of Activities

10. The promotion of the Engagement was reduced in volume and intensity in the run up to the local elections in order to respect the pre-election period but will recommence after 2 May 2019.
11. The activities planned over the coming period include;
    a. Further Britain Thinks focus groups and in-depth interviews in early May
    b. Launch of further campaign theme on digital including promotion of the piloting of the NHS App in Nottinghamshire
    c. Meeting with MPs in Westminster 14th May
    d. Completion of the Healthwatch engagement, securing a further 250 responses
    e. Specific sessions with Councillors from the City and County Councils – details tbc
    f. Targeted media activity with Nottingham Post and Mansfield Chad landing the campaign's key messages
    g. Activity planned over May and June to target communities who are seldom heard or do not traditionally engage with us;
        i. Deaf community
        ii. People who are LGBT+
        iii. People with a Learning Disability
        iv. Carers
        v. Students
        vi. Men 20-40

Recommendations

12. That the Board notes the results so far from the Engagement on the NHS Long Term Plan

13. That the Board notes the further planned activities to drive Engagement on the Long Term Plan
14. That the Board commits to promote and enhance those activities through their own organisations' networks and channels

Alex Ball
Director of Communications and Engagement
29 April 2019

Integrated Care System
Nottingham & Nottinghamshire

ICS Board, 9 May 2019
Item 9, Enc. F2

Long Term Plan Engagement and System Narrative – Update

9 May 2019

Integrated Care System
Nottingham & Nottinghamshire

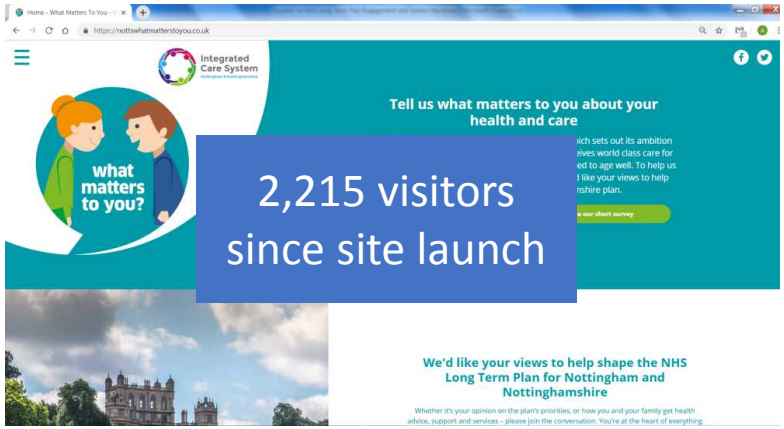
Context – Why

- Engagement on Long Term Plan
  - Generate insights and intelligence
  - Build confidence in the local plan when published

- System Narrative
  - Align around one articulation of our purpose
  - Support communication of this through the system and externally

Integrated Care System
Nottingham & Nottinghamshire

Engagement Activities



2,215 visitors since site launch

Social media activity has reached 65,206 people

Face-to-face events in communities

Media coverage includes website URL

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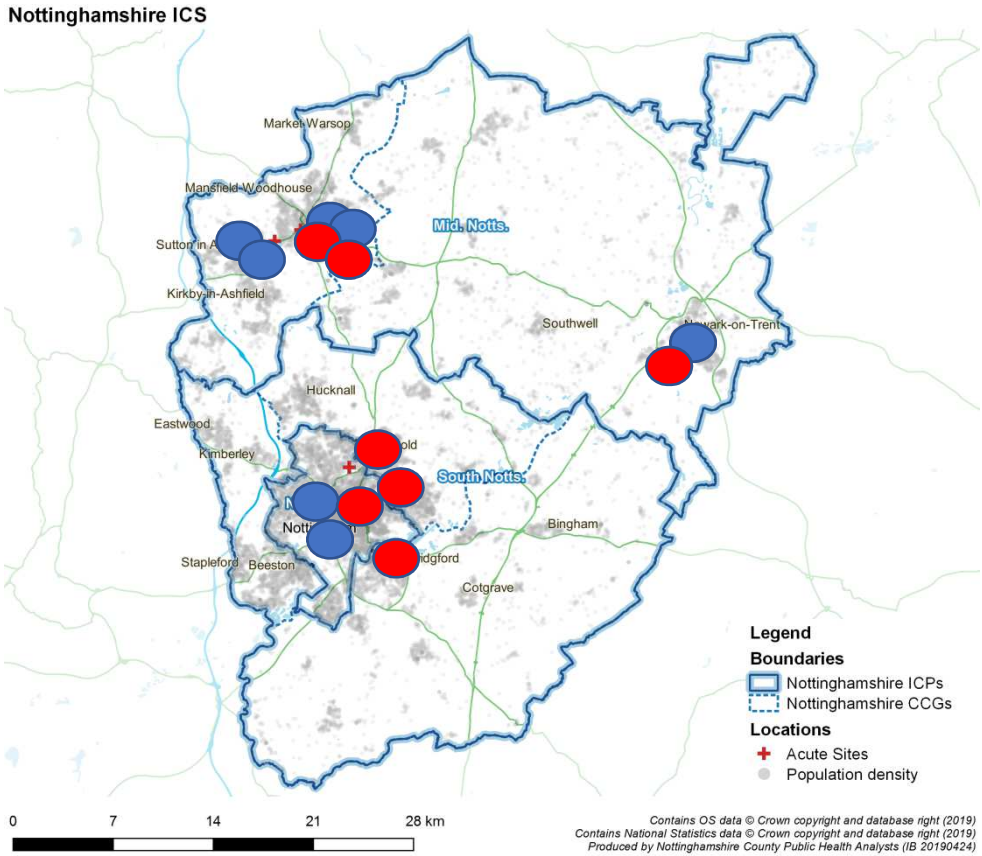
Engagement Activities

- Face-to-face engagement targeted across the patch
- Good geographic coverage, with deprived communities targeted across the footprint.

Key

= ICS Comms Team

= Healthwatch



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Use of Narrative

System narrative used to create copy for website and to shape the questions for the survey as well as being reflected in the social media posts and other materials.

However, with great improvements come new challenges.

While you are now living longer, many of these additional years are not being lived in good health and the challenges are not evenly spread across the local population. For example, if you are born in Ruddington today, you can expect 72 years of good health; but if you are born in Bilborough, you can expect just 52. We want to change that.

Take our short survey

As a health and care system, we are working to improve those additional years, enabling everyone to live a longer, happier, healthier and more independent life into their old age.

We aim to achieve this with better local access to health and care services, and a greater focus on the prevention of illnesses, not just the treatment. After all, prevention is better than cure.

As one of the first areas in the country to develop an Integrated Care System (ICS), Nottingham and Nottinghamshire is bringing our local NHS, councils and voluntary sector together.

We are combining healthcare and other services to look after you within your home and local community.

Being part of a combined health and social care system we have greater freedom to manage local services, to spend money on health and care, and to invest in what we know works.

Please tell us how important each of the following are to you

	Not important at all	Not very important	Neither unimportant or important	Important	Very important
Preventing ill health - More action on the things that create poor health such as smoking, alcohol and unhealthy eating	○	○	○	○	○
Children and young people's health - More action on services for children and young people including mental health services, maternity services and treating illnesses	○	○	○	○	○
Major health conditions - Better care for the major health conditions in our society such as cancer, diabetes and stroke - for example faster diagnosis and better treatment	○	○	○	○	○
Supporting our workforce - Making sure we have the right number of doctors, nurses and social care workers in the right places and that they have the right skills to provide what people need	○	○	○	○	○
Digital innovation in healthcare - Using things like Skype for appointments to help you get better access to your GP	○	○	○	○	○

The intelligence from the initial insights and responses is already being used to refine the narrative – in particular reflecting the unprompted priorities from the public.

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Initial Insights

- Analysis based on 300 responses (at 26/4), not yet representative of overall population.
- Detailed focus groups delivered by Britain Thinks in April and May and Healthwatch on track to secure 500 additional responses.
- Full and combined results across all sources to be shared later in the summer – targeting 1000 total responses, 4x focus groups and 36x in-depth interviews.

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Valuing Health and Care

When asked what they most valued about the NHS, respondents clearly indicated that the universal access followed model of care, free at the point of use was the most important thing, closely followed by the staff themselves.

What do you think is the best thing about the NHS?	
Free At The Point of Use	60%
Access to Services	28%
Helpful, Dedicated, Compassionate Staff	24%
High Standard of Care	11%

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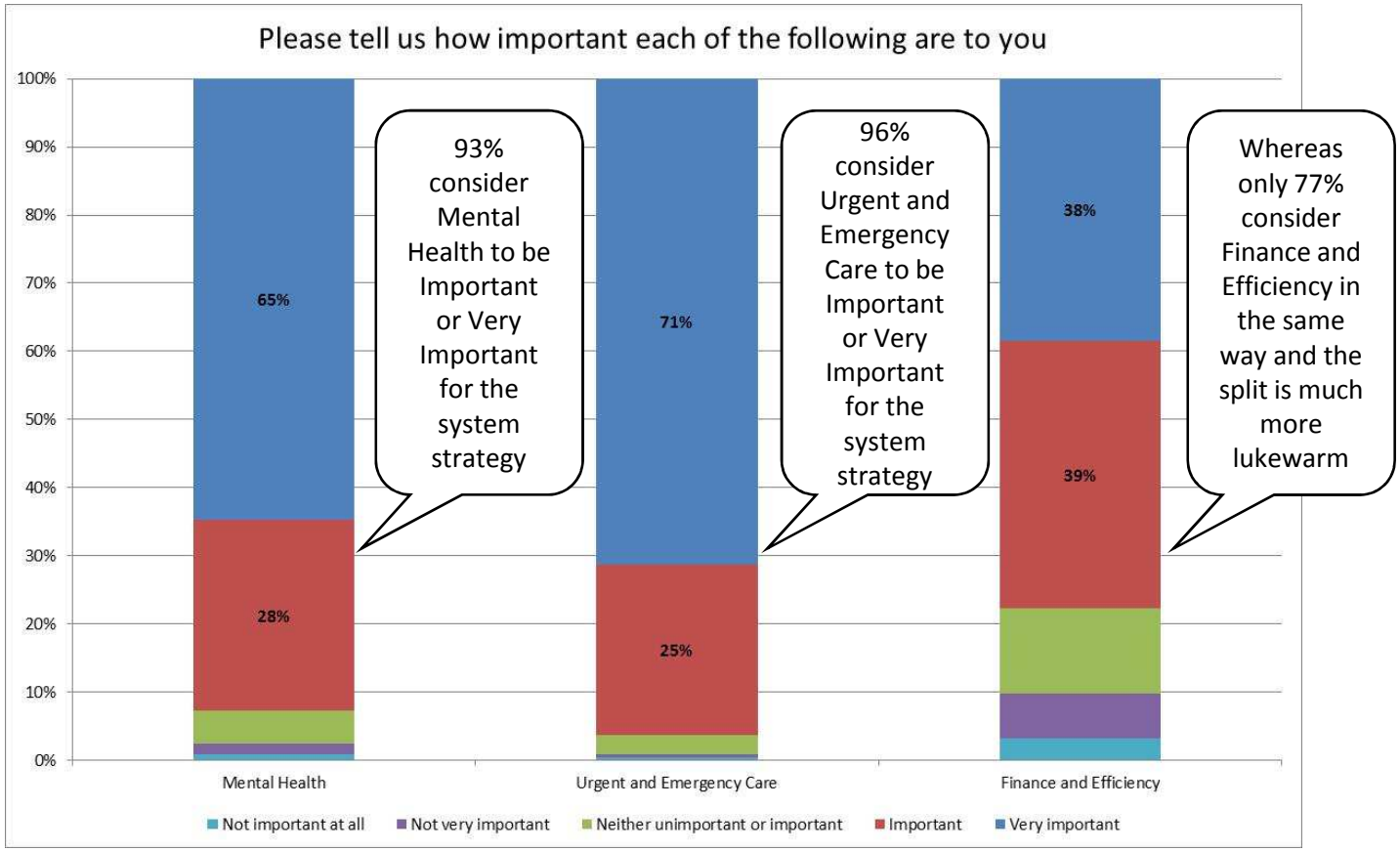
Our Top Priorities

Overwhelming support for our proposed top priorities of Mental Health and Urgent and Emergency Care.

Less strong support for a focus on Financial matters.



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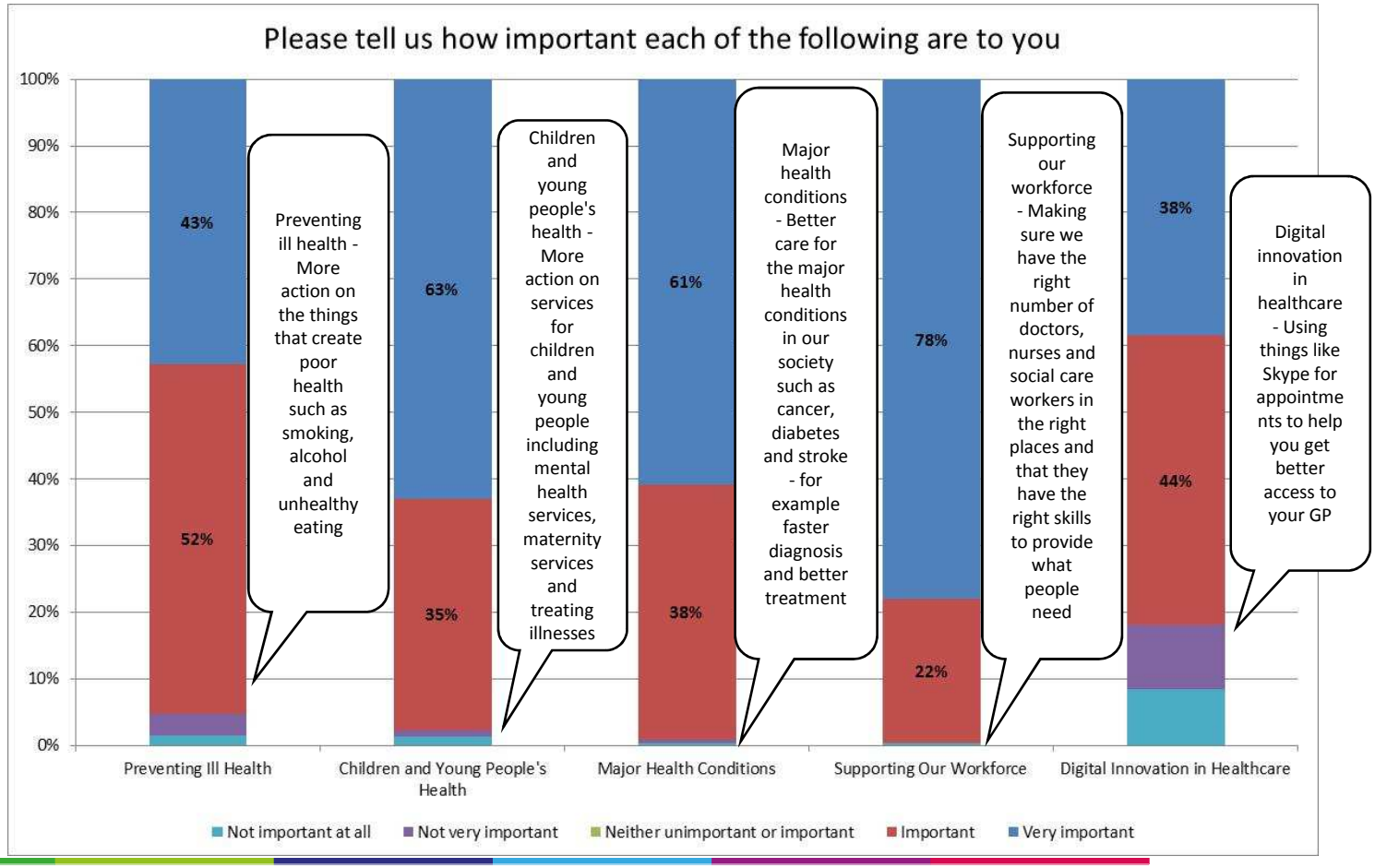
Our Next Priorities

Unanimous support for workforce, along with improvements for major conditions. Strong support also for focussing on children and young people. Slightly less support for work on prevention and much less enthusiasm for digital investment.



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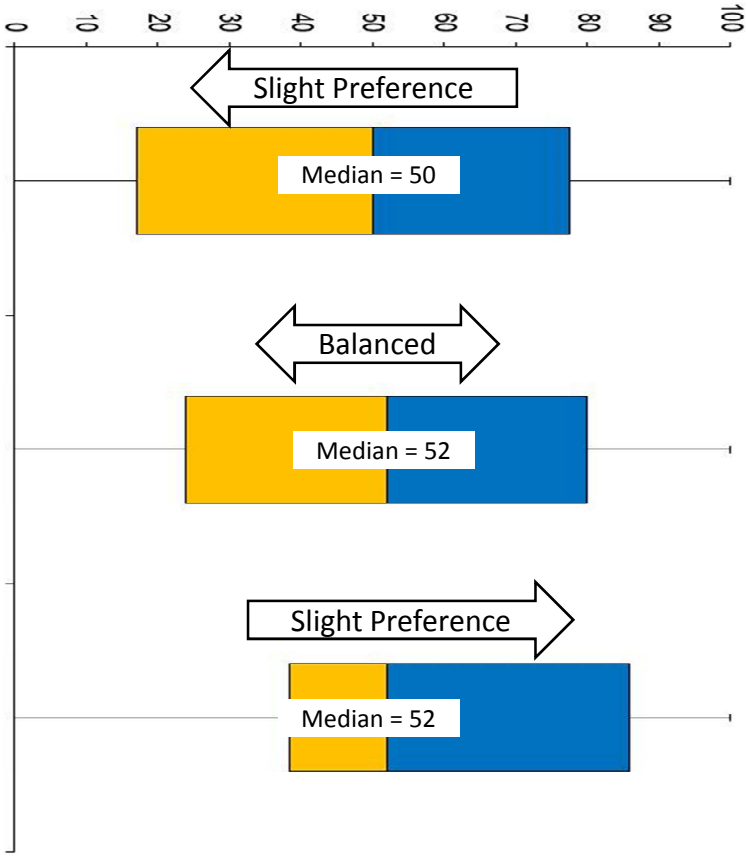
Tradeoffs

Asked to consider hypothetical tradeoffs, respondents indicate a preference for Prevention, but tempered with ensuring appropriate Treatment are available too and a need for professional clinical guidance to enable control of their own care. They also continued the theme of being wary of moving too fast on digital transformation.

Preventing people becoming ill – Keeping people fit and well so they are less likely to become ill



Treating people when they become ill – Making sure that people who become ill have the best possible treatment

Choice and control – Letting people manage their own health and wellbeing and choice of treatment

The best possible care and treatment without having to choose – Doctors and other health professionals deciding what is best for people and making sure it is provided

Investing in digital technology for healthcare – Using things like Skype for appointments to help people get better access to their GP

Investing in buildings and equipment for healthcare – Investing in the buildings and equipment used at locations where people go to for urgent healthcare

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Focus Groups

- When asked for three words or phrases to describe the state of the health and care system locally, responses included: *helpful*, *trustworthy* and *efficient.* However, *slow* and *stretched* are also mentioned
- For the most part, participants are extremely satisfied with the care they receive, particularly when thinking about specialists and consultants.
- But there are also significant concerns about access and waiting times including A+E waiting times, access to GPs, referral times and cancelled appointments – largely they attribute these to there not being enough doctors and nurses.

  - Other concerns mentioned include: Feeling that care is not joined up, with some feeling that they are bounced back and forth between specialists and their GP – and wish that they could be referred directly from one specialist to another without having to go back to their GP.

  - These frustrations are exacerbated by IT failures, notes not being transferred and long referral times

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Focus Groups

- When considering areas in which they would like to see improvement most focus on access to services and waiting times, with increasing the number of staff seen as the best way to do this. Importantly, few spontaneously mention other solutions as ways of reducing strain on services / waiting times (e.g. investment in prevention, digital services, more care in the community).

  - When prompted on prevention and digital services, there is little appetite to see greater investment in these areas – digital services are seen by many as a way of depriving them of valuable face to face time with a doctor.

  - Many are sceptical about the impact of prevention initiatives, feeling that others won't pay attention to them.

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Summary

- Framing the local system strategy when published as protecting the free-at-the-point-of-need model and underpinning the contributions of and support for staff will maximise its chance of landing well with external audiences.
- There is support for the proposed top three priorities but describing the strategy solely through the lens of financial efficiency would risk it being received poorly.
- Workforce is a critically important theme that needs to be front and centre.
- There is less support for digital transformation – will need to consider the use of persuasion tactics on this theme and ensure that it isn't seen as being about reducing access but instead about "joining up".
- There is some support for the prevention agenda but this needs to be balanced with messages around treatment improvements too and reassurance around effectiveness.
- Patients like the idea of being in control of their health but want professional medical guidance to underpin that too.

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Forthcoming Activities

- Further Britain Thinks focus groups and in-depth interviews in May and June.
- Launch of further campaign theme on digital including promotion of the piloting of the NHS App in Nottinghamshire.
- Meeting with MPs in Westminster 14th May.
- Completion of the Healthwatch engagement, securing a total of 500 responses.
- Specific sessions with Councillors from the City and County Councils – details tbc.
- Targeted media activity with Nottingham Post and Mansfield Chad promoting the engagement survey.
- Further face-to-face activities over May and June to target communities who are seldom heard or do not traditionally engage with us including: Deaf community, people who are LGBT+, people with a Learning Disability, carers, students, men 20-40.

ENC. G

Meeting:	ICS Board
Report Title:	Developing the roles and functions at ICS, ICP and PCN level
Date of meeting:	Thursday 9 May 2019
Agenda Item Number:	10.
Work-stream SRO:	Wendy Saviour
Report Author:	Deborah Jaines
Attachments/Appendices:	Annex A – System objectives, principles and behaviours Annex B – Summary of functions across the system Annex C – Extracts from NHS Long Term Plan

Report Summary:

A meeting of the system architecture working group (with extended membership of additional clinicians) was held on 20 March 2019 to further consider the development of the roles and functions for the Nottinghamshire ICS, ICPs and PCNs.

This paper:

- reminds the board of a consistent set of operating principles (already agreed on 15 February 2019),
- re-presents the Deloitte functions and
- proposes operating behaviours for the ICS, ICPs and PCNs.

Action:

☐ To receive
☒ To approve the recommendations

Recommendations:

1.	Endorse section 10 as an agreed description of how each part of the new system will relate to one another (the 'Operating Behaviours')
2.	Agree to receive a future report (section 6) on how relationships are working out in practice and how provider partnerships are overcoming potential inconsistencies of approach.
3.	Ensure that the organisations they represent use Annex B as the basis for the establishment of the ICPs and PCNs

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:	
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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Developing the roles and functions at ICS, ICP and PCN levels

9 May 2019

Introduction

1. On 15 February 2019, the **ICS Board agreed** the **principles** (Annex A) that all of the ICPs should work within and agreed that a workshop would be facilitated to ensure common understanding of what these might mean in practice. These principles have not changed. They are re-presented in this paper for ease of reference.

2. A workshop was held on 20 March as an extended meeting of the system architecture group to ensure that all organisations were represented at a senior level. This workshop considered the principles in Annex A and how these might be operationalised.

3. The model in **Figure 1** (below) was used to frame the discussion. The model in **Figure 2** has been developed as a high level worked example in relation to musculo-skeletal services.

Figure 1

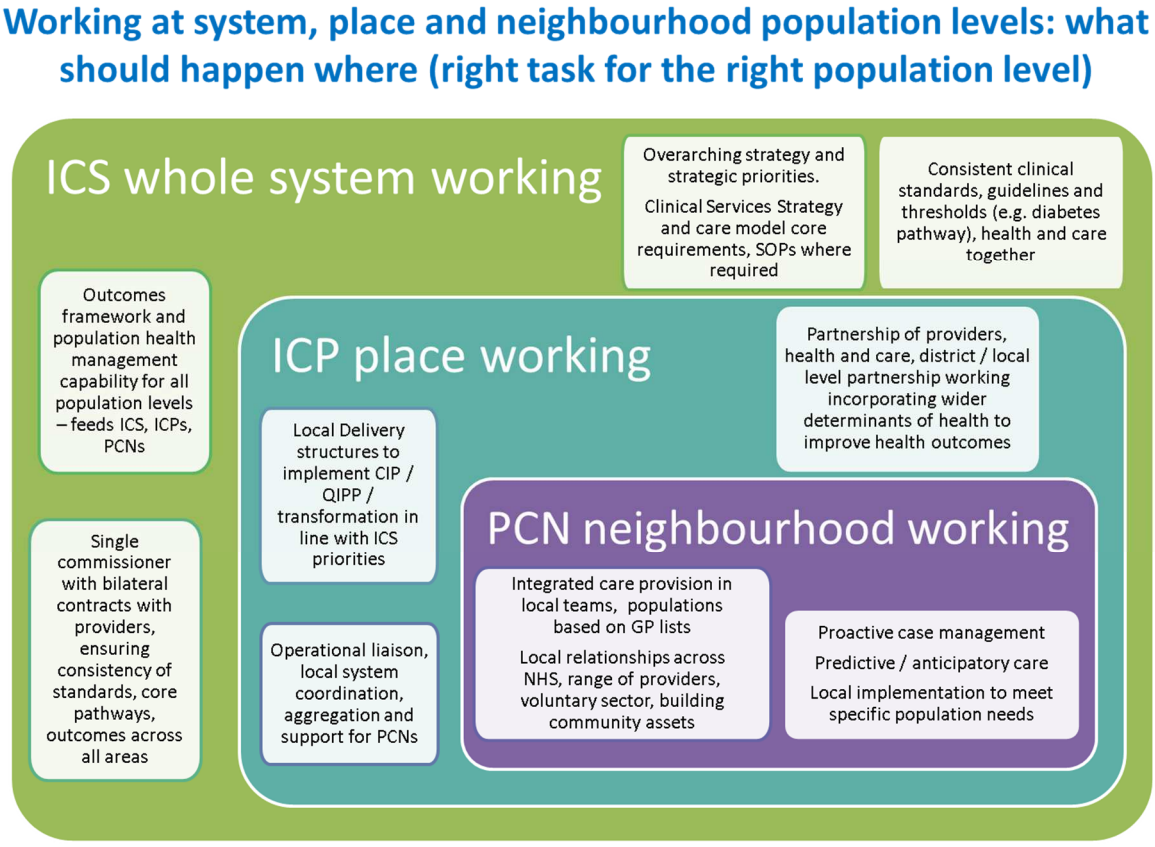
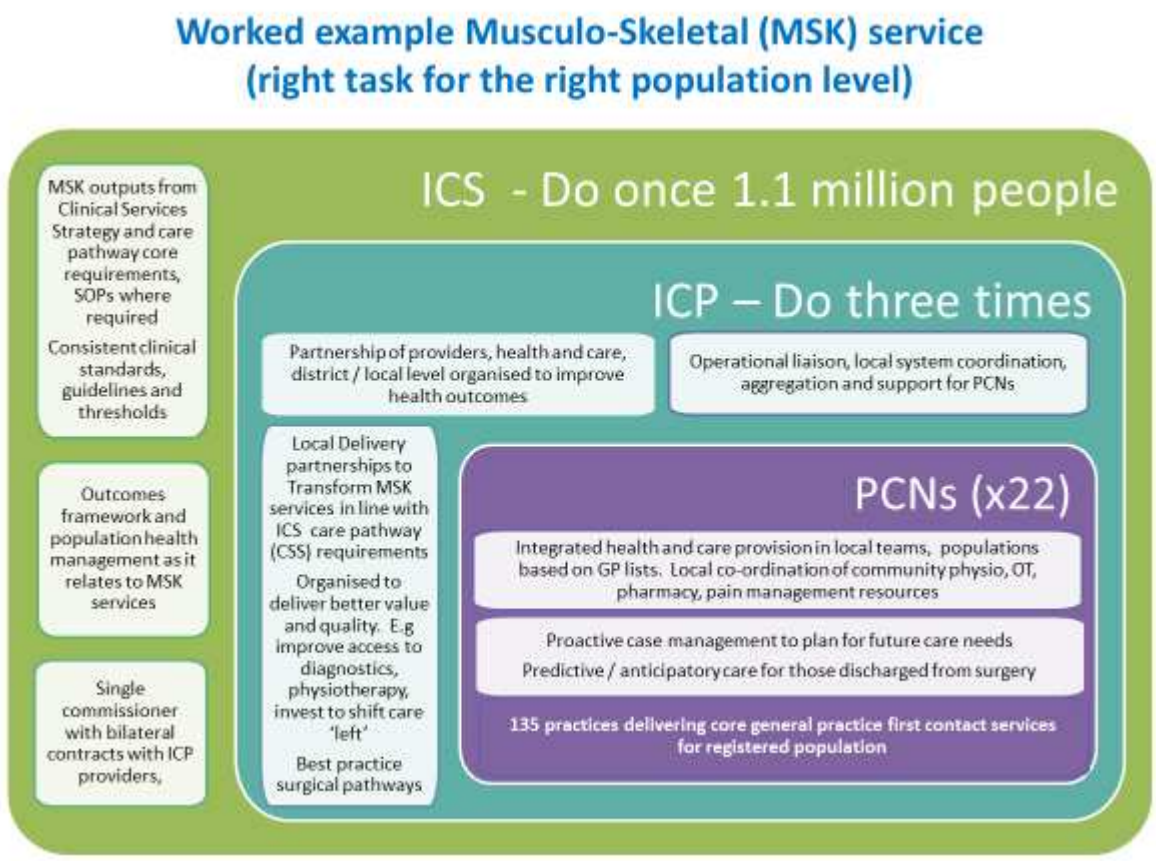


Figure 2



Discussion – what does each part of the system DO?

4. Annex B uses the Deloitte 'What happens where' model matched with the more detailed glossary (also provided by Deloitte) and is presented as an 'operating model' for each part of the system.

5. The respective contribution of system partners is starting to become clearer as the discussions about the establishment of ICPs and PCNs are taking place. However, for partners that will participate in more than one ICP and PCN, some concerns remain regarding possible duplication and inconsistency of approach.

6. There was recognition that the current model will remain incomplete until the PCNs and ICPs become operational as we need the operational experience of the new ways of working before it is possible to reflect upon and refine the arrangements for how we currently think things should work out. However, it would be helpful if the PCNs and ICPs could formally feedback where arrangements are not progressing as anticipated. A future report to the ICS Board could help in this regard.

7. Annex B shows what each part of the system will need to do and a more detailed description of this function. It shows where parts of the new system will need to work together to achieve the functional objectives.

8. Since the Deloitte work was undertaken, the Long Term plan has been published and the extracts relevant to the functioning of the ICS and its constituent parts are set out in Annex C.

9. Annexes B and C describe what the respective parts of the architecture will focus on.

Discussion – How does each part of the system RELATE to one another? (Operating Behaviours)

10. The output of the workshop on 20 March resulted in consideration of the principles and of the ways in which different parts of the system should relate to each other. The Board is asked to **ENDORSE** these:

The new system:

- Is a collaboration of equal partners working to (ICS) system objectives
- Will ensure cultural change through removing blocks to integrated care
- Will exploit opportunities to optimise existing single public estate/community assets

ICPs:

- Will undertake integrated provision and coordination of care, holding a clear contract value for what the providers are commissioned to deliver. This may result in ultimately moving towards capitated budgets in accordance with national policy intentions.
- Are an aggregation of Primary Care Networks (PCNs) and all other services that support health and wellbeing in a place
- Observe the overriding principle of equity of access to universal and targeted services to address health and wellbeing.
- Collaborate with other ICPs in the ICS to ensure consistency of entry and exit points for patients using the services of providers who are partners with more than one ICP. Key mechanisms for doing this will be;
    - The single Greater Nottinghamshire Transformation Steering Group currently being established will work across the whole of Greater Nottinghamshire to agree common pathways for redesign of services and common approaches to QIPP/CIP to ensure financial sustainability.
    - The single Greater Nottinghamshire A&E Delivery Board will remain the overarching vehicle for the oversight and re-design of the urgent care pathway in the City and South Nottinghamshire and will serve both ICPs – representation may need to be looked at to accommodate this. This will ensure consistency for the whole urgent care pathway.
    - The ICS-wide Clinical Services Strategy will develop clinical pathways for a range of specialties at an ICS level. As such, all 3 ICPs will be

expected to work to these pathways in order to secure improvements in outcomes for citizens.

- Meet jointly on a regular basis (e.g. every two months) with all constituent partners so that any issues of concern for provider partners regarding consistency or duplication can be discussed and worked through

- Have 'fit for purpose' governance and assurance arrangements in place
- Are governed via "articles of association" or memorandum of understanding
- Provide functions best realised at place level (e.g. business intelligence, workforce planning….)
- Promote cultural change ('Can do', not 'Can't do')
- Shift the emphasis of all constituent partners towards supporting self-care, prevention and proactive intervention
- Have a system transformation plan that is built in response to the single ICS strategy and outcomes framework
- Are able to develop a risk and reward sharing framework expressed through a system (ICS wide) control total
- Partners share responsibility for health and wellbeing, access, performance and financial performance of the ICP contract
- Ensure an open book approach to QIPP and FIP delivery, with enhancements relating financial efficiency to "best for population" health and wellbeing outcomes
- May seek to merge some teams into a single leadership structure where this reduces the constraints of optimal flexibility for patient care.

PCNs:

- Will work together and with other local health and care providers, around natural local communities to provide coordinated care through integrated teams
- Will offer a universal service to their patient population of 30,000-50,000
- Work with others to provide care in different ways to match different people's needs, including: flexible access to advice and support for 'healthier' sections of the population, and joined up multidisciplinary care for those with more complex conditions
- Work with others to focus on prevention and personalised care, supporting patients to make informed decisions about their care and look after their own health, by connecting them with the full range of statutory and voluntary services
- Will collaborate with other PCNs in the ICP area and with other providers to play their part in delivery of the ICP transformation plan, and ultimately the single ICS strategy and outcomes framework
- Will collaborate with other PCNs in the ICP area and with other providers to play their part in delivery of the overall ICP contract value and financial balance

Recommendations

11. The ICS Board are recommended to:

- Endorse section 10 as an agreed description of how each part of the new system will relate to one another (the 'Operating Behaviours')
- Agree to receive a future report (section 6) on how relationships are working out in practice and how provider partnerships are overcoming potential inconsistencies of approach.
- Ensure that the organisations they represent use Annex B as the basis for the establishment of the ICPs and PCNs

Annex A

SYSTEM OBJECTIVES, PRINCIPLES AND BEHAVIOURS

Overview

1. To provide a financial, governance and contractual framework that delivers the Commissioning Outcomes so to be able to meet demand from changing levels of need, changing funding levels, new legislation and/or policy imperatives by:
    - ensuring health and care system sustainability through reduced system cost whilst maintaining appropriate quality and Service User safety
    - securing best value for the public sector budget in terms of outcomes per pound spent
    - ensuring that integrated health and care services are delivered coherently and that fragmentation of service delivery is minimised by reducing organisational, professional and service boundaries
    - directing resources to the right place in order to adequately and sustainably fund the right care for improved patient outcomes
    - incentivising the achievement of positive outcomes for the benefit of the population's health and wellbeing
    - supporting the process of transition to new care, support and well-being models delivering improved outcomes for Service Users
    - protecting and promoting Service User choice.

Objectives

- improved outcomes for Service Users;
- seamless Service User journey/experience irrespective of their care needs (i.e. health or social care);
- health and care services that are accessible;
- health and care services are local where appropriate;
- health and care services place a focus on prevention
- health and care system sustainability through reduced system cost and
- and in doing all of the above) to protect and promote choice.

2. ICPs acknowledge and accept that the ICS Board may seek to shift activity and service specifications under the respective Services Contracts in order to achieve the Objectives.

Best for Service Decision Making

3. We know that we will have to make decisions together in order for Our ICS/ICPs to work effectively. We agree that we will always work together and make decisions on a Best for Service basis in order to achieve the ICS Objectives and the Outcomes, unless any one of the Reserved Matters listed applies (e.g. statutory duties).

4. We shall support each other to achieve compliance with each of our statutory responsibilities. Accordingly, nothing in this Agreement will require any of us to do anything which is in breach of Our legal obligations (including procurement and competition law) or which breaches any regulatory or provider licence requirements.

Principles and Behaviours

5. In striving to achieve the ICS Objectives and the Outcomes, We have committed to the following principles and behaviours:

6. *Principles*

Our agreed ' **Principles**' are that:

- We shall encourage cooperative behaviour between ourselves and engender a culture of "Best for Service" including no fault, no blame and no disputes where practically possible
- We shall seek to ensure that sufficient resources are available, including appropriately qualified staff who are authorised to fulfil the responsibilities as allocated
- We shall assume joint responsibility for the achievement of the Outcomes
- We commit to the principle of collective responsibility and to share the risks and rewards (in the manner to be determined as part of the agreed “transition arrangements) associated with the performance of the ICS Objectives
- Our activities shall adhere to statutory requirements and best practice by complying with applicable laws and standards including EU procurement rules, EU and UK competition rules, data protection and freedom of information legislation; and
- We agree to work together on a transparent basis (for example, open book accounting where possible) subject to compliance with all applicable laws, particularly competition law, and agreed information sharing protocols and ethical walls.

7. *Behaviours*

Our agreed ' **Behaviours**' are that:

- We shall collaborate and co-operate by establishing and adhering to the necessary governance arrangements
- We shall be accountable by taking on, managing and accounting to each other for the performance of Our respective roles and responsibilities
- We shall be open and communicate openly about major concerns, issues or opportunities relating to the delivery and the achievement of the Outcomes

- We shall learn, develop and seek to achieve full potential by sharing appropriate information, experience and knowledge so as to learn from each other and to develop effective working practices
- We shall work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost
- We shall adopt a positive outlook by behaving in a positive, proactive manner
- We shall act in a timely manner by recognising the time-critical nature of the Delivery plans and respond accordingly to requests for support
- We shall act in good faith to support achievement of the Outcomes and compliance with the agreed Principles; and
- We shall work together as a single, integrated high performance team ('one system, one budget') and make decisions to achieve the Outcomes.

8. Over the life of the ICP, the actual provision of Services will alter on the basis of the most effective utilisation of staff, premises and other resources (in terms of cost and quality) and whilst there will be co-operation between Us as to the design of care models this will not:
    - preclude competition between Us in respect of service provision as is needed to achieve the Commissioning Objectives and which will be reflected in the Services Contracts and changes to those Services Contracts; or
    - restrict the Commissioner statutory obligations including obligations under
    - procurement law to contract with provider(s) most capable of meeting the
    - Commissioning requirements, and obligations under Legislation (for example, the Public Contract Regulations 2015 and the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013).

ANNEX B

ICS Board Sets outcomes, Develops Strategy, Oversight, Standardisation *Improves health and social care outcomes by integrated commissioners. Rewarding outcomes rather than inputs.*					
	Strategic Commissioner *Develops the commissioning strategy through a needs-based assessment, holds the outcome based contract, and holds providers to account to deliver on the vision and outcomes.*				
		Integrated Care Providers *Reduce unwarranted variation in outcomes by aligning priorities, pooling resources recognising different local needs and starting points*			
			Primary care Networks *Align with overarching system vision. Maintain and improve population health by providing integrated health and social care services as part of a wider care network*		
ICS Board	Strategic Commissioner	ICP	PCN	**Headline Function**	**Activities**
				Vision and Outcomes setting	Identifying and communicating a compelling vision that health and care commissioners and providers share, and work towards Setting outcomes informed by evidence-based needs analysis and equity considerations Developing outcomes frameworks, co-designed with citizens, reflecting all national outcomes framework requirements and constitutional standards, and communicate expected outcomes as part of public engagement
				Strategic Quality assurance	Identifying and developing meaningful metrics for monitoring processes and outcomes Collecting, analysing and presenting these metrics for evaluation at regular intervals against a set of jointly agreed process, intermediate outcome, and outcome measures that the ICPs are held to account for
				Provider resilience and failure	Working pro-actively to support distressed providers to avoid un-planned provider failure, whilst simultaneously stimulating and encouraging development of a plural market Developing sustainability benchmarks along financial/safety of care domains; use benchmarks to track providers Designing and implementing mechanisms to manage any provider failure in cooperation with national bodies
				Capital and investment strategy	Developing framework for assessing capital and investment bids (including e.g. guidance on business case development) to help prioritise areas that are in line and support delivery of system-wide outcomes For capital schemes requiring external funding, evaluating bids for and monitoring to ensure delivery of ROI

				Regulatory Liaison and duties	Developing relationships with regulators Providing the link between the regulators and the system, supporting an regulatory intervention
				Regular public outcome reporting	Publication on a regular basis of general performance reports (e.g. annual reports) and specific initiative reports (e.g. STP or 5 year strategy documents) Ongoing publication of updates towards specified outcomes, based on agreed metrics
				Political engagement	Political engagement on issues related to health and population needs on a local, regional, and national level Where resources are pooled or working together, increased engagement with local authority and council agendas to reflect mutual interest in provision decisions
				Clinical and professional engagement	Developing and maintaining positive working relationships with clinicians and care professions Providing mechanisms (e.g. 'committees in common') for clinicians and care professions to be represented in the process of agreeing overall commissioning strategy
				Public and community engagement	Developing overarching community and population-wide engagement strategy Building relationships across the community with community leaders and asset stakeholders Engaging proactively through community campaigns to build positive interactions Supporting NHS workforce as members of the local community
				Provider relationship management	Developing and maintaining positive bilateral working relationships with local providers Provide mechanisms for providers to be represented in the process of agreeing overall commissioning strategy
				Strategic partnership management	Developing relationships with wider partners, for example with industry, academia, and neighbouring geographies
				Performance review and delivery	Delivery and monitoring of ICS accountability and performance framework
				Financial framework and system financial plan	Developing strategic system financial planning framework Establishing system financial plan
				Strategic system planning	Developing strategic system planning framework
				Health and care needs assessment	Collating, synthesising and analysing information about a population's underlying health status and needs Identifying priority areas for future intervention, through a Joint Strategic Needs Assessment (JSNA) or similar Updating assessment regularly to reflect any changes to local circumstances

				Service specification and standards	Identifying and agreeing a set of service standards relating to specific service domains and might include e.g. workforce requirements, quality expectations, access considerations, etc. Regular review of standards and updating them where appropriate and in line with national and international best practice and constitutional standards
				Decommissioning policy	Formulating the de-commissioning policy and service benefit review process to ensure best value and evidence based practice, including developing criteria, governance and processes around a consistent process of communication and change management to identify low-value and/or low-priority interventions Identifying and regularly reviewing and updating a list of interventions that do not meet the set minimum criteria and should therefore not be undertaken or delivered ("Restricted Procedures")
				Population health management data	Aggregating, presenting, assuring quality and analysing service user level data from health and care providers to enable the assessment of population-level health trends and needs Deploying robust mechanisms to protect service user confidentiality and the underlying service user level data
				Predictive modelling and trend analysis	Developing sophisticated forecasting models to understand the specific demand for health and care of a population and identify the implications of possible future scenarios Use predictive analytical modelling to accurately commission services, according to future demand and needs
				Information governance	Establishing structures that are compliant with national guidelines for good data governance Monitoring structures and governance systems to ensure continued compliance Using best practice to improve structures on an ongoing basis
				System incentive alignment	Development of new payment models to ensure that financial incentives are appropriately aligned to deliver best outcomes, and encourage providers to optimise their own cost base Establishing mechanisms for addressing any identified legacy incentives that are now counterproductive Continuing to review and update incentives where needed (e.g. for changes in key metrics)
				Strategic market shaping	Collecting and analysing data on provider stability to enable oversight of the 'health' of the market Proactively engage with and manage market elements to ensure a sustainable and vibrant provider market, including market stimulation, being mindful of broader collaboration, competition and choice rules in health care
				Horizon scanning	Exploring novel and unexpected issues as well as persistent problems and trends, including actively seeking out evidence-based best practice for proven new ways of working and matters at the margins of current thinking that challenge past assumptions in a comprehensive, structured and iterative way
				Tendering and procurement	Drafting of tender documents and engaging with potential providers to test and refine tender document Managing and evaluating bids against set of criteria to ensure procurement objectives are met Monitoring and managing vendor relationships and address potential conflicts or issues

				Contract design	Designing guidance on developing contract documents and processes using best practice methods
				Financial planning and management	Allocating funding to reflect priorities of the region Financial planning ranges from provider support and monitoring to need-based local-area projections
				Statutory reporting	Collating data gathered by providers relating to key provider metrics relating to performance and quality, including compliance with NHS constitutional standards Submitting as required in alignment with statutory reporting requirements to NHS regulatory bodies. Some of these organisations will aggregate and publish this information
				Performance review and management	Managing and tracking individual and aggregate performance against metrics, commissioner-level priorities, or compliance with national targets, in the specific context of future / ongoing procurement decisions Reporting findings (where required) to national bodies and / or in publicly available reports Use findings during annual review processes and commissioning procurement cycles
				Communications and consultation	Creating and implementing overarching regional communications strategy in order to build buy-in among stakeholders and convey shifting internal and external priorities to internal and external parties, including staff and service users Statutory consultation for major service reconfigurations
				Population level data integration	Linking and analysing service user level and population level data to understand specific demand for health and care services Identifying trends in the analysis, which may focus on a particular illness, pathway or population
				Risk profiling and stratification	Analysing service user data and trends to identify patterns in behaviour, such as unplanned admissions to acute services, that impact demand on local services, and assessment against national directives Building risk profiles and a stratification of population groups to understand their propensity to use services
				Integrated pathway design	Reviewing existing pathway to understand challenges and gaps Integrating provision and increasing collaboration across providers to reduce hand-offs and duplication Using pathway redesign best practice to inform approach to reviewing other existing pathways and developing new systems as necessary
				Cross care setting engagement	Developing links between provider organisations that serve the same service user pathway Identifying of gaps in pathway and integrating across care settings
				Service design	Planning and implementing specific health and care services which requires a clear understanding of the service user group targeted by the service and should be developed together with service users in a collaborative way Developing and testing of clinical protocols to ensure practicality and feasibility
				Service evaluation	Measuring of current service to assess current care and produce information to inform delivery of better care

					Iterative monitoring of service outcomes, against agreed criteria. Undertake evidence-based reviews of key services, using a risk-prioritisation approach, and enact appropriate steps to ensure best value high quality care
				Community based assets identification and integration	Identifying assets (including physical assets, third sector value, community activation, and social care and support) that can support community-based care for mental and physical health Determining metrics to evaluate scale, scope, and quality of currently and future provision utilising the assets Where the assets identified meet a provision need, integrate assets into the broader provision strategy
				Service and care coordination	Negotiating clear provider accountability for different elements of service user care between different service and care providers; communicating with providers and facilitating transitions between care settings; co-creating a plan of care; monitoring of service user journey; aligning resources with service user and population needs
				Case management	Assessing, monitoring, planning and linking individual service users with relevant services to manage and prevent illness Communicating with service users and different provider organisations to ensure smooth service user journey
				Demand management	Projecting demand for services to anticipate and manage required level of provision across time Identifying opportunities to alter the demand profile; and proactively shift service users and care activities into the most appropriate settings
				Referral management	Developing and operating an effective and streamlined approach to managing, completing, directing and monitoring referrals, based on uniform referral guidelines; Communicating with service users and providers to ensure a smooth transfer of care for service users between different service and care providers
				Transfer planning and management	Developing transfer plans most appropriate to the individual service user, including hospital discharge plans as soon and as safely as possible to minimise delays Engaging with case managers and other care providers in the pathway to identify future needs and services
				Workforce planning	Assessing implications of future demand for care on demand for workforce; predicting future need for various workforce groups; and evaluating gap between workforce demand and supply Developing options for addressing workforce gap regionally including identification of proposals to re-deploy and / or up-skill existing workforce across the system
				Joint role design	Designing job roles that seek to improve cross-service working and system integration, such as care coordinators Designing and streamlining role descriptions for staff across the system including e.g. developing shared job specifications across providers
				Training teaching and supervision	Setting consistent expectations of training and development for all staff groups Developing training and development pathways and curriculums for all staff groups Delivering ongoing workforce training and education including statutory training (in-house or outsourced)
				Health improvement	Identifying and delivering relevant health improvement advice to individual service users at all points of care ('Making Every Contact Count') Empowering service users to take greater control over their health through instruction on the self-care options available to them

				Digitally enabled care delivery	Identifying opportunities for digital care delivery across all pathways, care settings and interventions Developing, piloting and scaling up value-adding digitally enabled care elements to increase quality, reduce pressures on workforces and costs (e.g. using Robotics Process Automation to support clinical coding activities; Machine Learning and Artificial Intelligence technologies to support triaging of elective patients)
				Integrated shared care records	Assessing current state care records systems across providers Evaluating areas of potential alignment between care systems to support interoperability Identifying EHR system provider; securing investment in and coordinating roll-out of software across ICS
				Realtime, integrated utilisation data	Developing or acquiring data visualisation tools and infrastructure to collect and monitor service user flows, service demand and supply, performance and outcomes, in real time
				Clinical data mining	Building a standardised and secure data collection process that draws on individual service user clinical records to support cohort, population and pathway analysis
				Data warehousing	Designing and establishing structures to store service user-level clinical data Maintaining infrastructure to ensure smooth operation and continued protection of data confidentiality Responding to requests for tailored data sets
				Data analytics	Developing capabilities to conduct sophisticated analysis to track service, pathway and system performance and outcomes by using appropriate analytical methodologies which includes: pattern matching, forecasting, data visualisation, semantic analysis, sentiment analysis, network and cluster analysis, multivariate statistics, graph analysis, simulation, etc.
				Tech strategy and development	Developing a tech strategy that is aligned with the system strategy and objectives Identifying opportunities for investment in and use of technology, to increase care quality, and reduce costs and pressures in the system
				Integrated patient level cost of care assessment	Identifying required data across care settings and processes for collection of data Monitoring data quality Interrogating and analysing data to determine the cost of providing care on a per service user level across providers
				Predictive modelling and trend analysis	Developing or acquiring modelling tools to identify potential risks and shifts in needs, demand, or cost Utilising tools to inform understanding of current state and likely upcoming developments
				Population health data management	Collecting, centralising and aggregating population health data Establishing structures to store the data and support data management and protection Interrogating data to build a population-level understanding of health trends and needs
				Performance and quality reporting	Based on shared knowledge and best practices, collecting data relating to key provider metrics regarding performance and quality, including compliance with NHS targets, enabling the assessment of relative performance, and providing assurance based on pre-agreed contract arrangements

					Collating and submitting to national bodies (e.g. DHSC, NHSE, NHSI, etc.) and other organisations Publishing data where relevant
				Information governance	Establishing structures that are compliant with national guidelines for good data governance Monitoring structures and governance systems to ensure continued compliance Using best practice to improve structures on an ongoing basis
				Internal incentive re-alignment	Assessing incentives across an ICP and linking them to shared objectives Providing the freedom for further development of internal incentives Establishing mechanisms for addressing any identified legacy incentives that are now counterproductive Continuing to review and update incentives based on changes in key metrics Managing the flow of financial incentives across constituent providers
				Contact negotiation	Developing and implementing strategy for negotiating contracts with providers of services, commissioners and other third party organisations
				Quality improvement	Tracking quality-related metrics to ensure baseline requirements are met Reviewing of guidance and best practice, drawing on evidence from regulatory bodies and other localities Identifying areas for improvement and processes to drive improvement Collating and publishing reports on performance against targets where required
				Performance and cost of care management	Identifying cost and performance metrics and tracking performance by providers against them Developing cost and performance benchmarks for individual elements of the pathway Assessing performance of metrics against benchmarks and highlighting where discrepancies exist Cost of care should be real cost (rather than what commissioner is willing to pay for)
				Tendering and bids management	Developing / meeting specifications for goods and services to be procured or bid for from providers and clients Drafting of tender / bidding documents and engaging with potential providers and clients to refine documents For transformational services the risks and gains should be articulated and shared between buyer and seller
				Purchasing and procurement	Conducting ad-hoc and cyclical purchasing and procurement of needed products and services Developing vendor relationships and administer billing processes
				Supply chain management	Developing strategic relationships with care providers, and some key suppliers of goods and services in the provider supply chain (within the ICP) Managing providers to fulfil responsibilities as part of the ICP strategy

					Monitoring and investigating provider performance to ensure continuity and quality of services Raising and managing issues with under-performing providers as and when needed
				Capital and investment management	Implementing the capital management strategy developed by the ICS, to underpin funding decisions Developing balance sheet and cash-flow projections, monitoring of in-goings / outgoings, tracking against plan
				Patient engagement	Developing targeted service user engagement strategy Identifying and devising channels for constructive interaction, including e.g. service user advisory panels, citizens' forum and complaints process Building up supportive structures around these channels to support and encourage contribution
				Organisational development	Self-assessing needs and capabilities in order to institute development goals and targets Changing cultures and behaviours of staff, the public and providers Motivating staff to participate in goal setting and change
				Provider alliance engagement	Building structures and forums to facilitate engagement with other provider alliance members to build stronger
				Performance and quality reporting	Tracking quality-related metrics to ensure baseline requirements are met Reviewing of guidance and best practice, drawing on evidence from regulatory bodies and other localities Identifying areas for improvement and processes to drive improvement Collating and publishing reports on performance against targets where required

Annex C

Extracts from the Long Term Plan that are relevant to the governance of the ICS and its constituent parts:

1.51. We will continue to develop ICSs, building on the progress the NHS has already made. By April 2021 ICSs will cover the whole country, growing out of the current network of Sustainability and Transformation Partnerships (STPs). ICSs will have a key role in working with Local Authorities at 'place' level and through ICSs, commissioners will make shared decisions with providers on how to use resources, design services and improve population health (other than for a limited number of decisions that commissioners will need to continue to make independently, for example in relation to procurement and contract award). Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation.

1.52. Every ICS will have:

• a partnership board, drawn from and representing commissioners, trusts, primary care networks, and – with the clear expectation that they will wish to participate - local authorities, the voluntary and community sector and other partners;

• a non-executive chair (locally appointed, but subject to approval by NHS England and NHS Improvement) and arrangements for involving non-executive members of boards/ governing bodies;

• sufficient clinical and management capacity drawn from across their constituent organisations to enable them to implement agreed system-wide changes;

• full engagement with primary care, including through a named accountable Clinical Director of each primary care network;

• a greater emphasis by the Care Quality Commission (CQC) on partnership working and system-wide quality in its regulatory activity, so that providers are held to account for what they are doing to improve quality across their local area;

• all providers within an ICS will be required to contribute to ICS goals and performance, backed up by a) potential new licence conditions (subject to consultation) supporting NHS providers to take responsibility, with system partners, for wider objectives in relation to use of NHS resources and population health; and b) longer-term NHS contracts with all providers, that include clear requirements to collaborate in support of system objectives;

• clinical leadership aligned around ICSs to create clear accountability to the ICS. Cancer Alliances will be made coterminous with one or more ICS, as will Clinical Senates and other clinical advisory bodies. ICSs and Health and Wellbeing Boards will also work closely together.

1.53. NHS Improvement will take a more proactive role in supporting collaborative approaches between trusts. We will support trusts that wish to explore formal mergers to embed these benefits, supported by a new fast-track approach to assessing proposed transactions involving trusts that have been accredited as 'group' leaders. Each ICS will be required to implement integral services that prevent avoidable hospitalisation and tackle the wider determinants of mental and physical ill-health.

1.54. Funding flows and contract reform will support the move to ICSs as set out in Chapters Six and Seven. Service integration can be delivered locally through collaborative arrangements between different providers, including local 'alliance' contracts. Another option is to give one lead provider responsibility for the integration of services for a population. A new Integrated Care Provider (ICP) contract will be made available for use from 2019, following public and provider consultation. It allows for the first time the contractual integration of primary medical services with other services, and creates greater flexibility to achieve full integration of care. We expect that ICP contracts would be held by public statutory providers.

1.55. A new ICS accountability and performance framework will consolidate the current amalgam of local accountability arrangements and provide a consistent and comparable set of performance measures. It will include a new 'integration index' developed jointly with patients groups and the voluntary sector which will measure from patient's, carer's and the public's point of view, the extent to which the local health service and its partners are genuinely providing joined up, personalised and anticipatory care.

1.56. ICSs will agree system-wide objectives with the relevant NHS England/NHS Improvement regional director and be accountable for their performance against these objectives. This will be a combination of national and local priorities for care quality and health outcomes, reductions in inequalities, implementation of integrated care models and improvements in financial and operational performance. ICSs will then have the opportunity to earn greater authority as they develop and perform.

ENC. H

Meeting:	ICS Board
Report Title:	Development of the Model for Primary Care Networks
Date of meeting:	Thursday 9 May 2019
Agenda Item Number:	11.
Work-stream SRO:	Dr Nicole Atkinson / Dr Stephen Shortt
Report Author:	Angela Potter /Helen Griffiths
Attachments/Appendices:	Appendix 1 - Position on the Progress of the Primary Care Networks for Nottingham and Nottinghamshire Appendix 2 - Timeline for Establishment of Primary Care Networks

Report Summary:

The STP Leadership Board requested the development of a core Primary Care Network (PCN) specification and vision in September 2018.Three workshops were therefore proposed between January and March 2019 in order to bring cross organisational parties together to develop the required outputs.

In January 2019 *Investment and Evolution – A Five year framework for GP contract reform to implement The NHS Long Term Plan* was released. This resulted in a requested pause prior to considering the governance and PCN inter-relationships further.

This paper presents the outputs agreed through the workshops. There was a clear consensus around the vision and the core components of a PCN that each 30-70k PCN locality would aspire to.

The model is ambitious and will take a number of years to achieve. It strives to achieve the key deliverables in the Long Term Plan and support the system sustainability approach and provide considerable quality benefits to our populations. It is anticipated that all Practices will be aligned to a PCN, as well appointing a Clinical Director.

The Board is asked to approve the vision for the Primary Care Networks.

Action:

☐ To receive
☐ To approve the recommendations

Recommendations:

1.	To approve and agree the vision and aspirations of Primary Care Networks
2.	The ICS Board are asked to note and endorse the progress to date on the PCN configurations and delegate final approval to the Managing Director in time for the submission to NHSE&I by the deadline of 31st May 2019.

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 AND NOTTINGHAMSHIRE ICS DEVELOPMENT OF PRIMARY CARE NETWORKS

9 May 2019

Introduction

1. Across the Nottingham and Nottinghamshire ICS two cross sector workshops have taken place in January and February 2019 focused on the development of Primary Care Networks (PCNs). The purpose of these was to create a common vision and purpose and to develop the core requirements that it is expected to see as a minimum in each locality.
2. An initial focus of the workshops was on reviewing the governance arrangements and cross PCN working. However, the release of the document - *Investment and Evolution – A Five year framework for GP contract reform to implement The NHS Long Term Plan – January 2019* resulted in the timings of those conversations to be mis-aligned therefore that part of the work programme was postponed.

Nottinghamshire Vision for PCNs

3. Primary Care Networks provide the local infrastructure that will deliver a person-centred (holistic) approach to continuous lifetime care, rather than the traditional disease focused approach. They comprise integrated, cross organisational and cross professional groups of staff who come together as an integrated community offer.
4. There are currently anticipated to be 22 PCNs across the ICS. Each PCN will have a designated Clinical Director who will provide strategic and clinical leadership for the ongoing development of each network.
5. Please see Appendix 1 for a position statement on the establishment of the PCNs and recruitment to the Clinical Director positions.
6. Members at the workshops agreed the overarching aim:

PCNs will be at the heart of health and care provision; improving the wellbeing of our local populations through proactive, accessible, coordinated, and integrated health and care services.

7. The vision therefore is an integrated, place based care approach developed around natural communities. Key characteristics of each PCN will be:

    - An integrated and collaborative primary care workforce, with a strong focus on delivering quality services through partnership – ‘primary care’ is defined as first line services such as; general practice, community providers, secondary care, mental health, voluntary sector and social care
    - A supported and integrated workforce with a combined focus on prevention and personalisation of care with shared and improved qualitative health and care outcomes utilising population health management data

- Citizens that are taking personal responsibility for their own well-being and are actively engaged in the development of their local Primary Care Network and in strengthening their local community
- A proactive model of care, utilising risk stratification and targeted interventions to eliminate hospital admissions as a default for people who are not acutely unwell but do need some degree of help and support to prevent further deterioration

8. There are a range of core services that were identified through the workshops. These are detailed in figure 1 below whilst page 7 identifies the alignment with some of the potential core functions from the initial work undertaken by Deloittes in 2018.

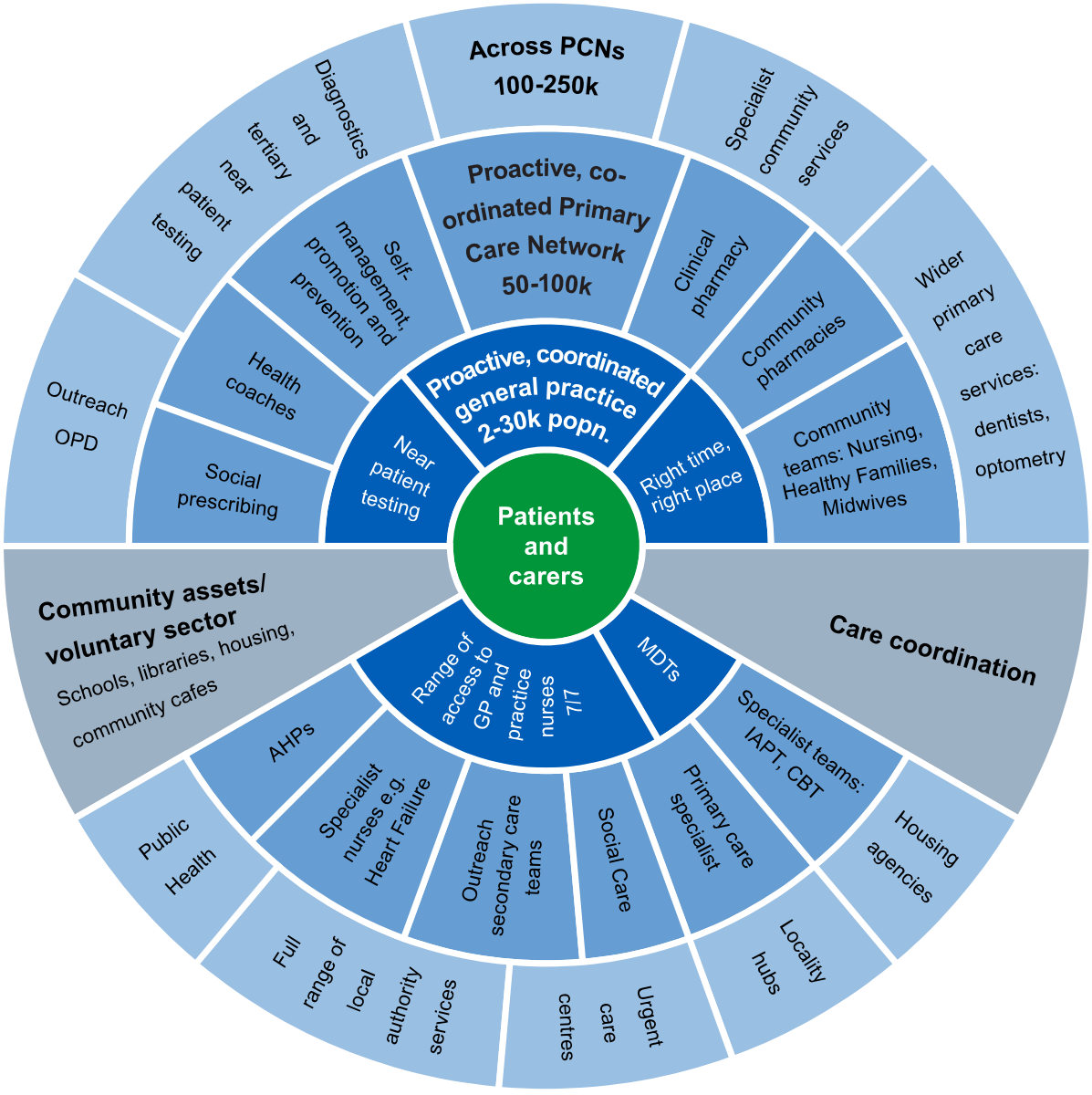


Figure 1 – The model of Primary Care Networks across the ICS

Delivery of the New Service Model

9. PCNs need to embrace a much wider approach than the traditional model of general practice. The approach will focus on the prevention agenda with the aim of reducing the need for complex care in future years. This will be achieved through;

    - Robust risk profiling and targeted, outcome based interventions
    - 100% coverage of population health management data that links into the wider community to enable people to proactively take control of their health and well-being
    - General Practice stratifying and proactively targeting at risk people in their locality
    - Patient choice and self-care, supporting patients to make choices about their care and look after their own health by connecting them with the full range of statutory and voluntary services.

10. Prevention needs to be seen to have an equal level of importance as treatment modalities and be implemented at scale. It should be accessed at all levels, from an individual GP consultation, right through to accessing the wider community assets. This will be achieved through:

    - An expansion of social prescribing and health coaching aligned and navigated through dedicated care co-ordinators.
    - Promotion and access to screening programmes will continue to have their profile raised with the aim that national priorities and targets are surpassed.
    - A focus on ‘what is important to you’ rather than ‘what is wrong with you’.
    - A focus on personalisation and personal health budgets which will also enable a more proactive approach to maintaining well-being.

11. Care co-ordination needs to take place across all levels of the health and care system from the individual consultation within the GP practice, through to co-ordinating with wider services across a number of PCN’s. This will be achieved through;

    - Shifting the response of care co-ordination to a more proactive focus so that care co-ordinators are able to actively contact patients and work alongside social prescribers and health coaches to proactively sign-post and motivate people to promote their well-being.
    - A well-developed JNSA at an ICS level and clear implementation plans developed through the ICPs. Local authority and voluntary sector organisations – housing, education, fire and police services, leisure, and environmental health services, along with engagement with local

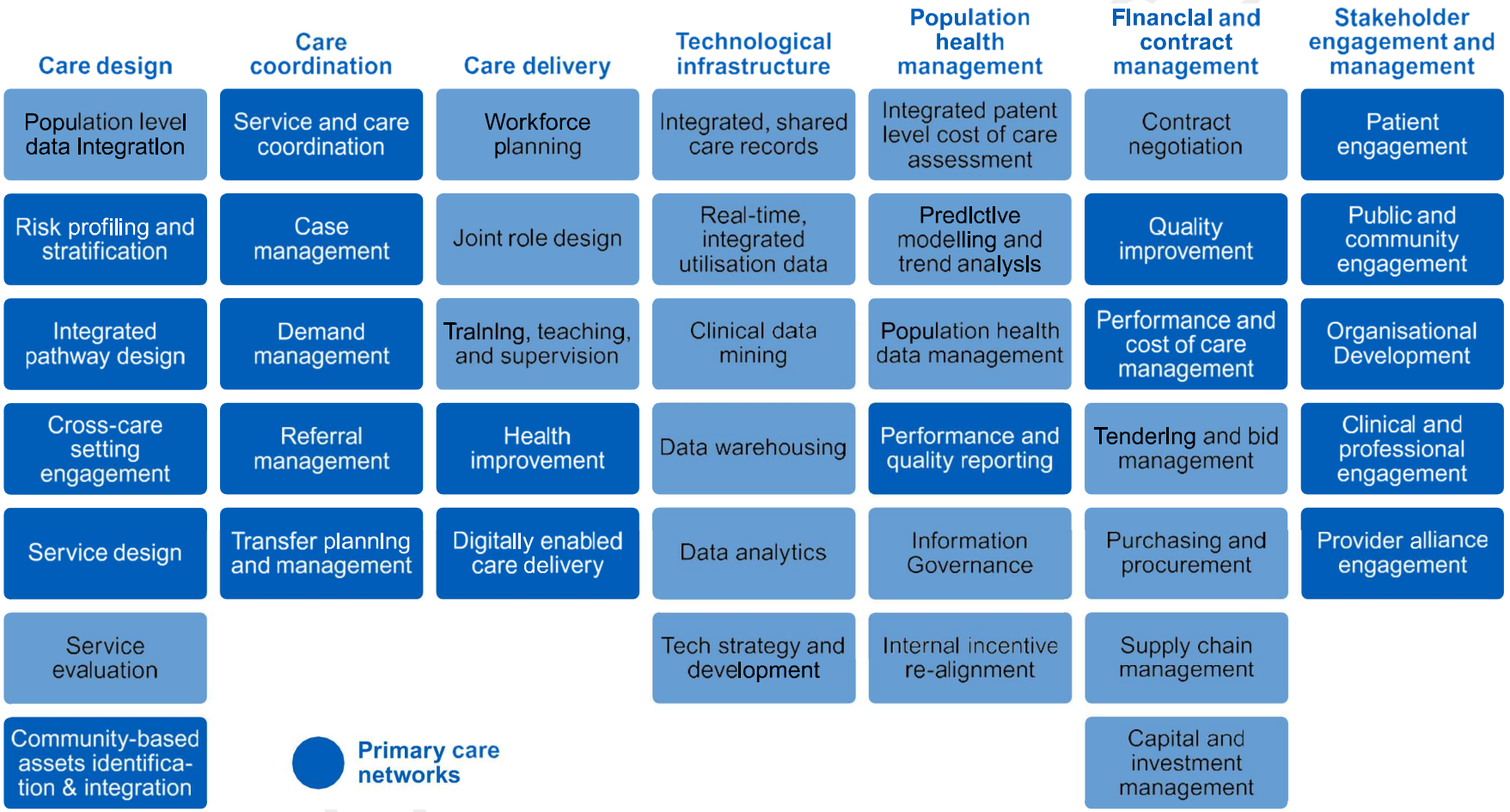
businesses and voluntary organisations will be key to supporting this agenda.

12. Addressing the wider determinants of health through engagement with the wider social network is vital. Issues such as debt, poor housing and social isolation can have a negative impact on a person's health and wellbeing. This will be addressed through:
    - Giving children and young people a *good start in life* by engaging with education providers in local communities and focusing on healthy families
    - Development of local strategies that will provide training and job opportunities, good quality housing and keep people connected to their local community by enabling people to create and engage with local community assets
    - Ensuring that parity of esteem is delivered between physical and mental health problems, and that a holistic approach is delivered to support patients and their families.
13. The workforce will move away from service specific care to a more generalist role and will be trained to treat the patient, not the disease, recognising that most patients may have one or more health or social care need.
14. The use of technology and effective information sharing will be critical. Utilising technology and information patients will have the ability to book their appointments online, re-order prescriptions, access their GP medical records and access online consultation services. Patients will be empowered by giving them the tools to support their own self-care as well as offering more telephone advice/video consultation appointments.

Next Steps

15. The new GP Contract and associated guidance gives a clear implementation framework and requirements for the early part of 2019/20.
16. It is anticipated that all Practices will be aligned to a PCN, as well appointing a Clinical Director. Please see Appendix 1 and 2 for the current configuration and proposed timeline for the establishment of PCNs.
17. Whilst it was acknowledged and accepted that there still remains a significant level of work to be undertaken to ensure a robust and resilience General Practice workforce that is willing to implement the PCN model, the galvanising of offers from other providers and the multi-organisational development should not be postponed indefinitely.
18. The ICS Board is therefore asked to endorse this vision as an outline model for PCNs and mandate its ongoing development through the ICP and respective provider organisation.

Based on the initial work undertaken by Deloittes in 2018 the following core functions could be assigned to PCNs



Appendix 1

Briefing: Position on the Progress of the Primary Care Networks for Nottingham and Nottinghamshire

1. Introduction

Further to the GP contract being issued (February 2019), and the publication of the NHS England and Improvement (NHSE&I) Network Contract Directly Enhanced Service (April 2019) the briefing paper summarises the work to date to establish Primary Care Networks (PCNs) across the Nottingham and Nottinghamshire ICS.

This paper summarises the current position on the PCN configurations and recruitment to the Clinical Director roles. Discussions are ongoing in some areas to confirm the final configurations; however progress is in line with the deadline for applications being submitted to the CCGs by 15th May 2019 as part of assurance to NHSE&I in signing practices up to the National DES.

2. Current proposed PCN configurations:

	PCN	Practice	Pop.	PCN ttl	CCG ttl
Mansfield & Ashfield	**1**	1 Ashfield House	5,982		
		2 Family Medical Centre	4,055		
		3 Health Care Complex	4,047		
		4 Jacksdale MC	3,949		
		5 Kirkby Health Centre	5,930		
		6 Kirkby Health Centre	4,163		
		7 Lowmoor Road	5,200		
		8 Selston Surgery	5,010	**38,336**	
	2	1 Ashfield Medical Practice	3,680		
		2 Brierley Park	9,148		
		3 Harwood Close	5,324		
		4 Skegby Family Medical Practice	8,927		
		5 Willowbrook Medical Practice	14,470		
		6 Woodlands Medical Practice	10,148	**51,697**	
	3	1 Acorn Medical Practice	2,989		
		2 Churchside Medical Practice	6,244		
		3 Forest Medical	14,968		
		4 Millview Surgery	8,447		
		5 Roundwood Surgery	13,162	**45,810**	

	4	1 Bull Farm PCRC	2,690		
		2 Meden Medical	6,106		
		3 Oakwood Surgery	13,197		
		4 Orchard Medical Practice	19,303		
		5 Pleasley Surgery	3,412		
		6 Riverbank Medical	4,502		
		7 Sandy Lane Surgery	5,954		
		8 St Peters Medical Practice	2,771	**57,935**	**193,778**

	PCN	Practice	Pop.	PCN ttl	CCG ttl
Newark & Sherwood	**1**	1 Abbey Medical Group	11,971		
		2 Bilsthorpe Surgery	3,256		
		3 Hill View Surgery	3,118		
		4 Major Oak Medical Practice	6,411		
		5 Middleton Lodge Practice	12,767		
		6 Rainworth Primary Care Centre	6,004		
		7 Sherwood Medical Partnership	15,660	**59,187**	
	2	1 Balderton Primary Care Centre	5,522		
		2 Barnby Gate Surgery	14,143		
		3 Collingham Medical Centre	6,994		
		4 Fountain Medical Centre	14,200		
		5 Hounsfield Surgery	4,074		
		6 Lombard Medical Centre	18,537		
		7 Southwell Medical Centre	12,347	**75,817**	**135,004**

	PCN	Practice	Pop.	PCN ttl	CCG ttl
Nottingham City	**1**	1 Leen View Surgery	9,483		
		2 Parkside Medical Practice	7,490		
		3 Rise Park Surgery	7,443		
		4 Riverlyn Medical Centre	3,014		
		5 Springfield Medical Centre	2,657		
		6 Queens Bower Surgery	4,309		
		7 Southglade Health Centre (SSAFA)	2,912		
		8 St Albans Medical Centre / Nirmala Medical Centre	7,263	**44,571**	

	3	1 Limetree Surgery	3,537		
		2 Aspley Medical Centre	7,724		
		3 Beechdale Surgery	4,151		
		4 Boulevard Medical Centre	1,903		
		5 Bilborough Medical Centre / Assarts Farm Medical Centre	8,754		
		6 Churchfields Medical Practice	9,449		
		7 Melbourne Park Medical Centre	8,575		
		8 RHR Medical Centre	3,081		
		9 Strelley Health Centre	4,415		
		10 Greenfields Medical Centre – Sharma	2,745		
		11 Mayfield Medical Practice	3,348		
		12 Bilborough Surgery	1,486	**59,168**	
	4	1 St Luke's Surgery	3,743		
		2 The Fairfields Practice	7,809		
		3 The Forest Practice	4,632		
		4 The High Green Medical Practice	9,182		
		5 Radford Medical Practice /NTU	20,650		
		6 Radford Health Centre – Phillips	3,487	**49,503**	
	5	1 Hucknall Road Medical Centre	13,184		
		2 The Alice Medical Centre	3,494		
		3 Sherwood Rise Medical Centre	5,885		
		4 Elmswood Surgery	8,921		
		5 Sherrington Park Medical Practice	4,693		
		6 Tudor House Medical Practice	6,653		
		7 Welbeck Surgery	4,128		
		8 The Medical Centre – Irfan	2,432	**49,390**	
	6	1 Bakersfield Medical Centre	5,553		
		2 Family Medical Centre	10,272		

		3 Green Dale Primary Care Centre	9,797		
		4 Mapperley Park Medical Centre	2,472		
		5 Victoria & Mapperley Practice	8,942		
		6 Wellspring Surgery	9,780		
		7 NEMS – Platform One Practice	10,738		
		8 Windmill Practice	8,920	**66,474**	
	7	1 Deer Park Family Medical Practice	10,189		
		2 Derby Road Health Centre	12,167		
		3 Grange Farm Medical Centre	5,415		
		4 Wollaton Park Medical Centre	8,619	**36,390**	
	8	1 Bridgeway Practice	4,475		
		2 Clifton Medical Practice	8,206		
		3 John Ryle Medical Centre	6,251		
		4 Meadows Health Centre – Larner	3,786		
		5 Rivergreen Medical Centre	8,944	**31,662**	
	U	1 Cripps Health Centre	44,808		
		2 Sunrise Medical Practice	6,741	**51,549**	**388,707**

	PCN	Practice	Pop.	PCN ttl	CCG ttl
Nottingham North & East	**1**	1 Oakenhall Medical Practice	7,234		
		2 Om Surgery	2,122		
		3 Torkard Hill Medical Centre	15,316		
		4 Whyburn Medical Practice	11,952	**36,624**	
	2	1 Calverton Practice	9,679		
		2 Daybrook Medical Practice	9,523		
		3 Highcroft Surgery	11,976		
		4 Stenhouse Medical Centre	12,131	**43,309**	

	3	1 Ivy Medical Group	7,063		
		2 Jubilee Practice	2,346		
		3 Park House Medical Centre	10,081		
		4 Peacock Healthcare	5,709		
		5 Plains View Surgery	6,810		
		6 Trentside Medical Group	11,627		
		7 Unity Surgery	3,795		
		8 West Oak Surgery	5,588		
		9 Westdale Lane Surgery	7,993	**61,012**	**140,945**

	PCN	Practice	Pop.	PCN ttl	CCG ttl
Nottingham West	**1**	1 Abbey Medical Centre	5,604		
		2 Bramcote Surgery	3,548		
		3 Chilwell Meadows	14,982		
		4 Manor Surgery	12,953		
		5 Oaks Medical Centre	10,267	**47,354**	
	2	1 Eastwood Primary Care Centre	19,891		
		2 Giltbrook Surgery	4,864		
		3 Hama Medical Centre	5,117		
		4 Hickings Lane Medical Centre	5,785		
		5 Linden Medical Centre	8,064		
		6 Newthorpe Medical Centre	7,259		
		7 Saxon Cross Surgery	7,469	**58,449**	**105,803**

	PCN	Practice	Pop.	PCN ttl	CCG ttl
Rushcliffe	**1**	1 Castle Healthcare Practice	16,816		
		2 Gamston Medical Practice	5,602		
		3 Musters Medical Practice	9,842		
		4 St Georges Medical Practice	11,254		
		5 West Bridgford Medical Practice	4,442	**47,956**	
	2	1 Belvoir Health Group	24,647		
		2 East Bridgford Medical Group	6,914		
		3 Radcliffe-on-Trent Health Centre	8,179	**39,740**	

	3	1 East Leake Medical Group	13,957		
		2 Keyworth Medical Centre	10,942		
		3 Orchard Surgery	8,411		
		4 Ruddington Medical Centre	6,867	**40,177**	**127,873**

3. Clinical Director Appointments:

3.1 Agreed Process:

Nottingham City	Mid Nottinghamshire	South Nottinghamshire
• Proposed election process for appointment of clinical directors for each PCN. PCNs opting to hold an election to be supported by LMC to ensure transparency and independence • Interim leads in place are current CCG clinical leads aligned to each PCN • Clinical director job description and application pack compiled and published on LMC website since **22nd March 2019** • Engagement with practices regarding configuration of PCNs, and clinical director election process ongoing • **22nd March to 12th April:** Application for CD posts open for PCNs wishing to hold elections • **15th-18th April:** Application Assessment Panel (PCN partner organisations) • **25th April to 3rd May:** voting open • **4th -5th May:** vote count and confirmed • **5th-10th May:** clinical directors announced	• Election process for appointment of clinical directors for each PCN. Election supported by LMC to ensure transparency and independence. • Clinical director job description compiled and published on LMC website **13th March 2019** • Clinical directors appointed • JPCCC received and approved the formation of the PCNs; providing assurance that all aspects were met as part of the CCG requirement in **April 2019.** • All PCNs have signed schedule 5 of the contract which sets out how they will make decisions and who will hold their central PCN budget. • PCN forward meetings have been established; PCN managers interim arrangements in place. • Monthly CD development sessions commenced.	• Engagement with practices regarding configuration of PCNs, and clinical director underway **1st March – 31st March** • Process for appointment of clinical directors for each PCN in place and agreed with Practices. Supported by LMC to ensure transparency and independence • Recruitment pack distributed to all practices **Monday 8th April,** and closed for Expressions of Interest 19th April • Partner organisations and lay reps are playing an active part in the Review Panels and recruitment process • Expressions of interest are under review by a panel which includes NHCT, patient rep, CCG officer, LMC where indicated. • Where a PCN has a contested appointment, voting will apply across member practices of the PCN. Voting will open **Tuesday 30th April** • Clinical Directors to be appointed by **10th May 2019**

3.2 Current Position of Clinical Director Appointments

ICP	PCN	Clinical Director Deputy Clinical Director	Process
Mid Notts	**Ashfield South**	Dr Junaid Dar Dr Deepa Balakrishnan	Confirmed 2/4/19
	Ashfield North	Dr Andrew Poutney Dr Gavin Lunn	Confirmed 29/3/19
	Mansfield South	Dr Milind Tadpatrikar	Confirmed at PCN meeting
	Mansfield North	Dr Khalid Butt Dr James Mills	Confirmed at PCN meeting
	Sherwood	Dr Kevin Korfe	Confirmed at PCN meeting
	Newark	Dr James Cusack	Confirmed at PCN meeting
City	**PCN 1** **PCN 3** **PCN 4** **PCN 5** **PCN 6** **PCN 7** **PCN 8** **PCN U**	EOI received	Clinical Directors identified. Panel assessment complete. Affirmation with practices in progress for PCNs 1,4,5,6,7,8,&U Confirmation 30th April. PCN 3 - panel assessment complete, 2 candidates in election process. Confirmation 5th May.
South Notts	**Eastwood and Stapleford**	EOI received	Panel review underway
	Bramcote and Beeston	EOI received	Panel review underway
	Rushcliffe North	EOIs received	Panel review underway
	Rushcliffe Central	EOIs received	Panel review underway
	Rushcliffe South	EOIs received	Panel review underway
	NNE PCN 1	EOIs received	Panel review underway

	NNE PCN 2	EOIs received	Panel review underway and voting opened 30/4/19
	NNE PCN 3	EOIs received	Panel review underway and voting opened 30/4/19

Appendix 2

Timeline for Establishment of Primary Care Networks

Date	Action
Jan-Apr 2019	PCNs prepare to meet the Network Contract registration requirements
By 29 Mar 2019	NHS England and GPC England jointly issue the Network Agreement and 2019/20 Network Contract
By 15 May 2019	All Primary Care Networks submit registration information to their CCG
23 May 2019	Mid Notts and Greater Notts Primary Care Committees in Common to meet to review and consider approval of PCN applications
By 31 May 2019	CCGs confirm network coverage and approve variation to GMS, PMS and APMS contracts
Early Jun	NHS England and GPC England jointly work with CCGs and LMCs to resolve any issues
1 Jul 2019	Network Contract goes live across 100% of the country
Jul 2019-Mar 2020	National entitlements under the 2019/20 Network Contract start: • year 1 of the workforce funding • ongoing support funding for the Clinical Director • ongoing £1.50/head from CCG allocations
Apr 2020 onwards	National Network Services start under the 2020/21 Network Contract

ENC. I1

Meeting:	ICS Board
Report Title:	May 2019 Integrated Performance Report
Date of meeting:	Thursday 9 May 2019
Agenda Item Number:	12.
Work-stream SRO:	Wendy Saviour
Report Author:	Sarah Bray
Attachments/Appendices:	None

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 risk:

- Urgent Care System delivery
- Mental Health services and service transformation delivery
- Financial Sustainability

Emerging Risks:

- Cancer performance due to the longevity and sustained level of below-target performance.
- Quality, due to performance across Transforming Care and Maternity.

Service Delivery Area	2018/19 ICS Performance		
	No. KPIs	% Not Achieved	% Achieved
Mental Health	10	30%	70%
Urgent & Emergency Care	5	80%	20%
Planned Care	6	33%	67%
Cancer	8	25%	75%
Nursing & Quality	9	22%	78%
Finance	7	71%	29%
Overall Performance Delivery	45	40%	60%

Nottingham and Nottinghamshire ICS - Performance Overview - as at 25th April 2019

Significant improvements have been made across Childrens Wheelchairs, which has moved from 61.2% Q4 2017/18 to achievement of 100% Q4 2018/19.

Assurance Framework Overview

Q3 2018/19 ICS Integrated Assurance Framework aggregated to ICS level, top 4 best and worst performing areas are.

Best Performing areas out of the 42 ICSs are:	**Worst Performing** areas out of the 42 ICSs are:
- GP Extended Access (1/42) - Choices in Maternity Service (3/42) - RTT (3/42) - Dementia Diagnosis (4/42)	- A&E 4 hour wait (40/42) - Maternal Smoking at time of delivery (38/42) - Cancers diagnosed at an early stage (35/42) - High quality adult social care (34/42)

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	☒	Off plan against forecast and year to date
Value for Money	☐	
Risk	☒	Service delivery and performance risks
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 Performance Overview

30th April 2019

Red Risks to System Delivery		
RAG	*Performance Issues*	*Actions to Address*
A: Mental Health	*Performance* concerns relating to: IAPT Access M&A CCG CYP Access & data capture issues EIP Condordant compliance & Data – Level 1 in Mid-Notts CCGs, as well as overall service delivery performance across the ICS *5YFV Transformation Areas* issues: Out of Area Inappropriate placements – outlier on volumes of placements, national data has now plateaued Liaison –service model at NUH Crisis – 24/7 CRHT service is not currently offered IPS – Service not delivered across the ICS Physical Health Checks are not in line with requirements	There are a significant number of performance and 5YFV transformation area concerns relating to Nottinghamshire. As a result the system has developed recovery plans for IAPT, EIP, CYP, Out of Area Placements (including Liaison & Crisis) and Physical Health Checks. Delivery of key requirements is not expected until 2019/20 for CYP and IAPT, with EIP aiming to achieve level 2 by the end of March 2019. Following the ICS Mental Health workshop in January, mental health leaders have linked in with areas of good practice, to enhance local service improvements. Executive Mental Health monthly oversight is in place across the ICS, to progress the actions required through the recovery plans.
B: Urgent Care	ICS A&E performance remains below target and has marginally increased to 79.75% March 2019 (NUH 64.22%/ SFHT 92.78%) EMAS performance has had small improvements seen over the last 2 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, including increases for over 75s. The performance continued to deteriorate through January and February, with small improvement March. Actions to address capacity gaps and front door service redesign continue to be implemented. Daily executive calls continue to be in place to respond to the pressures across the system. Both A&E Delivery Boards have provided 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.
G: Financial Sustainability	The system has under-delivered on the year-end position for the NHS System Control by £18.4 million, this is due to pressures in providers (activity / demand and pay expenditure), which was against a forecast under-delivery of £18.9m. The system has delivered £166.2 million of savings – NHS under-delivering by £8.3 million and Local Authority over-delivering by £4.4m	The system received £37.3 million of Provider Sustainability Fund (PSF). This system has received less PSF than planned due to non-delivery of A&E in Greater Nottingham, organisational financial position at NUH (Months 1-12) and system financial position (months 4-12). The system received £19 million of additional PSF Incentive funds in Month 12 alongside the core PSF Funding of £18.3 million. *Note: A&E PSF was not recoverable and finance PSF was recoverable*

Amber Risks To System Delivery		
C: Planned Care	RTT failed to achieve for the ICS 91.7%. Waiting lists remain are over March 2018 levels, however have continued to decrease, to 3.9% (Feb 19). (NUH -1.1%, SFHT 6.9%). SFHT +52 weeks values are in line with trajectory, expected nil at March 19. NUH have had sustained levels of breaches over recent months, which are being actively managed by the system. Children's wheelchair waits have significantly improved over the year to 100% delivery Q4.	SFHFT expected recovery of the 92% target by November 2018, however there is low confidence in achieving the standard before March 2019. SFHFT and the CCG are monitoring recovery plans at speciality levels, which include staffing and additional capacity. SHFT Waiting lists recovery back to March 18 levels is unlikely to be achieved by March 2019, due to data validation and activity increases. Additional activity has been directed through to the independent sector for certain specialties. 52+ waits recovery to nil is expected by Q2 2019/20 due to patient choice factors.
D:Cancer	Cancer 62 performance has reduced further to 79.61% February 2019. (SFHT 80.25% / NUH 75.31%). Pressures from increased urology referrals and convergence rates have impacted upon both trusts.	The trusts expected performance for March 19 & May 19 is 76-79%, as the trusts work through the increased demand, and capacity constraints during the winter period. Recovery is not expected to be achieved before Q2 2019/20.
E. Nursing & Quality	Transforming Care did not achieve Q3 trajectory +10 over planned levels, however there has been a significant improvement since Q1 reducing the variance by 4 CHC: ICS achieved both QP standards for Q3 maintaining an improved position. Mid Notts are unlikely to achieve Q3 28 day standard. Maternity did not achieve the continuity of carer 20% requirement, for 2018/19. Q4 performance was 2.2%.	TCP remains in regional escalation. Recovery plans are in place, focus on admission avoidance. The Mid Notts CCGs are working with the IDAT and Home First Pathway Team to ensure appropriate discharge/transfers. A clinical lead with LD expertise has commenced. Recovery is expected by the end Q4, improvements are noted for January 19. Maternity recovery plan is in place, revised trajectories are expected for June 2019, to progress towards the 35% requirement for March 2020. Pilots are commencing March and April 2019.
Primary Care	Delivery of 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 the establishment of the ICS Outcomes Framework.

CCG joint management arrangements are progressing.

Recommendations

1. The Board are asked to note the report:
   a. Integrated Performance Report and
   b. Key risk areas:
      - Urgent Care System delivery
      - Mental Health service and service transformation delivery
      - Financial Sustainability

Sarah Bray
Head of Assurance & Delivery
30th April 2019
sarah.bray6@nhs.net

Nottinghamshire ICS
System Integrated Performance Summary
ICS Board Thursday 9 May 2019, Item 12, Enc I2 May 2019

	Key Performance Indicator	18/19 ICS Basis	18/19 Required Performance	18/19 Reporting Period	2018/19 ICS Performance				Exception Narrative
					Latest Period	Month RAG	Month Delivery Trend	Forecast Delivery Risk	
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%	Q3 18/19	16.2%		↑		Due to a concerns relating to performance and plans to progress the 5YFV requirements, Exec level oversight established in ICS. Joint Recovery plans in place. CYP - The ICS achieved 16.2% against the 32% access standard in Q3 (based on national dataset). IAPT - ICS access target did not achieve for Jan 19. EIP - exceeded target in Feb 2019, achieving 68.1%. Ongoing actions to improve services delivery to ensure they are NICE compliant. OAPs – Continued reduction in out of area placement (OAP) occupied bed days (OBDs). However, the local trajectory was not achieved.
	CYP Eating Disorders Urgent 1st <1 weeks	CCG	95.0%	Q3 18/19	50.0%		-		
	CYP Eating Disorders Routine 1st <4 weeks	CCG	95.0%	Q3 18/19	100.0%		↑		
	IAPT Access	CCG	4.75%	Jan-19	4.61%		↓		
	IAPT Waiting Times - 6 weeks (Rolling Quarter)	CCG	75.0%	Jan-19	80.8%		↑		
	IAPT Waiting Times - 18 weeks (Rolling Quarter)	CCG	95.0%	Jan-19	99.2%		↓		
	IAPT Recovery Standards (Rolling Quarter)	CCG	50.0%	Jan-19	55.1%		↑		
	EIP NICE Concordant Care within 2 Weeks	CCG	53.0%	Feb-19	68.1%		↑		
	Inappropriate Out of Area Placements (bed days)	CCG	1698	Dec-18	2815		↓		
	Maintain Dementia diagnosis rate at 2/3 of prevalence	CCG	66.7%	Feb-19	75.8%		→		
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	Provider	90% Sept /95% Mar	Mar-19	79.7%		↑		Activity pressures continued into Q4, year on year ED attendances continue to rise. A&E – NUH performance remains low at 64.22%, demand had increased further with increased ED attends and ambulance arrivals. SFHFT failed to achieve national standard and local trajectory at 92.78% in Mar-19. Length of Stay - Mid-Notts completed self-assessment process against 8 High Impact Changes for Discharge and additional actions have been added to the DToC/LoS action plan, including service specification for integrated discharge team at SFHFT from May 2019.
	12 Hour Breaches	Provider	0	Mar-19	2		↓		
	NHS 111 50% population receiving clinical input	Provider	50.0%	Mar-19	56.8%		↑		
	Ambulance (mean) response time Category 1 Incidents	Provider	00:07:00	Mar-19	00:07:29		↓		
	Ambulance (mean) response time Category 2 Incidents	Provider	00:18:00	Mar-19	00:26:31		↓		
	Reduce DTOCs across health and social care- NUH	Provider	3.5%	Feb-19	3.22%		↑		
	Reduce DTOCs across health and social care- SHFT	Provider	3.5%	Feb-19	4.54%		↑		
Primary Care Delivering extended access, additional workforce, upgrading primary care facilities, and	Extended Access GP Services (evenings & weekends, holiday periods) 100% population by October 2018	CCG	100%	Mar-19	100.0%				Mid Notts CCG's have 100% population coverage since October 2018. National reporting is now reflective of this position.
	Invest balance of the £3 / head for general practice transformation support	CCG							
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%	Feb-19	91.7%		↑		RTT perfomance missed 91.72%, as previous month, waiting lists have reduced to +3.9% over March 18 overall as ICS. 52 Week Waits – SFHT list validation has now concluded. Breaches continued into Q4 due to patient choice for both trusts. Wheelchairs – 100% achieved for Q4
	RTT Waiting List - March 2019 incomplete pathway < March 2018	Provider	<March 18 56511	Feb-19	58,739		↓		
	+52 Week Waits - to be halved by March 2019, and eliminated where possible	Provider	15	Feb-19	13		↑		
	Diagnostics +6 weeks	Provider	0.9%	Feb-19	0.55%		↓		
	Children's Wheelchair Waits < 18 Weeks	CCG	92%	Q4 18/19	100.00%		↑		
	E-Referrals increased coverage 100% 1819	CCG	100%	Dec-18	104%				

Nottinghamshire ICS
System Integrated Performance Summary
May 2019

	Key Performance Indicator	18/19 ICS Basis	18/19 Required Performance	18/19 Reporting Period	2018/19 ICS Performance				Exception Narrative
					Latest Period	Month RAG	Month Delivery Trend	Forecast Delivery Risk	
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%	Feb-19	96.8%		↑		62 Day wait times in oncology continue to be an issue across a number of tumour sites at NUH. Urology continues to be an issue at SFHFT, with 8.5/15.5 breaches in Urology in Feb.
	Cancer 2 weeks - Breast Symptomatic Referrals	Provider	93.0%	Feb-19	96.6%		↓		
	Cancer 31 Days - First Definitive Treatment	Provider	96.0%	Feb-19	96.1%		↑		
	Cancer 31 Days - Subsequent Treatment - Surgery	Provider	94.0%	Feb-19	92.5%		↑		
	Cancer 31 Days - Subsequent Treatment - Anti Can	Provider	98.0%	Feb-19	99.5%		↑		
	Cancer 31 Days - Subsequent Treatment - Radiothy	Provider	94.0%	Feb-19	99.1%		↑		
	Cancer 62 Days - First Definitive Treatment - GP Referral	Provider	85.0%	Feb-19	79.6%		↓		
	Cancer 62 Days - Treatment from Screening Referral	Provider	90.0%	Feb-19	100.0%		↑		
E. Nursing & Quality									
Transforming Care Continued reduction of inappropriate hospitalisation of people with Learning Disabilities focusing on long stay (5 year +) placements	Reductions in patients against Local planning trajectories - Total for Nottinghamshire	CCG	36	Feb-19	52		↓		The Nottinghamshire TCP collectively (Specialised Commissioning & CCG) did not achieve the 2018/19 trajectory (+14). CHC: Provisional data shows Nottingham & Nottinghamshire ICS achieved both QP standards for Q3 maintaining an improved position. Maternity: Notts ICS assessed by NHSE as 'Requiring Some Support' as a result of delayed progress in implementing the Saving Babies Lives Care Bundle, continuity of carer ambition, and a higher than national average rates of Smoking at Time of Delivery.
	Learning Disability Mortality Reviews (LeDeR)	CCG	85%	Feb-19	7.00%		↑		
Continuing Health Care	Fewer than 15% of Continuing Health Care Full Assessments undertaken in acute setting	CCG	<15%	Feb 19	1%		↓		
	More than 80% eligibility decisions undertaken within 28 days from receipt of checklist	CCG	80%	Feb 19	93%		↑		
Maternity Deliver improvements in safety for maternity services, and improve personal and mental health service provision	Continuity of Care	Provider	20%	Mar-19	2.20%				
Quality Measures	Mixed Sex Breaches			Feb-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		Feb-19	0		↓		
	MRSA	Provider		Feb-19	1		↑		
	C-Difficile	Provider		Feb-19	26		↑		
	E Coli	Provider		Feb-19	72		↓		

Nottinghamshire ICS
System Integrated Performance Summary
May 2019

	Key Performance Indicator	18/19 ICS Basis	18/19 Required Performance	18/19 Reporting Period	2018/19 ICS Performance				Exception Narrative
					Latest Period	Month RAG	Month Delivery Trend	Forecast Delivery Risk	
F. Prevention & Public Health			To be developed and populated by public health and social care						Healthy life expectancy has increased both nationally and locally over recent years, however 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
G. Finance & Efficiency	Overall Financial Position (Health & Social Care): **Pre-PSF**	ICS	Nil Variance to Plan (£millions)	Mar-19	-£24.2		↓		The year-end position for the overall system is a deficit of £91.8m (Plan £67.7m deficit). The increased deficit is due to provider pressures (increased activity/demand and additional pay expenditure) and LA pressures.
	Provider Sustainability Funding (PSF)	ICS (NHS)			-£11.7		↓		The system has received £37.3m of provider sustainability funding (Plan £49m). This is lower than the plan due to non delivery of A&E performance in Greater Nottingham (months 1-12), organisational financial performance at NUH (months 4-12) & system financial performance (months 4-12). This has been offset by the receipt of PSC Incentive Funds of £19m.
	Overall Financial Position (Health & Social Care) : **Post-PSF**	ICS			-£35.8		↓		The net position of the overall system is a deficit of £54.5m (Plan £18.7m deficit).
	NHS System Control Total	ICS (NHS)			-£18.4		↓		The year-end position against the NHS system control total is a deficit of £86.1m (Plan £67.7m deficit). The increased deficit is due to provider pressures of increased activity/demand and additional pay expenditure.
	Savings Programme (6%)	ICS			-£3.9		↑		The system delivered £166.2 million of savings & efficiencies, this is slightly below the annual target of £170.1 million.
	Mental Health Investment Standard (MHIS)	ICS	£148.8 (Plan)	Mar-19	£155.5		-		The MHIS standard has been achieved, commissioning spend exceed the requirement by £6.7 million.
	Agency Ceiling	ICS	£45.4 (Plan)	Mar-19	£41.3		-		The agency ceiling target has been achieved, agency spend was £4.1 million lower that the plan.
H. Workforce									To be developed and populated by workforce propgramme lead

ENC. J

Meeting:	ICS Board
Report Title:	Mid Nottinghamshire Integrated Care Provider Update – May 2019
Date of meeting:	Thursday 9 May 2019
Agenda Item Number:	13.
Work-stream SRO:	
Report Author:	Richard Mitchell
Attachments/Appendices:	None

Report Summary:

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

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.

Mid Nottinghamshire Integrated Care Provider Update

9 May 2019

1. The Mid Nottinghamshire (Mid Notts) ICP Board has not met since the last ICS Board and this update is written before the next ICP Board meeting on 14 May.

2. On Friday 26 April, 16 colleagues from Mid Notts with partners from Greater Nottingham, Doncaster and Bassetlaw visited Wigan Council to understand more about the **Wigan Deal**, which is "an informal agreement between the council and everyone who lives or works here to work together to create a better borough." The visit was helpful and very impressive and there is now greater understanding about what NHS Wigan Borough Clinical Commissioning Group, Wigan Council, Bridgewater Community Healthcare NHS Foundation Trust, Wrightington, Wigan and Leigh NHS Foundation Trust, North West Boroughs Healthcare NHS Foundation Trust and GP Practices from across the borough (62 practices) and wider partners have done to improve services in Wigan.

3. Aims in Wigan are similar to aspirations in Mid Notts:

   - To join up health and social care services where people live
   - To help people to be physically and mentally well
   - To help people to live a full, active life doing what they like to do
   - To offer easy to access services
   - To provide people with the right treatment at the right time
   - To offer the best possible care in the most affordable way
   - To design services with people to meet their needs
   - To support people to take care of themselves and manage your own care
   - To build on the strengths of people & communities.

4. What was most impressive though was what Wigan have delivered and how they have achieved it:

5. The improvements have been delivered through:

    - Clearly stated and agreed acceptable attitudes and behaviours
    - Evidence that different conversations are taking place
    - Knowing their community better and a sense of true community spirit
    - Giving permission and freedom to redesign and innovate
    - Co-location of teams and partner agencies in a place

6. Wigan has a sense of identity although not all of the residents actually live in Wigan and a population of 320,000 with pockets of acute deprivation.

7. At the ICP Board in May it is planned to discuss; learning from Wigan and practical agreements and actions to implement this year, sense of identity for Mid Notts and the comms and engagement to implement relating to this, plans to spend transformation funding in 2019/20, health inequalities and population health, PCN/ ICP interface, relationship with health and wellbeing boards, system learning from winter 2018/19 and planning for winter 2019/20 and home first discharge.

Richard Mitchell
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9 May 2019