Integrated Care System Board
Meeting in Public

Thursday 1 July 2021 15:30 – 17:30
Via Zoom

Name	Organisation
Adele Williams	Councillor, Nottingham City Council
Alex Ball	Director of Communications and Engagement, Nottingham and Nottinghamshire CCG and ICS
Amanda Sullivan	Interim Exec Lead, ICS and Accountable Officer, Nottingham and Nottinghamshire CCG
Boyd Elliott	Councillor, Nottinghamshire County Council
Claire Ward	Non-Executive Director, Sherwood Forest Hospitals NHS Foundation Trust
Eric Morton	Chair, Nottingham University Hospitals NHS Trust
Fran Steele	Director of Strategic Transformation, North Midlands, NHSEI
John Brewin	Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust
John Doddy	Chair of Health and Wellbeing Board, Nottinghamshire County Council
Jon Towler	Non-Executive Director, Nottingham and Nottinghamshire CCG
Kathy McLean	ICS Independent Chair
Louise Bainbridge	Chief Executive, Nottingham CityCare Partnership
Lucy Hubber	Director of Public Health, Nottingham City Council
Melanie Brooks	Corporate Director Adult Social Care and Health, Nottinghamshire County Council
Michael Williams	Chair, Nottingham CityCare Partnership
Mike Crowe	GP and PCN Clinical Director (representing PCNs in Nottingham City ICP)
Nicole Atkinson	GP, Nottingham and Nottinghamshire ICS Clinical Lead and South Nottinghamshire ICP Clinical Lead
Richard Henderson	Chief Executive, East Midlands Ambulance Service
Richard Mitchell	Chief Executive, Sherwood Forest Hospitals NHS Foundation Trust
Rosa Waddingham	Chief Nurse, Nottingham and Nottinghamshire CCG and ICS
Stuart Poynor	ICS Finance Director, and Chief Finance Officer and Deputy Accountable Officer, Nottingham and Nottinghamshire CCG
Thilan Bartholomeuz	GP and Clinical Lead for Mid Nottinghamshire ICP (representing Mid Nottinghamshire ICP)
Tim Guyler	Assistant Chief Executive, Nottingham University Hospitals Trust

In attendance

Name	Organisation
Jane Ferreira (Item	Head of MSK, Sherwood Forest Hospitals NHS Foundation Trust

4)	
Joanna Cooper	Assistant Director, Nottingham and Nottinghamshire ICS
Jonathan Gribbin (Item 7)	Director of Public Health, Nottinghamshire County Council
Rebecca Larder	Programme Director, Nottingham and Nottinghamshire ICS

Apologies

Name	Organisation
Gavin Lunn	GP (representing PCNs in Mid Nottinghamshire ICP)
Hugh Porter	GP, Clinical Director and Interim Lead for Nottingham City ICP (representing Nottingham City ICP)
Mel Barrett	Chief Executive, Nottingham City Council
Paul Devlin	Chair, Nottinghamshire Healthcare NHS Foundation Trust
Tim Heywood	GP Lead (representing PCNs in South Nottinghamshire ICP)
Tracy Taylor	Chief Executive, Nottingham University Hospitals Trust

1. Welcome and introductions

KM welcomed colleagues to the meeting.

KM thanked NA as this will be her last formal meeting as the ICS Clinical Lead. KM highlighted that NA has made considerable progress developing system clinical leadership and engagement. NA will continue to be an ICS Board member as Clinical Lead for the South Nottinghamshire ICP.

2. Conflicts of Interest

No conflicts were noted in relation to the items on the agenda.

3. Minutes of 6 May ICS Board meeting, action log and ICS Board workplan

The minutes of the meeting held on 6 May 2021 were agreed as an accurate record of the meeting by those present.

AW highlighted that City Council are not able to sign up to the Partnership Agreement until it has been through formal governance processes. AW has some suggested amendments and will share with RL.

The action log and updates were noted.

4. Improving Musculoskeletal Health in the Mid Nottinghamshire Place

TB and JF presented the circulated citizen story on Improving Musculoskeletal Health in the Mid Nottinghamshire Place and shared a video of a citizen story - https://youtu.be/7iRe07RpwXs

KM thanked TB and JF on behalf of Board for the presentation and valuable feedback in the video which demonstrated a lived experience of services:

- NA highlighted this as a good example of how system partners should be working. NA interested to share the learning across the ICS.
- JB emphasised that this project provides good evidence of a transformational pathway adding value, and a good model for addressing equity of access. JB also advised on examples within mental health pathways such as IAPT and direct access, and mental health support teams into schools which support a whole school approach.
- RM noted that the three ICS Board principles for system working run through this work. RM welcomed the work taking a focus on addressing health inequalities in access and outcomes.
- MC highlighted the video and comment that it is key for patients to understand pathways. MC emphasised that clearly communicating the pathway to citizens is important in designing pathways.
- AS welcomed the presentation and how this service has developed through people coming together to think about the patient journey, value and how best to work as one team.

5. Report from the Independent Chair and Executive Lead

KM presented the circulated report from the Independent Chair and Executive Lead. KM highlighted that since the report was published a new Secretary of State has been appointed, which has resulted in a pause in the legislation. Leads are progressing work that can be taken forward, and will be mindful of changes in the timetable. System remains focussed on an April 2022 timetable.

AS highlighted that the June ICS Board development session was helpful to define how the system will work. Since the session, the ICS Design Framework was published. There is good alignment with local conversations, and work is underway to progress, which is important in our overall integration journey. A Transition and Risk Committee is in place to oversee this work.

6. ICS Board Partnership Agreement

KM presented the ICS Board Partnership Agreement. This has been developed and strengthened further since discussion at the May meeting. The Partnership Agreement will be used in practice and continue to be an iterative document. There will be wider engagement with system partners.

Board discussed and noted:

- NA advised that the South Nottinghamshire ICP discussed on 30 June and supported the agreement.
- AW highlighted suggested additions on ways of working: prioritising resources to impact on health inequalities, making a positive impact on the local economy and being environmentally responsible. AW also advised that City Council are yet to take through formal governance routes and would hope to strengthen the health inequalities narrative before doing so.
- RM highlighted that there is strong symbolism with the signatories to the agreement. RM suggested that Board need to strike a balance in signing up to

the agreement that doesn't mean that partners can't disagree in line with the system values. A test of the success of the agreement is how this percolates through our organisations.
- RH supportive of the Partnership Agreement on behalf of EMAS.

7. Future development and alignment of the Nottingham and Nottinghamshire Joint Strategic Needs Assessments with the Nottingham and Nottinghamshire ICS

JG and LH presented the circulated paper on the JSNA and asked Board to consider:
1. How can the ICS Board ensure the JSNA is robustly and sustainably resourced?
2. What products, populations and/or topics would the ICS Board like to see explored?

Board discussed and noted that this is the first of a series of Board discussions:
- KM suggested that ICS Board makes these links within the current governance structure, and the ICS Partnership in future.
- MB highlighted that this is core to business going forward, in particular mental health and collaborating on commissioning, planning, and data analytics.
- AW emphasised that this was a helpful conversation to operationalise the JSNA and intelligence team.
- AS advised that the JSNA is most valuable when seeking to understand new and emerging areas of need. Two areas of interest were suggested: the impact of Covid-19 on population health (long term and psychological impacts), and how this might change health services, and inequalities, and neurodevelopment disorders. There is a commitment to ensure capacity to develop the JSNA and commissioning capacity to support and unblock data sharing.
- TB highlighted that there is similar work in ICPs and that sharing and learning on ICP priorities would be welcome, as well as PCN profiles. TB queried the value of annual reviews.
- NA supportive of ensuring there is one version of the truth for data across the system and that this is presented at system, place and PCN levels. The PCN profiles were helpful and it would be useful to link with the support to networks and ehealthscope. NA suggested a discussion on how place can input and ensure the JSNA is core.
- JB emphasised that a single system data analytics hub function aligned with population health management (PHM) and wider determinants inputs would be really powerful in informing this agenda and driving it forward. NA supportive of this.
- AB welcomed the approach. Helpful to use JSNA as an opportunity to identify areas where there are barriers to access. AB offered to support this process with engagement resource.
- JF advised that within MSK work is underway to get local population health data and understand activity/access and outcomes across the Mid Nottinghamshire ICP in order to deliver impactful changes to improve healthy life expectancy and reduce inequity. JF asked what support is available to assist this work.

- MC welcomed the Nottingham and Nottinghamshire Insights products and advised that these have been used in practice to influence focus at PCN level. MC supportive of data / PHM in one place.
- JD highlighted that there are shared agendas across City and County, and that the ICS is a helpful mechanism to support this. JD advised that restoration is key, and that the big killers remain and have been exacerbated by Covid-19.
- AS advised that as agreed at a previous Board meeting, analytical and PHM resources are being aligned and CCG analytic functions are being repurposed to build on the work during the pandemic. This will support ICPs as well as system strategic planning and the PHM agenda. Discussions have been held in the early stages around aligning this resource virtually with partners and that will take time to evolve, recognising that organisations also have internal information and business intelligence needs.
- TG highlighted the importance of the JSNA as this gives population understanding. TG observed that in the past the JSNA has been underutilised and that this is an opportunity to address. Model of Clinical and Community Services Strategy (CCSS) in bringing key subject matter experts together could be utilised to develop the JSNA. There are City discussions underway on aligning the Place based partnership and the Health and Wellbeing Board (HWB) which will be helpful.
- MW reinforced the ICS Partnership having this strategic responsibility in the future way of working. Objectives focussed on healthy life expectancy, however Marmot work has highlighted that health inequalities are prevalent. MW suggested that work should be undertaken to understand why there are differences and reprioritising resources to rebalance this.
- JT endorsed a link to PHM, and observed that the JSNA doesn't feel visible. JT suggested that it might be helpful to bring to a future meeting and revisit alongside future ways of system working.

JG thanked colleagues for their questions and input and welcomed further actions for HWBs, the opportunity to explore working with ICS data intelligence. The ICP link to HWBs will be helpful going forward, and will provide opportunities for ICPs to steer the JSNA. JG reiterated that there are interventions that can be put in place nationally and locally to address health inequalities, but that reprioritisation is needed to support this. JG and LH are keen to ensure the JSNA focusses on key issues going forward.

Board acknowledged the joint and statutory responsibilities of the JSNA that falls to ICS partners. Board agreed that in this financial year ICS partners will contribute to the production of the JSNA, including by giving an on-going strategic steer for the future JSNA approach (such as prioritising work programmes areas and products to be developed). In future years, oversight of this work will become a responsibility of the ICS Partnership.

Board members are supportive of the next steps and raised no issues in relation to this item. KM is keen for the golden thread to connect through all levels of the system on this work.

8. Update Report on Improving Health and Wellbeing for 2021/22 priority population groups

AS presented the circulated report on Improving Health and Wellbeing for 2021/22 Priority Population Groups further to the discussion at the May meeting. Since the last meeting the signature schemes agreed have been established and are being tested. Metrics have been developed to monitor and report progress to ICS Board.

9. Integrated Performance Report

AS presented the Integrated Performance Report and highlighted that in quarter one the system has been balancing a number of challenges: increases in demand and presentations; a focus on the recovery of planned procedures and operations; vaccine roll out at pace; increased demand for mental health services in terms of demand and acuity; and concerns around maternity services with actions in place to address. The system has been identified as a national planned care accelerator site, which has enabled further activity to take place and citizens to access treatment in a timelier manner.

Board noted the approach to NHS Planning for 2021-22 and the years ahead.

Board discussed and noted:

- The additional report included on health inequalities was welcomed by Board members.
- KM commented on the predominant health focus of the reports and would welcome a wider system view of performance.
- JB emphasised the vaccination programme as a system priority. Good partnership working and collaboration is being seen from all partners, and data is being used to support roll out of the programme to address health inequalities. KM asked for the lessons learned to be captured. LH advised that the foundations of work are underway.
- FS advised that the system had a positive 'Big Push' weekend for the vaccination programme and NHSEI have asked to share this learning more widely.
- AW highlighted a continued focus on health inequalities and shared that Local Authorities supported the big weekend by door knocking to discuss with citizens.
- MC suggested a deep dive into the health inequalities data to understand the causes of inequalities, e.g. access to general practice and length of appointment. Potentially strengthening general practice would support in addressing these inequalities. Good progress has been made in recruiting to additional roles in PCNs to expand the mix of professionals working in general practice. However, barriers remain and further work is needed e.g. estates.
- RM highlighted that the System Delivery Dashboard is off track against all nine constitutional performance standards, and suggested that Board ensure that the governance is in place to address this. KM suggested that the SROs leading on this work as part of the distributed leadership approach take

personal responsibility to reflect and bring back thoughts for addressing performance issues.

- TB queried whether the health inequalities report reflects true health inequalities in the system. Learning from the MSK work suggests that the data could be a reflection of how services have been set up and clinical variation rather than deprivation and health inequalities. On the System Delivery Dashboard the four worst performing areas, TB asked how addressing these issues percolates through the organisations and system. TB offered to support further discussions as needed, and declared an interest in relation to being the clinical lead for the MSK programme.

ACTIONS:
Lessons learned on the Covid-19 vaccination programme to be captured and circulated to ICS Board members.
SROs for the nine performance standards to consider barriers to progress and support needed from the ICS Board to improve performance.

10. Report from the Transition and Risk Committee

JT presented the report from the Transition and Risk Committee and highlighted that no transition areas have been rated as red. The publication of the ICS Design Framework has enabled work to progress, noting the pause for the new Secretary of State being appointed.

In the short term Committee might take on assurance for the transition elements for People and Culture, Data, Analytics and Information Technology (DAIT) and Finance for three months whilst ICS governance is agreed. ICS Board supported this recommendation.

11. Report from the Quality Committee

Reports noted. RW highlighted the agreed quality principles for working together, which are aligned to the ICS Partnership Agreement.

Arrangements are underway to develop the Quality Committee. KM highlighted potentially widening the scope of the committee to include quality and inequalities.

12. Report from the Finance Committee

Report noted. SP highlighted the on-going work to improve working together for a more formalised approach in the future.

13. ICS Transition Governance

AS presented the circulated paper on the ICS Transition Governance arrangements. AS highlighted the publication of the ICS Design Framework and work underway to develop a statutory ICS. The proposed transition governance arrangements have

incorporated best practice from other systems, and have been endorsed by the System Executive Group. The proposed arrangements include the establishment of assurance committees, and recognise clinical and quality leadership development.

The final appendix to the report includes draft strategic risks which have been developed further to ICS Board discussion at the March development session.

Board agreed the ICS transition governance arrangements for 2021/22. JB highlighted the iterative and developmental nature of the ICS, and the workforce requirements. JB suggested giving consideration to raising the profile of People and Culture to ensure a higher level of oversight. Board endorsed this approach and asked AS to revise the transition governance arrangements to include a People and Culture Committee.

Board noted the requirement for the further development of these arrangements during the current year in readiness for potential statutory status from April 2022.

Board approved the Terms of Reference for both the ICS Transition and Risk Committee and the ICS Clinical Executive Group, and the proposed strategic risks to enable the full development of an ICS Board Assurance Framework.

ACTIONS:
AS to revise the transition governance arrangements to reflect the discussion at the ICS Board meeting.

14. Questions from members of the public relating to items on the agenda

Members of the public are now welcome to submit questions related to items on the agenda. No questions were received for this meeting.

Further consideration to be given to promoting this for future meetings.

15. Review of Meeting against Partnership Agreement

KM asked Board members if they felt that leadership is distributed, and if the meeting functioned inline with the ICS Partnership Agreement. Board members confirmed.

KM highlighted that a feedback questionnaire will be circulated to Board members and asked for support in completing and returning this.

Time and place of next meeting:
2 September 2021, 15:30 – 17:30

ICS Board 2 September: Item 3. Enc A2

ICS Board Meeting Log 2020/21 | **Active Actions**

Completed
Ongoing
Outstanding

Reference Number	Discussion/Rationale	Date	Action	Update/Comment	Action Owner	Deadline	Status
B288	9. Integrated Performance Report	01 July 2021	Lessons learned on the Covid-19 vaccination programme to be captured and circulated to ICS Board members.		Amanda Sullivan	31 July 2021	Outstanding
B291							

ICS Board Meeting Log 2020/21	Completed Actions

Completed
Ongoing
Outstanding

Reference Number	Discussion/Rationale	Date and time	Action	Update/Comment	Action Owner	Deadline	Status
B278	Item 6.Reshaping health services in Nottinghamshire; Tomorrow's NUH, and Clinical Services Strategy	10 December 2020	NA to circulate an update document on the Clinical Services Strategy to Board.	Clinical Services Strategy update on January 2021 agenda	Nicole Atkinson	31 March 2021	Completed
B279	Item 6.Reshaping health services in Nottinghamshire; Tomorrow's NUH, and Clinical Services Strategy	10 December 2020	RL to include the Board forward plan with future meeting papers.	ICS Board forward plan included with meeting papers.	Rebecca Larder	21 January 2021	Completed
B275	Item 5.Moving from CCG Commissioning Intentions to System Prioritisation and Strategic Planning	12 November 2020	AS to reflect ICS Board feedback into the proposed System Prioritisation and Strategic Planning approach; and update Board on next steps for embedding this new approach.	Feedback incorporated. ICS Board to be updated at the 21 January meeting during confidential discussion.	Amanda Sullivan	21 January 2021	Completed
B277	Item 6.Reshaping health services in Nottinghamshire; Tomorrow's NUH, and Clinical Services Strategy	10 December 2020	AB to ensure clear messaging that differentiates TNUH objectives with ICS objectives.	Incorporated into teams way of working.	Alex Ball	31 March 2021	Completed
B276	Item 4.Patient Story: Supporting Rough Sleepers in Nottingham	10 December 2020	AS to work with the CCG/ICP Group ensure learning and best practice on the different care approaches for rough sleepers; and with the System Executive Group ensure ICP plans for 2021/22 include a programme approach for this population group.	Actions being progressed through the CCG / ICP Group.	Amanda Sullivan	31 March 2021	Completed
B281	Item 4.Patient Story: Acute Home visiting Service in Mid Nottinghamshire	21 January 2021	HP share evaluations of the City acute home visiting service with TB.		Hugh Porter	18 February 2021	Completed
B280	Item 7.ICS System Level Outcomes Framework – Stock Take and Progress Update	10 December 2020	AH/System Executive Group to agree next steps in enabling the ICS to be accountable for achieving progress against the Outcomes Framework.	Item on the Board agenda for 6 May meeting	System Executive Group	30 April 2021	Completed
B282	Item 4.Patient Story: Acute Home visiting Service in Mid Nottinghamshire	21 January 2021	System Executive Group to consider how real time evaluation and analysis of pilots and initiatives can be embedded and shared across the system.	Item on the Board agenda for 6 May meeting	System Executive Group	31 March 2021	Completed
B284	Item 6.Clinical and Community Services Strategy Update	21 January 2021	System Executive Group to give further consideration to CCSS process for agreeing reviews, funding, and workforce implications as part of the work on system prioritisation and strategic planning.	Process incorporated as part of the work on system prioritisation and strategic planning.	System Executive Group	31 March 2021	Completed
B286	Item 6.People and Culture: Update on the delivery of the ICS People Plan 2020/21	18 February 2021	KM to consider with Chairs and Elected Members the non-executive/elected member involvement in assurance groups supporting the work of the ICS Board.	Item on the Board agenda for 6 May meeting	Kathy McLean	31 March 2021	Completed
B287	Item 7.ICP Updates	18 February 2021	Longer discussion on City ICP to be scheduled for the next meeting.	Item superceded	Hugh Porter	30 April 2021	Completed
B283	Item 4.Patient Story: Acute Home visiting Service in Mid Nottinghamshire	21 January 2021	System Executive Group to give consideration to widening access to the service across the system.	Acute home visiting will be considered as part of the community transformation review and development of a care model.	System Executive Group	31 March 2021	Completed
B285	Item 6.People and Culture: Update on the delivery of the ICS People Plan 2020/21	18 February 2021	KM to give consideration to a future Board development session on People and Culture.	Work is underway to develop a programme for the ICS Board development sessions.	Kathy McLean	30 June 2021	Completed

ICS Board Meeting Log 2020/21	Completed Actions

Completed
Ongoing
Outstanding

Reference Number	Discussion/Rationale	Date and time	Action	Update/Comment	Action Owner	Deadline	Status
B289	9. Integrated Performance Report	01 July 2021	SROs for the nine performance standards to consider barriers to progress and support needed from the ICS Board to improve performance.	The System Executive Group have considered and arrangements are being put in place to establish a monthly System Oversight Review Meeting to provide oversight of system performance. Issues will be escalated to the ICS Board as required.	SROs for the nine performance standards	02 September 2021	Completed
B290	13. ICS Transition Governance	01 July 2021	AS to revise the transition governance arrangements to reflect the discussion at the ICS Board meeting.	The transition governance arrangements have been updated in line with the discussion at the ICS Board and groups are being operationalised in line with this.	Amanda Sullivan	31 July 2021	Completed

ICS Board Meeting Log 2020/21	Decisions

Completed
Ongoing
Outstanding

Reference Number	Discussion/Rationale	Decision	Date	Update/Comment	Decision Owner	Deadline	Status
ICSB - D023	Item 3. Minutes of previous meeting/Action log and ICS Board workplan	The minutes of the meeting held on 18 February 2021 were agreed as an accurate record of the meeting by those present. The action log and updates were noted.	06/05/2021		Joanna Cooper		Completed
ICSB - D024	Item 3. Minutes of previous meeting/Action log and ICS Board workplan	The minutes of the meeting held on 6 May 2021 were agreed as an accurate record of the meeting by those present. AW highlighted that City Council are not able to sign up to the Partnership Agreement until it has been through formal governance processes. AW has some suggested amendments and will share with RL. The action log and updates were noted.	01/07/2021		Joanna Cooper		Completed
ICSB - D025	7. Future development and alignment of the Nottingham and Nottinghamshire Joint Strategic Needs Assessments with the Nottingham and Nottinghamshire ICS	Board acknowledged the joint and statutory responsibilities of the JSNA that falls to ICS partners. Board agreed that in this financial year ICS partners will contribute to the production of the JSNA, including by giving an on-going strategic steer for the future JSNA approach (such as prioritising work programmes areas and products to be developed). In future years, oversight of this work will become a responsibility of the ICS Partnership. Board members are supportive of the next steps and raised no issues in relation to this item. KM is keen for the golden thread to connect through all levels of the system on this work.	01/07/2021		Melanie Brooks and Mel Barrett	31/12/2021	Ongoing
ICSB - D026	10. Report from the Transition and Risk Committee	ICS Transition and Risk Committee proposed that it might take on assurance for the transition elements for People and Culture, Data, Analytics and Information Technology (DAIT) and Finance for three months whilst ICS governance is agreed. ICS Board supported this recommendation.	01/07/2021	Arrangements have been put in place for the three SROs to attend upcoming Transition and Risk meetings to provide assurance.	Jon Towler	31 July 2021	Completed
ICSB - D027	13. ICS Transition Governance	Board agreed the ICS transition governance arrangements for 2021/22 presented at the 1 July meeting with the addition of establishing a People and Culture Committee. Board approved the Terms of Reference for both the ICS Transition and Risk Committee and the ICS Clinical Executive Group, and the proposed strategic risks to enable the full development of an ICS Board Assurance Framework.	01/07/2021	Arrangements are underway to establish the agree transition governance structure for 2021/22.	Amanda Sullivan	31 July 2021	Completed

ICS Board Meeting Log 2020/21	Decisions

Completed
Ongoing
Outstanding

Reference Number	Discussion/Rationale	Decision	Date	Update/Comment	Decision Owner	Deadline	Status
ICSB - D028							

ICS Board Meeting Log 2020/21 **Register**

Attendees/Loggist	Meeting Dates										
	16/01/2020	13/02/2020	12/03/2020	17/09/2020	15/10/2020	12/11/2020	10/12/2020	21/01/2021	18/02/2021	06/05/2021	01/07/2021
NUH											
Chair	A	A	A	A	A	A	A	A	A	A	A
Chief Executive	A	A	A	A	A	A	A	A	A	A	D
SFH											
Chair	Apols	A	A	D	D	A	A	D	D	A	A
Chief Executive	D	A	A	A	A	A	A	A	A	A	A
NHCT											
Chair	A	A	A	A	A	A	A	A	A	A	Apols
Chief Executive	Apols	A	A	D	A	A	A	A	A	A	A
CCGs											
Accountable Officer	D	A	A	A	A	A	A	A	A	A	A
Non-Executive Director	A	Apols	A	A	A	A	A	A	A	A	A
City Council											
Chair, Health and Wellbeing Board	A	Apols	A	A	A	A	A	A	A	A	A
Chief Executive's Representative	A	Deputy	A	A	Apols	A	Apols	A	A	A	D
Councillor	A	A	Apols	A	A	A	A	A	A	N/A	N/A
County Council											
Chief Executive's Representative	A	A	Apols	A	Apols	A	A	Apols	Apols	Apols	A
Councillor	Apols	Apols	A	A	Apols	A	A	A	Apols	Apols	A
Chair, Health and Wellbeing Board	A	Apols	Apols	Apols	Apols	A	A	A	A	Apols	A
EMAS											
Chief Executive	D	Apols	A	A	A	A	A	A	A	A	A
NHSEI											
Director of Strategic Transformation, North Midlands					A	A	Apols	A	A	A	A
Nottingham CityCare Partnership											
Chief Executive	A	A	A	A	A	A	A	A	A	A	A
Chair	Apols	A	A	A	A	A	A	A	A	A	A
MN ICP											
Representative of Mid Notts ICP	A		A	A	Apols	A	A	A	Apols	A	A
Representative of Mid Notts ICP on behalf of PCNs	Apols	A	A			A	A	Apols	A	A	Apols
City ICP											
Representative of Nottingham City ICP	A	A	A	A	Apols	A	A	A	A	A	Apols
Representative of Nottingham City ICP on behalf of PCNs	Apols	Apols	A	A	A	Apols	A	Apols	A	A	A
South ICP											
Representative of South ICP	A	A	A	A	A	A	A	A	A	A	A
Representative of South ICP PCN on behalf of PCNs	A	A	A	A	A	A	A	A	Apols	A	Apols
Supporting roles											
ICS Director of Communications and Engagement	A	A	A	A	A	A	A	A	A	A	A
Clinical Director	A	A	A	A	A	A	A	A	A	A	A
ICS Independent Chair	A	A	A	A	A	Apols	Apols	A	A	A	A
Chief Nurse	A	A	Apols	A	A	A	A	A	A	A	A
ICS Finance Director	A	A	A	D	A	A	A	A	A	A	A
ICS Assistant Director	A	A	A	A	A	A	Apols	A	A	A	A
ICS Executive Lead	A	A	A	A	A	A	A	A	A	A	A

NOTTINGHAM AND NOTTINGHAMSHIRE INTEGRATED CARE SYSTEM

ICS BOARD WORK PROGRAMME 2021/22

Item	Action	Lead	September	November	January
Standing Business Items					
Introductions, apologies and Declarations of Interest	Note	ICS Independent Chair	/	/	/
Minutes and action log update	Approve	ICS Independent Chair	/	/	/
Report from the Independent Chair and Executive Lead	Discuss	ICS Independent Chair	/	/	/
Citizen Story					
Citizen Story	Note	Director of Communications and Engagement	/	/	/
Strategy and System Planning					
ICS Outcomes Framework Report	Discuss	ICS Executive Lead	/	/	
Insights on Health and Wellbeing in Nottingham and Nottinghamshire	Discuss	Directors of Public Health	TBC	TBC	TBC
Data, Analytics and IT	Discuss	SRO for Data, Analytics and IT		/	
People and Culture	Discuss	SROs for People and Culture		/	
System Approach to Citizen Involvement	Agree	Director of Communications and Engagement		/	
Governance and Assurance					
Integrated Performance Report	Note	ICS Executive Lead	/	/	/
Report from the Transition and Risk Committee	Endorse	Chair of the Transition and Risk Committee	/	/	/
Report from the Quality Group	Endorse	Chair of the Quality Committee	/	/	/

Item	Action	Lead	September	November	January
Report from the Finance Group	Endorse	Chair of the Finance Committee	/	/	/
ICS Governance and Terms of Reference	Approve	ICS Executive Lead			
Risk Management Arrangements and Board Assurance Framework	Approve	ICS Executive Lead		/	
Register of Interest for Key ICS Roles	Approve	ICS Independent Chair		/	
ICS Annual General Meeting	Note	ICS Independent Chair	TBC	TBC	TBC
Closing Items					
Questions from members of the public relating to items on the agenda	Discuss	ICS Independent Chair	/	/	/
Review of meeting against Partnership Agreement	Discuss	ICS Independent Chair	/	/	/

Item Number:	4	**Enclosure Number:**	B
Meeting:	ICS Board		
Date of meeting:	2 September 2021		
Report Title:	Representing what matters to local people in the Nottingham City Place Based Partnership		
Sponsor:			
Place Lead:	Dr Hugh Porter, Interim Lead and Clinical Director, Nottingham City ICP		
Clinical Sponsor:			
Report Author:	Kinsi Clarke, Partnerships Manager, Healthwatch Nottingham and Nottinghamshire Rich Brady, Programme Director, Nottingham City ICP		
Enclosure / Appendices:	**Appendix 1 – Flyer for VCS engagement event** **Appendix 2 – VCS engagement event stakeholder summary report** **Appendix 3 – Nottingham City Place programme priorities 2021/22**		

Summary:

As members of the Nottingham City Place Based Partnership, Healthwatch Nottingham and Nottinghamshire and Nottingham Community Voluntary Service play an important role in ensuring that the partnership priorities are representative of the needs of people living in Nottingham City.

This report details the work undertaken by Healthwatch Nottingham and Nottinghamshire and Nottingham Community Voluntary Service to ensure that the work of the City Place is informed by the views citizens, as well as the wide and diverse sector of voluntary and community organisations in Nottingham City.

Actions requested of the ICS Board

To receive the report and discuss how the ICS can demonstrate transparency that feedback from citizens is influencing decisions and how will this be communicated to communities to support building trust.

Recommendations:

1.	To **note** the work undertaken in partnership by Healthwatch Nottingham & Nottinghamshire and Nottingham Community Voluntary Service to ensure that what matters to local people is represented in the work of the Nottingham City Place Based Partnership.

Presented to:

Board	Partnership Forum	Clinical Executive Group	System Executive Group	Finance Directors Group
☒	☐	☐	☐	☐
Quality Group	**Transition and Risk Committee**	**Mid Nottingham-shire Place**	**Nottingham City Place**	**South Nottingham-shire Place**
☐	☐	☐	☒	☐

Contribution to delivering System Level Outcomes Framework ambitions

Our people and families are resilient and have good health and wellbeing	☒	Our people will have equitable access to the right care at the right time in the right place	☒	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	☐

Conflicts of Interest

☒ No conflict identified
☐ Conflict noted, conflicted party can participate in discussion and decision
☐ Conflict noted, conflicted party can participate in discussion, but not decision
☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision
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Risks identified in the paper

Risk Ref	Risk Category	Risk Description	Residual Risk				Risk owner
			Likelihood	Consequence	Score	Classification	
Ref	e.g. quality, financial, performance	Cause, event and effect There is a risk that…	L1-5	L1-5	L x I	Grading	*Person responsible for managing the risk*

Is the paper confidential?

☐ Yes
☒ No
☐ Document is in draft form

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.

Representing what matters to local people in the Nottingham City ICP

2 September 2021

Introduction

1. As members of the Nottingham City Place Based Partnership, Healthwatch Nottingham and Nottinghamshire and Nottingham Community Voluntary Service play an important role in ensuring that partnership priorities are representative of the needs of people living in Nottingham City.

2. Healthwatch Nottingham and Nottinghamshire and Nottingham Community Voluntary Service have worked in partnership to ensure that the work of the Place Based Partnership is informed by the views citizens, as well as the wide and diverse sector of voluntary and community organisations in Nottingham City.

Informing priorities for 2020/21

3. In January 2020, as part of the process for identifying the priority areas of focus for City Place partners, Healthwatch Nottingham and Nottinghamshire and Nottingham Community Voluntary Service hosted an event with 22 organisations from the community and voluntary sector to inform priority setting by providing insight into 'what matters to local people'.

4. The output of this event was used, alongside population health data and information, the ICS Strategy and accompanying outcomes framework, to inform the Nottingham City Place programme priorities for 2020/21.

5. Throughout 2020/21 Healthwatch Nottingham & Nottinghamshire and Nottingham Community Voluntary Service have played an active role within the different Place programme priorities.

2020/21 programme review

6. Ahead of 2021/22 the City Place Based Partnership undertook a formal review of its programme priorities. Programme leads reported a summary of progress in 2020/21 against key performance indicators and outcomes, highlighting any risks, issues and opportunities for 2021/22 before a decision was taken on the future of each programme.

7. As part of the programme review, on 4 March 2021, Healthwatch Nottingham and Nottinghamshire, in partnership with Nottingham Community Voluntary Service held an event with community and voluntary partners (**appendix 1**). The purpose

of this event was to ensure that voices of the citizens and the community and voluntary sector influenced the programme review process.

8. Community and voluntary sector partners who attended the event provided feedback on the way the City Place Based Partnership has been working in year 1, what the current issues of importance are to citizens and made recommendations for future areas of focus for the City Place. These were:

   - Focus on mental health
   - Black, Asian and minority ethnic (BAME) health inequality in and outside the context of Covid-19
   - Joined up work between partners to address the wider determinants of health which have been significantly exacerbated by Covid-19
   - More long-term approach, not crisis management
   - On-going assessment of the social prescribing programme, on its benefits and the voluntary sector's ability to absorb the referrals
   - Greater partnership with specialist services in the community and voluntary sector (domestic abuse, learning disability, etc.)
   - Community and voluntary sector being more at the centre of the system, not at the fringes

   A full summary of feedback from the event can be found in **appendix 2**.

Priorities for 2021/22

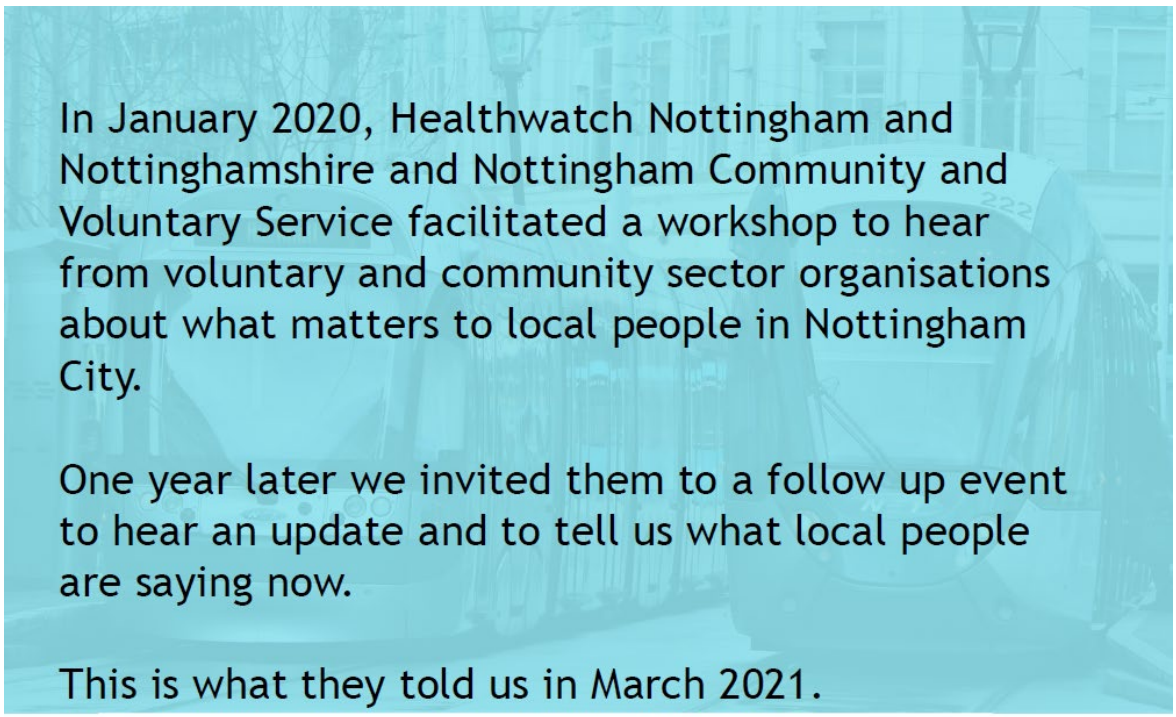
9. Many of the issues identified were being addressed within the current set of programmes which ran through 2020/21, providing further evidence that these programmes should continue into 2021/22. City Place programme leads have incorporated the feedback from the event into their respective programmes.

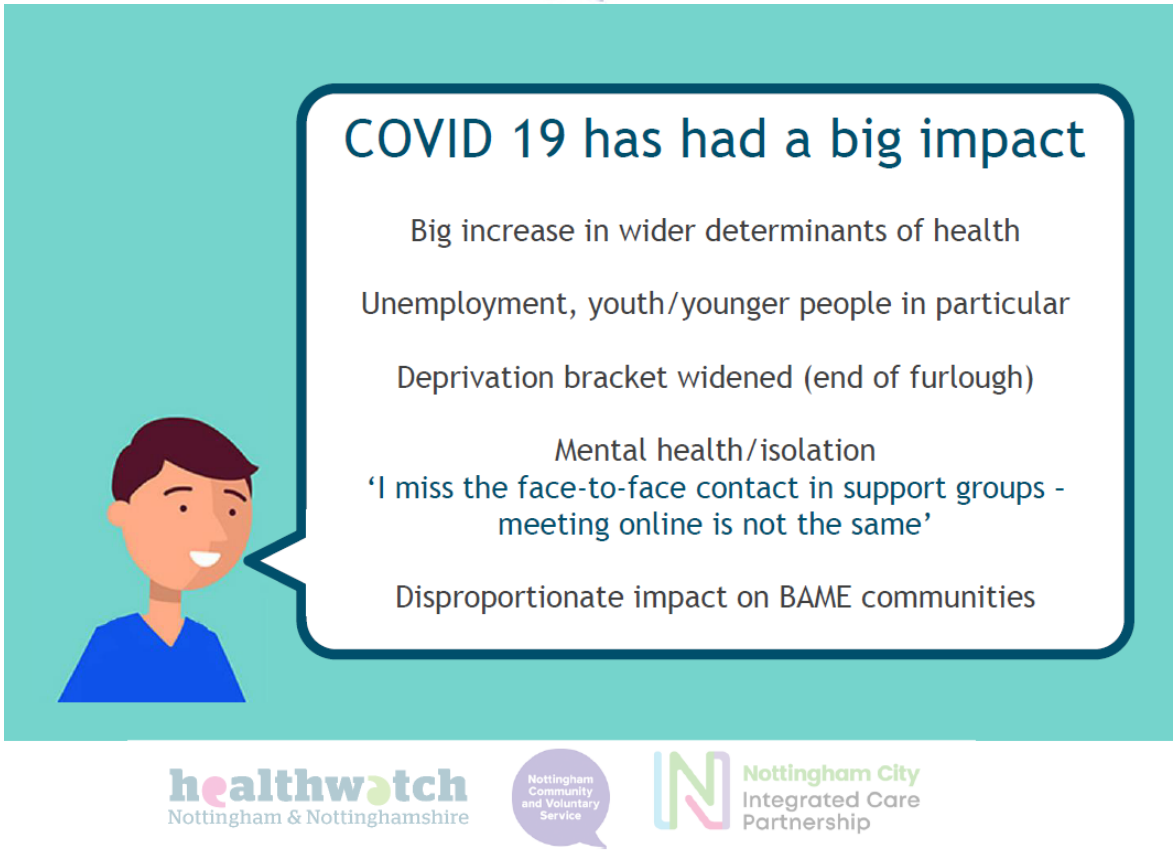
10. In addition, taking into account the feedback from citizens and community and voluntary sector partners, City Place partners have also agreed to develop a new programme for 2021/22 that will focus on improving the mental health and wellbeing on city residents (**appendix 3**).

11. The scope of the mental health programme is being agreed between partners and will build on the work of the Nottingham City Action for Better Mental Health Collaborative. It is anticipated that the programme will be the central point of contact in the city for with the on-going ICS mental health transformation programme.

Appendix 1 – Flyer for VCS engagement event

Appendix 2 – VCS engagement event stakeholder summary report





People from BAME communities

Deep lack of trust with mainstream/statutory services

Vaccine hesitancy in BAME communities as a result of the above

Structural health inequalities/racism

People do not feel engaged or represented from the outset

healthwatch Nottingham & Nottinghamshire
Nottingham Community and Voluntary Service
Nottingham City Integrated Care Partnership

People with learning disabilities (LD) and carers

Vaccine information not readily available in an accessible format

Concern among people with LD whether the vaccine will impact on their impairments or medication -
'I feel anxious about the side effects a vaccine could have on me'

People with LD reporting not being able to take carers/support workers to vaccine

Increased burden on unpaid carers

healthwatch Nottingham & Nottinghamshire
Nottingham Community and Voluntary Service
Nottingham City Integrated Care Partnership

NHS services are too disjointed

Not person centered, each part of the system is fixing a bit of 'you' but not the whole of you

"They just fix the bit they need to and they send you on your way, no follow up to link you to the next bit"

Communication still too complex
"I am a white woman who is eloquent in my language (English) and I struggle so much… …I can't imagine how someone who doesn't speak English is supposed to access services"

People having to tell their story over and over again

healthwatch Nottingham & Nottinghamshire
Nottingham Community and Voluntary Service
Nottingham City Integrated Care Partnership

Domestic abuse and violence against women

Rise in violence against women in general and sex workers; domestic homicide

Increased need for counselling and mental health support for women

Increased difficulties in accessing statutory mental health services, referrals not going anywhere

Massive increase in need for support from domestic abuse/women's services; demand greater than need, risk of volunteer burnout

healthwatch Nottingham & Nottinghamshire
Nottingham Community and Voluntary Service
Nottingham City Integrated Care Partnership

Mental Health

Young people are struggling with social isolation

Increased tension and conflict between and within households, intergeneration living arrangement, home schooling

Referrals to mental health are increasing but people are not being seen and it is hard to see how that is going to be resolved without a clear plan

Remote support has been helpful for some people but should not be the only offer "it's difficult to build up a rapport if not meeting up face to face"

healthwatch Nottingham & Nottinghamshire
Nottingham Community and Voluntary Service
Nottingham City Integrated Care Partnership

Ideas for future areas of focus for the Nottingham City Integrated Care Partnership

- Focus on mental health
- BAME health inequality in and outside the context of Covid19
- Joined up work between partners to address the wider determinants of health which have been significantly exacerbated by Covid19
- More long-term approach, not crisis management
- Ongoing assessment of the social prescribing programme, on its benefits and the voluntary sector's ability to absorb the referrals
- Greater partnership with specialist services in the community and voluntary sector (domestic abuse, learning disability, etc)
- Community and voluntary sector being more at the centre of the system, not at the fringes

healthwatch Nottingham & Nottinghamshire
Nottingham Community and Voluntary Service
Nottingham City Integrated Care Partnership

healthwatch Nottingham & Nottinghamshire
Nottingham Community and Voluntary Service
Nottingham City Integrated Care Partnership

Appendix 3 – Nottingham City ICP programme priorities 2021/22

	In 2021/22 City ICP partners will work together to improve the lives of citizens by:
1	Supporting people who face severe multiple disadvantages to live longer and healthier lives
2	Preparing children and young people to leave care and live independently
3	Supporting those who smoke to quit and reducing the number of people at risk of smoking
4	Increasing the number of people receiving flu vaccinations
5	Reducing inequalities in health outcomes in BAME communities
6	Improving the mental health and wellbeing outcomes of citizens
	As well as focusing on improving outcomes for citizens City ICP partners will:
7	Develop the Integrated Care Partnership and establish the ICP culture
8	Support our partners in response, recovery and restoration from Covid-19

Item Number:	5	**Enclosure Number:**	C
Meeting:	ICS Board		
Date of meeting:	2 September 2021		
Report Title:	Report from the ICS Independent Chair and ICS Executive Lead		
Sponsor:	Kathy McLean, ICS Chair and Amanda Sullivan, Interim ICS Executive Lead		
Place Lead:			
Clinical Sponsor:			
Report Author:	Joanna Cooper, Assistant Director, ICS		
Enclosure / Appendices:	None		

Summary:

The report provides an update on key messages relating to work across the ICS.

Actions requested of the ICS Board

To note the contents of the report.

Recommendations:

1.	None

Presented to:

Board	Partnership Forum	Clinical Executive Group	System Executive Group	Finance Directors Group
☒	☐	☐	☐	☐
Quality Group	**Transition and Risk Committee**	**Mid Nottingham-shire Place**	**Nottingham City Place**	**South Nottingham-shire Place**
☐	☐	☐	☐	☐

Contribution to delivering System Level Outcomes Framework ambitions

Our people and families are resilient and have good health and wellbeing	☒	Our people will have equitable access to the right care at the right time in the right place	☒	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	☒

Conflicts of Interest

☒ No conflict identified
☐ Conflict noted, conflicted party can participate in discussion and decision
☐ Conflict noted, conflicted party can participate in discussion, but not decision
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Risks identified in the paper

Risk Ref	Risk Category	Risk Description	Residual Risk				Risk owner
			Likelihood	Consequence	Score	Classification	
Ref	e.g. quality, financial, performance	Cause, event and effect There is a risk that…	L1-5	L1-5	L x I	Grading	*Person responsible for managing the risk*

Is the paper confidential?

☐ Yes

☒ No

☐ Document is in draft form

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Report from the ICS Independent Chair and ICS Executive Lead

2 September 2021

1. We are at a key point in our development, making excellent progress in many areas whilst maintaining a focus on the breadth and depth of work to do over the next few months. The challenge for us is to continue to work with our communities to bring about the changes we know will improve health and reduce inequalities, deliver on operational challenges, notably treating people who are waiting for operations and other forms of care, maintaining our Covid-19 vaccination programme and developing our systems and processes to support integration. Our report this month highlights some key areas for Board members to note.

ICS Boundary

2. A national decision has been made to confirm the boundary of our ICS. The County Council district of Bassetlaw will align with the Nottingham and Nottinghamshire ICS from April 2022.

3. This decision is part of the Health and Care Bill proposals to change ICS boundaries to provide greater alignment with Local Authority boundaries – the Ministerial statement can be read here.

4. As we move forward, a key difference will be the development of stronger connections between Nottinghamshire County Council and the NHS in the planning of health and care services to improve the health and wellbeing of local people, which we welcome.

5. We believe this is a positive step for our citizens and for our ICS in driving the delivery of excellent services across the region. As we move forward and encompass Bassetlaw as a distinct Place within our system, it is important we respect the needs and expectations of the community just as we do for our communities in Nottingham City, Mid Nottinghamshire and South Nottinghamshire.

6. We recognise that there are different views about making this change and that this was not the preferred outcome for all. We will work tirelessly with NHS colleagues from Bassetlaw to ensure a smooth transition and to welcome them into the Nottingham and Nottinghamshire system.

ICS Development

7. On 6 July the Health and Care Bill was introduced to Parliament and is an important step on our journey to becoming a statutory ICS by April 2022. This Bill formalises policies set out by NHSEI, in particular the Long Term Plan and

White Paper 'Integration and Innovation: Working together to improve Health and Social Care for all' published in February 2021.

8. NHSEI have published further guidance to support transition to becoming a statutory ICS. Guidance and supporting materials to support legal establishment and operational readiness for 1 April 2022 are now available. ICS Transition work-streams have continued to develop in line with the Health and Care Bill and national guidance. Further guidance is awaited as below:
   a. Guidance on effective partnership working
   b. Guidance on finance and resources

9. Work has been completed to ensure that the requirements of the Health and Care Bill and ICS Design Framework are covered in the scope of our ICS Transition Programme. Legislation and guidance is very permissive, in parts, with lots of opportunity for us to co-design our future arrangements.

10. Two workshops are confirmed in September for ICS Board members to consider and collectively shape the future operating model, agreeing the decision making/sign off requirements for each component.

11. Work is also underway to shape organisational development arrangements to support shadowing operating. A series of interviews is underway and a survey and focus group is planned to gain views on what will be important. Our intention is to agree the development plan in November 2021 in readiness to support shadow operating.

Leadership

12. We're also pleased to share news that Kathy has been confirmed as the Integrated Care Board (ICB) chair-designate, ready to assume the new role from April 2022 if Parliament confirms its creation. ICS leaders and independent chairs for NHS ICSs have responsibility for the future of the health and care systems within their region, to improve the health and care of the population covered by each respective system. To support the selection processes to these new and significant leadership roles NHSEI have developed a set of national leadership competencies, roles and responsibilities as well as a desired set of leadership values and behaviours in order to advance the ambitions of the NHS People Plan.

13. NHSEI confirmed that a robust selection process to appoint Kathy was undertaken by the system and they have confirmed that there is on-going stakeholder support.

14. On 1 September recruitment will begin for the ICB Chief Executive, and recruitment processes for other executive and non-executive roles will follow shortly in line with national guidance and timescales.

ICS Development Progression Tool Self-Assessment

15. NHSEI published a System Development Progression Tool in July. This tool replaces the ICS Maturity Matrix tool that the system previously self-assessed against. The Progression Tool is intended to sit alongside the ICS Design Framework and other guidance documents currently under development and is intended to support system planning and development throughout 2021/22. Use of the tool is not mandatory, however, is considered to be best practice and a self-assessment has been completed.

System Buddying Arrangements

16. Within Midlands region, Nottingham and Nottinghamshire ICS have been matched with Herefordshire and Worcestershire ICS for peer buddying. Contact details for colleagues leading key aspects of ICS design have been shared between the two systems and informal discussions are underway to share and learn from Herefordshire and Worcestershire.

17. An initial meeting has been held with the ICS Executive Lead, ICS Programme Director and Assistant Director and their counterparts. Regular discussions are being set up to support this arrangement.

18. In addition, buddy arrangements with colleagues in the South West have been agreed with Bath and North East Somerset, Swindon and Wiltshire (BSW), and Bristol, North Somerset and South Gloucestershire (BNSSG). System Development Plans have been shared, and a series of lunch and learn sessions during September / October are planned on key topics that the three systems have jointly identified.

System Development Plan

19. During this transition year, the system are required to submit a System Development Plan to NHSEI on a quarterly basis. The last iteration was submitted on 30 June.

20. A helpful feedback meeting was held with NHSEI, Amanda and colleagues from the system on 20 July. In summary, the plan is considered to be well developed: the breadth of coverage and articulation of the work-in-progress areas were commendable and the plan has significantly improved since the first iteration. Noted in particular are; citizen engagement/co-production, system analytics unit development, and the clarity in the direction of travel regarding the approach being developed with the Local Authority around joint commissioning.

21. Work is underway to develop the next iteration of the plan for submission by 30 September. It is anticipated that the plan will be informed by the further guidance published by NHSEI.

Covid-19 Vaccination Programme

22. Roll out of the Covid-19 vaccination programme has delivered more than 708,000 first doses and 600,000 second doses as at 15th August 2021. All sites are offering first and second dose walk ins to those aged over 18. Selected sites are offering walk-ins to those aged 16 and 17. All sites are on the National Booking System. All over 16 year olds and those aged 12-15 with identified vulnerabilities have been invited for their vaccine.

Feedback on key meetings

23. Over the coming period, Kathy is having a further round of one-to-one engagement meetings with ICS Board members as well as visiting partner organisations and front-line services.

Item Number:	6	**Enclosure Number:**	D
Meeting:	ICS Board		
Date of meeting:	2 September 2021		
Report Title:	Our Transition to becoming a Statutory ICS		
Sponsor:	Kathy McLean, ICS Chair and Amanda Sullivan, ICS Executive Lead		
Place Lead:			
Clinical Sponsor:			
Report Author:	Rebecca Larder, Programme Director, ICS and Joanna Cooper, Assistant Director, ICS		
Enclosure / Appendices:	None		

Summary:

On 6 July the Health and Care Bill was introduced to Parliament and is an important step on the journey to becoming a statutory ICS by April 2022. The Bill received its Second Reading on 14 July and will proceed to the Committee stage of its approval when the House returns from Recess in September.

ICS Transition work-streams have been established and continue to develop in line with the Health and Care Bill and national guidance. Further guidance is awaited. This paper provides ICS Board with a summary of the work underway on the transition to becoming a statutory ICS, subject to legislation, by April 2022.

As discussed at previous ICS Board meetings, the ICS Transition and Risk Committee are assuring these transition work-streams, alongside the three areas of the ICS Design Framework identified at the July 2021 meeting which ICS Board agreed to delegate to Committee in the short term for three months (Digital, People and Culture and Finance). A separate report is presented from Committee under item 13 of the Board agenda.

Actions requested of the ICS Board

To note the contents of the report.

Recommendations:

1.	Note the contents of the report
2.	Support the additional ICS Board development session

Presented to:

Board	Partnership Forum	Clinical Executive Group	System Executive Group	Finance Directors Group
☒	☐	☐	☐	☐
Quality Group	**Transition and Risk Committee**	**Mid Nottingham-shire Place**	**Nottingham City Place**	**South Nottingham-shire Place**
☐	☐	☐	☐	☐

Contribution to delivering System Level Outcomes Framework ambitions

Our people and families are resilient	☒	Our people will have equitable	☒	Our teams work in a positive, supportive	☒

and have good health and wellbeing		access to the right care at the right time in the right place		environment and have the skills, confidence and resources to deliver high quality care and support to our population	

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Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

Our Transition to becoming a Statutory ICS

2 September 2021

Introduction

1. On 6 July the Health and Care Bill was introduced to Parliament and is an important step on the journey to becoming a statutory ICS by April 2022. This Bill formalises policies set out by NHSEI, in particular the Long Term Plan and White Paper 'Integration and Innovation: Working together to improve Health and Social Care for all' published in February 2021. NHSEI have published further guidance to support this transition.

2. ICS Transition work-streams have been established and continue to develop in line with the Health and Care Bill and national guidance. Further guidance is awaited as below:
    i. Guidance on effective partnership working
    ii. Guidance on finance and resources

3. This paper provides ICS Board with a summary of the work underway on the transition to becoming a statutory ICS, subject to legislation, by April 2022.

4. As discussed at previous ICS Board meetings, the ICS Transition and Risk Committee are assuring these transition work-streams, alongside the three areas of the ICS Design Framework identified at the July 2021 meeting which ICS Board agreed to delegate to Committee in the short term for three months (Digital, People and Culture and Finance). A separate report is presented from Committee under item 13 of the Board agenda.

ICS Transition Work-streams

5. ICS Transition Programme work-streams have been established and are summarised in Annex 1 alongside reported progress to date:

Work-stream	Executive SRO	Programme Director
Integrated Care Partnership Work-stream	Melanie Brooks, Corporate Director Adult Social Care and Health, Nottinghamshire County Council	Rebecca Larder, ICS Programme Director
Integrated Care Board Establishment, Accountability and Governance Work-stream	Amanda Sullivan, CCG Accountable Officer / Interim ICS Executive Lead	Rebecca Larder, ICS Programme Director Lucy Branson, Associate Director of Governance, CCG
CCG Transition	Amanda Sullivan, CCG Accountable Officer / Interim ICS Executive Lead	Sarah Carter, Executive Director, CCG
Joint Commissioning for Integrated Care	Lucy Dadge, Chief Commissioning Officer, CCG	Iain Stewart, Programme Director, CCG

(NHS/LA)		
Integrated Commissioning with NHSEI	Lucy Dadge, Chief Commissioning Officer, CCG	Sarah Fleming, Head of Joint Commissioning, CCG
Provider Collaboratives at Scale	Tracy Taylor, Chief Executive, NUH	Tim Guyler, Assistant Chief Executive, NUH Sarah Furley, Director of Partnerships NHT
Place Work-stream	Hugh Porter, Interim Lead and Clinical Lead, City	Lorraine Palmer, Interim Programme Director, Mid Nottinghamshire
Communications and Engagement	Amanda Sullivan, CCG Accountable Officer / Interim ICS Executive Lead	Alex Ball, Director of Communications and Engagement, ICS / CCG
Clinical Leadership and Engagement Work-stream	Stephen Shortt CCG Clinical Chair / Rosa Waddingham ICS Chief Nurse	Rebecca Larder, ICS Programme Director

6. Work has been completed to ensure that the requirements of the Health and Care Bill and ICS Design Framework are covered in the scope of the ICS Transition Programme. Legislation and guidance is very permissive, in parts, with lots of opportunity for to co-design the future arrangements.

7. The leads for the Transition Programme work-streams meet every other week to ensure progress at pace and alignment of these complex work-streams.

8. Some work-stream plans remain at a high level at this time whilst further national guidance is awaited. More detailed plans are provided for those work-streams that can progress based on current knowledge of expected legislation and national policy.

9. At the 23 August Transition and Risk Committee meeting, Committee considered work-stream key achievements, big questions to be answered and the mechanisms to take these forward and an initial comprehensive programme risk log.

ICS Design

10. A forward programme of development workshops are planned for the ICS Board in September and October to consider and collectively shape the future operating model, and agree the decision making/sign off requirements for each component. The sessions are summarised in the below table:

Date	Topic
2 September	Formal ICS Board meeting
15 September	Additional Board development session to support ICS design: • Integrated Care Partnership (and links to HWBs)

	• Citizen / community voice
20 September	Additional Board development session to support ICS design (Integrated Care Board): • Functions, leadership resources and governance (including decision map)
7 October	Board development session confirmed in diaries: • Developing a People and Culture function • Developing a DAIT function
4 November	Formal ICS Board meeting

11. A programme of work is underway to support transition OD. An external provider has been commissioned to support understanding of the requirements to shape our OD plan. This work which will take place in three phases:
    a. From August onwards interviews will take place with 30 colleagues from across the system to share thoughts on progress to date, areas of challenge and focus needed over the coming period.
    b. A targeted survey will be developed and circulated to colleagues from across the system to provide a wider range of responses.
    c. A focus group will be held with colleagues from across the system to explore the interview and survey responses in greater depth.

12. The aim is to agree the development plan in November 2021 in readiness to support shadow operating.

External Assurance

ICS Development Progression Tool Self-Assessment

13. NHSEI published a System Development Progression Tool in July. This tool replaces the ICS Maturity Matrix tool that the system previously self-assessed against. The Progression Tool is intended to sit alongside the ICS Design Framework and other guidance documents currently under development and is intended to support system planning and development throughout 2021/22. Use of the tool is not mandatory, however, is considered to be best practice and a self-assessment has been completed.

System Buddying Arrangements

14. Within East Midlands region, Nottingham and Nottinghamshire ICS have been matched with Herefordshire and Worcestershire ICS for peer buddying. Contact details for colleagues leading key aspects of ICS design have been shared between the two systems and informal discussions are underway to share and learn from Herefordshire and Worcestershire.

15. An initial meeting has been held with the ICS Executive Lead, ICS Programme Director and Assistant Director and their counterparts. Regular discussions are being set up to support this arrangement.

16. In addition, buddy arrangements with colleagues in the South West have been agreed with Bath and North East Somerset, Swindon and Wiltshire (BSW),

and Bristol, North Somerset and South Gloucestershire (BNSSG). System Development Plans have been shared, and a series of lunch and learn sessions during September / October are planned on key topics that the three systems have jointly identified.

360 Assurance

17. Internal audit time has been planned to support the transition. A colleague from 360 Assurance has joined the ICS Transition and Risk Committee to support the Committee in their role. 360 Assurance will provide project assurance to the Committee on operation and delivery, and ensure links to the work of the CCG Audit and Governance Committee are made as part of the transition. They will also support Committee to ensure that issues reported are delivered, and will play an on-going role to ensure Committee is operating within the agreed Terms of Reference.

System Development Plan

18. During this transition year, the system are required to submit a System Development Plan to NHSEI on a quarterly basis. The last iteration was submitted on 30 June.

19. A feedback meeting was held with NHSEI and colleagues from the system on 20 July. In summary, the plan is considered to be well developed: the breadth of coverage and articulation of the work-in-progress areas were commendable and the plan has significantly improved since the first iteration. Noted in particular are; citizen engagement/co-production, system analytics unit development, and the clarity in the direction of travel regarding the approach being developed with the Local Authority around joint commissioning.

20. Work is underway to develop the next iteration of the plan for submission by 30 September. It is anticipated that the plan will be informed by the further guidance published by NHSEI.

ICS Boundary

21. A national decision has been made to confirm the boundary of the ICS. NHS Bassetlaw CCG will align with the Nottingham and Nottinghamshire ICS from April 2022.

22. The leads for the Transition Programme work-streams held a workshop on 6 August to discuss the implications. Key actions that have been undertaken since the boundary decision in relation to supporting this approach. The forward actions and mitigations are now embedded in the work-stream plans, and will be taken forward and reported into the Transition and Risk Committee through that route moving forwards.

Annex 1

Work-stream	Summary	Overall rating against national requirements	Tasks and Milestones	Resources for Delivery
Integrated Care Partnership Work-stream	Enable the statutory establishment of the Integrated Care Partnership functions and accountability and governance requirements informed by legislative requirements of ICSs and NHSEI policy.	G – On Track	A – Off Track (minor)	G – On Track
Integrated Care Board Establishment, Accountability and Governance Work-stream	Enable the ICS statutory establishment in support of ICS functions including but not limited to the accountability and governance requirements of ICSs informed by legislative requirements of ICSs and NHSEI policy.	A – Off Track (minor)	A – Off Track (minor)	G – On Track
CCG Transition	To enable the disestablishment of NHS Nottingham and Nottinghamshire CCG in line with NHSEI and legislative/technical requirements of this process.	A – Off Track (minor)	A – Off Track (minor)	A – Off Track (minor)
Joint Commissioning for Integrated Care (NHS/LA)	To achieve the vision of Integrated Health and Care within the ICS, joining up strategic leadership and the transformation of health and care to improve outcomes for our population, ensuring decision making is led and integrated at the appropriate population level, with an emphasis on subsidiarity.	N/A	A - Off track (minor)	G- On track
Integrated Commissioning with NHSEI	To achieve the vision of Integrated Care, to join up strategic leadership, transformation and improvement approaches to ensure decision making is led and integrated at the appropriate population level, with an emphasis on subsidiarity. To enable NHSEI commissioning and CCG commissioning to come together for the populations they serve and see the development of accountable speciality networks (ASNs) to break down organisational barriers and improve the quality of health and care for patients.	G – On Track	G – On Track	G – On Track

Work-stream	Summary	Overall rating against national requirements	Tasks and Milestones	Resources for Delivery
Provider Collaboratives at Scale	Support the development of provider collaboratives, specifically providers working at scale across multiple places, to achieve the benefits of collaborative working for people within the Nottingham and Nottinghamshire ICS and beyond.	A - Off track (minor)	N/A	N/A
Place Work-stream	Further oversee and support the development of Places within Nottingham and Nottinghamshire, ensuring they are a key pillar of the local integrated care model enabling decisions to be taken as close to the local population as possible.	G – On Track	G – On Track	G – On Track
Communications and Engagement	1. To describe to citizens, stakeholders and staff the benefits of working in a more integrated way across health and care 2. To ensure that staff and stakeholders are informed and involved in the development and establishment of the statutory ICS. 3. To establish the structures and approach required for citizen and patient involvement in the ICS from April 2022. 4. To ensure that citizens are informed about the establishment of the statutory ICS	G – On Track	G – On Track	G – On Track
Clinical Leadership and Engagement Work-stream	Develop and mobilise the clinical leadership and engagement; quality improvement, governance and assurance arrangements in support of ICS statutory status.	G – On Track	A - Off track (minor)	A - Off track (minor)

Item Number:	7	**Enclosure Number:**	E
Meeting:	ICS Board		
Date of meeting:	2 September 2021		
Report Title:	Implementation of the Health Inequalities Strategy		
Sponsor:	John Brewin, Chief Executive Nottinghamshire Healthcare NHS Foundation Trust		
Place Lead:			
Clinical Sponsor:			
Report Author:	Hazel Buchanan, Associate Director of Strategic Programmes and EPRR, Nottingham and Nottinghamshire CCG		
Enclosure / Appendices:	None		

Summary:

The paper provides detail that is being presented to the ICS Board on delivery against the ICS Health Inequalities Strategy. In summary:

1. The ICS Health Inequalities Strategy was approved in October 2020 and since that time, progress with implementation has both supported and been facilitated by NHS planning guidance and the NHSE/I Midlands health inequalities framework.

2. The ICS strategy outlines Strategy Objectives framed within the PHE Population Intervention Triangle (civic, community and service-based actions) which emphasises the importance of a system wide approach and working jointly between the NHS and Local Authorities. Action plans are progressing across the different objective areas of Health and Care Services, Lifestyle Factors and Living and Working Conditions.

3. Other key elements of the strategy are the Conditions for Success where again progress has been made and it will be vital that health inequalities remain at the forefront as the system transitions to the new structures outlined in the Government's Health and Care Bill in order to ensure that these are progressed further.

4. Taking forward the ICS Health Inequality strategy recognises the need to take a concerted and targeted approach informed by population health intelligence across the evolving infrastructure including actions taken by organisations, Neighbourhood, Place, System and Provider Collaboratives whilst recognising the role of Health alongside the Local Authorities and Public Health.

5. Next steps recognise the importance of leadership, working as a system and having a concerted approach, generating a learning environment and the value of data in order to drive forward change and impact on health inequalities.

Actions requested of the ICS Board

To note the paper being presented to ICS Board and to endorse the next steps.

Recommendations:	
1.	To note the paper being presented
2.	To endorse the next steps

Presented to:

Board	Partnership Forum	Clinical Executive Group	System Executive Group	Finance Directors Group
☒	☐	☐	☐	☐
Quality Group	**Transition and Risk Committee**	**Mid Nottingham-shire Place**	**Nottingham City Place**	**South Nottingham-shire Place**
☐	☐	☐	☐	☐

Contribution to delivering System Level Outcomes Framework ambitions

Our people and families are resilient and have good health and wellbeing	☒	Our people will have equitable access to the right care at the right time in the right place	☒	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	☒

Conflicts of Interest

☒ No conflict identified
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Risks identified in the paper

Risk Ref	Risk Category	Risk Description	Residual Risk				Risk owner
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Ref	e.g. quality, financial, performance	Cause, event and effect There is a risk that…	L1-5	L1-5	L x I	Grading	*Person responsible for managing the risk*

Is the paper confidential?

☐ Yes
☒ No
☐ Document is in draft form

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Integrated Care System
Nottingham & Nottinghamshire

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ICS Health Inequalities Strategy

02 September 2021

Introduction

1. The ICS Health Inequalities Strategy was approved in October 2020 and since that time, progress with implementation has both supported and been facilitated by NHS planning guidance and the NHSE/I Midlands health inequalities framework.

2. The ICS strategy outlines Strategy Objectives framed within the PHE Population Intervention Triangle (civic, community and service-based actions) which emphasises the importance of a system wide approach and working jointly between the NHS and Local Authorities. Action plans are progressing across the different objective areas of Health and Care Services, Lifestyle Factors and Living and Working Conditions.

3. Other key elements of the strategy are the Conditions for Success where again progress has been made and it will be vital that health inequalities remain at the forefront as the system transitions to the new structures outlined in the Government's Health and Care Bill in order to ensure that these are progressed further.

4. Taking forward the ICS Health Inequality strategy recognises the need to take a concerted and targeted approach informed by population health intelligence across the evolving infrastructure including actions taken by organisations, Neighbourhood, Place, System and Provider Collaboratives whilst recognising the role of Health alongside the Local Authorities and Public Health.

5. Next steps recognise the importance of leadership, working as a system and having a concerted approach, generating a learning environment and the value of data in order to drive forward change and impact on health inequalities.

Strategy Objectives

6. NHS planning guidance focuses on five priority areas including 1) restoring NHS services inclusively 2) mitigating against digital exclusion 3) ensuring datasets are complete and timely 4) accelerating preventative programmes which proactively engage those at greatest risk of poor health outcomes 5) strengthening leadership and accountability. These priority areas align with the ICS health inequality strategy and the Nottingham and Nottinghamshire ICS response and actions included in the planning submission were outlined by NHSE to be a particular strength in the plan.

7. Particular areas to highlight in relation to the progression of the ICS Health Inequality Strategy Objectives include the following:

- **Health and Care Services**

a. *Protect the Most Vulnerable from Covid-19* - Through the Covid-19 vaccination programme considerable efforts have been applied to targeting groups experiencing health inequalities and this has in turn provided extensive learnings in relation to working at place level, taking a culturally competent approach and supporting those most in need. Furthermore the responsive pathways implemented for the homeless and Severe Multiple Disadvantaged (SMD) demonstrates the opportunities in relation to place based and partnership working.

b. *Restore health and care services inclusively* – through efforts in relation to elective recovery analysis has been carried out on waiting lists and out-patients, and system wide consideration will be taken on actions that can be taken to support equitable access. A comprehensive personalisation programme is being implemented through the accelerator funding that particularly supports those most in need. Across Trusts there is a greater focus on pre-hab and pre-op lifestyle programmes in recognising the opportunity to impact on health need and improved outcomes whilst individuals are "waiting".

c. *Digitally enabled care* – throughout the pandemic efforts and opportunities have been maintained in increasing the uptake of the NHS App. This programme includes comprehensive research, public and voluntary sector input into digital exclusion including health literacy.

d. *Accelerate preventative programmes* includes lifestyle programmes mentioned below as well as the recruitment of Health Improvement Workers to support with SMI physical health checks. The Health Improvement Workers have been able to make contact with and undertake home visits to people on the SMI register who had not previously engaged with their GP surgery.

e. *Particularly support those who suffer mental ill health* includes detailed analysis by deprivation and ethnicity in relation to access to services and usage of different channels. Actions are being progressed across all areas of the Transformation and Expansion plans in relation to addressing inequities in relation to access, experience and outcomes.

- **Lifestyle Factors** – Supported by Long Term Plan commitments, the ICS has a strategic approach to the priorities of alcohol harm, smoking and weight management. Place Based Partnerships have identified priorities relevant to their populations supported by commitments through PCNs, including Link Workers and Health and Wellbeing Coaches. The ICS and Places are working directly with Public Health colleagues in order to provide a co-ordinated approach.
- **Living and Working Conditions** – Efforts are progressing in relation to partnership working with wider partners on economic and environmental opportunities. This includes a focus on employment including working with the local universities through the ICS Anchor Institution programme. Other relevant areas include the ICS Green Plan and Population Health Management includes wider socio-economic information i.e. employment data from DWP. Further work on other wider determinants of health are planned

with the two Directors of Public Health's leadership including a refreshed approach to developing the JSNAs as agreed at July's ICS Board.

Conditions for Success

8. The ICS Health Inequalities Group has been implemented and has scheduled meetings every two months. The Group is part of the ICS Governance arrangements and reports into the System Executive Group. The Group is an opportunity to bring all partners together along with Directors of Public Health and Health and Wellbeing Board Chairs in order to progress the strategy including the cultural elements that are fundamental to the ICS approach. Assurance will be provided through the ICS Quality Committee.

9. Each Place Based Partnership has a focus on health inequalities and prevention that aligns with the ICS Health Inequalities Strategy. Focus has predominantly been on the vaccination programme and learnings and opportunities from this are being applied to the wider engagement and understanding of local communities that will support impacting on health inequalities, including the identification of priority neighbourhoods. The ICS and Place Based Partnerships have been successful in bidding for national NHSE/I funding to implement a community model on embedding prevention, which will be supported by existing assets. This is an exciting opportunity to build on the learnings from the vaccination programme and to provide intelligence on how the ICS may be able to fund going forward.

10. The on-going development of PCNs is directly aligned to a system wide approach to health inequalities and recognises the opportunities at Neighbourhood level. A PCN conference held in June had a significant focus on health inequalities including a presentation from Dr Bola Owolabi, NHSE/I Director Health Inequalities. The conference highlighted local case studies and opportunities to impact on health inequalities. A local PCN framework is being developed that includes a focus on PHM and health inequalities including the completion of an inclusion health self-assessment. Furthermore, the on-going work to embed social prescribing will be a key element in the delivery of the health inequalities strategy.

11. The implementation of the Strategic Analytics Unit (SAU) supported by a Health Inequalities analyst will be instrumental in facilitating a system wide focus that includes an overall understanding and response to health inequalities. The proposed dashboard alongside the revised JSNAs will allow for system wide profiles and support a consistent understanding of our health inequalities. The local dashboard will sit alongside a regional and national dashboard on health inequalities. The established approach to Population Health Management along with the on-going provision of thematic reviews and analysis of data providing the tools for impactful interventions will continue to support the ICS in progressing with the Health Inequalities strategy. Further work on Impactibility is planned to assist in prioritisation of actions to meet ICS health outcomes targets.

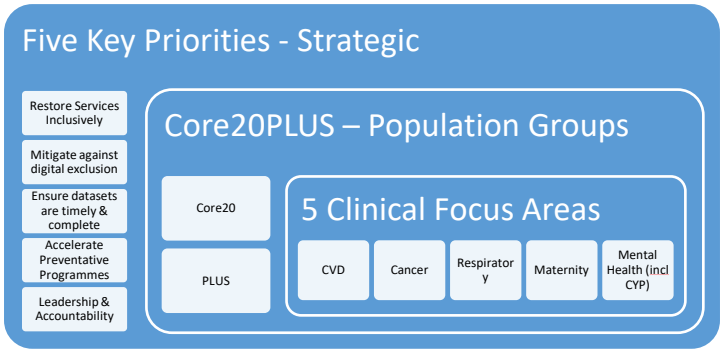
12. The outcomes framework supports monitoring and evaluation of the Health Inequalities strategy and through the ICS Health Inequality, Prevention and Wider Determinants Group ICS ambitions for Healthy Life Expectancy and contributors to this will be proposed to the ICS Board in November, which will significantly strengthen the ability to assess meaningful actions and progress on achieving ICS health outcomes.

13. Other actions include embedding Health Equity Assessments as part of the transformation programme and within the commissioning framework and with ICPs strengthening the approach to patient and public involvement and engagement.

Next Steps

14. NHSE/I Midlands have requested that all systems produce a Strategic Health Inequalities Plan that is based on the Long Term Plan and the impact of COVID on our communities. This presents an opportunity to refresh the Nottingham and Nottinghamshire ICS Health Inequalities strategy and implementation plan in line with the impact of Covid-19 and incorporate Bassetlaw accordingly. As part of this, we will continue to align implementation plans across the ICS including organisations, Place, Neighbourhoods, frameworks and transformation plans. Also, working with the Directors of Public Health, aligning the ICS Strategic Health Inequalities Plan with the Health and Wellbeing Board Health and Wellbeing Strategies.

15. NHSEI health inequality improvement programme includes five key priorities as outlined in 11 above and “Core 20 + 5”. Core 20 + 5 includes lowest 20% index multiple deprivation areas, ethnic groups plus five priority clinical areas including blood pressure detection, cancer diagnosis and screening, COPD, annual SMI checks, maternity continuity of carer. The + 5 areas have been included in the ICS plans and will be developed more fully in relation to the health inequality strategy.



16. Developing, agreeing and applying health gain metrics that can be presented and considered alongside financial savings and efficiency targets in relation to the concept of considering value in ICS prioritisation processes.

17. Agreement of healthy life expectancy ambitions as part of the ICS Outcomes Framework, at the November ICS Board to support a concerted targeted approach.

18. Progressing with plans for the ICS as an Anchor Institution, recognising the value to health inequalities and aligning with organisational Anchor Institution plans.

19. Developing and embedding a learning environment on health inequalities, increasing skills and knowledge across the system as well a collective understanding of our health inequalities and how to impact on them, including actively using Joint Strategic Needs Assessments (JSNAs), data and intelligence to inform change.

20. Developing and implementing the local health inequalities dashboard and data capabilities through the SAU alongside the development of JSNAs. Through the developments in data, including expanding on the PHM approach along with embedding a learning environment, the system will be better able to embed health equity assessments as a key element to informing change and transformation.

Recommendations

21. The ICS Board is asked to note progress and endorse the next steps.

Item Number:	8	**Enclosure Number:**	F
Meeting:	ICS Board		
Date of meeting:	2 September 2021		
Report Title:	Provider Collaboratives at Scale		
Sponsor:	John Brewin, NHFT CEO; Paul Robinson, SFH CFO; Tim Guyler, NUH Assistant CEO		
Place Lead:	*N/A*		
Clinical Sponsor:	*N/A*		
Report Author:	Simon Gascoigne, NUH Integration Manager		
Enclosure / Appendices:	None		

Summary:

This paper provides an update on the work progressing to establish an ICS Provider Collaborative at scale between Sherwood Forest Hospitals NHS Foundation Trust (SFH), Nottinghamshire Healthcare NHS Foundation Trust (NHFT) and Nottingham University Hospitals NHS Trust (NUH),

There is a requirement in the current legislative proposals that all statutory NHS providers are involved in at least one provider collaborative.

National guidance on provider collaboratives has recently been published. This provides a framework for the development of the ICS provider collaborative at scale. The guidance helpfully sets out:

- The benefits of provider collaboratives;
- Areas a provider collaborative may benefit from focusing on; and
- How provider collaboratives should work alongside other parts of the ICS infrastructure; including place based partnerships.

Discussions have been taking place throughout recent months with all three providers to develop thinking on the provider collaborative. On August 10th the CCG Accountable Officer and ICS Chair joined the discussion with the three providers. This paper summarises the output of those discussions.

Actions requested of the ICS Board

The ICS Board is asked to receive the update.

Recommendations:

1.	To receive and note the progress made to date
2.	Endorse the next steps

Presented to:

Board	Partnership Forum	Clinical Executive Group	System Executive Group	Finance Directors Group
☒	☐	☐	☐	☐
Quality Group	Transition and Risk Committee	Mid Nottingham-shire Place	Nottingham City Place	South Nottingham-shire Place
☐	☐	☐	☐	☐

Contribution to delivering System Level Outcomes Framework ambitions					
Our people and families are resilient and have good health and wellbeing	☒	Our people will have equitable access to the right care at the right time in the right place	☒	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	☒

Conflicts of Interest

☒ No conflict identified
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Risks identified in the paper

Risk Ref	Risk Category	Risk Description	Residual Risk				Risk owner
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Provider Collaborative Workstream Update to ICS Board

2nd September 2021

Purpose

1. The ICS Provider Collaborative work stream has identified that there are four emergent provider collaboratives across the Nottingham and Nottinghamshire ICS that involve one or more ICS partners and could be described as provider collaboratives at scale. These are:

   - ICS Provider Collaborative at Scale (SFH, NHFT and NUH)
   - East Midlands Acute Provider Network (SFH and NUH). This is a new partnership underpinned by a MOU at this time.
   - Adult Low and Medium Secure Services across the East Midlands known as IMPACT (9 partners including NHFT). This is a Lead Provider Model.
   - East Midlands Ambulance Service and Derbyshire Health United – 111 (EMAS). This is a new partnership underpinned by Board approval at this time.

2. This paper focuses on and provides ICS Board members with an update on the development of the ICS Provider Collaborative at Scale (SFH, NHFT and NUH).

Background

3. Discussions led by the three organisations Chief Executives and Chairs have been on-going for over a year, recognising that there are opportunities for the three organisations to work collaboratively for the benefit of patients and citizens.

4. The proposed legislative changes require all statutory NHS providers to be a part of at least one provider collaborative.

5. In recent weeks, national guidance has been published to support the development of provider collaboratives[1]. This alongside a national provider collaborative toolkit will help guide the development of our ICS provider collaborative at scale.

6. National guidance describes provider collaboratives as:

[1] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf

Provider collaboratives are partnership arrangements involving at least two trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements, to:

- *reduce unwarranted variation and inequality in health outcomes, access to services and experience*
- *improve resilience by, for example, providing mutual aid*
- *ensure that specialisation and consolidation occur where this will provide better outcomes and value.*

7. The system has received positive feedback from the NHSE/I regional team following completion of an initial baseline provider collaborative assessment.

ICS Provider Collaborative

8. Over the past couple of months the three partners have been exploring why the system should have a provider collaborative, what the ICS provider collaborative is and what it isn't; recognising that it is one part of the system infrastructure, and how it should be set up.

9. There has been a good level of debate between partners seeking to ensure system infrastructure that already exists is not destabilised and that the provider collaborative should focus on areas where it adds most value for the three statutory organisations to work together. These discussions were brought together at a meeting chaired by the ICS Chair on the 10th August.

10. Some key points from those discussions include:

- The provider collaborative exists for the benefit of patients and citizens providing an opportunity for the three organisations to align processes and resources to achieve these benefits.
- Partnership working between the three partners is not new. Working towards a provider collaborative will build upon existing partnership working; both bi-lateral and tri-lateral.
- The work towards a provider collaborative does not seek to destabilise existing partnership working at ICS, Place, bi-lateral or any other existing partnerships. National guidance recognises the importance of both place and provider collaboratives stating:
    - *'Providers may also work with other organisations within place-based partnerships, which are distinct from provider collaboratives. Place-based partnerships co-ordinate the planning and delivery of integrated services within localities and alongside communities, while provider collaboratives focus on scale and mutual aid across multiple places or systems.'*

- The provider collaborative will be supportive of initiatives happening at the level that makes sense for the population.
- The development of the provider collaborative will be iterative, non-linear and will be required to go through different stages of maturity. As a starting point it is proposed that a Provider Leadership Board (PLB) is established and reviewed every 6 months. National guidance describes a PLB as:
    - *'chief executives or other directors from participating trusts come together, with common delegated responsibilities from their respective boards (in line with their schemes of delegation), such that they can tackle areas of common concern and deliver a shared agenda on behalf of the collaborative and its system partners.'*
- The provider collaborative will be mindful of the impact on other system partners, its work will be open and transparent to system partners and, where there is an impact on system partners an assessment will be undertaken to determine whether the provider collaborative is the correct forum for that work. The national guidance recognises the importance of all system partners, the different component parts of the system and the importance of the collective whole. The guidance recognises the importance of sharing across all parts of the system to ensure efficiency, reduced duplication and shared learning.
- The provider collaborative will initially focus on:
    - Elective Care – access, variation and outcomes
    - Anchor organisations
    - An assessment of other areas suggested in the national guidance.

Next Steps

11. Next steps are guided by the national expectation that by April 2022 ICSs will:

- Identify the shared purpose of each collaborative and the specific opportunities to deliver benefits of scale and mutual aid.
- Develop and implement appropriate membership, governance arrangements and programmes (or reflect on this where collaboratives are already in place).
- Ensure purpose, benefits and activities are well aligned with ICS priorities.

12. These expectations reflect that the national ambition is to set something up by April and not be at full maturity.

13. The three partners have agreed to commence working towards a provider collaborative and have agreed to establish a PLB to oversee this work.

14. Next steps will include:

- Communication plan to be used to engage with different audiences both internal and external.
- Tripartite Board meetings to coproduce plans and agree priorities.
- Setting up the PLB to be in shadow form by January 2022.
- Establishing a development plan that is in line with national provider collaborative guidance.
- Progressing focused work on elective care and anchor organisations.
- Engaging with other partners to ensure clarity on how the provider collaborative interfaces and works alongside other system governance. This will include discussions with colleagues in Bassetlaw.

Item Number:	9	**Enclosure Number:**	G
Meeting:	ICS Board		
Date of meeting:	2 September 2021		
Report Title:	Improving Population Outcomes through our Signature Schemes – Progress Update		
Sponsor:	Amanda Sullivan, Interim Executive Lead, Nottingham and Nottinghamshire ICS		
Place Lead:	N/A		
Clinical Sponsor:	N/A		
Report Author:	Sarah Bray – Associate Director for System Assurance		
Enclosure / Appendices:			

Summary:

The paper outlines the approaches which are being taken across the system to move forward and embed an outcomes approach at the centre of all ICS activities, including;

- ICS Signature Schemes – 3 integrated service transformation areas
- Health Inequalities and Prevention
- Clinical Engagement
- Refresh of ICS Ambition for improved Healthy Life Expectancy
- Analytical Support

This will start to ensure that all system activities, including prevention and transformation activities are targeted at the agreed system outcomes, and will in turn provide a consistent way to monitor delivery in 2021/22.

Actions requested of the ICS Board

To discuss the various approaches being taken to embed outcomes across the system as outlined in this paper and to endorse the intention to refresh the system ambition for improvement to Healthy Life Expectancy through the Health Inequalities Group.

Recommendations:

1.	**NOTE** the routes being taken to embed an outcomes approach across all areas of planning, commissioning, service transformation and prevention.
2.	**NOTE** the additional support to be provided through the System Analytics Unit.
3.	**ENDORSE** the intention to refresh the system ambition for improved Healthy Life Expectancy.

Presented to:

Board	Partnership Forum	Clinical Executive Group	System Executive Group	Finance Directors Group
☒	☐	☐	☐	☐
Quality Group	Performance Oversight Group	Mid Nottingham-shire Place	Nottingham City Place	South Nottingham-shire Place

☐		☐		☐	
Contribution to delivering System Level Outcomes Framework ambitions					
Our people and families are resilient and have good health and wellbeing	☒	Our people will have equitable access to the right care at the right time in the right place	☒	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	☒

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Risks identified in the paper

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Is the paper confidential?

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ICS Outcomes Framework and Service Transformation
16th August 2021

Introduction

1. At the ICS Board in May 2021, an update was provided against the first aim of the outcomes framework – Improving the Health and Wellbeing of our population. This identified areas of concern for the health outcomes of the population of Nottingham and Nottinghamshire.

2. In addition, an approach for embedding a focus on improving population outcomes within service transformation was outlined at the May Board, with a progress update being received at the July Board.

3. This paper outlines how the ICS ambition to improve the outcomes of the population is becoming embedded through the ICS as a 'golden thread' through transformational change, health improvement ambition setting, tackling prevention and health inequalities, clinical engagement, underpinned by the ICS Outcomes Framework and supported through the establishment of system analytics.

Using the Outcomes Framework to drive and monitor transformation

4. Three transformation areas were identified to trial the approach to embedding the Outcomes Framework within service transformation, these are described as the 'Signature Schemes' for the system for 2021/22:
   a) Community care transformation
   b) Children and Young People
   c) Integration of Person Centred commissioning

5. Each signature scheme identified the System Level Outcomes which would be targeted through the clinical transformation being proposed, which in turn provided focus for the improvements to the Aims and Ambitions of the System Outcomes Framework.

6. Each area has subsequently undertaken significant engagement through the programmes with system partners to ensure there is an aligned understanding and commitment to delivery of these outcomes.

7. Analytical support has now been identified through the system performance function and the newly established System Analytics Unit, which will ensure that system priorities are clearly defined and agreed for these areas, and there is a shared understanding of how the interventions will impact on the system outcomes (and associated indicators and measures).

8. A review process will also be established to ensure there is a focus on impactable interventions for in-year delivery, and to identify mitigating actions where outcomes are off track.

9. An outline of the System Level Outcomes being targeted by the Signature Schemes is provided in the table below, six outcomes are areas of commonality across all schemes:

Aim	Ambitions	System Level Outcomes	1. PCC	2. CCT	3. CYP
1. Improving the health and wellbeing of our population	Our people will enjoy healthy and independent ageing at home or in their communities for longer		?	?	
	Our children have a good start in life	Increase in school readiness			✔
	Our people and families are resilient and have good health and wellbeing	Narrow the gap in the onset of multiple morbidities between the poorest and wealthiest sections of the population		✔	
	Our people and families are resilient and have good health and wellbeing	Increase the number of people who have the support to self-care and self-manage and improve their health and wellbeing	✔	✔	
	Our people will enjoy healthy and independent ageing at home or in their communities for longer	Increase in early identification and early diagnosis		✔	
2. Improving the overall quality of care and life our service users and carers are able to have and receive	Our people will have equitable access to the right care at the right time in the right place	Reduction in avoidable and unplanned admissions to hospital and care homes	✔	✔	✔
		Increase in appropriate access to primary and community based health and care services	✔	✔	
		Increase in the number of people being cared for in an appropriate care settings	✔	✔	✔
	Our services meet the needs of our people in a positive way	Increase in the proportion of people reporting high satisfaction with the services they receive		✔	
		Increase in the proportion of people reporting their needs are met	✔	✔	✔
		Increase in the number of people that report having choice, control and dignity over their care and support	✔	✔	✔
	Our people with care and support needs and their carers have good quality of life	Increase in quality of life for people with care needs	✔	✔	✔
		Increase in appropriate and effective care for people who coming to an end of their lives	✔	✔	
3. Improving the effective utilisation of our resources	Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population	Sustainable teams with skill mix designed around our population and mechanisms to deploy them flexibly to respond to care & support needs	✔	✔	✔
		Increase in 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	✔	✔	
		Increase in the number of people reporting a positive and rewarding experience working and training in the Nottinghamshire health and care system		✔	
ICS Signature Schemes 2021-22 1. Integration of Person Centred Care 2. Community Care Transformation 3. Children & Young People	Bold ticks = initial areas of focus				

a) Signature Scheme – Community Care Transformation (CCT)

10. Engagement events have been undertaken during May and June 2021 with system stakeholders, to collectively form a view of what 'good' looks like for community services and the outcomes which can be improved through delivering good community services. Seven areas of 'Collective Commitment' were agreed upon to focus the ambition of the programme, and alignment to the System Outcomes. These are:
    a. We will improve the health and wellbeing of citizens
    b. People will live independently in their own homes and communities
    c. We will empower citizens
    d. We will reduce inequalities in our population
    e. Our families and communities will be supported and valued
    f. We will improve the working life of our staff
    g. We will provide more efficient and better quality services

11. An evidence review of local, national and international practice is now being undertaken to consider the principles for delivery that are required to support the system to deliver these outcomes and commitments.

12. An outcomes and key results framework for the CCT programme will be developed in alignment with the System Outcomes Framework, which will;

- Describe a meaningful outcome for citizens/patients, enabling an interface between citizens/ patient outcomes and measureable metrics
- Develop specific outcome measures & metrics to incorporate within the System Outcomes framework, including establishment of ambition and improvement trajectories
- Incorporate a set of metrics for delivery and monitoring progress
- Inform commissioning and contract management approaches

13. The CCT outcomes and key results framework and the evidence review will form the basis of a design framework for community services that will be agreed by the system Community Care Co-production Council during a series of workshops in September and October. This will provide the blueprint for delivery of community services transformation which will take place in 100 day cycles in the autumn / winter.

b) <u>Signature Scheme – Children and Young People (CYP)</u>

14. A shared ambition for the strategic commissioning of children's health and care services has been agreed with strategic commissioning partners. The governance arrangements for the CYP strategic commissioning programme are being established over the summer months.

15. The submission to NHS England to be part of the Children and Young People's Transformation Programme, aims to develop an integrated care model for children and young people with complex mental health and care / placement needs. This will support the delivery of the ICS commitments to improving outcomes for children and young people.

16. Work will be undertaken with system analysts to identify core outcomes which will be targeted through this programme, to enable base lining, ambition and progress to be determined

c) <u>Signature Scheme – Integration of Person Centred Commissioning (IPCC)</u>

17. The IPCC scheme has identified five initial areas of focus (in the bold ticks above) and associated metrics, and has targeted initial actions towards these areas. A summary of current achievement and goals for this scheme are as follows;
    a. All people who may be eligible for Continuing Healthcare (CHC) receive a checklist and if positive are assessed under the national framework for CHC (this is an integrated assessment between health and social care). People are supported to live in their own homes with care homes considered if this is the persons wishes and the only option. CHC teams work closely with discharge to assess to reduce delays in transfer of care. People are assessed once discharged and within 28 days of referral.
    b. People eligible for CHC will be offered a Personal Health Budget (PHB) People may not be eligible for CHC but may require joint funded packages of

care with the local authority. These people will receive a joint assessment and be offered an integrated budget.

c. Each person is offered a Personal Health Budget (PHB) either notional, direct payment or through a third party. This enables people more choice and control over their lives. Each person who chooses their care at home via a PHB will have a personalised Care and Support Plan (CaSP). Each person will be reviewed at three months and then every year to ensure the package of care still meets their needs.
d. Each person who is at their end of life and rapidly deteriorating receives Fast Track. This enables personalised care to be implemented within 48 hours without the need for eligibility or financial assessments.
e. People are trained in personalisation approaches within teams. The ambition is to train more people through the national online training portal.

18. Next steps are to continue to develop measures of success for the above outcomes; explore further opportunities for an integrated approach to commissioning of specialist and high cost placements and implement joint appointments across health and social care to enable joint functions i.e. quality assurance/contract management.

Health Inequalities / Prevention

19. Through the Health Improvement and Prevention Group, focus is aligned to Long Term Plan priorities of Smoking, Alcohol and Weight Management, as identified by the Global Burden of Disease as the biggest contributors for poor Healthy Life Expectancy. System programmes are undertaking activities aligned to progressing system outcomes in these areas, including the CVD group and diabetes steering group.

Clinical Engagement

20. The Clinical Executive Group will have a role in reviewing the Signature Scheme plans and their alignment to the outcomes framework. The CEG will also be involved through some planned engagement work, in establishing 3 clinical priority outcome areas for focused ambition and improvement across the system, to inform the planning framework for 2022/23. This will potentially be aligned to the clinical areas with largest contribution to gap in life expectancy, which include circulatory, respiratory and cancer.

ICS Health & Well-being Improvement Ambition

21. Through the oversight of the Health Inequalities Group, a review has been undertaken of Healthy Life Expectancy and the main factors which influence Healthy Lift Expectancy. A proposed methodology and refresh of the system ambitions for Healthy Life Expectancy based on latest data and those areas which most influence it, is being discussed at the August meeting. These will be presented to the ICS Board in November as a proposed improvement ambition for the system, to inform and shape future years health and care planning.

Analytics Support

22. Analytics support is to be provided through the System Analytics Unit, who will work with each area to establish a system-wide approach to identification of

outcomes and supporting output metrics. They will undertake initial stocktake positions, determine the impact from Covid-19, and support the establishment of improvement trajectories for the outcomes identified by the schemes.

Next steps

23. Each of the transformation and prevention areas will further refine the outcomes, measures and indicators the programmes will deliver through stakeholder engagement and analytical support. This will enable the identification of any gaps in data collection and analysis that will need to be addressed and support the establishment of levels of ambition, and enable progress to be reviewed.

24. The ICS Board is asked to:

NOTE the routes being taken to embed an outcomes approach across all areas of planning, commissioning, service transformation and prevention.
NOTE the additional support to be provided through the System Analytics Unit.
ENDORSE the intention to refresh the system ambition for improved Healthy Life Expectancy.

Item Number:	10	**Enclosure Number:**	H1
Meeting:	ICS Board		
Date of meeting:	2 September 2021		
Report Title:	ICS Executive Lead Report – Integrated Performance		
Sponsor:	Amanda Sullivan		
Place Lead:			
Clinical Sponsor:			
Report Author:	Sarah Bray – Associate Director for System Assurance		
Enclosure / Appendices:	Enc H2: ICS Delivery Dashboard Enc H3: ICS Health Inequalities Access Dashboard		

Summary:

To provide an update on key events and information from the ICS Leadership Team.

This report supports the ICS Board in discharging its four core purposes of

a. Improving population health and healthcare
b. Tackling unequal outcomes and access
c. Enhancing productivity and value for money
d. Helping the NHS to support broader social and economic development.

In addition oversight is provided for the collective management of system resources and performance and delivery against the system plan.

Updates are provided for:

- System incident management
- 2021/22 Planning and Transformation;
- Integrated Performance (quality, service delivery, finance, people);
- ICS Development and Transition

Actions requested of the ICS Board

To note the challenges and progress made during 2021-22
To note the approach to NHS Planning for 2021-22 and the years ahead

Recommendations:

1.	To note the report

Presented to:

Board	Partnership Forum	Clinical Reference Group	System Executive Group	Finance Directors Group
☒	☐	☐	☒	☒
Quality Group	Transition and Risk Committee	Mid Nottingham-shire Place	Nottingham City Place	South Nottingham-shire Place
☐	☐	☐	☐	☐

Contribution to delivering System Level Outcomes Framework ambitions

Our people and families are resilient and have good health and wellbeing	☐	Our people will have equitable access to the right care at the right	☐	Our teams work in a positive, supportive environment and have the skills,	☐

		time in the right place		confidence and resources to deliver high quality care and support to our population	

Conflicts of Interest

☒ No conflict identified
☐ Conflict noted, conflicted party can participate in discussion and decision
☐ Conflict noted, conflicted party can participate in discussion, but not decision
☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision
☐ Conflict noted, conflicted party to be excluded from meeting

Risks identified in the paper

Risk Ref	Risk Category	Risk Description	Residual Risk				Risk owner
			Likelihood	Consequence	Score	Classification	
Ref	e.g. quality, financial, performance	Cause, event and effect There is a risk that…	L1-5	L1-5	L x I	Grading	*Person responsible for managing the risk*

Is the paper confidential?

☐ Yes
☒ No
☐ Document is in draft form

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 Executive Lead Report

20th August 2021

ICS Executive Overview

1. The first few months of 2021-22 has been a challenging period as the system has sought to increase and recover elective service activity, whilst experiencing rapid increases in emergency activity, increases in Covid-19 cases and continuing to progress with the vaccination roll-out. The increased pressures through emergency activity have started to impact upon the system's ability to recover elective services and tackle the rising numbers of patients waiting for treatment by the system. Safeguarding measures have been put in place, including routine contact with patients, assessments of potential harm, and joint system prioritisation reviews.

2. The key risks facing the system include the continuing pressures from the third wave of Covid-19, staff availability, demand beyond nationally assumed levels, harm to patients from extended waits, challenges meeting increasing demand (e.g. Primary Care, Long Covid) and financial risks.

3. The ICS also continues to progress towards the changes outlined in Integrating Care and are planning for the changes ahead, with an ICS Development plan now in place. This will be refreshed for the System Design Framework, actions arising from the System Progression Tool and the recently received 'ICS Readiness to Operate Statement' which systems will be required to complete as assurance.

4. The assignment of the ICS and NHS organisations into the System Oversight Framework Segments is being undertaken at a national level. The outcome of the process will be informed shortly, which will determine the level of support required from NHS England and Improvement.

Covid-19 Vaccination Programme - (Sarah Carter)

5. Roll out of the Covid-19 vaccination programme has delivered more than 708,000 first doses and 600,000 second doses as at 15th August 2021. All sites are offering first and second dose walk ins to those aged over 18. Selected sites are offering walk-ins to those aged 16 and 17. All sites are on the National Booking System. All over 16 year olds and those aged 12-15 with identified vulnerabilities have been invited for their vaccine.

System Transformation

System Transformation – (Stuart Poynor)

6. The ICS established a programme structure to oversee development and delivery of the ICS 2021-25 Transformation and Efficiency plan in January 2021. A very

senior SRO (usually CEO level) was identified for each programme, together with clinical lead, programme director and subject specialists. Where appropriate programmes have joint health and local authority leadership.

7. The Transformation and Efficiency Plan is a prioritised delivery plan for the NHS Long Term Plan and the ICS Outcomes Framework. It must improve health and wellbeing, the quality of services and the experience of staff whilst also addressing the system financial deficit. It should proactively address health inequalities and further develop the approach to Population Health Management.

8. The ICS has made significant progress developing the Transformation and Efficiency Plan. In support the ICS Strategy and Delivery Group has adopted a stronger programme assurance and programme discipline to accelerate and grip progress. Each programme now has an ambitious multi-year transformation pipeline which is being systematically developed in detail through Project Charters and Project Initiation Documents. Detailed plans are now emerging for Transformation due to deliver in 2021/22 and 2022/23 and this will continue to be driven at pace.

2021/22 System planning (Stuart Poynor)

9. The ICS Strategy and Delivery Group coordinated the development of the 2021/22 Single System Plan for the first half of the year (H1), which was submitted in line with national NHS requirements on the 3rd June. Although this was an NHS planning requirement it reflected many areas of joint working e.g. community transformation, hospital discharge etc.

10. Early indications are that NHS planning guidance for the second half of the year (H2) will be available in mid-September with submission of the final Single System Plan in early November. It is expected that the H2 NHS plan will be a continuation of the H1 NHS plan with additional focus on winter. The ICS Strategy and Delivery Group has commenced preparatory work in advance of national guidance.

System Performance

11. The integrated performance report reflects the 2021-22 system plan and performance for the system.

Quality (Rosa Waddingham)

12. Nottingham University Hospitals NHS Trust and Nottinghamshire Healthcare Foundation Trust remain under enhanced surveillance with improvement and action plans in place, as well as system-wide Quality Assurance Groups (QAG).

13. Local Maternity & Neonatal System are leading an active programme to support increased uptake of Covid-19 vaccinations of pregnant women as a system priority, with current uptake at 42% for first dose and 22% for second dose. Plans

are in place to develop system-wide training to support every contact counts and vaccination pilots are taking place in antenatal clinics.

14. Learning Disabilities and Autism Programme report system challenges around bed capacity and inpatient discharge due to national shortages in the building and labour sector as a result of Brexit and Covid-19. Fifteen community discharges are at risk due to delayed placement builds. Commissioners from CCG and LA's are looking at alternative community options with Nottinghamshire Healthcare Trust partners.

15. Work continues at pace on the ICS Shared Single View of Quality to support quality assurance and improvement. The development of the ICS Quality Dashboard, with support from the systems analytics unit, will allow for greater interrogation of system quality data, including at a place based level.

16. These areas are reviewed through the ICS Quality Committee.

Service Delivery (Stuart Poynor)

17. Since April there have been increased pressures across emergency services with levels of activity continuing to rise for A&E, ambulance services, mental health services, and across primary care. This was exacerbated into July with a local surge of Covid-19 demand. As a result of these pressures, despite quarter one seeing good levels of elective recovery, elective services have not been able to treat as many patients as planned since June. Waiting lists continue to rise as referrals have returned to pre-covid levels, with 84,959 patients waiting as at the end of June 2021. Focus is being maintained on treating priority patients and time critical surgery patients first, and working to reduce those waiting the longest.

18. As part of the recovery of services, all areas are being asked to recover services having regard to inequities and inequalities which may exist in access to services. Work has been undertaken to review waiting lists and cancer referrals across health inequalities factors, with actions being taken to address issues identified relating to age and deprivation. To support the understanding and oversight, a high level summary has been provided to reflect how different cohorts of patients across Nottinghamshire have accessed services on a 12 month rolling basis, since June 2020 (Appendix B). This will be routinely reviewed as services continue to increase capacity and develop new services and ways of treating patients.

Finance (Stuart Poynor)

19. At the end of July, ICS NHS organisations are presenting an aggregate favourable variance of £2.7m against the H1 plan. Covid-related expenditure is £6.3m better than plan (all providers) and staff-related costs are below plan due to challenges in recruiting to planned investments (NUH). This is offset by under-achievement of Elective Recovery Fund (ERF) income across the system and non-pay, Continuing Healthcare & prescribing overspends.

20. The position assumes £21.9m of Elective Recovery Fund (ERF) income to the end of July, which is £11.9m lower than planned levels. Much of this variance is driven by a change to ERF thresholds in Quarter 2 making ERF income more difficult to achieve.

21. The expected impact for the rule change across Q2 is £13.4m loss in income. Taking this into account, ERF income for H1 is expected to be £27.8m lower than plan with the remainder due to a shortfall in elective activity against the accelerator plan.

22. Alongside the change in income, a full assessment of ERF related costs has taken place to understand the financial impact of this change. Reduced costs have been experienced from lower than planned elective activity levels.

23. **The net impact of these changes is a £7.5m adverse variance at the end of H1**. This has been formally notified to NHSE/I and reported at month 4. The implications of this remain unclear.

24. Nottinghamshire County Council is reporting a £0.3m overspend at month 3 and are forecasting to be overspent by £1.3m at the end of March 2022. Increasing children's social care costs are the main driver of this. No financial information is available for Nottingham City Council.

People and Culture (Clare Teeney/Neil Pease)

25. The workforce report predominantly focuses on the three acute trusts within the system reporting on the quarter 1 position, i.e. June 2021. Primary care workforce data is also available for the June (Quarter 1) however due to national methodology changes the reported positions no longer align to the H1 plan submitted.

26. A key focus of Quarter 1 was the support to enable staff recovery. For the three NHS trusts sickness absence was 0.4% above the rolling 12 month average at 4.6%. The actual sickness absence as at 30 June saw 7% sickness absence with 2% being Covid-19 related. This static position is seen with a back drop of reduced utilisation of bank but an increase in agency similar to the levels seen in January 2021due to increased non-elective demand, Covid-19 and elective recovery requirements. This includes increased use of non-framework agencies in all three trusts reflecting the need for qualified and specialist skills.

27. Substantive staff numbers at the NHS Trusts, as at June, have remained static at 10.2% with trust vacancy rates ranging from 7.4% - 12.7%. The position against the H1 plan shows lower than expected staff in post of -5.81% (1,626.3). An increased focus on international recruitment for registered nurse and midwives with regional support to trusts is being put in place which will support the recovery of the intended system position already included in the workforce plans.

Primary Care:

28. The Primary care workforce position overall for June 2021 reports an improvement on the forecast in relation to the additional roles recruitment but still indicates a downward trajectory for General Practitioners and nurses. An increased numbers of trainees provides an opportunity to retain with a well-established Trainee Transition programme and New to Practice offer which also supports general practice nurses newly qualified and new to practice.

29. Workforce plans have been submitted to NHSE against the service development funds allocated to the system with a range of schemes approved by the Primary Care Delivery Board that builds on the existing workforce programme, supporting the wider workforce, addressing EDI and health and wellbeing approaches with more in reach to practices to support resilience of individuals and teams.

System Maturity (Rebecca Larder)

30. On 6 July the Health and Care Bill was introduced to Parliament and is an important step on our journey to becoming a statutory ICS by April 2022.

31. This Bill formalises policies set out by NHSEI, in particular the Long Term Plan and White Paper 'Integration and Innovation: Working together to improve Health and Social Care for all' published in February 2021.

32. NHSEI have published further guidance to support transition to becoming a statutory ICS. ICS Transition work-streams have continued to develop in line with the Health and Care Bill and national guidance. Further guidance is awaited as below:
    a. Guidance and supporting materials to support legal establishment and operational readiness for 1 April 2022
    b. Guidance on effective partnership working
    c. Guidance on finance and resources

System Development Plan

33. During this transition year, the system are required to submit a System Development Plan to NHSEI on a quarterly basis. The last iteration was submitted on 30 June.

34. A feedback meeting was held with NHSEI and colleagues from the system on 20 July. In summary, the plan is considered to be well developed: the breadth of coverage and articulation of the work-in-progress areas were commendable and the plan has significantly improved since the first iteration. Noted in particular are; citizen engagement/co-production, system analytics unit development, and the clarity in the direction of travel regarding the approach being developed with the Local Authority around joint commissioning.

35. Work is underway to develop the next iteration of the plan for submission by 30 September. It is anticipated that the plan will be informed by the further guidance published by NHSEI.

ICS Development Progression Tool Self-Assessment

36. NHSEI published a System Development Progression Tool in July. This tool replaces the ICS Maturity Matrix tool that the system previously self-assessed against. The Progression Tool is intended to sit alongside the ICS Design Framework and other guidance documents currently under development and is intended to support system planning and development throughout 2021/22. Use of the tool is not mandatory, however, is considered to be best practice.

37. To support the ICS Transition and Risk Committee fulfil its responsibilities of overseeing the system transition, a high level self-assessment against the tool has been completed owned by the work-streams. Leads have been asked to ensure that work-stream plans are aligned to the requirements, be cognisant of areas where there are gaps and areas to further develop.

System Buddying Arrangements

38. Within East Midlands region, Nottingham and Nottinghamshire ICS have been matched with Herefordshire and Worcestershire ICS for peer buddying. Contact details for colleagues leading key aspects of ICS design have been shared between the two systems and informal discussions are underway to share and learn from Herefordshire and Worcestershire.

39. An initial meeting has been held with the ICS Executive Lead, ICS Programme Director and Assistant Director and their counterparts. Regular discussions are being set up to support this arrangement.

40. In addition, buddy arrangements with colleagues in the South West have been agreed with Bath and North East Somerset, Swindon and Wiltshire (BSW), and Bristol, North Somerset and South Gloucestershire (BNSSG). System Development Plans have been shared, and a series of lunch and learn sessions during September / October are planned on key topics that the three systems have jointly identified.

SYSTEM DELIVERY DASHBOARD

ICS Board 2 Sept 21: Item 10. Enc H2

RAG	KPIs Achieved
	>75%
	60%-74%
	<60%

August 2021

Quality of Care, Access and Outcomes

Urgent Care -
June 2021:
Pressures are continuing to increase for A&E, ambulance and primary care services.
4 patients over 12 hours in A&E

Mental Health -
Focus on improvements for IAPT, Perinatal access and physical health checks.
Pressures remain on Out of Areas Placements due to reduced bed capacity.

Planned Care -
June 2021, elective 103%, outpatients 102% more than 19/20. 18 week backlog reduced to 23862. +52 weeks reduced to 3625 people. Diagnostics waiting list has stabilised.

Quality -
LD & A inpatients - risks to achieving the reductions required due to building supply issues.
LD AHC - expected to achieve targets

Cancer-
Capacity has been targeted towards cancer and priority patients. Patients waiting over 62 days has reduced to 237 at end of July. Welfare calls are being conducted.

522336 GP Appointments reported in June 2021 which is more than the plan, and 22% more than June 2020.
57% Face to Face, 44% Same Day

CQC Assessment Ratings	CQC - NHS Trusts	CQC - Nursing Homes	CQC - Residential Homes	CQC - GPs
Latest Assessment Period	02-Aug-21	01-Jul-21	01-Jul-21	01-Jul-21
Outstanding	0	6	16	18
Good	3	57	162	101
Requires Improvement	2	21	37	1
Inadequate	0	3	1	1
Not Rated	0	3	13	5

Preventing Ill-Health and Reducing Inequalities

2021 Covid Programme (@8.8.21)
All cohorts have been offered vaccines, including +16 years.
704,112 First doses
578,079 Second doses
System focus - vaccinations for pregnant women

Health Inequalities -
Targeted areas of work include elective recovery (review of waiting lists, DNAs, cancer treatments), personalisation, diabetes, CVD and respiratory

Leadership & Capabilities

NHSEI Assessments	ICS	NUH	SFHT	NHT
Segmentation Level	tbc	tbc	tbc	tbc

*Assessments undertaken through the new System Oversight Framework (Levels 1-4)

Finance and Use of Resources

Finance -
2021/22 Month 4 - NHS £2.6m favourable variance against plan. LA £0.3m adverse variance.
National change in ERF income thresholds has led to a £13.4m loss of income in Q2. H1 forecast has been changed to £7.5m deficit to reflect this. Implications of deficit position remains unclear.

People

Workforce -
Substantive staffing is off plan for June, with vacancy rate at 10.0%. Agency has been used more than expected due to increased covid pressures and elective recovery programmes. COVID related absence remained at 2%..
Focus is on international recruitment

Local Strategic Priorities

Quality Improvements -
Enhanced surveillance is in place across NUH and NHT - Quality improvement and actions plans are in place, as well as system wide Quality Assurance Groups.

Elective Recovery -
Recovery progressed well in Q1, however has been hampered by the increased Covid pressures during Q2. All available capacity is being utilised, with prioritisation of patients undertaken at system level, based on clinical need.

Financial Sustainability -
Underlying deficit is being addressed through ICS FD Group to inform H2 and medium term financial planning, focus on 'drivers of the deficit' and benchmarking to inform transformational programmes

Constitutional and H1 Plan Metrics Delivery

Service Area	No. KPIs	% Achieved	Delivery RAG	Assurance Level	Oversight Group
Planned Care & Diagnostics	9	88.9%			Performance Oversight Group
Cancer	9	44.4%			
Urgent & Emergency Care	11	45.5%			
Mental Health	12	58.3%			
Primary Care	3	66.7%			
Personalisation	4	75.0%			Quality Group
LD & Autism	2	50.0%			
People	8	62.5%			People
Finance & Use of Resources	9	66.7%			Finance

ICS System Outcomes Framework (SOF) - awaiting assessment

Best Performimg	Worst Performing

Progress against System Plan

Finance Group		YTD Var	YTD RAG	FOT Var	FOT RAG
Finance		£m		£m	
-NHS System - Non-COVID	H1 Plan	-3.6		-15.0	
-NHS System - COVID	H1 Plan	6.3		7.5	
NHS System - Total	H1 Plan	2.7		-7.5	
Local Authorities	Plan B/E	-0.3		-1.3	
Capital Envelope	Spend v Plan	10.5		-2.4	
Mental Health Investment Std	Spend v Plan	0.0		0.0	
Elective Recovery Funding	Income v Plan	-11.8		-27.8	

As at 31st July 2021

People & Culture Group	YTD Plan	YTD Actual	Variance	YTD RAG
Workforce *(NHS Provider Based)*				
-No. Substantive Staff	28286	26371	-1915	
-No. Clinical Non-Medical	18790	18290	-500	
-No. Medical & Dental	2812	2857	45	
-No. Other Staff	6684	5224	-1460	
-No. Bank Staff	1595	1574	-22	
-Agency Staff	823	891	68	
-Staff Sickness Absence %	-	4.6%	-	-
-Staff Turnover %	-	11.2%	-	-
Primary Care Workforce* (Quarterly)	2594	2453	-141	
Mental Health Workforce		tbc		
Community Crisis Workforce		tbc		

As at 31st July 2021 *PC June 2021

Capacity Cell

NHS Activity* *(Population Based)*	In Month Plan	In Month Actual	In Month Variance	In Month Var %	In Month RAG
- GP Referrals*	15,284	14,565	-719	95.3%	
- Elective	10,945	11,841	896	8.2%	
- Outpatients	60,308	68,318	8,010	13.3%	
- Non-Elective	10,636	10,366	-270	-2.5%	
- A&E	31,627	31,963	336	1.1%	

As at 31st July 2021 *GP Referrals compared to 2019/20 referrals

Capacity Cell

Capacity (Provider Based)	Period	Plan	Actual	Prior Yr	In Month RAG
-Primary Care Appointments	Jun-21	505,009	522,336	427,688	
-Acute Beds Available per day	Jun-21	2123	2147	1879	
-Adult Critical Care Beds Available per day	Jun-21	75	97	84	
-Community Crisis Response Contacts (Qtr)	Jun-21	1563	tbc		

Increased primary care appointments, as well as beds made available, highlights the building pressures across the system

H1 Plan = the plan for the first half of 2021/22

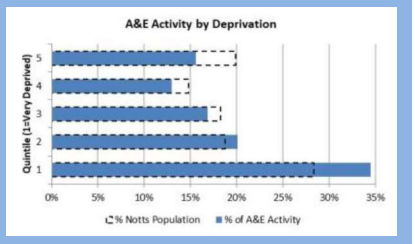
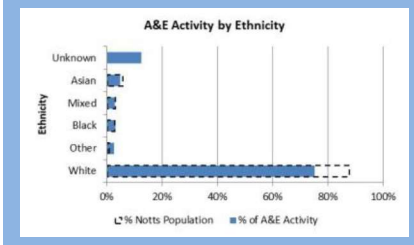
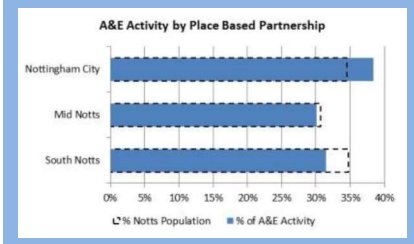
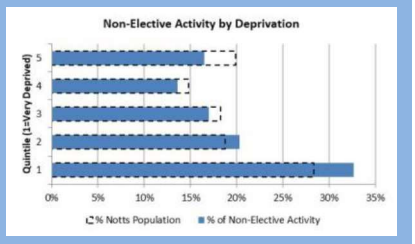
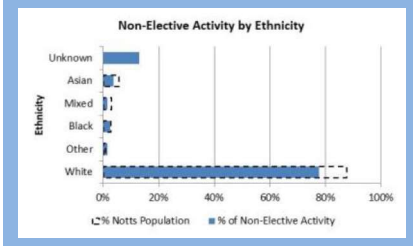
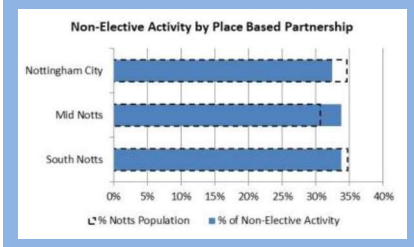
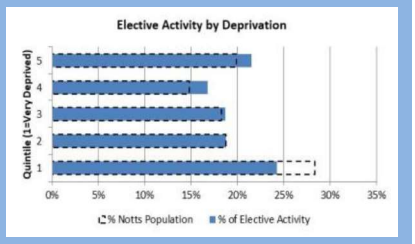
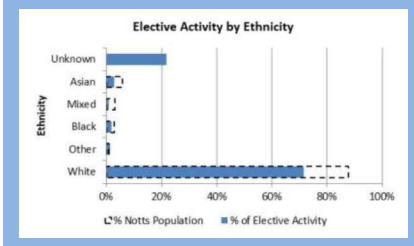
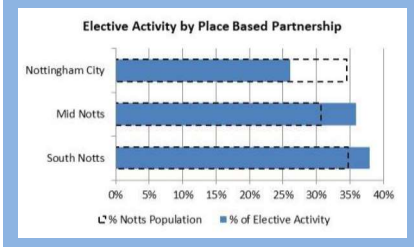
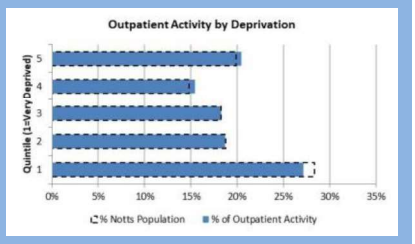
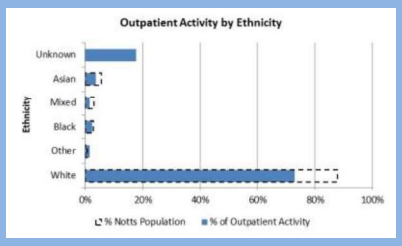
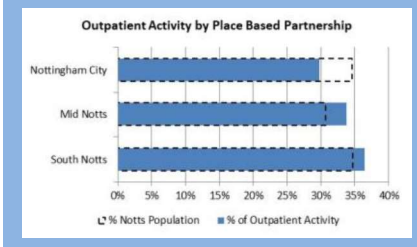
System Readiness to Operate

NHSEI have published an ICS Readiness to Operate Statement (ROS) with accompanying guidance, which will provide the basis of providing assurance to NHSEI and the ICS Board during the transition period. This supports and supplements the ICS Progression Tool. Further information will be provided to the Board.

HEALTH INEQUALITIES VIEW OF SYSTEM PERFORMANCE

Total Activity as % of population segment v system demographic profile

Purpose of the report is to determine whether there is unequal access to diagnosis and treatment across Nottinghamshire

	Deprivation Quintile (1-5)	**Ethnicity** (use groupings from National Pop Health)	**Place Based Partnership - Location**
A&E Attendances: July 2020 - June 2021 Activity			
Non-Elective Admissions: July 2020 - June 2021 Activity			
Elective Admissions: July 2020 - June 2021 Activity			
Planned Care: Total Outpatients: July 2020 - June 2021 Activity			
	A system review of 'Did Not Attends' has been undertaken by deprivation and age, with targeted actions being developed to focus on younger patients in areas of highest deprivation. A Self-referral hotline for lung checks is to be introduced, it is expected that this will particularly benefit patients from deprived communities, and support earlier diagnosis.	Annual Health Checks for patients with Serious Mental Illness, are being reviewed by age and ethnicity for patients who have not received their health check, to enable targeted outreach actions to be undertaken.	The review of 'Did Not Attends' will be re-freshed across Place Based Partnerships, to support actions to be undertaken across deprived communities.To support weight management programmes the system will develop a 'Population Health' approach to support targeted approaches and engagement with communities.

Item Number:	11	**Enclosure Number:**	I1
Meeting:	ICS Board		
Date of meeting:	2 September 2021		
Report Title:	ICS Finance Highlight Report		
Sponsor:	Stuart Poynor, ICS Chief Finance Officer		
Place Lead:	N/A		
Clinical Sponsor:	N/A		
Report Author:	Marcus Pratt, Programme Director - Finance, Nottingham and Nottinghamshire ICS		
Enclosure / Appendices:	Enc I2: Financial Framework		

Summary:

The ICS Finance Director's Group continues to meet on a regular basis to provide executive oversight of the current financial position and forward strategy. The group has moved from a weekly meeting to fortnightly but supplemented this with an Operational Director's of Finance Group, which meets on a weekly basis.

The operational group focus is on developing the system financial strategy and any day to day issues, with the Finance Director's Group providing direction, oversight, and a point of escalation.

This remains an interim structure which will be updated alongside the role of the ICS Finance Committee as it is developed.

Current areas of focus of the Finance Director's Group include:

Existing Financial Position

As detailed within the Integrated Performance Report a change in the national financial framework for the Elective Recovery Fund has led to an estimated reduction in income in Quarter 2 (July-September 2021) of £13.4m. ICS partners have been able to mitigate this in part through a reassessment of costs. However the current forecast is a deficit of £7.5m at the end of H1 (April-September 2021). Note that this is a change from the financial position reported to the board previously. Further detail can be found in the Integrated Performance Report (item 10).

Financial Planning and Strategy

The Finance Director's Group continues to develop the ICS Financial Strategy with the purpose of delivering a financially sustainable position within 3 years. In the absence of a financial settlement for the NHS beyond the first half of 2021/22, the ICS has worked with the regional team to agree a set of medium term assumptions.

These planning assumptions have been used to produce draft financial trajectories and efficiency requirements which have been used to support the on-going development of transformation and efficiency plans.

A detailed programme has been put in place to further develop this approach with next steps including:

- Further development of underlying system plans
- Development of 2021/22 H2 plans using assumptions aligned to the underlying plans.
- Agreement of how system resources will be allocated to support delivery of financial plans.
- Refine Long Term Plan assumptions to update medium-term plans leading to a financially sustainable position.

ICS Financial Framework – for approval

A key component of our financial strategy is the ICS Financial Framework which provides a set of rules which govern the way we manage the finances within the ICS. This aims to do three things:

- describe the collaborative behaviours expected of the parties
- describe processes for reaching consensus and resolving disputes about how best to use financial and other resources available to the ICS
- set out a mechanism for management of the aggregate financial position of the parties to achieve and maintain the system financial improvement trajectory for the ICS.

The framework has been agreed through the ICS Finance Director's and endorsed by the ICS Chief Executive Officers Group. Note that the framework reflects the current regulatory environment and will be updated to reflect transition guidance as it becomes available (see item 6. on the ICS Board agenda for further detail on the transition).

The detailed document can be found in appendix Enc I2.

The ICS Board is asked to **approve** the framework for use by ICS partners.

ICS Development

Using the national ICS Design Framework the ICS Finance Director's Group has undertaken a self-assessment of all financial elements. This has determined that significant progress has been made in all preliminary elements with good progress made towards the required position at the end of March 2022.

Approval and implementation of the ICS Financial Framework will support next steps in supporting collective risk management and ICS oversight and intervention requirements.

Actions requested of the ICS Board

1. The ICS DoFs Group has been taking forward actions, including development of an ICS Financial Strategy, Financial Framework, H2 and longer term plans, 21/22 reporting including impact of ERF and supporting the statutory development of the ICS.
2. The ICS Board is asked to APPROVE the ICS Financial Framework which can be found in Appendix Enc I2.

Recommendations:

1.	The ICS Board is asked to APPROVE the ICS Financial Framework which can be found in Appendix Enc I2.

Presented to:

Board	Partnership Forum	Clinical Executive Group	System Executive Group	Finance Directors Group
☒	☐	☐	☐	☐
Quality Group	**Transition and Risk Committee**	**Mid Nottingham-shire Place**	**Nottingham City Place**	**South Nottingham-shire Place**
☐	☐	☐	☐	☐

Contribution to delivering System Level Outcomes Framework ambitions

Our people and families are resilient and have good health and wellbeing	☒	Our people will have equitable access to the right care at the right time in the right place	☒	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	☒

Conflicts of Interest

☒ No conflict identified
☐ Conflict noted, conflicted party can participate in discussion and decision
☐ Conflict noted, conflicted party can participate in discussion, but not decision
☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision
☐ Conflict noted, conflicted party to be excluded from meeting

Risks identified in the paper

Risk Ref	Risk Category	Risk Description	Residual Risk				Risk owner
			Likelihood	Consequence	Score	Classification	
Ref	e.g. quality, financial, performance	Cause, event and effect There is a risk that…	L1-5	L1-5	L x l	Grading	*Person responsible for managing the risk*

Is the paper confidential?

☐ Yes
☒ No
☐ Document is in draft form

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.

DRAFT - Proposed Nottinghamshire ICS Financial Framework

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1. Changes to ICS Structure

This document has been written prior to statutory changes relating to Clinical Commissioning Groups (CCGs) and Integrated Care systems (ICS). On the 1st April 2022 the ICS will become a statutory body in its own right. The system will be overseen by the Integrated Care Board (ICB) which includes current ICS members. The new ICS organisation will include the transfer of the staffing and responsibility of Nottingham & Nottinghamshire CCG and Bassetlaw CCG.

This document doesn't currently include Bassetlaw CCG as a part of the Nottingham & Nottinghamshire ICS prior to April 2022, but would include Bassetlaw CCG as part of the ICS going forward. The document will be updated for changes to statutory organisations, system membership, and governance structures as these are clarified.

2. What is a financial Framework?

A financial Framework is a set of rules which govern the way we manage the finances within the ICS. This aims to do three things;

- describe the collaborative behaviours expected of the parties
- describe processes for reaching consensus and resolving disputes about how best to use financial and other resources available to the ICS
- set out a mechanism for management of the aggregate financial position of the parties to achieve and maintain the system financial improvement trajectory for the ICS, this includes the prioritisation of risk sharing/pooled budget arrangements.

3. Who does this document concern?

This document is intended for partner organisations of the Nottingham & Nottinghamshire ICS in support of the combined revenue control total. This control total is specific to Nottingham & Nottinghamshire CCG (until closure), Nottingham University Hospitals NHS Foundation Trust (NUH), Sherwood Forest Hospitals NHS Foundation Trust, and Nottinghamshire Healthcare NHS Trust.

To this end Nottingham City Council, Nottinghamshire County Council, City Care, EMAS, and PCNs have a specific section within the document.

The development of Place Based Partnerships, and the potential for forming separate organisations, or capitated budgets may require review and amendment of this document in the future.

A separate framework requires development for management of capital resource limits within the ICS.

4. Why do we need a financial framework?

- As individual entities we are still learning to work with each other, but now have a collective financial responsibility for delivery of financial targets across the system. This has been working well, but a financial framework allows a reduced variation in the way we handle things, and resolving issues as they arise, and aims to effectively manage those issues before they occur.

- While we are working as one system, each organisation is working under different financial regimes which come with different expectations. The impact of these could mean that the desire for joint working is potentially incongruent with the way organisations set up under the existing financial regimes.

- To support risk sharing arrangements in a planned way. See Section on risk sharing.

- A number of key issues as examples have been listed below to prompt the draft framework proposed in this slide/document.
  - How does the system minimise variation to plan?
  - A sovereign organisation may choose to make an additional financial commitment over the agreed plan, this however will impact on the overall system position, how would this be managed?
  - Related to the above if an organisation chooses to make additional financial commitment without ICS partner support, it may choose to 'fill up' its own savings bucket at the detriment of the ICS system planned savings, how is this managed?
  - Organisation may work unilaterally on service cuts or savings which then impact on the costs of partner organisations. How do all parties agree the impacts they have on each other's costs/savings/services?
  - An organisation may incur costs due to external factors and unforeseen circumstances that are not planned investments, and cannot be managed within the allocated budget, how is this managed?
  - Timescales – How do we ensure that decisions are made quickly where needed, e.g. new allocation and deciding how distributed in the system?
  - How do we ensure robust financial governance is maintained in all statutory organisations, while also requiring decisions to be made on a timely basis and in cross organisational structures?

- Post tariff hangover issues e.g. Maternity Tariff and Partially Completed Spells, Service Restrictions, Evidence Based Intervention (EBIs), and foreign nationals. How are these handled?
- How does the system ensure it is delivering good value for money?

5. Behaviours and Standards

This document has been written with an expectation of openness, transparency, and trust in mind between ICS partners. These principles should be considered in the application of the document. This also means that while the ICS develops and utilises this document there will be elements of clarity and refinement required. It's expected that in these cases partners use judgement for the spirit of document in its application; however this should be used to challenge each aspect of the framework.

Any ambiguity that cannot be resolved between partners, through use of the ICS DOFs Group or the ICS Chief Executives should then follow the escalation process; however this should be avoided wherever possible.

In Year Financial Management

6. Transition of Plans into Allocated Budgets

The Nottingham & Nottinghamshire ICS has agreed a plan for H1 (April to September) of 21/22, with indicative assumptions for H2 (October to March) pending national guidance. Once a plan is agreed by the ICS the following financial principles apply;

- Plans are based upon cost. This means any variations to plans are based on cost.
- Growth distribution within plans and planning is within separate documentation, which allows more regular updates, while minimising change to the financial framework documentation.
- ICS plans are allocated indicative budgets with individual organisations
- All organisations should operate within the agreed plan
- These allocated budgets will be replicated within contracts
- Contract values will not change in year for activity or performance.
- Contracts should identify how the allocation should be utilised, and the system priorities for that provider, these should align with the overall ICS strategy

- Changes to provision of services that may impact on cost should be agreed by the ICS partners

- Budget management responsibility is retained within each sovereign organisation for their element of the ICS plans. This means each organisation can make investment decisions within the identified budget value unless it impacts wider than that organisation. Materiality hasn't been specified as this will be different for each organisation, and circumstance, however is at an organisational level, and materiality is expected to be demonstrated.

- Variations to plans may be a contractual variation, for example additional funding has been provided to develop a specific service or exceptional where it results in a change to organisational or system planned surplus/deficit. Exceptional items are expected to be material to the organisation.

- Exceptional variations to agreed plans should be recommended ICS Chief Executives and approved by the ICS Board. A gateway to the Chief Executives recommendation will be provided by the ICS Service Change Cell.

- An organisation may incur costs due to external factors and unforeseen circumstances that are not planned investments. Where possible these should be proposed and agreed by the ICS in advance of any commitment, however recognising that some costs may need to committed by an organisation at short notice to meet patient safety, or performance needs that are materially unable to be met within the existing budgets, retrospective approval should be requested as soon as is practical. For example at a weekend an additional ward may be required to be opened in an acute The ICS DoFs will support ICS level reporting of in year financial performance and associated activity to the ICS Finance Committee, to support actions required in year to avoid unforeseen variation.

7. Investments

- The system has a single sign off process to support decision making, where the impact is above the agreed plan with NHS England's/Improvement, or impacts on more than one organisation within the ICS. Materiality is expected to be considered here in line with section 4. Where immaterial, but impacting on another organisation, this should be a direct discussion with the partner organisation.

- No additional investments over above the plan agreed with NHS England/Improvement will be made unless there is an agreed issue that needs urgently addressing. Any post planning investment proposals will need to be clear on the financial impact to each organisation, the argument for

the investment, and the impact of not taking forward, or delaying the investment to the next planning cycle.

- Proposals must be material to the organisation proposing the investment, and demonstrated in the proposal why this isn't able to be managed within existing budgets.
- Any in year proposals will require a view from the relevant service commissioner if proposed by a provider organisation and relevant service lead if proposed by a commissioner.

Note. Each forum for the viewpoint is to be provided as part of this document.

- Investments agreed above the signed off plan with NHS England/Improvement will also be subject to a disinvestment or additional savings process to ensure the position of the system doesn't worsen.
- Investments requiring additional system commitments/savings have to be recommended by the ICS Chief Executives and approved by the ICS Board. A gateway to the Chief Executives recommendation will be provided by the ICS Service Change Cell.
- Should a partner make a decision that impact on their ability to operate within their allocated budget that hasn't gone through the ICS approval process, the financial implications for that decision rest with that organisation. This includes responsibility for the cost of the investment, and any requirement to offset the cost is the responsibility of that organisation. The aforementioned organisation cannot seek support from the ICS in such a situation. It should be recognised that partners are working with a level of trust and transparency between them, and requirements for evidence should be appropriate. Any concerns of unreasonableness between partners, should allow escalation to ICS Chief Executives for an arbitration request.
- If a commitment is made within the existing plan, and doesn't impact on other ICS organisations, this is seen as acceptable within the sovereignty of the organisations indicative budget.

8. Multi-Organisation Savings Plans

- As per the plans each partner will have a savings target within the allocated
- budget, and contract.
- Unilateral decisions that impact negatively on the system position will be subject to challenge by the ICS Board, or delegated ICS Sub-committees as appropriate.

- Any savings scheme that impacts on more than one ICS organisation should be signed off by the ICS, these will need to detail any value changes proposed, up or down. Savings plans included both those that make direct cash releasing savings, and those that may improve service efficacy to allow the ICS to consider reducing capacity.

  Note – ICS organisations refers to all ICS organisations e.g. Local authorities, CityCare, and EMAS

- If there is an agreed savings solution which impacts on another organisation this may entail a funding transfer from the organisation making the saving to ensure no organisation loses out. The key is ensuring an overall system benefit.

- Any savings plans that are not multi-organisational are expected to follow an internal sign off process.

- Income from other sources needs to be factored into plans, and in year positions. Visibility of other income is required at a system level

- Savings plans will be recommended by the ICS Chief Executives Group, reviewed by the ICS Finance Committee, signed off by the ICS Board.

9. Activity/Performance Monitoring

- Activity will continue to be monitored and managed in line with previous monitoring arrangements. This ensures that all services maximise delivery in line with the system need and maximising service value. This will support a system level monitoring of performance, productivity, service costs and required efficiencies.

- Coding should be continuously improved to ensure robust and accurate recording of the clinical services delivered and the clinical needs of the patient population. This is subject to development by the System Analytics team.

- Counting and coding changes will not impact on the allocations/income received by ICS partners.

- A move away from National Tariff based payment should not affect the requirement for accurate coding.

10. How does the framework address 'real life' problems?

- The CCG has a Stoma contract which was originally procured in 2015 at a very favourable rate. The contract has been previously extended in line with the procurement, however now requires procurement, the expected increase in cost per annum is c£0.5m.

- The CCG should look to mitigate costs where possible, however as the cost is material it requires adding to the investment list and notified to other partners. A discussion on potential system options to mitigate should occur, i.e. can an ICS provider, provide the service. Assuming no mitigation is available, and it is confirmed as a legitimate cost across the ICS, it should be recognised as an additional pressure within the ICS.

- The CCG has a primary care IT contract ending which has previously been funded non-recurrently. The CCG wished to transfer to a new provider; however this will take time, and needs to extend the contract of the existing provider. The minimum extension is 12 months at a cost of c£60k. The new provider will not increase costs.

- Due to the low materiality, the CCG should manage this cost non-recurrently in the year. This issue shouldn't be escalated to ICS partners for consideration.

- There is a joint drugs group with members from Trusts and CCGs across Nottingham and Nottinghamshire (the Area Prescribing Committee) which reviews medicines for the drug formulary. Currently there is a ceiling to the value the committee can approve for new medicines.

- If the cost of the new medicine is within the committees approval limit should this be consumed by providers as part of their allocation. If the cost of the drug is above the committees approval limit, and not able to be managed by the provider due to materiality a proposal for investment will be developed which would be reviewed by leads in the ICS. The proposal should identify impacts on other partner organisations financially, and the basis for the request e.g. patient safety, or required performance, along with the impact if this isn't approved. The proposal will be reviewed by the ICS service change cell that will make a recommendation to the ICS Chief Executives. Appropriate disinvestment or savings plans to mitigate should be identified for the approval to go ahead.

- Over performance in activity has occurred, causing an increased cost in service provision. This has required the opening of an additional ward, how would this be managed by the framework?

- A priority of the ICS is patient safety, and organisations are able to make commitments in the short term within their own sovereignty to support patient safety. On this basis it's recognised that some proposals for exceptional variation may be retrospective, however should be submitted within a reasonable timeframe to avoid further undue costs, and support system mitigation. Firstly an organisation needs to determine if the impact is material,

or impacts on another party within the ICS. If the organisation is not able to financially manage the cost due to materiality a proposal for investment will be developed which would be reviewed by leads in the ICS. The proposal should identify impacts on other partner organisations financially, and the basis for the request e.g. patient safety, or required performance, along with the impact if this isn't approved. The proposal will be reviewed by the ICS service changed cell that will make a recommendation to the ICS Chief Executives. Appropriate disinvestment or savings plans to mitigate should be identified for the approval to go ahead.

11. Financial risk sharing

- Risk sharing arrangements need to be considered in the case where the collective financial management described above does not achieve financial targets.
- These arrangements should consider all ICS partners but may need to differ due to the existing regulatory and statutory arrangements.
- The principles of any financial risk (and reward) sharing agreement are based on agreeing fair and equitable funding to control expenditure whilst optimising outcomes.
- The Nottinghamshire ICS framework means that contracts work on cost based block contracts based on plans, and keeping positions to those plans. It's clear from the document there are risks to those plans, and variations. The routes of variation have been captured within the document; however this doesn't guarantee delivery of financial targets.
- Financial risk sharing agreements should be the final solution after all efforts have been made to manage the risk in-year.
- It's expected these risk shares will work in two ways. Primarily a planned route which allows a funding transfer to resolve 'bottom line' positions within a balanced economy to deliver a specific outcome, and secondly a risk share recognising a system shortfall.
- On the first basis, risk sharing will be by agreement in advance to allow for transfer of funds between ICS organisations to support delivery of specific organisational positions.
- If the above is not possible due to an overall shortfall, the position will be shared based on the best advantage for the system, and where there is no clear system advantage based on plan budget values. This is with the

exception of decisions made by individual organisations outside of ICS agreement e.g. unilateral investment not supported.

- Risk shares will need to be represented organisationally, to not impact on achievement of specific investment standards such as MHIS.
- Agreement of how overall position risk share transfers in a given year will be agreed by the ICS DoFs group, and ratified by the ICS Chief Executives Group.
- The above risk shares will exclude local authorities, CityCare, EMAS, and Specialised Commissioning. Any risk shares with these organisations will be specific agreements.
- Specific bespoke risk shares will be documented and recommended by ICS DoFs, and approved by the ICS Chief Executives.

12. Local Authorities, CityCare, and 3rd Party providers

- The issue to resolve is primarily about how to bind non-NHS bodies, such as local authorities and third-party providers, without creating an escalation in legal fees and transactional costs.
- For local authorities a model for this exists in terms of the better care fund and pooled budget arrangements, the section 75 requirements include written agreement on how overspends are to be managed.
- For third party providers, such as CityCare, and developing PCN providers then standard contractual mechanisms exist.
- It is proposed that due to these organisations not being part of the combined financial targets of the ICS, then risk shares will be specific to services and applied through the above mechanisms. Opportunity to apply risk sharing arrangements should be maximised, and therefore considered for each system transformation change. These risk shares should allow for the same conflict resolution processes, and escalation as other members of the ICS. Any risk share in these arrangements are subject to the specific agreement of those organisations, and in this document is set out as an intent to risk share to maximise involvement in delivery an overall system benefit.

13. Financial flows from outside the ICS

- Where ICSs overlap with neighbouring ICSs and their providers, there will be a degree of inter-ICS fund flows, to a greater or lesser extent, reflecting patient flows and choice. There will need to be transparency about these flows and occasions for joint management action to manage the risk,

depending on materiality to ICS partners as identified in section 4. This will be particularly relevant for ambulance trusts, mental health providers and tertiary providers, and they may be able to provide examples and experience on what is most effective.

- Where specialised commissioning payments, or similar at regional or national level, come to organisations within an ICS these are ring-fenced to that organisation.

14. Incentives and penalties

- The primary aim of the financial framework is to develop a fixed value that the ICS manages through the year. Therefore this would mean the removal of penalties and reduction of CQUINs between ICS partners for non-delivery.
- Quality monitoring requirements are still required.
- This would be subject to agreement by the Quality Committee of the ICS, which would also allow for its reintroduction should system failure occur.

15. Use of contingency/unallocated funds

- Best practice looks to avoid holding back significant sums from the planning process, in terms of a central contingency. This is in part because of the requirement on the public sector to use the funds allocated for the purposes intended and in part to discourage organisations relying on such funds to 'bail them out' or ending with last minute year-end expenditure resulting in a sub-optimal use of resources. However, there are often unforeseen costs and a small level of contingency set aside to support may be required. At the time of writing the Nottinghamshire ICS is not in a financial position to maintain any significant contingencies to meet unforeseen circumstance, however this should be reviewed each time plans are agreed.

16. Intervention

- Where individual organisations move into financial problems there will come a stage where they will need external intervention. The ICS has a role in co-ordinating collaboration or influence where it is clear that there are deeper issues with an organisation's financial management (short of regional or national intervention).
- The ICS by its nature should become a self-regulating system. Should an ICS organisation appear to be failing, then the ICS will use the ICS Finance Committee to agree appropriate interventions.

- Appropriate interventions need to be bespoke to the situation. These may include, but are not limited to additional monitoring, external review, and escalation to NHS EI.

- Formal escalation to NHS EI should be agreed by the Chief Executives, following recommendation by the ICS DoFs, or the ICS Finance Committee. This allows appropriate internal review, and messaging.

- To support managing the financial message and the timeliness of messages any informal escalation is by agreement of ICS DoFs.

17. Assurance

- Regular reporting to the ICS Finance Committee will allow monitoring of the financial risk, this will be primarily on historical outcomes and internal forecasts, which may pick up issues too late for resolution therefore;

- The ICS DoFs group and ICS Chief Executives group will monitor the financial health of the ICS organisations outside of the ICS Finance Committee allowing links to be made to other system information, improving timeliness of decision making.

18. Appeals and escalation

- While there may be a financial risk sharing agreement and memorandum of understanding, there will need to be a process for dispute resolution where this cannot be achieved by internal ICS processes. This may be between the NHS and local authorities or within the NHS where one organisation may feel that it is being treated unfairly.

- Primarily disagreements will follow an NHS Standard Contract disputes resolution process, or those set out in alternative agreements.

- Escalation to an ICS level should be agreed by Chief Executives of disputing originations, or a nominated director. This should be timely, and should be at this stage for no longer than two weeks unless by agreement of both parties.

- ICS escalation process will be decided by the ICS Finance Committee. This may include the appointment of an expert arbiter, or another impartial solution. But there might be occasions where NHSE would appear to be the arbiter for such final resolution, albeit every effort should be made within the ICS to resolve issues before they get to this stage.

Item Number:	12	**Enclosure Number:**	J
Meeting:	ICS Board		
Date of meeting:	2 September 2021		
Report Title:	ICS Quality Group highlight report		
Sponsor:	Rosa Waddingham, ICS Chief Nurse		
Place Lead:			
Clinical Sponsor:			
Report Author:	Rosa Waddingham, ICS Chief Nurse		
Enclosure / Appendices:	None		

Summary:

This paper provides a highlight report, from the Quality Assurance and Improvement Group (QAIG) which met on 28 July 2021. This group works collaboratively on behalf of the ICS to:

- Ensure the fundamental standards of quality are delivered – including review of information trends and themes, identification of system quality risks, oversight of shared system action plans, addressing inequalities and variation
- Improve continually the quality of services, in a way that makes a real difference to the people using them

This month's highlight report provides an overview of the providers under enhanced surveillance and the areas of concern or risk; and those providers under routine surveillance and any emerging concerns.

System quality and transformation projects are summarised, including key actions in relation to maternity transformation and learning disabilities/autism.

Actions requested of the ICS Board

The Committee are asked to note the following:

- Nottingham University Hospitals NHS Trust and Nottinghamshire Healthcare Foundation Trust remain under enhanced surveillance with improvement and action plans in place.

Recommendations:

1.	Support the proposed governance structure which enables QAIG to work on behalf of the ICS Quality Committee
2.	Support the development of a single system view of quality

Presented to:

Board	Partnership Forum	Clinical Executive Group	System Executive Group	Finance Directors Group
☒	☐	☐	☐	☐

Quality Group	Transition and Risk Committee	Mid Nottingham-shire Place	Nottingham City Place	South Nottingham-shire Place
☒	☐	☐	☐	☐

Contribution to delivering System Level Outcomes Framework ambitions

Our people and families are resilient and have good health and wellbeing	☐	Our people will have equitable access to the right care at the right time in the right place	☐	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	☒

Conflicts of Interest

☒ No conflict identified
☐ Conflict noted, conflicted party can participate in discussion and decision
☐ Conflict noted, conflicted party can participate in discussion, but not decision
☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision
☐ Conflict noted, conflicted party to be excluded from meeting

Risks identified in the paper

Risk Ref	Risk Category	Risk Description	Residual Risk				Risk owner
			Likelihood	Consequence	Score	Classification	
Ref	e.g. quality, financial, performance	Cause, event and effect There is a risk that…	L1-5	L1-5	L x l	Grading	*Person responsible for managing the risk*

Is the paper confidential?

☐ Yes
☒ No
☐ Document is in draft form

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

Quality Highlight Report
9 August 2021

Background

1. This report reflects highlights and exceptions from the Quality Assurance and Improvement Group (QAIG) which met on 28 July 2021. The QAIG has been established to undertake some of the detailed work that previously happened in Quality Group/Committee. As the ICS structure and committees are formalised in line with the structure agreed at the ICS, the Quality Committee will be re-established as a formal sub-committee of the ICS Board, with revised terms of reference and more independent chairing arrangements. At this point the QAIG will report into the Quality Committee, in the interim the QAIG will report directly to the ICS Board.

Enhanced Surveillance

2. There are currently three areas of enhanced surveillance within the system. These in the main relate to CQC visits although as ICS quality structures mature these will increasingly reflect local identification of key areas where we are working together to support early identification and action in relation to quality improvements. Where an area of the system has enhanced surveillance as well as a system action plan there are also single item Quality Assurance Groups (QAG) in place.

Nottinghamshire Healthcare NHS Foundation Trust

- Seacole Ward: quality improvement work on Seacole Ward had resulted in positive anecdotal feedback from a small number of staff and patients. QAIG Chair acknowledged the progress and requested that objective quality improvement measures are devised and reported.
- Priory Arnold: CQC restrictions remain in regard to admissions and progress against this work is monitored regularly by system partners including providers, commissioning, quality team and the CQC.
- On-going quality improvement programmes in relation to long term segregation; supporting open cultures; reporting and reviewing suicide and self-harm.
- Internal improvement board and quality action plan at Lings Bar.
- St Andrews Healthcare: currently providing care to 13 adults from Nottingham and Nottinghamshire in medium and low secure settings. The CQC have imposed conditions on the provider and a quality improvement action plan is in development with support from partners and the CCG. Enhanced surveillance recommended as a result of this action.

Nottingham University Hospitals NHS Trust

3. **Nottingham University Hospitals NHS Trust** remains under considerable pressure operationally and in response to external scrutiny in the main in relation to maternity services. However there are other key concerns identified in relation to;

- **Organisational Culture** – the need for improved Board to Ward assurance, greater capacity for quality improvement, openness and transparency and the use of quality intelligence to improve care.
- **Patient Safety** – incident and risk management, embedding learning from deaths, 12 hour breeches, recognition of the deteriorating patient, provision of harm free care and maternity safety.
- **Patient Experience** – most notably around the application of Duty of Candour (DoC).
- **Clinical Effectiveness -** in relation to clarity and use of guidelines**.**
- **Maternity –** safety and staffing remain key concerns and the progress against an agreed maternity quality improvement plan is reviewed at a monthly QAG. Progress against action has been made, albeit not at the pace the trust or partners would wish, this is likely to be further impacted by staffing and acuity challenges within maternity locally and across the region.

4. A system action plan is in place with CCG, ICS and trust colleagues working collaboratively. As a result the entire trust rather than just the maternity services is classified as requiring enhanced surveillance.

5. **Mediscan** (non-obstetric ultrasound (NOUS) provider) received a S31 notice from the CQC. The CCG suspended the contract with Mediscan on 9 July and work is now underway to ensure that alternative services are available and that patients are appropriately transferred to other NOUS providers. A further update will be provided to the Quality Team Assurance Meeting in September.

Routine surveillance

6. The QAIG reviewed key issues and risks (KIAR) in relation to other system providers including the care sector, whilst there were issues flagged no items that required further escalation.

System transformation and quality improvement

7. **Local Maternity and Neonatal System** retains its focus on patient safety in view of the Ockenden return for Q1 and the on-going enhanced surveillance at NUH. There is an active programme to support Covid 19 vaccinations of pregnant women. Further assurance is required with regard to confidence around neonatal deaths data for the county. A specialist MDT panel continues to meet fortnightly to review maternity serious incidents (retrospective and current from both NUH and SFH). A number of quality improvement projects were also described to QAIG in relation to the maternity and neonatal transformation programme.

8. **Learning Disabilities / Autism (LDA) Partnership** noted system / regional challenges around bed capacity for adult and child placements. All system partners are involved in the action planning for this. The Learning Disabilities

Mortality Review (LeDeR) three year strategy is under development and expected to be agreed in September 2021. LDA Partnership remains committed to the LDA Quality Framework with further updates proposed. System partners are currently on trajectory to meet children inpatient discharge targets although this is more challenging for adult inpatient reduction targets.

System Quality working groups

9. **Patient Safety Specialist Steering Group (PSSSG)**
   The Quality Group;
   - endorsed the system wide adoption of the WHO definition of harm and the National Reporting and Learning System (NRLS) descriptions
   - noted the impact of this adoption on the direction of work related to waiting lists and harms
   - support the PSSSG to develop a set of metrics which allow a wider review of harm than the current SI framework
   - ratified the draft PSSSG terms of reference and work plan

10. **Infection Prevention and Control – COVID-19** – no escalations although rise in Covid transmission, related outbreaks and resulting pressure across the system.

ICS Shared Single View of Quality

11. **ICS Quality Dashboard-** A task and finish group facilitated by SFH to support development of the quality dashboard has commenced. The Quality Group:

    - Endorsed the system wide engagement via the task and finish group, with terms of reference currently being drafted.
    - Noted the progress to date by the system's analytics unit towards building a Power BI dashboard which will continue to evolve to meet system requirements supported by the dashboard task and finish group.

Item Number:	13	**Enclosure Number:**	K
Meeting:	ICS Board		
Date of meeting:	2 September 2021		
Report Title:	Highlight Report from the ICS Transition and Risk Committee		
Sponsor:	Jon Towler, Chair of ICS Transition and Risk Committee.		
Place Lead:	N/A		
Clinical Sponsor:	N/A		
Report Author:	Joanna Cooper, Assistant Director, Nottingham and Nottinghamshire ICS		
Enclosure / Appendices:	None		

Summary:

At its 1 July meeting ICS Board agreed to delegate assurance to Committee to ensure that system enabling functions were developing in line with the overall ICS Board development, in addition to the transition work-streams. This was for a time limited period whilst further consideration is given to ICS assurance arrangements (i.e. three months). Discussions on People and Culture and Data, Analytics and Information Technology (DAIT) have taken place. A discussion on finance is scheduled for the September meeting. Strategic development decisions will be undertaken by the ICS Board.

ICS Transition and Risk Committee met on 23 August 2021. The Committee **received** and **noted** for information and assurance a number of reports relating to the ICS Transition, namely:

- ICS Boundary – Following a National decision to change the boundary of our ICS to include Bassetlaw, work has been undertaken to align the requirements of work-streams. Committee considered the practical implications, risks and mitigations.
- Feedback on the System Development Plan - Committee noted the feedback from NHSEI to current ICS development and transition plans, a self-assessment against the ICS Progression Tool led by the work-stream leads, and the system buddying arrangements being put in place with Herefordshire and Worcestershire within the Midlands, and two systems in South West.
- Work-stream highlight reports and a programme plan – Work-streams have developed in-line with the emerging guidance and there are no red risks to highlight at this time. Further guidance from NHSEI is anticipated over the coming period to inform the development of work-streams. In particular, further work is to be undertaken to agree the next steps for Place Based Partnerships once guidance is received.
- People and Culture – Committee considered progress against the requirements in the ICS Design Framework. A Task and Finish Group is being convened to consider and advise ICS Board on six key issues.

Key Messages for the ICS Board

1. A decision on the ICS Boundary has been made. Work is underway to implement this and ensure that transition work-stream plans are aligned.
2. Work-streams have developed in-line with the emerging guidance and there are no red risks to highlight at this time.
3. Further work is underway through the People and Culture work-stream to support the requirements within the ICS Design Framework:
    a. Appointment of a Board level SRO with clearly defined accountability of a People Function;
    b. Requirement for an ICS People Function appropriately resourced to deliver the requirements and with robust governance embedded in the ICS structure (People Assurance Committee);
    c. Clarity on the leadership, roles and responsibilities to establish a People Function over the next 6 months;
    d. Existing People and Culture Board and its membership is sufficient for current context but not fit for purpose post April 2022;
    e. Need for sustainable resources with the right skills/expertise to deliver the statutory requirements (current system deficit in analytical, OD, EDI and strategic workforce planning capacity and/or capability);
    f. Current lack of visibility of the workforce risks at ICS Board level to take appropriate action at system level.
4. Further to discussion at the July Committee meeting, Committee wish to escalate two issues to support the achievement of Digital requirements within the ICS Design Framework:

    From Requirement 1 – Digital and Data involvement in System Transformation:
    a. How does the 'System' wish to ensure the DAIT agenda is part of the transformational approach to care and service redesign rather than a technical 'back office' function?

    From Requirement 2 – Accountability and Responsibility
    b. Who could help us develop sustainable resource plans to best exploit the funding opportunities?

Committee propose that ICS Board use some dedicated board development time to discuss and consider People and Culture, and Digital issues in October. A paper will be produced to support this discussion.

Is the paper confidential?

☐ Yes
☒ No
☐ Document is in draft form

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