NNE Governing Body Public Meeting Agenda and Papers 16 April 2019

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Chair: Dr James Hopkinson
Enquiries to: ncccg.committees@nhs.net

NHS
Nottingham North and East
Clinical Commissioning Group

Governing Body
Meeting Agenda (Open Session)
Tuesday 16 April 2019 13:30 – 14:45

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

Introductory Items				
13.30	**1.**	**Welcome and apologies for absence**	JH	GB 19 027 - Verbal
	2.	**Confirmation of quoracy**	JH	GB 19 028 - Verbal
	3.	**Declarations of interest for any item on the agenda**	JH	GB 19 029
	4.	**Management of any real or perceived conflicts of interest**	JH	GB 19 030
	5.	**Questions from the public**	JH	GB 19 031 - Verbal
	6.	**Minutes of the meeting held on 15 January 2019**	JH	GB 19 032
	7.	**Action log and matters arising from the meeting held on 15 January 2019**	JH	GB 19 033
Strategy and Leadership				
13:40	**8.**	**Accountable Officer Report**	AS	GB 19 034
	9.	**Nottingham and Nottinghamshire Health and Care Integrated Care System (ICS) - System Operational Plan 2019/20**	AS	GB 19 035
Financial Stewardship				
14.00	**10.**	**2018/19 Financial Position Update**	JB	GB 19 036 - Verbal
	11.	**Financial Plans and Opening Budgets 2019/20**	JB	GB 19 037
	12.	**Approval to Delegate Authority/Limits** − Amendment to the Detailed Financial Policy − Better Care Fund Pooled Fund Agreement for 2019/20	JB	GB 19 038
Corporate Assurance				
14:20	**13.**	**Greater Nottingham Joint Commissioning Committee Quarterly Assurance Report**	LB	GB 19 039
	14.	**Assurance Framework**	LB	GB 19 040
	15.	**Equality Annual Report 2018/19**	HB	GB 19 041

	16. Workforce Report	HB	GB 19 042
	17. Risk and Assurance Report	LB	GB 19 043

Information Items

The following items are for information and will not be individually presented. Questions will be taken by exception.

-	**18. Primary Care Commissioning Committee Minutes** 12 December 2018	-	GB 19 044
-	**19. Patient and Public Involvement Committee Minutes** 13 November 2019	-	GB 19 045
-	**20. Clinical Cabinet Minutes** 17 October 2018, 21 November 2018 and 30 January 2019	-	GB 19 046
-	**21. Information Governance Management and Technology Committee Minutes** 4 December 2018	-	GB 19 047
	22. Audit and Governance Committee Minutes 6 December 2018	-	GB 19 048
-	**23. Nottinghamshire Safeguarding Adults Board Minutes** 11 October 2018	-	GB 19 049
	24. Nottinghamshire Safeguarding Children's Board Minutes 12 December 2018		GB 19 050

Closing Items

14:45	**25. Any other business**	JH	GB 19 051 - Verbal
	26. Risks identified during the course of the meeting	JH	GB 19 052 - Verbal
	27. Date of next meeting: *Extraordinary Meeting Tuesday 14 May 2019* *Room 5.03, Standard Court, Park Row, Nottingham NG1 6GN*	JH	GB 19 053 - Verbal

Confidential Meeting Motion

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

Minutes Presented	Previous ratified minutes received	Last Meeting (S)	On Agenda		Next Meeting
			Ratified Minutes	Highlight Report	
Audit and Governance Committee	27 September 2018	6 December 2018 28 February 2019	Y	Y	9 May 2019
Information Governance Management and Technology Committee	20 July 2018	4 December 2018 18 January 2019	Y	Y	11 April 2019
Nottinghamshire Safeguarding Adults Board	12 July 2018	11 October 2018 10 January 2019	Y	Y	TBC
Nottinghamshire Safeguarding Children's Board	19 September 2018	12 December 2018	Y	-	TBC
Nottinghamshire Health and Wellbeing Board	7 November 2018	9 January 2019	Y		7 March 2019
Primary Care Commissioning Committee	4 October 2018	12 December 2018 7 March 2019	Y	Y	16 April 2019
Clinical Cabinet	19 September 2018	17 October 2018 21 November 2018 30 January 2019 27 February 2019	Y Y Y	Y Y	Not applicable
Patient and Public Involvement Committee	10 July 2018	13 November 2018 22 January 2019	Y	Y	May 2019

Name	Current position (s) held in the CCGs	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Type: Financial	Type: Non-financial Professional Interests	Type: Non-financial Personal Interests	Is the interest indirect?	Date From:	Date To:	Action taken to mitigate risk
Allen, Terry	Lay Member - Financial Management and Audit (NHS Nottingham North and East CCG)	Price Waterhouse Coopers	Son employed by	✓			✓	01/11/2017	Present	This interest will be kept under review and specific actions determined as required.
Allen, Terry	Lay Member - Financial Management and Audit (NHS Nottingham North and East CCG)	Circle Nottingham NHS Treatment Centre	Close friend employed by as a consultant nurse	✓			✓	01/04/2018	Present	This interest will be kept under review and specific actions determined as required.
BEMROSE, Jonathan	Chief Finance Officer - Greater Nottingham CCGs	Westdale Lane Surgery.	Registered Patient			✓		01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to the Westdale Lane Surgery.
BEMROSE, Jonathan	Chief Finance Officer - Greater Nottingham CCGs	Westdale Lane Surgery.	Relatives registered patients			✓	✓	01/04/2013	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to the Westdale Lane Surgery.
BEMROSE, Jonathan	Chief Finance Officer - Greater Nottingham CCGs	Nottingham University Hospitals NHS Trust	Spouse is employed as a clerical worker in the Cardiology Department	✓			✓	01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
BRAMHALL, Nichola	Chief Nurse and Director of Quality for the Greater Nottingham CCGs	Oakenhall Medical Practice	Registered patient			✓		20/06/2018	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to the Oakham Hall Medical Practice.
CAMPBELL, Dr Ian	GP , Cluster Lead, GP Lead	Park House Medical Centre	Senior Partner	✓				21/04/2015	Present	Withdraw from a specified activity or relevant parts of meetings during which relevant are discussed and not to take part in any related vote.
CAMPBELL, Dr Ian	GP, Cluster Lead, GP Lead	Bodylibrium (weight loss and lifestyle business)	Partner	✓				21/04/2015	Present	This interest will be kept under review and specific actions determined as required.
CAMPBELL, Dr Ian	GP , Cluster Lead, GP Lead	Nutracheck/co/uk (weight loss business)	Medical Advisor	✓				14/07/2016	Present	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote.
CHAMPION, Janet	Lay Member (NHS Nottingham North and East CCG and NHS Nottingham West CCG) Associate Lay Member (Nottingham City CCG)	Health Education East Midlands	Lay Partner		✓			30/03/2016	Present	This interest will be kept under review and specific actions determined as required.

Name	Current position (s) held in the CCGs	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Type: Financial	Type: Non-financial Professional Interests	Type: Non-financial Personal Interests	Is the interest indirect?	Date From:	Date To:	Action taken to mitigate risk
CHAMPION, Janet	Lay Member (NHS Nottingham North and East CCG and NHS Nottingham West CCG) Associate Lay Member (Nottingham City CCG)	Royal Wolverhampton Hospitals NHS Trust	HR Consultancy work	✓				01/09/2017	01/10/2018	This interest will be kept under review and specific actions determined as required.
HOPKINSON, Dr James	Clinical Chair, NNE CCG	Calverton Practice (which is a provider of Primary Medical care services in NNE CCG)	GP and Partner	✓				01/04/2013	Present	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote.
HOPKINSON, Dr James	Clinical Chair, NNE CCG	NUH	Wife is an Allergy Nurse Specialist	✓			✓	01/04/2013	Present	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote.
HOPKINSON, Dr James	Clinical Chair, NNE CCG	Faculty of Sport and Exercise Medicine (an intercollegiate faculty of the Royal College of Physicians of London and the Royal College of Surgeons of Edinburgh, which works to develop the medical specialty of Sport and Exercise Medicine).	Fellow of		✓			01/04/2013	Present	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote.
HOPKINSON, Dr James	Clinical Chair, NNE CCG	NEMS	Shareholder	✓				01/04/2013	Present	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote.
KENNEDY, Dr Caitriona	GP Member	Trentside GP Practice	GP and Senior Partner			✓		14/07/2016	Present	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote.

Name	Current position (s) held in the CCGs	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Type: Financial	Type: Non-financial Professional Interests	Type: Non-financial Personal Interests	Is the interest indirect?	Date From:	Date To:	Action taken to mitigate risk
KENNEDY, Dr Caitriona	GP Member	County Health Partnerships	Part time Clinical Director for NNE Locality (*maximum of 1 day per week*).			✓		14/07/2016	Present	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote.
KENNEDY, Dr Caitriona	GP Member	NEMS	Shareholder	✓				01/04/2013	Present	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote.
KENNEDY, Dr Caitriona	GP Member	Health Partnerships	Clinical Director	✓				18/02/2014	01/02/2018	Withdraw from a specified activity or relevant parts of meetings during which relevant are discussed and not to take part in any related vote.
MADDOCK, Dr Elaine	GP Member	Stenhouse Medical Centre/	GP Partner	✓				02/08/2016	31/03/2019	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote.
MADDOCK, Dr Elaine	GP Member	Mill View Surgery, Mansfield	Husband is GP Partner	✓			✓	02/08/2016	31/03/2019	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote.
MOSS, Elaine	Chief Nurse and Director of Quality - NHS Mansfield and Ashfield Clinical Commissioning Group	No relevant interests declared	Not applicable							Not applicable
PANESAR, Paramijt	Assistant Clinical Lead	Ivy Medical Group	Partner	✓				01/04/2013	Present	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote.
SULLIVAN, Amanda	Accountable Officer - commencing 13 November 2018	No relevant interests declared	Not applicable							Not applicable
TEASDALE, Ben	Secondary Care Consultant	University Hospital Leicester/ Magpas Air Ambulance	Consultant in Emergency Medicine		✓			23/05/2016	30/11/2018	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote.
THOMPSON, Gary	Chief Operating Officer	Radcliffe on Trent Health Centre	Patient			✓		01/01/2018	Present	This interest will be kept under review and specific actions determined as required.
THOMPSON, Gary	Chief Operating Officer	Radcliffe on Trent Health Centre	Spouse is a patient			✓		01/01/2018	Present	This interest will be kept under review and specific actions determined as required.
WALTERS, Samantha	Accountable Officer to 31 October 2018		Knows Dr Jane Youde personally			✓		01/04/2013	07/11/2018	This interest will be kept under review and specific actions determined as required.

Name	Current position (s) held in the CCGs	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Type: Financial	Type: Non-financial Professional Interests	Type: Non-financial Personal Interests	Is the interest indirect?	Date From:	Date To:	Action taken to mitigate risk
WILKINS, Mike	Lay Member- Patient and Public Involvement (NHS Nottingham North and East CCG)	Water Works Charity	Trustee and Treasurer	✓				08/06/2015	Present	This interest will be kept under review and specific actions determined as required.
WILKINS, Mike	Lay Member- Patient and Public Involvement (NHS Nottingham North and East CCG)	Elmswood Surgery (City Practice)	Wife is employed as a Practice Nurse	✓			✓	27/05/2017	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to the Elmswood Surgery.

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Managing Conflicts of Interest at Meetings

1. A “conflict of interest” is defined as a “set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold”.

2. An individual does not need to exploit their position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur. In fact, a perception of wrongdoing, impaired judgement, or undue influence can be as detrimental as any of them actually occurring. It is important to manage these perceived conflicts in order to maintain public trust.

3. Conflicts of interest include:

   - Financial interests: where an individual may get direct financial benefits from the consequences of a commissioning decision.
   - Non-financial professional interests: where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their reputation or status or promoting their professional career.
   - Non-financial personal interests: where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit.
   - Indirect interests: where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision.

   The above categories are not exhaustive and each situation must be considered on a case by case basis.

4. In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals.

5. At the beginning of each formal meeting, Committee members and co-opted advisors will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting.

6. The Chair of the Committee (or Deputy Chair in their absence, or where the Chair of the Committee is conflicted) will determine how declared interests should be managed, which is likely to involve one the following actions:
    - Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements.
    - Allowing the individual to participate in the discussion, but not the decision-making process.
    - Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements.

NHS
Nottingham North and East
Clinical Commissioning Group

NHS Nottingham North and East Governing Body
UNRATIFIED Minutes of the meeting held in public on
Tuesday 15 January 2019 13:30 – 15:00
Chappell Room Civic Centre, Arnot Hill Park, Arnold, Nottingham, NG5 6LU

Present with voting rights:

Dr James Hopkinson	Clinical Chair
Terry Allen	Lay Member – Financial Management and Audit
Jonathan Bemrose	Chief Finance Officer, Greater Nottingham Clinical Commissioning Partnership
Nichola Bramhall	Chief Nurse and Director of Quality, Greater Nottingham Clinical Commissioning Partnership
Janet Champion	Lay Member – Patient and Public Involvement
Dr Caitriona Kennedy	GP Representative
Dr Elaine Maddock	GP Representative
Mike Wilkins	Lay Member – Primary Care

In attendance:

Lucy Branson	Corporate Director, Greater Nottingham Clinical Commissioning Partnership
Hazel Buchanan	Director of Strategy and Partnerships, Greater Nottingham Clinical Commissioning Partnership
Fiona Daws (minutes)	Corporate Governance Officer, Greater Nottingham Clinical Commissioning Partnership

Apologies:

Dr Ian Campbell	GP Representative
Dr Paramjit Panesar	Assistant Clinical Chair
Amanda Sullivan	Accountable Officer, Greater Nottingham and Mid-Nottinghamshire CCGs

Cumulative Record of Members Attendance (2018/19)					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Dr James Hopkinson	4	4	Dr Elaine Maddock[5]	4	4
Terry Allen	4	4	Dr Paramjit Panesar	4	2
Jonathan Bemrose	4	4	Dr Ben Teasdale[3]	3	1
Nichola Bramhall	4	3*	Gary Thompson[1]	3	2
Dr Ian Campbell	4	2	Sam Walters[2]	2	0*
Janet Champion	4	3	Mike Wilkins	4	4
Dr Caitriona Kennedy	4	3	Amanda Sullivan[4]	1	0

1 Temporary membership whilst acting as Accountable Officer
[2] Membership ceased September 2018
[3] Membership ceased October 2018
[4] Membership commenced November 2018
[5] Membership Ceased January 2019
** Nominated deputies attended meetings where apologies had been received*

Item

Introductory Items

GB 19 001 **Welcome and apologies for absence**

Dr James Hopkinson welcomed everyone to the meeting of the Governing Body in open session.

Apologies were noted as above.

Item

GB 19 002 **Confirmation of quoracy**
It was confirmed that the meeting was quorate.

GB 19 003 **Declarations of interest for any item on the agenda**
No interests were declared in relation to any item on the agenda.

Members were reminded of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

GB 19 004 **Management of any real or perceived conflicts of interest**
As no conflicts of interest had been identified, this was not necessary for the meeting.

GB 19 005 **Questions from the public**
No questions from the public had been received

GB 19 006 **Minutes of the meeting held on 16 October 2018**
The minutes of the previous meeting held on 16 October 2018 were reviewed, and confirmed as an accurate record and will be signed by the Chair.

GB 19 007 **Action log and matters arising from the meeting held on 16 October 2018**
No actions were outstanding or ongoing.

The following items were noted as complete and can now be closed:

(a) GB 18 105 – Integrated Governance Arrangements – Primary Care Commissioning Committee meeting in common approach is addressed within agenda item GB 19/009.
(b) GB 18 105 – Integrated Governance Arrangements – Information Governance, Management Technology Committee (IGMT) terms of reference have been circulated to Governing Body members for virtual approval.
(c) GB 18 107 – Workforce Report – workforce savings delivery by the staff alignment process has been added to the forward plan for the Governing Body meeting planned for 16 April 2019.

All other actions were noted as ongoing and there were no further matters arising.

Strategy and Leadership

GB 19 008 **Accountable Officer Report**
Jonathan Bemrose presented this agenda item. The following key points were highlighted and discussed:

(a) Staff from the six Nottingham and Nottinghamshire CCGs took part in a joint time-out session on 5 December 2018. This provided the first in a series of opportunities for staff to meet with peers and to think about how they will work together moving forward.
(b) Work is taking place across the system to support the additional pressures that winter is putting on the Emergency Department at Nottingham University Hospitals NHS Trust (NUH). This is attracting regulatory interest.
(c) The NHS Long Term Plan has been published; it reveals a broad range of national healthcare priorities that will guide the way we plan and fund services in Nottingham and Nottinghamshire. It will frame our local

transformation plans and spending priorities for the next five to ten years. Implementation of the plan is expected to save almost half a million more lives with practical action on major killer conditions. It is pleasing that the report aligns with the Greater Nottingham CCGs' direction of travel. One of the Nottingham Vanguard areas was mentioned in the national report.

(d) Members questioned whether there is extra funding for the Primary Care Networks (PCNs). It was explained that guidance on this is awaited and therefore a complete picture is not yet available.

(e) Regarding running costs:
- CCGs have been asked to deliver a 20% real terms reduction against their 2017/18 running cost allocation in 2020/21. An element of this will have been delivered as a result of the recent staff alignment across the Greater Nottingham CCGs.
- Greater Nottingham CCGs have traditionally underspent on their running costs allocations, which will contribute towards achieving the required reduction.

(f) A new 'blended payment' model is being introduced for non-elective admissions, Emergency Department attendances and ambulatory/same day emergency care.

(g) The Integrated Care System (ICS) Board has met for the first time in shadow form. The membership is currently being reviewed following feedback that increased clinical input is required.

(h) Local European Union exit readiness planning has commenced in preparation for a no deal Brexit.

(i) Giltbrook Surgery and Newthorpe Medical Practice will both move from NHS Nottingham North and East CCG to NHS Nottingham West CCG with effect from 1 April 2019.

The Governing Body:
- **RECEIVED** the Accountable Officer Report for information.

GB 19 009 **Integrated Governance Arrangements – Update**

Lucy Branson presented this item and the following key points were highlighted and discussed:

(a) The paper is a follow on from previous Governing Body meetings and focusses on Primary Care Commissioning Committees meeting in common, highlights necessary Remuneration Committee terms of reference changes and outlines the new arrangements for Research Excess Treatment Costs. It also provides a brief update from the Information Governance Management and Technology (IGMT) Committee.

(b) **Primary Care Commissioning Committee:** it was discussed at the last Governing Body and agreed in principle to move towards holding meetings in common.
- All Governing Bodies sought further assurance that a local flavour be maintained.
- NHS England has a model terms of reference, which has been adopted in the main, with additional CCG specific proposals.
- GPs move from being part of the membership to being in attendance in the proposed terms of reference. This will be consistent across the Greater Nottingham Clinical Commissioning Partnership.
- An independent GP role is proposed after reference to the Conflicts of Interest statutory guidance and the decision making process. This would be a new member for Nottingham North and East CCG.

Nottingham City CCG already has this post identified, although there is no incumbent.
- The steps in the change process will be incremental.
- The same challenge exists regarding quoracy as other meetings in common.
- The terms of reference retains the ability to make urgent decisions with the option that this can take place virtually.
- There is an allowance for deputies to attend as part of the delegation agreement.

The Governing Body:
- **APPROVED** the proposed terms of reference for the Primary Care Commissioning Committees and the associated 'meeting in common' arrangements.

(c) **Remuneration Committee:** following recent advice from NHS England and a review of the Terms of Reference, the following changes have been incorporated for approval:
- As the majority of CCG Remuneration Committees have made decisions that Governing Bodies should have made instead, it is now reflected that the Governing Body retains decision making responsibilities related to remuneration and that the Remuneration Committee will act in an advisory capacity.
- Latest guidance has set out that Audit Committee Chairs can continue to be members of the Remuneration Committees but not act as Chair of this meeting.
- Responsibility for approving the CCG's Human Resources policies and overseeing compliance with the requirements set out in the Equalities Act 2010 has been added.
- In light of the above it is proposed the Committee be renamed to Remuneration and Terms of Service Committee.

The Governing Body:
- **APPROVED** the proposed terms of reference for the Remuneration and Terms of Service Committee.

(d) **Managing Research Excess Treatment Costs:** there has been a drive to change to a standardised approach across the country with NHS England setting out a new way of working, replacing local arrangements. The six month trial basis includes that:
- All CCGs are to contribute financially to a national excess treatment costs pool to fund reimbursement incurred by CCG commissioned provider services.
- The national pool of funds is managed via the National Institute for Health Research Clinical Research Network.
- A provider threshold is introduced whereby the excess treatment costs are absorbed by provider organisations before they can access the national funding pool.
- Nottingham City CCG has been nominated to act as Lead CCG for the East Midlands region, holding decision making responsibility for costs. The Governing Body is asked to approve the delegation agreement for Nottingham City CCG to do this on their behalf.
- Providers are now required to accept an element of the associated risk.

Item

The Governing Body:

- **APPROVED** the delegation of the CCG's responsibilities for excess treatment costs to Nottingham City CCG and the required change to the Delegation Agreement for the Greater Nottingham Joint Commissioning Committee.

(e) **Information Governance, Management and Technology Committee:** further to the Committee meeting held on 4 December 2018 it is proposed that:

- Under the revised Terms of Reference, approved on 16 November 2018, the lay membership is increased from two to three, with the third member coming from Greater Nottingham.
- Following an initial six month period, the role of Data Protection Officer is permanently assigned to the Head of Information Governance. This approach is also being taken forward by the Mid-Nottinghamshire CCGs.

The Governing Body:

- **APPROVED** the change to the Information Governance, Management and Technology Committee terms of reference.
- **APPROVED** the Data Protection Officer role assignment to the Head of Information Governance.

GB 19 010 **Information Governance, Management and Technology Strategy**

Jonathan Bemrose presented this agenda item and highlighted the following:

(a) The strategy has been refreshed and outlines the strategic intent for delivery of the final year of the five year delivery timescale.
(b) The strategy reflects local ambition, the work required to meet the CCG's obligations in line with national standards and links to emerging Integrated Care System priorities.
(c) The Medical Interoperability Gateway (MIG) has been implemented and enables information to be accessed across the system.
(d) There is intent to move to a common General Practice System of Choice (GPSoC) environment.
(e) Systematised Nomenclature of Medicine (SNOMED) clinical coding will be adopted to support the effective clinical recording of data with the aim of improving patient care.
(f) Work is underway to identify the best solutions for improving patient access to online services in line with national requirements.
(g) All implemented products will comply with national data protection legislation.
(h) The Information Governance, Management and Technology Committee will be monitoring progress against the final year of the strategy.

The Governing Body:

- **APPROVED** version 4.6 of the Information Governance, Management and Technology Strategy.

Financial Stewardship

GB 19 011 **2018/19 Financial Position Update**

With the Chair's permission, this item was deferred to the confidential session

Item

of the meeting.

Quality Improvement

GB 19 012 **New Safeguarding Children Arrangements**

Nichola Bramhall presented this item, explaining the following key points to members:

(a) The final version of the arrangements has been published with significant rationalisation across the Greater Nottingham patch.
(b) A meeting has taken place to consider how the new arrangements should be funded and it is proposed to maintain contributions for 2019/20 at the same level as those to the Nottingham Safeguarding Children Board the previous year, to be reviewed during 2019.

The Governing Body:

- **APPROVED** the revised new Nottingham Safeguarding Children Arrangements.

GB 19 013 **2017/18 Nottinghamshire Safeguarding Children Board Annual Report**

Nichola Bramhall presented this item, highlighting the following:

(a) The annual report is a consolidation of the work throughout 2017/18 with focus around implementing the new arrangements.
(b) New interim portfolios have been established and Nichola Bramhall will be the lead for the City area and Elaine Moss across the County.

The Governing Body:

- **NOTED** the contents of the report.

Corporate Assurance

GB 19 014 **Greater Nottingham Joint Committee (GNJCC) Quarterly Assurance Report**

Lucy Branson presented the third quarterly report and the following points were highlighted and discussed:

(a) The report from the Greater Nottingham Joint Commissioning Committee to the Governing Body provides a level of assurance around the delegated arrangements and describes the work of the GNJCC during quarter three of 2018/19.
(b) Under the strategy and leadership section, the GNJCC continues to receive thematic reviews regarding commissioning priority areas - a Community Care review was received during this quarter.
(c) Winter planning arrangements across Greater Nottingham commenced in April 2018 and incorporated lesson learned from the 2017/18 winter period within 2018/19 plans. The report details the peak gap of 200 beds in the final quarter of 2018/19 and how it is being managed.
(d) The reporting timetable effective from September 2018 for Local Maternity Systems (LMS) consists of a highlight report which includes self-rating against regional milestones, national core deliverables and focussed deep dive reports. The outcome of the assurance meeting in September was that the LMS was rated as “some support was required”. As the new lead for the maternity transformation programme, Nichola will be undertaking a full review.
(e) Regarding section 3.2 Performance, improvements have yet to be seen in

Item

those areas where we are under formal escalation with NHS England, although it was stated that the quality of service delivery has improved.

The Governing Body:

- **RECEIVED** the GNJCC's Quarterly Assurance Report.

GB 19 015 **Risk and Assurance Report**

Lucy Branson presented the item and the following key points were highlighted in discussion:

(a) The report brings together the CCG's major risks for the attention of the Governing Body and the highlight reports from each of its sub-committees.
(b) There are five major risks currently documented on the organisational risk register; mitigating actions have been identified and are being closely monitored.
(c) The risk scores of a number of financial risks have been increased following the December 2018 Finance Committee.
(d) Highlight reports were received for each of the Governing Body's sub-committees.
(e) Risk GN082 relates to the Emergency Department reconfiguration and the potential risk this could have to patient safety during the winter period. Members were asked to consider whether the risks score for risk GN082 could be reduced.
(f) It is noted that risk GN087, relating to staff disengagement due to the restructuring process and changes, needs to be closely monitored as the upcoming merger has the potential to impact further on staff morale and productivity.

The Governing Body:

- **REVIEWED** the major risks and mitigating actions; and
- **NOTED** the work of its sub-committees.

Information Items

GB 19 016 **Primary Care Commissioning Committee Minutes**

Minutes from the 4 October 2018 meeting were received for information.

GB 19 017 **Patient and Public Involvement Committee Minutes**

Minutes from the 10 July 2018 were received for information.

GB 19 018 **Clinical Cabinet Minutes**

Minutes from the 19 September 2018 meeting were received for information.

GB 19 019 **Information Governance Management and Technology Committee Minutes**

Minutes from the 20 July 2018 meeting were received for information.

GB 18 020 **Audit and Governance Committee Minutes**

Minutes from the 27 September 2018 meeting were received for information.

GB 19 021 **Nottinghamshire Safeguarding Adults Board Minutes**

Minutes from the 12 July 2018 meeting were received for information.

GB 19 022 **Nottinghamshire Safeguarding Children's Board Minutes**

Item

Minutes from the 19 September 2018 meeting were received for information.

GB 19 023 **Nottinghamshire Health and Wellbeing Board Summary**
The summary from the 7 November 2018 meetings was received for information.

Closing Items

GB 19 024 **Any other business**
No other business was raised.

GB 19 025 **Risks identified during the course of the meeting**
No risks were identified to add to the risk register.

GB 19 026 **Date of next meeting:**
Tuesday 16 April 2019
Chappell Room Civic Centre, Arnot Hill Park, Arnold, Nottingham, NG5 6LU

Confidential Motion

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

SIGNED …… **Chair**

DATE ……

NHS
Nottingham North and East
Clinical Commissioning Group

NHS Nottingham North and East CCG

OPEN GOVERNING BODY: ACTION LOG from the meeting on 15 January 2019

AGENDA ITEM	ACTION	LEAD	DATE TO BE COMPLETED	COMMENT
ACTIONS OUTSTANDING				
No actions outstanding				
ACTIONS ONGOING				
No actions ongoing				
ACTIONS COMPLETED				
No actions completed				

NHS
Nottingham North and East
Clinical Commissioning Group

Meeting Title:	Open Governing Body				**Date:** 16 April 2019			
Paper Title:	Accountable Officer Report				**Paper Reference:** GB/19/034			
Sponsor:	Amanda Sullivan, Accountable Officer							
Previous Related Papers:	Standing agenda item							
Recommendation:	Approve	☐	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒
Summary Purpose of Paper:	The purpose of this paper is to present strategic updates and topical items to the Governing Body for information, assurance and approval (where relevant). This month's report includes: • CCG 360 Stakeholder Survey • Primary Care Networks – Registration Approval • Nottingham and Nottinghamshire Integrated Care System (ICS) Updates • Appointment of Independent Chair of the Safeguarding Adults Board • Update from the Health and Wellbeing Board • Appointment to Executive and Senior Leadership Team • National Updates							

If paper is for Approval/Endorsement, have the following impact assessments been completed?

Equality / Quality Impact Assessment	Yes No N/A	☐ ☐ ☒	Data Protection Impact Assessment	Yes No N/A	☐ ☐ ☒

Conflicts of Interest: *Recommended action to be agreed by the Chair at the beginning of the item.*

☒ 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
☐ Conflicted party is excluded from discussion

Have All Relevant Implications Been Considered? *(please tick where relevant)*

Clinical Engagement	☒	Patient and Public Involvement	☒
Quality Improvement	☒	Equality, Diversity and Human Rights	☒
Integration	☒	Innovation / Research	☒
Improving Health Outcomes / Reducing Health Inequalities	☒	Patient Choice / Shared Decision Making	☒

Financial Management	☒	Corporate Governance	☒
Is the Information in this paper confidential? Yes ☐ No ☒ **If yes, please state reason why:**			
Risk: *(briefly explain any risks associated with the paper*)	N/A		
Recommendation:	The Governing Body is asked to: • **RECEIVE:** The Accountable Officer Report for information. • **APPROVE:** The delegation of the process for registration approvals to the Primary Care Commissioning Committee.		

Accountable Officer Report

1. CCG 360 Stakeholder Survey

Clinical Commissioning Groups need to have strong relationships with a range of stakeholders in order to be successful commissioners within their local health and care systems and to improve quality and outcomes for patients.

The annual CCG 360° Stakeholder Survey has been conducted since 2013/14, enables stakeholders to provide feedback about their CCGs and primarily serves two purposes:

1. Provide CCGs with insight into key areas for improving their relationships with stakeholders and provide information on how stakeholders' views have changed over time.
2. Contribute towards NHS England's statutory responsibility to conduct an annual assessment of each CCG, through the CCG Improvement and Assessment Framework.

Fieldwork for the CCG 360° Stakeholder Survey was completed on 28 February 2019, with a final national response rate of 62% for NHS Nottingham North and East CCG. This is an improvement on the previous years' response rate of 43%.

The full results of the survey are attached at **Appendix A**. The Director of Communications and Engagement has been asked to analyse results across the six Nottingham and Nottinghamshire CCGs and to identify and take forward any required actions.

2. Primary Care Networks – Registration Approval

The NHS Long Term Plan (LTP) identifies Primary Care Networks (PCNs) as an essential building block of every Integrated Care System, and under the Network Contract Directed Enhanced Service (DES), general practice takes the leading role in every PCN. To be eligible for the Network Contract DES, a Primary Care Network needs to submit a completed registration form to its CCG by no later than 15 May 2019, and have all member practices signed-up to the DES.

The role of Commissioners has been set out in Section Two of the *Network Contract DES Guidance* published by NHS England (NHSE) on the 29 March 2019. The guidance is clear that Commissioners and Local Medical Committee's (LMC) will need to work closely and in partnership to support PCN formation and development at a local level in order to ensure 100 percent geographical coverage. All practices who wish to sign up to the DES must be included within a PCN; Commissioners and LMCs will also need to work with PCNs to ensure all patients are covered by a PCN.

The guidance specifies that Commissioners must:

- Liaise with the relevant Integrated Care System (ICS) or Sustainability and Transformation Partnership (STP) to ensure each PCN Network Area supports delivery of services within the wider ICS/STP strategy.
- Identify any issues with the proposed PCNs, both within individual PCN submissions, and when considering their registered population area as a whole.
- Engage with LMCs and bring practices together to resolve issues to ensure 100 per cent population coverage is achieved.

- Approve the submission, ensuring that the registration requirements have been met and that all PCN footprints make long term sense for service delivery and in the context of the GP contract framework.
- Commissioners should maintain accurate records of all approvals and rejections and will be required to demonstrate, if requested, the rationale for their decision.

In order for the CCG to execute this function, the Governing Body is asked to:

- **APPROVE the delegation of the process for registration approvals to the Primary Care Commissioning Committee.**

3. Nottingham and Nottinghamshire Integrated Care System (ICS) Updates

ICS launch "What Matters to You" campaign to support long term plan engagement

Next week, the ICS Communications and Engagement team will launch a campaign to engage patients and local people around the NHS long term plan. The campaign will ask local people what matters most to them about their health and care services.

There will be a dedicated campaign microsite and there will be running adverts, media and engagement activities over the next twelve weeks to find out what matters most to local people.

As well as overarching messages and questions, the campaign will put a key health area into focus each month, covering urgent, community and primary care, digital innovation, prevention and self-care, long terms conditions and mental health.

Healthwatch Nottinghamshire will be supporting the campaign and will be out in communities talking face-to-face with local people. The team are also working with social research agency Britain Thinks to run focus groups with local people to understand their views in relation to the main themes of the NHS Long Term Plan.

The intelligence from the campaign will support the ICS to develop a local five year plan in response to the Ten Year Plan's vision and objectives.

ICS Board Summary Briefing – February 2019

- Personalised Care Patient Story

  Continuing on from the introduction of this item at last month's meeting, the Board welcomed a presentation from colleagues from the ICS and the County Council on Integrated Personalised Care. The presentation brought to life through two case studies the benefits for both patients and the system of having a "different conversation" that seeks to truly understand what Looked After Children and care leavers with mental health needs might want from their health and care services. The Board welcomed the presentation and offered strong support for the current pilot to be continued beyond its current planned timeframe and to be expanded into other areas.

- Integrated Care Providers (ICPs) in Greater Nottingham

  The Board received a summary of the work undertaken in recent weeks exploring the optimum number of ICPs for the ICS and in particular how many ICPs should cover the Greater Nottingham area. A lengthy discussion was held exploring a number of options

for the way forward including the possibility of commissioning further work to explore this issue rather than taking a decision in the meeting. In that debate it was noted that the ICS Board had received several reports regarding this matter over the recent months and also that the ICS's status as an "accelerator" site meant that some decisions were judgement calls as much as scientific calculations. Following this discussion, the ICS Board agreed to proceed to a decision on this matter and confirmed the creation of three ICPs across the ICS footprint – one for Mid-Nottinghamshire and two for the Greater Nottingham area including one in line with the City Council local government boundaries.

- 2019/20 Operational Plan

  Following a number of national announcements and operational updates over the last few weeks, the Board welcomed an update on the planning process for the 19/20 financial year and the local system plan. The Board heard details of the financial allocation for 19/20 for the ICS including the additional money to support the transformation of General Practice as indicated in the new five year General Practice contract announced on 31 January 2019. The update also included details of the 'System Control Total' for the ICS and an update on the timetable of requirements for the 19/20 submissions for the system.

- ICS Workstreams

  Linked to the above item around the 19/20 plan, the five year local system plan and following the request from the Board in September 2018, a presentation was received outlining a revised approach to the ICS workstreams. The current workstreams for the ICS were originally set up in the context of the 2016 Sustainability and Transformation Partnership plan and refreshed in September 2017. Given that the STP has now become an Integrated Care System and the national NHS Long Term Plan has been published, it was felt to be the right time to review the workstreams to check they were still fit for purpose. The Board welcomed the review and asked that further work be done to focus on three particularly pressing areas: mental health; urgent and emergency care and; financial performance. The Board also asked that particular consideration was given to ensuring the best use of the limited resources across the ICS through streamlining and de-duplication and that partners from across the system are able to contribute at all levels.

- ICS Narrative

  In order to support the ICS's developing organisational structures and transformational delivery, the Board had previously requested a 'narrative' be developed to communicate more clearly to the public and staff what the ICS is and what impact it will make on the health and care services for Nottingham and Nottinghamshire. The Board therefore welcomed a presentation of the proposed narrative for the ICS which has been developed over the last few months with input from across the system and support from the national NHS England communications team. The Board agreed the proposed narrative for the system and offered some suggestions for further development of ways in which it could be deployed. The Board also asked for an update on the use of the narrative at the May meeting.

- Engagement on the NHS Long Term Plan and Local System Plan

  As described above, in the autumn of this year the ICS needs to publish a local system plan response to the national NHS Long Term Plan. To support the development of the content of this plan and to help ensure confidence in the plan when published, the ICS is

expected to conduct wide-spread engagement on the development of the plan over the summer. The Board received and endorsed an outline of the proposed approach to this engagement and asked for regular updates on progress at future meetings.

ICS Board Summary Briefing – March 2019

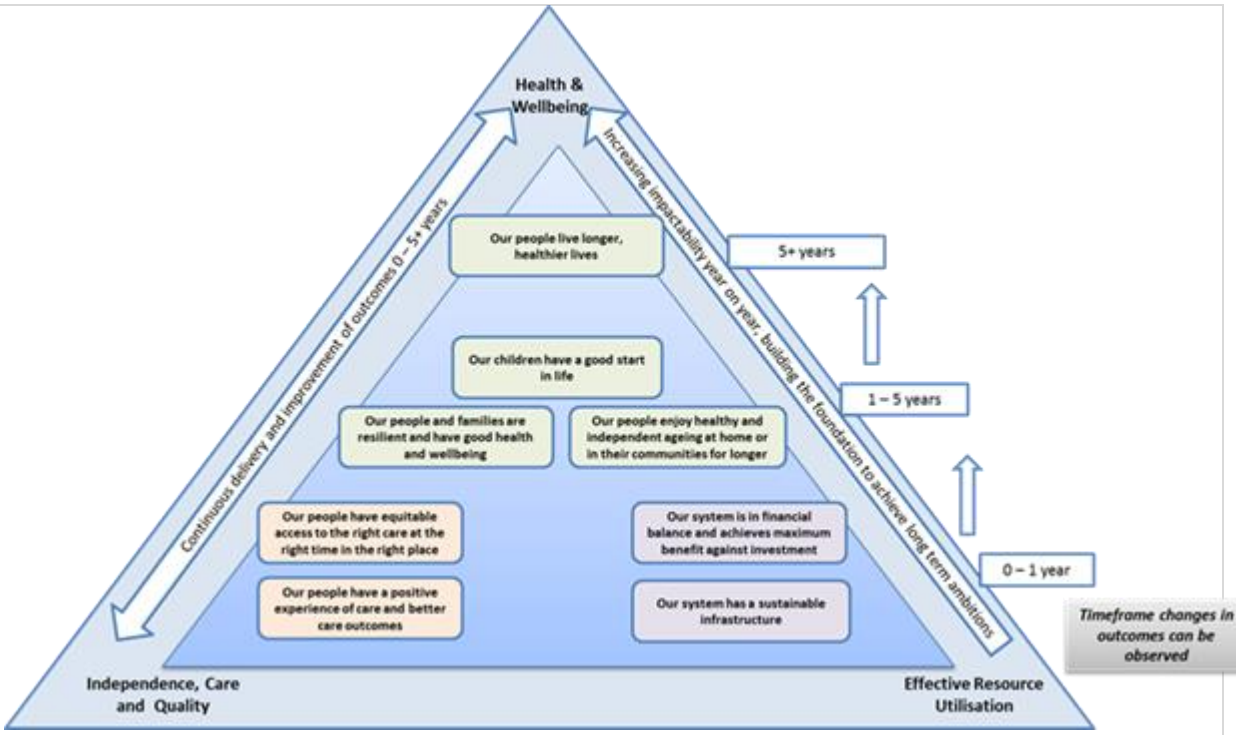
- Connected Nottinghamshire: Patient Story

  The Board welcomed a presentation from an expert patient and the Programme Director for Connected Nottinghamshire. The positive impact of the Medical Interoperability Gateway (MIG) was explored and brought to life through personal experience – in particular the additional convenience for the patient and time saved for clinicians in being able to see a live record of prescribed medications from primary care before proceeding with a secondary care operation. The Board discussed how these benefits could be spread more widely including there being a two-way flow of information back into primary care and also the potential opportunities for use in the ambulance service.

- ICS Outcomes Framework and ICS Strategy

  Two separate items came to the Board this month from the ICS's Director of Strategy: an update on the emerging 'Outcomes Framework' and also on the development of an ICS Strategy as required in the NHS Long Term Plan. Taking first the Outcomes Framework, or in simple terms, what difference will the ICS make to the citizens, patients and staff of Nottingham and Nottinghamshire in the future. The Outcomes Framework will enable both the leadership of the ICS and also patients and other stakeholders to judge the success of the work of the ICS and guide its strategic decision making. The Outcomes Framework will also enable other bodies that have an influence on the progress of the ICS, e.g., Health and Wellbeing Boards to align their work and activities. The Board welcomed the progress made since the initial presentation of this work in November 2018, in particular, the integration of care quality and financial sustainability to underpin the whole framework and a simplification of the overall approach with the confirmation of increasing healthy life expectancy as the priority outcome.

  The latest version of the Outcomes Framework can therefore currently be represented as follows;



The Board endorsed this refined approach and asked for a prototype dashboard for reporting on the metrics of progress to be brought to the next possible meeting.

Closely linked to the Outcomes Framework, the Board was also asked to discuss and agree an approach to developing the ICS's Strategy. The ICS's Director of Strategy summarised the conversations that had taken place over the last few weeks with members of the Board to canvas their views on the type and scope of strategy that would be most appropriate. Given the partnership nature of the ICS it was not surprising that a diverse range of opinions had emerged from those conversations, however all members recognised the need to create dedicated time as a Board to agree the strategic direction of the ICS. The Board therefore agreed to come together, separately to the substantive Board meeting, in late April to align their overall strategic approach and priorities and again in May/June to focus on plans for Urgent and Emergency Care, Mental Health and System Efficiency.

The ongoing development of both the Outcomes Framework and the Strategy will be supported and informed by the work being led by the ICS's Director of Communications and Engagement to engage with and gather insights from patients, members of the public and staff, as agreed at the February ICS Board meeting.

- <u>Mental Health Strategy</u>

  Following the discussion at the January ICS Board, the Chief Executive of Nottinghamshire Healthcare NHS Foundation Trust presented the updated ICS Mental Health strategy. With a focus on improving access to treatment, securing the stability of workforce, collaborating and integrating across the system and reducing impact of severe Mental Illness on life expectancy, the revised strategy has been developed in

partnership across the whole system and in collaboration with patients. The Board welcomed the updated and improved document and agreed it as the ICS's Mental Health strategy. The Board further agreed to ask the Integrated Care Providers (ICPs), with support from the Strategic Commissioner (the combined six CCGs for Nottinghamshire), to take this strategy and turn it into an operational plan for delivery to local populations. It was agreed that an update on progress on this would come back to the Board in around three months.

- 2019/20 Operational Plan

  The ICS's Director of Finance updated on the progress towards creating a balanced system plan for financial year 2019/20. There remain significant challenges in achieving this outcome, particularly in the Greater Nottingham part of the system and this will be discussed further in a meeting supported by regional NHS England / Improvement colleagues on 21 March 2019.

- Other – Public Board Meetings; Partnership Forum; EU Exit

  The Board considered a number of other items including agreeing the approach to holding the Board meetings in public from April, the feedback from the newly established Partnership Forum and a check on the system's preparations for the UK leaving the European Union.

  The next meeting of the ICS Board will be on 1 April 2019 with a single item to approve the submission of the ICS's 2019/20 financial plan. This will be followed by a full meeting on 11 April which will be held as a meeting in public for the first time.

ICS Board System Narrative

Attached at **Appendix B** is the final version of a system narrative that has been developed to raise awareness of the ICS, its objectives and its work. It also provides a deployment plan for communicating this narrative to key audiences.

The narrative aims tell the story of the ICS in a way that builds ownership, support and engagement amongst citizens, patients and staff. It is intended to convey the purpose of and values behind the ICS in a way that captures attention and builds support. It should:

- Connect with hearts and minds
- Simplify the complexities
- Build confidence and positive consideration.

The text of the draft narrative is intended for the general public. It will also form the basis of a range of communications products and marketing materials, summarised in the deployment plan that will communicate the purpose of the ICS to staff, system leaders and other stakeholders.

The extensive and ambitious engagement programme planned to share the key elements of

the NHS Long Term Plan and develop our local plan, provides an opportunity to utilise the narrative in our interactions with the public. The text will form the basis of our communications and engagement programme, providing a language to describe our local health and care system and what it aims to achieve.

The work to develop the narrative has been ongoing since November 2018 and has included a process of extensive engagement across the system with previous drafts being developed through the following:

- Discussion with the ICS Programme Delivery Group on 5 November 2018
- Discussion with the ICS Planning Group on 29 November 2018 and 22 January 2019
- Discussion with the ICS System Architecture Group on 22 January 2019
- Discussion with the ICS Advisory Group on 10 January 2019
- Discussion with the ICS Non-Executive and Councillors Group on 14 November 2018
- A half-day workshop with senior leaders from across the system facilitated by Times journalist Phil Collins and supported by the national team on 10 December 2018.
- Subsequent discussions with senior leaders across the ICS, with drafts circulated for feedback
- Circulation amongst the Communications leads (NHS providers, local authorities, EMAHSN) from across the ICS for feedback in January 2019.

Given the extensive engagement and input into this public-facing version of the narrative, further feedback on the content is not sought at this stage. This version of the narrative does not include descriptions of the internal system architecture of the ICS. It focuses on the things that matter to citizens and describes them in a way that they will understand and connect with. The deployment plan includes products intended for an internal system audience that will provide more technical, architecture-based versions of the narrative.

4. Appointment of Independent Chair of the Safeguarding Adults Board

Malcolm Dillon, the Independent Chair of the Safeguarding Adults Board will be stepping down at the end of March. Joy Hollister has been successfully appointed as the new Independent Chair for Nottingham City Safeguarding Adults Board. Joy was appointed following a rigorous selection process with representation from all three funding partners.

Joy brings a wealth of experience to the post, having recently retired as the Director of Adult Social Care for Derbyshire County Council and having held senior positions with responsibility for adults and children's social care, public health and housing in London, East Sussex and the East Midlands.

Malcom and Joy have already begun the process of handover and induction and have recently appointed Ross Leather as full time Board Manager to support Board activities.

5. Update from the Health and Wellbeing Board

The last meeting of the Health and Wellbeing Board took place on 26 March 2019, a summary from this meeting will be available in due course. All summaries are published on the Nottinghamshire County Council website.

A summary from the meeting on 9 January 2019 is attached at **Appendix C**. Highlights include:

- Safeguarding Children Annual Report – review of 2017-18 and future arrangements
- Director of Public Health Annual Report – focus on violence in Nottinghamshire
- Joint Strategic Needs Assessment (JSNA) chapter – autism – the chapter pulls together local and national evidence, best practice and data as well as feedback from people who are autistic & their families and the staff they work with.
- Evidence of need and recommendations to address
- JSNA Chapter – cancer – A new chapter outlining evidence of need & opportunities for prevention
- JSNA Chapter – sexual health and HIV – a refreshed chapter outlining health needs and recommendations to address them

6. Appointments to Executive and Senior Leadership Team

Plans to establish a joint leadership team for the CCGs in Nottingham and Nottinghamshire are making clear progress, as part of the first steps towards merging the six organisations.

On Monday 31 January the CCGs initiated a 30 day consultation with all senior managers and executives on a proposed new leadership structure.

The consultation led to a number of changes to the structure, which was shared with staff across the organisation in February. There is a mix of ICS and place based roles to reflect the emerging system architecture.

A number of key posts in the structure have now been filled (see **Appendix D**). The CCGs have advertised the remaining posts in the structure.

7. National Updates

NHS England and NHS Improvement

The Chair of NHS Improvement wrote to provider Chairs and Chief Executives to share some organisational changes in NHS Improvement and NHS England. Over the last year NHS England and NHS Improvement have been working together to develop the implementation approach for the NHS Long Term Plan and our own joint working arrangements.

They are moving to a single Chief Executive and single Chief Operating Officer model, and therefore are creating a single, combined post of Chief Operating Officer covering both

organisations. This role will report directly to Simon Stevens as the Chief Executive of NHS England who will lead both organisations. The Chief Operating Officer will, for regulatory purposes, also be the identified as Chief Executive of NHS Improvement and, in that capacity, will report to Dido Harding as Chair of NHS Improvement. The seven Regional Directors, the National Director of Emergency and Elective Care and the National Director for Improvement will report directly to the new Chief Operating Officer.

The new Chief Operating Officer role will be different in scope and nature from the role Ian Dalton chose to take eighteen months ago, and has therefore decided to leave NHS Improvement. Ian will work with our Boards and NHS Executive Group to manage the transition over the next few months.

NHS England (NHSE) and NHS Improvement (NHSI) have published NHS England and NHS Improvement funding and resource 2019/20: supporting 'The NHS Long Term Plan. This document provides information about NHSE and NHSI funding in 2019/20. It also sets out how the two organisations will support the Long Term Plan through distribution of funding, people and resources, to transform local health and care systems

Integrated Care Provider consultation response

NHS England has now published the response to the twelve-week consultation, which ran from August to October 2018, on the proposed contracting arrangements for ICPs. A wide range of stakeholders and members of the public gave feedback to the consultation. Details about the consultation response and next steps can be found on the NHS England website.

Campaign to support more GPs back to general practice

NHS England and Health Education England have launched a campaign to raise awareness of the support that is available for GPs return to general practice. It raises the profile of the GP Induction and Refresher scheme, which was relaunched in 2016 with a new package of support for doctors returning to the profession.

Kings Fund

The King's Fund has published Outcomes for mental health services: what really matters? This report examines the pursuit of outcomes by mental health services and highlights how frameworks for measuring outcomes are often too narrowly focused on clinical outcomes. The report challenges mental health services to adopt a broader perspective on outcomes as a basis for collaborating with service users and a foundation for delivering more humane and effective care.

National Audit Office

The National Audit Office has published NHS waiting times for elective and cancer treatment. This review presents data on the NHS performance against current waiting time standards for elective and cancer care in England, and some of the factors associated with that performance. It draws together existing evidence and analysis by the Department of Health and Social Care, NHS England, NHS Improvement and other stakeholders.

Department of Health and Social Care (DOHSC)

The Department of Health and Social Care has published Annual review of the Branded Health Service Medicines (costs) Regulations 2018. This document provides details of the first annual review of the regulations relating to the statutory scheme for branded medicines pricing.

Flash Glucose Monitoring: national arrangements for funding of relevant diabetes patients

The NHS Long Term Plan announced 'the NHS will ensure, in line with clinical guidelines, patients with type one diabetes benefit from life changing flash glucose monitors from April 2019, ending the variation patients in some parts of the country are facing'. Flash Glucose Monitoring is appropriate for certain people with diabetes alongside other technologies for people with differing diabetes management needs. The guidance sets out the criteria for flash glucose monitoring and the maximum amounts CCGs will be reimbursed for the ongoing costs of the flash glucose sensors.

Amanda Sullivan

Accountable Officer

April 2019

Nottingham North and East CCG
CCG 360° Stakeholder Survey 2018/19

Findings

Ipsos MORI
Social Research Institute

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Slide 8	Detailed findings
Slide 21	Appendix: methodology and technical details
Slide 23	Appendix: CCG Clusters

Summary: headline findings

The following charts show the summary findings for Nottingham North and East CCG indicating the percentage of stakeholders responding positively to the key survey questions.

Overall engagement

Overall, how would you rate the effectiveness of your working relationship with the CCG? — **90%**

% very good/fairly good

Overall, how would you rate (the CCG's) effectiveness as a local system leader, i.e. as part of an Integrated Care System (ICS)/Sustainable Transformation partnership (STP)? — **76%**

% very effective/fairly effective

Leadership and partnership working in the local health and care system

To what extent do you agree or disagree with EACH of the following statements:

% strongly agree/tend to agree

The CCG considers the benefits to the whole health and care system when taking a decision. — **67%**

The CCG actively avoids passing on problems to another system partner. — **57%**

The CCG works collaboratively with other system partners on the vision to improve the future health of the population across the whole system. — **71%**

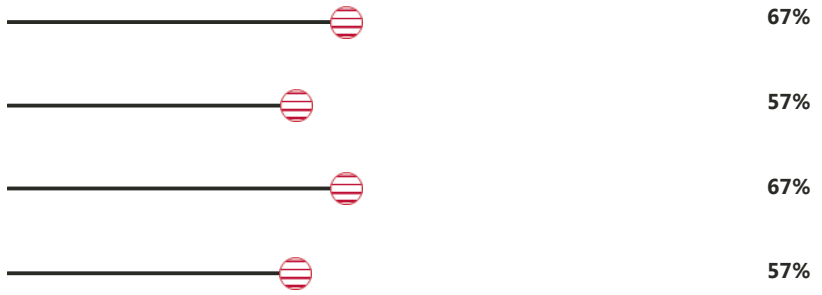
Nottingham North and East CCG

***Base = all stakeholders (21)**

Core functions

How would you rate the effectiveness of the CCG at doing EACH of the following:

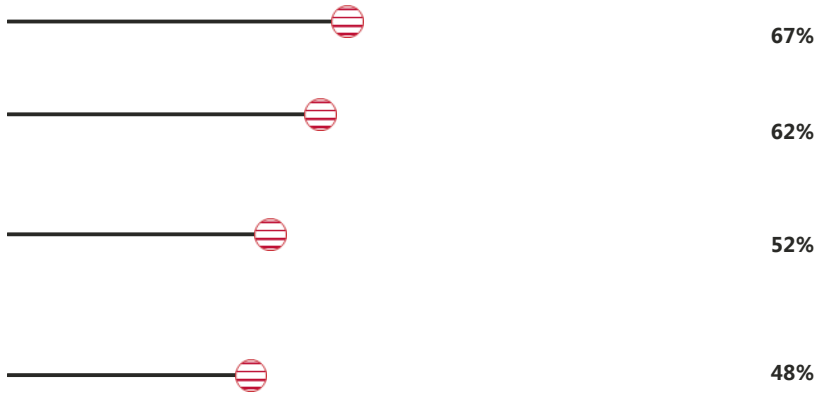
% very effective/fairly effective



Commissioning/decommissioning services

To what extent do you agree or disagree with EACH of the following statements about the way in which the CCG commissions/decommissions services?

% strongly agree/tend to agree



Nottingham North and East CCG

***Base = all stakeholders (21)**

Background and objectives

Clinical Commissioning Groups (CCGs) need to have strong relationships with a range of stakeholders in order to be successful commissioners within their local health and care systems. These relationships provide CCGs with valuable intelligence to help them make the effective commissioning decisions for their local populations.

The CCG 360º Stakeholder Survey, which has been conducted since 2013/14, enables stakeholders to provide feedback about their CCGs. The results of the survey serve two purposes:

1. Provide CCGs with insight into key areas for improvements in their relationships with stakeholders and provide information on how stakeholders' views have changed over time.

2. Contribute towards NHS England's statutory responsibility to conduct an annual assessment of each CCG, through the CCG Improvement and Assessment Framework.

Nottingham North and East CCG

Interpreting the results

- For each question, the response to each answer is presented as both a percentage (%) and as a number (n). The total number of stakeholders who answered each question (the base size) is also stated at the bottom of each chart and in every table. For questions with fewer than 30 stakeholders answering, we strongly recommend that you look at the number of stakeholders giving each response rather than the percentage, as the percentage can be misleading when based on so few stakeholders.

- Throughout the report, 'the CCG' refers to Nottingham North and East CCG.

- Where results do not sum to 100%, or where individual responses (e.g. tend to agree; strongly agree) do not sum to combined responses (e.g. strongly/tend to agree) this is due to rounding.

- There have been significant changes to the survey this year, such as the removal, rewording and reordering of several questions (including the answer codes). Additionally, the online format of the survey has changed this year and the ability for stakeholders to answer the questionnaire on behalf of multiple CCGs at the same time is a new feature, introduced to make participation easier and less time-consuming. These changes mean that we are unable to report on trend data. Please see slides 21 and 22 for more information on the methodology.

Nottingham North and East CCG

Using the results

- The following slides show the results for each question, with a breakdown also shown for each of the core stakeholder groups where relevant, as well as regional and cluster* comparisons.

- The comparisons are included to provide an indication of differences only and should be treated with caution due to the low numbers of respondents and differences in CCGs' stakeholder lists.

- Any differences are not necessarily statistically significant differences; a higher score than the cluster average does not always equate to 'better' performance.

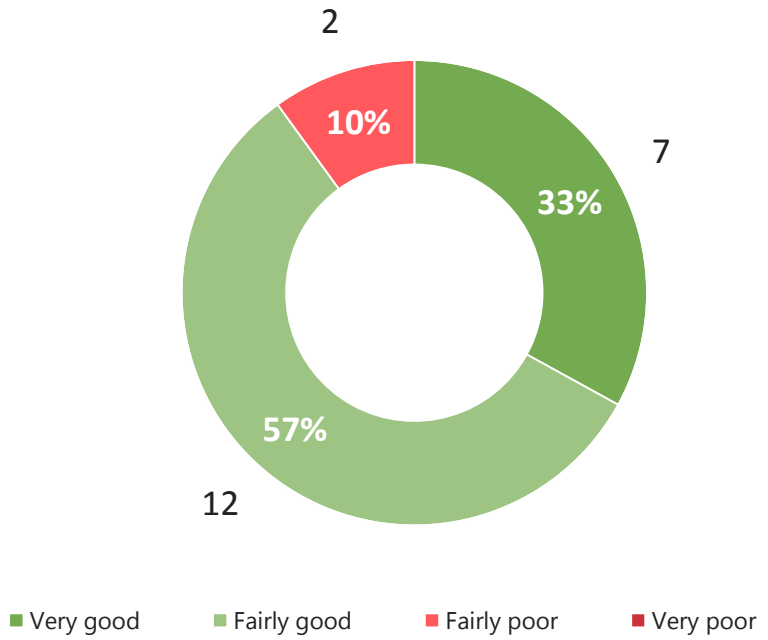
- The comparisons offer a starting point to inform wider discussions about the CCG's ongoing organisational development and its relationships with stakeholders. For example, they may indicate areas in which stakeholders think the CCG is performing relatively less well, for the CCG to discuss internally and externally to identify what improvements can be made in this area, if any.

*A cluster is the group of CCGs that are most similar to the CCG based on several population characteristics.

Nottingham North and East CCG

Q1. Overall, how would you rate the effectiveness of your working relationship with the CCG?

All stakeholders

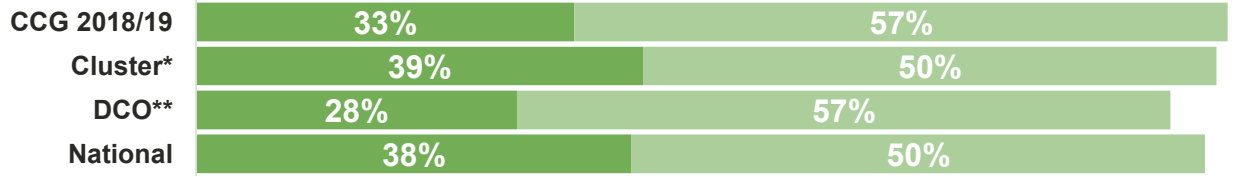


By stakeholder group

Stakeholder group	No. of participants	Very good/ Fairly good	Fairly poor/ Very poor
GP member practices	10	80% (8)	20% (2)
Health & wellbeing boards	1	100% (1)	-
Healthwatch and voluntary/patient groups	3	100% (3)	-
NHS providers	2	100% (2)	-
Other CCGs	2	100% (2)	-
Upper tier/unitary LA	3	100% (3)	-
Wider stakeholders	0	-	-

Regional and cluster comparisons

Percentage of stakeholders saying very good/fairly good

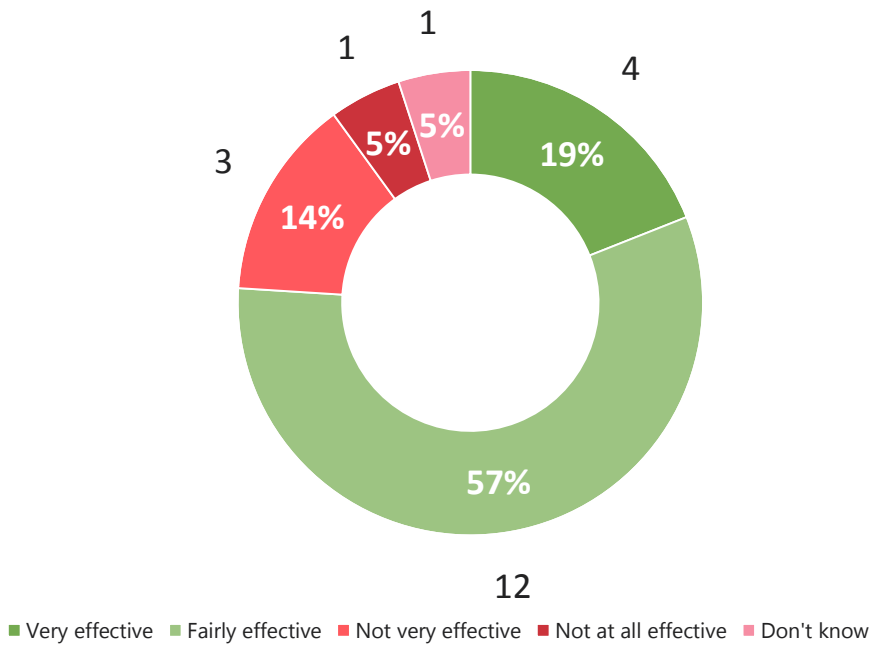


Number of participants: CCG 2018/19 (21), Cluster (585), DCO (513), National (7677).

*A cluster is the group of CCGs that are most similar to the CCG based on several population characteristics.
**The DCO is the group of local CCGs that fall under the same NHS England Director of Commissioning Operations (at sub-regional level) as the CCG

Q3. Overall, how would you rate the CCG's effectiveness as a local system leader, i.e. as part of an Integrated Care System (ICS)/Sustainable Transformation Partnership (STP)?

All stakeholders



By stakeholder group

Stakeholder group	No. of participants	Very effective/ Fairly effective	Not very effective/Not at all effective
GP member practices	10	70% (7)	20% (2)
Health & wellbeing boards	1	100% (1)	-
Healthwatch and voluntary/patient groups	3	67% (2)	33% (1)
NHS providers	2	100% (2)	-
Other CCGs	2	100% (2)	-
Upper tier/unitary LA	3	67% (2)	33% (1)
Wider stakeholders	0	-	-

Regional and cluster comparisons

Percentage of stakeholders saying very effective/fairly effective

Number of participants: CCG 2018/19 (21), Cluster (585), DCO (513), National (7677).

*A cluster is the group of CCGs that are most similar to the CCG based on several population characteristics.
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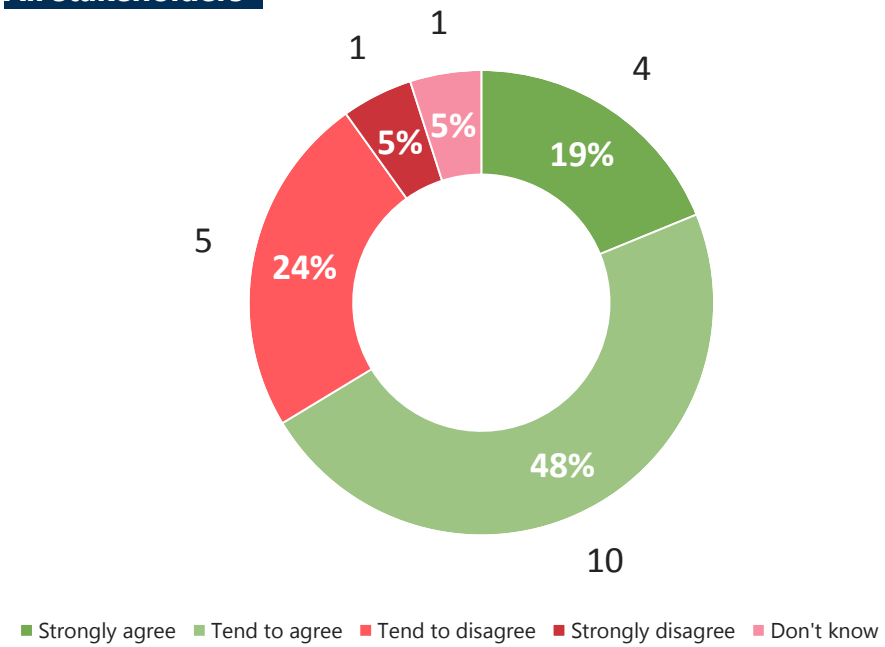
Q5a. "The CCG considers the benefits to the whole health and care system when taking a decision."

All stakeholders

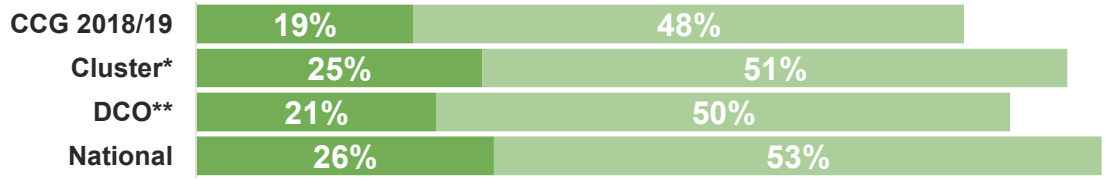


By stakeholder group

Stakeholder group	No. of participants	Strongly agree/Tend to agree	Strongly disagree/Tend to disagree
GP member practices	10	80% (8)	20% (2)
Health & wellbeing boards	1	100% (1)	-
Healthwatch and voluntary/patient groups	3	33% (1)	33% (1)
NHS providers	2	-	100% (2)
Other CCGs	2	100% (2)	-
Upper tier/unitary LA	3	67% (2)	33% (1)
Wider stakeholders	0	-	-

Regional and cluster comparisons

Percentage of stakeholders saying strongly agree/tend to agree



Number of participants: CCG 2018/19 (21), Cluster (585), DCO (513), National (7677).

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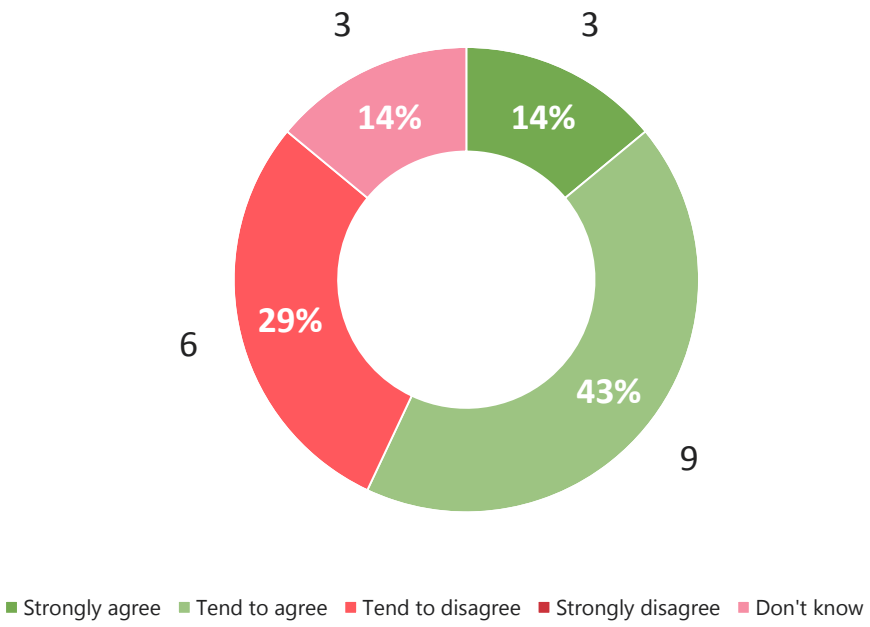
Q5b. "The CCG actively avoids passing on problems to another system partner."

All stakeholders

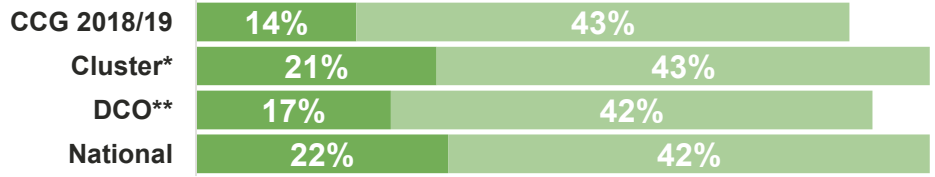


By stakeholder group

Stakeholder group	No. of participants	Strongly agree/Tend to agree	Strongly disagree/Tend to disagree
GP member practices	10	70% (7)	10% (1)
Health & wellbeing boards	1	100% (1)	-
Healthwatch and voluntary/patient groups	3	33% (1)	33% (1)
NHS providers	2	-	100% (2)
Other CCGs	2	100% (2)	-
Upper tier/unitary LA	3	33% (1)	67% (2)
Wider stakeholders	0	-	-

Regional and cluster comparisons

Percentage of stakeholders saying strongly agree/tend to agree



Number of participants: CCG 2018/19 (21), Cluster (585), DCO (513), National (7677).

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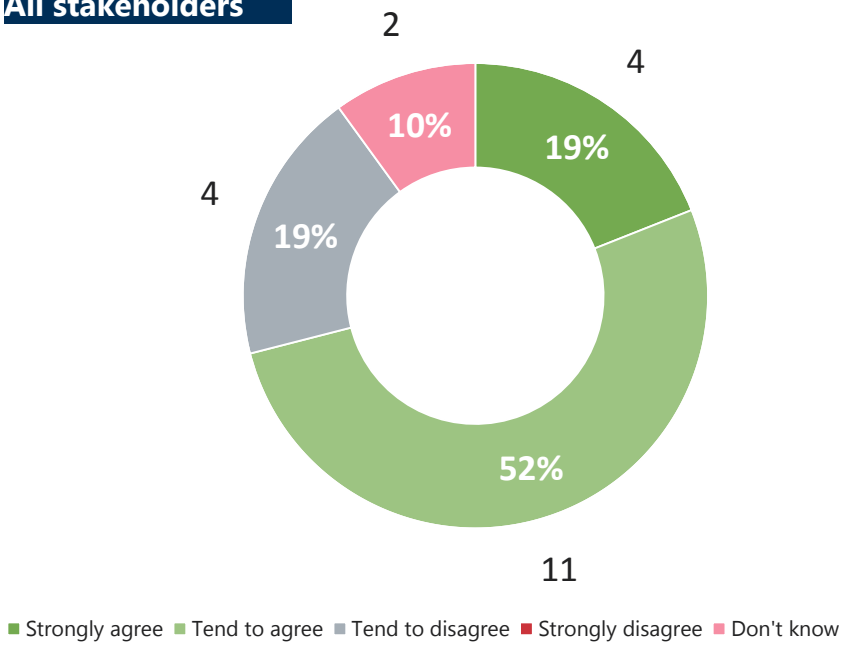
Q5c. "The CCG works collaboratively with other system partners on the vision to improve the future health of the population across the whole system."

All stakeholders

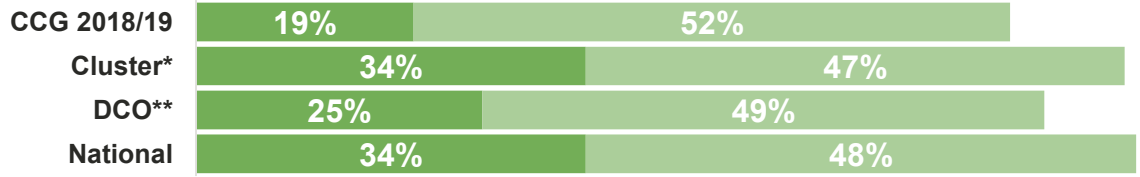


By stakeholder group

Stakeholder group	No. of participants	Strongly agree/Tend to agree	Strongly disagree/Tend to disagree
GP member practices	10	80% (8)	10% (1)
Health & wellbeing boards	1	100% (1)	-
Healthwatch and voluntary/patient groups	3	67% (2)	-
NHS providers	2	-	100% (2)
Other CCGs	2	100% (2)	-
Upper tier/unitary LA	3	67% (2)	33% (1)
Wider stakeholders	0	-	-

Regional and cluster comparisons

Percentage of stakeholders saying strongly agree/tend to agree



Number of participants: CCG 2018/19 (21), Cluster (585), DCO (513), National (7677).

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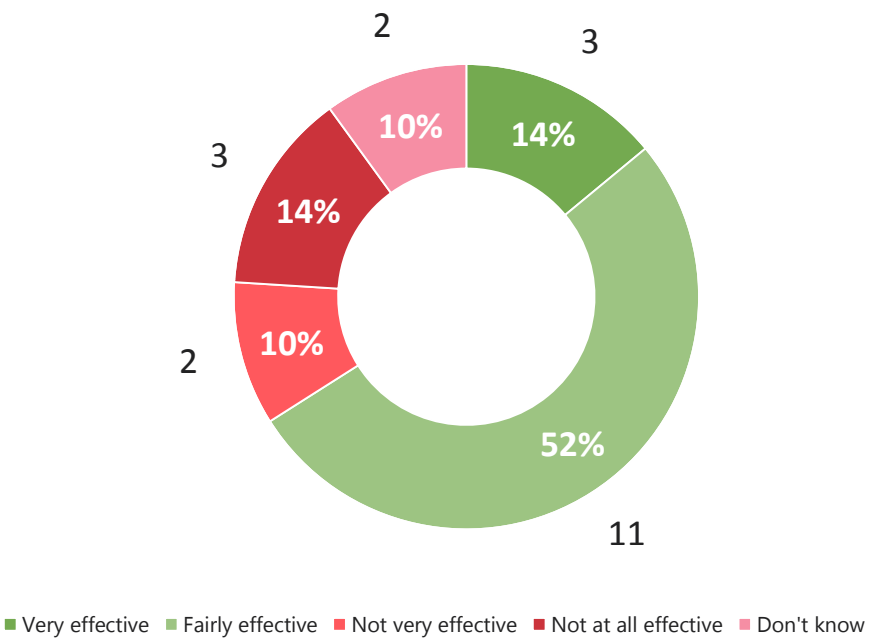
Q6a. "Improving health outcomes for its population."

All stakeholders



By stakeholder group

Stakeholder group	No. of participants	Very effective/ Fairly effective	Not very effective/Not at all effective
GP member practices	10	70% (7)	30% (3)
Health & wellbeing boards	1	100% (1)	-
Healthwatch and voluntary/patient groups	3	67% (2)	-
NHS providers	2	-	100% (2)
Other CCGs	2	100% (2)	-
Upper tier/unitary LA	3	67% (2)	-
Wider stakeholders	0	-	-

Regional and cluster comparisons

Percentage of stakeholders saying very effective/fairly effective

Number of participants: CCG 2018/19 (21), Cluster (585), DCO (513), National (7677).

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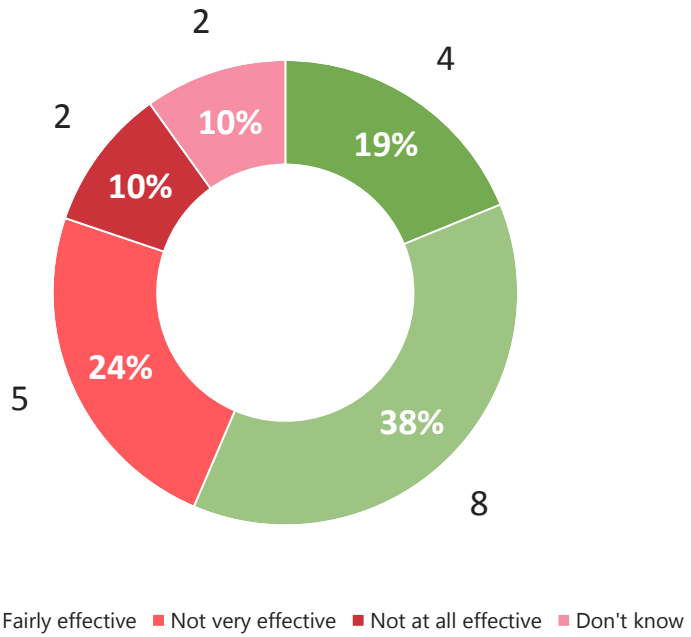
Q6b. "Reducing health inequalities."

All stakeholders

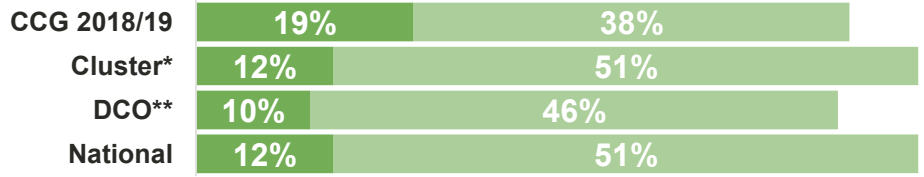


By stakeholder group

Stakeholder group	No. of participants	Very effective/ Fairly effective	Not very effective/Not at all effective
GP member practices	10	70% (7)	30% (3)
Health & wellbeing boards	1	100% (1)	-
Healthwatch and voluntary/patient groups	3	33% (1)	33% (1)
NHS providers	2	-	100% (2)
Other CCGs	2	100% (2)	-
Upper tier/unitary LA	3	33% (1)	33% (1)
Wider stakeholders	0	-	-

Regional and cluster comparisons

Percentage of stakeholders saying very effective/fairly effective



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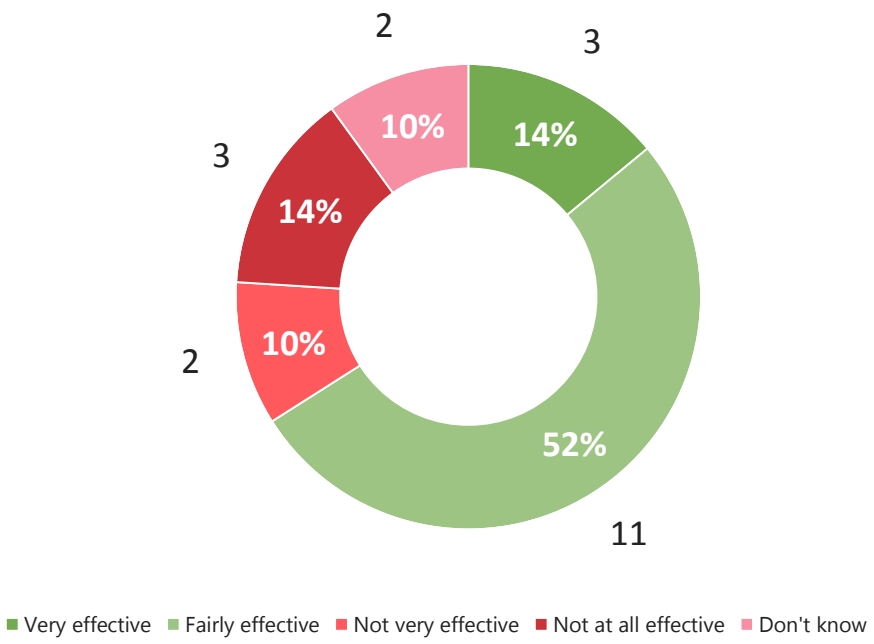
Q6c. "Improving the quality of the local health services."

All stakeholders



By stakeholder group

Stakeholder group	No. of participants	Very effective/ Fairly effective	Not very effective/Not at all effective
GP member practices	10	70% (7)	30% (3)
Health & wellbeing boards	1	100% (1)	-
Healthwatch and voluntary/patient groups	3	67% (2)	-
NHS providers	2	-	100% (2)
Other CCGs	2	100% (2)	-
Upper tier/unitary LA	3	67% (2)	-
Wider stakeholders	0	-	-

Regional and cluster comparisons

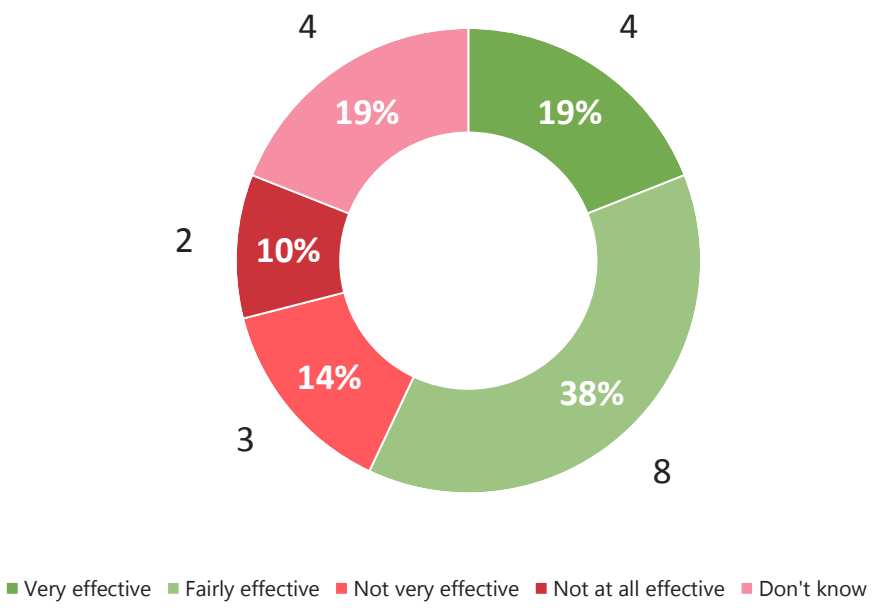
Percentage of stakeholders saying very effective/fairly effective

Number of participants: CCG 2018/19 (21), Cluster (585), DCO (513), National (7677).

*A cluster is the group of CCGs that are most similar to the CCG based on several population characteristics.
**The DCO is the group of local CCGs that fall under the same NHS England Director of Commissioning Operations (at sub-regional level) as the CCG

Q6d. "Delivering value for money."

All stakeholders

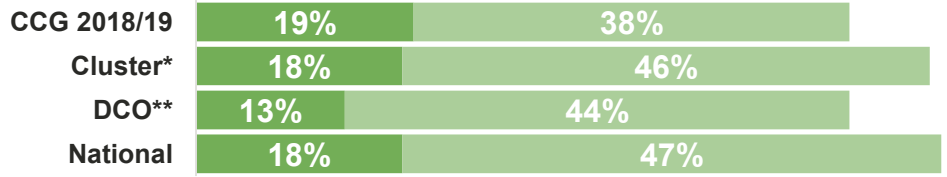


By stakeholder group

Stakeholder group	No. of participants	Very effective/ Fairly effective	Not very effective/Not at all effective
GP member practices	10	60% (6)	30% (3)
Health & wellbeing boards	1	100% (1)	-
Healthwatch and voluntary/patient groups	3	33% (1)	-
NHS providers	2	-	100% (2)
Other CCGs	2	100% (2)	-
Upper tier/unitary LA	3	67% (2)	-
Wider stakeholders	0	-	-

Regional and cluster comparisons

Percentage of stakeholders saying very effective/fairly effective



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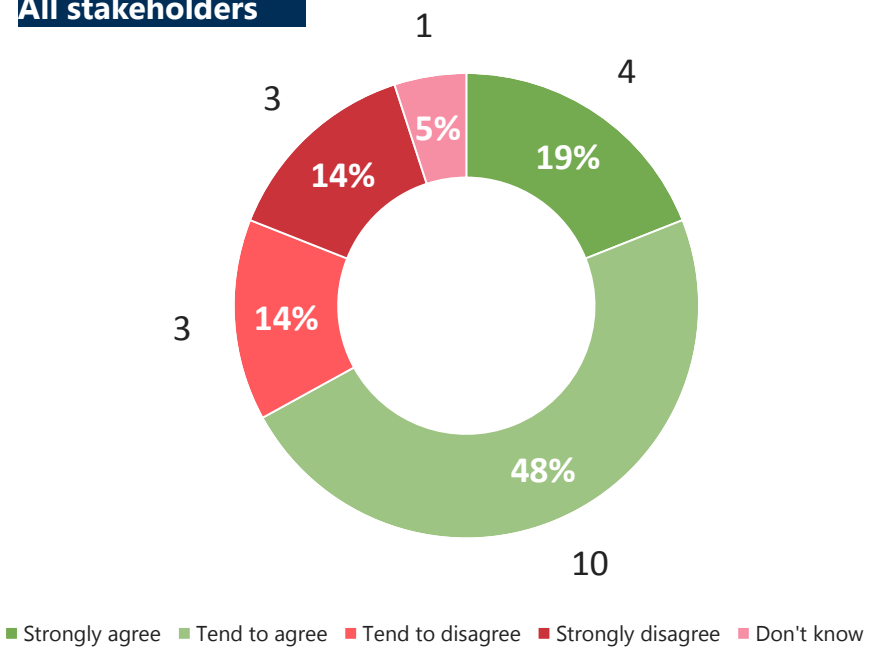
To what extent do you agree or disagree with EACH of the following statements about the way in which the CCG commissions/decommissions services?

Q8a. "The CCG involves the right individuals and organisations when commissioning/decommissioning services."

All stakeholders

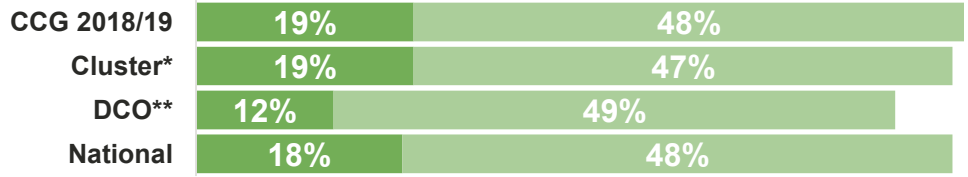


By stakeholder group

Stakeholder group	No. of participants	Strongly agree/Tend to agree	Strongly disagree/Tend to disagree
GP member practices	10	60% (6)	30% (3)
Health & wellbeing boards	1	100% (1)	-
Healthwatch and voluntary/patient groups	3	33% (1)	67% (2)
NHS providers	2	100% (2)	-
Other CCGs	2	100% (2)	-
Upper tier/unitary LA	3	67% (2)	33% (1)
Wider stakeholders	0	-	-

Regional and cluster comparisons

Percentage of stakeholders saying strongly agree/tend to agree



Number of participants: CCG 2018/19 (21), Cluster (585), DCO (513), National (7677).

*A cluster is the group of CCGs that are most similar to the CCG based on several population characteristics.
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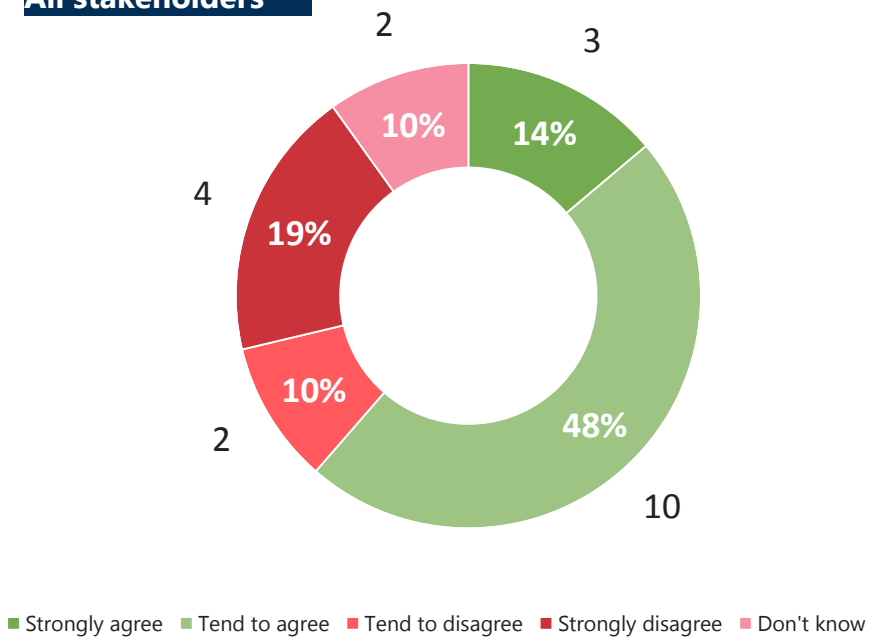
To what extent do you agree or disagree with EACH of the following statements about the way in which the CCG commissions/decommissions services?

Q8b. "The CCG asks the right questions at the right time when commissioning/decommissioning services."

All stakeholders



By stakeholder group

Stakeholder group	No. of participants	Strongly agree/Tend to agree	Strongly disagree/Tend to disagree
GP member practices	10	50% (5)	30% (3)
Health & wellbeing boards	1	100% (1)	-
Healthwatch and voluntary/patient groups	3	33% (1)	67% (2)
NHS providers	2	100% (2)	-
Other CCGs	2	100% (2)	-
Upper tier/unitary LA	3	67% (2)	33% (1)
Wider stakeholders	0	-	-

Regional and cluster comparisons

Percentage of stakeholders saying strongly agree/tend to agree

Number of participants: CCG 2018/19 (21), Cluster (585), DCO (513), National (7677).

*A cluster is the group of CCGs that are most similar to the CCG based on several population characteristics.
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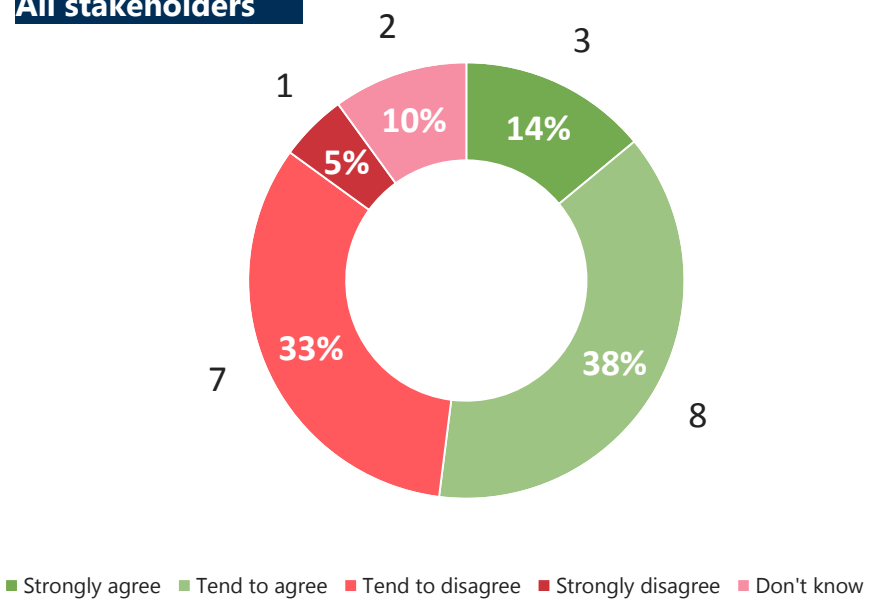
To what extent do you agree or disagree with EACH of the following statements about the way in which the CCG commissions/decommissions services?

Q8c. "The CCG engages effectively with patients and the public, including those groups within the local population who are at risk of experiencing poorer health outcomes when commissioning/ decommissioning services."

All stakeholders

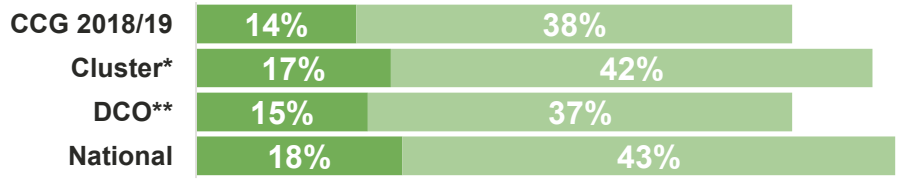


By stakeholder group

Stakeholder group	No. of participants	Strongly agree/Tend to agree	Strongly disagree/Tend to disagree
GP member practices	10	50% (5)	30% (3)
Health & wellbeing boards	1	100% (1)	-
Healthwatch and voluntary/patient groups	3	33% (1)	67% (2)
NHS providers	2	50% (1)	50% (1)
Other CCGs	2	100% (2)	-
Upper tier/unitary LA	3	33% (1)	67% (2)
Wider stakeholders	0	-	-

Regional and cluster comparisons

Percentage of stakeholders saying strongly agree/tend to agree



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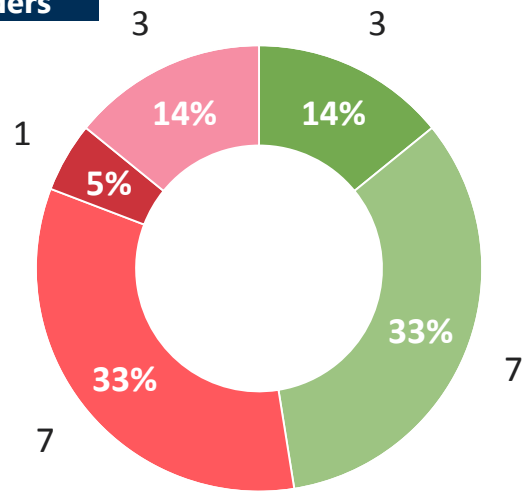
To what extent do you agree or disagree with EACH of the following statements about the way in which the CCG commissions/decommissions services?

Q8d. "The CCG demonstrates that it has considered the views of patients and the public, including those groups which experience poorer health outcomes and/or barriers to accessing health and care, when it is commissioning/decommissioning services."

All stakeholders

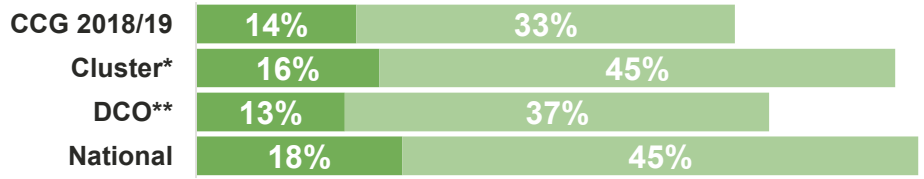


By stakeholder group

Stakeholder group	No. of participants	Strongly agree/Tend to agree	Strongly disagree/Tend to disagree
GP member practices	10	30% (3)	40% (4)
Health & wellbeing boards	1	100% (1)	-
Healthwatch and voluntary/patient groups	3	33% (1)	67% (2)
NHS providers	2	100% (2)	-
Other CCGs	2	100% (2)	-
Upper tier/unitary LA	3	33% (1)	67% (2)
Wider stakeholders	0	-	-

Regional and cluster comparisons

Percentage of stakeholders saying strongly agree/tend to agree



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Appendix: methodology and technical details

- It was the responsibility of each CCG to provide the list of stakeholders to invite to take part in the CCG 360º stakeholder survey. CCGs proposing to merge in April 2019 collaborated with each other to produce and submit a single stakeholder list across the merging CCGs.

- CCGs were provided with a specification of core stakeholder organisations to be included in their stakeholder list. Beyond this, however, CCGs had the flexibility to determine which individual within each organisation was the most appropriate to nominate. CCGs were also given the opportunity to add up to ten additional stakeholders they wanted to include locally (they are referred to in this report as 'wider stakeholders').

- Stakeholders who were nominated by more than one CCG or to represent more than one organisation had the opportunity to complete the questionnaire in a 'grid' format. They could choose to give the same responses for each CCG that asked them to take part and the organisations they represent, or to give different answers for each CCG and each organisation.

- Stakeholders were sent an email inviting them to complete the survey online. Stakeholders who did not respond to the email invitation, and stakeholders for whom an email address was not provided, were telephoned by an Ipsos MORI interviewer who encouraged response and offered the opportunity to complete the survey by telephone. Non-responding stakeholders were sent reminder emails and telephone calls to encourage participation.

Nottingham North and East CCG

Appendix: methodology and technical details

- Within the survey, stakeholders were asked a series of questions about their working relationship with the CCG. Stakeholders were asked all the same questions in this year's survey, with no bespoke CCG questions.
- Fieldwork was conducted between 14th January and 28th February.
- 21 of the CCG's stakeholders completed the survey. The overall response rate was 62%, which varied across the stakeholder groups as shown in the table opposite.

Survey response rates for Nottingham North and East CCG

Stakeholder group	Invited to take part in survey	Completed survey	Response rate
GP member practices *One from every member practice**	19	10	53%
Health & wellbeing boards *Up to two per HWB**	1	1	100%
Local Healthwatch *Up to three per local Healthwatch**	1	1	100%
Other patient groups and voluntary sector organisations or representatives *Up to eight**	2	2	100%
NHS providers *Up to two from each acute, mental health and community health providers**	3	2	67%
Other CCGs *Up to five**	2	2	100%
Upper tier or unitary local authorities *Up to five per local authority**	6	3	50%
Wider stakeholders	0	0	
All stakeholders	34	21	62%

*Specification from the core stakeholder framework

Nottingham North and East CCG

Appendix: CCG Clusters

Each CCG is compared to a cluster of the other CCGs to which they are most similar. The clusters are based on the following variables:

- Index of Multiple Deprivation averages (overall and health domain)
- Age of population
- Ethnicity
- Population registered with practices
- Population density
- Ratio of registered population to overall population

Based on these variables, the following CCGs form the CCG cluster for Nottingham North and East CCG

Airedale, Wharfedale and Craven CCG	South Cheshire CCG
Basildon and Brentwood CCG	South East Staffs and Seisdon Peninsula CCG
Cannock Chase CCG	South Eastern Hampshire CCG
Castle Point and Rochford CCG	Vale Royal CCG
Chorley and South Ribble CCG	Warrington CCG
Darlington CCG	Warwickshire North CCG
Newark and Sherwood CCG	West Cheshire CCG
North Tyneside CCG	West Lancashire CCG
Nottingham West CCG	Wyre Forest CCG
Redditch and Bromsgrove CCG	

Nottingham North and East CCG

For more information

ccg360stakeholder@ipsos-mori.com

Ipsos MORI
Social Research Institute

Meeting:	ICS Board
Report Title:	ICS System Narrative
Date of meeting:	16 February 2019
Agenda Item Number:	
Work-stream SRO:	David Pearson
Report Author:	Alex Ball
Attachments/Appendices:	None

Report Summary:

This paper introduces the final version of a system narrative that has been developed to raise awareness of the ICS, its objectives and its work. It also provides a deployment plan for communicating this narrative to key audiences.

The narrative aims tell the story of the ICS in a way that builds ownership, support and engagement amongst citizens, patients and staff. It is intended to convey the purpose of and values behind the ICS in a way that captures attention and builds support. It should:

- Connect with hearts and minds
- Simplify the complexities
- Build confidence and positive consideration.

The text of the draft narrative included with this paper is intended for the general public. It will also form the basis of a range of communications products and marketing materials, summarised in the deployment plan, that will communicate the purpose of the ICS to staff, system leaders and other stakeholders.

The extensive and ambitious engagement programme planned to share the key elements of the NHS Long Term Plan (LTP) and develop our local plan provides an opportunity to utilise the narrative in our interactions with the public. The text will form the basis of our communications and engagement programme, providing a language to describe our local health and care system and what it aims to achieve.

The work to develop the narrative has been ongoing since November 2018 and has included a process of extensive engagement across the system with previous drafts being developed through the following:

Discussion with the ICS Programme Delivery Group on 5th November 2018

- Discussion with the ICS Planning Group on 29th November 2018 and 22nd January 2019
- Discussion with the ICS System Architecture Group on 22nd January 2019
- Discussion with the ICS Advisory Group on 10th January 2019
- Discussion with the ICS Non-Executive and Councillors Group on 14th November 2018
- A half-day workshop with senior leaders from across the system facilitated by Times journalist Phil Collins and supported by the national team on 10th December 2018.
- Subsequent discussions with senior leaders across the ICS, with drafts circulated for feedback
- Circulation amongst the Communications leads (NHS providers, local authorities, EMAHSN) from across the ICS for feedback in January 2019.

Given the extensive engagement and input into this public-facing version of the narrative, further feedback on the content is not sought at this stage. This version of the narrative does not include descriptions of the internal system architecture of the ICS. It focuses on the things that matter to citizens and describes them in a way that they will understand and connect with. The deployment plan includes products intended for an internal system audience that will provide more technical, architecture-based versions of the narrative.

Action:
☒ To note ☒ To agree ☒ To agree the recommendation/s (see details below)

Recommendations:	
1.	To note and endorse the system narrative developed for a public audience
2.	To agree the deployment plan for the system narrative, advising on any other activity that will help develop awareness of the ICS and its objectives

Key implications considered in the report:		
Financial	☐	*Details to be inserted as appropriate*
Value for Money	☐	*Details to be inserted as appropriate*
Risk	☐	*Details to be inserted as appropriate*
Legal	☐	*Details to be inserted as appropriate*
Workforce	☒	*Details to be inserted as appropriate*
Citizen engagement	☒	*Details to be inserted as appropriate*
Clinical engagement	☒	*Details to be inserted as appropriate*
Equality impact assessment	☐	*Details to be inserted as appropriate*

Engagement to date:				
Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
☒	☒	☐	☐	☐
Performance Oversight Group	Clinical Reference Group	Mid Nottingham-shire ICP	Greater Nottingham ICP	-
☐	☐	☐	☐	☐

Contribution to delivering the ICS:	
Health and Wellbeing	☒
Care and Quality	☐
Finance and Efficiency	☐
Culture	☒

Is the paper confidential?
☐ Yes ☒ No Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

A public-facing narrative for the ICS

The narrative has been developed in three versions:

1. Longer narrative
2. A shorter narrative in three paragraphs
3. A single-paragraph narrative.

Each of these versions is included below.

---

1. Longer narrative (757 words)

Our challenge

In Nottinghamshire we have made great progress in improving people's health and wellbeing. Today, we can treat diseases and conditions we once thought untreatable. Thanks to advances in technology, everybody now has the power to take greater control of their own health. As a result, local people now live far longer than ever before.

A cancer patient in Nottinghamshire, for instance, is now far more likely to survive their illness than just a few years ago. Their cancer is detected earlier, they receive treatment earlier, and their chance of survival grows: 10% higher now than as recently as the year 2000. The story of a Bulwell resident who recently attended a community cancer screening is a typical example: during their 'Lung MOT', cancer was detected and immediately treated, greatly increasing their chances of a full recovery from a disease that is often detected late.

However, with great improvements come new challenges. While we now live longer, for many these additional years are not lived in good health. More people today live with multiple and long-term health conditions than ever before, each requiring complex treatment and care that places new strains on our health services. Perilous economic circumstances, poor housing, bad diets, smoking and the abuse of drugs and alcohol add to the pressures on some of our communities.

Moreover, the challenges are not evenly spread across the local population. If you are born in Ruddington today, for instance, you can expect 72 years of good health; but if you are born in Bilborough, you can expect just 52. This inequality is visible in access to health and care services too. It is easier to see a GP in some areas than others, or to find things to do to keep you active and fit. People tell us that they are forced to explain their health and care problems to multiple people before receiving the support they need.

The solution

As the challenges our health and care system faces change, so must our services. We must invest in both improving our resources and in ensuring we are as efficient and effective as possible with the resources we have and encourage people to share responsibility for their health and wellbeing.

In this endeavour, we start with a simple goal: to ensure everyone in Nottinghamshire has the best health and wellbeing that is possible for them. This means more people able to live full and independent lives in their homes, more care provided for them near those homes, better local access to GPs and hospital services, and a greater focus on the prevention of illnesses, not just their treatment. To do that, we must also invest in mental health services, recognising the critical link between physical and mental health.

Nottinghamshire has been chosen as one of the first areas in the country to develop what is known as an Integrated Care System (ICS). An ICS means bringing our local NHS, councils and the voluntary sector together to combine healthcare and other services to look after people within their homes and communities. As an ICS we will have much more freedom to manage local services, and how we spend money on health and care; invest in what we know works best for our local people: like focusing on preventing illnesses and providing more services near where people live. This will involve all health and care services working together.

We have already seen that this kind of collaboration works. Our work to identify people at risk of stroke has already prevented 44 strokes and 12 deaths. The enhanced care we provide to people living in care homes has resulted in a one-third reduction in people from care homes attending A&E.

Now we can improve on this progress. We will set challenging goals to ensure we succeed: increasing the number of those diagnosed with cancer who go on to lead healthy lives, reducing the numbers of strokes and heart attacks locally, and ensuring everyone has better access to their GPs; and to hospital doctors and A&E when that is the service that they need.

Our purpose

We have seen great progress in the healthcare provided in Nottinghamshire for the people of this county. Each step forward creates new challenges, however, and the ICS is our answer to the new challenges we face. Our vision for it is ambitious. Across Nottinghamshire, we seek to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently long into their old age.

2. Shorter narrative (360 words)

In Nottinghamshire we have made great progress in improving people's health and wellbeing. Today, we can treat diseases and conditions we once thought untreatable: cancer survival rates, for instance, have increased dramatically in just twenty years. However, with great improvements come new challenges. While we now live longer, for many these additional years are not lived in good health. The growing prevalence of long-term health conditions, for instance, places new strains on our health and care services. There is inequality evident in both the location of challenges and in access to services. In some areas, it is easier to access a GP than in others, or to find things to do to keep you active and fit. As a result, there is

considerable inequality in the number of healthy years people are living: from 52 in Bilborough to 72 in Ruddington.

As the challenges our health and care system faces change, so must our services. In this endeavour, we start with a simple goal: to ensure everyone in Nottinghamshire has the best possible health and wellbeing they can. This means more people able to live full and independent lives in their homes, more care provided for them near those homes, better local access to health and care services, and a greater focus on the prevention of illnesses, not just their treatment. Nottinghamshire has been elected one of the first areas in the country to develop what is known as an Integrated Care System (ICS), bringing our local NHS, councils and voluntary sector together to combine healthcare and other services to look after people within their homes and communities. We will now have greater freedom to manage local services, to spend money on health and care, and to invest in what we know works. We have already seen that this kind of collaboration works: now we can enhance and improve on this progress. We will set challenging goals to ensure we succeed.

Our vision for the ICS is ambitious. Across Nottinghamshire, we seek to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age.

3. Single paragraph narrative (64 words)

In Nottinghamshire, we have made great progress in improving people's health and wellbeing. However, with progress comes new challenges, such as the increase prevalence of long-term health conditions. The Integrated Care System brings together the local NHS, councils and the voluntary sector to meet today's needs: bringing care to people's communities and homes, and focusing on the prevention of illnesses not just their treatment.

Deployment plan

The deployment plan describes how we intend to distil the narrative into a range of activity and products that will reach key audiences. This includes creating a system-facing slide deck that describes both the purpose of the ICS and the core features of its architecture. It also includes plans for distributing the narrative through a range of channels to reach key audiences. The deployment plan is included in table 1 below.

The activity planned of engagement on the NHS LTP will also facilitate deployment of the ICS narrative.

Table 1 – Deployment plan

AUDIENCES	DELIVERABLE	TIMESCALES	DEPENDENCIES
PUBLIC; STAFF; GPs	Create final core text for public narrative and staff versions	Feb 2019	ICS Board to sign off final narrative Narrative text will shape our language on our local plan
SYSTEM LEADERSHIP; GPs	Develop core text and slides defining system architecture, including glossary of system terms and definitions of core features of an ICS	Feb 2019	
PUBLIC; STAFF	Create content for digital channels from core text and architecture materials	Feb 2019	Requires coordination across partner channels in lieu of single set of ICS channels
SYSTEM LEADERSHIP; COUNCILLORS; MPs; GPs	Develop stakeholder briefings from core text and architecture materials	Feb 2019	Briefings will link ICS narrative to the long-term plan and development of our local plan
SYSTEM LEADERSHIP	Develop slide deck and briefing notes to support staff conference	Mar 2019	Deliverable supports OD work and is an input to the staff conference
STAFF; COUNCILLORS; OSC; HWBB	Schedule series of face-to-face briefings across partner organisations	Feb 2019 – Jul 2019	Detailed plan to be developed to cover staff briefings; OSC; HWBBs

AUDIENCES	DELIVERABLE	TIMESCALES	DEPENDENCIES
PUBLIC; STAFF	Develop animation telling the story for the public	Apr 2019	Work to be commissioned and utilise new visual identity Animation will link system narrative with long term plan core elements
SYSTEM LEADERSHIP	Collate/create image library for ICS corporate documents	Mar 2019	Work to be commissioned as part of the visual identity project
SYSTEM LEADERSHIP	Create ICS visual identity and corporate templates	Mar 2019	Currently procuring agency support for visual identity project
PUBLIC; STAFF	Develop and collate work-stream case studies and core narratives using consistent templates and language, drawing from core text and architecture materials	Feb 2019 – Apr 2019	Existing case studies to be collated across workstreams and re-presented in consistent format with new visual identity

Alex Ball
Director of Communications and Engagement
alex.ball1@nhs.net

Nottinghamshire Health & Wellbeing Board

Health & Wellbeing Board Summary
9 January 2019

At this meeting:

Safeguarding Children Annual Report – review of 2017-18 & future arrangements

Director of Public Health Annual Report – focus on violence in Nottinghamshire

JSNA chapter – autism
Evidence of need & recommendations to address

JSNA Chapter - cancer
New chapter outlining evidence of need & opportunities for prevention

JSNA Chapter – sexual health & HIV
Refreshed chapter outlining health needs & recommendations to address them

Chair's report

Councillor Doddy highlighted the publication of the new 10 year plan for the NHS which includes a focus on preventing illness & tackling health inequalities.

Safeguarding Children Annual Report

Chris Few, Independent Chair of the Nottinghamshire Safeguarding Children Board presented the Board's Annual Report for 2017-18. He highlighted successes for the year which included training staff as well as a number of serious case reviews which have been completed. The Board has reviewed child deaths & is working to improve safer sleeping & asthma management as a result.

Chris explained that recent legislation will lead to Local Safeguarding Children Boards being replaced by new safeguarding arrangements. A new Nottinghamshire Safeguarding Children Partnership has been formed to oversee safeguarding and joint arrangements to review child deaths across the county & city have been introduced. The new partnership should enable greater involvement of schools & young people in the safeguarding arrangements.

Board members welcomed the report but raised concerns about the number of young people excluded from school& the impact of changes to Homestart services on children & young people in Mansfield & Ashfield.

Director of Public Health Annual Report 2018

The DPH annual report for 2018 focusses on violence prevention. The report was presented to the Board by Jonathan Gribbin, who explained that it covers a range of issues from self-directed violence through to domestic abuse & knife crime, some of which are not immediately visible but which have a serious impact on the people affected & their families. The nature of the issues also means that many people also suffer in silence.

As part of the presentation, Sarah Quilty outlined a newly funded initiative to ensure that frontline workers are equipped to routinely ask people about adverse childhood experiences. Sarah explained how emerging evidence indicates that being asked helps people to exercise increased control of their lives leading to improved outcomes for them.

There is also work in Nottinghamshire to tackle knife crime, which Dave Wakelin of Gedling Borough Council is leading across the county & city. Dave explained to Board members that the impact of knife crime on victims & their families is huge. In Nottinghamshire there is a partnership approach to dealing with the issues including local communities & community & voluntary organisations as well as the police & that the support of the Board would support that work.

JSNA chapter - autism

Anna Oliver presented the Board with a draft JSNA chapter on autism for approval. The chapter pulls together local & national evidence, best practice & data as well as feedback from people who are autistic & their families & the staff they work with.

🕑 Next meeting 2pm, Weds 6 March 2019 at County Hall, West Bridgford

Nottinghamshire Health & Wellbeing Board

Anna explained that the JSNA chapter identifies a number of issues which include diagnosis, transfer between children & adults services, the needs of different groups of people & employment.

The Board were asked to approve the chapter which sets out the evidence of need in Nottinghamshire. An action plan will be developed about how to address these needs & potential actions for the Board will be outlined in a paper later in the year.

Board members supported the chapter but suggested that the recommendation to support employment opportunities would best sit with the Place Department within the County Council. Members noted that there is more support available for people in crisis but suggested that diagnosis and early help could reduce the need for this support. Nottinghamshire is one of the only areas to have a specialist Asperger's Service which improves diagnosis rates locally.

JSNA Chapter - cancer

Another JSNA chapter was presented which outlines the issues around cancer in Nottinghamshire bring together evidence as well as identifying opportunities to improve prevention & outcomes for those people diagnosed with the disease.

Sue Coleman presented the chapter & explained that 4 out of 10 cancers are considered preventable & that not smoking, maintaining a healthy weight, eating fruit and vegetables and drinking less alcohol were key factors identified as being important in reducing the risk of being diagnosed with cancer. These are also linked to deprivation.

Many of the recommendations in the JSNA chapter are specific to health but there are a number which also relate to wider partners.

Board members asked for more information about the services in Bassetlaw. They also raised concerns about the impact of cancer on people who are working age & also around particular groups such as people who are deaf & need interpreters & trans people who may not access services because of stigma.

JSNA Chapter – sexual health & HIV

The sexual health chapter of the JSNA has been refreshed & the update was presented for approval by the Board by Matt Osborne. Matt explained that the chapter had been refreshed in collaboration with the City & that the recommendations will inform an action plan to address the health needs identified.

Matt explained that chlamydia testing remains a concern & that although the number of tests has increased it is still below average. The chapter also looks at future needs & that new tests as well as the roll out of new sex & relationships education would impact on available resources.

Board members welcomed the evidence & recommendations within the JSNA chapter but raised concerns about the impact of data sharing on anonymity. Members were also concerned about a perceived reluctance from schools to engage with sexual health services, as well as access to services for older people & the use of social media to promote healthy sex & relationships.

If you have any comments or questions about this summary please contact Nicola Lane nicola.lane@nottscc.gov.uk

🕑 Next meeting 2pm, Weds 6 March 2019 at County Hall, West Bridgford

Appendix D – Nottingham and Nottinghamshire CCGs – Executive and Senior Leadership Team

Post	Name
Accountable Officer	Amanda Sullivan
Chief Finance Officer	Vacant
Operational Director of Finance (Greater Nottingham)	Vacant
Operational Director of Finance (Mid-Nottinghamshire)	Mick Cawley
Associate Director of Performance and Information	Andy Hall
Turnaround Director	Stuart Poynor
Associate Director of Financial Recovery (Finance)	Vacant
Associate Director of Financial Recovery (Operations)	Jonathan Rycroft
Head of PMO	Vacant
Chief Nurse, Director of Quality and Governance / ICS Nurse	Elaine Moss
Associate Director of Nursing and Quality	Nichola Bramhall
Associate Director of Nursing and Personalised Care	Rosa Waddingham
Associate Director of Governance	Lucy Branson
Chief Pharmacist	Mindy Bassi
Director of Commissioning (Greater Nottingham)	Lucy Dadge
Locality Director (City)	Michelle Tilling
Locality Director (South Nottinghamshire)	Fiona Callaghan
Associate Director of Commissioning (NUH)	Mark Sheppard
System Delivery Director (UEC)	Caroline Nolan
Associate Director of Procurement and Commercial Development	Vacant
Associate Director of Delivery (Greater Nottingham)	Nina Ennis
Associate Director of Estates	Lynne Sharp
Associate Director of Joint Commissioning and Planning	Andrea Brown
Director of Commissioning (Mid-Nottinghamshire)	Vacant
Locality Director (Mid-Nottinghamshire)	David Ainsworth
Associate Director of PCN Development	Helen Griffiths
Associate Director of Primary Care Commissioning	Sharon Pickett
Associate Director of Delivery (Mid-Nottinghamshire)	Vacant
Associate Director of Commissioning (SFH)	Vacant
Associate Director of Commissioning (Mental Health and Community)	Maxine Bunn
Director of Special Projects	Gary Thompson
Associate Director of Special Projects and EPRR	Hazel Buchanan
Director of Transition Operations	Vacant

NHS
Nottingham North and East
Clinical Commissioning Group

Meeting Title:	Open Governing Body				**Date:** 16 April 2019				
Paper Title:	Nottingham and Nottinghamshire Health and Care Integrated Care System (ICS) System Operating Plan 2019/20				**Paper Reference:** GB/19/035				
Sponsor:	Amanda Sullivan, Accountable Officer								
Previous Related Papers:	-								
Recommendation:	Approve	☒	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☐	
Summary Purpose of Paper:	An initial draft of the Nottingham and Nottinghamshire Health and Care Integrated Care System (ICS) System Operating Plan 2019/20 was received by the Greater Nottingham Joint Commissioning Committee (GNJCC) at its meeting in January 2019. Comments received from the GNJCC and other relevant bodies within the ICS were then incorporated. Additional changes were made based on further triangulation work, planning developments and contract agreements. The Governing Body is responsible for the approval Nottinghamshire Health and Care Integrated Care System (ICS) System Operating Plan 2019/20; however, due to a final submission date of 11 April 2019, the GNJCC were requested to endorse the next iteration of the plan at its meeting in March 2019. The plan then continued to be developed and refined by the ICS Planning Group prior to the final submission date. Whilst the final plan was submitted in accordance with the national deadline, the Governing Body is requested to formally approve the Nottinghamshire Health and Care Integrated Care System (ICS) System Operating Plan 2019/20. In the next phase of planning, the Governing Body will be asked to support and contribute to the development of the five year strategy.								

If paper is for Approval/Endorsement, have the following impact assessments been completed?			
Equality / Quality Impact Assessment	Yes ☐ No ☐ N/A ☒	Data Protection Impact Assessment	Yes ☐ No ☐ N/A ☒

Conflicts of Interest: Recommended action to be agreed by the Chair at the beginning of the item.

☒ 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 ☐ Conflicted party is excluded from discussion			
Have All Relevant Implications Been Considered? *(please tick where relevant)*			
Clinical Engagement	☒	Patient and Public Involvement	☒
Quality Improvement	☒	Equality, Diversity and Human Rights	☒
Integration	☒	Innovation / Research	☒
Improving Health Outcomes / Reducing Health Inequalities	☒	Patient Choice / Shared Decision Making	☒
Financial Management	☒	Corporate Governance	☒
Risk: *(briefly explain any risks associated with the paper*)	N/A		
Recommendation:	The Governing Body is asked to: • **APPROVE:** the Nottinghamshire Health and Care Integrated Care System (ICS) System Operating Plan 2019/20		

System Operating Plan Overview (Draft as at 22nd March)

The ICS is required to submit a System Operating Plan Overview document on the 11th April to support the 2019/20 System Operational Plan. The paper includes the latest draft of the System Operating Plan Overview which has been completed in line with the technical guidance with review and oversight through the ICS Planning Group. Recognising that we have not yet concluded the planning round the draft includes the latest available information.

An earlier of the plan was brought to the February 2019 Joint Commissioning Committee meeting and comments received from that committee and other relevant bodies within the ICS have been incorporated within this latest draft. Additionally, further changes have been included based on additional triangulation work, planning developments and contract agreements. A summary of the recent changes is included as an attachment.

The draft will continue to be developed and refined by the ICS Planning Group ahead of the final submission on the 11th April, including the following changes:

- Updated for final system financial plan and position against the System Control Total
- Updated for final activity plan (net of do something plans)
- Updated for final operational performance plan
- Final provider organisational narratives to be added to annexes

Fig 1. Planning Timetable from NHS Planning Guidance (Jan 2019)

5.2 Timetable

Milestone	Date
Publication of: • Near final 2019/20 prices • 2019/20 standard contract consultation	21 December 2018
2019/20 deliverables, indicative CCG allocations, trust financial regime and control totals and associated guidance for 2019/20	Early January 2019
NHS Long Term Plan	7January 2019
2019/20 CQUIN guidance published	January 2019
2019/20 Initial plan submission – activity focused	14 January 2019
2019/20 National Tariff section 118 consultation starts	17 January 2019
STP/ICS net neutral control total changes agreed by regional teams	By 1 February 2019
Draft 2019/20 organisation operational plans	12 February 2019
Aggregate system 2019/20 operating plan submissions, system operating plan overview and STP led contract / plan alignment submission	19 February 2019
2019/20 STP/ICS led contract / plan alignment submission	19 February 2019
Final 2019/20 NHS Standard Contract published	22 February 2019
Local decision whether to enter mediation and communication to NHSE/I and boards/governing bodies	1 March 2019
2019/20 STP/ICS led contract / plan alignment submission	5 March 2019
2019/20 national tariff published	11 March 2019
Deadline for 2019/20 contract signature	21 March 2019
Parties entering arbitration to present themselves to the Chief Executives of NHS Improvement and England (or their representatives)	22-29 March 2019
STP/ICS net neutral control total changes agreed by regional teams	By 25 March 2019
Organisation Board / Governing body approval of 2019/20 budgets	By 29 March
Submission of appropriate arbitration documentation	1 April 2019
Arbitration panel and/or hearing (with written findings issued to both parties within two working days after panel)	2-19 April 2019
Final 2019/20 organisation operational plan submission	4 April 2019
Aggregated 2019/20 system operating plan submissions, system operating plan overview and STP/ICS led contract / plan alignment submission	11 April 2019
2019/20 STP/ICS led contract / plan alignment submission	11 April 2019
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 30 April 2019
Strategic planning	
Capital funding announcements	Spending Review 2019
Systems to submit 5-year plans signed off by all organisations	Autumn 2019

Nottingham and Nottinghamshire Health and Care Integrated Care System (ICS)

System Operational Plan Overview 2019/20

EXECUTIVE SUMMARY

This document sets out the Nottingham and Nottinghamshire ICS System Operational Plan for 2019/20. The purpose of the system plan is to provide better, joined up health and social care services for people in Nottingham & Nottinghamshire through closer collaborative working of health and social care system partners (NHS, local government and independent and voluntary sectors). Transformation will be enabled through engagement and consultation with our local population.

The ICS has implemented a system wide planning approach and co-ordinated regular discussions between providers and commissioners to ensure that our shared operating plan submissions are:

- Aligned with a single system plan and collective management of resources to meet the operational delivery requirements for 2019/20
- Credible and realistic, in phasing and deliverability

In order to achieve this position the ICS has taken a lead role in triangulating commissioner and provider plans and related contracts to ensure alignment in activity, income & expenditure and workforce assumptions.

This submission includes the system aggregation tool for contract and plan alignment. The ICS Planning Group has reviewed plans at a granular level to ensure contract and plan alignment.

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ANNEXES		
A	Achievement of Operational Planning Guidance Priorities and Deliverables - Urgent & Emergency Care - Planned Care - Cancer - Mental Health - Primary Care Networks - Care Homes - Learning Disabilities and Autism - Maternity - Prevention - Continuing Healthcare - Personalised Care including Personal Health Budgets	35
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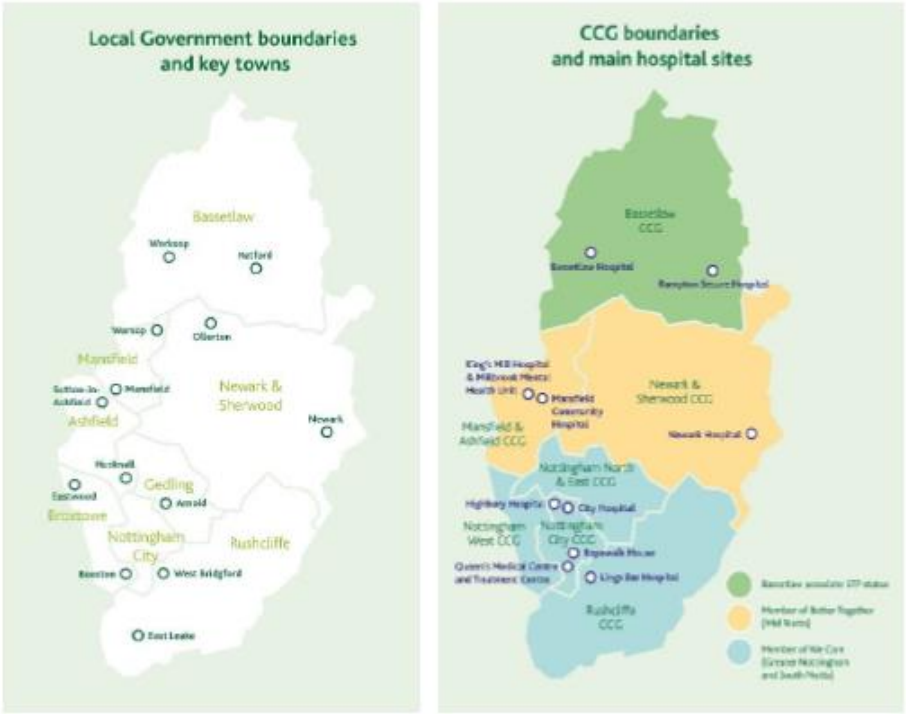
1. BACKGROUND AND INTRODUCTION

The Nottingham and Nottinghamshire Integrated Care System is one of the national 'accelerator' sites. It covers six CCGs, and a unitary and two-tier local government structure with a city council, and a county council with seven district councils. There are two major acute trusts and two transformation partners. There is a large mental health trust (Nottinghamshire Healthcare NHS Foundation Trust) and the local authorities both commission and provide services. East Midlands Ambulance Service (EMAS) is a key system partner to the ICS. There are a myriad of smaller health and care providers across all sectors (including primary care, pharmacy, dental and care sector). There are also two well established Health and Wellbeing Boards – city and county. A population of 1 million is covered by the ICS.

Bassetlaw forms part of the South Yorkshire and Bassetlaw STP footprint. However, the district of Bassetlaw is part of the Nottinghamshire Health and Wellbeing Board footprint, is coterminous with the boundary of Nottinghamshire County Council, and is provided with mental health and community services by Nottinghamshire Healthcare FT. Bassetlaw is also within the Nottinghamshire Transforming Care Partnership.

An overview of the Nottingham and Nottinghamshire footprint is provided below.



Work with system leaders has concluded that we will operate at three levels:

- Primary Care Networks (PCNs) – GPs, mental health, community services (likely to be 21 with PCNs working collectively as required serving 30,000-50,000 population) (Neighbourhood)
- Integrated Care Providers (ICPs), integrated provision and delivery of outcomes (c.350,000 population) (Place)
- Nottingham and Nottinghamshire Integrated Care System (ICS) for strategic planning, commissioning and oversight (> 1 million population) (System)

The development of this single system operating plan is a key part of our journey to be a fully integrated system. This document sets out a single narrative and aligns the key assumptions for income, expenditure, activity and workforce across the system. It provides a summary of the priorities for 2019/20 to drive better care delivery and outcomes for our population, whilst making significant progress in ensuring a sustainable financial position going forward.

As one of the national 'accelerator' ICS sites, coupled with our Managing Director maintaining the NHS England DCO functionality, the Nottingham and Nottinghamshire ICS is well positioned to move to an enhanced role of system leader as set out in the latest planning guidance.

The ICS Leadership Board (comprised of commissioner and provider Chief Executives and Chairs) is chaired by an independent chair meets on a monthly basis to consider the financial and operational performance position of the system.

The ICS has agreed the key priorities for 2019/20:

- **Maintain strong focus on quality and patient safety**
- **Addressing the financial challenge** e.g. maximising the value delivered for every £ spent. System Efficiency and Transformation Plan to take cost out and reduce the overall deficit of the system
- **Addressing key performance challenges** e.g. Urgent Care (Greater Nottingham) and Mental Health

The scale of the financial challenge for our system requires significant change with a 'do nothing' challenge of £157 million (5.6%) for health in 2019/20 to meet the notified system control total. This is a challenging position and all system partners are committed to working together at a system level.

The ICS Efficiency and Transformation Plan will focus on the following areas:

Demand management	• Primary care variation • Access / thresholds
Efficiencies	• System wide e.g. back office, estate • Business as usual (BAU) efficiencies
Maximise resource to the system	• Additional resource in to the system • Provider of choice – minimise stranded costs
Transformation	• New care models • GIRFT/Rightcare/Model Hospital • Menu of Opportunities (NHS England)
Decommissioning	• Service benefit review • Core offer

Key to all of this is the alignment of key assumptions and throughout the process we have validated and triangulated activity, finance and workforce information to deliver a system operating plan recognised and approved by all organisations.

Through the ICS Board the system has agreed there should be one System Plan (which can be presented at total system (ICS), Integrated Care Partnership (ICP) and organisation level).

The ICS has implemented a system wide planning approach to support the development of the 2019/20 operational plan (year one) and the five-year system plan in line with the agreed principle of one System Plan. An ICS Planning Group is in place and meets fortnightly to provide oversight and support the delivery of the five-year plan.

The ICS Planning Group continues to review plans at a granular level to ensure the final 2019/20 system operating plan is fully aligned and underpinned by organisational plans that together express the system priorities.

2. SYSTEM PRIORITIES AND DELIVERABLES

In this section we set out how we will use our resources to meet the needs of the population and what we will deliver in 2019/20, as year one of our five year plan.

To ensure we have a sustainable system the plan needs to deliver the key deliverables in the Long Term Plan and constitution, ensure a strong focus on patient safety and quality is maintained and ensure that expenditure remains within the resources available to the system. Specifically, the system plan will:

- Meet the constitution requirements
- Protect planned investment for the five-year forward view commitments in mental health, cancer and primary care
- Meet the Mental Health Investment Standard (where growth in mental health spend is greater than overall funding growth)
- Meet the Long Term Plan commitments (year one) that funding for community and primary medical services should grow faster than overall NHS revenue funding settlement
- Commission realistic and sustainable activity levels

A significant amount of joint planning between commissioners and providers has taken place across our Integrated Care Providers and ICS as a whole to agree and develop shared priorities for 2019/20. This approach will continue to develop and evolve through the year to ensure the successful delivery of plans.

Urgent and Emergency Care

Reducing pressure on emergency hospital admissions by increasing 'out-of-hospital' care is a key priority in The NHS Long Term Plan. The transformation of urgent and emergency care services and the delivery of national standards is a key priority for our ICS. We are fully committed to expanding and reforming urgent and emergency care services to ensure patients get the care they need fast, relieve pressure on A&E departments and better offset winter demand spikes.

We will:

- Integrate planning for community, primary and acute response to urgent care need across work streams and organisations;
- Support patients to navigate the urgent and emergency care system;
- Ensure patients get the care they need, fast and in most appropriate setting;
- Improve waits for A&E and hospital admission;
- Continue to reform hospital emergency care by further developing same day emergency care services;
- Respond to capacity challenge on acute beds by delivering key projects to improve the pathways; and
- Focus on workforce solutions with a whole system approach

Across our ICS we are sharing experiences and learning of tackling the issues and challenges faced by urgent and emergency care services to drive continuous improvements in performance.

19/20 priorities and deliverables	
• *System co-ordination of urgent and emergency care initiatives and capacity* • *Ensure multi-disciplinary teams across primary care are proactively reviewing the most at risk patients of admission (frail and LTCs)* • *Training to care home staff to better proactively manage residents* • *Implementation of Urgent Treatment Centre model* • *Further development of same day emergency care services* • *Developing community teams to support hospital admission avoidance*	• *Commission a single multidisciplinary clinical assessment service to support and navigate patients to the right care setting* • *Improve discharge planning* • *Developing community bedded care provision to support hospital admissions and reduce length of stay* • *Capital investment in emergency pathway addressing acute capacity. Funded via STP Wave 4 capital.*

Annex A section 1 and Annex B provide further detail.

Elective Care and RTT

The transformation of planned care services, particularly outpatient appointments, whilst maintaining constitutional standards is a core focus for our ICS to address increasing demands on services, facilities, waiting times and clinicians.

The ICS's approach to planned care is one of standardisation and collaboration, wherever possible establishing standardised pathways and approaches and replicating good practice and learning across our Integrated Care System.

Our focus on the redesign of outpatients aligns with the recently published NHS Long Term Plan, which identifies it as a priority area given hospital outpatient visits across England have nearly doubled over the past decade from 54 to 94 million. This is supported by The Royal College of Physicians who have argued that outpatient services need a radical overhaul.

Our ambition across the Nottingham and Nottinghamshire ICS is that people get fast access to advice and support, self-management information, and, where necessary, get to see the right health professional as quickly as possible. We want to ensure care is delivered in a responsive and person-centred manner as close to home as possible.

We made good inroads into the redesign and transformation of outpatients in 2018/19 including, for example, agreement on a single best practice, evidenced based model for MSK, establishment of a single service restriction policy and establishment of a single consultant to consultant referral policy.

We will continue to build on this work in 2019/20, and in line with The Long Term Plan our ambition is to avoid up to a third of face-to-face outpatient visits over the next five years.

NUH is leading the development of a National Rehabilitation Centre in collaboration with Partners. National capital funding has been awarded for this development and detailed planning has now commenced. The CCG and trust are working together to determine how this may benefit rehabilitation outcomes and will engage a wide range of stakeholders to develop plans.

19/20 priorities and deliverables	
• *Implement single MSK pathway* • *Implement community gynaecology service* • *Commence work on Urology pathway redesign* • *Commence work on ENT pathway redesign* • *Implement virtual clinics* • *Development of National Rehabilitation Centre*	• *Commence work to realise benefits identified by RightCare in MSK* • *Develop standardised referral guidelines* • *Develop standardised advice and guidance specifications* • *Re-procurement of treatment centre*

Annex A section 2 and Annex B provide further detail.

Cancer Treatment

Cancer, and in particular early diagnosis, is a key priority set out in The NHS Long Term Plan. We have established a single approach to the development and implementation of cancer services across the Nottingham and Nottinghamshire ICS to ensure consistency of best practice and shared learning.

For cancer care and services the Nottingham and Nottinghamshire ICS is committed to:

- Achieving the current and future waiting time standards and ensuring there is sufficient capacity to cope with growth;
- Improving outcomes to meet national expectations - particularly in deprived areas;
- Improving patient experience, particularly when patients are discharged from secondary care;
- Reducing variation in outcomes; and
- Improving efficiency.

A single cancer strategy and associated implementation programme has been established across the ICS. This is focused around three themes:

- Prevention – by addressing risk factors, especially smoking;
- Early Diagnosis – increasing % of cancers diagnosed at stage 1/2, reducing emergency presentations, leading to increased survival rates; and
- Improving Cancer Treatment and Care – achieving cancer waiting time targets, including 28 day referral to diagnostic metric, implementation of all aspects of recovery package, and implementation of risk stratified follow-ups.

19/20 priorities and deliverables	
• *Expand smoking cessation services at SFH, NUH and Nottingham Health Care Trust* • *Continue rollout of Lung MOT service* • *Continue to reduce metrics in CCG and GP cancer metrics* • *Monitor performance against new 28 day diagnosis target and implement plans where appropriate* • *Community cancer service to be expanded* • *Further embed digital solutions in the delivery of care*	• *Roll out non-specific / vague symptoms pathway* • *Continue to implement direct access diagnostics for primary care* • *Achieve and sustain 62 day cancer performance targets* • *Continue to implement all stages of Recovery Package* • *Increase uptake of screening, particularly amongst hard to engage groups* • *Development of sarcoma services across the region*

Annex A section 3 and Annex B provide further detail.

Mental Health

Improving mental health services and outcomes together with the consistent delivery of constitutional standards is a key priority for the ICS in 2019/20. There are already many positive aspects to the services provided by NHS and Local Authority partners in our area; however we recognise we need to do more. We have identified a set of five strategic objectives (or 'pillars') to drive our work and deliver the required standards:

- Establish an integrated system infrastructure
- Increase support for prevention, self-care and the wider determinates of health
- Implement a person centred approach to mental health
- Improve access to specialist services
- Achievement of the 5YFV workforce transformation standards

19/20 priorities and deliverables	
• *Develop an integrated commissioning structure* • *Develop an outcomes framework* • *Link with prevention, person and community centred work to implement social prescribing* • *Liaise with Suicide Prevention Partnership to identify priority areas for support working towards a reduction in suicide rates* • *Increase access to NICE concordant community-based specialist perinatal mental health services*	• *Increase annual physical health checks and follow up care for people living with SMI* • *Implement IAPT recovery plans to deliver access targets.* • *Implement crisis/liaison and OAP/urgent care action plan* • *Implement CYP recovery plan* • *Implement EIP action plan*

Annex A section 4 and Annex B provides further detail.

Primary Care and Community Health Services

Establishing Primary Care Networks underpinned by sustainable and resilient General Practice is at the core of the ICS' strategy. Our overarching aim is that Primary Care Networks will be at the heart of health and care provision; improving the wellbeing of our local populations through proactive, accessible, coordinated and integrated health and care services.

Our vision is an integrated care approach, focusing on place based care. Key characteristics are:

- A more integrated and collaborative primary care workforce, with a strong focus on partnerships – 'primary care' defined as first line services such as; general practice, public health, community providers, secondary care, mental health, voluntary sector and social care;
- A supported and integrated workforce with a combined focus on prevention and personalisation of care with shared and improved qualitative health and care outcomes utilising population health management data;
- Strong voice from partners working collectively to describe how clinical, social and financial drivers are aligned and focused;

- Provision of care aligned to population of circa 30,000 and 50,000, working collectively to deliver localised care, with the ability of at scale working; and
- Patient activation and strengthened local communities

Our work in this area in 2019/20 will focus on delivering this vision.

19/20 priorities and deliverables	
• *Improve health, wellbeing and primary care sustainability - Completion of ICS primary care strategy* • *Improve Integrated care and quality - Creation of PCN specification to be adopted across the system* • *Agree a PCN/PHM/Interventions framework.* • *Estates review to take place as part of clinical strategy to define the "where"* • *Workforce review to take place*	• *Implement the new GP contract* • *Build on the network of clinical pharmacists and the value they bring* • *Implement social prescribing* • *In Mid Nottinghamshire we will develop a strategy for first contact physiotherapists* • *Develop a prevention and health outcomes local delivery plan focussed on the key areas such as CVD, diabetes, stroke and cancer*

Annex A section 5 and Annex B provides further detail.

Care Homes

Providing enhanced care to care homes is key part of the ICS' strategy in line with the recently published NHS Long Term Plan. In 2019/20 we will create a shared ICS vision and strategy to facilitate scale and spread of enhanced care to care homes across the ICS footprint, driven forward by a single SRO. We will take learning from the local and national vanguards and focus on consistency of service across ICPs within the ICS footprint. A designated programme lead is in in post to provide oversight, co-ordination and link with locality leads, regional leads and national colleagues. Key areas of focus for the coming year are to:

- Develop an enhanced care home strategy to facilitate scale and spread; determine system priorities; focus on consistency of service across localities within the ICS footprint; and new innovation;
- Undertake benchmarking and a gap analysis on current provision; and
- Work with the national team to develop outcomes and success measures.

19/20 priorities and deliverables	
• *Strengthen links between GP practices and Care Homes* • *Continue to promote use of proactive care and extend services to reduce demand on urgent care* • *Embed proactive allocation of MDT support and resource* • *Establish approach to identify those with dementia in care homes* • *Promote use of 'This is Me' tool in care homes* • *Greater engagement with care home providers* • *Understand training and ongoing learning support options available to care home staff*	• *Implement Medicines Optimisation in Care Homes (MOCH)* • *Continue spread of vanguard recommendations* • *Share learning across ICS on EOL services* • *Increase use of EPaCCS* • *Use of advanced care planning to support end of life care needs* • *Increase engagement from MH, LD and younger adult care home and care home services* • *Scope opportunity for single-shared care home contract with Nottingham County Council* • *Better understand opportunities available to advance technology in care homes*

Annex A section 6 provides further detail.

Learning Disabilities and Autism

The Transforming Care Programme aims to transform care and support for people with learning disabilities and/or autism who display behaviour that challenges, including those with a mental health condition.

'Building the Right Support' is a national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.

As part of Building the Right Support Nottingham and Nottinghamshire has an established Transforming Care Partnership (TCP) with a joint ambition to reduce reliance on inpatient care through planning to reach a significantly reduced inpatient rate by March 2021. The TCP is committed to ensuring people with learning disability and/or autism get better support, whilst improving care quality and outcomes.

Across Nottinghamshire we will do more to ensure that all people with a learning disability, autism, or both can live happier, healthier, longer lives.

19/20 priorities and deliverables	
• *Open new community based provider* • *Increase the number of annual health checks* • *Review the ATU/Locked Rehab model of care* • *Evaluation of enhanced Services – ICATT, Forensics, Unplanned Care* • *Responding to the recommendations of the Learning Disability Mortality Reviews*	• *Increased focus on secure inpatients with forensic needs to ensure robust packages of support are available and that early discharge planning commences* • *Working towards an agreed pooled budget* • *Strengthen commissioning integration*

Annex A section 7 and Annex B provide further detail.

Maternity

In response to Better Births, providers and commissioners across the ICS are working together as part of a Local Maternity System (LMS) to deliver the recommendations. The Nottingham & Nottinghamshire LMS was formed in 2017 to drive forwards a local transformation plan so that by the end of 2020/21 we have improved the choice, personalisation and safety of our local maternity services, including neonatal services.

The Nottingham & Nottinghamshire LMS vision is that Maternity services should be safe, personalised, kind, professional and family friendly. Every woman should have access to information to make informed decisions and access support centred on their individual needs and circumstances.

This will be achieved by improving choice and personalisation of maternity services, continuity of care reducing the rates of stillbirth, neonatal death, maternal death and brain injury.

19/20 priorities and deliverables	
• *Implement IAPT pathway for perinatal mental health* • *Delivery of national and regional trajectories, including:* ➢ *Piloting of Continuity of Carer models* ➢ *Piloting a single co-produced personalised care plan for all women across the LMS* ➢ *Co-production with women - choices information for the LMS supporting women to make unbiased choices about their care and from three settings of birth* • *Review of postnatal care offer* • *Continued engagement with public and staff to ensure co-production of all LMS initiatives*	• *Start to explore potential pilot models for Continuity of Carer targeted towards women from BAME groups and those living in deprived areas.* • *Responding to the recommendations of the Neonatal Critical Care Review and working with the Clinical Services Strategy work stream to determine best governance and oversight* • *Implementation of maternity smoking cessation pathway (Nottingham City) and LMS wide smoking campaign* • *Piloting a community hub model – separate pilots in Mid-Notts and Greater Notts with services available to meet the needs of the local population* • *Scoping for an LMS wide Single Point of Contact for All women and Families*

Annex A section 8 and Annex B provide further detail.

Prevention

The NHS Long Term Plan sets out new commitments for action to improve prevention and a key role Integrated Care Systems have in this. The vision across the Nottingham and Nottinghamshire ICS is to maximise independence, good health and well-being throughout our residents lives. We want to empower local people to make healthier choices that support their own health and wellbeing. We want to ensure that people in our communities live long, healthy and independent lives.

This 'healthy' state of being should be experienced fairly by all our communities. We want to ensure that people living with an existing disability or long-term condition can live as well as possible through access to the right advice, treatment, care and support. We want to increase healthy life expectancy and reduce health inequalities between neighbourhoods. In order to tackle these inequalities, populations with the lowest healthy life expectancy will be targeted across the ICS.

The ICS fully recognises the need to drive forward the prevention agenda through 2019/20 as a core part of delivering a sustainable system. We will continue to develop a system which is focused on delivering improvements in the health, wellbeing and independence of our population, based on the '4 Pillars' identified by the Kings Fund . This means making connections between the following areas:

- Wider determinants of health and well-being
- Our health behaviours and lifestyles
- Communities, health and well-being
- Integrated care and relationships with communities.

19/20 priorities and deliverables	
• *Establishing alcohol champion in organisations across health, care and partner organisations, including a work programme* • *Embedding IBA into workforce policies and practices across the system* • *Effective case management and IBA through ED departments* • *Agreeing and implementing ICS level plan for tobacco* • *Further embedding prevention in ICS workstreams* • *Behaviour change approaches and interventions to support health and well-being* • *Consistently applied system wide approach to the detection of and diagnosis of Atrial Fibrillation*	• *Roll out of Patient Activation Measures, community signposting, including social prescribing, and health coaching and structured education* • • *Implementing relevant public facing campaigns to support primary and secondary prevention initiatives* • *Progress Children and Young People's prevention plan focusing on childhood healthy weight, school readiness, resilience, immunisations and vaccinations coverage* • *Developing the Prevention Framework to support the Long Term Plan*

Annex A section 9 and Annex B provide further detail.

Continuing Healthcare

In the NHS England Long Term Plan the focus on increased choice and control is a key element of these packages and an integrated and aligned approach will allow us to meet our ambitions.

As an ICS we are clear about our constituent organisations' statutory CHC responsibilities. We will maximise integration and a person centred approach across Continuing Healthcare, jointly funded (JF), S117, FNC and all individually funded packages of care within the CCGs with a single vision that will develop as the new system does through the year.

Moving forwards we will develop an integrated three year CHC strategy with social care partners across the ICS and continue to be a leader in person centred care.

19/20 priorities and deliverables	
• *A single SRO across the CCG footprint and develop an aligned strategy and processes* • *Work with LAs to have a clear local policy around joint funding, reducing number of inappropriate checklists received* • *Work to align CHC processes to developments in D2A and urgent care pathways* • *Increase training for staff and ensure that person centred care and support plans are used to support DST assessments* • *Continue to work in line with the review process outlined in the 2018 Framework, addressing current backlogs* • *All outstanding PUPoC appeal cases still with Arden & GEM to be completed*	• *Ensure all CCG staff authorised to verify MDT recommendations are trained to do so* • *Have a clear process in place for Assessors to use the previous checklist/DST to determine if a new DST required* • *Maximise use of appropriate end of life pathways, rather than using fast track referrals.* • *Strengthen brokerage arrangements and align these across the single CCG footprint* • *Personal Health Budgets* • *Ensure all CHC commissioning decisions/plans are based on the principles of personalisation*

Annex A section 10 and Annex B provide further detail.

Personal Care including Personal Health Budgets

The NHS Long Term Plan describes a fundamental shift in how the NHS needs to work alongside patients and individuals to deliver more person-centred care. As an ICS we fully believe we can improve the quality of care and health and wellbeing of local people and create a sustainable future for our local services through scaling up personalised care and empowering local people.

One of the five major, practical, changes to the NHS service model to bring about the change over the next five years is that "people will get more control over their own health, and more personalised care when they need it". The model offers a whole-population approach to supporting people of all ages and their carers to manage their physical and mental health and wellbeing, building community resilience and making informed decisions and choices when their health changes.

Prior experience of 2 IPC (Integrated Personal Commissioning) Programmes across Nottinghamshire (City & County), provides our system with a good track record of delivering personalised care and is regarded by national peers as a trailblazer in this area.

19/20 priorities and deliverables	
• *Build on the detailed mapping of local organisations and community support and implementation of agreed plans for the roll out of community centred approaches, including Social Prescribing & Community Connectivity.* • *Increased numbers of link workers and health coaches across the ICS, supporting LTC aspirations around the role, function and minimum quality standards for link workers being introduced to PCNs.* • *Ensure people in health and social care have one joined up plan that starts with an 'All About Me'* • *Across the ICS, work to achieve the standard of everyone eligible for an assessment under the Care Act experiencing a personalised approach to their assessment*	• *Implement ICS-wide plan for increasing the use of PAM and other relevant measures across the system; Target for 2019/20 is 9,663* • *Establish Evaluation Framework for measuring Community Centred Approaches* • *Increase the number of people with LTC and complex needs who receive a PHB to 2,900 people. (2018/19 target was 2,060)* • *Continue to exceed national targets, reaching 20,869 person centred care and support plans by 2020*

Annex A section 11 and Annex B provide further detail.

The table overleaf outlines Nottinghamshire ICS performance across all key performance areas:

New or Revised Measure

	Key Performance Indicator	2019/20			2018/19 Current Year Performance			
							2018/19 ICS	
		2019/20 Required Performance	2019/20 Planned Achievement	2019/20 Planned Performance	2018/19 Required Performance	2018/19 Reporting Period	Latest Period	Month RAG
A. Mental Health Deliver the MHFV, with a focus on Children and Young Peoples services (CYP), reductions in Out of Area Placements, improved access to mental health services (EIP / IAPT / Crisis and Liaison services)	CYP Access Rate	34%	✓	34%	32%	Q3 18/19	16.2%	
	CYP Eating Disorders Urgent 1st <1 weeks	95.0%	✓	100.0%	95.0%	Q3 18/19	50.0%	
	CYP Eating Disorders Routine 1st <4 weeks	95.0%	✓	100.0%	95.0%	Q3 18/19	100.0%	
	IAPT Access - 22% (Minimum 4.75% each Qtr, increases to 5.5% Q4) 2/3 of increase to be in IAPT-LTC	5.50%	✓	5.50%	4.61%	Dec-18	4.47%	
	IAPT Waiting Times - 6 weeks (Rolling Quarter)	75.0%	✓	75.1%	75.0%	Dec-18	80.8%	
	IAPT Waiting Times - 18 weeks (Rolling Quarter)	95.0%	✓	95.1%	95.0%	Dec-18	99.3%	
	IAPT Recovery Standards (Rolling Quarter)	50.0%	✓	50.0%	50.0%	Dec-18	55.2%	
	EIP NICE Concordant Care within 2 Weeks	56.0%	✓	60.0%	53.0%	Jan-19	66.7%	
	Inappropriate Out of Area Placements (bed days)	1080	✓	1440	1698	Dec-18	2815	
	Maintain Dementia diagnosis rate at 2/3 of prevalence	66.7%	✓	78.0%	66.7%	Feb-19	75.8%	
B. Urgent & Emergency Care Improved A&E performance in 2018/19, reduce DTOCs and stranded patients, underpinned by realistic activity plans. Implementation of NHS 111 Online & Urgent Treatment Centres.	Aggregate performance of 4 Hour A&E Standard	95%	x	91%	90% Sept	Feb-19	76.4%	
	12 Hour Trolley Breaches	0	✓	0	0	Feb-19	10	
	NHS 111 50% population receiving clinical input	50.0%			50.0%	Feb-19	52.8%	
	NHS 111 Direct Appointment Booking	>40%						
	Ambulance (mean) response time Category 1 Incidents	00:07:00			00:07:00	Oct-18	00:07:39	
	Ambulance (mean) response time Category 2 Incidents	00:18:00			00:18:00	Oct-18	00:30:27	
	Ambulance Handover Waits	<00:30:00						
	Manage Optimal Length of Stay-40% reduction in >21 days	220			277	Jan-19	337	
	Reduce DTOCs across health and social care- NUH	3.5%			3.5%	Jan-19	2.97%	
	Reduce DTOCs across health and social care- SHFT	3.5%			3.5%	Jan-19	4.30%	
C. Planned Care Improvements in planned elective activity, reductions in patients waiting over 52 weeks as well as reductions in overall waiting lists	RTT Incomplete 92% Standard	92%	✓	92.3%	92%	Jan-19	91.6%	
	RTT Waiting List - March 2019 incomplete pathway < March 2018	<March 18 56,511	✓	52,768	<March 18 56511	Jan-19	59,115	
	+52 Week Waits - to be eliminated (Potential fines £2.5k for Comm & Prov per breach)	0	✓	0	15	Jan-19	11	
	Diagnostics +6 weeks	0.9%	✓	0.8%	0.9%	Jan-19	0.72%	
	Children's Wheelchair Waits < 18 Weeks	92%	✓	95.0%	92%	Q3 18/19	90.00%	
	E-Referrals increased coverage 100% 1819	100%	✓	100.0%	100%	Dec-18	104%	
D. Cancer Delivery of all eight waiting time standards, implementation of nationally agreed radiotherapy specifications and diagnostic pathways, progress risk	Cancer 2 weeks - Suspected Cancer referrals	93.0%	✓	95.3%	93.0%	Jan-19	95.0%	
	Cancer 2 weeks - Breast Symptomatic Referrals	93.0%	✓	95.5%	93.0%	Jan-19	98.1%	
	Cancer 31 Days - First Definitive Treatment	96.0%	✓	97.6%	96.0%	Jan-19	93.8%	
	Cancer 31 Days - Subsequent Treatment - Surgery	94.0%	✓	96.7%	94.0%	Jan-19	83.9%	
	Cancer 31 Days - Subsequent Treatment - Anti Can	98.0%	✓	100.0%	98.0%	Jan-19	98.3%	
	Cancer 31 Days - Subsequent Treatment - Radiothy	94.0%	✓	97.3%	94.0%	Jan-19	97.5%	
	Cancer 62 Days - First Definitive Treatment - GP Referral	85.0%	✓	87.4%	85.0%	Jan-19	83.1%	
	Cancer 62 Days - Treatment from Screening Referral	90.0%	✓	97.2%	90.0%	Jan-19	84.0%	

3. ACTIVITY AND CAPACITY

3.1 3.1 Activity plan and assumptions

There is an ICS Planning Group, which is supported by an ICS Technical Planning group which facilitated an agreed framework and approach to activity planning across the ICS for 2019/20.

Activity planning has been undertaken at place level (ICP), with a joint approach across providers and commissioners to take forward the approach agreed across the ICS.

The required activity levels for 2019/20 have been modelled on the following basis:

- Baseline Forecast Outturn has been aligned at month 8 activity levels, with agreements reached as to estimated activity levels for the remaining four months of 2018/19. Any new service transformation activity impacts expected for the final four months of 2018/19 have not been included in the baseline forecast outturn (will be included as 2019/20 change).

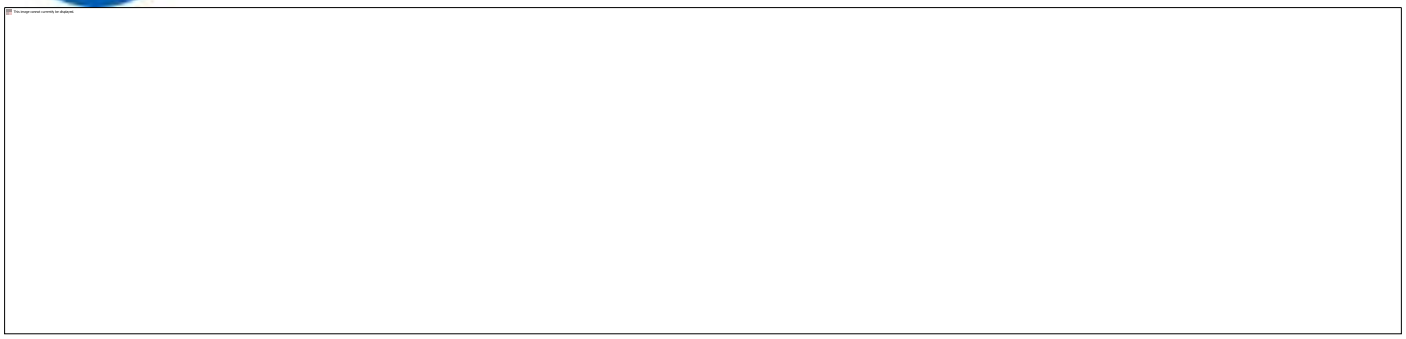
- Coding, counting and pathway changes from the current and prior years have been identified and moderated to prevent unintentional skewing of planned activity levels, changing coding as a result of revised front door at Nottingham University Hospitals and same day services.

- Growth assumptions at a local delivery level have been derived from a review of historical activity trends, demographic growth, adjustments for age and disease prevalence. These have been aligned at a place level (ICP), as a reflection of differential growth needs across the differing populations of the ICS. It is also acknowledged that there will be varying levels of growth across the different commissioners in the acute trusts, to reflect specialised and direct commissioning growth levels.

- Planning policy changes and assessment of required activity levels to deliver the planning requirements, including RTT, reduced incomplete waiting lists, improvement in A&E and cancer performance to ensure delivery of constitutional performance requirements, are to be reflected in the plans following rigorous assessment between the providers and commissioners.

- Work continues to model through the efficiency and transformation requirements required by the system, which will be transacted through the year. An initial assessment has been included in CCG plans, with a view to including within the provider plans following governance approval of the schemes.

The required activity levels for 2019/20 have been modelled on the following basis:



The table above reflects the activity submitted within 4th April plans. There is an error on outpatients (Mid Notts CCGs) where OP transformation has been incorrectly included twice. This has been flagged with NHSE/I and it is not possible to resubmit at this stage. The correct outpatient plan is materially aligned between parties.

3.1 Approach to capacity planning at a system level

An ICS Capacity and Demand Task & Finish group is in place to ensure we have a system capacity and demand model to support the development of the five-year system plan and to produce the 2019/20 system capacity plan, agreeing a common aligned approach which utilises the existing models and information sources in each organisation.

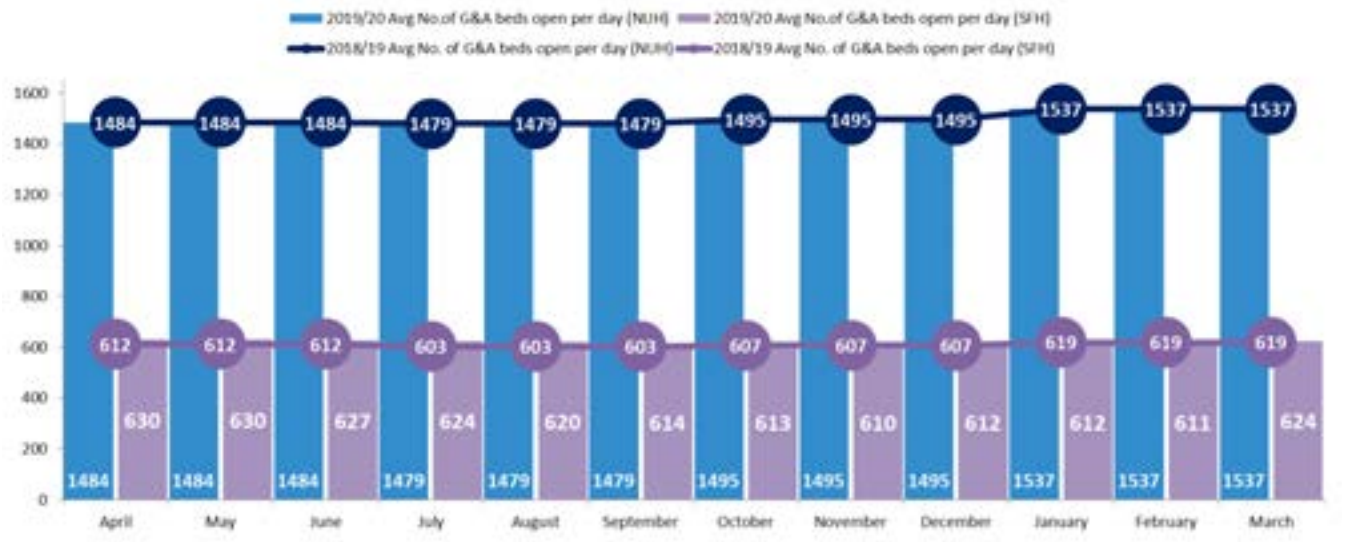
In developing the 2019/20 system operational plan, the system has identified the key capacity gaps and pressures as follows:

- Acute: bed capacity (Greater Nottingham), outpatients, theatres, diagnostics and critical care
- Community: ensuring appropriate utilisation of capacity in the community (NEL pathway)
- Mental Health: appropriate capacity for Out of Area patients and review of waiting lists

The system continues to develop plans to address the key capacity gaps and pressures, taking into account other constraints i.e. workforce, physical capacity (estate) and financial sustainability. The actions being taken are:

- Service and pathway transformation (impact on admission growth projections and bed utilisation through reduced LOS)
- Outpatient transformation – developing virtual hospital model
- Escalation capacity (internally provided and commissioned)
- Review of options for additional capacity in specific areas

Average number of G&A beds open per day (Total Provider NUH & SFH): 2019/20 Plan vs 2018/19



3.2 Winter Plan

Initial assessments of demand and profiling of elective and non-elective activity, including winter and seasonal variation, has been included in the planned phasing submitted.

		TOTAL NOTTINGHAMSHIRE CCGS ACTIVITY PHASING												
		2019/20 Activity Plan Proposal												
		7.9%	8.3%	7.9%	9.1%	8.3%	8.3%	9.1%	8.3%	7.9%	8.7%	7.9%	8.7%	Working Days
		8.2%	8.5%	8.2%	8.5%	8.5%	8.2%	8.5%	8.2%	8.5%	8.5%	7.9%	8.5%	Calendar Days
Code	Activity Line	April	May	June	July	August	September	October	November	December	January	February	March	2019/20 Total
E.M.7	Total Referrals (General and Acute)	7.9%	8.4%	7.9%	9.1%	8.2%	8.2%	9.1%	8.2%	7.8%	8.6%	7.8%	8.7%	**275,564**
E.M.8+9	Total Consultant Led Outpatient Attendances	8.4%	8.6%	8.1%	9.2%	8.0%	8.2%	9.0%	8.2%	7.4%	8.6%	7.7%	8.6%	**860,020**
E.M.10	Total Elective Admissions	8.0%	8.6%	8.3%	9.0%	8.1%	8.1%	9.2%	8.5%	7.3%	8.2%	7.9%	8.8%	**140,861**
E.M.11	Total Non-Elective Admissions	8.0%	8.2%	8.3%	8.3%	8.0%	8.2%	8.4%	8.3%	8.7%	8.7%	8.0%	8.9%	**124,575**
E.M.12	Total A&E Attendances excluding Planned Follow Ups	8.2%	8.4%	8.5%	8.6%	8.3%	8.1%	8.5%	8.3%	8.3%	8.2%	7.8%	8.7%	**397,748**

		TOTAL NOTTINGHAMSHIRE PROVIDER ACTIVITY PHASING												
		2019/20 Activity Plan Proposal												
		7.9%	8.3%	7.9%	9.1%	8.3%	8.3%	9.1%	8.3%	7.9%	8.7%	7.5%	8.7%	Working Days
		8.2%	8.5%	8.2%	8.5%	8.5%	8.2%	8.5%	8.2%	8.5%	8.5%	7.7%	8.5%	Calendar Days
Code	Activity Line	April	May	June	July	August	September	October	November	December	January	February	March	2019/20 Total
E.M.7	Total Referrals (General and Acute)	8.2%	8.7%	8.4%	8.8%	7.9%	7.9%	9.0%	8.5%	7.5%	8.4%	8.1%	8.6%	**261,861**
E.M.8+9	Total Consultant Led Outpatient Attendances	8.3%	8.8%	8.4%	8.8%	7.8%	7.8%	9.0%	8.6%	7.3%	8.4%	7.9%	8.8%	**981,996**
E.M.10	Total Elective Admissions	8.1%	8.7%	8.5%	9.0%	8.2%	8.0%	9.1%	8.5%	7.3%	8.1%	7.8%	8.8%	**155,471**
E.M.11	Total Non-Elective Admissions	8.0%	8.5%	8.3%	8.4%	8.2%	8.1%	8.6%	8.4%	8.3%	8.7%	7.9%	8.7%	**150,489**
E.M.12	Total A&E Attendances excluding Planned Follow Ups	8.1%	8.5%	8.4%	8.6%	8.2%	8.1%	8.6%	8.6%	8.3%	8.3%	7.9%	8.5%	**365,150**

3.4 Management of in-year demand fluctuations

The system will review the key activity metrics included in the system dashboards (total system and place) as the 2019/20 operational plan is developed.

An ICS Performance Oversight Group is in place to review monthly performance dashboards and escalate issues as required to the ICS Board.

3.3 Alignment of plans

As outlined in section 3.1 above, the ICS has implemented a system wide approach to activity and capacity planning (including providers and commissioners).

The ICS Planning Group has reviewed the planning assumptions at a granular level to ensure that we have a fully aligned activity plan.

4. WORKFORCE

4.1 Workforce plan and assumptions

Workforce is an essential element of a sustainable system plan and underpins successful operational delivery and transformational programmes. ICS Workforce & OD work stream is in place and is working with all partner organisations to develop a fully aligned long-term People and Culture Strategy supported by a two-year delivery plan (2019/21).

The Local Workforce Action Board (LWAB) is co-chaired by a system CEO and HEE Local Director and is supported by a robust governance structure with representation from clinical and other senior colleagues with interest and expertise in workforce development, education and organisational development.

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

4.2 Identification of workforce gaps and plans to address them

Workforce is a key challenge to the delivery of the system plan. Our People and Culture Strategy sets out our plans to understand the causes of our particular challenges and to take collaborative action to address them through five key priority areas:

1. Planning, Attracting and Recruiting our future workforce
2. Retaining staff and trainees, promoting career paths and talent management
3. Role redesign and development of new roles
4. Preparing and supporting people to work in new ways, including digital skills development
5. Enabling cultural change and leadership development to maximise system effectiveness

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

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

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

The table below outlines the key workforce gaps and plans to address them:

Issue	Gap	Plans to Address
Registered Nursing Workforce: - high number of vacancies - shortage of supply locally (and nationally) - reduced supply/applicants (changes to training/bursaries) - differential impact e.g. higher impact in Mental Health and Learning disabilities - Ageing workforce We recognise that the experiences of our students and trainees have an impact both on the quality of their learning and skills development and on their decision whether to apply to work in Nottinghamshire. We have a good track record in attracting registered nurses and AHPs to work locally following graduation, however the current supply is not sufficient to meet our needs. Employers are competing for a reduced supply of registered nurses and midwives. They can readily move if we do not offer career development, preceptorship and post registration education opportunities.	Agency spend peaked for this staff group in May 2018 at **£682,379.01** with a total spend between April and September 2018 of **£3.7m**. Turnover is high at 11.14% as is voluntary turnover at **8.14%.** Vacancy rates are also extremely high **18.92%** which equates to a vacancy figure of **1,412** FTE. Absence rates are also higher than the ICS especially within the Core nursing workforce. Even though demand is increasing and there is more workforce required across the system commissions have reduced from Autumn 16 **(1345)** to Autumn 17 **(1279)** across the East Midlands.	**Nursing Associate Role:** Co-ordinated, system-wide approach to development & roll out of Nursing Associate role (250 in training across the patch) **Nursing Associate Programme:** In place to build support workforce and future supply into registered roles. **Legacy Mentor:** Project to retain experienced nurses by enabling them to service improvement project, develop new skills and pass on skills to younger members of the team **International Recruitment:** International recruitment of nurses is being explored by providers. **Established Learning & Development Partnership:** To co-ordinate our approach to innovative models of education & training and maximising the effective use of our education funding. **New partnership with Nottingham Trent University:** To develop bespoke programmes, increase capacity and develop work based learning. **New approaches to recruitment:** Through assessment centre models and building brand through recruitment campaigns **Adopting Employer of Choice models and BAME initiatives** **Magnet Hospital at NUH** **NHSI Retention Action Plans in place** **Schemes in place to support EU staff to remain in employment locally**
GPFV workforce expansion trajectories: Nottinghamshire requirement to deliver 77 WTE additional GP capacity, together with additional other staff types by 2020: Clinical Pharmacists, Physician Associates, Practice Nursing, IAPT workers		**Retention Schemes**: Including Fellowships, Portfolio Careers, Transition Support, Mentoring & Careers Support and International Recruitment. **Targeted Enhanced Recruitment Incentives.** **General Practice Nursing 10 Point Plan** **Training Hub**: Infrastructure and support to networks of practices to offer clinical placements and deliver education & training

Issue	Gap	Plans to Address
Psychiatry medical vacancies and ageing workforce coupled with lower future supply through training programme		Clinical Information Assistant role. Potential for Physician Assistant in MH. Advanced Clinical Practice Development
MHFV workforce expansion trajectories: **CYP** – expansion plans show an overall growth within eating disorders and CYP access, these plans are being discussed and funding will be agreed once the staffing model has been confirmed.	Projected 29.9 wtes increase (with 28.8 within nursing).	Development of **revised services models and reviewing new roles** (including trainee nurse associates and PSW's).
Perinatal – plans to meet the expansion targets show that there need to be a growth of around 11 wtes	Projected 11 wtes increase (with 5.0 within nursing).	Development of **revised services models and reviewing new roles** (including trainee nurse associates and PSW's).
IAPT – expand qualified IAPT practitioners by 66 wtes to meet 2020/21 expectations. *Data shows that over previous cohorts 30% of trainees are within Notts Healthcare, which gives approx. 52 wtes available; these do not include the recruitment to current vacancies.*	Projected 66 wtes increase to meet the target, estimates show approx. 52 supply plus turnover losses	Development of **PWP roles** to support the increased access targets, **introduction of band 5-6 accelerated programme** and discussion of HIT/PWP funded posts with HEE.
Crisis – plans shows an increase of 35.4 wtes, including 23.2 wtes new roles, 12.2 wtes from current staffing in other teams.	Projected 23.2 wtes increase (with 19.3 within nursing).	Development of **revised services models and reviewing new roles** (including trainee nurse associates and PSW's).
EIP - plans to meet the expansion targets show that there need to be a growth of around 28.3 wtes	Projected 28.3 wtes increase (with 6.7 wtes within nursing).	Development of **revised services models and reviewing new roles** (including trainee nurse associates and PSW's).
Better Births workforce implications: Increased requirements for registered midwives and maternity support workers to deliver BB ambitions of continuity of carer, increased home births	Agency spend peaked at £65,499 during July 2018 for this work stream (data excludes NUH Agency Spend). Vacancy rates are much lower than average for the Better Births work stream at 8.41%. Voluntary turnover is also lower than other sub work streams at 5.16%.	Developing **workforce modelling approach** to test out a range of scenarios that will support the development of a workforce plan. Developing proposal to take co-ordinated approach to **Maternity Support Worker** development based on success of **Trainee Nursing Associate project.**

Issue	Gap	Plans to Address
Medical Staff: Particular difficulties in filling our training places in Psychiatry, Paediatrics and Emergency Medicine where there are already vacancies in SAS and consultant roles. Shortages in Healthcare of Older People, Stroke, Radiology, Oncology and Radiology Outsourcing of simple planned procedures to other providers in specialities such as Gynaecology has led to a loss of medical training capacity locally that will impact on the future supply of consultants if we do not take mitigating action.		**Medical Workforce Group** established to develop bespoke solutions working with HEE. **Piloting Medical Team Administrator** roles across all settings to release clinical capacity. Development of **Advanced Clinical Practice skills and upskilling** in urgent care through the Urgent & Emergency Care Partnership to roll out national Blueprint. Potential to introduce **Physician Associate roles** as part of medical team. **R&R financially based incentives.** **Joint appointments.** **Grow our own consultants through the CESR route.** Creating attractive **Clinical Fellowship schemes** leading to recognised training scheme appointments.
Healthcare Scientists	HCS reflects 5% of the workforce, but supporting 80% of diagnostic decisions Increasing demand on services affects ability to offer training places. Challenges to maintaining quality management systems for certified and accredited services.	The **Scientist Training Programme (STP)** is well subscribed to, resulting in high calibre trainees (Number of STP training places are insufficient for the national need). Degree level apprenticeships for **Practitioner Training Programme (PTP)** are growing. **Opportunities to strengthen Clinical Academic Careers for HCS.** **Successful overseas recruitment in Nuclear Medicine and Radiotherapy Physics**.
Social Care/residential care Local Authorities have seen significant reductions in their budgets since 2010 alongside demographic changes which have led to a large increase in demand for social care services. A workforce intelligence data report was published by Skills for Care in June 2018, assessing vacancy rates for the whole of Adult social care across all sectors, including not for profit, private, public and people employed as well as personal assistants.	9% vacancy rate = 2000 posts	To support the sustainable delivery of services authorities have **set out to change existing relationships and the expectations of partners and the public by focusing on outcomes that promote independence, fairness and value for money** in line with system-wide ambitions. **Development of Ambassador network and co-ordination across health and social care** to attract young people into careers in the sector. Roll out of **Holistic Worker competences** to upskill and improve job satisfaction and patient/citizen experience

Issue	Gap	Plans to Address
The report estimated that the turnover rate in Nottinghamshire was 30.1%, which was slightly lower than the East Midlands average of 33.1% and similar to England at 30.70%.		
Independent Sector Our independent sector partners in nursing, residential settings and home care providers have traditionally found it difficult to recruit and retain people with the right skills and values and this is exacerbated when the statutory sector has shortages of care staff and is competing for the same cohort of people. We are reliant on having a resilient and well skilled independent sector with the capacity to enable effective discharge to the most appropriate setting or home environment.		Working with **Optimum Workforce Leadership to support investment in workforce development in independent sector nursing and care homes**. Supporting development of **Advanced Clinical Practice** in the sector Engagement of the sector in the **Holistic worker competence programme** improves job satisfaction, outcomes and upskills the sector Inclusion of independent sector partners in the **Notts Talent Academy initiative**
Population skills levels Nottinghamshire has a lower educational attainment standard from our schools and a generally low skill, low wage economy. We have a key role in working with our partners across education and the Local Enterprise Partnership to raise attainment and aspiration levels to support young people and other less represented groups in our population to access and succeed in career opportunities in our health and care system.		We will be prioritising **the further development of our Talent Academy** approach to take this forward during 2019/20 that will include working with schools and disadvantaged groups in the population to equip them to take up employment.
Agency Usage Our current difficulties in recruiting to registered nursing and consultant medical vacancies in key specialties has led to system wide reliance on using expensive agency staff and a number of providers are not meeting the NHSE standard for a cap on agency spend. High usage of short term agency staff also increases the potential clinical risk for patients where there are vacancies in these nursing and medical roles i.e. not just a financial risk.		Our HR & OD Collaborative has prioritised this as an area for collaborative action and is currently scoping the opportunities to include: • **Collaborative bank models** & building supply of bank staff • Increasing **joint appointments** with partners • **Talent Management & Succession Planning** together with longer term workforce planning to attract substantive appointments • **Wellbeing and attendance policies** to reduce absence levels
Learning & Development The current financial constraints in the system impact on our ability to support		We will need to develop new models of training delivery through work-based and competence assessment routes to ensure

Issue	Gap	Plans to Address
our people to develop the enhanced skills and knowledge they need to work to the top of their licence or to improve the way they deliver care. Year on year reductions in traditional funding routes to support continuing professional development of existing staff are impacting on our ability to offer development opportunities and therefore retain our experienced staff.		we optimise our education resources and ensure we deliver quality education. There are opportunities to **work with ICS partners to develop system wide education models and optimise use of our skilled people to deliver training.** **Working in partnership with D2N2** to explore additional opportunities to access education & training support and potential ESF bid **Leadership development programmes** internally and through EMLA
Apprentice Levy There is a significant and current workforce challenge across Nottinghamshire providers in relation to the apprentice levy. Whilst the levy does offer opportunities, it causes different financial challenges for organisations (particularly smaller and private sector employers i.e. GPs and Care Homes). Larger organisations are also finding it difficult to support the financial demands of apprenticeships as they are supported in practice and salary backfill is not included. Therefore one of the biggest workforce challenges is identifying how we can support apprentices, for example training nursing associates, degree nurse apprentices, when there is an expectation that the employer carries the cost of the salary and supernumerary time working.		**System wide Apprenticeship Group** in place to scope issues and develop action plan to optimise utilisation of the levy and maximise apprenticeship routes into careers.

4.3 Alignment of plans

The LWAB and ICS workforce team are working with the ICS Technical Planning Group to ensure that workforce information and future planning is aligned with finance and activity plans.

The Workforce work stream has engaged with Programme Directors across the delivery boards of the main ICS programmes to offer expertise to support understanding of workforce implications of transformation plans and resources to support delivery. This has led to continued development in 2018-19 of the infrastructure to support training and development, new ways of working and testing new roles in order to bridge skills shortages.

The HR & OD collaborative will also bring together the shorter term workforce plans for each organisation with a particular focus on common risks and skill shortages to ensure we have plans in place to meet these challenges. This will include work on collaborative bank models where appropriate, flexible employment models and work on alternative roles to improve the skill mix for

the longer term. This work along with the whole system workforce modelling focusing on determining the skills required to support population need and place based care now needs to be put into practice to enable the change in the STP/ICS programmes and ensure delivery of the priorities.

We have established strategic professional lead groups working across the ICS to develop shared approaches and strategies for workforce recruitment and retention. These include the Nottinghamshire Nursing & Midwifery Cabinet, Allied Health Professional Cabinet, Medical Workforce Group and Pharmacy Medicines Optimisation Group that includes a focus on workforce issues.

5. FINANCIAL POSITION

The ICS is facing significant financial pressures across health and the financial plan is a year-end deficit of £69.6 million (before MRET, PSF and FRF) for 2019/20. NUH has not accepted organisational control total due to a technical issue with MRET. This has led to the year-end deficit being £1.9 million higher than the notified system control total of £67.7 million. NUH have raised the issue directly with NHSE/I and await a response.

The system can access conditional funding of £57.4 million (PSF, FRF and MRET) if it agrees and delivers the plan. Of this, £27 million relates to NUH and is dependent on the outcome of the MRET issue above.

The ICS is committed to collectively managing the resources of the system and has continued to develop and embed a system planning approach for the 2019/20 operational plan and five-year system plan (2019/24)

5.1 Financial plan and assumptions

For 2019/20 the ICS has a "do nothing" financial gap of £147 million (5.3%). The net health resource for Nottingham & Nottinghamshire (funds coming into the system) in 2019/20 - is £2.6 billion with a forecast do-nothing spend of £2.8 billion of expenditure.

The table below outlines the "do nothing" challenge of the ICS:

DO NOTHING FINANCIAL PLANS 2019/20	Total ICS £Ms	M Notts ICP £Ms	G Nottm ICP £Ms	SFH £Ms	NHT £Ms	NUH £Ms	MN CCGs £Ms	GN CCGs £Ms
System Income	2,576.2	753.9	1,822.3	83.6	284.0	621.9	523.0	1,063.7
ICS: inter-organisational transactions	0.0	0.0	0.0	216.4	176.4	436.2	-299.3	-529.6
Total System Expenditure	-2,790.6	-840.8	-1,949.8	-354.3	-477.4	-1,124.0	-247.8	-587.0
Net Position - (Deficit) / Surplus:	-214.4	-87.0	-127.4	-54.3	-17.1	-65.9	-24.1	-53.0
	7.7%	10.3%	6.5%	15.3%	3.6%	5.9%	4.6%	5.0%
Control Total before MRET, SF and FRF - (Deficit) / Surplus	-67.7	-40.6	-27.0	-41.5	0.0	-27.0	0.9	0.0
DO NOTHING GAP TO CONTROL TOTAL BEFORE MRET, SF AND FRF	-146.8	-46.3	-100.4	-12.8	-17.1	-38.8	-25.0	-53.0
Do Nothing Gap /Income %	5.3%	5.5%	5.1%	3.6%	3.6%	3.8%	4.8%	5.0%

An ICS Technical Planning Group is in place to ensure that a consistent financial framework has been used across providers and commissioners.

Section 6 covers the development of Efficiency and Transformation Plans to address the financial gap.

5.2 Development of system financial framework

During 2018/19 the Nottingham and Nottinghamshire system:

- agreed the 50% partial incentive scheme for system control (total ICS)
- fully embedded system financial reporting, developing an ICS Board finance dashboard and highlight report
- implemented a system approach to financial governance, including escalation process.

The system recognises that we need to further develop the system financial framework for 2019/20 to support the system to address the current financial and operational pressures. A series of system-wide workshops, supported by the National Pricing Team, are being held to establish the approach for 2019/20. This includes exploring new approaches, including aligned incentive contracts.

The national ICS Financial Framework has been received by the ICS. As in 2018/19, the ICS Board will consider scenarios and agree the position for Nottingham & Nottinghamshire ICS. The ICS will respond as to whether it will participate in the ICS Financial Framework by 26th April 2019.

5.3 Alignment of plans and contracts

In pulling the system financial plan together the ICS has developed a robust process of plan and contract alignment between organisations. This is based on the joint development of plans between organisations to ensure that there is clear clinical leadership and commitment to the plans, with a system approach to quality assurance, cost impact assessment and review for replicability across the wider system where appropriate.

The contract alignment process is overseen by the ICS Finance Directors Group and contained a number of checkpoints throughout the planning cycle, including submitting returns in line with the national time and a weekly contract tracker. Issues are escalated to the Financial Sustainability Group as required.

Current position:

		11th April National			
		Do Nothing £000s	Do Something £000s	Total £000s	%
Sherwood Forest	MN CCGs	0	0	0	0.0%
	GN CCGs	0	0	0	0.0%
	Spec Comm	0	0	0	0.0%
Total Sherwood Forest		0	0	0	0.0%
NUH	MN CCGs	0	0	0	0.0%
	GN CCGs	0	0	0	0.0%
	Spec Comm	0	0	0	0.0%
	NHSE DCO	0	0	0	0.0%
Total NUH		0	0	0	0.0%
NHT	MN CCGs	0	0	0	0.0%
	GN CCGs	0	0	0	0.0%
	Spec Comm	-11	0	-11	0.0%
	NHSE DCO	0	0	0	0.0%
Total NHT		-11	0	-11	0.0%
EMAS	MN CCGs	-708	0	-708	6.4%
	GN CCGs	-1,093	0	-1,093	7.4%
Total EMAS		-1,801	0	-1,801	7.6%
Overall Contract Variance		**-1,812**	**0**	**-1,812**	**-0.1%**

The contract between East Midlands commissioners and EMAS remains outstanding with an estimated contract gap of £1.8 million (Nottinghamshire only). The national dispute policy is being followed (currently at mediation stage).

5.4 Key risks to delivery of System Control Total

The system is facing a challenging financial position in 2018/19, with a forecast adverse variance against the system control total of £18.9 million. The key financial pressures in 2018/19 are activity/demand (including winter), premium pay costs and non-delivery of savings & efficiency programmes. This has resulted in an exit underlying deficit of £141 million.

The underlying recurrent financial position means that the challenging system financial position continues into 2019/20; with 5.3% do nothing financial gap (after adjusting for system control total and before MRET, provider sustainability funding and financial recovery fund).

The draft financial plan is forecasting a financial deficit of £69.6 million (before provider sustainability funding, MRET and financial recovery fund), this is £1.9 million higher than the notified system control total of £67.7 million in year deficit. The adverse variance to control total is due to a technical issue with MRET at NUH. This has been raised directly with NHSE/I by NUH who await a response.

The ICS has a savings and efficiency challenge of £146.8m (5.3%) in 2019/20. At the point of submission (4th April) plans totalling £120m have been put in place.

Organisations continue to develop and strengthen transformational plans. Existing schemes are being rapidly developed to implementation stage and further plans are being identified to meet the financial challenge for 2019/20. Further review of pipeline schemes are underway. To support this approach external support has commissioned in CCGs and NUH.

The ICS has produced an opportunities pack to support the production of plans through workshops and facilitated discussions with ICPs/organisations. The opportunities pack now incorporates the Bronze Pack produced by NHSE. Transformational Plans have been mapped to the opportunities pack for 2019/20.

An ICS-led review of opportunities for Estates and Back Office functions is underway with plans to be developed by end of July.

5.5 Capital Investment

Investment in our estate is essential to maintaining operational services and increasing capacity in critical areas. In 2019/20 the ICS plans to invest £95.5m of capital funds rising to £436.5m over 5 years. Provider organisations are accessing mixed sources of investment to fund this, including internal cash resources, public dividend capital, external loans (to be approved) and STP Wave 4 capital (to be approved).

A list of the ICS' top 10 plans by value (totalling £61m) can be found in the table below. This shows a mixture of schemes aimed at increasing acute capacity to meet increasing demand and tackle operational performance and backlog maintenance/equipment replacement.

Capital Scheme	19/20 planned spend (£'000)
Emergency Pathway Improvement - STP Wave 4	10,669
NUH Ward Renewal Project- Phase 1	10,654
IT & Communications infrastructure and upgrades	6,498
Service Dev - Interoperative MRI scanner	5,580
Backlog & Stat Forensic	5,557
Misc Minor Schemes inc alts and upgrades	5,269
QMC - New ward to address capacity gap	5,151
Medical Equipment - Minor Medical Equipment Replacement	4,247
Estates - Infrastructure (various)	4,008
National Rehabilitation Centre - Business Case Development	3,550

Despite the investment above, lack of capital resource remains a key risk to the ICS. 2019/20 plans focus on maximising utilisation of high quality, long-term estate to enable the release of poorer quality estate.

6. EFFICIENCY AND TRANSFORMATION

To deliver the cost reduction challenge of 5.6% across the system, the ICS has put in place processes to develop a plan that will deliver schemes at the following levels:

- **Individual organisations** - have developed internal business as usual efficiency plans as per normal practices
- **Place (ICP)** – ICPs have worked together to develop and implement further schemes that will impact on both commissioners and providers providing an overall reduction in cost.

Processes are in place to risk-assess and share schemes across the system. This provides full oversight and provides the opportunity for replication where appropriate (within a consistent framework) and an understanding of ICP and organisational impact.

A number of pipeline schemes are also in development, which will be used as contingency and mitigation over and above schemes developed at plan stage.

The ICS Planning Group continues to monitor the overall Efficiency & Transformation Plan, including risk assessment, as plans are finalised for submission on the 11th April and to establish 2019/20 reporting. The ICS Board receives monthly updates.

6.1 Key system-wide efficiencies

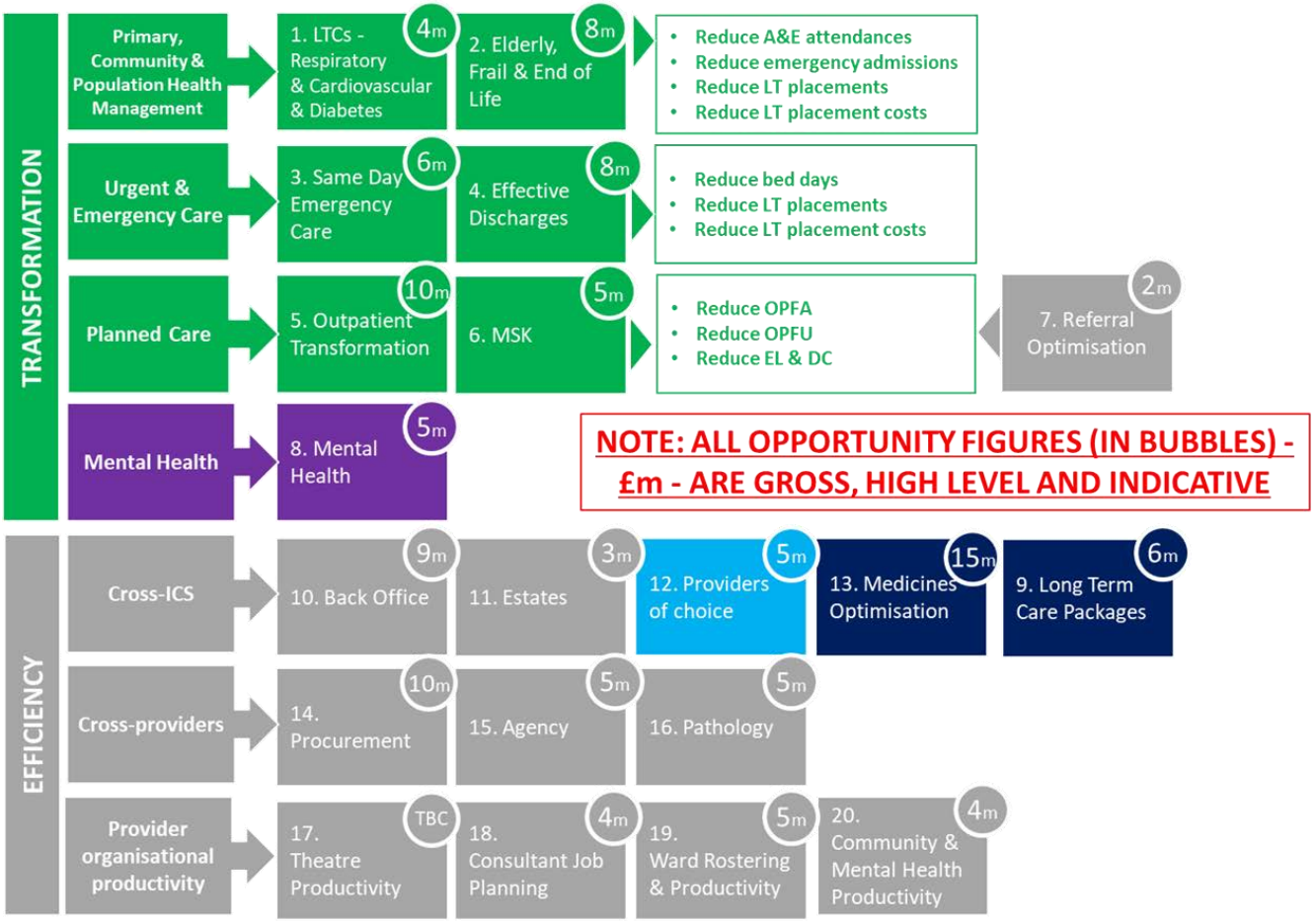
The table below outlines the latest health system position on savings and efficiency programmes, compared to the financial "do nothing" gap of £147 million:

Latest Plan (QIPP/CIP/FEP)	SFH	NHT	NUH	MN CCGs	GN CCGs	System Total
Red	4.2	2.8	1.9	0.9	5.8	15.6
Amber	8.2	5.4	6.7	6.5	8.6	35.5
Green	0.4	5.4	9.5	17.6	36.0	68.9
Total Schemes	**12.8**	**13.6**	**18.1**	**25.0**	**50.5**	**120.0**
Remaining Unidentified Gap	0.0	3.5	18.9	0.0	2.5	24.9
Control Total Not Accepted	0.0	0.0	1.9	0.0	0.0	1.9
Total Savings Target (£Ms)	12.8	17.1	38.8	25.0	53.0	146.8
Total Savings Target (%)	3.6%	3.6%	3.8%	4.8%	5.0%	5.3%

Risk Adjusted Delivery (£Ms)	**5.5**	**7.8**	**16.3**	**21.0**	**40.1**	**90.7**
Risk Adjusted Delivery (%)	**42.7%**	**45.8%**	**42.0%**	**83.9%**	**75.7%**	**61.8%**

The ICS has developed an Opportunities Pack to support 2019/20 operational planning and the development of the five-year plan. This pack consolidates our local position on RightCare, Model Hospital, GIRFT and Whole Systems Opportunity Analysis (WSOA) Bronze Pack and identifies opportunities for 2019/21:

ICPs are continuing to review the opportunities pack to develop further schemes to address the remaining unidentified gap.
The areas of focus of value and efficiency plans for 2019/20 will be based on the 20 high level themes identified in the ICS Opportunities Pack:



6.2 Alignment of system-wide efficiencies for 2019/20 with long-term transformation priorities

The development of the operational plan for 2019/20 (year one) is closely aligned to the five-year plan. The ICS Planning Group has oversight and assurance for both the short-term and long-term pan, ensuring alignment across both.

6.3 Impact of efficiencies on quality of care

Joint Equality and Quality Impact Assessments (provider and commissioner) are to be undertaken in order to understand the impact of operational plans outside of organisational silos appreciating the issues and risks that arise.

ICPs are to build upon the EQIA process adopted by the Mid Nottinghamshire Alliance which provides a clear two stage process. Plans will be assessed in relation to the impact on patients or quality (QIA) and the impact on groups with protected characteristics (EIA). Where this is an impact on individuals, patients, or protected groups a full assessment will be completed and recommendations will be made to the ICP. An ICS EQIA Review Group has been established and senior quality leads across the ICS will jointly review and monitor the EIA & QIA process making recommendations to the ICP whilst reporting to the ICS Planning Group on impacts at a system level.

People are encouraged to be partners in their own care and can expect to experience improvements. Our focus will be to work as a system to see measurable improvements in the key care and quality indicators. Success will be assurance that services will be further improved based on what people tell us about their perceptions and personal experience of care, building upon the values of the people working across the health and care sector and their commitment to providing the best possible care and advice. We will ensure that quality is prioritised and that outcomes are monitored, managed, challenged, and reported across the system. The ICS is strengthening its structures with the introduction of both a Chief Nurse and Medical Director at the ICS Partnership Board. Both roles will provide system leadership for quality improvement.

System quality improvement plans aligned to ICS priorities and ambitions are outlined within Annex A. Organisations within the ICS are successfully adopting quality improvement methodology. The ICS intends to build upon this work to create a learning culture and system-wide approach to quality, service improvement, and redesign.

ANNEXES

ANNEX A - Achievement of Operational Planning Guidance Priorities and Deliverables

Section 1 - Urgent & Emergency Care (Mid Notts)

Why this is important

The mid Nottinghamshire system benefits from a high performing and resilient urgent care system, with the Sherwood Forest Hospitals NHS Foundation Trust achieving the A&E 95% standard consistently. This has been supported in recent years by the introduction of a number of innovative new care models through the Mid Nottinghamshire Better Together Programme and as a NHS England Vanguard.

Levels of urgent care activity increased significantly between 2015/16 and 2016/17. This trend reversed in 2017/18; however, year to date activity in 2018/19 is significantly higher than the same period in 2017/18. The extended flu season and heatwave in 2018/19 are understood to have contributed to this. It is not operationally or financially sustainable to continue with this level of demand on the urgent care system.

The mid Nottinghamshire system also needs to ensure it is meeting the national standards and specifications for an integrated urgent care pathway.

The intent of the Urgent Care programme in 2019/20 is to maximise the investment, productivity and clinical effectiveness of urgent care services through the process of redesign and re-specification of existing resources to create a more integrated urgent care system that responds quickly to the publics needs and reduces demand on emergency services.

Our ambition

To ensure patients access the most appropriate services to meet their health and care needs including self-care, primary care and community services. A&E will be for emergencies only.

Primary Care will lead proactive identification and care planning for patients at risk of admission to hospital for example the frail and those living with long term conditions.

There will be integration of resources currently spanning secondary and community services which will result in an integrated rapid response service. This service will provide a single point of access (SPA) as well as community and A&E based rapid assessment for patients at immediate risk of acute admission with interventions including intensive home based care and / or step up community bed based care. This service will also proactively manage discharges into the Home First integrated discharge pathways delivering a discharge to assess approach.

There will be a single provider for community beds with access for 'step up' and 'step down' through a SPA. Community beds will be ANP led with GP medical cover provided. 'Step up' community beds will be based at Fernwood, Oakham and Lindhurst wards. Community bed based intensive support will be provided for 14 days with a further 14 days of home based care as required. Pathways for non-weight bearing patients and CHC cohorts will also be commissioned.

Implementation of the nationally mandated Integrated Urgent Care (IUC) pathway will occur across Nottinghamshire, aiming to provide care closer to people's homes and help tackle the rising pressures on all urgent care services (primary and secondary). This will be delivered by procuring a clinical assessment service available to 111 to ensure patients are directed to the right service first time. This model will also support EMAS to hear and treat, see and treat and reduce conveyance rates to SFHFT.

Our approach

Transformation of the end to end Urgent Care Pathway by October 2019 incorporating:

- A new integrated rapid response service specification with the aim to deliver a two hour community based urgent care service to prevent admission and facilitate discharge.
- More prevention, self-care and proactive care and crisis planning particularly for the frail, elderly and those living with long term conditions.
- Enhanced urgent access into general practice (primary care at scale optimisation) and further development of the Acute Home Visiting Service.
- Re-specification of A&E front door triage and streaming to facilitate discharge including signposting and direct booking into Primary Care appointments.
- Implementation of the Urgent Treatment Centre model as per the national specification at PC24 and Newark.
- Procurement of a clinical assessment service (CAS) to provide additional clinical assessment of 111 calls, supporting delivery of a safe reduction in ambulance conveyance to A&E.

Enhanced Community Services access and provision including:

- A new integrated rapid response service specification with the aim to deliver a two hour community based urgent care service to prevent admission and facilitate discharge.
- Re-specification of the community bed base to ensure an ANP led model that incorporates the HFID pathways.

Focus in 2018/19

- Ensuring that effective risk stratification was completed across Primary Care, with a particular focus on identifying those with moderate and severe frailty
- Providing an enhanced care homes service to the homes who have the most non elective admissions to hospital
- Increasing the number of ambulatory care pathways available at PC24
- Ensuring intensive home support services available in the community are provided across all of mid Notts
- Integrating clinical navigation and intensive home support services
- Holding MDTs for those individuals who are high intensity users of services to create care plans to reduce dependency
- Commissioning and mobilising an integrated EOL service
- To increase activity through the ambulatory care unit at SFHFT
- To reduce EMAS conveyance rates to A&E
- To re-specify a number of community services

Focus in 2019/20

- Ensuring that MDTs across Primary Care are proactively reviewing those most at risk of admission (including the frail and those with long term conditions) with support from newly appointed navigators
- Providing training to care home staff so that they can proactively manage residents before they deteriorate (significant 7 project)
- Re-specifying the services provided at PC24 and Newark UCC in line with the national UTC specification
- Commissioning an integrated rapid response service across mid Notts to proactively prevent admission to and facilitate discharge from hospital
- To expand the role of the HVSU post to include a focus on alcohol dependency
- To commission a clinical assessment service to support 111 and ensure patients receive the right care first time, reducing activity at A&E
- Re-specifying community bed provision to support the HFID workstream and reduce length of stay at SFHFT
- To ensure that community services specifications are aligned across mid Notts and greater Notts

Planned impact of changes

Outcome area	Metrics	Baseline	2019/20
Clinical outcomes	Attendances at A&E Admissions to A&E EMAS conveyances to A&E		3% reduction
Patient experience			
Safety/Quality	DTOCs LOS	4.7%	3.5% 40% reduction
Resource sustainability	QIPP savings		

Section 1 - Urgent Care (GN)

Why this is important

2018/19 continued to be a challenging year for urgent care in Greater Nottingham and emergency care access has not achieved the level required.

However, work in 2018/19 has shown progress in a number of areas including additional acute and community capacity, admission avoidance programmes, improving hospital processes, reducing acute length of stay and improving discharge processes and transfers of care.

Despite the significant work undertaken, the collective impact of all the schemes has not addressed the volume and need from the population. Main areas of concern were extended waits for A&E care and hospital admission and the cancellation of elective operations.

Robust activity, demand and capacity planning for 19/20 clearly shows the anticipate volume of demand from our population requires whole pathway and system reform to respond to the existing and growing need from an ageing population, including high levels of complex and diverse needs.

Our ambition

Deliver urgent care system change committed to improving A&E performance to meet the national requirements. respond to the existing and growing need from our population

- integrated planning for community, primary and acute response to urgent care need across work streams and organisations
- ensure patients get the care they need fast and in most appropriate setting; improve waits for A&E and hospital admission
- Respond to capacity challenge on acute beds by delivering key projects to improve the pathways
- Focus on workforce solutions with a whole system approach

A cross-system A&E Delivery Board has matured and functions as a truly multi-organisation assurance and leadership team. The 19/20 approach to operational planning includes discussing the activity modelling and challenge not just between GN CCP and NUH, but across local authority and community providers. We will build on the current cross-system collective focus to prioritise and deliver key change.

Respond to the ICS System Efficiencies work stream assessment of national and local benchmarking tools that identified the need to focus on the following non-elective areas:

- Same day emergency care
- Long-term conditions
- Elderly, frail & end of life

Our approach

Initiatives	Interventions (deliverables)
System-wide leadership	A&E delivery board with cross-organisational representation to take the lead on delivery and assurance of initiatives and changes to the system
	Coordination of initiatives and response aligned to system flow- pre-hospital, length of stay and discharge
	Combined provider and commissioner leadership across work streams based on expertise and need
Admission avoidance and pre-hospital	Planned Integrated Urgent Care (IUC) procurement planned to deliver key outcomes
	Comprehensive model of same day urgent care across the acute and community pathways
	Ensure joined up and appropriate 111 response and enable direct booking to services to meet the needs of individual patients
Improvements to length of stay and acute flow	Continued improvement to NUH front door pathway to ensure appropriate response to minor and major urgent presentations
	Improve discharge planning to minimise delays when patients are ready to leave hospital

	Deliver joint GNCCP and NUH incentive scheme with focus on frailty and respiratory same day ambulatory care
Improved discharge pathways	Ensure patients who are ready to leave hospital are enabled to do so
	Develop social care reablement and homecare provision to ensure capacity
	Ensure integrated discharge function is embedded and resourced across all system partners
	Improve the efficiency and usage of community beds
Contingency planning to meet the forecast shortfall in acute bed capacity	Develop options for provision of additional acute bed capacity in the event of insufficient system redesign being delivered in year.

Focus in 2018/19

- Establishment of A&E delivery board to provide assurance point oversee the implementation of recovery plans, ensuring the following:
- Proactive care based on risk stratification of population
- Responsive care navigation
- Multi-disciplinary teams, based around community and Primary Care Hubs
- Intensive Recovery Model (step up/step down)
- Population access to urgent care services with 24/7 single front door services
- Full implementation of the Urgent Treatment Centre model

Focus in 2019/20

- Build on the 19/20 approach to operational planning, discussing the activity modelling and challenge not just between GN CCP and NUH, but across local authority and community providers
- Confirm a detailed system wide knowledge of pathways, flow and capacity across primary, community and acute care
- Through the leadership of the A&E Delivery Board, confirm system-wide agreement to the urgent and emergency care target operating model and pathways and robust joint planning around each of the changes and monitoring of the anticipated benefit. This should include the impact of proactive care initiatives to ensure a truly integrated approach to delivering against the capacity challenge.
- Address potential overlap and duplication in the focus of some of the pieces of work – especially in relation to the Same Day Emergency Ambulatory Care.
- A single ICS footprint approach for integrated urgent care, care navigation and respiratory including the procurement of a Clinical Assessment Service (CAS) and Urgent Treatment Centres (UTCs) in line with national guidance. The CAS will provide a 'consult and complete' model for patients calling 111, reducing onward referrals to other services including ambulances and A&E. It will also facilitate health and social care professionals to navigate the system. UTCs will provide face to face treatment for patients with minor injuries and illnesses. The service will be GP led and option at least 12 hours a day.

Coordination of initiatives and system change will be delivered through work plans aligned to the operational system flow:

a) Pre-hospital and admission avoidance

i) **Conveyance**: To reduce the number of patients conveyed to Type 1 and Type 2 ED by ambulance, by at least 2% against forecast plan by April 2020. 17/18 target was 1.5% and current achievement at December 18 is 2.4%. To achieve this, the Greater Nottingham system will;

- Increase use of community pathfinder (paramedic clinical navigation system) by 12% against 17/18 baseline by April 2020
- Increase the % of care home calls directed to a clinical advisor from 111 from 22% to 50% by April 2020
- Implement a non injured falls pathway by September 2020 to reduce ambulance dispatch to non-injured fallers (and therefore conveyance). In line with the Mid

Notts pathway outcomes, it is expected that 95% of referrals from EMAS will be managed though the non injured falls pathway.

- Roll out access to Service Finder (next generation Directory of Services) by April 2020 to EMAS clinical triage teams and paramedics to support clinical navigation of patients to the correct service and enable an alternative to ambulance dispatch.

ii) **Avoid unnecessary attendance**: To develop and improve pathways for managing patients that do not require an ED level response, including proactive response for At Risk groups and high volume service users. Activities include;

- Increasing the % of patients who are directly booked from the Integrated Urgent Care Service to in hours GPs from 5.59% to 25% by April 2020. Currently booking 304 of 5,442 potential patients who were identified by 111 as requiring a primary care response.
- Use of interoperability technology to implement a direct booking pathway from Integrated Urgent Care to primary care extended access hubs by April 2020.
- Maintain at least 70% of 111 low acuity ambulance dispatches receiving a clinical assessment prior to dispatch in line with national IUC KPIs (50% target) throughout 18/19
- Maintain at least 60% of all 111 calls receiving a clinical assessment in line with national IUC KPIs (50% target) throughout 18/19
- Maintain at least 70% diversion from integrated urgent care to an alternative service of those patients receiving clinical intervention for low acuity and ED pathway
- Implement a High Volume Services Users pathway in ED to reduce attends and same day/short stay admissions through implementing pathway improvements, with a focus on the following patient cohorts; frailty, mental health and alcohol by April 2020
- Expand the utilisation of the RESPECT tool for End of Life (EoL) patients the first phase will be a focus on respiratory to improve better outcomes for patients and enable them to die in their preferred place of death. Evidence shows that 80% of people would prefer to die at home rather than hospital (Evidence also shows that at EoL each patient will have 4 to 5 ED admissions). By expanding on RESPECT this will avoid inappropriate admissions.

iii) **Avoid unnecessary admission**: To develop and improve pathways for managing patients at risk of admission in the community with wrap around services for At Risk groups including end of life and respiratory Support the delivery of a comprehensive model of same day emergency care across acute and community pathways. Activities include;

- To achieve the national ambition of 30% of patients receiving Same Day Emergency care which will include all diagnostic tests, treatment and care that are required being delivered in a single day to avoid unnecessary overnight hospital stays
- Developing the frailty pathway to increase discharges from the front door to reduce admissions.
- Developing the pathway for patients with mental health to increase discharges from the front door to reduce admissions.
- Roll out of Call for Care. Review underway against existing specifications in order to develop a plan to finalise the approach The alignment of the NHT contracts across Mid and Greater Notts will offer a consistent approach, including a 7 day service 8am-10pm to support the hospital avoidance programme. Roll out will be in place for October 2019.
- Implement the Hospital to Home scheme in April 19 to reduce re-admissions associated with respiratory conditions (target of 20% reduction for COPD

patients)

b) **Length of stay and flow**

a) **Front Door pathways:** Continuous improvement work continues on the front door pathways which started in December 2018. Working with the front door teams to allow access to back door discharge to assess services.

b) **internal flow:** Focussed work on pathway redesign to reduce length of stay during the inpatient episode of care, and an excellence in discharge programme to minimise delays when patients are ready to leave hospital

c) **Incentive scheme:** This is a programme of work initiated through NUH: GN CCP contract discussions in 2018/19. Initial areas of focus in 2018/19 were pathway redesign across NUH and primary care in frailty and respiratory. The proposed main focus for 2019/20 is Same Day Emergency Ambulatory Care.

d) **Options to develop additional acute capacity:** in addition to the focus on redesign, work is also being undertaken to develop potential options for the provision of additional acute capacity in case insufficient alternative schemes can be identified to mitigate the current forecast gap in capacity vs expected demand in 2019/20.

c) Discharge Pathways

i) **Homecare Provision**: Develop social care reablement and homecare provision to ensure adequate capacity to meet current and projected system demand

- Develop Home First Strategy to provide adequate capacity and capability within the domiciliary home care market.
- Local Authority and Health group looking at how to increase home care capacity.
- Explore how to increase large care packages >27hrs/week & 4x a day double ups.
- Develop at home services as part of discharge to assess, with health, social care and domiciliary providers to increase pathway 1 discharges, such as the Lancashire Model.
- Work with acute staff and local authority to reduce over commissioning at discharge for packages of care and to reduce failed packages to ensure effective use of home care capacity

ii) **Integrated Discharge Function**: Build on the system IDT taking the steps to create an IDF across system partners that is resourced to meet system demand.

- Development of IDT to IDF increase capacity, activity, productivity and flow
- Identify recurrent funding for posts to secure longevity and sustainability within the team.
- Reduce delayed transfers of care and medically safe for discharge.
- Develop a 7 day service to ensure flow across the system and reduce peaks and troughs of variation
- Support the NUH excellence in discharge work to improve the transport flow, ensuring patients are ready for transfer, with medications and information required for discharge.
- Continue to support long length of stay meetings, working with divisional nurses to embed themes and learning to collectively reduce delays in transfer.
- Reduce CHC DST assessments to remain within the 15% undertaken in an acute setting.
- To reduce delayed transfers of care, to within the National target of <3.5% and increase National performance against other areas.
- Reduce the medically safe for transfer list to <100.

iii) **Community Beds**: Improving the efficiency and utilisation of community beds and planning for the increasing acuity of patients with more complex needs.

- Model community bed capacity to ensure capacity and level of capability to flexibly manage demand.
- Procure community bed service to commence April 2020.

- Develop a seamless process to reduce time of MSFD to transfer to community bed.
- Work with local authority colleagues to agree a community bed specification that is consistently used across stakeholders to ensure the principles of service offer, eg GP cover in hours/out of hours is provided and costed across the organisations.
- Work with the Healthcare Trust to embed D2A principles into mental health beds and review the offer for community beds for patients with a primary mental health need.
- Secure escalation framework for community beds with private provides to ensure increased capacity at times of extreme pressure.

Planned impact of changes

Outcome Area	Metrics	Baseline	2019/20
Clinical Outcomes	• A&E target	78.8% (YTD)	90% trajectory by August 19 agreed between NUH and NHSI
	• Establish ambulatory emergency care streams and clinical decision units to avoid unnecessary overnight stays.		To achieve the national ambition of 30%
	• Manage people assertively to avoid or reduce long lengths of stay in hospital to ensure we have fewer than 199 patients in hospital with a length of stay more than 20 days.	comparing month 1-6 in 2018/19 to the previous year, there has been a 42.8% reduction in excess bed days	Reduction admissions by a further 1.5% from Month 10
	• Reducing Unnecessary conveyance to Type 1 and Type 2 departments		To reduce the number of patients conveyed to Type 1 and Type 2 ED by ambulance, by at least 2% against forecast plan by April 2020.
	• Increasing clinical assessment to reduce attendances		Maintain at least 60% of all 111 calls receiving a

			clinical assessment in line with national IUC KPIs (50% target) throughout 18/19
	DTOC % of assessments for long term care within the acute	3.2% Jan 2019	Maintain under 3.5% Target to meet the National performance of <15%
Patient Experience	• Reduce waits for A&E care • Reduced length of stay especially for those [patients with a wait of over 20 days • Consistent care in relation to patient need • Discharge to preferred place	78.8% (YTD)	90% by August 19 Over 21 day LOS to below 200
Safety/Quality	• Reduce delays in emergency care, ED • Address workforce gaps including in ED services and across the system • Increase capacity in social care reablement and homecare provision • Integrated discharge function embedded across services in all system partners • Improve the acuity capability of community beds • Same day emergency ambulatory care whenever appropriate including for frailty and respiratory. Main cohort of patients in the H2H service will be a focus on COPD, with other respiratory conditions such as Asthma and Bronchiectasis		Improved patient experience and quality outcomes
Resource Sustainability	• Increase number of direct bookings through Integrated Urgent Care to in hours primary care • Address workforce gaps in ED • Deliver against training plan for identify areas of specialist training need • Deliver against training plan for system-wide skills need across health and social care • Deliver against training plan to increase capacity and efficiency in homefirst service • Increased utilisation of community beds from 85 % to 92 % occupancy. • Work with system partners to develop substantive and recurrently funded posts to ensure continuity of service.	5.59%	92%

Section 2 - Planned Care

Why this is important

The transformation of planned care services whilst maintaining constitutional standards is a core focus for the ICS to address a number of key challenges in planned care:

- Increased growth is outstripping existing capacity across many components of the pathway
- Different referral guidance is in place across NUH, Circle and SFT
- Benchmarking demonstrates performance is not in line with upper quartile performance in a number of specialties for new to follow-up ratios and DNAs.
- Clinicians identify that some patients attending clinics do not need to be seen in secondary care
- GPs value advice and guidance but models vary across specialties
- Care closer to home – patients spending time going back and forth for tests once seen by secondary care
- Numerous speciality specific pathways exist across STP footprint
- Requirement to achieve financial balance as a system
- NUH, Circle and SFHFT all have some pressured services failing RTT in elective orthopaedics, urology general surgery and ENT

Our ambition

Our ambition is that people get fast access to advice and support, self-management information, and, where needed, get to see the right health professional as quickly as possible. We want to ensure care is delivered in a responsive and person-centred manner, and, critically, as close to home as possible.

Our objectives are:

- Deliver a 33% reduction in face to face outpatient appointments
- Deliver consistency and standardisation across planned care pathways

Further opportunities being considered include specialty level transformation schemes, patient initiated follow ups, virtual clinics, one stop shops, specialist nurse led follow ups and shifting activity to alternative settings.

Our approach

Initiatives	Interventions (deliverables)	DM	E	MR	T	D
Managing Elective Activity	Full implementation of service restriction policy SRP using blueteq as the Prior Approval process	✓				
	Single consultant to consultant referrals policy across the ICS	✓				
	Consistent standardised referral guidelines	✓				
	ICS standard approach to advice and guidance specifications	✓				
Pathway and model of care redesign	Gynaecology - Implement a single model for a community service				✓	
	MSK - delivery of single model				✓	
	Ophthalmology - implementation of high impact changes				✓	
	Diabetes - develop model for foot care across the ICS; optimise take up of the NHS Diabetes prevention programme; improve performance in relation to the 8 care processes, ensure Diabetic Specialist nurse input is available in secondary care to improve recovery and to reduce lengths of stay and future re-admission rates				✓	
	Gastroenterology – develop model in line with transformation handbook and best practice				✓	
	Cardiology - More succinct referral triage process following appropriate workup in primary care and improved referral quality; specialist capacity focused on those patients that need it.				✓	
	ENT - more focused point of access to the ENT pathway; less centralised model				✓	
	Urology – development new standardised pathway					

Initiatives	Interventions (deliverables)	DM	E	MR	T	D
Surgical care transformation	Standard peri-operative pathway in place to optimise health for patients requiring surgery		✓			
	Optimal direct access to diagnostics to support clinical decision-making		✓			
	Best practice across theatre-based, day case, out-patient procedures and community-based procedures; including the delivery of the opportunities identified in Getting it Right First Time, Model Hospital and RightCare		✓			
DM: Demand Management E: Efficiency MR: Maximise Resource into System T: Transformation D: Decommissioning		✓			✓	

Focus in 2018/19

- Standard ICS community based gynecology model and 6 most common pathways in Gynaecology agreed across the ICS
- Single MSK model agreed across the ICS
- Single Service Restriction Policy agreed with common prior approval system in place
- ICS wide Consultant to Consultant referral policy agreed by CCGs and CRG.
- Health optimisation has gone live in 4 specialities in GN. Best practice surgical optimisation pathway agreed. Patient information leaflets have been updated in further languages to support health optimisation.
- Increased standardisation within diabetes with ICS wide standard approach to diabetes patient structured education in place, ICS wide Gestational diabetes pathway agreed with mobilisation underway.; high level service model drafted
- Ophthalmology transformation action plans submitted to NHSE in place to deliver high impact interventions
- Focused work in both Delivery Units to reduce outpatient attendances and contacts which do not add patient benefit; Patient Initiated Follow Ups(PIFU) being introduced by Providers
- Continued to support and ensure use of standardised templates (F12 and Arden Gem) across the ICS

Focus in 2019/20

- Implement MSKN pathway across whole ICS
- Commence work to realise opportunities identified by Rightcare in MSKN – Procedures
- Implement community gynaecology across whole ICS
- Identify and develop referral guidelines in an agreed number of specialties
- Implement 1 diabetic pathway across ICS
- Implement standardised advice and guidance specifications
- Implement virtual clinics in specialties not undergoing whole pathway redesign
- Implement neurology virtual clinics for chronic headaches
- Commence work in Urology and ENT pathway redesign
- Reduce 52 week waiters and reduce waiting list

Planned impact of changes

Outcome area	Metrics	Baseline	2019/20
Patient experience	Achievement of RTT standards Reduced waiting list Reduce 52 week waiters	92.16% (Oct 18) 59,440	92% Reduced
Safety/ Quality	Reduce the number of foot amputations	116	105

Section 3 - Cancer

Why this is important

Cancer is a major cause of mortality and years of life lost.

For cancer care and services the Nottingham and Nottinghamshire ICS is committed to:

- Achieving the current and future waiting time standards;
- Improve outcomes to meet national expectations, particularly in deprived areas;
- Improve patient experience, particularly when patients are discharged from secondary care;
- Reduce variation in outcomes; and
- Improve efficiency.

We currently perform below the 62 day constitutional standard (82.1%/85%) and want to quickly improve on this. We want to consistently maintain our current performance above the 2 week wait (95%/93%) and 31 day (96.5%/96%) standards.

We experience significant variation in outcomes locally, and outcomes are significantly lower than national average in parts of our ICS.

Our ambition

Our overarching vision is to deliver the key Cancer Taskforce Report recommendations as set out in the NHS England Cancer Strategy Implementation plan 'Achieving World-Class Cancer Outcomes Taking The Strategy Forward'.

Our aims are to:

- Increase prevention;
- Speed up diagnosis;
- Improve the experience of patients; and
- Help people living with and beyond the disease

Our objectives are:

1. All NHS providers in the ICS are compliant with NICE Guidance PH48 Smoking acute, maternity and mental health services
2. Improve 1 year survival rates, achieving 75% target by 20/21
3. Improve early diagnosis rates to 62% by 20/21 and 75% by 28/29
4. Deliver all NHS constitutional cancer waiting time standards including new 28 day referral to diagnosis target being introduced in 2019
5. Ensure all elements of the Recovery Package are commissioned.
6. Improve patient experience and satisfaction of services, pathways, measured via the annual National Cancer Patient Experience Survey.

Our approach

Initiatives	Interventions (deliverables)	DM	E	MR	T	D
Prevention	NHS Provider Trusts to fully implement NICE PH48 guidance Smoking: acute, maternity and mental health services		✓	✓	✓	
Early Diagnosis	Implement Non-specific (vague) symptoms pathway.	✓	✓		✓	
	Commission services to deliver earlier diagnosis of cancer in areas of the STP with high incidence and / or late presentation e.g. Lung MOT service	✓	✓		✓	
	Increase cancer screening rates in areas of the STP with low performance. Commission service to contact non-responders on-behalf of practices. Commission local awareness campaigns.		✓		✓	
	Address clinical variation in GP cancer metrics – 2WW referrals, emergency presentations, referral conversion, % of cancers detected via 2WW. Identify via GP cancer profiles.		✓		✓	
	Implement full suite of GP Direct Access Diagnostics as per NICE Guidance NG12: Suspected cancer: recognition and referral		✓		✓	
Improving Cancer Treatment and Care	Implement National Timed Cancer pathways (Lung, Colorectal and Prostate), utilising Cancer Alliance Transformational funds	✓	✓		✓	
	Commission all parts of the Recovery Package– Holistic Needs Assessment, Treatment Summary, Cancer Care Reviews, Health and Wellbeing Events.		✓		✓	
	Commission personalised risk stratified follow up pathways of care		✓		✓	
	Evaluate Cancer Integrated IAPT Pilot in Nottingham City, with the intention to roll out across the ICS		✓		✓	

DM: Demand Management E: Efficiency MR: Maximise Resource into System T: Transformation D: Decommissioning

Focus in 2018/19

Prevention

- Smoking cessation service now permanently based at NUH, SFHFT and Healthcare Trust to support staff and patients quit smoking.

Early diagnosis:

- Non specific / vague symptoms pathway piloted (as per 10 yr Plan).
- Lung MOT Service piloted in Nottingham City (as per 10 yr plan). Being expanded to Mansfield and Ashfield CCG as part of national programme.
- Good progress in implementing Direct Access Diagnostics for Primary Care, including FIT for Colorectal Cancer (one first in country).
- CCG and GP Practice cancer profiles produced highlighting variation in practice. Outliers identified.

Improving Cancer Treatment and Care:

- Improved 62 day cancer performance. Good progress in implemented National Timed Pathways for Lung, Prostate and Colorectal.
- Good progress implementing all stages of Recovery Package across ICS. Community Cancer Service piloted. Integrated IAPT service being piloted.

Focus in 2019/20

Prevention

- Expand smoking cessation service based at NUH, SFHFT and Healthcare Trust (pending funding via NHS Plan)

Early diagnosis

- Roll out Non-specific / vague symptoms pathway across ICS (as per 10yr Plan).
- Continue to roll out Lung MOT Service across City CCG and expand into Mansfield and Ashfield CCG (as per 10yr plan).
- Continue to implement Direct Access Diagnostics for Primary Care,
- Continue to reduce variation in CCG and GP Practice cancer metrics.

Improving Cancer Treatment and Care

- Achieve and sustain 62 day cancer performance targets partly through continued implementation of National Timed Pathways for Lung, Prostate and Colorectal.
- Monitor performance against new 28 day diagnosis target and implement plans where appropriate.
- Continue to implement all stages of Recovery Package across ICS.
- Community Cancer Service to be expanded across ICS

Planned impact of changes

Outcome area	Metrics	Baseline	2019/20
Clinical outcomes	Increase one year survival Earlier stage diagnosis Reduced emergency presentations	**71.5%** [1] (2015) 48% (Q1 2017) 18% (2017)	74.5% 58% 16.5%
Patient experience	National Patient experience score – overall National Patient experience score – support in primary and community care	8.9 0.59	9.0 0.65
Safety/ Quality	Reduced emergency admissions with cancer diagnosis	5306 (17/18)	5129

[1] significantly below National average 72.3%

Section 4 - Mental Health

Why this is important

Overall Nottinghamshire has a range of social factors that means it is more likely to see a higher incidence of mental health illness than elsewhere, including rising crime rates; high levels of alcohol and drug abuse, homelessness, an unacceptable life expectancy gap; high unemployment rates in the City and high levels of social economic deprivation.

Currently we are not meeting the constitutional standards for IAPT access, Children and Young People access and Out of Area Placements. We are also struggling to consistently achieve some transformation assurance standards:

- Out of area inappropriate placements – outlier on volumes of placements and these continue to increase
- Liaison – provision at NUH
- Crisis – a 24/7 Crisis Resolution and Home Treatment Team is not offered
- Individual Placement and Support – a service is not currently provided
- Physical Health Checks – not in line with best practice

Across the ICS Mental Health service users currently account for 19% of all A&E attendances and result in 26% of all unplanned admissions to hospital.

Our ambition

Our aims are to:

- Reduce inequalities and narrow the gap between Severe Mental Illness life expectancy and the rest of the population by 3 years
- Increase healthy life expectancy by 3 years against the baseline
- Deliver constitutional and transformation assurance standards
- Ensure everyone can access mental health services in the right place at the right time
- Create one integrated strategic commissioning function that harmonises approaches, whilst responding to local need
- Have the workforce to deliver mental health services and ensure we have a mentally health aware workforce

We have identified a set of five key strategic objectives (or 'pillars') that will frame our work:

- Establish an integrated system infrastructure
- Increase support for prevention, self-care and the wider determinates of health
- Implement a person centred approach to mental health
- Improve access to specialist services
- Achievement of the 5YFV workforce transformation standards

Our approach

Initiatives	Interventions (deliverables)	DM	E	MR	T	D
Establishing integrated system infrastructure	Create one ICS integrated strategic commissioning function	✓	✓	✓	✓	✓
	Develop an outcomes framework that informs how services are shaped, how funding flows and how further improvement efforts should be focused	✓	✓	✓	✓	✓
	Transfer funding between services to give the maximum impact in terms of cost effectiveness and clinical impact	✓	✓	✓	✓	✓
Increase support for prevention, self-care and the wider determinants of health	Introduce population health management that segments, stratifies and identifies people at risk of mental health problems				✓	
	Expand Personal Health Budgets				✓	
	Making Every Contact Count (MECC) in all organisations	✓				
	Reduce suicide rates					
	Commissioning and delivery of perinatal mental health services				✓	
	Expand individual placement and support (IPS) into Mid-Nottinghamshire				✓	
Person centred approach to MH	Annual physical health checks for people living with SMI and follow up care, delivered across primary and secondary care				✓	
	Increase access to IAPT services				✓	
	Dual diagnosis service				✓	

Initiatives	Interventions (deliverables)	D M	E	M R	T	D
Improve access to specialist services	Increase local capacity to reduce out of area placements				✓	
	Improve liaison services				✓	
	Improve crisis services				✓	
	Improve access to early intervention psychosis				✓	
Achievement of the 5YFV transformation workforce standards	Identify workforce gaps				✓	
	Explore new ways of working				✓	
	Develop wider workforce skills by mental health in induction, training, supervision and appraisals				✓	

DM: Demand Management E: Efficiency MR: Maximise Resource into System T: Transformation D: Decommissioning

Focus in 2018/19

- All age mental health strategy development - This involved 3 large stakeholder events (80-100 attendees) and a further 10 engagement events plus a review of all grey literature and documents from stakeholders relevant to the task e.g. JSNAs, MH strategies, homeless strategy etc.
- Set up a mental health and social care partnership board to support implementation of the strategy
- Reconstituted Board in December to now deliver strategy
- Set up task force for Out of Area Placements and Urgent Care
- SROs identified for strategic pillars
- Action plans developed for delivery of the strategy
- Set up performance meetings to target achievement and recovery of the constitutional standards.
- Held 2 patient/carer engagement events to establish how they may contribute to the strategy going forwards.
- Held a workshop focusing on delays in transferring/discharging from inpatient mental health facilities
- Held a workshop with voluntary services in identifying how they can be best engaged in mitigating crisis.
- Group set up to focus on personal health budgets for people with personality disorder
- Feeding in mental health into the PHM/Expert panel group – Programme Director member of this group
- Developed business case to expand IPS into Mid-Notts
- Developed a business case to expand street triage and introduce tri-triage approach with EMAS to be presented to GN and MN March 19.

Focus in 2019/20

Integrated system infrastructure

- CCGs create a single commissioning function
- Align Local Authority strategic commissioning resource
- Develop outcomes framework
- All CCGs must meet the Mental Health Investment Standard (MHIS). Full information is in section 3.6 of the NHS Operational Planning and Contracting Guidance 2019/20.
- Commissioners develop a comprehensive picture of current activity and spend on MH cohort

Prevention, self-care and the wider determinants of health

- Link with PHM workstream with regards to risk stratification of MH population cohort incl. quantification and characterisation of cohorts
- Map staff training offer and uptake; prioritise training; provide training
- Link with prevention, person and community centred workstream to implement social prescribing (picking up debt, loneliness and low level anxiety/depression), PHBs to be introduced in personality disorders and expand shared decision making, alcohol prevention and making every contact count.

- Liaise with Suicide Prevention Partnership to identify priority areas for support working towards a 10% reduction in suicides by 20/21
- Each CCG, as part of an STP footprint, should ensure increased access to NICE concordant community-based specialist perinatal mental health services (in secondary care settings) for at least 4.5% of their population birth rate, equating to an additional 20,000 women nationally.
- Link with homelessness group to develop and implement action plan for homeless citizens
- Expand programme of individual placement support into Mid Notts
- Begin to scope out work being undertaken across county and city for adverse childhood experiences.

Person centred approach to MH

- Identify services in place to deliver annual physical health checks and follow up care for people living with SMI
- Link with primary care workstream in the development of place based multidisciplinary teams, sharing responsibility for monitoring and managing the physical health of people with SMI between primary and specialist mental health services
- Undertake actions identified in IAPT access recovery plans to achieve current IAPT standard. Action plan required for delivery of IAPT LTC and IAPT 22% access rates by end 19/20 – *Please see attached document for further detail*
- Target cognitive behavioural treatments and social interventions for those at risk due to their long term physical condition
- Link with primary care workstream in the development of Integrate mental health support with primary care and chronic disease management programmes
- Scope appropriate pathways for patients with co-existing mental health and substance misuse issues
- Scope feasibility of expanding current Time to Change activity into County

Improve access to specialist services

- Implement crisis/liaison and OAP/urgent care action plan this includes actions identified below:
    - Transfer 16 spot purchased beds into a sub-contract in order to achieve better value and ensure care is closer to home, commence development/implement Red2Green and continuity of care
    - Develop a full business case for NHT inpatient provision which is informed by other urgent mental health care pathway transformation to deliver appropriate adequate local bed provision
    - Complete review and reconfiguration of current Crisis and Home Treatment Teams and mobilise new care model to ensure services meet the minimum functions of: (i) urgent and emergency community mental health assessment, and (ii) intensive home treatment as an alternative to inpatient admission, 24 hours a day, and 7 days per week
    - Spread coverage of liaison mental health teams through sustained commissioning of Core24 teams by 2020/21. Progress plans for acute hospitals to have mental health liaison services that can meet the specific needs of people of all ages, including children and young people and older adults by 2020/21
    - Work to ensure crisis teams meet core fidelity standards by 20/21
    - Develop new care model for Local Mental Health Teams and local multi-agency urgent response
    - Implement improvement plan for the Nottinghamshire Crisis House
    - Implement findings of the Liaison Psychiatry Service models, ensuring continued Core 24 compliance
- CYP – undertake actions articulated in CYP recovery plan. Develop actions to support the 19/20 requirement of increasing access to 34% of estimated 2004 CYP prevalence.
- CYP - CCGs should ensure there is a crisis response 24/7 which combine crisis, liaison and intensive community support functions that meets the needs of under 18 year olds.
- CYP - Deliver against regional implementation plans to ensure that by 2020/21, inpatient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements, within a context of 150-180 additional beds by 2020/21.

- EIP - CCGs to ensure the 2018/19 commitment for NICE concordance for EIP from the implementation plan is met; then deliver against the further ambition for 50% of services to be graded at level 3 by the end of 2019/20.

Please see attached document for further detail

5YFV transformation workforce standards

- Each CCG should work closely with their NHS and non-NHS provider partners and ALBs locally to deliver against workforce plans, including expansion and enabling of training and retention schemes. Workforce requirements should form part of finance and mental health investment plan discussions to ensure alignment with CCG financial submissions.
- Continue work to deliver expansion in the capacity and capability of the CYP workforce building towards 1,700 new staff and 3,400 existing staff trained to deliver evidence-based interventions by 2020/21.

Planned impact of changes

See below

1 Out of Area Placements and Crisis Resolution and Home Treatment Teams

Overview

In the 12 month period from October 2017 to October 2018, there were approximately 20,488 inappropriate out of area occupied bed days (OBDs) attributed to patients from Nottinghamshire.

The commissioners and providers within the ICS have jointly developed a recovery action plan to achieve the national requirement of zero inappropriate out of area placements by March 2021. The actions identified in the plan will deliver 24,820 OBDs, including 15,330 OBDs in local subcontracted provision by the end of 2019/20. If all interventions deliver against plan it will result in the eradication of inappropriate out of area placements and a reduction in the number of subcontracted beds required in the local area by 31 March 2021.

2018/19

To date the actions within the plan have delivered a reduction in the number of out of area occupied bed days of 29.3% from the end of quarter 1 to the end of quarter 3 in 2018/19. In addition, the length of stay, at discharge, in Nottinghamshire Healthcare NHS Foundation Trust beds has reduced from an average of 44 days in 2017/18 to an average of 36 days in December 2018. The length of stay in out of area placements reduced from an average of 43 days in April 2018 to a maintained average of 28 days since August 2018. The reduction in length of stay in out of area beds has been supported by the employment in May 2018 of an out of area Case Manager for Acute and Psychiatric Intensive Care.

Other actions undertaken during 2018/19 include:

- Mid Notts Crisis Resolution and Home Treatment Teams (CRHTs) are (as of December 2018) gatekeeping Mental Health Act Assessments resulting from S136s. Home treatment is being offered where there is capacity to do so.
- Greater Nottingham CRHTs are piloting daily in-reach into Rowan 1 ward supporting discharge.
- All staff in NHT wards are trained to use 'Red2Green' and this is also being rolled out to any subcontracted wards. 'Red2Green' is a system successfully implemented by Cheshire and Wirral to improve flow through mental health inpatient wards. Anticipated impact is a reduction in OBDs of 1,095 per annum.
- A workshop was held with system partners in January 2019 to review reasons for delayed discharge for all patients with length of stay over 50 days. Actions have been identified and will be monitored through the Taskforce to deliver the expected reduction of 365 OBDs per annum from Q4 2018/19.
- Winter resilience funding is being utilised to increase discharge and home treatment packages.

If all remaining actions deliver as expected during 2018/19 and there is no increase in demand during the final quarter of the year, the anticipated performance is approximately 3,345 inappropriate out of area bed days compared to a Q4 trajectory of 2,520. That equates to around 17,825 bed days compared to a target of 15,341 across the full year 2018/19. It should be noted

that this is against the original trajectory submitted to NHSE, and due to the timing of data availability the impacts will not be immediately seen through 2018/19 performance reporting. A revised trajectory for 2019/20 has been submitted to NHSE, which is based on the analysis that has taken place 2018/19 to understand the reasons for the number of out of area placements and the known impact of agreed interventions, which will still ensure the overall reduction is achieved by 2020/21.

2019/20

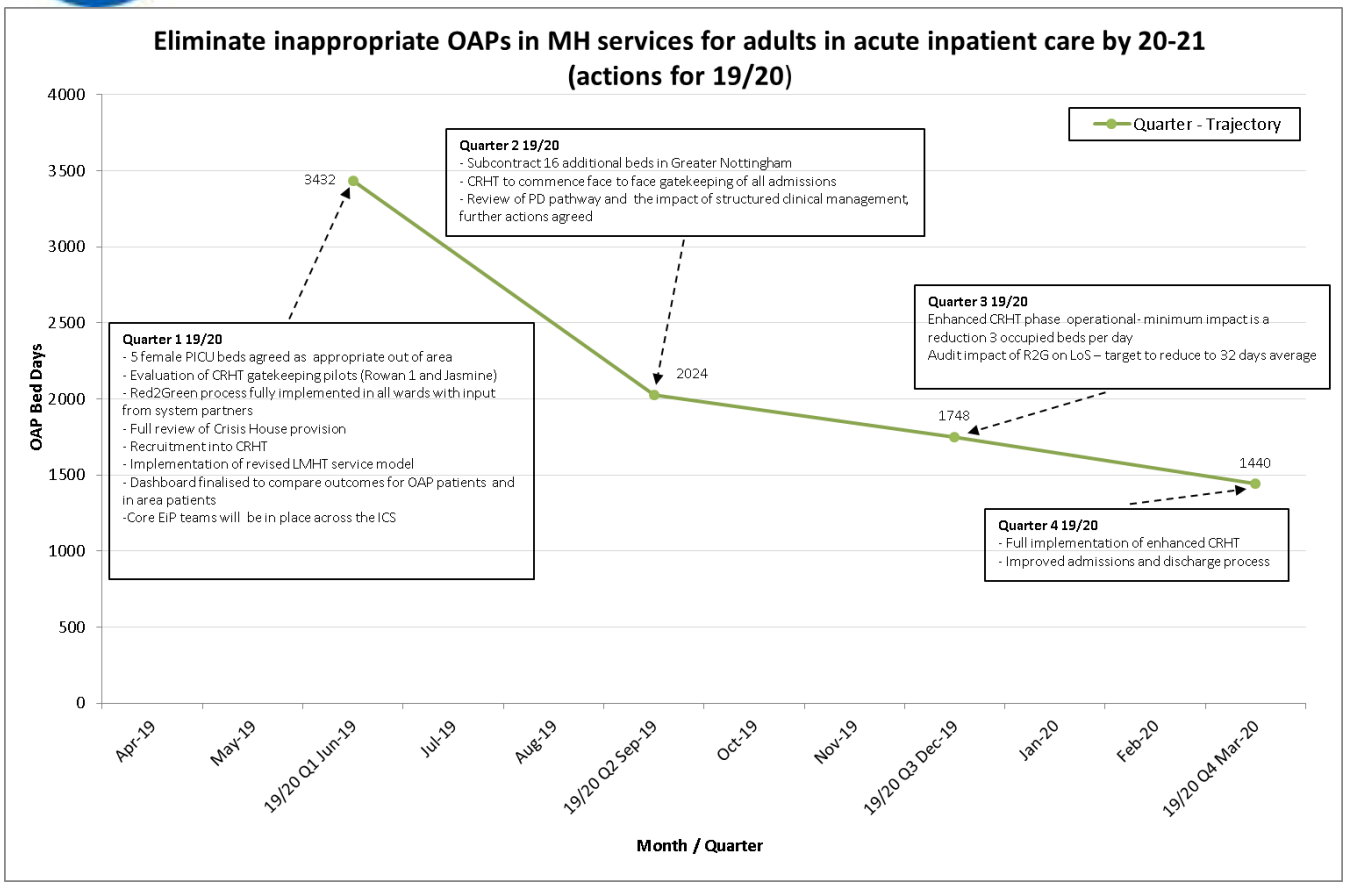
To further reduce the number of inappropriate bed days, specific immediate actions are being taken to increase the number of 'in-area' placements during 2019/20. 16 additional beds will be available from 1 July 2019 equating to 5,840 OBDs per year (FYE) and 5 additional subcontracted PICU beds put in place in December 2018 which will deliver 1,865 OBDs per year (FYE). Adherence to Continuity of Care principles will ensure these beds are not defined as inappropriate out of area.

In addition to the specific actions described here, it is recognised that a medium to long term strategy is required to completely eliminate inappropriate out of area placements. Commissioners and providers are working together to achieve this by developing joint detailed service specifications, with supporting demand and capacity analysis and measurable Key Performance Indicators for inpatient, PICU and Crisis Resolution and Home Treatment services and community mental health teams to ensure system flow. The challenge locally and nationally is availability of workforce required to fill these posts, which will need to be factored in to performance recovery trajectories. To address this, Nottinghamshire Healthcare NHS FT is exploring more innovative ways of delivering services, learning from models which have been implemented elsewhere.

Re-designed specifications which will deliver the national requirement have been agreed with further work underway to identify how these can be delivered within the existing financial envelope (which is in line with national benchmarked mental health spend) plus additional investment targeted where needed from the mental health investment standard. This includes consideration of the configuration of services within the urgent and emergency care pathway including Crisis Resolution and Home Treatment Teams, Crisis House, Liaison Psychiatry and Acute and Psychiatric Intensive Care inpatient wards. The main deliverables of the transformation programme are:

- Reconfigured core fidelity compliant Crisis Resolution and Home Treatment Team model prioritised for mobilisation in early 2019/20 to ensure services meet the minimum functions of urgent and emergency community mental health assessment, and intensive home treatment as an alternative to inpatient admission, 24 hours a day, 7 days per week. The anticipated impact starting in quarter 2 of 2019/20 is a full year effect reduction of 1,460 OBDs per annum.
- Implementation of a revised care model for the Liaison Psychiatric Service following the review of both current core provision and the additional Core 24 funded expansion to ensure compliance with Core 24 requirements and a positive contribution to delivering the 4 hour ED standard.
- Review and redesign of NHT inpatient provision with a full business case being developed which is informed by other urgent mental health care pathway transformation to deliver appropriate adequate local bed provision. This will be presented to the Trust Board in June 2019. The current draft bed proposal equates to 13,505 fewer out of area OBDs with the impact from April 2021. This will be reviewed in a timely manner pending agreement of the impact of the whole pathway transformation proposal to ensure there is no delay in expanding the current bed base, if required.

The chart below defines the trajectory for 2019/20 to achieve zero inappropriate excess bed days by 2020/21, and identifies specific actions which will impact during the period to March 2020.



A revised trajectory has been submitted to NHSE which equates to no more than 8,644 bed days in 2019/20.

2 Early Intervention in Psychosis (EIP)

Overview

The ICS is achieving the 2 week wait standard for EIP and actions have been implemented which have eliminated the inconsistency of data and improved its accuracy. This process will inform the continued delivery of the standard.

However the service is not currently NICE compliant. NHSE has identified that the service in Greater Nottingham is level 2 compliant and Mid Nottinghamshire is only level 1 compliant and as such an Intensive Support Team has been supporting Mid Notts to assess the service and make recommendations to improve service delivery. The main recommendation from the IST report is to have dedicated and specialist staff to deliver the EIP service, and not to integrate them into Local Mental Health Teams (LMHTs). The challenge in achieving this is the low numbers of referrals from Newark and Sherwood (prevalence suggests only 13 people per year). Furthermore, there is a requirement to develop a cohort of staff trained in CBTp (Cognitive Behavioural Therapy in Psychosis). There is currently only one member of staff trained across the ICS and only 1 course is available nationally, and this will prevent CCGs from achieving level 4. This issue is being discussed with Health Education England.

2018/19

As with Out of Area Placements, commissioners and providers within the ICS have jointly developed a recovery action plan to achieve level 2 in Mid Notts and make progress towards level 3 in Greater Nottingham by 31 March 2019, and then deliver against the further ambition of 50% of services to be graded at level 3 by the end of 2019/20.

Short term actions identified in the recovery action plan include:

- As Mid Notts does not currently have an Individual Placement and Support (IPS) Service a Part A bid to be a wave 2 site has been submitted. The IPS in Greater Nottingham will now prioritise working with EIP patients

- To achieve a more specialist EIP function pending whole mental health service transformation the service is in the process of identifying a core team of staff to work across the Mid Notts area. This will include specific clinical/professional lead roles to provide supervision and further development of the services. This will be in place during Q4 of 2018/19.
- Currently there are approximately 20% of EIP staff trained in Behavioural Family Therapy. Training an increased number of staff will be prioritised as the new model develops. During Q4 of 2018/19 staff will be trained in family interventions to support EIP. The course is provided by NHT and is 5 full days.
- All EIP staff will receive physical health check training by the end of the financial year.
- There will be a focus on the identification of patients requiring EIP services through working with GPs to develop skills and ensuring robust triage

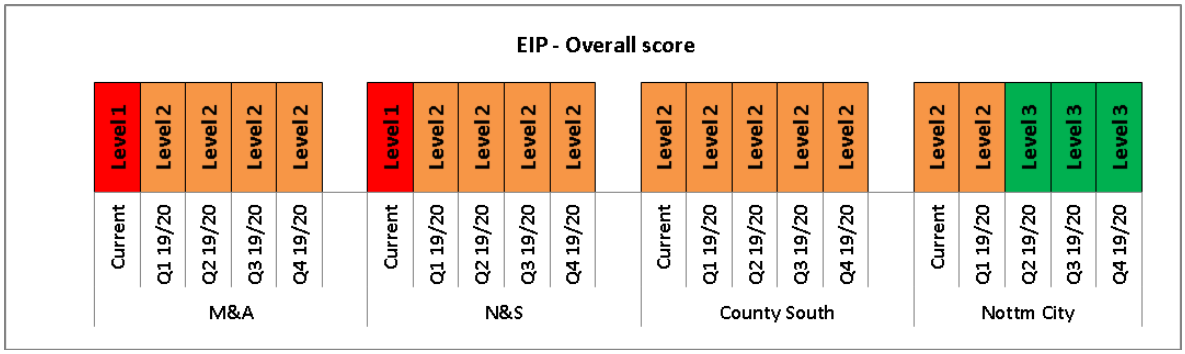
2019/20

Whilst these actions will deliver a more immediate improvement in NICE compliance, we recognise that a medium to long term strategy is required to achieve the further ambition of level 3 compliance across the ICS. As part of the broader transformation programme outlined above, commissioners and providers are working together to achieve this by developing joint detailed service specifications, with supporting demand and capacity analysis and measurable Key Performance Indicators. A reconfigured EIP model is being developed to ensure the specialist pathway is protected within the Local Mental Health Team model.

Local Mental Healthcare Teams (LMHTs) - LMHTs now assess and treat community, assertive outreach and Early Intervention in Psychosis (EIP) patients. Commissioners are working with NHT to ensure the LMHTs are better aligned to Primary Care Networks and to work towards re-specifying them to create a holistic Community Mental Healthcare Team (CMHT) pathway with separate service specifications for each element of the service. There is also work underway to ensure secondary care patients are discharged back to primary care when clinically appropriate. It is likely that NHT will need to address workforce shortfalls to fully implement the required functionality in CMHTs by adapting workforce models. Workforce remains a significant risk locally in delivery of the mental health standards and as such requires an innovative approach to delivery models which the Trust are already developing.

It is expected that CCGs will need to invest to deliver NICE compliance and as such are confirming for the 2019/20 contract how the totality of core mental health services can be delivered within the existing financial envelope, and how the MHIS is prioritised prioritising spending according to need and identifying any residual funding gaps which will still exist after implementing the most efficient and innovative delivery models and thus identifying the level of targeted additional investment required to deliver the national standards.

The chart below defines the trajectory for 2019/20 to move towards a NICE compliant service.



3 Improving Access to Psychological Therapies (IAPT)

Overview

The ICS met the access target in November 2018 data achieving 4.82% against a 4.61% target. This is the rolling three month NHSE target, as supplied on the core data pack. However the targets are not being met consistency, Mansfield & Ashfield CCG did not meet the target, achieving 3.94%.

It has been identified that the access target has been breached in individual CCG's due to the underperformance of the main IAPT provider in the ICS, who currently delivers 50% of the activity. The highest levels of referrals are taken in these CCGs and the provider has the greatest capacity issues in these areas. Analysis shows there are sufficient referrals in the system to meet

access targets, however there are increasing numbers of patients waiting for assessment, and as these patients are only counted once they have entered treatment, this impacts on performance against access targets.

2018/19

Greater Nottingham CCGs have been working with NHSI and the main local IAPT provider to design an interim pathway to reduce waits. The pathway has been in place from the end of February 2019, with waiting list issues expected to be resolved by the end of May 2019. The CCGs are also working with providers to increase Step 2 activity from 19% to 60% in line with the IAPT manual. This action will reduce waits for patients and will help avoid a recurrence of the current wait issues, thus delivering the standards by the end of May 2019

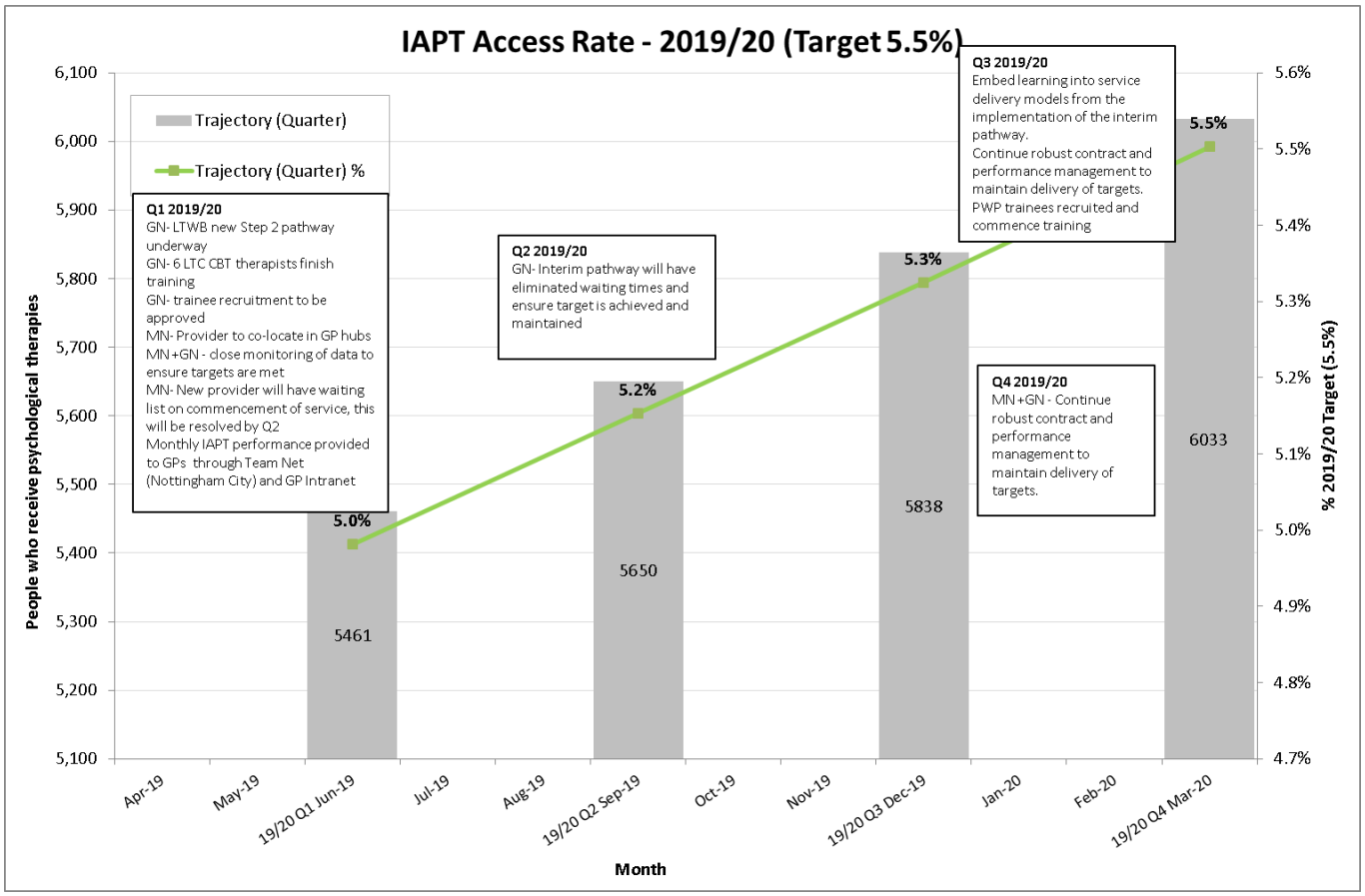
2019/20

To address current performance, the CCGs in Mid Nottinghamshire have recently tendered for a new IAPT service to commence on 1 April 2019 and have awarded a contract to a sole provider. They will be performance managed closely to ensure all standards are met. At present an exit strategy for the two remaining providers is in place with an in depth mobilisation plan for the new provider. The new contract in Mid Notts will not be at capacity immediately as fewer than expected staff, have chosen to TUPE into the new provider, however a robust recruitment plan is in place, it is anticipated that the new provider will have a waiting list in quarter 1 but performance will be on track by quarter 2.

Greater Nottingham will be re-tendering IAPT services during 2019/20 for commencement of a new contract from 1 April 2020.

To support delivery, Mid Notts have identified 2 additional trainee places, one to commence in February 2019 and one in March 2019. They now have a total of 4 trainees. Greater Nottingham have 15 trainees, 6 finishing in March 2019 and 9 finishing in March 2020. There is an expectation that these trainees will TUPE to new providers following tender processes. Training places for 2019/20 are being confirmed with NHSE and plans will be put in place to ensure this is delivered.

The chart below defines the trajectory for 2019/20 to achieve the IAPT access target.



4 CYP

Overview

With regard to the target to increase the number of children and young people receiving treatment from the NHS commissioned community service, there have been ongoing issues with some providers not being able to flow data to the MHSDS and therefore at this stage it remains difficult to establish a clear understanding of the access rate.

2018/19

Data issues have been identified and work is ongoing with providers and the North of England CSU to resolve them, all data is now being submitted to MHSDS but it is not showing in all national performance reports. The anticipated timescale for resolution is end of Quarter 4 2018/19. Commissioners have worked with the relevant providers and have now achieved access to local data to enable an informed analysis of actual delivery against the target, though this position will not be able to be reflected in national data until all the data flow issues have been resolved.

Following a provider led capacity and demand review, capacity requirements are being jointly analysed to ensure there is sufficient capacity within Nottinghamshire Healthcare NHS Foundation Trust to meet the access target. An area for improvement has been agreed jointly and has been incorporated into the joint recovery action plan which is in place to secure performance against the targets. This work will focus on bringing the conversion from assessment to treatment in line with National benchmarking figures. Current conversion rates are approx. 53% and we would expect this to be around 75% in line with benchmarking data available. This would indicate there is sufficient capacity within the system to meet the access target.

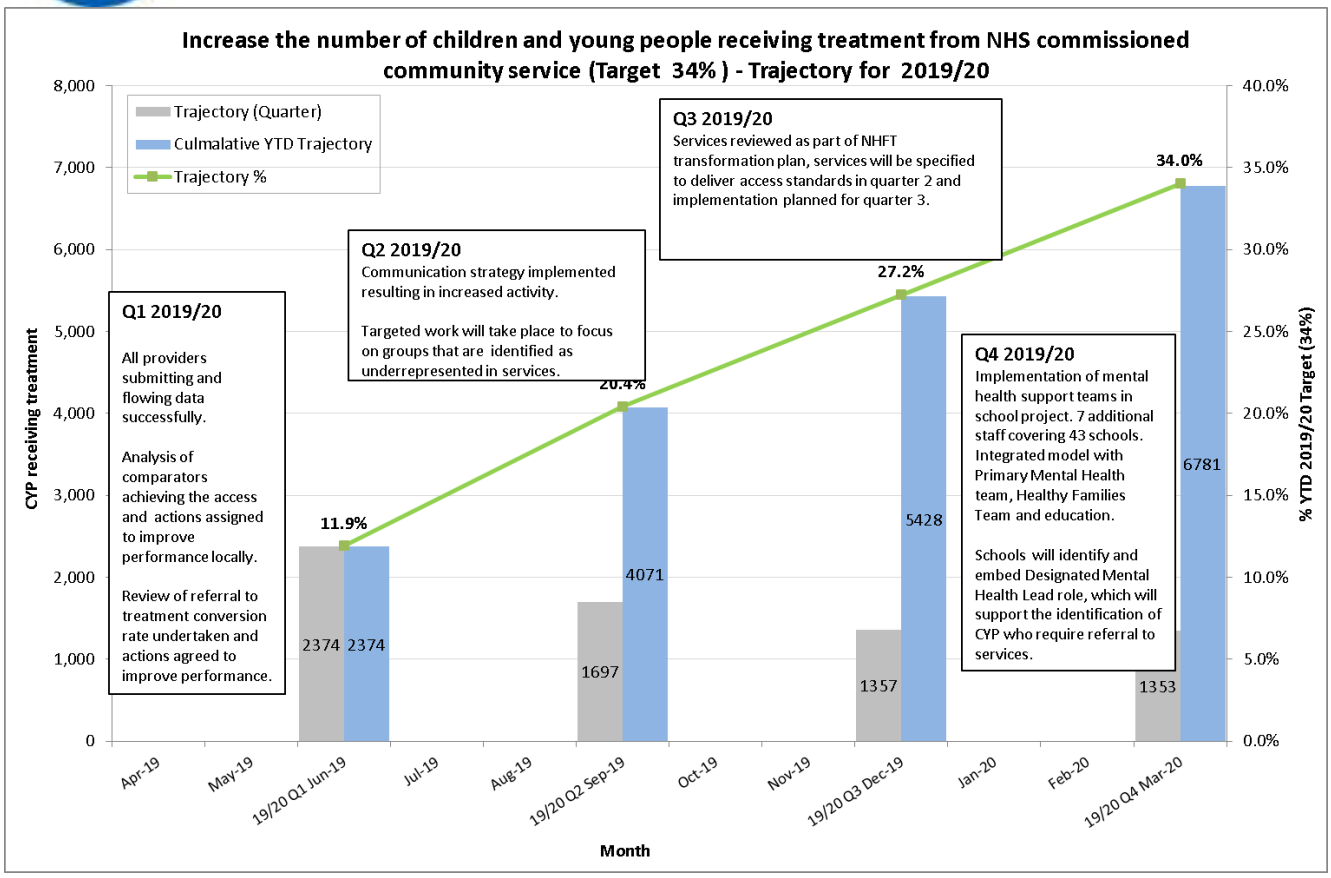
To secure an increase in referrals a communication strategy has been implemented in Nottingham City which is expected to increase referrals by 10% across all providers by end of July 2019. This approach is in the process of roll out across the remainder of the ICS. In addition analysis of actions being taken in systems that are achieving the access standards is being undertaken and actions will be implemented in Nottinghamshire based on this.

2019/20

Analysis undertaken in 2018 highlighted that the CAMHS Eating Disorder Service did not have sufficient capacity to meet the waiting time standard whereby 95% of patients receive their first definitive treatment within 4 weeks for routine cases and within one week for urgent cases by 2020/21. As such, additional funding was agreed to increase available capacity and the service will move to a same day ‘assess and treat’ model once staff are in place. It is expected that the waiting time standard will be achieved by the end of February 2019.

A review and re-specification of Children and Young People’s mental health services forms part of phase 2 of the mental health transformation programme through which services across Mid Notts and Greater Nottingham will be aligned through a consistent service specification. The focus for children and young people’s mental health will continue to have an emphasis on prevention, early identification and intervention, using evidence-based approaches that present good value for money. Where a mental health problem or disorder is identified services will be commissioned to ensure children and young people have access to timely, integrated, high quality and multidisciplinary mental health services that are accessible and responsive to individual need in line with the NHS Long Term Plan (2019).

The chart below defines the trajectory for 2019/20 to achieve the CYP access targets.



5 PH/SMI

Overview

Performance in Quarter 3 has increased to 31.8% across primary care against a target of 50% for the indicators that can currently be reported. This is an increase from 30.6% in quarter 2 2018/19, national performance was reported as 18.3% and regionally it was 15.2%.

The health check has 12 components, 6 can currently be reported and plans are being agreed to enable the collection and reporting of the further 6 indicators from April 2019.

2018/19

During quarters 3 and 4 there has been a focus on increasing the number of health checks, through targeted work with GP practices, delivering practical solutions to achieve the standard including:

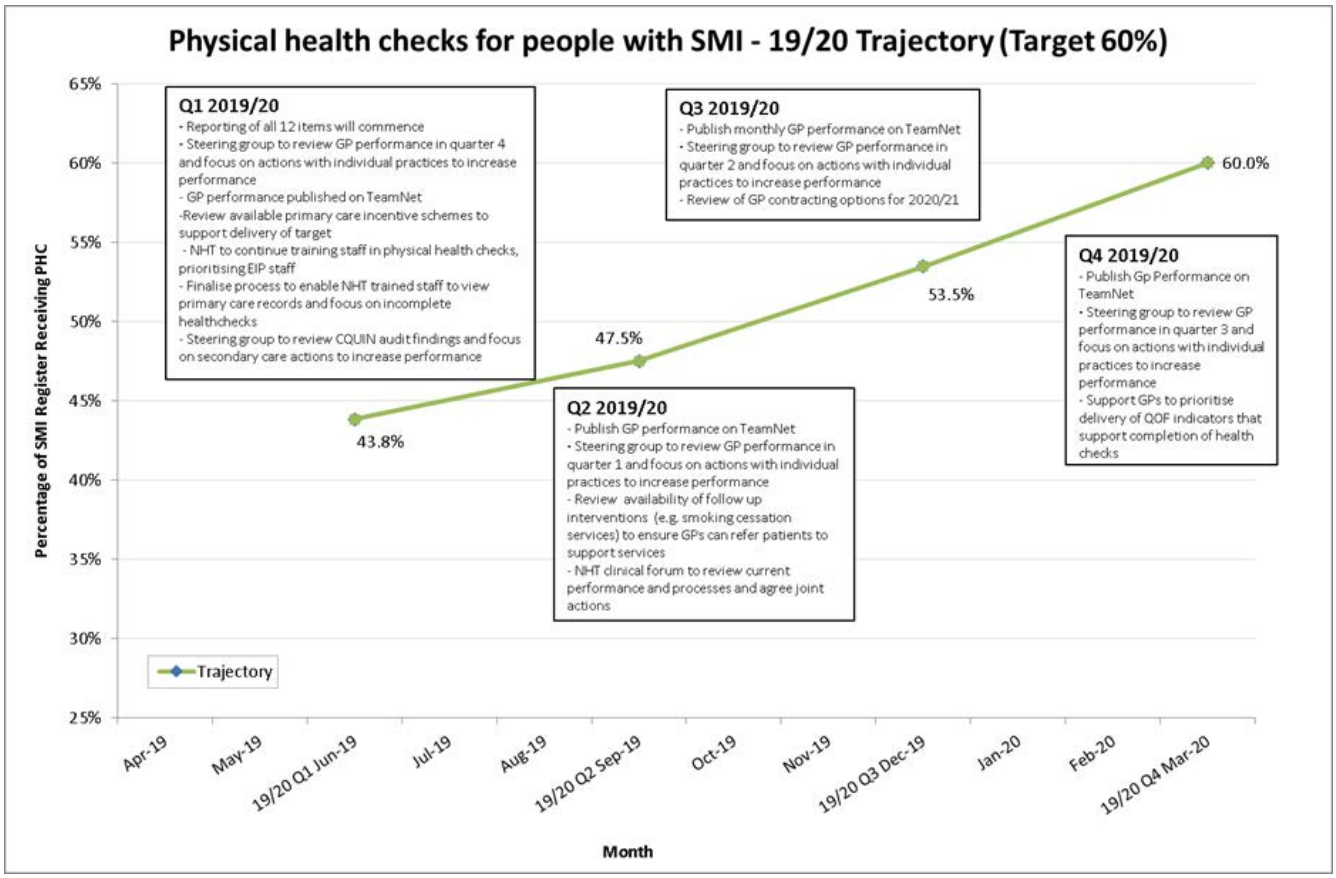
- Analysis of e-healthscope data has been completed and the number of incomplete checks by practice has been identified and input into GP workflows.
- “How to” guidance for this has been developed and incorporated into GP communications
- A draft GP communications plan has been developed which identifies specific actions for January 2019. This includes presentations to GP Cluster Boards and Clinical Councils which have already begun.

For the additional 10% which is expected nationally to be delivered through secondary care, Nottinghamshire Healthcare NHS Foundation Trust are completing an audit of physical healthcare assessments on inpatient wards, EIP services and other patients in the community on a Care Programme Approach as part of the current CQUIN. In addition a shared care protocol is being agreed between the Trust and GPs for physical health checks for people with SMI and the appropriate follow-up checks

2019/20

During 2019/20 the actions implemented in 2018/19 are expected to deliver a month on month increase in performance in respect of the existing 6 components which can be reported. The actions outlined in the commissioner and provider jointly agreed recovery action plan are expect to achieve the 60% standard for the original 6 components by the end of quarter 4 2019/20. The anticipated delivery timeline for the further 6 components will be assessed once the national requirement is fully understood.

The chart below defines the trajectory for 2019/20 to achieve the PH/SMI targets.



Section 5 - Primary Care Networks

Why this is important

Primary care is described as the 'front door of the NHS' and provides patients with community-based access to medical services for advice, prescriptions, treatment or referral, usually through a GP, nurse or other health or care professional. It has been estimated that around 90 per cent of interactions in the NHS take place in primary care.

GP workload in our area has grown, year on year both in volume and complexity with our population now reaching approx. 976,963 served by 135 GP practices. The health of people in Nottingham and Nottinghamshire is varied compared with the England average; the health of our population is generally worse than the England average with it being one of the 20% most deprived districts. Between 18-34% of our children live in low income families. Alcohol related harm hospital stays, self-harm and smoking related deaths are all worse than the England average.

It is our ambition to support local people to be able to live healthy and fulfilling lives well into old age. This means that we have to be bold and ambitious in our plans for primary care. We will bring together health and social care within our Primary Care Networks, utilising the ICS plan as a central shared vision. The health benefits and far reaching impact of primary care at the helm of care coordination will diminish the inequalities in lifespan and illnesses that exist in our area. People who live in economically deprived areas will be able to maximise their health potential as fully as their more affluent neighbours.

General Practice is an integral part of the Primary Care Networks enabling care for our people to be co-ordinated , this includes the interface between primary care and hospitals, each entity working collaboratively to remove obstacles. We will move from a model of predominantly reactive care to one of proactive care, eliminating hospital admissions as a default for people who are not acutely unwell but need help and support, this will be delivered through our strategic approach to prevention and proactive care, reducing admissions whilst reinvigorating working relationships and dialogue between primary and secondary care clinicians.

Our ambition

Our vision is to an integrated care approach, focusing on place based care. Key characteristics are:

- A more integrated and collaborative primary care workforce, with a strong focus on partnerships – 'primary care' defined as first line services such as; general practice, public health, community providers, secondary care, mental health, voluntary sector and social care etc.
- A supported and integrated workforce with a combined focus on prevention and personalisation of care with shared and improved qualitative health and care outcomes utilising population health management data;
- Strong voice from partners working collectively to describe how clinical, social and financial drivers are aligned and focused through the ICP provider forums;
- Provision of care aligned to population of circa 30,000 and 50,000, working collectively to deliver localised care, with the ability of at scale working; maximising the economies of scale
- Patient Activation and strengthened local communities including social prescribing and self care initiatives

Our overarching aim is that Primary Care Networks will be at the heart of directing and providing health and care provision; improving the wellbeing of our local populations through proactive, accessible, coordinated and integrated health and care services.

Our approach

Initiatives	Interventions (deliverables)	DM	E	MR	T	D
Extended Access to Care - Deliverables under GP5YFV	Core opening hours between 8am and 6.30pm daily	✓				
	Extended access" 6pm - 9pm during the week and 8am -12 midday on Saturdays and Sundays	✓				
Population Health Management	Define joint system and sub population outcomes	✓	✓	✓	✓	✓
	Segmenting the population, and stratifying based on need	✓	✓	✓	✓	✓
	Agree standardised interventions and approach to meet locality needs	✓	✓	✓	✓	✓
Integrated Working	Development of PCNs to work in integrated teams to improve the wellbeing for the local population		✓		✓	
Workforce Sustainability	Develop a HR collaborative to enable the delivery of new models of care		✓		✓	
	Develop a population/place based approach to workforce re-design		✓		✓	

DM: Demand Management E: Efficiency MR: Maximise Resource into System T: Transformation D: Decommissioning

Focus in 2018/19

- Meeting CCG commissioned extended access across the system with GP Access contracts in place across Nottingham and Nottinghamshire
- Primary Care Networks in place and are currently being reviewed to ensure they are fully functioning and integrated - commencing with workforce plans at PCN level
- ICS Population Health Management Team in place
- ICS Primary Care Strategy being developed
- PHM Expert Panels have been arranged and are taking place to focus on LTC
- ICP Local delivery plan for key priorities aligned to the new GP contract
- Mid Notts priorities for alignment with the PCNs:
  - to commission a single provider for mental health support aligned to PCNs
  - maternity hubs
  - exploration of dental opportunities
  - focus on high volume service users across the public sector
  - centralised acute home visiting
  - care home wrap around provision
  - social workers co-located as part of the SoS integration pilot
  - embed non clinical navigators to enhance risk stratification
  - work with secondary care to transform outpatient care
  - work in Newark PCN to develop an integrated approach to urgent on the day demand strategy

Focus in 2019/20

- Improve health, wellbeing and primary care sustainability - Completion of ICS primary care strategy
- Improve Integrated care and quality - Creation of PCN specification to be adopted across the system
- Agree a PCN/PHM/Interventions framework.
- Estates review to take place as part of clinical strategy to define the "where"
- Workforce review to take place
- Implement the new GP contract
- Build on the network of clinical pharmacists and the value they bring
- Implement social prescribing
- In Mid Notts we will develop a strategy for first contact physiotherapists
- Develop a prevention and health outcomes local delivery plan focussed on the key areas such as CVD, diabetes, stroke and cancer
- Greater Nottingham has established an Integration Board, the first priority of which is to shape a detailed work programme for 2018/19 and beyond. Key to this is the continued work with commissioners to agree the scope of services to be included in the PCNs and the phasing of this, and to put in place the appropriate contracting framework. The planning assumption is that the phasing will be as follows, but this is still subject to agreement:

Phase 1

- Adult community services – general health and mental health (those services covered in the NHCT contract)
- Enhanced primary care services
- Medicines management
- Prescribing
- Referral Support Service
- Population health management and tactical commissioning

Phase 2

- Children and young people's health services
- Adult social care

Phase 3

- Third sector commissioning

Section 6 - Care Homes

Our approach

Initiatives	Interventions (deliverables)	DM	E	MR	T	D
Enhanced primary care support	Access to consistent, named GP and wider primary care service	✓				
	Medicine reviews	✓				
	Hydration and nutrition support	✓				
	Access to out-of-hours/urgent care when needed	✓				
Multi-disciplinary team (MDT) support including coordinated health and social care	Expert advice and care for those with the most complex needs				✓	
	Helping professionals, carers and individuals with needs navigate the health and care system				✓	
Reablement and rehabilitation	Rehabilitation/reablement services				✓	
	Developing community assets to support resilience and independence				✓	
High quality end-of-life care and dementia care	End-of-life care				✓	
	Dementia Care				✓	
Joined-up commissioning and collaboration between health and social care	Co-production with providers and networked care homes	Enabler				
	Shared contractual mechanisms to promote integration (including Continuing Healthcare)	Enabler				
	Access to appropriate housing options	Enabler				
Workforce development	Training and development for social care provider staff	Enabler				
	Joint workforce planning across all sectors	Enabler				
Data, IT and technology	Linked health and social care data sets	Enabler				
	Access to the care record and secure email	Enabler				
	Better use of technology in care homes	Enabler				

DM: Demand Management E: Efficiency MR: Maximise Resource into System T: Transformation D: Decommissioning

Focus in 2019/20

Enhanced primary care support

- Strengthen to links between GP practices and Care Homes by increasing alignment.
- Continue to work with NHSE national team to implement Medicines Optimisation in Care Homes (MOCH) to facilitate timely and structured medication reviews.
- Continue to promote the use of proactive care and extend services to reduce demand on urgent, emergency and out of hours care.
- Continue to spread vanguard recommendations such as 'Red Bags' and trusted assessor roles to facilitate prompt and efficient transfers of care.

MDT in-reach support

- Work with partners to embed proactive allocation of MDT support and resource to care home population using risk stratification indicators to focus attention and resource on those who are frail or at risk of admission to hospital and those with the greatest potential to benefit

Reablement and rehabilitation

- Work with the ICS community centred approaches team to develop community assets and mapping

High quality end of life care and dementia care

- Work with the EOL service established in MN and share learning in commissioning a GN service
- Increase use of the Electronic Palliative Care Co-ordination System (EPaCCS) to support individuals to die in their preferred place of care
- Use of advances care planning to support end of life care needs
- Work to establish an approach to identify those with dementia in care homes.
- Promote the use of 'This is Me' tool in care homes.

Joined up commissioning between health and social care

- Work with providers of care homes services using care home forums and provider engagement events to collectively deal with issues and provide opportunities for 2-way feedback.
- Work to increase engagement from mental health, learning disability and younger adult care home and home care services.
- Articulate links between the EHCH and wider whole system initiatives such as transformation, QIPP,

CQUIN and STP/ICS work priorities

- Scope opportunities to work with Nottinghamshire County Council to introduce a single -shared care home contract based on a similar model to the current shared care home contract with Nottingham City

Workforce development

- Understand the training and ongoing learning support options available to care home staff.
- Continue to promote engagement with recognised organisations such as Optimum Workforce Leadership, Health Education England, Skills for Care, Academic Health Science Network, East Midlands Patient Safety Collaborative and colleges and universities to support continuing professional development, career pathways and training. We will continue to encourage and promote leadership development opportunities available.
- Increase the number of nursing associates and continue to progress and enhance engagement with the 'Holistic Worker' programme.

Data, IT and Technology

- Work to understand opportunities available to advance technology in care homes to deliver technology enabled care.
- Work with NHSE national team to increase the number of social care providers utilising NHS mail to improve sharing of information between health and social care organisations.
- Increase the numbers of care services compliant with the Data Security and Protection Toolkit (DSPT), which replaced the previous Information Governance (IG) toolkit from April 2018 and is a pre-requisite for NHS mail access.

Section 7 - Learning Disabilities and Autism

Why this is important

The Transforming Care Programme aims to transform care and support for people with learning disabilities and/or autism who display behaviour that challenges, including those with a mental health condition.

'Building the Right Support' is a national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.

As part of Building the Right Support Nottinghamshire has an established Transforming Care Partnership (TCP) with a joint ambition to reduce reliance on inpatient care through planning to reach a significantly reduced inpatient rate by March 2021. The TCP is committed to ensuring people with learning disability and/or autism get better support, whilst improving care quality and outcomes.

Across Nottinghamshire we will do more to ensure that all people with a learning disability, autism, or both can live happier, healthier, longer lives.

Our ambition

- Continued investment in community support so that by 2023/24 Nottinghamshire has a seven day specialist multidisciplinary service and crisis care to support people in their communities.
- Continue to implement a full 'Building the Right Support' provision: by March 2023/24, inpatient provision will have reduced to less than half of 2015 levels:
  - *TBC Indicative Targets for 2019/20 ADULTS - 16 (NHSE) and 16 (CCG) = 32 (TCP)*
  - *TBC Indicative Targets for 2020/21 ADULTS – 15 (NHSE) and 11 (CCG) = 26 (TCP)*
  - *TBC Indicative Targets for 2019/20 & 2020/21 CYP*
- Over the next three years, to ensure that waiting times for autism diagnosis will be included alongside work with children and young people's mental health services to test and implement the most effective ways to reduce waiting times for specialist services.
- To ensure that all children and young people with a learning disability, autism or both with the most complex needs will have a designated keyworker.
- To continue to expand the STOMP programme – a national project involving different organisations to stop the over medication of people with a learning disability, autism or both
- To work towards every person with a learning disability, autism or both having a digital flag in their patient record to ensure staff have a better understanding of their needs.
- To invest in eyesight, hearing and dental services for children and for these to be included in reviews as part of general screening services; supported by easily accessible, ongoing care.
- To tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people
- Over the next five years to implement the NHS Improvement learning disability improvement standards to all services funded by the NHS.
- To continue to offer more work opportunities to people with a learning disability and autistic people.

Our approach

Initiatives	Interventions (deliverables)	DM	E	MR	T	D
Activity - Admissions & Prevention	Enhanced Specialist Forensic Team	✓	✓	✓	✓	
	Enhanced ICATT Team	✓	✓	✓	✓	
	TCP-wide Care Coordinator & Social Supervision	✓	✓	✓	✓	
	CP dynamic risk register	✓	✓	✓	✓	
	Continuation of an Unplanned (Respite) Care Service	✓	✓	✓	✓	
	Targeted carer support	✓	✓	✓	✓	
	Review of current pathways for early diagnosis of LD/autism;	✓	✓	✓	✓	
	Working towards a single point of contact and DoS	✓	✓	✓	✓	
Increase support for prevention, self-care and the wider determinants of health	Continuation of an Advocacy Service	✓	✓	✓	✓	✓
	Review of Respite/Unplanned service	✓	✓	✓	✓	✓
	Review of the ICATT specification	✓	✓	✓	✓	✓
	Review of the Community Forensic Team;	✓	✓	✓	✓	✓
	Evaluation of ICATT/Unplanned Care	✓	✓	✓	✓	✓
	ATU and Locked Rehab (Modelling & Capacity)	✓	✓	✓	✓	✓
	Market Engagement to ensure the needs are met locally	✓	✓	✓	✓	✓
	Ensuring annual health reviews for all on the LD register.	✓	✓	✓	✓	✓
	Expending the offer of unplanned care into the North of the County	✓	✓	✓	✓	✓
	Expanding the community forensic team to include in-reach function into low/medium secure settings	✓	✓	✓	✓	✓
	Decrease in number of acute beds available on Orion Unit in line with commissioning intentions and Notts TCP published plan.	✓	✓	✓	✓	✓
Integrated Care Support & Finance	PHB Managers aligned to the TCP to increase uptake and utilisation;	✓	✓	✓	✓	
	Delivery of an agreed Housing Strategy;	✓	✓	✓	✓	
	Capital Bids ; Capacity Modelling;	✓	✓	✓	✓	
	Utilisation of Transformation Funding (non-recurrent) and movement into BAU	✓	✓	✓	✓	
	TC to work within the scope of a pooled budget arrangement; working towards an integrated commissioning model across health and local authority;	✓	✓	✓	✓	
	Learning from mortality reviews	✓	✓	✓	✓	
Workforce Planning & Development	Learning & Development TNA	✓	✓	✓	✓	
	Review of SALT capacity	✓	✓	✓	✓	
	Review Drugs & Alcohol Services (communication, publicity, access);	✓	✓	✓	✓	
	Targeted support packages for families & carers	✓	✓	✓	✓	
	Cultural Change	✓	✓	✓	✓	
	Learning from other systems	✓	✓	✓	✓	
	To improve its understanding of the needs of people with autism.	✓	✓	✓	✓	
	Provide and commission direct training for front line staff within community based teams and services such as staff working within residential care and supported living settings, in Positive Behavioural Support, active support, personality disorder and attachment theory, to strengthen the resilience of the local workforce.	✓	✓	✓	✓	
Communications , Engagement, & Coproduction	Full Public consultation between Jan and June 2016, including face to face, focus groups, individual feedback, online survey, information available in easy read versions. Ongoing co-production with families and their carers;					✓
	Inform and evaluate ICATT & Unplanned Care					✓
	Service User/Staff Feedback					✓
	Service Directory					✓

Focus in 2018/19

Activity – admissions and prevention

- New unplanned care model and expanded ICATT team, has successfully reduced numbers of acute admissions
- Previous inpatient provider de-registered an inpatient unit and registered as a community based service
- Successful bids for non-recurrent funding to kick start new model and absorb double running costs

Strategic and operational commissioning

- System-wide TC Programme Board with work-streams established.
- PMO with new Executive Lead and Programme SRO identified.
- Successful transfer of funding from specialised commissioning hub, distributed across the partnership using pooled budget principles.

Focus in 2019/20

Activity – admissions and prevention

- Second inpatient provider is opening a new community based service in June 19
- Increased focus on secure inpatients with forensic needs to ensure robust packages of support are available and that early discharge planning commences to reduce the overall number of NHSE inpatients

Increase Support for prevention, self-care and the wider determinants of ill health

- Increase the number of annual health checks
- Review the ATU/Locked Rehab model of care
- Evaluation of enhanced Services – ICATT, Forensics, Unplanned Care

Strategic and operational commissioning

- Strengthening alignment to the ICS
- Strengthening alignment to the Mental Health work-stream
- Delivery of national and regional trajectories/targets
- Working towards an agreed pooled budget
- Strengthen commissioning integration

Integrated Care Support and Finance

- Responding to the recommendations of the Learning Disability Mortality Reviews

Planned impact of changes

Outcome area	Metrics	Baseline (end Dec18)	2019/20	2020/21
Reduction in Inpatient Numbers	2019/20 18.5 specialised commissioned adult inpatients per million adult population and 18.5 CCG commissioned adult populations per million adult population 2020/21 inpatient targets – 17 specialised commissioned adult inpatients per million adult population and 13 CCG commissioned adult inpatients per million adult population	CCG 17 CCG Trajectory 31 Mar 2019 (13) NHSE 34 NHSE Trajectory 31 Mar 2019 (24) TCP = 51 Nb. Includes CYP	CCG 16 NHSE 16 TCP = 32 Nb. Not including CYP (TBC)	CCG 11 NHSE 15 TCP = 26 Nb. Not including CYP (TBC)
Reduction in the Number of available CCG Inpatient Beds	Reduction in block contract for ATU beds from 16-8 beds. Reduction in use of spot purchased locked rehab beds. Working with providers of locked rehab to develop new community based models of care.	CCG 20 CCG Trajectory 31 Mar 2019 (13)	CCG 16 NHSE 16 TCP = 32	CCG 11 NHSE 15 TCP = 26
Reduction in Length of Stay within an inpatient setting	5 Year Plus Cohort -reduction in the number of people who are in hospital settings for more then 5 years. Increased scrutiny on long stay cohort. Low secure and locked rehab providers to work towards approx. lengths of stay (15-24 months) with discharge planning to commence from admission. CTRs to challenge lengths of stay, promote discharge planning and provide a voice to service users and their families.	CCG 4 CCG Trajectory 31 Mar 2019 (3) NHSE 13 NHSE Trajectory 31 Mar 2019 (18) TCP = 17 (-8) Nb. Includes CYP	TBC	TBC
Annual Health Checks	improve uptake of the existing annual health check in primary care for people aged over 14 years with a learning disability, so that at least 75% of those eligible have a health check each year	TBC	TBC	TBC

Section 8 - Maternity

Why this is important

The National Maternity review, "Better Births" (2016), established a vision for maternity services to become safer, more personalised, kinder, professional and more family friendly. Despite improvements in quality and outcomes, maternity services continue to be in the spotlight nationally and unwarranted variation continues to exist.

In response to Better Births, providers and commissioners are working together as part of a Local Maternity System (LMS) to deliver the recommendations. The Nottingham & Nottinghamshire LMS was formed in 2017 to drive forwards a local transformation plan so that by the end of 2020/21 we have improved the choice, personalisation and safety of our local maternity services, including neonatal services.

Nottingham and Nottinghamshire have a varied, diverse and socially complex population. A high number of babies are born to mothers from BAME groups and to those under 18 years of age.

Parts of our system have high rates of smoking at time of delivery which leads to high and variable rates of still birth and neonatal death.

Nottinghamshire's rate of stillbirth and neonatal death (5.02 per 1,000) has improved however there remains variation across the system with Mansfield & Ashfield continuing to have the highest rate (6.49 per 1,000).

Our ambition

The Nottingham & Nottinghamshire LMS vision is that Maternity services should be safe, personalised, kind, professional and family friendly. Every woman should have access to information to make informed decisions and access support centred on their individual needs and circumstances.

This will be achieved by:

- Improving choice and personalisation of maternity services so that all pregnant women have a personalised care plan and are able to make choices about their maternity care; during pregnancy, birth and postnatally.
- Most women receiving continuity of the person caring for them throughout their whole pregnancy pathway whilst identifying digital opportunities to improve access and involvement.
- Reducing the rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% by 2020/21; creating a system which is committed to learning from incidents across the ICS and with others.

Our approach

Initiatives	Interventions (deliverables)	DM	E	MR	T	D
Continuity of Carer	A continuity of carer pathway (antenatal, intrapartum and postnatal) will be co-designed and offered to women and families				✓	
	As per the LTP vulnerable and deprivation cohorts will be a focus for the continuity offer	✓			✓	
	Improved continuity of carer in the antenatal and postnatal period for all women and families	✓			✓	
Personalised Care	All women will have a personalised care plan developed with her midwife and other health professionals which sets out her decisions about her care and reflects her wider health needs	✓			✓	
	Unbiased information and support to women will be provided to make choices about all aspects of their care, including choice of provider and birth setting	✓				
	All women will be able to access their personalised care plan and health records via a digital maternity tool, developed in line with the ICS's digital roadmap.		✓			
	Community hubs will be developed to provide a 'one stop shop' for antenatal and postnatal services for the women and her family				✓	
Safer Carer	A reduction of still birth, neonatal death, maternal death and brain injury rates	✓				
	Improved multi-professional working, breaking down barriers to provide safer and personalised care				✓	
	Implementation of an electronic maternity record to share data and information between professionals supported by electronic referrals		✓			
Improve access to specialist services	Improved access to postnatal physiotherapy	✓			✓	
	A debrief service will be developed for women and families following a difficult birth				✓	
	Specialist perinatal mental health services will be available from preconception to 24 months postnatal and the support offer to fathers / partners will be expanded				✓	

Focus in 2018/19

- System-wide Programme Board with workstreams established.
- Recent establishment of a PMO with new Executive Lead and Programme SRO identified. Full review of programme governance underway.
- Engagement with system wide workforce modelling (Whole Systems Partnership) alongside the Derbyshire STP.
- Close working with Connected Nottinghamshire around digital access to maternity records and improvements to current processes across both Trusts.
- Agreement of an IAPT pathway for perinatal mental health.

Focus in 2019/20

- Strengthening alignment across the ICS workstreams
- Implementation of agreed IAPT pathway for perinatal mental health
- Delivery of national and regional trajectories, including:
  - Piloting of Continuity of Carer models
  - Piloting a single co-produced personalised care plan for all women across the LMS
  - Co-production with women - choices information for the LMS supporting women to make unbiased choices about their care and from three settings of birth
- Start to explore potential pilot models for Continuity of Carer targeted towards women from BAME groups and those living in deprived areas.
- Responding to the recommendations of the Neonatal Critical Care Review and working with the Clinical Services Strategy work stream to determine best governance and oversight
- Implementation of maternity smoking cessation pathway (Nottingham City) and LMS wide smoking campaign
- Piloting a community hub model – separate pilots in Mid-Notts and Greater Notts with services available to meet the needs of the local population
- Review of postnatal care offer
- Continued engagement with public and staff to ensure co-production of all LMS initiatives
- Scoping for an LMS wide Single Point of Contact for All women and Families

Planned impact of changes

Outcome area	Metrics	Baseline	2019/20
Clinical outcomes	• Smoking at time of delivery	15.8%	13.1%
	• Reduce maternal mortality	15	7.5
	• Breast Feeding Initiation		
	• Nottinghamshire LMS	69%	73%
	• Nottingham City LMS	71%	75%
	• Breast Feeding at 6-8 weeks		
	• Nottinghamshire LMS	40%	44%
	• Nottingham City LMS	48%	52%
	• Maternal mortality rate (per 100,000 maternities)	15	7.5
Patient experience	• Number of women able to choose from three places of birth	0	75%

Outcome area	Metrics	Baseline	2019/20
Safety/ Quality	• Reduction in still births and neonatal deaths	5.88	5.17
	• Number of personalised care plans	0	50%
	• Number of women giving birth in midwifery settings	16.5%	25.5
	• Continuity of Carer (full pathway)	0	15%
	• Antenatal continuity	72.6%	80%
	• Postnatal continuity	38%	90%
Resource sustainability			

Section 9 - Prevention

Why this is important

As society and medical technology progress, we naturally expect people to live longer, healthier lives. Since 2010, however, not only have overall improvements in life expectancy stalled in England, but the inequality gap between the longest and shortest life expectancies has widened.

Much of the disease burden responsible for this is inherently preventable to begin with: almost all preventable ill health is driven by the four lifestyle factors of smoking, alcohol, physical inactivity and poor diet. Failure to prevent this burden equates to a sizeable proportion of our population suffering from preventable disease, which is inequitably distributed. It also constitutes a significant strain on services: around 50% of all GP appointments, 64% of outpatient appointments and 70% of hospital bed days are due to preventable ill health, representing an estimated £7 of every £10 spent on health and social care.

Overall, 40% of the burden on health services in England may be avoidable through preventative action. The clear importance of prevention has been repeatedly acknowledged, and committed to, in national and local policy.

Our ambition

Our vision is to maximise independence, good health and well-being throughout our lives. We want to empower local people to make healthier choices that support their own health and wellbeing. We want to ensure that people in our communities live long, healthy and independent lives.

This 'healthy' state of being should be experienced fairly by all our communities. We want to ensure that people living with an existing disability or long-term condition can live as well as possible through access to the right advice, treatment, care and support.

By enabling communities to support people to have a healthy lifestyle, with support from local services to do this, we aim to help people to manage their own health and wellbeing, alongside health and social care services if required.

Our vision is to develop a system which is focused on delivering improvements in the health, wellbeing and independence of our population, based on the '4 Pillars' identified by the Kings Fund . This means making connections between the following areas:

- Wider determinants of health and well-being
- Our health behaviours and lifestyles
- Communities, health and well-being
- Integrated care and relationships with communities.

Our approach

Initiatives	Interventions (deliverables)	DM	E	MR	T	D
Primary Prevention						
Reduce the impact of smoking	Improve pathways for commissioned services for smoking cessation	✓				
	Full implementation of the NICE guidance supporting smoking cessation in secondary care (PH48) and NICE guidance smoking: stopping in pregnancy and after childbirth	✓				
	Train and support the workforce in MECC across health and social care	✓				
	Embed tobacco as a driver for system leadership at Board level – organisational contracting requirement to sign up to tobacco declaration	✓				
	Effective enforcement and prevention activities	✓				
Reduce the impact of alcohol	Increase population level understanding of risk and harm	✓				
	Prevent alcohol harm through wider related local/national policy	✓				
	Embed a systematic approach to Alcohol Identification and Brief Advice (IBA)	✓				
	Identify 'alcohol champions' in key organisations across the system	✓				
	Include alcohol as a priority for employee health and wellbeing	✓				
	Ensure better communication of identified alcohol risk between some key parts of the system	✓				
	Case manage Emergency Department (ED) High Volume Service Users (HVSU)	✓				
	Agree and embed pathways for service users with co-existing mental health and substance misuse issues.	✓				
Increase immunisation against infectious diseases	Flu vaccination programme	✓				
	Childrens' immunisation and vaccinations uptake/coverage	✓				

Initiatives	Interventions (deliverables)	DM	E	MR	T	D
Secondary prevention						
Reduce the impact of cancer	*Cancer interventions are reflected in the cancer section*	✓				
Reduce the impact of diabetes	Proactive care delivered by multi-disciplinary teams in Primary Care Networks to detect disease as soon as possible	✓				
Reduce the impact of cardiovascular disease	Proactive care delivered by multi-disciplinary teams in Primary Care Networks to detect disease as soon as possible	✓				
DM: Demand Management E: Efficiency MR: Maximise Resource into System T: Transformation D: Decommissioning						

Focus in 2018/19

- Approval for and implementation of Prevention Framework
- Alcohol agreed as the short term prevention priority for the ICS
- Alcohol 8 point action plan agreed and implemented
- Prevention priorities agreed for each of the ICS workstreams
- Embedding prevention at an organisational level by aligning a Public Health Registrar to the Trusts

Focus in 2019/20

- Establishing alcohol champion in organisations across health, care and partner organisations, including a work programme
- Embedding IBA into workforce policies and practices across the system
- Effective case management and IBA through ED departments
- Agreeing and implementing ICS level plan for tobacco
- Further embedding prevention in ICS workstreams
- Consistently applied system wide approach to the detection of and diagnosis of Atrial Fibrillation
- Implementing relevant public facing campaigns to support primary and secondary prevention initiatives
- Progress Children and Young People's prevention plan focusing on childhood healthy weight, school readiness, resilience, imms and vacs coverage
- Developing the Prevention Framework to support the Five Year Strategy including alignment with the

Planned impact of changes

TBC

SECTION 10 - CONTINUING HEALTHCARE (CHC)

Why this is important

CHC provision is one of our statutory responsibilities, has a strong basis in case law, and significant review and oversight. The process for the NHS to decide on eligibility for NHS Continuing Healthcare is mandated[1], along with the forms to be used.
Provision of support to other individual packages such as S117 is also mandated through the Care Act (2014)[2].

In the 10 year plan the focus on increased choice and control is a key element of these packages and an integrated and aligned approach will allow us to meet our ambitions.

Whilst small in number these are often high cost packages as they provide long term ongoing care to the most complex people in our systems, increasing integration into existing services offers an opportunity to increase quality and provide value for money.

Our ambition

Whilst we are clear about our statutory CHC responsibilities, we will maximise integration and a person centred approach across CHC. We will include all jointly funded (JF), S117, FNC and all individually funded packages of care within the CCGs with a single vision that will develop as the new system does through the year.

Moving forwards we will develop an integrated three year CHC strategy with social care partners across the ICS and continue to be a leader in person centred care.

Our approach

Initiatives	Interventions (deliverables)	DM	E	MR	T	D
Strategy & Leadership	Single SRO across the CCG footprint and develop an aligned strategy and process				✓	
	Develop an integrated 3 year CHC strategy with social care partners across the ICS and continue to be a leader in person centred care				✓	
Screening	Establish a clear local policy around joint funding, reducing the number of inappropriate Checklists received	✓				
	Align CHC processes to developments in D2A and urgent care pathways				✓	
Full assessment	Improve the detail of recommendations	✓				
	Increase staff training	✓				
	Ensure that person centred care and support plans are used to support DST assessments	✓				
Verification	All CCG staff authorised to verify MDT recommendations are trained to do so	✓				
	Clearer assessments and recommendations allowing it to be clear, and recorded when/why CHC eligibility is not agreed	✓				
FNC	Process in place for Assessors to use the previous checklist/DST to determine if a new DST required – this will reduce time spent on reviews		✓			
Fast Track	Maximise use of appropriate end of life pathways, rather than using fast track referrals.		✓			
	Increase training for referring clinicians to reduce inappropriate referrals	✓				
Brockerage	Strengthen brokerage arrangements and align these across the single CCG footprint.		✓			
	Include NCC as an associate commissioner on the existing care homes contract led by Nottingham City Council, with all 6 CCGs as associates.			✓		
Personal Health Budgets	Ensure all CHC commissioning decisions/plans are based on the principles of personalisation and Person Centred Care.				✓	
	Deliver all CHC homecare packages (including fast track when possible) via a PHB.				✓	
Review and Case Management	Work in line with the review process outlined in the 2018 Framework, addressing current backlogs.		✓			
	Embed the principles of person centred care in our case management approach, reviewing the existing resource to ensure it supports this.				✓	
	increase integration around case management though the work being done as part of the integrated personalisation pilot, and wider engagement of CHC staff in commissioning of new pathways.				✓	
PUPoc & Appeals	All outstanding PUPoC appeal cases still with Arden & Gem to be completed, supported by an ICS approach to managing new PUPoCs.		✓			
	Establish a single local resolution policy across ICS.		✓			
	Ensure that the CHC pathway is used appropriately and that communication to patients, families and staff is clear		✓			

DM: Demand Management E: Efficiency MR: Maximise Resource into System T: Transformation D: Decommissioning

Focus in 2018/19

- Increased integration, personalisation and management of costs through service re-procurement.
- Achievement of quality premiums related to CHC
- Involvement in NHSE CHC Strategic Improvement Programme (SIP) and embedding learning.

[1] https://www.events.england.nhs.uk/upload/entity/30215/national-framework-for-chc-and-fnc-october-2018-revised.pdf
[2] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Focus in 2019/20

Strategy and Leadership

- A single SRO across the CCG footprint and develop an aligned strategy and processes.

Screening

- Work with LA colleagues to have a clear local policy around joint funding, reducing number of inappropriate Checklists received.
- Work to align CHC processes to developments in D2A and urgent care pathways.

Full Assessment

- Improve the detail of recommendations, increase training for staff and ensure that person centred care and support plans are used to support DST assessments

Verification

- Ensure all CCG staff authorised to verify MDT recommendations are trained to do so. This will be supported by clearer assessments and recommendations allowing it to be clear, and recorded when/why CHC eligibility is not agreed.

FNC

- Have a clear process in place for Assessors to use the previous checklist/DST to determine if a new DST required – this will reduce time spent on reviews.

Fast Track

- Maximise use of appropriate end of life pathways, rather than using fast track referrals. We will increase training for referring clinicians to reduce inappropriate referrals

Brokerage

- Strengthen brokerage arrangements and align these across the single CCG footprint. We will also work to include NCC as an associate commissioner on the existing care homes contract led by Nottingham City Council, with all 6 CCGs as associates.

Personal Health Budgets

- Ensure all CHC commissioning decisions/plans are based on the principles of personalisation and Person Centred Care. All CHC homecare packages (including fast track when possible) will be delivered via a PHB.

Review and Case Management

- Continue to work in line with the review process outlined in the 2018 Framework, addressing current backlogs. We will embed the principles of person centred care in our case management approach, reviewing the existing resource to ensure it supports this

PUPoc & Appeals

- All outstanding PUPoC appeal cases still with Arden & Gem to be completed, supported by an ICS approach to managing new PUPoCs. We will also have a single local resolution policy across ICS.

Planned impact of changes

In line with the NHS Continuing Healthcare Strategic Improvement Programme [3]

- Reduce the variation in patient and carer experience of CHC assessments, eligibility and appeals.
- Ensure that assessments occur at the right time and place, with fewer assessments taking place in hospitals.
- Identify and implement best practice and once agreed national standards
- Make the best use of resources – offering better value for patients, the population and the tax payer.
- Continue the successful integration of CHC into the Personalisation and Choice targets and work, supporting the ICS ambitions/targets around person centred care and support plans and PHBs/IBs.
- By April 2019, NHS England expect that everyone living in their own home in receipt of CHC funding will have a personal health budget – we will extend this across all packages offered by the services in line with ambitions in the 10 year plan, especially focussing on fast track and care homes.

We will also

- Increase the integration of care with the local authorities to reduce duplication and cost in both process and care packages.
- Support the delivery of discharge pathways by providing assessments out of hospital in a timely manner in line with the NHSE Quality Premium targets.

[3] https://www.england.nhs.uk/healthcare/nhs-chc-strategic-improvement-programme/

- Less than 15% of assessments conducted in an acute setting
- More than 80% of cases with an eligibility decision is made within 28 days from receipt [4]

- Increase value for money on care packages, focussing on market management, person centred approaches and regular review to deliver planned savings in 2019/20.
- Improve the quality of care delivered by alignment with domiciliary and EHCH programmes

[4] https://www.england.nhs.uk/wp-content/uploads/2018/04/annx-b-quality-premium-april-18.pdf

Section 11 - Personalised Care including Personal Health Budgets

Why this is important

We can improve the quality of care and health and wellbeing of local people and create a sustainable future for our local services through scaling up personalised care and empowering local people.

One of the five major, practical, changes to the NHS service model to bring about the change over the next five years is that "people will get more control over their own health, and more personalised care when they need it".

The model offers a whole-population approach to supporting people of all ages and their carers to manage their physical and mental health and wellbeing, building community resilience and making informed decisions and choices when their health changes

Prior experience of 2 IPC (Integrated Personal Commissioning) Programmes across Nottinghamshire (City & County), provides our system with a good track record of delivering personalised care and is regarded by national peers as a trailblazer in this area.

Our ambition

Our vision is to maximise independence, good health, and wellbeing throughout our lives, shifting the focus from 'what is wrong with you' to 'what matters to you'.

Our ambition and overall objective is to continue to be a leader in Personalised Care and deliver universal implementation of the Comprehensive Model of personalised care: making it a golden thread through everything we do, making it business as usual and an everyday reality for people by delivering the following objectives:

- Embedding of Shared decision making in 30 high-value clinical situations in primary care, secondary care and at the primary/secondary interface where it will have the greatest impact on experience, outcomes and cost – to be achieved by 2029
- For Nottinghamshire, by March 2020, a minimum of 20,869 people will have benefitted from Personalised care and support plans, across both specialist and targeted tiers of the Comprehensive Model.
- Around 5% of the population (50,000 people) will benefit from social prescribing every year
- Additional link workers in place across the system. National target is that "30,000 people with long-term conditions who also have low levels of knowledge, skills and confidence will have an assessment of their knowledge, skills and confidence (activation level),with 1 million benefitting from supported self-management approaches". For Nottingham, this means a minimum of 9,663 people in 2019/20
- Expand Personal Health Budgets to people with long term conditions or complex needs to 4% of the population, with 50% of the budgets being achieved through provider led services. For Nottingham, this means a minimum of 2,900 people will benefit from a PHB or integrated budget during 2019/20.
- From April 2020, everyone eligible for an assessment under the Care Act will experience an integrated and personalised approach, through joined up assessments, support plans and budgets across the 23 Primary Care Networks

Our approach

Initiatives	Interventions (deliverables)	DM	E	MR	T	D
Integrated Accelerator Project	Assessments for people with health and social care needs; personalised care and support planning for health and social care outcomes; and offering of more integrated personal budgets for health and social care funding (where beneficial)	✓	✓	✓	✓	
Personalised care and support planning	Proactive, personalised conversations which focus on what matters to individuals, delivered through a six-stage process and paying attention to clinical as well as wider health and wellbeing needs	✓	✓	✓	✓	

Initiatives	Interventions (deliverables)	DM	E	MR	T	D
Personal health budgets and integrated personal budgets	Accelerate the roll out of Personal Health Budgets to give people greater choice and control over how care is planned and delivered.	✓	✓	✓	✓	
	Ensure all people receiving home-based NHS CHC have this provided as a PHB by default by 2019/20.	✓	✓	✓	✓	
	Explore and expand PHBs in fast track NHSE CHC-funded homecare packages and test out using budgets proactively in EOL care, to reduce the need for fast track.	✓	✓	✓	✓	
	Children and young peoples continuing care, and moving to a default position	✓	✓	✓	✓	
Workforce	Develop workforce skills by embedding PCSP in induction, training, supervision and appraisals.	✓	✓	✓	✓	
	Develop professional skills and behaviours to deliver PCSP as fundamental ways of working across health and social care staff, involving the VCSE workforce as appropriate to facilitate better cross-system working.	✓	✓	✓	✓	
Social prescribing	A clear understanding of what assets or resources exist and are strong within local communities	✓	✓	✓	✓	
	Systematic referral to sources of non-clinical support through social prescribing and community connecting roles, building and stronger partnerships with the voluntary, community and social enterprise sector.	✓	✓	✓	✓	
	Identify existing link workers and support the introduction, training and quality assurance of link workers joining PCNS across Nottingham and Nottinghamshire					
	Work with ICPs and PCNs to agree best approach to delivering social prescribing on a place basis, building on what already exists in communities.					
Supported self-help and volunteering	A proactive & universal offer of support to people with long term physical and mental health conditions to build knowledge, skills and confidence leading to improved ability to self-manage and build community capacity.	✓	✓	✓	✓	
	People, their families and carers will be encouraged to develop their knowledge, skills and confidence by being involved in local community groups and giving their time back to others. For some people, this may provide volunteering and work opportunities to find paid employment.					
Health Coaching, self-management education, peer support and PAM	Giving people the support they need to manage their health in a way that suits them best, tailored to their level of knowledge, skills and confidence, and measured through tools such as the Patient Activation Measure (PAM).	✓	✓	✓	✓	
	Increasing members of the ICS workforce who are trained health coaches,	✓	✓	✓	✓	
Shared Decision Making	Clinicians and practitioners involving people more fully in designing support around their individual needs and circumstances by embedding Shared Decision Making and enabling choice, so that people are knowledgeable and supported as equal partners in decisions about their care and treatment	✓	✓	✓	✓	
DM: Demand Management E: Efficiency MR: Maximise Resource into System T: Transformation D: Decommissioning						

Focus in 2018/19

- The ICS signed an MOU with NHSE to be a demonstrator site for the Comprehensive Model of Personalised Care. Significant work is in place to support the scale up of the model, increasing numbers of PHBs, integrated budgets and personalised care & support planning As at Q3, current performance is 1,503 PHBs out of a target of 2,060 and 12,497 personalised care and support plans out of a target of 10,840.
- Establishment of Integrated Accelerator Sites to deliver integrated assessments of peoples' needs in a personalised way.
- Establishment of Delivery Groups across the ICPs that will oversee the design of best model / approach to delivering social prescribing and community connectivity across the GN ICP. Work underway to agree a plan for roll out; Plan due by June 2019.
- Develop a better understanding of the incident of community based approaches and extent to which people are benefitting from these approaches through greater engagement and ongoing links with the VCSE and existing community assets.
- Increased access to self-management support, health coaching and community based approaches; As at Q3, current performance is 15,638 out of a FYE target of 10,840

Focus in 2019/20

- Build on the work of the delivery groups, specifically: detailed mapping of local organisations and community support (collaborating with local authority community development) and implementation of agreed plans for the roll out of community centred approaches, including Social Prescribing & Community Connectivity.
- Increased numbers of link workers and health coaches across the ICS, supporting LTC aspirations around the role, function and minimum quality standards for link workers being introduced to PCNs.
- Implement ICS-wide plan for increasing the use of PAM and other relevant measures across the system; Target for 2019/20 is 9,663

- Establish Evaluation Framework for measuring Community Centred Approaches – Aim is to have a bespoke measurement tool for use across the ICS to make 'like for like' measurement of services once established.
- Increase the number of people with LTC and complex needs who receive a PHB to 2,900 people. (2018/19 target was 2,060)
- Continue to exceed national targets, reaching 20,869 person centred care and support plans by 2020, working collaboratively to ensure people in health and social care have one joined up plan that starts with an 'All About Me'
- Across the ICS, work to achieve the standard of *everyone eligible for an assessment under the care Act experiencing a personalised approach to their assessment*

Planned impact of changes

Outcome area	Metrics	Baseline	2019/20
Patient experience	Use of PAM and other relevant measures		9,663
	No. of people with a LTC and complex need who receive a PHB		2,900
	No. of people with a person centred care and support plan		2,900
	No. of people who access measurement tools, self –management and peer support		9,663

Key measures and metrics to be developed

Choice & Control

a) Number of people who have an integrated personalised care and support plan
b) Number of people who have a personal health budget
c) Number of people who receive a direct payment for social care services

Connections to community based support to keep well, independent and healthy ('Social Prescribing')

a) Number of people who access advice and information e.g. LION/Notts. HY
b) Number of people who are connected to community based support including peer based support
c) Number of people accessing social prescribing/community signposting
d) Number of people who take up the advice following social prescribing/community signposting

People gain and maintain the knowledge, skills and confidence necessary to manage their own health and care

a) Number of people who are supported to manage their own health and care through impact measurement tools
b) A minimum of 9,663 people access measurement tools, self-management and peer support during 2019/20

People (with long term conditions and disabilities) are supported to live independently in the community

a) Number of people who live in a care home (good is low)
b) Number of people who access short term support (high is good)

People receive joined up care and support

a) Number of people who receive an integrated care and support plan

ANNEX B - Assurance Statements

Programme	Next step deliverable (please refer to column C of the master spreadsheet)	MN ICP Description of plans that are in place or will be put in place to support achievement of the deliverable	GN ICP Description of plans that are in place or will be put in place to support achievement of the deliverable
Cancer	All providers must start collecting mandatory data items for the 28-day faster diagnosis standard cohorts and, working through their Cancer Alliance, use the data to improve time to diagnosis, in particular for lung, prostate and colorectal cancers, before the standard is introduced in 2020. All Cancer Alliances should implement the national timed pathway for oesophago-gastric (OG) cancer by the end of 2019/20.	SFHT have implement latest Infoflex update and are monitoring average time to diagnosis for each tumour site National timed pathway for oesophpgp-gastric cancer not started yet	NUH and Circle has started collating 28 day diagnosis data via Infoflex and monitoring performance by tumour site. National timed pathway for oesophago-gastric (OG) not yet available. Significant transformation of the pathway in place which is expected to be within the timed pathway e.g. straight to test, one-stop shop for diagnosis.
Cancer	Show improvement in the proportion of cancers diagnosed at stage 1 and 2, as progress towards the ambition of 75% cancers diagnosed at stage 1 and 2 by 2028/29, and reduce the proportion of cancers diagnosed following an emergency admission. All Alliances should work with the national programme to begin the roll out of Rapid Diagnostic Centres (RDCs) – starting with one RDC in each Alliance geography – and to transform diagnostic provision in their area. Where relevant, CCGs should participate in the national targeted lung health checks programme.	SFHT have updated Infoflex and it is now able to collect staging data. Implementation of national timed pathways for colorectal, lung and prostate will increase proporton of cancers diagnosed at early stage. FIT for symptomatic patients implementied. Direct Access to diagnostics implemented as per NICE guidance. Targeted Lung Health MOTsto be implemented in M&A CCG as part of national programme. Vague symptoms pathway being expanded in Mid Notts Need clarity from National Team on what is meant by Rapid Diagnostic Centre. Is it a building or pathway?	Good progress in implementing national timed pathways for colorectal, lung and prostate will increase proporton of cancers diagnosed at early stage. FIT for symptomatic patients implementied. Direct Access to diagnostics implemented as per NICE guidance. Targeted Lung Health MOTs being delivered in Nottingham City. Vague symptoms pathway being expanded into Greater Notts
Cancer	Improve uptake of screening for bowel, cervical and breast cancers. Support the rollout of FIT in the bowel cancer screening programme and the implementation of HPV primary screening for cervical cancer [clarification to Annex B by Cancer Programme]	Take up of screening programmes in mid Notts is better than the national average. Roll out of Macmillan GP Quality Toolkit will increase practice focus on improving take up Nottinghamshire started HPV pilot on 01/06/18. Latest report from PHE is that results are now being returned within target of 14 days.	Working with CRUK to support geographies with low screening uptake rates. CCGs working with NHSE to implenet FIT and HPV screening.
Cancer	Implement the new radiotherapy service specification, including the establishment of Radiotherapy Networks.	Will work with Specialised Commissioning and Cancer Alliances to implement.	Will work with Specialised Commissioning and Cancer Alliances to implement.
Cancer	All providers should work with their designated Genomic Laboratory Hub to implement the national genomic test directory, the patient choice offer and fresh-frozen pathways.	Will work with Specialised Commissioning and Cancer Alliances to implement.	Will work with Specialised Commissioning and Cancer Alliances to implement.
Cancer	Ensure full implementation of breast cancer personalised (stratified) follow-up protocols by the end of 2019/20, so that from April 2020 approximately two-thirds of patients who finish treatment for breast cancer are on a supported self-management follow-up pathway. All Cancer Alliances should have in place clinically-agreed protocols for stratifying prostate and colorectal cancer patients and systems for remote monitoring by the end of 2019/20.	Partial implementation of breast follow-up protocols started in December '18. SFHFT piloting remote monitoring portal using Infoflex	Breast cancer personalised (stratified) follow-up protocols in place and implemented. Protocols in place rfor Prostate and Colorectal cancer. To be implemented in 19/20. NUH piloting remote monitoring portal using Dr Doctor.
Cancer	Support delivery of regional plans for implementation of Phase 1 of the Cancer Workforce Plan.	Will work with Cancer Alliance and HEE to implement phase 1.	Will work with Cancer Alliance and HEE to implement phase 1.
Continuing Healthcare	Ensure that in more than 80% of cases with a positive NHS Continuing Healthcare (CHC) Checklist, the NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the Checklist (or other notification of potential eligibility). In addition, ensure there are no referrals breaching 28 days by more than 12 weeks in each reporting quarter, or by Q4 2019/20.	Currently achieving - no cases over 12 weeks for a number of consecutive months	
Continuing Healthcare	Develop plans to incorporate Continuing Healthcare strategic improvement programme opportunities into QIPP for 2019/20 through continued standardisation of process and adoption of best practice including the implementation of digital solutions, use of CHC SIP tools and guidance, and use of the CHAT assurance tools. All CHC QIPP plans greater than £500k or 5% of the total 2019/20 CCG Continuing Care budget must be signed off by the Chief Nurse at the CCG. Detailed QIPP plans outlining how the financial efficiencies will be achieved must be provided to NHSE regional teams by the end of quarter 1 and achievement against these plans should be reviewed at least on a quarterly basis.	Yes - Plan in place, CHAT utilised, ICS SRO and CCG Executive Leadership, Engagement with national SIP priorities and communities of practice	
Continuing Healthcare	Ensure that less than 15% of all full assessments for NHS CHC funding take place in an acute hospital setting.	Plans in place for sustainability & oversight	
Personal Health Budgets	Ensure the delivery of all new Continuing Healthcare home-based packages (excluding fast track), using the personal health budgets model as the default delivery process in all CCGs.	No known issues with PHBs and CHC As an early adopter of personalisation and a demonstrator site in both 17/18 and 18/19 the CHC programmes are already fully aligned to offering both person centred care and support plans and integrated and personal health budgets for home care packages. As indicated in our 19/20 plan we have a stretch ambition to extend this to both fast track and jointly funded packages.	

Programme	Next step deliverable (please refer to column C of the master spreadsheet)	MN ICP Description of plans that are in place or will be put in place to support achievement of the deliverable	GN ICP Description of plans that are in place or will be put in place to support achievement of the deliverable
Elective	Ensure all local transformation plans reflect the recommendations in the elective care specialty handbooks, where a relevant specialty has been identified as a priority.	MSK: Clinical review and triage - in place across Mid Notts; work in year to share best practice to ensure aligned offer to patients Standardised referral template - in place Self management/education and patient passport - some good practice within Mid Notts (use of MSK apps; info on websites) work with providers will spread good practice across the patch FCP - See below Telephone follow ups - virtual clinics, non face to face and PIFU being driven via the standard approach to OP re-design with SFHFT Diabetes: A&G - in place Shared learning events - event on 28th February planned for improvements to footcare; PLTs in individual CCG areas; looking to develop more systematic approach - project plan to be produced by sub group focusing on improvements in relation to the 3 Treatment Target; Group not yet established - to be agreed at meeting of Steering Group on 14th February Patient education events - standardised approach to structured education now in place across ICS; sub group being formed to review other patient information and education pathways Meds management in diabetes pathway -- deep dive info provided by RightCare on meds management in diabetes pathway being reviewed by MM team to understand whether need to move from current practice of MM reviews being undertaken as part of routine work by practice pharmacists MDT in GP Practices - currently different operating models in place across ICS; sub group focusing on improvements in relation to the 3 Treatment Target will review practice; Group not yet established - to be agreed at meeting of Steering group on 14th February. Approach unlikely to be Practice base due to capacity constraints Full programme of work in Diabetes is wider than the initiatives within the Handbook	
		Ophthalmology: Standard cataract referral form - Mid Notts standard cataract referral form was replaced with a new Prior Approval Form and standard referrals forms which have been in place since the introduction of the community ophthalmology service - to be reviewed by end of July 2019 Direct referral from optometrists to secondary care - dependant on optometrists being able to use e-RS; currently they do not have nhs.net accounts which is NHSE responsibility as commissioner. We plan to explore this further during 2019/20. Triage of glaucoma referrals - in place Patient decision aids - RightCare decision aids for Cataracts are in place. Consideration will be given to wider use of decision aids as part of response to any capacity gaps shown from demand and capacity review Virtual clinics - virtual clinics, non face to face and PIFU being driven via the standard approach to OP re-design with SFH Gastro: A&G in place Patient Initiated Follow Ups in place as of end of January 2019 Abnormal anaemia pathway being developed Improving access to diagnostics via a fibroscanner Dermatology: GPSI led triage and community service in place across Mid Nottinghamshire TeleDerm being utilised across the CCGs in primary care with interpretation from specialists	
Elective	Continue to embed First Contact Practitioner (FCP) services, participate in the national evaluation process, and roll out FCP services more widely where opportunities are identified locally.	Mid Notts has introduced a variance on the FCP model, where all patients are able to self refer to Physio, as part of the wider MSK service. This is currently in place and working successfully, however it has increased demand. Mid Notts are the pilot for ICS and are supplying monthly data to centre in relation to this model.	Awaiting results and learning from national and local pilot
Elective	Maintain failsafe prioritisation processes and policies in all areas to manage the risk of harm to ophthalmology patients, and act on the outcomes from the eye health capacity reviews	SFHFT have a failsafe process in place and will have a policy by end of March 2019. Eye health capacity review due to be submitted to NHSE on 18th March with final submission on 31st March. Once completed plans to address gaps in capacity will be developed but cannot be started until model is completed. Timetable is: ICS stakeholder group to be established once ICS response to proposal for eye quality board is determined Detailed analysis of: capacity gaps, previous and existing projects in place to manage capacity, impact of initiatives in transformation handbook etc - end of May 2019 Detailed project plan to address capacity gaps - end of June	NUH will have failsafe process and policy in place by end of March. Eye health capacity review due to be submitted to NHSE on 18th March with final submission on 31st March. Once completed plans to address gaps in capacity will be developed but cannot be started until model is completed. Timetable is: ICS stakeholder group established once ICS response to proposal for eye quality board is determined Detailed analysis of capacity gaps, projects within NUH previously tried to manage capacity, impact of initiatives in transformation handbook etc - end of May 2019 Detailed project plan to address capacity gaps - end of June
Elective	Utilise capacity alerts on the NHS e-referral Service as a tool to support shifts in flows of activity identified in local commissioning plans and as a tool to support recovery where referral or activity plans are not being delivered in year.	Initial awareness raising webinar held with CCG and Providers. Vicki Johnson from NHSE is arranging meeting to discuss the detail of the scheme and experience of areas who already have capacity alerts. Following this meeting, project plan will be developed.	Initial awareness raising webinar held with CCG and Providers. Vicki Johnson from NHSE is arranging meeting to discuss the detail of the scheme and experience of areas who already have capacity alerts. Following this meeting, project plan will be developed.
Maternity	Continue against trajectory to deliver improvements in safety towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and by 50% in 2025.	Trajectory & Plan agreed at LMS / ICS level (Jun 18) . Plans include: A range of interventions to reduce still birth, neonatal death, maternal death and brain injury rates; Improved multi-professional working, breaking down barriers to provide safer and personalised care; and Implementation of an electronic maternity record to share data and information between professionals supported by electronic referrals	
Maternity	Deliver full implementation of the Saving Babies' Lives Care Bundle (v2) by 31st March 2020.	Saving Babies Lives care bundle (v2) will be rolled out (once published). Plan in place for roll out.	
Maternity	Increase the number of women receiving continuity of the person caring for them during pregnancy, birth and postnatally so that by March 2020, 35% of women are booked on to a continuity of carer pathway. All reasonable endeavours must be undertaken to ensure that continuity of carer is provided to groups that experience the poorest outcomes, such as women from ethnic minorities and the most deprived socio-economic groups. Continuity of carer should	Plan in place to pilot a number of CoC pilots during 2019/20. Plans include: Full continuity pathway for most women and families; Enhanced and targeted CoC for the most vulnerable women and babies; and Improved continuity of carer in the antenatal and postnatal period LMS current trajectory is set at 10% by March 2019 and 15% by March 2020, this is due to be reviewed in Feb 19 the LMS, this will include a focus on vulnerable groups as per LTP.	
Maternity	Continue against trajectory to deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 all women have a personalised care plan.	LMS plan in place whihc includes: Personalised Care Plan for All Women; Unbiased information and choices for All Women; Care closer to home with access to range of services; Digital access to Maternity Records; Antenatal and postnatal services accessible in a local community hub	
Maternity	Continue against trajectory to deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 more women can give birth in midwifery settings.	LMS plan in place whihc includes: Personalised Care Plan for All Women; Unbiased information and choices for All Women; Care closer to home with access to range of services; Digital access to Maternity Records; Antenatal and postnatal services accessible in a local community hub	

Programme	Next step deliverable (please refer to column C of the master spreadsheet)	MN ICP Description of plans that are in place or will be put in place to support achievement of the deliverable	GN ICP Description of plans that are in place or will be put in place to support achievement of the deliverable
Mental Health	Additional CCG baseline funding should be used for its intended purpose to deliver commitments as set out in Implementing the Five Year Forward View for Mental Health and in all guidance related to mental health finances for this 2019/20 planning round.	All CCGs have planned to invest above 18/19 expenditure levels at a rate of allocation growth plus 0.7% for mental health excluding LD and dementia and within this to increase the CAMHs investment in line with the indicative allocation baselines. The CCGs and Trust are jointly undertaking a re-specification and demand and capacity modelling exercise to determine the service level gaps to deliver the 5 Year forward View. This will then inform the prioritised investment plan over the next 2 years to ensure requirements are fully met.	
Mental Health	All CCGs must meet the Mental Health Investment Standard (MHIS). Full information is in section 3.6 of the NHS Operational Planning and Contracting Guidance 2019/20.	All CCGs have planned to invest above 18/19 levels at a rate of allocation growth plus 0.7% for mental health excluding LD and dementia and within this to increase the CAMHs investment in line with the indicative allocation baselines. This has been reflected in CCG financial plan template submissions and will be monitored monthly through the Non ISFE returns.	
Mental Health	STP/ICS leaders, including an identified lead mental health provider, will review each CCG's investment plan underpinning the MHIS to ensure it covers all of the priority areas for the programme and the related workforce requirements. Any outstanding concerns will be escalated to the NHS England/NHS Improvement regional teams.	Plans will be jointly developed and agreed with the main provider underpinned by the joint demand and capacity modelling and service specification agreement. Project plans and timescales for completion of this work through to implementation plans will be reflected in the NHS Standard Contract Service Development and Improvement Plan. This will inform as a minimum the 2 year investment plan to deliver 5 Year Forward View requirements but will also underpin the 5 Year Plan due in the autumn. Plans will be shared in full with the ICS Strategic Mental Health Group.	
Mental Health	Each CCG should work closely with their NHS and non-NHS provider partners and ALBs locally to deliver against workforce plans, including expansion and enabling of training and retention schemes. Workforce requirements should form part of finance and mental health investment plan discussions to ensure alignment with CCG financial submissions.	Demand & capacity modelling is being undertaken jointly with the main provider and will inform the workforce planning. Commissioners and provider are working collectively to determine how to deliver the FYFV standards within the available financial envelope. In IAPT CCGs are working with providers to agree access trajectories and delivery plans including the recruitment of trainees and workforce development in line with the financial investment plan. CCGs are represented in ICS workforce planning meetings.	
Mental health	Continue work to deliver expansion in the capacity and capability of the CYP workforce building towards 1,700 new staff and 3,400 existing staff trained to deliver evidence-based interventions by 2020/21.	The partnership wide , Children and Young People's Mental Health workforce steering group is currently refreshing it's action plan which includes a programme of training on a universal, Level One , Level Two and Specialist level which will be offered across partners in both the City and County and that we expect to benefit 200-300 staff. In the County, in addition to the trailblazer there are 4 trainee Wellbeing Practitioner and 2 RTT CBT posts. In the City training is routinely offered to all targeted CAMHS Staff in practice based on evidence and team alsobeing trained in time limited psychodynamic psychotherapy. The ICS Local Workforce Action Board will ensure that there is appropriate crossover between children and adult services and to address the ambition of the 0-25 offer outlined in the NHS 10 Year Plan. Work will be further developed following a HEE Regional Mental health workforce planning workshop on February 15th. A funding application has been submitted to rollout training across 200 staff in the the partnership around addressing parental conflict . Funding has been secured to recruit 2 additional therapists and 5 additional well-being practitioners.	
Mental health	Continue to show evidence of local progress to transform children and young people's mental health services through publication of refreshed joint agency Local Transformation Plans aligned to STPs. This will support the requirement to increase access to 34% of estimated 2004 CYP prevalence (measured via SDCS). Additional funding will be provided to support the delivery of staff trained in CYP IAPT interventions. STPs as part of their workforce planning are expected to work with partners to ensure that staff trained by HEE through the 'recruit to train' programme are offered contracts by providers to maintain momentum in improving access in line with FYFVMH commitments. Further funding will be provided to specific CCGs to support the delivery of mental health support teams in schools and colleges and 4-week pilots in 2019/20.	The Local Transformation Plan has been published on CCG websites and is currently 'partially assured'. To achieve assurance further information and plans around funding, workforce and crisis care will be included. A SMART delivery plan to accompany the LTP is being developed. This work will be completed by the end of March for a refreshed planto be published in April.	
Mental health	Each CCG, as part of an STP footprint, should ensure increased access to NICE concordant community-based specialist perinatal mental health services (in secondary care settings) for at least 4.5% of their population birth rate, equating to an additional 20,000 women nationally. This means: •Ensuring effective use of additional CCG baseline investment for these services to continue and expand further following transformation funding in 2017/18 and 2018/19, as set out for 2019/20 in Chapter 3 of Implementing the Five Year Forward View for Mental Health.	Transformation funding was provided by NHSE and plans are currently being discussed to ensure ongoing funding to achieve the standard in 2019. Commissioners will continue to monitor the numbers of women accessing the service in relation to the local birth rate. The Steering Group which oversaw the transformation will continue to support the service in line with maternity transformation programme.	
Mental health	Ensure continued focus on improving access to psychology therapies (IAPT) services through meeting core IAPT offer requirements, all areas commissioning IAPT-LTC (psychological therapies for people with Long Term Conditions) services, and co-location of therapists in primary care. This requires CCGs to expand access, including for underrepresented groups like older people and BAME. For IAPT-LTC, this means CCGs should ensure they issue a contract variation to their local IAPT provider for the delivery of IAPT-LTC, and increase funding to the provider to achieve 22% access, whereby two thirds of the increase in access should be delivered within the IAPT-LTC service.	The new IAPT access rates will be included in all contracts for April 19. Mid Notts has included LTC in new contracting arrangements from April 19, which include the continuation of successfully co-located IAPT Pain and Cancer services at Kings Mill hospital. Greater Notts has continued to fund wave 2 pilot work through tariff and widened it's reach to include all of Greater Nottingham. This includes Cancer, Pain and Respiratory services. Currently only IAPT Cancer services are co-located. Greater Nottingham will ensure LTC is embedded in future contracts as re-procurement plans progress in 2019. There will be a continued focus on primary care co-location with plans to co-locate services within new primary care hubs in Mid Notts. Greater Nottingham already has successful co-location with the University practices.	
Mental health	Use additional 2019/20 baseline funding to stabilise and bolster core adult and older adult community mental health teams and services for people with the most complex needs, including people with diagnoses of personality disorder and eating disorders. Alongside this, undertake preparatory work for the mobilisation of a new integrated primary and community model as part of the Long Term Plan. This preparation should include strengthening local relationships between primary care, secondary care, local authorities and VCS services, developing understanding of local need through information and data (such as the NHS England and NHS Benchmarking Network community mental health services stocktake), and early workforce planning.	Plans will be jointly developed and agreed with the main provider underpinned by the joint demand and capacity modelling and service specification agreement. Project plans and timescales for completion of this work through to implementation plans will be reflected in the NHS Standard Contract SDIP. Plans will be shared in full with the ICS Strategic Mental Health Group.	Plans will be jointly developed and agreed with the main provider underpinned by the joint demand and capacity modelling and service specification agreement. Project plans and timescales for completion of this work through to implementation plans will be reflected in the NHS Standard Contract SDIP. Plans will be shared in full with the ICS Strategic Mental Health Group.
Mental health	All CCGs are encouraged to work with regional teams to develop plans to establish baselines and track access to PT-SMI (psychological therapies for people with severe mental illness, defined in the Five Year Forward View for Mental Health as Psychosis, Bipolar Disorder and Personality Disorder). For psychosis, this includes working with providers on delivering required training.	Commissioning intentions and specifications for psychological therapies are currently under development with the intention of tendering for contract commencement in April 2020. Any learning from demonstrator sites will be incorporated as appropriate. In the meantime, IAPT providers already see stable SMI patients who would benefit from IAPT.	

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Mental health	For Crisis Resolution Home Treatment Teams (CRHTTs), CCGs must ensure that by the end of 2019/20 all populations have access to services for adults and older adults that are commissioned to meet the minimum functions of: (i) urgent and emergency community mental health assessment, and (ii) intensive home treatment as an alternative to inpatient admission, 24 hours a day, 7 days per week. This means that the services providing these functions can: •be accessed directly by telephone on a 24/7 basis, by new and known patients, with the contact details made clearly and publicly available to the local population; •be accessed 24/7 by all system partners (including police, ambulance, NHS111, GPs, members of the public); •visit people in their homes (or wherever they present in the community) on a 24/7 basis to conduct face to face assessments for people with urgent/emergency mental health needs; and •visit people under the care of the intensive home treatment function, as many times per day as needed, on a 24/7 basis. Commissioners should work with providers to assess local levels of demand and capacity in these functions, with a view to increasing capacity to achieve the above, and further increasing capacity as necessary by 2020/21, to enable robust provision in line with the UCL CORE Crisis Resolution Team Fidelity Scale.	CRHT services in Nottinghamshire are being reviewed and a process has commenced to re-specify services during quarter 4 2018/19. The service model that will be commissioned will meet all the required national standards. A mobilisation plan for the new service is being developed and implementation and delivery will be managed through the contracting process.	
Mental health	Spread coverage of liaison mental health teams through sustained commissioning of Core24 teams to reach 50% of acute hospitals by 2020/21. Alongside this, 100% of areas should be progressing plans for their general acute hospitals to have mental health liaison services that can meet the specific needs of people of all ages, including children and young people and older adults by 2020/21.	Liaison mental health teams that are commissioned in Nottinghamshire meet the Core 24 standards. Services are commissioned to meet the needs of people of all ages.	
Mental health	CCGs should ensure there is a crisis response that meets the needs of under 18 year olds. These should be staffed by practitioners who are trained and competent in meeting the specific mental health needs of children and young people. CCGs should then work towards delivering age-appropriate 24/7 crisis provision for children and young people (CYP) which combine crisis, liaison and intensive community support functions. This should apply whether or not the model selected by the CCG is a dedicated CYPMH service for 24/7 or extended hours, or a blended model that relies on Core24 to support CYP at some point during the 24 hours.	A nurse-led CAMHS liaison function is provided to Queen's Medical Centre and King's Mill Hospital between the hours of 10am to 10pm, Monday to Friday and 10am to 8pm, Saturday/ Sunday and Bank Holidays, with assessment within one hour of presentation at ED. The team provide follow-up assessment/ treatment to those young people admitted to a paediatric ward requiring a short-term admission with acute or significant mental health needs. The team also provide training to upskill ED, paediatric ward and liaison psychiatry staff. The adult service works closely with the CAMHS liaison team to ensure 24/7 support, they will assess children and young people and out of hours the emergency cover is provided by the adult service. Work is planned to review the joint working between adult mental health liaison and CAMHS liaison and identify if there are opportunities to improve current practice. CAMHS CRHT operate 7 days per week, 365 days per year as per the following operational hours;- Monday to Friday: 8am to 10pm and -Weekends and Bank Holidays: 10am to 6pm.Out of hours the emergency cover is provided by the on-call rota for in line with existing service provision. Work is planned to review the joint working between adult mental health and CAMHS and identify if there are opportunities to improve existing practice.	
Mental health	As per the second part of the national standard for Early Intervention in Psychosis (EIP), CCGs are to ensure the 2018/19 commitment for NICE concordance for EIP from the implementation plan is met; then deliver against the further ambition for 50% of services to be graded at level 3 by the end of 2019/20.	The 2 week standard is being achieved across the ICS. Mid Notts CCGs scored level 1 on the self-assessment and Greater Nottingham scored level 2. There is a jointly owned recovery action plan in place with specific actions to improve the scoring. It is anticipated that the score will not change in April as the self-assessment has been completed before the changes have taken effect. As such a snap shot self-assessment will be completed in May for Q4 18/19.	
Mental health	Ensure 60% national increase in access to Individual Placement and Support (IPS) services in 2019/20 through delivery against STP trajectories in line with best practice.	Greater Nottingham has a service. Mid Notts have bid for wave 2 funding. A decision is expected in early March 2019. If successful Mid Notts intend to adope the same model as the Greater Nottingham service.	
Mental health	Alongside the 66.7% Dementia Diagnosis Rate (measured via SDCS), improve post-diagnostic dementia care in line with published guidance.	A newly commissioned ICS wide contract with Alzheimers Society began in October 2018. This service supports people with dementia and their carers with an information and sign posting service, offering advocacy and dementia specific advice. The contract also supports dementia cafes and carer support within communities, working with wider voluntary sector organisations and care providers to offer training in best practice dementia support. During quarter 4 2018/19 the service is being reviewed against the WELL standards.	
Mental health	Deliver against multi-agency suicide prevention plans, working towards a national 10% reduction in suicides by 2020/21. This includes working closely with mental health providers to ensure plans are in place for a zero-suicide ambition for mental health inpatients.	Nottinghamshire has a joint suicide prevention strategy that the CCGs and providers contribute to and actions are aligned with the Crisis Care Concordat. The mental health core contract includes quality measures around suspected suicides. This will continue to be reported and monitored by the CCGs, with a deep dive already having been undertaken.	
Mental health	Commissioners should ensure all providers, including third sector and independent sector providers, submit comprehensive data to the Mental Health Services Data Set (MHSDS) and Improving Access to Psychological Therapies Data set. Commissioners should work with providers to ensure data quality is proactively reviewed, national guidance is adhered to and the breadth of data submitted to the MHSDS accurately reflects local activity. Commissioners should routinely monitor MHSDS data and are encouraged to use MHSDS commissioner extracts to inform local discussions with providers. A mid-year review will be undertaken, and CCGs will be expected to ensure appropriate contract penalties are applied where providers have failed to meet data reporting and data quality standards.	Significant work has been undertaken through the EIP data quality improvement plan to align SDCS and MHSDS data. For the October – December 2018 period the data was aligned for the SDCS and MHSDS primary submissions. A monthly report is now produced by the provider which incorporates SDCD and MHSDS comparisons over time to ensure the quality of submissions is being maintained and is monitored through the formal contract process. The NHS Digital MHSDS data quality report for November shows the main MH provider is performing well in most data quality areas. Commissioners do not currently have access to MHSDS data extracts and whilst Nottinghamshire Health Informatics Service has confirmed that this in on the DSCRO's roadmap for future data flows no date has been confirmed. For IAPT, the NHS Digital November monthly data quality report confirms the validity of all Nottinghamshire provider's data. This has been the case for the previous 12 months.	

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Primary Care	Actively support the establishment of Primary Care Networks (PCNs) within the geographical area to ensure that every practice in England is a part of a local PCN (serving populations of around 30,000 to 50,000) as soon as is possible, to achieve 100% coverage by 30 June 2019 at the latest.	PCNs are fully operational and holding PCN contracts.	All GP practices in Greater Nottingham have been aligned into Primary Care Networks since early 2019. Work has included a new geographical boundary to meet the new GP contract requirment of minumum 30K population. Local engagement is being finalised during February, with final version to be published by February 28th 2019. PCN meetings are planned for the coming year and set up as a framework to support this. Primary Care Network meetings have finalised PCN sizes, discussed governance and developed ideas around clinical directors and the election process.
Primary Care	Support the introduction of any nationally-agreed contract arrangements for PCNs, ensuring that community services are configured in line with PCN boundaries.	Community services have been recommissioned to align services around PCNs. The CCG will ensure each PCN has in place the new requirements fit for the GP contract.	The CCGs are looking to the recently published new GP Contract documentation to to ensure compliance , whilst enhancing the capacity and capability of the offering. Recent internal organisational changes have aligned the community and primary care commissioning more closely. The Care Delivery Groups (which predate the PCNs) already co-ordinated across primary, community and social care, and this work is being built upon to further enhance the alignment of the offering, particularly as new services are commissioned or contracts are renewed.
Primary Care	Provide a minimum of £1.50 per head of financial support to PCNs for their management and organisational development. This investment should start in 2019/20 and continue each year until 31 March 2024	The CCG will build this into the financial planning for 2019/20 and we have a track record of investing the national requirements from CCG baseline during 2018/19	The financial support investment to PCNs has been incorporated into the GN CCGs financial plan for 2019/20 and will be factored in recurrently for subsequent years
Primary Care	Support PCNs in their development and ensure they are practically supported to access the PCN Development Programme by 31 March 2020.	A dedicated PCN manager is in place and CCG resources identified to support the development of each PCN. Local development programme has been developed and the CCG are reviewing the content before commissioning the provider.	Greater Nottingham is committed to supporting the PCN development and will actively support the PCN Development Programme when it is in place. Meanwhile, local initiatives are already in place with locality teams focussed heavily on working with practices to ensure they are engaged in their PCNs and effectively contributing to their development.
Primary Care	Ensure that PCNs are provided with primary care data analytics for population segmentation and risk stratification based on national data, complemented with local flows, to allow them to understand in depth their populations' health and care needs for symptomatic and prevention programmes including screening and immunisation services by 1 July 2019 at the latest, and then on an ongoing basis at regular intervals as agreed locally.	This reource currently comes from the CCG B.I support team and needs further exploration	Planning is underway via the ICS lead / Clinical Expert Group for population health managament data to be idenfitied per PCN. Any work arising from this will be supported and discussed through our local PCN programme steering group. This work is in progress: a review of data requirements has been led by Andrew Haw and he is working closely with the CCG Data Management Team and, using the GP Repository for Clinical Care (GPRCC) we should be able to develop the required data analytics at PCN level.
Primary Care	Ensure that PCNs work together including at place level to ensure they play a full role in improving services commissioned and provided at that level, including urgent and emergency care services, and ensure every PCN is working to implement the comprehensive model for personalised care.	Each PCN has a GP leader and they meet regularly to discuss collective priorities, shared vision and aims and objectives. PCN plans will be developed to commence April 2019..	Weekly planning is underway across the 4 Greater Nottingham localities (currently configured as 17 PCNs) to have a consistent approach to improving services commissioned / redesign that also incorporates personalised care and emergency care.
Primary Care	Ensure that the delegated budgets received are used to support the development of all practices in the context of PCN development, with a detailed local plan published by 1 July 2019 showing that every practice is actively engaged and all activity is completed by 31 March 2020 (ensuring delivery of at least two high-impact actions set out in the GPFV including Online consultations; Reception and clerical training; and Time for Care), to be determined through a diagnostic/evidence-based approach that enables deployment of targeted development offers in the most effective way to support, strengthen and transform services for the benefits of staff and patients locally.	PICs will predominantly hold the budgets for PCNs and through the governance strucutre in Mid Notts, decisions around spend will be made based on the priorities in the local plans.	Greater Nottingham are currently reviewing the relevant guidance and developing plans to ensure that delegated budgets are used in the most appropriate way to ensure impact and value for money, and that high impact actions from the proscribed list are undertaken.
Primary Care	Ensure that the local practice development plans continue to identify those practices who need more intensive and immediate support to stabilise, build their resilience and become sustainable. 75% of 2019/20 sustainability and resilience funding (allocated by NHS England) must be spent by 31 December 2019, with 100% of the allocation spent by 31 March 2020.	GP practices across Mid Notts have had access to national, ring-fenced GPFV funding to support GP Resilience in 2016/17, 2017/18 and 2018/19. This funding has been used for eg: to undertake 'diagnostic' work with practices to identify areas for improvement and further support, for specialist advice and guidance eg human resources, rapid intervention and management support for practices at risk of closure, to align back office functions such as policies and procedures, to support practices to prepare for CQC visits, to implement a standardised approach to health and safety across practices, and to facilitate GP engagement events to support the development of PCNs. Given the effectiveness of the model used to date, Mid Nottinghashire CCGs are developing plans for the use of this funding subject to NHSE specific requirements adopting a similar methodology to before.	GP practices across Greater Nottingham have had access to national, ring-fenced GPFV funding to support GP Resilience in 2016/17, 2017/18 and 2018/19. This funding has been used for eg: to undertake 'diagnostic' work with practices to identify areas for improvement and further support, for specialist advice and guidance eg human resources, rapid intervention and management support for practices at risk of closure, to align back office functions such as policies and procedures, to support practices to prepare for CQC visits, to implement a standardised approach to health and safety across practices, and to facilitate GP engagement events to support the development of federations. Given the effectiveness of the model used to date, Greater Nottingham CCGs are developing plans for the use of this funding subject to NHSE specific requirements adopting a similar methodology to before. We will continue to identify those practices who need more intensive and immediate support to stabilise, build their resilience and become sustainable. 75% of sustainability and resilience funding will be spent by 31 December 2019, with 100& by 31 March 2020

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Primary Care	• Recruit the share of the additional 5000 doctors and maximise the impact of the over 5000 other health professionals already recruited since the GPFV was published as part of the multidisciplinary workforce, using all available channels and initiatives. This must include development of a detailed STP/ICS workforce plan with trajectories detailed by role type, taking into account local multi-disciplinary workforce needs (based on capacity and demand), working with PCNs as they develop to recruit an expanded range of clinicians and other professionals. As part of this, plan specifically to retain as many GP trainees as possible at an STP/ICS level after completing specialist training; with as many of these as possible taking up substantive roles in the local primary care workforce by 31 March 2020.	ICS Trajectory submitted as part of the Operational Plan Performance templates. Trajectories include relaistic assessment of the impact of IGPR: One Gp in post in MN wirh pipeline interest of 5-6 . Targeted approach with Nottingham City practices using teh NHSE team to support state of readiness as candidates want city lifestyle Recruitment strategies through increased engagement opportunities and development of a PR material selling the benefits of working and living in Nottinghamshire Retention strategies in place: Trainee Transition, Fellowhips , Portfolio Plus, GP-s(Mentoring & Support) Fellowship Lite, Preceptorship, Clincal Leadership development and support to increasing GPs with special interest sful appraoch to increasing practices that are Tier 2 sponsors 14 approved and further 6 in the process. The system is well placed to offer posts ans support to teh international medical graduates due to complete training in 19/20 and 20/21: 17 qualify in 20/21 and 66 in 20/21 across the NM DCO Engagement with PCN leads has already resulted in consideration of collaborative approach to workforce planning.	ICS Trajectory submitted as part of the Operational Plan Performance templates. Trajectories include relaistic assessment of the impact of IGPR: One Gp in post in MN wirh pipeline interest of 5-6 . Targeted approach with Nottingham City practices using teh NHSE team to support state of readiness as candidates want city lifestyle Recruitment strategies through increased engagement opportunities and development of a PR material selling the benefits of working and living in Nottinghamshire Retention strategies in place: Trainee Transition, Fellowhips , Portfolio Plus, GP-s(Mentoring & Support) Fellowship Lite, Preceptorship, Clincal Leadership development and support to increasing GPs with special interest sful appraoch to increasing practices that are Tier 2 sponsors 14 approved and further 6 in the process. The system is well placed to offer posts ans support to teh international medical graduates due to complete training in 19/20 and 20/21: 17 qualify in 20/21 and 66 in 20/21 across the NM DCO Engagement with PCN leads has already resulted in consideration of collaborative approach to workforce planning.
Primary Care	Maximise retention of experienced, effective staff (doctors, nurses and other health professionals), with specific actions/focus in areas which have greatest workforce challenges and with roles where attrition is highest. This includes actions which are shown to have positive impact, (identified by the GP Retention Intensive Support Sites and wider retention programmes) and are tailored to local circumstances. The national GP Retention Scheme should also be offered to support all eligible GPs who cannot work a regular part-time position (up to 4 sessions per week) to remain in practice.	Retention strategies are in place for GPs.(see above) GP Retention Scheme has been utilised over 18/19 with 10 GPs taking part in the scheme. The scheme will continue to be promoted as part of the engagement strategies in place for 19/20 Within the GPN 10 PP there are also retention schemes with a focus on training and education opportunities to upskill staff Retention of clinical pharmacist roles will be better assisted through the certainity of funding for practices that will enable them to fully embed with in the practices.	Retention strategies are in place for GPs.(see above) GP Retention Scheme has been utilised over 18/19 with 10 GPs taking part in the scheme. The scheme will continue to be promoted as part of the engagement strategies in place for 19/20 Within the GPN 10 PP there are also retention schemes with a focus on training and education opportunities to upskill staff Retention of clinical pharmacist roles will be better assisted through the certainity of funding for practices that will enable them to fully embed with in the practices.
Primary Care	Continue planned investment in upgrading local primary care facilities, ensuring completion of the pipeline of Estates and Technology Transformation schemes and other STP primary care capital schemes (that support the interoperability with other clinical and administrative systems).	This is a three year project linked to the GPFV and we are in year 2/3 being green on all aspects of spend and implementation.	The four Greater Nottingham CCGs each have a Governing Body approved Estates Strategy which identifies the estates issues in each CCG and the opportunities for development. The strategies produced in 2016 were a requirement to enable each CCG to bid for capital funding from the Primary Care Infrastructure Fund (PCIF) which then became the Estates Transformation and Technology Fund (ETTF). The CCGs' estates issues are now incorporated into the STP Estates Strategy and potential schemes forming part of the estates workbook. They will also be informed by emerging themes from the clinical strategy and developing models for Primary Care Network (PCN) hubs. Two successful wave 1 STP capital schemes progressing: 1 primary care hub completed working with PAU on evaluation of FBC; 2 OBC being developed. Three further OBCs in development for PCN hubs across Greater Nottingham in preparation for potential wave 5 STP capital. One is a One Public Estate scheme working with other public sector parties in N2. Section 106 funding is actively requested from developers via district councils where planning policy is in place. This funding is used to offset the financial impact of providing primary care facilities as a result of population growth.
Primary Care	Ensure oversight of schemes within the geographical area and work closely to ensure these schemes are delivered as planned within the timescales and budget set out for each project so that the benefits of this investment are realised by the improved facilities being used to support multidisciplinary working and the expansion of the primary care workforce.	Senior CCG programme lead provides oversight of project delivery reporting to the Priamry Care Commissioning Committee.	GN Primary Care Estates team in place to oversee all schemes – key principles for new schemes are to ensure integration of health and social care teams and promote multi-disciplinary working, allow for expansion in primary care and for services out of hospital, creating PCN hubs. Primary Care Estates Strategy to be developed early 2019/20 to ensure continued robust pipeline of priorities.
Primary Care	Ensure that all GP practices are technically enabled to provide all the functionality that will be offered through the NHS App, as part of the Digital Primary Care transformation plan to ensure it is available to 100% of the population by 31 July 2019.	Through connected notts we have a digital patient facing strateg in place and local resource in Mid Notts identified for implementation.	Using national funding a great deal of work has already been undertaken in readiness for this roll-out. The first NHS App enabled Practices have gone live as phase one of the Public Facing Digital Service Strategy commences. A procurement team has been established to manage the process of adding additional capabilities in line with the ICS requirements and robust plans are in place to ensure compliance by the agreed deadline in 2019. Nottinghamshire has developed a Public Facing Digital Services strategy, and secured funding over and above GPFV funding, through Health Service Led Investment (HSLI) funding, leading to procurement of a digital solution which will, through the NHS App, offer additional functionality for patients. In addition to NHS App functions this will allow patients to view their whole health record (including letters); to manage their appoitments across primary and secondary care; to use 'symptom checking software' to signpost them to the most appropriate locally tailored disposition; to conduct remote consultations with clinicians (not just GPs); and to improve management of long-term conditions.
Primary Care	Support connectivity by keeping in touch with all doctors in the locality, whether they are working on a sessional or substantive basis.	Fully compliant via various media sources: Practice visits, GP Bulletin, Whatsapp group, weekly Snippets from the Dir of Primary Care	All practices receive weekly updates which they are encouraged to share widely with all staff (including sessional staff). These updates include commisioning information, service and pathway changes, training and development opportunities etc. Each CCG also has a clinical cabinet (or equivalent group) which provides a forum for members to be involved in commissioning decisions and the development of PCNs.
Primary Care	Deliver the GP nursing plan including working with HEE and higher education institutions to support nurses to choose primary care as a first destination and to retain experienced nurses already working in primary care.	Dedicated programme manager in post working across Nottinghamshire,	Dedicated programme manager in post working across Nottinghamshire,

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Primary Care	Continue with commissioning and deployment of 180 pharmacists and 60 pharmacy technician posts (funded by the Pharmacy Integration Fund, with support from NHS England Regional Independent Care Sector Programme Management Offices), to improve medicines optimisation for care home residents by 31 March 2020.	Nottinghamshire has seen a good take up of the pharmacist posts created with 32 in post across the county. The maximum quota is in place in mid Nottinghamshire with targeted work in City practices. Local Pharmcist ambassador in place	Nottinghamshire has seen a good take up of the pharmacist posts created with 32 in post across the county. The maximum quota is in place in mid Nottinghamshire with targeted work in City practices. Local Pharmcist ambassador in place
Primary Care	Ensure that clinical pharmacists are recruited into practices in line with approved applications for the clinical pharmacist programme.	As above - Nottinghamshire fully engaged	As above - Nottinghamshire fully engaged
Primary Care	Ensure all staff in primary care settings have access to the support of a training hub and capacity to participate in training programmes (e.g. e-learning resources held by HEE); and that there is a plan to develop the agreed set of required functions by 31 March 2020.	Alliance of training hubs inplace (Collation of 4 hubs created in initilalaunch by HEE) Programme Director in post from 1.4.19 Delivery already over and above HEE SLA requirements with strong regional and national connections and Nottinghamshire regarded as an exemplar on Approach to Urgent & Emergency Care training Trainng hub leading TNA across practices and care homes Tranining Hub supported dedicated programme resource for GPN and are supporting delivery plan Project work around training needs in Care Homes completed and evaluated well Strengthening of the hub and spoke model now an alliance hub ensuring coverage across the county	Alliance of training hubs inplace (Collation of 4 hubs created in initilalaunch by HEE) Programme Director in post from 1.4.19 Delivery already over and above HEE SLA requirements with strong regional and national connections and Nottinghamshire regarded as an exemplar on Approach to Urgent & Emergency Care training Trainng hub leading TNA across practices and care homes Tranining Hub supported dedicated programme resource for GPN and are supporting delivery plan Project work around training needs in Care Homes completed and evaluated well Strengthening of the hub and spoke model now an alliance hub ensuring coverage across the county
Primary Care	Work with HEE to ensure robust training programmes are in place to adequately support workforce plans.	HEE are partners in the system LWAB and regional transformation managers and workforce relationship managers are connected to the Strategic Workforce Group and decision making. HEE are included in our education and learning partnership with HEI providers and maintain a close working relationship with thet Training Hub.	HEE are partners in the system LWAB and regional transformation managers and workforce relationship managers are connected to the Strategic Workforce Group and decision making. HEE are included in our education and learning partnership with HEI providers and maintain a close working relationship with thet Training Hub.
Primary Care	Continue providing extended access to general practice services, including at evenings and weekends, for 100% of the population. This must include ensuring access is available during peak times of demand, including bank holidays and across the Easter, Christmas and New Year periods.	Fully compliant with national requirements	The CCGs in Greater Nottingham successfully achieved 100% extended access coverage from 1 September 2018 and this will continue in 2019/20. An assessment of capacity and demand is taken annually as part of the Christmas and New Year winter pressures planning process. Existing contracts for the provision of extended access in three out of four CCGs in Greater Nottingham (Nottingham City, Nottingham North and East, and Nottingham West) are due to expire on 31st March 2020 and the contract in Rushcliffe is due to expire on 30th September 2019. The CCGs are committed to working with NHSE over the next few months to ensure that re-procurement of the service is completed in such a way as to comply with procurement rules and regulations, in the context of the transfer of the funding into the new Network Contract DES by April 2021.
Primary Care	Integrate extended access with other services at scale to deliver value for money and efficiencies and support compliance with national core requirements to maximise capacity, availability and utilisation of appointments for 100% of the population.	Commenced wider service offers already including ear syringing and dressings clinic.	Integration plan underway to extend the range of services and to co-ordinate activity with the wider health system
Seven Day Services	Continue to rollout the seven-day services four priority clinical standards to five specialist services (major trauma, heart attack, paediatric intensive care, vascular and stroke) and the seven-day services four priority clinical standards in hospitals to meet the overall ambition of 100% population coverage by 2020/21.	Mid-Notts have self-assessed as 'established' currently for 7 day services, with an ambition of reaching 'mature' against the High Impact Change for Discharge model, although we are already displaying some examples of mature and exemplary at Q3. Call for Care operates 7 days per week and Community Pathfinder operates 24/7. Social Care packages can be re-started during weekends when advance discharge planning is in place – this will be strengthened by the go live of the Home First Integrated Discharge (HFID) work stream. The new Home First Response Service funded by social care can respond within 24 hours providing capacity is available. Social Care teams operate 7 day working	
Transforming Care	CCGs to work with local partners to plan for and invest in appropriate community provision to support people to live in their local communities, in line with the Building the right support service model.	TC Plan in place, includes: continuations of an enhanced Specialist Forensic Team; enhanced ICATT team ; TCP-wide Care Coordinator & Social Supervision; TCP dynamic Risk Register; continuation of an Unplanned (Respite) Care Service ; targeted carer support; review of current pathways for early diagnosis of LD/autism; and working towards a single point of contact and DoS	
Transforming Care	Ensure more children and young people with a learning disability, autism or both get a community Care, Education and Treatment Review (CETR), such that 90% of under-18s admitted to hospital have either had a community CETR or a CETR post-admission.	TC Plan in place with a CYP Steering Group reporting into the TC Programme Board. CYP trajectories to be in place for 19/20 and 20/21. Working with the whole life disabilities services, LA and SpeCom. TC have low CYP numbers however learning from current activity to inform future ways of working	
Transforming Care	CCGs to ensure that they are represented at CETRs for Children and Young People who are inpatients; and can demonstrate an increase in compliance and quality of C(E)TRs in line with national policy.	TC Plan in place with a CYP Steering Group reporting into the TC Programme Board. CYP trajectories to be in place for 19/20 and 20/21. Working with the whole life disabilities services, LA and SpeCom. TC have low CYP numbers however learning from current activity to inform future ways of working	
Transforming Care	CCGs to have a dynamic risk stratification process in place with a clear function of identifying those at risk of admission and to ensure that this is reviewed and updated on a regular basis.	TC manages a dynamic risk register. ICATT support. RCA for all admissions/re-admissions	
Transforming Care	CCGs are a member of a Learning from Deaths report (LeDeR) steering group and have a named person with lead responsibility.	CCG Executive Lead in place. Quality & Safeguarding now taking the lead for oversight and support. LeDer to be integral to both the Commissioner Safeguarding Strategic Group and the TC Programme Board	
Transforming Care	There is a robust CCG plan in place to ensure that LeDeR reviews are undertaken within 6 months of the notification of death to the local area.	The number of reviews unallocated is currenty high therefore a sustainable recovery plan is in place. Additional support and resource in place	
Transforming Care	CCGs have systems in place to analyse and address the themes and recommendations from completed LeDeR reviews.	CCG Executive Lead in place. Quality & Safeguarding now taking the lead for oversight and support. LeDeR to be integral to both the Commissioner Safeguarding Strategic Group and the TC Programme Board. Due to the number of reviews yet to be allocated the timeliness of the learning is challenged hence confidence levels, however plans are in place to address	
Transforming Care	An annual report is submitted to the appropriate board/committee for all statutory partners, demonstrating action taken and outcomes from LeDeR reviews.	CCG Executive Lead in place. Quality & Safeguarding now taking the lead for oversight and support. LeDeR to be integral to both the Commissioner Safeguarding Strategic Group and the TC Programme Board.	
Transforming Care	There is a process in place to proactively identify children and young people and adults who are subject to regular and or prolonged restrictive practices including the use of seclusion/long term segregation and ensure that appropriate safeguarding and review measures are followed.	TC working with NHSE DCO to ensure oversight. TC working with providers to support. TC/CCG working with Quality Teams	

Programme	Next step deliverable (please refer to column C of the master spreadsheet)	MN ICP Description of plans that are in place or will be put in place to support achievement of the deliverable	GN ICP Description of plans that are in place or will be put in place to support achievement of the deliverable
UEC	Maintain a 50%+ proportion of NHS 111 calls receiving clinical assessment.	Mid Notts already achieve over 50% of its 111 calls receiving clinical triage. The CAS curently operating across the ICS and will be strengthened in 19/20 via the IUC procurement which will result in a further expansion of the % of calls that can receive clincial input. Service specifications are curently being drafted.	Greater Nottingham already achieve over 50% of its 111 calls receiving clinical triage. The CAS curently operating across the ICS and will be strengthened in 19/20 via the IUC procurement which will result in a further expansion of the % of calls that can receive clincial input. Service specifications are curently being drafted.
UEC	Increase the percentage of people triaged by NHS 111 that are booked into a face-to-face appointment, where this is needed, to greater than 40% by 31st March 2020.	Direct Booking is already in place for the Newark UCC.A trial is in-place for Direct Booking into OOH appointment slots. An ICS-wide Direct Booking working groupis in place to progress Primary Care Direct Booking. The IUC procurement and associated service specifications will provide further opportunities to expand this %.	An ICS-wide Direct Booking working groupis in place to progress Primary Care Direct Booking. The IUC procurement and associated service specifications will provide further opportunities to expand this %
UEC	By 31st March 2020, reduce 'A&E by default' selections on the Directory of Services (DoS) to less than 1% by the commissioning of appropriate services that are accurately recorded on DoS.	The ICS continues to review the DOS, ensuring that the relevant alternative services are prioritised on each profile. The IUC procurement in 19/20 will ensure sign posting to appropriate services to reduce the A&E dispositions further.	As a key enabler to attendance/admittance avoidance, we have a dedicated lead for DOS management and the incidents of A&E by default selections is closely monitored.
UEC	Designate the majority of urgent treatment centres (UTC) by December 2019, with any exceptions to be agreed with the Regional Director.	Plans in place for mid-Notts for Newark UCC & PC24 to become UTCs. Wrapped up in overall ICS-wide IUC procurement project. Current plans will deliver against the national time frame. Programme board and prject plan in place to achieve national timescales. NHSE members of the programme board to provide support.	This is a key deliverable of the Integrated Urgent Care (IUC) procurement
UEC	Deliver a safe reduction in ambulance conveyance to EDs with trajectories to be agreed between services and their lead commissioners.	Transformation scheme & contract CQUIN for 18/19 around conveyance reductions in place and monitored fortnightly. Stipulation of the planning guidance & forward View for 19/20 & *confidential* plans to reflect contractually in 19/20.	Cross-organisational work stream has been set up with a shared purpose to reduce conveyance, agreeing a target trajectory is a key deliverable of this group. The group brings together primary, community, ambulance and acute service leads to drive delivery of key initiatives to reduce conveyance e.g. redesigned falls pathway, use of UCC, NEMS and community beds as initial response
UEC	All ambulance services to meet, as a minimum, a baseline level of digital maturity including access to and usage of patient information at scene (e.g. Summary Care Record, Patient Demographic Service, Electronic Patient Record), access to service information at scene (e.g. DoS) and establishing Electronic Prescribing.	EMAS are undertaking work locally, however it's identified that the success fo some of this will be enabled by national progress on the workstream, which is behind plan in some areas.	This is indentified as a key enabler to attendance/admittance avoidance and will be jointly progressed across the system partners.
UEC	Ensure 100% of ambulance handovers occur within 30 minutes.	SFHFT have a plan to address ambulance pre-handover times. Prior to January SFHFT handovers were the lowest they had been. Currently working to an internal threshold of 10% tolerance of pre-handovers over 15 min. Handovers are a standing agenda item for the Mid-Notts A&E Delivery Board. Some post-handover activities are currently 'hidden' in Vehicle Off Road time, however this will soon change & then discussions can take place around accurate EMAS post-handover times.	Currently achieving the target of 100% of ambulance handovers occur within 30 minutes and will continue to monitor closely with assurance to the A&E Delivery Board
UEC	Ensure 100% of trusts are providing Same Day Emergency Care (12 hours day / 7 days week) by September 2019 with the aim of delivering 30% of non-elective admissions via SDEC by March 2020, and are providing a frailty service (70 hours a week) by December 2019.	Frailty service - Project is Green BRAG rated @ SFHFt & is on track to deliver by December 2019 which is national time frame. Reported on monthly as part of the UEC NHSE return. Frailty pathway in place at SFHFT. 12 hour SDEC service in place at SFHFT (AECU) already. Trust and CCG continue to work on increasing actiivty through the unit via a QIPP transformation workstream. National upward trend of ambulatory care episodes evident in Mid-Notts, ambulatory care transformation work stream in place, with plans to expand further in 19/20. However, there is a project planned for 19/20 which is aimed at ambulatory care sensititve conditions & treating these in the community. The better this project performs, the lower the % of ambulatory conditions being treated in the acute will be, and therefore this % may reduce.	This is a key deliverable of the Integrated Urgent Care (IUC) procurement and supported by changes to NUH front door and internal flow. This will build on the existing Frailty team as an intergrated discharge team (IDT) at NUH front door. Build on the Incentive Scheme work initiated through NUH: GN CCP contract discussions in 2018/19. Initial areas of focus in 2018/19 were pathway redesign across NUH and primary care in frailty and respiratory. The proposed main focus for 2019/20 is Same Day Emergency Ambulatory Care
UEC	Nationally, deliver a 40% reduction in long stay patients (and long stay beds) from the March 2018 baseline by March 2020.	SFHFT have revised their LoS trajectory in light of previous non-achievement. Transformation schemes and planned system improvements e.g. the Home First integrated Discharge Scheme will contribute to the reduction of LoS. SFHFT have an action plan in place and are following the best practice guidance in long stay reviews and has also confirmed this approach with ECIP. Commissioning intentions for 19/20 include redesignation of the community beds currently managed by SFHFT to improve patient flow and reduce LOS.	Further develop existing social care reablement and homecare first provision to ensure capacity, ensure integrated discharge function is embedded and resourced across all system partners and improve the efficiency and usage of community beds.
UEC	Continue to make progress on reducing delayed transfers of care (DTOC) to achieve and maintain a national average DTOC position of 4,000 or fewer daily delays, with local targets to be set for 2019/20 through Better Care Fund (BCF) plans. Further detail on these expectations as well as wider requirements for BCF plans will be published later in 2019.	Mid-Notts DToC rate continues to be above trajectory. A revised action plain is in discussion and a recent patient level audit identified that system-wide & SFHFT transformational schemes will deliver marginal gains to reduce the overall DToC levels. The revised guidance from November is being considered by system partners and this will ensure accurate of identification and recording of DToCS. Commisisoning intentions to redesignate the current community bed stack will also positively impact on DTOC rates.	Local targets have been set and progressed is monitored via the A&E Delivery Board for assurance. BCF leads are in place to respond to the plans when they are published Cross-organisational transformation plans to further develop social care reablement and homecare first provision to ensure capacity, ensure integrated discharge function is embedded and resourced across all system partners and improve the efficiency and usage of community beds.

Programme	Next step deliverable (please refer to column C of the master spreadsheet)	MN ICP Description of plans that are in place or will be put in place to support achievement of the deliverable	GN ICP Description of plans that are in place or will be put in place to support achievement of the deliverable
Diabetes	Take action to reduce variation in achievement of the diabetes treatment targets (HbA1c, blood pressure and cholesterol for adults and HbA1c only for children) between GP practices in the CCG, particularly where the treatment target achievement in an individual GP practice is below the England average of 40.8%.	2017/18 performance was: Nottingham West - 40.8% City - 34.8% Nottingham North and East - 37.1% Rushcliffe - 38.3% Mansfield and Ashfield - 36.4% Newark and Sherwood - 37.9% Actions being taken are: - work to improve and standardise coding and recording in primary care - development of real time monitoring tool and E-healthscope workflow to support practices in identifying current position in relation to targets for each paptient - focus on Practice Nurse education to support delivery of targets - sharing good practice across the ICS noting that NW CCG is rated as outstanding Project plan will be developed by end of April	
Diabetes	Ensure mechanisms are in place to refer individuals identified with Non-Diabetic Hyperglycaemia to the NHS Diabetes Prevention Programme to support them in reducing risk of Type 2 diabetes.	Referrals and initial assessments ino the NHS Diabetes Prevention Programme have been consistently higher than the target in 2018/19. In order to further improve the referrals the following actions are being taken: - ensure standardised coding for pre-diabetes is completed - pre-diabetic care included in the workflow described above	
Diabetes	Ensure referrals are generated in line with agreed targets and local population need.	Referrals to the NDPP are in line with targets but the conversion of referrals to people completing the course is not as high as expected and uptake across the ICS is lower than the national average. Work is underway to: - visit Practices with low referral rates - work with the provider to offer improved access (waiting list validation to reduce wait time form referral to initial assessment, improve range of times and locations, etc) especially in areas where there is greatest health inequality - pro-active communications and engagement plan to make people more aware of diabetes risk factors - work with the Clinical Network re digitial access to the programme	
Public Health	For public health services the key aim is to support the commitments within the Cancer Strategy and the Section 7a public health functions agreement in relation to population screening and national immunisation programmes. For CCGs the focus will be on supporting NHS England to improve the quality and access to the diabetic eye and cancer screening programmes, the MMR immunisation programme, as well as the planning and delivery of an adequate cancer workforce covering symptomatic and screening services. To support this, CCGs must: • have a coherent plan to work with the local Public Health commissioning teams of NHS England to improve the quality, access to screening and immunisation programmes with a requirement to prioritise the public health service needs as part of PCN development and the sustainability and resilience of practices; and • work with PHE workforce planning team data, NHS England regions and local public health commissioning teams to develop plans supporting the prevention commitments for adequate workforce for the symptomatic and screening programme care pathways	CCGs work closely with NHSE and Public Health England on screening and immunisation programmes. At a CCG level, this is overseen by the Health Protection Strategy Group that covers Nottingham and Nottinghamshire. During 2019/20 opportunities will be agreed as part of the development of PCNs. In the meantime plans are being taken forward to work with community nursing staff on raising awareness. The following plans are in place in relation to immunisation and screening programmes: Immunisation i) Childhood Imms Uptake - The Screening and Immunisation Team (SIT) works with stakeholders to develop initiatives to increase uptake as part of the North Midlands MMR Elimination Action Plan ii) School Age Immunisation Service continues to focus on areas where uptake is lower iii) National MMR Strategy - developing a Derby/Notts elimination strategy. The SIT have agreed that local work will be targetted based on trends in immunisation uptake iv) The HPV Immunisation programme for boys will be commissioned from Sept 2019 v) The HPV vaccination programme has been agreed and will be implemented across both Trusts by March 2019 vi) Shingles vaccination - A promotional pack is being developed for GP practices in order to increase the uptake of shingles vaccinatio programme. A shingles campaign was run on local radio to increase awareness. <u>Screening</u> i) Antenatal and newborn screening - Early Booking Campaign implemented. Reviewing the option to move to electronic referrals for FA1. ii) Abdominal Aortic Aneurism Screening - uptake rates have increased across all CCGs. iii) Cervical Screening - TAT HPV Primary Screening commenced from 1st June 2018. On track to clear backlog by March 2019. iv) ANNB and DESP - quality assurance visits have been carried out. v) Bowel cancer screening - FIT Hub procurement is ongoing. Commissioners have a plan with screening centres to ensure that FIT is in place for 1 April 2019. vi) Breast Screening - Challenges in relation to mobile units to be considered by Health and Wellbeing Boards, CCGs, Local Authorities and Public Health. Other Initiatives Following a successful non-recurrent funding bid to NHSE North Midlands a project was set up with the aim of increasing the take up of the three NHS Cancer Screening Programmes (bowel, breast and cervical) and the Abdominal Aortic Aneury Screening Programme in people who have learning disabilities. With the support of CCGs, NHSE, Cancer Steering Group and LD Forum the project has had a positive impact.	
Public Health	CCGs need to ensure they have capacity in place to deliver: •the additional colposcopies and cancer treatment that we expect to result from the conversion to HPV primary screening for cervical cancer in the short to medium term; and •the treatment of additional bowel cancer cases likely to follow the switch from FOBt to FIT 120ug/g.	These pathways are commissioned by NHSE with the corresponding assurance process. The CCGs are managing implications and risks and this is supported by the ICS cancer workstream.	
Public Health	CCGs will support the implementation of the flu programme, with particular emphasis on: •·supporting improvement in uptake and reducing variation, and ensuring the recommended vaccines are used; •ensuring that there are clear arrangements in place to support oversight of the flu programme between October and March every year, which are broadly in line with the operating protocol developed for 2018/19; •supporting general practices to target at-risk population groups to improve uptake and coverage of the flu vaccination to achieve national uptake ambitions, also having a named flu lead in place whose role is to ensure that practices have ordered sufficient vaccine and that there are mechanisms in place to monitor supply and demand and to drive up uptake of flu vaccines; • supporting general practices (subject to national funding) to sustain and improve uptake and coverage of the routine childhood vaccination to achieve WHO targets for elimination and eradication of vaccine preventable diseases, improve cancer screening and immunisation uptake, flu vaccination uptake and other national	CCGs across Nottingham and Nottinghamshire each have a named individual that has been working with GP practices on flu uptake, including the management of vaccines. CCGs have worked with GP practices and community pharmacists to monitor supply and demand. The flu programme is part of the Nottingham and Nottinghamshire Winter Plan and has been supported by a comprehensive approach using the Stay Well This Winter Campaign. The CCGs have commissioned services for the management of prophylaxis both in and out of flu season. Childhood Vaccination is part of the ICS prevention plan. Also through the Health Protection Strategy Group and the Health Protection Response Group and working with Localities, plans will be implemented to support practices (subject to national funding) to sustain and improve uptake and coverage of the routine childhood vaccination to achieve WHO targets. In the meantime, pilot work to increase flu vaccine uptake is being carried out in one localityin partnership with the Local Authority Practices received a joint letter from NHSE, the Council and the CCG to encourage take up of the offer from the manufacturer to provide direct support to the practice around call & recall trainng and promotional ideas. Work on this pilot will be evaluated and consideration given to rolling it out more widely following this.	

ANNEX C - Nottingham University Hospitals 2019-20 Operational Plan Narrative

Introduction

Nottingham University Hospitals (NUH) 2019-20 operational plan narrative has been developed in response to The NHS Long Term Plan, and the 2019-20 Nottingham and Nottinghamshire Integrated Care System (ICS) operational plan.

The annual planning process has been overseen by the Director of Finance, Chief Operating Officer, and Director of Strategy and Transformation and subject to regular oversight by the Trust's formal governance procedures. This included divisional confirm and challenge of budgets with Divisional Management Teams, executive level challenge and review at the Trust's Senior Management Team (which includes clinicians), and scrutiny through the Trust's Finance Committee. This oversight process aimed to ensure consistency between the quality, activity, financial and workforce elements of the plan. The final 2019-20 plan was approved by the Trust Board in March 2019.

As per requirements in the NHS Planning Guidance, this narrative is organised in the following sections:

1. Activity Planning
2. Quality Planning
3. Workforce Planning
4. Financial Planning
5. Link to the local sustainability and transformation plan

1. Activity Planning

The following section outlines our approach to developing our operational activity and capacity plans in alignment with commissioners. It describes our activity model for 2019/20, the underlying growth assumptions, outlines our activity plan for delivering key operational standards and describes our approach to bed capacity planning.

1.1 Activity Model

In collaboration with our commissioners and led by our services, we have jointly agreed an activity model based on anticipated demand for our services; this is being used to inform our contract negotiations.

The activity planning model has been based on our triangulated forecast outturn, adjusted for issues discussed and agreed jointly with commissioners. This outturn will be reviewed to ensure that no material movements have occurred and that the base model is robust. This ensures that planning assumptions are built on a robust footing and are agreed with our commissioners.

The Trust and Commissioners have jointly worked on the activity model, populating known activity changes; including changes to activity levels for, approved business cases, impact of service changes, coding and counting, and contract terminations. The model builds in growth to ensure that demographic changes to the population as described by the ONS, disease prevalence and historical trends in underlying growth for services have been considered and included within the activity model.

As described below the Trust has worked to ensure that the activity plan includes sufficient activity to enable the Trust to continue to meet/aim to recover key operational standards in relation to RTT, Cancer and diagnostics waiting times.

Point of Delivery	Change in Activity between 18/19 and 19/20	2019/20 Activity Growth %	Emergency Pathway Redesign	QIPP
Accident and Emergency	5,952	3.3%	23,957	0
Emergency Spells	5,004	5.6%	15,465	-250
Planned Care Spells	4,155	3.8%	0	-706
Outpatients	30,629	4.7%	0	-15,620
Other	212,224	0.1%	0	0

The table above reflects the NUH operational plan as described by its contracts (including locally priced services, some of which are excluded from the national NHSI submission). The Plan includes the required activity to aim to recover (as required) performance standards for RTT, Cancer and diagnostics waiting times and contractually agreed QIPP. The table shows the growth in planed activity and growth rate for Emergency and Planned admissions, Outpatient attendances and type 1 A&E Attendances.

As part of the trust plan to recover the A&E performance standard the trust has redesigned the emergency pathway, the changes made from the transformation have been agreed contractually and the additional activity after transformation expected is shown in the table below.

Specialty	Point of delivery	Activity
Acute Medicine	Short Stay Emergency	4,883
Emergency Department	Short Stay Emergency	10,582
Emergency Department	A&E Attendance	23,955

1.2 Performance trajectories

Performance trajectories have been established across the elective, cancer and emergency pathways.

The 18-week referral to treatment (RTT) and 6-week diagnostic standards are forecast to be above the national target year round. An element of recovery of headroom in the 18-week standard has been modelled in alignment with activity plans. In line with planning guidance, there is a slight reduction forecast in the total number of incomplete RTT pathways when comparing March 2018 outturn with March 2020.There are 52-week wait breaches included in our trajectory for the beginning of the year – these represent patient choice that we are currently aware of and often relate to the same patients for a number of months. The forecast is reduced to zero from August onwards on the basis that we have no currently known breaches after that point.

The forecast for the cancer standards shows continued delivery of those standards that have remained strong in 2018/19. The two cancer standards that we have forecasted recovery in 2019/20 are the 31-day subsequent surgery and the 62-day RTT standards. The forecast is for recovery in August 2019 and October 2019 respectively primarily on the basis of the expected impact of improvements in Urology and the time required to clear existing backlogs.

The emergency access standard remains one of the key challenges for the Trust. The scale of accuracy of the trajectory is limited due to unknowns and multiple variables that can impact on patient flow and performance within the Trust and across the system. The trajectory is ambitious based on our 2018/19 position. Further work is required across the system to agree all actions that will underpin delivery of the trajectory.

The ambulance handover trajectory is constructed based on 3% growth in ambulance arrivals and the delivery of improved timeliness of handover as a result of the first contact changes in the 'majors' section of our Emergency Department that were implemented mid-March 2019. Greater than 30 minute handovers have been profiled to be eliminated during 2019/20 as new handover processes are embedded and data quality work takes place to resolve current issues where the double-pinning process prevents the clock from being stopped.

1.3 Capacity Planning

Our 19/20 capacity plan has been developed based on continuing to meet, and aiming to recover, the key operational standards included in our performance trajectories. It is recognised that some of the Trust's current operational and financial inefficiency is linked to capacity constraints around beds, theatres and critical care (adult and paediatric).

Modelling has been undertaken to provide an indication of the forecast capacity required to deliver our 19/20 activity plan (adult G&A beds, theatres, critical care, diagnostic imaging, and workforce). Clinical divisions have reviewed the outputs and identified capacity shortfalls across several areas.

The following mitigating actions have been developed for our capacity plan to support the delivery of the key operational standards:

- Right-sizing our core adult G&A beds – converting a proportion of previous escalation beds into core beds, investment to create additional wards, investment in a modular theatre to enable our bed base to be reconfigured and additional capacity released;
- Seasonal beds – retaining escalation bed capacity on each site to account for seasonality and to provide resilience to manage for unplanned changes in demand;
- Length of stay improvements – continued focus on peer benchmark improvements for identified specialities. Progress has been made as a health and care system in reducing acute length of stay and reducing the number of long stay patients in hospital. It is recognised that there is further work to do and there will be continued focus on this in 2019/20.
- Critical care expansion – investment in both adult and paediatric critical care to ensure elective activity can be delivered and care provided safely.

Our capacity plans, and the mitigations above, are significantly dependant on external central capital funding (see section 4.4) otherwise there is a substantial capacity gap, and timely recruitment to support the additional capacity at safe staffing levels. It is important to emphasize the significant workforce risks that may impact on the delivery of elements of our activity plan – further details described in the workforce section (section 3).

2. Quality Planning

2.1 Approach to quality Improvement leadership and governance

Improving patient safety, effectiveness and experience is our highest priority. Our ambitions for improvement are informed by combining national and local commissioning priorities. We are supporting our system partners to achieve the five year ambitions in the STP to (i) secure additional years of life; (ii) improve the health-related quality of life for those with long-term conditions including mental health conditions; (iii) reduce the time people spend avoidably in hospital; (iv) increase the proportion of older people living independently at home; (v) increase the proportion of people having a positive experience of hospital care; (vi) increase the number of people with mental health issues having a positive experience of health and social care outside hospital; (vii) make significant progress towards reducing avoidable deaths in hospital.

We aspire to put quality at the heart of everything we do at Nottingham University Hospitals. This is reflected in our revised Trust Strategy 2018-2028. Our vision is to provide outstanding health outcomes for patients, summarised by our promise to ensure patients receive consistently high quality, safe care with outstanding outcomes and experience.

To meet our vision NUH has a range of well-established Quality Improvement vehicles within the Trust. These span from front line shared governance models, integrating human factors and patient safety science through to a board development programme (leadership for improvement). The Trust, along with the Nottinghamshire Integrated Care System (ICS), has selected QSIR as its service change methodology to ensure consistency and will work closely with those partners, as well as more local partners in the Greater Nottingham Integrated Care Partnership.

The Trust has an overarching quality strategy with associated annual quality priorities. Our quality priorities reflect what our patients, partners and staff tell us matters most to them and are based on feedback from a number of sources including patient surveys, 'Friends and Family' test responses, social media and online feedback, 15 steps challenges, incidents, clinical risks[5] and complaints.

We were awarded an overall rating of 'good' by CQC (Mar 2016) and await the results of our recent CQC assessment from December 2018/January 2019. The Trust has an established CQC peer review process in place across all wards and departments which assesses compliance with the five CQC key lines of enquiry and associated fundamental standards using the CQC ratings of outstanding, good, requires improvement and inadequate. A programme management approach is in place to monitor the improvement actions from the most recent CQC inspection with reporting and monitoring via Divisional governance forums, Nursing and Midwifery Board, Divisional Performance Meetings and the Board Quality Assurance Committee.

The Quality agenda is led by the Medical Director and Chief Nurse. Quality is managed through a Quality Management Structure which includes monitoring of priorities through the Trust Quality, Risk and Safety Committee.

Each Division is led by a Divisional Leadership Team comprising a Divisional Director, Divisional General Manager and Divisional Nurse/Midwife. Each month our Divisional Leadership Teams are held to account for their performance against the Trust's agreed quality and performance targets, and with compliance against expected standards in each of their clinical services. This accountability has been enhanced with the establishment of the Quality, Risk and Safety Committee, chaired by either the Medical Director or Chief Nurse. Through the scheduled reporting to this committee, Divisions and Corporate teams are required to provide assurance around the domains of safety, effectiveness, patient experience and risk management. Additionally, Divisional Leadership Teams provide a quality account to the Board committee, the Quality Assurance Committee twice a year against the quality domains.

2.2 *Summary of the Quality Improvement Plan.*

NUH has an ambitious quality improvement plan, summarised below. This relates to local and national quality priorities to be implemented over 2019-20. Key quality priorities for 2019-20 will also be described in our Quality Account to be published by the end of June 2019.

[5] Our top clinical risks at 20 aligned to our quality improvement priorities are associated with; Care of the acutely unwell patient [DATIX 680/7080], Seven day services [DATIX 80457], Staffing [DATIX 6355/8033/7820/8025], Cleanliness [DATIX5549] and ED overcapacity/overcrowding [DATIX 7087/7881].

Alignment to Trust Strategy and National Priorities	Quality Component	Priorities
		Patient Safety
Patients National requirement	Medicines Safety	• NUH's medicines optimisation strategy (available on request) sets out 5 key objectives for Medicines Optimisation at Nottingham University Hospitals.
Patients, People, Partners, Performance and Potential National requirement	Safe Staffing	The Trust board is committed to ensuring that levels of nursing staff, which includes registered nurses, midwives and healthcare assistants, are correct to meet the care requirements of our patients across all areas. This is achieved through: • Daily completion and response to the safe staffing App • Regular review of Staffing Risk assessment • Annual Ward Establishment Review, with mid-year review • Non ward Establishment Review • Implementation of NHSI latest guidance 'Developing Workforce Safeguards' • Implementation of NHSI latest guidance ' E-Rostering the clinical workforce: levels of attainment and meaningful standards' • Implementation of NHSP interface with rosters • Continual collaboration with NHSP
Patients and People National requirement [SI Framework, Statutory Duty of Candour]	Improving the quality of Serious Incident investigation, learning and improvement	• Establish a Patient Safety Investigation faculty, equipping colleagues with a bespoke training programme in support of high quality investigations, focused on using methodologies that diagnose system issues (rather than focused on individuals). • Improve our support (including Duty of Candour) of patients, families and carers involved in the investigation process through appointing to a Patient and Family Liaison Officer post. • Implement our revised process for managing Duty of Candour at NUH. • Establish a Rapid Incident Response Team to focus on patient, family and staff support early on and to support early learning/mitigations to risk. • Implement a Learning from Incident and LFD strategy to inform improvements in response to adverse events.
Patients and People National requirement [NHS Patient Safety Strategy]	Safety Culture	• Align work with safety spaces, the freedom to speak up guardian and our safety conversations to support a culture where safer care can flourish. • Build capacity and capability to support our staff in response to significant events. • Spread our Learning from Excellence programme to other Divisions outside of the Family Health Division.
Patients National Requirement [CQUIN and Safety Strategy]	Recognise and Rescue the Deteriorating Patient (EWS)	• Implement NEWS2. • Align teams and resources [operational delivery and improvement] in support of optimising the care and outcomes of the acutely unwell patient. • Focus on ensuring appropriate escalation and response to the deteriorating patient. • Improve the management of patient handover with

		increased use of Nervecentre and through the implementation of key principles in a new Trust Handover Policy. • Maintain sepsis screening and delivery of IV antibiotics in ≤1 hour in ≥90% of cases as per NHS standard contract 19/20. • Integrate e sepsis screening into Maternity services.
Places	Order Communication and Results Reporting	• Implement pan trust and evaluate impact. • Link to handheld- Nervecentre to push time critical/deranged results to clinical teams.
Learning from Deaths		
Patients, People and Partners National requirement [NQB/CQC]	Learning from Deaths	• Implement a Learning from Incident and LFD strategy to inform improvements in response to case reviews. • Establish a peer review network and introduce a process to quality assure the content and quality of SJCR reviews. • Further develop M&M leads role around the LFD agenda, including alignment of SJCR and M&M processes. • Develop Guidance on the Principles of Advanced Care Planning [end of life care].
Patients National requirement [CQC/NHSI/NHS Digital]	Mortality Indicators	• Maintain SHMI as in line with or better than expected [≤100].
Patients National requirement [DoH]	Medical Examiner	• Implement Medical Examiner [ME] Team in 2019-20. • Align national ME processes into Nervecentre. • Support Integrated Care System learning through ME team.
Patients and Partners	End of life care	NUH has an End of Life Care Strategy and action plan in response to CQC assessment. Our strategic objectives are: 1. ***To provide care of the highest quality***– each person is seen as an individual with choice provided, care coordinated, communication prioritised, comfort and well-being maximised. 2. ***To provide the best experience for patients and their loved ones*** – to ensure we make the last stage of life the best possible experience for patients, families and carers 3. ***To have confident and supported staff*** – staff working together with confidence, honesty, consistency and with the ability to provide high quality care whatever the circumstances of dying. Key deliverables against each of the strategic objectives have been defined to the end of 2019.
Harm Free Care		
Patients National requirement	Infection Prevention and Control	• Deliver IPC programme of work in support of core strategic aims including the prevention and reduction of MRSA, specifically MRSA bacteraemia and C.difficile infection. • Drive changes to infection pathways in support of reducing Anti-Microbial Resistance [AMR].
Patients	VTE	• Move VTE assessment from NOTIS to Nervecentre by July 2019.

National requirement [NHS Contract]		• Meet and sustain ≥95% VTE assessment compliance by November 2019. • Implement in patient anticoagulation dosing service of warfarin.
Patients National requirement [Safety Thermometer]	Falls	• Sustain improvements in falls reduction (we have realised significant reductions in falls and associated harm over the last 4 financial years) • Falls service review. • Introduce ward based 'projects' to reduce the incidence of falls.
Patients National requirement [Safety Thermometer]	Pressure Ulcers	• Reduce the number of category 2, 3 and 4 pressure ulcers. • Determine locally agreed pressure ulcer reduction objectives for Divisions / Specialties. • Embed Rapid Learning Events – opportunities for real-time multi-disciplinary discussions as a key part of the Harm Free Care investigation process. • Trust wide focus on Quality Improvement, led by the Harm Free Care Improvement Group. • Strengthen and refine ward based 'projects' to embed fundamental principles of effective pressure ulcer prevention measures at the clinical front line. • Create ward based 'Excellence in Harm Free Care Link Teams' to support all clinical areas. • Enhance the quality of continence related care across the Trust.
Patients	Continence	• Achieve Divisional and multi-professional representation at monthly Continence Steering Group meetings. • Integrate continence promotion and management of incontinence into existing relevant training programmes (infection prevention and control, nutrition, tissue viability and falls). • Create a Continence page on the Intranet with educational resources and guidance. • Enhance the quality of the continence and catheter related assessments on NerveCentre and develop associated clinical rules to support outcomes. • Trust wide roll out of education, support and guidance to promote the effective use of incontinence pads and pants. This will improve patient care and experience as well as reducing cost.
Clinical Effectiveness		
Patients and Potential National requirement [NHS Contract]	National Clinical Audits	• We will ensure our patients receive outstanding clinical outcomes. • Agree areas for focused improvement and monitor impact of interventions.
Patients, People and Potential National requirement [NHSE/NHS I]	Seven Day Services	• NUH has self-assessed as compliant in eight of the ten seven day service standards. Actions are in place to address gaps in compliance and will continue to be monitored through the seven day service steering group. We will monitor progress against delivery of the 4 prioritised standards (by undertaking the NHS Self-Assessment and report to Board). NUH does not anticipate meeting the core standards prior to April 2020. • We will continue to explore possible relevant outcome

		metrics including length of stay, mortality (weekday and weekend) and readmissions. • We will continue to engage with our Greater Nottingham Transformation Board and Better Care Fund partners to develop a shared plan for the delivery of services across 7 days.
Patients	Clinical Guidelines	• ≥90% of Clinical Guidelines will be in date. • An options appraisal will be developed to support a decision on whether a single guidelines platform should be developed.
Patients National requirement [NICE]	NICE	• We will select quality standards to review and develop a programme to monitor and support their implementation across the Trust or ICS.
Patients National requirement	Response to external best practice (NCEPOD, MBRACE)	• NUH will participate in all eligible studies. • We will continue to review all relevant publications, identifying through a gap analysis areas to improve our knowledge of best practice and thereby improving quality, safety and experience.
Patient Experience		
Patients	Mental health standards (Early Intervention in Psychosis and Improving Access to Psychological Therapies)	• We will work in liaison with our commissioners and Liaison psychiatry to agree service development and improvement plans [SDIPs], ensuring there are adequate and effective levels of liaison psychiatry services for patients cared for at NUH.
Patients	Improving patient experience through use of feedback	• Triangulate our patient experience data e.g. national local surveys, online, involvement events on an annual basis and use this alongside national and local priorities to identify areas for improving the patient experience.
Patients	Patient Centred Care	• Create patient centred care involving patients in their own care, carers and developing citizen engagement.
Patients	Caring for our patients with Dementia	• Our work caring for patients with dementia will continue to be developed, adapting practice, implementing milestones as identified in our Dementia Strategy.
Other		
Patients, Performance, Potential National requirement	National CQUINs	• Deliver national CQUIN programme.

2.3 Summary of quality impact assessment process and oversight of implementation

Maintaining the quality (safety, effectiveness and patient experience) of services is a core requirement of our Financial Efficiency Programme. All Financial Efficiency Programmes (FEPs) are subject to a full Quality Impact Assessment (QIA) where they have a potential quality impact on a clinical service or where they require a workforce reduction. All QIAs are reviewed and signed off by the Medical Director and Chief Nurse. The QIA process requires each FEP to identify risks based on the Trusts Risk Management approach. Where there is a risk of an impact, the assessment must set out which metric is likely to be impacted and why, so that both mitigating actions and ongoing monitoring can take place. The monitoring of the quality impacts is maintained throughout the year as part of the general performance framework. Serious Incidents and patient experience data, along with the core safety and quality metrics, are continuously monitored as early warnings of any potential impact of the scheme.

Triangulation of quality, workforce and financial indicators is undertaken each month by the Board, using the Integrated Performance Report. This report contains multiple indicators that the Board uses to monitor performance on key metrics and to identify areas that need improvement. The same data is also used at monthly Divisional performance meetings to drive improvements down to a speciality level. In addition, during the month, HR, Finance and Information triangulate metrics including activity, workforce spend, length of stay, acuity and bed occupancy to predict the current months financial position. This information is then published in the Finance and Investment Committee (FIC) report. This data then helps make informed, evidence-based decisions. For example, high levels of cancelled operations led to a theatre utilisation improvement project which in turn increased productivity and improved quality.

3. Workforce Planning

The workforce plan for 2019-20 has been co-ordinated through the Trust's People Investment and Planning Group (PIPG). During November 2018 Divisions identified their 'Top 5' people issues and challenges to inform the ongoing people planning and investment agenda and scheme of work. Running parallel to the conversations were consultations around the proposed 2019-20 workforce plan (which is used to inform the NHSI return as part of the Annual Planning Cycle).

The Director of HR chairs the Nottinghamshire Strategic Workforce Group (SWG) tasked with identifying and planning for the key workforce implications emerging from the Nottingham Integrated Care System (ICS). The Deputy Director of HR is a member of the HR/OD Collaborative, a key delivery workstream of the SWG. Progress against our workforce plan is measured through The People Committee with Board oversight. Monthly performance meetings consider key KPIs including turnover, bank and agency spend.

The identification of key people issues, highlight the following key challenges:

Description of workforce challenge	Impact on workforce	Initiatives in place
Need for service transformation to provide the right skills in the right place at the right time for patients	• Increase in demand but also complexity of patients is resulting in an increased need to review and reshape workforce plans	• Closer system working • Developing workforce safeguards, using a triangulated approach to deciding staffing requirements
Significant nursing (adult and children) and midwifery vacancies, compounded by shortage of nurses locally and nationally	• Difficulty in recruiting to establishment • Using expensive bank/agency to fill gaps Particularly an issue during time of increased demand for some services (Emergency Department, Acute areas) Compacted by • Reduced supply since removal of nursing bursaries/fees • Ageing workforce • Increased retirements • Difficulties in developing cross system working/transformation of workforce , due to the HR and finance systems / process variance	• Attending local, regional and national recruitment events to promote NUH as place to work outlining the support available alongside educational and developmental opportunities • Recruitment in line with Higher Education Institutes outputs where possible (N.B. can sometimes be only 1 output per year – September) • Investing in trainee nurse associate role positions • Focussed work on 'hot spot areas' as outlined in our NHSI retention action plan • Provision of information from leavers surveys in Divisions to inform local action. • Magnet programme to promote care excellence along with development opportunities to improve retention for nursing and midwifery

Description of workforce challenge	Impact on workforce	Initiatives in place
Lack of Junior doctor workforce	• May result in reduced staffing levels, gaps in rotas and reliance on more senior grades to cover • Increase in exception reporting highlighting insufficient resource to cope with the workload • The transition to an Advanced Clinical Practitioner (ACP) workforce as an alternative brings short term financial challenges	• Exploration of alternative roles, including Physician Associates and Medical Team Assistants alongside our ACP programme • Liaison with Health Education England (HEE) to support and participate in national and local recruitment strategies • Chief Registrar role to ensure junior doctors are represented at Divisional Leadership Team level • Specialities to identify their needs going forward and to utilise Trust Fellows to fill the gaps on the training rotas • Introduction of additional training opportunities, e.g. Certificate of eligibility for Specialist Registration (CESR) as alternative routes to consultant as an attraction mechanism
Lack of availability of training and development for all staff at a time when available funding has been reduced	• May impact retention ,with staff leaving to join other health related organisations who will offer course/personal development/training packages • If managers do not receive appropriate development and support they will be unable to support staff properly and staff will become dissatisfied • Need to deliver/release staff to attend training identified as essential/critical by Care Quality Commission (CQC) e.g. Critical courses	• Creative ways of maximising training opportunities in the Trust • Utilisation of in-house workshops and training to develop our workforce • Links with training organisations to generate income into the organisation that can be utilised to support staff training • Co-delivery of Apprenticeships • Admin academy and mentoring • Significant investment in an internal leadership development programme. • Increased collaboration across the ICS to get maximum return from limited funding
Difficulty in Recruitment and Retention (R&R) of specialised service staff such as Physiologists and Perfusionsists. Similarly difficult to attract applicants for certain trades, e.g. electricians, fitters and plumbers	• National shortages with local competition over R&R premia adding to issue	• Local recruitment and retention groups to action plan • Current interim R&R premia to be reviewed • Closer working with local Trusts to action plan and stop competing • Reviewing different approaches to recruitment, apprenticeships, succession planning, graduate schemes at university

Aligned to these challenges are a number of Trust wide workforce risks:

Description of workforce risk	Impact of risk	Risk response strategy	Initiatives in place
If we are unable to provide appropriate numbers of skilled staff	High	• Robust planning within the clinical Divisions and associated	• Working with HEE to ensure early notification of medical trainee gaps

Description of workforce risk	Impact of risk	Risk response strategy	Initiatives in place
within identified 'fragile services', then there is a risk to the sustainability of these services due to potential shortages of crucial staff, leading to the inability to deliver safe quality care to patients.		programme of work • Nursing establishment reviewed six monthly • Winter capacity plans in place. • Building our employment brand through recruitment campaign • Utilisation of bank, agency and locum staff as appropriate and in line with agency caps	• Attendance at appropriate recruitment events; including 2 large scale NUH events per year and corporate nursing recruitment events • Establishing senior support for development of new roles, including apprenticeships • Longer term planning to anticipate new services becoming fragile • Focus on growing our own staff including consultants • Recruitment and retention initiatives to promote NUH as employer of choice
If we are unable to build, develop and sustain sufficient staff resilience (numbers and capability), then NUH will not be able to meet demand or deliver safe care, leading to an overall inability to achieve our constitutional targets and objectives.	High	• PIPG programme of work to establish development support for new roles, including apprenticeships. • Workforce Race Equality Standard (WRES) action plan • Building our employment brand through improved recruitment campaigns • Comprehensive training and development programmes. • Staff Wellbeing programme.	• Review of the Wellbeing and Attendance Policy • Continue to build stronger relationships with university and other education institutions creation of alternative roles. • Develop employment models to enable staff to cross organisational and professional boundaries • Enabling Change Leadership development programme and Influencer and Accountability Training

Description of workforce risk	Impact of risk	Risk response strategy	Initiatives in place
Risk of failure to provide safe/high quality care due to inadequate nurse/midwifery staff numbers	High	• Practice Development Matrons are currently working 40% of their time clinically as part of the nursing workforce numbers. • Non ward based staff rostered to work clinically • Staffing levels reviewed daily • Monthly staffing report to Board Sub Committee • Monitor metrics from e-roster system as part of nurse performance meeting	• Review of establishments and advertisement of posts for nurse associates due to qualify in January 2019 • Continued work via the Institute of Nursing and Midwifery Care Excellence to increase nurse retention rates • Continued work to actively support and implement Black, Asian and Minority Ethnic (BAME) shared governance priority actions • Development of Nursing and Midwifery 3-5 year workforce plan • Continued recruitment strategy to maximise numbers of registered nurses attracted from outside of NUH • Development of business cases to support nurse associates and apprenticeships • Maximise use of Allied Health Professional (AHP) roles to support skill mix where appropriate
If staff who are European Union (EU) nationals leave the Trust because they are not adequately reassured by the Trust regarding their employment position the Trust will have a significant number of vacancies.	Low	• EU nationals identified as 4.4% of workforce. Identification of roles and departments • Decision to reimburse staff with the settlement scheme application (although this may no longer be required following announcement on 21.1.19) • Dedicated communication and engagement with EU nationals to reassure as far as possible	• Strong retention rate of EU staff • Talent management framework for nursing staff being developed • Additional support provided for overseas nurses generally • Staff intranet site developed. • Dedicated staff mailing list to enable proactive communication and engagement with this group of staff

The vacancies within Nursing and Medicine has already been covered at length within the narrative, other professional groups with significant challenges are detailed in the table below.

Description of long-term vacancies,	Whole-time equivalent (WTE) impact	Impact on service delivery	Initiatives in place, along with timescales
Recruitment into substantive Healthcare Scientists (HCS) posts in all specialisms and at all levels is challenging, with a number of specialisms listed on the shortage occupation register	6% 31 posts are currently vacant	• HCS reflects 5% of the workforce, but supporting 80% of diagnostic decisions • Increasing demand on services affects ability to offer training places • Challenges to maintaining quality management systems for certified and accredited services	• The Scientist Training Programme (STP) is well subscribed to, resulting in high calibre trainees (Number of STP training places are insufficient for the national need) • Degree level apprenticeships for Practitioner Training Programme (PTP) are growing • Opportunities to strengthen Clinical Academic Careers for HCS • Successful overseas recruitment in Nuclear Medicine and Radiotherapy Physics

The workforce plans for 2019-20 review our current workforce numbers and how we can look at the shape, size and skill mix in our teams to deliver efficient and safe care to patients, whilst managing unprecedented demand on the system with workforce transformation our key driver.

People Transformation Initiatives

- Expansion of ACP role, including development of an ICS ACP strategy
- Appointment of Physician Associates in Medicine
- Continued development of Trust Grade roles to full rota gaps
- Development and expansion of Medical Team Assistant Role
- Active participation in review of Model Hospital information to identify opportunities
- Active participation with Getting it Right First Time (GIRFT) programme
- Long standing nursing, midwifery and medical banks in place to reduce agency costs
- Development of a Registered Nurse Apprenticeship and business case to support positions for existing NUH staff
- Development of the Midwifery Assistant role and training programme

ICS Linkages and Opportunities

NUH is well represented and actively contributing to the workforce elements of ICS System Planning and Workforce Transformation to include:

- Participation in the Legacy Mentor Project
- Developing Notts ACP Framework
- Supporting Nottinghamshire Talent Academy with the largest number of work experience placements, increasing participation at careers events and schools interventions
- Refreshing priorities for ICS People and Culture Strategy
- Delivery of frailty module on behalf of the system
- Combined approach to Urgent and Emergency care programme

In 2019-20 NUH will participate in a number of initiatives to include:

- Portability models to develop flexible models of employment and transferability of skills/training
- Delivery of Quality Improvement Skills through train the trainer model and improvement project
- Embedding the approach to workforce redesign using modelling

NUH representatives on ICS groups and forums (related to workforce) feedback to PIPG on a monthly basis.

4. Financial Planning

4.1 Financial Forecasts and modelling

The Trust has been set a control total (before conditional funding) of £27.040m deficit. At the time of the draft plan submission in February, the Board had insufficient assurance that this control total could be met. Since February the Trust has continued to work on the drivers of its plan in order to achieve the best position possible by the start of the 2019/20 financial year. The Trust set itself five key tests (below) against which it could measure whether it had obtained sufficient assurance on the plan, including whether to accept the financial control total in the final plan submission:

- Has sufficient activity been contracted to achieve regulatory standards?
- Does the Trust have a plan to develop sufficient capacity to deliver the planned activity? Is there capital funding available to support the development of the required capacity?
- Is the Trust able to recruit the workforce required to deliver the activity?
- Does the plan contain sufficient contractual income to support delivery of the Control Total?
- Is the Trust's efficiency programme sufficient to meet the financial plan?

The Trust Board met again on Thursday 28 March and discussed the 2019/20 annual plan in light of the five tests it had set itself to assess to viability of the operational plan. Overall, the Board's view was that significant progress had been made in improving the detail of the annual plan; particularly around understanding the capacity constraints facing the Trust and also in negotiating contracts with key commissioners. Both of these issues support improvement in the Trust's key objectives: to improve performance of both our emergency care pathway and our financial performance. However, there are still significant risks to delivery of our plan that are not yet resolved, particularly in creating the additional capacity (and the associated workforce) and also in delivering an efficiency programme sufficient to meet the financial control total.

- Activity – the plan includes a jointly agreed activity model based on anticipated demand for our services.
- Capacity – The Trust's operational plan is dependent on closing a capacity gap which requires: investment in one new ward, one new theatre, upgrades to our adult and paediatric critical care facilities and moving patients in our acute bed stock into the newly refurbished St Francis wards on the City hospital campus. These additional facilities will enable a number of service moves that will create better clinical adjacencies, improve pathway efficiency and significantly increase the number of acute medical beds on the QMC campus, thus supporting the step change we are planning in emergency care. The total capital funding requirement to support these changes is £16m. The Trust has previously been awarded £10.7m of STP wave 4 funding which could be one contribution to meeting this requirement, but we do not have a funding source for the residual £5.3

million. Without this capital funding there is a substantial capacity gap. A key risk is that any capital funding will not be available in a timely enough manner to deliver the required capacity in time to impact our performance over the 2019/20 winter period. We have looked at the trusts internal capital programme, however, the Trust would not be able to fund these moves internally given its significant estate backlog issues.

- Workforce – there remains uncertainty on whether the Trust could recruit permanent staff sufficiently to safely operate all the additional capacity once opened. However, provided the go ahead is given early in the year, managers are confident that they could recruit to critical care with sufficient time to adequately train and orientate the required staff. The Trust's current success rate at filling ward staffing vacancies would not be sufficient to staff the additional ward beds, so there is a risk that some degree of staffing would be at a premium or agency basis.
- Income – the Trust has reached contract agreements for 2019/20 with the Greater Nottingham CCG consortia and NHS England Specialised commissioning. The value of the contract to be signed with the 4 GN CCGs is £404.6m (NUH's aspiration was £407m and commissioners had initially offered £395m). The proposed contract with Nottinghamshire CCGs is to move away from a traditional payment by results (PbR) contract to a block contract called an aligned incentive contract. This will lead a different risk profile across our contracts. For other commissioners including NHSE specialised commissioning our contracts will remain on a payment by results basis. The table below outlines the contract form for our different commissioners:

Commissioner	Contract Form	Contract Value £m
Greater Nottingham CCGs - Activity Element	Block - with cap and collar	396.6
Greater Nottingham CCGs - Pass through medicine	PbR	8.0
Mansfield / Ashfield & Newark / Sherwood CCGs	Block - with cap and collar	31.6
Associates	PbR	73.0
NHS England Specialised Commissioner	PbR	356.8
Other - Non Contract Activity	PbR	64.5
	Total	**930.5**

  - In negotiating the contract it has become clear that the MRET adjustment, described in the tariff guidance as being financially neutral, has had a negative effect for the Trust. The income reduction incurred by the Trust from commissioners will be £5.228m overall, but only £3.368m is reimbursed to the Trust in the conditional funding set as part of the overall control total. Consequently the Trust will incur a pressure of £1.860m that is over and above that expected when the Control Totals were set, this is currently represented in our plan as a miss against our control total.
  - The final CQUIN included in the contract are yet to be finalised. However, although the Trust is unable to cost the implications of CQUIN requirements the block arrangement removes uncertainty on the overall level of income receivable from the CCG Consortia.

- Efficiency programme – the Trust requires at least £37m of efficiency to be delivered in order to realise the financial plan target of £27m deficit prior to conditional funding. Divisions have been set internal targets of £41m. The delivery of this level of efficiency is the most substantial financial risk in the plan, with circa £21m of plans identified to date prior to risk rating. In order to bring more certainty to this issue, the Board has brought in further external support to provide greater granularity and scale to the level of identified financial efficiency for 2019/20 to improve board assurance.

The Board agreed that a plan could be submitted, aligned to delivery of the financial control total provided the residual three issues could be resolved (recognising that there would still be substantial risks in delivery of this plan).

1. There has been a change to the tariff guidance at the most recent and final issue, whereby the MRET adjustment included in the control total (£3.368m) is no longer financially neutral, as the reduction the Trust will receive from commissioners will be £5.228m. Consequently, the Trust will incur a pressure of £1.860m that is over and above that expected when the control totals were set. We have shared our understanding of this issue with the NHSI team, and it may be that this issue is more material to NUH than other trusts as a consequence of the scale of emergency care that NUH provides as a proportion of its overall activity base and the fact that it is the East Midlands major trauma centre, and hence draws a higher number emergency patients from a catchment beyond its local commissioners base. Our request is that our Control total should be adjusted to take account of the change notified in mid-March.
2. The Board has agreed to an aligned incentive plan with local commissioners that moves away from PbR and introduces more financial certainty for both parties while trying to incentivise action that avoid emergency admissions to the Trust. Heads of Terms have been agreed, but further work is required on the detailed risk share agreement to ensure it does not pass an unacceptable level of risk to the Trust. We will finalise these points with our local commissioners over the next few days.
3. The Trust's operational plan is dependent on closing a capacity gap which requires: investment in one new ward, one new theatre, upgrades to our adult and paediatric critical care facilities and moving patients in our acute bed stock into the newly refurbished St Francis wards on the City hospital campus. These additional facilities will enable a number of service moves that will create better clinical adjacencies, improve pathway efficiency and significantly increase the number of acute medical beds on the QMC campus, thus supporting the step change we are planning in emergency care. The total capital funding requirement to support these changes is £16m. The Trust has previously been awarded £10.7m of STP wave 4 funding which could be one contribution to meeting this requirement, but we do not have a funding source for the residual £5.3 million. A key risk is that any capital funding will not be available in a timely enough manner to deliver the required capacity in time to impact our performance over the 2019/20 winter period. We have looked at the trusts internal capital programme, however, the Trust would not be able to fund these moves internally given its significant estate backlog issues. The Trust would appreciate an urgent meeting with NHSI to discuss whether these capital funds could be made available in time to support the plan that we have created?

The key movements between the 2018/19 forecast and the 2019/20 plan are:

- Full year effect and underlying position (£13.2m) – The reversal of one-off benefits in 2018/19 including release of deferred commercial R&I income; update to inventory policy and control; and some additional capitalisation. These one-off measures add to the underlying pressure in 2019/20. In addition the Trust will incur around £9m of full year effect of cost commitments made in 2018/19.
- Impact of the 2019/20 national tariff £18.2m – the assessment of the new tariff has been calculated at £26.4m, less the national agenda for change funding of £10.2m received in 2018/19 only. Assumed inflation on other income sources of £2m.
- Inflation (£31m) – comprising pay award and incremental costs of £19.4m; offset by a reduction in CNST/RPST contributions to NHS Resolution of £0.9m; non pay and drugs inflation of £7.8m; and a forecast increase of £4.9m in depreciation, dividend and interest charges due to higher borrowing.
- Margin from activity growth (as costed by the Trust) of £6m – the activity plan with CCGs and NHSE has been agreed. The additional activity has been valued at £22.6m

compared to the 2018/19 M9 forecast outturn, which is delivered for an additional cost of £16.4m. In addition, there is further £8.2m invested in pass through drugs and devices.

- Central costs reinstated in the plan (£6m) - £5.5m contingency; £2.4m apprenticeship levy, £0.5m CQUIN costs; £0.5m for local CEA awards; £1.5m other costs less £1.6m additional income to be allocated and £2.6m QIPP saving on pass through to be allocated.
- The impact of CIPs and revenue-generation schemes £37m – in addition to the earned margin of £6 described above, the Trust is assuming a further £31m in other efficiency schemes.

4.2 Efficiency savings for 2019/20

The draft 2019/20 plan includes a programme of efficiency improvement designed to deliver £37m of savings for the organisation from additional margin on activity growth, additional sources of income and expenditure reduction. The Trust has set 'stretch' targets of £41m to Divisions.

To date, around £23.9m has been identified, leaving a planning risk which the Trust is addressing. The delivery of the Financial Efficiency Programme (FEP) and achievement of the associated financial savings will be a critical component of the Trust achieving its financial plan in 2019/20.

The plan financial efficiency workstreams targets are shown in the table below:

CIP 19/20 Plan - All Schemes (£000's)											
	Cancer & Specialties	Clinical Support	Corporate	Estates and Facilities	Family Health	Medicine	Surgery	Total	Target	% achieved	Gap
Bed Efficiency	70.1					432.3	456.6	959.0	1,594.4	60.1%	-635.4
Medical Pay & Productivity	61.9		22.0		7.1	294.0	384.4	769.3	3,644.4	21.1%	-2,875.1
Medicines Management	365.1	53.7			145.3	348.2	317.8	1,230.0	1,480.6	83.1%	-250.5
Nursing & Midwifery	24.0					60.0		84.0	3,416.7	2.5%	-3,332.7
Other Income - Clinical	1,128.0	145.6	594.7		912.7	1,275.6	412.3	4,468.9	4,327.8	103.3%	141.1
Other Income - Non-Clinical	84.6	209.5	694.0	550.0	963.0	120.0	6.8	2,628.0	4,327.8	60.7%	-1,699.8
Other Non Pay	646.3	491.9	137.6		5.0	238.2	1,274.9	2,793.8	2,277.8	122.2%	506.0
Outpatient Efficiency					465.0		75.0	540.0	2,733.3	19.8%	-2,193.3
Procurement	936.8	1,000.8	563.1	676.7	317.2	587.2	1,513.2	5,605.1	6,947.2	80.7%	-1,342.2
Technology		80.0	17.8	104.0				201.8	2,277.8	8.9%	-2,076.0
Theatres Efficiency	466.0	399.0			670.0		85.0	1,562.6	4,555.6	34.3%	-2,993.0
Workforce Other	850.0	58.9	297.7					1,206.5	3,416.7	35.3%	-2,210.1
Total FEP	4,566.8	2,449.9	2,326.8	1,330.7	3,493.2	3,345.6	4,525.9	22,039.0			
Target	5,890.0	7,574.3	2,194.4	2,164.4	7,473.2	7,966.6	7,746.5	41,009.3			
% achieved	78%	32%	106%	61%	47%	42%	58%	54%			
Gap	-1,323.2	-5,124.4	132.4	-833.6	-3,979.9	-4,621.0	-3,220.6	-18,970.3			

Within the Trust, each clinically led division has an associate General Manager who takes the lead on FEP for their division. The programme is supported by the Better for You Team that take responsibility for leading the Wave Programme which supports specialities in the Clinical Divisions through a structured process of change and improvement including the scoping and implementation of changes that significantly improve the financial performance of the specialities. The FEP programme and the Wave Programme in particular make extensive use of the Trusts Service Line Reporting (SLR) information, Patient Level Costing (PLICS) information and of the Carter Model Hospital and the Getting it Right First Time (GIRFT) recommendations.

The Trust PMO is overseen by an experienced and permanently appointed ex-Finance Director in the role of Director of Financial Recovery. As part of the Financial Recovery Plan process, the Director of Financial Recovery meets with Divisional General Managers on a weekly basis to ensure senior oversight of all FEP delivery plans. All Divisions are subject weekly escalation meetings between Divisional FEP leads and the PMO to provide a tightly focussed governance of specific actions needed on all high value FEP schemes in order to address any barriers to delivery both quickly and efficiently.

The delivery of the top 10 highest risk schemes is overseen by the Director of Financial Recovery to ensure sufficient focus on finalisation of all plans, mitigation of risks and delivery of finances.

The Trust has engaged Ernst and Young to help to provide greater granularity and scale to the level of identified financial efficiency for 2019/20 to improve board assurance. This has identified an initial six week timetable to week commencing 13 May to work with key stakeholders to identify and quantify further schemes up to the required divisional £41m target.

4.3 Agency rules

The Trust will continue to make effective use of the agency rules by ensuring the follow steps implemented previously continue in 2019/20:

- Ensuring compliance with rate caps through effective procurement and enhanced monitoring of agency requests for medical and nursing staff by dedicated teams with Finance and Human resources;
- Doing more work in difficult to fill specialist nursing roles, such as critical care and paediatrics, to improve rate compliance; and
- Incentivising “good behaviours” in the control environment.

More work will be undertaken during 2019/20 to address the ‘demand’ for agency staff generated within the Trust through further work on the control environment. The Trust will implement an interface from the Trust rota system to the NHS Professionals systems used to generate the need for an agency or bank shift. This will allow closer control of the demand for agency staffing, ensure such shifts and properly authorised and are consistent with the rota. The Trust will also ensure best practices are used in rota development, in areas such as hours owed and lost time, in order to help manage demand.

The Trust is joining the regional bank collaborative which will allow Trusts within the region to ‘police’ their own staff who may be signing up to do more costly agency shifts at other local providers rather than filling shifts through overtime with their own employer. This is being worked on for 2020/21.

4.4 Capital Planning

The Trust occupies an estate which is in need of major investment, internal funding is being prioritised/focussed on addressing the significant backlog maintenance (total backlog of £136m, including critical and statutory backlog of £104m, which is the second highest level of critical infrastructure risk of all NHS provider organisations) and replacement of equipment (ICT and medical) with external funding being sought to support the immediate need for additional capacity in key areas to recover some of the Trust’s key constitutional standards. The 19/20 capital programme focuses on addressing significant Trust risks which are associated with capacity gaps, estates infrastructure, clinical safety and replacement of aging medical equipment (backlog of £9.9m).

The Trust has undertaken capacity and demand modelling which outlines significant growth in activity is required to enable to the Trust to meet the constitutional standards. This has creates a pressing need to ensure the Trust has sufficient capacity across the entire estate in particular ward, theatre and critical care capacity, in order to deliver the planned activity for 19/20.

The capital plan for 2019-20 is £64.9m; made up of £31.4m internally generated funds, £3.55m of National Rehabilitation Centre business case development funding, Capital Investment Loan funding for our Ward Renewal Programme (Phase 1), £16m additional central capital funding and £3.3m of grants and donations (to fund dedicated iMRI equipment and other charity purchases).

The Trust continues to develop our long term estates plans, aligned to the STP Clinical Service Strategy for Nottingham and Nottinghamshire, which will enable us to secure a sustainable future for healthcare services across the Nottinghamshire Health Care system.

The Trust continues to develop a strategic option for women's / children's block at QMC to support service consolidation, efficiencies and enable other service moves to QMC (e.g. stroke) to better develop the 'hot' and 'cold' site approach to patient services.

4.4.1. Clinical Services

The Trust has undertaken a capacity and demand review in readiness for 19/20 and identified significant constraints which will be addressed through improved productivity and investment in additional capacity to manage the bed shortfall across the year and within critical care.

The plan for delivery of the required capacity includes improving the use of the current estates through ward moves and improving LOS within specialties, implementing ambulatory services along with the investment in the estate to enable increased capacity. The Trust is looking to continue to develop services within the Emergency Pathway through increasing capacity in specific areas, building on the work undertaken in 18/19 within ED, to ensure that we address risks in the long term.

In order to address the immediate capacity issues across the emergency pathway the Trust has identified a number of areas for investment including the expansion of our Adult Critical Care (£4.5m) and Paediatric Critical Care (£3.7m) facilities, investment in additional ward capacity at City Hospital and QMC (£5m) through refurbishment of underutilised estate along with investment in additional theatre capacity through a modular build (£2.7m) at the City Hospital campus and ST Francis; linked to the need for more acute medical beds and quality.

In order to deliver the improvement to the emergency pathway and increase capacity to meet demand and improve patient care, the Trust will develop a business case for submission to NHSI, utilizing approved STP Wave 4 capital funding, supporting the delivery of the Nottinghamshire STP.

During 2019-20 the Trust will also complete the reconfiguration of our Brachytherapy facility (£358k) and our Fertility Service, upgrading the fertility clinic (£587k), to enable the service to meet regulatory requirements. In addition to this, we are looking to commence the installation of a NUH charity funded inter-operative MRI scanner at QMC. The Trust intends to also support the upgrade and development of our Mortuary services to ensure that we meet our regulatory requirements.

The Trust has bid to become the provider of services from the Nottingham NHS Treatment Centre. If this bid is successful, the Trust will be required to invest in equipment to re-equip the centre. The final outcome of the bid is unknown at this stage, so there is no capital cost included in our plan to cover this item at this stage.

The capacity plans for 2019/20 will enable clinical service moves, which will enable more ambulatory treatment in medical and surgical specialties. In future years, the Trust will need to invest in endoscopy facilities in order to comply with the requirements of a JAG accreditation assessment. The Trust also lacks decant facilities

4.4.2 Primary Infrastructure

Around one third of the Trusts internally generated capital programme in 2019-20 will be allocated to address high and significant estates backlog and fire risks. Key engineering projects identified, are the replacement of the Theatres 1-17 ventilation systems at the QMC and commencing the upgrading the electrical infrastructure for local power at the City Campus.

In order to start to address the existing urgent principal fire and primary infrastructure risks, we will look to undertake upgrade works to a number of our City Campus wards (including the Burns Unit) in 2019-20. Alongside this a number of clinical services will be required to decant whilst upgrade works are carried out across the City Campus, in order to facilitate this, we have developed an Outline Business Case for our Ward Renewal Programme, which aims to deliver or medium term strategy. This will deliver four generic modular built wards designed to accommodate 24-bed units inclusive of eight isolation rooms which will be capable of accommodating a range of clinical services. The Outline Business Case is requesting a Capital Investment loan of £17.4m (£10.7 of which will be spend in 2019-20) over 25 years to be made available to cover the capital cost, with associated additional CRL cover.

4.4.3 Medical equipment

The Major Medical Equipment priorities include upgrading two X Ray Rooms (£1.1m), upgrading the equipment within the Paediatric Endoscopy service and commencing works on our 'Project 2020' to replace the aging equipment within our Radiotherapy department over a five year period. The Trust will be interested in seeking support for any STP or central funding which becomes available to replace linear accelerators, as has been the case over the past decade.

Minor medical equipment priorities include the commencement of multi-year rolling replacement programmes for adult critical care ventilators and defibrillators. The Trust currently has £4.7m worth of medical equipment that is rated high risk for replacement which the programme will focus on in 2019-20.

5. Link to the local sustainability and transformation plan

The vision of the Nottinghamshire ICS/STP is sustainable, joined up high quality health and social care services that maximise the health and wellbeing of the local population. Through the ICS Board, the system has agreed there is one System Plan (which can be presented at total system (ICS), Integrated Care Partnership (ICP) and organisation level). NUH have played a key role in the development of this with representation at the ICS level planning group by the Director of Integration, the Operational Director of Finance and the Deputy Director of Strategy. The Director of Integration has also led the planning work at the ICP level.

The ICS Planning Group continues to review plans at a granular level to ensure the final 2019/20 system operating plan is fully aligned and underpinned by organisational plans that together express the system priorities and deliver the system control total. The process is therefore highly integrated and ensures the NUH operating plan is aligned with the ICS vision.

The ICS has agreed the following 3 key priorities for 2019/20. These are described below, along with how this is addressed in the NUH operational plan:

5.1 Maintain a strong focus on quality and patient safety.

Quality is at the heart of everything at NUH. The Trust Strategy 2018-28 includes our vision to provide outstanding health outcomes for patients, summarised by our promise to ensure patients receive consistently high quality, safe care with outstanding outcomes and experience.

Improving patient safety, effectiveness and experience is our highest priority. Our ambitions for improvement are informed by combining national and local commissioning priorities and are described further in section 2. We are supporting our system partners to achieve the five year ambitions in the STP to:

- secure additional years of life;

- improve the health-related quality of life for those with long-term conditions including mental health conditions;
- reduce the time people spend avoidably in hospital;
- increase the proportion of older people living independently at home;
- increase the proportion of people having a positive experience of hospital care;
- increase the number of people with mental health issues having a positive experience of health and social care outside hospital; and
- make significant progress towards reducing avoidable deaths in hospital.

5.2 Addressing the financial challenge

This involves maximising the value delivered for every £ spent. System Efficiency and Transformation Plan to take cost out and reduce the overall deficit of the system. Addressing the financial challenge is a key part of our 2018-28 strategy – see section 4.

5.3 Addressing key performance challenges

The NUH operating plan includes the required activity to recover (as required) performance standards for RTT, Cancer and diagnostics waiting times. These are described more in section 1.2 along with plans to improve the A&E performance standard.

Areas of the ICS Efficiency and Transformation Plan that NUH will directly help to deliver are:

- Demand Management. NUH will be working with system partners to optimise referrals into secondary care including developing referral best practice guidelines.
- System wide efficiencies. Benchmarking opportunities across the system include estates; medicines usage; agency costs; theatre and ward productivity; consultant job planning.
- Maximise resources to the system. Examples include through getting additional resources and by minimising stranded costs after completion of transformation projects.
- Decommissioning. Working with system colleagues to review service benefits and stop carrying out activity where that is agreed to be clinically appropriate and is in line with the system clinical services strategy.

Transformation plans have been driven by identifying opportunities from national benchmarking systems including GIRFT, Rightcare and Model Hospital. Examples are given in section 2 and 3.

ANNEX D - Provider Operating Plan Narrative: Nottinghamshire Healthcare

1. Activity Planning (Max 2 Pages)

Our Approach to Activity Planning

We are actively engaged with the external work across the ICS and with commissioners to develop and agree contracts for 2019-20. At the time of writing, we are in detailed discussions with regard to the overall financial envelopes available and the efficiency requirement across the system in order to achieve the required system control total.

At the same time, local commissioners are re-specifying our core community and mental health services, and this will include re-specification of the activity and capacity required to meet the Five Year Forward View targets and mental health investment standards, along with the commitment in the planning guidance to increase investment into community services and associated priorities in the NHS Long Term Plan. We expect to be able to reflect the outcome of these negotiations in our final plan.

The Trust works with a range of contracts including block, outcome, activity, cluster based mechanisms and a new capitation approach. This creates a significant challenge in reporting comparable activity plans across the complex portfolio of Trust services. To ensure activity plans are realistic, 'confirm and challenge' processes with our commissioners are embedded in contract development and have been aligned with the ICS assumptions.

The main movements in our activity plan for 2019/20 relate to the closure of a Rampton ward and the full year effect of the Trusts' new Hopewood CAMHS unit. There are also smaller changes, some of which largely offset each other, with decreases mostly related to the full-year impact of QIPP schemes implemented in 2018/19.

Community activity

Internal demand and capacity modelling is currently underway utilising national NHSE/I demand and capacity modelling tools, though recognising these are not yet sufficiently sophisticated for mental health and community services. Our modelling takes account of a range of factors:

- Forecast outturn from 2018/19 and trends from previous years
- Analysis of population growth, health needs (e.g. increasing levels of frailty), prevalence trends and commissioners' intentions and spending levels
- Meridian informed 'norms' on workforce productivity and activity ie applying the learning from the Trust's work with Meridian
- Review of service capacity through a range of approaches, including CIP development and internal service reviews
- Winter resilience planning.

The demand and capacity modelling is informing our work with commissioners on the new service specifications for community and mental health services.

Along with internal demand and capacity modelling work, we are also working with partners in the ICS on developing a system wide model. This will incorporate secondary, community and primary care data and be used to support system wide planning and service developments. The first priority of the ICS modelling has been to focus on acute care.

Across our community and mental health service portfolio, there are a number of areas where activity will change in 2019/20, with examples below:

- The Trust's ongoing response to the Mental Health Five Year Forward View, including the need to

Inpatient Service Area	2018/19	2019/20	Variance	Comments
Older People Rehab	72	72		
Palliative Care	18	18		
Adult Mental Health	179	179		Trust also sub contracts beds from private sector
Older People Mental Health	90	90		
Child & Adolescent Mental Health	32	32		
Children's Development Centre	8	8		
Learning Disabilities	16	14	-2	Bed reductions through the Transforming Care programme
Perinatal Mental Health	8	8		
Substance Misuse	17	0	-17	The Trust closed the Woodlands Unit in 2018
Low Secure /Community Forensic	86	86		
Medium Secure	176	176		

  deliver core crisis standards 24/7 – at the time of submitting this plan, the Trust is working with commissioners through the contracting round to determine activity and funding levels
- Increases in offender health activity through new contracts for Leicester and Gartree HMPs
- Decrease in Specialist Palliative care provision in Mid Notts, linked with QIPP and new model of EoL care through the Alliance
- Decrease in IAPT activity in Mid Notts due to loss of the contract for the Trust.

Planned Inpatient Activity

Table 1 shows the current bed numbers across all services and our forecast over the next year, and the variance from 2018/19.

High Secure	340	322	-18	Bed closures in line with the National Offender Pathway Plan
	1,042	**1,005**	**-37**	

Table 1: Planned Inpatient Bed Numbers

- CAHMS – in 2018, the Trust opened Hopewood, its new campus for community and inpatient CAMHS and perinatal mental health services. This brought on line an additional 20 CAMHS beds, including a PICU, which opened Autumn 2018.
- Adult mental health (AMH) - a key priority internally and for the system is to address local capacity issues regarding out of area (OOA) placements. The Trust has put sub-contract arrangements in place with local private sector providers to reduce the number of patients having to be cared for outside of Nottinghamshire and is in discussion with commissioners about the future funding of this additional capacity. At mid-February 2019, the Trust was purchasing 57 additional AMH beds from the private sector through a combination of sub-contracts and spot purchasing. The Trust also has a comprehensive internal transformation programme for AMH, which includes initiatives to improve patient flow, and to improve access to crisis support services in order to reduce the demand on inpatient services. In addition, the Trust is assessing likely future inpatient demand and an options appraisal to consider whether the Trust should develop more internal inpatient capacity.

The Trust uses private and 3rd sector sub-contractors to provide services in a range of circumstances:

- Specialist treatment, support and advice. For example, for dentistry and optometry within prison and forensic settings.
- Pathway management. For example, the use of 3rd sector organisations to provide more economical services and to enable full coverage across care pathways
- Flexible capacity. For example, working with other local providers to meet increased urgent care demand, such as step down services, as part of winter resilience plans.

2. Quality Planning (Max 4 Pages)

Introduction

The executive lead for quality improvement in the Trust is the Executive Director or Nursing, Dr Julie Attfield. The Trust's Quality Strategy supports the delivery of the overall Trust strategy and sets out our ambition for quality. The Quality Strategy which will be refreshed for 2019/20 includes the Trusts quality priorities.

1. Approach to quality improvement, leadership and governance

Quality First
As part of our continued review of our quality governance framework, a new model 'Quality First', is being implemented. This brings together the various structures/ systems/ processes/ frameworks currently in place to oversee the quality of care provided which often work independently of each other into one 'brand'. Quality First starts with the Trusts Quality Strategy and is underpinned by Quality Improvement, to ensure sustainable improvements are implemented to address quality concerns. Fundamental to Quality First are clear quality standards, the revision of our Compliance Assessment Reviews (CARe) to introduce a clinical accreditation for clinical teams, quality summits to support clinical teams not meeting the required standards and use of the right information in the right place. Implementation of the framework also includes the use of Quality Champions.

Quality Improvement Governance System
The Quality Committee is chaired by a Non-Executive Director, and through a strategic approach, the Committee maintains oversight and undertakes scrutiny in order to inform the Board of the level of assurance identified that robust quality governance arrangements are in place throughout the Trust and that these are working effectively.

This Committee, which oversees the implementation of the Quality Strategy, is supported by other relevant groups. During 2019/20, as part of our continued strengthening of the quality governance framework, we are simplifying and streamlining reporting to prevent duplication. This includes reducing the number of direct supporting groups from six to four and a complete review of the information flows and metrics used at the Board, Trust and division level groups. It is through this framework that quality is monitored at trust and division level, risks to quality identified, escalated appropriately, improvement actions agreed and monitored and where appropriate, deep dives into identified issues commissioned and outcomes reported and acted upon. Metrics used to measure quality relate to NHSI's Single Operating Framework, CQC Insight and locally agreed indicators relevant to any current quality concerns or focussed improvement activity.

CQC Compliance
The latest CQC well-led inspection report published in February 2018 rated the Trust as good overall. All domains were 'good' with the exception of 'safe' which was rated 'requires improvement'. The improvement plan in response to the 'must' and 'should do' actions identified is now closed with ongoing monitoring of continued and sustained improvement part of routine governance processes. The next well-led inspection is in March 2019 and core service inspections ongoing. Rampton Hospital was inspected separately in March 2018 and the report published in June 2018 with an overall rating of 'requires improvement'. Implementation of the improvement plan following this is making good progress. The Trust has an ambition to improve our overall CQC rating to 'outstanding'. Our quality improvement plans for 2019/20 will support progress towards achieving this. Improvement plans in response to CQC inspections are monitored by the Quality Committee and Board.

Quality Improvement Capacity and Capability

The Trust has a Quality Improvement Strategy to ensure there is an embedded culture of continuous quality improvement. To achieve this vision, we will:

- Engage with patients, carers, staff, stakeholders
- Build improvement capability
- Support teams to deliver Quality Improvement
- Embed the QI methodology

Our approach ensures QI is staff led and patient centred. There is a focus on measurement to evidence that change is an improvement and implementation of a consistent 'Model for Improvement' methodology to achieve evidenced and sustainable improvements. The Trust has a QI team and hub and as at 10th January 2019 we have trained 607 staff members in the QI Bronze award and plain to train a further 800 in 2019. Some staff have also completed silver training. During 2019/20 we are going to ensure there is greater strategic alignment with the quality priorities as part of our Quality First framework. This will be the vehicle for operational and clinical teams, with the support of Quality Champions, to assess their compliance with quality standards and to target their own priorities for Quality Improvement. There are currently over 50 QI projects in various stages across the Trust and the impact of these will be measured through the Quality Committee.

In 2019 the Trust is establishing a new Learning Forum which will have a clinical and operational focus to understand and consider solutions to problems in care identified through a variety of processes including incidents, learning from deaths, patient, carer and staff feedback, CARe reviews and CQC inspections. The outcomes from this forum will be used to commission future QI projects.

2. Summary of the Quality Improvement Plan

Each year the Trust agrees quality priorities which are developed in consultation with our staff, patients, carers, partners, stakeholders and our Council of Governors. We consider issues identified from incidents, performance monitoring, CQC inspections, complaints and all other forms of feedback. There is also consideration of national priority areas. The priorities have defined outcomes and measures and the Quality Committee receives a report on progress towards achieving each priority bi-monthly. These are also reported on in the statutory Quality Report the Trust is required to prepare in accordance with the Quality Account Regulations. For 2018/19 we undertook a fundamental review of our quality priorities, which are long term improvements and therefore we intend to continue with these for 2019/20 with clearly defined outcomes and measures for the year as part of our overall quality improvement programme. Our 2019/20 Quality Priorities are:

SAFE	**1. Improve medicines optimisation with a focus on:** • **Missed doses of critical medication** • **Accurate recording of medicines administered** • **Management of controlled drugs** • **Safe storage** **2. Improve the physical healthcare of patients with a focus on the use of NEWS* to recognise and act on physical health deterioration** **3. Reduce the number of our patients who die from apparent suicide and reduce self-harm** **4. Reduce restrictive practice to ensure the 'least restrictive' principle is applied for all patients**
EFFECTIVE	**5.** Improve the quality of and access to clinical records **6.** Improve compliance with the Mental Health Act, Mental Capacity Act and Deprivation of Liberties
CARING	**7.** Improve involvement in care planning and treatment decisions and ensure they are recovery focussed

RESPONSIVE	**8.** To reducing waiting times in services where delays in access could potentially cause harm and improve the experience whilst waiting
WELL-LED	**9.** Making the Trust a great place to work by improving the well-being our staff

Responsibility for implementation of the improvements to achieve the defined outcomes sits with relevant groups within the governance structure. For some priorities, specific groups have been established, for example a group to develop a new suicide prevention strategy and a QI project group regarding Restrictive Practice and Violence Reduction.

Actions to mitigate risks on the Board Assurance Framework are monitored through the Board and committee structure. The current top risks to quality are:

Risk Summary	Summary of Actions
Reliance on Out Of Area private beds to manage admissions to adult mental health beds	Development of business case Processes to ensure bed flow is optimal
Recruitment into high secure services to ensure safe staffing levels to prevent lone working at night and/or the cancellation of patient day time activities and compromise of the integrity and safety of the hospital	Review effectiveness of 'golden hello' initiative and other Rampton Hospital workforce strategies.
Recruitment and retention of an engaged and appropriately skilled and motivated workforce	Continue development of solutions for staff bank, recruitment drives, streamline recruitment processes, develop approaches for reward, recognition and workforce retention, extend implementation of E-Rostering and participation in NHSI Improvement programme.

Table 2: Top Risks to Quality

Learning - from National Investigations and Deaths

The Trust has considered the findings of the Gosport Independent Panel regarding the deaths of patients at Gosport War Memorial Hospital. This led to a deep dive into the Trusts use of syringe drivers, staff training and data on the use of opioids which was received by the Quality Committee. The Trust has robust systems in place, however to further strengthen oversight, some actions have been identified which will be monitored through the governance framework.

The Trust has made significant progress with implementing the recommendations in the National Quality Boards Learning from Deaths guidance which will continue into 2019/20. More deaths are now reported and reviewed and the Mortality Surveillance Group considers comprehensive mortality data to identify any potential concerns that require further exploration. Particular areas for focus in 2019/20 are implementation of guidance on supporting bereaved families and skilling staff to undertake this support, a review of our approach to investigation and a safe clinical environment including reduction of ligature risks.

Infection Prevention and Control and NEWS2

The Trust does not have any specific external targets relating to these; however they continue to be priority areas for us. Through the Trust's Infection, Prevention and Control Committee, ICP audits and incidents are reviewed and improvement actions monitored.

Implementation of NEWS2 is one of our quality priorities to recognise and act on physical health deterioration. The priority was for an electronic NEWS2 tool to be used which was implemented in in-patient and community teams Staff are now required to record NEWS2 scores, deterioration scores, the

action taken and outcome for the patient. Data to monitor implementation of this is now available which will continued to be reviewed and when required used to trigger improvement action.

NHS Long Term Plan
The Trust welcomes the priorities set out in the Long Term Plan and the renewed commitment to mental health and community services. We are assessing the implications for the Trust and will build these into our planning processes, including the quality plan. As a key partner in the ICS, we will also continue to work with partner organisations on the development of the local system's long term plan for implementing the commitments

3. Summary of quality impact assessment process and oversight of implementation

The Trust has a well-established Service Development and Cost Improvement Plan (CIP) quality governance process. Quality Impact Assessment (QIA) is an essential element against which all schemes are evaluated.

CIP schemes are developed at Team, Directorate or Divisional level and each considers the potential risks to quality using a standardised QIA tool that considers risks across five domains – Safety, Effectiveness, Experience, Workforce and Regulatory. The assessment includes baseline measures; which indicators will be used to monitor impact; and where / how performance will be escalated.

The evaluation of risk is a two-stage process which considers the initial risk and the residual risk following mitigating actions identified from the initial risk assessment.

All proposed CIP schemes where financial impact is greater than £200k and/or the QIA is scored as 8 or greater trigger further input as part of the risk based process. A Short Form Business Case is completed that documents all aspects of the scheme.

Divisional confirm and challenge is undertaken of individual schemes and of the cumulative CIP plan. Confirm and challenge sessions can often include senior managers, clinical leads, corporate representatives, service users, carer representatives and governors. If appropriate and sufficiently significant in nature, schemes are submitted to the local Health Scrutiny Committees for review.

All Divisional CIP schemes are reviewed by the Associate Medical and Nursing Directors, and their approval or rejection is recorded.

All schemes are also reviewed by the Medical Director and Executive Director of Nursing to consider their impact across the five domains and that they are realistic and deliverable, including consideration of the key performance indicators identified for each scheme. The Executive Leadership Team undertakes a formal confirm and challenge process of all schemes, requiring all rejected or challenged schemes to be reworked, or removed if quality impact cannot be assured.

Each QIA records specific CIP metrics, how frequently they are reported and to whom, and the responsible lead. As well as financial delivery, these metrics can cover quality, activity and workforce, to ensure that information is triangulated.

Regular Divisional monitoring allows identification of early issues which are escalated in-line with the Trust Risk Management approach and acted on appropriately.

The QIA metrics are monitored monthly through Divisional governance and assurance infrastructure and are presented each month to the Trust's executive team. Oversight from the Board of Directors is through its sub-committees – with the Quality Committee providing assurance in respect of quality impact.

Where appropriate, the Quality Committee may commission deep dives during the year into individual higher risk schemes to fully understand and consider any emerging risks to quality. These deep dives would include a consideration of the cumulative impact of several schemes on a particular pathway, service, team or professional group. Where quality issues are identified through the Trust's quality monitoring processes there is consideration of the impact of any previous schemes.

This process is fully aligned to the system-level QIA approach for QIPP schemes, with a move towards standardised documentation and a system-level QIA tool. All QIPP schemes of any impact or significance follow the same internal process.

Workforce Planning (Max 4 Pages)

Board approved workforce plan

Our People and Culture strategy was signed off by the Board in 2017 and has led to an organisational wide *Developing our People and Culture* programme. Supporting this are our workforce plans. Their impacts are widely scrutinised and challenged to understand the impacts on the overall workforce, service, quality and patient safety. Any risks identified are properly and appropriately addressed. Our open and transparent process enables plans to be changed and refined to help mitigate those risks. All plans are signed off by the Board of Directors who also receive information on staffing levels.

The Workforce, Equality and Diversity (WED) Committee of the Board regularly reviews reports on staffing capacity and capability, including details relating to workforce plans.

The Trust's comprehensive Strategic Workforce Plan is near completion. It sets out the strategic context and focus over the next 5 years, and is aligned to national and local drivers and integrated with other strategies and programmes in the Trust, such as the Clinical Strategy. The plan details the current shape of the Trust's workforce and future projections, and provides analysis by staff groupings.

It sets out plans across priority areas such as: Resourcing, Retention and Recognition; Wellbeing and Absence Management; Workforce Education and Leadership. It also describes our workforce risks, challenges and mitigations. The Plan will be signed off by the WED Committee and Board of Directors. From this, we will develop tactical divisional plans that will support delivery. These plans will be closely monitored and reviewed periodically.

As part of the Trust's governance processes, key workforce metrics are reported to the Board of Directors and divisional operational meetings on a monthly basis. These provide clarity around any changes across our workforce and support the identification of workforce risks. Our metrics triangulate workforce, quality and safety to show key information and support a greater understanding of the Trust's overall workforce position. The WED Committee receives regular detailed workforce information and is responsible for ensuring the appropriate scrutiny and assurance around key workforce data and risks. Escalation of issues and reports on assurance from this committee are received by the Board of Directors. Workforce risks are assessed and reviewed regularly by the operational Divisions and within the Human Resources team.

Integrated and aligned workforce planning

The workforce projections for 2019-20 have been developed, challenged and agreed within each clinical division. Workforce plans are driven by the Trust Board's determination to realise the strategic objective to 'make the Trust a great place to work' and take account of the outcomes of the recent National Staff Survey, CQC Well-Led Inspection, leadership development programmes and other activities focussed on improving staff engagement and organisational culture. The Trust remains committed to the leadership development agenda and will invest resources in 2019/20 in medical leadership development, support of nursing leadership through the Nursing Strategy, a continuation of Vision 21 and responsiveness to the CAMHS Cultural review.

Our plan supports clinical strategies and known commissioning intentions and takes account of known CIP schemes, transformation schemes and service developments reflected in the Trust's financial plan for 2019-20. They also reflect the changing landscape and new models of care that will support the service transformation plans.

We have robust systems for managing and monitoring agency spend, along with a process to ensure that appropriate safe staffing levels are met.

Workforce challenges and responding initiatives

Description of workforce challenge	Impact on workforce	Initiatives in place
Workforce supply challenge	Decrease in workforce numbers and workforce gaps in specific roles, ageing workforce	We have developed plans to increase our staffing, including: • increase in Advanced Clinical Practitioners (2 in place, with an ambition to develop a further 20 by March 2020 • increase in Peer Support Workers, creating a further 12 roles • developing Non-Medical Responsible Clinicians, we have 2 in place and a further 16 planned • developing our Trainee Nurse Associates roles, with 80+ in training and a further 80-100 planned in March 2019. We are also exploring different ways of working and how traditional work models can be practiced differently Offer additional payments where we have labour market pressures and retention issues. Raising the Trust profile through job fairs, reducing the requirements of agency staff, extending the internal bank, e-rostering roll-out and streamlining recruitment processes
Ability to support, mentor and develop the competencies of newly qualified professionals	An immature, inefficient workforce where staffing numbers are reduced and not closely matched to required activity	Continue to grow our workforce and mitigate against training gaps with flexible workforce models, with the ability to retain skills and experience. We have introduced Bank Legacy Mentors, which is a flexible working offer to staff that have retired or left, who can provide additional mentoring support to preceptors. We are exploring different ways of working such as peripatetic teams to deploy experienced staff into areas of need and increase sharing of skills and experience.
Maintaining the health and wellbeing of our workforce	An increase in sickness absence, a demotivated workforce	Through our Health and Wellbeing strategy, we will continue to deploy key initiatives and schemes to support this, eg MSK service, Occupational Health, Staff Counselling, Health and Wellbeing Champions.
Maintaining Trust values	Lack of engagement and behaviours not reflecting our positive values	• Continue to develop our Values and Behaviour Charter. • Appraisal and supervision approaches are being reviewed. • Continue to embed our zero tolerance approach to bullying and harassment and our “speak up” programme. • Implementation of Vision 21 Leadership programme for Bands 7 to 8b. • Training of 20 Expert Recruiters in values based recruitment to commence implementation of values based assessments. • Review of language in Trust workforce policies to ensure they reflect our values.
Maintaining staff voice	Staff are unable to voice concerns	• Open conversations programme, to enable staff to share opinions with Executive Directors. • A regular staff voice report to the Board and staff voice

Description of workforce challenge	Impact on workforce	Initiatives in place
		platform. • Introduction of Divisional listening events • Introduction the Freedom to Speak Up Guardian and a current review of processes. • Use of the National staff survey and Friends and Family test as key data for the staff voice reports and platforms and for feedback data for the use of shaping actions at WED Committee and Divisional forums.

Table3: Workforce Challenges

Workforce risks, issues and mitigations

Three of the top five organisational risks are workforce related, summarised in the table below:

Description of workforce risk	Impact of risk (high, medium, low)	Risk response strategy	Timescales and progress to date
Recruitment and retention issues in High Secure Services	High	Implement changes to local induction process. Engage meaningfully with staff via DOPACT process and staff survey. Pilot underway to outsource exit interviews for greater depth of information. Scrutiny of lone working at night data. Use bank/overtime to cover staffing shortfalls. Implementing 'itchy feet' conversations. Career pathways across Trust identified	Induction process revised, positive feedback received. Exit interviews due to be outsourced February 2019. Hope to use data to improve employee experience. Itchy feet conversations work in progress with ward managers; aim to embed these routine questions as part of managerial supervision.
Effective support and management of staff health, wellbeing and resilience	High	Continue to link with national and local initiatives, supported by Health and Wellbeing Champions	Ensuring smoke free environments, supporting Mental Health, promoting wellbeing and lifestyle changes are all embedded in the Trust, and will continue to be supported throughout 2019.
Inability to recruit and retain an engaged, skilled and motivated workforce	High	Competency programmes to develop skills internally across nursing and AHP, Band 2/3 and 5/6 nursing programmes and Band 4 Nurse Associates. Additional learning packages, rotation and flexible working	Programmes being rolled out throughout 2019

Table 4: Workforce Risks

Long term vacancies

Due to the shortage of Band 5 nurses across all areas we will continue to consider additional payments to our staff, where we have labour markets pressures that make it difficult to recruit or retain staff in sufficient numbers at the normal salary rate. In addition we will continue to develop new roles and increase workforce numbers in some areas. This will include increased numbers of Nurse Associates, Apprenticeships and Peer Support Workers and 'growing our own' to manage workforce gaps.

A summary of our long-term vacancies is set out below:

Description of long-term vacancy, including the time this has been a vacancy post	Whole-time equivalent (WTE) impact	Impact on service delivery	Initiatives in place, along with timescales
Shortage of Band 5 nurses in High and Medium Secure Services, rolling advert for all areas for last 2 years	69 wte in High Secure 20 wte in Medium Secure	Difficultly in recruiting to full establishment; occasions of lone working particularly at night, increased use of junior roles to staff clinical areas, reliance on bank or overtime and adverse impact on patient care (cancelled activity)	• Rolling advert in place, values based recruitment embedded via assessment centres and patient interview panels. • Work underway to pilot Nurse Associates on 4 wards to inform changes to workforce modelling and establishments. • Recruitment, Retention & Wellbeing lead focussing purely on recruitment activity of Band 5 RMN nurses. • Financial incentives recently introduced (Golden Hello, Refer a Friend, local allowance of £1800 for High Secure ward based band 5 staff nurses & £1500 for Medium Secure ward based band 5 staff nurses) • Exploring competency programmes to develop the skills internally across nursing and allied health professional roles, such as a Band 2-3 programme, Band 4 Nurse Associates, Band 5-6 nursing. • Incentivising through additional learning packages, rotation and flexible working.
Shortage in medical recruitment	7.5 wte in Local Partnerships.	Gaps filled by current workforce and by locum workers. Quality and continuity if locums are short term and change. Diverted cost and MDT dynamic.	• Developing networks and promoting the Trust as an employer of choice to Higher Trainees and within specialty networks. • Using research, academic and special interest to shape jobs. • Introduction of the New Consultant retreat as part of on boarding.
Shortage within specialist areas of expertise in AHP	41% of Band 5 AHP leavers were due to promotion and lack of internal opportunities. From April 18 there have been 23.7 wte Band 6 vacancies compared to 6.9 band 5 vacancies.	Quality, continuity and cost impact of resourcing via agency or gaps remaining unfilled.	• Advertising of development posts and link posts to provide greater career opportunity.
Shortage of Psychological		Length of time to	• Competency package developed to

Description of long-term vacancy, including the time this has been a vacancy post	Whole-time equivalent (WTE) impact	Impact on service delivery	Initiatives in place, along with timescales
Wellbeing Practitioners in IAPT		appointment and waiting list. Need for agency cover.	provide automatic uplift from Band 5 to 6 on evidence of competency acquisition. • Introduction of Band 4 role to support qualified staff and act as a ready pool of trainees who can commence as soon as training places are released.

Table 5: Long Term Vacancies

System Workforce Planning

The Trust is fully involved in the ICS Workforce & OD workstream and is working with all partners on the development of a system level People and Culture Strategy. We have contributed to the system-wide workforce information database and the future activity projections to assess the impact of service demand on the future size and shape of our workforce, and the gaps. We have ensured our workforce planning is reflected in the system's plan and vice versa.

A system wide HR and OD collaborative comprising all provider organisations is in place. The Collaborative brings together the workforce plans for each organisation with a particular focus on common risks and skill shortages to ensure there are system plans to meet these challenges. This will include work on collaborative bank models where appropriate, flexible employment models and work on alternative roles to improve the skill mix for the longer term.

3. Financial Planning (Max 6 Pages)

Financial Forecasts and Modelling

The financial plan for 2019/20 has been completed in line with the new financial framework for providers and the planning assumptions set out in the NHS operational planning and contracting guidance plus the impact of the 19/20 national tariff; NHS Standard Contract and Commissioning for Quality and Innovation (CQUIN) guidance.

The Trust enters 2019/20 with anticipated achievement of its primary financial objectives for 2018/19. Delivery of the overall financial efficiency target has been supported by non-recurrent measures and mitigations. The 2018/19 outturn position included in the table below outlines the achievement of the planned surplus (pre ICS PSF), supported by a strong cash position and Finance and Use of Resources rating score of 1.

The 2019/20 plan is shown alongside the 2018/19 forecast outturn on Table 6, highlighting the primary financial elements, although there are currently a number of risks to the delivery that are being actively mitigated. This is discussed further in the 'Risks to Delivery' section. As can be seen below, the Trust has submitted a plan which meets the pre PSF control of break-even, with resulting PSF of £3.7m.

FINANCIAL SUMMARY (Numbers in £'m)	M11 FOT 18/19	Plan 19/20
INCOME & EXPENDITURE		
Total income	**463.4**	**465.3**
Total operating costs	**-434.5**	**-438.6**
EBITDA	**28.9**	**26.7**
EBITDA margin %	**6.2%**	**5.7%**
Net Surplus before impairment (including PSF)	**7.1**	**3.7**
Net I&E margin %	**1.5%**	**0.8%**
Net Surplus excluding PSF	**3.6**	**0.0**
OTHER KEY FINANCE INFORMATION		
Year-end cash balance	**42.0**	**33.7**
Financial Improvement Target	**18.1**	**17.1**
Capital cash expenditure (before disposals)	**14.7**	**20.0**
Agency Spend (Ceiling £10.1m)	**8.4**	**8.1**
Single Oversight Framework (Use of Resources)	**1**	**2**

Table 6: Financial Summary

As can be seen in Table 6 above and within the detailed template submissions, the Trust Use of Resources Rating (UOR) under the NHSI Single Oversight Framework incorporates five measures of financial robustness: capital serving capacity which is the degree to which the organisations generated income covers its financial obligations; liquidity that is measured by the number of days of operating costs held in cash or cash equivalent form; Income and Expenditure (I&E) margin; variance to planned I&E margin; and performance against agency ceiling. All measures and the overall rating are scored from the optimum level of 1 to the adverse rating of 4.

The 2019/20 plan leads to an overall UOR rating of 2 as demonstrated in Table 7 below at year-end. Due to both the reduced level of surplus this year the overall score actually drops from 1 to a 2, primarily due to the capital servicing capacity score which is now a 3, where it has previously been at 2.

Finance and Use of Resources Metric	Outturn	Plan
	2018/19	2019/20
Capital Servicing Capacity (x)	**2**	**3**
Liquidity (days)	**1**	**1**
I&E Margin (%)	**1**	**2**
Distance from control total	**1**	**1**
Agency Spend	**1**	**1**
Overall Score (Rounded)	**1**	**2**

Table 7: Finance and Use of Resources Metric

The assumptions underpinning the plan and the implications where these are uncertain is a key factor in understanding the overall risk of delivering our financial targets. The assumptions on tariff and for pay and price increases for providers is as set out in the national planning document. With the submission of our plan contracts have been finalised with CCG's, the full tariff uplift has been assumed along with the income reduction from the centrally funded pay award last year that was non-recurrent.

The Trust has only included known and agreed service changes within the plan, in line with our contracts and QIPP arrangements. The closure of a Rampton ward and full year effect of the Hopewood unit are the main service changes but there are a number of smaller changes that largely offset each other. The equivalent information on what has been assumed within our plan for CCG income will be that used within the triangulation submissions. This year the change with CQUIN to move half of that income into baseline prices has been assumed as a neutral impact on income overall. The Trust indicative £3.7m from the Provider Sustainability Fund will again be reliant on the delivery of our control total.

As part of the work done to date for the interim financial submission, the baseline of our current expenditure was established with the impact of inflation included. The pay expenditure split between substantive, bank and agency from our latest forecast has been included and the agency plan of £8.1m is within the agency ceiling of £10.1m.

Financial Improvement Programme

The Trust is continuing with the development of the financial improvement plan for 2019/20 of £17.1m. At submission of the plan £3.5m (20%) remains unidentified. Although there are some services in the Trust that may see income growth, such as mental health services this is not material but has been worked through with commissioners as part of the contracting round. The plan primarily focusses on cost reduction.

We have adapted the NHSE/I efficiency plan for our purposes and use it to monitor progress.

The Trusts Financial Improvement Programme for 2019/20 centres on five themes:

- Clinical service reviews – our Service Review and Redesign Process has been strengthened. A standardised approach owned by all directorates, and including clinical ownership of any redesign,

will draw from experts from divisional and corporate departments to support the reviews using a wide range of information, including internal and national benchmarking. In some instances, these reviews will be with commissioners as part of the system efficiency programme

- Management and admin – to review and align operational management structures and clinical leadership. Also to continue the admin review to ensure the rollout of a streamlined and effective support service system.
- Corporate and infrastructure reviews – review service offers and ensure the requirements are delivered in the most efficient way. We have made good progress over the last two years in reviewing our estates and facilities functions and this will continue into 2019/20, including the drive for efficiencies through space utilisation. We also continue to use the national benchmarking of corporate functions to inform our plan. The Trust has also entered into collaboration with a neighbouring organisation to provide financial services which will realise savings for both. Further work with ICS colleagues is planned for 2019/20 onwards to realise further economies of scale across the ICS back office functions.
- Workforce initiatives – including initiatives to maximise the benefits of E-Rostering, review shift patterns; reduce agency spend; and expand bank capacity. The plan also continues the roll-out of using workforce productivity methodologies and tools.
- Income generation – to explore all opportunities in corporate functions and clinical training.

The Trust works as an active partner in the ICS in the work to identify and develop plans for system efficiencies, both at ICP and ICS level. This includes working collaboratively to identify joint opportunities for 'cost out' schemes. This work is underpinned by a set of jointly agreed principles.

The Trust has a robust approach to the identification, quality assurance and monitoring of the delivery of efficiency savings. We have a clearly articulated process, supported by a suite of standardised documentation, including business case templates. Our overall framework provides clear lines of accountability and assurance, both for financial and quality monitoring. An outline of the quality assurance process is covered under the Quality Planning section of this Operational Plan. This includes the approach for QIPP, where a system level QIA process is in place.

The identification of efficiency opportunities arises in a number of ways, often through individual teams developing ideas and proposals. As highlighted above as part of a service review programme; the Trust is using benchmarking and other information to understand where we have variation and opportunities which will then be embedded into our financial improvement programme.

Recognising the need to go further, both for internal and system level purposes, the Trust intends to strengthen its PMO process and move to a centralised model for 2019/20. In order to inform the design and operating model of a centralised PMO, we recently commissioned best practice advice from independent experts and a review of our current arrangements. This review confirmed our overall framework and governance structure is robust but given the challenges faced in 2019/20, it supported the strengthening of our current arrangements.

At the time of signing off this plan, the Trust has a target for financial improvements of £17.1m. The current financial improvement position is summarised below in Table 8, as included within the detailed NHSI planning templates, along with an analysis of the current risk rating:

Financial Improvement Summary	2019/20		%
Recurrent efficiencies identified (19/20 delivery)	13,174		77%
Non recurrent schemes identified	447		3%
Unidentified Schemes (NR)	3,479		20%
Total Financial Improvement	**17,100**		
High Risk Schemes Identified	2,843		17%
High Risk Schemes (unidentified)	3,479		20%
Medium Risk Schemes	5,365		31%
Low Risk Schemes	5,413		32%
Total	**17,100**		

Table 8: Financial Improvement Summary

The level of schemes rated 'high risk' in the above is still relatively high but this has reduced since the interim plan. Focused work will to continue to validate and mitigate the risks around the programme. It is important to note that a high number of the schemes are transformational in nature and relate to system wide initiatives across the ICP/ICS, therefore mitigations will also be explored at this level as we proceed in to the new financial year.

There will be ongoing work through the above efficiency programme in continuing to assist and support the identification of additional financial improvement schemes, along with a tight grip on all proposed investments and other in year savings will be the focus of regular review, and recorded as financial improvement where it is applicable. Should the impact of risks and cost pressures also reduce between the interim and final plan submission there will be a corresponding reduction within the unidentified and high risk numbers shown above.

Risks to Delivery of Control Total

Table 6 above and the detail within the submission templates show that we have planned for the Control Totals set out by NHSI for the Trust for 2019/20. The significant risks and current unknowns in achieving the delivery of our plan include:

- Currently the Trust has identified financial improvement schemes of £17.1m for 2019/20, with a significant element of high risk schemes and an unidentified gap of £3.5m.
- An agreed level of QIPP savings in 2019/20 has been included in the plan but these are not material. As part of the contracting round there has been an agreement to work on service reviews across certain services which will aim to deliver more QIPP in year. These may well attract a different level of re-investment and this is a key principle of the upcoming work. Whilst we will continue to discuss and negotiate against any cost pressures resulting from QIPP if services are de-commissioned or re-tendered there is a risk of some level of stranded costs.
- There is an ongoing dialogue between the Trust, our District Valuer (DV) and the external auditors Price Waterhouse Coopers (PwC) around our proposed change to the assessment of asset lives across our estate. Should we not reach an agreement there will be a significant increase in the cost of our annual capital charges (depreciation and PDC dividend), which in effect would reverse the c.£3m efficiency saving that has been accounted for in 2018/19.

- New Care Models – the Trust is leading a programme in the East Midlands for secure services, and is a partner in the South Yorkshire programme. It is not yet clear what, if any, the impact will be in 2019/20 as a shadow year.

- The Trust continues to have a major financial risk around the use of private beds for Adult Mental Health patients. This is a growing financial pressure in 2018/19 with the full year forecast of c. £10.8m, which is £6.8m above plan. The Trust has an internal transformation programme in place to reduce bed pressures and has secured non recurrent funding from commissioners for investment in key interventions aimed at reducing the risks to finance and quality.

- The Trust will always have ongoing requirements for investments that are both necessary and immediate. Some would only be actioned after all of the above risks are mitigated and there is confidence in the delivery of our efficiency programme. Others such as the costs to deliver the CQC action plan will have to be incurred regardless.

- The view from heads of procurement of similar trusts in our region is that the impact of the top slice from tariff regarding supply chain & procurement towers is likely to lead to a cost pressure going forward and not be completely covered by savings as it was intended. The planned top slice for the Trust is £415k.

- The Trust has been in dialogue with NHS Property Services (NHSPS), and CCG's locally around the funding to pay NHSPS has always been via a pass-through from CCG allocations. NHSPS have a long standing problem with a number of NHS organisations around its invoicing and allocation of cash paid, which has led to the Department of Health to appoint an arbiter to resolve and establish whether the supposed monies owed to NHSPS, are valid and if so by whom. The risk remains that the Trust could suffer a financial detriment, should the DH process look to swiftly resolve the debt position issue without the full detailed audit trail taking place.

Further work and refinement of these risks will continue along with mitigation plans and programmes.

Capital Expenditure

The proposed and affordable capital expenditure plan for 2019/20 is £20.0m. This is funded by depreciation and existing cash, along with the cash generated by the 2019/20 surplus. It should be noted that the Trust has disposed of property with proceeds of £1.4m in 2018/19, which has been factored into the level of planned capital expenditure for 2019/20. Due to the general uncertainty on realising any property disposals it is not prudent to include any asset sale proceeds in the plan for 2019/20. The Trust is not dependent on future asset sales to fund its capital programme, but a continued focus on the efficient use of Trust estate and timely disposal where appropriate remains a key priority. Table 9 below shows a breakdown of the broad themes:

Capital Expenditure	2019/20
	£m
Backlog Maintenance and Statutory compliance	**8.0**
Alterations and upgrade	**5.3**
Equipment Replacement	**0.2**
IM&T Investment	**6.5**
Total	**20.0**

Table 9: Capital Expenditure

The above level of capital investment of £20m for 2019/20 was proposed and agreed by the Finance and Performance Committee at its last meeting. Briefly, the strategic areas we will progress in 19/20 included within the above are as follows:

Projects to address backlog maintenance requirements and ensure continued compliance with clinical, environmental, security and Health & Safety standards including: window replacement in clinical and non-clinical areas (£1.1m); roof replacement works at various hospital sites (£0.7m) fire protection works around the Trust (£1.3m); investment in carbon and energy efficient lighting throughout the Trust with significant lifetime cost and environmental benefits (£1.2m); refurbishment of entire hospital kitchen at Wells Road Centre to meet current and future needs and standards (£0.7m).

There is significant investment planned in upgrading security and patient safety facilities at Highbury, (£0.7m) Rampton (£0.8m), Wathwood (£0.2m) and Arnold Lodge (£0.2m) as well as investment in smaller schemes across the Trust. There are plans to expand the District Heating Main at Rampton to maximise the energy and cost savings offered by the recently built Energy Centre on the site (£1.5m). In addition there is planned investment in pharmacy facilities at Wells Road Centre to support the Trust's Pharmacy Strategy (£0.6m). The Trust is investing in options to develop AMH inpatient bed capacity as part of managing a reduction in out of area placements; numerous other smaller schemes designed to address changing clinical models, mitigate emerging risks and improve the Trust capacity to provide high quality patient care.

There will continue to be significant investment in the Trust's information technology and communications infrastructure with expansion of the Storage Area Network capacity (£2m) and the purchase of Windows 10 compliant end point devices to ensure staff are working as efficiently as possible with modern devices running supported software (£1.7m).

4. Link to the Integrated Care System Plans (2 Pages)

Alignment with local ICS vision

The Trust operates within two ICS footprints: i) Nottingham & Nottinghamshire and ii) South Yorkshire & Bassetlaw – both of which are designated Accelerator ICS sites. The most significant of these in terms of our portfolio is the Nottingham & Nottinghamshire ICS. However, the Trust is fully engaged and an active partner in both and our Operational Plan is aligned to the ICSs' priorities.

Both ICSs have much in common and share aspirations regarding scaling up primary and community services and delivering more integrated care. As one of the leading providers of community and mental health services, our Trust is well placed and committed to playing a significant role in shaping and implementing new models of care. And we will continue to champion the need for parity of esteem.

The Trust's Strategy and our refreshed Clinical Vision are both aligned to the system aims, for example the need to organise services around patients, not organisation, and for better integrated ways of working.

The Trust is a key player in the governance and delivery structures for both ICSs.

Nottingham & Nottinghamshire

The ICS Leadership Board has agreed and adopted an ICS Planning Approach for the development of the system plan to ensure a fully joined up and transparent approach across Health and Social Care. The ICS plan will reflect the system priorities and deliverables, (many of which are similarly priorities for the Trust's plan), including:

- Meeting the constitution requirements
- Protecting planned investment for the five-year forward view commitments in mental health, cancer and primary care
- Meeting the Mental Health Investment Standard (where growth in mental health spend is greater than overall funding growth)
- Meeting the Long Term Plan commitments (year one) that funding for community and primary medical services should grow faster than overall NHS revenue funding settlement
- Commissioning realistic and sustainable activity levels.

The ICS is currently finalising its delivery architecture and it is anticipated to have three Integrated Care Providers (ICPs) – Nottingham City, Greater Nottingham and Mid Notts. These will be supported by Primary Care Networks (currently anticipated to be 23 PCNs in total).

Establishing PCNs, underpinned by sustainable and resilient General Practice is a key priority for the ICS strategy. The Trust's Director of Business Development is the director lead for PCN development across the system and the Trust is a key partner, with primary care, in the future design and model. This builds on work already prioritised in the Trust to continue to build strategic and operational alignment with primary care.

The ICS is also currently taking forward the development of an Acute, Community and Primary Care Clinical Services Strategy along with an All Ages Mental Health Strategy. Although being developed independently there is full alignment and synergy across both strategies. Population health management and risk stratification will be key approaches to targeting appropriate healthcare interventions at those most in need.

The system wide Mental Health Strategy (developed with the Trust's Medical Director as the SRO) has identified five strategic objectives (or 'pillars') to drive improvement work and deliver the required standards:

- Establish an integrated system infrastructure
- Increase support for prevention, self-care and the wider determinates of health
- Implement a person centred approach to mental health
- Improve access to specialist services
- Achievement of the 5YFV workforce transformation standards

A detailed PID is underdevelopment, setting out key milestones, for the system's mental health programme.

In line with the requirements in the Long Term Plan, the ICS is currently reviewing and refreshing its five year strategic plan. The Trust is an active participant in all aspects of this work programme and recognises the need to continuously review our own delivery models and approaches in line with the system priorities.

The Trust is also fully involved and active in the emerging ICP footprints (currently aligned to Greater Nottingham and Mid Notts), both of which are developing Transformation Plans for 2019/20. For example, in Mid Notts, the Trust is a partner in the development of ICP level PIDs across four broad transformation themes: Urgent Care; Elective Care; Primary Care and Proactive Community Services; and Mental Health. This work is underpinned by and benefits from the existing Mid Notts Alliance, of which the Trust is a full member, and which has already developed new approaches, for example for MSK and End of Life services.

Working within an ICS gives us the opportunity to spread the lessons and new ways of working developed through the local Vanguards across a wider footprint, at scale and with more pace.

In both ICP footprints, the transformation work is being aligned, where relevant to a re-specification of the Trust's core community and mental health services. At the time of submitting this plan, the impact in 2019/20 of the re-specifications is not yet modelled through.

South Yorkshire & Bassetlaw

Bassetlaw is identified as one of local 'places' within the South Yorkshire & Bassetlaw ICS, and we are working closely with Bassetlaw CCG on a potential 'roadmap' for the Trust being the main delivery vehicle for the development of an integrated provider contract. Dialogue is at an early stage and will continue to be worked through as the Service Delivery and Improvement Plan develops to reflect the Bassetlaw Place and Out of Hospital strategy. This may include the renegotiation of payment mechanism as we move away from block contracts.

New Care Models for Tertiary Mental Health Services

As well as fully participating in ICS development, the Trust's plans also take account of the New Care Models programme.

In terms of our Forensic Services, the Trust is leading a programme in the East Midlands for secure services, and is a partner in the South Yorkshire programme. This is a significant strategic priority for the Trust. It is not yet clear what, if any, the impact for the Trust will be in 2019/20 as a shadow year. The programme will include developing a new clinical model and provider partnership agreement.

5. Membership and Elections (one page)

In December 2017 the Trust undertook an election to fill 10 vacancies on the Council of Governors. Electoral Reform Services led the election process which concluded in February 2018. All seats except one were contested; only one nomination was received for South Yorkshire and the rest of the East Midlands Constituency. In December 2018 the Trust undertook an election to fill 14 vacancies on the Council of Governors. Electoral Reform Services led the election process which is due to conclude in February 2018.

The Council of Governors has a statutory duty to represent the views of the membership and the wider public on key issues relating to the Trust's forward plans, its objectives, priorities and strategy.

During 2018/19 Governors have continued to hold the Trust to account on its priorities through the monthly accountability sessions and its formal Council meetings. Governors have had the opportunity to join in focus sessions with the CQC as part of the Well-Led Review, and support the "Developing Our People and Culture Together" (DOPACT) programme. Governors have taken the opportunity to engage with their constituents by:

- Attending consultation events
- Attending local Trust Annual Members' Meeting/Annual General Meeting
- Members attending the Council of Governors meeting
- Membership of the Mid Notts Better Together Board
- Contact from members via the Trust website

The Trust will continue to seek to further enhance the processes by which the Council of Governors is engaged and supports the development of the Trust's future plans, ensuring that all stakeholders have an opportunity to contribute.

We seek to ensure a representative (reflecting geographies, services and demographic diversity) and appropriately engaged membership which adds value in terms of informing the development and provision of high quality services. A database is maintained and is used to analyse representativeness of the Trust's membership to focus recruitment (although there are no set targets for membership recruitment we aim to have a greater public membership base than staff and to focus on an engaged membership).

The Trust plans to improve links with third sector organisations and local communities to improve engagement and membership representation based on demographics of our communities and the Trust membership. A working group 'working with and engaging our communities' includes the Head of Equality and Diversity, Director of HR, and the Head of Involvement. The main aim is to have a more strategic and co-ordinated approach to engaging communities. This group meets bi-monthly and reports back to the Quality Committee.

We have two active Involvement Centres that engage service user, carer and volunteer members in a wide range of activities. The Involvement Centres play a key role in supporting people to work with the organisation. We have developed our approach and strategy over a number of years and are proud of our approach which has won national awards and international interest. The involvement centres support people to get involved in services and provide staff across the Trust with space to work with service users, carers and volunteers on co-production and decision making**.** The centres provide a focal point for volunteers to be part of wider community of volunteers across the Trust. This has included participation in service development groups, Trust induction and training, staff recruitment, Patient-Led Assessments of the Care Environment (PLACE) audits, collecting feedback, projects such as the Ideal Ward Round and Ideal Waiting Room projects. Members are also involved though the Nottingham Recovery College, accessing a range of courses.

There is a monthly development seminar provided to Governors from a variety of Trust services which provide an overview of the service, alongside discussions on risks and opportunities. Governors also attend regional and national development sessions and conferences hosted by NHS Providers.

ANNEX E - Provider Operating Plan Narrative: Sherwood Forest Hospitals

- Introduction

We are proud of our achievements in 2018/19 and we recognise we can improve further. In the context of the developing Integrated Care System (ICS) for Nottinghamshire, we have developed a new 5 year strategy, setting out our vision that through working together, we will see healthier communities and outstanding care for all. Our plan for 2019/20 represents the first year of our five year strategy, as well as our contribution to the first year of the ICS' five year plan.

- Activity planning

Working with Divisions and service lines, the Trust utilises the Intensive Support Team (IST) capacity modelling tool to plan new outpatient activity levels and to help understand the capacity constraints. The urgent care pathway activity has been modelled to reflect historical trends with all activity based on 2018/19 forecast out-turn activity, with 5 year regression analysis of trends, demographics and disease prevalence overlaid. These have been agreed with the ICS and ICP. This gives the 'do nothing' pre-transformation/efficiency scheme position shown in Table 1, alongside the transacted transformation reductions as at 20 March 2019.

Table 1 - Activity plan for 2019/ 20 (post-transformation schemes)

	Provider Adjusted FOT	Counting and Coding Changes (C & C)	Underlying Trend and Demographic Growth	Transformational Change	19/20 Annual Plan	Growth Before Transformational Change, C & C.
GP Referrals (General and Acute)	66,655		1,133		67,788	1.70%
Other Referrals (General and Acute)	23,804		405		24,209	1.70%
Total Referrals (General and Acute)	90,459		1,538		91,997	1.70%
Consultant Led First Outpatient Attendances	103,058		1,780		104,838	1.73%
Consultant Led Follow-Up Outpatient Attendances	239,214		7,912	-34,594	212,532	3.31%
Total Consultant Led Outpatient Attendances	342,272	712	9,692		352,676	2.83%
Total Outpatient Appointments with Procedures	52,693	2,611	1,491		56,795	2.83%
Total Elective Admissions - Day case	36,286		1,023		37,309	2.82%
Total Elective Admissions - Ordinary	5,681		118		5,799	2.08%
Total Elective Admissions	41,967		1,141		43,108	2.72%
Total Non-Elective Admissions - 0 LoS	12,699	297	312		13,308	2.46%
Total Non-Elective Admissions - +1 LoS	26,372		712		27,084	2.70%
Total Non-Elective Admissions	39,071		1,024		40,095	2.62%
Total A&E Attendances excluding Planned Follow Ups	129,798		2,160		131,958	1.66%
Type 1 A&E Attendances excluding Planned Follow Ups (as a subset of total attendances)	105,351		1,748		107,099	1.66%

Further Transformation schemes are in the pipeline and are subject to a jointly produced project initiation document, which is approved by individual partners prior to final joint agreement at the Mid Nottinghamshire Transformation Board. The activity impact of pipeline schemes will be reported as a variation to the activity plan in-year.

This joint approach is also underpinned by new contracting models designed to enable transformational change.

The ICP Transformation Board adopts a system-wide approach to taking activity and costs out of the system, ensuring the acute footprint is 'right sized', whilst improving outcomes for patients. ICP plans inherently have high levels of delivery risk and as a consequence, it is operationally necessary for the Trust to retain its capacity, workforce, and cost base in the short term to deliver performance against historical activity trends.

Capacity

New outpatients:

As an ICP, we have contracted a mechanism to underpin an ambitious plan to transform outpatients. This will reduce demand for new face to face outpatient appointments, use current capacity more productively and/or provide capacity in a different setting. First and foremost we will improve clinic utilisation and use the Model Hospital and outpatient improvement dashboard to identify areas of good practice from other organisations. We have engaged with Medefer to deliver a virtual hospital model in 3 specialties; Cardiology, Gastroenterology and Dermatology – this will be implemented in quarter 1 of 2019/20.

In December 2018 we undertook a programme of demand and capacity modelling, with the support of the NHSI Intensive support team (IST) for New Outpatients and 2WW. The output (unadjusted for 2019/20 growth assumptions) indicated a significant capacity gap in 6 specialties to deliver demand at the 85th percentile. Each specialty has developed a plan to close the gap.

Follow up outpatients:

The outpatient transformation programme will focus predominantly on developing specialty specific and clinically led plans to reduce unnecessary follow ups and will build on the schemes identified and implemented in 2018/19. This includes the roll out of Patient Initiated Follow up's (P.I.F.U) in 5 specialties, with 4 more identified for 2019/20. In addition to this, with our commissioners we have agreed service specifications for Advice & Guidance, Virtual clinics and a revised Consultant to Consultant policy in a bid to provide the right patient interaction in the right setting but also to reinvest clinical time to close any new outpatient and other capacity gaps. Whilst we will see a reduction in some follow up activity from April 2019, the opportunities available and actions required to deliver the transformational change will continue to be scoped in the early part of 2019/20; the activity plan will therefore be weighted towards a reduction in follow ups in the latter part of the year.

Inpatient and Day-case:

The 2019/20 inpatient and day case activity plan will mirror that of the 2018/19 plan in terms of a reduction in routine inpatient activity (notably orthopaedics) in January and February 2020, with a focus on day case activity in the same period. To ensure that patients do not wait excessively there will be a focus on increasing theatre productivity, but if necessary the independent sector will be utilised in Quarter 3 and Quarter 4. Building on the relationships and agreements supported by the CCG in 2018/19, additional capacity can be mobilised quickly and patients can be offered the choice of multiple local independent providers.

Non-elective:

We will continue work with partners to reduce the demand on emergency admissions and a key element of this will be to maximise the utilisation of same day emergency care. We have an established same day emergency care model in place which is available at least 12 hours per day, 7 days per week.

During Q3 of 2018/19, we established long stay reviews of all patients with a length of stay of ≥ 21 days. The review process is undertaken in line with best practice guidance and in conjunction with community health partners. The result has been a reduction in the number of patients with longer lengths of stay and a reduction in the number of occupied bed days. A number of key themes have been identified and we will continue to work with health and social care partners on agreed actions to ensure timely discharge from inpatient care, with a focus on 'home first'.

The winter plan for 2019/20 will have the following key objectives:

- Safely avoiding admissions
- Safely increasing our bed numbers available to medical patients
- Safely avoiding delays to patients care in hospital
- Maintain operational grip and control

As part of this, we will plan to flex inpatient capacity from surgical to medical beds, in a phased manner, in order to safely manage the winter peaks in emergency medical admissions. In addition, we will plan to increase the overall acute and community bed capacity for winter 2019/20 in line with winter 2018/19 levels.

Performance

Emergency care:

We expect to continue to deliver timely access to emergency care during 2019/20, in line with our trajectory for the past year. During 2018/19 we made significant improvements in reducing ambulance handover times. Building on this during 2019/20 we expect that less than 10% of ambulance handovers will take over 30 minutes, with the rare occasion where an ambulance handover may take over 60 minutes being treated as a clinical incident. The system is clear on the physical constraints that our Emergency Department has to significantly improve handover times in 2019/20. We will continue to work with partners to assess the impact of any future schemes as they are identified.

RTT:

Whilst the bridge to close the gap between demand and capacity is developed, the intention is to continue to deliver incomplete RTT performance of at least 90% for April 2019 – March 2020, with an aspiration of delivering 92% in quarter 3. Recovery of the standard will be underpinned by specialty specific plans that clearly articulate the root cause and actions being taken to close an increase in demand or a capacity gap. The expectation is that as these plans deliver, performance will improve.

We will continue to take actions to reduce the overall size of the waiting list. These are listed above in terms of eliminating unnecessary new and follow up activity – 85% of the RTT PTL is non admitted activity. It is important to note that the March 2018 starting point excluded the transfer of community

paediatric activity which commenced in Q3 2018/19. This would equate to an increase of 1,100 to the March 2018 baseline.

52 week waits:

We completed a significant historic data quality exercise in 2018/19 which identified a number of 52+ waits. This work is not expected to impact on 2019/20. Systems and processes are in place to minimise the risk of avoidable 52+ waits, including weekly oversight of the PTL by the Deputy COO for elective care, with an escalation to the Chief Operating Officer for any patient at week 40 or above without a confirmed plan. A suite of data quality reports are in place to ensure Divisions and the Data Quality team are well sighted on any potential errors and can take appropriate and timely action to rectify. The trajectory will be set at zero 52+ waits for the period April 2019 – March 2020.

Cancer:

Against a backdrop of increasing demand we are planning to deliver the 2WW standard in 2019/20. Performance is also expected to be maintained for breast symptomatic, 31 day, 31 day subs and screening although a very small number of breaches (often 1 or less) can result in failure of the standard.

The main risk in terms of consistent performance is with the 62 day standard. To reduce variability in performance our focus in 2018/19 has been reducing the time to diagnosis. For 2019/20, our Cancer system (Infoflex) has been updated to enable shadow collection of the 28-day Faster Diagnosis Standard data items and this will subsequently underpin any improvement and recovery plans. We will continue to work with partners across the ICP and ICS to ensure that optimal pathways are followed to deliver timely care for patients and it is anticipated that the 85% standard will be met for Q1. However, this is subject to change in light of guidance published on 2 April 2019 confirming new breach allocation rules with effect from 1 April 2019.

Diagnostics:

We will continue to deliver the 6 week diagnostic standard of no more than 1% of patients waiting six weeks or more for a diagnostic test.

- Quality planning

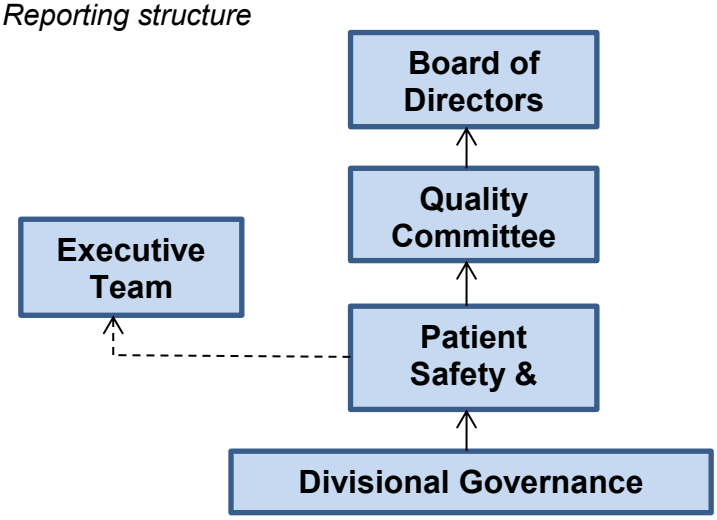
Approach to quality improvement, leadership and governance

In April 2018, we were visited by the Care Quality Commission (CQC) and given an overall rating of *Good* and *Outstanding* for the *Caring* domain. No regulatory sanctions were applied during the visit. However a number of areas for consideration were noted and have been included within our overall improvement programme.

Our quality improvement agenda is shaped by our experiences of the past three years, as well as our pursuit of new ways to improve the experience of patients when they are in our care. We continue to build on the robust governance structures implemented in 2015, in particular the successful implementation of the Patient Safety Quality Group (PSQG), co-chaired by the Executive Medical

Director and the Chief Nurse. The reporting structure from 'ward to board' provides the required assurances that our patients receive the high quality, safe care they deserve. The reporting structure is illustrated in *Figure 1*.

Figure 1 – Reporting structure



PSQG is the Trust's key Quality and Safety Committee, overseen by the Executive Team. It meets monthly, providing a reporting and assurance role to the Trust Board's Quality (Assurance) Committee. PSQG drives the patient safety and quality agenda across the organisation, being the vehicle to monitor the effectiveness of governance in its widest sense and hold defined specialist areas and the clinical divisions to account.

The PSQG Annual Work Plan is aligned to that of the Quality Committee. A number of sub-groups ensure that timely and accurate accounts of quality standards are presented, good practice is recognised and rewarded, risks to the safety of patient care are identified and remedial action taken where required. Most importantly the sub-groups ensure that lessons are learned and shared across the organisation.

Quality Improvement approach

In addition to using internal intelligence sources to identify and drive improvement initiatives, we work closely with local health and social care partners to support wider improvement programmes. We also take account of external sources such as GIRFT with the clinical divisions providing exception report to PSQG on their GIRFT performance.

We have a Nottinghamshire-wide training approach to QI, which we jointly deliver with Nottingham University Hospitals and Nottinghamshire Healthcare Trust. This uses the nationally accredited QI training approach 'QSIR', and has been recognised as national best practice by the NHS Improvement's Act Academy.

We launched our QI approach in July 2018, which is underpinned by the globally recognised Institute of Healthcare Improvement's 'Model for Improvement'. In three months, over 60 staff received training to support the QI approach, and by June 2019, an additional 34 staff will be accredited at QSIR Practitioner level. The training plan over 2019/20 is expected to reach 150 staff, with 60 QSIR Practitioners.

A further focus for QI is to progress the Safety Culture Programme, which has received regional interest. The Safety Culture Programme was undertaken within ED, Maternity and Theatres over 2018/19. This

work will continue into 2019/20, with a re-survey of 29 ward areas. The Programme directly supports understanding cultural enablers and barriers to delivering outstanding patient care, and empowers staff to lead improvement in their area.

Summary of the quality improvement plan

To build upon our significant quality improvement journey we introduced our Quality Strategy in April 2018. It is led by the executive Medical Director and reflects our ambition for sustainable, high value, high quality services delivered in partnership with other health and social care providers across the Nottinghamshire footprint. We believe we can demonstrate outstanding care and be one of the best providers of healthcare in the country and our Quality Strategy gives us the road map to get there. The Strategy reflects our quality priorities and takes account of national, local and independent reports and enquiries. Our Quality priorities are sub-divided into four campaigns:

- *Campaign One: A positive patient experience.* By 2021 we aim to change behaviours and the way care is delivered to impact positively on how care is experienced by those who use and depend upon the services we provide.
- *Campaign Two: Care is safer.* By 2021 we aim to focus on frailty and learning disability adapting to meet the healthcare needs of an increasingly elderly patient population and, by delivering 'better basics', reduce exposure to harm or complications of care.
- *Campaign three: Care is clinically effective.* By 2021 we aim to ensure patient care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.
- *Campaign Four: We stand out:* By 2021 we aim to be a leader in the delivery of high quality, safe healthcare, striving for excellence on our journey to outstanding.

We will use the Quality Priorities to monitor service improvement, demonstrate that high quality care and services are being provided and highlight areas where further improvements are required. Each year, we will review and identify the quality priorities, establishing an implementation plan to drive forward the Quality Strategy. This annual plan is known as the Advancing Quality Programme (AQP).

The progress made towards implementation of the Quality Strategy is monitored and reviewed each month by the Executive Medical Director and Chief Nurse. Progress is reported to the Quality Committee and Board routinely as part of a cycle of business for the Board of Directors. In addition, the following areas will continue to be prioritised in 2019/20:

Seven-day services:

- *Clinical standard 2 – Time to 1st Consultant Review:* We have performed consistently above the national average and within the top quartile within the East Midlands region. It is expected that our performance will continue to improve through 2019/20 as we are widening the cohort of patients across all five of our clinical divisions.
- *Clinical Standard 5 – Access to Diagnostics (for patients admitted as an emergency or with critical care needs):* We continue to meet this standard as we provide the full complement of consultant directed diagnostics on-site for both weekdays and the weekend.
- *Clinical Standard 6 – Access to Diagnostics (for inpatients):* We continue to meet this standard as we provide the full complement of consultant directed diagnostics on-site for both weekdays and the weekend.

- *Clinical Standard 8 – Consultant daily reviews:* We continue to meet the 'twice daily' consultant review, whereby all patients requiring a twice daily review by a consultant or designated senior clinician received one. Ensuring that 'all' patients were reviewed by a Consultant or designated senior clinician is more challenging, particularly over weekend and bank holiday periods as the most acutely unwell patients and new admissions must take priority. However, we continue to perform amongst the best nationally against this element of the standard.

Learning from deaths:

We were early implementers of the national Learning from Deaths Guidance that came into effect in April 2017. A quarterly report is presented to the Board of Directors, which includes a dashboard illustrating performance against a number of quality measures including compliance with the requirement to review >90% of all deaths, specifically highlighting those deaths where avoidable factors have been identified, and our overall position against the Hospital Standardised Mortality Ratio (HSMR). Crucially the dashboard highlights the learning points identified from reviews of deaths accepted by the Coroner for Inquest, those involving patients with a learning disability and those deaths reported to STEIS and investigated under our Serious Incident Policy.

The learning themes from our mortality reviews have helped shape some of the Quality Strategy and it is expected we will continue to optimise our learning opportunities, sharing good practice across the organisation and wider health system.

The implementation of the ReSPECT Tool and the introduction of the 'Medical Examiner' role will further facilitate the way in which we communicate with and support bereaved families at such a difficult time.

Gram negative bloodstream infections (GNBSI):

We have worked closely with the wider health economy to establish the main causes of GNBSI. The majority of GNBSI's are identified on admission from the community and we are working closely with our community colleagues to improve and reduce these risks. There are regular cross health economy meetings to interrogate the themes identified from the surveillance and review methods to improve the situation.

Locally we are involved in a number of initiatives. These include a bi-weekly multidisciplinary antimicrobial stewardship ward round, the introduction of integrated catheter packs to reduce catheter associated urinary tract infections (CAUTI), improving continence education with staff and providing improved products for use in hospital. In addition, we have participated in the NHSI UTI collaborative to seek other quality improvements that may improve the diagnosis of UTI's in over 65 year olds, opting to progress 'the to dip or not to dip' initiative. We have already seen evidence that these efforts are reducing the incidence of hospital associated GNBSI.

NEWS2:

We successfully implemented the NEWS2 project in December 2018, three months ahead of the national April 2019 deadline. This electronic system enables clinical staff to identify and act on the very early signs a patient is acutely unwell or their condition is deteriorating, and ensure the appropriate response is enacted.

Summary of quality impact assessment process and oversight of implementation

For all Financial Improvement Programme (FIP) initiatives, a Quality Impact Assessment (QIA) needs to be completed. Quality is described and assessed according to 5 CQC domains, each of which must be considering during the initial assessment (stage 1). This is performed to quantify potential impacts (be they positive, neutral or adverse) on quality, from any FIP initiative. Where potential adverse impacts are identified they are risk assessed using a standardised scoring matrix; any adverse risk score identified that is greater than 8, requires a more detailed assessment (stage 2) within that CQC domain.

Stage 1

a. Completion – All QIAs must be completed by the clinical lead with direct input from the operational teams and documented by the workstream lead;
b. Approval – The QIA must then be physically signed by the relevant Divisional Clinical Chair to confirm approval before the scheme proceeds to 'go-live'.

Stage 2

a. Completion – If any of the CQC domains are scored with an adverse impact greater than 8, completion of a stage 2 QIA is required by the clinical lead in collaboration with the operational team. This advises the plan that has been put in place to manage and/or reduce the adverse impact.
b. Approval:
    i. As with stage 1, the stage 2 QIA needs to be physically signed off by the Divisional Clinical Chair to confirm their approval.
    ii. Further approval is then required from the Executive Medical Director and/or Director of Nursing, where they will provide feedback on whether to reject, revise or accept the scheme.

A FIP scheme is only able to proceed to 'go live' if the QIA has been approved in full.

QIAs are revised through the life cycle of a FIP delivery every 3, 6 and 12 months. QIAs that have reached stage 2 are reviewed every month. If new risks or unintended consequences have materialised post 'go-live', a scheme may be stopped or amended accordingly.

For transformational changes across the Mid Notts ICP, a joint QIA process is followed, ensuring that Directors of Nursing grant approval before final sign off at ICP Transformation Board. The content of this joint QIA aligns to our internal process.

Workforce planning

Our workforce plan is linked to our workforce strategy, "Maximising our Potential", which seeks to attract, engage, develop, nurture and retain staff whilst supporting optimum performance. This strategy was approved by our Board in 2017 and contains annual implementation plans, with progress regularly reported to our Board and associated Committees.

Our workforce baseline is derived from the worked whole time equivalents (wte) in month 11 of 2018/19, incorporating year-end assumptions and approved business cases. This results in 4,111.16 wte, with a flexible employment model of both permanent and temporary staffing, increasing to 4,392.62 (wte). Our workforce plan reflects our numerical and skill mix requirements and is aligned with the ICS People & Culture Strategy. The workforce plan is consistent with our financial, quality and activity plans and we recognise the importance of our workforce being flexible in supporting and responding to our efficiency

plans for 2019/20. Performance against plan is assessed in-year through an Executive-led Workforce Planning Group.

In developing our workforce plans, divisional teams are supported by HR and Finance teams to ensure workforce capacity is both affordable and sufficient to deliver anticipated activity levels. Historically we have been disproportionately reliant on a temporary workforce. This was primarily due to recruitment challenges which arose for a number of reasons, including our geographic location, market factors affecting the domestic supply of available qualified staff and challenges with international recruitment. This resulted to a dependence on temporary workers to cover vacancies and rota gaps.

In the past 18 months we have made significant progress in increasing our substantive workforce and extending our pool of available bank workers. This has significantly reduced our dependency on higher cost agency staff and since April 2017, we have delivered our agency control total. However, workforce challenges remain. These are described in the following table:

Table 2 – Workforce challenges:

Description of workforce challenge	Impact on workforce	Initiatives in place
1. Historical challenges to recruiting to establishment within the Registered Nurse profession (Adult Nursing) and Medical roles at consultant level. 2. Demographic changes including an ageing workforce and shifting cultural attitudes to careers	Reliance and dependency on bank and agency Critical workforce gaps in some clinical services	Plans to recruit a cohort of 25wte nurses from the Philippines due to start in Q4 2018/19
		Revised approach to attract registered nurses using an assessment centre model
		Focused approach to medical appointments including joint appointments with neighbouring NHS providers
3. Loss of experienced staff e.g. through retirement	As above, in addition to loss of particular skills and experience	Financially based recruitment and retention initiatives, particularly for medical staff in critical services.
		Supporting the career development of staff at all levels e.g. through nurse rotations and talent management conversations as part of appraisals

Part of our approach to workforce planning is to ensure that we optimally utilise the workforce that we already have and support the delivery of efficiency savings for 2019/20. Electronic rostering and electronic job planning are key parts of our strategy and they are already well embedded in the organisation for both nursing and medical staff. However, despite these mitigating approaches, workforce risks remain.

Table 3 – Workforce risks:

Description of workforce risk	Impact of risk	Risk response strategy	Timescales and progress to date
Limited number of Registered Nurses across the Trust resulting in high levels of vacancies	High	Using bank and agency staff to cover gap. Monthly gap analysis reviewed as part of Board Assurance Framework. Use of a recruitment brand based on our journey of improvement and the positive experience of existing staff. Active recruitment to nursing bank. Use of nurse associates and nurse apprentices	Successful recruitment campaigns through targeted approaches. Additional cohorts of international nurses and nurse associates to increase workforce numbers in 2019
Medical vacancies remaining in a number of critical specialties	High	Using bank and agency staff to cover gap. Monthly gap analysis reviewed in conjunction to forecasted and projected demand. HEEM junior doctor allocations, the use of Clinical fellows and CESR. Active recruitment to medical bank. Introduction of Advance Clinical Practitioner and Doctors Administrator.	Successful recruitment campaigns (including from the EU and beyond) through targeted approaches. Effective use of Clinical Fellow Programme and CESR, which is being extended into Geriatrics.

We will continue to work closely with Health Education East Midlands (HEEM), and be guided by the Local Workforce Action Board (LWAB) to develop its wider workforce, influence national and local workforce and training strategies, enable system leadership and develop new flexible roles for the health and social care system. We plan to continue to work with partners such as EMLA and NHS Elect to develop the existing workforce. This partnership working is vital as we continue to address the challenges resulting from long term vacancies.

Table 4 – Long term vacancies

Description of long-term vacancy, including the time this has been a vacancy post	WTE impact	Impact on service delivery	Initiatives in place, along with timescales

Registered Nurse at Band 5	125 wte	Impact on rostering and patient safety	Developing alternative roles and approaches to mitigate impact on service delivery. Additional cohorts of international nurses planned in 2019 along with a further Nursing Associate cohort.
Medical recruitment to the specialties of Geriatrics, Stroke, Radiology	11.4wte	Impact on rostering and patient safety	Working in partnership with neighbouring NHS providers to develop joint and rotational appointments in an attempt to overcome existing challenges along with revised recruitment and attraction strategies that are service focused. Extension of CESR programme into Geriatrics.

The combined impact of internal efficiency improvements and the ICS led transformation work will result in a planned re-shaping of our services over the medium and longer term. There will be some fluctuation in workforce over the next two years too. We will see growth in some areas through the introduction of new roles to meet planned activity changes, but a reduction in others due to meeting our financial control total and responding to ICS changes, resulting in an overall increase of 35 wte. The challenge we face is flexibly meeting planned and unplanned activity growth, which inevitably requires bank and agency resources.

We recognise the pressures across the wider system regarding workforce availability, flexible skilling and costs and we are aligning our approach with that of the ICS in the following areas:

1. Planning, attracting and recruiting our future workforce
2. Retaining staff and trainees, promoting career paths and talent management
3. Role redesign and development of new roles
4. Preparing and supporting people to work in new ways, including digital skills development
5. Enabling cultural change and leadership development to maximise system effectiveness

We are also taking a lead role in the establishment of a Talent Academy for the system and we coordinate all work experience placements for Nottinghamshire.

The Apprenticeship Levy continues to be an effective tool in supporting workforce transformation across our organisation and the wider ICS. We intend to develop and grow year on year the number of apprenticeships we support. We are determined to achieve an appropriate balance of clinical and non-clinical apprenticeships and are exploring ways that we can utilise the apprenticeship levy to support clinical services e.g. through engaging additional cohorts of Trainee Nurse Associates and the introduction of a Nurse Apprentice role that aims to address the changes to professional access to

bursaries. The levy is also being used to support leadership development with levy funded Masters Programmes.

We closely monitor international recruitment and have assessed the risk associated with EU nationals in our workforce. We anticipate the impact of Brexit on our workforce supply to be minimal, due to our limited reliance on EU staff. However, we have taken steps to make funding available to cover the cost of our EU staff applying to the settlement scheme as a precautionary measure.

Our corporate back office services benchmark well using the Model Hospital tool, in relation to costs and return on investment. However, we will continue to drive efficiencies and consider alternative delivery options to ensure that the maximum possible proportion of the available resources is focused on the direct provision of local health services.

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- Financial planning

Financial Forecasts and Modelling

For the revenue plan, we have accepted a control total of £14.87m deficit. Within this, receipt of £6.46m of Provider Sustainability Funding (PSF) and £14.81m of Financial Recovery Funding (FRF) has been planned for.

Table 5 – Control total

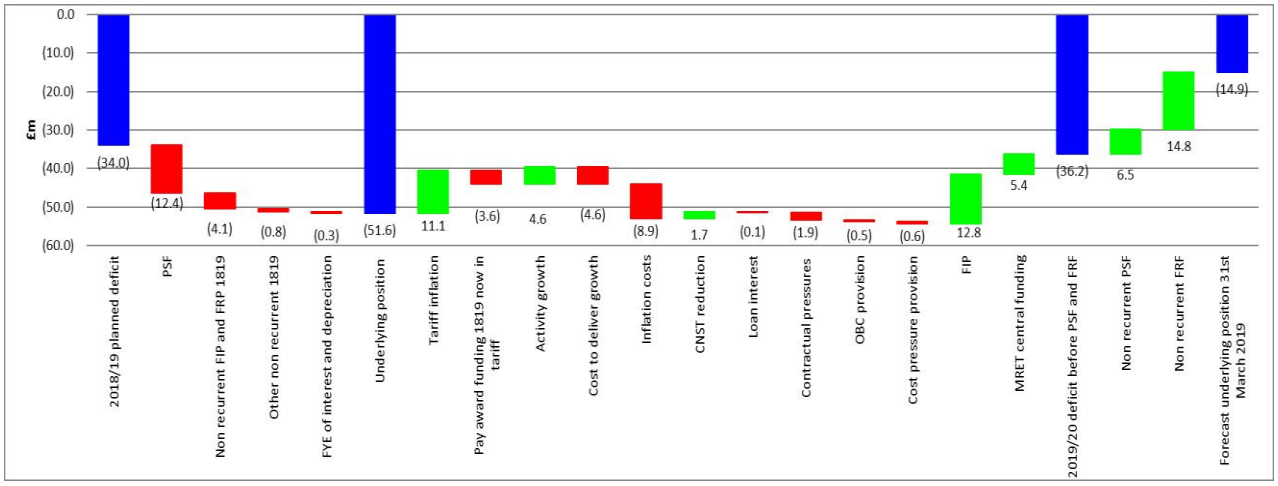
	Revised control total £m
Control total pre PSF and FRF	(36.133)
PSF	6.459
FRF	14.807
Control total post PSF	**(14.867)**

The 2019/20 plan includes the impact of the new financial framework for providers. Most significantly for our organisation, this includes changes to the national tariff inflation and structure, PSF and FRF. For 2019/20 the marginal rate emergency tariff (MRET) has been removed and the equivalent funding of £5.39m will be transferred to us via a central fund. Nationally, just under half of the PSF funding has been moved into emergency tariff prices, for which we have a benefit of £6.43m. The remaining PSF of £6.46m has been assumed based on acceptance and delivery of the proposed control total. There are no performance requirements that need to be delivered to receive this funding.

Because we remain in financial deficit after PSF we are entitled to FRF monies, which are designed to non-recurrently support the delivery of essential NHS services. A total of £14.81m is made available on the acceptance of the control total and this has been assumed. We continue to develop our 5 year financial strategy alongside our overall strategy.

The chart below details the assumptions within our financial plan for 2019/20:

Chart 1 – Financial plan assumptions



Key assumptions to note are as follows:-

- We are forecasting to exit this financial year with a deficit of £51.60m after adjusting for non-recurrent PSF, non-recurrent Financial Improvement Programme (FIP) and Financial Recovery Programme (FRP) delivery.
- The benefit from changes to tariff prices is 5.75%, a total of £11.1m, which includes transfer of PSF into prices and increases in tariff to fund the Agenda for Change pay award in both 2018/19 and 2019/20.
- System-wide activity modelling equates to income growth of £4.60m. At this stage cost is presumed to equal this, whilst work continues on capacity requirements and system wide planning for savings delivery. This will be resolved for contractual agreement and final plan.
- Inflation costs are estimated to be £8.9m. This includes all pay, non-pay and PFI inflation. Percentages have been used from NHSI models where appropriate with PFI estimated in line with our local model.
- CNST costs will reduce in 2019/20 as notified by NHS Resolution.
- Loan interest on borrowings will increase by £0.1m to service the deficit and the timing of receipt of PSF and FRF.
- Contractual pressures, including the loss of a Pain service tender, contractual provision and loss of contribution to overheads as a result of changes at Mansfield Community Hospital, are a total pressure of £1.9m.
- A provision of £0.5m has been made for investment in outline business cases (OBC), which is consistent with 2018/19.
- A remaining £0.6m provision has been made for in year cost pressures associated with the normal course of business.

- FIP is assumed at £12.8m (4.1%). This is made up of £3.34m (1.1%) of tariff requirement, a further £1.57m (0.5%) of efficiency required by NHSI, £1.9m (0.6%) for contractual pressures, £0.50m (0.15%) of OBC provision, £0.60m (0.19%) of other cost pressures, £4.10m (1.30%) reflecting non delivery of recurrent FIP in 2018/19 and £0.79m (0.25%) to support delivery of the proposed control total.
- MRET central funding of £5.385m is expected.
- PSF of £6.46m and FRF of £14.81m are forecast based on acceptance of our control total (and delivery of it for PSF receipt).

The assumptions above will leave the Trust with a Single Oversight Framework (SOF) score for finance of 3.

Cash

In order to support the deficit plan revenue cash borrowing of £14.87m will be needed in-year. A further £5.32m will be needed to support the timing of PSF and FRF being received quarterly in arrears. A total of £20.18m of revenue borrowing has therefore been assumed at a rate of 1.5%, in line with previous borrowing terms.

In 2019/20 £67.1m of previously taken revenue loans reach maturity and require repayment. NHS Improvement has previously indicated that new revenue loans can be taken to support this. This has been assumed within the plan at continuing rates of 1.5%, thus having no effect on the revenue position.

Efficiency savings for 2019/20

The most significant risk to delivery of the revenue plan is the delivery of the FIP programme. We have a programme structure in place, with programmes grouped into transactional efficiency, and transformational change. Each Programme is led by an executive sponsor (Table 6). Programmes are aligned to transformation plans in the ICP and ICS. Programmes are shown in the table below.

Table 6 – FIP structure

	Prog No.	Target	Programme	Indicator	ator
Tactical	1920-01	£ 4,967	2.2% Tariff deflator clinical divisions	National tariff	
	1920-02	£ 650	2.2% Tariff deflator across Corporate	National tariff	
	1920-03	£ 400	Tactical Procurement	EY, Model Hospital	
	1920-04	£ 200	Energy Efficiency	Staff submitted ideas	s
	1920-05	£ 100	Waste Management	Staff submitted ideas, EY	s, EY
	1920-06	£ 1,098	Continuation from 2018/19 FIP	FIP Pipeline	
Transformational	1920-07	£ 500	Outpatient Operating Model	ICP strategic alignment, PLICS, RCI	nt, PLICS, RCI
	1920-08	£ 500	Non-Ward Based Nursing/PAM	EY, Model Hospital	
	1920-09	£ 500	Nursing taskforce - phase 2	Agency ceiling, Model Hospital	l Hospital
	1920-10	£ 500	Medical Taskforce - phase 2	Agency ceiling, Model Hospital	l Hospital
	1920-11	£ 1,100	Managing Demand	Operational teams	
	1920-12	£ 250	Diagnostics Taskforce	EY, Model Hospital, Operational teams	Operational teams
	1920-13	£ 100	Paperless Working	Staff submitted ideas	s
	1920-14	£ 1,500	Best Value Reviews	Model Hospital, PLICS	S

Progress of the development of schemes is reviewed in a monthly Executive-led Financial Sustainability Panel (see Figure 2), reporting to the Trust Board through the Finance Committee.

Figure 2 – Financial Improvement Governance

Trust Management Group		
Month end reporting		
Financial Sustainability Panels		
Purpose 1. Track progress towards financial sustainability at divisional level, taking into account the requirements of FIP to reach control total, and play part in delivering system balance 2. Track progress towards financial sustainability of cross cutting, transformational schemes		
Participants **Chair:** Richard Mitchell - tbc **Execs** - all **Ops:** Triumvirates on rotation according to cohort **SROs** - on rotation according to cohort	**Format:** Each SRO to present flash report to panel in a timed 20 min slot. Once planning is complete and in delivery, reporting and attendance to panel will be by exception only	**Duration**: 2 hours **Frequency:** Weekly

Cohort A	Cohort B	Cohort C
D&O - 1.1% Tariff deflator, 18/19 FIP schemes	**Medicine** 1.1% Tariff deflator, 18/19 FIP schemes	**W&C** - 1.1% Tariff deflator, 18/19 FIP schemes
Outpatient Operating Model	**UEC** - 1.1% Tariff deflator, 18/19 FIP schemes	**Corporate** - 1.1% Tariff deflator [3 services]
Diagnostics Taskforce	**Surgery** - 1.1% Tariff deflator	Tactical Procurement, Energy, Waste Manag.
Medical Taskforce - phase 2	Managing Demand	Paperless Working
Non-Ward Based Nursing		Best Value Reviews
Nursing Taskforce - phase 2		

A further risk to delivery of the financial plan is the impact of QIPP schemes. We are committed to working together across the system to develop financial models that support operational delivery of high quality services more cost effectively and will fully engage in developing financial models that support financial delivery for all partners. Interdependency of system transformation /efficiency schemes ('QIPP) and FIP schemes will also be reviewed in the monthly Financial Sustainability Panels (Figure 2).

Agency rules and expenditure

We have an agency ceiling of £16.66m, which we are expecting to meet in 2019/20. Much improvement in agency expenditure has been made in the last 2 years, with a reduction to a forecast of £14.94m at the end of 2018/19 from £29.10m at the end of 2016/17. However, we recognise that we remain an outlier and as a result we actively monitor and manage agency expenditure on a proactive basis. We

have both a medical and nursing taskforce in place, with the remit to manage overall expenditure, with a particular focus on agency expenditure. These taskforces will remain in place in 2019/20 and will particularly focus on reducing agency expenditure across those areas that are typically more difficult to recruit to.

The Executive Team continues to review and sign off any breaches of the agency rules on a weekly basis. Agency usage is linked primarily to numbers of vacancies and active recruitment strategies are in place for medical and nursing staffing, including overseas recruitment and consideration of new ways of working (see Workforce Planning for further information). We are also working across the system to transform services and reduce cost. Successful implementation of these changes will reduce system wide reliance on agency staffing.

Capital Plan

The capital plan for 2019/20 is £10.83m, including an estimate of £0.30m of donated assets. This is prioritised based on a risk assessment by capital leads for Estates, IT and Equipment, incorporating divisional input. It ensures that essential equipment is replaced in a timely manner, as well as aiming to invest in key priorities to support patient safety and efficiency, such as electronic prescriptions management (EPMA).

We are planning to internally generate £11.69m of capital funding via depreciation. After accounting for all commitments against this internally generated fund, including PFI loan repayments of £9.75m and £1.71m of capital loan repayments, borrowing of £10.28m will be required to support this plan. This borrowing has been assumed at a rate of 1.12% based on average life modelling of assets being borrowed against.

-

Links to the local sustainability and transformation plan

Nottinghamshire is one of the first wave of Integrated Care Systems (ICS) in England. In mid-Nottinghamshire, we work closely with partners as one of three Integrated Care Providers (ICPs) in the ICS. In planning for 2019/20 we have worked collaboratively, regularly meeting and planning with the CCG, Nottinghamshire Healthcare NHS FT and the County Council. Our plans for the coming year reflect this partnership working, as well as the broader priorities of the ICS.

As an acute provider, we are on a journey of continuous improvement and learning, seeking to be an outstanding provider of healthcare. However, we also recognise that we also have a unique opportunity and responsibility to support our local communities in becoming healthier. This is a key priority of the ICS and we will be increasing our focus on prevention and supporting health and wellbeing of our staff and patients in 2019/20. This will include aiming for 80% of eligible smokers admitted to our hospitals being offered Nicotine Replacement Therapy (NRT) and being seen by a specialist stop smoking advisor by the end of the year. We will continue with the provision of alcohol advice and support and targeted care for those living on the street.

The majority of our staff live within 10 miles of one of our hospitals and therefore an integral part of the communities we serve. In 2019/20, we will have a particular focus on staff health and wellbeing and will be launching our ‘Health Heroes’ programme, designed to support and promote healthy living amongst our workforce.

Transformation plans for 2019/20

We are building on a strong foundation of partnership working in mid-Nottinghamshire, with some specific approaches yielding benefits in 2018/19, providing a strong platform for 2019/20, for example:

End of Life:

In October 2018, a new End of Life service was launched collaboratively between local providers, underpinned by a 'shadow' capitated budget. The service provides a single pathway, supporting patients and carers both before and during times of crisis and enabling patients to leave hospital to their planned place of care. In addition to the patient benefits of this personalised care, the model supports the avoidance of unnecessary ED attendances and hospital admissions. The benefits that we are already seeing will increase and become more widespread as the model is embedded in 2019/20.

High volume service users:

We continue to work with partners to support 'High volume service users' i.e. individuals who frequently attend ED or are admitted non-electively. We will build on the work to date in 2019/20, to ensure that relevant services (including GP practices) are aware of the individual patients and are able to proactively support them.

Home First Integrated Discharge:

This project is a priority for partners across mid-Nottinghamshire in 2019/20. It is underpinned by the principle that where possible, patients should be discharged home, with support from community and social care providers. This will ensure that only those patients requiring bedded rehabilitation are transferred to Mansfield Community and Newark Hospitals. The model aims to reduce length of stay for these patients and ensure that patients do not remain in hospital if they can be supported in their usual place of residence.

In addition to these programmes already underway, we are working with our CCG and provider partners, to develop further transformation and efficiency programmes for the coming year, underpinned by a number of jointly agreed principles, as follows:

- Working together for the benefit of the system
- Aligned objectives and incentives to achieve system change
- A cost pressure causes a problem for the system, whilst a cost saving creates an opportunity for the system
- Openness and transparency i.e. an 'open book' approach
- Risks should be shared and collectively managed
- Contracts should reflect system objectives, incentivise delivery and enable transformation

Our jointly agreed transformational programmes are themed around the following system priority areas:

- Urgent care
- Elective care
- Mental health
- Primary care and proactive community services

These programmes continue to be developed and underpinned by analysis of benchmarking, including the use of Model Hospital and Right Care date. Some specific developments in scope are as follows:

- Integrated rapid response service providing a single point of access (SPA) and community or ED based rapid assessment for patients at immediate risk of acute admission. Interventions include intensive home based care and / or step up community bed based care;
- Implementation of an Integrated Urgent Care (IUC) pathway across Nottinghamshire, aiming to provide care closer to people's homes and help tackle the rising pressures on all urgent care services (primary and secondary). This model will also aim to support to EMAS to hear/treat, see/treat and reduce conveyance rates;
- Outpatient redesign, through considering settings and approaches other than face to face secondary care appointments. This includes use of advice and guidance, enhanced or virtual triage and telephone consultation. This will:
    - Ensure patients are seen in the most appropriate way and environment;
    - Ensure the cost of activity delivery is covered by income;
    - Reduce activity in overall terms;
    - Reduce waiting list initiatives;
    - Create medical capacity for other elective clinical duties.

Membership and elections

As a Foundation Trust we have a Council of Governors, this consists of Public, Staff, Volunteer and appointed Governors. One of the key roles of the governors is engagement with their constituencies in order to gain feedback and report to the Council and subsequently the Board of Directors. Our governors achieve this aim by holding regular 'Meet your Governor' events across all three hospital sites and out in the community. At these events new members are recruited and patients, visitors and staff are given the opportunity to discuss their views of the services provided. A regular report is provided to the Council of Governors on the outcomes of these events.

During the year the governors have reviewed their committee structure and have refreshed the Membership and Engagement Committee to allow all governors membership of the committee. The committee meets quarterly and is currently chaired by the lead governor. In order to ensure the governors are also addressing another of their statutory duties, 'to hold the Non-Executive Directors to account', governors are now observers on all board committees. This enables the governors to gain assurance regarding how the Non-executive directors hold the executive to account and how strategic objectives are progressed and implemented. The observers then report their observations from the meetings back to the Council.

In April 2019 we will be undertaking governor elections for seventeen governors across all public, staff and volunteer constituencies. Once all the new governors have been elected we will undertake training

needs analysis as part of their induction in order to inform the governor development programme for the coming year.

The promotion of the election and the induction will reflect feedback from current governors and those who resigned during the year to ensure any members nominating themselves for election understand and are able to commit to the time commitments required. These include only attendance and participation in Council of Governor meetings, as well as attendance at Board Committees, governor workshops and forums, 'meet your governor' events and external development events.

The Nottingham and Nottinghamshire Integrated Care System

System Operational Plan 2019/20 (11th April Submission)

KEY MESSAGES AND SUPPORTING INFORMATION

Board Update: System Plan Submission 11th April (Version : 9.3)

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The Nottingham and Nottinghamshire Integrated Care System

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Key Messages – Financial Plan (NHS)

The Nottingham and Nottinghamshire Integrated Care System

Requirement	Latest Position
System Control Total (SCT) : Operational Plan delivers **in year-deficit of £67.7 million**, before provider sustainability funding (PSF), financial recovery fund (FRF) and marginal rate emergency threshold (MRET) ICSs are expected to link an element of PSF to the delivery of the system control total	• System Operational Plan (April): **in year deficit of £69.6 million**, **£1.9 million worse than system control total**. NUH has not accepted organisational control total, this is due to a technical issue with MRET funding which NUH have raised directly with NHSE/I (awaiting response). • The system can access conditional funding of £57.4 million (PSF, FRF and MRET) if it agrees and delivers the plan. Of this, £27 million relates to NUH and is dependent on the outcome of the MRET issue above. • Greater Nottingham part of the ICS system is in regional escalation process (led by Regional DoF). Meeting held on 21st March and outputs of meeting are: ➢ Expect system to **agree 2019/20 plan which meets system control total and addresses operational pressures** (ambitious/credible) ➢ Expect **system to agree contracts for 2019/20** ➢ Develop a **five-year system wide recovery plan for quarter 1** (five-year plan) ➢ Request for further information on plans (CIP/QIPP plans, programme infrastructure and oversight). This was submitted on 1st April. • National working group has reviewed options (included Nottinghamshire ICS MD and FD). A letter has been issued by national team outlining the scheme and requesting a response by the 26th April. Scenarios are being developed and will be considered at the Financial Sustainability meeting on the 24th April. • Key elements of the scheme are: ➢ To be eligible to sign up to the incentive scheme the ICS must be planning to deliver the System Control Total (and individual control totals accepted by partner organisations) ➢ Expected to link the same value of PSF to the delivery of SCT (2018/19 = £4.9 million) ➢ Transformational Funding will be available if the ICS participates in the incentive scheme (£5 million) ➢ Freedoms and flexibilities will be agreed with NHS England and Improvement
Contracts: Agreed contracts by 21st March 2019	Contracts are now agreed for Nottinghamshire Healthcare, Nottingham University Hospitals, Sherwood Forest Hospitals and CityCare. **Outstanding Contracts**: **EMAS remains outstanding with an estimated contract gap of £1.8 million.** The national dispute policy is being followed (currently at mediation stage).

Key Messages – Financial Plan (NHS)

The Nottingham and Nottinghamshire Integrated Care System

Requirement	Latest Position

Transformation Plan :

ICS is projecting that expenditure is 7.7% higher than income projections. After adjusting for the system control total we have a **do nothing financial gap of £146.8 million 5.3%**

To address the financial and operational challenges the system needs to focus on how services are transformed to be delivered within available resources (finance, workforce and capacity).

Transformational Plans are being developed at ICP level.

- Current position (draft): **£120 million identified and £26.8 million unidentified/gap to control total**
- **Risk adjusted delivery currently assessed at 61.8%** (based on individual organisation assessments)

Latest Plan (QIPP/CIP/FEP)	SFH	NHT	NUH	MN CCGs	GN CCGs	System Total	MN ICP	GN ICP
Red	4.2	2.8	1.9	0.9	5.8	15.6	6.5	9.1
Amber	8.2	5.4	6.7	6.5	8.6	35.5	17.4	18.0
Green	0.4	5.4	9.5	17.6	36.0	68.9	20.7	48.2
Total Schemes	**12.8**	**13.6**	**18.1**	**25.0**	**50.5**	**120.0**	**44.6**	**75.4**
Remaining Unidentified Gap	0.0	3.5	18.9	0.0	2.5	24.9	1.7	23.1
Control Total Not Accepted	0.0	0.0	1.9	0.0	0.0	1.9	0.0	1.9
Total Savings Target (£Ms)	12.8	17.1	38.8	25.0	53.0	146.8	46.3	100.4
Total Savings Target (%)	3.6%	3.6%	3.8%	4.8%	5.0%	5.3%	5.5%	5.1%

Risk Adjusted Delivery (£Ms)	**5.5**	**7.8**	**16.3**	**21.0**	**40.1**	**90.7**	**30.3**	**60.4**
Risk Adjusted Delivery (%)	**42.7%**	**45.8%**	**42.0%**	**83.9%**	**75.7%**	**61.8%**	**65.5%**	**60.1%**

At this point in the financial year **we would expect the risk adjusted percentage to be at least 75%,** the system is taking the following actions to improve the current position:

- ICPs/organisations continue to develop and strengthen transformational plans, existing schemes are being rapidly developed to implementation stage and further plans are being identified to meet the do nothing challenge for 2019/20. Further review of pipeline schemes underway. External support commissioned in CCGs and NUH.
- Opportunities pack produced in January – workshops and facilitated discussions with ICPs/organisations. The opportunities pack now incorporates the Bronze Pack produced by NHSE. Transformational Plans have been mapped to the opportunities for 2019/20 (see schedules 2d-f) .
- Review of opportunities for Estates and Back Office functions underway (through Financial Sustainability Group). To develop plans for 2019-21 by end of July.

- **The system needs to main a strong focus during April.** The ICP Transformation plans are being reviewed weekly, including the level of savings identified, position on contract negotiations and risk assessment.

- **The CCG plans include QIPP schemes that are expected to be contracted in year, schemes are currently being developed and taken through ICP structures/processes. The scale of this is £12.5 million in Mid Nottinghamshire and £5.6 million in Greater Nottingham.**

Key Messages – Activity and Capacity Plan

The Nottingham and Nottinghamshire Integrated Care System

Requirement	Latest Position
Activity Plan: System operational plan should include a realistic and sustainable level of activity.	• ICPs have worked together to align do nothing activity plans (with joint demand modelling tool): - 3 year rolling average, adjusted for non recurrent factors, with the exception of referral growth which is a local model - coding and counting adjustments (NUH front door and same day services) - reflecting demographic and disease prevalence factors - additional activity to recover RTT , cancer and mental health access standards • ICS has reviewed activity submissions and produced analysis packs at each stage in the planning cycle to support ICPs in developing activity plans. The latest plan submissions have been reviewed, key issues are: **Do Something Activity Reductions (All)** – latest activity plans reflect an aligned position for contract QIPP plans. Discussions are ongoing for QIPP schemes to be contracted in year, this continues to be monitored through the ICS Planning Group. **Outpatients (MN)** – MN CCGs plans incorrectly include OP transformation schemes twice, overstating activity reductions in Mid Nottinghamshire by -8%. This has been flagged with NHSE/I and there is no opportunity to resubmit at this stage. **Waiting Lists (MN)** – MN system submitted a rebasing request for March 2018 level (community paediatrics at Sherwood Forest), awaiting response. **52WW (All)** – small number in early part of 2019/20 (known patients exercising patient choice).
Capacity Plan: System operational plan supported by aligned capacity plan	The system has identified the key capacity gaps and pressures as follows: • **Acute: bed capacity (Greater Nottingham), outpatients, theatres, diagnostics and critical care** • **Community: ensuring appropriate utilisation of capacity in the community (NEL pathway)** • **Mental Health: appropriate capacity for Out of Area patients and review of waiting lists** The system continues to develop plans to address the key capacity gaps and pressures, taking into account other constraints i.e. workforce, physical capacity (estate) and financial sustainability, as follows: ➢ Service and pathway transformation (impact on admission growth projections and bed utilisation through reduced LOS) ➢ Outpatient transformation – developing virtual hospital model ➢ Escalation capacity (internally provided and commissioned) ➢ Review of options for additional capacity in specific areas

Key Messages – Operational Performance

The Nottingham and Nottinghamshire Integrated Care System

Requirement	Latest Position
Operational Performance - plans should demonstrate ambitious improvement and credible/realistic plans in all areas that are not delivering in 2018/19	• Draft submissions have been reviewed by ICS Planning Group. • Discussed at ICS Planning Group (supported by detailed pack) where performance queries have been highlighted across all key areas by individual organisations. ICPs have reviewed the queries and have addressed for final submission.
Red ICS Performance Area: Urgent Care (GN)	A&E improvement trajectory submitted by Nottingham University Hospitals to deliver 90% from September. This was reviewed and agreed by the Greater Nottingham A&E Delivery Board. Nottingham University Hospital will be included in a pilot to review metrics for 2019/20.
Red ICS Performance Area: Mental Health (All)	Trajectories and supporting actions have now been developed for all key performance targets, reviewed by ICPs and Mental Health leads. Now reflected in system plan overview document and will be included in final plan submission.
Amber ICS Performance Area: Cancer (GN)	• NUH developed recovery plan and trajectory which delivers 85% from October 2019. GN CCGs will recover in quarter 2 (range of providers). • Fortnightly calls in place with NUH and NHSI.

Risk Assessment

The Nottingham and Nottinghamshire Integrated Care System

The ICS Planning Group has reviewed the draft system operational plans and ongoing work to develop the plan submissions for April.

As part of this review the ICS Planning Group asked each ICP/Planning footprint to complete a self-assessment across a range of areas. This was discussed at the ICS Planning Group.

The table outlines the overall RAG and areas of focus:

	Self-Assessment (ICP/Planning Footprint)	ICS Planning Group
Mid Nottinghamshire	**Overall RAG: Amber**	**Overall RAG: Amber**
	Key areas of focus continue to be: - **Transformational Plans** (using ICS opportunities pack to develop further opportunities) - Aligning workforce plans - Reviewing capacity pressures and mitigating actions	ICS Planning Group asked that quality review looks at overall plan (currently EQIA process in place for transformational schemes).
Greater Nottinghamshire	**Overall RAG: Amber/Red**	**Overall RAG: Amber/Red**
	Key areas of focus continue to be: - **Transformational Plans** (using ICS opportunities pack to develop further opportunities) - **Reviewing capacity pressures and mitigating actions**	ICS Planning Group asked that quality review looks at overall plan (currently EQIA process in place for transformational schemes which needs embedding at system level).

The Nottingham and Nottinghamshire Integrated Care System

SUPPORTING INFORMATION

Schedule 1a:
2019/20 Allocation of Resources (NHS England)

The Nottingham and Nottinghamshire Integrated Care System

- National core CCG allocations have increased by 5.7%, 2.3% is a transfer of funding from other NHS budgets and 3.4% is real terms growth (to fund realistic activity growth, tariff/inflationary pressures , MHIS, 5YFV and LTP)
- Nottinghamshire CCGs have received 5.62% uplift (£75.1 million) and have a closing distance from target (DFT) of -1.38%.
- Nottinghamshire Primary Care allocations have increased by 6.59% (£9.3 million), this is to fund core GP contract, 5YFV and LTP.

	2018/19 £Ms	2019/20 £Ms	Change £Ms	Change %	
Clinical Commissioning Groups (CCGs)	75,596	79,885	4,289	5.7%	- 2.3% is a transfer of funding (£1bn PSF to NEL Tariff, 18/19 Pay Uplift and ambulance funding) - 3.4% real term growth CCGs growth funding to cover: - realistic and sustainable level of activity - protecting funding for 5YFV commitments, particularly in mental health and cancer services - Mental Health Investment Standard (MHIS) - Long Term Plan commitment that funding for community health services should grow faster than the overall NHS revenue funding settlement
Commissioner Sustainability Fund (CSF)	400	300	-100	-25.0%	All CCGs are expected to be in financial balance in the future due to changes in allocations and financial framework. CSF will be phased out, this will commence in 2019/20 with a 25% reduction.
General Practice	8,162	8,786	624	7.6%	- Covers core GP contract and other related primary medical services - protecting funding for 5YFV commitment - Long Term Plan commitment that funding for primary medical services should grow faster than the overall NHS revenue funding settlement
Specialised Services	17,675	19,114	1,439	8.1%	Uplift to meet tariff changes, inflation and long term plan commitments. *Note: No adjustment has been made for changes to the commissioner rules (allocation adjustment from specialised services to core CCGs to be agreed in March)*
Place Based Commissioning Budgets	**101,833**	**108,085**	**6,252**	**6.1%**	
Provider Sustainability Fund (PSF)	2,450	1,250	-1,200	-49.0%	- Reduction: £1bn transferred to NEL Tariff and £0.2bn to FRF - 2019/20 PSF will be 100% on financial delivery - ICSs will have System Control Total (ICS Financial Framework not yet issued)
Financial Recovery Fund (FRF)	0	1,048	1,048	-	- Non-recurrent support for Providers in deficit who have agreed Control Total - Provider sector to be back in sustainable financial balance by 2023/24
Central MRET Funding	0	442	442	-	MRET abolished for 2019/20 - funding held centrally (control total adjustment)
Provider Support	**2,450**	**2,740**	**290**	**11.8%**	
Other Direct Commissioning	**6,728**	**6,963**	**235**	**3.5%**	- NHSE commissioned services - dentistry, community pharmacy, ophthalmology services, public health, armed forces and health & justice - Uplift covers pay increases (18/19), inflation and additional public health immunisation and screening
Other Allocated System Funding (inc. LTP)	**1,764**	**2,037**	**273**	**15.5%**	Includes funding for Long Term Plan commitments and service developments
NHS England Central Admin & Programme	**1,195**	**1,148**	**-47**	**-3.9%**	
Total	**113,969**	**120,973**	**7,004**	**6.1%**	

Schedule 1b:
2019/20 Nottinghamshire Place Based Allocations

The Nottingham and Nottinghamshire Integrated Care System

Nottingham & Nottinghamshire ICS - Place Based Allocations									
	Mid Nottinghamshire ICP			Greater Nottingham ICP					ICS
	M&A	N&S	Total	City	NNE	N.West	Rush	Total	Total
CORE CCG									
18-19 Allocation (£Ms)	266.9	174.1	**440.9**	440.2	188.9	119.6	146.0	**894.7**	**1,335.7**
19-20 Allocation (£Ms)	282.0	184.2	**466.2**	464.5	199.6	126.3	154.3	**944.6**	**1,410.7**
Uplift £Ms	15.2	10.1	**25.2**	24.3	10.6	6.6	8.3	**49.8**	**75.1**
Uplift %	5.68%	5.80%	**5.73%**	5.52%	5.63%	5.54%	5.66%	**5.57%**	**5.62%**
Closing DFT %	*-0.61%*	*-0.81%*		*-3.40%*	*-2.99%*	*2.12%*	*2.23%*		***-1.38%***
PRIMARY CARE									
18-19 Allocation (£Ms)	26.7	18.0	**44.7**	48.6	19.6	12.7	16.0	**96.7**	**141.5**
19-20 Allocation (£Ms)	28.4	19.1	**47.5**	52.2	20.8	13.4	17.0	**103.3**	**150.8**
Uplift £Ms	1.6	1.1	**2.7**	3.7	1.2	0.7	1.0	**6.6**	**9.3**
Uplift %	6.08%	6.19%	**6.12%**	7.54%	6.15%	5.71%	6.26%	**6.81%**	**6.59%**
Closing DFT	*4.13%*	*4.09%*		*-4.99%*	*3.46%*	*6.04%*	*4.13%*		***0.84%***
SPECIALISED									
18-19 Allocation (£Ms)	49.8	30.4	**80.2**	121.5	42.3	26.4	32.5	**222.8**	**303.0**
19-20 Allocation (£Ms)	53.9	32.9	**86.8**	131.3	45.8	28.6	35.2	**240.9**	**327.6**
Uplift £Ms	4.1	2.5	**6.6**	9.8	3.5	2.1	2.7	**18.1**	**24.6**
Uplift %	8.13%	8.23%	**8.17%**	8.07%	8.17%	8.03%	8.21%	**8.11%**	**8.12%**
Closing DFT	*-6.15%*	*-4.08%*		*0.74%*	*4.81%*	*1.36%*	*2.78%*		***-0.16%***
TOTAL PLACE									
18-19 Allocation (£Ms)	**343.4**	**222.4**	**565.9**	**610.2**	**250.8**	**158.7**	**194.5**	**1,214.3**	**1,780.1**
19-20 Allocation (£Ms)	**364.2**	**236.1**	**600.4**	**648.0**	**266.1**	**168.2**	**206.5**	**1,288.8**	**1,889.2**
Uplift £Ms	**20.8**	**13.7**	**34.5**	**37.8**	**15.3**	**9.5**	**11.9**	**74.5**	**109.0**
Uplift %	**6.06%**	**6.16%**	**6.10%**	**6.19%**	**6.10%**	**5.97%**	**6.14%**	**6.13%**	**6.13%**
Closing DFT	**-1.12%**	**-0.90%**		**-2.72%**	**-1.25%**	**2.28%**	**2.47%**		**-1.00%**

See breakdown on schedule 1c

Schedule 1c:
2019/20 Nottinghamshire CCG Allocations

The Nottingham and Nottinghamshire Integrated Care System

	Mid Nottinghamshire ICP			Greater Nottingham ICP					ICS
	M&A	N&S	Total	City	NNE	N.West	Rush	Total	Total
CORE CCG									
18-19 Allocation (£Ms)	266.9	174.1	**440.9**	440.2	188.9	119.6	146.0	**894.7**	**1,335.7**
19-20 Allocation (£Ms) **	282.0	184.2	**466.2**	464.5	199.6	126.3	154.3	**944.6**	**1,410.7**
Uplift %	5.68%	5.80%	**5.73%**	5.52%	5.63%	5.54%	5.66%	**5.57%**	**5.62%**

** *Excludes transfer of ambulance funding (additional £6 million for Nottinghamshire)*

Allocation Uplift (£Ms)		**15.2**	**10.1**	**25.2**	**24.3**	**10.6**	**6.6**	**8.3**	**49.8**	**75.1**
Breakdown:									
Transfer of Funding - 18/19 Pay Uplift	1.06%	2.8	1.8	**4.7**	4.7	2.0	1.3	1.5	**9.5**	**14.2**
Transfer of Funding - PSF to non-elective tariff £1bn	1.23%	3.3	2.1	**5.4**	5.4	2.3	1.5	1.8	**11.0**	**16.4**
		6.1	4.0	**10.1**	10.1	4.3	2.7	3.3	**20.5**	**30.6**
Realistic and sustainable activity levels	2.17%	5.8	3.8	**9.6**	9.6	4.1	2.6	3.2	**19.4**	**29.0**
Price Uplifts (19/20 uplift, litigation and transfers within tariff)	0.71%	1.9	1.2	**3.1**	3.1	1.3	0.8	1.0	**6.4**	**9.5**
Prescribing (net of efficiencies)	0.29%	0.8	0.5	**1.3**	1.3	0.5	0.3	0.4	**2.6**	**3.9**
Other efficiencies (CHC, Evidence Based Interventions)	-0.22%	-0.6	-0.4	**-1.0**	-1.0	-0.4	-0.3	-0.3	**-2.0**	**-2.9**
Mental Health Additional Funding	0.23%	0.6	0.4	**1.0**	1.0	0.4	0.3	0.3	**2.1**	**3.1**
Other	0.18%	0.5	0.3	**0.8**	0.8	0.3	0.2	0.3	**1.6**	**2.4**
Allocation formula/pace of change (national average 5.65%)		0.1	0.3	**0.3**	-0.6	0.0	-0.1	0.0	**-0.7**	**-0.4**
		9.0	6.1	**15.2**	14.2	6.3	3.9	4.9	**29.4**	**44.5**

Schedule 2a:
2019/20 Financial Plan Summary (4th April)

The Nottingham and Nottinghamshire Integrated Care System

Do Nothing Scenario

Do Nothing Expenditure Gap (to break-even)
ICS expenditure projection exceeds income by **£214.4 million (7.7%)**

- GN ICP – £127.4 million (6.5%)
- MN ICP – £87.0 million (10.3%)
- Range across organisations is 3.6% to 15.3%

↓

NHS System Control Total is £67.7m in-year deficit (before MRET, PSF and FRF)

↓

Do Nothing Financial Gap
After adjusting for control total the ICS has a do nothing financial gap of **£146.8 million (5.3%)**

- GN ICP – £100.4 million (5.1%)
- MN ICP – £46.3 million (5.5%)
- Range across organisations is 3.6% to 5.0%

Following contract resolution there is no triangulation gap between ICS organisations.

Local Authority information to be added when available.
See schedules 2b and 2c for further detail.

Do Something Plan – to Address Financial Gap 5.8%

Total ICS: Gap = £146.8 million (5.3%)

Identified schemes £120.0 million
Gap £26.8 million

Gap includes £1.9m control total not agreed by NUH

	ICS Total £Ms	ICS Total %
IDENTIFIED		
Red	15.6	10.7%
Amber	35.5	24.2%
Green	68.9	47.0%
Total Schemes	120.0	81.8%
Unidentified	24.9	16.9%
Control Total Not Accepted	1.9	1.3%
Total Savings Target	146.8	100.0%

Greater Nottingham ICP: Gap = £100.4 million (5.1%)

Identified schemes £75.4 million
Gap £25.0 million

Gap includes £1.9m control total not agreed by NUH

	GN ICP £Ms	GN ICP %
IDENTIFIED		
Red	9.1	9.1%
Amber	18.0	18.0%
Green	48.2	48.0%
Total Schemes	75.4	75.1%
Unidentified	23.1	23.0%
Control Total Not Accepted	1.9	1.9%
Total Savings Target	100.4	100.0%

Mid Nottinghamshire ICP: Gap = £46.3 million (5.5%)

Identified schemes £44.6 million
Gap £1.7 million

	MN ICP £Ms	MN ICP %
IDENTIFIED		
Red	6.5	14.0%
Amber	17.4	37.6%
Green	20.7	44.6%
Total Schemes	44.6	96.2%
Unidentified	1.7	3.8%
Control Total Not Accepted	0.0	0.0%
Total Savings Target	46.3	100.0%

Schedule 2b:
2019/20 Finance Do Nothing Gap (4th April)

The Nottingham and Nottinghamshire Integrated Care System

DO NOTHING FINANCIAL PLANS 2019/20	Total ICS £Ms	M Notts ICP £Ms	G Nottm ICP £Ms	SFH £Ms	NHT £Ms	NUH £Ms	MN CCGs £Ms	GN CCGs £Ms
System Income	2,576.2	753.9	1,822.3	83.6	284.0	621.9	523.0	1,063.7
ICS: inter-organisational transactions	0.0	0.0	0.0	216.4	176.4	436.2	-299.3	-529.6
Total System Expenditure	-2,790.6	-840.8	-1,949.8	-354.3	-477.4	-1,124.0	-247.8	-587.0
Net Position - (Deficit) / Surplus:	-214.4	-87.0	-127.4	-54.3	-17.1	-65.9	-24.1	-53.0
	7.7%	10.3%	6.5%	15.3%	3.6%	5.9%	4.6%	5.0%
Control Total before MRET, SF and FRF - (Deficit) / Surplus	-67.7	-40.6	-27.0	-41.5	0.0	-27.0	0.9	0.0
DO NOTHING GAP TO CONTROL TOTAL BEFORE MRET, SF AND FRF	-146.8	-46.3	-100.4	-12.8	-17.1	-38.8	-25.0	-53.0
Do Nothing Gap /Income %	5.3%	5.5%	5.1%	3.6%	3.6%	3.8%	4.8%	5.0%

Funding which may be accessed if organisational control totals are accepted (to reduce the control total deficit above):

	ICS	MN ICP	GN ICP	SFH	NHT	NUH	MN	GN
Sustainability Funding (Provider)	27.5	8.3	19.2	6.5	3.7	17.3		
Sustainability Funding (Commissioner)	0.0	0.0	0.0				0.0	0.0
Financial Recovery Fund (Provider)	21.2	14.8	6.4	14.8	0.0	6.4		
MRET (Provider)	8.8	5.4	3.4	5.4	0.0	3.4		
TOTAL	57.4	28.5	28.9	26.7	3.7	27.0		

- ICS has projected a **do nothing expenditure position** (before MRET, PSF and FRF) of **£214.4 million deficit (7.7%).** The do nothing expenditure position deficit range across organisations is 3.6% to 15.3%.
- The system has a control total of £67.7 million deficit for 2019/20, **giving a do nothing financial gap** of **£146.8 million (5.3%).** The do nothing financial gap (after control total) range across organisations is 3.6% to 5.0%.
- *NUH have not accepted their control total within their final plans, this is due to a technical funding issue on MRET. NUH have raised this issue directly with NHSE/I and are awaiting a response. The access to £27.0m of PSF, FRF and MRET funding is dependent on the resolution of this issue.*

Schedule 2c:
2019/20 Finance Do Something Gap (4th April)

The Nottingham and Nottinghamshire Integrated Care System

2019/20 System Control - Savings Analysis							ICP View	
"Do Something" Savings £'m	SFH	NHT	NUH	MN CCGs	GN CCGs	System Total	MN ICP	GN ICP
Total "Do Nothing" Gap	-12.8	-17.1	-38.8	-19.5	-40.8	-129.1	-40.9	-88.2
of which:								
FYE of 18/19 Savings			-1.6	-5.5	-12.2	-19.3	-5.5	-13.8
New 19/20 Savings Target	-12.8	-17.1	-37.2	-14.1	-28.6	-109.8	-35.4	-74.4

Analysis of Savings £'m	SFH	NHT	NUH	MN CCGs	GN CCGs	System Total	MN ICP	GN ICP
Identified Savings	-12.8	-13.6	-18.1	-25.0	-50.5	-120.0	-44.6	-75.4
Remaining Unidentified Gap	0.0	-3.5	-18.9	0.0	-2.5	-24.9	-1.7	-23.1
Control Total not yet accepted			-1.9			-1.9		-1.9
Total Savings Target	-12.8	-17.1	-38.8	-25.0	-53.0	-146.8	-46.3	-100.4

% Savings identified - of savings target	100%	80%	47%	100%	95%	82%	96%	75%
% savings identified - of total resources	3.6%	2.9%	1.8%	4.8%	4.7%	4.3%	5.3%	3.9%
% savings target	3.6%	3.6%	3.8%	4.8%	5.0%	5.3%	5.5%	5.1%

Schemes £'m	SFH	NHT	NUH	MN CCGs	GN CCGs	ICS Total	MN ICP	GN ICP
Red	4.2	2.8	1.9	0.9	5.8	15.6	6.5	9.1
Amber	8.2	5.4	6.7	6.5	8.6	35.5	17.4	18.0
Green	0.4	5.4	9.5	17.6	36.0	68.9	20.7	48.2
Total Schemes	**12.8**	**13.6**	**18.1**	**25.0**	**50.5**	**120.0**	**44.6**	**75.4**

Risk Adjusted Plan	5.5	7.8	16.3	21.0	40.1	90.7	30.3	60.4

Analysis of Savings Target £'m	SFH	NHT	NUH	MN CCGs	GN CCGs	System Total	MN ICP	GN ICP
Recurrent Saving Target	-12.8	-17.1	-35.9	-18.3	-53.0	-137.1	-39.7	-97.5
Non-Recurrent Savings Target	0.0	0.0	-2.9	-6.7	0.0	-9.6	-6.7	-2.9
Total Savings	-12.8	-17.1	-38.8	-25.0	-53.0	-146.8	-46.3	-100.4

Schedule 2d:

2019/20 Finance Do Something Plans mapped to Opportunities Pack – Total ICS (4th April)

The Nottingham and Nottinghamshire Integrated Care System

ICS Opportunity Pack - Comparison to ICS Plans (£m)		Opportunies Pack	ICS - Current plans - RAG				Difference
No.	Title		Green	Amber	Red	Total	
1	LTCs - Respiratory, Cardiovascular, Diabetes	4.0	3.5	4.0	-	**7.5**	**3.5**
2	Elderly, Frail and End of Life	8.0	4.8	1.6	-	**6.3**	**- 1.7**
3	Same Day Emergency Care	6.0	5.1	-	-	**5.1**	**- 0.9**
4	Effective Discharges	8.0	0.6	2.2	-	**2.8**	**- 5.2**
5	Outpatient Transformation	10.0	6.9	2.1	0.1	**9.1**	**- 0.9**
6	MSK	5.0	3.1	-	-	**3.1**	**- 1.9**
7	Referral Optimisation	2.0	0.0	-	-	**0.0**	**- 2.0**
8	Mental Health Outcomes	5.0	-	-	-	**-**	**- 5.0**
9	Long term care	6.0	5.9	0.4	-	**6.3**	**0.3**
10	Back Office	9.0	2.8	1.3	1.1	**5.2**	**- 3.8**
11	Estates	3.0	0.0	0.9	0.7	**1.6**	**- 1.4**
12	Providers of choice	-	0.2	2.4	-	**2.6**	**2.6**
13	Medicines Optimisation	15.0	12.9	1.1	-	**14.0**	**- 1.0**
14	Procurement	10.0	8.5	3.2	-	**11.7**	**1.7**
15	Agency	5.0	-	-	0.5	**0.5**	**- 4.5**
16	Pathology	5.0	-	0.3	0.9	**1.2**	**- 3.9**
17	Theatre Productivity	-	-	0.4	-	**0.4**	**0.4**
18	Consultant Job Planning	4.0	-	0.5	1.0	**1.5**	**- 2.5**
19	Ward rostering and productivity	5.0	-	0.5	0.3	**0.8**	**- 4.2**
20	Community and mental health	4.0	4.5	2.5	2.3	**9.4**	**5.4**
		114.0	**58.9**	**23.3**	**6.9**	**89.1**	**- 24.9**

Other	Other & unspecified workforce	0.9	6.6	1.8	**9.4**
	Other	9.3	7.7	4.5	**21.6**
	Total identified	**69.1**	**37.7**	**13.3**	**120.0**

The mapping above is indicative and we are working with organisations to refine this as schemes are further developed

Schedule 2d:

2019/20 Finance Do Something Plans mapped to Opportunities Pack - Mid Nottinghamshire (4th April)

The Nottingham and Nottinghamshire Integrated Care System

ICS Opportunity Pack - Comparison to ICP Plans (£m)		MN Opp	Mid Notts ICP - Current plans				Difference
No.	Title		Green	Amber	Red	Subtotal	
1	LTCs - Respiratory, Cardiovascular, Diabetes	1.5	1.2	0.5	-	**1.7**	**0.2**
2	Elderly, Frail and End of Life	3.5	3.3	-	-	**3.3**	**- 0.2**
3	Same Day Emergency Care	2.0	0.3	-	-	**0.3**	**- 1.7**
4	Effective Discharges	3.0	0.6	2.1	-	**2.7**	**- 0.3**
5	Outpatient Transformation	3.0	3.1	1.5	-	**4.6**	**1.6**
6	MSK	1.0	0.3	-	-	**0.3**	**- 0.7**
7	Referral Optimisation	1.1	-	-	-	**-**	**- 1.1**
8	Mental Health Outcomes	2.5	-	-	-	**-**	**- 2.5**
9	Long term care	1.5	1.3	-	-	**1.3**	**- 0.2**
10	Back Office	3.5	1.0	1.0	0.1	**2.1**	**- 1.4**
11	Estates	1.0	-	0.8	0.2	**1.0**	**- 0.0**
12	Providers of choice	-	-	2.2	-	**2.2**	**2.2**
13	Medicines Optimisation	4.0	3.9	-	-	**3.9**	**- 0.1**
14	Procurement	4.0	1.1	1.8	-	**2.9**	**- 1.1**
15	Agency	3.8	-	-	0.2	**0.2**	**- 3.5**
16	Pathology	1.5	-	0.3	0.9	**1.2**	**- 0.4**
17	Theatre Productivity	-	-	-	-	**-**	**-**
18	Consultant Job Planning	1.0	-	0.5	-	**0.5**	**- 0.5**
19	Ward rostering and productivity	1.0	-	0.5	-	**0.5**	**- 0.5**
20	Community and mental health	2.0	3.3	0.3	0.3	**3.9**	**1.9**
		40.9	**19.5**	**11.3**	**1.7**	**32.6**	**- 8.3**

Other	Other & unspecified workforce		0.4	5.2	0.9	**6.6**
	Other		0.3	3.2	1.9	**5.5**
	Total identified		**20.3**	**19.8**	**4.6**	**44.6**

Schedule 2d:

2019/20 Finance Do Something Plans mapped to Opportunities Pack - Greater Nottingham (4th April)

The Nottingham and Nottinghamshire Integrated Care System

ICS Opportunity Pack - Comparison to ICP Plans (£m)		GN Opp	Greater Nottm ICP - Current plans				Difference
No.	Title		Green	Amber	Red	Subtotal	
1	LTCs - Respiratory, Cardiovascular, Diabetes	2.5	2.3	3.5	-	**5.8**	**3.3**
2	Elderly, Frail and End of Life	4.5	1.4	1.6	-	**3.0**	**- 1.5**
3	Same Day Emergency Care	4.0	4.9	-	-	**4.9**	**0.9**
4	Effective Discharges	5.0	-	0.1	-	**0.1**	**- 4.9**
5	Outpatient Transformation	7.0	3.8	0.6	0.1	**4.5**	**- 2.5**
6	MSK	4.0	2.7	-	-	**2.7**	**- 1.3**
7	Referral Optimisation	0.9	0.0	-	-	**0.0**	**- 0.9**
8	Mental Health Outcomes	2.5	-	-	-	**-**	**- 2.5**
9	Long term care	4.5	4.6	0.4	-	**5.0**	**0.5**
10	Back Office	5.5	1.8	0.3	1.0	**3.1**	**- 2.4**
11	Estates	2.0	0.0	0.2	0.5	**0.7**	**- 1.3**
12	Providers of choice	-	0.2	0.2	-	**0.4**	**0.4**
13	Medicines Optimisation	11.0	9.0	1.1	-	**10.1**	**- 0.9**
14	Procurement	6.0	7.4	1.4	-	**8.8**	**2.8**
15	Agency	1.3	-	-	0.2	**0.2**	**- 1.0**
16	Pathology	3.5	-	-	-	**-**	**- 3.5**
17	Theatre Productivity	-	-	0.4	-	**0.4**	**0.4**
18	Consultant Job Planning	3.0	-	-	1.0	**1.0**	**- 2.0**
19	Ward rostering and productivity	4.0	-	-	0.3	**0.3**	**- 3.7**
20	Community and mental health	2.0	1.2	2.3	2.1	**5.5**	**3.5**
		73.2	**39.3**	**11.9**	**5.2**	**56.5**	**- 16.7**

Other	Other & unspecified workforce	0.4	1.4	0.9	**2.8**
	Other	9.1	4.5	2.5	**16.1**
	Total identified	**48.9**	**17.9**	**8.6**	**75.4**

Schedule 3:
Planning and Contract Triangulation (4th April)

The Nottingham and Nottinghamshire Integrated Care System

		5th March National				11th April National			
		Do Nothing £000s	Do Something £000s	Total £000s	%	Do Nothing £000s	Do Something £000s	Total £000s	%
Sherwood Forest	MN CCGs	-999	-14,195	-15,194	7.3%	0	0	0	0.0%
	GN CCGs	0	0	0	0.0%	0	0	0	0.0%
	Spec Comm	-27	-142	-169	1.7%	0	0	0	0.0%
Total Sherwood Forest		-1,026	-14,337	-15,363	6.8%	0	0	0	0.0%
NUH	MN CCGs	-2,162	-609	-2,771	8.6%	0	0	0	0.0%
	GN CCGs	0	-12,000	-12,000	2.9%	0	0	0	0.0%
	Spec Comm	-1,210	-7,969	-9,179	2.6%	0	0	0	0.0%
	NHSE DCO	0	0	0	0.0%	0	0	0	0.0%
Total NUH		-3,372	-20,578	-23,950	2.9%	0	0	0	0.0%
NHT	MN CCGs	27	-1,463	-1,436	2.3%	0	0	0	0.0%
	GN CCGs	143	0	143	-0.1%	0	0	0	0.0%
	Spec Comm	-165	0	-165	0.1%	-11	0	-11	0.0%
	NHSE DCO	214	0	214	-0.7%	0	0	0	0.0%
Total NHT		219	-1,463	-1,244	0.4%	-11	0	-11	0.0%
EMAS	MN CCGs	-555	0	-555	6.4%	-708	0	-708	6.4%
	GN CCGs	-1,110	0	-1,110	7.4%	-1,093	0	-1,093	7.4%
Total EMAS		-1,665	0	-1,665	7.0%	-1,801	0	-1,801	7.6%
Overall Contract Variance		**-5,844**	**-36,378**	**-42,222**	**-3.0%**	**-1,812**	**0**	**-1,812**	**-0.1%**

Totals by Commissioners:									
	MN CCGs	-3,689	-16,267	-19,956	6.4%	-708	0	-708	0.2%
	GN CCGs	-967	-12,000	-12,967	2.4%	-1,093	0	-1,093	0.2%
	Spec Comm	-1,402	-8,111	-9,513	1.8%	-11	0	-11	0.0%
	NHSE DCO	214	0	214	-0.5%	0	0	0	0.0%
Overall Contract Variance		**-5,844**	**-36,378**	**-42,222**	**-3.0%**	**-1,812**	**0**	**-1,812**	**-0.1%**

Schedule 4a:
Activity Plan – Total Organisation (4th April)

The Nottingham and Nottinghamshire Integrated Care System

Organisational Performance	CCG Total Year on Year Growth Comparator								Provider Total Trust Year on Year Growth Comparator								Pre QIPP Growth Gap Prov vs CCGs)	Post QIPP Growth Gap Prov vs CCGs)
	FY 16/17	FY 17/18	18/19 FOT	2019/20 Plan					FY 16/17	FY 17/18	18/19 FOT	2019/20 Plan						
	% Yr on Yr Change	% Yr on Yr Change	% Yr on Yr Change	% Growth	% Transform-ational Change	% Net Growth	*Real Growth (exc. C&C)	**Pre QIPP Growth	% Yr on Yr Change	% Yr on Yr Change	% Yr on Yr Change	% Growth	% Transform-ational Change	% Net Growth	Real Growth (exc. C&C)	Pre QIPP Growth		
Total Referrals	**0.03%**	**-6.87%**	**-1.12%**	3.64%	-3.79%	-0.15%	**-0.15%**	**3.64%**	**0.86%**	**-5.05%**	**-0.93%**	3.16%	-1.71%	1.45%	**1.45%**	**3.16%**	-0.48%	1.61%
Total Outpatients	**2.35%**	**-0.30%**	**-0.05%**	1.93%	-6.90%	-4.97%	**-2.36%**	**1.93%**	**2.63%**	**1.38%**	**2.03%**	4.37%	-5.53%	-1.16%	**-1.39%**	**4.37%**	**2.44%**	**3.81%**
Total Electives	**6.11%**	**-3.12%**	**-2.38%**	3.61%	-1.25%	2.36%	**2.36%**	**3.61%**	**4.56%**	**-1.01%**	**0.32%**	3.50%	-0.47%	3.03%	**3.02%**	**3.50%**	-0.12%	0.67%
Total Non_electives	**4.18%**	**0.29%**	**5.83%**	17.34%	-1.09%	16.25%	**4.65%**	**17.34%**	**3.45%**	**1.40%**	**7.38%**	16.56%	-0.26%	16.31%	**4.35%**	**16.56%**	-0.78%	0.05%
Total A&E Attendances	**2.91%**	**-1.00%**	**3.71%**	8.12%	-0.52%	7.60%	**2.23%**	**8.12%**	**2.72%**	**-0.38%**	**4.79%**	8.90%	-0.23%	8.67%	**1.54%**	**8.90%**	0.78%	1.07%

**** Coding and Counting changes excluded from the Real Growth.***

***** Transformational Change excluded from Pre QIPP Growth.***

Note:

- Pre-QIPP growth differences are predominantly due to allocation methodology in alignment tool , there are no alignment issues.
- There is an error on outpatients (Mid Notts CCGs) where OP transformation has been incorrectly included twice. This has been flagged with NHSE/I and it is not possible to resubmit at this stage.

Do Nothing Growth Assumptions

- There has been an exhaustive piece of work carried out across the ICS footprint projecting recurrent and non-recurrent demand taking into account the following for all 6 CCGs:
  - Population growth
  - Demographic shift
  - Impact of estimate disease prevalence increases for Dementia, Diabetes, Cancers and CVD
  - Impact of non-recurrent shifts in demand, for example waiting list volumes
  - Estimation for other known factors which have a material impact on demand, for example shift in social deprivation, changes in clinical thresholds, pathways changes, etc.
- Coding, counting and pathway changes from the current and prior years have been identified and moderated to prevent unintentional skewing of planned activity levels, changing coding as a result of revised front door at NUH.

Do Something Assumptions

- CCG QIPP is shown within the transformational change column and is aligned for contracted QIPP schemes. Discussions are ongoing for QIPP schemes to be contracted in year – these are being developed and going through ICP/organisational processes.

Schedule 4b:
Activity Plan – Total ICPs, activity between providers and commissioners in ICS (4th April)

The Nottingham and Nottinghamshire Integrated Care System

ICP Total (GN ICP + MN ICP)	CCG Total Year on Year Growth Comparator								Provider Total Trust Year on Year Growth Comparator								Pre QIPP Growth Gap Prov vs CCGs)	Post QIPP Growth Gap Prov vs CCGs)
	FY 16/17	FY 17/18	18/19 FOT	2019/20 Plan					FY 16/17	FY 17/18	18/19 FOT	2019/20 Plan						
	% Yr on Yr Change	% Yr on Yr Change	% Yr on Yr Change	% Growth	% Transform-ational Change	% Net Growth	Real Growth (exc. C&C)	Pre QIPP Growth	% Yr on Yr Change	% Yr on Yr Change	% Yr on Yr Change	% Growth	% Transform-ational Change	% Net Growth	Real Growth (exc. C&C)	Pre QIPP Growth		
Total Referrals	**0.72%**	**-6.41%**	**-0.66%**	3.59%	-3.54%	**0.05%**	0.16%	3.59%	**0.79%**	**-5.30%**	**-0.85%**	3.13%	-1.69%	**1.44%**	1.44%	3.13%	-0.46%	1.39%
Total Outpatients	**2.42%**	**-0.44%**	**0.01%**	1.49%	-7.35%	**-5.86%**	-2.86%	1.49%	**2.69%**	**1.14%**	**2.13%**	4.41%	-6.20%	**-1.79%**	-2.22%	4.41%	2.92%	4.07%
Total Electives	**6.18%**	**-3.13%**	**-2.81%**	3.53%	-1.25%	**2.28%**	2.47%	3.53%	**5.26%**	**-0.84%**	**-0.51%**	3.26%	-0.41%	**2.86%**	2.85%	3.26%	-0.27%	0.57%
Total Non_electives	**4.07%**	**0.52%**	**5.88%**	17.94%	-1.05%	**16.89%**	4.79%	17.94%	**3.66%**	**1.33%**	**7.59%**	17.02%	-0.25%	**16.77%**	4.38%	17.02%	-0.92%	-0.11%
Total A&E Attendances	**3.00%**	**-1.32%**	**3.81%**	7.63%	-0.57%	**7.06%**	2.08%	7.63%	**2.66%**	**-0.32%**	**4.75%**	9.09%	-0.23%	**8.86%**	1.54%	9.09%	1.46%	1.80%

**** Coding and Counting changes excluded from the Real Growth.***

***** Transformational Change excluded from Pre QIPP Growth.***

Note:

- Pre-QIPP growth differences are predominantly due to allocation methodology in alignment tool , there are no alignment issues.
- There is an error on outpatients (Mid Notts CCGs) where OP transformation has been incorrectly included twice. This has been flagged with NHSE/I and it is not possible to resubmit at this stage.

Historical Trend Review – Do Nothing Growth

The GN system has reviewed and revised NEL and A&E attendances do nothing growth to be more in line with average three year rolling historical trends.

Significant coding & counting changes have been included in GN for the revised front door model and same day services. Mid-Notts have not yet adjusted for same day services adjustments.

Do Something Growth – Transformational Change

CCG QIPP is shown within the transformational change column and is aligned for contracted QIPP schemes. Discussions are ongoing for QIPP schemes to be contracted in year – these are being developed and going through ICP/organisational processes.

Schedule 4c:
Activity Plan – Greater Nottingham (4th April)

The Nottingham and Nottinghamshire Integrated Care System

Greater Notts ICP (GN CCGs @ NUH and NUH @ GN CCGs) NHSE Methodology	CCG Total Year on Year Growth Comparator								Provider Total Trust Year on Year Growth Comparator								Pre QIPP Growth Gap Prov vs CCGs)	Post QIPP Growth Gap Prov vs CCGs)
	FY 16/17	FY 17/18	18/19 FOT	2019/20 Plan					FY 16/17	FY 17/18	18/19 FOT	2019/20 Plan						
	% Yr on Yr Change	% Yr on Yr Change	% Yr on Yr Change	% Growth	% Transform-ational Change	% Net Growth	Real Growth (exc. C&C)	Pre QIPP Growth	% Yr on Yr Change	% Yr on Yr Change	% Yr on Yr Change	% Growth	% Transform-ational Change	% Net Growth	Real Growth (exc. C&C)	Pre QIPP Growth		
Total Referrals	**1.52%**	**-3.98%**	**-3.18%**	4.90%	-2.69%	**2.20%**	2.38%	4.90%	**2.12%**	**-0.99%**	**-3.77%**	3.92%	-2.67%	**1.25%**	1.25%	3.92%	-0.98%	-0.96%
Total Outpatients	**1.49%**	**0.10%**	**-2.49%**	5.57%	-3.18%	**2.40%**	2.53%	5.57%	**2.23%**	**2.66%**	**1.33%**	4.89%	-2.36%	**2.53%**	2.46%	4.89%	-0.68%	0.14%
Total Electives	**3.58%**	**-2.97%**	**0.36%**	3.73%	-1.56%	**2.17%**	2.47%	3.73%	**2.97%**	**-0.96%**	**3.65%**	3.60%	-0.64%	**2.96%**	2.96%	3.60%	-0.13%	0.78%
Total Non_electives	**1.75%**	**4.30%**	**5.25%**	25.68%	-0.48%	**25.20%**	6.94%	25.68%	**0.36%**	**5.26%**	**7.53%**	24.26%	-0.37%	**23.89%**	5.37%	24.26%	-1.42%	-1.31%
Total A&E Attendances	**2.49%**	**0.35%**	**3.11%**	11.24%	-0.30%	**10.94%**	2.96%	11.24%	**1.47%**	**1.23%**	**3.88%**	13.48%	-0.37%	**13.11%**	1.47%	13.48%	**2.24%**	**2.17%**

**** Coding and Counting changes excluded from the Real Growth.***

***** Transformational Change excluded from Pre QIPP Growth.***

Note: Pre-QIPP growth differences are predominantly due to allocation methodology in alignment tool , there are no alignment issues.

Joint work has taken place with NUH colleagues to align the activity within the templates using a common methodology. The growth agreed at the confirm and challenge meetings with the NUH divisions has been mirrored within the NUH segment of the CCG corporate plans to ensure planning alignment. This has brought together the contractual and corporate planning processes.

The coding and counting changes for the GN CCGs pertain to NUH only. Specifically, these relate to the transfer of Follow up activity to Outpatient first and outpatient procedure. There is also agreed additional activity for Urology Rightsizing and Gastroenterology.

CCGs have added QIPP adjustments for Referrals which brings the real growth closer to National Growth Assumptions.

Do Something Growth – Transformational Change

CCG QIPP is shown within the transformational change column and is aligned for contracted QIPP schemes. Discussions are ongoing for QIPP schemes to be contracted in year – these are being developed and going through ICP/organisational processes.

Schedule 4d:
Activity Plan – Mid Nottinghamshire (4th April)

The Nottingham and Nottinghamshire Integrated Care System

Mid Notts ICP (MN CCGs @ SFH and SFH @ MN CCGs)	MN CCGs Year on Year Growth Comparator								SFH Year on Year Growth Comparator								Pre QIPP Growth Gap Prov vs CCGs)	Post QIPP Growth Gap Prov vs CCGs)
	FY 16/17	FY 17/18	18/19 FOT	2019/20 Plan					FY 16/17	FY 17/18	18/19 FOT	2019/20 Plan						
	% Yr on Yr Change	% Yr on Yr Change	% Yr on Yr Change	% Growth	% Transform-ational Change	% Net Growth	Real Growth (exc. C&C)	Pre QIPP Growth	% Yr on Yr Change	% Yr on Yr Change	% Yr on Yr Change	% Growth	% Transform-ational Change	% Net Growth	Real Growth (exc. C&C)	Pre QIPP Growth		
Total Referrals	**-0.66%**	**-10.72%**	**4.17%**	1.27%	-5.06%	**-3.79%**	-3.79%	1.27%	**-1.34%**	**-12.44%**	**4.63%**	1.77%	0.00%	**1.77%**	1.77%	1.77%	0.50%	**5.56%**
Total Outpatients	**3.76%**	**-1.22%**	**3.64%**	-4.08%	-13.06%	**-17.14%**	-10.23%	-4.08%	**3.31%**	**-0.93%**	**3.25%**	3.74%	-11.55%	**-7.80%**	-8.73%	3.74%	**7.82%**	**9.34%**
Total Electives	**10.59%**	**-3.37%**	**-7.84%**	3.18%	-0.71%	**2.47%**	2.47%	3.18%	**9.04%**	**-0.66%**	**-7.00%**	2.68%	0.00%	**2.68%**	2.66%	2.68%	-0.50%	0.21%
Total Non_electives	**8.51%**	**-6.27%**	**7.13%**	2.74%	-2.17%	**0.57%**	0.57%	2.74%	**10.23%**	**-5.79%**	**7.70%**	2.40%	0.00%	**2.40%**	2.37%	2.40%	-0.35%	1.83%
Total A&E Attendances	**3.84%**	**-4.02%**	**5.00%**	1.65%	-1.01%	**0.64%**	0.64%	1.65%	**4.71%**	**-2.89%**	**6.25%**	1.66%	0.00%	**1.66%**	1.66%	1.66%	0.00%	1.01%

**** Coding and Counting changes excluded from the Real Growth.***

***** Transformational Change excluded from Pre QIPP Growth.***

The Outpatients is not aligned due to a QIPP scheme at Mid Notts CCG that has been erroneously double counted under the Coding and Counting Change column. If the error was to be amended, the Outpatients Plan will be aligned. The Nottinghamshire ICS has requested NHSE to allow for the amendment at Mid Notts. Currently, NHSE is not accepting any revisions to the final plans but there may be an opportunity in the near future for revisions.

Joint work has taken place with SFHT colleagues to align the activity within the templates using a common methodology, based on a combination of latest provider adjusted and centrally supplied FOT.

Review of historic trends and validation of 'do nothing' growth has been undertaken to ensure the system is confident on levels – confirmed they are 3 year rolling average and include same day adjustments. Do Something Growth – Transformational Change

CCG QIPP is shown within the transformational change column and is aligned for contracted QIPP schemes. Discussions are ongoing for QIPP schemes to be contracted in year – these are being developed and going through ICP/organisational processes.

Schedule 5:
Operational Performance (4th April)

The Nottingham and Nottinghamshire Integrated Care System

New or Revised Measure

	Key Performance Indicator	2019/20			2018/19 Current Year Performance			
		2019/20 Required Performance	2019/20 Planned Achievement	2019/20 Planned Performance	2018/19 Required Performance	2018/19 Reporting Period	2018/19 ICS Latest Period	2018/19 ICS Month RAG
A. Mental Health Deliver the MHFV, with a focus on Children and Young Peoples services (CYP), reductions in Out of Area Placements, improved access to mental health services (EIP / IAPT / Crisis and Liaison services)	CYP Access Rate	34%	✓	34%	32%	Q3 18/19	16.2%	
	CYP Eating Disorders Urgent 1st <1 weeks	95.0%	✓	100.0%	95.0%	Q3 18/19	50.0%	
	CYP Eating Disorders Routine 1st <4 weeks	95.0%	✓	100.0%	95.0%	Q3 18/19	100.0%	
	IAPT Access - 22% (Minimum 4.75% each Qtr, increases to 5.5% Q4) 2/3 of increase to be in IAPT-LTC	5.50%	✓	5.50%	4.61%	Dec-18	4.47%	
	IAPT Waiting Times - 6 weeks (Rolling Quarter)	75.0%	✓	75.1%	75.0%	Dec-18	80.8%	
	IAPT Waiting Times - 18 weeks (Rolling Quarter)	95.0%	✓	95.1%	95.0%	Dec-18	99.3%	
	IAPT Recovery Standards (Rolling Quarter)	50.0%	✓	50.0%	50.0%	Dec-18	55.2%	
	EIP NICE Concordant Care within 2 Weeks	56.0%	✓	60.0%	53.0%	Jan-19	66.7%	
	Inappropriate Out of Area Placements (bed days)	1080	✓	1440	1698	Dec-18	2815	
	Maintain Dementia diagnosis rate at 2/3 of prevalence	66.7%	✓	78.0%	66.7%	Feb-19	75.8%	
B. Urgent & Emergency Care Improved A&E performance in 2018/19, reduce DTOCs and stranded patients, underpinned by realistic activity plans. Implementation of NHS 111 Online & Urgent Treatment Centres.	Aggregate performance of 4 Hour A&E Standard	95%	x	91%	90% Sept	Feb-19	76.4%	
	12 Hour Trolley Breaches	0	✓	0	0	Feb-19	10	
	NHS 111 50% population receiving clinical input	50.0%			50.0%	Feb-19	52.8%	
	NHS 111 Direct Appointment Booking	>40%						
	Ambulance (mean) response time Category 1 Incidents	00:07:00			00:07:00	Oct-18	00:07:39	
	Ambulance (mean) response time Category 2 Incidents	00:18:00			00:18:00	Oct-18	00:30:27	
	Ambulance Handover Waits	<00:30:00						
	Manage Optimal Length of Stay-40% reduction in >21 days	220			277	Jan-19	337	
	Reduce DTOCs across health and social care- NUH	3.5%			3.5%	Jan-19	2.97%	
	Reduce DTOCs across health and social care- SHFT	3.5%			3.5%	Jan-19	4.30%	
C. Planned Care Improvements in planned elective activity, reductions in patients waiting over 52 weeks as well as reductions in overall waiting lists	RTT Incomplete 92% Standard	92%	✓	92.3%	92%	Jan-19	91.6%	
	RTT Waiting List - March 2019 incomplete pathway < March 2018	<March 18 56,511	✓	52,768	<March 18 56511	Jan-19	59,115	
	+52 Week Waits - to be eliminated (Potential fines £2.5k for Comm & Prov per breach)	0	✓	0	15	Jan-19	11	
	Diagnostics +6 weeks	0.9%	✓	0.8%	0.9%	Jan-19	0.72%	
	Children's Wheelchair Waits < 18 Weeks	92%	✓	95.0%	92%	Q3 18/19	90.00%	
	E-Referrals increased coverage 100% 1819	100%	✓	100.0%	100%	Dec-18	104%	
D. Cancer Delivery of all eight waiting time standards, implementation of nationally agreed radiotherapy specifications and diagnostic pathways, progress risk	Cancer 2 weeks - Suspected Cancer referrals	93.0%	✓	95.3%	93.0%	Jan-19	95.0%	
	Cancer 2 weeks - Breast Symptomatic Referrals	93.0%	✓	95.5%	93.0%	Jan-19	98.1%	
	Cancer 31 Days - First Definitive Treatment	96.0%	✓	97.6%	96.0%	Jan-19	93.8%	
	Cancer 31 Days - Subsequent Treatment - Surgery	94.0%	✓	96.7%	94.0%	Jan-19	83.9%	
	Cancer 31 Days - Subsequent Treatment - Anti Can	98.0%	✓	100.0%	98.0%	Jan-19	98.3%	
	Cancer 31 Days - Subsequent Treatment - Radiothy	94.0%	✓	97.3%	94.0%	Jan-19	97.5%	
	Cancer 62 Days - First Definitive Treatment - GP Referral	85.0%	✓	87.4%	85.0%	Jan-19	83.1%	
	Cancer 62 Days - Treatment from Screening Referral	90.0%	✓	97.2%	90.0%	Jan-19	84.0%	

- Table completed based on performance at March 2020.
- A&E Performance includes Sherwood Forest and Nottingham University Hospital. However, Nottingham University Hospital will be included in a pilot to review metrics for 2019/20.

NHS
Nottingham North and East
Clinical Commissioning Group

Meeting Title:	Open Governing Body			**Date:** 16 April 2019				
Paper Title:	Financial Plans and Opening Budgets 2019/20			**Paper Reference:** GB/19/037 a				
Sponsor:	Jonathan Bemrose, Chief Finance Officer							
Previous Related Papers:	The paper was received at the Greater Nottingham Joint Commissioning Committee on 27 March 2019							
Recommendation:	Approve	☒	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☐
Summary Purpose of Paper:	The purpose of this paper is to provide an update on the 2019/20 draft financial plans as submitted to NHS England in February 2019 and the subsequent draft opening budgets for 2019/20. At its meeting on 24 March 2019, the Greater Nottingham Joint Commissioning Committee endorsed for approval the 2019/20 opening budgets based on 14 February 2019 Financial Plans submitted to NHS England.							

If paper is for Approval/Endorsement, have the following impact assessments been completed?

Equality / Quality Impact Assessment	Yes ☐ No ☐ N/A ☒		Data Protection Impact Assessment	Yes ☐ No ☐ N/A ☒

Conflicts of Interest: Please consider whether there are any conflicts of interest considerations relevant to either paper authors, meeting members or attendees.

☒ 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
☐ Conflicted party to be excluded from meeting

Have All Relevant Implications Been Considered? *(please tick where relevant)*

Clinical Engagement	☐	Patient and Public Involvement	☐
Quality Improvement	☐	Equality, Diversity and Human Rights	☐
Integration	☐	Innovation / Research	☐
Improving Health Outcomes / Reducing Health Inequalities	☐	Patient Choice / Shared Decision Making	☐
Financial Management	☒	Corporate Governance	☐

Is the Information in this paper confidential? Yes ☐ No ☒

If yes, please state reason why:

Risk: *(briefly explain any risks associated with the paper*)	**The CCP has a £48m QIPP requirement in 2019/20**
Recommendation:	The Governing Body is asked to: • **APPROVE** the 2019/20 opening budgets based on 14 February 2019 Financial Plans submitted to NHS England. • **NOTE** an update on the opening budgets following the submission to NHS England of the final Financial Plans for 2019/20.

NHS
Greater Nottingham
Clinical Commissioning Partnership

2019/20 Financial Plans & Budget Setting

1. Introduction

1.1. The purpose of this paper is to provide an update on the Clinical Commissioning Partnership (CCP) 2019/20 draft financial plans as submitted to NHS England in February 2019 and the subsequent draft opening budgets for 2019/20.

1.2. The CCP submitted a break-even draft financial plan for 2019/20 to NHS England in line with the CCP's advised 2019/20 Control Total. Discussions are currently underway regarding the Nottinghamshire wide system control total, which has been issued by NHSE/NHSI at £67.7 million deficit (prior to application of provider sustainability funding (PSF), provider financial recovery fund (FRF) and marginal rate emergency threshold (MRET)). Control Totals have not yet been agreed by Nottingham University Hospitals Trust.

1.3. The national deadline for signing 2019/20 contract variations and contracts is 21 March 2019. Linked to this is the requirement to submit the final financial plans for 2019/20 to NHS England on the 4 April 2019.

1.4. Under the CCP's constitution, responsibility for approving the budgets that meet the financial duties for the organisation is delegated to the Joint Committee.

2. Allocations, Business Rules and Planning Assumptions

2.1. Allocations for 2019/20 have been announced in January and were taken to the January meeting of the Joint Committee. Greater Nottinghamshire CCP has a combined allocation of c £1.06 billion and is c £17 million short of the fair shares target.

£million	City	NNE	NW	Rushcliffe	Greater Notts
Core Services					
2018/19 Baseline	£440.2	£188.9	£119.6	£146.0	£894.7
2019/20 Allocation	**£464.5**	**£199.6**	**£126.3**	**£154.3**	**£944.7**
Core Uplift %age	5.5%	5.7%	5.6%	5.7%	5.6%
Distance from Target %age	-3.40%	-2.99%	2.12%	2.23%	
Distance from Target £m	-£16.4	-£6.2	£2.6	£3.4	-£16.6
Primary Care					
2018/19 Baseline	£48.6	£19.6	£12.7	£16.0	£96.9
2019/20 Allocation	**£52.2**	**£20.8**	**£13.4**	**£17.0**	**£103.4**
Core Uplift %age	7.4%	6.1%	5.5%	6.3%	6.7%
Distance from Target %age	-4.99%	3.46%	6.04%	4.13%	
Running Costs					
2018/19 Baseline	£7.4	£3.2	£2.0	£2.7	£15.3
2019/20 Allocation	**£7.4**	**£3.4**	**£2.0**	**£2.7**	**£15.5**
Total 2019/20 Allocation	**£524.1**	**£223.8**	**£141.7**	**£174.0**	**£1,063.6**

Note, in addition to the above, there is c £3million access funding made recurrent, hence the difference when comparing to the resource limit in section 5.

2.2. The national planning guidance sets out a number of finance assumptions and business rules. Those assumptions and rules are detailed below, showing what is included in the CCP Financial Plans:-

- Minimum 0.5% Contingency (CCP Plan 0.5%)
- Remain within the Administration Costs Allocation (CCP plan under on running costs)
- Meet the CCP's stipulated Control Total (breakeven for the CCP)
- National policy – achievement of the Mental Health Investment Standard
- National policy – Better Care Fund contribution (minimum included in CCP plan)
- National policy £1.50 per head set aside for Primary Care Network development (included in CCP plan)

2.3. Whilst a £50 million (5.6%) uplift to core allocation is higher than settlements in recent years, the level of tariff inflation, activity growth requirements and pre-commitments mean that there is still a challenging QIPP / savings requirement of £48 million in order to deliver a balanced financial plan. A Source and Application of Funds statement is included below to demonstrate how the resource uplift has been utilised.

3. Key Planning Outputs

3.1 The CCP 2019/20 Financial Plan:

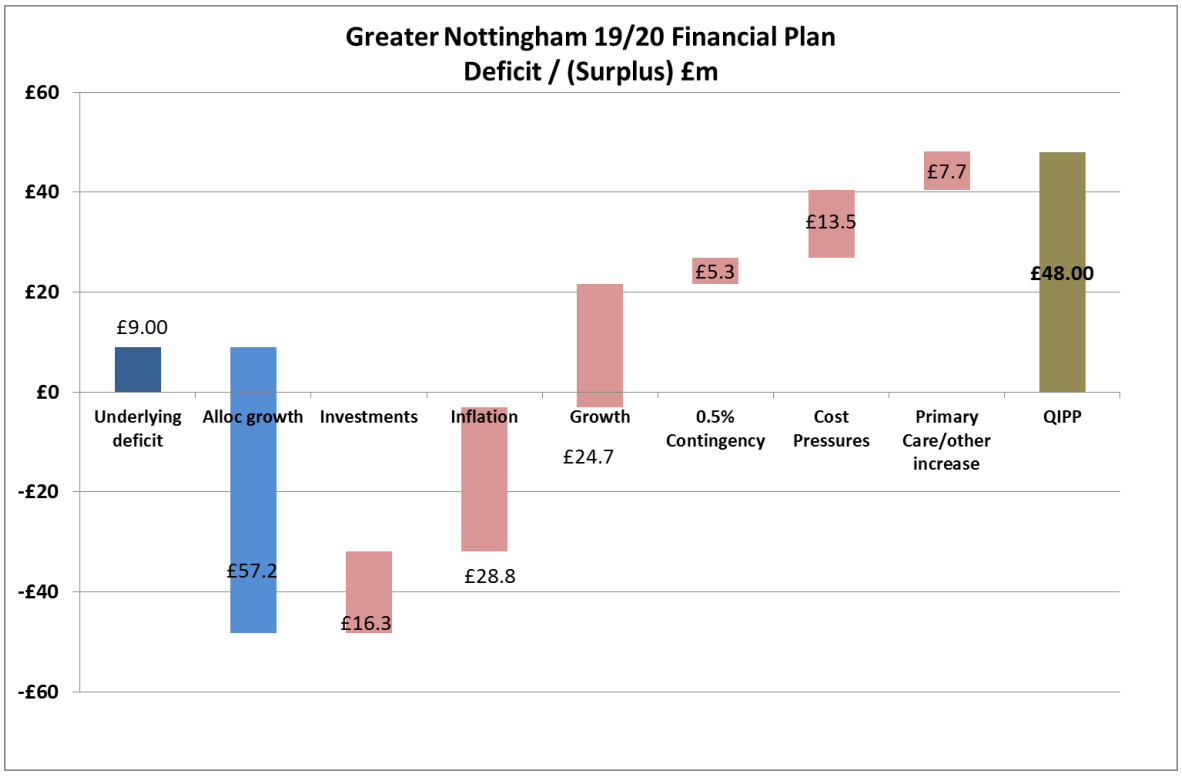
3.1.1 Delivers in year breakeven

3.1.2 Delivers an exit Underlying Surplus of £0.6 million

3.1.3 Requires £48 million QIPP savings

3.1.4 Maintains a brought forward cumulative surplus £19.3 million (1.8%)

3.2 The £57 million allocation growth is utilises per the Source and Applications of Funds waterfall below. The level of growth, inflation and the requirements for 2019/20 give rise to a £48 million savings requirement to deliver the breakeven plan.



3.3 Investments of £16.3 million include £7.9 million to meet Mental Health Investment Standard requirements, £1.5 million system resilience pressures making recurrent the 2018/19 over-commitment, £1.1 million £1.50 per head primary care requirement, MRET and readmissions reserves £0.9 million and Better Care Fund increase in minimum contribution £0.4 million. Cost Pressures include Contract/Risk/Transformation reserves of £12 million and Patient transport anticipated pressures of £1.1 million. Note that this is a draft plan pre contract agreements and the reserves are likely to be utilised in settling the 2019/20 contracts.

4. Risks & Mitigations

4.1. At this stage there are still significant risks relating to settlement of contracts. This includes where contracts settle in relation to contract envelopes and, a component of this, the amount of QIPP that is negotiated in to contract baselines. In particular, current discussions suggest that the NUHT contract will be significantly above contract envelopes.

4.2. In addition to contract positions, the delivery of the remaining challenging QIPP target presents a risk. Delivery of required QIPP targets in Prescribing and Continuing Healthcare will be key but high risk.

4.3. Emergency pressures and system resilience also present financial risk. The plan builds in an additional £1.5 million to make recurrent resilience pressures from 2018/19. There is no further provision for new pressures.

4.4. The re-organisation in to a Nottinghamshire wide Integrated Care System (ICS) and the associated merger of the Nottinghamshire CCGs provides opportunity for system-wide approach to efficiency savings delivery. However, there is clearly a risk arising from this re-organisation that should also be noted whilst new structures are agreed and implemented.

4.5. In mitigation, the CCP has £5.3 million contingency and £12m other available reserves at draft plan stage. It is anticipated that a large proportion of these will be utilised during the contracting process and any residual will be required for in year pressures.

5. 2019/20 Opening Budgets

5.1. The 2019/20 draft opening budgets, by programme heading with associated QIPP targets, are shown below. Total QIPP requirement is £48.0 million, 4.5% of allocation.

Budget	Budgets pre QIPP	QIPP (bal to FY 18/19)	QIPP 19/20	Net budgets
Allocation				**1,067,160**
Expenditure				
Acute	516,356	-11,765	-12,768	491,823
Mental Health	112,997	-15	-860	112,122
Community	102,987	-184	397	103,200
Continuing Care	77,359	-2,626	-1,150	73,583
Prescribing	97,304	-2,266	-1,132	93,906
Primary Care	21,454	0	0	21,454
Other Programme	62,546	-83	-14,495	47,968
Primary Care Co-Commissioning	102,806	0	0	102,806
Running Costs	15,533	-1,080	-10	14,443
Contingency	5,855	0	0	5,855
Total Expenditure	**1,115,197**	**-18,019**	**-30,018**	**1,067,160**

Nb. PCCC contingency is included in contingency line

6. Recommendations

The Joint Committee is asked to:

- **Approve** the 2019/20 opening budgets based on 14 February 2019 Financial Plans submitted to NHS England.
- **Note** an update on the opening budgets will be provided to the Governing Body following the submission to NHS England of the final Financial Plans for 2019/20.

Ian Livsey
Deputy CFO
12 March 2019

NHS
Nottingham North and East
Clinical Commissioning Group

Meeting Title:	Nottingham North and East CCG Governing Body				**Date:** 16 April 2019				
Paper Title:	Delegated Authority/Limits - Amendments to the Detailed Financial Policies - Approval of the Better Care Fund Pooled Fund agreement for 2019/20				**Paper Reference:** GB/19/038				
Sponsor:	Jonathan Bemrose, Chief Financial Officer								
Previous Related Papers:	N/A								
Recommendation:	Approve	☒	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☐	
Summary Purpose of Paper:	The Governing is asked to approve the following two items: <u>Amendments to the Detailed Financial Policies</u> The Greater Nottingham CCGs' (joint) Detailed Financial Policies have been amended to reflect a change to Appendix 1, section 15 (delegated authority limits) to the Nottinghamshire Area Prescribing Committee. It is proposed that the limit is increased to £80,000 across the six Nottingham and Nottinghamshire CCGs, as opposed to £10,000 which was based on a single CCG previously. The Governing Body is asked to approve the amendment to the Detailed Financial Policies. Work will be undertaken to create a single aligned set of Detailed Financial Policies across Nottingham and Nottinghamshire, reflecting the recent changes in governance and staffing arrangements. <u>Sign off of the Better Care Fund (BCF) Pooled Fund agreement for 2019/20</u> The 2019/20 BCF Section 75 agreement with Nottinghamshire County Council requires approval from the Governing Body. At this stage, the Section 75 agreement is still in draft form as the final BCF guidance from NHS England has not yet been published. The final version is not anticipated to change apart from potentially minor changes once the financial minimum contributions that CCGs must make to the pool are confirmed. The CCG's contribution in the draft Section 75 is at the minimum required. The draft 2019/20 BCF Section 75 is attached at Appendix A The Governing Body is asked to delegate approval to the Accountable Officer once planning guidance is finalised, subject to there being no material changes in the guidance.								

If paper is for Approval/Endorsement, have the following impact assessments been completed?					
Equality / Quality Impact Assessment	Yes No N/A	☐ ☐ ☒	Data Protection Impact Assessment	Yes No N/A	☐ ☐ ☒

Conflicts of Interest: Please consider whether there are any conflicts of interest considerations relevant to paper authors, members or attendees.

☒ 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

☐ Conflicted party to be excluded from meeting

Please identify conflicted party and specify reason for conflict:

Have All Relevant Implications Been Considered? *(please tick where relevant)*			
Clinical Engagement	☐	Patient and Public Involvement	☐
Quality Improvement	☐	Equality, Diversity and Human Rights	☐
Integration	☐	Innovation / Research	☐
Improving Health Outcomes / Reducing Health Inequalities	☐	Patient Choice / Shared Decision Making	☐
Financial Management	☒	Corporate Governance	☒

Is the Information in this paper confidential? Yes ☐ No ☒

If yes, please state reason why:

Risk: *(briefly explain any risks associated with the paper*)	
Recommendation:	The Governing Body is asked to: • **APPROVE** the amendment to the Detailed Financial Policies • **APPROVE** the delegation of approval of the Better Care Fund (BCF) Pooled Fund agreement for 2019/20 to the Accountable Officer, subject to no material changes in the guidance

Nottingham North and East
Clinical Commissioning Group

Meeting Title:	Nottingham North and East CCG Governing Body			**Date:** 16 April 2019				
Paper Title:	Delegated Authority/Limits - Amendments to the Detailed Financial Policies - Approval of the Better Care Fund Pooled Fund agreement for 2019/20			**Paper Reference:** GB/19/038				
Sponsor:	Jonathan Bemrose, Chief Financial Officer							
Previous Related Papers:	N/A							
Recommendation:	Approve	☒	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☐
Summary Purpose of Paper:	The Governing is asked to approve the following two items: <u>Amendments to the Detailed Financial Policies</u> The Greater Nottingham CCGs' (joint) Detailed Financial Policies have been amended to reflect a change to Appendix 1, section 15 (delegated authority limits) to the Nottinghamshire Area Prescribing Committee. It is proposed that the limit is increased to £80,000 across the six Nottingham and Nottinghamshire CCGs, as opposed to £10,000 which was based on a single CCG previously. The Governing Body is asked to approve the amendment to the Detailed Financial Policies. Work will be undertaken to create a single aligned set of Detailed Financial Policies across Nottingham and Nottinghamshire, reflecting the recent changes in governance and staffing arrangements. <u>Sign off of the Better Care Fund (BCF) Pooled Fund agreement for 2019/20</u> The 2019/20 BCF Section 75 agreement with Nottinghamshire County Council requires approval from the Governing Body. At this stage, the Section 75 agreement is still in draft form as the final BCF guidance from NHS England has not yet been published. The final version is not anticipated to change apart from potentially minor changes once the financial minimum contributions that CCGs must make to the pool are confirmed. The CCG's contribution in the draft Section 75 is at the minimum required. The draft 2019/20 BCF Section 75 is attached at Appendix A The Governing Body is asked to delegate approval to the Accountable Officer once planning guidance is finalised, subject to there being no material changes in the guidance.								

If paper is for Approval/Endorsement, have the following impact assessments been completed?			
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Conflicts of Interest: Please consider whether there are any conflicts of interest considerations relevant to paper authors, members or attendees.

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☐ Conflicted party to be excluded from meeting

Please identify conflicted party and specify reason for conflict:

Have All Relevant Implications Been Considered? *(please tick where relevant)*			
Clinical Engagement	☐	Patient and Public Involvement	☐
Quality Improvement	☐	Equality, Diversity and Human Rights	☐
Integration	☐	Innovation / Research	☐
Improving Health Outcomes / Reducing Health Inequalities	☐	Patient Choice / Shared Decision Making	☐
Financial Management	☒	Corporate Governance	☒

Is the Information in this paper confidential? Yes ☐ No ☒

If yes, please state reason why:

Risk: *(briefly explain any risks associated with the paper*)	
Recommendation:	The Governing Body is asked to: • **APPROVE** the amendment to the Detailed Financial Policies • **APPROVE** the delegation of approval of the Better Care Fund (BCF) Pooled Fund agreement for 2019/20 to the Accountable Officer, subject to no material changes in the guidance

Bevan Brittan

Dated XXXXXXX

Nottinghamshire County Council

and

NHS Bassetlaw Clinical Commissioning Group
NHS Mansfield and Ashfield Clinical Commissioning Group
NHS Newark and Sherwood Clinical Commissioning Group
NHS Nottingham North and East Clinical Commissioning Group
NHS Nottingham West Clinical Commissioning Group
NHS Rushcliffe Clinical Commissioning Group

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES AS SPECIFIED IN THE NOTTINGHAMSHIRE COUNTY BETTER CARE FUND

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THIS AGREEMENT is made on XXXXXXXXXXXXX

PARTIES

(1) **Nottinghamshire County Council** whose principal place of business is at County Hall, West Bridgford, Nottingham NG2 7QP (the **Council**)

(2) **NHS Bassetlaw Clinical Commissioning Group** whose principal place of business is at Retford Hospital, North Road, Retford Nottinghamshire, DN22 7XF **(Bassetlaw CCG)**

(3) **NHS Mansfield and Ashfield Clinical Commissioning Group** whose principal place of business is at Hawthorn House, Ransom Wood Business Park, Southwell Road West, Rainworth, Mansfield, Nottinghamshire, NG21 0HJ (**Mansfield and Ashfield CCG**)

(4) **NHS Newark and Sherwood Clinical Commissioning Group** whose principal place of business is at Balderton Primary Care Centre, Lowfield Lane, Balderton, Nottinghamshire, NG24 3HJ (**Newark and Sherwood CCG**)

(5) **NHS Nottingham North and East Clinical Commissioning Group** whose principal place of business is at Civic Centre, Arnot Hill Park, Arnold, Nottingham NG5 6LU (**Nottingham NE CCG"**)

(6) **NHS Nottingham West Clinical Commissioning Group** whose principal place of business is at Stapleford Care Centre, Church Street, Nottingham, NG9 8DB (**Nottingham W CCG**)

(7) **NHS Rushcliffe Clinical Commissioning Group** whose principal place of business is at Easthorpe House, 165 Loughborough Road, Ruddington, Nottingham, NG11 6LQ (**Rushcliffe CCG**)

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the County of Nottinghamshire (excluding the City of Nottingham).

(B) Each CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the population of NHS Bassetlaw CCG, NHS Mansfield and Ashfield CCG, NHS Newark and Sherwood CCG, NHS Nottingham North and East CCG, NHS Nottingham West CCG and NHS Rushcliffe CCG.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCGs and the Council establish a pooled fund for this purpose.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also means through which the Partners will pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives; and

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services.

(G) The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.

(H) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this agreement including its Schedules and Appendices.

Approved Expenditure means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price..

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

BCF Finance, Planning and Performance Subgroup means the sub group identified in Schedule 2.

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the plan attached at Schedule 6 setting out the Partners plan for the use of the Better Care Fund.

CCG means each clinical commissioning group who is a party to this Agreement.

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement

Commencement Date means 00:01 hrs on 1st April 2018.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability.

Default Liability means any sum which is agreed or determined by Law (or in accordance with the terms of a Services Contract) to be payable by any Partner(s) to the Provider as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under the relevant Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract, liable to the Provider.

District Councils means the seven district councils within Nottinghamshire County being Bassetlaw; Broxtowe; Mansfield; Ashfield; Gedling; Newark & Sherwood and Rushcliffe.

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:
(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and
(h) any other event,
in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Health Related Functions

Health Related Functions means those health related functions listed in Regulation 6 of the Regulations as are exercisable by the Council as are relevant to the commissioning of the Services and which may be further described in each Scheme Specification.

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund.

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Integrated Commissioning means arrangements by which all Partners commission Services in relation to an individual Scheme on behalf of each other in exercise of both the NHS Functions and Health Related Functions through integrated structures.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partners in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Planning Guidance as are amended or replaced from time to time.

Non elective Admissions means the number of non-elective (emergency) First Finished Consultant Episodes (FFCEs) for the general and acute specialities derived from the NHS monthly activity return in accordance with the “Everyone Counts: Planning for Patients 2014/15-2018/19: Technical definitions for Clinical Commissioning Groups and Area Teams” first published on 23 December 2013.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Scheme Specification.

Non Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 10.4.

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each CCG and the Council, and references to "**Partners**" shall be construed accordingly.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause 7.3.

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause 8.

Steering Group means the Steering Group responsible for review of performance and oversight of this Agreement as set out in Schedule 2.

Programme Manager shall be Sarah Fleming or such other person agreed by the Steering Group from time to time.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Section 113 Officer means an officer of the Council who, pursuant to s113 of the Local Government Act 1972, may perform functions on behalf of other public bodies.

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Service Credit means any sum which is agreed or determined by Law (or in accordance with the terms of a Services Contract) to be payable by the Provider to any Partner(s) as a consequence of (i) breach by the Provider of an obligation(s) in whole or in part) under the relevant Services Contract or (ii) any act or omission of a third party for which the Provider is, under the terms of the relevant Services Contract, liable to any or all Partner(s).

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individual for whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health.

Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Steering Group.

Unit of planning means the non-statutory collaboration between the CCGs in a geographical area based on the provision of service to a population. The units of planning are:

1. North: Bassetlaw CCG

2. Mid Nottinghamshire: Mansfield and Ashfield CCG and Newark and Sherwood CCG

3. South Nottinghamshire: Nottingham North and East CCG, Nottingham West CCG, Rushcliffe CCG.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 This Agreement shall continue until 31st March 2020 unless it is:

a) terminated earlier in accordance with Clause 22 (or otherwise lawfully terminated); or

b) extended in accordance with clause 2.3.

2.3 The Partners may (through the Steering Group) agree to extend the term of this Agreement provided that:

a) the matter is discussed at least 3 months prior to the expiry of this Agreement (in accordance with clause 2.2);

b) the Partners are in unanimous agreement; and

c) the maximum period in respect of the extension shall be twelve (12) months.

2.4 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

a) the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

b) any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

a) treat each other with respect and an equality of esteem;

b) be open with information about the performance and financial status of each; and

c) provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme Specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish one or more of the following:

a) Lead Commissioning Arrangements;

b) Integrated Commissioning;

c) Joint (Aligned) Commissioning

d) the establishment of one or more Pooled Funds

in relation to Individual Schemes (the "Flexibilities").

From the Commencement Date, the Partners agree to establish a Pooled Fund for the Services.

4.2 Where the Partners agree pursuant to a variation (in accordance with clause 30), each CCG delegates to the Council and the Council agrees to exercise on each CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4.3 Where the Partners agree pursuant to a variation (in accordance with clause 30), the Council shall delegate to one or more CCG and each such CCG agrees to exercise on the Council's behalf the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such functions as shall be agreed from time to time by the Partners.

5.3 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be in the form set out in Schedule 1 shall be shall be completed and agreed between the Partners. The initial scheme specification is set out in schedule 1 part 2

5.4 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.5 The introduction of any Individual Scheme will be subject to business case approval by and the Steering Group and Health and Wellbeing Board.

6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

The following provisions 6.1 to 6.6 shall apply where the Partners agree unanimously that there is Integrated Commissioning in respect of an Individual Scheme:

6.1 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme, the relevant Partners (identified within the Scheme Specification) shall work in cooperation and shall endeavour to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

6.2 The Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

6.3 The Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partners Financial Contribution in respect of that particular Service in each Financial Year.

6.4 The Partners shall comply with the arrangements in respect of the Joint (Aligned) Commissioning as set out in the relevant Scheme Specification.

6.5 Each Partner shall keep the other Partners and the Better Care Fund Steering Group regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

6.6 The Steering Group will report back to the Health and Wellbeing Board as required by its Terms of Reference.

Appointment of a Lead Commissioner

The following provision 6.7 shall apply where the Partners agree unanimously a Lead Commissioner arrangement in respect of an Individual Scheme

6.7 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:

a) exercise the relevant delegated functions (either NHS Functions or Health Related Functions) as identified in the relevant Scheme Specification;

b) endeavour to ensure that such functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

c) commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

d) contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

e) comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

f) where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the “Commissioner” and “Co-ordinating Commissioner” with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

g) undertake performance management and contract monitoring of all Service Contracts;

h) make payment of all sums due to a Provider pursuant to the terms of any Services Contract.

i) keep the other Partners and the Steering Group regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as set out in the Scheme Specifications.

7.2 Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 It is agreed that the monies held in a Pooled Fund may only be expended on the following:

a) the Contract Price for the plan schemes as in Schedule 1; and

where agreed by the Partners pursuant to a variation (under clause 30):

b) where any Partner is to be the Provider, the Permitted Budget;

c) Third Party Costs;

d) Default Liability (where agreed pursuant to clause 7.5);

e) Approved Expenditure

(together "Permitted Expenditure").

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner.

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners.

7.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

a) holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

b) providing the financial administrative systems for the Pooled Fund;

c) appointing the Pooled Fund Manager;

d) ensuring that the Pooled Fund Manager complies with its obligations under this Agreement; and

e) making payments from the Pooled Fund in accordance with this Agreement to the Partners and District Councils.

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

a) which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

b) which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager in respect of each Individual Service where there is a Pooled Fund shall have the following duties and responsibilities:

a) the day to day operation and management of the Pooled Fund;

b) ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

c) maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

d) ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

e) reporting to the Steering Group as required by the Steering Group and the relevant Scheme Specification;

f) ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

g) preparing and submitting to the Steering Group Quarterly reports (or more frequent reports if required by the Steering Group) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Steering Group to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

h) preparing and submitting reports to the Health and Wellbeing Board as required by it.

8.3 In carrying out their responsibilities as provided under Clause 8.2 the Pooled Fund Manager shall have regard to the recommendations of the Steering Group and shall be accountable to the Partners.

8.4 The Steering Group may agree to the viring of funds between Pooled Funds.

8.5 Save where expressly stated in a Scheme Specification, nothing in this Agreement shall make the Host Partner or Pooled Fund Manager responsible for:

a) the management of any Service Contracts (save those to which it is a direct contracting party);

b) the payment of (or receipt of) any additional monies under Service Contracts.

8.6 Each Partner shall be responsible for the management of the Service Contracts to which it is a party and its actions or inactions in respect of such Service Contracts (unless agreed otherwise in a Scheme Specification).

8.7 No Partner shall incur additional costs in respect of its Service Contracts unless:

a) it proposes to fund such costs directly from its own budget; or

b) it has the prior unanimous agreement of all Partners that such costs may be drawn from the Pooled Fund as Approved Expenditure.

9 NON POOLED FUNDS

The following provisions of clause 9 shall apply where the Partners agree Non Pooled Funds in respect of an Individual Scheme:

9.1 Any Financial Contributions agreed to be held within a Non Pooled Fund will be notionally held in a fund established for the purpose of commissioning that Service as set out in the relevant Scheme Specification. For the avoidance of doubt, a Non Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Partnership Regulations.

9.2 When introducing a Non Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

a) which Partner if any shall host the Non-Pooled Fund

b) how and when Financial Contributions shall be made to the Non-Pooled Fund.

9.3 The Host Partner will be responsible for establishing the financial and administrative support necessary to enable the effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.

9.4 The Partners shall ensure that Services commissioned using a Non Pooled Fund are commissioned solely in accordance with the relevant Scheme Specification.

9.5 Where there are Joint (Aligned) Commissioning arrangements, both Partners shall work in cooperation and shall endeavour to ensure that:

a) the NHS Functions funded from a Non-Pooled Fund are carried out within the CCG Financial Contribution to the Non- Pooled Fund for the relevant Service in each Financial Year; and

b) the Health Related Functions funded from a Non-Pooled Fund are carried out within the Council's Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year.

10 FINANCIAL CONTRIBUTIONS

10.1 The Financial Contribution of each CCG and the Council to any Pooled Fund or (where relevant) Non-Pooled Fund for the first Financial Year of operation of each Individual Scheme shall be as set out in the relevant Scheme Specification. Where this Agreement is extended (as agreed by the Steering Group in accordance with clause 2) the Partners shall agree at Steering Group any revisions to the Financial Contributions.

10.2 Each CCGs Financial Contribution shall be determined by the Unit of Planning to which it belongs.

10.3 The Partners shall each pay their Financial Contributions as set out in each Scheme Specification.

10.4 With the exception of Clause 13, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Steering Group minutes and recorded in the budget statement as a separate item.

11 NON FINANCIAL CONTRIBUTIONS

11.1 The Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of Service Contracts and the Pooled Fund).

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The Partners have agreed risk share arrangements as set out in schedule 3, which provide for financial risks arising within the commissioning of services from the Pooled Funds.

Overspends in Pooled Fund

12.2 The Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

12.3 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Steering Group in accordance with Clause 12.4.

12.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Steering Group is informed as soon as reasonably possible and the provisions of the relevant Scheme Specification and Schedule 3 shall apply.

Overspends in Non Pooled Funds

The following provisions 12.5 and 12.6 shall apply where the Partners agree that there is a Non Pooled Fund in respect of an Individual Scheme:

12.5 Where in Joint (Aligned) Commissioning Arrangements any Partner forecasts an overspend in relation to a Partners Financial Contribution to a Non-Pooled Fund that Partner shall as soon as reasonably practicable inform the other Partners and the Steering Group.

12.6 Where there is a Lead Commissioning Arrangement the Lead Commissioner is responsible for the management of the Non-Pooled Fund. The Lead Commissioner shall as soon as reasonably practicable inform the other Partners and the Steering Group.

Underspend

12.7 In the event that expenditure from any Pooled Fund or Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the process set out in Schedule 3 shall apply.

13 CAPITAL EXPENDITURE

Neither Pooled Funds or Non Pooled Funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

14 VAT

The Partners shall agree the treatment of the Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the Audit Commission to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998.

15.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Subject to Clause 16.2, and 16.3, if a Partner (“First Partner”) incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner (“Other Partner”) which constitutes negligence, fraud or a breach of contract in

relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Steering Group.

16.3 If any third party makes a claim or intimates an intention to make a claim against a Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Partner that may claim against the other indemnifying Partner will:

a) as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

b) not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

c) give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

16.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

16.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective standing orders and standing financial instructions).

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

17.3 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

17.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

18 CONFLICTS OF INTEREST

The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in schedule 7.

19 GOVERNANCE

19.1 Overall strategic oversight of partnership working between the Partners is vested in the Health and Wellbeing Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

19.2 The Partners have established a Steering Group to provide system leadership to ensure delivery of the Better Care Fund Plan to improve outcomes for the people of Nottinghamshire.

19.3 The Steering Group is based on a joint working group structure. Each member of the Steering Group shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them and their unit of planning to make decisions which enable the Steering Group to carry out its objects, roles, duties and functions as set out in this Clause 19 and Schedule 2.

19.4 The terms of reference of the Steering Group are set out in Schedule 2.

19.5 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

19.6 The Steering Group shall be responsible for the overall approval of the Individual Services, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

19.7 Each Services Schedule shall confirm the governance arrangements in respect of the Individual Service and how that Individual Services is reported to the Steering Group and Health and Wellbeing Board.

20 REVIEW

20.1 Save where the Steering Group agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any Pooled Fund (and where relevant Non Pooled Fund), and the provision of the Services within 3 Months of the end of each Financial Year.

20.2 Subject to any variations to this process required by the Steering Group, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.

20.3 The Partners shall within 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 20. A copy of this report shall be provided to the Steering Group.

20.4 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

21 COMPLAINTS

21.1 The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by any Partner giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

22.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.

22.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

22.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of Clauses 1, 15, 16, 22.6, 23, 25, 26, 28, 29 and 39.

22.5 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users. Such transition activity may include the agreement of further contracts pursuant to s75 of the 2006 Act.

22.6 Upon termination of this Agreement for any reason whatsoever the following shall apply:

a) the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to Service Users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

b) where a Partner has entered into a Service Contract which continues after the termination of this Agreement, the relevant Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

c) the Lead Commissioner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Commissioner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

d) where a Service Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

e) the Steering Group shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

f) Termination of this Agreement shall have no effect on the liability of any rights or remedies of any Partner already accrued, prior to the date upon which such termination takes effect.

22.7 In the event of termination in relation to an Individual Scheme the provisions of Clause 22.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Partners arising out of this Agreement, a Partner may serve written notice of the dispute on the other relevant Partner, setting out full details of the dispute.

23.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Partners' respective chief executives and chief officers or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, a Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.5 Nothing in the procedure set out in this Clause 23 shall in any way affect a Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 The Partners shall not be entitled to bring a claim for a breach of obligations under this Agreement by another Partner or incur any liability to another Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partners as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

a) the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

b) the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

a) may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

b) will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

c) shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Act to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

27 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING

The Partners will follow the Information Governance Protocol set out in schedule 8, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 1998 Act**.**

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partners in writing. A notice shall be deemed to have been served if:

a) personally delivered, at the time of delivery;

b) posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

c) if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

a) if to the Council, addressed to the Chief Executive,

Address: Chief Executive's Office
County Hall
West Bridgford
Nottingham
NG2 7QP
Tel: 0115 9773582
Email: chief.exec@nottscc.gov.uk

and

b) if to a CCG, addressed to:

CCG	Accountable Officer	Telephone	Email
NHS Bassetlaw CCG Retford Hospital North Road Retford Nottinghamshire DN22 7XF	Idris Griffiths	01777 274400	idris.griffiths@nhs.net
NHS Mansfield and Ashfield CCG Hawthorn House Ransom Wood Business Park Southwell Road West Rainworth Mansfield Nottinghamshire NG21 0HJ	Amanda Sullivan	0300 300 1234	amanda.sullivan7@nhs.net
NHS Newark and Sherwood CCG Balderton Primary Care Centre Lowfield Lane Balderton Nottinghamshire NG24 3HJ	Amanda Sullivan	0300 300 1234	amanda.sullivan7@nhs.net
NHS Nottingham North and East CCG Civic Centre Arnot Hill Park	Amanda Sullivan	0300 300 1234	amanda.sullivan7@nhs.net

Arnold Nottingham NG5 6LU			
NHS Nottingham West CCG Stapleford Care Centre Church Street Nottingham NG9 8DB	Amanda Sullivan	0300 300 1234	amanda.sullivan7@nhs.net
NHS Rushcliffe CCG Easthorpe House 165 Loughborough Road Ruddington Nottingham NG11 6LQ	Amanda Sullivan	0300 300 1234	amanda.sullivan7@nhs.net

30 VARIATION

No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render a Partner directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, no Partner will have authority to, or hold itself out as having authority to:

a) act as an agent of the other;

b) make any representations or give any warranties to third parties on behalf of or in respect of the other; or

c) bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

THE CORPORATE SEAL of THE
COUNCIL OF NOTTINGHAMSHIRE
was hereunto affixed in the presence of:

Signed for on behalf of:
NHS Bassetlaw Clinical Commissioning Group

_____

Idris Griffiths
Authorised Signatory

Signed for on behalf of:-
NHS Mansfield and Ashfield Clinical Commissioning Group
NHS Newark and Sherwood Clinical Commissioning Group
NHS Nottingham North and East Clinical Commissioning Group
NHS Nottingham West Clinical Commissioning Group
NHS Rushcliffe Clinical Commissioning Group

Amanda Sullivan
Authorised Signatory

SCHEDULE 1 – SCHEME SPECIFICATION

SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF SERVICES AND FINANCIAL CONTRIBUTIONS

Scheme	Bassetlaw £	Mansfield and Ashfield £	Newark and Sherwood £	Nottingham North and East £	Nottingham West £	Rushcliffe £	Nottinghamshire County Council £	Total £
A. Seven Day Working				£303,139	£205,346	£225,457		**£733,942**
B. Delayed Transfers of Care				£2,541,521	£1,119,642	£1,929,818		**£5,590,981**
C. Reducing non-elective admissions				£2,789,429	£2,236,537	£2,123,031		**£7,148,997**
D. Support to social care				£116,108	£73,074	£78,614		**£267,796**
E. Enabling				£173,592	£115,375	£135,486		**£424,453**
F. Proactive care (community based)		£7,664,898	£4,996,353					**£12,661,251**
G. Patient and carer support		£165,415	£106,782					**£272,197**
H. Better Together Implementation Support		£254,865	£170,047					**£424,912**
I. 7 day access to services	£753,567							**£753,567**
J. Mental Health Liaison	£440,777							**£440,777**
K. Discharge / Assessment incl. Intermediate Care	£3,107,780							**£3,107,780**
L. Respite services	£21,000							**£21,000**
M. Improving Care Home quality	£75,000							**£75,000**
N. Telehealth	£455,610							**£455,610**
O. Support for carers	£240,640	£305,717	£197,344	£226,999	£142,533	£164,705		**£1,268,544**
P. Protecting social care	£2,429,216	£4,152,072	£2,510,121	£3,223,378	£2,463,197	£2,422,021		**£17,057,413**
Q. Disabled Facilities							£6,441,437	**£6,441,437**

Scheme	Bassetlaw £	Mansfield and Ashfield £	Newark and Sherwood £	Nottingham North and East £	Nottingham West £	Rushcliffe £	Nottinghamshire County Council £	Total £
Grant								
R. Care Act Implementation	£312,209	£515,645	£320,370	£385,370	£259,728	£284,012		**£2,060,996**
S. Improved Better Care Fund							£21,590,371	**£21,590,371**
Total	**£7,835,799**	**£13,058,612**	**£8,301,017**	**£9,759,536**	**£6,615,432**	**£7,363,144**	**£28,031,808**	**£80,547,908**

The Host Partner for the Pooled Funds detailed in the table above is Nottinghamshire County Council and the Pooled Fund Manager, being an officer of the Host Partner is the Service Director of Finance and Procurement.

2 COMMISSIONING, VARIATION AND TERMINATION

2.1 The Partners may terminate their respective Service Contracts in accordance with the term and termination clauses included in that Service Contract.

2.2 The relevant Partner shall inform the Pooled Fund Manager (in writing) of the termination or variation of a Service Contract at the same time as the Provider.

2.3 In the event of a Service Contract termination, the relevant Partner shall be responsible for identifying further schemes to ensure the Better Care Fund Plan is delivered and the minimum contribution to the Pooled Fund is delivered subject to Clause 5.5.

3 FINANCIAL GOVERNANCE ARRANGEMENTS

3.1 The Partners shall establish their Financial Contribution at the commencement of the Financial Year. The overall level of contributions into the Pooled Fund may be increased to reflect service developments or decreased to reflect budgetary pressures. Any material requests to vary the Pooled Fund will need to be recommended and formally recorded by the Steering Group for recommendation and approval by the Health and Wellbeing Board, in accordance with the terms of this Agreement and the constitutional and financial regulations of each of the Partners.

3.2 The Partners shall endeavour to maintain expenditure against the Pooled Fund in line with their agreed contribution levels for the Financial Year. Where expenditure against contribution is exceeded by any Partner then the conditions specified in Schedule 3 will apply.

3.3 Each CCG agrees that Financial Contributions must remain at or above the minimum contribution level for each Unit of Planning.

3.6 Any underspends at year end may (subject to each organisation's standing orders and standing financial instructions) be carried over into the next years Pooled Fund subject to the formal request from the responsible commissioning organisation and as agreed and recorded by Partners at the Steering Group.

3.7 The Pooled Fund Manager shall have delegated authority to transfer budget between schemes provided that:
3.7.1 in respect of the CCGs, a formal request has been received from the relevant Chief Finance Officers; or
3.7.2 in respect of the Council, a formal request has been received from the Director of Adult Social Care, Health and Public Protection
For schemes jointly funded by a CCG(s) and the Council, approval from both responsible commissioning organisations is required.

3.8 The Pooled Fund Manager is not authorised to overspend within a month. Where the commissioning organisation as identified in each Scheme Specification seeks to spend more money than is contained in the Pooled Fund for that Scheme then it shall, unless all the Partners agree otherwise, be responsible for the additional contributions to the Pooled Fund which must be made by the responsible commissioning organisation prior to the payment being made from the Pooled Fund.

3.9 The process for managing overspends and underspends at Financial Year end or on termination or expiry of the agreement is in Schedule 3.

4 Management reporting to partner organisations

All Partners shall provide monthly management information as required by the BCF Finance, Planning and Performance Subgroup and the Steering Group. The Partners shall present quarterly information to the Health and Wellbeing Board. The format of reporting is set out in Schedule 5.

5 VAT

The VAT regime of the organisation making the payment to the Provider(s) will apply for each scheme.

6. GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

6.1 Each Partner shall be responsible for reviewing the delivery of the schemes to which it is a party.

6.2 The Partners shall report scheme delivery and impact upon performance metrics on a monthly basis to the BCF Finance, Planning and Performance Subgroup and escalated monthly on an exception basis to the Steering Group if there is significant risk to the ongoing delivery of the scheme. The Steering Group will escalate on an exception basis quarterly to the Health and Wellbeing Board where there is a significant risk to delivery of the Better Care Fund Plan in accordance with the BCF Terms of Reference in Schedule 2.

7. LEAD OFFICERS

Partner	Lead Officer	Lead Finance Officer	Address	Telephone Number	Email Address
Nottinghamshire County Council	Melanie Brooks Corporate Director Adult Social Care and Health	Nigel Stevenson Service Director of Finance and Procurement	County Hall West Bridgford Nottingham NG2 7QP	0115 8043928	melanie.brooks@nottscc.gov.uk Nigel.stevenson@nottscc.gov.uk
Bassetlaw CCG	Idris Griffiths Chief Operating Officer	Therese Paskell Chief Finance Officer	Retford Hospital North Road Retford Nottinghamshire DN22 7XF	01777 274400	idris.griffiths@nhs.net therese.paskell@nhs.net
Mansfield and Ashfield CCG	Amanda Sullivan Chief Officer	Mick Cawley Chief Finance Officer	Hawthorn House Ransom Wood Business Park Southwell Road West Mansfield Nottinghamshire NG21 0HJ	01623 673232	amanda.sullivan7@nhs.net
Newark and Sherwood CCG	Amanda Sullivan Chief Officer	Mick Cawley Chief Finance Officer	Hawthorn House Ransom Wood Business Park Southwell Road West Mansfield Nottinghamshire NG21 0HJ	01623 673232	amanda.sullivan7@nhs.net
Nottingham North and East CCG	Amanda Sullivan Chief Officer	Jonathan Bemrose Director of Finance	Civic Centre Arnot Hill Park Arnold	01623 673232	amanda.sullivan7@nhs.net Jonathan.bemrose@nhs.net

Partner	Lead Officer	Lead Finance Officer	Address	Telephone Number	Email Address
			Nottingham NG5 6LU		
Nottingham West CCG	Amanda Sullivan Chief Officer	Jonathan Bemrose Director of Finance	Stapleford Care Centre Church Street Stapleford Nottingham NG9 8DB	01623 673232	amanda.sullivan7@nhs.net Jonathan.bemrose@nhs.net
Rushcliffe CCG	Amanda Sullivan Chief Officer	Jonathan Bemrose Director of Finance	Easthorpe House 165 Loughborough Road Ruddington Nottingham NG11 6LQ	01623 673232	amanda.sullivan7@nhs.net Jonathan.bemrose@nhs.net

8. INTERNAL APPROVALS

Each Partner's own scheme of delegation will apply.

9. NOT USED

10. Non-financial contributions

Council contribution

	Details	Charging arrangements	Comments
Premises	Desk space	None	Hot desk provision for Programme Manager (3 days per week)
Premises	Meeting rooms	None	Use of meeting rooms for BCF meetings.
Assets and equipment	Computer and phone	None	Access to computer and landline phone for Programme

	Details	Charging arrangements	Comments
			Manager when hot-desking on Council premises.
Human resources	Finance staff	None	Council will incur resource utilisation of finance staff through hosting/administering the pooled budget.
Human resources	BCF Lead	None	One day per week for BCF programme activities including supervision of Programme Manager

CCG Contribution

Each CCG shall contribute:

	Details	Charging arrangements	Comments
Premises	Desk space	None	Hot desk provision for Programme Manager (2 days per week) at any CCG location
Premises	Meeting rooms	None	Use of meeting rooms for BCF meetings.

PART 2 – AGREED SCHEME SPECIFICATIONS

The scheme specifications are contained within the Nottinghamshire Better Care Fund plan which can be found on the Nottinghamshire County Council website http://www.nottinghamshire.gov.uk/caring/yourhealth/developing-health-services/health-and-wellbeing-board/bettercarefund/

SCHEDULE 2 – GOVERNANCE

The governance arrangements for monitoring delivery of the Better Care Fund, including the Pooled Fund, are set out within the terms of reference.

Terms of Reference
BCF Programme Stee

SCHEDULE 3 – RISK SHARE, OVERSPENDS AND UNDERSPENDS

Pooled Fund Management

1 The Partners shall report to the Steering Group on planned and actual expenditure and savings per scheme on a monthly basis. Mitigating actions will be agreed by the Council or relevant Unit of Planning and documented in the finance and performance report approved by the Steering Group. Over and under spends against the Better Care Fund Plan shall be reconciled by the Host Partner on a quarterly basis.

Overspend

2 The Partners agree that Overspends shall be apportioned in accordance with this Schedule 3.

3 The Partners shall manage Overspends at an organisation or Unit of Planning level, and escalate these to the Steering Group if the value exceeds that which can be managed within the organisation or relevant Unit of Planning. If the Steering Group is unable to reach agreement on managing the Overspend this will be escalated to the Health and Wellbeing Board for agreement. Each Unit of Planning has an established contingency to manage Overspends. For the purpose of the Pooled Fund, expenditure on Protecting Social Care Services, Disabled Facilities Grants, Social Care Capital and Care Act Implementation shall remain within the financial allocation as detailed in Schedule 1. All material changes to scheme funding shall be reported by the relevant Partner / Unit of Planning to the Health and Wellbeing Board.

4 The Steering Group shall acting reasonably having taken into consideration all relevant factors including, where appropriate, the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints agree appropriate action in relation to Overspends which may include the following:

4.1 any action that can be taken in order to contain expenditure;

4.2 whether there are any Underspends that can be vired from any another fund in the Unit of Planning or Council maintained under this Agreement;

4.3 how any Overspend shall be apportioned between the CCGs within a Unit of Planning, such apportionment to be just and equitable taking into consideration all relevant factors.

5 The Partners agree to co-operate fully in order to establish an agreed position in relation to any Overspends.

6 Subject to any continuing obligations under any Service Contract entered into by each Partner, the relevant Partner may give notice to terminate a Service Contract or Individual Scheme where the Service Contract provides. Notwithstanding such termination, the relevant Partner shall be required to maintain its minimum contribution to the Pooled Fund subject to clause 5.5.

Underspend

7 The Partners shall manage Underspends at an organisation or Unit of Planning level, and may be transferred to alternative schemes within the Pooled Fund subject to approval from the contributing partner's local decision making bodies as stated in Schedule 1.

8 Where there is an Underspend at the end of the Financial Year or at termination of the Agreement such underspend shall be managed by the Partner whose Financial Contributions to the Pooled Fund were intended to meet the expenditure to which the Underspend relates. In cases other than termination, Underspends may be carried forward to the subsequent Financial Year subject to approval from the relevant Partner's local decision making body.

SCHEDULE 4– NOT USED

SCHEDULE 5 – PERFORMANCE ARRANGEMENTS

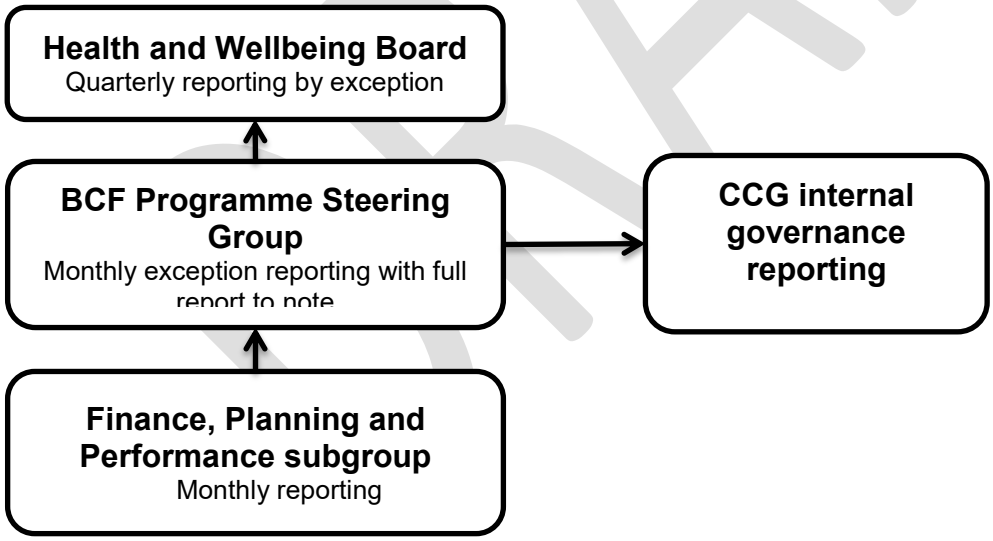
Performance metrics

There are six metrics for monitoring the delivery of the Better Care Fund Plan:

Ref.	Metric
BCF1	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population
BCF2	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
BCF3	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
BCF4	Delayed transfers of care (delayed days) from hospital per 100,000 population
BCF5	Patient / Service User experience: • Disabled Facilities Grants • GP Patient Survey • Friends and Family Test •
BCF6	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes directly from a hospital setting per 100 admissions of older people (aged 65 and over) to residential and nursing care homes

Performance reporting

A governance structure is in place for monthly reporting of delivery of the BCF Plan against performance metrics, scheme delivery, risk register and financial expenditure and savings as shown in the diagram below:



Monthly and quarterly performance monitoring will take place in accordance with the BCF memorandum of understanding below.

20150223 BCF Memorandum of unde

A quarterly report will be submitted to the Health and Wellbeing Board in accordance with national guidance.

SCHEDULE 6 – BETTER CARE FUND PLAN

The Nottinghamshire Better Care Fund plan can be found on the Nottinghamshire County Council website http://www.nottinghamshire.gov.uk/caring/yourhealth/developing-health-services/health-and-wellbeing-board/bettercarefund/

SCHEDULE 7 – POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

Nottinghamshire County Council's Code of Conduct shall apply to all County Councillors and co-opted members. CCG policies will apply to their employees and members.


Bassetlaw.pdf


Mid notts.pdf


NCC.pdf


NW.pdf

SCHEDULE 8 – INFORMATION GOVERNANCE PROTOCOL

Information governance will be conducted in accordance with the Notts Information Sharing protocol attached below.

Information Sharing Protocol.pd

SCHEDULE 9 – PAYMENT PROTOCOL

1. Payments into the Pooled Fund are set out in the payment schedule attached below and will be initiated by BACS transfer on the first working day of the month by the Partners.

2. The Host Partner shall arrange for the transfer of money into the relevant Partner account by BACS transfer on the fourth working day of the month as shown in the payment schedule below.

3. Each Partner shall be responsible for the payments to Providers contracted to deliver the services as set out in Schedule 1.

4. A quarterly reconciliation meeting will be held by the Finance Planning and Performance Sub Group to reconcile monthly planned payments with actual payments with the balance being paid back into the Pooled Fund (such balance may include any Service Credits received). Payments into the pool will be adjusted to take account of any underspend (in accordance with paragraph 9 and 10 of Schedule 3).

5. Each Partner shall have the right to impose a fine for late payment in accordance with paragraphs 6 and 7 below.

6. For the purposes of this agreement the Council may fine individual CCGs for late payments net of the contribution to be paid to the late paying CCG. The fine will be levied at the LIBID (London Interbank Bid rate) of the day(s) payment is overdue plus 1% for each day of late payment.

7. Individual CCGs may fine the Council for late payments of the due amount specified in the payment schedule below. The fine will be levied at the LIBID (London Interbank Bid rate) of the day(s) payment is overdue plus 1% for each day of late payment.

2018/19 Better Care Fund Payment Profile

Contributing partner	Annual Contribution £	Protecting Social Services £	Carers £	Care Act Implementation £	Annual Payment to NCC £	Net Monthly Payment to NCC £
NHS Bassetlaw	£7,835,799	£2,429,216	£240,640	£312,209	£2,982,065	£248,505
NHS Mansfield and Ashfield	£13,058,612	£4,152,072	£305,717	£515,645	£4,973,434	£414,453
NHS Newark and Sherwood	£8,301,017	£2,510,121	£197,344	£320,370	£3,027,835	£252,320
NHS Nottingham North and East	£9,587,911	£3,166,694	£223,007	£378,593	£3,768,294	£314,025
NHS Nottingham West	£6,499,099	£2,419,881	£140,027	£255,161	£2,815,069	£234,589
NHS Rushcliffe	£7,233,662	£2,379,429	£161,809	£279,018	£2,820,256	£235,021
Nottinghamshire County Council	£6,441,437	£0	£0	£0		
Nottinghamshire County Council	£21,590,371	£0	£0	£0		
Total	**£80,547,908**	**£17,057,413**	**£1,268,544**	**£2,060,996**	**£20,386,953**	**£1,698,913**

NHS
Nottingham North and East
Clinical Commissioning Group

Meeting Title:	Open Session Governing Body			**Date:** 16 April 2019					
Paper Title:	GNJCC Quarterly Assurance Report			**Paper Reference:** GB/19/039 a					
Sponsor:	Lucy Branson, Corporate Director								
Previous Related Papers:	Regular quarterly report, first received July 2018.								
Recommendation:	Approve	☐	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒	
Summary Purpose of Paper:	The Greater Nottingham Joint Commissioning Committee (GNJCC) is required to make quarterly written reports to the Governing Bodies of the Greater Nottingham CCGs to provide assurance that it is effectively discharging its delegated responsibilities. This is the fourth quarterly report, which has been developed in line with the GNJCC's terms of reference, and describes the work of the GNJCC during the fourth quarter of 2018/19. This and future reports will incorporate standing assurances in relation to quality, performance, finance and risk, along with assurances on strategy development and delivery and key commissioning decisions.								

If paper is for Approval/Endorsement, have the following impact assessments been completed?			
Equality / Quality Impact Assessment	Yes ☐ No ☐ N/A ☒	Data Protection Impact Assessment	Yes ☐ No ☐ N/A ☒

Conflicts of Interest: Please consider whether there are any conflicts of interest considerations relevant to either paper authors, meeting members or attendees.

☒ 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
☐ Conflicted party to be excluded from meeting

Have All Relevant Implications Been Considered? *(please tick where relevant)*

Clinical Engagement	☒	Patient and Public Involvement	☒
Quality Improvement	☒	Equality, Diversity and Human Rights	☒
Integration	☒	Innovation / Research	☒
Improving Health Outcomes / Reducing Health Inequalities	☒	Patient Choice / Shared Decision Making	☒

Financial Management	☒	Corporate Governance	☐
Is the Information in this paper confidential? Yes ☐ No ☒ **If yes, please state reason why:**			
Risk: *(briefly explain any risks associated with the paper*)	As detailed within the report.		
Recommendation:	The Governing Body is asked to: • **RECEIVE:** The Quarterly Assurance Report from the GNJCC and feedback on any additional requirements for future reports.		

NHS
Greater Nottingham
Clinical Commissioning Partnership

Greater Nottingham Joint Commissioning Committee

Quarterly Assurance Report

April 2019

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Foreword

I am pleased to present the last quarterly assurance report for 2018/19 from the Greater Nottingham Joint Commissioning Committee (GNJCC). The GNJCC has met three times since the last quarterly update, on 30 January 2019, 27 February 2019 and 27 March 2019.

The current membership of the GNJCC is set out at **Appendix A**, along with each member's attendance at meetings to date. The Greater Nottingham Clinical Commissioning Partnership Governance Structure and its Annual Work Programme for 2018/19 are provided for information at **Appendix B** and **Appendix C** respectively.

Links to GNJCC papers will continue to be sent to all Governing Body members prior to each meeting. Full papers packs can also be accessed here: http://www.rushcliffeccg.nhs.uk/your-ccg/joint-commissioning-committee/.

I welcome any observations or questions that you may have in relation to the work of the GNJCC or the content of this report, and I can be contacted via the following email address for this purpose: ncccg.committees@nhs.net.

Jenny Myers

Independent Chair, Greater Nottingham Joint Commissioning Committee

1. Introduction

The Greater Nottingham Joint Commissioning Committee (GNJCC) is required to make quarterly written reports to the Governing Bodies of the Greater Nottingham CCGs to provide assurance that it is effectively discharging its delegated responsibilities.

This report has been developed in line with the GNJCC's terms of reference, and describes the work of the GNJCC during the last quarter of 2018/19. The reports include standing assurances in relation to quality, performance, finance and risk, along with assurances on strategy development and delivery and key commissioning decisions.

2. Strategy and leadership

The GNJCC has delegated responsibility for:

- Developing an aligned vision, values and set of strategic objectives for the Greater Nottingham CCGs, recognising each CCG's specific local needs, and recommending these for approval by the Greater Nottingham CCGs' Governing Bodies.
- Developing the Commissioning Strategies and Operational Plans (and other associated enabling strategies and plans) of the Greater Nottingham CCGs, aligning these where relevant, and recommending them for approval by the Greater Nottingham CCGs' Governing Bodies. The enabling strategies and plans will include, but not be limited to, those relating to information technology, estates, workforce and organisational development, patient and public engagement and communications.
- Overseeing and managing delivery of approved strategies and plans, recommending variations for approval, as required.
- Making decisions on the services that should be commissioned for the population of the Greater Nottingham Area, in line with approved strategies and plans, and arranging for the commissioning of these services.

The following sections summarise the work of the GNJCC relevant to the above during its January, February and March 2019 meetings.

Appendix D summarises the work of the GNJCC's Clinical Commissioning Executive Group.

2.1 Thematic reviews

A programme of thematic reviews is included within the GNJCC's Work Programme that focus on a range of commissioning priority areas, aligned to the Greater Nottingham CCGs' Commissioning Strategies and Operational Plans. The reports update on key deliverables within the Operational Plan and other relevant strategies/plans, highlighting key achievements and challenges, any quality concerns and actions being taken, where relevant.

There have been three thematic reviews during the last quarter, as summarised at 2.1.1, 2.1.2 and 2.1.3 below.

2.1.1 Cancer:

Highlights from the review:

- The review focussed on the delivery of the cancer section of the Greater Nottingham Clinical Commissioning Partnership Operational Plan (Operational Plan) and delivery against national standards and targets. It was confirmed that relevant processes and metrics are in place to deliver the key performance targets, with mitigating actions in place where there are risks to delivery.
- Greater Nottingham is achieving all cancer constitutional standards apart from the 62 day referral to treatment target, both for Nottingham University Hospitals and Greater Nottingham CCGs (combined).
- Transformational funds have been secured from the East Midlands Cancer Alliance in 2018/19 (£1.5m) to implement nationally agreed rapid cancer diagnostic and assessment pathways at both Nottingham University Hospitals and Sherwood Forest Hospitals. These pathways will have a positive impact on 62 day performance in 19/20 and prepare the system for implementation of the new 28 day referral to diagnosis standard due to go live in 2020/21.
- A local cancer strategy has been developed by the Integrated Care System (ICS) Cancer Workstream. Progress reports are produced on a monthly basis at a Mid Nottinghamshire and Greater Nottingham level and are monitored by the ICS Programme Board and a Joint Cancer Alliance, NHS England and NHS Improvement Cancer Board.

Successes, Issues, Risks and Mitigations:

- In September 2018, NHS England published the latest Clinical Commissioning Group Improvement and Assessment Framework for Cancer (CCG IAF) 2017/18. The assessment covers four domains related to early diagnosis, waiting times, survival rates and patient experience. For the Greater Nottingham CCGs, one CCG was rated as outstanding (Rushcliffe CCG), two as good (Nottingham North and East CCG and Nottingham West CCG) and one as requiring improvement (Nottingham City CCG). Using part- year data, the assessment has been updated locally to show that all of the Greater Nottingham CCGs are now rated as good. The final year ratings are still subject to change.
- A key national outcome measure included in the CCG IAF is one year survival for all cancers. The national target is to achieve 75% one year survival by 2020/21. All CCGs are similar to the national average and forecast to achieve the 2020/21 target, with the exception of NHS Nottingham City CCG. A programme of work to improve early diagnosis and therefore, one year survival, across Greater Nottingham is in place.

2.1.2 Mental Health:

Highlights from the review:

- The review focussed on the delivery of Mental Health across Greater Nottingham in line with the Operational Plan against national standards and targets.
- A broad range of mental health services are commissioned by the CCGs for the population of Greater Nottingham including: Children and Young People's Crisis and Eating Disorder Services, Increasing Access to Psychological Therapies (IAPT/Talking therapies), Psychiatric Intensive Care Units and Locked Rehabilitation. The majority of services are commissioned from Nottinghamshire Healthcare NHS Foundation Trust (NHT).
- A key driver for commissioners and providers has been to work towards achieving the nine standards outlined in Mental Health Five Year Forward View, published in 2016. Since the

publication of the Mental Health Five Year Forward View, improving mental health has increased in prominence as a national priority.

- The NHS Long Term Plan, published on 7 January 2019, has identified a further five ambitions for mental health up to 2023/24.
- During 2018, an 'All Age Integrated Mental Health and Social Care Strategy' was drafted, with CCG members involved in its development. Workstreams identified within the strategy are accountable to the Integrated ICS Mental Health and Social Care Partnership Board. Once the strategy is finalised, the board will drive the agreement and implementation of actions to deliver the strategic objectives.
- Following the publication of '*Future in Mind – Promotion, protecting and improving our children and young people's mental health and wellbeing'* in 2015, CCGs were required to coordinate and oversee implementation of a system-wide Local Transformation Plan (LTP) to improve children and young people's emotional and mental health. The plan was updated in October 2018 and published on CCG and partner websites.

Successes, Issues, Risks and Mitigations:

- Performance against national standards and the Operational Plan has improved in a number of areas; however, this continues to be an area of focus.
- The number of people in treatment for drug and alcohol misuse is rising in NHS Nottingham City for all substances, but falling steadily in the wider County; demonstrating the distinct social differences between the areas.
- There are service development improvement plans, which are ICS partner recovery action plans, in place for:
    - Children and Young People's Mental Health and Wellbeing
    - Increasing Access to Psychological Therapies
    - Early Intervention in Psychosis
    - Out of Area Placements and Urgent Care, which incorporates psychiatric liaison and crisis resolution and home treatment
    - Physical Health and Severe Mental Illness

  Bi- monthly assurance meetings have been established with NHS England (NHSE). In addition, where actions are provider specific, the plans are performance managed through the formal contract governance structure and process.
- As part of agreeing the 2019/20 contract with NFT, a process of re-specification and prioritisation of services is being undertaken; ensuring services are modelled and resourced to meet local need and national standards for mental health services within the existing financial envelope.

2.1.3 Transforming Care – Learning Disabilities :

Highlights from the review:

- The review focussed on the delivery of Transforming Care – Learning Disabilities (LD) across Greater Nottingham, in line with the Operational Plan, against national standards and targets and to provide assurance on the work being undertaken to deliver the local Transformation Care Programme (TCP) against the nationally agreed inpatient targets.
- National reports from 2012 and 2015 highlighted that there is more that needs to be done to improve the care and services available to people with learning disabilities and/or autism spectrum disorders.
- In June 2015, five 'fast track' areas were established that would be forerunners for the transformation of services for people with a LD and/or autism and challenging behaviours, or a

mental health condition. The areas were chosen based on the numbers of in-patient beds they had within the area in order to effective the biggest change. Nottinghamshire (including Bassetlaw) was one of the five areas chosen.

- A national service model was published during October 2015 which included national planning assumptions for redesigning services. 'Building the Right Support' is a national plan to develop community services and reduce the use of inpatient facilities. The assumptions aim to achieve a 45 to 65% reduction of CCG commissioned inpatient capacity and a 25 to 40% reduction of NHSE commissioned capacity.
- Within the TCP there are six workstreams that undertake key deliverables; admissions and prevention, strategic commissioning, operational commissioning, workforce planning and development, integrated care and support and communication and engagement.
- Non-recurrent funding has been received from NHSE during the current year to support the transformation

Successes, Issues, Risks and Mitigations:

- An Operational Committee is in place which oversees the detail of each of the six TCP workstreams. Representatives from all the main local Providers who provide LD and autism services are on the Committee.
- A Service Users and Carers Reference Group is in place to ensure that patient and public feedback and/or consultation is considered as part of the Programme's implementation
- There has been significant reduction in the number of inpatients the CCGs are commissioning during the year (approximately 50% from January 2018 to February 2019). This, in turn, has had a significant impact on social care. NHSE inpatient numbers have remained at similar levels across the year. As at February 2019, NHSE has eleven patients above target.
- There are key challenges contributing to the national targets not being met:
    - The ability of local provides to detail with the complexity and needs of the patient cohort.
    - Lack of staff skills and experience needed to work with the patient cohort, alongside the amount of support registered managers of such services will need.
    - The pressure to meet trajectories. The TCP is working closely with NHSE to ensure there is balance between meeting trajectory targets and trying to ensure that discharges are safe, realistic and sustainable.
    - Market engagement and management; as local partners have observed an increasing lack of community places due to saturation of the local residential and supporting living market.

2.2 European Union (EU) Brexit and Operational Readiness

At its meeting in February 2019, an update was received in relation to CCGs and NHS funded providers giving assurance that preparations were being put in place for a no-deal EU Exit in line with Department of Health and Social Care operational guidance. This involved NHSE undertaking an EU Exit preparedness assurance process to confirm that actions outlined in the guidance had been undertaken.

The CCGs and providers were represented at a NHSE regional EU Exit event, where national NHS EU Exit planning leads outlined the contingencies in place, including maintaining a minimum of six weeks additional supplies of medicines; medical devices and consumables. NHSE has established a regional EU Exit Team which provides CCGs and providers with a direct route to escalate any concerns and request further information. Arrangements were also in place to open a National NHS Operational Response Centre to

ensure there is a coordinated response to any EU Exit related disruptions after the UK left the EU.

Multi-agency coordination continues through the Nottinghamshire Local Resilience Forum (LRF) Brexit Strategic Boards, this includes CCG and provider representation. Weekly reporting to the LRF is ongoing, ensuring all parties are aware of current levels of planning.

2.3 Integrated Care Providers (ICP) Options Assessment Outcome

At a meeting of on 15 February 2019, the ICS Board considered the output of an independent review led by Price Waterhouse Coopers concerning the optimal configuration of ICPs for the Nottingham and Nottinghamshire ICS. A review of the emerging evidence base at the time was provided and it was concluded that there should be three ICPs:

- An ICP for the City of Nottingham
- An ICP for the area of Nottinghamshire covering Broxtowe, Gedling and Rushcliffe
- An ICP for the area of Nottinghamshire covering Ashfield, Mansfield, Newark and Sherwood.

At its meeting in February 2019, the GN JCC confirmed its support for three ICPs in Nottingham and Nottinghamshire. Any comments made by the committee were verbally reported to the ICS Board in March 2019.

2.4 Nottingham and Nottinghamshire Health and Care Integrated Care System (ICS) – System Operational Plan 2019/20

In March 2019 the GN JCC endorsed the Nottingham and Nottinghamshire ICS System Operational Plan for 2019/20.

The purpose of the plan is to provide better, joined up health and social care services for people in Nottingham and Nottinghamshire through closer collaborative working of health and social care system partners (NHS, local government and independent and voluntary sectors). Transformation will be enabled through engagement and consultation with our local population.

This was the culmination of a programme of work led by the ICS and the implementation of a system wide planning approach and regular co-ordinated discussions between providers and commissioners to triangulate plans and related contracts to ensure alignment in activity, income and expenditure and workforce assumptions.

At its meeting in January 2019, the GNJCC received an initial draft of the plan, the Committee's comments and those of other relevant bodies within the ICS were then incorporated. Additional further changes were included based on further triangulation work, planning developments and contract agreements. A further iteration of plan was received at the committee meeting in March which included the latest available information and a summary of changes.

The draft continued to be developed and refined by the ICS Planning Group prior to the final submission date of 11 April 2019.

2.5 Communication and Engagement Strategy

The strategic context for the communications and engagement work of the Integrated Care System (ICS) and the CCGs in Nottingham and Nottinghamshire was outlined at the committee meeting in March 2019. The Team's overarching role is to 'consistently describe the added value the ICS brings – over and above its constituent parts – in delivery more years of health life expectancy for the citizens of Nottingham and Nottinghamshire'.

There are four key aims and objectives to support the achievement of this goal:

- Supporting and celebrating the integrated working with local authorities and other partners.
- Educating and reassuring that there is a plan that protects a taxpayer funded NHS including the role of personal responsibility.
- Enabling staff and stakeholders to understand the work of the Integrated Care System (ICS) and contribute to its development and feedback their views.
- Gathering and championing strategic patient and citizen insights on the health and care services of Nottingham and Nottinghamshire including to support financial sustainability.

Key areas of focus include:

- The need for the engagement structure to be fit for purpose for the CCGs, and wider structures, to ensure that Patient and Public Involvement (PPI) forums are clearly feeding into governance decision making forums at ICS, ICP and Primary Care Network (PCN) level. The challenge will be to continue to involve people during a period of sustained change.
- The launch of the 'What Matters to You' campaign to support NHS Long Term Plan engagement. Existing GP and stakeholder channels will be used to support this campaign. Digital channels will be used to engage at a 'grass roots' level.
- The engagement and consultation work required to support the NHS merger; this includes external stakeholders and internal staff.

Different mechanisms to communicate, in particular, the use of digital and online media are being explored. A video was produced following the March 2019 committee meeting which summarised the key messages from the meeting presented by Dr Sonali Kinra, Independent GP Advisor. It was uploaded to social media (Twitter) and received a positive number of interactions. A link is provided below:
https://twitter.com/NHSNottingham/status/1110126081674219522

3. Quality and performance

The GNJCC has delegated responsibility for a range of quality functions, including the requirement to improve the quality of commissioned services. It also has delegated responsibility for overseeing and managing performance against the standards set out in the NHS Constitution and any other nationally set, or locally agreed, performance indicators.

The GNJCC has established monthly performance reporting requirements and quarterly quality reporting requirements. These reports are scrutinised in detail by the Quality and Performance Committee prior to their presentation.

The following sections summarise the latest quality and performance information received by the GNJCC.

3.1 Quality

The following sections describe the work of the GNJCC and its Quality and Performance Committee during the period January 2019 to March 2019 to ensure the quality of CCG commissioned services.

3.1.1 Quarterly Assurance Framework and Provider Quality Dashboards:

Quarterly Quality Reports are received by the GNJCC and its Quality and Performance Committee. These describe performance against the CCG Improvement and Assessment Framework (IAF) and Quality Premium indicators. The reports also summarise the quality performance of the providers of services commissioned by the CCGs, either as coordinating or associate commissioners.

The following areas are highlighted for information:

- **Accident and Emergency 4 hr Standard:** performance continues to be significantly under both national standard and local trajectory.
- **Cancer RTT:** 62-day performance remains below the 85% standard largely due to the complexity of patients on key pathways (Lung, LGI and Urology) linked to the increases in demand seen during 2018/19. Assurance was provided that clinical harm reviews are being undertaken where patients approach the waiting threshold.
- **Transforming Care:** NHSE commissioned inpatients remain significantly over trajectory and are predicted to be between nine to eleven cases over by year end. CCG are currently one case over and predicted to be on target or one case over by year end. This is of particular concern given that the NHSE commissioned target is almost halved next year. A review of delayed or failed discharges during the year has been undertaken, which identified the importance of supporting new providers to develop capacity and capability to manage complex patients and ensuring that all required steps to ensure a safe discharge have been taken in a timely manner. Fortnightly case review meetings have been established to ensure that there is sufficient grip and focus on discharges.

3.1.2 Equality Quality Impact Assessments (EQIAs):

There has been a continued focus on the Equality Quality Impact Assessment (EQIA) process and the EQIA Log has been updated to include details of all schemes where the EQIA process has been commenced, as well as those that have been completed. The EQIA log will be replaced with a Business Case Register and an EQIA Log which aims to align and integrate the EQIA process within the business case decision making process. This is due to be presented at the next committee meeting in April 2019.

3.1.3 Deep Dives

During quarter four, two deep dives were undertaken to provide additional scrutiny as a result of concerns raised by the committee.

- **Care Homes:** the Quality Team responsible for nursing homes presented an in-depth summary of quality monitoring in nursing homes, including a reactive and proactive approach to Quality Improvement. From April 2019 a new dashboard will support the team and wider stakeholders to quality assure and early identification of concerns
- **NUH Emergency Department Deep Dive**: a deep dive was undertaken jointly by the Quality Team and Urgent Care Team, with the support and cooperation of Nottingham University Hospital Trust (NUH) staff. The report triangulated quantitative and qualitative information, with a view to determining the impact of continued performance below target on the three domains of quality. Whilst a direct correlation could not be made between low levels of performance and quality indicators, it was identified that this undoubtedly increases risk of adverse impact. A number of recommendations for the provider, commissioners and regulators were made, which will now be incorporated into an overarching action plan.

3.1.4 Reports and Updates:

The following report has been received for assurance in relation to compliance with the CCGs' statutory requirements:

- Special Educational Needs and Disability (SEND) Assurance Report: the bi-annual assurance report was received to provide assurance that the CCGs are meeting their responsibilities in relation to the SEND reforms.

3.2 Performance

Appendix E sets out a summarised view of performance against a range of key national indicators. The latest position is shown by CCG as well as from a provider perspective.

There are three areas of performance that remain in formal escalation with NHSE. Children waiting less than 18 weeks for a wheelchair is no longer in escalation.

Actions being taken to address these areas of under-performance are set out in the sections below.

3.2.1 Accident and Emergency (A&E) 4-hour wait:

Actions being taken to improve performance:

- Daily Chief Executive Officer (CEO) level calls are in place with system trusts, CCG, NHSE/ICS and urgent care director in attendance to directly address and resolve operation issues quickly and ensure appropriate high level oversight of the system.
- NHS Improvement (NHSI) have approved lifting the CAP on temporary staff (bank, locum, agency, etc.) to allow NUH to compete with surrounding trusts who have been paying above CAP and attracting staff away from the Nottinghamshire system.
- Dynamic daily discharge targets were successfully implemented from the end of January 2019
- St Francis opened its first ward at the end of December 2018. In January 2019 further beds have been opened as staff have been recruited. All 45 beds will be open when safe staffing allows
- Revised system triggers and actions have been agreed and implemented during February /

March and have successfully reduced system reporting levels without reducing the focus on actions that are required. A full review of the new system will form part of a system wide winter review during Q1 2019/20

Timeline for recovery:

- The A&E performance trajectory aims to deliver 78% by April 2019, with the trajectory increasing to 84% in June 2019 and 90% by September 2019.
- The latest data shows that the trajectory is not being met.

3.2.2 Cancer 62-day GP urgent referral to treatment:

Actions being taken to improve performance:

All Tumour Sites

- Individual tumour site Recovery Action Plans (RAPs) are in place. Progress against these are reviewed on a fortnightly rolling basis
- East Midlands Cancer Alliance transformation funding has been released to CCGs and Providers in order to redesign pathways in Urology, Lung, and Colorectal cancer. This will reduce diagnosis and treatment waiting times and improve 62 day performance

Lower Gastrointestinal

- Daily huddles to review patients over 40 days and identify those that require escalation of actions
- Referrals are static - the department is still recalibrating following the introduction of the FIT pathway
- Cancer Centre is reviewing all standard operation procedures
- Plans devised to move to same day CT/Endoscopy. Additional theatre capacity secured to reduce surgery waits

Endoscopy

- Between 2014/15 and 2017/18 there has been a 42% rise in referral rates
- Plans are in place to refurbish clinic room at Queens Medical Centre (QMC) to increase capacity by up to 15% - £125k for equipment (bid in place for Transformational funds)
- A case of need has been approved to appoint an additional consultant surgeon
- Mobile decontamination unit to be in place by May - will provide greater resilience to the service

Urology

- Waiting list initiatives at weekends to reduce surgery waiting times. Routine patients now being transferred to local private provider to undertake routine non cancer treatments to release capacity at NUH
- A case of need has been approved to appoint an additional consultant surgeon

Gynaecology

- Case for need to recruit another consultant has been approved internally
- Waiting list initiatives in place to reduce the backlog, which has started to see improvement
- The option to move routine patients to the private sector and release capacity in theatres for cancer patients is being explored

Timeline for recovery:

It is forecast that performance will initially fall as backlog numbers are reduced in March and April. Performance will then start to recover with the impact of the reduced backlog and transformational work. The recovery of the target is predicted for Quarter three 2019/20.

3.2.3 Transforming Care Partnership (TCP) - Reliance on inpatient care for people with learning disabilities or autism:

Actions being taken to improve performance:

- There is a continued focus on ensuring that discharge plans are robust and timely and close monitoring of these at individual patient level. Concerns in relation to discharge plans are escalated to the Senior Responsible Officer (SRO) and TCP Programme Manager to address at service / provider level
- The TCP have been successful in obtaining the additional funding requested from NHSE in our 'doing things differently' bid as well as a small amount of investment which has been allocated to a number of TCPs. This means that there is an extra £685,000 of funding available and will be used to support community infrastructure.
- The NHSE Associate Director of Nursing & Quality, Nottinghamshire Health and Care Sustainability and Transformation Partnership continues to work with the Nottinghamshire TCP to ensure links with the Nottinghamshire ICS and NHSE DCO/Regional TCP teams.
- A Nottinghamshire Transforming Care Virtual Support Team is being established. This is being set up by the Local Government Association in conjunction with the Nottinghamshire ICS. This team aims to identify the priority areas for Nottinghamshire and will work together to co-produce a bespoke support package and plan which addresses local needs and strategic development as well as coordinating the deployment of resources to support its delivery.
- Nottinghamshire TCP remains on level three support, due to the TCP wide trajectory for inpatients not being met, predominantly within secure beds commissioned by NHSE.

Timeline for performance recovery:

- Recovery trajectories for CCG / Specialised Commissioning and the TCP overall for 2018/19 has been modelled, reviewed and approved regionally and nationally.
- These can be seen below for the entirety of the 2018/19 year

Monthly inpatient Trajectories 2018/19	Q1 2018/19			Q2 2018/19			Q3 2018/19			Q4 2018/19		
	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Non-secure	25	24	23	22	21	20	19	18	17	16	15	13
Secure	30	29	28	27	26	26	26	25	24	24	24	23
TCP Totals	55	53	51	49	47	46	45	43	41	40	39	36

3.3 Better Care Fund (BCF) Annual Report

The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

At its meeting in March 2019, the GN JCC received a report which provided an overview of the performance of the BCF in 2018/19 against four key areas:

- Reporting against national indicators;
- Expenditure and forecast variance;
- Governance structure and roles and responsibilities; and
- 2019/20 plans and the future of the BCF.

The planning guidance for 2019/20 was due to be published in December 2018, however has been delayed nationally. Assurances have been provided by NHSE that there will be limited change in 2019/20. Work has been undertaken for both the Nottingham City CCG and South County CCG BCFs to ensure that draft plans are in place, based on estimated allocations for CCGs and Local Authorities.

4. Financial stewardship

The GNJCC has delegated responsibility for overseeing and managing all financial matters relating to the commissioning of services in the Greater Nottingham area, including the development and approval of the Greater Nottingham Financial Recovery Plan.

The GNJCC has established monthly financial reporting requirements, covering the overall financial position, statutory financial duties and Financial Recovery Plan delivery. The reports received by the GNJCC are also scrutinised in detail by the Finance Committee prior to their presentation.

The following sections summarise the latest financial information received by the GNJCC (month 11).

4.1 Financial position

The forecast year end position for key financial duties, targets and internal key financial indicators for the CCGs are summarised in the tables below and at **Appendix F**.

Key Financial Duties	Nottm City	NNE	NW	Rushcliffe
Remain within the Revenue Resource Limit (£1.05 Bn)				
Achieve the 'Control Total' (in year breakeven)				
Remain within Running Cost Allowance (£15.0 M)				
Remain within the Cash Balance Limit				
Better Payments Practice Code				

Key Internal Financial Indicators	Nottm City	NNE	NW	Rushcliffe
QIPP – achievement of overall target				
Achieve Underlying Surplus				
Risk Reserves – level utilised to balance position				
Co-commissioning – spend remains within budget				
Acute services – spend remains within budget				
Continuing healthcare – spend remains within budget				
Prescribing – spend remains within budget				

NHSE - CCG Improvement & Assessment Framework	Nottm City	NNE	NW	Rushcliffe
Forecast v plan for the year: Red - below plan				
Year to date financial position: Amber 0.1% to 2%; Red > 2% over plan				
Net risk: Amber 1% to 2%; Red > 2% of planned spend				
YTD QIPP: Amber < 80% plan				
FOT QIPP: Amber < 90% plan				
MHIS achievement: Amber unachieved				
I&A OVERALL RATING: Red - any red; Amber - any amber				

The financial position for the year to date can be summarised, as follows:

a) The overall forecast for the Greater Nottingham CCGs is delivery of the key financial duties.

b) Acute spend remains significantly over plan with a year to date adverse variance of £23.1million. A combination of contract over performance and savings targets not delivered remain the drivers of the over spend.

c) Contingency and risk reserves are brought into the year to date position to form the main mitigation for the acute pressure. Underspends on other budgets areas, notably Prescribing and Continuing Healthcare, also form part of the mitigations.

d) A noted in prior month, the Greater Nottingham CCGs have received an additional £7 million allocation from NHSE to offset the offline risk issues noted in the Deloitte's review. The CCGs continue to forecast full delivery of the breakeven Control Total.

e) The reported underlying position at £9 million deficit is consistent with that reported in Month 10. Recurrent acute pressures noted above are the main driver of the underlying deficit. The £9 million deficit reflects the position from the Deloitte's review.

CCG	Recurrent Planned Surplus / (Deficit) £'000	Recurrent (Pressures) / Benefits £'000	Forecast Exit Surplus / (Deficit) £'000
Nottingham City	4,418	(5,418)	(1,000)
Nottingham, North & East	725	(4,725)	(4,000)
Nottingham West	461	(461)	0
Rushcliffe	569	(4,569)	(4,000)
Total	**6,173**	**(15,173)**	**(9,000)**

Further information in relation to revenue expenditure can be found at **Appendix G**.

Appendix H provides the full Operating Cost Statement for NHS Nottingham North and East CCG.

4.2 Financial Recovery Plan

QIPP delivery shows a forecast delivery of £48.2 million against the £52.5 million target. Of the £48.2 million, £11.1 million is non recurrent. It is essential that QIPP schemes are delivered in the remaining months of the year to minimise risk against both the in year and underlying position. **Appendix I** summarises the current Financial Recovery Plan (FRP) delivery forecast.

4.3 Financial Plans and Opening Budgets 2019/20

At its meeting in March 2019, the GNJCC endorsed the 2019/20 draft financial plans (as submitted to NHSE in February 2019) and the subsequent draft opening budgets for 2019/20. An update on the opening budgets will be provided to the Governing Body following this submission.

Allocations for 2019/20 were announced in January 2019. The Greater Nottingham CCGs have a combined allocation of c £1.06 billion.

£million	City	NNE	NW	Rushcliffe	Greater Notts
Core Services					
2018/19 Baseline	£440.2	£188.9	£119.6	£146.0	£894.7
2019/20 Allocation	**£464.5**	**£199.6**	**£126.3**	**£154.3**	**£944.7**
Core Uplift %age	5.5%	5.7%	5.6%	5.7%	5.6%
Distance from Target %age	-3.40%	-2.99%	2.12%	2.23%	
Distance from Target £m	-£16.4	-£6.2	£2.6	£3.4	-£16.6
Primary Care					
2018/19 Baseline	£48.6	£19.6	£12.7	£16.0	£96.9
2019/20 Allocation	**£52.2**	**£20.8**	**£13.4**	**£17.0**	**£103.4**
Core Uplift %age	7.4%	6.1%	5.5%	6.3%	6.7%
Distance from Target %age	-4.99%	3.46%	6.04%	4.13%	
Running Costs					
2018/19 Baseline	£7.4	£3.2	£2.0	£2.7	£15.3
2019/20 Allocation	**£7.4**	**£3.4**	**£2.0**	**£2.7**	**£15.5**
Total 2019/20 Allocation	**£524.1**	**£223.8**	**£141.7**	**£174.0**	**£1,063.6**

The 2019/20 draft opening budgets, by programme heading with associated QIPP targets are shown below. The total QIPP requirement is £48.0 million, which is 4.5% of allocation.

Budget	Budgets pre QIPP	QIPP (bal to FY 18/19)	QIPP 19/20	Net budgets
Allocation				**1,067,160**
Expenditure				
Acute	516,356	-11,765	-12,768	491,823
Mental Health	112,997	-15	-860	112,122
Community	102,987	-184	397	103,200
Continuing Care	77,359	-2,626	-1,150	73,583
Prescribing	97,304	-2,266	-1,132	93,906
Primary Care	21,454	0	0	21,454
Other Programme	62,546	-83	-14,495	47,968
Primary Care Co-Commissioning	102,806	0	0	102,806
Running Costs	15,533	-1,080	-10	14,443
Contingency	5,855	0	0	5,855
Total Expenditure	**1,115,197**	**-18,019**	**-30,018**	**1,067,160**

5. Risks

The GNJCC has been delegated responsibility for overseeing and managing risks in line with the Greater Nottingham CCGs' Integrated Risk Management Framework, reporting to the Greater Nottingham CCGs' Governing Bodies as appropriate.

As at March 2019, the GNJCC were sighted on the GNCCP's three major risks, as follows:

- Failure to deliver the Financial Recovery Plan (FRP) and saving schemes (predominantly but not solely related to un-transacted acute QIPP) will impact directly on our ability to deliver our financial control total.
- There is a risk that patient safety in Emergency Department will be compromised as a result of departmental reconfiguration during the busy winter period which has the potential to make tracking and observation of patients more difficult *(the wording of this risk is to be reviewed as the reconfiguration has now been concluded*).
- As a result of the restructuring process and period of ongoing change and uncertainty, staff may become disengaged which could result in low morale and reduced productivity

.

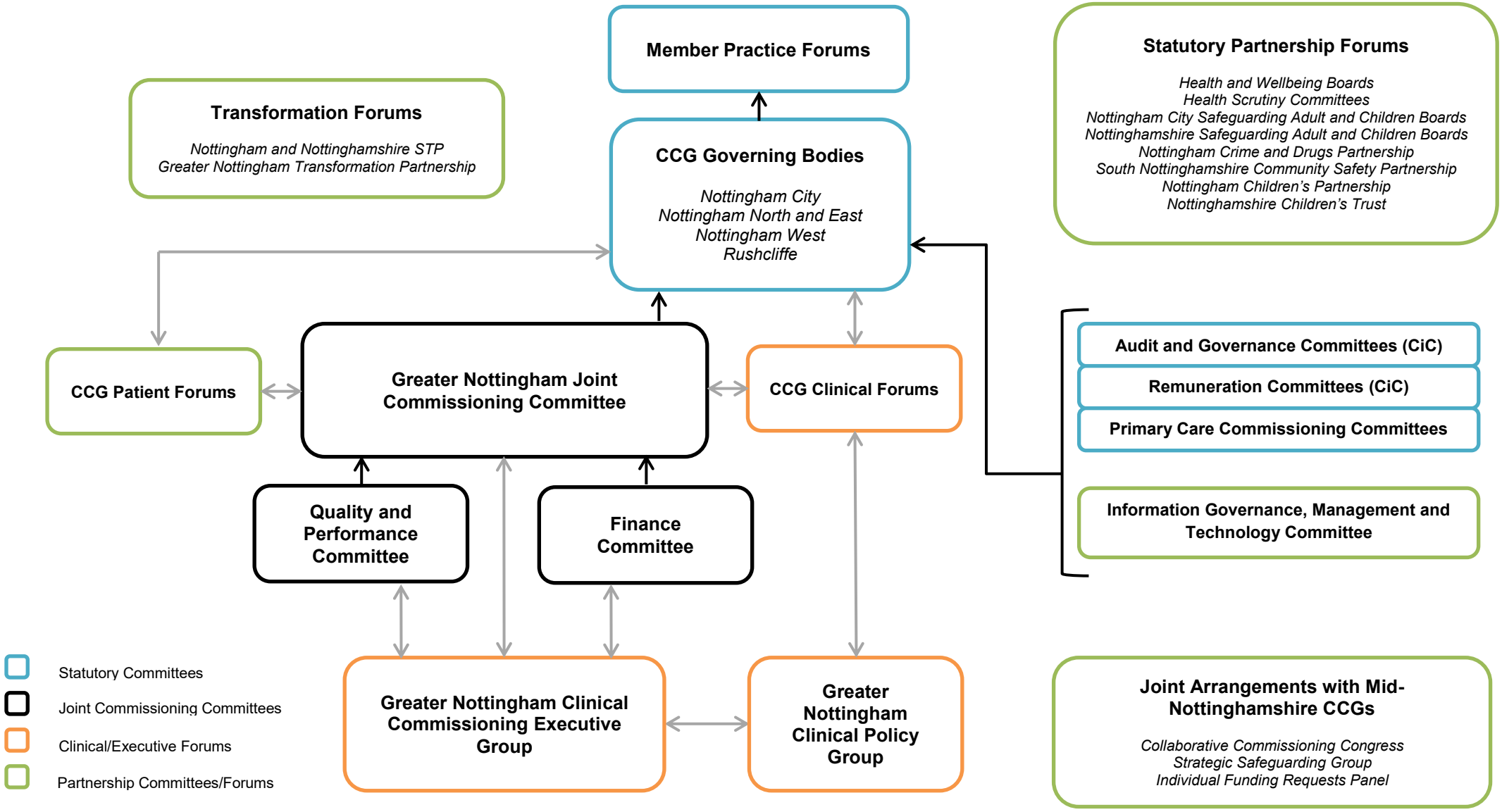
Appendix A: Membership, meeting dates and attendance

Member	Name	Attendance		
		Possible	*Actual*	*Comment*
Accountable Officer, Nottingham and Nottinghamshire CCGs	Dr Amanda Sullivan	4	3	Membership started November 2018
Chief Finance Officer, Greater Nottingham CCGs	Jonathan Bemrose	10	10	
Chief Nurse and Director of Quality, Greater Nottingham CCGs	Nichola Bramhall	10	9	
Acting Accountable Officer, Greater Nottingham CCGs	Gary Thompson	3	3	Membership started July and ceased October 2018
Accountable Officer, Greater Nottingham CCGs	Samantha Walters	5	1	Gary Thompson acted as deputy at the May and June 2018 meetings Membership ceased September 2018
Independent Chair	Jenny Myers	10	10	
Clinical Chair, NHS Nottingham North and East CCG	Dr James Hopkinson	10	7	
Clinical Chair, NHS Nottingham West CCG	Dr Nicole Atkinson	10	8	
Clinical Chair, NHS Nottingham City CCG	Dr Hugh Porter	10	8	Dr Margaret Abbott acted as deputy at the June 2018 meeting
Clinical Chair, NHS Rushcliffe CCG	Dr Stephen Shortt	10	10	
Lay Member	Janet Champion	8	7	Membership started June 2018
Lay Member, Patient and Public Involvement	Sue Clague	10	10	
Lay Member, Financial Management and Audit	Terry Allen	10	9	
Lay Member	Carol Knott	2	1	Membership ceased May 2018
GP Advisor	Dr Sonali Kinra	9	6	Membership started May 2018
Secondary Care Doctor	Dr Ben Teasdale	7	5	Membership ceased December 2018
Secondary Care Doctor	Dr Adedeji Okubadejo	3	3	Membership started January 2019
Chief Executive, Nottingham City Council	Ian Curryer	1	0	Membership ceased April 2018
Chief Executive, Nottinghamshire County Council	Anthony May	1	0	Membership ceased April 2018

Date	Time	Venue	Date	Time	Venue
25 April 2018	09:00-13:00	Stapleford Suite, Stapleford Care Centre	31 October 2018	09:00-13:00	Boardroom, Standard Court
30 May 2018	09:00-13:00	Clumber Room, Easthorpe House	28 November 2018	09:00-13:00	Chappell Room, Gedling Civic Centre
27 June 2018	09:00-13:00	Boardroom, Standard Court	31 January 2019	09:00-13:00	Clumber Room, Easthorpe House
25 July 2018	09:00-13:00	Chappell Room, Gedling Civic Centre	27 February 2019	09:00-13:00	Boardroom, Standard Court
26 September 2018	09:00-13:00	Clumber Room, Easthorpe House	27 March 2019	09:00-13:00	Clumber Room, Easthorpe House

Click on the months above to access the full GNJCC papers for that particular meeting.

Appendix B: Greater Nottingham Clinical Commissioning Partnership – Governance Framework



Appendix C: GNJCC Annual Work Programme 2018/19

	APR	MAY	JUNE	JULY	SEPT	OCT	NOV	JAN	FEB	MAR	NOTES
Strategy and Leadership											
Aligned Vision, Values and Strategic Objectives[1]			✓								
Operational Plans[1]	✓					✓			✓	✓	Mid-year delivery update in October 2018
Health and Care System Transformation Plans				✓	✓		✓		✓		Indicative timeframes for reports – to be confirmed.
Thematic Reviews: Commissioning Priorities			✓	✓	✓	✓	✓	✓	✓	✓	
Health and Wellbeing Strategies – Delivery Updates					✓						Indicative timeframes for report – to be confirmed.
Better Care Fund Report						✓					Indicative timeframes for report – to be confirmed.
Winter Plan					✓						
Quality Improvement Framework/Strategy[2]				✓							
Patient and Public Engagement Framework/Strategy[2]					✓						
Equality and Diversity Framework/Strategy[2] (including Equality Objectives)[1]						✓					
GNJCC Governance Framework (including sub-committee terms of reference)	✓	✓	✓							✓	
Annual Work Programme	✓	✓								✓	
Quality and Performance											
Patient Story			✓	✓	✓	✓	✓	✓	✓	✓	The monthly patient stories will be linked to the programme of thematic reviews
Quality Report	✓				✓		✓		✓		Due again May 2019
Performance Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Annual Report: Complaints and Patient Experience					✓						
Annual Report: Infection, Prevention and Control					✓						
Annual Report: Nottinghamshire County Safeguarding (Adults and Children)						✓					

[1] *To be endorsed for approval by the Greater Nottingham CCGs' Governing Bodies.*
[2] *A 'Framework' describes an overall strategic approach and sets out what needs to be achieved in order to reach its objectives. It can be considered an 'umbrella' document, under which a number of policies and procedures may exist to support it.*

	APR	MAY	JUNE	JULY	SEPT	OCT	NOV	JAN	FEB	MAR	NOTES
Annual Report: Nottingham City Safeguarding (Adults and Children)						✓					
Annual Report: Looked After Children						✓					
Annual Report: Serious Incidents							✓				
Financial Stewardship											
Finance Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	To include statutory financial duties, Financial Recovery Plan updates and contract updates
Contracting and Procurement Report				✓		✓		✓			Due again April 2019
2018/19 Financial Plans and Opening Budgets[3]	✓										
2019/20 Financial Plans and Opening Budgets										✓	
Corporate Assurance											
GNJCC Assurance Framework			✓				✓				Due again April 2019
Annual Assurance Report: Patient and Public Involvement					✓						
Annual Assurance Report: Public Sector Equality Duty							✓				
Annual Assurance Report: Research								✓			
Annual Assurance Report: Joint Strategic Needs Assessment									✓		

In addition to the specific papers detailed above, the GNJCC will also:

a) Routinely consider the Committee Members' registered and declared interests at the start of each meeting.
b) Receive minutes from the previous meetings, along with updates against an ongoing log of agreed actions.
c) Receive monthly updates on pertinent strategic and leadership areas from the Accountable Officer and four Clinical Chairs.
d) Receive monthly updates in relation to any risks rated as 'high/red'.
e) Receive summary reports from each of its sub-committees in order to demonstrate that delegated responsibilities are being effectively discharged. These will culminate in the presentation of Annual Assurance Reports from each sub-committee at financial year-end.
f) Receive updates from key strategic partnership forums, including the Leadership Board of the Nottingham and Nottinghamshire Sustainability and Transformation Partnership and Nottingham City and Nottinghamshire County Health and Wellbeing Boards.
g) Endorse or approve policies and procedures as and when required. Additional policies and procedures, as approved by the Greater Nottingham CCGs' Governing Bodies will be received as necessary.

[3] *Received following approval by the Greater Nottingham CCGs' Governing Bodies.*

Appendix D: Clinical Commissioning Executive Group – Highlight Report

Detailed below is a summary of the main areas of focus for the Clinical Commissioning Executive Group (CCEG) at its most recent meetings in January 2019 to March 2019:

Single Musculoskeletal (MSK) Model

At the 9 January meeting, the Group received a paper to endorse the enactment of a contract extension for existing MSK models across the Greater Nottingham CCGs and to establish a Greater Nottingham Clinical Commissioning Partnership Service Improvement Post (with support team) to act as an integrator to deliver single MSK model across Greater Nottingham.

The Group supported the contract extension and acknowledged the need to procure a provider (existing or external) to act as an integrator however, recognised further clarity was needed in relation to Integrated Care Provider (ICP) arrangements.

Direct access gynaecology ultrasound pathway for suspected ovarian cancer

The Group received a business case to change the pathway for patients with suspected ovarian cancer to ensure they are referred for a direct access ultrasound scan (USS) in line with NICE Guidelines recommendation NG12. The proposed pathway provides a safer, more streamlined pathway for patients, supports GPs with equivocal test results and also assists Nottingham University Hospital (NUH) in meeting the 28 day referral to diagnosis target. The long term aim is to extend the pathway out to all Greater Nottingham CCGs, and the Treatment Centre, pending a successful pilot with NHS Nottingham City CCG practices.

The Group approved a twelve month pilot of the pathway.

GP Interpretation and Translating Services across NHS Nottingham City CCG

At the 9 January 2019 meeting, the Group received a paper in relation to GP Practice Interpreting and Translation Service for NHS Nottingham City CCG.. The current provider is Nottingham CityCare Partnership and the contract was due to end on the 31 December 2018. The Group was asked to approve a direct award to Nottingham CityCare Partnership for a twelve month extension.. This will enable the CCG to review the service and plan how to progress procurement or enter into negotiation with the incumbent provider. The Group approved a direct award for twelve months.

Funding for Protected Learning Events (PLTs) across Greater Nottingham

The Group received a paper reviewing the arrangements in place across Greater Nottingham for the funding of PLTs. The review identified that significant variations exist in relation to the funding, organisation and contractual arrangements for PLTs. The Group requested a further piece of work is undertaken to review proposals for the future provision of PLTs across Greater Nottingham and Mid Nottinghamshire. Consideration should be given to future learning and development requirements to support Primary Care Networks (PCNs).

Interim Home Care – Contract Review Phase 1

At the 9 January 2019 meeting, the Group received a paper in relation to an Interim Homecare service. The service provides an interim service to citizens discharged from the acute trust, community beds, reablement or urgent care services where a long term care package has been sourced. It is designed to be short term (up to 8 weeks). The service supports the most complex of patients and reduces system pressures relating to discharge. The Group approved a direct award/contract extension for a six month period on the basis of the recurrent contract value. A system-wide review will

look at the gaps in current homecare provision; alternative models and make recommendations for future commissioning.

Frailty Unit Incentive Scheme Proposal

The Group received a business case to expand the service offered by the Frailty Unit co - located with the Emergency Department. The Frailty unit is currently open Monday to Friday 8am till 5pm, and is proposed to open 8am-8pm 7 days per week. The frailty service is led by clinicians from Health Care of the Elderly (HCOP). The Group approved the proposed business case, with ongoing reviews to ensure it is delivering the intended outputs.

Community Fracture Liaison Service

At the 23 January 2019 meeting, the Group received a paper outlining options for re – procurement of the Community Fracture Liaison Service for NHS Nottingham North & East; NHS Nottingham West and NHS Rushcliffe CCGs. Procurement support has been secured (NHS South, Central and West CSU) on the 31 December 2018. It has been advised that the timeframes will not allow for a new contract to be tendered and implemented by the 1 April 2019. As such, a tender exemption is being sought.

The Group approved the tender exemption for the extension of the contract with the current provider for (up to) a period of twelve months. The Group supported the options presented in principle dependent on whether a formal risk sharing agreement could be agreed with the provider. A formal decision will be made by the Group once feedback on this was provided.

NHS Nottingham City CCG Protected Learning Time (PLT) Admin Post

At the meeting on 9 January 2019, the Group asked for assurance in respect of the consistency, equity and value for money relating to PLT events across the four CCGs in the Greater Nottingham Clinical Commissioning Partnership (GNCCP). It had been identified that the contract with Nottingham CityCare Partnership for PLT administration for NHS Nottingham City CCG was due to expire on 31 March 2019. It was proposed that the administration of the PLT is delivered internally to enable Primary Care Networks (PCNs) to manage their own agenda, supported by the Locality. The rationale, risks and savings behind the proposal were discussed and supported by the Group.

Implementing an efficient and effective Colorectal Cancer Pathway

Nottingham University Hospital (NUH) and the GNCCP introduced the Rapid Colorectal Cancer Diagnosis pathway, based on National evidence in November 2017. The introduction of this pathway using the Faecal Immunochemical Test (FIT) has been assessed locally as an effective pathway for stratifying patients for the two week wait (2ww) colorectal referral. During the implementation phase of the pathway, a ‘window’ referral process was included. The Greater Nottingham FIT Steering Group proposed the implementation of a streamlined pathway; removing the window referral process and introducing pre-referral baseline tests. The proposed pathway changes are anticipated to continually improve the experience and outcomes for patients. The Group approved the implementation of the new Colorectal Cancer Pathway.

High Volume Service User (HSVU) Service – Business Case

It was proposed that a HSVU post is commissioned, in response to the Right Care work which highlighted potential opportunities for reducing alcohol related admissions within the gastroenterology area. A significant proportion of patients admitted to ED will have a significant alcohol misuse issue. The proposal incorporated lessons learnt from a previous post which evaluated as effective in reducing alcohol consumption and dependence, increasing uptake of alcohol recovery services and

improving the social environment of patients. The Group supported the principles of the proposal; however, further work was requested to determine if current resources could be reconfigured to provide this support.

INR Phlebotomy Service

NHS Nottingham City CCG commission Nottingham CityCare Partnership to provide INR and Domiciliary Phlebotomy; the contract end date for the service is 31 March 2019. The aim of this service is to provide a phlebotomy clinic and domiciliary phlebotomy service for adults across Nottingham City that are on Warfarin anticoagulation therapy or are being monitored under the Shared Care Protocol. Approval was sought to direct award the service to Nottingham CityCare Partnership for one year, to enable a review of the specification and referral criteria to take place. The extension will align with work that is taking place to review GP enhanced services.

NHS Nottingham City CCG also commissions the Nottinghamshire Healthcare Trust to provide a paediatric phlebotomy service to patients up to the age of twelve years. The contract end date for the service is 31 March 2020. An extension will enable commissioners to review both services. The Group approved a direct award to Nottingham CityCare Partnership for one year.

Self-Care Plan in 2018/19

The Self-Care Plan in 2018/19 was to align NHS Nottingham City CCG's guidance with the other CCG's across Greater Nottingham. Following an engagement processes, the guidelines were adopted in October 2018. The Greater Nottingham CCGs' agreed to initially target four clinical areas for active implementation of the self-care plan (based on PrescQipp data). The areas chosen were Vitamin D maintenance dose prescribing, emollients, hay fever and pain. The Group supported the ongoing active implementation according to NHS England (NHSE) and local guidelines.

NEMS and NUH ED Primary Care Streaming Service

At the meeting in December 2018, the funding of an interim Urgent Treatment Unit (UTU) was approved until March 2019. Nottingham University Hospitals (NUH) and NEMS have been working in partnership in the UTU, as part of the wider development of the Urgent and Emergency Care Centre at Queens Medical Centre. The UTU provides 24/7 care for patients with minor injury and minor illness who attend the Urgent and Emergency Care Centre. A NEMS GP, Nurses and Health Care Assistant (HCA) treat the minor illness presentations, alongside NUH Junior Medics, Advanced Care Practitioners (ACPs) and Nurses to treat the minor injury presentations. A contract variation is requested to the NEMS contract to continue to deliver a 24/7 streaming service at QMC until the Integrated Urgent Care procurement is completed in October 2019. The Group approved the continuation of the combined NEMS/NUH UTU service model.

Non-Emergency Patient Transport Service (NEPTS)

The Group received a business case to approve a short extension to the current service by way of a five month direct award until 30 November 2019 to the incumbent provider Arriva Transport Solutions Limited (ATSL) to allow sufficient time for evaluation of the future procurement options. The current (NEPTS) contract is in place across GNCCP, Mid Nottinghamshire Clinical Commissioning Groups (MNCCG) and Bassetlaw CCG (BCCG) and has been in place since 1 July 2012. The Group approved the service extension up to 30 November 2019.

Greater Nottingham Referral Scheduling and Support (RSS) – Business Case

There are two RSS services in Rushcliffe and in Nottingham City. The Rushcliffe Clinical Assessment Service (CAS) is an in-house service, whereas the Nottingham City CAS is a commissioned service

which is provided by NEMS Community Benefit service. The Nottingham City CAS contract with NEMs is due to end 31 July 2019. Approval was sought to extend the contract for one year which will provide an opportunity to review the RSS models across the Greater Nottingham system with the aim of developing a single point of access for all referrals. The Group requested that a further review of the proposed model is undertaken to establish a clear way forward for RSS.

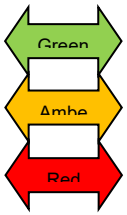
Appendix E: Performance against key national indicators

Indicator			Standard	Latest data period		Latest period data								
						CCG						Provider		
				CCG	Provider	Total Notts	Grt Notts	City	NNE	NW	Rush	NUH	Circle	EMAS Notts
A&E	12 Hour Trolley Waits	=	0		Jan-19							✓		
Cancer	2 Week Wait	=>	93%	Jan-19	Jan-19			✓	✓	✓	✓	✓	✓	
	2 Week Wait - Breast Symptoms	=>	93%	Jan-19	Jan-19			✓	✓	✓	✓	✓		
	31 Day Decision to Treat to First Treatment	=>	96%	Jan-19	Jan-19			✗	✗	✗	✗	✗	✓	
18 Weeks RTT	Incomplete %	=>	92%	Jan-19	Jan-19			✓	✓	✓	✓	✓	✗	
	Incomplete number of 52 week waiters	=	0	Jan-19	Jan-19			✗	✗	✓	✓	✗	✓	
Diagnostics	Patients waiting longer than 6 weeks	<=	1%	Jan-19	Jan-19			✓	✓	✓	✓	✓	✗	
Cancelled Operations	Rebooked within 28 Days	=	0		Jan-19							✗	✓	
	Urgent Operation Cancelled for a Second Time	=	0		Jan-19							✓	✓	
Wheelchairs	Children waiting less than 18 weeks for a wheelchair	=>	92%	Q3 2018-19	Q3 2018-19			✓	✓	✓	✓	✓		
DToC	As a % of occupied beds (Greater Nottingham)	<=	3.5%		Jan-19		✓							
	Beds Occupied by Long Stay Patients (7+ days)	<=	697		Feb-19		✗							
	Beds Occupied by Long Stay Patients (21+ days)	<=	269		Feb-19		✓							
Ambulance	Category 1 – Life-threatening illnesses or injuries - Average	<=	00:07:00		Feb-19			✓	✗	✗	✗			✗
	Category 2 – Emergency calls - Average	<=	00:18:00		Feb-19			✗	✗	✗	✗			✗
	Category 1 – Life-threatening illnesses or injuries - 90th centile	<=	00:15:00		Feb-19			✓	✓	✓	✓			✓
	Category 2 – Emergency calls - 90th centile	<=	00:40:00		Feb-19			✗	✗	✗	✗			✗
	Category 3 – Urgent calls - 90th centile	<=	02:00:00		Feb-19			✗	✗	✗	✗			✗
	Category 4 – Less urgent calls - 90th centile	<=	03:00:00		Feb-19			✓	✓	✗	✓			✓
Activity Variance to Plan (YTD)	GP Referrals (G&A)	<=	2%	Jan-19			✓	✓	✓	✓	✓			
	Other Referrals (G&A)	<=	2%	Jan-19			✓	✓	✓	✗	✗			
	Total Referrals (G&A)	<=	2%	Jan-19			✓	✓	✓	✓	✓			
	All 1st OP - Consultant led	<=	2%	Jan-19			✓	✓	✓	✓	✓			
	Follow-up OP - consultant led	<=	2%	Jan-19			✓	✓	✓	✓	✓			
	Total Elective spells - Day Cases	<=	2%	Jan-19			✓	✓	✓	✓	✓			
	Total Elective spells - Ordinary	<=	2%	Jan-19			✓	✓	✓	✓	✓			
	Total Elective spells	<=	2%	Jan-19			✓	✓	✓	✓	✓			
	Non-elective spells complete - 0 Length of Stay	<=	2%	Jan-19			✗	✗	✗	✗	✗			
	Non-elective spells complete - 1+ Length of Stay	<=	2%	Jan-19			✗	✗	✗	✗	✗			
	Non-elective spells complete	<=	2%	Jan-19			✗	✗	✗	✗	✗			
	A&E Attendances excluding follow ups	<=	2%	Jan-19			✓	✓	✓	✓	✗			
	Number of Completed Admitted RTT Pathways	<=	2%	Jan-19			✓	✓	✓	✓	✗			
	Number of Completed Non-Admitted RTT Pathways	<=	2%	Jan-19			✓	✓	✗	✓	✓			
	Number of New RTT Pathways (Clockstarts)	<=	2%	Jan-19			✓	✓	✗	✗	✓			
Improving Access to Psychological Therapies	Entering Treatment - Month	=>	1.5%	Dec-18				✗	✗	✗	✗			
	Entering Treatment - Rolling Three Months	=>	4.6%	Dec-18				✓	✗	✓	✓			
	Recovery Rate	=>	50%	Dec-18				✓	✓	✓	✓			
	Waiting Times - First Treatment within 6 Weeks	=>	75%	Dec-18				✓	✓	✓	✓			
	Waiting Times - First Treatment within 18 Weeks	=>	95%	Dec-18				✓	✓	✓	✓			
Dementia	Diagnosis Rate	=>	67%	Jan-19				✓	✓	✓	✓			
EIP	Treated within two weeks % - Rolling Three Months	=>	50%	Jan-19				✓	✓	✓	✓			
CYP Eating Disorders	Routine Cases <4 Weeks - Complete Pathways	=>	95%	Q3 2018-19				✓	✓		✓			
	Urgent Case <1 Week - Complete Pathways	=>	95%	Q3 2018-19					✓					
Continuing Health Care	Full NHS CHC assessments taking place in acute hospital setting	<=	15%	Q3 2018-19				✓	✓	✓	✓			
	NHS CHC eligibility decisions made by CCG within 28 days	=>	80%	Q3 2018-19				✓	✓	✓	✓			
TCP: Learning Disability Inpatients	Reliance on Inpatient Care for People with LD or Autism with a length of stay of 5 years and over – CCG Commissioned	<=	5	Dec-18		✓								
	Reliance on Inpatient Care for People with LD or Autism with a length of stay of 5 years and over – NHSE Commissioned	<=	20	Dec-18		✓								
	Reliance on Inpatient Care for People with LD or Autism with a length of stay of 5 years and over – Total	<=	25	Dec-18		✓								
Out of Area Placements	Inappropriate Out of Area Placement Bed Days (NHCT)	<=	2852	Q3 2018-19		✗								

Appendix F: Summary of financial duties/targets – Greater Nottingham CCGs

Statutory Duties - Remain within Revenue Resource Limit	Year to Date (£'000)	Forecast Out-Turn (£'000)	Risk Rating	Comments
Cumulative Surplus b/f	17,737	19,349	Green	The Greater Notts CCGs are reporting delivery of the b/f cumulative surplus of £19,349k
Running Costs	(51)	(51)	Green	The Greater Notts CCGs are forecasting an overspend position of £51k for Running Costs. However, the Running Cost budget in the ledger is lower than the Running Cost allowance which will be achieved.
Other budget areas incl reserves	53	55	Green	The Greater Notts CCGs are forecasting an underspend position of £55k for other budget areas.
TOTAL	**17,739**	**19,353**	Green	Overall forecast of In Year Breakeven / delivery of the b/f surplus

Better Payments Practice Code	Year to Date (%)	Target (%)	Comments
By Number: Non NHS	99.1	95.0	All targets are achieved
By Number: NHS	99.4	95.0	
By Value: Non NHS	99.7	95.0	
By Value: NHS	99.6	95.0	



Indicates that the organisation is forecasting to achieve its target by the financial year-end

Indicates that there is some cause for concern and the organisation may not achieve its target unless action is taken

Indicates that the organisation will not achieve its target by the financial year-end without immediate intervention

Appendix G: Revenue expenditure position – Greater Nottingham CCGs

Greater Nottingham CCP	Annual Budget £000	Budget to Date £000	Actual to Date £000	Variance under/ (overspend) £000	Movement from Previous Month £000
Commissioned Services					
Acute Care	470,758	431,471	454,570	(23,099)	(3,844)
Mental Health Care	105,888	97,051	93,867	3,184	1,435
Community Care	90,819	83,179	83,172	7	(30)
Continuing Care	72,824	66,664	66,612	52	(111)
Primary Care	22,854	20,791	19,223	1,568	1,022
Prescribing	95,040	86,855	84,209	2,646	(546)
Delegated Co-Commissioning	96,260	82,495	80,766	1,728	1,749
Other Programme Services	43,818	39,333	37,911	1,422	133
Contingency, Reserves and Developments	15,365	12,545	0	12,545	465
Total Programme Costs	**1,013,626**	**920,384**	**920,331**	**54**	**273**
CCG Running Costs	15,097	13,599	13,650	(51)	(273)
Total Expenditure	**1,028,723**	**933,983**	**933,980**	**4**	**0**
Planned Historic Surplus	19,349	17,737	0	17,737	1,612
Total Revenue Position	**1,048,072**	**951,719**	**933,980**	**17,740**	**1,612**

Appendix H: Operating Cost Statement – Nottingham North and East CCG

Nottingham North & East CCG Operating Cost Statement		Ledger Position £'000. Variance: Favourable / (Adverse)				
OCS Area	OCS Description	Annual budget	YTD Budget	YTD Actual	YTD Variance	In Month Movement
Acute Services (AS)	Circle Indep. Sect Treatment Ctr	8,812	8,100	8,192	(92)	(39)
	East Midlands Ambulance Service	4,560	4,150	4,069	81	0
	AS - Nottingham CityCare	177	162	162	(0)	(0)
	Nottingham University Hospitals	81,891	75,067	76,943	(1,876)	(287)
	AS - Savings Requirement	(628)	(580)	0	(580)	(62)
	AS - Other NHS	1,819	1,666	1,808	(142)	38
	AS - Other Non NHS	3,384	3,098	3,493	(395)	(128)
	AS - Sherwood Forest Hospitals (SFHFT)	4,997	4,574	5,479	(905)	(142)
	AS - Resilience	670	613	898	(286)	(78)
Acute Services (AS)		**105,682**	**96,849**	**101,043**	**(4,194)**	**(698)**
Delegated Co-Commissioning (DCC)	DCC - Enhanced Services	382	350	365	(15)	(9)
	GMS/PMS Payments	13,987	12,840	12,834	6	10
	Other	1,412	14	20	(6)	(2)
	Property Costs	1,687	1,528	1,476	53	(11)
	QOF	1,928	1,185	1,185	0	0
Delegated Co-Commissioning (DCC)		**19,396**	**15,917**	**15,879**	**38**	**(13)**
Community Health Services (CHS)	Local Partnerships	12,074	11,058	11,064	(7)	(22)
	Integrated Comm Equip Loan Service	656	601	611	(10)	0
	CHS - Other NHS	603	557	642	(86)	(24)
	CHS - Other Non NHS	3,511	3,214	3,123	91	32
	CHS - Sherwood Forest Hospitals (SFHFT)	1,012	928	928	0	0
Community Health Services (CHS)		**17,856**	**16,357**	**16,368**	**(11)**	**(14)**
Continuing Care Serivces	Continuing Care	14,636	13,402	12,749	653	53
	CHC Assessment Service	380	348	330	18	3
	Funded Nursing Care	1,874	1,711	1,796	(84)	(19)
Continuing Care Serivces		**16,890**	**15,462**	**14,875**	**587**	**36**
Mental Health Services (MHS)	Improv. Access to Psych. Therapies	1,258	1,153	957	196	8
	Locked Rehab	827	757	722	34	35
	Section 117	1,516	1,417	1,535	(118)	4
	MHS - Non Contracted Activity	348	319	299	20	20
	Nottinghamshire Healthcare Trust	13,495	12,257	12,134	123	64
	MHS - Other NHS	158	145	160	(15)	2
	MHS - Other Non NHS	307	285	193	91	5
Mental Health Services (MHS)		**17,910**	**16,333**	**16,001**	**331**	**138**
Corporate Costs	Non-Pay	938	708	470	238	(8)
	Pay	2,277	2,087	2,255	(168)	(15)
Corporate Costs		**3,215**	**2,795**	**2,725**	**70**	**(22)**
Other Programme Services (OPS)	Corporate Costs	(2,668)	(1,902)	(1,920)	17	(3)
	NHS Property Services	941	863	864	(1)	(1)
	OPS - Other Non NHS	3,768	3,454	3,454	0	0
	Patient Transport	911	837	933	(97)	(10)
Other Programme Services (OPS)		**2,953**	**3,252**	**3,332**	**(80)**	**(15)**
Primary Care Services (PCS)	PCS - Enhanced Services	999	915	746	169	142
	GP Forward View	669	516	516	0	(0)
	PCS - GP IT	457	420	421	(1)	1
	PCS - Medicines Management	403	370	373	(4)	(4)
	Out of Hours	1,309	1,200	1,237	(37)	(1)
	Pathways	584	535	278	256	(19)
	Prescribing	21,961	20,069	19,552	517	(166)
Primary Care Services (PCS)		**26,381**	**24,025**	**23,124**	**900**	**(48)**
Developments and Reserves	Contingency	973	973	0	973	0
	Committed/ Investments/ Other	1,665	1,386	0	1,386	635
Developments and Reserves		**2,638**	**2,359**	**0**	**2,359**	**635**
Planned Historic Surplus	Planned Historic Surplus	4,069	3,730	0	3,730	339
Planned Historic Surplus		**4,069**	**3,730**	**0**	**3,730**	**339**
		216,990	**197,079**	**193,348**	**3,731**	**339**

Appendix I: Financial Recovery Plan – Month 11 position

The table below summarises the current Financial Recovery Plan (FRP) delivery forecast:

Current Position	Overall	Forecast
Full Year Effect of 17/18 Schemes	£23.96m	£22.07m
18/19 New Schemes	£26.44m	£14.99m
Non Recurrent transactional schemes		£11.09m
Total	**£50.41m**	**£48.15m**
Target	£52.52m	£52.52m
Shortfall / Surplus	**(£2.11m)**	**(£4.37m)**

The value of the schemes identified is £4.37m under target; non recurrent transactional schemes have been identified to support QIPP delivery in 2018-19.

The forecast delivery by programme area is shown in the table below:

Programme Areas	Current Position	No Risk	Low Risk	Medium Risk	High Risk	FRP	Movement from FRP
Primary Care	**£0.46m**	-	459754	-	-	**£0.00m**	**£0.46m**
Community Care	**£3.47m**	£3.38m	£0.08m	£0.01m	£0.00m	**£4.74m**	**(£1.27m)**
Urgent Care	**£0.82m**	-	£0.82m	-	£0.00m	**£7.75m**	**(£6.93m)**
Prescribing	**£9.41m**	-	£9.41m	-	-	**£6.40m**	**£3.01m**
Planned Care	**£18.29m**	£12.21m	£6.08m	-	£0.00m	**£27.75m**	**(£9.46m)**
Continuing Health Care	**£3.01m**	£0.09m	£2.91m	-	-	**£3.44m**	**(£0.43m)**
Mental Health	**£0.28m**	£0.28m	-	-	-	**£0.29m**	**(£0.01m)**
Internal Efficiencies	**£0.46m**	-	£0.46m	-	-	**£0.52m**	**(£0.06m)**
Estates	**£0.01m**	£0.01m	-	-	-	**£0.06m**	**(£0.05m)**
Non Recurrent transactional schemes	**£11.09m**	£11.09m	-	-	-	**£0.00m**	**£11.09m**
Pipeline Schemes	**£0.86m**	£0.40m	-	-	£0.46m	**£0.00m**	**£0.86m**
Total	**£48.15m**	**£27.46m**	**£20.23m**	**£0.01m**	**£0.46m**	**£50.95m**	**(£2.80m)**

The year to date QIPP delivery is £42.11m against a plan of £48m (Month 11)

NHS
Nottingham North and East
Clinical Commissioning Group

Meeting Title:	Governing Body				**Date:** 16 April 2019				
Paper Title:	Governing Body Assurance Framework: 2018/19 year-end position				**Paper Reference:** GB/19/040 a				
Sponsor:	Elaine Moss, Chief Nurse								
Previous Related Papers:	-								
Recommendation:	Approve	☐	Endorse	☐	Review	☒	Receive/Note for: • Assurance • Information	☒	
Summary Purpose of Paper:	The purpose of this paper is to present the year-end position of the 2018/19 Governing Body Assurance Framework.								

If paper is for Approval/Endorsement, have the following impact assessments been completed?

Equality / Quality Impact Assessment	Yes No N/A	☐ ☐ ☒	Data Protection Impact Assessment	Yes No N/A	☐ ☐ ☒

Conflicts of Interest: Please consider whether there are any conflicts of interest considerations relevant to paper authors, members or attendees.

☒ 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
☐ Conflicted party to be excluded from meeting

Please identify conflicted party and specify reason for conflict:

Have All Relevant Implications Been Considered? *(please tick where relevant)*

Clinical Engagement	☐	Patient and Public Involvement	☐
Quality Improvement	☐	Equality, Diversity and Human Rights	☐
Integration	☐	Innovation / Research	☐
Improving Health Outcomes / Reducing Health Inequalities	☐	Patient Choice / Shared Decision Making	☐
Financial Management	☐	Corporate Governance	☐

Is the Information in this paper confidential? Yes ☐ No ☒
If yes, please state reason why:

Risk: *(briefly explain any risks associated with the paper*)	**-**
Recommendation:	The Committee is asked to: • **Review and comment** on the year-end position of the Assurance Framework. • **Affirm** that sufficient levels of controls and assurances are in place in relation to the Greater Nottingham CCGs' strategic risks. • **Approve** to the archiving of risk 6 (as proposed in section 4.1) • **Provide feedback** on further areas for assurance that are not already captured within the Assurance Framework

2018/19 Governing Body Assurance Framework: Year-end Position

1. Introduction

The purpose of this paper is to present the year-end position of Greater Nottingham CCGs' Joint Governing Body Assurance Framework for scrutiny and comment.

2. Background Information: The Role of the Governing Body Assurance Framework

The purpose of the Governing Body Assurance Framework (Assurance Framework) is to provide the Governing Body with confidence that the organisation has identified its strategic risks and has robust systems, policies and processes in place (controls) that are effective and driving the delivery of its objectives (assurances). It should provide confidence and evidence to management that '*what needs to be happening is actually happening in practice'*. The Assurance Framework has also been aligned to the assurance components of the NHS England CCG Improvement and Assessment Framework 2018/19; thus providing the Governing Body with an integrated mechanism for receiving assurances.

The Assurance Framework plays an important role in informing the production of the organisation's Annual Governance Statement and is the main tool that Governing Bodies should use in discharging their overall responsibility for ensuring that an effective system of internal control is in place.

3. Monitoring and Scrutiny Roles and Responsibilities

The Greater Nottingham CCGs have a joint Integrated Risk Management Framework, which clearly defines roles and responsibilities in relation to the monitoring and scrutiny of its strategic risks.

The **four statutory CCG Governing Bodies** have ultimate responsibility for risk management and as such, need to be satisfied that internal control systems are functioning effectively. The Governing Bodies are also responsible for setting the organisation's risk culture and appetite; ensuring that these are aligned to organisation's strategy and support the delivery of its objectives. Formal updates of the Assurance Framework have been presented to the July and October 2018 meetings of the Governing Bodies.

The four statutory **CCG Audit and Governance Committees** are responsible for the continual review of the relevance and rigour of the Assurance Framework and the risk management arrangements that surround it. These Committees are also responsible for approving the CCGs' Strategic Internal Audit Plans, which are derived from the strategic risks on the Assurance Framework. This ensures that areas of high risk receive an independent and objective review and that the Audit and Governance Committee is able to consider the findings of the resultant reports and the appropriateness of management responses.

The Audit and Governance Committee will provide assurance to the Governing Body in support of the Annual Governance Statement; specifically commenting on the fitness for purpose of the Governing Body Assurance Framework and the completeness and embedment of risk management in the organisation. As such, committee members have

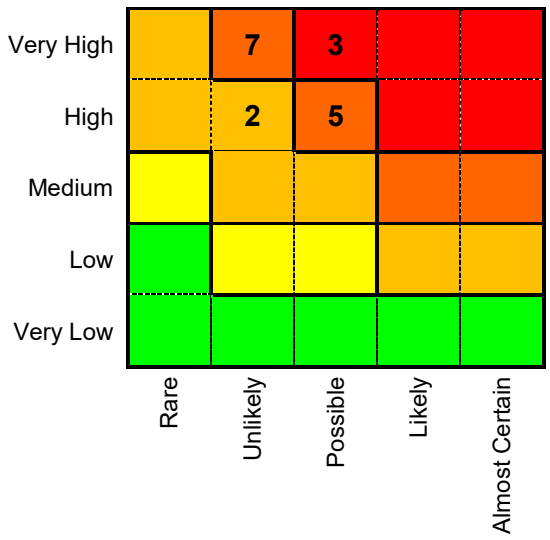
received updates throughout the year on the development and implementation of the CCGs' joint risk management arrangements.

4. Governing Body Assurance Framework: Current Position

The strategic risks shown in the Assurance Framework have been identified as high-level, *potential* risks that are unlikely to be fully mitigated unless the external environment changes significantly. Currently, there are 17 strategic risks identified in the following areas:

Patient and Member Practice Engagement	Probity in Decision-making	Procurement, Patient Choice and Competition	Equality Duties
Collaborative and Joint commissioning Arrangements	Effective Workforce and Leadership Model	Quality Improvement	Performance Monitoring and Reporting
Productivity, Efficiency and Financial Sustainability	Delivery of Commissioning Priorities	Safeguarding Children and Adults	Health System Resilience
Investment and Disinvestment Decisions	Financial Management and Reporting Arrangements	Health and Social Care Transformation	Primary Care Delegation Agreement
Patient and Public Consultation and Engagement			

The current residual strategic risk profile is summarised below:



The three red rated strategic risks are as follows:

- Risk 11: Improvements in the quality (patient safety, patient experience and clinical effectiveness) of commissioned services may not be achieved.
- Risk 16: Known and potential increases in demand may significantly exceed capacity within our major providers.
- Risk 17: System transformation in Nottinghamshire may not deliver the required system reconfiguration or financial sustainability across the health and social care system within the required timeframe.

The complete Assurance Framework is attached at **Appendix A**.

Examples of the potential consequences of the strategic risks materialising are provided at **Appendix B** (this is not an exhaustive list and there may be many more examples). This shows that each risk has the potential to impact on the delivery of statutory duties and on the achievement of domains in the NHS England Improvement and Assessment Framework.

4.1. Risk proposed for archiving

Following the Q4 review, it is proposed that the following strategic risk (risk 6) is archived due to the arrangements now in place across Nottinghamshire:

Arrangements for collaborative commissioning with other CCGs in Nottinghamshire and joint commissioning with the Local Authorities may not be suitably robust.

5. Gaps in Controls and Assurances

Gaps in controls or assurance are identified where an additional system or process is needed, or where there is a lack of evidence that controls are effective. If the gap is risk rated above amber/green then it is added to the Corporate Risk Register and monitored through the routine risk reports to the respective committees (e.g. Finance Committee).

Currently, there are three major risks on the Corporate Risk Register which are associated with gaps in controls and/or assurances:

GBAF Risk Ref.	Identified Gap in Control / Assurance	Risk	
		Ref.	Rating (IxL)
Risk 4 *(Effective workforce and leadership model)*	As a result of the restructuring process, and period of ongoing change and uncertainty, staff may become disengaged which could result in low morale and reduced productivity.	GN087	Red (4x4)
Risks 11, 12 and 16 *(Quality improvement, Achievement of performance targets, Demand exceeding capacity)*	There is a risk that patient safety in ED will be compromised as a result of departmental reconfiguration and high reliance on temporary medical workforce during the busy winter period which has the potential to make assessment, management, tracking and observation of patients more difficult.	GN082	Red (4x4)

GBAF Risk Ref.	Identified Gap in Control / Assurance	Risk	
		Ref.	Rating (IxL)
Risk 13 *(Failure to achieve recurrent savings)*	Failure to deliver the Financial Recovery Plan (FRP) and saving schemes (predominantly but not solely related to unidentified QIPP) will directly impact on our ability to deliver our financial control total for 2019/20.	GN108	Red (5x3)

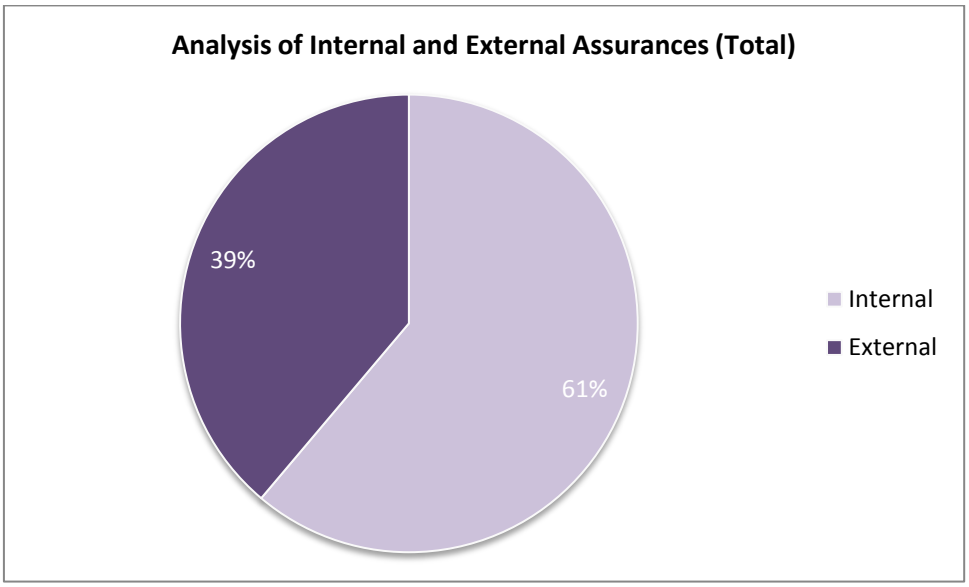
The progress of actions to mitigate the above risks is reviewed at every meeting of the Greater Nottingham Joint Commissioning Committee. They are also included within the routine Risk and Assurance Reports received by the CCGs' Governing Bodies.

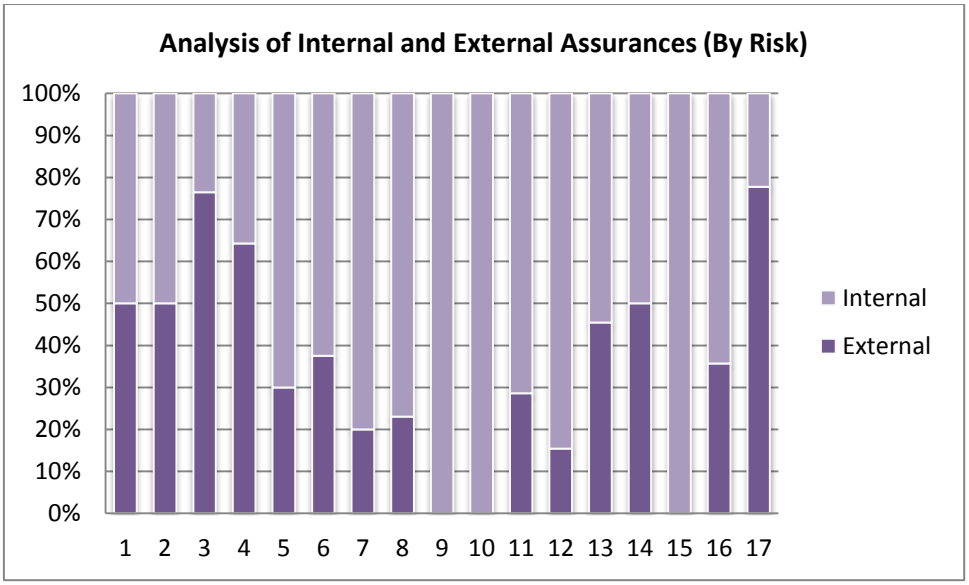
Actions relating to gaps that have been risk rated amber/green or below (acceptable or low risk) are outlined in the main Assurance Framework document. These are reviewed in conjunction with the risk owners (who are all senior managers) on a quarterly basis.

6. Review of Assurances

Meetings have recently been held with Senior Managers to review risks, controls and assurances within the Assurance Framework. At this time, there are no identified gaps in internal assurances across any of the strategic risks. A breadth of external assurances has also been received by the CCGs across the 2018/19 financial year; the majority of which have provided positive assurance against the key controls to which they relate.

A review of the internal and external assurances set out within the Assurance Framework has been has been completed. This has shown that the overall split of internal and external assurances against all identified controls is 61% internal and 39% external, which we believe to be at an acceptable level.





However, further analysis shows a variation in the number of assurances against each risk; with the largest being risk 11 (with 28 total assurances) and the smallest number being risk 15 (with two total assurances). In addition, this analysis found that risks 9 (*General and specific public sector equality duties may not be met)* and 10 (*Procurement, patient choice and competition arrangements may not be compliant with current legislative requirements and national guidance*) are the only strategic risk areas that have not received any independent assurances during the year. This was highlighted to the Audit and Governance Committee as part of a comprehensive 'assurance mapping' exercise at its meeting in December 2018 and it was agreed that these areas would be considered for review in the 2019/20 Internal Audit Plan.

7. Head of Internal Audit Opinions

The Governing Body Assurance Framework and the CCGs' risk management arrangements are a key element of the CCGs' year-end Head of Internal Audit Opinions. The CCGs have received the output of the Stage 1 and Stage 2 Head of Internal Audit work programme (September 2018 and February 2019 respectively). The Head of Internal Audit Opinion states:

'Our Stage 2 work programme has confirmed that the Assurance Framework processes are continuing to embed within the Organisations' governance structures. The arrangements identified in Stage 1 have been put in place by the CCGs and continue to develop.

There has been minimal movement in risks scores during the year, but this is as expected by the CCGs given that the Assurance Framework records significant strategic risks.

Deep dive reports relating to aspects of risk management are now being reported to each meeting of the Audit and Governance Committees-in-Common and will support further refinements in the risk management processes'.

8. Next Steps

A key focus in Q1 of 2019/20 will be aligning risk management arrangements across the Mid-Nottinghamshire and Greater Nottingham CCGs. This will include bringing together the Assurance Frameworks of the Mid-Nottinghamshire and Greater Nottingham CCGs, in addition to establishing a single Corporate Risk Register. It is anticipated that the joint Assurance Framework will be presented to the Governing Body meetings 'in common' in July 2019.

9. Recommendations

The Governing Body is requested to:

- **Review and comment** on the year-end position of the Assurance Framework.
- **Affirm** that sufficient levels of controls and assurances are in place in relation to the Greater Nottingham CCGs' strategic risks.
- **Approve** to the archiving of risk 6 (as proposed in section 4.1)
- **Provide feedback** on further areas for assurance that are not already captured within the Assurance Framework

Lucy Branson
Director of Governance

April 2019

NHS Nottingham North and East Clinical Commissioning Group

NHS Nottingham West Clinical Commissioning Group

NHS Rushcliffe Clinical Commissioning Group

NHS Nottingham City Clinical Commissioning Group

2018/19 Greater Nottingham Clinical Commissioning Partnership Joint Governing Body Assurance Framework

Year-end Position (March 2019)

Definitions

A Board/Governing Body Assurance Framework is a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect (HM Treasury Guidance on Assurance Frameworks, 2012).

Risk management is the term applied to a logical and systematic method of identifying, evaluating, treating, monitoring and communicating risks associated with any activity in a way that will enable the CCG to minimise losses and maximise opportunities.

Risk mitigation is the term applied to how risks are going to be controlled in order to reduce the likelihood of their occurrence or their impact on the organisation.

Strategic risks are defined as those that threaten the achievement of strategic objectives.

Controls are the processes/mechanisms put in place by management to help accomplish specific goals or objectives. These could include strategic CCG roles and responsibilities, governance arrangements, work streams, policies, training etc. For the purposes of the Governing Body Assurance Framework, **key controls** are those on which the organisation places reliance upon.

Assurances provide the evidence or the “avoidance of doubt” that appropriate controls are in place and operating effectively. These assurances can be **internal**, e.g. regular and ad-hoc management reports to the Governing Body and evidence through Committee minutes that duties are being effectively discharged or **external**; independent reports/opinions from auditors, inspectors, regulatory bodies, etc.

Gaps in controls or assurance are identified where an additional system or process is needed, or where there is a lack of evidence that controls are effective. If the gap is risk rated above amber/green, then it will be added to the Partnership's Corporate Risk Register and monitored through established Committee risk reporting processes.

List of Strategic Risks

Risk Ref.	Strategic Risk Description	NHS England IAF Domain	A1	O1	O2	O3	E1	E2	Executive Lead (Responsible Officer)	Risk Rating (I X L)	Potential / Target Risk Score (I X L)
			To deliver health and care system sustainability via a new model of care for Greater Nottingham	Achieve defined standards of quality across all commissioned services	Improve health outcomes and healthy life expectancy	Reduce health inequalities	Organise ourselves appropriately for the future	Embed a strong organisational culture and competency			
1	Arrangements for engaging and communicating with member GP practices may not be sufficiently robust	Leadership	✓				✓		Chief Operating Officer (Locality Directors)	4 x 3	4 x 3
2	The Clinical Commissioning Groups' delegated functions relating to primary medical services may not be delivered	Better Care				✓	✓		Chief Operating Officer (Locality Directors)	4 x 3	4 x 2
3	Arrangements for ensuring openness, transparency and accountability in decision-making may not be suitably robust.	Leadership		✓	✓	✓	✓		Chief Operating Officer (Corporate Director)	5 x 2	5 x 2
4	The organisation may not be successful in recruiting, developing and retaining an effective workforce and leadership model	Leadership		✓	✓	✓	✓	✓	Chief Operating Officer (Director of Strategic Planning)	4 x 3	4 x 2
5	Children and vulnerable adults may not be appropriately safeguarded in accordance with legislative and statutory frameworks and guidance	Leadership				✓			Chief Nurse/ Director of Quality	5 x 2	5 x 2
6	Arrangements for collaborative commissioning with other CCGs in Nottinghamshire and joint commissioning with the Local Authorities may not be suitably robust	Leadership				✓	✓		Accountable Officer (Chief Commissioning Officer and Chief Operating Officer)	4 x 2	4 x 2
7	Commissioning priorities to reduce health inequalities and improve health outcomes (as defined within the CCGs' strategic objectives and Operational Plan) may not be delivered	Better Health		✓	✓	✓	✓		Accountable Officer (Chief Commissioning Officer and Chief Operating Officer)	4 x 3	4 x 3
8	Patient and public consultation and engagement may not be fully embedded within all stages of the commissioning cycle	Leadership		✓	✓	✓			Chief Operating Officer (Director of Strategic Planning)	5 x 2	5 x 2
9	General and specific public sector equality duties may not be met	Leadership		✓	✓	✓		✓	Chief Operating Officer (Director of Strategic Planning)	5 x 2	5 x 2

Risk Ref.	Strategic Risk Description	NHS England IAF Domain	A1	O1	O2	O3	E1	E2	Executive Lead (Responsible Officer)	Risk Rating (I X L)	Potential / Target Risk Score (I X L)
			To deliver health and care system sustainability via a new model of care for Greater Nottingham	Achieve defined standards of quality across all commissioned services	Improve health outcomes and healthy life expectancy	Reduce health inequalities	Organise ourselves appropriately for the future	Embed a strong organisational culture and competency			
10	Procurement, patient choice and competition arrangements may not be compliant with current legislative requirements and national guidance	Leadership		✓			✓		Chief Commissioning Officer (Director of Contracting and Procurement)	**5 x 2**	**5 x 2**
11	Improvements in the quality (patient safety, patient experience and clinical effectiveness) of commissioned services may not be achieved	Better Care		✓	✓	✓	✓		Chief Nurse/ Director of Quality	**5 x 3**	**5 x 3**
12	The CCG may not have robust procedures in place to monitor national and local performance indicators, including the access targets set out in the NHS Constitution	Better Care				✓	✓		Chief Commissioning Officer (Director of Performance and Information)	**4 x 2**	**4 x 2**
13	The organisations may fail to identify and achieve recurrent financial savings	Sustainability				✓	✓		Chief Finance Officer (Director of Financial Recovery)	**4 x 3**	**4 x 3**
14	Appropriate and effective financial management and reporting arrangements may not be in place.	Sustainability					✓		Chief Finance Officer	**5 x 2**	**5 x 2**
15	Investment and disinvestment decisions may not be robust and consistent when considering the prioritisation of existing or planned healthcare	Sustainability		✓	✓	✓	✓		Chief Operating Officer (Director of Strategic Planning)	**5 x 2**	**5 x 2**
16	Known and potential increases in demand may significantly exceed capacity within our major providers.	Better Care				✓	✓		Chief Operating Officer (System Delivery Director and Director of Strategic Partnerships)	**5 x 3**	**5 x 3**
17	System transformation in Nottinghamshire may not deliver the required system reconfiguration or financial sustainability across the health and social care system within the required timeframe	Leadership				✓	✓	✓	Accountable Officer (Chief Commissioning Officer and Chief Operating Officer)	**5 x 3**	**5 x 2**

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
1	Chief Operating Officer (Locality Directors)	Arrangements for engaging and communicating with member GP practices may not be sufficiently robust	12	4	3	12	4	3

Key roles and responsibilities
• Clinical Leaders at the Greater Nottingham Joint Commissioning Committee • Clinical Leaders/GP Leads for member practices at the Governing Bodies • Clinical Cabinet / Clinical Council / Clinical Development Group responsibilities in relation to member practice engagement • Locality Director responsibilities in relation to member practice engagement

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	CCG Constitutions and Inter Practice Agreements, which set out a range of mechanisms for member practice engagement, including: • Named member practice representatives; • Clinical Cabinet / Clinical Council / Clinical Development Group meetings; and • Membership meetings / forums.	• Clinical Groups' minutes routinely received by Governing Bodies • CCG membership forum meetings	• Annual CCG 360 Stakeholder Survey (results not yet analysed)	None identified	
2	Primary Care Quality Framework	• Primary Care Commissioning Committee (and sub-committee) reporting arrangements • PCCC minutes reported to the Governing Bodies (quarterly)	• Annual CCG 360 Stakeholder Survey (results not yet analysed) • 2018/19 Internal Audit Primary Care Delegated Commissioning Review (**PENDING**)	None identified	None Identified

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
3	Mechanisms for member practice communications, including: • Locality GP Bulletins; • GP Net	None identified	• Annual CCG 360 Stakeholder Survey (results not yet analysed)	None identified	None Identified

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
2	Chief Operating Officer (Director of Primary Care)	The Clinical Commissioning Groups' delegated functions relating to primary medical services may not be delivered	12	4	3	8	4	2

Key roles and responsibilities
• Executive lead for Primary Care at the Governing Bodies • Director of Primary Care

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	CCG Primary Care Commissioning Committees established as the corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.	• Primary Care Commissioning Committee (and sub-committee) reporting arrangements • PCCC minutes reported to the Governing Bodies (quarterly) • Primary Care quality reporting to the Governing Bodies (quarterly)	• NHS England Improvement and Assessment Framework • 2018/19 Internal Audit Report - Primary Medical Care Delegated Commissioning (**PENDING**)	None identified	None Identified
2	Primary Care Quality Framework (including Practice Performance Review and Development Visits Programme)	• Primary Care Commissioning Committee (and sub-committee) reporting arrangements	• Annual CCG 360 Stakeholder Survey (results not yet analysed) • 2018/19 Internal Audit Primary Care Delegated Commissioning Review (**PENDING**)	None identified	None Identified

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
3	Chief Operating Officer (Corporate Director)	Arrangements for ensuring openness, transparency and accountability in decision-making may not be suitably robust.	10	5	2	10	5	2

Key roles and responsibilities
• All Governing Body, Joint Commissioning Committee and Committee Member roles in relation to ensuring that standards of business conduct are upheld and Governing Bodies and Joint Commissioning Committee meetings held in public • CCG Clinical Chairs and Accountable Officer specific responsibilities in ensuring that proper governance arrangements are in place • Executive Lead for Corporate Governance at Governing Bodies and Joint Commissioning Committee • Lay Members with oversight responsibility of conflicts of interest (Conflict of Interest Guardian) at Governing Bodies and the Audit and Governance Committees • Audit and Governance Committee Chairs are Freedom to Speak Up Guardians • Audit and Governance Committees exist to scrutinise every instance of non-compliance with the CCG's Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies and monitoring compliance with the CCG's Conflicts of Interest Policy and Gifts, Hospitality and Sponsorship Policy

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	Greater Nottingham CCP Conflicts of Interest Policy sets out the CCGs' requirements in relation to ensuring openness and transparency in business transactions, including: • Maintenance and publication of a Register of Declared Interests Arrangements for managing standing declared interests and those declared in meetings; • Specific requirements for managing GP interests in procurements; and • Maintenance and publication of a Procurement Decisions Log.	• Biannual Probity Assurance Reports to the Audit and Governance Committees (Sept 2018) (next report due to be received May 2019)	• 2017/18 CCG AGSs submitted to NHS England (May 2018) • 2018/19 Mth 9 AGSs submitted to NHS England (January 2019) • NHS England Self-Certification Assurance Process • 2017/18 Internal Audit Report: Conflicts of Interest for individual CCGs (Significant Assurance) • 2018/19 Internal Audit Report: Conflicts of Interest (**PENDING** March 2019)	None identified	None identified

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
2	Gifts, Hospitality and Sponsorship Policy, which sets out the CCGs' requirements regarding gifts, hospitality and sponsorship, including: • Maintenance and publication of a Gifts, Hospitality and Sponsorship Register	• Biannual Probity Assurance Reports to the Audit and Governance Committees (Sept 2018) (next report due to be received May 2019)	• 2017/18 Internal Audit Report: Conflicts of Interest for individual CCGs (Significant Assurance) • 2018/19 Internal Audit Report: Conflicts of Interest (**PENDING** March 2019)	None identified	None identified
3	Raising Concerns (Whistleblowing) Policy, which sets out arrangements for employees of the CCGs to voice any concerns they have in relation to the conduct of the organisation.	• Biannual Probity Assurance Reports to the Audit and Governance Committees (Sept 2018)(next report due to be received May 2019)	None identified	None identified	None identified
4	Fraud, Corruption and Bribery Policy, which sets out the anti-fraud, corruption and bribery arrangements in place within the four Greater Nottingham CCGs.	None identified	• Annual Self Review Tool (SRT) submission to NHS Counter Fraud Authority (**PENDING**) • 360 Assurance 2017/18 Counter Fraud, Bribery and Corruption Annual Report (May 2018) • 2018/19 Counter Fraud, Bribery and Corruption Annual Report (**PENDING** May 2019)	None identified	None identified
5	Conflicts of Interest and Gifts and Hospitality mandatory training for all staff.	• Workforce Reports to the Governing Bodies (latest October 2018; **PENDING** April 2019)	• NHS England Self-Certification Assurance Process **(the Greater Nottingham CCGs reported a compliance rate of 79% in the 2018/19 annual return. This is below the NHSE threshold of 90% and immediate action is being taken to address this).** • 2017/18 Internal Audit Report: Conflicts of Interest for individual CCGs (Significant Assurance) • 2018/19 Internal Audit Report: Conflicts of Interest (Pending April 2019)		Due to the absence of central systems, there is a current lack of assurance that mandatory training is being undertaken. (Risk ref GN040)

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
4	Chief Operating Officer (Director of Strategic Planning)	The organisation may not be successful in recruiting, developing and retaining an effective workforce and leadership model	12	4	3	8	4	2

Key roles and responsibilities
• CCG Chairs and Accountable Officer responsibilities in relation to the CCGs' leadership model

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	Suite of Human Resources (HR) policies to ensure best practice in arrangements for recruitment, development and retention, including: • Recruitment and Selection Policy and Procedure; • Maintaining Employee Health and Wellbeing Policy; • Management of Absence Due to Ill Health Policy and Procedure; and • Flexible Working Policy.	• Workforce Reports to the Governing Bodies (latest October 2018; **PENDING** April 2019)	• Mindful Employer Charter signatories • National Annual NHS Staff Survey	Joint policies are yet to be developed for the CCGs.	None Identified
2	CCG Constitution (Standing Orders), which set out the required appointment process for Governing Body members.	None identified	• NHS England Improvement and Assessment Framework (IAF) process	None Identified	None Identified

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
3	Establishment and monitoring of workforce KPIs, including: • Vacancies in funded establishment • Turnover and Retention Rates • Sickness Absence Rates • Uptake of Staff Appraisals (including appointed Governing Body members)	• Workforce Reports to the Governing Bodies (latest October 2018; **PENDING** April 2019)	• National Annual NHS Staff Survey • 2018/19 Internal Audit Review - Workforce and OD Review (**PENDING**)	None identified	The breakdown of central monitoring mechanisms have resulted in a lack of assurance of staff sickness being recorded consistency. (Risk ref GN088)
4	Arrangements for staff engagement and communication, including: • Establishment of a joint Staff Experience Group (SEG) across GN and MN CCGs; • Weekly ICS Comms bulletins; and • Wider staff engagement events.	• Accountable Officer (AO) Reports to the Governing Bodies (quarterly) and Joint Commissioning Committee (monthly)	• National Annual NHS Staff Survey • 2018/19 Internal Audit Review - Workforce and OD Review (**PENDING**)	As a result of the restructuring process, and period of ongoing change and uncertainty, staff may become disengaged which could result in low morale and reduced productivity (CCP risk ref GN 087).	None Identified
5	Greater Nottingham CCGs' Organisational Development Plan (Phase 1) to support the single CCG merger process.	• Single CCG Steering Group (SCSG) Workstream Highlight Reports (bi-monthly)	• National Annual NHS Staff Survey • 2018/19 Internal Audit Review - Workforce and OD Review (**PENDING**)	None identified	None identified
6	Annual Programme of Greater Nottingham Joint Commissioning Committee and Governing Body Development Sessions	• Governing Body Development Session reporting to the Single CCG Steering Group (SCSG)	None identified	None identified	None Identified

Action(s)	Responsible Officer	Due Date	Progress update (March 2019)
Shared Human Resources policies to be developed	Director of Strategic Planning	April 2020	Five joint GN and MN HR Policies are due to be approved at the next Remuneration Committee (April 2019).

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
5	Chief Nurse/ Director of Quality	Children and vulnerable adults may not be appropriately safeguarded in accordance with legislative and statutory frameworks and guidance	10	5	2	10	5	2

Key roles and responsibilities
• Executive Lead for Safeguarding at Governing Bodies and Joint Commissioning Committee • Chief Nurse/ Director of Quality member of Safeguarding Boards • Designated Nurse and Dr and Lead Practitioners for Adult, Children and LAC Safeguarding

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	Safeguarding Children, Young People and Vulnerable Adults Framework and supporting safeguarding policies (which link in with the relevant local authority safeguarding policies and procedures), including: • Safeguarding Assurance Group (SAG) meetings; • Strategic Safeguarding Partnership Group meetings; • Safeguarding Assessment and Analysis Framework (SAAF); • Section 11 Audits; and • Robust systems for monitoring/managing/reporting Serious Incidents, Serious Case Reviews and complaints/allegations and Domestic Homicide Reviews.	• Safeguarding Children and Safeguarding Adults Annual Assurance Reports received by Governing Bodies. • Safeguarding highlight reports to Governing Bodies. • Safeguarding Children and Adults Board minutes presented to Governing Bodies (quarterly)	• 2017/18 Internal Audit Review – Nottingham City CCG Quality Governance (Significant Assurance) • NHS England Safeguarding Assurance Tool (regular submissions required) • Mock Joint Targeted Area Inspection (JTAI) chaired by Independent chair of Children's Board (November 2018)	None identified	None identified

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
2	CCG membership at Local Safeguarding Children Board and Safeguarding Adults Board (and Sub-Committee structure)(for City and County Local Authorities)	• Safeguarding Children and Safeguarding Adults Annual Assurance Reports received by Governing Bodies. • Safeguarding highlight reports to Governing Bodies. • Safeguarding Children and Adults Board minutes presented to Governing Bodies (quarterly)	None identified	None identified	None identified
3	Safeguarding Children and Adults mandatory training for all staff.	• Workforce Reports to the Governing Bodies (latest October 2018; **PENDING** April 2019)	None identified	None identified	Due to the absence of central systems, there is a current lack of assurance that mandatory training is being undertaken. (Risk ref GN040)

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
6	Accountable Officer (Corporate Director)	Arrangements for collaborative commissioning with other CCGs in Nottinghamshire and joint commissioning with the Local Authorities may not be suitably robust	8	4	2	8	4	2

Key roles and responsibilities
• Executive lead for collaborative and joint commissioning at the Joint Commissioning Committee

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	• Clinical Commissioning Partnership established across four Greater Nottingham CCGs, which includes all commissioning decisions being delegated into a Joint Commissioning Committee (JCC). The JCC membership includes the local authorities.	• Quarterly Assurance Reports to the Governing Body meetings (July 2018, October 2018, January 2019 and **PENDING** April 2019).	• 2018/19 Internal Audit - Review of Governance Arrangements (February 2019) *Significant Assurance Received*	None identified	None Identified
2	• Collaborative Commissioning Arrangements MOU, which sets out the collaborative commissioning process, reporting and assurance arrangements, roles and responsibilities and management of the MOU. • Collaborative Commissioning agreements in place for non-Notts led contracts	Routine Performance Reports to the Joint Commissioning Committee	• NHS England Improvement and Assessment Framework assurance processes.	None identified	None Identified

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
3	• Section 75 Framework Partnership Agreements between the CCGs and Local Authorities.	• Better Care Fund Plan Annual Report presented to the Joint Commissioning Committee (March 2019).	None identified	None identified	None Identified

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
7	Chief Operating Officer and Chief Commissioning Officer	Commissioning priorities to reduce health inequalities and improve health outcomes (as defined within the CCGs' strategic objectives and Operational Plan) may not be delivered	12	4	3	12	4	3

Key roles and responsibilities
• Lay Member with lead oversight responsibilities for planning and performance at Joint Commissioning Committee • Clinical Commissioning Executive Group duty to develop the Commissioning Strategies and Operational Plans (and other associated enabling strategies and plans) of the Greater Nottingham CCGs • Clinical Commissioning Executive Group role to consider business cases for new investments, recurrent funding allocations and all decommissioning and disinvestment proposals, ensuring their clinical and cost effectiveness, whilst assessing any associated equality and quality impacts and feedback from patient and public engagement and consultation activities

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	Joint 2018/19 strategic objectives agreed for Greater Nottingham CCGs (approved by Governing Bodies and Joint Commissioning Committee).	• Reporting on development and delivery of joint strategic objectives to Governing Bodies (October 2018) and Joint Commissioning Committee (June and September 2018). • 2018/19 Programme of Thematic Reviews (linked to strategic objectives) in place for the Joint Commissioning Committee (Transforming Care (March 2019), Mental Health (Feb 2019), Cancer (Jan 2019), Primary Care (Nov 2018), Elective Care (Oct 2018), Community Care (Oct 2018) and Children and Families (July 2018). • Quarterly Assurance reports to the Governing Bodies	• NHS England Improvement and Assessment Framework assurance process	None identified	None Identified

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
2	CCG 2018/29 Operational Plans (endorsed by Joint Commissioning Committee and approved by Governing Bodies).	• 2018/19 Programme of Thematic Reviews (linked to strategic objectives) in place for the Joint Commissioning Committee (Transforming Care (March 2019), Mental Health (Feb 2019), Cancer (Jan 2019), Primary Care (Nov 2018), Elective Care (Oct 2018), Community Care (Oct 2018) and Children and Families (July 2018)). • Quarterly Assurance reports to the Governing Bodies (quarterly)	• NHS England Improvement and Assessment Framework assurance process	None identified	None Identified
3	Decision making Principles/ processes in place to support investment / disinvestment decisions via the Clinical Commissioning Executive Group (e.g. the consideration of business cases which are required to demonstrate reductions in health inequalities and improvements in health outcomes).	• CCEG minutes presented to the Joint Commissioning Committee (monthly). • Summary of CCEG activity presented to the Governing Bodies (quarterly). • Quarterly Assurance reports to the Governing Bodies (quarterly)	None identified	None identified	None Identified

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
8	Chief Operating Officer (Director of Communication and Engagement)	Patient and public consultation and engagement may not be fully embedded within all stages of the commissioning cycle	10	5	2	10	5	2

Key roles and responsibilities
• Lay Member with lead oversight responsibility for PPI at each Governing Body • Quality and Performance Committee duty to oversee arrangements for ensuring that patient feedback and patient and public engagement and consultation are integral in commissioning decisions • Clinical Commissioning Executive Group duty to consider business cases for new investments, recurrent funding allocations and all decommissioning and disinvestment proposals, ensuring their clinical and cost effectiveness, whilst assessing any associated equality and quality impacts and feedback from patient and public engagement and consultation activities.

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	Patient and public engagement forums' roles in ensuring that the views of patients, carers, the wider public and local communities are involved in all elements of the commissioning cycle.	• Communication and Engagement updates provided to the Quality and Performance Committee (March 2019) • Communication and Engagement Strategy update provided to the Joint Commissioning Committee (March 2019)	• Annual CCG 360o Stakeholder Survey (2018/19 results yet to be analysed • Internal Audit scheduled for 2018/19 - Communication and Engagement Review (**PENDING** due Q1 2019/20)	None identified	None Identified

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
2	Equality / Quality Impact Assessment (EQIA) process (e.g. EQIA screening tool and assessment requirements).	• Business Case / EQIA Log presented to the Quality and Performance Committee (monthly). • EDS2 Annual Equality Performance Self-Assessment to the Quality and Performance Committee (April 2019). • Quality and Performance minutes and highlight reports to Joint Commissioning Committee (monthly). • Risk and Assurance reports to the Joint Commissioning Committee (monthly) • Quarterly Assurance reports to the Governing Bodies (quarterly)	None Identified	None identified	There is a risk that outcomes from Equality and Quality Impact Assessments may not be robustly monitored and/or acted upon, which in turn, may result in certain members of the population being disadvantaged and/or discriminated against (CCP risk ref GN 091).
3	Decision making principles/ processes in place to support investment / disinvestment decisions via the Clinical Commissioning Executive Group (CCEG) (e.g. business cases presented should provide assurance that appropriate consultation and engagement activities have been undertaken).	• CCEG minutes presented to the Joint Commissioning Committee (monthly). • Summary of CCEG activity presented to the Governing Bodies (quarterly). • Business Case / EQIA Log presented to the Quality and Performance Committee (monthly). • EDS2 Annual Equality Performance Self-Assessment to the Quality and Performance Committee (April 2019).	• Internal Audit scheduled for 2018/19 - Communication and Engagement Review (**PENDING** due Q1 2019/20)	None identified	None Identified

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
9	Chief Operating Officer (Director of Strategic Planning)	General and specific public sector equality duties may not be met	10	5	2	10	5	2

Key roles and responsibilities
• Lay Member with lead oversight responsibility for PPI on the Governing Bodies and Joint Commissioning Committee • Quality and Performance Committee duties to monitor performance in relation to Goals 1 and 2 of the NHS Equality Delivery System (better health outcomes for all / improved patient access and experience), including progress against equality objectives and associated action plans • Clinical Commissioning Executive Group duty to consider business cases for new investments, recurrent funding allocations and all decommissioning and disinvestment proposals, ensuring their clinical and cost effectiveness, whilst assessing any associated equality and quality impacts and feedback from patient and public engagement and consultation activities.

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	• Equality, Diversity and Inclusion control framework, including: - Assessment of population health needs to inform commissioning decisions (JSNA); - Completion of Equality Impact Assessments as part of service planning and policy development; - Public engagement arrangements; - Contract monitoring arrangements to ensure compliance with NHS Standard Contact requirement regarding EDS2; and - Workforce monitoring arrangements.	• Annual reporting of Workforce Race Equality Standards (WRES) to Governing Bodies (**PENDING** July 2019) • Annual Equality Report to Governing Bodies (**PENDING** April 2019) • Risk and Assurance reports to the Joint Commissioning Committee (monthly) • Quarterly Assurance reports to the Governing Bodies (quarterly)	None identified	Due to the scale and pace of changes required for transformation and financial recovery, Equality and Quality Impact Assessments may not be routinely completed, or sufficiently utilised, to support decision making. This may, in turn, result in changes being made without full consideration of the impact on quality and health inequalities. (CCP risk ref GN 015)	None identified

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
2	Adoption of the NHS Equality Delivery System for assessing the organisation's equality performance.	• EDS2 Annual Equality Performance Self-Assessment 2018/19 to Quality and Performance Committee (March 2019).	None identified	None identified	None identified
3	Mandatory training for all staff in relation to Equality and Diversity	• Workforce Reports to the Governing Bodies (latest October 2018; **PENDING** April 2019)	None identified	None identified	Due to the absence of central systems, there is a current lack of assurance that mandatory training is being undertaken. (Risk ref GN040)
4	Joint Equality Impact Assessment process established to support delivery of the Greater Nottingham Financial Recovery Plan – initial screening, detailed planning and monitoring. CCEG role to review EQIAs as part of business case approval process.	• Business Case / Equality Impact Assessment log presented to Quality and Performance Committee (monthly) • CCEG minutes presented to the Joint Commissioning Committee (monthly). • Summary of CCEG activity presented to the Governing Bodies (quarterly).	None identified	None identified	None identified

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
10	Chief Commissioning Officer (Director of Contracting and Procurement)	Procurement, patient choice and competition arrangements may not be compliant with current legislative requirements and national guidance	10	5	2	10	5	2

Key roles and responsibilities
• Audit and Governance Committees duty to monitor compliance with Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies, including review of all waivers.

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	• CCGs' Prime Financial Policies set out the their arrangements for meeting procurement law, including: - Approved limits for competitive quotations and tenders (incl. OJEU requirements); - Clear categories and approval requirements for exemptions from a competitive process; - Advance contract notice requirements; and - Publication of contract awards.	• Register of Procurement Decisions and Register Of Tender Waivers presented to the Audit Committee (February 2019). • Contract updates provided to the Finance Committee (monthly). • Primary Care Commissioning Committees role in approving direct awards to GP Practices. PCC minutes presented to the Governing Bodies (quarterly). • CCEG minutes presented to the Joint Commissioning Committee (monthly) • Summary of CCEG activity presented to the Governing Bodies (quarterly)	None identified	None identified	None identified

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
2	Contracts Database, which enables timely reporting of contract expiry dates and proactive planning of procurement activity.	• Phase 1 Contracts Review, presented to the Clinical Commissioning Executive Group (November and December 2018). • Phase 2 Contracts Review (PENDING June 2019) • CCEG minutes presented to the Joint Commissioning Committee (monthly) • Summary of CCEG activity presented to the Governing Bodies (quarterly)	None identified	None identified	None identified
3	Procurement training is provided to relevant members of CCG staff.	• Workforce Reports to the Governing Bodies (latest October 2018; **PENDING** April 2019)	None identified	Procurement training needs to be formalised within the CCGs' training requirements. (I3 x L1 = A/G)	None identified
4	GN CCP Procurement Policy which sets out how decisions to award contracts for both healthcare and non-healthcare should be approached, reflecting current regulatory obligations, national policy and statutory guidance.	• Register of Procurement Decisions and Register Of Tender Waivers presented to the Audit Committee (February 2019).	None identified	None identified	None identified

Action(s)	Responsible Officer	Due Date	Progress update (March 2019)
Procurement training to be formalised within the CCGs' mandatory training requirements.	Chief Commissioning Officer(s)	October 2019	Procurement training will be mandated on a role-specific basis. This will be determined by line managers as part of the new starter induction process. A training needs assessment will be completed during 2019/20.

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
11	Chief Nurse/ Director of Quality	Improvements in the quality (patient safety, patient experience and clinical effectiveness) of commissioned services may not be achieved	15	5	3	15	5	3

Key roles and responsibilities
• Executive Lead for Quality Improvement at Governing Bodies and Joint Commissioning Committee • Quality and Performance Committee duty to seek assurance that local healthcare services are being delivered by staff with the appropriate level of skills and training in order to continuously improve and promote high standards of quality and care

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	The CCGs' Quality Assurance Framework, which sets out the CCGs' approach to improving outcomes for the population. Its routine processes include: - Risk-based Quality Visits Programmes (across primary, community and secondary care); - Arrangements for sharing good practice and learning lessons (including serious incident management, complaint investigations and adult and children's safeguarding arrangements) - Monitoring of provider compliance with CQC Essential Standards of Quality and Safety; - An Early Warning System; and - Completion of EQuality Impact Assessments as part of service reviews and pathway redesigns.	Routine quality reporting, to the following forums: • Governing Bodies (quarterly); • Joint Commissioning Committee (monthly); • Quality and Performance Committee (monthly). • Quality 'deep dive' thematic reviews to the Quality and Performance Committee (monthly) (NUH ED, Care Homes, NUH Maternity) • 'Deep dive' thematic reviews to the Joint Commissioning Committee (monthly). • Annual Assurance of Local Providers Quality Accounts to the Quality and Performance Committee. Annual reporting to the Quality and Performance Committee in relation to: • Infection Prevention and Control (August 2018); • Prescribing / Controlled Drugs (August 2018); • Serious Incidents (Nov 2018); and • Complaints and Comments (August 2018).	• NHS England Improvement and Assessment Framework assurance process • Quality Surveillance Group (with CCG membership) reviews quality issues across all commissioners • Care Quality Commission inspections (primary and secondary care local providers) • 2018/19 Internal Audit: GN CCGs Primary Care Quality Monitoring Follow-up (February 2019)	None identified	There is a risk that patient safety in ED will be compromised as a result of departmental reconfiguration and high reliance on temporary medical workforce during the busy winter period which has the potential to make assessment, management, tracking and observation of patients more difficult (CCP risk ref GN 082). Continued failure to deliver the ambulance targets caused by a shortage of trained paramedics, delays in A&E handovers and level of staff sickness resulting in potential for poor patient experience, poor clinical outcomes and damage to the reputation of the organisation (CCP risk ref GN 006).

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
2	Established contract management framework for monitoring and reporting quality indicators and metrics, including: - Quality schedule requirements; - Commissioning for Quality and Innovation (CQUIN) Framework indicators; and - Quality review meetings / scrutiny panels with providers.	Routine quality reporting, to the following forums: • Governing Bodies (quarterly); • Joint Commissioning Committee (monthly); • Quality and Performance Committee (monthly). • Quality 'deep dive' thematic reviews to the Quality and Performance Committee (monthly) • NUH Emergency Department 'At a Point in Time' Deep-dive Review (presented to Quality and Performance Committee in March 2019)	• Quality Surveillance Group (with CCG membership) reviews quality issues across all commissioners • Care Quality Commission inspections (primary and secondary care local providers)	None identified	Ability of providers to provide safe high quality care is compromised due to the difficulties in being able to recruit, develop and retain an effective workforce with the potential to lead to impact on patient care and outcomes. (Risk ref GN011)
3	Arrangements for ensuring greater personalised care and shared-decision making, including an established offer of Personal Health Budgets to specific groups and individuals (in line with national guidance).	Routine quality reporting, to the following forums: • Governing Bodies (quarterly); • Joint Commissioning Committee (monthly); • Quality and Performance Committee (monthly). • Quality 'deep dive' thematic reviews to the Quality and Performance Committee (monthly)	• 2018/19 Internal Audit: Personal Health Budgets Follow-up (February 2019) • 2018/19 Internal Audit: Continuing Healthcare and NHS Funded Nursing Care Financial Arrangements Follow-up (February 2019)	None identified	None Identified
4	Individual CCG Complaints Policies in place, which set out the organisations' approach to handling complaints and concerns about commissioned services.	• Annual Report for Complaints and Patient Experience to Quality and Performance Committee.	None identified	None identified	None Identified

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
12	Chief Commissioning Officer (Director of Performance and Information)	The CCG may not have robust procedures in place to monitor national and local performance indicators, including the access targets set out in the NHS Constitution	**8**	**4**	**2**	**8**	**4**	**2**

Key roles and responsibilities
• Executive Lead for Performance Management at the Joint Commissioning Committee • Information, Governance, Management and Technology Committee duty to provide assurance to the Governing Bodies that sufficient attention is being placed on data quality of both mandated and local datasets generated by the CCGs and their providers. • Quality and Performance Committee duty to oversee the development, implementation and monitoring of performance management arrangements, including scrutiny of identified action plans to address shortfalls in performance.

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	• Operational Plans which detail the CCGs' approach to delivery against their key requirements. • Contract management arrangements, including routine performance monitoring, regular contract meetings and escalation requirements when recovery actions are required	• 2018/19 Operational Plans endorsed by Greater Nottingham Joint Commissioning Committee (April 2018) and approved by Governing Bodies (May 2018) Routine performance reporting, to the: • Joint Commissioning Committee (monthly); • Governing Bodies (quarterly); • Quality and Performance Committee (monthly); and • Finance Committee (monthly). • Routine contract updates provided to the Finance and Performance Committee (monthly). • Risk and Assurance reports to the Joint Commissioning Committee (monthly) • Quarterly Assurance reports to the Governing Bodies (quarterly)	• 2017/18 Internal Audit: Data Quality and Performance Management Framework (Local Partnerships) rcd February 2019. Significant Assurance received.	None identified	There is a risk that patient safety in ED will be compromised as a result of departmental reconfiguration and high reliance on temporary medical workforce during the busy winter period which has the potential to make assessment, management, tracking and observation of patients more difficult (CCP risk ref GN 082). Continued failure to deliver the ambulance targets caused by a shortage of trained paramedics, delays in A&E handovers and level of staff sickness resulting in potential for poor patient experience, poor clinical outcomes and damage to the reputation of the organisation (CCP risk ref GN 006).

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
2	CCG Data Quality Policies which sets out the CCGs' arrangements for maintaining and increasing high levels of data quality, including: - Data quality approach; - Data validation routines; and - Data standards.	• Data Quality reporting to Information Governance, Management and Technology Committee (December 2018) • Risk and Assurance reports to the Joint Commissioning Committee (monthly) • Quarterly Assurance reports to the Governing Bodies (quarterly)	• 2017/18 Internal Audit: Data Quality and Performance Management Framework (Local Partnerships) rcd February 2019. Significant Assurance received.	None identified	None identified

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
13	Chief Finance Officer (Director of Financial Recovery)	The organisations may fail to identify and achieve recurrent financial savings	12	4	3	12	4	3

Key roles and responsibilities
• Turnaround Director responsibility for financial sustainability and delivery of savings opportunities • Chief Finance Officer responsibility to ensure effective financial management • Lay Member with lead oversight responsibility for financial management and audit at the Joint Commissioning Committee • Finance Committee role to oversee the development, implementation and monitoring of the CCGs' Financial Recovery Plan. This will include consideration of the differing financial positions of the CCGs • Potential impact on achievement of NHS England IAF domain - Leadership

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	Greater Nottingham financial recovery infrastructure, including: • Established Financial Recovery Delivery Board and Financial Recovery Delivery Group; • Established PMO and supporting operational structures; • Identification of SROs and subsequent scheme monitoring and scrutiny processes.	Routine finance reporting to the: • Governing Bodies (quarterly); • Joint Commissioning Committee (monthly); • Finance Committee (monthly). • Routine QIPP performance reporting to the Financial Recovery Delivery Board (monthly) and Finance Committee (monthly). • Routine system-wide finance reporting (including CCGs' QIPP position) to the ICS Finance Group (monthly).	• NHS England Improvement and Assessment Framework assurance process. • 2017/18 Internal Audit Report: QIPP / PMO Review (Limited Assurance) (subsequent follow-up identified actions had been appropriate addressed) • Ernest & Young Review: The Nottingham and Nottinghamshire ICS High-level review of 2018/19 collective financial position and recovery plan (January 2019). • Deloitte Review: 2018/19 Financial Position and Forecast Outturn Review (December 2018) • Deloitte Review: 2019/20 QIPP Programme Review (February 2019)	None identified	Failure to deliver the Financial Recovery Plan (FRP) and saving schemes (predominantly but not solely related to unidentified QIPP) will directly impact on our ability to deliver our financial control total for 2019/20 (CCP risk ref GN 108).

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
2	CCGs' Detailed Financial Policies set out the their arrangements for meeting procurement law, including: - Approved limits for competitive quotations and tenders; - Clear categories and approval requirements for exemptions from a competitive process; and - Publication of contract awards.	• Register of Procurement Decisions and Register Of Tender Waivers presented to the Audit Committee (February 2019).	None identified	None identified	None Identified

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
14	Chief Finance Officer	Appropriate and effective financial management and reporting arrangements may not be in place.	10	5	2	10	5	2

Key roles and responsibilities
• Executive Lead for financial management at the Governing Bodies and Joint Commissioning Committee • Audit and Governance Chairs at Governing Bodies • Audit and Governance Committees duty to monitor the integrity of the financial statements of the CCG and any formal announcements relating to the organisation's financial performance • Finance Committee exists to scrutinise arrangements for ensuring the delivery of the Greater Nottingham CCGs' statutory financial duties, including the achievement of the Greater Nottingham Financial Recovery Programme (FRP) • Financial Recovery Delivery Board established to oversee the delivery of the Greater Nottingham CCG's Financial Recovery Delivery Programme, including the development of a robust and re-prioritised financial recovery plan (FRP) and to ensure that actions contained are delivered to support achievement of the annual Control Total

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	Established arrangements for financial management and reporting, as set out within: - CCG Constitutions, Standing Orders, Scheme of Reservation and Delegations and Prime Financial Policies; and - Detailed Financial Policies and Schedule of Delegated Matters	Routine finance reporting to the: • Governing Bodies (quarterly); • Joint Commissioning Committee (monthly); • Finance Committee (monthly). Routine system-wide finance reporting (including CCGs' financial position) to the ICS Finance Group (monthly). • 2018/19 Annual Accounts presented to the Audit Committee and Governing Bodies (PENDING April 2019) (all statutory duties forecast to have been met)	• NHS England Improvement and Assessment Framework assurance process. • 2018/19 Internal Audit Report: Financial Management and Key Financial Systems (PENDING April 2019) • 2018/19 Annual Accounts Audit (KPMG) (PENDING May 2019) • Ernest & Young Review: The Nottingham and Nottinghamshire ICS High-level review of 2018/19 collective financial position and recovery plan (January 2019). • Deloitte Review: 2018/19 Financial Position and Forecast Outturn Review (December 2018) • Deloitte Review: 2019/20 QIPP Programme Review (February 2019)	None identified	None identified

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
2	The CCGs' overarching contract management framework, including: - Contract negotiation process and monthly contract monitoring meetings with Providers; - Associate contract management arrangements; - System for scrutiny of clinical coding; and - QIPP targets incorporated into contracts and monitored through the contract monitoring meetings.	Routine finance reporting to the: • Governing Bodies (quarterly); • Joint Commissioning Committee (monthly); • Finance Committee (monthly). • Routine contract performance reporting to the Finance Committee (monthly). • Routine QIPP performance reporting to the Financial Recovery Delivery Board (monthly) and Finance Committee (monthly). • Routine system-wide finance reporting (including CCGs' financial position) to the ICS Finance Group (monthly). • 2018/19 Annual Accounts presented to the Audit Committee and Governing Bodies (PENDING April 2019) (all statutory duties forecast to have been met)	• NHS England Improvement and Assessment Framework assurance process. • 2018/19 Internal Audit Report: Financial Management and Key Financial Systems (PENDING April 2019) • 2018/19 Annual Accounts Audit (KPMG) (PENDING May 2019) • Ernest & Young Review: The Nottingham and Nottinghamshire ICS High-level review of 2018/19 collective financial position and recovery plan (January 2019). • Deloitte Review: 2018/19 Financial Position and Forecast Outturn Review (December 2018) • Deloitte Review: 2019/20 QIPP Programme Review (February 2019)	None identified	There is the potential that the CCGs' contract monitoring arrangements may not be suitably robust in order to predict when potential financial pressures become unmanageable for a provider. There is a risk that this could impact on the CCG in terms of additional financial costs and resources and affect the delivery of objectives/duties (Risk Ref GN047)
3	Financial management training is provided to relevant members of CCG staff.	• Workforce Reports to the Governing Bodies (latest October 2018; **PENDING** April 2019)	None identified	Financial management training needs to be formalised within the CCG's training requirements. (I3 x L1 = A/G)	None identified

Action(s)	Responsible Officer	Due Date	Progress update (March 2019)
To formalise financial management training within the CCGs' mandatory training requirements.	Chief Finance Officer	October 2019	Financial Management training will be mandated on a role-specific basis. This will be determined by line managers as part of the new starter induction process. Training will be delivered by the Finance Team and a training needs assessment will be completed during 2019/20.

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
15	Chief Operating Officer (Director of Strategic Planning)	Investment and disinvestment decisions may not be robust and consistent when considering the prioritisation of existing or planned healthcare	10	5	2	10	5	2

Key roles and responsibilities
• Executive Lead for financial management and audit at the Joint Commissioning Committee • Lay Member with lead oversight responsibility for financial management and audit at the Greater Nottingham Joint Commissioning Committee • Clinical Commissioning Executive Group duty to consider business cases for new investments, recurrent funding allocations and all decommissioning and disinvestment proposals, ensuring their clinical and cost effectiveness, whilst assessing any associated equality and quality impacts and feedback from patient and public engagement and consultation activities

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	Decision making principles/processes in place to support investment / disinvestment decisions via the Clinical Commissioning Executive Group (CCEG) (e.g.to consider options appraisals, impact assessments and prioritisation criteria).	• CCEG minutes presented to the Joint Commissioning Committee (monthly). • Summary of CCEG activity presented to the Governing Bodies (quarterly).	None identified	None identified	None Identified

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
16	Chief Operating Officer (System Delivery Director and Director of Strategic Partnerships)	Known and potential increases in demand may significantly exceed capacity within our major providers.	15	5	3	15	5	3

Key roles and responsibilities
• Accountable Officer responsibilities for system resilience • System Delivery Director- Urgent Care (Joint post across CCGs and NUH) • Deputy Director of Urgent Care • Director of Strategic Partnerships • Emergency Preparedness, Resilience and Response (EPRR) & Partnership Manager

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	System performance infrastructure for A&E and wider performance targets, including: • CCG membership on the A&E Delivery Board (monthly); • CCG membership on A&E Escalation meetings (weekly); • Chief Executive / AO 'winter' calls (daily); • Attendance at Regulator performance meetings (with NHSI/NHSE); • Attendance at Regulator Escalation performance meetings (with NHSI/NHSE); • ICS Programme Workstreams (e.g. Urgent and Emergency Care, Cancer and End of Life); • Attendance at ICS Performance Oversight Group (POG); and • Multi-partner system performance reports (received daily).	Performance reporting to: • Governing Bodies (quarterly); • Joint Commissioning Committee (monthly); • Quality and Performance Committee (monthly); and • Finance Committee (monthly). • NUH Emergency Department 'At a Point in Time' Deep-dive Review (presented to Quality and Performance Committee in March 2019) • Risk and Assurance reports to the Joint Commissioning Committee (monthly) • Quarterly Assurance reports to the Governing Bodies (quarterly)	• NHS England Improvement and Assessment Framework (IAF) assurance process • Regulator Escalation process • ICS Performance Reporting (to ICS Board)	None identified	There is a risk that patient safety in ED will be compromised as a result of departmental reconfiguration and high reliance on temporary medical workforce during the busy winter period which has the potential to make assessment, management, tracking and observation of patients more difficult. (CCP risk ref GN 082).

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
2	Emergency Preparedness, Resilience and Response (EPRR) Planning Arrangements, which includes the: • Establishment of the Greater Nottingham and Mid Notts CCG EU Exit Group (bi-monthly meetings).	• Emergency Preparedness, Resilience and Response Assurance Report to Governing Bodies (October 2018) • Brexit reports to the Joint Commissioning Committee	• NHS England assessment of compliance with core EPRR Standards • NHS England 'Brexit' preparedness assurance process	None identified	None identified

STRATEGIC RISK DETAIL

Risk Ref.	Lead	Risk description	Risk score	Risk score		Target Risk score	Risk score	
				I	L		I	L
17	Accountable Officer	System transformation in Nottinghamshire may not deliver the required system reconfiguration or financial sustainability across the health and social care system within the required timeframe	15	5	3	10	5	2

Key roles and responsibilities
• Chair and Accountable Officer responsibilities for system transformation

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
1	• CCG Executive and lay membership on the Nottingham and Nottinghamshire ICS Board (and supporting Committee infrastructure, including Finance, Planning, Governance and Clinical Reference Groups). • Appointment to Locality Director posts which are aligned with ICP 'footprints'. • Establishment of 21 Primary Care Networks (PCNs) across Mid-Nottinghamshire and Greater Nottingham CCGs.	• ICS updates reported to Governing Bodies and Greater Nottingham Joint Commissioning Committee via Accountable Officer (AO) Reports.	• NHS England engagement within the ICS Board infrastructure • Ernst & Young Review: The Nottingham and Nottinghamshire ICS High-level review of 2018/19 collective financial position and recovery plan (January 2019). • Deloitte Review: 2018/19 Financial Position and Forecast Outturn Review (December 2018) • Deloitte Review: 2019/20 QIPP Programme Review (February 2019) • Internal Audit Report: STP Governance Review Follow up (October 2018) (all original risk areas identified addressed)	None Identified	None Identified

	Controls	Internal Assurance	External Assurance	Gaps in controls	Gaps in assurance
2	Single CCG merger project infrastructure, including: • CCG Merger Programme Board; • CCG Merger Project Group; • CCG Merger Plan; and • Established Merger Workstreams (Workforce and OD, Governance and Due Diligence and Communication and Engagement).	• Assurance reporting to Merger Programme Board, Governing Bodies and Directors' Group (**PENDING** April 2019)	• NHS England assurance processes (e.g. attendance at CCG Programme Board, weekly assurance AO updates).	None Identified	None Identified

Independent Assurances 2018/19

Date (received or expected)	Assurance	External assessment completed by:	Reviewed internally by:	Positive or Negative Assurance	Mapped to Risk Ref(s)
Apr-18	Conflicts of Interest Self-Assessment (quarterly and annual submission)	NHS England	Audit and Governance Committees	Positive	RISK3,
Apr-18	CCG 360o Stakeholder Survey 2018	NHS England	Governing Bodies	Overall Positive, however areas for improvement across individual CCGs and some areas reviewed.	RISK1, RISK8, RISK14
May-18	Annual Governance Statements 2017/18 (including Head of Internal Audit Opinions 2017/18)	NHS England/DH	Audit and Governance Committees	Positive	RISK3,
May-18	Annual Accounts 2017/18 (including ISA 260 reports)	NHS England/DH	Audit and Governance Committees	Positive	RISK14
May-18	Internal Audit Report – Conflicts of Interest	_	Audit and Governance Committees	Positive - Significant for all four CCGs	RISK3,
Jul-18	Conflicts of Interest self-assessment (quarterly submission)	NHS England	Audit and Governance Committees	Positive	RISK3,
Jul-18	NHS England Improvement and Assessment Framework 2017/18 (quarterly and annual assessment)	NHS England	Governing Bodies	Positive (Rating of 'requires improvement' for Nottingham City and 'good' for Nottingham North and East, Nottingham West and Rushcliffe)	RISK2, RISK6, RISK7, RISK11, RISK14, RISK16,
Sep-18	Financial Control and Governance Self-Assessment	NHS England	Audit and Governance Committees	Positive	RISK14
Sep-18	NHS England's Management of the Primary Care Support Services Contract With Capita Report	NAO	Audit and Governance Committees	Negative	
Sep-18	Internal Audit Report – QIPP PMO Arrangements	360 Assurance	Audit and Governance Committees	Negative - Limited assurance provided. Assurance provided to the Audit and Governance Committees that required actions are being implemented.	RISK14
Oct-18	Conflicts of Interest self-assessment (quarterly submission)	NHS England	Audit and Governance Committees	Positive	RISK3,
Dec-18	Internal Audit Report - STP Governance Review Follow-up	360 Assurance	Audit and Governance Committees	Positive	RISK17
Dec-18	Capita ISAE 3402 final Type II report	KPMG	Audit and Governance Committees	Negative	
Dec-18	Internal Audit -Head of Internal Audit Opinion (Stage 1)	360 Assurance	Audit and Governance Committees	Positive	
Dec-18	Internal Audit Report - GDPR	360 Assurance	Audit and Governance Committees	Positive	
Dec-18	2018/19 Financial Position and Forecast Outturn Review	Deloitte	Finance Committee	Positive - as confirmed reported figures.	RISK 13, RISK 14
Jan-19	Conflicts of Interest self-assessment (quarterly submission)	NHS England	Audit and Governance Committees	Positive	RISK3,
Jan-19	High-level review of the 2018/19 collective financial position and recovery plan (for Nottingham and Nottinghamshire ICS)	EY	Finance Committee	Positive	RISK 13, RISK 14
Feb-19	Data Security Standards Stage 1 Memorandum: Governance Arrangements	360 Assurance	Audit and Governance Committees	Positive	
Feb-19	Data Quality and Performance Management Framework - Local Partnerships	360 Assurance	Audit and Governance Committees	Positive	RISK 12
Feb-19	AGEM Service Auditor Reports (SARs)	Deloitte	Audit and Governance Committees	**Pending**	
Feb-19	Internal Audit - Head of Internal Audit Opinion (Stage 2)	360 Assurance	Audit and Governance Committees	Positive	

Feb-19	2019/20 QIPP Programme Review	Deloitte	Finance Committee	Negative - risk adjusted identified schemes from £17.7m to £13.9m; resulting in wider savings gap.	RISK 13, RISK 14
Mar-19	Internal Audit Report - Governance 2018/19	360 Assurance	Audit and Governance Committees	Positive	
Mar-19	Internal Audit Report - Risk Management 2018/19	360 Assurance	Audit and Governance Committees	Positive	
Mar-19	Internal Audit Report - Primary Medical Care Delegated Commissioning 2018/19	360 Assurance	Audit and Governance Committees	**Pending**	RISK2
Mar-19	Internal Audit -Data Security Standards Stage 2	360 Assurance	Audit and Governance Committees	**Pending**	
Mar-19	Internal Audit Report - Conflicts of Interest 2018/19	360 Assurance	Audit and Governance Committees	Positive	RISK3,
Mar-19	Internal Audit Report - Workforce Review 2018/19	360 Assurance	Audit and Governance Committees	**Pending**	RISK4,
Mar-19	Internal Audit Report - Communication and Engagement 2018/19	360 Assurance	Audit and Governance Committees	**Pending**	RISK8,
Mar-19	Internal Audit Report - key Financial Systems and Financial Management Arrangements 2018/19	360 Assurance	Audit and Governance Committees	Positive	RISK10, RISK13, RISK14

Appendix 2: CCP Scoring Matrix

Table 1 - Impact scores (I)

What is the severity of the impact?					
Impact Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Insignificant or minor**	**Moderate**	**Significant**	**Very Significant**	**Major**
Impact should it happen	**No or slight impact on the CCG's objectives**	**Moderate Impact on the CCG's objectives**	**Significant impact on the CCG's objectives**	**Impact on the CCG's objectives affecting delivery over several areas**	**Impact on the CCG's objectives requiring radical review**

Table 2 Likelihood score (L)

What is the likelihood that harm, loss or damage from the identified hazard will occur?					
Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it happen?	**This will probably never happen/occur**	**Do not expect it happen/ recur but it is possible it may do so**	**Possibly may happen**	**Highly probable that it will happen**	**Likely to occur**

Table 3 Risk scoring = Impact x likelihood (I x L)

Very High – 5	**A**	**A/R**	**R**	**R**	**R**
High – 4	**A**	**A**	**A/R**	**R**	**R**
Medium – 3	**A/G**	**A**	**A**	**A/R**	**A/R**
Low – 2	**G**	**A/G**	**A/G**	**A**	**A**
Very Low – 1	**G**	**G**	**G**	**G**	**G**
	Rare - 1	**Unlikely - 2**	**Possible - 3**	**Likely - 4**	**Almost Certain - 5**

Impact

Likelihood

Appendix B – Strategic Risks

Risk Ref.	Strategic Risk Description	Potential consequences of risk materialising:	Executive Lead (Responsible Officer)	Risk Rating Q4 (Impact x Likelihood)	Target Risk Score (Impact x Likelihood)
1	Arrangements for engaging and communicating with member GP practices may not be sufficiently robust	• Commissioned services may not reflect requirements of local patient populations or complement existing local services • Members may not be suitably engaged in future system developments • Potential impact on the delivery of statutory requirements • Potential impact on achievement of NHS England IAF domain - Leadership	Chief Operating Officer (Locality Directors)	**4 x 3**	**4 x 3**
2	The Clinical Commissioning Groups' delegated functions relating to primary medical services may not be delivered	• Core primary medical services may not be available or meet required standards • Delegated functions may be removed by NHS England • Potential impact on achievement of NHS England IAF domain - Better Care	Chief Operating Officer (Director of Primary Care)	**4 x 3**	**4 x 2**
3	Arrangements for ensuring openness, transparency and accountability in decision-making may not be suitably robust.	• Decisions may not be appropriate (or not taken appropriately) or the best option to meet the needs of the local population • Inability to demonstrate high standards of business conduct and potential loss of public trust • Individuals may not be protected to engage in discussions/decision-making • CCGs may be open to challenge on decisions Potential impact on the delivery of statutory requirements • Potential impact on achievement of NHS England IAF domain - Leadership	Chief Operating Officer (Corporate Director)	**5 x 2**	**5 x 2**
4	The organisation may not be successful in recruiting, developing and retaining an effective workforce and leadership model	• Workforce capacity and capability may be insufficient to deliver required CCG functions • Organisational memory may be lost with increased staff turnover • Staff rights and pledges, as set out in the NHS Constitution, may not be met • Potential impact on achievement of NHS England IAF domain - Leadership	Chief Operating Officer (Director of Strategic Planning)	**4 x 3**	**4 x 2**

Risk Ref.	Strategic Risk Description	Potential consequences of risk materialising:	Executive Lead (Responsible Officer)	Risk Rating Q4 (Impact x Likelihood)	Target Risk Score (Impact x Likelihood)
5	Children and vulnerable adults may not be appropriately safeguarded in accordance with legislative and statutory frameworks and guidance	• Children and vulnerable adults may be unable to access appropriate services • Safeguarding concerns may not be identified, reported and managed and information may not be shared with other appropriate bodies • Potential impact on the delivery of statutory requirements • Potential impact on achievement of NHS England IAF domain – Better Care	Chief Nurse/ Director of Quality	**5 x 2**	**5 x 2**
6	Arrangements for collaborative commissioning with other CCGs in Nottinghamshire and joint commissioning with the Local Authorities may not be suitably robust	• Patient services commissioned may not reflect requirements of patient populations or complement existing local services • The CCGs may not be assured that services are commissioned and delivered as required • The CCGs may lack assurance that appropriate legal arrangements are in place (eg. Section 75 agreements with the local authorities) • Potential impact on achievement of NHS England IAF domain - Leadership	Accountable Officer (Chief Commissioning Officer and Chief Operating Officer)	**4 x 2**	**4 x 2**
7	Commissioning priorities to reduce health inequalities and improve health outcomes (as defined within the CCGs' strategic objectives and Operational Plan) may not be delivered	• Patient services commissioned may not reflect requirements of patient population • Patients may be unable to access the right services or receive different levels of care • Potential for financial impact caused by avoidable hospital admissions • Potential impact on the delivery of statutory requirements • Potential impact on achievement of NHS England IAF domain - Better Health	Accountable Officer (Chief Commissioning Officer and Chief Operating Officer)	**4 x 3**	**4 x 3**
8	Patient and public consultation and engagement may not be fully embedded within all stages of the commissioning cycle	• Patient services commissioned may not reflect requirements of local patient populations • Potential for missed opportunities to improve the design and delivery of local services • Potential for challenge on the CCGs' decisions Potential impact on the delivery of statutory requirements • Potential impact on achievement of NHS England IAF domain - Leadership	Chief Operating Officer (Director of Strategic Planning)	**5 x 2**	**5 x 2**

Risk Ref.	Strategic Risk Description	Potential consequences of risk materialising:	Executive Lead (Responsible Officer)	Risk Rating Q4 (Impact x Likelihood)	Target Risk Score (Impact x Likelihood)
9	General and specific public sector equality duties may not be met	• Patient groups may be unable to access the right services and the equality of health outcomes may not be achieved • Workforce and services may not reflect local population • Potential impact on the delivery of statutory requirements • Potential impact on achievement of NHS England IAF domain – Leadership	Chief Operating Officer (Director of Strategic Planning)	**5 x 2**	**5 x 2**
10	Procurement, patient choice and competition arrangements may not be compliant with current legislative requirements and national guidance	• CCGs may be open to legal challenge on procurement decisions • Patients may be unable to make choices about their healthcare • The CCGs' Social Value priorities and obligations may not be achieved • Potential impact on the delivery of statutory requirements • Potential impact on achievement of NHS England IAF domain - Leadership	Chief Commissioning Officer (Director of Contracting and Procurement)	**5 x 2**	**5 x 2**
11	Improvements in the quality (patient safety, patient experience and clinical effectiveness) of commissioned services may not be achieved	• Patients may not receive high quality care • Care delivered by commissioned services may not be in line with national guidance and current best practice • CCGs may receive complaints or criticisms regarding commissioned services • Potential impact on the delivery of statutory duties Potential impact on achievement of NHS England IAF domain - Better Care	Chief Nurse / Director of Quality	**5 x 3**	**5 x 3**
12	The CCG may not have robust procedures in place to monitor national and local performance indicators, including the access targets set out in the NHS Constitution	• Potential inability to detect unwarranted clinical variations or to benchmark performance against comparable areas • The CCGs may not be able to hold providers to account for under-performance or be assured that corrective actions are in place • Financial and managerial decisions may not be supported by timely and accurate information • Potential impact on the delivery of statutory duties • Potential impact on achievement of NHS England IAF domain - Better Care	Chief Commissioning Officer (Director of Performance and Information)	**4 x 2**	**4 x 2**

Risk Ref.	Strategic Risk Description	Potential consequences of risk materialising:	Executive Lead (Responsible Officer)	Risk Rating Q4 (Impact x Likelihood)	Target Risk Score (Impact x Likelihood)
13	The organisation may fail to identify and achieve recurrent financial savings	• Impact on delivery of the system control total. • Potential impact on the delivery of statutory duties • Potential impact on achievement of NHS England IAF domain – Sustainability	Chief Finance Officer / Turnaround Director	**4 x 3**	**4 x 3**
14	Appropriate and effective financial management and reporting arrangements may not be in place.	• Insufficient oversight and scrutiny of the CCGs finances at the Governing Bodies and Joint Commissioning Committee • Finance risks may not be highlighted to the right forum in a timely manner • Potential impact on the delivery of statutory duties Potential impact on achievement of NHS England IAF domain – Sustainability	Chief Finance Officer	**5 x 2**	**5 x 2**
15	Investment and disinvestment decisions may not be robust and consistent when considering the prioritisation of existing or planned healthcare	• Patient services commissioned may not reflect the needs of local patient populations or reflects the CCGs agreed commissioning priorities • Patient services may not be equitable, clinically effective or lead to improved health outcomes Loss of opportunities to find better alternatives that satisfy a range of principles, whilst being clinically and cost-effective. • Potential impact on the delivery of statutory duties • Potential impact on achievement of NHS England IAF domain – Sustainability	Chief Operating Officer (Director of Strategic Planning)	**5 x 2**	**5 x 2**
16	Health community resilience to known and potential increases in demand may significantly exceed capacity within our major providers	• Patient services and quality of care may not be maintained during periods of increased activity (eg. seasonal, in response to a major incident etc.) • Potential impact on delivery of statutory duties • Potential impact on achievement of NHS England IAF domain – Better Care	Chief Operating Officer (System Delivery Director and Director of Strategic Partnerships)	**5 x 3**	**5 x 3**

Risk Ref.	Strategic Risk Description	Potential consequences of risk materialising:	Executive Lead (Responsible Officer)	Risk Rating Q4 (Impact x Likelihood)	Target Risk Score (Impact x Likelihood)
17	System transformation in Nottinghamshire may not deliver the required system reconfiguration or financial sustainability across the health and social care system within the required timeframe	• System-wide efficiencies may not be fully realised • Potential impact on achievement of NHS England IAF domain - Sustainability	Accountable Officer (Chief Commissioning Officer and Chief Operating Officer)	**5 x 3**	**5 x 2**

NHS
Greater Nottingham
Clinical Commissioning Partnership

Meeting Title:	Open Governing Body			**Date:** 10 April 2019				
Paper Title:	Equality Annual Report 2018/19			**Paper Reference:** GB/19/041 a				
Sponsor:	Hazel Buchanan							
Previous Related Papers:								
Recommendation:	Approve	☒	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☐
Summary Purpose of Paper:	The purpose of this paper is to advise the Greater Nottingham Clinical Commissioning Partnership of work undertaken during 2018/19 to ensure that the CCGs of the Greater Nottingham Clinical Commissioning Partnership meet the requirements of the Public Sector Equality Duty (PSED) of the Equality Act 2010. The PSED requires all public sector organisations to analyse and measure their equality performance and prepare associated information for publication annually. To fulfil this requirement the NHS has established the Equality Delivery System (EDS2) Toolkit. The information in this report forms the draft Annual Equality Report, which will be published on the Greater Nottingham CCGs' websites. Appendix A of the report contains the EDS2 Annual Equality Self-assessment. This report has was presented and discussed at the April 2019 Quality and Performance Committee who are responsible for in-year monitoring of performance against goals 1 and 2 of EDS2. Overall, the committee were assured with the content of the report and made the following specific comments; • future scheduling of report preparation should allow for longer lay member review of the draft paper and a face to face meeting for discussion (a one week virtual review of the paper was scheduled this year), • it was noted that a degree of interpretation had been used to assess an 'average' score in order to reach a Greater Nottingham aligned base-line • it was highlighted that the role of Quality Scrutiny Panel in reviewing the equality assurance requirements included in provider contracts was particularly important as the basis for our assurance for goals 1 and 2.							

If paper is for Approval/Endorsement, have the following impact assessments been completed?			
Equality / Quality Impact Assessment	Yes ☐ No ☐ N/A ☒	Data Protection Impact Assessment	Yes ☐ No ☐ N/A ☒
Conflicts of Interest: Please consider whether there are any conflicts of interest considerations relevant			

to paper authors, members or attendees.
☒ 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 ☐ Conflicted party to be excluded from meeting **Please identify conflicted party and specify reason for conflict:**

Have All Relevant Implications Been Considered? *(please tick where relevant)*			
Clinical Engagement	☐	Patient and Public Involvement	☒
Quality Improvement	☒	Equality, Diversity and Human Rights	☒
Integration	☐	Innovation / Research	☐
Improving Health Outcomes / Reducing Health Inequalities	☒	Patient Choice / Shared Decision Making	☐
Financial Management	☐	Corporate Governance	☐

Is the Information in this paper confidential? Yes ☐ No ☒

If yes, please state reason why:

Risk: *(briefly explain any risks associated with the paper*)	
Recommendation:	The Governing Body is asked to: **APPROVE** the results of the EDS2 Annual Equality Self-assessment (Appendix A) **APPROVE** Agree the content of the Annual Equality Report for publication (including Appendix A)

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Greater Nottingham Clinical Commissioning Partnership

Annual Equality Report 2018 (including EDS2 self-assessment)

1. Welcome

We are pleased to present our latest Annual Equality Assurance Report on how the Greater Nottingham Clinical Commissioning Partnership (GNCCP) meets the Public Sector Equality Duty of the Equality Act 2010. The GNCCP is a partnership organisation of the four CCGs in Greater Nottingham, which includes Nottingham City CCG, Rushcliffe CCG, Nottingham North & East CCG and Nottingham West CCG. Geographically, this area covers people living in Nottingham City, Rushcliffe, Beeston, Chilwell, Stapleford, Eastwood, Hucknall, Gedling, Lowdham, Arnold and Carlton.

We are committed to embedding equality and diversity considerations into all of our commissioning processes and employment practices. We recognise that equality is about ensuring that access to opportunities are available to all by taking account of people's differing needs and capabilities. This means that everyone has varying needs and may require different levels of support to access and benefit from health services.

We believe that diversity is about recognising and valuing differences through inclusion, in line with the 'protected characteristics' defined by the Equality Act 2010. These include age, disability, gender re-assignment, marriage or civil partnership status, pregnancy and maternity, race, religion or belief, sex, or sexual orientation.

During 2018/19, the commissioning functions and Executive leadership were fully integrated across the four Greater Nottingham CCGs, this included work to establish a joint approach to embedding equality and diversity in all our commissioning activities. In line with this, we have undertaken a joint assessment of our equality performance across the four CCGs for 2018/19. We continue to make progress to improve our equality performance and are taking this opportunity to highlight some specific examples to demonstrate that progress.

The information in this paper, together with the NHS Equality Delivery System report (EDS 2) is presented to the four GNCCP Governing Bodies to demonstrate that their CCGs are meeting the requirements of the Public Sector Equality Duty (the EDS 2 self-assessment report is contained in full in Appendix A).

During 2019, Greater Nottingham Commissioning Partnership will be moving to an aligned commissioning function across all six Greater Nottingham and Mid-Notts CCGs, which will include Nottingham City, Rushcliffe, Nottingham North & East, Nottingham West, Newark and Sherwood and Mansfield and Ashfield CCGs. The report also details some of the actions we plan to take in partnership during 2019 with other CCGs in Nottinghamshire to build on the work we have undertaken so far to align our equality activities and progress our equality vision.

2. Our population

This section summarises some key characteristics of the population we service across Greater Nottingham and reflects some significant difference in population demographics. It is important that the diversity of our population and health needs are understood to ensure everyone benefits from equal access to services we commission.

Greater Nottingham CCGs serve a population of approximately 761,733 registered with our member GP Practices.

- Nottingham City CCG- approximately 388,745
- NNE CCG- approximately 150, 339
- Rushcliffe CCG - approximately 128,418
- NW CCG- approximately 94,231

Age

- Nottingham City has a younger population than the national average, due largely to the presence of the two universities. Full-time university students account for approximately one in eight of the population.
    - There is a high turnover of population and there are high levels of international migration, gaining young adults due to migration, both international and within Britain, whilst losing all other age groups - this includes losing families with children as they move to the surrounding districts.
- By contrast Rushcliffe, NNE and NW CCGs have a higher proportion of working age and older adults, with higher percentage of over 65s and over 85s than the nation population average.
- The split between men and women across Greater Nottingham is almost 50:50.
    - However, the percentage of men aged 25 to 39 is unusually high in Nottingham (e.g. 117 men to every 100 women in the 35 to 39 age-group). This is particularly the case in inner city areas.

Ethnicity

- Nottingham City is ethnically and culturally diverse with approximately 35% of the population from a black and minority ethnic (BME) background .The Asian/Asian British group is the largest BME group in Nottingham, making up 13% of the total population; Black/African/Caribbean/Black British, mixed or multiple ethnicity and White (not White British) groups each account for 6 – 7% of the total population.
- Whilst black and minority ethnic (BME) populations are relatively low in NNE, NW and Rushcliffe CCGs as a whole (4% compared with 15% nationally), within the districts of Broxtowe, Gedling and Rushcliffe there are larger population groups (7% each district), mainly Asian and Mixed/Multiple Ethnic groups. BME populations in Nottinghamshire have a younger age profile than the general population.
- Some districts of Nottingham have a higher number gypsy and traveller population; the 2007 Housing Needs Assessment estimated the total number of gypsy and traveller households across Rushcliffe, Broxtowe and Nottingham to be 134.

Deprivation

- Deprivation is measured nationally using the Index of Multiple Deprivation (IMD) across all Council areas and the England average IMD score is 22. Across Greater Nottingham there are areas of affluence but also areas of deprivation:
    - Nottingham City is the eighth most deprived area in the country, the IMD score is 3.5
    - The CCGs in South County have lower deprivation scores than the national average of 22; Rushcliffe - 8, Nottingham West – 16 and NNE- 8. However, it is important to note that there are some areas of high deprivation within all CCGs.

Health Outcomes and Health Inequality

- This variation in deprivation is reflected in the health and wellbeing outcomes across Greater Nottingham:
    - Despite its young age structure, Nottingham has a higher than average rate of people with a limiting long-term illness or disability. Nearly half of the City's older people have at least one long-term condition e.g. dementia, diabetes or respiratory disease and many have more than one.
    - Life expectancy in Nottingham City is significantly lower than the England average, with approximately 3 years less for men and 2 years less for women (Nottingham: 77.0 men; 81.1 women. England: 79.5 men; 83.1 women). Nottingham's life expectancy between the most and least affluent areas differs by approximately 8 years for both men and women. Healthy life expectancy for both men and women in Nottingham is also significantly lower than the England average with men living 5.9 years less in good health and women 8.8 years less.
    - The largest contributors to the difference are circulatory diseases, cancer, respiratory and digestive disease.

3. Equality and diversity considerations in commissioning processes

3.1 Identifying and assessing health needs

We recognise that is essential for us to fully understand the health needs of our population and a key way we do this is by producing a Joint Strategic Needs Assessment (JSNA) in conjunction with the Local Authority. This identifies where inequalities exist and describes the future health and wellbeing needs of our population.

The JSNA examines a variety of behavioural factors and the health needs for children, young people, families, and adults. A standard template is used for all JSNA chapters and comprehensive guidance has been produced for chapter authors, which requires that consideration be given to all protected characteristics.

Local Authority Public Health colleagues also complete targeted Health Needs Assessments (HNAs) in areas where there is a lack of information. This has resulted in JSNA chapters being dedicated to areas such as black and minority ethnic communities, maternities and pregnancies, physical disabilities and learning disabilities, along with chapters focusing on a number of inclusion health groups, including people who are homeless, asylum seekers and carers.

The JSNA and supporting HNAs form a key part of the evidence base on which commissioning decisions are made in order to improve health outcomes and reduce health inequalities.

Health Needs Assessment (HNA) of the Black and Minority Ethnic Communities in Nottingham City

The HNA was commissioned to enable a better understanding of the City's BME population and its diverse communities and cultures across the following themes: Access to services; Mental health; Data collection; Community engagement; Communication and resources; Partnership working; Discrimination; and Lifestyle risk factors. The CCG, in partnership with Nottingham City Council, are responding to the recommendations from the HNA, which launched in January 2018. A BME Community of Practice stakeholder group is being led by the local authority to devise an action plan, which addresses the range of recommendations to tackle health inequalities and to improve health outcomes for Nottingham's BME population.

The initial focus of the Community of Practice group has on the mental health findings and the GNCCP and mental health providers are working with the group to engage discuss and develop service changes that will address the health inequalities experienced by this group.

Homelessness Prevention Joint Strategic Needs Assessment

During 2018/19, the GNCCP has been working closely with the City and County Local Authorities to understand and develop actions to address the health needs of homeless population. Nottingham City Local Authority took a cross-sector approach to the refresh of the Homeless Prevention Strategy.

Ill health can be both a cause and consequence of homelessness, although it is not always identified as the trigger of homelessness .The physical and mental health of people who experience homelessness are poorer than that of the general population. They often experience the most significant health inequalities with life expectancy 30 years lower than the general population. The GNCCP recognises the role of health commissioning and will agree health specific actions to work in partnership with services to support better outcomes for homeless people.

It will be important for the Nottinghamshire CCGs to work closely with the local authorities to determine future approach and prioritisation of Joint Strategic Needs Assessments and how these will support strategic commissioning at a Nottinghamshire-wide ICS level and at a smaller, place and neighbourhood level.

3.2 Use of research evidence

We also fund our own research where there is a gap in the evidence base that limits effective commissioning or further development of services to improve patient outcomes. We use the findings to support the delivery of our commissioning priorities and the continual improvement of patient care, health outcomes and the effectiveness of health services.

Recent examples of research commissioned include:

- *An exploratory research study was commissioned to look at the Mental Health Needs of Nottingham's Homeless population and was published in July 2018.The findings will inform how we can work with local partners to better meet needs and promote and support timely mental health service uptake for people who are homeless.*

- *An exploratory study was commissioned to look at improving the mental health outcomes of Nottingham's lesbian, gay, bisexual and trans (LGBT) population and is due to be published in 2019. Evidence indicates that LGBT people are at higher risk of mental health problems, self-harm and suicide, and report lower well-being compared to the wider population due to discrimination, harassment, bullying, rejection and social isolation. Other factors such as age, religion or ethnicity can further complicate mental distress. The focus for the research is the prevention, early diagnosis and self-care of mental health issues. Findings will inform how primary and community health services can be best commissioned to better meet the mental health needs of LGBT people.*

3.3 Patient and public involvement

We are committed to putting the voice of patients and the public at the heart of our commissioning activities. We recognise the importance of Equality Impact Assessments informing engagement plans and in turn, feedback affirming the impact assessments.

This includes involving people in how we make decisions, how we design services and how we review them. Alongside the integration of commissioning function across Nottinghamshire CCGs, it has been important to progress work to develop a patient and public involvement approach that align to the new commissioning and decision making processes.

Our structures for engagement will need to:

- Be aligned to decision making
- Be representative of the diversity of Nottinghamshire populations and their health needs
- Provide a consistency of approach across the whole area
- Connect into the vast array of organisations, groups and networks that can provide insight and facilitate conversations with patients and the public
- Enable engagement at a whole system Nottinghamshire-wide area and at more local neighbourhood level

Eastern European community engagement

A key part of the CCG's approach to engagement is improving our understanding of the needs of people who are seldom heard. Work continues with the local authority 'New and Emerging Communities' to understand the needs of emerging population groups and receive feedback about their experience of accessing health services. The findings are then fed back to the commissioners of the services concerned. This includes considering learning from the Nottingham Modern Slavery Forum.

We continue to strengthen our joint working with local Voluntary and Community Sector (VCS) leaders. This provides the opportunity to learn more about the wider engagement work of organisations and extend the reach of our engagement activities to ensure we reach our underserved communities.

3.4 Equality Impact Assessments

The GNCCP uses Equality and Quality Impact Assessments (EQIAs) and the template brings together consideration into a single systematic assessment process, which informs and accompanies service change decision making. The assessments help to ensure that we do not disadvantage people from protected characteristic and inclusion health groups by the way that we commission health services. They also help us to develop a better understanding of the communities we serve. We consider that EQIAs are an integral part of transparent and accountable service planning and policy development.

During 2018, work continued to align equality impact assessment processes across all four Greater Nottingham CCGs and guidance information was sent out to staff to ensure the process is understood across the aligned commissioning function.

CCGs and providers across the country are facing great financial challenges to bring about financial recovery, while maintaining or improving quality services. It was recognised that the Greater Nottingham Financial Recovery Plan includes a wide range of schemes that cover different services and it is recognised that these may affect different people to differing degrees across the Greater Nottingham population. There is close working between the Financial Recovery Project Management Office (PMO), Strategic Planning, Equality and Diversity and Quality Teams to help to ensure a proactive approach continues to take place to complete EQIAs. As such, impact assessments and patient and public engagement activities are being managed on a scheme-by-scheme basis, using a consistent, pre-defined approach in order to ensure that the individual and collective impact of proposed schemes are fully understood prior to any decision-making

Equality Impact Assessments:

Equality Impact Assessments are required to be completed whenever we are considering any action that may impact on or have an influence on local health services. This includes commissioning plans, GP practice changes, changing or removing a service, policy or function and is embedded in quality issues/changes, business case and contract management processes. EQIAs are treated as 'live' documents, and as such, are revisited at key stages of scheme development and implementation, particularly following the conclusion of any patient and public engagement and consultation activities to inform decision-making.

An example of this robust assessment was seen in the review of the Community Gynaecology Service across Nottinghamshire where the findings of the EQIA highlighted a higher risk of Female Genital Mutilation (FGM) in the Nottingham City population and the need for mandatory safeguarding reporting. As a mitigating action, the procurement documentation and questions for the evaluation included the request that the provider shall ensure that all staff are trained, and a safeguarding protocol is in place, on identifying and confirming known causes of Female Genital Mutilation (FGM) in girls under the age of 18 and women aged 18 and over. Reporting must be in line with the Department of Health's guidance on mandatory reporting in healthcare, if FGM is identified. The mitigating action will help to ensure that this service change does not lead to any negative impact on the safeguarding of this group.

3.5 Improving access to services

The CCG is committed to ensuring that people, carers and communities can readily access appropriate services and this is an important element of assessing the impact of any change to service provision.

Improve Cancer Screening Rates

In an attempt to improve cancer screening rates in Nottingham West, the CCG has enlisted the help of its Patient Participation Groups (PPGs) and Patient Reference Group (PRG). A representative from Cancer Research UK attended the PRG meeting in August 2018 to deliver a presentation on cancer and cancer screening, following which the PPGs were tasked with a number of actions including:

- *Updating display boards at their GP practice with free promotional resources*
- *Discuss with the practice staff what they are doing to try and improve uptake*
- *Request that practices display the slide show provided by Cancer Research UK on the TV screens in waiting rooms*

The CCG also liaised with Broxtowe Borough council and shared the promotional resources with the local Community Action Teams in the Beeston area, where uptake was particularly low, largely due to the language barrier amongst the high number of Eastern European residents. As of October 2018 all practices have seen an improvement in screening rates and the Beeston practices achieved and continue to achieve the national target of 80%.

3.6 Contract management arrangements

We use the national NHS Standard Contract to commission the services we are responsible for. The NHS Standard Contract mandates NHS providers to implement the NHS Equality Delivery System Toolkit (EDS2). This Toolkit helps NHS organisations to deliver better outcomes for patients and communities, and better working environments for staff, which are personal, fair and diverse with equality of opportunity and treatment for all. It includes 18 outcomes grouped under four overarching goals and is designed to obtain, analyse and grade the evidence required to demonstrate compliance with the Public Sector Equality Duty of the Equality Act. The NHS Standard Contract also mandates implementation of the NHS Accessible Information Standard. It defines an approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

Establishing provider reporting cycle: We are committed to embedding equality and diversity considerations into our contract monitoring processes. As such, we have devised a four-year cycle of assurances that we are seeking from our main providers (Nottinghamshire Healthcare Foundation Trust, Nottingham CityCare Partnership and Nottingham University Hospitals NHS Trust), starting from 2017/18. The cycle includes the following requirements:

- A general assurance at the beginning of the contract year to demonstrate providers' compliance with EDS2, as mandated by the NHS Standard Contract.
- An assurance that the Accessible Information Standard (AIS) is being implemented.

- Reports of the outcome of a cycle of 'deep dives' - focused exercises to provide in-depth and comprehensive reviews on the extent to which providers are addressing specific EDS2 outcomes.
- These requirements are reported to the Quality Scrutiny Panel for review and discussion.

For 2018/19 we have sought assurances on two specific areas: people report positive experiences of the NHS and people's complaints about services are handled respectfully and efficiently; the second is that fair NHS recruitment and selection processes lead to a more presentative workforce at all levels, with training and development of opportunities taken up and positively evaluated by staff.

The workforce race equality standard (WRES) was agreed by the NHS Equality and Diversity Council to ensure that staff from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. This was included in the NHS standard contract from 2015/16 and from 2017 independent healthcare providers are required to publish their WRES data. CCGs are also required to report against the WRES but this information may not be published depending on the size of the organisation. Since the CCGs are in effect still small organisations, this information is not published but is utilised by HR to monitor against the standard and agree an action plan.

This has been followed by the introduction of the Workforce Disability Equality Standard (WDES), which enables NHS organisations to the compare the experiences of disabled and non-disabled staff- reporting against the WDES came into force from 1st April 2019.

4. Equality and diversity within our workforce

4.1 Recruitment, selection and the working environment

Our employees are essential to the provision of high quality healthcare and we are committed to maintaining a working environment that promotes the health and wellbeing of our whole workforce. A workforce report is provided to Governing Bodies on a six monthly basis in order to ensure robust assurance against this commitment.

We operate fair, inclusive and transparent recruitment and selection processes and our Recruitment and Employment Checks Policy is in line with the requirements of the Equality Act. All vacancies are advertised via the NHS Jobs website and our recruitment process includes a number of measures to minimise the opportunity for discrimination and bias. For example, candidates' personal details are not made available to recruiting managers until after shortlisting has taken place. Also, an interview is guaranteed to any candidate with a disability whose application meets all of the essential criteria for the post (Guaranteed Interview Scheme).

We also take action to ensure that all relevant information is obtained and recorded during the recruitment process in a form that can be analysed and reported by protected characteristics, to determine whether any equality issues need to be addressed.

We expect all of our managers to work to the Code of Conduct for NHS Managers, which requires them to ensure that no one is unlawfully discriminated against because of their protected characteristics or economic status.

To help demonstrate that the CCG promotes equality of opportunity, and to help achieve its workforce equality objective, we have obtained accreditation as a Mindful Employer and as a user of the Disability Confident Scheme symbol.

The first annual staff survey undertaken by the aligned GNCCP commissioning function took place during October and November 2018. The survey was distributed to 253 members of GNCCP staff and an overall response rate of 82% (205 staff) was achieved. The self-assessment for many of the EDS2 outcomes for goals 3 and 4 has been informed by the staff survey.

Since 2014 the CCGs across Nottinghamshire have recognised the valuable contribution that apprenticeships make, by bringing young people into our workforce and developing the skills of local people. Participation in the scheme also sends a positive message to our workforce and population about our values and our commitment to engaging with our community. We are very pleased to report that two of our former apprentices subsequently secured permanent posts with us and a further three gained employment in other local health organisations. We will explore further opportunities to participate in local apprentice schemes following the completion of staff restructure associated with the alignment of commissioning function across all six CCGs.

5. How we measure and monitor our equality performance

The Public Sector Equality Duty (PSED) of the Equality Act 2010 requires all public sector organisations to analyse and measure their equality performance and prepare associated information for publication annually. Therefore the information in this paper, together with the NHS Equality Delivery System report (EDS 2) is presented to the four GNCCP Governing Bodies to demonstrate that their CCGs are meeting the requirements of the PSED.

5.1 The NHS Equality Delivery System (EDS2)

The NHS Equality Delivery System was introduced during 2011 to help NHS organisations deliver better outcomes for patients and communities, and better working environments for staff, which are personal, fair and diverse with equality of opportunity and treatment for all. The toolkit was refreshed during 2013 and is now known as EDS2.

The integration of commissioning functions and Executive leadership across the four Greater Nottingham CCGs was fully established during 2018/19 and in line with this, work has been undertaken to review the approach taken to equality performance assessment across the CCGs in previous years. This has enabled the GNCCP to adopt a consistent, aligned approach for its 2018/19 EDS2 assessment.

The EDS2 toolkit was developed to obtain, analyse and grade the evidence required to demonstrate compliance with the PSED of the Equality Act 2010. It includes a set of 18 outcomes grouped under four overarching goals:

- Goal 1 - Better health outcomes
- Goal 2 - Improved patient access and experience
- Goal 3 - A representative and supported workforce
- Goal 4 - Inclusive leadership

It is against these outcomes and goals that organisational equality performance is analysed and graded and further action determined.

The EDS2 guidance states that, essentially, there is just one factor to focus on within the grading process. For most outcomes the key question to consider is:

'How well do people from protected groups fare, compared with people overall?'

The full report on the 2018/19 EDS 2 self-assessment is contained in Appendix A.

6. Conclusion

During the last twelve months we have made progress in aligning our CCGs' approach and processes to meet the requirements of the Public Sector Equality Duty. We have built on existing strengths and changed ways of working were necessary in order to ensure consistency and robust equality process during a time of organisational restructure.

Reviewing and assessing our equality performance across the four aligned CCGs in Greater Nottingham has shown that we continue to make progress in the aim to ensure that the services are designed and delivered to meet the diverse needs of our population.

During 2019, Greater Nottingham Commissioning Partnership will be moving to an aligned commissioning function across all six Greater Nottingham and Mid-Notts CCGs, which will include Nottingham City, Rushcliffe, Nottingham North & East, Nottingham West, Newark and Sherwood and Mansfield and Ashfield CCGs. To ensure that equality and inclusion is fully embedded into the day to day work of the CCGs and part of the organisation culture as we continue to restructure and evolve our commissioning organisation, the following key actions will be taken forward:

- Produce an Equality, Diversity and Inclusion Framework and equality governance arrangements at CCG, ICP and ICS level
- Identify the significant differences in population demographics across Nottinghamshire and ensure these are recognised, assessed and addressed through commissioning and service redesign and delivery
- Understand the implications of the national launch of EDS 3 and how this will support alignment of equality and inclusion work programmes across the ICS system
- Use the EDS2 self-assessment to inform development of equality objectives for the CCGs and establish an annual equality performance work programme and action plan (aligned to agreed equality priority areas [see Appendix A, page 28]).

EDS2 Annual Equality Performance
Self-assessment 2018/19

1. Introduction

This paper reports on the results of the Greater Nottingham Clinical Commissioning Partnership's (GNCCP) equality performance self-assessment process against the four goals of the NHS Equality Delivery System (EDS2).

The Quality and Performance Committee is responsible for monitoring the GNCCP's performance in relation to Goals 1 and 2 of the NHS Equality Delivery System, including progress against equality objectives and associated action plans. The Committee is also asked to review and agree the self-assessment process taken to measure GNCCP's performance against EDS2 goals 3 and 4.

The Public Sector Equality Duty (PSED) of the Equality Act 2010 requires all public sector organisations to analyse and measure their equality performance and prepare associated information for publication annually. Therefore the information in this paper will be used to inform a report to the four GNCCP Governing Bodies to demonstrate that their CCGs are meeting the requirements of the PSED.

2. The NHS Equality Delivery System (EDS2)

The NHS Equality Delivery System was introduced during 2011 to help NHS organisations deliver better outcomes for patients and communities, and better working environments for staff, which are personal, fair and diverse with equality of opportunity and treatment for all. The toolkit was refreshed during 2013 and is now known as EDS2.

The EDS2 toolkit was developed to obtain, analyse and grade the evidence required to demonstrate compliance with the PSED of the Equality Act 2010. It includes a set of 18 outcomes grouped under four overarching goals:

- Goal 1 - Better health outcomes
- Goal 2 - Improved patient access and experience
- Goal 3 - A representative and supported workforce
- Goal 4 - Inclusive leadership

It is against these outcomes and goals that organisational equality performance is analysed and graded and further action determined.

The EDS2 guidance states that, essentially, there is just one factor to focus on within the grading process. For most outcomes the key question to consider is:

'How well do people from protected groups fare, compared with people overall?'

For each outcome, EDS2 requires the following RAG^{plus} rating system to be applied:

Undeveloped	No evidence for any protected group of how people fare, or evidence shows that the majority of people in only 2 or fewer protected groups fare well
Developing	Evidence shows that the majority of people in 3 to 5 protected groups fare well
Achieving	Evidence shows that the majority of people in 6 to 8 protected groups fare well

Excelling	Evidence shows that the majority of people in all 9 protected groups fare well

See here for further information on the protected characteristic groups defined by the Equality Act.

The grading system encourages organisations to use the toolkit flexibly and selectively, so that key local health inequalities can be embraced. In addition, it provides specific guidance for commissioners on how to focus their grading process, particularly in relation to several of the outcomes in goals 1 and 2 that are 'patient-facing' and therefore predominantly provider-focused. The evidence that EDS2 is designed to collect also helps to demonstrate compliance with several rights and pledges in the NHS Constitution.

3. Approach and Evidence for the 2018/19 EDS2 assessment

The integration of commissioning functions and Executive leadership across the four Greater Nottingham CCGs was fully established during 2018/19 and in line with this, work has been undertaken to review the approach taken to equality performance assessment across the CCGs in previous years. This has enabled the GNCCP to adopt a consistent, aligned approach for its 2018/19 EDS2 assessment.

The latest EDS2 assessment published for the South County CCGs was for 2016/17. That was a combined assessment undertaken in conjunction with Nottingham University Hospitals NHS Trust (NUH). Consequently, some of the evidence underpinning the latest reported assessment for the South County CCGs was specific to NUH. This has been factored in when completing the self-assessment for the GNCCP.

As many of the EDS2 outcomes for goals 1 and 2 are predominantly provider-focused, Nottingham City CCG developed arrangements for seeking assurance on the equality performance of its main providers (Nottinghamshire Healthcare Foundation Trust, Nottingham CityCare Partnership and NUH). This was formalised and supported through the NHS Standard Contract, which mandates providers to implement EDS2. A system is in place to seek those assurances via contract monitoring processes and in line with these requirements the GNCCP continues to receive a range of assurances from its providers. These reports have been reviewed to provide information and evidence for the 2018/19 Greater Nottingham EDS2 assessment (**Appendix B** provides further details of those assurances and the associated reporting timetable).

The self-assessment for many of the EDS2 outcomes for goals 3 and 4 has been informed by the first national staff survey undertaken by the GNCCP during October and November 2018. The survey was distributed to 253 members of GNCCP staff and an overall response rate of 82% (205 staff) was achieved.

Pages 3 to 15 provide information against the outcomes of EDS2 goals 1 and 2 and **pages 15 to 24** provide information against the outcomes of EDS2 goals 3 & 4 to support the 2018/19 self-assessment.

Goal 1: Better health outcomes		
1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities (for CCGs, the focus is on commissioning and procurement)**	During 2018, the GNCCP has supported the Joint Strategic Needs Assessment (JSNA) Steering Groups in both County and City to support an aligned input into JSNA development and prioritisation across Greater Nottingham. Discussion has begun on how the approach to JSNA development will, over time, support and respond to the evolving integrated care system and integrated care providers. This will help to ensure that the JSNA chapters address all nine protected characteristics and inclusion health groups, in order to accurately identify and address health inequalities. However, the Joint Strategic Needs Assessment Annual Report to the Nottingham City Health and Wellbeing Board in September 2018 did indicate that chapter development had been delayed as a result of transitional arrangements and in order to understand the strategic priority areas of the aligned GNCCP. During 2018/19, letters outlining the GNCCP's commissioning intentions were issued to its main providers. Commissioning intentions for 2019/20 and the relevant basis on which they were developed were published during 2018/19. One of the stated commissioning approaches is to advance the GNCCP's focus on population health management, enhancing its infrastructure, intelligence and interventions, more deeply understanding its population and agreeing priority areas for collective focus. Work is ongoing by the Communications and Engagement team to produce an ICS-level Engagement Framework/Strategy. It will define priorities for engagement and the approach required to ensure that the GNCCP will meet its statutory duties regarding patient and public participation. These require promoting the involvement of patients and carers in decisions which relate to their care or treatment and ensuring that CCGs commission services which promote involvement of patients across the full spectrum of prevention or diagnosis, care planning, treatment and care management. In particular it will address requirements in the Health and Social Care Act 2012 for CCGs to have regard to the need to reduce inequalities between patients with respect to their ability to access health services.

Goal 1: Better health outcomes		
		A proactive approach is in place to ensure that relevant staff instigate Equality/Quality Impact Assessments (EQIAs) when the GNCCP plans, changes or removes services or functions. This has included embedding these requirements within all business case and contract management processes. Further information on EQIAs is included in outcome 2.1. The importance of completing EQIAs has been further emphasised to staff, as they need to be completed to assess the impact of proposed QIPP schemes in support of the GNCCPs' financial recovery plan. The EQIA process has been implemented across the GNCCP for all commissioning activity, not just for financial recovery. The support that staff receive to complete EQIAs provides an opportunity for them to develop a greater understanding of the potential impact of QIPP schemes on patients/carers; it also increases colleague awareness of equality of access to the services the GNCCP commissions and the impact of decommissioning services. To further support staff to complete robust EQIAs, a section on the GNCCP Intranet is being established to provide a 'library' of associated material and information on the nine protected characteristics, local population profiles and links to further information. Progress was made during 2018 to review and align a GNCCP Business Case process, template and guidance information. The template and guidance require commissioners to carry out the following key activities at an early stage to support the consideration of impact and risks: • Identify links to national and local strategic direction • Quality and Equality impact analysis – EQIA • Stakeholder engagement – including clinical and public • Contracting and finance requirements • Evidence base and clinical leadership The business case template will require commissioners to identify relevant key stakeholder groups, outline how clinical and public engagement has informed development of the business case and indicate how engagement and communication will continue to inform the

Goal 1: Better health outcomes		
		success of the proposal. Further development will be required during 2019 to continue to align the business case and QIPP process across CCGs and to promote and provide guidance to staff to carry out the activities listed above. JSNA intelligence and completed EQIAs are being used to inform the development of specifications to support service commissioning The engagement function for the GNCCP uses a standard set of questions established by Nottingham City CCG for collecting a range of demographic data during engagement exercises. Over time the questions have been amended, particularly in response to comments from the public. They are now due to be formally reviewed and revised where necessary.
1.2	**Individual people's health needs are assessed and met in appropriate and effective ways**	As noted in section 3 and detailed in Appendix B, the GNCCP has sought equality information from key providers via contract monitoring processes. General assurance on compliance with EDS2 and assurance on compliance with the Accessible Information Standard (AIS) has been used, where available, to inform the assessment of this outcome for 2018/19. Also used, where received to date, have been the results of key providers' deep dives associated with EDS2 outcomes 2.3 and 2.4. Assurances have been received from our key providers that they are implementing EDS2, as required by the NHS Standard Contract. Information has also been received on the extent to which those providers have put in place systems to support their implementation of the AIS. A significant factor in doing so is the IT systems in place. For example, NUH's October 2018 Equality and Diversity Annual Report stated that progress to fully implement AIS has been slow, due to the need to enable alerts for recording patients disability information and communication requirements on the Medway PAS system. The report confirmed that it remained an organisational priority. Details of key providers' deep dives associated with EDS2 outcomes 2.3 and 2.4 are

Goal 1: Better health outcomes		
		provided against those specific outcomes below. The following information contained in the Primary Care Quality Dashboard of eHealthscope is used as part of the GNCCP's Primary Care Quality Monitoring, Support and Escalation Process to monitor GP performance and to address any areas of under-achievement: • Carer information • Consent Policy in place • How to complain/feedback on website • Chaperone advice • You said – we did • Treated with care and concern • Needs met • Overall experience The Monitoring, Support and Escalation Process also includes addressing any areas of under-achievement. Results of the Process are included in the Primary Care Quality Assurance Framework reports submitted to the Primary Care Commissioning Committee. However, the data collected and collated on eHealthscope does not support analysis at a protected characteristic level. The GNCCP's Joint Commissioning Committee has a schedule of thematic review reporting to provide assurance on the delivery against the Operational Plan and delivery against national standards and targets. It is intended to allow the Committee to be assured that relevant processes and metrics are in place in relation to the delivery of key performance targets, with mitigating actions in place where there are risks to delivery. The reports are accompanied by a patient story to provide a 'deep dive' of an entire patient's experience associated with key commissioning areas. This provides particularly important insight into implementation of changes in pathways. In August 2018 a patient story detailed a patient's

Goal 1: Better health outcomes		
		experience of the pilot community diabetes foot clinics; the patient has had diabetes for 50 years and had been regularly attending the clinic at Dundee House at the City Hospital campus. In June 2018 the patient was told about a pilot that was taking place in Beeston, which was slightly more convenient than Dundee House. The patient enjoyed having a fixed appointment time, being seen on time and by one clinician for all of their treatment, rather than the three or four clinicians at Dundee House. Free parking is also available in a supermarket nearby, rather than having to be dropped off at Dundee House and wait to be collected, so the total time from leaving home to returning is much quicker. The detail in the patient story offered assurance that the transition was being managed effectively and safely i.e. the hospital reception booked the appointment in the community before the patient left. This point is also relevant to outcome 1.3. Another example is the patient story contained in the Cancer thematic review; in this story a patient who accessed the mobile lung MOT check close to home in Bulwell provides evidence of success in commissioning services targeted at communities and patients with identified higher risk of ill health. In line with the equality assurance requirements set out in section 3 of the above report, key providers will be required to undertake and report on a deep dive of this specific outcome during 2020/21.

Goal 1: Better health outcomes		
1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed**	The general assurance from key providers on compliance with EDS2 and with the Accessible Information Standard has, where available, been used to inform the assessment of this outcome for 2018/19. Reference to assurances received is outlined in outcome 1.2 above. In line with the equality assurance requirements outlined above, key providers will be required to undertake and report on a deep dive of this specific outcome during 2019/20. During 2018/19 the GNCCP has aligned the CCGs' approaches and made significant progress in embedding a population health approach. The health of a population is influenced by a wide range of factors, including the protected characteristics of Age and Sex. Population health is based on understanding the local population and improving the health outcomes of groups of individuals with similar healthcare needs, with services being co-ordinated and delivered in the most efficient and effective way. Improving population health also means developing targeted approaches to improving health equity. This includes action to reduce inequalities in access, quality and outcomes of care. The sharing of up to date, relevant data across care services is helping to understand the individual needs of patients with multi-morbidities and those at risk of increasingly poor health outcomes. It fits with self-care and requires the NHS and the patient to take responsibility to prevent disease, extend life and promote health. It will also support patients transitioning from one service to another.

Goal 1: Better health outcomes		
1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse**	As part of the GNCCP's Primary Care Quality Monitoring, Support and Escalation Process to monitor Greater Nottingham's GP performance and to address any areas of under-achievement, the following information contained in the Primary Care Quality Dashboard of eHealthscope is used: • Carer information • Consent Policy in place • How to complain/feedback on website • Chaperone advice • You said – we did • Treated with care and concern • Needs met • Overall experience The Monitoring, Support and Escalation Process also includes addressing any areas of under-achievement against the areas listed above. Results of the monitoring are included in Primary Care Quality Assurance Framework reports, which are submitted to the Primary Care Commissioning Committee. However, the data collected and collated on eHealthscope does not support any analysis at a protected characteristic level. In line with the equality assurance requirements outlined above, key providers will be required to undertake and report on a deep dive of this specific outcome during 2019/20.
1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities**	The assessment of this outcome has been based on recognising the GNCCP's role in supporting and promoting uptake to immunisations and population screening programmes in order to protect the health of the local population, reduce health inequalities and improve health outcomes. A further element of the GNCCP's Primary Care Quality Monitoring, Support and Escalation

Goal 1: Better health outcomes		
		Process described in outcome 1.4 above is to monitor and address the information eHealthscope contains on: • flu vaccinations (for people over 65, at risk patients, children and pregnant women) • immunisations (over 2s and pre-school children) • screening (cervical, bowel and breast) Results are also included in Primary Care Quality Assurance Framework reports and submitted to the Primary Care Commissioning Committee. Again, the data collected and collated on eHealthscope does not support analysis at a protected characteristic level, but flu vaccinations focus on the protected characteristics of Age and Pregnancy & Maternity, with immunisations focusing on Age and screening on Age and Sex. An output of the monitoring is to identify GP practices where uptake of vaccination, immunisation and screening is lower than expected and to work with practices to identify potential reasons. Where it is established that communication barriers and/or cultural beliefs may be a cause, the GNCCP provides and promotes information leaflets in various languages and formats. The GNCCP uses social media (Twitter and Facebook) to promote a range of screening, vaccination and other health promotion services. The following summarised messages provide a few examples of services addressed: • The Lung Health MOT can save your life. • Is your smear test overdue? • Do you know the symptoms of Stroke? • It's #ProstateCancerAwarenessWeek - how much do you know? • Do you know the symptoms of ovarian cancer? • If you have heart, lung or kidney disease, ask for your free flu jab. Keep your 2 or 3 year-old protected from #flu this winter with the nasal spray vaccination.

Goal 1: Better health outcomes		
		• Keeping warm during the winter months is particularly important for over 65s and those with heart and lung conditions. • For help to stop smoking speak to your GP practice about Stub It! • If you have a long term condition and are worried how common ailments may be affecting you, your pharmacist can help. • Today is the start of #SelfCareWeek. • Great top tips from @NottsCC on #fallsprevention . • NHS 111 pilot in the East Midlands enables patients with minor illnesses to have an appointment booked with their local pharmacist. • The cold weather can have an impact on your mental health. • See how your alcohol calories add up by completing our Drink Free Days Calculator. • Over 2.5m people have already made the first step to a healthier 2019 by taking the free #HowAreYou quiz. Why not join them? • Too much sugar can lead to serious health problems like type 2 diabetes.

Goal 2: Improved patient access & experience		
2.1	**People, carers and communities can readily access hospital, community or primary care services and should not be denied access on unreasonable grounds**	The requirements of this outcome refer to either a care setting or to a service. The GNCCP uses an EQIA template that brings together equality and quality impact considerations into a single systematic assessment process. One of the functions of an EQIA is to assess whether proposed changes could have a positive, negative or neutral impact, depending on people's different protected characteristics defined by the Equality Act 2010. This helps to ensure that the services commissioned by the GNCCP are as accessible as possible to all of the population it serves. In line with the equality assurance requirements outlined above, key providers were required to undertake and report on a deep dive of this specific outcome during 2017/18.
2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care**	The GNCCP is developing increased access to self-management support, health coaching and community-based approaches for patients, particularly for those on long-term condition pathways. An example of this is the development of a single Musculo-skeletal model across Greater Nottingham, encompassing elective orthopaedic, pain management and rheumatology. In particular the service model is designed to have a positive impact on patients with a disability, by providing access to tailored conservative management options. If a disability impacts on a patient's ability to participate in a treatment, these interventions will be adjusted where possible (e.g. by using exercise classes). In line with the equality assurance requirements outlined above, key providers are being required to undertake and report on a deep dive of this specific outcome during 2020/21.

Goal 2: Improved patient access & experience		
2.3	**People report positive experiences of the NHS**	In line with the equality assurance requirements outlined above, key providers are being required to undertake and report on a deep dive of this specific outcome during 2018/19. The information received to date has therefore informed the self-assessment process. For example, CityCare Partnership's February 2019 Equality and Diversity Deep Dives report provided details of a range of systems to address this outcome. In particular it described its inclusive model of gathering feedback, ensuring that all patients and citizens, their families and carers have opportunities to provide feedback on the quality of their experience, treatment and care, through a variety of methods. The report was illustrated with case studies. When Nottingham City CCG introduced it equality assurance requirements, it agreed that Nottinghamshire Healthcare Trust's planned Equality and Diversity programme for 2018 to 2021 (which included a cycle of deep dives) would satisfy the CCG's assurance requirements. One of the deep dives relevant to EDS2 outcome 2.3 has been focused on the need to improve assessment and delivery of personalised care and timely access to mental health care for Lesbian, Gay and Bisexual adolescents. Another has been on Improving BME men's access to mental health care services. Assurances on progress against both of these areas was reported to the GNCCP in February 2019. A patient story was included in the Mental Health Thematic Review paper to the February 2019 meeting of the GNCCP's Joint Commissioning Committee. The patient had been impressed by the compassionate, sensitive and responsive care received from the staff at the service attended. The patient also felt that the counselling ended at a point where they were able to suggest solutions to their own problems and could handle things independently. Information on action to address this outcome is also outlined in 1.4 above.
2.4	**People's complaints about services are handled respectfully and**	The GNCCP has a Complaints and Concerns Policy and Procedure, which reflects current regulations and guidance. This helps to support the efficient handling of complaints. It also

Goal 2: Improved patient access & experience		
	efficiently	helps to ensure that complaints are handled respectfully, by stating that: • the purpose of the policy is to ensure that patients, relatives, carers and all other users of local health services have their complaints and concerns dealt with in confidence and impartiality, with courtesy in a timely and appropriate manner • all employees of the GNCCP should ensure that they respond to a complaint or concern in a positive manner, are able to signpost complainants and people bringing concerns to the Quality Team and are aware of the Policy • Complainants will be offered independent advocacy support when making a complaint and, where appropriate, specialist advocacy services • the GNCCP will support complainants with information and communications needs to enable them to make a complaint in line with the scope of the NHS Accessible Information Standard 2015. The first Annual Complaints and Patient Experience Report for the GNCCP was issued in June 2018. It noted that In April 2015 the then Patient Experience Team developed a complaints satisfaction survey process. This has subsequently been implemented in the GNCCP and has been adopted nationally by NHS England. The Annual Report noted that in 2017/18 only five* surveys were returned. Although the response rate was low and therefore of limited value: • all respondents knew they had a right to make a complaint and felt that the response they received was personal to them • four out of five felt that their concerns were taken seriously, felt listened to and understood and felt their complaint was handled fairly. *Experience indicates that complainants' responses will depend on the outcome of their complaint even though they are asked about the process, not the outcome. In line with the equality assurance requirements outlined above, key providers are being required to undertake and report on a deep dive of this specific outcome during 2018/19.

Goal 2: Improved patient access & experience		
		The information received to date has therefore informed the self-assessment process. For example, CityCare Partnership's February 2019 Equality and Diversity Deep Dives report referred to in 2.3 above provided details of a range of systems to address this outcome. As well as outlining the organisation's Complaints procedures, it detailed the range of training, guidance and online support available. This is designed to ensure that staff are supported when reviewing and responding to feedback and investigating complaints and can respond to the needs of all their service users. Equality assurance reports have also been received from Circle Nottingham, regarding the Nottingham NHS Treatment Centre. Its April 2018 Equality, Diversity and Inclusion Report indicated that Circle has developed an action plan with accountable leads, based on specific EDS2 outcomes, including outcome 2.4.

Goal 3: A representative and supported workforce		
3.1	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels**	Included against this outcome and others below are the responses to a number of questions in the 2018 national staff survey, which have been used to inform the self-assessment. It should be noted that the % responses are those for the GNCCP overall, although the scores did vary across the four CCGs for many of the questions. The 2018 GNCCP staff survey requested details of respondents' age, gender, ethnicity, sexuality, disability and religion. The respondents indicated that: • Just over 90% identified as white British/white any other white background • 74% identified as female • 86% were either Christian or had no religion • 89% were heterosexual (with 9% preferring not to say) • 85% considered that they had no physical or mental health condition expected to last

Goal 3: A representative and supported workforce		
		more than 12 months • 64% were aged 41 and over The survey also asked whether: • the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age. *70.5% of the respondents agreed.* Analysis of the survey findings against those individual protected characteristics did not indicate conclusively that anyone fared less favourably, compared with the workforce overall. It is intended that an action plan will be developed in conjunction with the Staff Partnership Group to address all relevant results of the 2018 staff survey. The Employee Staff Record (ESR) system collects information on Age, Disability, Marriage and Civil Partnership, Race, Religion or Belief, Sex and Sexual Orientation. Available information suggests that the GNCCP's small workforce is not currently reflective of Greater Nottingham's diverse population. Therefore the GNCCP plans to introduce bi-annual requests to encourage staff to check their demographic information on ESR to ensure that the GNCCP has up to date information on the diversity of its workforce. The requests will include consistent re-assurance that personal information is not accessed or used by anyone other than those with a requirement to view it. The GNCCP is continually working with staff to reduce the number of 'do not wish to declare' responses on ESR across all protected characteristics. This will help to improve the information on the organisation's workforce diversity and establish the extent to which the GNCCP's workforce is representative of the population it serves. Using data from ESR, the October 2018 quarterly Workforce report to Governing Bodies included a profile of the GNCCP's workforce against six of the protected characteristics. Being a small organisation employing approximately 320 members of staff imposes a number of restrictions on the extent to which it is possible to analyse workforce data without

Goal 3: A representative and supported workforce		
		compromising the anonymity of individual members of staff. Therefore, for the protected characteristics that include categories with low numbers (i.e. fewer than 5% of the workforce), the headcount was only presented as a percentage range. The GNCCP advertises its job vacancies via NHS Jobs, the online recruitment website for jobs in the NHS, at local Job Centres and on the 'Indeed' recruitment websites. NHS Jobs collects, and is able to report on, equality monitoring information that it requests from applicants. This includes information on the protected characteristics of Age, Disability, Marriage and Civil Partnership, Race, Religion or Belief, Sex and Sexual Orientation. This information can then be analysed in relation to the candidates at each stage of the recruitment process (i.e. overall applicants, those shortlisted for interview, those appointed). An interview is guaranteed to any candidate with a disability whose application meets all of the essential criteria for the post (Guaranteed Interview Scheme). It is acknowledged that a significant amount of internal recruitment took place during 2018 due to the restructuring; it is also acknowledged that significant work is required across the organisation to develop and embed equality practices within its recruitment, employee relations management and change management practices. It is planned that this work will be developed over the next 18 months across the GNCCP and the Mid Nottinghamshire CCGs, working with Arden and GEM CSU and Nottingham CityCare Partnership. Use will be made of key recommendations arising from an external review of Nottingham City CCG's entire recruitment and selection process, which it commissioned in 2014 as a way of delivering against its equality objective to increase the diversity of its workforce. For example, it is intended that monitoring of the recruitment and selection process will be introduced from April 2019, whereby the known demographic characteristics of applicants will be reviewed through the shortlisting, interview and successful appointee stages. During 2014/15, Nottingham City CCG signed up to the Nottingham Jobs Pledge, which has a key focus on tackling youth unemployment in the City. Three Apprenticeship roles were created within the CCG's staffing structure and it participated in the Apprenticeship Scheme run by New College Nottingham. The third cohort commenced in 2016 and four

Goal 3: A representative and supported workforce		
		former apprentices are currently employed by the GNCCP. The GNCCP recognises the valuable contribution that apprenticeships make to the organisation, by bringing young people into its workforce and developing the skills of local people. During this period of organisational change it is not considered appropriate to initiate an apprenticeship scheme but there are plans to develop one in the future. The NHS Equality and Diversity Council announced in 2014 that it had agreed action to ensure employees from black and minority ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace. This led to the NHS Workforce Race Equality Standard being introduced. In May 2019 a report against the indicators of this Standard is due to be produced for the GNCCP. In line with the equality assurance requirements outlined above, key providers are being required to undertake and report on a deep dive of this specific outcome during 2018/19. The information received to date has therefore informed the self-assessment process. For example, CityCare Partnership's February 2019 Equality and Diversity Deep Dives report referred to in 2.3 above stated that outcome 3.1 is highlighted within CityCare's EDS2 action plan. Actions to demonstrate this include (but not exclusively) fair recruitment, monitoring career pathways in promotion and monitoring reasons for staff leaving. Because of the equality initiatives undertaken, an improvement has been indicated in CityCare's recruitment of minority staff including BME staff, male staff and staff who do not describe themselves a heterosexual.

Goal 3: A representative and supported workforce		
3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations**	The Terms of Reference for the GNCCP's Remuneration and Terms of Service Committee includes responsibility for implementing the Equality Act 2010 (Specific Duties and Public authorities) Regulations 2017. The Regulations, which apply to public bodies with 250 or more employees, places a duty to publish annual information relating to pay. Although each of the GNCCP's CCGs is a statutory organisation employing fewer than 250 staff, the GNCCP does plan to produce a report on its gender pay gap during 2019. The GNCCP has no current plan to commission an Equal Pay audit from its Internal Audit provider.

Goal 3: A representative and supported workforce		
3.3	**Training and development opportunities are taken up and positively evaluated by all staff**	The 2018 GNCCP staff survey asked the following question: • Have you had any training, learning or development in the last 12 months (excluding mandatory training)? *47.3% of the respondents agreed.* The staff appraisal process is a key opportunity for identifying and addressing training needs and requests. However, the October 2018 quarterly Workforce report noted that, due to the alignment of the CCGs and the significant changes in line management that have occurred, it has been difficult for the appraisal process to be completed for many staff. A Performance Development Review Form has been developed for 2018/19 as an interim measure while a more robust and purposeful appraisal process is developed. It includes a Self-development section, which asks individual members of staff what they think are their training and development needs for the coming year. The GNCCP accesses courses run by the East Midlands Leadership Academy, although a report from the Academy has indicated that only two members of staff attended their courses during the first two quarters of 2018/19. Unfortunately the report does not detail attendance at conferences that the Academy organises, yet they can be an important source of training. There has been little uptake of any external courses by GNCCP staff as participation has not been approved for financial reasons. In line with the equality assurance requirements outlined above, key providers are being required to undertake and report on a deep dive of this specific outcome during 2018/19. The information received to date has therefore informed the self-assessment process. For example, CityCare Partnership's February 2019 Equality and Diversity Deep Dives report referred to in outcome 3.1 above stated that outcome 3.3 is highlighted within CityCare's EDS2 action plan. Actions to demonstrate this include (but not exclusively) review of staff training undertaken, delivery of training within safe and open forums and leadership and development training.

Goal 3: A representative and supported workforce		
3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source**	The 2018 GNCCP staff survey asked the following questions: • In the last 12 months how many times have you personally experienced physical violence at work from managers or other colleagues? *100% answered Never*. • In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers or other colleagues? *90% answered No.* Two formal concerns raised around bullying/treatment in the workplace have recently been received from staff, which are being investigated.
3.5	**Flexible working options are available to all staff, consistent with the needs of the service and the way people lead their lives**	The 2018 GNCCP staff survey asked the following question: • How satisfied are you with the opportunities for flexible working patterns*? 85% of the respondents were satisfied or very satisfied.* The October 2018 Workforce report to the Governing Bodies stated that a third of GNCCP staff work on a part-time basis, demonstrating that staff are still accessing the number of flexible working opportunities available following the merger of the management structures.

Goal 3: A representative and supported workforce		
3.6	**Staff report positive experiences of their membership of the workforce**	In addition to the questions referred to above, the 2018 GNCCP staff survey also asked the following: How satisfied are you with the following aspects of your job: • The recognition I get for good work. *59% of the responses were positive* • The support I get from my immediate manager. *71% of the responses were positive* • The support I get from my work colleagues. *78% of the responses were positive* • The amount of responsibility I am given. *65% of the responses were positive* • The opportunities I have to use my skills. *60% of the responses were positive* • The extent to which my organisation values my work. *39% of the responses were positive* • My level of pay. *53% of the responses were positive* To what extent would you recommend your organisation as a place to work? *46% of the responses were positive* As already noted, the scores varied across the four CCGs for many of these questions and it is intended that an action plan will be developed in conjunction with the Staff Engagement Group to address all relevant results of the 2018 staff survey. The Performance Development Review Form in use for 2018/19 includes a Feedback on the Organisation section, which asks whether there is anything further the CCG (sic) can do to ensure that the culture and approach supports equality and diversity in the workplace and in the work it does.

Goal 4: Inclusive leadership		
4.1	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations**	Members of the GNCCP's Governing Bodies have a collective and individual responsibility for ensuring compliance with the PSED of the Equality Act 2010. This in turn supports the delivery of successful equality outcomes for the GNCCP, both as a commissioner as an employer. Each of the Governing Bodies has a Lay Member lead for patient and public involvement and equality. They have a lead role in ensuring that patient and community interests are at the heart of discussions and decision-making arrangements. Specifically they should ensure that the CCGs respond to feedback and recommendations from patients, carers and the public and establish effective relationships with involvement and engagement fora. The Terms of Reference of the GNCCP's Joint Commissioning Committee (JCC) identify that it is responsible for the development of equality objectives and recommending them for approval by the GNCCP's Governing Bodies. The JCC is also responsible for the oversight and management of delivering approved equality objectives. Its delegated functions include the requirements to comply with the PSED of the Equality Act 2010 and with the duty on public authorities under section 6 of the Human Rights Act 1998. A log of all business case or service change proposals is maintained, which tracks the completion of associated EQIAs, their findings and any identified mitigating actions. The log is reviewed to prompt updates on mitigating actions and is presented to the GNCCP Quality and Performance Committee every month.

Goal 4: Inclusive leadership		
4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed**	The front sheet template for papers submitted to the GNCCP's Governing Bodies, its Joint Commissioning Committee, Primary Care Commissioning Committee and Quality & Improvement Committee prompts authors to indicate whether an EQIA has been completed and whether Equality and Human Rights implications have been considered for the associated paper. It also requires any risks associated with the paper to be briefly explained. The GNCCP's Clinical Commissioning Executive Group is responsible for evaluating, scrutinising and quality assuring the clinical and cost effectiveness of new investments, recurrent funding allocations and all decommissioning and disinvestment proposals. This includes receipt of EQIAs to ensure an assessment of any associated equality and quality impacts arising from proposals, along with consideration of feedback from patient and public engagement and consultation activities.
4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination**	The 2018 GNCCP staff survey asked the following question: • In the last 12 months have you personally experienced discrimination at work from your manager, team leader or other colleagues, because of your ethnic background, gender, religion, sexual orientation, disability, age or other? *96% of the respondents answered No.* As part of the redesign of the organisation's new appraisal/performance management process, a competency framework is being established. This framework will help to support performance and development across the organisation. Core dimensions will include Equality, Diversity and Inclusion in the Workplace and Leadership Competency.

4. 2018/19 EDS 2 Assessment Outcome

The GNCCP's EDS2 self-assessed grades for 2018/19 are reported against each outcome in the tables below. The self-assessed grades for each of the 18 outcomes have been arrived at in accordance with the following principles:

- Consideration of the available evidence underpinning the latest reported EDS2 assessments for Nottingham City CCG (2017/18) and the South County CCGs (2016/17)
- Transparent and pragmatic use of available information, including the equality assurances received to date via contract monitoring arrangements with our key providers
- A focus on the actions that the CCGs are able to take or influence as commissioners of health services
- Proportionate identification of any known significant variations in equality performance, balancing identified progress and good practice with challenges, problems or concerns.

The evidence and scoring of each outcome has been submitted to a number of the GNCCP's lay and independent members to obtain an independent assurance on the assessment approach and findings.

From the information available, there have been no significant positive or negative variations in equality performance identified across the GNCCP during 2018/19 that would impact on the assessment process. This suggested that it was reasonable to compare the previous grades reported by the South Nottinghamshire CCGs and Nottingham City CCG and where possible to arrive at an 'average' grade. This approach has been adopted for all of the outcomes where the previous grades were the same. For outcomes that were previously graded differently, current available information has been used to determine an average grade. The results are provided in the table below:

- Goal 1 - Better health outcomes
- Goal 2 - Improved patient access and experience
- Goal 3 - A representative and supported workforce
- Goal 4 - Inclusive leadership

	EDS2 goals 1 and 2 and associated outcomes								
	1.1 C	1.2 P	1.3 P	1.4 P	1.5 PH	2.1 P	2.2 P	2.3 P	2.4 P
GNCCP's EDS2 self-assessed grades for 2018/19 (Achieving, Developing, Undeveloped)	A	A	D	D	A	D	D	D	A
City CCG's reported grades for 2017/18	A	D	D	D	A	D	D	U	D
County CCGs' reported grades for 2016/17	D	A	D	D	D	D	D	D	A

Key:

C: A predominantly Commissioner-focused outcome
P: A predominantly Provider-focused outcome
PH: A predominantly Public Health-focused outcome

	EDS2 goals 3 and 4 and associated outcomes								
	3.1	3.2	3.3	3.4	3.5	3.6	4.1	4.2	4.3
GNCCP's EDS2 self-assessed grades for 2018/19 (Achieving, Developing, Undeveloped)	D	D	D	A	A	D	A	D	D
City CCG's EDS2 self-assessed grades for 2017/18	D	D	D	A	A	D	A	D	D
County CCGs' reported grades for 2016/17	A	A	D	D	A	D	D	D	D

5. Next steps & Recommendations

5.1 Produce the GNCCP's Annual Equality Assurance Report for 2019

The report will reference the EDS2 process and high level of overview of equality and inclusion priorities that have been identified and the next steps for the organisation to improve equality performance.

5.2 Continue to align and evolve the approach to meeting the PSED

Completing an aligned GNCCP 2018/19 EDS2 assessment has formed a good basis for future work to further bring together into a unified approach the Nottinghamshire CCGs' existing arrangements for improving equality performance and meeting the PSED. The following elements are key features of this work:

- Produce an Equality, Diversity and Inclusion Framework and equality governance arrangements at CCG, ICP and ICS level
- Identify the significant differences in population demographics across Nottinghamshire and ensure these are recognised, assessed and addressed through commissioning and service redesign and delivery
- Understand the implications of the national launch of EDS3 and how this will support alignment of equality and inclusion work programmes across the ICS system
- Establish an annual equality performance work programme and action plan (aligned to agreed equality objectives [see section 5.3 below]).

5.3 Use the EDS2 self-assessment to inform development of equality objectives for the CCGs

The PSED of the Equality Act 2010 includes a statutory requirement for public sector organisations to have a set of equality objectives, which are reviewed and refreshed every four years.

The process of assessing evidence for each assurance area has provided valuable information in order to identify key equality priority areas. These are listed in **Appendix A** and have been mapped to one or more EDS2 outcomes that the priority areas will help to address. These can be taken forward to develop specific equality objectives, which will reflect the organisation's commitment to taking equality, diversity and inclusion into account throughout the organisation's activities.

The Quality and Performance Committee is requested to:

- **Agree the results of the self-assessment process for EDS2 goals 1 to 4**
- **Support the inclusion of the EDS2 self-assessment results in the GNCCP's annual Equality Assurance report (to meet the requirements of the Public Sector Equality Duty) for submission to the April 2019 meetings of the Governing Bodies**
- **Support the proposed next steps, including use of the identified equality priority areas to develop specific equality objectives.**

Appendix A: Proposed equality priority areas, mapped to EDS2 outcomes

	EDS2 goals 1 and 2 and associated outcomes								
GNCCP's proposed equality priority areas, mapped to outcomes for EDS2 goals 1 and 2	**1.1**	**1.2**	**1.3**	**1.4**	**1.5**	**2.1**	**2.2**	**2.3**	**2.4**
1. **Joint Strategic Needs Assessment (JSNA):** Continue to work with the GNCCP and Nottingham/Nottinghamshire Public Health to ensure that JSNA chapters address all protected characteristic and inclusion health groups, support accurate identification of health inequalities across Greater Nottingham and inform equality considerations of the CCP's commissioning intentions.	✓	✓			✓				
2. **Patient and public engagement:** Apply the GNCCP's Engagement Framework to ensure that input from Greater Nottingham's diverse population is obtained, to understand and address its health needs.	✓	✓		✓		✓	✓	✓	✓
3. **Equality/Quality Impact Assessments (EQIAs):** Ensure that service redesign is supported by robust EQIAs that are initiated and acted upon at relevant stages in the commissioning cycle. Ensure impact assessments and mitigating actions are built into project delivery and evaluation plans.	✓	✓	✓	✓		✓		✓	
4. **Research:** Maintain the GNCCP's commitment to the promotion of research which is essential to the continual improvement of patient care, population health, health outcomes and the effectiveness of services.	✓	✓				✓		✓	
5. **Contract management:** Continue to embed equality assurance requirements in key provider contracts. Apply the GNCCP's service review processes to obtain assurance that patients are able to access services equitably and that their communication needs are met. Improve the availability of information analysed by protected characteristics, so that it is possible to more meaningfully determine how well people from protected characteristic groups fare, compared with people overall.	✓	✓	✓	✓		✓	✓	✓	✓
6. **Communication:** Identify and address barriers to communication that may prevent patients from accessing health services commissioned by the GNCCP.	✓	✓		✓	✓	✓	✓	✓	
7. **Cultural competence:** Obtain assurances from key providers that the diversity of Greater Nottingham's population is reflected in the cultural awareness and competency training received by their staff.									

	EDS2 goals 3 and 4 and associated outcomes								
GNCCP's proposed equality priority areas, mapped to outcomes for EDS2 goals 3 and 4	**3.1**	**3.2**	**3.3**	**3.4**	**3.5**	**3.6**	**4.1**	**4.2**	**4.3**
1. **Recruitment and selection:** Increase the diversity of the GNCCP's workforce, focusing on specific protected characteristics.	✓				✓				
2. **Cultural competence:** Establish a programme for supporting GNCCP employees to develop their cultural awareness and competency.			✓	✓		✓	✓	✓	✓

Appendix B – Equality assurance requirements included in provider contracts from 2017/18

We are committed to embedding equality and diversity considerations into all aspects of our commissioning arrangements, including our contract monitoring processes. To do this we have devised a four-year cycle of assurances that we are seeking from our providers, starting from 2017/18. The cycle includes the following requirements:

- A general assurance at the beginning of the contract year to demonstrate providers' compliance with EDS2, which is mandated by the NHS Standard Contract.

  This is expected to take the form of an annual equality assurance report, in line with the requirements of providers' own internal governance arrangements and Board reporting, including details of how they are meeting the Public Sector Equality Duty.

  The report should clearly describe the systems and processes in place for measuring equality performance and include the most recent results of EDS2 grading exercises. Any gaps or systems weaknesses and associated risks should also be identified. Where relevant, the report should contain an action plan outlining how those gaps/risks are being addressed, including a progress update.

  We recognise that certain providers historically may not have used the EDS Toolkit to review and improve their equality performance. However, we still expect Board-level reports from them in line with the requirements outlined above, to clearly demonstrate how equality performance is measured and assessed for people in the protected characteristic groups defined by the Equality Act 2010, and for people in inclusion health groups.
- An assurance that the Accessible Information Standard (AIS) is being implemented, again in line with individual providers' internal governance and Board reporting arrangements.
- Reports of the outcome of a cycle of 'deep dives' - focused exercises to provide in-depth and comprehensive reviews on the extent to which providers are addressing specific EDS2 outcomes. The section of the EDS2 guidance on 'Assessing and grading performance' (p16) offers a variety of acceptable approaches that may potentially be adopted as a framework for the reviews.

  In addition we require one deep dive that does not correlate specifically with any of the EDS2 outcomes, but focuses on workforce cultural competence. We consider this to be a fundamental element of equality performance in light of the expanding diversity of Nottingham City's population across all of the protected characteristics and inclusion health groups.

  Reports on the findings of each deep dive should be in line with the requirements for general assurance reports and should contain a level of information expected by providers' Boards, including an action plan outlining how any identified gaps and risks are being addressed, supported by a progress update. The timetable for these requirements is summarised below:

Appendix B – Equality assurance requirements included in provider contracts from 2017/18

	2017/18	2018/19	2019/20	2020/21
General assurance on compliance with EDS2	✓	✓	✓	✓
Assurance on compliance with the Accessible Information Standard *By 2018/19 the CCG expects to receive an assurance that the AIS is being fully implemented.*	✓	✓		
Deep dives associated with the following equality performance areas:				
People, carers and communities can readily access hospital, community or primary care services and should not be denied access on unreasonable grounds.	✓			
The increasing diversity of Nottingham City's population is reflected in the cultural awareness and competency training received by staff.	✓			
People report positive experiences of the NHS and people's complaints about services are handled respectfully and efficiently.		✓		
Fair NHS recruitment and selection processes lead to a more representative workforce at all levels, with training and development opportunities taken up and positively evaluated by all staff.		✓		
Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed.			✓	
When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse.			✓	
Individual people's health needs are assessed and met in appropriate and effective ways.				✓
People are informed and supported to be as involved as they wish to be in decisions about their care.				✓

NHS
Nottingham North and East
Clinical Commissioning Group

Meeting Title:	Open Governing Body			**Date:** 16 April 2019					
Paper Title:	Workforce Report			**Paper Reference:** GB/19/042					
Sponsor:	Hazel Buchanan								
Previous Related Papers:	Greater Nottingham Bi-Annual Workforce Report (October 2018)								
Recommendation:	Approve	☐	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒	
Summary Purpose of Paper:	To provide an overview of the current workforce position and an overview of the staff survey results. Key points from the paper include the following: • The headcount has slightly increased throughout the year (headcount includes GN CCP and ICS staff and Governing Body members and Clinical Advisors). A vacancy control process continues to be in place. • There was a peak in new starters between September to January and this has reduced in March. • The staff turnover target of 1.5% has been maintained in 8/12 months. • The proportion of staff across the pay bands has remained consistent, with a slight reduction in band 8a and increase in band 7 staff. • Actions are planned to develop and embed equality practices within our recruitment, employee relations and change management procedures to encourage our workforce to better represent our population. • There have been considerable fluctuations in short and long term absences over the past 12 months. • Continued action is required to increase compliance with mandatory training and appraisals. • The staff survey highlighted key areas of focus including health and wellbeing, staff morale, appraisals and staff engagement. • A comprehensive OD plan has been implemented to support staff, managers and the leadership teams through the next 12 months.								
If paper is for Approval/Endorsement, have the following impact assessments been completed?									
Equality / Quality Impact Assessment	Yes ☐ No ☐ N/A ☒			Data Protection Impact Assessment	Yes ☐ No ☐ N/A ☒				

Conflicts of Interest: Please consider whether there are any conflicts of interest considerations relevant to either paper authors, meeting members or attendees.

☒ 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

☐ Conflicted party to be excluded from meeting			
Have All Relevant Implications Been Considered? *(please tick where relevant)*			
Clinical Engagement	☒	Patient and Public Involvement	☒
Quality Improvement	☒	Equality, Diversity and Human Rights	☒
Integration	☒	Innovation / Research	☒
Improving Health Outcomes / Reducing Health Inequalities	☒	Patient Choice / Shared Decision Making	☒
Financial Management	☒	Corporate Governance	☒
Is the Information in this paper confidential? Yes ☐ **No** ☒ **If yes, please state reason why:**			
Risk: *(briefly explain any risks associated with the paper*)	**Mandatory Training Compliance** **Sickness Reporting** **Appraisal Completion**		
Recommendation:	The Governing Body is asked to: • **ACKNOWLEDGE** the Workforce Report		

NHS
Greater Nottingham
Clinical Commissioning Partnership

Greater Nottingham CCP - Workforce Report
April 2019

1. Introduction

The report provides the Greater Nottingham Clinical Commissioning Partnerships Governing Bodies with an update on the current workforce position relating to the period of April 2018 to March 2019.

2. Staffing Levels

The CCP's staffing levels during the period of April 2018 to March 2019 by headcount and whole-time equivalent (WTE) status are illustrated at Figure 1 below. This shows that whole-time equivalent and headcount numbers have steadily increased over the course of the year.

As well as GN CCP staff, the numbers include staff recruited specifically to the ICS, individuals who have been recruited on a fixed term contract in relation to project work and Governing Body members and clinical advisors (recognising their different contractual status).

A vacancy control process continues to be in place with final decisions on recruitment being approved by the Exec Team.

Figure 1 – Staffing levels by headcount and WTE

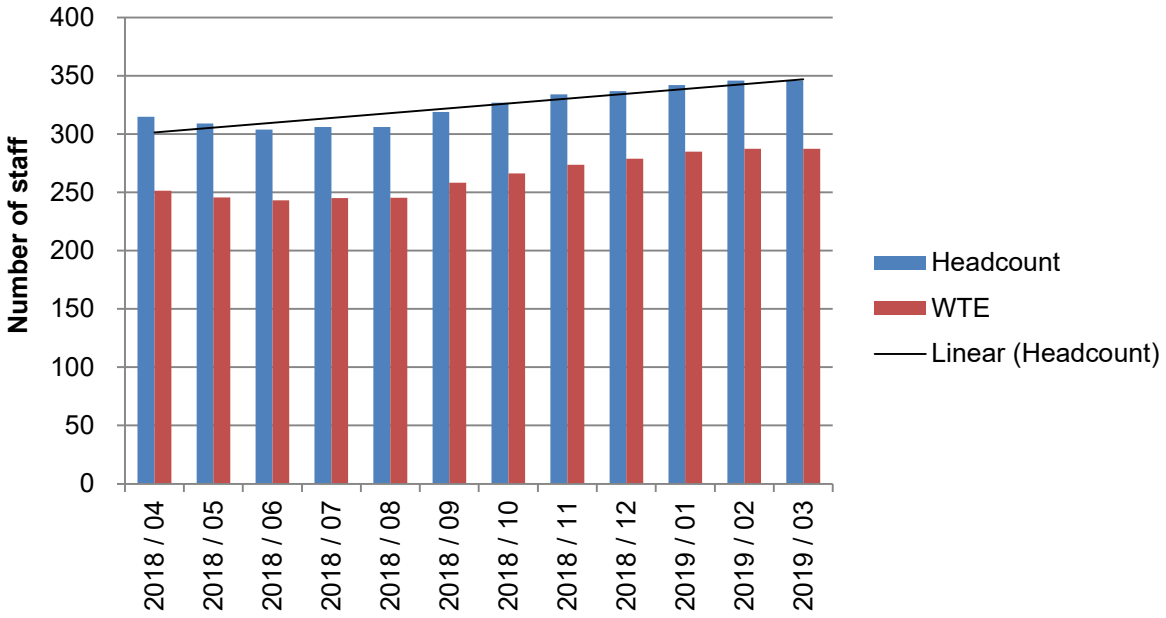
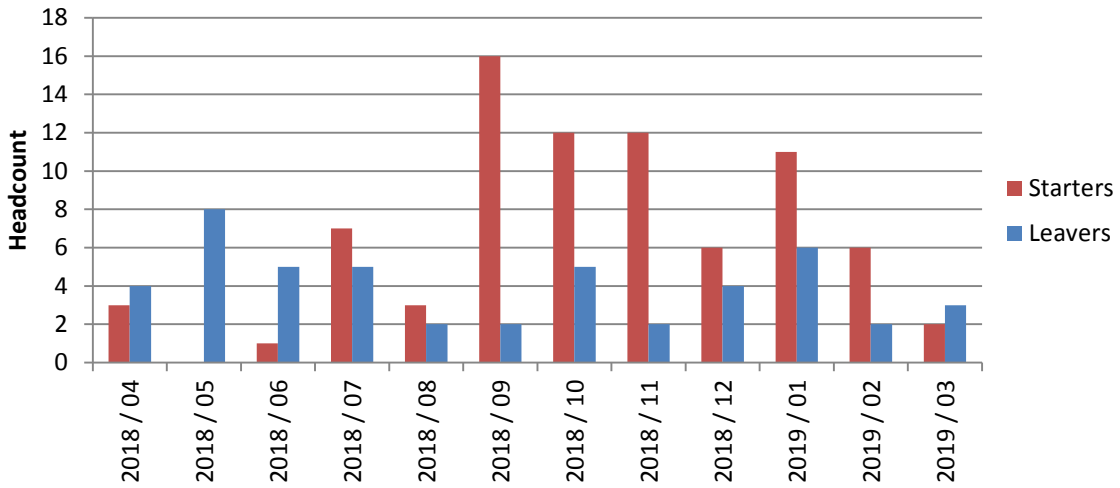


Figure 2 illustrates the CCP's starters and leavers during the financial year. We had a higher number of starters (79) in comparison to leavers (48). This is a reflection of the recruitment to the ICS team, along with new roles through the restructure in Greater Nottingham (i.e. Medicines Management). There has also been an increase in across system working which

in turn has encouraged a number of secondments that were granted to staff and required backfill opportunities to substantive roles.

Figure 2 – Starter and Leavers for financial year 2018/19

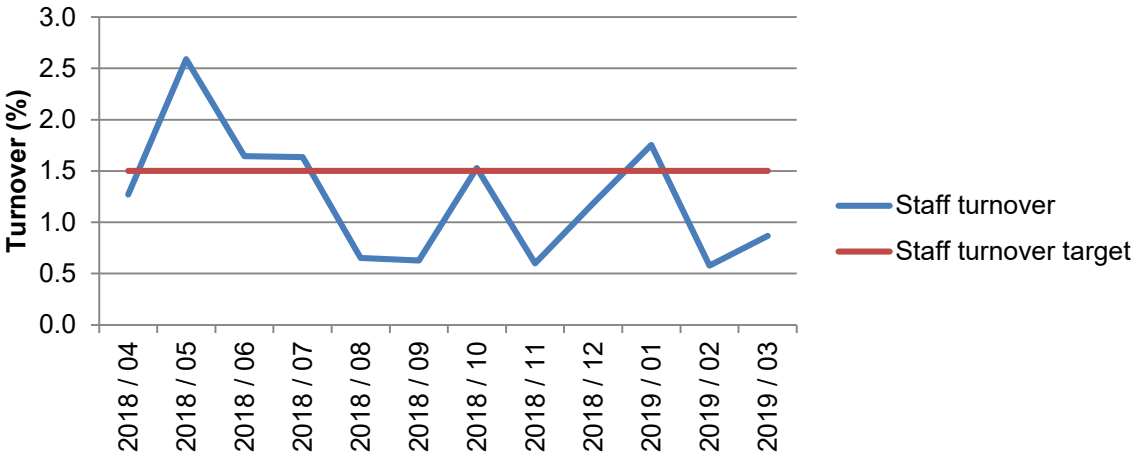


3. Staff Turnover

As mentioned in the Workforce Report presented in October, it is important to monitor turnover rates for the CCP as an organisation. The impact of high staff turnover could be detrimental via loss of skills, experience and organisational knowledge. There is also significant impact through the cost and time requirements associated with recruiting and training replacement staff.

It is however recognised that a certain amount of natural staff turnover should be seen as healthy in order to maintain staff motivation and to ensure that the CCP continues to benefit from new perspectives. The CCP's monthly turnover rates, against a target of 1.5%, are illustrated at Figure 3 below. The tables illustrates that since the CCP formed in June 2018, with exception of October and January the CCP has managed to stay below the target. Prior to June, it illustrates that the CCP were working in excess of that target however, that is a reflection of the impact of the restructure. Therefore, 5 out of 12 months peak above the target rate of 1.5%. As indicated in the previous workforce report it is worth noting that due to the overall size of the organisation, a small number of staff leaving within the same month will cause a peak in the CCP's turnover figures. For example, the CCP had 5 leavers in October and following that 6 in January which has caused a significant effect to the reported percentage.

Figure 3 – Staff turnover rates for 2018/19

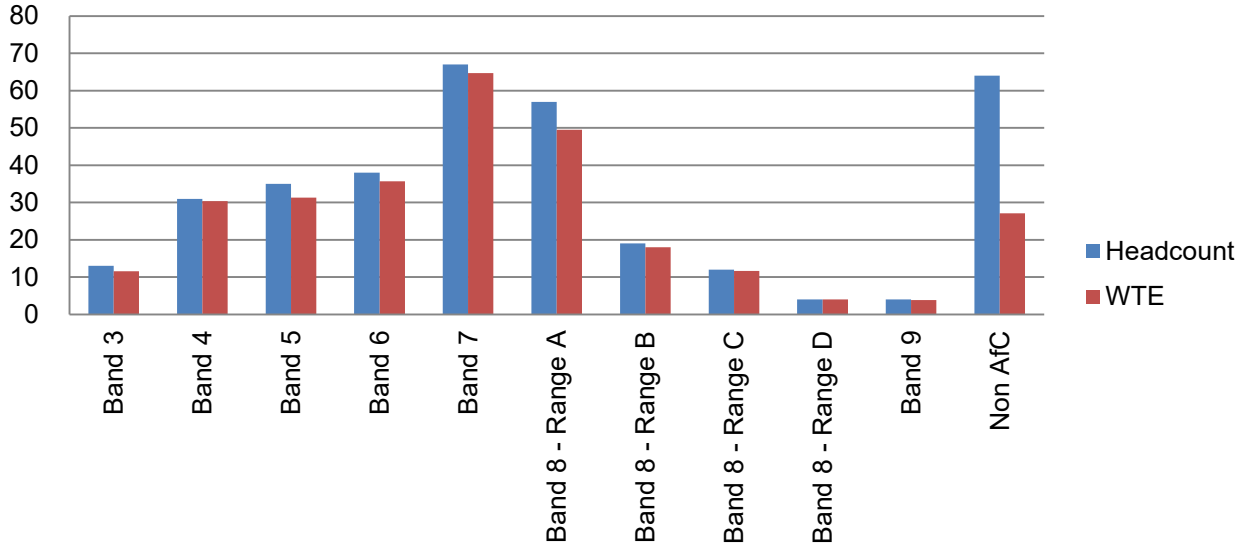


4. Workforce Profile

The banding distribution of the CCP's staffing structure as of 31st March 2019 is illustrated at Figure 4 below. This shows that the vast majority of the CCP's workforce are on Bands 4 to 8a. Whilst overall staffing figures have increased since the previous Workforce Report, the proportion of the workforce within each band hasn't changed significantly over this period with the exception of a decrease in Band 8a and an increase in Band 7's. WTE figures are as expected due to the smaller number of part-time staff illustrated through the marginal difference between headcount and WTE. Figure 4 also includes those who are on any form of non agenda for change contract including the Very Senior Manager contracts or individuals on Contracts for Services. The pay scale for Very Senior Manager contracts ranges from 8c upwards. Whilst the headcount for this group is 64, the whole time equivalent is 27, reflecting the nature of the contracts.

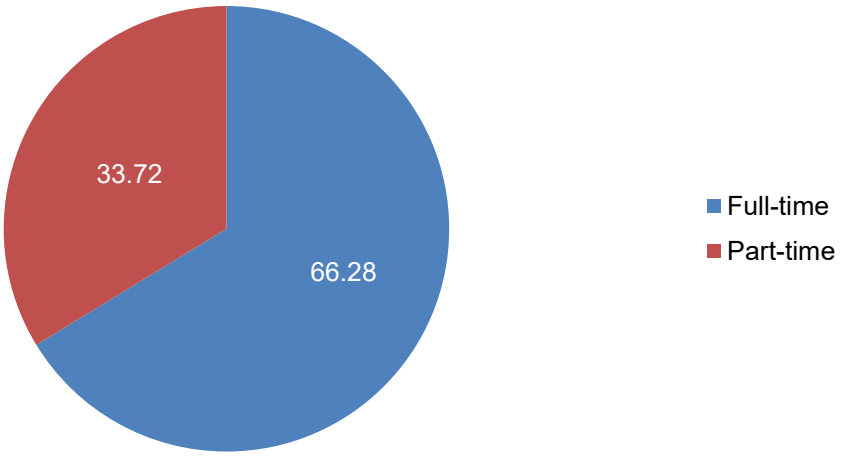
Since the previous Workforce Report, the Senior Leadership Team have undergone a consultation to consolidate the executive and director teams of both the CCP and Mid-Notts to a single Senior Leadership Team. As part of the process, there is on-going work to assimilate the Senior Leadership Team on to Agenda for Change bandings.

Figure 4 - Staff in Post by Pay Band (Headcount and WTE)as of 31st March 2019



An analysis of the CCP's workforce by working hours is provided at Figure 5 below, which shows that 116 members of staff or 33.7% work on a part-time basis. This demonstrates that staff members are still accessing the number of flexible working opportunities available. This will be discussed further later in the report when discussing the staff survey results.

Figure 5 - Staff in post by full-time and part-time (%)



5. Workforce Equality Objectives

The CCP continues to be committed to being a fair and inclusive employer, and it is a statutory requirement that each CCG within the CCP has up to date equality objectives. Following the Workforce Report in October and given the direction of travel towards one Strategic Commissioner i.e. one CCG across the Nottinghamshire footprint, focus has been placed on taking the steps required to assimilate staff and the existing structures into new

formation to fit into the indicated new system wide approach to delivering healthcare. So whilst, the previous Workforce Report in October identified that work was required to identify equality objective themes that are aligned to the CCP's strategic objectives and to agree an optimal number of equality objectives. There is a wider piece to do now across the 6 Nottinghamshire CCG's in aligning strategic objectives and in turn, identifying equality objective themes that fit.

The following figures (6-11) display the current profile of the CCP's workforce against six of the protected characteristics (gender, sexual orientation, religion, age, nationality and disability) as defined by the Equality Act 2010. Being an organisation employing just 344 members of staff imposes a number of restrictions on the extent to which it is possible to analyse workforce reports without compromising the anonymity of individual members of staff. With this in mind, for characteristics that include categories with low numbers (i.e. less than 5% of the workforce), the headcount is presented as a percentage range.

We are continually working with staff to reduce the number of 'do not wish to declare' options across all protected characteristics. We will reintroduce the bi-annual requests to review and update personal data, provide consistent reassurance that personal data is not used or accessed by anyone other than those with a requirement to view it, and actively demonstrate that all processes are fair and transparent to increase employees ease with declaring their protected characteristic status.

Figure 6 – Profile of the religious beliefs of staff members (%)

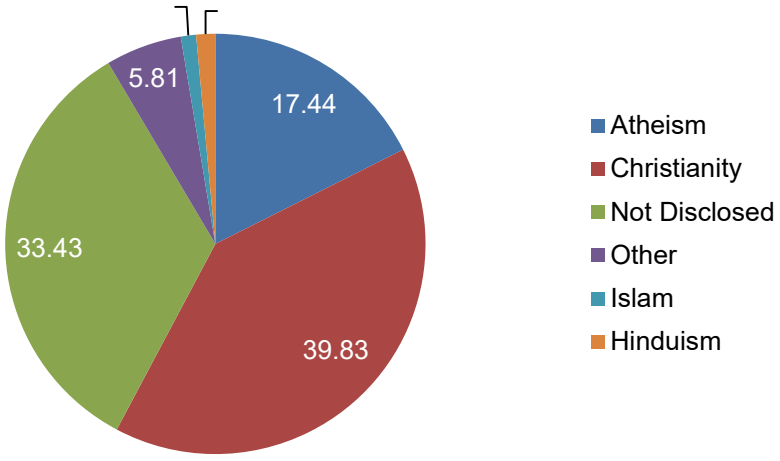


Figure 7 – Profile of the nationalities of staff members (%)

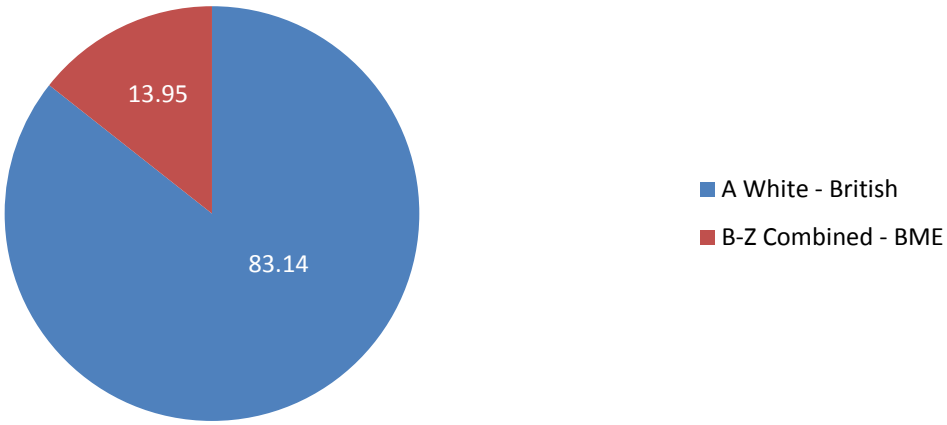


Figure 8 – Profile of the status of staff members based on disability (%)

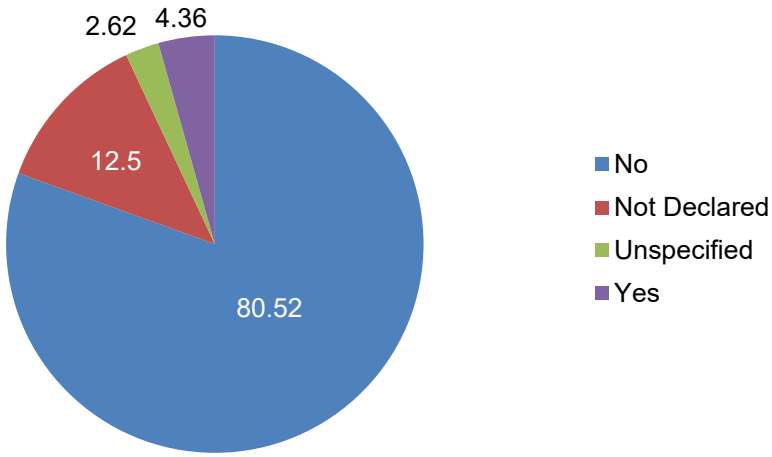


Figure 9 – Profile of the staff members sexual orientation (%)

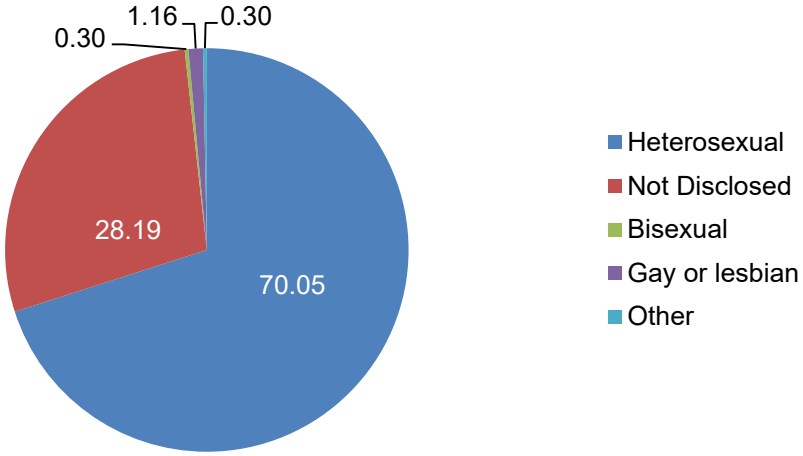


Figure 10 – Profile of staff members gender (%)

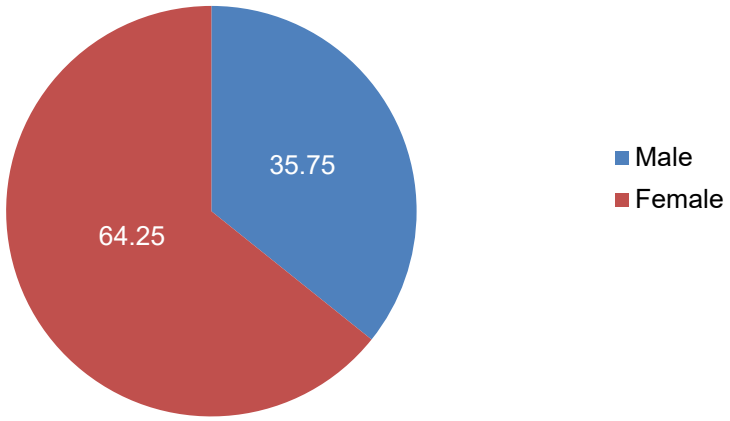
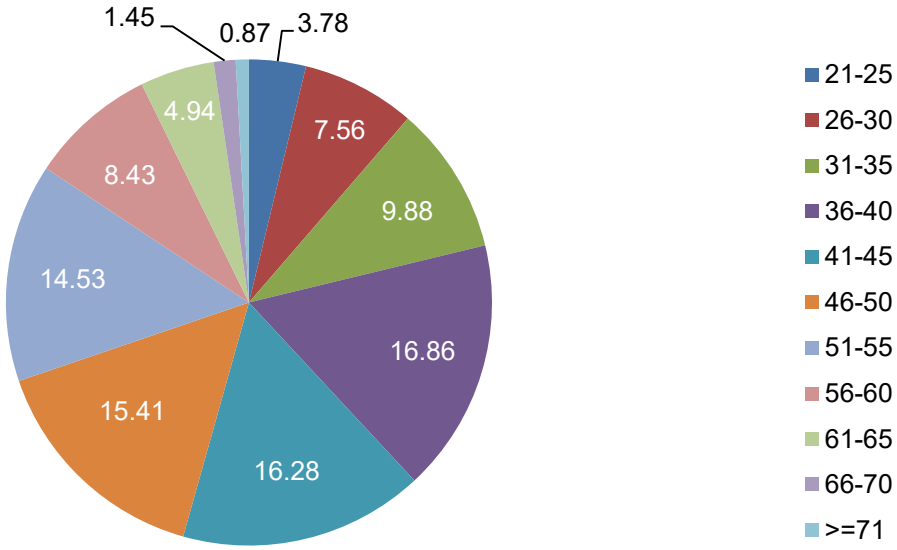


Figure 11 – Profile of the age of staff members at the CCP (%)



The following table summarises the breakdown of staff by protected characteristic. Appendix 1 provides an overview of the demographics in relation to the Greater Nottingham population. When taking into consideration the ethnicity in Nottingham and Nottinghamshire, proportionately as an average the number of staff from a BME background is low. There is significant work that needs to be carried out across the CCP to develop and embed equality practices within our recruitment, employee relations management and change management practices that will be developed over the next 12 months. This is to encourage our workforce to better represent the population the CCP serve across Nottingham and Nottinghamshire.

	Protected Characteristic	% of headcount as of 31 March 2019
Age	16 – 30	11.4
	31 – 40	26.7
	41 – 50	31.7
	>50	30.2
Gender	Male	26.4
	Female	73.5
Ethnicity	White British	83.1
	BME	14
	Do not wish to declare / Not stated	<5%
Disability	Yes	<5%
	No	80.5
	Do not wish to declare / Not stated	15.2
Sexual Orientation	Heterosexual	70
	Lesbian/Gay/Bisexual/Other	<5%
	Do not wish to declare / Not stated	28.2
Religion/ Belief	Atheism	17.4
	Christianity	39.8
	Hinduism	<5%
	Islam	<5%
	Other	6.5
	Do not wish to declare / Not stated	33.7

6. Sickness Absence

Sickness absence can be problematic for small organisations as it is more difficult to cover the absence of key individuals or disseminate the work between teams.

Figure 12 below provides details of the CCP's monthly sickness absence rates for the period of April 2018 to March 2019. The figure shows a fluctuating picture of absence across the year. This should be used in conjunction with figure 13.

The CCP were previously concerned that sickness absence wasn't being accurately recorded due in part to the large changes in line management following the merger of the management structures. This remains on the HR agenda especially given there is still the technological barrier that is restricting the accurate recording of sickness absence through ESR Supervisor Self Service. The HR team continue to attempt to remedy this via working with the managers to complete Absence Returns for HR to record on the teams behalf. This may explain in part the increase in absence recorded and the fluctuations in the rates of absence. The HR team continue to work to reduce the absence to keep it below our agreed tolerance of 2.5% of the workforce.

Figure 12 – Sickness rates (%)

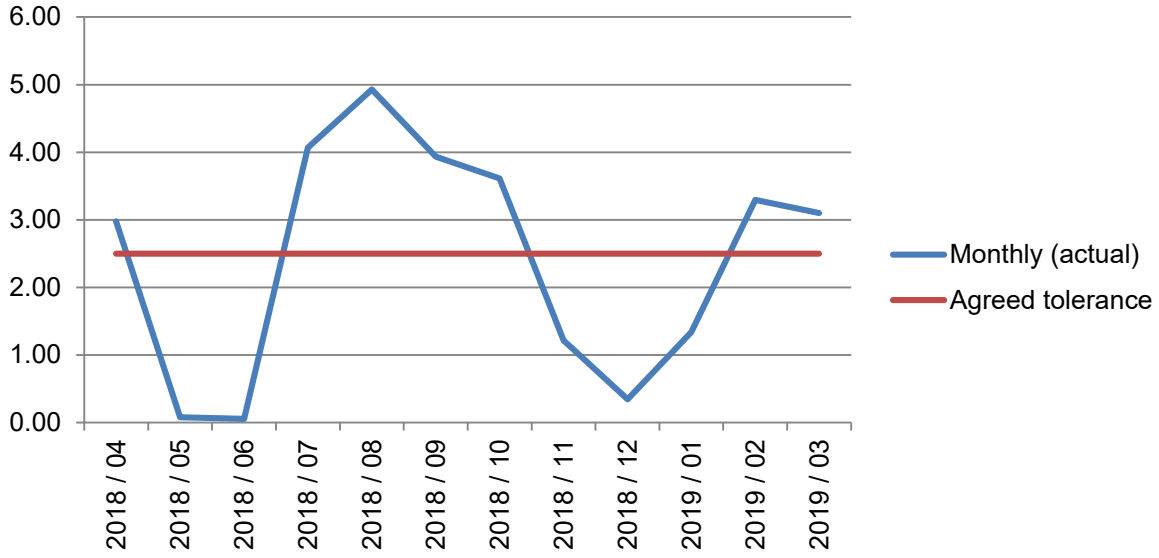
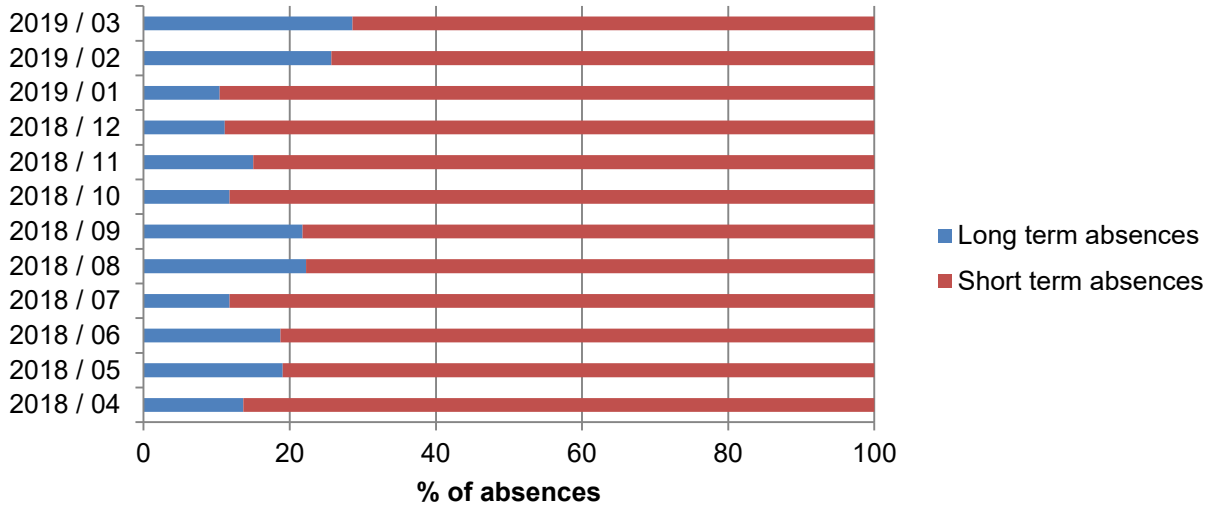


Figure 13 provides an analysis of short term and long term (defined as 28 or more consecutive days) absences over the period April 2018 to March 2019. All individuals that have been identified as breaching internal policy triggers for short term absence are being met with in line with the requirements of the Greater Nottingham CCG's Sickness Absence Policies.

The figure shows fluctuations in long term absences with the annual high being March 2019. This may be indicative of news of a further restructure to align us to the changing NHS landscape across Nottingham and Nottinghamshire. In addition to the length of absence the CCP also monitor the reason for absence (available in the below table) to ensure that we are able to offer appropriate interventions to our staff if there is a repeated cause of absence across the organisation or within a specific team.

Figure 13 – Long-term vs. short-term absence



The table below details the 'top 5' reasons for absence during the period between April 2018 and March 2019.

	Reasons for Absence
1	Cold, Coughs and Flu
2	Gastro problems
3	Mental Health
4	Headache
5	Other known causes - not elsewhere classified

Naturally the reasons provided in ESR are not an exhaustive list and therefore, 'other known causes' is used in cases where they don't deem an appropriate heading under the list provided. This has increased since the previous workforce report. Reason 6 and 7 show significant numbers and these are ear, nose and throat and gynaecology retrospectively.

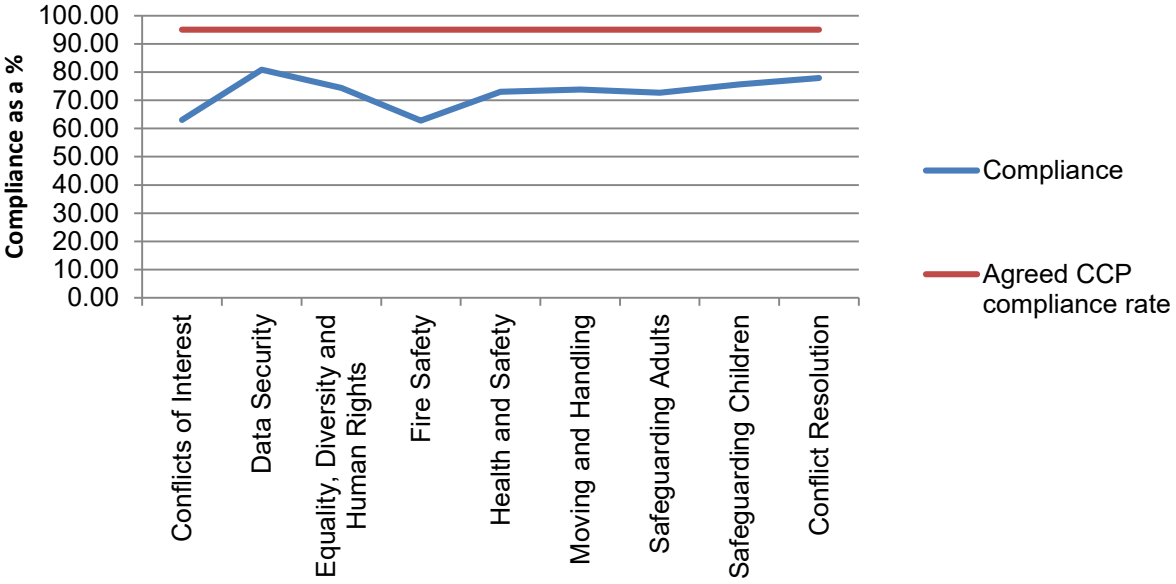
Staff wellbeing is vitally important to the success of the CCP and especially in times of significant change. We have continued to work with our Occupational Health provider to ensure staff awareness of commons workplace conditions and injuries.

7. Statutory and Mandatory Training

The CCP has an agreed compliance target of 95% for all statutory and mandatory training undertaken across the Greater Nottingham CCGs.

Figure 14 demonstrates the current compliance rates for all statutory and mandatory training across the CCP. This is dramatically under the compliance target set at the CCP.

Figure 14 - Uptake of Statutory / Mandatory Training



As demonstrated in Figure 14, the completion rate for the mandatory training modules maintains an area of concern and somewhere where immediate attention is required especially in those areas where it is statutorily required.

The HR team will continue to contact individual members of staff directly to highlight any outstanding modules, and offer to support where necessary and appropriate to ensure these are completed. Regular reminders are being issued to staff via the Staff Communications which is disseminated weekly via email across the CCP.

8. Staff Appraisals

A simplified appraisal form was issued to all staff around the time the previous workforce report was issued to the Governing Body. This was to encourage compliance to the process as throughout the change process via numerous changes in line management there had been low completion rates. A more robust and purposeful performance management process is in development following the appointment of the Organisational Development Manager to the HR & OD team. This has an accompanying competency framework (linked to values and behaviours across the CCP and the Mid Nottinghamshire CCG's to make it fit for purpose in the single commissioner). This is currently being reviewed by the newly amalgamated Staff Engagement Group (SEG) for Mid-Nottinghamshire and Greater Nottinghamshire CCG's.

It is our aim to continue to work with individuals and their Line Managers to increase the compliance figures and to have launched the new performance management process to provide feedback to the Governing Body in the next Workforce Report.

9. Staff Survey

The CCP participated in the National Staff Survey for 2018 which was administered by Picker Institute Europe.

There was a good response to the survey at 82% and the results were reasonable considering the context at the time. The survey has provided valuable feedback which is

being taken into consideration in relation to the current restructure and actions have been assimilated into the OD plan. Further information on the survey can be found in Appendix 2.

10. Staff Partnership Group

As stated in the previous Workforce Report, the CCP implemented a Staff Partnership Group in order to work proactively and collaboratively with employees on staff engagement. This has been superseded with the development of the Staff Engagement Group (SEG) working across both the CCP and Mid-Nottinghamshire.

This group met for the first time at a facilitated workshop on the 21st March to lay the foundations for working together as part of the newly amalgamated SEG. They will meet for the first joint SEG meeting on the 3rd May where they will be expected to provide feedback to a number of items currently with them for comment.

11. Organisational Development Plan

In conjunction with East Midlands Leadership Academy, the CCP developed an Organisational Development Plan in order to help our employees to identify with Greater Nottingham CCP. This was an interim plan looking in the immediate to mid-term in anticipation of the changes in the NHS landscape. These are now beginning to take shape.

This has been replaced with a new OD plan to support the merger of Greater Nottingham and Mid-Notts through to the move to the new system architecture. The OD plan also takes into consideration the Greater Nottingham and Mid-Notts staff surveys and as such, provides the action plan to support the outcomes.

During the focus groups conducted last year, the following themes were identified via CCP staff as needing to be addressed/ developed:

- Establishing organisational objectives
- Visible leadership
- Developing and celebrating existing teams

The OD Manager has been mindful on these when working with colleagues in the wider system to develop the OD plan to integrate the Greater Notts and Mid Notts CCG's together with the view to embed the plan and develop the workforce for the new landscape.

The 1st Staff Timeout, since the appointment of new Executive Team members, took place on the 1st April 2019 with approximately 210 Nottingham and Nottinghamshire staff in attendance. The timeout was well attended, positively evaluated and gave CCG employees an opportunity to meet new Exec Team members and understand more about the ICS, ICPs and PCNs. The next stage of the OD Plan will be to continue to improve resilience throughout the organisation as the new teams form.

12. HR Actions

Changes in the wider NHS landscape have changed the CCP's direction of travel. However, actions continue in relation to ensuring that workforce issues are addressed and robust HR is provided.

Actions taken over the past six months in relation to HR and GN CCP include:

The OD Manager commenced with the CCP on 15th October 2018 and has been working closely with teams in relation to specific and team development.

Line managers are being encouraged to conduct regular 1-2-1's with their staff members and have appraisals using the new simplified appraisal process whilst the new performance management process is being ratified.

The Staff News is being circulated on a weekly basis to Mid Notts and Greater Notts CCG employees. AO updates regularly headline the Staff News and EMLA CPD opportunities are frequently advertised.

The HR Manager also commenced with the CCP on 15th October 2018 and has been working with managers to support them with managing absence cases in their teams, performance issues and providing general HR guidance.

Line managers have been informed of an internal process to record absence on ESR via issuing it to the HR team who upload it centrally rather than via the old Supervisor Self Service method given the cross-organisational working occurring throughout the CCP.

Direct input and support to the Shared CCG Workforce and OD workstream.

Regular review and update of the risk register with the Corporate Governance and Assurance Manager.

13. Recommendations

The Governing Body is requested to:

- Consider and comment on the current workforce information contained within this report;

Appendix 1 – Nottingham and Nottinghamshire Population

This section summarises some key characteristics of the population we service across Greater Nottingham and reflects some significant difference in population demographics.

Age

- Nottingham City has a younger population than the national average, due largely to the presence of the two universities. Full-time university students account for approximately one in eight of the population.
    - There is a high turnover of population and there are high levels of international migration, gaining young adults due to migration, both international and within Britain, whilst losing all other age groups - this includes losing families with children as they move to the surrounding districts.
- By contrast Rushcliffe, NNE and NW CCGs have a higher proportion of working age and older adults, with higher percentage of over 65s and over 85s than the nation population average.

Gender

- The split between men and women across Greater Nottingham is almost 50:50.
    - However, the percentage of men aged 25 to 39 is unusually high in Nottingham (e.g. 117 men to every 100 women in the 35 to 39 age-group). This is particularly the case in inner city areas.

Ethnicity

- Nottingham City is ethnically and culturally diverse with approximately 35% of the population is from a black and minority ethnic (BME) background – an increase from 19% in 2001.The Asian/Asian British group is the largest BME group in Nottingham, making up 13% of the total population; Black/African/Caribbean/Black British, mixed or multiple ethnicity and White (not White British) groups each account for 6 – 7% of the total population.
- Whilst black and minority ethnic (BME) populations are relatively low in NNE, NW and Rushcliffe CCGs as a whole (4% compared with 15% nationally), within the districts of Broxtowe, Gedling and Rushcliffe there are larger population groups (7% each district), mainly Asian and Mixed/Multiple Ethnic groups. BME populations in Nottinghamshire have a younger age profile than the general population.
- Some districts of Nottingham have a higher number gypsy and traveller population; the 2007 Housing Needs Assessment estimated the total number of gypsy and traveller households across Rushcliffe, Broxtowe and Nottingham to be 134.

Deprivation

- Deprivation is measured nationally using the Index of Multiple Deprivation (IMD) across all Council areas and the England average IMD score is 22. Across Greater Nottingham there are areas of affluence but also areas of deprivation:
    - Nottingham City is the eighth most deprived area in the country, the IMD score is 3.5

- The CCGs in South County have lower deprivation scores than the national average of 22; Rushcliffe - 8, Nottingham West – 16 and NNE- 8. However, it is important to note that there are some areas of high deprivation within all CCGs.

Appendix 2 – Staff Survey Results

2018/19 Greater Nottingham Clinical Commissioning Partnership Staff Survey Results

1.0 Introduction

The Greater Nottingham Clinical Commissioning Partnership (GNCCP) took part in the NHS National Staff Survey between October and December 2018. This was timely in that the CCGs' staff were formally operating as Greater Nottingham from June 2018.

The 2018 staff survey was sent to 253 members of staff and 205 (82%) responded. The average response rate for the benchmarked group was 81%.

2.0 Structure of the Survey

The survey was undertaken as single organisation and the reporting is reflected as one organisation. We are unable to provide comparative data from previous surveys from the four separate CCGs as there were significant differences in how the organisations undertook their separate staff surveys.

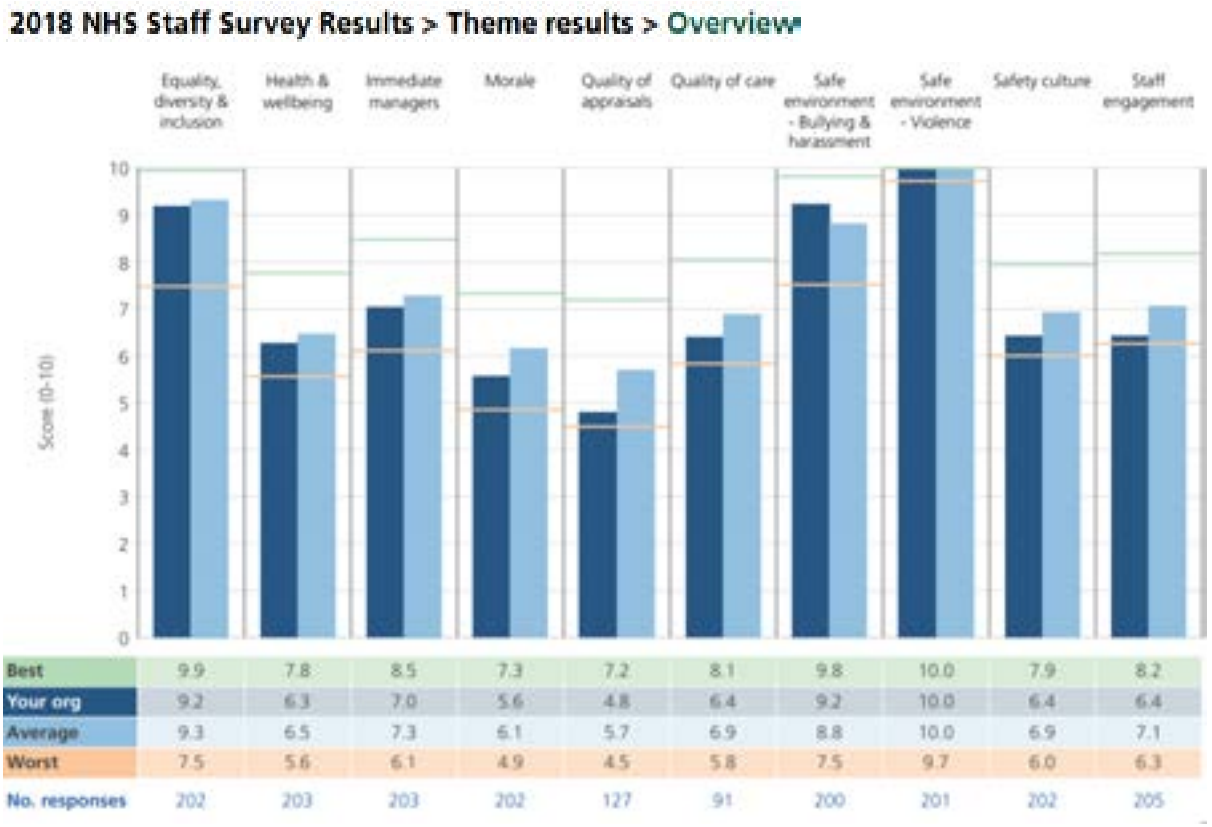
In previous years we have been in a position to split the responses to survey down to directorate level, in order to aid in the identification of any areas of concerns or best practice and celebration. However, for this survey we have identified the four separate CCGs as the directorate level and where appropriate the responses for the four CCGs will be shared within the report.

The survey is based on ten themes with questions structured around an individual's job, their manager, health, well-being and safety at work, personal development and the organisation itself.

Comparison across a benchmarked group is provided. GN CCP has been benchmarked across 69 CCGs.

3.0 Survey Results

The following chart provides an overview of the themes and additional information is provided on the key areas of focus from the survey.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.9	7.8	8.5	7.3	7.2	8.1	9.8	10.0	7.9	8.2
Your org	9.2	6.3	7.0	5.6	4.8	6.4	9.2	10.0	6.4	6.4
Average	9.3	6.5	7.3	6.1	5.7	6.9	8.8	10.0	6.9	7.1
Worst	7.5	5.6	6.1	4.9	4.5	5.8	7.5	9.7	6.0	6.3
No. responses	202	203	203	202	127	91	200	201	202	205

GN CCP is close to average for the benchmarked group. Key areas for particular focus are health and wellbeing, morale, appraisals and staff engagement.

The following provides further context in relation to the areas identified for improvement and actions being taken as a result. The OD plan takes into consideration the full feedback received through the survey.

i) Health and Wellbeing

The results were most positive in relation to flexible working and least positive in relation to action taken by the organisation on health and wellbeing. Workplace stress was highlighted with GN CCP being slightly higher than the average for the benchmarked organisations. Results were positive in relation to support and communication from immediate managers.

Actions:

- Access to Occupational Health is being promoted as part of support during the current restructure.
- Where requested, work environment assessments are being carried out by Occupational Health.
- Health and wellbeing is part of the overall OD plan.
- Time to Change programme is being implemented – structured programme to support staff with mental health.

ii) Morale

Results were positive in relation to encouragement and flexibility in how work is done from line managers. Respect from colleagues was reasonable but strained relationships at work were identified as an area for improvement. Approximately 43% of respondents identified that they often think about leaving the organisation (43%) and equally will look for a job in a new organisation in the next 12 months. (Transversely 45% said they would recommend the CCG as a place to work).

Actions:

- Structured OD plan including resilience workshops for employees and line managers (May/June).
- Provision of team development in the immediate term and as part of the wider OD plan.
- Ongoing promotion of one to one coaching (provided through EMLA).
- HR support to Associate Directors in working with teams on the development of structures.

iii) Appraisals

Respondents did not feel that the appraisal process supported them to improve how they did their job and also that it made them feel their work was valued by the organisation. There was also a low response rate (17%) in relation to organisational values being discussed as part of the appraisal process.

Actions:

- As part of the move to merger, re-establishment of values across the CCGs
- New appraisal process being developed with the Staff Engagement Group.
- New appraisal process includes values based competency framework.
- Improved monitoring of the completion of appraisals being carried out.
- Structured OD plan.

iv) Staff Engagement

Staff engagement covered three areas including motivation, ability to contribute to improvements and recommendation of the organisation as a place to work. A low number of respondents felt that communication between the senior management team and staff is effective (192%). In considering these results with responses for appraisals, there was a sense of support from line management but they did not feel valued by the organisation. Staff felt they were able to make improvements in their work and that of their teams. Approximately 55% were enthusiastic about their job and look forward to coming to work.

Actions:

- A review and update of the weekly team bulletin has been carried (including changing the date that it's distributed).

- Implementation of Staff Partnership Group which is now a wider Staff Engagement Group covering Greater Nottingham and Mid Notts.
- Structured comms and engagement plan as part of GN and Mid Notts merger and system architecture.
- Vision and values to be part of next staff timeout.
- Structured OD Plan.
- To implement a new staff intranet.

To add further context to the responses, the following table provides information on the questions which received the highest response rates.

Question	Percentage of Positive Responses
Not experienced harassment, bullying or abuse from other colleagues	90%
Not felt pressure from colleagues to come to work when not feeling well enough	88%
Have you felt pressure to come to work despite feeling unwell by your immediate line manager?	86%
Satisfied with opportunities for flexible working patterns	85%
I am trusted to do my job	81%

4.0 Conclusion

The survey was done at a time when the organisation was re-establishing itself following the move to a single management structure and the results reflect this. However, all feedback must be used to inform the way in which the current restructure is managed, including the overall commitment of the Exec Team. Staff communication and involvement in developing the new organisation, including shared vision and values, will be fundamental as part of this. The Staff Engagement Group will play a key role in sense checking and confirming that the leadership have listened.

NHS
Nottingham North and East
Clinical Commissioning Group

Meeting Title:	Governing Body – Open Session				**Date:** 16 April 2019			
Paper Title:	Risk and Assurance Report				**Paper Reference:** GB/19/043			
Sponsor:	Lucy Branson, Associate Director of Governance							
Previous Related Papers:	Standing Item							
Recommendation:	Approve	☐	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒
Summary Purpose of Paper:	The purpose of this report is to update the Governing Body on current major risks to the Greater Nottingham Clinical Commissioning Partnership and to provide an overview of the work performed by the Governing Bodies' sub-committees at their recent meetings.							

Equality / Quality Impact Assessment	Yes ☐ No ☐ N/A ☒	Data Protection Impact Assessment	Yes ☐ No ☐ N/A ☒

Conflicts of Interest: Please consider whether there are any conflicts of interest considerations relevant to paper authors, members or attendees.

☒ 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
☐ Conflicted party to be excluded from meeting

Please identify conflicted party and specify reason for conflict:

Have All Relevant Implications Been Considered? *(please tick where relevant)*

Clinical Engagement	☒	Patient and Public Involvement	☒
Quality Improvement	☒	Equality, Diversity and Human Rights	☒
Integration	☒	Innovation / Research	☒
Improving Health Outcomes / Reducing Health Inequalities	☒	Patient Choice / Shared Decision Making	☒
Financial Management	☒	Corporate Governance	☒

Is the Information in this paper confidential? Yes ☐ No ☒
If yes, please state reason why:

Risk: *(briefly explain any risks associated with the paper)*	The report contains major risks from the Joint Risk Register.
Recommendation:	The Governing Body is requested to: • **COMMENT** on the major risks, and specifically, as to whether

	sufficient management actions are in place; • **RECEIVE** an overview of the work of its sub-committees

Risk and Assurance Report

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Section 1: Major Risks

Introduction

Since the last meeting of the Governing Bodies, respective risks from the Greater Nottingham Clinical Commissioning Partnership's (CCP's) Corporate Risk Register have been presented to, and discussed at, meetings of the:

- Directors' Group;
- Audit Committee;
- Joint Commissioning Committee;
- Finance Committee; and
- Quality and Performance Committee.

As part of the governance workstream established as a pre-cursor to the potential merger between the six CCGs, work has commenced to integrate governance and assurance arrangements across the organisations. Discussions have been held with Mid-Nottinghamshire colleagues to initiate the bringing together of the operational risk registers and Governing Body Assurance Frameworks. These will be joint documents across the six statutory CCG organisations for 2019/20.

Major 'Red' Risks

As at April 2019, there are four major risks on the Risk Register, which is a reduction of one since the previous meetings of the Governing Bodies (January 2019). The risk which has been archived is risk reference **GN 055** '*Acute Contract 2018/19 Financial Performance does not remain within planned levels'*. The decision to archive was made by the Finance Committee at its meeting in March 2019, as acute providers have not remained within their planned activity levels, resulting in financial performance also exceeding planned levels and therefore the risk had materialised. It may be appropriate to revisit the need for a new 2019/20 contract performance risk dependent on the outcome of current contract negotiations.

Full narrative detail of the four remaining red risks is presented in **Table 1** below.

Risk Ref:	Committee Oversight:	Risk:	Previous Risk Score			Controls and Actions in Place:	Current Risk Score		
			I	L	Score		I	L	Score
GN053	Finance Committee	Non-delivery of financial plan for 2019/20 due to deterioration in underlying position of the CCGs *Risk Owner – Chief Finance Officer*	3	4	**12**	• Monthly Performance and Financial Reporting to the Joint Committee and through its sub-committee structure. • Reporting to GP Practices via the Practice Packs. • Detailed reports to FRG/QIPP groups for rigorous performance monitoring. • Contract Monitoring Meetings with Providers and Contract Executive Boards/meetings. • Greater Nottingham Financial Recovery PMO in place and has been operating for the last year, with processes and reporting set up and embedded. • Greater Nottingham Vacancy Control process • Practice engagement incentive schemes • Further development of practice budgets/packs • On-going generation of QIPP schemes • Roll out / implementation of QIPP/transformation schemes from Greater Notts Transformation programme • Contingency & Other Reserves • Investment Slippage	**4**	**4**	**16**
Update: *It was highlighted that contract negotiations with the CCGs main providers are continuing and the CCGs' 2019/20 financial position continues to be a significant risk are until contract values are agreed. Work in relation to identifying further QIPP savings continues. The CCGs have reported the savings 'gap' to NHSE and presented overall (and risk rated) QIPP opportunities.* *Further work has been undertaken by Deloitte to support figures being presented and further potential opportunities.* *Monthly ICS Finance Directors (FDs) meetings are being held and a system wide finance report has been developed.* *CCG finance reporting to the GN Governing Bodies/Joint Commissioning Committee/ Finance Committee is continuing to be developed to report across both MN and GN CCGs. Clear financial reporting is being defined in the single CCG governance structure.* *It was highlighted that the 2019/20 Financial Plan has been submitted in line with national reporting requirements.*								
GN082	Quality and	There is a risk that patient safety in ED will be compromised as a result	4	4	**16**	• A&E Delivery Board provides oversight and maximises flow	**4**	**4**	**16**

Risk Ref:	Committee Oversight:	Risk:	Previous Risk Score			Controls and Actions in Place:	Current Risk Score		
	Performance	of departmental reconfiguration during the busy winter period which has the potential to make tracking and observation of patients more difficult *Risk Owner – Chief Nurse and Director of Quality.*				• ED Remedial Action Plan • Quality and Performance is monitored via monthly NUH Quality and Performance meeting, quarterly Quality Scrutiny Panel and monthly Quality and Performance Committee • Quality Assurance Framework used by NUH to monitor quality • Joint quality visits conducted with NHS Improvement • Quarterly Quality Assurance report to Quality Scrutiny Panel • 12 hr breaches subject to Root Cause Analysis • Systems professional standards developed • 8 weekly reporting to Quality Scrutiny Group due to enhanced surveillance • Hourly head check of patients in blue central area. • Holistic Assessment Tool (HAT) and MDT team-working/accountability being implemented. • New SOPs and handover processes in Initial Assessment Unit (IAU). • Quality and safety metrics continue to be monitored. • New team based allocation for area being implemented in phased approach.			

Update: *It was highlighted that feedback had been received from a recent joint NHSI / CCG visit to the NUH A&E Department. Positive feedback had been received in relation to patient experience, however, concerns were identified regarding workforce / staffing levels within A&E (e.g. higher than expected levels of locum workers and unfilled shifts).*

A further CCG led visit was scheduled to the A&E Department. This visit focused on 12 hour breaches, in particular, any which relate to mental health. A meeting was held between the CCG, NUH and NHS England on the 15th March 2019.

The formal report from the recent CQC inspection has now been published; overall good rating, but requires improvement for Safe Care.

NUH continues to be held to account via contracting and quality forums. Regular reviews of Serious Incidents (SIs) and/or potential patient safety issues are being undertaken.

Risk Ref:	Committee Oversight:	Risk:	Previous Risk Score			Controls and Actions in Place:	Current Risk Score		
Recommendations from the NUH ED 'Deep Dive' review are being shared with colleagues to establish a formal action plan. *Assurance has been received that specialist nurses are being used in the Service to support delivery.*									
GN087	EMT	As a result of the restructuring process and period of ongoing change and uncertainty, staff may become disengaged which could result in low morale and reduced productivity *Risk Owner – Chief Operating Officer*	4	4	**16**	• Staff appraisals process refreshed for the Greater Nottingham CCP and communicated to line managers • Weekly Greater Nottingham staff news updates to keep staff informed and engaged • Staff engagement sessions led by the Accountable Officer • Results for staff survey 2018/19 received and feedback has been considered as part of the development of the CCGs' OD Plan.	**4**	**4**	**16**
Update: *Weekly ICS communication regarding the organisational restructures has continued, as planned. An OD Plan (Phase 1) has been produced to support the single CCG merger process. The OD Plan includes any actions required following the output of the 2018/19 Staff Survey.* *An independent Chair of the Staff Engagement Group has been identified for the March 2019 meeting. The first meeting is due to be held on Thursday 22nd March 2019.* *There is an all staff Away Day arranged for Monday 1 April in relation to merger and organisational restructuring. Individual Executive portfolios are also arranging sessions for their respective portfolios. Meetings of the Single CCG Steering Group have now been diarised until April 2020. A Workforce and Organisational Development Workstream of the SCSG has been established, with the Head of Business Partners (Gem CSU) as the nominated lead. Meetings are being held fortnightly. The merger plan outlines each 'task' required within the Workforce and OD Workstream.*									
GN108	Finance Committee	Failure to deliver the Financial Recovery Plan and savings schemes (predominantly but not solely related to unidentified QIPP) will directly impact on our ability to deliver our financial control total for 2019\20.	4	4	**16**	• Established Joint Finance Committee (across the GN CCP) with clear membership and reporting structure • Financial Recovery Group (across the GN CCP), which reports Finance Committee • Appointment of a Turnaround Director (across the six MN and GN CCGs) • Established GN and MN Financial Recovery PMO • Nominated SRO leads for individual QIPP schemes. Associated QIPP reporting and scrutiny processes (including QIPP 'tracker' and associated processes). • Finance Report provided to the Finance Committee and JCC (monthly) and to Governing Bodies (quarterly)	**4**	**4**	**16**

Risk Ref:	Committee Oversight:	Risk:	Previous Risk Score			Controls and Actions in Place:	Current Risk Score		
						• Financial Recovery Plan Update Reports to the Finance Committee (monthly) • Attendance at the ICS Finance Group (along with all system partners) • ICS Finance Report (monthly)(in development) • ICS lead in place to identify further system-wide savings 'opportunities' • Regulator (NHS England) financial reporting, challenge and scrutiny processes. • Contingency and Other Reserves To implement the 11 point plan in response to the CCGs' significant financial challenges, which will include: • Agreement of 'block' contracts (to cap risk); • Develop and mobilise further QIPP opportunities; • Strengthen FRDB and FRDG governance arrangements (which includes establishment clinical leadership); • Establish a joint system Transformation Group; • Develop a single CCG Financial Recovery and Accountability Framework; • Confirm Executive SROs, Programme Directors, Programme Managers and delivery teams (and establish Programme Delivery Boards); and • Develop engagement strategy to raise awareness and promote a culture of QIPP delivery and turnaround.			

Section 2: Sub-Committees

To discharge its duties effectively, the Governing Body has a number of formally constituted committees with delegated responsibilities as set out in the CCG's Constitution and Scheme of Reservation and Delegation:

- the Audit and Governance Committee
- the Primary Care Commissioning Committee
- the Clinical Cabinet
- the Patient and Public Involvement Committee
- the Information Governance, Management and Technology Committee

The following committees have also been established with partners under a memorandum of understanding:

- Nottinghamshire Safeguarding Adults Board
- Nottinghamshire Safeguarding Partners Strategic Group (formerly Nottinghamshire Safeguarding Children's Board)
- Internal Safeguarding Strategic Group

The following summaries and highlight reports provide an overview of the work performed by these committees at their recent meetings. Minutes from the meetings described will be presented for information once ratified.

1. Audit and Governance Committee 28 February 2019

- The meeting was held 'in common' with the Audit and Governance Committees of the other Greater Nottingham CCGs.
- The Committee received the Greater Nottingham CCGs' (joint) Register of Procurement Decisions and (joint) Register of Tender Waivers, along with an assurance report as to how the accuracy of the registers was ensured.
- The Committee received a progress report on the 2018/19 Internal Audit Plan and concerns were raised that progress against planned days was at 44% at this stage of the year. Assurance was provided that the plan would still be delivered.
- Members received the final internal audit reports for reviews of the Greater Nottingham CCGs' governance arrangements and Data Quality and Performance Management Framework: Local Partnerships (South County CCGs only). An audit opinion of significant assurance had been provided for both.
- The Head of Internal Audit Opinion Stage 2 Memo was presented. The opinion stated that the CCGs' Assurance Framework processes were continuing to embed within the organisations'

governance structures and that the arrangements identified during Stage 1 continue to develop.
- The CCG's External Audit Plan 2018/19 was received. This outlined the approach to this year's audit of the financial statements. An overview of the 2018/19 Annual Report and Accounts timetable was also presented.
- The Committee approved the proposal for the direct award of the contract for Internal Audit and Counter Fraud Services for 2019/20 and 2020/21.

2. Primary Care Commissioning Committee 7 March 2019

- The Committee received the updated Primary Care Commissioning Committee Terms of Reference (as approved by the Governing Body in January 2019). It was explained that plans for the Greater Nottingham CCG Primary Care Committees to start meeting 'in common' were on hold now that a decision had been made to align with the Mid-Nottinghamshire CCGs.
- The specification for the General Practice Enhanced Delivery Service (GPEDS) was received by the Committee.
- A comprehensive update regarding Extended Access was received. The service commenced on 1 September 2018 on a rota basis agreed by all practices
- Members received a summary of the new GP Contract reform in relation to workforce/workload; indemnity costs; improvements to the Quality Outcomes Framework (QOF) and Network Contract Directed Enhanced Service (DES).

3. Clinical Cabinet 30 January 2019 and 27 February 2019

30 January 2019
- Members were updated that the Nottingham City Clinical Commissioning Group pilot of the "two week wait non-specific symptoms due to suspected cancer" pathway has been successful and work was underway to extend this across Nottinghamshire.
- A brief financial update was presented in addition to an update on System Architecture and how the CCG would develop a Primary Care Network (PCN) model.
- A summary of key points was received by members regarding "Primary Care at Scale" including:
  - Member practices are required to appoint a Clinical Director of NNE Primary Integrated Community Services (PICS) – nominations for the role were requested.
  - Locality configuration will need to support the move towards Primary Care Networks.
- Members received an update on the Nottingham North and East General Practice Federation with PICS providing a presentation on their organisation, experience, support offer and services.

27 February 2019
- Members received a proposal regarding the Primary Care Network configuration for Nottingham North and East. It was recognised that there are differing challenges with practice population health.
- The draft Primary Care Network governance structure was shared with members, acknowledging that further discussions are required with PICS to clarify support.
- It was confirmed that Dr James Hopkinson had been appointed as the Clinical Lead for PICS (NNE).
- New GP Contract changes were received and noted by members.
- Members received an update on the Local Enhanced Services that will be offered to practices in 2019/20.

This was the final meeting of the Clinical Cabinet and these will now be superseded by the Primary

Care Network meetings.

4. Patient and Public Involvement Committee 22 January 2019

The meeting held on 22 January 2019 provided an opportunity for the Chair to provide feedback following a recent Patient and Public Involvement Steering Group meeting. This included highlighting areas that were known to work well locally; such as the Local Authority group strengthening links with Gedling Borough Council and the wider community.

5. Information Governance, Management and Technology (IGMT) Committee 18 January 2019

- The Committee received the updated annual work programmes for 2018/19 and 2019/20; both now make reference to GP Information Technology (IT) provision and the IT capital bids process.
- The Committee agreed that it will continue to submit an annual report to the Governing Bodies to demonstrate that all delegated responsibilities have been discharged. This report will be extended to incorporate the annual Caldicott Guardian report.
- The inaugural Operational Delivery Group is due to take place during February 2019. The Group will provide Director level oversight for Information Governance, Management and Technology projects and priorities for the six Clinical Commissioning Groups.
- The Committee received the quarter three Information Governance Assurance Report and were advised that the key area of focus is the completion of the project work required to meet the mandatory assertions for the annual Data Security and Protection Toolkit (DSPT) submission. Meeting the 95% Data Security Awareness Training compliance threshold remains a challenge however work is taking place to address this, with classroom based sessions available to staff unable to access the online training module.
- The Committee was advised that there are seven IGMT risks currently documented on the organisational risk register; three of these have been updated since the December 2018 meeting, however, there has been no change to the risk scores and profiles. The identification and management of partnership and system risks remains an area of focus; planned work to ensure that all risks identified within partnership forums are systematically captured and transferred to the risk register is underway.
- The Data Quality Report identified that Nottingham University Hospitals NHS Trust (NUH) Healthcare Resource Group (HRG) four coding (used for identifying national tariff cost) is now above the national average. The Committee commended this improvement.
- The Removable Media Policy was approved subject to additional amendments and clarification around identified areas of ambiguity.

6. Nottinghamshire Safeguarding Adults Board 10 January 2019

ASSURE
• **Audit of Adult Safeguarding Boards:** a presentation outlining key findings from the recent audit was shared. Consideration is being given to the local implementation of any relevant recommendations.
ADVISE

- **Modern Slavery:** a six monthly update report, including details of local cases, was received from the Nottinghamshire Police. A profile has been developed and shared with agencies which identifies individuals most at risk of modern slavery. Clarity is being sought regarding the role of the Safer Nottinghamshire Board in preventing modern slavery.
- **Independent Inquiry into Child Sexual Abuse (IICSA):** the report following hearings in Nottingham and Nottinghamshire is due for publication in July 2019. Partners have already established a lessons learned log and are able to evidence changes as a result of this. Any new recommendations arising from the report will be taken forward by the Strategic Management Group for Operation Equinox.
- **ADASS Audit of Local Safeguarding Adult Board Engagement with Prisons:** A number of recommendations have been made which the Board are considering how to progress locally.

ALERT

- There were no issues identified that require escalation to Governing Body.

7. Nottinghamshire Safeguarding Strategic Leadership Group

As a result of the new safeguarding arrangements, the Safeguarding Children Board has been replaced with a **Strategic Leadership Group**. The next meeting is due to take place on 11 April 2019 and a highlight report will be presented to the Governing Body at the meeting.

Nottingham North and East
Clinical Commissioning Group

Primary Care Commissioning Committee
Ratified Minutes of the Public Meeting held on
Wednesday 12 December 2018, 1:00pm – 2:00pm

Clumber Meeting Room, Easthorpe House, 165 Loughborough Road, Ruddington, Nottingham, NG11 6LQ

Members

Mike Wilkins (MW)	Lay Member – Primary Care (Chair)
Terry Allen (TA)	Lay Member – Financial Management & Audit
Ian Livsey (IL)	Deputy Chief Finance Officer
Esther Gaskill (EG)	Head of Primary Care Quality
Sharon Pickett (SP)	Locality Director

In attendance

Lucy Cassidy (LC)	Practice Liaison Officer, Local Medical Committee
Julie Kent (JK)	Contract Manager, NHS England
Nina March (NM)	Governance Administrator (minutes)
Rachael Rees (RR)	Head of Primary Care & MCP Development
Kerrie Woods (KW)	Senior Contract Manager, NHS England

Apologies

Janet Champion (JC)	Lay Member
Dr Caitriona Kennedy (CK)	GP Representative
Jane Laughton (JL)	Health Watch
Annie Meakin (AM)	Practice Liaison Officer, Local Medical Committee
Stewart Newman (SN)	Director of Commissioning
Dr Parmajit Panesar (PP)	GP Representative
Amanda Sullivan (AS)	Accountable Officer

Member's cumulative attendance 2018/19

Name	Possible to date	Actual	Name	Possible to date	Actual
Mike Wilkins	4	4	Esther Gaskill	4	4
Terry Allen	4	2	Ian Livsey	4	3
Janet Champion[1]	2	2	Parm Panesar	4	1
Sharon Pickett	4	4	Caitriona Kennedy	4	0

[1] Membership ceased September 2018

Item

Introductory Items

PCCC 18 061 Welcome and apologies

Mike Wilkins welcomed everyone to the Nottingham North and East Primary Care Commissioning Committee.

Apologies were noted as above.

PCCC 18 062 Confirmation of quoracy

It was confirmed that the meeting was quorate.

Item

PCCC 18 063 **Declarations of interest for any item on the agenda**

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

Lucy Cassidy declared a new Conflict of Interest (COI) as a registered patient at Park House Medical Centre in Carlton. Nina March will ensure this is added to the COI register.

PCCC 18 064 **Management of any real or perceived conflicts of interest**

Not required as no conflicts of interest had been identified.

PCCC 18 065 **Questions from the public**

It was confirmed that no questions from the public had been received.

PCCC 18 066 **Minutes of the meeting held on 2 August 2018**

The minutes were agreed as an accurate record and will be signed by the Chair.

PCCC 18 067 **Matters arising and actions from the meeting held on 2 August 2018**

There were no actions or other matters arising in relation to the minutes.

Agenda Items

PCCC 18 068 **Ivy Practice Merger Update**

Kerrie Woods presented this item and highlighted the following:

a) The contractual merger between the Ivy Medical Group and Apple Tree Medical Practice took place on 1 March 2018, approved by the Committee on Thursday 17 December 2017.
b) Approval of the merger was contingent on the practice moving towards opening hours that reflect core contract hours and no longer support routine afternoon closures. The Practice was asked to implement core opening hours at one of the three sites by 1 October 2018 at the latest.
c) Recruitment of a salaried doctor for seven sessions per week remains unsuccessful; this role is currently being back filled by locums.
d) As at November 2018 the Practice was continuing to close on Thursday afternoons as a result of limited capacity within the clinical team. Practice staff will be meeting during December 2018 to identify how to deliver the revised opening hours and were hopeful that these will be available to patients from the 17 December 2018.

Julie Kent entered the meeting room at this point.

The following items were raised in discussion:

e) It was queried if the salaried GP post with the practice was advertised extensively for recruitment. Advertisement for the position was advertised through several processes, including the LMC (Local Medical Committee) portal, local training schemes and social media.
f) There were discussions surrounding the advertisement of opening hours for the practice. It was confirmed that following discussions with the practice receptionist earlier that morning and a review of the practice website, current opening hours still include Thursday and lunch break closures.

ACTION:
Kerrie Woods will write a letter to the Practice to confirm the outcome

Item

of their meeting and seek further information relating to the Thursday afternoon closures and timescales.

The Committee **NOTED** the update and advised

- They will await the practice meeting on the 18 December 2018 and will review opening hours with the Practice. However, if opening hours remain the same a letter will be sent to the practice requesting opening hours be revised.

PCCC 18 069 Extended Access

Rachael Rees provided a verbal update as follows:

a) The Extended Access service has been running since September 2018, the first quarter of data will be available to share with the committee when this quarter has ended.
b) There has been an utilisation rate between 70% - 90% for attendance. However, Health Care Assistant data has been low as all individual Practices manage this data differently.
c) Patient feedback will be available from January 2019 onwards but to date, the service is running successfully with no complaints or concerns received. Extended Access has been highly advertised through publications and social media.

The following items were raised in discussion:

d) The attendances of weekend visits were raised and whether any improvements were noted. Members' are advised that there have been no major changes recorded and only a small number of 'did not attend' (DNA) appointments.

The Committee **NOTED** the verbal update on Extended Access.

PCCC 18 070 Winter Pressures

Rachael Rees provided a verbal update as follows:

a) The verbal update was provided to reinforce the importance of Winter Pressures. Primary Care and Secondary Care are both actively supporting the alleviation of winter pressures where possible.
b) Social media is being used to promote Winter Pressures to members of the public. The information has been viewed multiple times and it is hoped that this will help to reduce the number of attendances at the Emergency Department over the winter period.

There were no items raised in discussion.

The Committee **NOTED** the verbal update on Winter Pressures.

PCCC 18 071 South Nottinghamshire Clinical Commissioning Groups' Second General Practice Splenectomy Vaccination and Antibiotic Audit Report

Esther Gaskill presented the South Nottinghamshire Clinical Commissioning Groups' Second General Practice Splenectomy Vaccination and Antibiotic Audit Report and highlighted the following:

a) The report is providing a summary of the South Nottinghamshire Clinical Commissioning Groups (CCGs) Second General Practice Splenectomy

Item

Vaccination and Antibiotic Audit, including methodology, findings, results and recommendations.

b) It was identified that Children and adults suffering with asplenia or splenic dysfunction may have an increased risk of infection and sub-optimal response to vaccination. Therefore, additional vaccines are advised for these patients.
An audit has been carried out to check the vaccination status for all asplenic patients. All data was collected between November 2016 and May 2017. From the data collected a total of 435 patients in Nottingham in 44 South Nottinghamshire GP Practices were identified and reviewed. The results showed that there a significant number of patients at risk of harm, these results were shared with individual practices and at CCG protected learning time events.

The following points were raised in discussion:

c) It was advised that it would be beneficial for Esther to discuss the splenectomy audit recommendations with Dr Mike O'Neil. As it was identified in the Nottingham West Primary Care Commissioning Committee that there may be a better way of embedding the work in practice.

ACTION:
Esther Gaskill will liaise with Dr Mike O'Neil regarding splenectomy audit recommendations.

The Committee **NOTED** the South Nottinghamshire Clinical Commissioning Groups' Second General Practice Splenectomy Vaccination and Antibiotic Audit Report.

Quality

PCCC 18 072 **Primary Care Quality Highlight Report Q2 2018/2019**

Esther Gaskill presented the Primary Care Quality Highlight Report Q2 2018/2019 and highlighted the following:

a) The Primary Care 2018/19 Q2 dashboard results were available from 24 October 2018. The results showed that the majority of practices achieved an overall 'green' rating. Practices including, the Peacock Surgery, Highcroft Surgery and Whyburn Medical Practice received an overall 'amber' rating and will be supported by the Quality Team to identify where improvements can be made.
b) Following an inspection from the Care Quality Commission (CQC) in August 2017, the Highcroft Surgery received an overall rating of 'good' and a 'requires improvement' for the responsive domain. The practice was issued a Requirement Notice in relation to Regulation 17 Health and Social Care Act (HSCA) 2008 (RA) Regulations 2014 – good governance. The notice stated that the practice will need to continue to work towards improving patient experience by assessing and monitoring access to appointments. The Practice developed an action plan to address this and the CQC carried out another inspection in August 2018, the results provided a 'good' rating against each domain. This achievement was noted at the Primary Care Quality Group and a congratulatory email was sent to the practice on behalf of the CCG.
c) The CQC carried out an inspection at Om Surgery in December 2017 and the practice received an overall of 'requires improvement'. The CQC

Item

requested the practice make improvements to ensure care and treatment is provided in a safe way to patients and to address the issues highlighted in the national GP patient survey results. A follow up visit was undertaken in April 2018 to support the practice in achieving the actions required and the practice and CCG pharmacist are working together to ensure safe prescribing and management of medications.

There were no items raised in discussion.

The Committee **NOTED** the Primary Care Quality Highlight Report Q2 2018/2019.

PCCC 18 073 **Any other business**
There was no other business to report.

PCCC 18 074 **Risks identified during the course of the meeting**
No risks were identified.

PCCC 18 075 **Date of next meeting:**
TBC

Signed: ……..
Chair

Date: …….

NHS
Greater Nottingham
Clinical Commissioning Groups

Minutes
PPI Committee
Tuesday 13th November 2018, Chappell Room, Arnold Civic Centre

Present:

Janet Champion (JC) (Chair)	PPI Lay Member, NNE Governing Body
Deborah Bellamy (DB)	Patient and Public Representative
Sharon Bentley (SB)	Patient and Public Representative
Francis Henman (FH)	Patient and Public Representative
Terry Lock (TL)	Park House PPG

In Attendance:

Nikki Biddlestone (NB)	GN Engagement Manager
Kate Horton (KH)	GN Engagement Officer

Apologies:

Sharon Pickett (SP)	Deputy Chief Officer
Elaine Maddock (EM)	Governing Body GP Representative
Kathryn Sanderson (KS)	Patient and Public Representative

Item		Action
PPI 18/030	**Welcome and Apologies** Janet Champion (JC) welcomed the group. Apologies were noted above.	
PPI 18/031	**Declarations of Interest** No Declarations of Interest were made in relation to the agenda.	
PPI 18/032	**PPI Review** Tim Markham introduced himself and the piece of work he is doing to review the PPI Committees. Tim was attending each meeting that takes place similar to the NNE PPI Committee across the 4 x CCGs in Greater Nottingham. Tim confirmed that his observations so far were: • common themes • common concerns • Gaps • Comments of too many groups Tim asked the group for their comments in relation to these points. A discussion took place on the member's thoughts. Members also raised important points that requested to be taken into consideration during the review.	

	Tim asked for members to feel free to email him with any additional thoughts or comments. Nikki to circulate Tim's email address to members. Tim confirmed that a steering group meeting would be taking place on 29 November where summary would be discussed.	**NB**
PPI 18/033	**Minutes and Actions from previous meeting 10th July 2018** The summary of the meeting held on 10th July 2017 were checked for accuracy and approved as a true and accurate record.	
PPI 18/034	**GN Engagement update** Nikki provided an update regarding the engagement activities that had taken place / taking place at the moment – please see summary below: **Treatment Centre** Report has now been produced and shared. Procurement process underway now and once the successful bidder has been confirmed we will share news with the group. **Gluten Free** Implementation of the outcome of GF consultation. Media release 7 November on CCG websites for full information. **OTC – City only** Engagement carried out and report produced and shared with City groups. **Summary of Events** **Public Event -** 13th Sept (John Godber Centre, Hucknall, 4pm-6.30pm). **AGM –** 26th Sept (Conference Centre, Nottm) **Engagement Team** Kate Horton is the newly appointed Engagement Officer for GN. Kate will be creating links within the communities of the City CCG area. Nikki Biddlestone is the GN Engagement Manager and will be creating links within the community of NNE CCG area. Helen Limb is GN Engagement Officer and will be creating links within the communities of Rushcliffe and Nottm West CCG Area. Alex Ball is now in post as Director of Comms and Engagement. Jenny Goodwin is now in post as Head of Comms and Engagement, Operational delivery for the CCGs **Gynaecology** Survey was re-opened /extended to allow more engagement and feedback to take	

	place with patients and members of the public. **Previous numbers**: 65 surveys completed (7 were incomplete so couldn't be analysed) **Now**: 95 surveys completed (1 x focus group) Updated report in the process of being produced (Healthwatch are doing this). **MSK (Musculoskeletal)** Engagement will be taking place to seek the views of a 'single point of access' for patients to access MSK services. • Survey on-line and via hard copy. Open between Monday 22nd October – 18th November • Liaising with providers to attend MSK clinics to promote surveys • Distribution to all contacts and PPGs/committee members **Podiatry** EQIA will help inform the Engagement plan – in the process of being produced. Looking to implement a Greater Nottingham Model with the principals of the Sheffield model with local content. Engagement timeline tbc but hoped to take place in Jan/Feb 2019.	
PPI 18/035	**STP update** Nikki had been provided with the following update from Lewis Etoria: Work is progressing to develop LICPs across Nottinghamshire. However, this work is still in conceptual stage and we have yet to establish the role and remit of LICPs, their size and make-up, their level of responsibility and their relationship with the rest of the health and care system. There are some key meetings taking place over the next few weeks which should more clearly set out the future direction of LICPs in Nottinghamshire. At this point we will be looking to develop a communications and engagement plan to support the development of LICPs.	
PPI 18/036	**AOB** **Connected Notts update** Terry Lock (TL) gave an update on Connected Notts to the group.	
Details of the next meeting Tuesday 22nd January 2019, 3pm –Meeting room 1, Gedling CIvic Centre, Arnold. NG5 6LU		

All attendees should be aware that there is a requirement to comply with the Freedom of Information Act 2000. The minutes and papers from this meeting could be released as part of a request for information

Nottingham North and East
Clinical Commissioning Group

Minutes of
Clinical Cabinet Meeting – NNE CCG

17th October 2018 1:30 – 3.30pm
Civic Centre, Arnot Hill Park, Arnold, Nottingham, NG5 6LU

Present

Clinical GP Representatives:

Dr James Hopkinson (JH)	Clinical Chair and Calverton Practice (Chair)
Dr Paramjit Panesar (PP)	Assistant Clinical Chair and Ivy Medical Practice
Dr Umar Ahmad (UA)	Plains View Surgery
Dr Ashish Alurwar (AA)	Highcroft Surgery
Dr Ian Campbell (IC)	Park House Medical Centre
Dr Gerry Gallagher (GG)	Daybrook Medical Practice
Dr Nicholas Gilmore (NG)	Oakenhall Medical Centre
Dr Claire Hatton (CH)	Jubilee Practice
Dr Prakash Kachhala (PK)	Torkard Hill Medical Practice
Dr Manas Karpha (MK)	West Oak Surgery
Dr Caitriona Kennedy (CK)	Trentside Medical Practice
Dr Azim Khan (AK)	Unity Surgery
Dr Suman Mohindra (SM)	Om Surgery
Dr Amelia Ndirika (AN)	Whyburn Medical Practice
Dr Elaine Maddock (EM)*	Stenhouse Medical Centre

Other Members:

Jonathan Bemrose (JB)	Chief Finance Officer
Jeff Burgoyne (JBu)	Patient and Public Representative
Sharon Pickett (SP)	Deputy Chief Officer

In Attendance

Sergio Pappalettera (SPa)	Contract and Information Manager
Toi~Fan Choi (TFC)	Locality Administrator (Minute-taker)

Apologies

Dr Sarah Bamford (SB)	Newthorpe Medical Centre*
Jonathan Gribbin (JG)	Public Health
Dr Akila Malik (AM)	Westdale Lane Surgery
Mandy Moth (MM)	Practice Manager
Colleen Mulvany (CM)	Practice Nurse
GP Representative	Peacock Practice*
Dr Jacques Ransford (JR)	Giltbrook Surgery*
Kathryn Sanderson (KS)	Patient and Public Representative
Dr Ben Teasdale (BT)	Secondary Care Consultant

Item		Actions
CC 18/070	**Welcome and Apologies** Dr James Hopkinson (JH) welcomed the members to the meeting. Apologies were noted as above. The meeting was declared quorate (attended: 13 x GPs clinical and 5 x Non-clinical). JH informed members that Dr Ben Teasdale (BT) is stepping down. JH will discuss about covering this role with other governing bodies. JH will also write to BT thanking him for his contribution and services. **Updated 21.11.2018 – BT's letter was posted.**	**Completed**
CC 18/071	**Declaration of Interest** The Chair reminded cabinet members of their obligation to declare any interest they may have on any issues arising at cabinet meetings which might conflict with the business of NNE Clinical Commissioning Group. Declarations of the Clinical Cabinet were listed in the CCG's Register of Interests. JH noted that the Register was available either via the secretary to the Clinical Cabinet or the CCG website at the following link: http://www.nottinghamnortheastccg.nhs.uk/contact-us/freedom-of-information/conflicts-of-interest/ A declared interest was raised by Jeff Burgoyne (JBu) relating to the Pain subject as he is currently a patient and had received a copy of PK's email querying services of the Pain Clinic. JH confirmed to JBu that there was no conflict of interest in this situation.	
CC 18/072	**Minutes of last meeting held on 19th September 2018.** The minutes of last meeting were approved as accurate with one amendment – JBu pointed out that on the third item of CC 18/063, it should be "reduction in secondary care", not "reduction in pain cases". **Updated 18.10.2018 – Correction was completed. The September minutes was then ratified and filed on the NNE database.**	**Completed**
CC 18/073	**Matters arising and actions from the last meeting held on 19th September 2018** Item CC 18/061 – 24-hrs tape monitoring to commissioning at a local service. Sharon Pickett (SP) confirmed that she has passed this item on to Elective Care Team for their action.	**Completed**

	Dr Paramjit Panesar (PP) said he will raise this at the CPD group and look at patient whole pathway.	
CC 18/074	**Agenda Items:** **Finance Update** Jonathan Bemrose (JB) explained to members about the main part of the finance position from the PowerPoint presentation and highlighted the following points: (1) This financial report is submitted to join committees, NHSE and governing bodies. (2) NNE CCG is performing well. It has £1.71m overspent. (3) YTD Variance – in total £10.86m overspent across all 4 CCGs. SP informed members that they had a GN Top 10 Practices meeting this morning and the main focus was to look at the top 10 overspent practices which are mainly from City. Ian Trimble is supporting practices and the feedback was positive with practices are keen to engage to improve services and reduce unwarranted variation e.g. referral rate.	
CC 18/075	**Activity Report** Sergio Pappalettera (SPa) presented 2018/19 **Activity Report** for the period of April 2018 – August 2018 (Month 5) highlighted as follows: (1) GP referrals – up 1.8% compared to last year (i) Routine – up 0.6% compared to last year, mainly from dermatology, ENT and general surgery / vascular surgery. (ii) 2WW – up 6.0% compared to last year, also higher than last 2 years; mainly from urology and dermatology. (2) Day cases – up 4.3% compared to last year, mainly from gastroenterology (endoscopies), oncology / radiotherapy / chemotherapy, cardiology (various diagnostic procedures), urology (bladder / prostate procedures) and dermatology (minor skin procedures). JH/PP asked the reason why cardiology cases have been increased. SPa said he will investigate and update the findings. **Action – SPa.** **Updated 18.10.2018 – SPa emailed (attached below) the findings to JH/PP.** Increase in Cardiology Day Case	**Completed**

	(3) Elective – down 6.3%. Trauma and orthopaedic is the largest reduction. (4) Non-elective (i.e. Emergency Admissions) – up 6.1% which was comprised of 50% for age between 0-14 (children) and 50% for age 55+. Most of the increase was in 0-1 length of stay (i.e. short stay). (5) A&E – up 1.8%, mainly from age group of 25-44 and 55-79, and from Locality 1. There was an increase from SFH and Ilkeston minor injury unit. JH informed members that work is underway to improve capacity at A&E and improve the A&E 4-hour target performance. The layout of the Emergency Department has been redesigned in order to improve the delivery of the right services to the right patients at the right place. Extra18 cubicles will be created and the Department will expand into the Fracture Clinic. The Spinal unit has been moved to a different location to make way for the Fracture Clinic. The deadline for completion is December and the official opening date of the redesigned Emergency Department is 24th December. JH questioned there was a big difference (10 times difference) in the figures of the Cost Variance Against Budget between Outpatient First (-£4,273) and Outpatient Follow Up (£40,776). SPa said he would check the figures. **Action - SPa** **Post meeting - SPa emailed (attached below) and confirmed the figures are correct.**  Outpatient First - figures.msg Ian Campbell (IC) queried about the population figures for Park House Medical Centre have been using in the reports. SPa will check the figures. **Action – SPa** **Updated 18.10.2018 - SPa emailed (attached below) and confirmed Park House registered population figures are correct.**  Park House Registered Population The Cabinet **acknowledged** the reports.	**Completed** **Completed**
CC 18/076	**Federation Development and Event on 11th October 2018** ➢ JH provided members an update on the Federation Event on 11th October. The event was to provide guidance to General Practices considering networking / federating into an entity	

	with a set of common objectives in order to achieve and maintain sustainability and exploring new innovative ways of working together to deliver primary care at scale. One of the objectives is to free GP time to focus on more complex / chronic patient clinical needs. There was important learning from the experience of those primary care organisations that have already been through the process which might aid those starting the journey. Mike Farrar provided a presentation on that day and emphasised on the urgency for the development of the Federation. (For info only: The PowerPoint presentation was circulated to all clinical cabinet members on 12.10.2018 by JH/TFC) Mike Farrar also commented that there were many positive feedback in particular from care home patients. JH said on that day two small groups were divided to create and discuss ideas, e.g. what do we want and need, how to work together to build a strong team, what are the realistic actions to meet our population needs / chronic care, how to work more efficient to achieve financial saving, triage telephone enquiries to different teams e.g. medical, administrative, acute, etc to direct right patients to right place for right service. JH also explained the future LICPs (Local Integrated Care Partnerships) comprises of General Practices from Greater Notts (4 CCGs) and Mid Notts (2 CCGs). One of the key components that enables the LICP to work is GP at scale, i.e. GP Federation. There are two ICPs footprints (i.e. Gr Notts and Mid Notts). Each ICP contains all the components required for a full health care system (Acute hospitals, Mental Health, GPs, Social Care, etc). The aim is that all parts of the system will work together to ensure the total budget be spent in the most efficient way. ➢ Caitriona Kennedy (CK) raised concerns on lack of guidance for locums and registrars in terms of their roles, expectations and pathway and suggested a template might be useful. PP seconded and suggested an induction pack could be introduced in terms of skills matrix, expectations, and so on. CK was happy to lead and design the template / induction pack. PP volunteered to assist CK. **Action – CK/PP/Ongoing, to be updated as and when required.** ➢ Federation and partnership support from NAPC (National Association of Primary Care) – PP raised the NAPC are keen to continuing offer the federation their support in developing primary care at scale	**CK/PP/ Ongoing**

	going forward. (For info only: PP emailed (attached below) and explained in detail to members on 10.10.2018)  Email from Dr PP.msg PP summarised that there are some significant benefits for larger federation in continuing with NAPC support. For example: (1) Financial support – The initial £30k funding is available for the federation to use with a partnership agreement with the NAPC to support the development of the federation. (2) National support and networking – The NAPC would be able to link the federation with other PCH sites to provide support and expertise in taking the next steps in federation development. Possibility to access new schemes / national programmes, initiatives and funding. (3) Future funding – The NAPC is currently lobbying for future funding central for ways to support their federation partnerships. Therefore the federation may be able to access future years funding depending on what's available. PP expressed that the NAPC in this scenario would be another great partnership for the federation that we simply engage with to our mutual success in the same way. We will now need to look externally and engage with other agencies and partners to take our federation and its development forward. Members expressed the initial funding has brought the incentive and attraction. PP volunteered to meet with NAPC to discuss this further in detail. JH will also involve discussion / agreement / right way to go forward. **Action – PP/JH/Ongoing, to be updated as and when required.**	**PP/JH/ Ongoing**
CC 18/077	**Risks identified during the course of the meeting** No risks were identified.	
CC 18/078	**Any Other Business** ➢ JBu confirmed that concerns about the Pain Clinic service had been raised at PPG Forum meetings over the past 12 months. At present waiting time for back pain	

	injections was 10 weeks. SP advised JBu to suggest patients phone the PALS team and raise concerns so that feedback and appropriate actions can be taken by the teams. ➢ JH answered Prakash Kachhala's (PK) issues relating to his email on 10.10.2018 12:30hrs: Community Pain Clinic – JH said he believes the commissioned service is supposed to give specific advice to GPs about what to prescribe to patients (inc checking contra-indications etc). JH is still awaiting Greg Hobbs' response. ECG Interpreting Service – JH suggested that it is more cost effective to send small numbers (e.g. 5) ECGs per year to A&G cardiology than the previous contract with Broomwell. ASS1 Forms – PK strongly feels that GPs should not be doing ASS1 forms for drugs that GPs are not prescribing or allowed to prescribe such as chemotherapy. It was seconded by JH. JH has emailed Shelley Gibson (CCG pharmacist) and Mariea Kennedy for more information. JH also suggested to take this issue up with Notts Healthcare. *Elaine Maddock (EM) from Stenhouse Medical Centre arrived at 3.20pm. EM attended a practice visit at Torkard from 1.30pm, a part of CCG work. **Meeting Closed: 3.30pm (ahead of schedule of 4.30pm).**	
	Date, Time and Venue of Next Meeting Wednesday 21st November 2018, 1.30pm-4.30pm Chappell Room, Civic Centre, Arnot Hill Park, Arnold, Nottingham, NG5 6LU (Deadline for submitting papers: 12 Nov, Papers/Agenda circulated: 14 Nov) **SIGNED: …… (Chair)** **DATE: ……..**	

Record of Attendance 2018

Members / Date	24 Jan	21 Feb	21 Mar	18 Apr	16 May	20 Jun	18 Jul	15 Aug	19 Sep	17 Oct	21 Nov	19 Dec	Total Attended *(min x10 per practice)*	
Possibility	**1**		**2**		**3**	**4**	**5**		**6**	**7**			**Times / % 7**	
Clinical GP Representatives														
Calverton Practice / Chair			√		√	√	√		√	√			6	86%
Daybrook Practice							√			√			2	29%
Giltbrook Practice*			√										1	14%
Highcroft Practice	√		√		√	√	√		√	√			7	100%
Ivy Practice / Ass Chair	√		√			√	√		√	√			6	86%
Jubilee Practice							√			√			2	29%
Newthorpe Practice*			√			√			√				3	43%
Oakenhall Practice			√		√	√	√		√	√			6	86%
Om Practice			√		√	√	√		√	√			6	86%
Park House Practice			√		√	√	√		√	√			6	86%
Peacock Practice*														0%
Plains View Practice	√		√		√	√	√			√			6	86%
Stenhouse Practice	√		√		√	√	√		√	√			7	100%
Torkard Hill Practice	√		√		√		√		√	√			6	86%
Trentside Practice			√		√	√			√	√			5	71%
Unity Practice					√				√	√			3	43%
West Oak Practice						√	√			√			3	43%
Westdale Lane Practice	√				√	√	√		√				5	71%
Whyburn Practice	√		√		√	√	√		√	√			7	100%
Other members														
Chief Finance Officer / Deputy	√		√		√	√	√		√	√			7	100%
Contract & Information Manager	√		√		√		√		√	√			6	86%
Deputy Chief Officer	√		√		√	√			√	√			6	86%
Patient & Public Representative	√		√		√	√	√		√	√			7	100%
Practice Manager	√		√		√	√							4	57%
Practice Nurse														0%
Public Health Representative			√										1	14%
Secondary Care Consultant	√				√	√							3	43%
Administrator (Minute-Taker)	√		√		√	√	√		√	√			7	100%
Total Attended	14		20		19	19	18		18	20				

√ **= Attendance**
Blank = Apologies / Non Attendance / No Meeting

**Practices of Giltbrook and Newthorpe – are also attending the Clinical Cabinet in Nottingham West CCG.*
**Peacock Practice – is currently no clinical lead.*

Nottingham North and East
Clinical Commissioning Group

Minutes of
Clinical Cabinet Meeting – NNE CCG

21st November 2018 1:30 – 4.30pm
Civic Centre, Arnot Hill Park, Arnold, Nottingham, NG5 6LU

The Clinical Cabinet meeting was properly called / scheduled. The Chair has called this meeting to order and declared the meeting adjourned due to lack of a quorum. This meeting was not official and members at present informally discussed the agenda items. Certain actions were suggested at the meeting without a quorum and would re-decide those actions officially at the subsequent quorate meeting. Minutes of the meeting were kept, since a meeting was held, even though no quorum was present.

Present

Clinical GP Representatives:

Dr James Hopkinson (JH)	Clinical Chair and Calverton Practice (Chair)
Dr Umar Ahmad (UA)	Plains View Surgery
Dr Claire Hatton (CH)	Jubilee Practice
Dr Smita Jobling (SJ)	Highcroft Surgery
Dr Azim Khan (AK)	Unity Surgery
Dr Elaine Maddock (EM)	Stenhouse Medical Centre
Dr Akila Malik (AM)	Westdale Lane Surgery
Dr Suman Mohindra (SM)	Om Surgery

Other Members:

Jonathan Bemrose (JB)	Chief Finance Officer
Jeff Burgoyne (JBu)	Patient and Public Representative
Stewart Newman (SN)	Director of Commissioning / Deputy Locality Director, NNE
Kathryn Sanderson (KS)	Patient and Public Representative

In Attendance

Jayne Bouch (JBo)	Primary Care Manager
Sergio Pappalettera (SPa)	Contract and Information Manager
Rachael Rees (RR)	Head of Primary Care & MCP Development
Toi~Fan Choi (TFC)	Locality Administrator (Minute-taker)

Apologies

Dr Sarah Bamford (SB)	Newthorpe Medical Centre*
Dr Prakash Kachhala (PK)	Torkard Hill Medical Practice
Dr Manas Karpha (MK)	West Oak Surgery
Dr Amelia Ndirika (AN)	Whyburn Medical Practice
Dr Paramjit Panesar (PP)	Ivy Medical Practice

Not Present

GP Representative	Daybrook Medical Practice
GP Representative	Giltbrook Surgery*
GP Representative	Park House Medical Centre
GP Representative	Peacock Practice*
GP Representative	Oakenhall Medical Centre
GP Representative	Trentside Medical Practice
Jonathan Gribbin (JG)	Public Health
Mandy Moth (MM)	Practice Manager
Colleen Mulvany (CM)	Practice Nurse

Item		Actions
CC 18/079	**Welcome and Apologies** The Chair and members at present waited for 25mins for enough people to arrive and when there were not, the Chair declared that the meeting adjourned due to lack of a quorum. This meeting was not official and members at present informally discussed the agenda items. The meeting was NOT declared quorate (attended: 7 x GPs clinical and 5 x Chair and Non-clinical members = total 12 members). *(Quoracy – 14 members including Chair and/or Deputy Chair, with at least 5 members who are not GP member practice representatives.)* Dr James Hopkinson (JH) welcomed the members to the meeting. Apologies were noted as above. **Introduction** JH informed members that Amanda Sullivan is the interim Accountable Officer. JH met with Amanda on Monday and one of her key priorities is planning to achieve financial sustainability across the system. There will be an update in the future in regard of future planning and functions. JH also told members that Fiona Callaghan has been appointed as the Locality Director of NNE CCG and she will be starting her new role in January 2019. JH said he will write a thank-you letter on behalf of Clinical Cabinet, NNE CCG and Greater Notts to Sam Walters for her support and contribution. **Action – JH.** **Updated 26.11.2018 – Sam Walters' letter was posted.** Federation: JH informed members that he had attended a two-day workshop about the development of the ICP/LICPs and it was very well-attended. The workshop included ICS strategies,	**Completed**

	new structure, how to develop Primary Care Networks (PCN) or Neighbourhood, what are the low risks and the flexibility of PCN, what scale we can do, and so on. JH showed and passed an A3-sided coloured map to members to look at. JH said SN and RR will give an update on the Federation Development later on at the meeting.	
CC 18/080	**Declaration of Interest** The Chair reminded cabinet members of their obligation to declare any interest they may have on any issues arising at cabinet meetings which might conflict with the business of NNE Clinical Commissioning Group. Declarations of the Clinical Cabinet were listed in the CCG's Register of Interests. JH noted that the Register was available either via the secretary to the Clinical Cabinet or the CCG website at the following link: http://www.nottinghamnortheastccg.nhs.uk/contact-us/freedom-of-information/conflicts-of-interest/ No other declarations of interest were received in relation to the agenda.	
CC 18/081	**Minutes of last meeting held on 17th October 2018.** The minutes of last meeting were not approved at the meeting and to be brought forward to the subsequent quorate meeting. Dr Elaine Maddock (EM) queried a few areas within sections CC 18/074, CC 18/076 and CC 18/78 on the draft minutes. The Chair agreed those items to be amended. **After meeting: The draft minutes has been revised (attached below) to be approved at the next quorate meeting.**  Unratified Minutes of Clinical Cabinet Meeti	**Completed**
CC 18/082	**Matters arising and actions from the last meeting held on 17th October 2018** The Chair confirmed that there were no formal matters arising or actions from the meeting held in October. **All actions were completed.**	

CC 18/083	**Agenda Items:** **Finance Update** Jonathan Bemrose (JB) provided an update on the financial position and highlighted the following points: (1) There was no major change compared to last month between the four CCGs in Greater Nottingham. (2) There are still financial pressures on acute contracts (mainly NUH). (3) NNE CCG is still performing slightly better than NW CCG and Rushcliffe CCG. (4) Across the four Greater Nottingham CCGs, in Month 7 we are currently on target to meet the CCGs control total by year end if things do not suddenly deteriorate.	
	Activity Report Sergio Pappalettera (SPa) presented 2018/19 **Activity Report** for the period of April 2018 – September 2018 (Month 6) and highlighted as follows: **GP Referrals** • GP Referrals to Outpatient first appointments (seen) are up by +1.2% o 2WW: +7%, mostly Upper GI, Urology and Dermatology, but there are year-on-year fluctuations o Routine: -0.5%, however increase in: Dermatology, General and Vascular Surgery **Day Cases (DC) & Elective Inpatients (EL)** • DC are up by + 3.4% o Increase in: Clinical Oncology; Gastroenterology; Dermatology; Cardiology; Ophthalmology; Neurology; Spinal Surgery • EL are down by -6.8% o However increase in: Neurosurgery (NNE only, not sure yet if relates to "un-coded" spells issue at NUH or specialised: very major spinal reconstruction procedures) **Emergency Admissions** • Emergency spells up by + 4.7% • Increase in: o 0-14 (+44%) and 60-74 (+12%) age groups o Short-stay admissions (same day discharges): +16% o Admissions to "diagnose" (symptoms & signs); o Respiratory and Digestive Systems diseases JH asked about the cost variance against budget of £508k in	

	Respiratory Medicine (on page 3) and SPa explained that it was mainly (50%) from children. JH also queried about CHC and SPa replied that there has been an increase in costs in September. Members also looked at and discussed about the data in the diagram relating to 2WW GP Referrals to Outpatient First Attendances by each NNE practice (on page 5). The discussion was compared the data with deprivation element. The Cabinet **acknowledged** the reports.	
CC 18/084	**Practice Variation Information** Dr Elaine Maddock (EM) and Sergio Pappalettera (SPa) both presented and showed how to use the eHealthScope system, and search, retrieve and interpret GP Referrals data from the dashboards. The presentation covered GP referrals to First Outpatient Attendances for the following Specialties: Cardiology, Dermatology, Gynaecology, Respiratory Medicine, Trauma & Orthopaedics, Upper & Lower GI, and Urology. Emergency admissions for Ambulatory Care Sensitive (ACS) conditions were also discussed. Although the live eHealthScope was used for the presentation, copies of all charts and dashboards shown at the meeting have been collated in the attached document for information. CC 18 084 - Practice_Variation.pd EM and JH pointed out that in most specialties there does not seem to be any clear correlation between deprivation and referrals. Members were looking at the Ophthalmology specific data. EM said there is an Eye Referrals website which provides useful information and guidance. EM will send the link to TFC for members' information. **Action – EM** **Updated 27.11.2018 – EM forwarded the link (below).** **https://www.eyereferrals.org/** Members were also looking at the Trauma and Orthopaedics – GP Referred (Urgent and Routine) data (on page 14 of 23 in the	**Completed**

	PowerPoint presentation). Om surgery had shown a very high referral rate and Dr Suman Mohindra (SM) agreed to investigate the reason. Members also enquired if Om were referring Orthopaedics patients via CMATS. **Action – SM.** **Updated 27.11.2018 – The Practice Manager of Om Surgery confirmed that they do refer Orthopaedics patients via CMATS. Outstanding - Awaiting investigation results.** EM informed members that through the Primary Care Networks / Neighbourhoods, the Care Co-ordinators will be able to use eHealthScope to support general practices. EM updated members that currently there is one Care Co-ordinator in Locality 2, a new member will be starting the role in Locality 1 and Locality 3 has not got a Care Co-ordinator at the moment. JB was pleased and complimented the enthusiasm and engagement of each member at present in relation to the use and discussion of the Practice Variation eHealthScope Dashboards and its data. JB also said we could all learn, reflect and feedback any actions and/or ideas/suggestions. For example, (i) It was mentioned that doing "punch biopsies" in the Practice appears to be linked to lower referral rates in Dermatology. Therefore it was acknowledged that this was something that could be done in more GP Practices. (ii) High referrals rates could be explained by a larger number of locums in some practices or by the anxiety of doctors in some specialties (for example Gynaecology or Paediatrics) or even specialist expertise in certain areas (Upper and Lower GI or Dermatology).	**SM**
CC 18/085	**NNE Information and Performance Paper** Not discussed.	
CC 18/086	Federation Development Update Stewart Newman (SN) has summarised the main points of the Delivery Change document that had been prepared following the meeting to explore the next steps in developing the GP Federations in NNE and NW. SN distributed the summary sheet (attached below) to members. The document also provides a summary of the emerging guidance around the development of Primary Care Networks and SN reviewed where we are in the process.  Delivering Change.docx	

	Rachael Rees (RR) explained about the model of Super-practices and the advantages of them, e.g. greater resilience, economy of scale (in terms of procurement, IT, consultant/legal fee, etc), better workforce recruitment and retention, investment, personal development, etc. JH suggested SN/RR e.g. visit and discuss these development with practices, identifying advantages and disadvantages, risks / problems / obstacles, option choices, etc. to be reported back at the next Clinical Cabinet (on 30th Jan 2019). **Action – SN/RR.** **Updated 30.11.2018 – An email (attached below) relating to the Delivery Change in NNE, Primary Care Networks and Super Partnerships was circulated.**  Email of 30.11.18 - Delivery Change.msg **Updated 24.01.2019 – Fiona Callaghan confirmed action completed.** EM informed members that she attended the Collaborative of Greater Nottingham GP Providers (another hierarchy of the Federation) meeting yesterday to discuss how the federations could be joined and work together in a way to create a more resilient working environment and functions.	**Completed**
CC 18/087	**Terms of Reference (ToR) Review** JH said the structure has changed and the ToR are required to reflect this. JH suggested SN/RR to draft revised ToR and circulate them for comments. **Action – SN/RR.**	**SN/RR**
CC 18/088	**Risks identified during the course of the meeting** No risks were identified.	
CC 18/089	**Any Other Business** No other business. **Attendance Details:** Dr Claire Hatton of Jubilee Practice – arrived at 2.30pm Kathryn Sanderson – left at 3.30pm Dr Azim Khan of Unity Surgery – left at 4pm Dr Suman Mohindra of Om Surgery – left at 4pm **Meeting Closed: 4.30pm**	
	Date, Time and Venue of Next Meeting *(No monthly meeting scheduled in December 2018)* Wednesday 30th January 2019, 1.30pm-4.30pm Chappell Room, Civic Centre, Arnot Hill Park, Arnold, Nottingham, NG5 6LU	

	(Deadline for submitting papers: 21 Jan, Papers/Agenda circulated: 23 Jan) **SIGNED: …… (Chair)** **DATE: ……..**	

Record of Attendance 2018

Members / Date	**24 Jan**	**21 Feb**	**21 Mar**	**18 Apr**	**16 May**	**20 Jun**	**18 Jul**	**15 Aug**	**19 Sep**	**17 Oct**	**21 Nov**	**Dec**	**Total Attended** *(min x10 per practice)*	
Possibility	**1**		**2**		**3**	**4**	**5**		**6**	**7**	**8**		**Times / % 8**	
Clinical GP Representatives														
Calverton Practice / Chair			√		√	√	√		√	√	√		7	88%
Daybrook Practice							√			√			2	25%
Giltbrook Practice*			√										1	13%
Highcroft Practice	√		√		√	√	√		√	√	√		8	100%
Ivy Practice (Ass Chair till end of Sept)	√		√			√	√		√	√			6	75%
Jubilee Practice							√			√	√		3	38%
Newthorpe Practice*			√			√			√				3	38%
Oakenhall Practice			√		√	√	√		√	√			6	75%
Om Practice			√		√	√	√		√	√	√		7	88%
Park House Practice			√		√	√	√		√	√			6	75%
Peacock Practice*														0%
Plains View Practice	√		√		√	√	√			√	√		7	88%
Stenhouse Practice	√		√		√	√	√		√	√	√		8	100%
Torkard Hill Practice	√		√		√		√		√	√			6	75%
Trentside Practice			√		√	√			√	√			5	63%
Unity Practice					√				√	√	√		4	50%
West Oak Practice						√	√			√			3	38%
Westdale Lane Practice	√				√	√	√		√		√		6	75%
Whyburn Practice	√		√		√	√	√		√	√			7	88%
Other members														
Chief Finance Officer / Deputy	√		√		√	√	√		√	√	√		8	100%
Contract & Information Manager	√		√		√		√		√	√	√		7	88%
Deputy Chief Officer / Deputy	√		√		√	√			√	√	√		7	88%
Patient & Public Representative	√		√		√	√	√		√	√	√		8	100%
Practice Manager	√		√		√	√							4	50%
Practice Nurse														0%
Public Health Representative			√										1	13%
Secondary Care Consultant	√				√	√							3	38%
Administrator (Minute-Taker)	√		√		√	√	√		√	√	√		8	100%
Total Attended	14		20		19	19	18		18	20	13			

√ **= Attendance**
Blank = Apologies / Non Attendance / No Meeting (No meeting scheduled in Dec 2018)
**Practices of Giltbrook and Newthorpe – are also attending the Clinical Cabinet in Nottingham West CCG.*
**Peacock Practice – is currently no clinical lead.*

Nottingham North and East
Clinical Commissioning Group

Minutes of
Clinical Cabinet Meeting – NNE CCG

30th January 2019 13:30 – 16.10
Civic Centre, Arnot Hill Park, Arnold, Nottingham, NG5 6LU

Present

Non-Clinical Representatives:

Dr James Hopkinson (JH)	Clinical Lead (Chair)
Jeff Burgoyne (JBu)	Patient and Public Representative
Fiona Callaghan (FC)	Locality Director, NNE
Rachael Rees (RR)	Head of Primary Care & MCP Development – Deputy to Deputy Locality Director, NNE
Kathryn Sanderson (KS)	Patient and Public Representative

Clinical GP Representatives:

Dr Umar Ahmad (UA)	Plains View Surgery
Dr Ashish Alurwar (AA)	Highcroft Surgery
Dr Ian Campbell (IC)	Park House Medical Centre
Dr Kate Evans (KE)	Stenhouse Medical Centre
Dr Gerry Gallagher (GG)	Daybrook Medical Practice
Dr Prakash Kachhala (PK)	Torkard Hill Medical Practice
Dr Manas Karpha (MK)	West Oak Surgery
Dr Caitriona Kennedy (CK)	Trentside Medical Practice
Dr Umar Khaliq (UK)	Westdale Lane Surgery
Dr Azim Khan (AK)	Unity Surgery
Dr Elaine Maddock (EM)	Stenhouse Medical Centre
Dr Suman Mohindra (SM)	Om Surgery
Dr Amelia Ndirika (AN)	Whyburn Medical Practice
Dr Paramjit Panesar (PP)	Ivy Medical Practice
Dr Sarah Webster (SW)	Oakenhall Medical Centre
Dr Caroline Wight (CW)	Calverton Practice

In Attendance

Dr Nina Lewis (NL)	Consultant Gastroenterologist, NUH
Candice Lau (CL)	Service Improvement Manager, NNE
Alison Rounce (AR)	PICS (Primary Integrated Community Services Ltd)
Stephen Andersen (SA)	PICS
Dr Kelvin Lim (KL)	PICS
Toi~Fan Choi (TFC)	PA / Locality Administrator, NNE (Minute-taker)

Apologies

Jonathan Bemrose (JB)	Chief Finance Officer
Jonathan Gribbin (JG)	Public Health
Dr Claire Hatton (CH)	Jubilee Practice
Stewart Newman (SN)	Director of Commissioning / Deputy Locality Director, NNE
Sergio Pappalettera (SPa)	Contract and Information Manager

Not Present

GP Representative	Giltbrook Surgery*
GP Representative	Peacock Practice*
GP Representative	Newthorpe Medical Centre*
	Practice Manager
	Practice Nurse

Item		Actions
CC 19/01	**Welcome, Introductions and Apologies** Dr James Hopkinson (JH) welcomed everyone to the meeting. Apologies were noted as above. It was confirmed that the meeting was quorate. JH welcomed Fiona Callaghan (FC), the newly appointed NNE Locality Director to everyone. JH also welcomed the Primary Integrated Community Services Ltd (PICS) team to join this meeting.	
CC 19/02	**Presentation of Non-specific Symptoms Suggestive of Cancer New 2WW Pathway** JH welcomed Dr Nina Lewis (NL), Consultant in Gastroenterology and General Medicine to join the Clinical Cabinet and present this item. Members were introduced themselves to NL. NL described and explained to members using the PowerPoint presentation of the Non-Specific Symptoms due to Suspected Cancer Pathway. In summary, this new 2WW pathway NL has designed from direct observation and analysis of what happens to patients referred to existing 2WW suspected cancer pathways at NUH. Sometimes it called 'vague symptoms pathway'. Following successful grant application from Cancer Research UK, NL delivered a pilot of the '2WW non-specific symptoms due to suspected cancer' pathway in collaboration with Mr James Catton [NUH Cancer Lead and UGI surgeon] and Dr Eleanor James [Consultant Clinical Oncologist]. This pilot ran for a year from January 2017 – January 2018 and was open only to	

	referrals from 50% of Nottingham City CCG practices. With clear supporting evidence of objective benefit from the pilot, Nottingham City CCG commissioned the '2WW non-specific symptoms due to suspected cancer' pathway in February 2018 with all Nottingham City CCG practices eligible to refer patients to the pathway. This pathway remains fully operational and accessible to all Nottingham CCG practices with typical referral rates of 1 patient each day to the '2WW non-specific symptoms due to suspected cancer' pathway. With a wish to extend this 2WW pathway to all potential patients in Nottinghamshire, NL applied for and was successful in obtaining a grant to fund this implementation from The Cancer Alliance, NHS England. NL would like to start introducing '2WW non-specific symptoms due to suspected cancer' pathway in NNE CCG and once established in NNE CCG to extend the pathway to involve Rushcliffe CCG practices as service capacity allows. Prior to today's meeting, Dr Elaine Maddock, NNE CCG Cancer Lead, has already presented this pathway to NNE CCG with approval obtained by NNE CCG to support this pathway's introduction. Work is ongoing and underway to expand clinical service capacity, required to facilitate introducing this 2WW pathway to NNE CCG. Initial changes are shortly to be actioned, including increasing NL 2WW slots, other gastroenterologists having 2WW slots. A 2WW post-registrar fellow working with NL under her leadership is shortly to be advertised. NL is also exploring alternative ways of working e.g. GPwsi working alongside NL in a primary care setting assessing patients referred along this pathway to increase clinical capacity. There were several members asking questions e.g. are there other sites hosting a similar pathway, patients presenting with abnormal scans showing metastases ?where is primary which would be suitable for referral along the pathway. NL finished the presentation and left the meeting. **Updated 01.02.2019: Presentation, guidelines and referral form were sent and shared with members.**	
CC 19/03	**Declaration of Interest** The Chair reminded cabinet members of their obligation to declare any interest they may have on any issues arising at cabinet meetings which might conflict with the business of NNE Clinical Commissioning Group. Declarations of the Clinical Cabinet were listed in the CCG's Register of Interests. JH noted that the Register was available either via the secretary to the Clinical Cabinet or the CCG	

	website at the following link: http://www.nottinghamnortheastccg.nhs.uk/contact-us/freedom-of-information/conflicts-of-interest/ No other declarations of interest were received in relation to the agenda.	
CC 19/04	**Minutes of last meetings held on 17th October 2018 and 21 November 2018** The minutes of last meetings were approved at the meeting. **Updated 01.02.19: Both minutes were ratified and stored in the NNE shared drive.**	**Completed**
CC 19/05	**Matters arising and actions from the last meetings held on 17th October 2018 and 21 November 2018** The Chair confirmed that there is no outstanding action on 17th Oct 2018. On the minutes of 21 Nov 2018, item CC 18/084 from Om Surgery was actioned, investigated and reported to the Chair by the practice manager on 29.01.2019. FC confirmed that she has asked Sergio about the latest update and the trend is slightly improved. For item CC 18/087 regarding the Terms of Reference, FC said this meeting of the Clinical Cabinet will focus on developing the NNE Locality as we move to the emerging model of Primary Care Networks. Therefore a new ToR will require reflecting the new model/structure as a steering group. **Action – to create a new ToR by and discuss it at next meeting.** **All actions were completed except 21 Nov 2018 item CC 18/087 to be carried forward.**	**FC**
	Agenda Items: **A Brief Finance Update** JH and FC passed on a financial update from Jonathan Bemrose that across the four Greater Nottingham CCGs, in Month 8 we are currently on target to meet the CCGs control total for 18/19. The financial savings required for 19/20 across Greater Nottingham will be approx. £48m.	

CC 19/06	**Update on System Architecture** FC explained to members using the PowerPoint presentation of the Developing NNE Locality and discussed how NNE would develop the model for Primary Care Networks. **Updated 31.01.2019: Presentation was sent and shared with members.** Some members felt that a clearer description of planning guidance, structure, concept and governance is necessary. Other points arising from this discussion were change system, deployment and investment. Alison Rounce (AR) suggested we should debate how and what it is now (i.e. current) but not about future.	
CC 19/07	**Update on Whyburn Medical Practice** Rachael Rees (RR) informed members that the invitation to tender (ITT) is live for the Whyburn Medical Practice. The ITT is as per normal procurement process. It is expected that a new provider will be identified by the end of March / beginning of April. RR informed the group that there are local elections on 2nd May, due to Purdah we are unsure when the announcement of the successful bidder will be made, but we will inform all member practices as soon as we can. Dr Elaine Maddock (EM) expressed sympathy on behalf of all Clinical Cabinet members to Dr Amelia Ndirika (AN) and Whyburn Medical Practice for what has happened to Whyburn. General discussion about how to strengthen general practice resilience. Suggestions included preventative measures implementation, distress scoring system, council involvement, working together to explore options etc.	
CC 19/08	**Primary Care at Scale in Nottingham North and East Locality** FC presented her set of notes on the Primary Care at Scale in NNE Locality and went through each section with members. The key points were summarised as follows: (1) <u>Member Practices are required to appoint at Clinical Director of NNE PICS</u>. Dr Ian Campbell (IC) has undertaken the role of Clinical Director for NNE PICS since November 2017 and is now stepping down from the role. FC on behalf of the Clinical Cabinet thanked Ian for his leadership of the federation. JH informed members that he has put himself forward to undertake the role of Clinical Director. JH welcomed other practice members if they would like to put their names	

	forward. **Action – The Locality team to request other nominations for the role of Clinical Director for PICS and undertake a Practice vote.**	**FC**
	(2) Clinical Leadership of Primary Care Networks (Section 5) Members were discussing, looking at and comparing the current 3 Localities configuration with other options e.g. a two-localities example from the presentation (on page 15). General discussion and it was mixed and divided for a two-localities example in terms of footprint, size, demography, geography, practice alignment and relationship, social services, road networks, local authorities, communities, etc. FC said we need to agree where we are by next meeting. Members agreed that a discussion on locality configuration should take place at the upcoming locality meetings. **Action – FC to circulate information and get GP feedback.** **Updated 01.02.2019: A detailed email with key descriptions and actions agreed to progress developments in NNE was distributed to all NNE GPs, Practice Managers and Practice Nurses. Deadlines were set.** At the meeting it was agreed to ask for nominations for leadership of the PCNs. The current Locality structure in NNE means that we would be looking for 3 PCN leads for Locality 1, 2 and 3. This will be a paid role.	**Completed**
	(3) New Approaches to the General Practice Partnership Model (Section 6) FC asked members thoughts of opportunity. Then Alison Rounce (AR) of PICS presented their presentation to members (see CC 19/09 below). There was no indication from the group that that further work should be progressed.	
	(4) Clinical Leadership for Service Areas This role is currently being worked up but it is anticipated that this would be a portfolio role across the whole PCN area (3 Localities). There will also be opportunity for this role to work across the ICP/ICS level. This will be a paid role.	
	(5) Upcoming Locality Meetings (in February) At the meeting it was agreed that there would be further focused discussions at the next set of Locality meetings on the following: • Current configurations of Localities as they develop into PCNs: o Consideration of the number and size of the PCNs o Ensure that any proposed change to PCN size and geography enables collaboration across GP Practices and other providers • Explore opportunities to work through NNE PICS o What are some of initial ideas and opportunities	

	that could be acted on • Consider the service development for the Acute Visiting Scheme. **Action – All members to ensure practice representation at the upcoming locality meeting. JH and PICS to be invited to take part in the discussion** Dr Caitriona Kennedy asked if we can use PLT to discuss the PCN developments as these were in the diary. **ACTION - The Locality team to review an opportunity to use PLT session for PCN development.**	**All TFC** **TFC**
CC 19/09	**Update on the NNE GP Federation** • **Development the Federation** Alison Rounce (AR) presented PICS presentation on their organisation, experience, support offer, services, track record, etc to members. General discussion and Dr Kelvin Lim suggested PICS can bring some information relating to return on investment, financial data of Mid Notts to show members at next meeting. **Updated 31.01.2019: Presentation was sent and shared with members.** **Updated 01.02.2019: Invites were sent to PICS for next meeting.** • **Service Improvement** FC presented the notes of Acute Home Visiting Service on behalf of Stewart Newman to members. **Action – to further discuss the AVS options at the upcoming locality meetings** **Action – PICS to present at the Clinical Cabinet in February the evaluation of the AVS service underway across Mansfield and Ashfield**	**ALL** **Ali Rounce**
CC 19/10	**Any Other Business** **Care Home LES:** Dr Prakash Kachhala (PK) asked whether the Care Home LES would continue. CL replied that funding for the LES for 2019/2020 has been approved. Both the GP LES and Care Home Team are currently being reviewed to determine the enhanced elements with a view to align the service specs across South Notts. The LMC have produced guidance on GP services to care homes which has been taken into consideration as part of the review. **Updated 01.02.2019: A Care Home – Provision of GP Service Guide Oct 18 was sent and shared with members.** **Extended Access:** Dr Caitriona Kennedy (CK) showed a leaflet and informed members that there is a free 12-week programme for patients	

	being provided by the Nuffield. CK asked about Extended Access and Rachael Rees confirmed that National Directed Enhanced Services for Extended Access has been confirmed that it will continue for 2019/2020 and practices will receive appropriate specification and contracts for NHS England shortly. **PPG Representative:** Jeff Burgoyne (JB) raised concerns that there were some practices have not got a PPG at yesterday PPG Forum. At yesterday's meeting 10 practices were represented. JB said it is a contractual requirement for all practices to form a patient participation group (PPG) and make reasonable efforts for this to be representative of the practice population. JB emphasised that they are a group of volunteer patients that meet on a regular basis to discuss the services on offer, and how improvements can be made for the benefit of patients and the practice. There is no extra cost for the practices but an available resource for them to use. His own PPG had recently conducted a Patient survey which involved over 100 volunteer hours. **Meeting Closed: 4.10pm**	
CC 19/11	**Date, Time and Venue of Next Meeting** Wednesday 27th February 2019 at 2.30pm - 4.30pm Chappell Room, Civic Centre, Arnot Hill Park, Arnold, Nottingham, NG5 6LU **SIGNED: …… (Chair)** **DATE: ……..**	

Information Governance, Management and Technology Committee
RATIFIED Minutes of the meeting held on 04 December 2018, 15:00 – 17:00
Chappell Room, Civic Centre Arnot Hill Park, Arnold, Nottingham NG5 6LU

Present:	
Sue Sunderland	Lay Member (Chair), Greater Nottingham Clinical Commissioning Partnership
Nichola Bramhall	Chief Nurse and Director of Quality, Greater Nottingham Clinical Commissioning Partnership (Caldicott Guardian)
Lucy Branson	Corporate Director, Greater Nottingham Clinical Commissioning Partnership
Mick Cawley	Chief Finance Officer, Mid-Nottinghamshire CCGs (SIRO)
Andy Hall	Director of Performance and Information, Greater Nottingham Clinical Commissioning Partnership
David Heathcote	Lay Member, Mid-Nottinghamshire CCGs
Dr Mike O'Neil	GP Representative, Greater Nottingham Clinical Commissioning Partnership
In attendance:	
Helen Clark	Governance Officer (minutes)
Ruth Lloyd	Head of Corporate Governance, Mid-Nottinghamshire CCGs
Apologies:	
Terry Allen	Lay Member, Greater Nottingham Clinical Commissioning Partnership
Loretta Bradley	Head of Information Governance, Greater Nottingham Clinical Commissioning Partnership
Elaine Moss	Chief Nurse and Director of Quality and Performance, Mid-Nottinghamshire CCGs' (Caldicott Guardian)
Dr Carter Singh	GP Representative, Mid-Nottinghamshire CCGs'
Gary Thompson	Chief Operating Officer, Greater Nottingham Clinical Commissioning Partnership, SIRO

Cumulative Record of Members Attendance (2018/19)					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Nichola Bramhall	3	1	Sue Sunderland[1]	1	1
Elaine Moss	3	0	Terry Allen[1]	1	0
Mick Cawley	3	3	Lucy Branson[1]	1	1
Gary Thompson	3	0	Andy Hall	3	3
Dr Carter Singh[1]	1	0	Jaki Taylor[2]	2	2
Dr Mike O'Neil	3	3	Ruth Lloyd[2]	2	2
David Heathcote[1]	1	1	Loretta Bradley[2]	2	2

[1]*Membership commenced as at December 2018*
[2]*Membership ceased as at July 2018*

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Introductory Items

IGMT 18 083 **Welcome and apologies for absence**
Sue Sunderland welcomed everyone to the Information Governance, Management and Technology Committee and a round of introductions was made.

Apologies were noted as above.

IGMT 18 084 **Confirmation of quoracy**
It was confirmed that the meeting was quorate.

IGMT 18 085 **Declarations of interest for any item on the agenda**
No interests were declared in relation to any item on the agenda. The Chair reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

IGMT 18 086 **Management of any real or perceived conflicts of interest**
As no conflicts of interest had been identified, this item was not necessary for the meeting.

IGMT 18 087 **Minutes of the meeting held on 20 July 2018**
It was agreed that the minutes were an accurate record of the meeting.

IGMT 18 088 **Action log and matters arising from the meeting held on 20 July 2018**
The action log was reviewed and the following actions discussed:

(a) It was agreed that action IGMT/18/026 and IGMT/18/008 were operational actions that no longer fell within the remit of the IGMT Committee. They will remain on the action log until Lucy Branson has identified an appropriate forum for onward referral.

All other actions were noted as ongoing or complete and there were no further matters arising.

Items for Discussion/Information

IGMT 18 089 **Terms of Reference and Forward Work Programme**
Lucy Branson presented this item. The following key points were highlighted:

(a) The Terms of Reference have been approved by all six Governing Bodies.
(b) Members are asked to be mindful that meetings dates for the remainder of 2018/19 are being finalised, but it may not be possible to get a full complement of members present at each meeting.
(c) Dates for meetings throughout 2019/20 have been set.
(d) It is proposed that lay membership is been bolstered from two members to three to support the Committee's ability to provide the desired level of scrutiny and assurance.
(e) An initial work programme has been produced for the remainder of 2018/19 and 2019/20; however, this will need to be further developed as the Committee evolves.

The following points were made in discussion:

(f) There is a complex operational delivery meeting infrastructure that members are keen to understand.
(g) It will be the responsibility of the relevant IGMT Committee member to

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convert the information discussed at the various operational delivery meetings into an assurance report.

At this point Dr Mike O'Neil joined the meeting.

(h) Members are keen to understand where risks related to operational delivery are escalated to.
(i) Members agreed that the forward work programme needs to include; an annual update on GP IT provision, a policy work programme, and the IGMT Strategy for annual review.
(j) It was also noted that moving forward the quarterly information governance assurance report will include an update on the Data Security and Protection Toolkit and General Data Protection Regulation in a single report.
(k) The forward work programme will continue to develop, and as such, will be included on subsequent agendas for review and input.

At this point Nichola Bramhall joined the meeting.

(l) The work plan also needs to align with the Estates and Technology Transformation Fund (ETTF) cycles to enable the Committee to be sighted on priorities and enable colleagues to respond to short notice requests from NHS Digital to make capital bids.

The Committee:

- **RECEIVED** the terms of reference and **SUPPORTED** the proposed increase to lay membership.
- **REVIEWED** the draft Annual Work Programme for the remainder of 2018/19 and 2019/20.
- **NOTED** that meeting dates are currently being finalised for 2019/20.

ACTIONS:

- **Lucy Branson to update the forward programme to include an annual update on GP IT provision, a policy work programme, the IGMT Strategy for annual review and IT capital bid priorities.**
- **Andy Hall to liaise with Andy Evans regarding bring a paper to the January 2019 meeting to agree the IT priorities to support capital bids.**
- **Lucy Branson and Mick Cawley to seek approval from the Governing Bodies to increase the lay membership of the IGMT Committee from two to three members.**

IGMT 18 090 **Operational Delivery Infrastructure**

Lucy Branson gave a verbal updated regarding the Operational Delivery Infrastructure. The following key points were highlighted:

(a) There is a shared ambition to establish clear arrangements for the oversight of operational delivery regarding the IT, information management and information governance agendas.
(b) Andy Hall and Lucy Branson will meet with Jaki Taylor, Director of Nottinghamshire Health Informatics Service (NHIS), to test whether the existing NHIS meeting infrastructure relating to cyber security remains fit for purpose, and to identify areas requiring refinement.
(c) The establishment of an IGMT Operational Delivery Group for the six

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CCGs will provide assurance to the IGMT Committee that operational workstreams are being effectively managed and delivered.

The following points were made in discussion:

(d) Members are supportive of streamlining the existing operational delivery infrastructure.
(e) It was reiterated that there needs to be clear governance around where risks to operational delivery are reported and at what point they need to be escalated to the IGMT Committee.
(f) Identified gaps in the existing infrastructure will be identified and a report will come back to the January 2019 Committee for review.

The Committee:

- **NOTED** the verbal update.

ACTION:

- **Andy Hall and Lucy Branson to meet with Jaki Taylor, Director of Nottinghamshire Health Informatics Service (NHIS), to test whether the existing NHIS meeting infrastructure relating to cyber security remains fit for purpose, and to identify areas requiring refinement.**

IGMT 18 091 **IGMT Strategy**

Andy Hall presented this item. The following key points were highlighted:

(a) The CCGs are four years into a five year strategy; it is reviewed annually to ensure it continues to align with national and local priorities.
(b) The strategy reflects local ambition, the work required to meet the CCGs' obligations in line with national standards and links to emerging Integrated Care System priorities.
(c) When the Local Digital Roadmap was produced, Nottinghamshire was an exemplar and has been more successful than other organisations at attracting capital bids.
(d) As per national requirements the CCGs are obliged to ensure all GP Practices can operate a GP System of Choice (GPSoC) compliant system. In Mid-Nottinghamshire all practices operate a GPSoC compliant system. In Greater Nottinghamshire, 80% of practices use TPP SystmOne system and 20% use EMIS Web.
(e) There is a general trend to move over to SystmOne, as this will allow practices to have shared access to patient records.
(f) There is a national directive to move to a new Health and Social Care Network (HSCN) which will replace the N3 Connection.
(g) The Medical Interoperability Gateway (MIG) has been implemented and enables information to be accessed across the system.
(h) Assistive technology will be implemented where clinical benefit can be identified.
(i) Some of the proposed initiatives have already been implemented as the strategy has come to the IGMT for endorsement later than desired.

The following points were made in discussion:

(j) The summary provided by Andy gave context to the strategy, which members appreciated.
(k) Members are keen to see the strategy accompanied by a work plan reflecting the CCGs' priorities and the elements of the strategy that the Committee needs to seek assurance on as part of its delegated responsibilities.
(l) Designing a strategy beyond three years into the future is challenging

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given the changing health and social care landscape.

(m) Members are keen for an executive summary to accompany the strategy when it is submitted to the Governing Bodies to contextualise what is currently being delivered and the impact this will have on both the patient and the practitioner.

(n) It is suggested that the first output of the Operational Delivery Group (once established) is to summarise the benefits to patients in achieving the strategy.

(o) It is recognised that in some instances, cultural attitudes to technology rather than the technological tools themselves are the obstacle to implementation.

(p) The CCGs have a responsibility to ensure systems are compliant with national standards.

(q) It is recognised that a delay in endorsing the strategy for approval to the Governing Bodies could pose a risk as it is needed to support the capital bids submission to NHS Digital.

The Committee:

- **ENDORSED** the refreshed IGMT Strategy for submission to the CCGs' Governing Bodies for approval.

ACTION:

- **Andy Hall to liaise with Andy Evans about producing a twelve month work plan to draw out the elements of the strategy that the IGMT Committee is seeking assurance on as part of its delegated responsibilities.**

Items for Assurance

IGMT 18 092 **General Data Protection Regulation (GDPR) Update**

Lucy Branson presented this item. The following key points were highlighted:

(a) The paper provides an update on compliance with the requirements of the EU General Data Protection Regulation (GDPR).

(b) To ensure preparedness, implementation plans had been developed using the Information Commissioner's Office's '12 Steps to GDPR Compliance' guidance.

(c) An overview of the actions taken to date is set out in the report, along with a description of the ongoing 'business as usual' activities that will ensure continued compliance.

(d) Key areas of ongoing work relate to the annual data flow mapping and information asset register refresh and the work to continue to embed 'privacy by design' principles within commissioning processes.

(e) 360 Assurance conducted an audit of GDPR preparedness and both Mid-Nottinghamshire and Greater Nottingham CCGs' have received significant assurance, with only a small number of low risk issues identified.

(f) A review of the interim DPO appointment in Greater Nottingham has been completed and it has been agreed that the preferred approach to assignment of this role needs to be aligned across the six CCGs. An options appraisal has been undertaken which recommends that the role is assigned to the Information Governance Leads on a permanent basis.

The following points were made in discussion:

(g) The new Data Security and Protection Toolkit is designed to ensure that organisations' are GDPR compliant.

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(h) The Information Governance Alliance (IGA) is clear that the DPO does not need to be a member of the Governing Body.
(i) The DPO needs to have expert knowledge and the outline of the role requirement aligns with the Head of Information Governance's job description.
(j) The allocation of the DPO role to the Information Governance Leads is supported by Committee members.

The Committee:

- **RECEIVED** the GDPR compliance update;
- **ENDORSED** the assignment of the DPO role to the Information Governance Leads. Approval will be sought from the Governing Bodies for this role to be formerly assigned on a permanent basis.

ACTION:

- **Lucy Branson and Mick Cawley to seek approval from the Governing Bodies to assign the role of the Data Protection Officer to the Head of Information Governance (Greater Nottingham) and the Head of Corporate Governance (Mid-Nottinghamshire).**

IGMT 18 093 **Cyber Security Update**

Lucy Branson presented this item. The following key points were highlighted:

(a) The full report has been deferred to a future IGMT Committee meeting.
(b) Andy Hall and Lucy Branson will meet with Jaki Taylor at NHIS to sense check the existing infrastructure around cyber security monitoring.

The following point was made in discussion:

(c) Members are keen to have complete assurance that all risks identified through the Root Cause Analysis following the 2017 cyber-attack have been addressed and remaining low risk actions have been subsumed into business as usual workstreams.

The Committee:

- **NOTED** the verbal update.

IGMT 18 094 **Data Security and Protection Toolkit Report**

Lucy Branson presented this item. The following key points were highlighted:

(a) The Data Security and Protection Toolkit is built around the ten national data security standards and will demonstrate organisational compliance with the GDPR.
(b) An overview of the similarities and differences between the new toolkit and its predecessor was provided.
(c) A detailed training needs assessment will be conducted across key roles related to the Information Governance, Information Technology and Data Management agenda.
(d) A significant amount of work has already been undertaken but final steps are required to confirm that the assertions are complete. The number of completed assertions is as expected for this point in the financial year and will continue to increase during the coming months.
(e) An action plan setting out areas where further actions are required prior to year-end is attached to the paper.
(f) 360 Assurance will audit compliance with the toolkit as standard.

The Committee:

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- **NOTED** the Data Security and Protection Toolkit Update.

IGMT 18 095 **Data Quality Report**

Andy Hall presented this item. The following key points were highlighted:

(a) The level of coding compliance of major providers is routinely monitored.
(b) The level of coding compliance at Nottinghamshire Healthcare NHS Foundation Trust isn't as high as that of other providers, but is within the normal range of a mental health provider.
(c) The number of unidentified codes at Nottingham University Hospitals NHS Trust has dropped below 1%, which is a significant improvement on previous performance following the issue of a breach notice.

The Committee:

- **NOTED** the content of the Quarterly Data Quality Report.

IGMT 18 096 **Risk Report**

Lucy Branson presented this item. The following key points were highlighted:

(a) The consolidated risk report provides a summary of identified IGMT risks.
(b) Two new risks have been identified:
    - There are identified vulnerabilities on the Citrix platform, which is a national issue. Mitigating actions are being explored and Jane Godden, Head of Commissioning (Continuing Healthcare and Individual Care Packages) will provide a coordinated response on behalf of all six CCGs.
    - There is a risk that the alignment and accessibility of corporate records within Greater Nottingham will be impacted by a delay in the G Drive Project. A project plan and mitigating actions are in place.
(c) Risk GN025, GDPR Preparedness, and GN071, the Records and Information Group not being operational, are proposed for archiving as both have been mitigated.
(d) Work is taking place to ensure there is a consistent and systematic approach to capturing and recording risks across all six organisations, particularly those pertaining to partnership arrangements.

The Committee:

- **RECEIVED** the risk report;
- **APPROVED** the archiving of risks GN025 and GN 071;
- **NOTED** the work required to ensure that all partnership risks (relevant to the CCGs) are being systematically captured.

Closing Items

IGMT 18 097 **Risks identified during the course of the meeting**

No risks were identified during the course of the meeting.

IGMT 18 098 **Any other business**

There was no other business to be discussed.

IGMT 18 099 **Date of next meeting:**

18 January 2019, 13:30-16:00
Committee Room, Civic Centre, Arnot Hill Park, Arnold, Nottingham NG5 6LU

NHS Nottingham City CCG Audit and Governance Committee
NHS Nottingham North and East CCG Audit and Governance Committee
NHS Nottingham West CCG Audit and Governance Committee
NHS Rushcliffe CCG Audit and Governance Committee

RATIFIED Shared Minutes of the Meetings Held in Common on 6 December 2018, 09.30 – 11:30
Board Room, Standard Court, Park Row, Nottingham, NG1 6GN

		Organisation			
		NHS Nottingham City CCG	NHS Nottingham North and East CCG	NHS Nottingham West CCG	NHS Rushcliffe CCG
Members present:					
Tim Woods	Lay Member – Financial Management and Audit (Convener of the meetings in common)	✓*		✓*	
Terry Allen	Lay Member – Financial Management and Audit		✓*		
Sue Clague	Lay Member	✓**			✓**
Sue Sunderland	Lay Member	✓*			
Mike Wilkins	Lay Member		✓**		

** As the Audit and Governance Committee Chair*
*** As a Lay Member Representative*

In attendance:					
Jonathan Bemrose	Chief Finance Officer	✓	✓	✓	✓
Lucy Branson	Director of Corporate Development	✓	✓	✓	✓
Jo Simmonds	Head of Corporate Governance & Assurance	✓	✓	✓	✓
Nina March	Governance Administrator (Minutes)	✓	✓	✓	✓
Claire Page	360 Assurance – Internal Audit	✓	✓	✓	✓
Richard Walton	KPMG –External Audit	✓	✓	✓	✓

Apologies:					
Ian Blair	Lay Member – Financial Management and Audit				✓
Beverley Brooks	Lay Member			✓	
Janet Champion	Lay Member		✓	✓	

Ref	Item
	INTRODUCTORY ITEMS
AG 071/18	**Welcome and apologies**
	Tim Woods, as convener of the meeting, welcomed everyone to the Audit & Governance meetings in common.
	Apologies were noted as above.
AG 072/18	**Confirmation of quoracy**
	It was confirmed that the NHS Nottingham City CCG, NHS Nottingham North and East CCG and the NHS Nottingham West CCG Audit and Governance Committees were quorate.
	It was noted that NHS Rushcliffe CCG was not quorate due to the absence of Ian Blair; however, it was agreed that it was appropriate to continue as the number of lay members present would still make the meeting effective and Sue Clague would be able to report back to the Rushcliffe CCG Governing Body.
AG 073/18	**Declarations of interest for any item on the agenda**
	There were no declarations of interest in relation to any items on the agenda.
AG 074/18	**Management of any real or perceived conflicts of interest**
	As there were no identified conflicts of interest, this item was not required.
AG 075/18	**Minutes from the previous Committee meetings in common held on 27 September 2018**
	The minutes were agreed as an accurate record.
AG 076/18	**Action log and matters arising from the Committee meetings in common held on 27 September 2018**
	There were no outstanding actions to comment on. Updates on the actions in progress were provided as follows: a) **Greater Nottingham CCG's Joint Probity Arrangements** – Jo Simmonds is developing guidance for the Freedom to Speak up Guardian roles as there is no specific guidance for CCGs. All other actions were noted as complete or in progress.
	GOVERNANCE AND RISK
AG 077/18	**Organisational Risk Report**
	Jo Simmonds presented this item, explaining that the purpose of the report was to present the CCGs' joint risk register and to show the findings following a recent 'assurance mapping exercise'. The following key points were highlighted and discussed: a) The Risk Register is the central repository for all of the CCGs' operational risks (including risks for the individual organisations if necessary) and is the result of bringing together all risks from the individual CCGs. Discussions have been held with risk leads across the organisations to confirm scoring and to ensure that the risk wording is reflective of the CCGs in the new partnership arrangements. b) As previously discussed with members, all committees within the CCGs' joint governance arrangements are responsible for monitoring risks related to their duties. Whilst concerns had previously been raised that this approach appeared fragmented and may not allow for scrutiny of the register in its entirety; the arrangements appeared to be working well and this would hopefully be validated in the upcoming internal audit review of risk management. A risk around the complexity of arrangements remained on the risk register.

c) An assurance mapping exercise had recently been undertaken as part of work to further develop the CCGs' joint Assurance Framework. This demonstrated that key controls and assurances were in place or expected for the majority of risks on the Assurance Framework; the exception being that no independent assurances were expected with regard to procurement arrangements, collaborative commissioning arrangements or public sector equality duties.

Discussion ensued as follows:

d) Comments were raised on the risk 'GN087' (staff turnover). It was confirmed that this had reduced from being a major risk as the rate of staff turnover had slowed down.

e) With regard to independent assurances on the Assurance Framework, members queried whether no indications that controls weren't effective could be taken as positive assurance. It was agreed that this type of intelligence could not be translated into the Assurance Framework.

The Committees NOTED the Organisational Risk Report.

INTERNAL AUDIT

AG 078/18 Internal Audit Progress Report

Claire Page presented the Internal Audit Progress Report.

The following key points were highlighted:

a) The report provides a summary of the work carried out for Internal Audits for the Greater Nottingham CCGs since the Audit and Governance Committees met in September 2018.
b) Currently, there are 47 actions across the CCGs that require follow up to confirm if they have been implemented. Internal Audit will work with the Governance and Assurance team to ascertain the current status of these actions.
c) One of the key areas of work in relation to the 2018/19 plan is the Data Security and Protection Standards review. Terms of Reference have been agreed for this review which is being carried out in two stages.
d) Regular liaison meetings occur with Jonathan Bemrose and meetings were underway with other managers across the CCGs around the scope of individual audits. Papers for the Governing Bodies and Joint Commissioning Committee are also reviewed on a regular basis to look at key issues and risks impacting on the CCGs.
e) Regular liaison meetings are also arranged with the Audit & Governance Committees' Chairs, in-between Audit and Governance Committee meetings to provide an update on progress with the Internal Audit Plans.

Discussion ensued as follows:

f) The length of time specified for the Primary Medical Care Delegated Commissioning mandated review was queried as this is stated to cover a three to four year programme of work. It was confirmed that the four years is not an estimate for how long this will take but an allocated amount of time to cover all areas of work required.

The Committees NOTED the progress against the Internal Audit Report.

AG 079/18 General Data Protection Regulation Final Report

Claire presented the final General Data Protection Regulation Report.

The following key points were highlighted and discussed:

a) The audit carried out on the General Data Protection Regulation (GDPR) has assessed the effectiveness and appropriateness of arrangements in place across the CCGs to meet the requirements. This included the assessment of the governance framework and operational resources in place to identify the implications of GDPR,

the actions that have been required and the delivery of those actions.

b) An opinion of significant assurance had been issued, with three low-risk recommendations made. It was noted that one action to update the CCGs' privacy notices had already been implemented.

The Committees NOTED the General Data Protection Regulation Final Report.

EXTERNAL AUDIT

AG 080/18 External Audit Progress Report

Richard Walton presented the External Audit Progress Report.

The following key points were highlighted and discussed:

a) Two events were hosted by KPMG; a two day event with system leaders from hospitals across America and Europe as well as a roundtable meeting in Toronto Canada. The events focused on building a culture of continuous quality improvement and sharing individual and common challenges.
b) Benchmarking of the CCGs position in Greater Nottingham against the other CCGs in the Midlands has identified that:
   - All four CCGs are reporting a surplus position consistent with plan and are also forecasting a year end achievement of plan.
   - Greater Nottingham CCGs have the highest QIPP plan; the schemes being more transactional in nature.
   - The current financial performance being reported by providers ranges from a surplus position of over 5% to a deficit of 8% of turnover. The underlying position is however more consistent.
   - Providers are reporting a high level of agency spend.
   - The majority of Trusts are behind plan to achieve their Cost Improvement Programme (CIP) schemes, however are forecasting an improvement to this position by the end of the financial year.

c) It was confirmed that Andy Bostock at KPMG would be responsible for signing off the CCGs' Annual Accounts.

The Committees NOTED the External Audit Progress Report.

FINANCIAL REPORTING

AG 081/18 Capita ISAE 3402 final Type II report

Jonathan Bemrose presented the final Capita ISAE 3402 Type II report.

The following key points were made:

a) A summary of the improvements made since the Interim Type II Report was given, highlighting continued progress in addressing the control weaknesses identified in previous reports.
b) As a result of the audits undertaken, further enhancements have been made to the control framework, Standard Operating Procedures (SOPs) and training programmes. Many of the improvements are reflected in the report.
c) The governance surrounding the control frameworks continues to receive significant focus ensuring that the framework continues to evolve and there is greater compliance.
d) It is anticipated that the next phase of testing will address the remaining issues listed in the report.

The following points were raised in discussion:

e) The reduction in the number of control objectives qualified from seven to three was

noted.

f) The members reaffirmed their concerns and will continue to do so until assurance is received that the issues have been resolved. It was recognised that more work needs to be undertaken; however, it was acknowledged that progress was being made.

The Committees NOTED the Capita ISAE 3402 final Type II report.

AC 082/18 NHS Property Services Update

Jonathan Bemrose presented the NHS Property Services Update.

The following key points were highlighted:

a) Since the last update to the Committees in September 2018, discussions have taken place between NHS Property Services (NHSPS), the Department of Health and the CCGs to understand the billing model for NHSPS.
b) There remains a £800k difference between what the Greater Nottinghamshire CCGs and NHSPS believe to be the balance owed. NHSPS have been requested to provide further information to support their position. A further meeting has also been arranged.
c) Billing models have been received for 2018/19 and are being validated.

The following points were raised in discussion:

d) In response to concerns raised at the previous meeting as to whether the 2018/19 billing model would put additional financial pressure on the CCGs, assurance was given that discussions are on-going which will enable the CCGs to understand the level of risk to the financial position.

The Committees NOTED the NHS Property Services Update.

AG 083/18 Deloitte's Due Diligence Review Update and Engagement Letter

Jonathan Bemrose presented the Due Diligence Review Update and Engagement Letter. The following was highlighted:

a) The letter has been received from Deloitte UK setting out their proposed arrangements for reviewing the financial position and forecast outturn for 2018/19 financial year for the Greater Nottingham and Mid Nottinghamshire CCGs.
b) The letter is addressed to the Accountable Officer and requests confirmation that the scope of information set out in the letter (and its enclosures) is sufficient for the needs of the CCGs.

Following discussion, the members agreed that at this point, it was difficult to see how this work added any value further to that provided following the Capability and Capacity review; However, it was hoped that the outcome would result in some constructive recommendations for the CCGs.

The Committees NOTED the Deloitte's Due Diligence Review Update and Engagement Letter.

AC 084/18 Finance Control and Governance Self-Assessment (Virtual Decision)

Jonathan Bemrose provided a verbal update on the Finance Control and Governance Self-Assessment explaining that this has been virtually approved by members in November 2018.

The Committees NOTED the virtual decision made to approve the Finance Control and Governance Self-Assessment.

Ref	Item
	CLOSING ITEMS
AG 085/18	**Any Other Business**

Clare Page left the meeting at this point.

A paper will be presented at the next meeting in February 2019 regarding the Internal Audit contract with 360 Assurance. The contract ends in March 2019 and will require a decision to determine whether the contract will continue.

AG 086/18 **Risks identified during the course of the meeting**

No new risks were identified.

AG 087/18 **Key issues and recommendations to highlight to the Governing Bodies**

There were no key issues or recommendations to highlight to the Governing Bodies.

AG 088/18 **Date of next meeting:**

The following dates are proposed and will be confirmed with members following the meeting:

- 28 February 2019

Tim Woods closed the meeting and thanked everyone for their attendance.

Minutes of the
Nottinghamshire Safeguarding Adults
Board Meeting

Held on 11th October 2018

Nottinghamshire Safeguarding Adults Board
C/o Safeguarding Adults Strategic Team
County Hall
West Bridgford
Nottingham
NG2 7QP
Tel No: 0115 977 3911

Attendance List for the NSAB Meeting
12th April 2018

BOARD MEMBERS				
NAME	**ORGANISATION**	**PRESENT**	**APOLOGY**	**ABSENT**
Allan Breeton Chair	Independent Chair, Nottinghamshire Safeguarding Adults Board	√		
Amanda Sullivan Vice Chair	Chief Operating Officer - Newark and Sherwood Clinical Commissioning Group	√		
David Pearson Board Member	Corporate Director, Adult Social Care, Health and Public Protection, Nottinghamshire County Council	√		
Paul Johnson	Service Director - Strategic		√	

Board Member	Commissioning, Adult Access and Safeguarding			
Steve Edwards Board Member	Service Director, Children's Social Care, Nottinghamshire County Council		√	
Laurence Jones *Deputy for Steve Edwards*	Temporary Service Director Commissioning and Resources, Nottinghamshire County Council	√		
Claire Bearder Board Member	Group Manager, Access and Safeguarding, Nottinghamshire County Council		√	
Stuart Sale Board Manager	Nottinghamshire Safeguarding Adults Board Manager, Safeguarding Adults Strategic Team, Nottinghamshire County Council	√		
Ruth Hyde Board Member	Chief Executive Officer, Broxtowe Borough Council	√		
Andrew Gowan Board Member	Detective Superintendent Head of Public Protection Investigation and Intelligence Command, Nottinghamshire Police	√		
Bob Bearne Board Member	Regional Manager, The Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company Limited		√	
Julie Gardner Board Member	Associate Director, Safeguarding and Social Care, Nottinghamshire Healthcare NHS Trust	√		
Bella Dorman Board Member	Head of Safeguarding, Nottingham University Hospitals NHS Trust	√		
Moira Hardy Board Member	Deputy Director of Nursing, Midwifery and Quality, Doncaster & Bassetlaw Hospitals NHS Foundation Trust		√	
Elizabeth Boyle *Deputy for Moira Hardy*	Doncaster & Bassetlaw Hospitals NHS Foundation Trust		√	
Tina Hymas-Taylor Board Member	Head of Safeguarding, Sherwood Forest Hospitals NHS Foundation Trust	√		
Elaine Moss Board Member	Director of Quality and Governance, Newark and	√		

	Sherwood Clinical Commissioning Group			
Nichola Bramhall Board Member	Director of Nursing and Quality, Nottingham North & East CCG		√	
Nicola Ryan Board Member	Interim Chief Nurse, NHS Bassetlaw Clinical Commissioning Group		√	
Maria Stanley Board Member	Head of Safeguarding, East Midlands Ambulance Service	√		
Hester Kapur Board Member	Evidence and Insight Officer, Healthwatch Nottinghamshire	√		
Julie Burton Board Member	Senior Probation Officer, Nottinghamshire National Probation Service		√	
Hazel Roberts Board Member	Inspection Manager, Care Quality Commission		√	
Andy Macey Board Member	Group Manager, Nottinghamshire Fire and Rescue Service	√		
ASSOCIATE BOARD MEMBERS				
NAME	**ORGANISATION**	**PRESENT**	**APOLOGY**	**ABSENT**
Deborah Kitson Associate Member	Chief Executive Officer, Ann Craft Trust		√	
OTHER ATTENDEES				
NAME	**ORGANISATION**	**PRESENT**	**APOLOGY**	**ABSENT**
Teresa Ackroyd Minute Taker	Nottinghamshire Safeguarding Adults Board Administration Safeguarding Adults Strategic Team, Nottinghamshire County Council	√		
Annie Greer Guest	Strategic Development Manager - DoLS	√		
Zoe Butler Guest	Nottingham College	√		

Minutes of the NSAB Meeting
11th October 2018

Agenda Item	Discussion	Action by	By date
1.	**Welcome, Introductions and Apologies**		
	Allan Breeton welcomed all to the meeting, apologies were given as detailed above, and introductions were made.		
2.	**Minutes of the Board Meeting held on the 12th July 2018**		
	Points of Accuracy There were no points of inaccuracy raised and the minutes were agreed to be a true and accurate record of the meeting. Matters Arising The actions from the meeting held in July are detailed on the attached Action Log.		
3.	**Deprivation of Liberty Safeguards – Update from the Local Authority**		
	Annie Greer, Nottinghamshire County Council Strategic Development Manager – DoLS, joined the meeting to give an update on Deprivation of Liberty Safeguards - a paper had been distributed before the meeting. There was a discussion about the content of the report. Bella Dorman from NUH raised concerns about the language used in the report, stating that 'inappropriate referral' for cases that were closed without an assessment being required was not the correct term and the reasons should be separated. Members agreed that this would make it clearer. David Pearson suggested that the DoLS assurance report that goes to ASCH committee would be more useful for NSAB however, it was stated that this should include Bassetlaw Hospital. There was a discussion about creating strategic links between the DoLS Team and acute trusts.		

3.1	**Action: Annie Greer email contact details to be shared with board members.** Alan thanked Annie for attending the board meeting.	**Teresa Ackroyd**	**12.10.18**
4.	**Sub-Group Chair Action Plan Co-ordination Meeting Update**		
	Allan commented this had been a useful meeting for chairs of the sub groups. Sub group are now working towards strategic plan action plans.		
5.	**Sub Group Updates**		
5.1	**Learning and Development Sub-Group Update** Ruth informed the meeting that the September Train the Trainer event was cancelled and another event is being planned. Two self-neglect events are taking place, one on the 17th October 2018 and another on 26th October. These are joint events with the City. Allan has offered to attend and support the event on the 17th October.		
5.2	**Safeguarding Adults Reviews Sub-Group Update** Amanda informed the meeting that Safeguarding Adults Review now has a SAR Champion, Rhonda Christian, who has joined the national network. There was a SAR referral from the Police. However, following good discussion by the sub group, it was agreed that no SAR was required but that further work was undertaken by individual agencies. Feedback was provided from the 'deep dive' review of Annesley House and work with F13's parents – this work is now concluded. **Quality Assurance Sub-Group Update** Stuart presented the data report, noting the following: **Performance Indicator 1a** shows that 45.2% of safeguarding referrals led to Section 42 Enquiries in the first quarter of 2018/19. This is below the Board's three year target of 60%. The QA sub group recommended that a target of 56% should be adopted for the first year of the new strategic plan. *The Board did not agree to this recommendation – instead the board agreed that the target will be set*		

	at 60% over the next 3 years. **Performance Indicator 1b** shows that the percentage of those adults at risk who are asked what their desired outcomes were was 76.8% in the first quarter of 2018/19. This is below the Board's target of 80%. **Performance Indicator 1c** shows that the level of satisfaction that adults have with their outcomes decreased slightly from 89.9% in 2017/18 to 85.0% in the first quarter of 2018/19. **Performance Indicator 1d** has shown an increase from 66.9 in 2017/18 to 68.1% in the first quarter of 2018/19. However, it should be noted that the principles of "Making Safeguarding Personal" means that the risk to an individual may not always be removed or reduced depending on the choices they make. **Performance Indicator 1e** shows that the number of adults subject to two or more enquiries in a 12 month period reduced from 370 at the end of the 2017/18 financial year to 303 at the end of the first quarter of 2018/19. **Performance Indicator 1f** shows that the percentage of adults at risk lacking mental capacity who are supported to give their views in the first quarter of 2018/19 was 82.6% which is more than the Board's target of 80%.and higher than the 81.6% achieved in 2017/18. **Missing Performance Indicator** The performance indicator showing the percentage of those adults whose desired outcomes were fully achieved is not available. Changes were made to the local authority Mosaic recording system to bring questions in line with other East Midlands local authorities. Technical issues have prevented this information from being retrieved from Mosaic until now. **Graph 1** shows the trends for referrals by quarter over the last three quarters of 2017/18 and the first quarter of 2018/19. The number of referrals reduced by 32 from the fourth quarter whilst those resulting in Section 42 enquiries were 72 lower than the previous quarter. **Graph 2** shows the breakdown of referrals by the top five organisations in terms of percentage of		

	referrals that led to Section 42 Enquiries (where 20 or more referrals have been received). Most organisational types had been adversely affected by the reduction in the overall proportion of referrals proceeding to section 42 enquiries. The only exception was care and nursing homes which recovered from a low position in the previous quarter. There was a discussion about 'what good looks like' in relation to appropriate referrals, with the possibility of looking at those agencies who make a higher proportion of appropriate referrals to see if any lessons can be shared.		
5.3	**Action: QA sub group to explore 'what good looks' and consider how this can be used to support other agencies.**	**QA Sub Group Chair**	**10.01.2019**
5.4	**ACTION: QA Sub Group to set performance target 1a as 60% over the 3 years of the strategic plan**	**QA Sub Group Chair**	**10.01.19**
6.	**Refreshments**		
7.	**Citizen's Voice Video**		
	A short Citizens video was shown to the board members as a way of helping reflect and remind members of who the board's work seeks to support.		
8.	**Update for David Pearson.** • **Social Care Green Paper** • **Sustainability & Transformation Plan**		
	David Pearson gave a presentation of the Social Care Green Paper and also regarding the Sustainability and Transformation Plan (STP). **Action: David Pearson's presentations on the Social Care Green Paper and the STP to be shared with Board Members.**	**Teresa Ackroyd**	**10.01.19**
9.	**Procedures and Guidance for Raising a Concern and Referring.**		
	There was a discussion in the meeting around Procedures and Guidance for Raising a Concern and Referring. A couple of suggestions and minor changes were suggested. Members were given an opportunity to give feedback by Friday 19th October 2018, subject to any further comments, the procedures and guidance would be ratified after this date, with a view to launching them on 1st November		

	2018.		
10.	**NSAB Links to other Boards**		
	A paper around NSAB links to other boards was presented to the meeting. It showed some similarities and a further meeting has been set in November 2018. Further updates will be brought to the board if they are relevant.		
11.	**CCG GP Assurance Report**		
	Elaine Moss presented a report on CCG GP Assurance to the meeting. Elaine explained that there was a robust process around reviewing. The second part of the paper was around self-assessments and Elaine explained that a good process is in place. The board and chair were satisfied that this provided the relevant level of assurance around GPs and safeguarding.		
12.	**IICSA Update**		
	Andy Gowan presented an update to the board around IICSA. Evidence is now being heard relating to Nottinghamshire and further update will be provided in January.		
13.	**Nottinghamshire & Nottingham FGM Steering Group Update**		
	Stuart had received a paper from the Nottinghamshire and Nottingham FGM Steering Group around Zero Tolerance Motion and FGM joint Strategic Needs Assessment Recommendations. The action plan paper sets out how the FGM steering group and partner agencies of this will work to achieve the motions under the City of Zero Tolerance Motion and FGM Joint Strategic Needs Assessment Recommendations. The board fully endorsed the zero tolerance approach.		
14.	**Chair's Update**		
	Allan informed the board that he had completed the		

14.1	National Chairs Audit and he will share the results with the board when he receives them. **Action: Allan to share with the board results from the National Chairs Audit when he receives them.** Allan asked the board to consider if there organisation has plans in place regarding the potential of a Brexit deal or no deal. Members advised that they have forums in place. Safeguarding audits week taken place work ongoing. Ann Craft Trust have an Older Abuse Day on the 15th June 2019 Board Members asked to support and contact ACT if they would like to be involved.	**Allan Breeton**	**10.01.19**
15.	**Organisational Updates**		
	David Pearson informed the board that Paul McKay was leaving the authority to move to West Sussex to be Corporate Director.		
16.	**AOB and Closing Remarks**		
	Allan reminded members that the next NSAB Partnership event will take place on 20th November and encouraged members to attend and promote across their organisation.		
17.	**Close**		

Nottinghamshire SAFEGUARDING CHILDREN Board

Working in Partnership to Safeguard Children & Young People

Minutes of the

NSCB Full Board Meeting

12 December 2018

Venue: The John Fretwell Centre near Mansfield, Notts. NG19 8LL

V0.5

Nottinghamshire Safeguarding Children Board
Children, Families and Cultural Services
County Hall
West Bridgford
Nottingham
NG2 7QP
Tel No: 0115 97 73935

Nottinghamshire Safeguarding Children Board
Wednesday 12 December 2018 - Attendance List

NAME	ROLE, ORGANISATION	PRESENT	APOLOGIES	DEPUTY ATTENDED
Chris Few **(Chair)**	Independent Chair, NSCB	**Y**		
Julie Gardner **(Vice Chair)**	Associate Director for Safeguarding & Social Care, Nottinghamshire Healthcare NHS Trust	**Y**		
Colin Pettigrew	Corporate Director, Children and Young People's Services, Nottinghamshire County Council (NCC)	**Y**		
Steve Edwards	Service Director, Youth Families & Social Work, NCC	**Y**		
Marion Clay	Service Director, Education, Learning & Skills, Children and Families, NCC	**Y**		
Laurence Jones	Group Manager, Commissioning and Resources Children and Family Services, NCC	**Y**		
Joe Foley	Group Manager, Safeguarding, Assurance and Improvement group, NCC	**Y**		
Rachel Miller	Group Manager, Early Help, NCC	**Y**		
Paul Johnson	Service Director - Strategic Commissioning, Access and Safeguarding, Adult Social Care, NCC			
Kate Allen	Consultant in Public Health, Children's Integrated Commissioning Hub and Public Health, NCC			
Cathy Burke	Deputy Chief Nurse (Designated Nurse Safeguarding Adults, Children & LAC), NHS Bassetlaw Clinical Commissioning Group (CCG)	**Y**		
Val Simnett	Designated Nurse, Safeguarding Children, NHS Nottinghamshire CCGs	**Y**		
Diamond Emmanuel	Designated Doctor for Safeguarding, Nottingham University Hospitals (NUH) NHS Trust		**A**	
Nadya James	Consultant Paediatrician & Designated Doctor for Safeguarding, NUH NHS Trust		**A**	**Y**
Dr Rebecca Sands	Consultant Paediatrician & Designated Doctor for Safeguarding, Nottinghamshire County North	**Y**		
Tina Hymas-Taylor	Head of Safeguarding, Sherwood Forest Hospitals NHS Trust	**Y**		
Rick Dickinson	Acting Deputy Director of Nursing, Midwifery & Quality – Doncaster & Bassetlaw Hospitals (DBH)			
Elaine Moss	Chief Nurse & Director of Quality, NHS Newark & Sherwood and Mansfield/ Ashfield CCGs			
Nichola Bramhall	Director of Nursing and Quality, Nottingham North and East, Nottingham West and Rushcliffe CCGs			
Nicola Ryan	Interim Chief Nurse, Executive Lead Quality and Safety NHS Bassetlaw CCG			
Bella Dorman	Head of Safeguarding, NUH NHS Trust		**A**	**Y**
Maria Stanley	Ambulance Operations Manager, Safeguarding, East Midlands Ambulance Service (EMAS)		**A**	**Y**
Bushra Ismaiel	Designated Doctor for Safeguarding, DBH		**A**	
Bob Bearne	Assistant Chief Executive, D L N & R Community Rehabilitation Company Ltd	**Y**		
Nigel Hill	Head of National Probation Service, Nottinghamshire	**Y**		
Andrew Gowan	Head of Public Protection, Nottinghamshire Police	**Y**		
Clare Mayne	Service Manager, Early Intervention Team, Cafcass	**Y**		

Leanne Monger	Newark & Sherwood District Council (*District & Borough Council representative*)	**Y**		
Sue Fenton	Manager, Home Start Nottingham (*Voluntary sector representative*)	**Y**		
NSCB Officers				
Steve Baumber	Service Manager, Partnerships and Planning, Safeguarding Assurance & Improvement Group, NCC	**Y**		
Bob Ross	NSCB Development Manager, NCC	**Y**		
Trish Jordan	NSCB Training Coordinator, NCC	**Y**		
Michelle Elliott	NSCB Administrator, NCC		**A**	
Carol Fowler **(minutes)**	Administrator, NCC	**Y**		
NCC Councillor				
Tracey Taylor	NCC Lead Member with responsibility for Children's Social Care	**Y**		
Guests (and agenda item/s attended)				
Liz Byrne	Representing NUH NHS Trust			
Clare Hudson	Representing EMAS			
Bea Jackson & Holly Smitheman	Re Appendix C			
John Evans & Izzy Martin	Re Appendix F			

Agenda Item & Paper circulated	Discussion	Action
Welcome & Apologies	Chris Few welcomed everyone to the meeting. Introductions were made and apologies noted. A flyer has been tabled from the Nottinghamshire Children and Families Alliance re an event where Prof. Gill Richards, Nottingham Trent University, will present research from her book '*Working Class Girls, Education and Social Mobility….*'. Places on the 17 January 2019 event are free to all but must be booked via the NSCB training website.	
Draft Minutes of previous Full Board meeting *Appendix A*	Draft minutes of the full Board meeting, 19 September 2018, were reviewed. The minutes were agreed an accurate record of the last meeting. Actions were reviewed: [page 6] Joe Foley said that work is ongoing re linking in with the Domestic and Sexual Abuse Executive; he will update after January 2019. [page 7 - 8] Actions for Steve Baumber and Michelle Elliott have been completed.	
Executive update *Appendix B*	Julie Gardner provided a summary of the last meeting of the Executive based on the report provided and thanked members of the group for their work. No further questions/comments	
MASH Audit - understanding enquiries which result in no further action *Appendix C*	Joe introduced guests Bea Jackson and Holly Smitheman who were in attendance for this item and provided a presentation summarising the accompanying report. Of the 34% of cases audited which resulted in 'no further action' there were themes of: *mental health and well-being* (self-harm in young people and overdoses in parents/ carers - referred by hospital trusts); *harmful sexual behaviour* (most commonly referred by schools); and *domestic abuse* (referrals by GPs, EMAS, Police). Recommendations A) to I) are shown throughout and listed at the end of the report. Questions/ comments: Chris said the report shows a more nuanced picture than referrals that are just not meeting thresholds. Julie: it was a good report, which showed the complexity of the health role in the referral process. She queried whether the role of the MASH health teamshould be reviewed. She wondered if, rather than only child protection (level 4) cases, health colleagues should be involved at the beginning of the process. Val Simnett agreed there was an opportunity to review the model.. Tina Hymas-Taylor: acute hospital trust staff make referrals in difficult situations and can only give what information they have; she invited any partner to observe a Friday night shift. Becky Sands noted the acute trust referrals which were 'NFA' are not due to poor judgement. A follow up meeting with health staff has proved very useful and this identified a follow up piece of work, which can be taken	

	forward in partnership, to encourage staff to make more holistic assessments. Cathy Burke: the Board has previously discussed alternatives, for example staff first having a conversation with their agency safeguarding lead and thought there was some value in that. Laurence Jones said that in light of advances in technology there should be opportunities to provide wider access to systems amongst partners and this was a much larger piece of work. Val Simnett noted that *Connected Notts*. has an agenda to link various electronic systems. Cllr. Taylor expressed concern re the police's policy of referring all domestic abuse, if there are children, having resource implications on the MASH. Andy Gowan said that the report was well balanced and there was evidence of good decision making in the MASH. He noted that 50% of the domestic abuse cases which are 'NFA' have a repeat enquiry; and he felt this justified the police policy although he was open to it being reviewed. The information is also discussed in ENCOMPASS meetings in the MASH and shared with relevant schools. Steve Edwards: written referrals need to be detailed in order to allow the MASH to work effectively otherwise time was being wasted following up with phone calls to get further detail. The MASH's purpose is to deal with level 4 - significant harm cases; the most vulnerable children and young people and he questioned whether it was the best use of a CAMHS or Women's Aid worker to divert them to work in the MASH. The MASH Governance Group is not working as effectively as it could and there is a problem with representation. **ACTION:** It was agreed that the new safeguarding arrangements should include MASH reports from the MASH Governance Group. Chris Few: in the new arrangements, strategic partners may want to consider whether the MASH needs a refocus away from level 4 to become a wider access point. Leanne Monger said she would welcome feedback on contacts made to the MASH by district and borough council staff. Sue Fenton said she would welcome feedback on contacts made by voluntary sector staff. **ACTION**: Joe Foley said that the report recommendations will be converted into firm actions which will be monitored by the re-launched MASH Governance Group. Marion Clay: that at recent visits, there was a recognisable shift that schools have a role to play. Cathy suggested some positive examples be shared in the report. Bea agreed that they would add case studies to demonstrate good practice.	**SB** **JF**
Update on the investigations into allegations of historical abuse (Operation Equinox); and	Colin Pettigrew: he and others provided evidence to the IICSA public hearings in Oct. 2018. Learning from victims and survivors who contributed to the hearing was clear; the importance of being believed, access to therapy, access to justice, the lifelong impact on the survivors and the importance of apologies and contrition from the relevant organisations. Andy Gowan updated re the latest criminal convictions and ongoing cases.	

the Independent Inquiry into Child Sexual Abuse (IICSA) *Appendix D*	Andy Gowan presented to the Chief Constable on Monday with a recommendation that Terms of reference of Op. Equinox are extended, with increased resources, to mainstream its work and include peer-on-peer abuse and abuse of positions of trust. They plan to involve a survivor in training staff. Val Simnet felt it was striking how survivors felt they were not heard at the time and the importance of ensuring that the voice of looked after children is heard under the new safeguarding arrangements.	
Pathway to Provision update *Appendix E*	Steve Baumber updated: the majority of changes proposed in the consultation events have been incorporated into v 8 of the guidance and are outlined in the report. Cathy Burke queried whether adverse childhood experiences (ACEs) should be included in the guidance. SteveB said it was implicit throughout. Laurence suggested they include a weblink to ACEs on the new safeguarding website instead. There was Board agreement to publish version 8 Pathway to Provision.	
Refreshments Break		
Harmful Sexual Behaviour (HSB) update on the new Panel *Appendix F*	Joe Foley introduced guests Izzy Martin and John Evans who provided an update on the work of the new HSB panel and other measures intended to improve the response to HSB. Trish Jordan advised that the training team had been overwhelmed with interest for two HSB training events in Feb. 2019. Two more dates have been added in March and May 2019. Questions/comments Rachel Miller: HSB was a multi-agency issue; there should be multi-agency partners on the panel. Joe agreed that other agency partners will be invited Cllr. Taylor noted that of 30 cases, there was a cluster of nine in Mansfield. She queried if there were any common links. John said none was apparent. Joe: connections will be made if information is known. Izzy commented that one theme was not residing with parents but with grandparents. Laurence Jones commented that older data of this type does not exist; but analysis will improve as we gather more information. Andy Gowan & Joe Foley concurred that the definition of HSB [at page 1] is coherent with the police definition.	
Transfer to new Safeguarding Arrangements *Appendix G*	Steve Baumber summarised: from 1st Jan. 2019 the new arrangements will start. For three months the NSCB will work in the background, to conclude any SCRs, but cease to exist 31 March 2019. The new structure consists of: • a Strategic Leadership Group (SLG) - three safeguarding partners plus an independent scrutineer - who will meet quarterly; • the Nottinghamshire Safeguarding Children Partnership (NSCP) - 'the partnership' - a larger group who will meet three times a year;	

	• a Safeguarding Assurance and Improvement Group (SAIG) meeting quarterly; • a Learning & Workforce Development Group meeting 6 times a year (2 of which for procedures); and • Child Safeguarding Practice Review Group; frequency of these meetings will be decided by the existing SIR sub group on 16 Jan. Steve Baumber advised that dates for the new meetings were available in hard copy and that members should wait formal invites to ensure there is no confusion over attendance. Nationally there is an early adopter programme however there were only a few that had published their arrangements at this stage and therefore it was unlikely that any learning would be available before the requirement to publish. He suggested that the new arrangements could be adjusted as we learn from our own experience and that of other areas. Cathy Burke: governance of child death review/ the Child Death Overview Panel is not clear and may be moving, possibly to be led by Public Health. Bob Ross noted there was a clear shift to the Dept. of Health – with two strategic partners (not Police). Joe Foley: senior partners will be meeting in Jan. 2019 to iron out arrangements for this stream of work. Julie Gardner thanked Steve Baumber for all his work. Chris Few echoed his thanks.	
Reflection on the closure of the NSCB	This was the last NSCB full board meeting and Chris Few reflected on the last 12 years. Cathy Burke was the longest serving Board member, having been part of its predecessor, the Area Child Protection Committee. He and Julie attended their first Board meeting almost 10 years ago, in April 2009. In 2010/11 the Board developed and oversaw the safeguarding improvement programme. Some things implemented since then feel so embedded it is hard to imagine them not there. They supported the implementation of the MASH in 2012 and in 2013 took ownership of the Pathway to Provisions multi-agency guidance. The NSCB have undertaken 17 Serious Case Reviews, all of which have contributed to an improvement in safeguarding arrangements. With SCR DN11 they were one of the first LSCBs to publish a report in full. Their training provision is excellent and has gone from strength to strength. He thanked Trish, Becky Sands and the training pool; for many frontline staff it is an introduction to the work of the NSCB. Web-based CP procedures were introduced and, since 2014, multi-agency audits have become routine. It is the end of an era but there are new opportunities. He thanked Board members present and past; he thanked Julie Gardner, as vice Chair. He thanked Chairs of the sub groups, Board officers and administrative support staff. Colin Pettigrew recognised Chris' contribution over 10 years: he has led through challenging times, has encouraged learning and provided professional challenge.	

For info: Safeguarding Survey 2018 *Appendix H*
For info:Female Genital Mutilation (FGM) Annual Report *Appendix I*