NHS
Nottingham and Nottinghamshire

Integrated Care Board Meeting Agenda (Open Session)

Thursday 14 November 2024 09:00-12:00

Chappell Meeting Room, Arnold Civic Centre, NG5 6LU

"Every person enjoying their best possible health and wellbeing"

Our aims: to **improve outcomes** in population health and healthcare; **tackle inequalities** in outcomes, experiences and access; enhance **productivity and value for money**; and support broader **social and economic development**.

Our guiding principles: **prevention** is better than cure; **equity** in everything; and **integration** by default.

Our core values:

- We will be open and honest with each other.
- We will be respectful in working together.
- We will be accountable, doing what we say we will do and following through on agreed actions.
- We will challenge each other if we fall short of upholding our aims and guiding principles.
- We will work with our population and put their needs at the heart of the ICS.

	Item	Presenter	Type *(For Assurance, Decision, Discussion or Information)*	Enc.	Time
	Introductory items				
1.	Welcome, introductions and apologies	Kathy McLean	-	-	09:00
2.	Confirmation of quoracy	Kathy McLean	-	-	-
3.	Declaration and management of interests	Kathy McLean	Information	✓	-
4.	Minutes from the meeting held on: 12 September 2024	Kathy McLean	Decision	✓	-
5.	Action log and matters arising from the meetings held on: 12 September 2024	Kathy McLean	Discussion	✓	-
	Leadership and operating context				
6.	Citizen Story: Experience of autistic people and citizens with a learning disability	Rosa Waddingham	Discussion	✓	09:05
7.	Chair's Report	Kathy McLean	Information	✓	09:15
8.	Chief Executive's Report	Amanda Sullivan	Information	✓	09:20
	Strategy and partnerships				
9.	Development of the Provider Collaborative	Claire Culverhouse	Discussion	✓	09:35
10.	Clinical and Care Professional Leadership Arrangements	Dave Briggs	Discussion	✓	09:55
	Delivery and system oversight				

	Item	Presenter	Type *(For Assurance, Decision, Discussion or Information)*	Enc.	Time
11.	Assertive and Intensive Community Mental Health Care – Review and Action Plan	Maria Principe	Assurance	✓	10:10
12.	Primary Care Access Improvement Plan Update	Maria Principe	Assurance	✓	10:25
13.	Quality Report	Rosa Waddingham	Assurance	✓	10:45
14.	Service Delivery Report and Winter Plan	Maria Principe	Assurance	✓	11:00
15.	Finance Report	Marcus Pratt	Assurance	✓	11:15
	Governance				
16.	Board Assurance Framework – Biannual Update	Lucy Branson	Assurance	✓	11:30
17.	Committee Highlight Reports: • Strategic Planning and Integration Committee • Quality and People Committee • Finance and Performance Committee • Audit and Risk Committee • Remuneration and Human Resources Committee	Committee Chairs	Assurance	✓	11:45
	Information items *The following items are for information and will not be individually presented. Questions will be taken by exception.*				
18.	2024/25 Board Work Programme	-	Information	✓	-
	Closing items				
19.	Risks identified during the course of the meeting	Kathy McLean	Discussion	-	11:55
20.	Questions from the public relating to items on the agenda	Kathy McLean	-	-	-
21.	Any other business	Kathy McLean	-	-	-
	Meeting close	-	-	-	12:00

Confidential Motion:

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

2024/25 Schedule of Board Meetings:

Date and time	Venue
09 January 2025, 09:00-12:30	Rushcliffe Arena, Rugby Road, West Bridgford, NG2 7YG
13 March 2025, 09:00-12:30	Rushcliffe Arena, Rugby Road, West Bridgford, NG2 7YG

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/11/2024
Paper Title:	**Declaration and management of interests**
Paper Reference:	ICB 24 061
Report Author:	Jo Simmonds, Head of Corporate Governance
Report Sponsor:	Lucy Branson, Director of Corporate Affairs
Presenter:	Kathy McLean, Chair

Paper Type:							
For Assurance:		For Decision:		For Discussion:		For Information:	✓

Summary:

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

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

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

Recommendation(s):

The Board is asked to **note** this item for information.

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

Appendices:
Appendix A: Extract from the ICB's Register of Declared Interests for members of the Board. Appendix B: Managing Conflicts of Interests at Meetings.

Board Assurance Framework:
Not applicable to this report.

Report Previously Received By:
Not applicable to this report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Register of Declared Interests

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

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

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

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

Name	Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To	Action taken to mitigate risk
ADAMOU, Marios	Non-Executive Director	South West Yorkshire Partnership NHS Foundation Trust	Employed as a Consultant Psychiatrist	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	Marios Adamou LTD - providing educational and advisory services	Director	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Marios Adamou Ltd.
ADAMOU, Marios	Non-Executive Director	University of Huddersfield	Visiting Professor			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	Advance Occupational Healthcare Ltd.	Director	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Advance Occupational Health Ltd.

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BRIGGS, David	Medical Director	British Medical Association	Member		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Nottingham Business Improvement District (BID) - a business-led,not for profit organisation helping to champion Nottingham.	Non-Executive Chair		✓			01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by BID.
JACKSON, Stephen	Non-Executive Director	Nottingham High School	Governor		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Portland College	Governor		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Marketing Nottingham - A not for profit business and the official place marketing organisation for Nottingham City.	Non-Executive Director		✓			01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Marketing Nottingham.
JACKSON, Stephen	Non-Executive Director	Derbyshire Health United CIC - A not for profit community interest company providing a range of health service provisions.	Non-Executive Director	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by DHU CIC).

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JACKSON, Stephen	Non-Executive Director	Imperial Business Consulting Ltd - a management consultancy business, based in Leicestershire.	Joint Owner and Chief Executive Officer	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Imperial Business Consulting Ltd
JACKSON, Stephen	Non-Executive Director	Ravenshead Surgery (Abbey Medical Group)	Registered patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
JACKSON, Stephen	Non-Executive Director	Nottingham City Transport	Spouse is a Non Executive Director				✓	01/11/2023	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Nottingham Ice Centre	Spouse is a Non Executive Director				✓	01/11/2023	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Birmingham Women's and Children NHS Foundation Trust	Non-Executive Director	✓				01/10/2024	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by Birmingham Women's and Children NHS Foundation Trust.
LIM, Dr Kelvin	Primary Care Partner Member	NEMS Healthcare Ltd	Shareholder	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangement) relating to services that are currently, or could be, provided by NEMS CBS.

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LIM, Dr Kelvin	Primary Care Partner Member	Church Walk Medical Services	Shareholder	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to primary medical services
LIM, Dr Kelvin	Primary Care Partner Member	Eastwood Primary Care Centre	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from
MAJID, Ifti	Mental Health Partner Member	Nottinghamshire Healthcare NHS Foundation Trust	Chief Executive	✓				07/12/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by Nottinghamshire Healthcare NHS Trust
MAJID, Ifti	Mental Health Partner Member	NHS Confederation: BME Leaders Network	Chair		✓			07/12/2022	Present	This interest will be kept under review and specific actions determined as required.

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MAJID, Ifti	Mental Health Partner Member	NHS Confederation: Mental Health Network	Board Member and Trustee		✓			07/12/2022	Present	This interest will be kept under review and specific actions determined as required.
MAJID, Ifti	Mental Health Partner Member	Ellern Mede - provider of high intensity children and young people's eating disorder services	Spouse is Managing Director				✓	07/12/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Ellern Mede.
MAJID, Ifti	Mental Health Partner Member	Knowledge Exchange Group – provider of public sector conferencing	Member of the organisations Advisory Board				✓	01/12/2023	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by the Knowledge Exchange Group Ltd.
MCGREGOR-RILEY, Dr Victoria	Acting Director of Strategy and System Development	Sheffield Teaching Hospitals NHS Foundation Trust	Spouse employed as a consultant surgeon				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

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MCGREGOR-RILEY, Dr Victoria	Acting Director of Strategy and System Development	GP Practice in Bassetlaw	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
MCGREGOR-RILEY, Dr Victoria	Acting Director of Strategy and System Development	Managers in Partnership	Trade Union Representative (voluntary)			✓		01/09/2022	Present	This interest will be kept under review and specific actions determined as required.
MCGREGOR-RILEY, Dr Victoria	Acting Director of Strategy and System Development	Nottingham University NHS Trust (NUH)	Son employed as a Project Coordinator				✓	04/05/2023	Present	This interest will be kept under review and specific actions determined as required.

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MCLEAN, Kathy	ICB Chair	Kathy McLean Limited- Private limited company offering health related advice	Director	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning
MCLEAN, Kathy	ICB Chair	Barts Health NHS Trust (London)	Non-Executive Director	✓				01/07/2022	30/06/2024	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Barking, Havering and Redbridge University Hospitals NHS Trust	Non-Executive Director	✓				01/09/2022	30/06/2024	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS Employers	Member of the Workforce Policy Board		✓			TBC	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS Employers	Chair of the national negotiation committee for Staff and Associate Specialists on behalf of NHS Employers		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Care Quality Commission (CQC)	Occasional Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	The Public Service Consultants Ltd (Public Sector Consultancy)	Interim Chair	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by The Public Service Consultants Ltd.

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MCLEAN, Kathy	ICB Chair	Oxehealth Ltd (vision-based patient monitoring and management)	Member of the advisory board	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Oxehealth Ltd.
MCLEAN, Kathy	ICB Chair	NHS Derby and Derbyshire Integrated Care Board	Chair	✓				01/05/2024	Present	This interest will be kept under review and specific actions determined as required.
PRATT, Marcus	Acting Executive Director of Finance	British Telecom	Shareholder	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PRINCIPE, Maria	Acting Director of Delivery and Operations	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
ROBINSON, Paul	NHS Trust and NHS Foundation Trust Partner Member	Sherwood Forest Hospitals NHS Foundation Trust	Chief Executive	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangement) relating to services that are currently, or could be, provided by Sherwood Forest Hospitals NHS Foundation Trust.
SULLIVAN, Amanda	Chief Executive	Hillview Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.

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TOWLER, Jon	Non-Executive Director	Sherwood Medical Practice	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
TOWLER, Jon	Non-Executive Director	Major Oak Medical Practice, Edwinstowe	Family members are registered patients				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	The Conservation Volunteers: a national charity bringing together people to create, improve and care for green	Chair (Trustee and Director)	✓				01/12/2022	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	The Conservation Volunteers: a national charity bringing together people to create, improve and care for green spaces.	Fellow director is a senior manager at Everyturn Mental Health				✓	01/12/2022	Present	This interest will be kept under review and specific actions determined as required.
WADDINGHAM, Rosa	Director of Nursing	NHS Professionals (An NHS staff bank, owned by the Department of Health and Social Care)	Member of the Advisory Board		✓			01/09/2023	Present	This interest will be kept under review and specific actions determined as required.

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WADDINGHAM, Rosa	Director of Nursing	Florence Nightingale Foundation (FNF) (A charity supporting Nurses and Medwives to improve patient care)	Chair of the FNF Members' Advisory Group		✓			01/09/2023	Present	This interest will be kept under review and specific actions determined as required.
WADDINGHAM, Rosa	Director of Nursing	Specsavers	Son is Dispensing Manager at Specsavers, Bingham				✓	01/02/2024	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be provided by Specsavers
WILLIAMS, Melanie	Local Authority Partner Member	Nottinghamshire County Council	Corporate Director for Adult Social Care and Health	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by Nottinghamshire County Council
WILLIAMS, Melanie	Local Authority Partner Member	Orchard Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.

Name	Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To	Action taken to mitigate risk
The following individuals will be in attendance at the meeting but are not part of the Board's membership:										
BRANSON, Lucy	Director of Corporate Affairs	St George's Medical Practice	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
KING, Daniel	VCSE Alliance Chair	Nottingham Trent University	Employee	✓				06/09/2023	Present	This interest will be kept under review and specific actions determined as required.
HUBBER, Lucy	Director of Public Health, Nottingham City Council	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
NAGRA, Mandy	Interim System Delivery Director	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
VAN DICHELE, Guy	Local Authority Partner Member - Deputy	United Response National Charity for People with Learning Disabilities	Trustee	✓				15/04/2024	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be provided by United Response National Charity

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VAN DICHELE, Guy	Local Authority Partner Member - Deputy	Nottinghamshire County Council	Director	✓				15/04/2024	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by Nottinghamshire County Council

Appendix B

NHS
Nottingham and Nottinghamshire

Managing Conflicts of Interest at Meetings

1. A conflict of interest is defined as a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.
2. An individual does not need to exploit their position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur. In fact, a perception of wrongdoing, impaired judgement, or undue influence can be as detrimental as any of them actually occurring. It is important to manage these perceived conflicts in order to maintain public trust.
3. Conflicts of interest include:
    - Financial interests: where an individual may get direct financial benefits from the consequences of a commissioning decision.
    - Non-financial professional interests: where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their reputation or status or promoting their professional career.
    - Non-financial personal interests: where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit.
    - Indirect interests: where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision.
    - Loyalty interests: where decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process.

    The above categories are not exhaustive, and each situation must be considered on a case-by-case basis.
4. In advance of any formal meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals.
5. At the beginning of each formal meeting, members and others attending the meeting will be required to declare any interests that relate specifically to a

particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting.

6. The Chair of the meeting (or person presiding over the meeting) will determine how declared interests should be managed, which is likely to involve one the following actions:

    - Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to decision-making arrangements.
    - Allowing the individual to participate in the discussion, but not the decision-making process.
    - Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to decision-making arrangements.
    - Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.

Integrated Care Board (Open Session)
Unratified minutes of the meeting held on
12/09/2024 09:00-11:30
Rushcliffe Arena, Rugby Road, West Bridgford

Members present:

Dr Kathy McLean	Chair
Professor Marios Adamou	Non-Executive Director
Dr Dave Briggs	Medical Director
Stephen Jackson	Non-Executive Director
Dr Kelvin Lim	Primary Care Partner Member
Ifti Majid	NHS Trust/Foundation Trust Partner Member
Caroline Maley	Non-Executive Director
Marcus Pratt	Acting Director of Finance
Amanda Sullivan	Chief Executive
Jon Towler	Non-Executive Director
Rosa Waddingham	Director of Nursing

In attendance:

Lucy Branson	Director of Corporate Affairs
Victoria McGregor Riley	Commissioning Delivery Director (deputising for Lucy Dadge)
Mandy Nagra	Interim Director of Service Delivery (from item ICB 24 052)
Guy Van Dichele	Interim Director of Adult Services, Nottinghamshire County Council (deputising for Melanie Williams)
Sue Wass	Corporate Governance Officer (minutes)

Apologies:

Lucy Dadge	Director of Integration
Paul Robinson	NHS Trust/Foundation Trust Partner Member
Melanie Williams	Local Authority Partner Member

Cumulative Record of Members' Attendance (2023/24)

Name	Possible	Actual	Name	Possible	Actual
Kathy McLean	3	3	Stuart Poynor[1]	1	1
Marios Adamou	3	3	Marcus Pratt[2]	2	1
Dave Briggs	3	3	Paul Robinson	3	1
Lucy Dadge	3	1	Amanda Sullivan	3	3
Stephen Jackson	3	3	Jon Towler	3	3
Kelvin Lim	3	3	Catherine Underwood[1]	1	1
Ifti Majid	3	2	Rosa Waddingham	3	3
Caroline Maley	3	2	Melanie Williams	3	1

1 – Board membership ceased June 2024
2 – Board membership commenced July 2024

Introductory items

ICB 24 042 Welcome, introductions and apologies

The Chair welcomed members to the meeting of the Board. A round of introductions was undertaken and apologies noted as above.

ICB 24 043 Confirmation of quoracy

The meeting was confirmed as quorate.

ICB 24 044 Declaration and management of interests

No interests were declared in relation to any item on the agenda.

The Chair reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

ICB 24 045 Minutes from the meeting held on: 11 July 2024

The minutes were agreed as an accurate record of the discussions.

ICB 24 046 Action log and matters arising from the meeting held on: 11 July 2024

All actions were noted as completed.

As a matter arising, the Chair noted that a question from a member of the public had been raised relating to the minutes of the last meeting regarding patient stories, specifically the question was '*In the July minutes it states that Patient Stories will be reinstated from the September Board meeting, but I cannot see that on the agenda. Can you comment please?'*

In response, it was noted that there was not a separate agenda item for a patient story. The approach was to incorporate citizen stories, experience, and engagement within relevant reports. For today's meeting, this was incorporated into the agenda item on the Joint Forward Plan and related to the ICB's prevention priority. This provided a citizen's view of the Newark Best Years Hub and feedback received at a Diabetes Health Checks event in Ashfield South. Feedback from a Nottinghamshire carer relating to a pilot of Dementia Specialist Admiral Nurses was also included within this month's Chief Executive's Report, which set out the ICB's achievements during quarter one of 2024/25. Nevertheless, the ICB would continue to review the approach to citizen's stories to make sure they added value to

future agenda items and continued to set the context for the work of the Board.

Leadership

ICB 24 047 Chair's Report

Kathy McLean highlighted the following points from her report:

a) Noting the tragic events in Southport and the consequential riots in recent months, Kathy reiterated the ICB's zero tolerance of racism towards, or from, colleagues and patients. Referencing the development session that the Board had held in April on the Race Health Inequalities Maturity Matrix, it was noted that all Board members had equality objectives that related to setting a culture that did not tolerate discrimination of any description.

b) Discussing the headlines from Lord Darzi's rapid investigation of the state of the NHS that had been commissioned by the Government, and which had been released a few hours prior to the meeting, it was clear that the ten-year health plan, to be published in Spring 2025, would set national priorities for the coming years. It was encouraging that several headlines within the report advocated solutions already high on the ICB's priorities, such as prevention and moving care into the community. Further analysis would be available at the next meeting.

c) There was clear messaging from the Government that there would be no additional financial input in the short term. Hence the focus would be to continue to ensure that the NHS system was brought into financial balance within available resources. Colleagues from all organisations continued to work well together to maintain and improve the quality of services.

d) Visiting colleagues on the front line of services provided an excellent opportunity to help understand what was happening at a local level. Meeting teams at Collingham Primary Care Network and the School of Artisan Food in Welbeck had been inspirational.

e) Following NHS England's approval of the Board's revised membership and the recent departure of two Executive Directors, interim executive appointments of Marcus Pratt, Victoria-McGregor-Riley and Maria Principe had been made.

f) Further amendments to the ICB's Constitution had been made to reflect NHS England's publication of a revised model constitution and updated statutory governance guidance for ICBs. These were set out within the report; however, members were asked to specifically note

the introduction of the role of Senior Non-Executive member, which Jon Towler had been appointed to fulfil alongside his Vice-Chair role.

g) A number of proposed revisions had been made to Committee terms of reference to reflect changes in membership in line with the introduction of new executive roles and to enact the outcome of the recent committee effectiveness review. The proposed changes had been incorporated within an updated ICB Governance Handbook that was shared with the Board as part of the papers pack. Interim committee chairing arrangements would also be enacted from 1 October, prior to new Non-Executive Directors being appointed.

The Board:

- **Noted** the Chair's report for information.
- **Approved** the ICB's updated Governance Handbook.
- **Approved** the appointment of interim Committee Chairs.

ICB 24 048 Chief Executive's Report

Amanda Sullivan highlighted the following points from her report:

a) Building on the earlier discussion regarding the zero tolerance approach to racism in the NHS, Amanda noted that all leaders of the Integrated Care System (ICS) had signed a statement of solidarity against racism.

b) Over the summer NHS England had completed its narrative assessment of the ICB. It had concluded that the ICB had demonstrated effective leadership and a strong collaborative approach, having strengths in areas such as health inequalities and shared decision making. It had noted challenges relating to several areas, including urgent and emergency care, learning disabilities and autism services, and the system financial position. Overall, it was considered a fair assessment.

c) Since the last meeting, the Care Quality Commission (CQC) had published its final report into the care and treatment of Valdo Calocane by Nottinghamshire Healthcare NHS Foundation Trust (NHT). The report clearly indicated several areas for improvement for the Trust. NHS England had subsequently issued further national guidance, which included not discharging people if they did not attend appointments and the sharing of risk assessments with partners and patients' families. The ICB continued to support the oversight of improvements needed at NHT.

d) The ICB continued to engage with General Practice during their taking of collective action over the imposition of the 2024/25 GP contract. This was an ongoing situation, which was being monitored closely.

e) Despite current challenges, there had been positive progress in several areas and a new quarterly report captured these achievements and showcased the excellent work that was taking place in Nottingham and Nottinghamshire.

f) The report also referenced the work undertaken by the vaccination programmes, as part of the preparations for winter. A new emergency preparedness, resilience, and response (EPRR) exercise programme had also been released by NHS England to ensure that all organisations were well prepared to respond to a wide range of emergency scenarios.

The following points were made in discussion:

g) With reference to the section of the report that detailed further service delegations from NHS England, a query was raised on the capacity of the ICB to absorb the governance and oversight of the services. In response it was noted that governance of the new delegation would be through the established East Midlands Joint Committee arrangements. The ICB was currently working through the detail of the services to understand the opportunities they may present for service improvement. Board members emphasised the need to ensure all delegated services contributed to the transformation of services.

h) Discussing the report from the NHS Confederation regarding progress on the Hewitt Review, and specifically the comment that pace had been slower than expected on work to define and measure preventative action, a query was raised asking whether anything could be done locally to progress this. It was noted that the work of the System Analytics and Intelligence Unit (SAIU) supported the Nottingham and Nottinghamshire system to be well-placed to make progress in this area. It was agreed that further discussion on prevention, looking at current arrangements and scaling opportunities, would be progressed outside of the meeting, with Dave Briggs taking the lead.

i) Ifti Majid asked the Board to note that the Care Quality Commission's (CQC) Section 48 Review on the care and treatment of Valdo Calocane by NHT had been a review of available evidence and that staff had not been interviewed; this should not be confused with the Independent Homicide Review. Recommendations from the CQC's

report had been incorporated into the Trust's Improvement Plan. An offer was made to have a more in-depth discussion with the Board on the tensions between restrictive practices versus public protection and the consequential effects on clinical practice. This was welcomed and would be incorporated into the October Board seminar, which would be focused on mental health services. In discussion it was agreed that the seminar would also examine learning disability and autism inpatient performance metrics.

j) Regarding the section in Amanda's report noting the publication of the interim report into the operational effectiveness of the CQC, Ifti asked the Board to note that NHT's recent experience of working with the CQC had been extremely positive. It was noted that the final report from Dr Penny Dash's review was expected in October.

The Board **noted** the Chief Executive's Report for information.

Action: Dave Briggs to present an update on current arrangements for preventative care to the Strategic Planning and Integration Committee, alongside an options appraisal for scaling up arrangements. The output of this work to then be incorporated into the annual refresh of the Joint Forward Plan.

Strategy and partnerships

ICB 24 049 **NHS Nottingham and Nottinghamshire Joint Forward Plan: Delivery Update**

Victoria McGregor Riley presented the item and highlighted the following points:

a) The report provided the first progress update for 2024/25 on delivery of the Joint Forward Plan (JFP), with a focus on four clinical priority areas: prevention; proactive management of long-term conditions and frailty; navigation and flow to reduce emergency pressures in physical and mental health settings; and timely access and early diagnosis for cancer and elective care.

b) A JFP Delivery Group had been established to oversee delivery of outcomes across all workstreams, focusing on collective ownership of oversight and delivery.

c) Key areas highlighted in the report were the earlier identification of hypertension diagnosis to mitigate the risk of cardiovascular disease within the ICB's patient population; the development of targeted case findings specifically focused on population health needs, for example,

diabetes; and the Best Years Hub, which was a good example of an intervention that was not medically driven.

d) Risks to the continued progress of the JFP were highlighted, with particular attention being drawn to the challenging and complex financial and operating environment, which may have a short-term impact on progress with improving outcomes.

The following points were made in discussion:

e) Members noted that it was helpful to see an assessment of progress to date and welcomed the work that had been undertaken to improve the monitoring and oversight of delivery.

f) Noting the rise in demand for children and young people's mental health services, members queried whether this was also a priority. It was noted that mapping of early years mental health services was currently being undertaken and future plans may include the establishment of a Children and Young People's Transformation Board. This was an area that was wider in scope than purely healthcare provision and there was a need to take a holistic view and work closely with partners.

g) Members noted how the early diagnosis of hypertension within deprived communities was having a meaningful impact, with the challenge to ensure that good practice and learning was taken into other areas.

h) Discussing how the financial challenge posed a considerable risk to delivery of the JFP, members noted that the Government's ten-year health plan may provide a clearer indication of investment priorities.

i) In the short term, it was noted that there remained an imperative to continue to challenge clinical practice to examine historical provision, for example over-medicalisation. There was also a need to shift resource to areas that would have the greatest impact on health inequalities and outcomes.

j) Noting that the ICB was not able to invest in the Health Inequalities and Innovation Fund (HIIF) in this financial year, members challenged the ICB on whether it was possible to shift significant resource towards prevention activity. It was noted that the HIIF was not the only area of activity on the prevention agenda. Furthermore, the ambition in the JFP was as much about creating synergies and pooling collective resources, as it was setting investment priorities.

k) Discussing how to ensure priorities were clearly communicated, it was noted that it would be helpful to have a stocktake of the progress

of the wider system. It was noted that the Integrated Care Partnership would be best placed to oversee progress within the wider system.

l) In conclusion, the Chair noted that in these challenging times it was natural for organisations to retrench and lose the wider benefits of integration. This should continue to be challenged relentlessly.

The Board **noted** progress on delivery of the NHS Joint Forward Plan.

Delivery and system oversight

ICB 24 050 Nottingham and Nottinghamshire Five Year ICS People Plan

Rosa Waddingham presented the item and highlighted the following points:

a) The ICB was responsible for developing robust arrangements with partners to support a 'one workforce' approach by leading system development and implementation of the ICS People Plan.

b) Predecessor organisations to the ICB had had a People Strategy, a People Plan 2019-2024 and a People Board that provided oversight and assurance. The refreshed ICS People Plan being presented built from this early work and incorporated various additional national people and planning requirements.

c) A one-year Delivery Plan was appended to the report for information, the progress of which would be overseen by the Quality and People Committee.

d) The ICS People Plan was distinct from the system workforce plan, also discussed within the report, which was financially driven, linked to the pay bill, and formed part of the annual operational planning process.

The following points were made in discussion:

e) The Chair noted that the Plan should define what the system wanted the health and care workforce to look like in five years' time, which would provide a goal to work towards. It was noted that all transformation programmes within the system were being asked to identify their future workforce requirements, which will be brought together to articulate this.

f) Members also fed back that the Plan, as currently written, omitted some crucial information. In particular, it was felt that the Plan would benefit from further explanation of why the Plan was needed and

include a clear description of how patients and communities would benefit from its delivery.

g) Members unanimously supported the principles within the Plan as a statement of ambition but noted that there needed to be much more detail underpinning these, in terms of actions, measures of success, resourcing, and an assessment of risk.

h) Members stressed that the Plan needed to be more radical, with a clear vision for the future.

i) It was agreed that the Executive would develop the Plan further, taking into account national policy directives, local need, and the comments of Board members. It should also further examine and quantify workforce needs. A more detailed Plan would be presented to a future Board meeting following scrutiny by the Quality and People Committee.

The Board **noted** the current version of the Nottingham and Nottinghamshire Five Year ICS People Plan, having discussed further developments that were required prior to its approval.

Action: Rosa Waddingham to present an updated ICS People Plan to the January 2025 meeting of the Quality and People Committee and subsequently to the Board for approval in March 2025.

ICB 24 051 Quality Report

Rosa Waddingham presented the item and highlighted the following points:

a) The report provided a summary of compliance against quality improvements required for 2024/25, and the actions and recovery timeframes for those targets currently off track.

b) A high level of oversight continued to be maintained as NHT continued to progress a comprehensive and complex programme of improvement work to address identified quality and safety improvements. The ‘safe now’ safety huddles had provided a higher level of oversight and visibility of issues. Although some progress was being made, it was a mixed picture, and the Quality and People Committee would be undertaking a deep dive review at its next meeting.

c) Maternity care at Nottingham University Hospitals NHS Trust (NUH) remained a focus. A series of insight visits had been scheduled, which would also examine the urgent and emergency care pathway at the Trust as part of winter planning preparations.

d) Focus within Sherwood Forest Hospitals NHS Foundation Trust (SFH) was on improvements regarding sepsis diagnosis and the CQC had recently inspected the Trust on this issue.

e) Ongoing risks remained around the challenging target for learning disability and autism adult inpatient numbers. Several issues were impacting on performance, including an inability to commission alternatives to admissions, local authority frameworks to secure community placements, and overall patient flow. A robust process had been developed to attempt to resolve these issues.

f) Local Maternity and Neonatal System services remained under enhanced surveillance; however, an independent maternity senior advocate was now in place to support families who had experienced issues with their care. The Maternity Voices Partnership had also been strengthened.

g) The Board was asked to note that revised national targets, issued over the summer, would make infection, prevention and control performance look much improved.

The following points were made in discussion:

h) Marios Adamou, Chair of the Quality and People Committee, asked the Board to note that the Committee had continued to take limited assurance from the Quality Oversight Report regarding the effectiveness and the impact of actions being taken to improve the quality and safety of services.

i) In response to a question about the absence of a continuous improvement strategy at SFH, and whether this should be cause for concern, it was noted that the ICB's Quality Team would be checking whether the Trust's response to escalating issues was appropriate before making a judgement. An update on findings would be provided in the next quality report to the Board.

j) Discussing the issues relating to learning disability and autism adult inpatient numbers, members queried whether there was effective partnership working with local authorities. It was noted that NHS cost thresholds made negotiation difficult. There were also issues on how partners worked together on discharge and flow. It was noted that these issues would be raised at the October Board seminar, which would have a focus on mental health services.

k) Regarding issues within Nottingham CityCare Partnership, members noted that the implementation of caseload capping had had an adverse impact on GP services. It was noted that this had now ceased, and the organisation was now able to work within activity levels and was meeting district nursing requirements. Enhanced

oversight of CityCare services would continue to ensure sustained improvements.

The Board **noted** the report.

Action: Rosa Waddingham to provide an update on the outcome of quality visits to SFH within the next quality assurance reports to the Quality and People Committee and the Board.

At this point Mandy Nagra joined the meeting.

ICB 24 052 Service Delivery Report

Mandy Nagra presented the item and highlighted the following points:

a) The report provided a summary of compliance against targets required for 2024/25, and the actions and recovery timeframes for those targets currently off track.

b) There were several areas of improved performance. Improvements had been seen in the four-hour wait performance at NUH, with the Trust achieving local plans from April to July. Ambulance turnover times had also continued to improve. There were several areas where the NHS system continued to benchmark well both regionally and nationally, including community waits, the cancer faster diagnosis standard and mental health metrics.

c) Despite some improvement, performance was still not at a level that patients should expect; therefore, Nottingham and Nottinghamshire had moved into Tier two NHS England oversight arrangements for urgent and emergency care during August, which ensured direct oversight and support from NHS England. This support would help ensure sustainable improvements in performance ahead of winter.

d) Diagnostic waiting times continued to be below planned levels, and NHS England had visited the NHS system to identify areas for additional support. It was imperative to address diagnostic performance issues, as it impacted on cancer treatments and elective waiting times.

e) Delivery of the 65-week waiting time target continued to be a challenge; however, good progress was being made in most specialities. The volume of long waiters in Ear Nose and Throat services at NUH was the largest challenge and focus was on actions to reduce the backlog.

The following points were made in discussion:

f) Stephen Jackson, Chair of the Finance and Performance Committee, asked the Board to note that the Committee had taken partial assurance from the improved performance trajectory in several areas. The Committee had supported the move to begin to plan for the next financial year, with operational delivery aligned to financial planning.

g) Members asked for an assessment of how embedded the improvements in performance were. It was noted that not all improvements had been embedded and there were still some underlying challenges to address. Work was intensive, requiring continued focus on identifying and challenging operational inefficiencies.

The Board **noted** the report.

ICB 24 053 Finance Report

Marcus Pratt presented the item and highlighted the following points:

a) At the end of month four, the NHS system reported a deficit position of £70 million, representing an adverse variance of £2 million.

b) The forecast remained in line with the planned deficit of £100 million.

c) Additional funding would be made available to mitigate the impact of the industrial action and fund the national Agenda for Change pay award. There had been a clear message that no further funding would be available, and the NHS system was required to deliver its financial plan.

d) There was considerable risk in the plan, particularly around the delivery of the required efficiency target of £251 million, and tighter grip and control measures and governance arrangements remained in place to support delivery.

The following points were made in discussion:

e) Stephen Jackson, Chair of the Finance and Performance Committee, asked the Board to note that although focus needed to remain on this financial year, it was equally important that the Committee should now begin to oversee the development of next year’s plan, which needed to address the deficit in full. This was scheduled for consideration at the Committee’s the forthcoming meeting.

f) Members went on to discuss the risks to the plan in the context of winter pressures and the resilience of staff. It was noted that the embedment of efficiencies over the next few months would be crucial.

The Board **noted** the report.

Governance

ICB 24 054 Committee Highlight Reports

The report presented an overview of the work of the Board's committees since its last meeting in July 2024; it aimed to provide assurance that the committees were effectively discharging their delegated duties and included assessments of the levels of assurance the committees had gained from their work during the period.

The Chair noted that updates from committee chairs had already been provided during related discussions under items ICB 24 051, ICB 24 052 and ICB 24 053. Further updates were invited by exception and no other points were raised.

The Board **noted** the reports.

Information items

ICB 24 055 2024/25 Board Work Programme

This item was received for information.

Closing items

ICB 24 056 Risks identified during the course of the meeting

No new risks were highlighted.

ICB 24 057 Questions from the public relating to items on the agenda

One question had been received, which had been discussed under item ICB 24 046.

ICB 24 058 Any other business

Noting that this was the last meeting for two members, Carline Maley and Lucy Dadge, on behalf of the Board, the Chair thanked them both for their

valuable contributions to the NHS over many years and in various different roles.

There was no other business, and the meeting was closed.

Date and time of next Board meeting held in public: 14 November 2024 at 09:00 (Civic Centre)

NHS
Nottingham and Nottinghamshire

ACTION LOG from the Integrated Care Board meeting held on 12/09/2024

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Closed – action completed	11.07.2024	ICB 24 028: Chief Executive's Report	To present to the September meeting of the Quality and People Committee the outcome of a review across NHS system partners to ensure high standards of quality of care within pressurised services.	Rosa Waddingham	14.11.2024	Presented to the 18 September meeting of the Quality and People Committee – see Committee Highlight Report at agenda item 17.
Open – On track	12.09.2024	ICB 24 048: Chief Executive's Report	To present an update on current arrangements for preventative care to the Strategic Planning and Integration Committee, alongside an options appraisal for scaling up arrangements. The output of this work to then be incorporated into the annual refresh of the Joint Forward Plan.	Dave Briggs	05.12.2024	Not yet due – scheduled for presentation at the 5 December meeting of the Strategic Planning and Integration Committee.
Open – On track	12.09.2024	ICB 24 050: ICS People Plan	To present an updated ICS People Plan to the January 2025 meeting of the Quality and People Committee and subsequently to the Board for approval in March 2025	Rosa Waddingham	13.03.2025	Not yet due – scheduled for presentation at the 15 January meeting of the Quality and People Committee and the 13

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
						March meeting of the Board.
Closed – action completed	12.09.2024	ICB 24 051: Quality Report	To provide an update on the outcome of quality visits to SFH within the next quality assurance reports to the Quality and People Committee and the Board.	Rosa Waddingham	14.11.2024	Presented to the 16 October meeting of the Quality and People Committee – see Committee Highlight Report at agenda item 17. Update also included in the Quality Report at agenda item 13.

Key:

Closed – Action completed or no longer required	Open – Off track (may not be achieved by expected date of completion)
Open – On track (to be achieved by expected date of completion)	Open – Off track (has not been achieved by expected date of completion)

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/11/2024
Paper Title:	**Citizen Story: Experience of autistic people and citizens with a learning disability and how this informs reasonable adjustment, service delivery and patient outcomes**
Paper Reference:	ICB 24 064
Report Author:	Carol Raaff, Head of Professional Standards and Leadership, Charlotte Reading, Head of Learning Disabilities and Autism Transformation and Commissioning Fiona Johnson, Oliver McGowan Training Lead Trainer
Executive Lead:	Rosa Waddingham, Director of Nursing
Presenter:	Rosa Waddingham, Director of Nursing

Paper Type:							
For Assurance:		For Decision:		For Discussion:	✓	For Information:	

Summary:

Delivering a one-size-fits-all care model is ineffective. Reasonable adjustments and personalisation place the person at the centre of care, focuses on what is important to them and shapes how best to deliver the care that they need.

One of the core aims of the Nottingham and Nottinghamshire Integrated Care Strategy (2023-27) addresses inequalities, with the principle that there is equity in everything. Autistic people and people with learning disabilities experience significant health inequalities, linked to barriers in accessing appropriate service provision. The NHS Joint Forward Plan identifies the need to address the health and support needs of autistic people and people with learning disabilities and to ensure that there is adequate community provision to avoid inappropriate hospital admissions.

In some cases, not listening to our citizens can cause harm. Oliver McGowan from Bristol, died after being given an anti-psychotic drug he was allergic to, despite repeated warnings from his parents. Oliver McGowan's family firmly believe that they were not listened to and that this directly contributed to his death. Primary legislation was introduced on 1 July 2022, requiring all health and care staff working in CQC-registered organisations to undertake mandatory training on learning disability and autism. Along with other ICBs, Nottingham and Nottinghamshire ICB has taken the decision to also include their staff in this essential training in order to reduce health inequalities and to support service improvements to better health outcomes.

This report contains three Nottingham and Nottinghamshire citizen stories – Hannah, who is autistic, and Shimara and Lizzie, who have learning disabilities. It describes the impact and harm inflicted when individual needs are not appropriately accounted for and highlights the power of reasonable adjustments in transforming outcomes. Lizzie and Shimara also describe what it means to them being Oliver McGowan co-trainers.

Recommendation(s):

The Board is asked to **discuss** the citizen stories shared within this report.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	The paper aims to provide insight into how people with a learning disability and autistic people experience services, why Oliver's Training is important and how it could improve care provision and engagement with health and care being delivered.
Tackle inequalities in outcomes, experience, and access	Improved access to and engagement with health and care services can lead to reduced health inequalities, improved experience, and better outcomes. People with learning disabilities die 20 years younger than the general population and autistic people die 16 years younger than the general population. This is due to barriers in accessing services and getting the services they need. People with learning disabilities are more likely to experience some physical health conditions, such as respiratory, coronary, and gastric conditions and mental health problems. Autistic people are more likely to experience mental health problems and experience suicidal ideation than the general population.
Enhance productivity and value for money	Reasonable adjustments and providing appropriate and personalised adaptions to care can lead to better utilisation of resources. Evidence demonstrates that this leads to a reduced need for hospitalised care.
Help the NHS support broader social and economic development	Working with self-advocacy groups to employ (and pay) local Oliver McGowan co-trainers will improve partnerships with relevant voluntary organisations and the lives of individual co-trainers.

Appendices:
Appendix A: A life turned upside down at 10: my journey to being 18 Appendix B: Stories from two Oliver McGowan Training co-trainers

Board Assurance Framework:
Not applicable.

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No, but the item does contain information about personal lives. Written consent from the individuals, their support worker and the self-advocacy group has been obtained.

Experience of autistic people and citizens with a learning disability and how this informs reasonable adjustment, service delivery and patient outcomes

1. All three citizens mentioned in this paper live in Nottingham and Nottinghamshire. Lizzie has had experiences of care services in another system as well as those provided in Nottingham and Nottinghamshire.

Introducing Hannah

2. Hannah is 21. She enjoys crafting, nature, listening to audio books, watching TV series and films, and listening to music. Hannah struggles with many aspects of daily life including eating, personal care, mobility, and she has severe travel sickness. Her full story is outlined in Appendix A.
3. When she was ten years old, she ran up the garden steps and fell over, scaped her knees, arms and hands and it caused a constant burning sensation in her foot. This became unbearable when using the shower. This led to walking difficulties and needing physiotherapy but Hannah continued to experience constant pain in her feet. In addition, Hannah experiences constant pain in her abdomen as a result of an appendectomy when she was 12 years old. It led to depression and weight loss and spending 11 months in a mental health hospital.

What it was like in hospital

4. Hannah felt that none of the treatments in hospital worked and that there was a lack of understanding. Hannah thought “If these people are experts, why can’t they help? Am I just too broken, too different?”
5. “I had nightmares for years after I came out. To this day, if I eat with a group of people, I still see the hospital dining room and I don’t want to eat…When I finally got out, I was worse than when I went in. Just as sick, just as much pain. If anything, everything was worse. The only positives were my diagnoses of autism, Chronic Regional Pain Disorder, Somatisation Disorder and Anxiety.”

6. “I made more progress at home than in hospital by doing it our way. Doctors have treatments that work 99 per cent of the time, but I fall into that 1 per cent…”

7. Hannah experienced more stays in an acute hospital due to weight loss and had to be fed through a nasogastric tube, which were traumatic for her and triggered the thoughts and feelings Hannah had experienced as a 12-year-old.

The impact of reasonable adjustments and personalised care

8. Hannah spends almost all her time in her bedroom, which has now been moved downstairs alongside a downstairs wet room so that Hannah can feel part of the family. Hannah has identified the support she needs to keep herself well and receives a personal budget through the Nottinghamshire County Council and a Personal Health Budget through the ICB to access Center Parcs three times a year. Whilst Hannah has had to experience short acute hospital stays due to her physical health and weight loss, she has not had a mental health hospital admission. She has also received funding for a wheelchair adaptor that allows her to experience more mobility when out walking her dog, Summer.

9. “The only time I get out is to go to Center Parcs…The whole of Center Parcs screams life. Look at me I’m alive, I’m going, I’m changing, look at me.”

10. In 2023, she weighed 33.4 to 36.1kg, giving her a BMI of 15 to 16.2kg.m^{-2}. She has to force herself to eat and drink but she remains underweight, under threat of having to be readmitted if she loses any more. She does not want to be in hospital.

11. Hannah is working with the sensory occupational therapist to increase her sensory exposure in a controlled and managed way and wants to work with professionals to find solutions that help her.

12. She is receiving therapy around her avoidant restrictive food intake disorder from a therapist specialised in eating disorders and autism. The therapist is working at Hannah’s pace and has offered flexible appointments online and at Center Parcs.

13. Hannah’s General Practitioner has prescribed anti-sickness injections to help with her travel sickness so that Hannah can obtain the maximum benefit from her stays at Center Parcs.

14. Hannah is now starting to go outside for short walks near her home, in the evenings when there are less people around.

Introducing Lizzie and Shimara

15. Lizzie has a learning disability. Lizzie used to self-harm and put soil in her cuts, which led to hospitalisation. She did not feel listened to by the medical teams around her and this resulted in being aggressive and needing to be medicated for her behaviour.
16. Shimara has a learning disability but she has an opinion and wants to be asked. “People have made assumptions about me, made choices without asking me. When I left Primary school, it was decided that I was going to Special School. I wasn’t asked for my opinion. I wanted to feel “normal” and stay with my friends. I was unhappy and put my mask on. The only positives were holidays and dancing which was stopped. If I had gone to mainstream school, I would have got my Level 2 in Maths and English. I am now 25 and studying Maths and English to reach my dream job of working in school. My friends at 25 are settled in jobs, careers. I fell into the cracks…” “…people have judged me and said I can’t do things when I CAN. I just need more time to help me process different information.”
17. In her annual check, the GP talked to her like a small child and talked over her. It made her feel angry.
18. More information about Lizzie and Shimara can be found in Appendix B.

Getting involved in Oliver’s Training and its impact so far

19. Oliver McGowan Training is mandatory training for all staff working in CQC-registered organisations. It was brought into law as part of an amendment to the Health and Social Care Act 2022. The training has been co-produced and is co-delivered by experts with lived experience of learning disability and an autistic person. The purpose of the training is to raise awareness of the need for reasonable adjustments and personalised care to enable genuine equity for the learning disabled and autistic community. The ICB is also being trained and leading the roll-out of the training for the ICS.
20. Both Lizzie and Shimara were attracted to the training because of their desire to improve the understanding of health and care staff and care given to other people like them.

21. For Shimara, the training has given her confidence to pursue an ambition to be a teacher. “It gives [her] a chance to be a 25-year-old.”

22. For Lizzie, this is her first job and she now knows that she can hold down a job and enjoy it. She feels more like an adult now. She has a bank account and money. She is able to do think herself more and is more independent. She feels better about herself.

How Oliver’s Training is being rolled out across the ICB and the ICS

23. The Chief Nurses from across the ICS directed the ICB to develop, agree and conduct a pilot for health (including primary care) and social care in order to test the infrastructure required to deliver the training and to inform an options appraisal for wider roll out of the training. The pilot programme is being led by the Quality Team with the Head of Professional Standards and Leadership and the Assistant Director of Nursing, Quality Improvement Programmes and Leadership leading on the development.

24. A system-wide Steering Group was established in 2023 to shape decisions needed to develop the pilot and future roll-out and to provide financial oversight. The Group has stakeholder representatives from across health and social care partner organisations, with key leads from learning disabilities and autism specialities and workforce. Oversight was provided by the ICS Learning Disabilities and Autism Executive Board. While the Board continues to receive updates, governance moved to the People and Culture Steering Group on 1 October 2024 to facilitate the programme’s transition to business as usual.

25. NHS England key performance indicators are linked to developing the necessary infrastructure to train the NHS workforce over the next three years. The number of NHS staff in Nottingham and Nottinghamshire who need to be trained is approximately 42,500. The ICB, along with the Steering Group, considers it essential that social care colleagues are included in the roll-out. Funding to train social care staff has not yet been identified and this risk has been raised at system level.

26. The programme will not achieve the NHS England milestone key performance indicator of delivering the Tier Two (the more detailed learning for staff with responsibility for providing care) training to a third of eligible NHS staff in 2024/25 but will have trained additional social care staff not included in the key performance indicators. We have created enough Tier One (for staff who

require a general understanding of the support required) training capacity created to train one third of the NHS eligible workforce but meeting this key performance indicator will depend on appropriate organisational drivers. However, progress is positive with some organisations (most notably Nottinghamshire Healthcare Trust) significantly improving Tier One training uptake.

27. There has been significant progress over quarter two, which has enabled Tier Two delivery to start. However, it has taken longer than anticipated to build the infrastructure for Oliver's Training. We will start 2025/26 in a stronger position but effective maturity into business as usual, and meeting the KPIs will require partnership working and collective prioritisation of the training.

28. The next piece of work is for organisations to embed the learning to maximise the training impact.

Potential impact of mandatory learning disability and autism training

29. Oliver's Training involves people with a lived experience of autism and learning disabilities, drawing on their stories and is a starting point to reduce harm, improve adjusted care, and reduce health inequalities.

30. It is costly to deliver and for staff to access but this needs to be balanced against the costs of higher tiers of care, such as hospital, when community provision is not meeting needs.

31. This sort of learning disability and autism training has the potential to transform the way care is delivered and the effectiveness of interventions and to improve health outcomes.

32. The training is expected to have an impact on the number of avoidable deaths due to physical health conditions and death by suicide and close links will be made with the Learning from the Life and Death Reviews for people with Learning Disabilities and Autistic people (LeDeR) to understand how the training is making a difference.

Appendix A: A life turned upside down at 10: my journey to being 18 – Hannah Greensmith

Editorial comment

The format of this paper differs from other *GAP* papers in that it takes the form of an autobiographical story. It is written by Hannah who is 18 years old and autistic. Although mostly confined to her bedroom, she maintains hopes of regaining enough health to pursue her dreams. She wrote this as part of a fundraising campaign to enable her to have an extended stay at Center Parcs, a place she loves and where she feels she could start to move forward again into her hoped for future. She writes vividly about what she was like and her passions before she became ill, following a fall in the garden aged ten. Her story illustrates how hospital admissions and interventions can sometimes exacerbate situations, leading to serious consequences for emotional and physical wellbeing.

Hannah describes her parents as her superheroes and as the people who have helped her the most. The lessons within her story are to really listen with an open mind to children and their parents; not to go on doing things that aren't working, even if they usually do work for other people, and that if a person has a strongly held belief as to what might help them, even if it is outside the usual provision offered, to give it genuine consideration.

Note: The Editor has put in some headings as signposts to Hannah's story.

Introduction

Hi, you don't know me, and I don't know you and that in my opinion isn't right. You are fundraising for me, yet don't know me. I want to change that. I have to admit, I have no clue how to start this, so I'm going to use a technique I learnt in a poetry club at my secondary school; that's not to think and just write what you feel… let it go wherever it goes. I'm sure I will go off topic, if that's even possible to go off topic when talking about oneself, but I guess that is also for you to decide. So how can I start telling you about myself?

Let's start with, I love stories and books: action, romance, historical, mystery, detective, thriller, sci fi, fantasy, young adult fiction, poems, plays, dystopian, horror, fairy tales, classics, retellings and modern ones. Give me a book and I'll read it, basically. Well, at least, that's how it used to be. I get dizzy trying to read now. I can't focus on the words and as someone who devours books, that, more than anything I've ever read, is a tragedy. The silver lining is audiobooks. There are so many out there, such a range and so many to listen to. They connect me to my past, whether its Dad reading Rainbow Fairy books when I was small, or Grandma teaching me to read Magic Key books for the first time, or Grandad telling his own stories – I always loved to listen to them.

I'm a bit of a perfectionist. I like everything done the best it can be. If something is worth doing, it's worth doing right. Maybe that's why it took so long to getting to write this, because this, more than anything, has to be perfect, because this is my story.

As someone who hides in books, I know the power of a good book. They can make you laugh. They can make you cry. The characters can become your best friends and your worst enemies and, as someone who lacks excitement, they can give me a lot of what I lack. So, given how much I identify with stories, I should stop beating around the bush and tell you mine.

Feeling different

I always knew I was different. I could see it in the way others acted. I could feel it when I was with them. I could talk like them, hang out with them, but it was always different, but I was fine with that. I was unique and I embraced it, wrapped my weirdness around me and was comfortable in it. Who else would dress up in a barrel and go as Diogenes for Ancient Greek day in Year 5? No one. No one but me, that is.

Before my troubles

I had fun – a lot of fun. It's almost hard looking back to those times now, knowing how much has changed. If I could go back in time and see myself, would I warn her about the troubles ahead, or let her enjoy being a carefree child while she still could be? Tell her not to grow up so fast, to enjoy being young because her world was about to implode? Would I tell her she needs to be strong or tell her to do everything she wanted, because soon she won't be able to? Tell her to treasure every book, every walk to school, every rainfall, every mouthful of food while she still can? Tell her to run and dance and ice skate? Tell her that she should embrace PE while she still can? Granted I'd have thought myself crazy, at that last one. I hated PE!

Give me book reports, Pythagoras' theorem, and trigonometry. Give me up-cycling, art and painting and a French dictionary. Give me pages and pages and pages of scripts in drama. Give me score after score of piano sheet music. Give me as many dance routines as I can handle! I'll do it and gladly, but not PE, never PE. I don't even know why I hated it so much, anymore. I danced for fun at weekends, I took ice skating lessons, I did gymnastics for a while. Tennis, badminton and netball all had their turns as well, but best out of all of them, and the hardest to give up, was swimming.

When I was little I had so many ear infections, one after another, and they knocked me 'flat on my ass' (excuse the language, but that's the saying). I loved being in the water, flying through it, alive in the water, becoming one with it, front crawl, breaststroke, back stroke, butterfly, diving. Those were the good days, but again,

as they say, *all good things come to an end*, and so my life, while not a perfect fairy tale, took a turn for the worse.

Happy endings in fiction

I've always envied characters in books. They have signs their world was going to change. It might not be good to begin with, but they all know they will get through it, and as a reader, you know they will survive and have a happy ending – well most of the time. I tend to stay away from sad stories. Life is sad enough, I think. Find ones with adventure and excitement, where good always wins, where every hurdle can be jumped, where every lock has a key, where every problem has a solution. I envy that too. They can find answers while I can't. Sometimes their problems are so big and yet they still find a way. That gives me hope as well, I guess, but I digress once again.

Fairy tale to tragedy in my life: a simple fall

So back on track, fairy tale to tragedy. ….. well, not exactly tragedy, but what else can you call it when life turns upside down and leaves you lost and hopeless? It wasn't so bad at the start, at least that's what I think now, knowing what I do and having been through what I have. It was simple really. When I was 10, I ran up the garden steps and fell over. Who knew the impact this would come to have? I scraped my knee and arms and hands and banged my foot. Nothing serious you would think, nothing to worry about, but the pain in my foot stayed. It never left. It still hurts now just as bad as when I fi banged it. When I got in the shower, it burned.

I should mention here that I am unable to feel heat. I've given myself actual burns by accident and not felt them at all. In summer, I'm in a hat, coat, gloves and scarf. I have hot water bottles all year round, and then moved to heated blankets. I just don't feel the heat. When I was little, it was so hard to understand how other children weren't feeling cold in the playground, in skirts and short sleeves. My feet burned and burned bad, like walking on burning coals. We did all we could, put a bag of frozen peas on, stood in cold water, stopped wearing socks, held a fan on them. I went for an X-ray and had an MRI on my birthday. I thought that birthday would be the worst I ever had. If only I knew then what was to come. We still we couldn't figure out was wrong. I started having physiotherapy to correct my walking as I had started to avoid putting pressure on my foot and was walking incorrectly. I was on crutches and teased and bullied at school. I loved school. I love to learn, but the people around me made this safe, comfortable place, scary. I remember writing poetry to express how I felt and crying for hours in my room with my parents. I thought: *"It won't be long, the doctors know what to do. I won't be like this for long. It will just fade and be a bad memory, nothing more … just a small blip in my story, nothing worth noting."*

A year later

A year and a bit after I fell, I got this pain in my body … this awful clawing pain. It was like nothing I've ever felt, and I don't have the words to accurately describe it. I likened it to being punched, over and over again, with spikes being stabbed and slashed, like someone was squashing, pushing, pulling my internal organs, and ripping me apart from the inside. No one could help. I was screaming until I couldn't scream anymore. I was twisting, turning, writhing, anything and everything I could.

I can still see my dad crying, the tears rolling down his face (and please remember my dad doesn't cry). I think this was the fi time I saw him cry, really cry. He was sobbing and just kept saying, 'Sorry'. I couldn't work out what he meant at fi My mind wasn't thinking straight, so distorted by pain. It was later I realised he was sorry he couldn't help… sorry I was in pain… sorry he couldn't take it away… sorry his little girl is hurting, and he couldn't help. I know now he felt hopeless and afraid. No one knew what was happening and he was scared. Mum was too, but she handled it. She didn't break down, but stood strong and fearless in the situation in front of her. Determined and resolved, she took charge and, as she does with everything, she sorted it. Without her we would fall apart. That's not a guess or a theory. That's a certainty. She told, more like ordered, Dad out of my room to calm down and gave him some tissues. I don't know how I saw it, or why the simple act of giving him some tissues stuck in my mind, but it did. She called the hospital and asked what to do. Then we were off to A and E. Dad had to carry me downstairs, I couldn't walk by myself.

Experiences of A and E

We got a room in A and E. I remember the fi book in a Series of Unfortunate Events was on the bookshelf at the end of the bed. It's ironic now, really, a *Series of Unfortunate Events*, what a joke. I remember Dad asked if he could do anything. I said, "Read," he asked, "Read what?" I replied, *"Series of Unfortunate Events"*. Bear in mind, I was saying this in between screams and he and Mum smiled, actually smiled. "Only you could say that Hannah" and they laughed, only a little, but it was enough to release some of the stress and fear they both felt. Eventually, I was given morphine, it felt like I was laying on the water, just floating, no pain, just me in the water. My screams stopped and Mum and Dad calmed down a little. I told them I was swimming and the water was good. Then I slept.

When I woke, I was told they were going to remove my appendix. I don't remember much of the operation, just waking up in pain and feeling sick. A nurse told me to press a button if it hurts. I did, then I threw up and that hurt more. I kept pressing and kept vomiting so I stopped pressing the button. I told the nurse if I pressed the button, I would be sick. She told me I wouldn't be, and that

earlier I had been sick as I had just woken up and my body was shocked. I listened to her, pressed the button and I vomited again. They stopped telling me to press the button after that, but the pain never went. The terrible pain which sent me to A and E did go, but not the pain after waking up. It's still here as I write this, twinging at every thought, a painful reminder I can never escape what happened.

Life back at school

I managed to make it back to school for a little while. I think I blocked a lot out my mind, preferring to stay in the present and not dredge up the pain. I remember I felt so unwell in one history class, I thought I was going to be sick. My head and the room were spinning and nothing was where it should be. I just wanted to go home and lie down. I wanted to go to the office and get them to call my Mum, but the teacher refused. She was a good teacher but I think it was my Head of Year who told my teachers not to let me leave class. The Head of Year didn't like me much and didn't believe me. When we said I needed gradual schooling, that I wasn't well enough to come back full time, her compromise was that I came in for a half day for 2 or 3 days and then back to full time. But, I couldn't handle full time. It's so, so hard for me. Mum is a warrior, my warrior. She has fought longer and harder than everyone I have ever known. You read about heroes and heroines in stories, all their amazing feats, all the battles they've won, the hardships they overcame, but the real hero is my Mum. She has fought harder than all of them. She is my hero. I can't imagine anyone fi for me like she has and that just makes the rest of my story more tragic, for this is only the beginning.

Depression and weight loss

It had been about 2 months since my appendix operation and 15 or 16 months since the injury to my foot. Nothing was getting better. Every day was harder and harder than the last. I slipped into depression. I was losing hope, and fast. I could see the hope in my parents' eyes but see it slowly dying, bit by bit. They wanted me to get better and I couldn't do it, get better. I wasn't eating much. I was in so much pain. It was no life and it got to the point I didn't want it. I was in a dark place; stuck in a hole I couldn't get out of. My weight had slowly been slipping and I was still in pain.

I went back to hospital and was tube fed and felt like dying. Everything they gave me to eat or drink, or medicine to take, I vomited it back up. The tube became all I had, and I hated it. I kept trying and kept vomiting. My Dad stayed with me every night switching to Mum during the day. All I did was vomit and sleep, wake up in the middle of sleeping and vomit again. When I was little, Dad couldn't be in the same room as me if I was vomiting. He couldn't handle it. He had a very rude awakening in hospital I'm afraid, but he handled it, I don't know how, but somehow, he did. I finally started keeping things down but was in pain and depressed.

I was told to talk to a man from the hospital Psychiatric Team. That was when I fi told anyone I was suicidal. Mum broke down in tears right there. The look on her face broke my heart. Dad wasn't on the ward but when Mum told him, he had tears running down his face. He looked broken too and I hated that I broke them - the two people who stood by me through everything. They sat on my bed and held me, and we all cried. I don't know how long we sat crying together, but it felt good having them with me.

Later we were told about a hospital over 100 miles away where we were told they might help me. My problems were not physical - that's why I hadn't been healing. They would get me better. I could have my life back, be an actress, an archaeologist, an author, whatever I wanted, travel the world, and go to far off places. But so much hope ended in disappointment, yet again. I was told I might be there for 3 to 6 months.

My time in the specialist hospital

For a while things were hard, but good. I had a timetable, a strict one, with all the time accounted for. I threw myself into it, not giving myself time to think, attending all the meetings (not that I had a choice in the matter), going to the school, participating in lessons and being just as much of a student as I used to be. We went to the park every day for an hour. It was scary being so far away from home and without my parents. I'd never been so far away from home in my life and only away from my family on school trips that lasted 3 nights tops, and even on those, I missed my parents. So, imagine, if you can, being away from home, away from your family, in a strange place, with strange people. I did what most 12-year-olds would do, I cried myself to sleep and powered on in the days. Physio, meals, lessons, therapy sessions. I was on auto pilot, with one thought – get better. I could only see my parents from 5pm to 8pm on Tuesdays and Wednesdays, then Fridays 3pm 'til 8pm, Saturday 10am 'til 8pm, and Sunday 10am 'til 3pm.

The first weekend I wasn't allowed out, and that was fine. Then for the next few months, I was allowed out with my parents. We went everywhere we could. We went to museums and art galleries. I was getting stronger each week. I missed home like crazy. There was a park with a playground, but I never went on it. I wasn't strong enough and was in a wheelchair, but it didn't matter. I loved the park as I was back in nature. I was alive in nature, free and myself. I thought to myself it's only for a short time, right? Wrong. I didn't get to come home for 3 months – and then only for weekends. Not much had changed. I was still in just as much pain as before, but my weight was healthier, I was more mobile, and my depression was less.

Weekends at home

I was allowed to come home for weekends after three months at the hospital and

during the train ride home I loved seeing the countryside – open fi hedgerows, trees, sheep and pigs. I saw the birds in the sky and wanted to fly away with them. I get horribly travel sick and felt very unwell after each journey and then had to return to the hospital on Sunday. I was so unwell that simple things became impossible and I couldn't do them. My activities during the week stopped. I just rested and tried not to be sick. My eating decreased, my happiness, no matter how brief, was gone. I started feeling better towards the end of each week, only to go home again on Friday and come back Sunday. This routine became harder and harder. I was a ghost of myself, an empty shell. I felt empty. I felt nothing but sick, I couldn't even bring myself to feel depressed. I went through my days on auto pilot. I didn't feel well enough to call my parents anymore. I couldn't read or watch TV. I didn't participate in lessons, meetings and physio. I wasn't myself, not really. It felt like the Hannah that was died in that place, is buried in the walls of that hospital. I wasn't there - not really - although there were moments, small glimmers of hope every now and then, doing a jigsaw with the friend I made in there, laughing at jokes.

My thoughts on food now and as a child

I tolerate food. I eat but I don't like it. Food causes pain and sickness. Food is a fight. I can taste the food, but it's like knowing everything is laced with poison, having it turn to ash and rusty nails and become rotten in your mouth. When drinking, I can taste it but it's like drinking acid, not because it burns or tastes foul, but because after I've swallowed it, it feels like it wants to come back up. I know I need food and that it keeps me healthy, and that I need it to avoid being in hospital. So, I eat what I can, when I can. It's not much, but it works. I have my 'go to food', basically food that is the easiest to force down. If I can think of something I can eat, Dad goes and buys it. Yesterday, me and Mum joked that Dad is doing more to help feed me now than when I was a baby. We laughed about it a lot. It's the little moments like that that make you happy, that stick in your head. With all the rubbish and struggles, it's good to laugh, whether it be about a book on a shelf or how terrible Dad was at helping when I was a baby.

Even as a baby I was a fussy eater. If anyone did any- thing, I'd stop feeding. Someone walking into the room, someone turning the page in a book or a newspaper, everything had to be still. I should have known then. Food was never easy through my childhood either. I ate what I could, but never as much as the other kids my age. School dinner was the same from Year 3 to Year 8, a jam sandwich on one slice of white bread, some kind of dried fruit like a school bar, fruit flakes or a handful of dried mango, and a chocolate biscuit like a Kit Kat or a Twix or a handful of Krave breakfast cereal, every day. Even a meal like that seems very hard now and that's sad. Looking back and knowing I could manage that easily, without wanting to vomit, without pain. I wish I could have that back.

Life after hospital and reflections on my experience there

I was no better after spending 11 months in the hospital and professionals could not see a way to help me. If anything, I was worse than when I went in, so I was discharged. I had so much stress around eating that when my relatives visited eating with them became a challenge. All I could remember was the staff saying: *"Come on Hannah, you need to eat. Come on pick your fork up, pick up the pizza, take a bite. It's not hard, it won't hurt you".* I would yell in my head *"You don't know anything. You don't know how I feel, and yes, yes it's going to hurt. It always hurts each time, always".* They didn't understand. I finally thought someone would understand me, but even they didn't. I was there for help, they tried, I'll give them that, but everything didn't work for me. Graded exposure, talking, pushing through it, changing thinking patterns … none of it helped. It only made things harder. I thought more than once, *"If these people are experts, why can't they help? Am I just too broken, too different?*

But I didn't have the energy to feel sad about it. I wrote poems, poem after poem, to get the negativity, the numbness, any small emotion… I wrote it down. Mum read them and mum cried. I hated seeing her cry, but I knew if I didn't write them, she would worry I was bottling it up and the only way to get better was to let them help. I tried and I tried. I did everything asked of me, no matter how hard, and what happened? It got harder. It was the worst time in my life. I had nightmares for years after I came out. To this day, if I eat with a group of people, I still see the hospital dining room and I don't want to eat. It's been 5 years and my mind is still on that ward, the one small corridor and 7 rooms that were my life for nearly 11 months. When I fi got out, I was worse that when I went in. Just as sick, just as much pain. If anything, everything was worse. The only positives were my diagnoses of autism, Chronic Regional Pain Disorder, Somatisation Disorder and Anxiety. Try explaining that to a 13 year old! I like to think I was a smart 13 year old, but so much was happening. I couldn't think an hour ahead, let alone a day or a year. I could only live in the moment. If I looked forward, all I saw was pain, sickness and misery, or the memories of hospital I was trying to forget. The only thing keeping me grounded was my parents. I would be lost without them, truly and honestly lost.

Slow improvements once I was home

Things started getting better after a while when I was home again. We did things OUR way, not what the doctors told us we had to do to get better. We did what WE thought would help, what WE came up with, OUR solutions, and they worked better, so we did it OUR way and it was fine. I started taking steps independently, even though I was in a wheelchair most of the time. I read a couple books. I wrote my own stories. I did crafts. I cooked; I ate; I went out. I started to feel like myself. I found happiness, no matter how small. I still hurt and was still feeling

sick, but I managed. Then I pushed myself too hard, I did too much, and I crashed. I crashed, and I burned. Everything went up in flames and hope drifted away like smoke on a breeze. It was only small, but then again, the smallest stone can cause an avalanche. I got sick, that's all, just a stomach bug but I'd lost weight and the doctors were worried.

So, I visited to the local hospital again. I was already feeling sick, so the car ride was horrible. They did some tests and sent me home, once again in the car. So, I was feeling sick and had to have two car rides in one day. I'd say it nearly killed me, but physically, I was fine. I was so unwell after that. I couldn't get out of bed. I didn't drink for 64 hours or eat for 10 days. The worry came back in my parents' eyes, though they didn't acknowledge it. It was hard, probably harder than they realised. A few months later my weight became too low and I was admitted to hospital. It was like the last few years never happened. I was back where I started, in a hospital bed, but the only upside was my head was in a better place and I was so, so thankful for that.

This was during Covid so, once again, my Mum became a superhero and stayed by my bed, day and night, through everything, the vomit, the tears, the bad news and the good. We sat on the bed together and binge- watched series. We laughed and talked but when food came, it was serious again. I couldn't do it. I couldn't eat, no matter how hard I tried. It was like being trapped in a never ending cycle. Eventually, my body went into starvation mode, and I had another nasal-gastro tube. I was sleeping all day and all night. It was my mind protecting me from the trauma I was reliving for, although I was 17, my mind went right back to being that scared, hopeless 12 year old who wished for death. The tube made everything brand new. I managed to stay awake a couple hours most days and I asked Mum to kill me. The pain and hurt in her eyes was haunting, the worst thing I have ever seen and likely will ever see, but she knew it wasn't me. It was what the tube was doing to me, the memories I was reliving. I managed 4 days before it became too much, so I pulled it out.

Things got better but also got worse. I didn't have a very nice doctor. While on the tube, my weight gain goal was 0.5-1kg a week. Once I pulled the tube out, it went up to a goal of 1-1.5kg. If this was not met, I was told I would be sectioned, and they would force me to eat. I remember thinking, *"What on earth woman? You can't just say that to someone who is struggling. Wayyyyyy too much pressure! I never do well under pressure."*

I fought though and I never stopped. I couldn't manage complete meals even on my best days. I couldn't manage the portions they gave me even before I was ill. I wouldn't have managed it, so me and Mum hatched a plan. We split the meals up and spread them out over the day. The doctor said we were cheating, but we were

doing what we were asked to, and I was eating and gaining weight. Mum got up all through the night to feed me, to make sure I got it all in, and I did. It was hard, but we did it our way. They wanted to send me to another mental health unit or an eating disorder unit, but the eating disorder units couldn't help my mental health, and the mental health centres couldn't accommodate my eating, so it was decided that I would be discharged and come home – I was better at home anyway.

Improved progress at home

I made more progress at home than in hospital by doing it our way. Doctors have treatments that worked 99 per cent of the time, but I fall into that 1 per cent and no one knows how to help me anymore. I don't want to be this way forever. It's not a good life. Yes - it's been worse, it's been a heck of a lot worse, but I'm trapped in my bedroom. I am the proverbial princess in a tower, but not trapped by a dragon or an evil step-parent or wicked witch, trapped by my own mind. My mind is my prison and each day I fight to get out. My room is lovely but it's still four walls and me. I have the curtains closed, I can't look outside without feeling sad that I can't be out there. My mental health isn't bad. I have hope even when it's hopeless. I look around my room and say this won't be forever. I stay trapped in my tower fighting, an internal battle for freedom.

My love of the outdoors and Center Parcs The only time I get out is to go to Center Parcs. The woods, the nature, I'm free. I look up and see the stars and imagine I'm shining with them. I see the birds and think of flying with them. I manage to get out of bed there, even just for a walk around the lake, ah, the lake it's gorgeous. The whole of Center Parcs screams life. Look at me I'm alive, I'm growing, I'm changing, look at me. Look, see me, see my trees, see my animals, see my water, see my life. It's a magical place really. That energy is like nothing else.

I still struggle, it doesn't take away everything. I'm still in pain. I still feel sick, but the atmosphere is healing. My parents try to take me three times a year and we normally go for seven days, but with my travel sick- ness I spend all the first day being ill and the second starting to feel better. On the third day, I'm picking up and getting strong but just as I start to get better, it's time to go home. I manage to go around the lake, be in nature, being free, feeling life flow around me. That feeling can't be stated or described enough to do it justice. The words just don't exist for how it feels. I can get a dictionary, but the word isn't invented. You could search forever and not find it.

I get to swim in the pool. They have an accessible slope and a chair to go in the water. I feel young again. I feel a flicker of who I was, the life filled with excitement I've not felt for so long. I get stronger each day though, and each day is easier than

the last. I just need longer.

The restaurants are really good there as well. It has food that's as good as food ever is. I can't go to the restaurants and eat in anymore, but they do take away to the villa which we really appreciate. It lets me eat, it lets me swim, it lets me out. Center Parcs is the biggest thing that's helped since my story turned bad, since the unfortunate events started. I hope a long enough stay at Center Parcs is enough to stop the unfortunate events, to turn this story, my story on its head once again, and set me back on track.

Concluding comments

Everyone's story is different, each tell it different and each end different, some happy, some sad, some scary, some exciting. As for me, well, that's for you to decide. Am I a girl lost in memories, am I an empty shell, am I a princess in a tower, am I a fighter, am I hopeless, or am I hopeful? All I know is that writing this, I am a storyteller, and now I have told my story.

Hannah

Appendix B: Stories from two Oliver McGowan Training co-trainers (October 2024)

Introduction:

Information for this citizen story has been compiled by Fiona Johnson, an Oliver McGowan Lead Trainer. She has worked with Unanima, who is supporting the Oliver McGowan Training programme.

Unanima is a Mansfield-based theatre company that started in 2008. The cast is exclusively learning disabled and autistic. They create witty, provocative, and compelling performances based on their lives, experiences and questions the about the world. The underlying purpose is to stimulate social change.

Two of the cast are also now Oliver McGowan Co-trainers. Their words have been included, along with words from the CEOs of Unanima, and an Access Support Worker who supports the Co-trainers.

Who was Oliver McGowan?

Oliver McGowan had mild hemiplegia, focal partial epilepsy, a mild learning disability and later a diagnosis of high functioning autism. Oliver's disabilities did not hold him back. He played for the England Development football squads. He was a registered athlete and was ranked third best in the country for track 200 metres. Oliver was a member of Team Bath and was being trained to become a Paralympian.

He had been to the hospital multiple times for seizures. During his last hospital visit, doctors gave him an antipsychotic drug called Olanzapine to sedate him. Oliver's parents were concerned because he had previously had a bad reaction to this Olanzapine, and Oliver and his parents clearly said they did not want him to have it. After being given the drug, Oliver had a severe reaction that caused his brain to swell, and he died 17 days later and at the age of 18. This happened in 2016.

His family firmly believe they were not listened to, and this contributed directly to his death.

On 28 April 2022, Learning Disability and Autism Training, became law as part of an amendment to the Government's Health and Social Care Act 2022. Primary legislation introduced a requirement for mandatory training on learning disability and autism on the 1st of July 2022 within the Health and Social Care Act (2022). This applies to all staff working in CQC-registered organisations.

Our Oliver McGowan Training Lead Trainers are working with self-advocacy groups such as Unanima and Autistic Nottingham, to recruit and train up experts with lived experience (EWLE) to become Oliver McGowan co-trainers.

The view of Unanima CEOs:
We feel this work is incredibly important for both the NHS staff that will receive it, the EWLE that are delivering it, and the future learning disabled and autistic people that will experience improved treatment as a result of it.

For the EWLE trainers, being involved (and paid) provides an opportunity for them to personally reclaim some power and status that has been denied them due to how their experiences of condemnation and attitudinal discrimination have so woefully subjugated and failed them.

For NHS workers, having this training provides an opportunity to gain a positive and knowledgeable lens with which to view learning disabled and autistic people with.

Above all else, this project sets the bar higher for what people see learning disabled and autistic people being capable of. Seeing them eloquently make arguments about how learning disabled and autistic people should be treated, in and of itself provides undeniable evidence that they are capable of more and deserve more. The investment that the EWLE team have shown in ‘Access Mentors’ has been key in this; the presence and of a trusted and well-liked figure of support has allowed the experts to authentically achieve more than most people would have believed they could. These access mentors are the ‘reasonable adjustments’ to life that are an essential element in the pursuit of genuine equity for the learning disabled and autistic community. Their role unlocks the opportunity for meaningful and purposeful occupation, which in turn is perhaps the most crucial ingredient for mental wellbeing, fulfilment, and true happiness.

Tracy Radford, CEO of Unanima

Dr Brad English, CEO of Unanima

Lizzie, a Tier 1 Co-trainer, Unanima:

Tell me about why you decided to get involved with the Oliver Mc Gowan Training?

I wanted to do this because some of the doctors didn't listen to me. I self-harmed and put soil in my cuts. I was poorly in the head. One of the doctors said to me "I am the doctor and you are the patient". I was admitted into hospital because of my self-harm. I got cellulitis and I knew there was soil in my arm. I told the doctor and he argued with me, he didn't listen to me.

When I was in rehab to get me back into the community the staff used to wind me up. At one point I was on 1:1 over 24 hours. In hospital you get checks hourly, every 30 minutes or 15 mins. The staff used to wind me up because they got that chunk of money giving me 1:1.

What do you mean by: they "wound me up"?

I asked for a calming tablet and the staff said "No" so I said "F—ck off" and was put in restraint. After a calming tablet you weren't allowed out. If you had PRN you weren't allowed. I felt they were doing it to punish me – I wasn't able to go out into the grounds or community. Section 17 leave couldn't happen.

Do you think working as a co trainer for the Oliver Mc Gowan training has helped you in any way?

"Instead of the abuse in hospital I look on life – it's positive to my life. I can relate to Oliver. Fortunately, the doctors didn't kill me. I want to protect other people".

"My head in clearer now because I am helping others now and trying to make a difference to other people's lives".

"This is my first job. I now know that I can hold down a job and enjoy it at the same time. I feel more like an adult now. I have a bank account and I have money. I have

been able to go shopping on my own and buy things for myself. First time in a long time I have been able to enjoy things – have a social life".

"I feel now that I can do things by myself a lot more. I am more independent. I have more confidence now. I was stuck in my body. My job has helped me to stop feeling cr-p. I have gained colleagues and friends working with the other expert K. This has been comforting. K is caring. I enjoy the time and our relationship".

Shimara, a Tier 2 co-trainer, Unanima:

Tell me about why you decided to get involved with the Oliver Mc Gowan Training?

“I wanted to learn more about Autism to help my nephew (he is autistic). I wanted to “put my life out there”, let people see Shimara. In my life sometimes people have judged me and said I can’t do things when I CAN. I just need more time to help me process different information.”

“People have made assumptions about me, made choices without asking me. When I left Primary school, it was decided that I was going to Special School. I wasn’t asked for my opinion. I wanted to feel “normal” and stay with my friends. I was unhappy and put my mask on. The only positives were holidays and dancing which was stopped. If I had gone to mainstream school, I would have got my Level 2 in Maths and English. I am now 25 and studying Maths and English to reach my dream job of working in school. My friends at 25 are settled in jobs, careers. I fell into the cracks…”

Is there anything in what you know as Oliver’s Story that is familiar to you?

“Yes, having an opinion and being asked. In my annual check – up with my GP I was spoken to like a small child. The doctor talked over me. She was a “B” she was telling me that I needed to lose weight, needed to respect my mum. It made me angry. My mum was with me. I had to “kick off” to get a right to choose who I saw. This was because of the stress of this. I told the doctor that she was “patronising us” (myself and my sister T). I told the doctor that “I couldn’t have her” (for the review) and another person my asthma nurse saw me after that.”

Do you think working as a co trainer for the Oliver Mc Gowan training has helped you in any way?

“…It gives me a chance to be a 25-year-old…”

“My ambition is to be a teacher, but I didn’t think I had the confidence to do this until Oliver Mc Gowan.”

Closing thoughts from Bonnie Brown, Access Support Worker at Unanima:

I think this has been such a fantastic opportunity for all involved. Not only has it been great for the experts to be involved in something meaningful like this, but it has also given them really valuable experience in what it means to have a real job; getting to grips with arriving on time, arranging how to get there, managing their diaries, invoicing, and preparing for sessions. The growth in all of the experts has been fantastic to see, for some this is about self-confidence, but for others it has been even more life-changing than that, with one learning to read in-part through the process of this training.

It feels such an important way to pave the way for better healthcare for all learning disabled and autistic people.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/11/2024
Paper Title:	**Chair's Report**
Paper Reference:	ICB 24 065
Report Author:	Dr Kathy McLean, ICB Chair
Report Sponsor:	Dr Kathy McLean, ICB Chair
Presenter:	Dr Kathy McLean, ICB Chair

Paper Type:							
For Assurance:		For Decision:		For Discussion:		For Information:	✓

Summary:

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

Recommendation(s):

The Board is asked to **note** this item for information.

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	The work of the Chair is focussed on meeting the four core aims.
Tackle inequalities in outcomes, experience, and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

None.

Board Assurance Framework:

Not applicable for this report.

Report Previously Received By:

Not applicable for this report.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Chair’s Report

Introduction

1. We are now well into the second half of this financial year and in the initial phase of the winter pressures period. On both fronts we are well prepared and delivering well but we will need to ensure that all of our financial and operational plans deliver to the top end of our expectations.
2. In terms of financial performance, as an ICB we remain on track with our commitments to NHS England and performing well in terms of delivering efficiencies for the full year – but there remains a lot still to be done, with a challenging second half year ahead of us. Similarly, all system partners remain committed to delivering our system-wide efficiencies and achieving the agreed position with NHS England, albeit with a degree of risk now materialising within our plans.
3. Our winter plans are built on the learnings from last year and have been robustly tested by all system partners to ensure that we have the best possible arrangements to keep patients cared for and staff supported throughout the busy period. There is no additional winter funding to establish additional schemes over the periods of peak demand in the way that we had in previous years; all system partners are aware of this position and have developed their plans in this context.
4. We know that the ‘flu season in the southern hemisphere means that this year’s respiratory illness incident will be high and so the importance of vaccination by staff and residents against ‘flu, Covid-19 and Respiratory Syncytial Virus (RSV) cannot be overstated.
5. Whilst we continue to progress with this year’s financial and operational plans, the Government’s plans for the longer-term future of the NHS have started to crystalise. Following on from the publication of Lord Darzi’s Independent Report into the NHS, the Secretary of State has set out the three ‘shifts’ he expects to see: from hospital to community, from analogue to digital and from treatment to prevention.
6. Following this, in recent weeks the Government has launched what it calls, “the biggest national conversation about the future of the NHS since its birth”. Members of the public, as well as NHS staff and experts, are invited to share their experiences, views and ideas for fixing the NHS via the Change NHS online platform, which will be live until the start of next year, and available via the NHS App.
7. The ICB, and all NHS partners, will contribute to this in a variety of ways but I am pleased that we have already started this conversation with two key leadership groups in our system: our Foundation Trust Governors and the Non-

Executive Directors. In mid-October I was delighted to meet with Governors from all across our system and share an update on how we are progressing with our Integrated Care Strategy and also to discuss the changing external context we are working in – in particular the new Government and the new East Midlands Combined County Authority and Mayor. We also took this opportunity to discuss the three 'shifts' and how our system can contribute to this thinking.

8. Right at the end of October I was also pleased to meet with Non-Executive Directors from across the NHS organisations in our system to discuss our financial position and undertake a similar discussion on the 'shifts' and the Government's Ten-Year Plan. Both of these discussions were well-informed, stimulating and energising.

Developing our system

9. I continue to share the successes and achievements of our system on a national stage through my work with NHS Confederation and also bring back learnings and ideas from other systems. I was therefore pleased to be invited to be part of the latest podcast 'Health On The Line' with Matthew Taylor from the Confederation. We discussed the current position of ICSs just over two years from formal establishment in July 2022 and what the future might bring. Colleagues can have a listen here: https://www.nhsconfed.org/podcast/exploring-ICS-progress-two-years-on.

10. On a similarly positive and forward-looking basis, it was great for leaders of NHS Nottingham and Nottingham ICB and NHS Derby and Derbyshire ICB to meet with Claire Ward, Mayor of the East Midlands at the start of October. Claire was elected in May and heads up the East Midlands Combined County Authority (EMCCA), which brings together the City and County Councils across Nottingham, Nottinghamshire, Derby and Derbyshire, as well as working closely with the District and Borough Councils. The EMCCA has a remit to work, in partnership with other bodies, to harness the potential of the East Midlands, making it the best place to live, to work and to learn.

11. Directly elected Mayors and Combined Authorities are a key part of the new Government's plans for the country, supporting the drive for economic growth and tackling inequalities. There are lots of ways that our two ICBs will want to work together with the Mayor and the Combined Authority, in particular thinking about how our work on health inequalities can be linked to economic growth. I am also very excited about how we can take advantage of my role as Chair of both ICBs, which means that Mayor Claire and I have completely aligned geographic responsibilities.

12. I have continued to be out and about across our system and further afield, including attending a regional event on our 'Fourth Aim'; meeting with front-line teams delivering specialist care for children and families; observing the care

delivered by the low secure and community forensic teams; visiting the team at Highbury Hospital and also Rosewood Primary Care Network.

In the last couple of weeks, the Integrated Care Partnership (a joint Committee between the ICB and the City and County Councils) met to consider progress on our Integrated Care Strategy. The Partnership received a detailed update on strategy delivery as well as the outcomes we are seeing and also a summary of insights from patients and service users on their experience of care. The full pack of papers for those who are interested can be accessed here: https://healthandcarenotts.co.uk/wp-content/uploads/2021/05/ICP-28.10.24.pdf. The next meeting is 24 March 2025 where we will be considering the Integrated Care Strategy for the coming year, supported by discussions at the Partners Assembly in February 2025.

13. By the time of the Board meeting, we will have just held our second Health and Care Awards celebrating projects and activities that contribute to our four aims as an ICS and our three principles of prevention, equity and integration. This year saw a further really strong and large set of nominations, many of which could easily have won – so we should send congratulations to all the shortlisted and winning entries and look forward to those examples inspiring others to think about their work in a different way.

Looking forward

14. We have three key priorities ahead of us for the next few months: firstly, deliver on our financial commitments as a system for this year and start planning for next year. Secondly, ensure that quality of care and operational performance is maintained over winter. And thirdly contribute to the Government's response to the Darzi Report and the development of the Ten-Year Plan for the NHS. I know that all members of the Board will fully participate in all three of these activities.

15. I also want to thank all staff across the health and care system ahead of winter – from the work of managers and leaders in steering the approach and the efforts of frontline colleagues, we all have a part to play over the next few months.

Board matters

16. Our Non-Executive Director recruitment process is currently underway and I hope to be able to report on the outcome of this in the near future. I also anticipate being able to confirm during December an appointment to the Local Authority Partner Member role previously held by Catherine Underwood. It is my hope that newly appointed colleagues will be able to join us at our Board meeting in January.

17. Our Board Annual Work Programme is routinely provided as part of our papers pack at every meeting. This continues to be reviewed on an ongoing basis to ensure the full breadth of the Board's role can be discharged, balancing agenda time appropriately between key strategic priorities and ensuring appropriately timed governance oversight, scrutiny and transparency, while making best use of the work of the Board's committees.

18. Following recent Board discussions, I am pleased that we have a story reflecting the lived experience of a group of our citizens back at the top of our agenda at this meeting, and this will be the approach going forward.

19. As colleagues will see from my recent visits detailed above, and as is obvious from the external scrutiny and reports, ensuring that mental health services are delivering the level of quality we expect is one of my top priorities. To that end, it was great to meet as a Board with wider partners in October as part of our schedule of Board seminars to consider the wider mental health landscape. In a well-attended and wide-ranging discussion, we explored the current experience of care by our population, including those in groups with protected characteristics as well as looking at the performance metrics. We agreed a number of actions to take this work forward and there will be an update to the Board in January.

20. I am looking forward to our Board seminar scheduled for December, which will be focussed on primary care, considering aspects of general practice, pharmacy, optometry and dental services.

21. Finally, looking forward to our schedule for 2025/26, I would like to highlight that a decision has been taken to move our Board meeting day to the second Wednesday of each month from April 2025 onwards. This is to avoid clashes with the Board meetings of our Trust partners, thus enabling future nominations from all relevant partners to our Board membership.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/11/2024
Paper Title:	**Chief Executive's Report**
Paper Reference:	ICB 24 066
Report Author:	Amanda Sullivan, Chief Executive
Report Sponsor:	Amanda Sullivan, Chief Executive
Presenter:	Amanda Sullivan, Chief Executive

Paper Type:							
For Assurance:		For Decision:		For Discussion:		For Information:	✓

Summary:

This report provides a summary of recent local and national developments and areas of interest for Integrated Care Boards (ICBs) and the wider NHS.

Recommendation(s):

The Board is asked to **note** this item for information.

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

Appendices:

A: 'You said, we did' Response to 2023 NHS Staff Survey
B: ICB Workforce Demographics
C: Briefing Paper – Delegation of additional specified Specialised Acute Services and Mental Health, Learning Disability and Autism specialised services and associated workforce.

Board Assurance Framework:

Not applicable.

Report Previously Received By:

Not applicable.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Chief Executive's Report

Independent Investigation of the National Health Service in England

1. Lord Darzi's evaluation of the NHS was released on the day of our previous meeting on 12 September. Since this time, we have all had the opportunity to read and digest its messages; and in the intervening two months we have seen the launch of steps to respond to the findings of report.
2. The report includes some very stark messages about access to care, the health of our population and the economic and societal consequences of widespread ill health. There are huge variations in the quality of care provided and we can see that clearly within Nottingham and Nottinghamshire. There is a paradox in that we are providing new treatments and interventions but waiting times for many aspects of care have risen beyond acceptable levels.
3. The report identifies a list of important themes for how to repair the NHS, which are very much in line with our direction of travel over the past two years. These include:
    a) Re-engaging staff to make positive change and re-empowering patients to take as much control of their care as possible.
    b) Locking in the shift of care closer to home by hardwiring financial flows.
    c) Simplifying and innovating care delivery for a neighbourhood NHS, bringing together primary, community and mental health services.
    d) Driving productivity in hospitals through better operational management and capital investment in modern buildings and equipment.
    e) Tilting towards technology to unlock productivity and maximise the benefits of digital systems.
    f) Contributing to the nation's prosperity by getting more people off waiting lists and back into work.
    g) Reforming to make the structure deliver, clarifying roles and accountabilities, ensuring the right balance of management resources in different parts of the structure, and strengthening key processes such as capital approvals.
4. The message concerning finance is clear; we have to deliver our 2024/25 financial plan and next year will have a similar level of challenge for our local NHS system. This gives us the opportunity and the imperative to transform services and ensure our system overheads are optimised.
5. Lord Darzi's summary can be accessed here: https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england/summary-letter-from-lord-darzi-to-the-secretary-of-state-for-

health-and-social-care. The full report can be read here: https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf.

National conversation to develop the ten-year health plan

6. During October, following the publication of Lord Darzi's review, NHS England launched a national conversation 'Change NHS: help build a health service fit for the future' to help develop the ten-year plan for the NHS.

7. NHS England Chief Executive, Amanda Pritchard, has emphasised the importance of listening to patients, staff and the public in order to set health priorities for the next ten years. To this end, a portal has been launched www.change.nhs.uk for individuals to provide their views and ideas.

8. As part of 'Change NHS', NHS England Midlands is hosting a regional engagement session on 28 November to gather leadership insights to inform the ten-year plan. Eight colleagues from our Integrated Care System, representing the ICB, NHS Trusts and Local Authorities will be in attendance to provide feedback from a Nottingham and Nottinghamshire perspective.

9. We anticipate publication of the ten-year health plan in the Spring.

New Hospitals Programme

10. Further to my report at the last meeting, the Department of Health and Social Care has published terms of reference for its internal review of the New Hospitals Programme. The review will examine options for putting the New Hospital Programme onto an affordable and deliverable footing.

11. The review will examine the appropriate delivery of those schemes that sit within the scope of the review, which includes the Tomorrow's NUH Programme, assessing the schemes against the overall constraints to hospital building and wider health infrastructure priorities, and presenting a full range of options to be taken forward for the overall size and ambition of the programme in order to provide a clear approach for the programme going forward.

12. The review will feed into the spending review process, where decisions on the outcome will be taken in the round and the government will confirm the outcome of the review as part of that process.

Winter Planning

13. NHS England has confirmed its operating assumptions for the remainder of the financial year, specifically stating the steps that ICBs are expected to take to

support the delivery of safe, dignified and high-quality care for patients over the winter period.

14. The delivery priorities remain unchanged from those agreed in system delivery plans at the beginning of the financial year. However, given the continuing high demand for services, NHS England is asking systems to re-confirm that their demand and capacity plans are appropriate and that they are taking all possible steps to maintain and improve patient safety and experience.

15. The Nottingham and Nottinghamshire system's Winter Plan has been developed with input from all system partners. It is much wider than an urgent and emergency care plan, and aims to deliver a safe, effective and affordable winter.

16. Communication with the public and our front-line staff will be imperative across winter, including ensuring that we continually remind our frail older populations of basic key messages around hydration, movement and keeping warm over the winter months.

17. Further detail on the Winter Plan can be found at agenda item 14 of today's meeting.

Executive Lead for Nottingham City Place-Based Partnership

18. In September, Tim Guyler, Executive Director of Strategy and Integration at Nottingham University Hospitals (NUH), was appointed as the new Lead for Nottingham City Place-Based Partnership (PBP). Tim is one of the longest serving members of the PBP's Executive Team and brings a wealth of experience from his work at NUH, as well as his leadership in supporting the design and implementation of the Nottingham and Nottinghamshire Integrated Care System.

Place Based Partnerships Leadership Forum

19. A Place Based Partnership (PBP) and ICB Leads Group has been established to provide a positive environment for ongoing engagement between the ICB and PBPs. The Group provides an opportunity for Chairs/Convenors and Clinical Leads of all four PBPs to meet with the ICB's Chief Executive and Director of Strategy and System Development. The purpose of the new Group is to support the evolution of PBPs as key partnerships supporting delivery of system priorities whilst remaining sensitive to local population needs. The Group will ensure that PBP involvement in ICB and ICS forums is further strengthened, recognising the leadership role of PBPs within the health, care and wellbeing system.

20. Two meetings have now taken place, with discussion focused on delivery of Place Plans with learning shared between the PBPs. Future meetings will consider the contribution of PBPs to system priorities, including supporting delivery of the proactive care model for frailty and long-term condition management as part of Integrated Neighbourhood Working. PBPs are also now represented on the system Transformation Delivery Group to ensure their contribution to delivery of system priorities is recognised. This will provide a further opportunity for increased PBP involvement in health and care planning and delivery, as well as broader social and economic development.

2023 Staff Survey Action Plan

21. As previously reported, the ICB took part in the 2023 national NHS Staff Survey, achieving a 72% response rate. The results showed good progress in a number of key areas; however, highlighted some areas where further action was required to provide clarity regarding the ICB's structure, roles and priorities, to support staff with significant workloads, and to further embed ICB values and expected behaviours.

22. Since this time, the ICB's Executive Team has led on the development and implementation of an action plan to address the feedback, with progress being overseen by the executive-led Human Resources Steering Group and the Remuneration and Human Resources Committee. An update report was presented to the Committee during October, which confirmed that all actions except one had been delivered or were on track to be delivered within agreed timeframes.

23. The key aims of the action plan have been to improve communication, embed values and behaviours, provide a focus on health and wellbeing, build career opportunities, maximise effective cross-team working and recognise and reward excellence. Of note have been the listening events, which were part of the ICB's commitment to focus on embedding its values and behaviours. These sessions were well received by staff as a welcome, safe, and open space to discuss values and to meet new colleagues. Appendix A summarises the actions that haven taken.

24. This year's staff satisfaction survey has recently been launched and our aim is to achieve a 90% completion rate.

ICB Workforce Update

25. Key metrics relating to the ICB's workforce continue to be monitored by the executive-led Human Resources Steering Group and the Remuneration and Human Resources Committee. The following paragraphs provide a summary of the information presented to meetings during October 2024.

26. The ICB's whole-time equivalent (WTE) headcount remains stable, with 565 WTE posts and a total headcount of 632. Since our establishment, the ICB has seen spikes of increases in headcount due to the transfer of staff from NHS England in line with the delegation of commissioning functions and our ICB's host role for the East Midlands. The ICB has an agreed vacancy authorisation process with enhanced controls introduced in August; this mirrors arrangements across the NHS system.
27. Turnover is generally decreasing with a current rate of 12.3%.
28. The ICB's rolling sickness absence rate is 3.7% against a target of 3.5%, and whilst the variance is small, sickness absence rates are continuing to increase; delays accessing treatment (beyond what the ICB can support through occupational health) are impacting individuals' ability to return to work.
29. The ICB's 2024 Gender Pay Gap, Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) reports and associated action plans have been published here: https://notts.icb.nhs.uk/about-us/safeguarding/equality-inclusion-and-human-rights/. Progress in delivery of the action plans will be monitored by the executive-led Human Resources Steering Group and the Remuneration and Human Resources Committee.
30. An illustration of the ICB's workforce demographics is provided at Appendix B.

Honorary Professorship at Nottingham Trent University

31. I am delighted to report that Rosa Waddingham, Director of Nursing, has accepted an invitation to become an Honorary Professor at Nottingham Trent University, as a three-year appointment from 11 November. The appointment recognises the importance of collaborators in adding value to teaching and research activities and will involve activities such as the provision of lectures, postgraduate seminars and support, and the sharing expertise not available within the University.

Delegation of additional specialised acute, mental health, learning disability and autism services

32. Last year, ICB Boards approved the delegation of 59 specialised services and approved in principle the next phase of delegation for an additional number of acute specialised services and mental health, learning disability and autism (MHLDA) services for 2025/26.
33. ICB Boards will need to be assured and approve the final elements of the specialised services delegation prior to 1 April 2025. With this in mind, Appendix C provides a detailed briefing paper for the Board regarding the steps

and stages of the delegation process, including the associated finance and workforce considerations.

34. A finalised Delegation Agreement and Joint Working Agreement will be presented for Board approval in March 2025.

Developments in national Freedom to Speak Up arrangements

35. NHS England has recently written to all ICB Chairs and Chief Executives setting out its expectations and next steps for Freedom to Speak Up arrangements. Following the roll out of the national policy at the beginning of the year, NHS England has asked ICBs to ensure that national Freedom to Speak Up arrangements are in place in their own organisations and in all Trusts within their systems. In addition, ICBs are being asked to extend arrangements to primary care settings to ensure that primary care workers are aware of, and have access to, speaking up routes. This will enable primary care staff to feel more confident to raise concerns, which will in turn support patient safety.

36. Rosa Waddingham, Director of Nursing, is the executive lead overseeing this work and an update will be provided to the Board at its next meeting in January 2025.

Sexual misconduct in the NHS: Launch of new framework, training and communications campaign

37. Building on the Sexual Safety Charter, launched last year, NHS England has launched a policy framework on sexual misconduct. The framework is designed to help staff to understand their rights and responsibilities, recognise and report sexual misconduct at work, and get advice and support.

38. The suite of tools made available from NHS England to implement the Framework will be taken forward by the ICB, overseen by Rosa Waddingham, Director of Nursing, as executive lead for domestic abuse and sexual violence. An update will be provided to the Board in March 2025.

39. The sexual misconduct policy framework can be accessed here: https://www.england.nhs.uk/publication/national-people-sexual-misconduct-policy-framework/.

Health and Wellbeing Board updates

40. The Nottinghamshire County Health and Wellbeing Board last met on 11 September 2024, and discussed the progress of the County's Best Start Strategy, the Special Educational Needs and Disabilities Strategy, and approved two Joint Strategic Needs Assessments relating to children. The papers for the meeting can be found here:

https://www.nottinghamshire.gov.uk/dms/Committees/tabid/62/ctl/ViewCMIS_CommitteeDetails/mid/381/id/548/Default.aspx

41. The Nottingham City Health and Wellbeing Board last met on 25 September 2024. The meeting received an Age Friendly Nottingham Annual Report, the Nottingham and Nottinghamshire Integrated Mental Health Pathway Strategic Plan 2024/25-2026/27, and an update on the delivery of the Health and Wellbeing Strategy. The papers and minutes from the meeting are published on Nottingham City Council's website here: https://committee.nottinghamcity.gov.uk/ieListMeetings.aspx?CId=185&Year=0

East Midlands Combined County Authority Update

42. The Board of the East Midlands Combined County Authority (EMCCA) approved nominations for key political leadership roles for the East Midlands region at its meeting in September 2024.

43. Portfolio leads at EMCCA will each be responsible for leading a number of key priority areas for the region, working with the Mayor and their Board colleagues to make the region more prosperous, sustainable and fairer, helping people and businesses to create and seize opportunities.

44. Cllr Nadine Peatfield, Leader of Derby City Council, has been appointed as Deputy Mayor. Portfolio leads are:

    a) Transport and Digital Connectivity: Cllr Ben Bradley and Cllr Anthony McKeown (deputy).

    b) Skills and Employment: Cllr Paul Hezelgrave and Cllr Milan Radulovic (deputy).

    c) Investment: Cllr Neghat Khan and Cllr Simon Spencer (deputy).

    d) Farming and Rural Affairs: Cllr Barry Lewis and Cllr Paul Peacock (deputy).

45. More information about the EMCCA can be found here: https://www.eastmidlands-cca.gov.uk/.

The State of Integrated Care Systems 2023/2024: Tacking today while building for tomorrow: An NHS Confederation report

46. This report is based on a survey of ICS leaders' opinions, comprising the views of chairs and chief executives across ICBs. Headline findings from the report indicate that although over 90% of leaders state that their system has made a commitment to shift resources into the community, only 54% of respondents considered that their system was making progress. There is concern that lack

of long-term investment and directive on national policies is focussing on short term performance and financial issues, as identified in the Darzi report.

47. The report makes five recommendations to the government for consideration as part of the development of the ten-year plan. These relate to:

    a) The need for multi-year funding settlements for both revenue and capital.

    b) The need to for a new NHS payment scheme that supports the shift towards integration and more preventative healthcare.

    c) The need to evolve and embed the new operating model with and through ICBs to tackle issues in the wider system.

    d) The need for oversight arrangements to be balanced between short-term and longer-term objectives.

    e) The need to give ICBs more levers to devolve decision making to place and neighbourhoods, without prescribing specific actions or timelines.

48. The full report can be found here: https://www.nhsconfed.org/publications/state-integrated-care-systems-.

Independent review into the operational effectiveness of the Care Quality Commission

49. Following publication of the interim review in July, the Department of Health and Social Care has published the full report on Dr Penelope Dash's review of the Care Quality Commission (CQC). The review found *"significant failings in the internal workings of CQC, which have led to a substantial loss of credibility within the health and social care sectors, deterioration in the ability of CQC to identify poor performance and support a drive to improved quality, and a direct impact on the capacity and capability of both the social care and healthcare sectors to deliver much-needed improvements in care."*

50. Seven recommendations are detailed within the report:

    a) Rapidly improve operational performance, fix the provider portal and regulatory platform, improve use of performance data within CQC, and improve the quality and timeliness of reports.

    b) Rebuild expertise within the organisation and relationships with providers in order to resurrect credibility.

    c) Review the Single Assessment Framework and how it is implemented to ensure it is fit for purpose, with clear descriptors, and a far greater focus on effectiveness, outcomes, innovative models of care delivery and use of resources.

    d) Clarify how ratings are calculated and make the results more transparent.

    e) Continue to evolve and improve local authority assessments.

f) Formally pause ICS assessments.

g) Strengthen sponsorship arrangements to facilitate CQC's provision of accountable, efficient and effective services to the public.

51. The CQC has accepted the recommendations from both this report and the recommendations from the complementary review on the Single Assessment Framework, undertaken by Sir Mike Richards. The CQC will now work with providers, colleagues, people who use services, local government, and wider stakeholders to develop a plan on how it will implement these changes and make sure it is realistic about what can be delivered by when.

52. The full reports can be found here: https://www.cqc.org.uk/publications/review-cqcs-single-assessment-framework-and-its-implementation and here: https://www.gov.uk/government/publications/review-into-the-operational-effectiveness-of-the-care-quality-commission-full-report/review-into-the-operational-effectiveness-of-the-care-quality-commission-full-report#next-steps

Terms of reference for the government's review of the safety of the health and care landscape

53. This independent review of patient safety across the health and care landscape, recently announced by the Department of Health and Social Care, follows on from Dr Dash's Report, and will be used to inform the government's ten-year health plan.

54. The independent review will focus on the six key organisations overseen by the Department of Health and Social Care, which have a significant impact on safety, namely the CQC, the National Guardian's Office, Healthwatch England, the Health Services Safety Investigation Body, the Patient Safety Commission and NHS Resolution.

55. The primary task of the independent review will be to assess whether the current range and combination of organisations delivers effective leadership, listening, learning (including investigations and their recommendations) and regulation to the health and care systems in relation to patient and user safety (and to what extent they focus on the other domains of quality). Based on this assessment, the review will make recommendations on whether greater value could be achieved through a different approach or delivery model.

56. The review will also map the overall landscape of current bodies that undertake regulatory or non-regulatory activity with respect to quality (including safety), set standards in respect of quality (including safety) and handle quality (including safety) issues as part of their workload.

57. The full terms of reference can be accessed here: https://www.gov.uk/government/publications/review-of-patient-safety-across-

the-health-and-care-landscape-terms-of-reference/review-of-patient-safety-across-the-health-and-care-landscape-terms-of-reference.

NHS England Chair to stand down

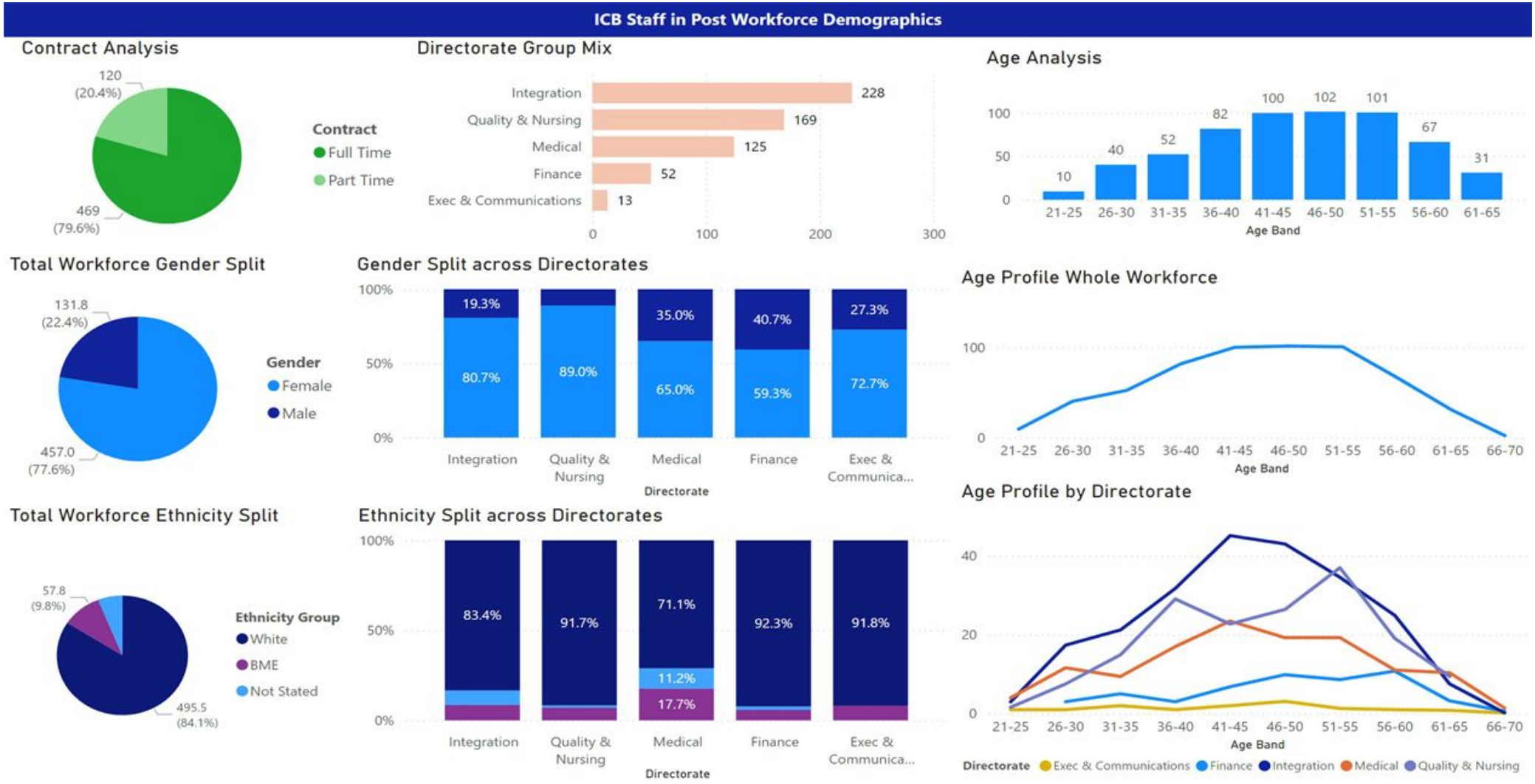
58. It has been announced that Richard Meddings, Chair of NHS England since March 2022, will stand down at the end of March 2025. The Department of Health and Social Care will shortly advertise the role of Chair to allow for an open and competitive process to take place, as well as the necessary parliamentary approvals.

Appendix A

NHS
Nottingham and Nottinghamshire

You said...		...we did
Recognise and reward excellence		Introduced staff recognition scheme
Clearly communicating purpose and vision		Purpose and vision on intranet, reiterated at staff briefings
Support staff in 'speaking up'		FTSU guardian recruited
Focus on embedding our values and behaviours		Held values and behaviours sessions, regular values blogs, staff events
Focus on health and wellbeing		Health and wellbeing tips in staff news, focus on sickness absence management
Build opportunities for people to get to know each other		Programme of open house events and staff events
Improving communication about organisation changes		Regular updates at staff briefings on challenges and financial situation
Better and more timely appraisals and career conversations		Re-launched appraisal process with training planned

Appendix B: ICB Workforce Demographics



APPENNDIX C

BRIEFING PAPER

DATE: November 2024

PAPER TITLE: Delegation of additional specified Specialised Acute Services and Mental Health, Learning Disability and Autism specialised services and associated workforce.

PURPOSE: INFORMATION ☒ DECISION ☐

EXECUTIVE SUMMARY: This paper provides a summary of the process for the delegation of additional specialised acute services, and Mental Health, Learning Disability and Autism (MHLDA) services and the corresponding staff resources in ICB's in 2025/26.

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1. INTRODUCTION AND PURPOSE OF THE PAPER

1.1 The purpose of this paper is to update Boards on the next phase of specialised service delegation to ICBs to be undertaken by April 25, and the aligned transfer of staffing resource.

1.2 ICB Boards approved the delegation of 59 Acute Specialised Services on 1 April 2024. The next phase of delegation includes the following:

i. An additional number of acute specialised services

ii. Mental health Learning Disability and Autism (MHLDA) specialised services

1.3 In line with nationally agreed processes, the staffing resource to support the on-going commissioning responsibilities for these services will transfer on 1 July 2025. The team is currently hosted by NHS England (NHSE) and working on behalf of the ICBs supported by the arrangements of the current delegation agreement.

1.4 A small number of acute and MHLDA specialised services will remain commissioned through NHSE.

1.5 ICB Boards will need to be assured and approve the final elements of the specialised services delegation prior to April 25.

2. BACKGROUND AND CONTEXT

2.1 ICBs were set up to work with all partners to create a system where decisions are taken as locally as possible, with frontline clinicians and professionals at the centre of driving change and supporting patients and communities having a say on how the changes are being proposed.

2.2 However, at the inception of ICBs a significant proportion of the population's care was managed outside of the ICS through NHSE as specialised services

2.3 In December 2023, the NHSE Board approved the 11 Midlands ICBs' applications for the delegation of an initial 59 specialised acute services to the Midlands ICBs. In Spring 2024, the Board reviewed the remaining services and determined the final list of specialised services to be either retained by NHSE or delegated to ICBs across all parts of the country on 1st April 2025.

2.4 Although NHSE remains accountable to the Secretary of State for the services, under delegation the responsibility for all decision relating to the planning, design, quality, finance, and delivery, transfer to ICBs this includes:

i. Decisions in relation to the commissioning and management of the delegated services

ii. Planning delegated services for the population, including carrying out needs assessments

iii. Undertaking reviews of delegated services in respect of the population

iv. Supporting the management of the specialised commissioning budget for delegated services

v. Co-ordinating a common approach to the commissioning and delivery of delegated services with other health and social care bodies in respect of the population where appropriate

vi. Such other ancillary activities that are necessary to exercise the specialised commissioning functions.

2.5 Whilst national specifications and standards remain for Specialised Services, delegation provides the opportunity to ensure that planning is based on the needs of local populations, and that value is realised across pathways.

2.6 The responsibility for delivery of Specialised Services sits collectively with the Muli-ICB partnership (East and West Joint Committees) and this multi-ICB arrangement is a formal requirement of delegation. Therefore, if a service in one ICB is having issues then is it the multi-ICB partnership who will have oversight and the responsibility through the hosted Specialised Commissioning team to resolve.

2.7 The multi-ICB commissioning footprints for the Midlands are:

- East Midlands (Notts and Nottinghamshire ICB, Derby and Derbyshire ICB, Lincolnshire ICB, Leicester, Leicestershire and Rutland ICB, and Northamptonshire ICB)

- West Midlands (Birmingham & Solihull ICB, the Black Country ICB, Shropshire, Telford and Wrekin ICB, Staffordshire & Stoke-on-Trent ICB, Herefordshire and Worcestershire ICB, Coventry and Warwickshire ICB).

3. THE DELEGATION PROCESS

3.1 A Delegation Agreement currently exist between individual ICBs and NHS England. This arrangement was agreed in relation to the 59 services delegated in April 2024. Therefore, a new delegation agreement will be required to reflect the additional service responsibilities and any agreed developmental arrangements from April 2025. The agreement will be presented to the ICB Board for approval in early 2025.

3.2 In addition to the new Delegation Agreement, a hosting agreement and new ICB Joint Working Agreement will be required to support the staff transition and management of services through the host ICB on behalf of the 11 ICB's and the retained functions of NHS England. As previously agreed, the host ICB will be BSOL ICB.

3.3 The current programme infrastructure to oversee the delegation process has relevant representation from the 11 ICB's and is managed through 6 key workstreams: - Governance, BI, Workforce and People, Finance & Contracting, Quality and Comms & Engagement.

3.4 An executive leadership function has been agreed to provide strategic direction to the delegation programme. The Executive Leadership Group (ELG) is co-chaired by David Melbourne, CEO lead from the West Midlands Joint Committee and Caroline Trevithick, CEO lead from the East Midlands with Roz Lindridge as Executive lead from NHSE.

3.5 The work programme and associated governance has been reviewed considering lessons learnt from earlier delegations. This includes clearer accountability, focus on communications and engagement and a jointly owned work plan.

4. BENEFITS OF MHLDA DELEGATION

4.1 The delegation of MHLDA specialised provision will include the majority of CAMHS inpatient services, Adult Low and Medium secure provision, Adult ED inpatient beds and Perinatal (Mother and Baby) Units. Some services, including high secure services, will remain commissioned by NHSE.

4.2 Currently these services are commissioned through formal Provider Collaborative arrangements. NHSE will novate contracts with 8 lead providers who are supported by provider collaborative agreements.

4.3 The provider collaborative model in MHLDA has already impacting on how ICB populations access care, ensuring a reduction in OOA placements, reduced LOS and improved quality frameworks for example. The delegation of the services to ICBs will ensure further opportunity to drive pathway improvements to ensure that population needs are met in the least restrictive environment and realising value through early intervention and/or safe and responsive discharge.

4.4 Expected benefits are summarised below:

5. FINANCE

5.1 The budget for all delegated services will be transferred to ICBs upon delegation. ICB Directors of Finance and NHSE, through the finance and contracting specialised services subgroup, are developing mechanisms for financial governance, building on those developed for the delegation of acute specialised services in April 2024.

5.2 Although there is already a financial risk framework within the provider collaboratives, consideration needs to be given to a process for managing financial risk exposure between ICBs. These will be developed through the finance and contracting subgroup as part of the 2025/26 planning process.

6. THE WORKFORCE

6.1 There is a dedicated specialised services workforce currently employed and hosted within NHSE which will be transferred to BSOL ICB. The hosted team will work on behalf

of all 11 ICBs to commission delegated specialised services, working with the retained team in NHSE.

6.2 A national process for transfer has been agreed with a single date for transfer on 1st of July 2025.

6.3 The TUPE consultation on transfer will take place between April – June 2025.

6.4 To continue to develop our joint working and approach to integrated commissioning, there will still be functions that the ICB hosted team and the NHSE retained teams work on together and functions that each team will undertake on behalf of the other; these functions will be described in the agreements between the ICBs and NHSE.

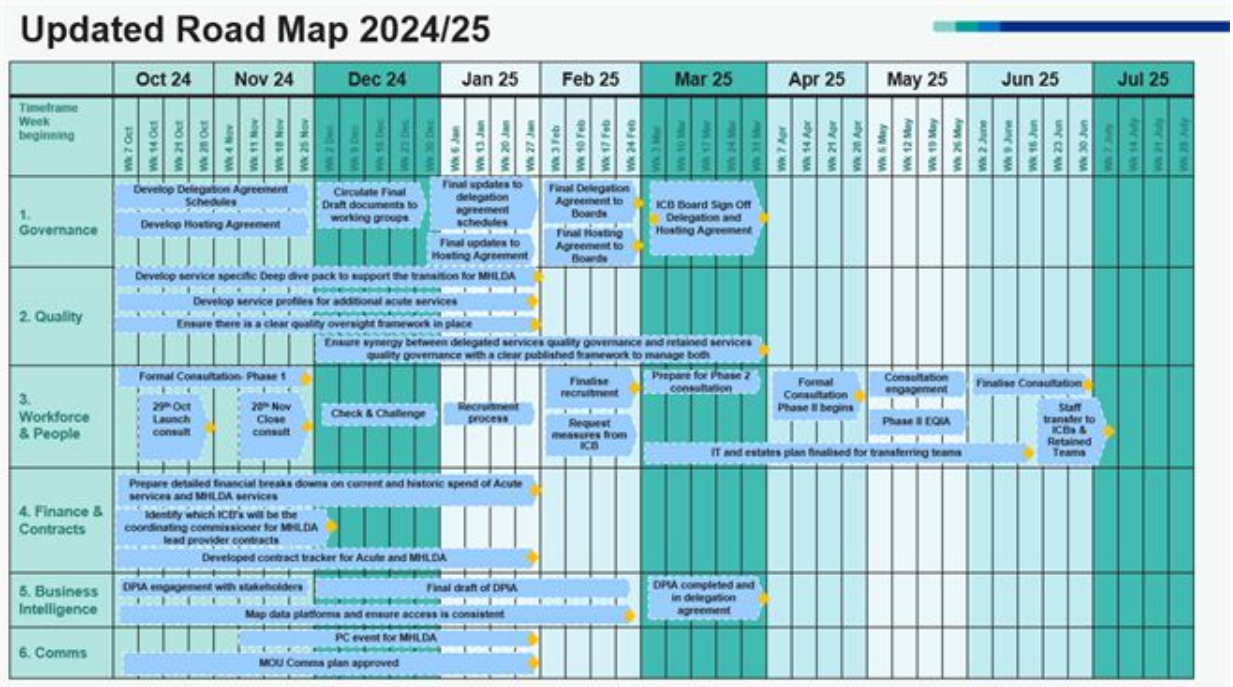
7. REQUIREMENTS OF ICB BOARDS

7.1 In summary ICB boards will receive the following document for approval:

Item	Action	Date
Delegation Agreement	Approval	Feb/March Boards
Hosting Agreement	Approval	June Boards
Joint Working Agreement	Approval	Feb/March Boards

APPENDICES

1. HIGH LEVEL TIMELINE FOR DELEGATION PROGRAMME



2. LIST OF SERVICES FOR DELEGATION

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease (adults)
		29S	Severe asthma (adults)
		29L	Lung volume reduction (adults)
		29V	**Complex home ventilation (adults)**
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
6	Adult secure mental health services	**22S(a)**	**Secure and specialised mental health services (adult) (medium and low) – excluding LD/ASD/WEMS/ABI/DEAF**
		22S(c)	**Secure and specialised mental health services (adult) (Medium and low) – ASD MHLDA PC**
		22S(d)	**Secure and specialised mental health services (adult) (Medium and low) – LD MHLDA PC**

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Complex interventional cardiology
		13Z	Cardiac surgery (outpatient)
8	Adult specialist eating disorder services	**22E**	**Adult specialist eating disorder services MHLDA PC**
9	Adult specialist endocrinology services	27E	Adrenal Cancer (adults)
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08O	Neurology (adults)
		08P	Neurophysiology (adults)
		08R	Neuroradiology (adults)
		08S	Neurosurgery (adults)
		08T	Mechanical Thrombectomy
		58A	Neurosurgery LVHC national: surgical removal of clival chordoma and chondrosarcoma
		58B	Neurosurgery LVHC national: EC-IC bypass (complex/high flow)
		58C	Neurosurgery LVHC national: transoral excision of dens
		58D	Neurosurgery LVHC regional: anterior skull based tumours
		58E	Neurosurgery LVHC regional: lateral skull based tumours
		58F	Neurosurgery LVHC regional: surgical removal of brainstem lesions
		58G	Neurosurgery LVHC regional: deep brain stimulation
		58H	Neurosurgery LVHC regional: pineal tumour surgeries - resection
		58I	Neurosurgery LVHC regional: removal of arteriovenous malformations of the nervous system

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
	Adult specialist neurosciences services (continued)	58J	Neurosurgery LVHC regional: epilepsy
		58K	Neurosurgery LVHC regional: insula glioma's/complex low grade glioma's
		58L	Neurosurgery LVHC local: anterior lumbar fusion
		58M	Neurosurgery LVHC local: removal of intramedullary spinal tumours
		58N	Neurosurgery LVHC local: intraventricular tumours resection
		58O	Neurosurgery LVHC local: surgical repair of aneurysms (surgical clipping)
		58P	Neurosurgery LVHC local: thoracic discectomy
		58Q	Neurosurgery LVHC local: microvascular decompression for trigeminal neuralgia
		58R	Neurosurgery LVHC local: awake surgery for removal of brain tumours
		58S	Neurosurgery LVHC local: removal of pituitary tumours including for Cushing's and acromegaly
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery (adults)
		34R	Orthopaedic revision (adults)
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
		11T	**Renal Transplantation**
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery (adults)
		29Z	Adult thoracic surgery services: outpatients
29	Haematopoietic stem cell transplantation services (adults and children)	**02Z**	**Haematopoietic stem cell transplantation services (adults and children)**
		ECP	**Extracorporeal photopheresis service (adults and children)**

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
32	Children and young people's inpatient mental health service	**23K**	**Tier 4 CAMHS (general adolescent inc eating disorders) MHLDA PC**
		23L	**Tier 4 CAMHS (low secure) MHLDA PC**
		23O	**Tier 4 CAMHS (PICU) MHLDA PC**
		23U	**Tier 4 CAMHS (LD) MHLDA PC**
		23V	**Tier 4 CAMHS (ASD) MHLDA PC**
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services (adults and children)
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services (adults and children)
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services (adults and children)
		08Z	Complex neuro-spinal surgery services (adults and children)
45	Cystic fibrosis services (adults and children)	**10Z**	**Cystic fibrosis services (adults and children)**
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services (adults and adolescents)
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services (adults and children)
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services (adults and children)
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services (adults and children)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection (adults)
72	Major trauma services (adults and children)	34T	Major trauma services (adults and children)
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services (adults and children)
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
98	Specialist secure forensic mental health services for young people	**24C**	**FCAMHS MHLDA PC**
103A	Specialist adult haematology services	**03C**	**Castleman disease**
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer (adults)
		01K	Malignant mesothelioma (adults)
		01M	Head and neck cancer (adults)
		01N	Kidney, bladder and prostate cancer (adults)
		01Q	Rare brain and CNS cancer (adults)
		01U	Oesophageal and gastric cancer (adults)
		01V	Biliary tract cancer (adults)
		01W	Liver cancer (adults)
		01X	**Penile cancer (adults)**
		01Y	Cancer Outpatients (adults)
		01Z	Testicular cancer (adults)

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		04F	Gynaecological cancer (adults)
		19V	Pancreatic cancer (adults)
		19C	Biliary tract cancer surgery (adults)
		19M	Liver cancer surgery (adults)
		19Q	Pancreatic cancer surgery (adults)
		24Y	Skin cancer (adults)
		29E	**Management of central airway obstruction (adults)**
		51A	Interventional oncology (adults)
		51B	Brachytherapy (adults)
		51C	Molecular oncology (adults)
		61M	Head and neck cancer surgery (adults)
		61Q	Ophthalmic cancer surgery (adults)
		61U	Oesophageal and gastric cancer surgery (adults)
		61Z	Testicular cancer surgery (adults)
		33C	Transanal endoscopic microsurgery (adults)
		33D	Distal sacrectomy for advanced and recurrent rectal cancer (adults)
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence (adults)
		33B	Complex inflammatory bowel disease (adults)
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
112	Specialist gynaecology services for children	73X	Specialist paediatric surgery services - gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
114	Specialist haemoglobinopathy services (adults and children)	**38S**	**Sickle cell anaemia (adults and children)**
		38T	**Thalassemia (adults and children)**
115	Specialist immunology services for adults with deficient immune systems	**16X**	**Specialist immunology services for adults with deficient immune systems**
115A	Specialist immunology services for children with deficient immune systems	**16Y**	**Specialist immunology services for children with deficient immune systems**
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
124	Specialist perinatal mental health services (adults and adolescents)	**22P**	**Specialist perinatal mental health services (adults and adolescents) MHLDA PC**
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs (adults and children)
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
		19B	Specialist services for complex biliary diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	**05C**	**Specialist augmentative and alternative communication aids (adults and children)**
		05E	**Specialist environmental controls (adults and children)**
		05P	Prosthetics (adults and children)
135	Specialist paediatric surgery services	23X	Specialist paediatric surgery services - general surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital
ACC	Adult Critical Care	ACC	Adult critical care

END

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/11/2024
Paper Title:	**Development of the Provider Collaborative**
Paper Reference:	ICB 24 067
Report Author:	Claire Culverhouse, Managing Director – Provider Collaborative
Executive Lead:	Victoria McGregor-Riley, Acting Director of Strategy and System Development
Presenter:	Claire Culverhouse, Managing Director – Provider Collaborative

Paper Type:							
For Assurance:		For Decision:		For Discussion:	✓	For Information:	

Summary:

This paper provides an update to Board members on the progress of development of the Provider Collaborative in Nottingham and Nottinghamshire, Notts Healthier Together. The paper includes a summary of where we were last time we discussed this topic with the Board, a description of where we are now with the development of our four work programmes and sets out our proposed next steps.

Recommendation(s):

The Board is asked to **discuss** the content of the paper.

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	The Provider Collaborative will form a core component of a functioning health and care system, so over time will be able to play a role in delivering all of the core aims of the ICB.
Tackle inequalities in outcomes, experience and access	As above
Enhance productivity and value for money	As above
Help the NHS support broader social and economic development	As above

Appendices:

None.

Board Assurance Framework:

This paper provides assurance in relation to the management of the following ICB strategic risk(s):

- Risk 3: Financial sustainability – Failure to achieve financial sustainability across the system.

Report Previously Received By:

This paper builds on a previous paper to the Board in July 2023 and discussions at the Board development session in June 2024.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Development of the Provider Collaborative

Introduction

1. The Provider Collaborative in Nottingham and Nottinghamshire, Notts Healthier Together, has been developing for some time. The last presentations to the ICB's Board in July 2023 and at the Board Development Session in June 2024, set out the approach. This paper builds on those updates and provides the Board with a current position and an opportunity for discussion about how we most effectively step into our role as a supportive component of the broader system.

Background

2. Notts Healthier Together is a collaborative of the five NHS Trusts across the Nottingham and Nottinghamshire area: Sherwood Forest Hospitals NHS Foundation Trust (SFH); Nottinghamshire Healthcare NHS Foundation Trust (NHT); Nottingham University Hospitals NHS Trust (NUH); Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBH); and East Midlands Ambulance Services NHS Trust (EMAS).
3. The collaborative is just one of several components of the wider health and care system and our role in the system cannot be determined in isolation, but as part of a broader system discussion. For that reason, we have kept our mission statement simple: 'We will work together, as relevant, for the benefit of our patients, our colleagues and teams and our communities'.
4. There are both strengths and weaknesses of working collaboratively across our organisations. Over the past two years we have built, maintained and increased the quality and strength of our relationships. We are regularly sharing ideas, opportunities and information between provider organisations, helping each other more readily where we can. Our collaborative programmes are now taking shape and the Distributed Executive Group that we have established for the collaborative is operating more effectively as a shared team.
5. However, we know that collaboration is not always easy, it has taken time for us to get to this stage and it is often much slower for us to move forward together. We have improved the way in which we work together and have the foundations to be able to move into the delivery of tangible benefits for our patients, teams and communities. We know that we now have to move beyond collaboration and into performance and efficiency improvements.
6. A stocktake meeting of member organisations' Chairs and Chief Executives took place on 11 October. At this session we:

a) Reconfirmed our appetite for collaboration in our identified programme areas.

b) Gained a better understanding where members sat on the spectrum of collaboration through to integration for each of our work programme areas.

c) Agreed to rapidly invest in some short-term work, in order to effectively assess the impact of varying options of collaboration to integration in each area.

7. The Collaborative wants to maximise its contribution to the wider system and much of the work that we undertake collaboratively will support us to deliver our organisational and system ambitions. The Collaborative is committed to contributing to the system transformation programme and we believe will begin to bring benefit from 2025/26.

Approach to work programmes

8. There are four agreed programmes of work for Notts Healthier Together: corporate services; people and culture; estates; and planned care.

9. Over the last six months there have been progressive conversations with colleagues from across the system about mobilising these programmes in order to generate impact through 2025/26. The role that Notts Healthier Together is now being asked to play in the system is both as a vehicle to support a strategic role for providers into the future, as well as a shorter-term vehicle to support us in meeting some of our system challenges.

10. When we consider the impact of collaboration, we are clear that whilst financial opportunities are a priority, some of the added value of increased collaboration will be improvements to service quality, productivity or sustainability. In defining potential impact of the collaborative work programmes, we will consider a range of benefits and the drivers of collaboration and value added will be articulated in the most appropriate form.

11. In continuing to accelerate our collaborative work, we are also cognisant of the challenges that our teams face currently in terms of capacity, so we know that we need to create the resource to support this work.

Progress

12. When we last presented to the Board in June 2024, we committed to four things:

a) Reconfirmation and agreement of shared purpose for each of the work programmes.

b) Clarifying roles and responsibilities for delivery and oversight of the work programmes.

c) Aligning resource across the system to support mobilisation and delivery of the work programmes.

d) Clarification of governance processes.

13. The remainder of this paper will provide an update on each of the work programmes individually, but from an overarching perspective, we believe that we have made progress in each of these areas, although there is still work to do across some of our programme areas.

14. The Provider Collaborative work programmes currently report into the collaborative Distributed Executive Group and then on to the Collaborative Leadership Board. We have also recently started reporting into the new ICS Transformation Delivery Group.

Programme one: corporate services

15. Claire Hinchley, Acting Director of Strategy and Partnerships at SFH is the Senior Responsible Officer (SRO) for this programme. Three services are in scope which are procurement, payroll, and legal services (clinical and human resources legal services). Different levels of interest from different organisations align to each of the three services. Organisations in scope include NHT, EMAS, SFH, and NUH.

16. There is no dedicated resource for this programme, so the Collaborative has recently agreed some short-term investment, to enable consideration of options and potential impact for each of the three areas covering:

a) Transactional – e.g. shared service desks.

b) Professional – e.g. people with expertise working together, aligned contracts and processes.

c) Strategic – e.g. single organisational lead on behalf of the system, single service with single employer.

17. There are benefits and risks to each of the three levels of collaboration or integration, each requiring resource within services to take forward the identified actions and additional project resource to support that process. Each of the three levels need to consider:

a) Appetite for change and palatability of risks at system, organisational, service and professional level.

b) Clarification of the problems we are trying to solve/opportunities we seek, whether these are aligned, and whether collaboration or integration is the right answer.

c) Assessment of whether the effort and resource request is palatable to achieve anticipated outcomes.

18. The recently funded work will conclude with an options appraisals on each area to be considered by our Leadership Board by the end of the year, determining our next steps.

Programme two: people and culture

19. Jen Guiver, Chief People Officer (CPO) at NHT is the SRO for this programme. Jen is working closely with CPOs from SFH and NUH, as well as Philippa Hunt and Jo Worrell from the ICB.

20. The programme has evolved over time as the landscape and priorities for the CPOs in the system have changed. Originally, the work-stream aspired to improve colleague movement across the system by aligning various pre-employment checks and mandatory training requirements. There was also a project to introduce a shared 360 Appraisal across the collaborative. In addition, we worked up plans to better align our flexible workforce offers.

21. However, in summer 2024 it was agreed to merge the Scaling Up People Service Vanguard NHS England project with the collaborative work to concentrate the limited resource available on the following projects:

    a) Procurement of people services systems and contracts for services including the Employee Assistance Programme.

    b) Wellbeing services (excluding Occupational Health).

    c) Workforce portability, including passporting.

    d) Electronic Staff Record utilisation and attainment.

    e) Recruitment, commencing with ‘time to hire’ metrics and associated TRAC (electronic recruitment system) configuration.

22. The programme has had to pivot in recent weeks to respond to the financial challenge across all three providers and for the next six months the collaborative members will be focussing on the premium pay work. Therefore, the work-streams are now:

    a) Creating a value for money bank rate card across the Provider Collaborative.

    b) Enhancing vacancy controls across the Provider Collaborative.

    c) Achieving agency cost reductions through collaborative procurement.

    d) Reducing premium pay associated with Waiting List Initiatives, etc.

23. Currently we are quantifying the financial value of these schemes but will need to undertake further work to quantify and align the impact of this from a service and financial perspective.

Programme three: estates

24. Alison Wyld, Director of Finance at NHT is the SRO for this programme. Alison is working closely with Dawn Chambers, Strategic Director, Estates and Facilities (NHT). The programme involves NHT, NUH, SFH, as well as the ICB and EMAS in some parts. The programme is focusing on the following three areas: space utilisation; becoming greener; and strategic opportunities.

25. **Space utilisation** will look at how we can collaboratively rationalise and share the estate resulting in a reduction in operating costs and backlog maintenance. It will identify pockets of underutilisation, initially within corporate estate, later within clinical areas. This programme will also include the development and implementation of a centralised booking system, and the alignment and adoption of a set of agreed utilisation parameters, including smarter working principles and flexible design standards. Simple and consistent service level agreements and lease arrangements are also planned for development to facilitate and accelerate better sharing of the estate.

26. A pilot scheme looking at three to four corporate properties is planned, and the Collaborative has recently supported additional resource in the form of a computer aided design technician and a space technician/consultant to develop an option appraisal to relocate services into one or two buildings, and disposal of the remainder, which will result in a capital receipt.

27. **Becoming greener** will focus on where we can reduce energy consumption and losses, investing in energy saving measures, behaviour change and upgrading building fabric. This programme will also focus on where we can generate/increase on-site renewable energy. Work is already happening in these areas, so it is therefore important to bring people together to map the current work and scope any additional areas on which to collaborate, rather than setting up as a new work programme.

28. We believe there could also be opportunities to manage waste, improve our buying power and economies of scale, target high areas of spend such as food, fleet electrification and a system wide approach to reduce emissions, and supporting a healthier workforce with active travel options.

29. Projects such as environmental control of the temperature of theatres, medical gases, asthma medication and inhalers etc. could directly impact on quality and clinical operational outcomes and support both the sustainability and financial agenda.

30. **Strategic opportunities** will follow on from the Nottingham and Nottinghamshire Infrastructure Strategy and will look at how estate opportunities may stimulate clinical, operational and workforce transformation (working alongside the corporate services and people and culture work-streams).
31. This will include better 'insight,' looking at best practice and innovation, creating a single data source, benchmarking, and identifying and monitoring key performance indicators for strategic delivery. Any 'investment' will take a systematic, partnership approach to identifying, prioritising and securing capital from a variety of sources.
32. The next steps for the estates programme are to deliver the space utilisation pilot with the three to four corporate sites and identify the short-term actions that will deliver benefits quickly.

Programme four: planned care

33. Lisa Kelly, Chief Operating Officer for NUH is the SRO for the Planned Care programme and Lisa is working closely with Rachel Eddie, Chief Operating Officer for SFH on this.
34. The programme focusses on:
    a) Reducing unwarranted variation and inequality in health outcomes.
    b) Improving access to services and experience.
    c) Increasing focus on prevention.
    d) Increasing value for the Nottinghamshire pound.
35. Priorities for work-streams will be to:
    a) Ensure that specialisation and consolidation occur where this will provide better outcomes and value – linked to fragile services and shared assets.
    b) Ensure Population Health Management and health inequalities intelligence are embedded within the programme – linking to work on value-based commissioning.
    c) Standardise pathways, policies and administration.
36. Areas of current collaboration are mainly focussed on operational support for planned care performance. Future collaboration being explored includes reviewing consolidation of fragile services and bringing together Patient Treatment Lists where appropriate.
37. There is more work to do to ensure that we have the most effective model in place to resource this programme, given the need for strong clinical leadership. Work is currently underway to articulate the resource need, to be able to

identify the areas of biggest impact and opportunity, and to pursue those most effectively.

Moving forward

38. We believe that this update demonstrates the evolution of our work programmes from our last discussion with the Board. We know that there is still work to do but we do believe that the definition and clarity of our programmes is there, and we have identified resource and capacity to support most of our programmes, so we are shifting from concept into action.

39. There is a recognised importance of balancing the Collaborative as an enabler to deliver improvements within organisations from both a financial and qualitative perspective, alongside the areas where the Collaborative could deliver an additional 'premium' to the work of individual organisations. As part of our work, we will need to identify where that premium is, quantify it, and work out how we can transact that across our member organisations.

40. Our summary next steps are:

    a) **In November/December**: Present to the ICB's Board; undertake pilot scheme in estates and options appraisal work within corporate services; quantify resource need for planned care and agree how to support; and quantify the impact of the actions being taken in the people and culture work.

    b) **In January**: Hold a joint provider Board/Non-Executive Director session to discuss our approach with wider Board members before any decisions are taken to member organisations' Boards.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/11/2024
Paper Title:	**Clinical and Care Professional Leadership Arrangements**
Paper Reference:	ICB 24 068
Report Author:	Amanda Robinson, Head of the Systems Analytics and Intelligence Unit Carol Raaf, Head of Professional Standards and Leadership
Executive Lead:	Dave Briggs, Medical Director
Presenter:	Dave Briggs, Medical Director

Paper Type:							
For Assurance:		For Decision:		For Discussion:	✓	For Information:	

Summary:

This paper sets out how the ICB's Collaborative Clinical and Care Transformation Leadership Group (CCCTLG) has embedded the NHS England framework to 'Building strong integrated care systems everywhere' and highlights some of the key achievements that have been made to date and how we continue to work collaboratively to develop new ways of working to deliver and exceed the core expectations and five principles for integrated care systems:

- **Principle 1**: Integrating clinical and care professionals in decision-making at every level of the Integrated Care System
- **Principle 2**: Creating a culture of shared learning, collaboration and innovation, working alongside patients and local communities
- **Principle 3**: Ensuring clinical and care professional leaders have appropriate resources to carry out their system role(s)
- **Principle 4**: Providing dedicated leadership development for all clinical and care professional leaders
- **Principle 5**: Identifying, recruiting and creating a pipeline of clinical and care professional leaders.

The CCCTLG draws its membership from across partners and wider clinical and professional cabinets and networks and includes clinicians and caregivers representing a range of professions and experience from the different sectors of health and care, including health and care professionals that work in a variety of sectors and settings including public health and social care.

Recommendation(s):

The Board is asked to **discuss** the arrangements established for clinical and care professional leadership across the system.

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	CCCTLG has clinical/professional overview of the ICS and its delivery plans, provides clinical oversight of system strategies and ensures a strategic approach is taken to transformation, including taking an active role in agreeing overall clinical prioritisation for transformation and providing coherence and consistency across

How does this paper support	the ICB's core aims to:
	transformation programmes. By embedding the core principles of 'Building strong integrated care systems everywhere' this group significantly impacts the quality of care and health outcomes for the populations we serve.
Tackle inequalities in outcomes, experience and access	CCGTLG has a common purpose across the clinical and caregiving community for improving population outcomes, health inequalities, quality, and cost of care. Overseeing the development of strategic clinical leadership to system improvement roles, promoting equality of opportunity and diversity ensuring clinical leaders are representative of the population served.
Enhance productivity and value for money	CCCTLG ensures a strategic approach is taken to transformation including taking an active role in agreeing overall clinical prioritisation for transformation including productivity and value for money, providing coherence and consistency across transformation programmes.
Help the NHS support broader social and economic development	This group, from a clinical and care giver perspective that alignment and linkages between system priorities, work-streams and groups including the clinical cabinets, supports the broader social and economic developments.

Appendices:
None.

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 5: Health inequalities and outcomes – Failure to identify and/or deliver service transformation to address health inequalities and improve outcomes.

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Clinical and Care Professional Leadership Arrangements

Background

1. The clinical and care professional leadership (CCPL) programme is a national programme aiming to build and strengthen professional leadership within Integrated Care Systems (ICS). The national CCPL programme described in 'Building strong integrated care systems everywhere', and the ICS implementation guidance on effective clinical and care professional leadership sets out the following five key principles that we have adopted and are working towards across the Nottingham and Nottinghamshire ICS:

    a) Integrating clinical and care professionals in decision making at every level of the ICS.

    b) Creating a culture of shared learning, collaboration and innovation, working alongside patients and local communities.

    c) Ensuring clinical and care professional leaders have appropriate resources to carry out their system role(s).

    d) Providing dedicated leadership development for all clinical and care professional leaders.

    e) Identifying, recruiting and creating a pipeline of clinical and care professional leaders.

2. In Nottingham and Nottinghamshire, we set out a clear vision, charter and principles in 2022 and these continue to describe our journey and commitment to clinical leadership. Defining the role that all our professionals play in shaping health and care for our local population and ensuring high-quality care for all. Ensuring that the clinical and care voice represents the needs of the individual/service user/patient/carer, works collaboratively and recognises the benefits of integration, the ICS Collaborative Clinical and Care Leadership and Transformation Group (CCCTLG) therefore values the contributions of all professionals.

3. The following sections set out the progress to date against the five principles.

Integrating clinical and care professionals in decision making at every level of the ICS

4. The CCCTLG has been established for a couple of years and draws its membership from across partners and wider clinical and professional cabinets and networks. Professional groups in their various guises e.g. Allied Health Professionals Cabinet, Pharmacy Faculty, Nursing and Midwifery Cabinet, Advanced Practice Steering Group, etc.

5. At present the Group meets monthly with an agenda flexible enough to ensure this clinical reference group has system oversight, ownership and co-development across the ICS. It recognises all professionals and the valuable contributions they make, highlighting the importance of the clinical voice and integration at all levels of decision-making, e.g.
    a) Strategies and strategic decision making.
    b) Transformation and pathway changes.
    c) Winter planning/plans.
    d) Tomorrow's NUH (Nottingham University Hospitals NHS Trust).
    e) 30-minute handover plans.
    f) Research Strategy.
    g) Clinical Design Authority (CDA) Senates, recommendations and outputs.
6. The Group recognises that as the system matures, more can be done to ensure sufficient representation continues to grow and is embedded within the governance and reporting structure of the ICS.

Creating a culture of shared learning, collaboration and innovation, working alongside patients and local communities

7. The CCCTLG has hosted workshops to create an ICS vision, charter and principles for Nottingham and Nottinghamshire. These were originally developed in 2022 and continue to describe our journey and commitment to clinical leadership. In order to progress our approach to clinical and care professional leadership, a workshop was held in December 2023 to continue the conversation and ambitions.
8. Clinical Design Authority Senates are a continuous cycle that supports performance and transformational activity through CCCTLG. The transformational process brings together and promotes collaborative, shared learning with clinical, professional experts and leaders, using data and intelligence to drive evidence-based recommendations. Working collaboratively with programme boards on the recommended outputs of the senate our aim is to oversee system transformation through data and intelligence that is measurable, has clear reporting and governance with the ultimate intention of having a positive impact on the ICS Outcomes Framework.
9. To date several senates have taken place. The membership includes stakeholders from across the system with many exceeding 50-60 participants with a specialist interest (clinical and non-clinical, health and care) on system agreed priority areas including Cardiovascular Disease, Chronic Obstructive Pulmonary Disease, Frailty, and Serious Mental Illness/ Personality Disorder.

10. Three further senates (End of Life, 90-Day Readmissions and Diagnostics) are planned to be presented to CCCTLG in the coming months; however, it is recognised that the membership to these senates should be expanded to become more inclusive.

11. The ICB Health and Care Professions Network: The ICB has developed a Health and Care Professions Network for their registered health and care professionals. It provides touchpoints and opportunities to network with each other, explore how to better utilise skills and expertise and to share ideas. This Network also enables support for re-registration/revalidation, supervision, and opportunities to support clinical placements, which further feeds into better preparing our future workforce. Most Network meetings have been quarterly and on-line, but the first face-to-face half-day event was held in September.

12. Innovation Challenge – Building Innovation Together, has continued to build a culture of collaboration across our health, care and third sector to support transformation and service redesign. This interactive event focused on addressing our most pressing local “wicked challenges” through collaboration and innovation. The day shared practical insights into systems leadership, simplifying key concepts before participants explored how they could apply these ideas within their own roles and for this challenge. Throughout the day, system leaders worked in groups to apply systems leadership in practice, helping to shape the ICS Quality Framework. The event incorporated a blend of dialogue and applied Accelerated Design Methodology, driving forward the practical implementation of concepts discussed. With a focus on commitments to act, systems leaders were empowered to take ownership to lead when returning to their respective organisations.

13. November 2024 will see a further event for system leaders across the Nottingham and Nottinghamshire ICS. This workshop is for senior leaders from all partner organisations who have the ambition to network, connect and explore opportunities to develop their system leadership role. It is an event that has been designed in collaboration with NHS Elect and all system partners.

14. There is an appetite for multisector multi-organisational collaborations across the system and some of this partnership working is already in place. One example is Operational Delivery Groups associated with Transformation Boards, such as those related to Learning Disability and Autism, Community Services and Maternity and Neonatal transformation programmes. The patient voice is at the centre, with service user representation, surrounded by specific workstreams that bring together all stakeholders across each of the relevant sectors, including representation from quality teams.

15. At a professional leadership level, a Professional Advocate Network has been set up for Professional Nurse and Professional Midwifery Advocates respectively. This enables shared learning, collaboration, innovation and support to ensure that these roles are embedded within the ICS. These roles

support a model for clinical supervision and leadership that support advocacy, education and quality improvement of care and service delivery.

16. Another example is the ICS Research Strategy. This has been co-produced with all professional groups and sectors through an extensive consultation exercise. The next step is to develop an ICS Research Hub that will provide visibility to new and existing research projects and opportunities as well as support and expertise for those interested in and already undertaking research within the system.

Ensuring clinical and care professional leaders have appropriate resources to carry out their system role(s)

17. Nottingham and Nottinghamshire has embedded clinical and professional leaders across the system by enrolling Clinical Design Authority members that support ICS planning, transformation, and delivery through allocated funding for task and finish pieces of work. This model enables professional leadership resource to be utilised cross system for all priority areas of work through protected allocated time. In additional to this Deputy Medical Directors, Clinical Directors and Locality leads have funded protected time to support system working and leadership roles. With the SAIU, data and intelligence is a central resource provided to professional leaders that promotes transformational activity and includes primary care GP allocated time.

18. The system funded a Leadership Nurse Fellow to map nursing placements across the system and develop a strategy to track demand and capacity, alongside placement quality. This was a short-term project that has now ended but has led to the identification of further gaps such as the need for standardised supervisor and assessor training for practice educators. Further work that has continued is to develop a Safe Learning Environment Charter for students and practice educators. The Task and Finish Group consists of representatives from a range of professions and sectors and is a collaborative partnership to expand and embed work started in midwifery. NHS England funding has provided funding and the spending plan will be agreed through the ICS Clinical Placement Subgroup following a maturity matrix and mapping exercise.

19. The Leadership Nurse Fellow worked alongside a second Leadership Nurse Fellow who has been working to expand clinical placements in the nursing fields of learning disabilities mental health within care settings. This has led to a highly successful collaboration with local universities and the ICB/County Council. Clearer pathways have been established for identifying suitable care settings with the Integrated Quality and Market Management Team and this has led to a doubling of the number of learning disability care home placements (from 11.8 to 22% in 7 months). While both of these placement projects have had a positive impact, there is insufficient ICS clinical placement oversight and

quality assurance. This a risk and puts Nottingham and Nottinghamshire behind other ICSs.

20. There are Primary Care Network Lead Nurses across South Nottinghamshire, Nottingham City and Mid-Nottinghamshire and Bassetlaw who work with the General Practice Nurses and who provide dedicated resource and coordination to the voice and needs of General Practice Nurses.

21. Six Additional Roles Reimbursement Ambassadors are employed to establish a network of peer support for the Additional Roles Reimbursement workforce in primary care to attract, retain and develop this multiprofessional team. Ambassadors also aim to shape the effective utilisation of their skills within their scope of practice to the top of their licence, in order to shape and deliver services within primary care.

22. The system has a Nursing and Midwifery Cabinet, an Allied Health Professional Cabinet, an Allied Health Professional Workforce Programme (previously called the Allied Health Professional Faculty), a Medicines Optimisation Board and a Pharmacy Faculty. Roles within the Pharmacy and Allied Health Professional Faculty/Workforce Programmes receive funding that is due to be lost in March 2025 and November 2024 respectively. Cabinet Chairs are voluntary at present. All professional groups seek representation from professionals in a wide range of sectors and specialities.

23. The Midlands Social Care Nursing Advisory Council is one of seven regional councils. It aims to ensure a stronger collaboration between social care nursing and clinical and care professionals from other sectors such as health, research and universities. The forum also aims to influence and shape the work of ICB nurse colleagues and their teams. The Chair of the Midlands Social Care Nursing Advisory Council is a social care nurse from Nottinghamshire who is integrated into the Nursing and Midwifery Cabinet and other professional conversations. The Social Care Nursing Advisory Council will provide a key link for clinical and care professional leadership, including supported living and domiciliary care.

Providing dedicated leadership development for all clinical and care professional leaders

24. A Population Health Management system leadership improvement programme is currently underway in conjunction, with an aim to offer clinical and care professionals working together to understand how we can change the system to better support prevention, frailty and as a result, improve flow and urgent and emergency care. The programme has core elements of leadership curriculum common to all professionals, and working groups formed into learning sets focussed on specific areas of change within the system. The groups will be made up of clinical and care professionals working together across the system

on real change, providing both short term benefit and laying the foundation for longer term system change as these approaches are embedded into future workstreams that they are involved in. This is programme is scheduled to offer nine full days of protected leadership time over an 18-month period.

25. Health and care partners offer a range of leadership development programme that are run through NHS Elect and the NHS Leadership Academy.

26. Nottingham University Hospitals NHS Trust (NUH) and Sherwood Forest Hospitals NHS Foundation Trust successfully ran a leadership development programme for their nurses, midwives and Allied Health Professional staff. The ICB welcomed the opportunity to partner with NUH to run a satellite programme for two of their own nurses. This has led to developing a more bespoke 12-month Fellowship opportunity for ICB clinical and care professionals that will start in 2025. This is based on the NUH structure and adapted to acknowledge the different professional development needs of ICB staff. The 2025 programme will also include a General Practice nurse.

27. The Multiprofessional Support Unit run by the Nottingham Alliance Training Hub has been established to deliver education activity that supports the professional development of the system's increasing and diverse primary care workforce. It aims to integrated professional learning between professionals as well as providing uni-professional learning for the Additional Roles Reimbursement roles and existing primary care professionals. It also provides support for clinical supervisors, supervisor training and new to practice support for those new to primary care.

Identifying, recruiting and creating a pipeline of clinical and care professional leaders

28. The ICS system-wide Talent Management Strategy spans five years, with a planned one-year refresh. Its primary aim is to align leadership development and talent management across the ICS, a new joined up approach, doing together what we cannot do alone. Incorporating the latest thinking for effective approaches to health and care integration, enhancing collaboration, system leadership, talent pipelines and continuous improvement within the ICS.

29. Through the Clinical Design Authority, our current position is good and supports the continuous recruitment of clinical and professional leaders. A continuous funding allocation has enabled the Clinical Design Authority to create and build a network of Bank/Agency clinical and non-clinical professionals that can be utilised on a task and finish basis for specific programmes of work, from across all system partners, this is communicated through various routes to maintain and attract an on-going pipeline of professional system leadership.

30. We recognise that Nottingham and Nottinghamshire has a poor record of recruiting and retaining clinical and care professionals from global majority

backgrounds, particularly within higher leadership positions. An Ethnic Minority Delivery Group has been set up to focus on the deep dive into the data that shows this restricted career progression. This Group has representation from nurses and midwives from ethnic minority backgrounds and aims to explore barriers and solutions. An Allied Health Professional Global Majority Aspiring Leaders Development Day was set up for ten Allied Health Professionals in May 2024. The purpose was to bolster the Allied Health Professional leadership talent of ethnic minority Allied Health Professionals and support succession planning for future senior roles. This was followed up by online coaching.

31. The ICS has a culture of shared learning, collaboration and innovation working when in partnership with the Nottingham Trent University to provide a multisector, multiprofessional NextGEN event for 80 year 9 students in July 2024. The students were from under-represented groups to prepare the pipeline into the NHS and social care as they move through their schooling career. Young people were given the opportunity to interact with nurses, midwives, pharmacists, occupational therapists, physiotherapists, and speech and language therapists through a series of bespoke activities helping them to understand these professions through activities and experiential learning. The event was led by Ambassadors from primary and secondary care (from all four health providers), as well as social care.

Risks and issues

32. Over the past two years CCCTLG has evolved and been developing across the ICS. Loss of posts within the People and Culture Team poses a risk to maintaining some of the momentum within clinical and care professional leadership (CCPL). In addition, further work is needed to ensure that CCPL underpins the work of the ICS; the transformation and improvements needed to serve our population well within our resources.

33. The Allied Health Professional Workforce Programme will come to an end in November 2024 and the some of the work of the Pharmacy Faculty will also end in November, with all funding ceasing in February 2025. Further consideration and system commitment needs to be given as to how these functions are continued within a governance structure that ensures true clinical and care professional leadership and support for the current and future workforce. Other clinical and care professional leadership needs to be considered alongside these risks, such as the clinical placement oversight gap.

34. CCCTLG had previously agreed a Chief Allied Health Professional system role, this is still a gap and required to continue to embed CCCTLG, integration and collaboration in the system and still needed at every level and to support with service transformation.

Next steps

35. While much work has already been done, we recognise that we have some way to go. An extensive CCCTLG mapping exercise needs to take place across the ICS to ensure that CCCTLG underpins system strategies and drives forward our maturity against the National framework. As part of that, it will be important to identify how professionals working in all sectors and areas of the ICS, and at all levels are represented. This will demonstrate how front-line clinicals are able to provide ideas, voice concerns and generally feed into service transformation and efficiency conversations to achieve the best outcomes for our population.

36. We are also as part of the next phase looking to rejuvenate the meetings through consultation e.g. Changing the date and time, reviewing, and revising the membership and agendas as a minimum, ensuring attendance and representation is such that it represents all the ICS, including Programme boards, quality, workforce etc. There is also a need to make sure that the Allied Health Professionals, Local Maternity and Neonatal System, Pharmacy, Social Care faculties and cabinets are supported and have a voice at CCCTLG and extending the membership across Provider Collaboratives will be an enabler in to how we deliver true transactional transformation at all levels of the system. Ensuring governance of CCCTLG is embedded not only in the ICB but across stakeholders and providers with a clear structure, and reporting / escalation routes.

37. This is an iterative process and will take time to fully embed, however the journey to ‘Build strong integrated care’ will continue to develop through CCCTLG and the decision-making groups with clear and visible engagement between system and frontline professionals, shaping how we all work collectively to meet our strategic priorities and ICS outcomes framework.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/11/2024
Paper Title:	**Assertive and Intensive Community Mental Health Care- Review and Action Plan**
Paper Reference:	ICB 24 069
Report Author:	Kate Burley, Deputy Head of Mental Health Commissioning
Executive Lead:	Maria Principe, Acting Director for Delivery and Operations
Presenter:	Maria Principe, Acting Director for Delivery and Operations

Paper Type:							
For Assurance:	✓	For Decision:		For Discussion:		For Information:	

Summary:

In March 2024, the Care Quality Commission (CQC) published the first part of a special review into mental health care at Nottinghamshire Healthcare NHS Foundation Trust (NHT) following the conviction of Valdo Calocane in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber.

Subsequently, the 2024/25 NHS Priorities and Operational Planning Guidance asks that all Integrated Care Boards (ICBs): "*Review their community services by Q2 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge."* Systems are required to present the results of the review and action plans to an ICB Board meeting in open session.

The paper provides an overview of the Review of Intensive and Assertive Community Mental Health Care undertaken in Nottinghamshire in September 2024, including the review process, review findings and the action plan in place to address the service gaps identified.

A workshop was held with stakeholders to undertake the review using a Maturity Index Self-Assessment Tool, developed by NHS England. As part of the review ICBs had to declare if they were 'assured' or 'not assured' with the service provided.

The outcome of the review in Nottinghamshire concluded that the ICB is not assured that the services provided by NHT are currently able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow up. This is based on the following findings:

- It is acknowledged that although some assertive engagement is taking place within NHT, there is no standardised pathway, resulting in inconsistencies in practice. NHT merged Assertive Outreach Teams with Local Mental Health Teams a number of years ago and although some of the Assertive Outreach staffing exists within some community teams, it is not standardised and resulted in difficulty in maintaining engagement due to the generic nature of the Local Mental Health Teams and caseload sizes.
- Workforce planning and job plans do not reflect the assertive engagement way of working. Caseloads are not reduced and largely comprise a broader mix of presentations and needs.

Summary:

- There is pressure in step up and step down pathways impacting the responsiveness of some services.
- There are gaps in training for new staff in assertive engagement approaches.
- Improved communication channels with partners are required alongside more involvement of people with lived experience and carers in pathway developments.
- The review also identified that more could be done to support medication adherence.

Actions already undertaken by NHT since the findings of the special review include a review of their Did Not Attend (DNA) policies. The Trust has confirmed to the ICB and NHS England that people who require intensive and assertive support would not be discharged on the basis of non-attendance or lack of engagement. NHT has also put measures in place to identify individuals with complex needs who find it hard to engage and will monitor these for Risk Assessment, Care Plan, Care and Treatment Order status, Multidisciplinary team review and date last seen. This is monitored through Patient Tracking List Meetings.

An action plan has been developed to address the identified gaps. The majority of actions are to be completed during quarter three of 2024/25, alongside work to quantify any resource requirements and configuration of the workforce to meet current guidelines.

A Task and Finish Group has been established to take forward the actions and monitor progress and will report to the Rapid Improvement Board, which reports into the Improvement Oversight and Assurance Group. The ICB will work with NHT to agree how it will gain assurance against delivery of the plan.

Recommendation(s):

The Board is asked to **note** the outcome of the Assertive and Intensive Community Mental Health Care review and that there is an action plan in place.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	The review and action plan utilises national guidance on how to meet the needs of individuals who require intensive and assertive community care, ensuring access to evidence based treatment. Research evidence and outcome data suggest that assertive outreach models reduce admissions and promote effective engagement with individuals who are the most unwell and the ongoing action plan will continue to be developed in line with the best available evidence.
Tackle inequalities in outcomes, experience and access	Research evidence and outcome data suggest that assertive outreach models reduce admissions and promote effective engagement with individuals who are the most unwell.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	Many people who experience psychosis are able to receive evidence-based care and treatment which enables them to recover from their psychotic episode and/or be supported to live a life that is meaningful to them alongside the management of ongoing symptoms. Part of the model includes Individual Placement and

How does this paper support	the ICB's core aims to:
	Support (employment support) supporting people to find or maintain employment which in turn can support their recovery.

Appendices:
Appendix A: Assertive and Intensive Action Plan

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risks: • Risk 1: Timely and equitable access – Failure to ensure timely and equitable access to urgent and emergency care, elective and cancer care and mental health services. • Risk 4: Quality improvement – Failure to systematically improve the quality of healthcare services.

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Assertive and Intensive Community Mental Health Care- Review and Action Plan

Background and context

1. In March 2024, the Care Quality Commission (CQC) published the first part of a special review into mental health care at Nottinghamshire Healthcare NHS Foundation Trust (NHT) following the conviction of Valdo Calocane in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber.
2. Subsequently, the 2024/25 NHS Priorities and Operational Planning Guidance asked that all Integrated Care Boards (ICBs) "Review their community services by quarter two 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge."
3. Many people who experience psychosis can receive evidence-based care and treatment enabling them to recover from their psychotic episode and/or be supported to live a life that is meaningful to them alongside the management of ongoing symptoms. However, some people particularly where paranoia is present, struggle to access evidenced-based care and treatment. This can be due to services not being able to meet people's needs, the impact of symptoms including paranoia, or a lack of understanding from the individual that they are unwell. For this group of people, it is critical that mental health services meet the person's needs by adapting their engagement approach, providing continuity of care, and offering a range of treatment options for people experiencing varying intensity of symptoms. People with these needs can be vulnerable to harm from themselves and others; for a very small number of people, relapse can also bring a risk of harm to others.
4. National guidance was published in July 2024: NHS England » Guidance on intensive and assertive community mental health treatment. ICBs were asked to use this to review policies and practices they have to identify and provide appropriate care to people with severe mental illness who might need intensive and assertive community care. ICBs were asked to confirm if they are assured that services can identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow-up and use the review to identify gaps and barriers to providing good care and report these back to NHS England by 30 September 2024.
5. Reviews should identify actions services need to take to ensure people are receiving and engaging in the care they need and that DNAs (Did not Attends) are never used as a reason for discharge from care for this vulnerable patient group.

6. NHS England has requested that systems share estimated costs to close the gaps in care identified in the reviews and how that will build on the services in place by 13 November 2024.

7. Within 12 months, NHS England will publish evidence-based guidance and national standards for high-quality, safe care for people with complex psychosis and paranoid schizophrenia.

Review process

8. The review of services provided by NHT comprised a facilitated workshop on 9 September 2024 at Duncan MacMillan House with over 60 stakeholders from NHT, NHS Nottingham and Nottinghamshire ICB, NHS England, Nottingham City Council, Nottinghamshire County Council, carer representatives and representatives from the community and voluntary sector. Provision was reviewed using the Maturity Index Self-Assessment Tool with facilitated groups reflecting upon their experience and evidence of how services are delivered. Each group summarised their findings with opportunities for questions. Engagement with people with lived experience of services took place on 12 September 2024.

9. Information from the workshop was collated and recommendations were presented to the Trust Executive Leadership Team on 18 September, prior to meeting with the ICB on 20 September to present and discuss the results of the review.

Review findings and action plan

10. The review identified the following gaps, barriers, and challenges to meet the needs of the group of patients requiring assertive engagement in line with the national guidance:

    a) NHT does not have a dedicated Assertive Outreach Team or associated Standard Operating Procedure, and this has resulted in inconsistencies in practice. A review of the current Local Mental Health Team Standard Operating Procedure has been undertaken and an additional insert detailing the procedure for an Assertive and Intensive service has been developed in October and will be implemented through November.

    b) The Local Mental Health Teams comprise full multi-disciplinary teams; the individual practitioners hold full and mixed caseloads and are not consistently available to provide interventions at the intensity that may be required in line with the national guidance, or with the reduced recommended caseloads that enables this intensity. Workforce resource requirements are being reviewed by mid-November.

c) Clinical pathways and step-up and step-down policies are in place. However, the review recognised that some of these pathways are experiencing significant pressures, which can impact upon responsiveness. It also recognised that communication channels with partners could be improved. It was identified that staff, people with lived experience and carers need to be more involved in reviewing and developing services.

d) Training in Psychosocial Interventions and Psychological Interventions is required to complement the existing service offer. Psychosocial Intervention training has been sourced and staff will attend in February 2025. A full workforce plan will be developed upon confirmation of the service model by mid-November.

e) A review of clinical risk assessment is underway including a shift away from the reliance upon predictive tools, and full consideration of the historical and contextual implications. Safeguarding was considered to be an area of strength, rated by stakeholders in the self-assessment. Services recognise the importance of working with families and respect to confidentiality. The above Psychosocial Intervention training opportunity includes working with families.

f) There was good understanding of the legal framework that supports care and treatment. A review of the use of Community Treatment Orders has been completed; the use of Community Treatment Orders has increased since the special review and is currently being benchmarked with other trusts. A Community Treatment Order is an order for supervised treatment in the community with certain conditions, meaning patients can be treated in the community rather than in hospital, but can be returned to hospital if necessary. The reasons behind the increase are being explored further but is likely to be due to risk when patients are discharged from wards and patients not being discharged from Community Treatment Orders.

g) Links with partner agencies are well established and the review provides opportunities to further develop these working relationships to ensure a more integrated offer to this patient group.

h) Outcome measures are being rolled out across Local Mental Health Teams including nationally mandated Dialog+, Recovering Quality of Life and Goal Based Outcomes. The Bexley engagement tool, an evidence-based clinical outcome measure that assesses the impact of interventions and changes to patient engagement levels is being considered within the action plan. Outcome measures provide a measure of impact and effectiveness on care and treatment when paired with earlier scores. Further work is in hand to better understand the mental health needs of local people. Whilst data is used to monitor outliers and themes,

consistent use of outcome measures will provide further opportunities to inform service developments.

i) The Trust is implementing the Patient and Carer Race Equality Framework. Data is available on the use and access to services by all patient groups, which will be used to better explore equality of access and experience by the end of November.

j) Policies and oversight are in place for use and effectiveness of medicines and this is well evidence-based. Actions have been identified to improve medication adherence and compliance. Best practice guidelines will be developed by NHT by the end of November.

k) There are established processes for capturing patient feedback and hearing their experience. These are being reviewed to increase participation and co-production and utilising this to improve experience.

l) The Trust has an established process for implementing and reviewing policies and ensuring that they are fair and equitable to all groups of staff and patients, work is underway to ensure staff are adhering to policies.

11. Actions already undertaken by NHT since the findings of the special review include:

a) NHT reviewed their Did Not Attend (DNA) policies and confirmed to the ICB and NHS England that people who require intensive and assertive support would not be discharged on the basis of non-attendance or non-engagement. Further amendments have made the policy more explicit. National discharge standards have been adopted and a discharge checklist is in place with routine monitoring.

b) Through work undertaken within the Local Mental Health Teams, the service can identify individuals with complex needs who find it hard to engage and monitor these for Risk Assessment, Care Plan, Community Treatment Orders status, Multidisciplinary team review and date last seen, and this is monitored through Patient Tracking List Meetings.

12. Based on the information provided for the review and acknowledging the positive developments and improvements since the special review findings, the ICB is not assured that the services provided by NHT are currently able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow up. This outcome was reported back to NHS England at the end of September.

13. An Assertive and Intensive Engagement Improvement Plan has been developed during October to address the gaps highlighted in the self-assessment. The plan presented at Appendix A will be ratified by the Trust's Rapid Improvement Board, Chaired by NHT's Executive Director of Nursing and Quality in November. A Task and Finish Group has been established to

take forward the actions and monitor progress and will report to the Rapid Improvement Board and into the Improvement Oversight Assurance Group. The ICB will work with NHT to agree how it will gain assurance against delivery of the plan.

Next steps

14. The process for monitoring and reviewing the actions are outlined in the paper.
15. The ICB and NHT will continue to review national guidelines when published.

Appendix A: Assertive and Intensive Action Plan

1. Function of assertive and intensive case management

The self-assessment identified that the Local Mental Health Teams do not provide a discrete Assertive Intensive treatment pathway within a generic service model. In a number of teams, this patient group is distributed amongst multiple staff who hold generic caseloads. The associated actions are shown below:

Action	Lead	Timescale	Measures	Progress
Confirm Assertive and Intensive Community Treatment pathway case list	Operations Manager	04/10/24	Review of Assertive and Intensive Community treatment lists complete	Complete
Each Local Mental Health Team to review Assertive and Intensive Community Treatment list against full caseload on an ongoing basis	Operations Manager	30/11/24	Each Local Mental Health Team confirms Assertive and Intensive Community Treatment List	In-progress
Confirm operational standards	Operations Manager	14/10/24	Proportion of contacts Proportion of Multi-Disciplinary Team Reviews No discharges due to Did Not Attend (DNA) All discharges planned and approved by the Multi-Disciplinary Team X2 DNAs escalated to Associate Director of Operations- Community	Complete

Action	Lead	Timescale	Measures	Progress
Confirm monthly monitoring/reporting (Risk Assessment, Care Plans, Community Treatment Orders, Multi-Disciplinary Team reviews, date last contact)	Operations Manager	04/10/24	Monitoring reports confirm oversight and monitoring of individual cases	Complete

2. Clinical pathways

The self-assessment identified that the current service offer does not fully align to the maturity index and national guidance. The aim is to develop a consistent service model and practice to meet the needs of people who require an Assertive and Intensive approach. The associated actions are shown below:

Action	Lead	Timescale	Measures	Progress
Detail the current Assertive and Intensive Community Treatment pathway within the Local Mental Health Teams Standard Operational Policy (SOP)	Director of Nursing	31/10/24	Standard Operational Policy in place	In-progress
Confirm the SOP with stakeholder groups	Director of Nursing	15/11/24	Summary Standard Operating Procedure confirmed and shared with stakeholders	In-progress

Action	Lead	Timescale	Measures	Progress
Proposal developed by Task and Finish group for approval and business case (where necessary)	Director of Nursing	15/11/24	Operation model agreed and costed	In-progress

3. Workforce

The self-assessment identified that the Local Mental Health Team workforce plan is informed by the generic service model. The Aim is to develop a consistent clinical offer with staff having enhanced specialist skills, Multi-Disciplinary Team support and capacity to meet individuals' needs. The associated actions are shown below:

Action	Lead	Timescale	Measures	Progress
Include Assertive and Intensive Community treatment in Local Mental Health Team demand and capacity modelling	Associate Director of Operations	15/11/24	Demand and Capacity report approved by Adult Community Services Rapid Improvement Board	In-progress
Produce comprehensive Multi-Disciplinary Team workforce plan as determined through gap analysis above	Associate Director of Operations	15/11/24	Workforce plan agreed at Rapid Improvement Board	In-progress
Commission specialist training for practitioners working in the pathways (Psychosocial Interventions - PSI)	Associate Director of Operations	31/10/24	Psychosocial Interventions training provision confirmed and dates agreed	In-progress

Action	Lead	Timescale	Measures	Progress
Specialist supervision to be provided to Assertive and Intensive Community treatment practitioners	Associate Director of Operations	15/11/24	Clinical supervision compliance rates Confirmation of Reflective Practice in place	In-progress
Caseload norms to be agreed (circa 15) as part of the service model development	Associate Director of Operations	30/11/24	TBC subject to operational model	In-progress

4. Risk assessment

The Risk assessment process is to be reviewed, informed by a Personalised Approach to Risk, supported through training. The associated actions are shown below:

Action	Lead	Timescale	Measures	Progress
Review risk assessment policy, guidance and best practice	Associate Medical Director	15/11/24	Revised policy in place	In-progress

5. Legislation

Action in place to ensure services apply the legislative framework consistently. The associated actions are shown below:

Action	Lead	Timescale	Measures	Progress
Mental Health Law team to review use of Community Treatment Orders, benchmark with other similar Trusts, Reviewed by Clinical Director and Consultant Medical staff and Non-Medical ACs	Deputy Director	31/10/24	Community Treatment Order report completed and reviewed	Complete

6. Interface with other services

Actions in place to improve joint working across partner agencies are shown below:

Action	Lead	Timescale	Measures	Progress
Explore with Integrated Care Board and Partners opportunities for closer working arrangements within this care and treatment pathway	Head of Community Transformation	30/11/24	Decision upon partner agencies contribution to this care and treatment pathway	Not yet started; to commence following agreement of the clinical model

7. Recovery and personalisation

Actions in place to continue to develop a more personalised approach to care are shown below:

Action	Lead	Timescale	Measures	Progress
Confirm interim care management policy pending guidance on future of Care Programme Approach	Head of Community Transformation	15/11/24	Care management policy in confirmed	In-progress
Roll out use of outcome measures - e.g. - Bexley, Recovering Quality of Life, Goal Based Outcomes and Dialog+	Head of Community Transformation	31/12/24	Monitoring report for Local Mental Health Team as a proxy for Assertive and Intensive Community treatment patients	In-progress

8. Meeting the needs of diverse populations

Actions in place to ensure people can access treatment and care appropriate to their needs and potential inequalities are identified and addressed are shown below:

Action	Lead	Timescale	Measures	Progress
Review Equality, Diversity and Inclusion (EDI) data to ensure services are inclusive with patients actively supported to access appropriate interventions e.g., Learning Disability and Autism, Ethnicity, Disability	Director of Nursing	30/11/24	Reports on access and use by protected characteristics in place	In-progress
Review enablement strategies	Director of Nursing	30/11/24	Identify any gaps or service deficits	This action will be commenced on review of

Action	Lead	Timescale	Measures	Progress
				the EDI data

9. Medicine management

Actions in place to ensure people are supported to obtain the maximum benefit from medicines are shown below:

Action	Lead	Timescale	Measures	Progress
Develop good practice guidelines that promotes adherence	Associate Medical Director	30/11/24	Best practice guidelines in place	In-progress

10. Experts by experience

Actions in place to improve people's experience and involvement in their care and treatment are shown below:

Action	Lead	Timescale	Measures	Progress
Agree trajectory for % rating experience Good and Very Good	Director of Nursing	31/10/24	75% rate good/very good by 31/12/2024	In-progress
Establish a Quality Improvement project to strengthen co-production	Director of Nursing	30/11/24	Quality Improvement project confirmed with confirmed measures	In-progress

11. Discharge

Actions in place to strengthen discharge arrangements to ensure they are safe and effective are shown below:

Action	Lead	Timescale	Measures	Progress
Review all Assertive and Intensive Community treatment pathway discharges for assurance	Head of Community Transformation	14/10/24	Records confirm 100% discharges determined by Multi-Disciplinary Team	Complete
Discharge checklist	Head of Community Transformation	31/10/24	100% compliance	In-progress

12. Data

Actions in place to ensure data is more readily accessible to support decision making are shown below:

Action	Lead	Timescale	Measures	Progress
Review prevalence/benchmark data	Deputy Director	10/11/24	Predictive incidence of people requiring Assertive and Intensive Community Treatment pathway confirmed to contrast with local data	In-progress
Caseload management tool e.g. MAST	Deputy Director	15/11/24	Agreement to implement appropriate caseload monitoring tool	In-progress

13. Policy variation and control

Actions in place to ensure policies and practice is aligned to the service operational requirements in line with national standards are shown below:

Action	Lead	Timescale	Measures	Progress
Review Discharge and Transfer, and Did Not Attend (DNA) policies to exclude DNA as a reason for discharge for this patient group	Deputy Director	30/09/24	Policies reviewed and confirmation provided to Integrated Care Board and NHS England	Complete
Review and implement strategies that support access, awareness and adherence to policies	Deputy Director	31/10/24	Effective systems to support staff awareness and support. Monitoring at supervision	In-progress

14. Governance

Actions in place to enhance clinical and operational governance routines to support learning, safety and experience are shown below:

Action	Lead	Timescale	Measures	Progress
Review Clinical Quality and Governance framework, template and support with Clinical Leads	Associate Director of Operations	30/11/24	Consistent model of Quality Governance across all Local Mental Health Teams	In-progress

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/11/2024
Paper Title:	**Primary Care Access Improvement Plan Update**
Paper Reference:	ICB 24 070
Report Author:	Esther Gaskill, Deputy Associate Director Primary Care
Report Sponsor:	Dave Briggs, Medical Director
Presenter:	Dave Briggs, Medical Director

Paper Type:							
For Assurance:	✓	For Decision:		For Discussion:		For Information:	

Summary:

NHS England published the 'Delivery plan for recovering access to primary care' on 9 May 2023. The plan included the requirement for all ICBs to develop a system-level primary care access improvement plan.

The Nottingham and Nottinghamshire plan was presented to the Board in November 2023 with an update presented in May 2024. The plan sets out the actions being taken across the four key national commitments published in the 'Delivery plan for recovering access to primary care':

- Empowering patients to manage their own health.
- Implementing modern general practice access.
- Building capacity.
- Cutting bureaucracy.

This report provides a further update on progress to date with the implementation of the plan and the actions being taken.

Recommendation(s):

The Board is asked to **receive** the update report for assurance regarding the delivery of the system-level primary care access improvement plan.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	Sustainable Primary Care is essential to improving outcomes for the population, as the first point of contact for many people requiring health care and support, as well as preventing illness and escalation of need.
Tackle inequalities in outcomes, experience and access	General Practice is key to tackling inequalities, through an in depth understanding of local need and awareness of the local support available. In delivering the plan, a focus on current inequities in access will need to be identified and managed.
Enhance productivity and value for money	Delivering optimal access to General Practice supports productivity across the system by ensuring people can access care in a timely way based on their needs.

How does this paper support	the ICB's core aims to:
Help the NHS support broader social and economic development	General Practice is embedded within communities, understanding local need. Working as part of Integrated Neighbourhood Teams enables General Practice to support that need, building social capital within local areas.

Appendices:
Appendix A: Summary of plan progress

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 2: Primary care – Failure to reduce unwarranted variation and improve access to primary medical services and pharmacy, optometry and dental (PODs) services.

Report Previously Received By:
Previous reports presented to the board in November 2023 and May 2024.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Primary Care Access Improvement Plan Update

Background

1. NHS England published the ‘Delivery plan for recovering access to primary care’ on 9 May 2023, recognising the capacity challenges being experienced by primary care and the impact this has on patient experience, recommending measures to address the challenges.
2. The plan built on policy areas such as the Fuller Stocktake Report (Next steps for integrating primary care 2022) and recent national contractual changes to the GP Contract and Network Contract Directed Enhanced Service (DES).
3. ICBs were required to publish a system-level Primary Care Access Improvement Plan in line with national expectations on delivery. The Nottingham and Nottinghamshire plan was presented to the Board in November 2023. It set out the actions being taken across the four key national commitments published in the ‘Delivery plan for recovering access to primary care’:
    a) Empowering patients: by rolling out tools people can use to manage their own health and investing in the expansion of services offered by community pharmacy.
    b) Implementing ‘Modern General Practice Access’: so that patients know on the day how their request will be handled, based on clinical need and continuing to respect their preference for a call, face-to-face appointment or online response.
    c) Building capacity: to enable practices to offer more appointments from more staff.
    d) Cutting bureaucracy: to give practice teams more time to focus on patients’ clinical needs.
4. A progress update regarding the plan’s delivery was presented to the Board in May 2024. This report provides a further update on progress to date in implementing the Primary Care Access Improvement Plan.

Oversight

5. The Primary Care Strategy Delivery Group continues to have oversight of the Primary Care Access Improvement Plan. The Group meets monthly and is chaired by the ICB’s Chief Executive, with membership including Primary Care Network (PCN) Clinical Directors, the Local Medical Committee, transformation leads for workforce, estates and digital, and ICB leads for primary care commissioning, contracting and quality.

6. The Group agreed four initial priority areas, including improving access to primary care services.

7. A task and finish group was established and continues to oversee the access pillar and implementation of the Primary Care Access Improvement Plan. Actions and timescales for delivery have been identified for each access component so that there are clear measurements for assessing delivery.

8. Metrics have been developed by the System Analytics and Intelligence Unit (SAIU) to support monitoring of delivery; a dashboard facilitates this and ensures ICB officers, PCNs and practices can review the access data, which includes:

    a) GP Appointment Data (GPAD):

        i) % of same day appointments
        ii) % of appointments booked within two weeks
        iii) % of face-to-face appointments
        iv) % of GP appointments and
        v) % of Did Not Attend (DNA)

    b) Digital / on-line data:

        vi) % practices with online appointments booking
        vii) % patients enabled for repeat prescriptions online
        viii) % patients with prospective online records access

    c) Patient experience data:

        ix) Family and Friends Test submission and scores

    d) Community Pharmacy:

        x) % practices referring to community pharmacy consultation service

9. The 2024/25 GP Contract has been amended to require practices to provide data on eight additional telephony metrics through a national data extraction. This commenced in October 2024. The eight metrics are:

    a) Call volumes

    b) Calls abandoned

    c) Call times to answer

    d) Missed call volumes

    e) Wait time before call abandoned

    f) Call backs requested

    g) Call backs made

    h) Average call length time

Implementation progress

10. The following table provides a Red (minimal progress), Amber (moderate progress), Green (good progress) (RAG) rated summary of progress in May and October 2024, against the key commitments in the Primary Care Access Improvement Plan.

Key Commitments	Deliverable	Progress Rating May 2024	Progress Rating Oct 2024	Comments / Rational
Empowering Patients	Self-referral pathways			58 self-referral pathways now identified nationally and being explored locally. Target revised to 8,739 self-referrals per month by March 2025. On track to achieve.
	Community pharmacy services			Pharmacy first launched, blood pressure service and contraception services expanded.
Modern General Practice Access	Digital telephony and online tools			100% practices with online tools in place and digital telephony by 2025.
	National GP Improvement Programmes			25 practices completed the support level framework or National GP Improvement Programmes, 11 currently participating and four due to undertake between October 2024 and March 2025.
	Local National GP Improvement Programmes			No local programme in place (see paragraph 22).
	Support Funding			£650,000 allocated, practices continue to be encouraged to apply for funding for the remainder of 2024/25.
	Training			Care Navigation, Digital Lead training undertaken, continue to promote the National Training Offer.
Capacity	Additional Roles Reimbursement Scheme			Additional Roles Reimbursement Scheme roles widened in 2024/25, awaiting confirmation for funding in 2025/26.
Reducing bureaucracy	Primary – secondary care interface			Development plans in place national benchmark assessment tool completed and being reviewed.

11. For a summary of progress made against each of the main actions between November 2023 and October 2024, please refer to Appendix A. The following sections provide further detail.

Empowering patients

Self-referral pathways

12. Self-referral routes for a number of services continue to be expanded, with 48 pathways now nationally identified. There is a target of 8,739 self-referrals per month by March 2025. In August 2024, the Nottingham and Nottinghamshire monthly average across 2023/24 was 7,934. ICB colleagues are working together to better understand the data requirements to ensure all eligible self-referrals are captured.

13. A communications campaign will be undertaken to support the promotion of self-referrals being the ‘go to’ option for both professionals and citizens. This will include signposting to a dedicated website to include all the self-referral pathways once the information has been confirmed by providers.

Community pharmacy services

14. The national recovery plan includes the relaunch / implementation of several community pharmacy services that aim to increase access to practices through directing patients with simpler conditions to pharmacies.

15. Pharmacy First launched on 31 January 2024 and includes seven new clinical pathways as well as incorporating the existing Community Pharmacy Consultation Service and urgent medicines supply. The pathways have both a walk in and referral mechanism and pharmacists can supply a prescription only medicine if appropriate. In Nottingham and Nottinghamshire, as of 31 August 2024, there are 211, over 95%, of community pharmacies registered to provide the service. Between February and July 2024 there have been 942,684 clinical pathways consultations. This service is estimated to save 1,000 hours of practice appointment time a month across the ICB area.

16. The Blood Pressure service, which includes case finding and referral from the practice has been expanded so that all suitably trained members of the Community Pharmacy team can now provide the service. Between April and June 2024, 14,380 blood pressure checks were undertaken by Community Pharmacy in Nottingham and Nottinghamshire. As of August 2024, 187 pharmacies are actively providing the service and 194 are signed up to deliver the service.

17. The Oral contraception service has expanded to include both initiation and continuation of oral contraception. General practice can now refer any patient to this service. As of August 2024, there are 158 pharmacies registered for the service. A regional webinar with presentations from specialists and local

pharmacists took place in November 2024 to help increase confidence in signing up and delivering this service. In June 2024, 110 oral contraception consultations took place in Community Pharmacies in Nottingham and Nottinghamshire.

Modern general practice access

Digital telephony

18. Significant progress has been made in migrating 17 practices from an analogue to a cloud-based telephony system. All have signed contracts, with 15 already migrated, and the remaining two scheduled for go-live after resolving infrastructure issues. Additionally, 83 other practices are being supported to transition to an improved cloud-based system, with all Nottingham and Nottinghamshire practices expected to complete the migration by 2025.

Use of digital services integrated care products (online tools)

19. All practices now have an online consultation tool, enabling patients to make administrative and medical requests. Over the past 12 months, online consultations have increased by 39%, with around 38,500 completed monthly. The Primary Care Access Improvement Plan implementation group monitors progress, and practices receive support to enhance availability for patients.

20. The ICS Digital Strategy aims to make the NHS App the main access point for online services. As of September 2024, 56% of Nottingham and Nottinghamshire GP patients over 13 years of age use the App, with 2,500 new registrations per month. Over 82,000 repeat prescriptions are ordered monthly via the App, saving an estimated 30 seconds per order. The Digital Notts Public Facing Digital Services Team is working to boost App uptake through local events, such as university enrolment days, to promote digital confidence and increase usage.

Uptake and participation in General Practice Improvement Programmes

21. 32 practices have completed or are undertaking the national support programmes. The participation is well spread across Place-Based Partnerships (PBPs) with a number of practices working in high areas of deprivation taking part. The programme supports practices to review their capacity and demand and prepare for implementing modern general practice access models.

Local hands-on support to practices

22. Due to the need to identify financial savings in 2023/24 and 2024/25, the funding allocated to develop a local support offer to practices via the Primary Care System Development Funding was withdrawn. Any practice wishing to access support has been able to do so through one of the national support programmes.

Transition cover and transformation support funding

23. To date over 50 practices have approached the ICB for transformation support funding to enable them to prepare for implementation of elements of a modern general practice access model. Approximately £650,000 has been allocated for:

    a) Sessional GPs for a limited period (to enable practice GPs to prepare for implementation).

    b) Support from experienced peers (to support the practice in readiness for implementation).

    c) Additional sessions, for a limited period, from current practice staff, clinical or non-clinical (to prepare for implementation).

    d) Additional training e.g. care navigator training for all reception staff to enable full implementation of the new access model.

24. Practices are able to continue to apply for funding (an average of £13,500 per qualifying practice) throughout the remainder of 2024/25.

Training: Care Navigation

25. Approximately 330 individuals have attended Care Navigation training provided by the Nottingham Alliance Training Hub or through completing NHS England's national programme. An online national training offer continues to be shared with general practice colleagues.

26. Nottingham Alliance Training Hub has developed a local offer to support practices who identified further training needs around care navigation. Funding to support delivery of these sessions is being explored.

Training: Digital and Transformation Leads

27. The twelve-month Digital and Transformation Lead Development Programme delivered by NHS England has been specifically designed to equip individuals in the Digital and Transformation Lead Additional Roles Reimbursement Scheme with the core skills to be able to lead transformational change. Of the 18 Digital and Transformation Leads in post, five are taking part in the programme. Additional leads will be supported to participate should further cohorts be announced for 2025/26.

Access improvement

28. All PCNs developed a Capacity and Access Improvement Plan (in 2023, 70% of the associated Capacity and Access Payment was paid by NHS England to PCNs during 2023/24 without any conditions). To support flexibilities in general practice, the ICB's Executive Team decided to pay PCNs 100% of the 30% Capacity and Access Improvement Plan payment for 2023/24. The returns submitted by PCNs were reviewed and provided rich data in terms of patient experience and how PCNs will use this data to continue to make improvements in access.

29. For 2024/25 all PCNs will receive 70% of the Capacity and Access Payment monthly. The remaining 30% Capacity and Access Improvement Plan focuses specifically on implementing the following three domains of the modern general practice access model:
    a) Better digital telephony.
    b) Simpler online requests.
    c) Faster care navigation, assessment and response.
30. PCN Clinical Directors are required to confirm that each practice has implemented all listed components for a domain to receive payment. No claims were received in quarter one, but claims are anticipated from quarter two onwards.
31. Specific examples of improving access at Place level include:
    a) Nottingham City East PCN On Day Service: extra urgent same day appointments are available at a central hub within St Ann's Valley Centre that practices can utilise if they are at full capacity. This service is operationally managed by the Nottingham City GP Alliance and operates for five days a week with appointments undertaken by two GPs. Given the positive feedback from practices and patients, the PCN will self-fund and extend the service until at least 31 March 2025.
    b) In South Nottinghamshire a project to improve access to urgent and routine appointments and continuity of care for frail, elderly patients who are frequent attenders, and housebound patients has been undertaken. This has supported staff morale/retention, and reduced workload and fatigue for all staff groups. Patients in the above cohorts are able to have a code assigned that indicates how the healthcare professional reviewing them feels they would benefit from continuity of care.
    c) In Bassetlaw, the Worksop Integrated Team (a PCN hub jointly operated by two Worksop PCNs) has helped primary care tackle urgent presentations (there is no urgent care centre or walk in centre available in Bassetlaw). The hub provides Emergency Department streaming and works to an Acute Respiratory Infection hub model but is not limited to respiratory presentations. It has enabled practices to focus on chronic, complex patients including running a frailty pilot. This is mirrored by a hub at Retford Hospital operated by Retford and Villages PCN, which was established in September 2023. This offers approximately 600 appointments per month and is split between urgent appointments, and reviews support for frail patients.
    d) A Mid-Nottinghamshire Housebound Nurse Service has been established. Delivered by PCN Additional Roles Reimbursement Scheme Nurses, the service sees all housebound patients to complete a number of reviews,

including long term condition reviews, over 75s health checks and vaccinations. In the future the service will be expanded to include patients in care homes (in conjunction with the care home nursing team). There is also collaboration with the community learning disability nurse to review learning disability patients that are in residential homes. During 2023/24, 1,300 patients were seen and reviewed.

e) Two Bassetlaw practices have implemented new digital triage systems to enhance patient access and reduce practice workload. The Anima system (Riverside Health Partnership) has greatly reduced the number of calls made to the practice and directs the patient request straight to the most appropriate member of the practice team. Smart Triage (Larwood Health Partnership) has recently been purchased to both effectively help triage patients and put the patient in control of booking the mode of appointment they would prefer.

Capacity

Using full Additional Roles Reimbursement Scheme budget

32. Approximately 620 whole time equivalent staff are currently employed within Nottingham and Nottinghamshire PCNs through this scheme in a number of different roles.

33. The number of reimbursable roles has been widened in 2024/25, and role restrictions removed. The number of staff employed has decreased slightly over the last couple of months whilst confirmation of funding for 2025/26 is awaited.

Reducing bureaucracy

Improve primary-secondary care interface

34. ICB colleagues continue to work closely with secondary care providers to improve relationships and the interface between general practice and secondary care. The focus has been on wider system working, reducing duplication, acknowledging each other's roles, and communication. Plans to continue to progress this joint work are in place and have been brought together and refreshed through completion of NHS England's recent assessment tool.

35. The interface work is gaining national recognition having been presented to both the NHS Confederation and with Kiran Collinson (Deputy Medical Director, NHS England) in October 2024 at the national Best Practice Conference (Birmingham).

36. Work is also underway across both acute trusts in the system to allow non-GP professionals to directly refer urgent clinical presentations to urgent and same-day facilities, rather than requiring a GP to make the referral.

37. A South Yorkshire interface meeting has been established, chaired by the Local Medical Committee with representation from the ICB and the main acute providers. The meeting's current workplan includes development of prescribing guidance between primary and secondary care, and a review of how communications can be improved.

38. Interface work with East Midlands Ambulance Services NHS Trust (EMAS) continues to progress, with a local GP Fellow involved in collaborating on improvement of communication to a GP following an EMAS patient attendance and maximising population health management opportunities.

39. Work with Nottinghamshire Healthcare NHS Foundation Trust is underway to improve communication between GPs and long-term mental health patients and enhance referral triage processes.

40. Nottingham CityCare Partnership and independent sector consultants can now directly make two week wait referrals for cancer patients. Exploring smartcard and Electronic Records Services access, which will enable advice and guidance requests to go directly to NUH, is in progress.

Register with a GP surgery service

41. Practices have been supported to adopt NHS England's new online 'Register with a GP surgery service', which aims to streamline and digitise patient registration. The target is for 90% of practices to be signed up by the end of October 2024 and 100% by the end of the year. Currently, 92% of Nottingham and Nottinghamshire practices are enrolled, with plans in place to achieve full coverage by year-end.

Communication plan

42. A system communication plan to support patient understanding of the new ways of working in general practice, including digital access, multidisciplinary teams and wider care available has been developed. A variety of ICB and partner channels have been used to promote key messages to our audiences, including websites, social media, print and broadcast media, stakeholder communications, TeamNet and the intranet. Key milestones for 2024/25 to date have included:

    a) Continued promotion of Pharmacy First services.

    b) Highlighting care navigator role, including production of new video.

c) Enhanced promotion of diabetes support services, including creation of a new website and new videos.

d) Roll-out of all Primary Care national campaign assets on local channels.

43. For 2024/25 and into 2025/26, an updated communications plan to reflect NHS England's and local priorities is being prepared; however, this is pending confirmation of the national campaign schedule, following the election of the new Government. This will include:

a) Response to any impact of collective action.

b) Highlighting primary / secondary care integration.

c) Promotion of the online 'Register with a GP service'.

d) Promotion of full range of care options available to patients, in addition / support of GP services during the winter period.

e) #ThanksDoc campaign to demonstrate improved GP access.

f) Increase awareness of impact of 'Did Not Attends'.

Risks and issues

44. General Practice resilience continues to be challenged across many practices, impacting on staff health and wellbeing, and operational delivery. The ICB's Primary Medical Services Support and Assurance Groups aim to provide a systematic 'early warning system' that provides an opportunity to support practices at risk of being unsustainable. This is limited by the information providers choose to share with the ICB and constrained by the level of support that can be offered by the ICB when a practice is struggling.

45. The relationship the ICB has with GPs is different to that of the former Clinical Commissioning Groups. This is a risk to delivery of the Primary Care Access Improvement Plan and Primary Care Strategy due to disengagement from GP colleagues, which is heightened with current Collective Action. Various forums for GP/ICB engagement (e.g. One Voice Forum, Place based Partnership meetings, Primary Care Strategy Group) have been established to improve and mitigate this.

46. The uplifts in the value of the GP contract are significantly below inflation and increases the risk of financial viability for practices and the potential for contract hand backs, as well as disengagement from Local Enhanced Services. This could lead to an increase in financial pressure on the ICB as well as deplete ICB capacity to find alternative commissioning solutions.

Next steps

47. The Primary Care Strategy Group will continue to oversee the implementation of the Primary Care Access Improvement Plan through a programmatic approach that includes consideration of any future developments or contractual requirements.

48. The table at Appendix A provides a summary of progress made against each of the main actions between November 2023 and October 2024. A Red (minimal progress), Amber (moderate progress), Green (good progress) (RAG) rating has been used to map progress.

Appendix A: Summary of plan progress

Primary Care Access Improvement Plan Action	November 2023 Position	October 2024 Position
Expand self-referral routes (falls services, musculoskeletal services, audiology for older people including loss of hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services)	Five of the seven pathways for implementing self-referral already had self-referral pathways in place. For the remaining two pathways (Audiology and Wheelchairs services) discussions due to take place	58 self-referral pathways now identified nationally and being explored locally. Target revised to 8,739 self-referrals per month by March 2025. On track to achieve.
Expand Community pharmacy services (oral contraception and blood pressure services)	156 pharmacies providing the blood pressure service 44 pharmacies registered for the oral contraception service	Between April 2024 and June 2024, 14,380 blood pressure checks were undertaken by Community Pharmacy in Nottingham and Nottinghamshire.187 pharmacies are actively providing the service and 194 are signed up to deliver the service. The Oral contraception service has expanded to include both initiation and continuation of oral contraception. General practice can now refer any patient to this service. 158 pharmacies are now registered for the service. Pharmacy First launched on 31 January 2024 and includes seven new clinical pathways. As of 31 August 2024, 211 (over 95%), of community pharmacies are registered to provide the service. Between February 2024 and July 2024 there have been 942,684 clinical pathways consultations.
Digital telephony Sign up practices ready to move from analogue to digital telephony	111 already Cloud Based 17 analogue	All 17 analogue practices have signed cloud-based telephony contracts, with 15 already migrated, and the remaining two scheduled for go-live after resolving infrastructure issues. Additionally, 83 other practices are being supported to transition to an improved cloud-based system.

Primary Care Access Improvement Plan Action	November 2023 Position	October 2024 Position
Use of digital services integrated care products (online tools)	A small number of practices identified as having tools that did not meet the national requirements	All practices have an online consultation tool in place, enabling patients to make administrative and medical requests. Over the past 12 months, online consultations have increased by 39%.
Uptake and participation in national GP Improvement Programmes	Nine practices signed up to intermediate / intensive National GP Improvement Programmes	25 practices completed the support level framework or National GP Improvement Programmes, 11 currently participating and four due to undertake between October 2024 and March 2025.
Local hands-on support to practices	A local programme was in development	The funding allocated to develop a local support offer to practices via the Primary Care System Development Funding was withdrawn for 2023/24 and 2024/25 to support the ICB's financial position. Any practice wishing to access support has been able to do so through one of the national support programmes.
Transition cover and transformation support funding	£0 support funding allocated	Approximately £650,000 allocated for: • Sessional GPs for a limited period • Support from experienced peers • Additional sessions, for a limited period, from current practice staff • Additional training e.g. care navigator training.
Training	114 individuals undertaken care navigation training	330 individuals have attended. Care Navigation training provided by the Nottingham Alliance Training Hub or through completing NHS England's national programme. Of the 18 Digital and Transformation Leads in post, five are taking part in the national training programme.

Primary Care Access Improvement Plan Action	November 2023 Position	October 2024 Position
Access Improvement	Capacity and Access Improvement Plan developed by all PCNs	2024/25 Capacity and Access Improvement Plan 30% focuses specifically on implementing the following three domains of the Modern General Practice. Access model: • Better digital telephony • Simpler online requests • Faster care navigation, assessment and response. Requires PCN clinical director assessment and sign off.
Using full Additional Roles Reimbursement Scheme budget	Approximately 600 whole time equivalent staff employed	Approximately 620 whole time equivalent staff employed.
Improve primary-secondary care interface	Providers across primary care, community service, mental health and secondary care working together to improve patients' experience of transitions of care between providers	Work ongoing, development plans in place. National benchmark assessment tool completed and reviewed.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/11/2024
Paper Title:	**Quality Report**
Paper Reference:	ICB 24 071
Report Author:	Nursing and Quality Business Management Unit
Executive Lead:	Rosa Waddingham, Director of Nursing
Presenter:	Rosa Waddingham, Director of Nursing

Paper Type:							
For Assurance:	✓	For Decision:		For Discussion:		For Information:	

Summary:

The report provides updates on quality and safety matters relating to the following NHS trusts for which the ICB has responsibility, based on the NHS Oversight Framework (NOF):

- Nottinghamshire Healthcare NHS Foundation Trust
- Nottingham University Hospitals NHS Trust
- Sherwood Forest Hospitals NHS Foundation Trust

The report also provides exception reporting for areas of enhanced oversight, as per the ICB's escalation framework (included for information at Appendix one):

- Nottingham CityCare Partnership Community Interest Company
- Urgent and Emergency Care
- Maternity
- Special Educational Needs and Disabilities
- Looked After Children

The report should be read in conjunction with the full Integrated Performance Report, which is provided for Board members separately.

Recommendation(s):

The Board is asked to **receive** this report for assurance.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	Provides an overview of quality and performance within the system which supports the view of outcomes relating to population and healthcare.
Tackle inequalities in outcomes, experience and access	Quality oversight provided by the paper is central to understanding the impact on outcomes, experiences and access.
Enhance productivity and value for money	Quality reporting takes account of obligations in terms of social value and the related quality of service current performance.
Help the NHS support broader social and economic development	The mitigations and quality assurance within the report support social and economic development principles.

Appendices:
Appendix one: Escalation Framework

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 1: Timely and equitable access – Failure to ensure timely and equitable access to urgent and emergency care, elective and cancer care and mental health services. • Risk 4: Quality improvement – Failure to systematically improve the quality of healthcare services.

Report Previously Received By:
Quality and safety matters are routinely reported to every meeting of the Quality and People Committee

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Quality Report

Nottinghamshire Healthcare NHS Foundation Trust – NHS Oversight Framework Segment Four (NOF 4)

Risk

1. Nottinghamshire Healthcare NHS Foundation Trust (NHT) continues to respond to address identified quality and safety improvements and continues to focus on progressing a comprehensive complex programme of improvement work.
2. The Trust has been in NOF 4 for eight months (February to October 2024) with significant support from NHS England, the regional oversight recovery intensive support team, the ICB and individuals from other systems. Whilst progress is noted against key areas for improvement and detailed through oversight and governance arrangements, the collective impact of improvement activity on patient safety, patient experience and patient outcomes has not been fully evaluated.

Mitigation

3. The Integrated Oversight and Assurance Group (IOAG) meeting took place on 25 October 2024. In preparation, NHS England's system quality lead for Nottingham joined the weekly safe now meetings to provide additional scrutiny.
4. Weekly safe now huddles are embedded and now include exception and escalation challenges in the weekly safe now meetings with ICB colleagues, which aligns to Trust operational midweek meetings to ensure matters noted have a robust feedback mechanism. This new arrangement will be evaluated at the end of quarter three 2024/25.

Assurance

5. Assurance remains limited, both in terms of the overall progress made to date and in terms of the Trust's capacity to sustain and build on improvements.
6. The Trust continues to make progress. Updates of key areas of improvement aligned to the section 48 review recommendations were received by the IOAG on 11 September 2024. The Trust detailed improvement work in intensive and assertive engagement, clinical risk assessment and crisis services.
7. The Trust's quality improvement approaches, led by its Director of Improvement, is linking implementation to the system quality framework and wider system partners, such as East Midlands Ambulance Services NHS Trust (EMAS), looking at opportunities to undertake joint improvement work.

Nottingham University Hospitals NHS Trust – NHS Oversight Framework Segment Four (NOF 4)

Risk

8. Nottingham University Hospitals NHS Trust (NUH) remains in a challenged position in providing safe and high-quality care in response to regulatory requirements.
9. The operational flow pressures in the Emergency Department remains, as does the work on the NHS England pressurised services and the finalisation of the Winter Plan with whole system contributions.

Mitigation

10. Weekly discussions continue between senior leadership colleagues within the ICB, NUH and EMAS.
11. Implementation of the 45-minute handover protocol with NUH as an early adopter has commenced.
12. Winter planning continues.

Assurance

13. Assurance is limited, in view of the complexity and risks.
14. Engagement from the Trust remains good, and they are active participants in key system quality and improvement groups.

Sherwood Forest Hospitals NHS Foundation Trust – NHS Oversight Framework Segment Two (NOF 2)

Risk

15. Concerns relate to the improvement capacity for the Trust following the Prevention of Future Deaths notices and the development of the Trust's continuous quality improvement strategy.

Mitigation

16. Good progress has been made on the completion of the Trust's Quality Improvement Plan.

Assurance

17. Learning from coronial enquiries and prevention of future death notices continues within the Trust. A positive quality visit to the Trust showed the considerable progress in delivering the Emergency Department Improvement Action Plan.
18. The report following the unannounced visit by Care Quality Commission to the emergency department during August 2024 has yet to be published.

19. Engagement from the Trust remains good, and the Trust is an active participant in key system quality and improvement groups.

Nottingham CityCare Partnership CIC – Enhanced Oversight

Risk

20. There is a risk to patient safety and quality of care across services arising from concerns that led to CityCare being escalated to enhanced oversight, through the system quality group and ICB oversight mechanisms.

21. Capping of Community Nursing and Integrated Home Care Service caseloads continues.

Mitigation

22. Clinical work is prioritised but the process to ensure action is taken when caseload management time is affected is still under development.

23. A quality improvement plan has been developed by CityCare and this informs the discussions in agreement with the organisation.

24. Meetings between the ICB Head of Quality and CityCare's Deputy Director of Nursing continue to review the indicators of success, with metrics in development and documentary evidence for the improvements, which are captured in the improvement plan.

20. The ICB has increased oversight through regular joint quality visits, including an independent visit to the Urgent Treatment Centre in October 2024.

21. The ICB assesses and triangulates improvements through Accountability Performance Framework meetings, which allows check and challenge at the review meetings.

22. The Joint Action Plan for the Contract Performance Notice has been shared with the ICB. Planning is in place to maintain oversight of open actions, where the ICB triangulates progress at the organisations' Care Groups Accountability Performance Framework Groups.

Assurance

23. Assurance around the progress towards delivery of CityCare's improvement plan and the areas identified in the contract performance notice is more positive. The formal contract notice has been lifted because of sustained improvement.

Urgent and Emergency Care – Enhanced Oversight

Risk

24. Quality and patient safety concerns remain as a result of delays and extended waits for patients on the Urgent and Emergency Care (UEC) pathway. While NUH remains under significant scrutiny due to performance issues, there is wider impact felt by system partners including Sherwood Forest Hospitals NHS Foundation Trust (SFH), community services and NEMS.

Mitigation

25. The UEC Board and the ICS System Quality Group are proactively collaborating to monitor these risks and any emerging issues. There are regular insight visits and peer reviews both at NUH and SFH, which are led and supported where possible by the ICB Quality team.
26. NUH and SFH have undertaken an assessment in relation to the six areas of focus on quality of care and experience in pressurised services for trust board assurance and identified areas of risk for further development.
27. Winter planning is taking place with a whole system approach and visit by NHS England to assess this was undertaken 31 October 2024.
28. UEC safety huddles are being implemented on an ICS basis to ensure rapid escalation and resolution of quality and safety issues at a clinical executive level.

Assurance

29. There is partial to limited assurance for UEC. Performance scrutiny is intense, and work continues informed by quality and safety priorities into focus.

Maternity – Enhanced Oversight

Risk

30. If the quality of maternity services does not continue to improve, services provided may not meet optimal care standards. This may result in potential risk of harm (i.e. physical and psychological) and poor patient experience for women, birthing people, their babies, and families.

Mitigation

31. The Local Maternity and Neonatal System (LMNS) Quality and Outcomes dashboard development is in phase two (the first phase of the dashboard migration to PowerBI is now completed and has been published).
32. New Maternity and Neonatal Voices Partnership (MNVP) volunteers are being assigned to projects and activities to support the system to increase engagement to diverse or vulnerable groups.

33. Both SFH and NUH continue to work towards full Saving Babies Lives Care Bundle Version Three (SBLCBv3) compliance.

34. A Social Prescribing Pilot for Maternity and Neonatal Services business case and recommendation to fund a 3-year pilot was endorsed by the LMNS Executive Partnership Board in September 2024.

35. The Maternity and Neonatal Independent Senior Advocate has now received referrals and has started to work with families. There are plans being developed to evaluate the impact.

Assurance

36. The LMNS programme has partial assurance and remains in enhanced oversight. There is evidence of sustained commitment to mandated quality and safety improvement programmes.

Special Educational Needs and Disabilities – Enhanced Oversight

Risk

37. Due to system capacity, financial challenges, and complexity of medical conditions and health needs, quality of provision and experiences for children and young people with Special Educational Needs and Disabilities (SEND) in Nottingham and Nottinghamshire may deteriorate further.

38. It has been identified that there is an increase in inequality and equity of commissioned provision across the system, when responding to meeting the needs of children and young people with SEND, who have complex medical health needs.

39. Publication of the system wide SEND Joint Commissioning Strategy has been further delayed due to Nottingham City commissioning leads still developing appropriate governance structures for sign off and approval.

Mitigation

40. Nottinghamshire local area SEND partnership annual delivery action plan; combines the SEND strategy, ICS Joint Commissioning Strategy and Priority Action Plan priorities for delivery and monitors oversight of activity required to improve outcomes for children and young people with SEND.

41. An Event was held on 6 September 2024, facilitated by Bowne Jacobson, to bring strategic leaders across the system to collaboratively respond to the challenges relating to meeting the needs of children and young people with complex health needs in education settings and transport.

42. The Nottingham City Council legal advice team have confirmed the governance for approval of the ICS SEND Joint commissioning strategy, it will be presented at the Corporate Executive Board meeting on the 22 November 2024.

Assurance

43. Nottinghamshire County SEND Improvement Board continues to offer monitoring and scrutiny of improvement arrangements.

44. Nottingham City SEND Partnership has agreed to participate in a regional SEND Peer Challenges to explore agreed key lines of enquiries to assure the local area partnerships that it is responding to and improving meeting the needs of children and young people with SEND.

45. Both local areas' SEND Partnership Assurance Improvement Groups continue to develop and strengthen partnership arrangements, whilst having oversight and accountability for SEND arrangements and report into SEND Executive leadership groups, for each local area.

Looked After Children – Enhanced Oversight

Risk

46. Overall, delays for Initial Health Assessments and Review Health Assessments continues.

Mitigation

47. Monthly recovery meetings continue between NUH and the ICB to review recovery plan and monitor performance, and similarly a remedial action plan has been agreed with NHT to progress at pace to minimise waiting times. The monthly meetings scheduled to review progress inform the quarterly position.

Assurance

48. Waiting times remain at three weeks across the ICS footprint for Initial Health Assessments and have done so for quarters one and two.

49. Key performance indicators and local authority data is triangulated, and any discrepancies reviewed responsively.

Appendix 1: Escalation Framework

The ICS developed an Escalation Framework, to provide structure and consistency across all areas of oversight for escalation of concern through the governance routes of the system, and which then feed into the formal governance of the ICB. The framework has been created based upon work undertaken through the quality route building upon previous National Quality Board (NQB) guidance.

Monitoring level	Routine	Further Information Required	Enhanced	Escalated Risk
What does this mean?	No specific areas of concern identified	Potential for concern. Key milestones not achieved. More information required to determine level of risk	Delivery or quality concerns identified.	Serious specific risk to delivery or quality identified, including where there is a need to act rapidly to protect patients or staff.
What action should be taken?	Actions to be taken by relevant operational oversight group	Agree route to follow up to gain necessary information to assess risk and agree who will lead.	Agree actions and schedule for discussion at each Operational oversight Group until concerns resolved.	Trigger escalation single subject review /deep dive / risk summit.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/11/2024
Paper Title:	**Service Delivery Report and Winter Plan**
Paper Reference:	ICB 24 072
Report Author:	Sarah Bray, Associate Director of Performance and Assurance Rob Taylor, Deputy Director of Performance and Assurance
Executive Lead:	Maria Principe, Acting Director of Delivery and Operations
Presenter:	Maria Principe, Acting Director of Delivery and Operations

Paper Type:							
For Assurance:	✓	For Decision:		For Discussion:		For Information:	

Summary:

The purpose of this report is to present progress against compliance and commitment targets as required for 2024/25. The report describes the key drivers behind performance and actions being taken to address areas of concern in all service delivery performance areas. This report should be read in conjunction with the full Integrated Performance Report, which is provided for Board members separately.

Increased demand as well as operational pressures have led to a reduction in four-hour accident and emergency wait performance for the system, particularly at Nottingham University Hospitals NHS Trust (NUH). Future improvements are required from increased clinical capacity as part of the winter plan, including the expansion of respiratory services, opening of Newell Ward, and operational adjustments like the 'Tag and Send' system for specialty routing.

A regional visit took place on 30 October to examine the urgent and emergency care system at NUH in operation. The regional team provided positive verbal feedback, commending our system on its cohesive leadership and shared understanding of the challenges ahead. They highlighted that the leadership team within the system is aligned on the issues and in agreement with the actions needed to address them. Additionally, the Emergency Department was specifically recognised for marked improvements in safety and quality, as well as for implementing several innovative practices. A formal letter detailing this feedback, along with actionable next steps, will follow within the next ten days.

Discharge rates remain stable at NUH, averaging 300 daily discharges. September recorded 216 patients eligible for discharge (vs. a target of 325). The System Discharge Board addresses discharge challenges, focusing on streamlining the Patient 2 and Patient 3 bed processes, contributing to sustained performance.

A sharp increase in >60-minute ambulance delays at the Queen's Medical Centre (QMC) impacted September's performance, with 3,029 hours lost in ambulance handovers. Sherwood Forest NHS Foundation Trust (SFH) maintained quicker handover times despite increased demand. Consistency in performance across all ambulance handover sites remains an urgent priority.

The number of patients waiting over 78 weeks was reduced to zero by the end of September. However, patients waiting 65 weeks or more remained above plan with 269

Summary:
patients against a plan of zero. The ambition remains to achieve a maximum wait of 65 weeks in all specialties except Ear, Nose and Throat (ENT) by the end of November 2024, with the remaining ENT patients treated in December. Key cancer treatment targets were met in August. NUH also developed a trajectory plan to address breast screening capacity, adding 1,400 weekly appointments from mid-October, with efforts underway to enhance broader screening operations. Overall diagnostics backlogs remain behind the operational plans for NUH and SFH, but improvements have been seen. Echocardiography performance improved notably at SFH, with tests nearly doubling year-over-year, reducing six-week waiters from 1,783 to 986 and improving wait time performance by 13.7% in month. Technical changes to the national diagnostics waiting times collection were implemented in September, which had a material impact on performance for endoscopy modalities at NUH. However, the Trust is aiming to recover this position during the remaining months of the financial year. Mental health services are performing well, notably in dementia diagnosis. NHS Talking Therapies exceeded six-week (98.5%) and 18-week (99%) targets, though the first to second wait improvement trajectory is slightly behind. Child and Young People (CYP) Eating Disorders face compliance challenges due to low patient volume and consultant availability. The volume of Out of Area placements has reduced materially during September and October at Nottinghamshire Healthcare NHS Foundation Trust (NHT). A Mental Health Oversight Board is being established to facilitate surveillance and in-depth discussions on services, including out-of-area placements. NHT saw a reduction in patients waiting over 52 weeks for community services decreasing from 57 in August to a projected 28 in September. Adult continence services remain a key challenge, with elimination of 52-week waits projected by December 2024. The System Winter Plan has been completed and submitted to NHS England. Initial feedback was positive for the approach taken to ensuring system engagement for the plan.

Recommendation(s):
The Board is asked to **receive** the report for assurance regarding the progress against service delivery plans and targets.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	Provides an overview of the performance of services, including timely access, which will impact upon the outcomes in population health
Tackle inequalities in outcomes, experience and access	Provides information relating to performance viewed across health inequality population cohorts
Enhance productivity and value for money	Provides information in relation to productivity and volumes of activity being undertaken across the system
Help the NHS support broader social and economic development	Addressing long waits, ensuring patients with high clinical needs are seen quickly and supporting patients to 'wait well' while tackling long waits, will support patients to return to work where possible.

Appendices:
None.

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 1: Timely and equitable access – Failure to ensure timely and equitable access to urgent and emergency care, elective and cancer care and mental health services. • Risk 2: Primary care – Failure to reduce unwarranted variation and improve access to primary medical services and pharmacy, optometry and dental (PODs) services. • Risk 4: Quality improvement – Failure to systematically improve the quality of healthcare services.

Report Previously Received By:
The report elements have been previously reported to the Finance and Performance Committee and discussed through the System Oversight Group (A) Delivery.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No

Service Delivery Report and Winter Plan

Key Performance Metric Summary

1. The table below provides a summary of the key performance indicators for urgent care, planned care, mental health, primary care and community services. The table includes the latest monthly position against the plan as well as the plan for March 2025. The plan for March 2025 is included to enable current performance to be viewed alongside the year end ambition.

Programme Area	Key Metric	Metric Basis	Latest data Period	Plan	Actual	Variance	Plan Mar-25	SPC Variation	ICB Ranking	IPR Page No.
Urgent Care	Total A&E Attendances	Provider	Sep-24	33262	33644	382	35574	Common Cause		44
Urgent Care	A&E 4hr % Performance (All types)	Provider	Sep-24	72.6%	69.6%	-3.1%	78%	SC Improving High	31/42	46
Urgent Care	12 hour waits as % of overall attendances	Provider	Sep-24	2.0%	6.1%	4.1%	2%	SC Improving Low		46
Urgent Care	Hospital Handover Delays >60 minutes	Provider	Sep-24	625	1221	596	0	Common Cause		45
Urgent Care	Hospital Handover Delays > 30 Minutes	Population	Sep-24	1971	2592	621	0	Common Cause	5/5	45
Urgent Care	Ambulance Total Hours Lost	Provider	Sep-24	1896	3029	1133	347	Common Cause	4/5	45
Urgent Care	Ambulance Cat 2 Mean Response Time	Population	Sep-24	00:26:17	00:38:22	00:12:05	00:22:38	SC Improving Low	4/7	48
Urgent Care	No. Patients utilising Virtual Ward	Provider	Sep-24	218	293	75	236	SC Improving High	25/42	47
Urgent Care	Length of Stay > 21 days	Provider	Sep-24	435	344	-91	430	SC Improving Low		
Urgent Care	No Criteria to Reside	Provider	Sep-24	325	216	-109	2703	SC Improving Low	20/42	47
Planned Care	78 Week Waiters	Provider	Aug-24	0	1	1	0	SC Improving Low	7/42	
Planned Care	65 Week Waiters	Provider	Aug-24	103	577	474	0	SC Improving Low	17/42	50
Planned Care	52 Week Waiters	Provider	Aug-24	3940	4397	457	2265	Common Cause	14/42	50
Planned Care	2ww 62 Day Backlog	Provider	Aug-24	312	346	34	283	SC Improving Low	20/42	
Planned Care	Cancer 28 Day Faster Diagnosis	Provider	Aug-24	76.6%	82%	5.4%	78.1%	SC Improving High	6/42	53
Planned Care	Cancer - 62 Day	Provider	Aug-24	61.8%	65.0%	3.1%	70.2%	Common Cause	32/42	53
Planned Care	Cancer - 31 Day	Provider	Aug-24	91.7%	93.0%	1.2%	96.1%	SC Improving High	25/42	53
Planned Care	Op Plan Diagnostics 6-week Performance	Provider	Aug-24	73.7%	68.7%	-5%	84.1%	SC Improving High	32/42	54
Mental Health	Inappropriate Out of Area Placement	Population	Aug-24	31	21	-10	4371	SC Improving Low	36/42	57
Mental Health	Talking Therapies - >90 Days 1st&2nd Trtmnt	Population	Aug-24	10%	44.3%	34.3%	10%	SC Concerning High		56
Mental Health	Talking Therapies - Reliable Improvement	Population	Aug-24	67%	68.4%	1.4%	10%	Common Cause		56
Mental Health	Talking Therapies - Reliable Recovery	Population	Aug-24	48%	44.3%	-3.7%	10%	Common Cause		56
Mental Health	SMI Health Checks	Population	Sep-24	4100	5494	1394	4371	SC Improving High	10/42	58
Mental Health	CYP Eating Disorders - Urgent	Population	Mar-24	95%	88%	-7%	95%	SC Concerning Low	20/42	59
Mental Health	CYP Eating Disorders - Routine	Population	May-24	95%	92%	-3%	95%	SC Concerning Low		59
Primary Care	Primary Care - GP Appointments	Population	Aug-24	591439	582260	-9179	713,967	Common Cause		62
Primary Care	Primary Care - % book 2 Weeks	Population	Aug-24	84%	81.8%	-2.2%	90%	SC Improving High	39/42	62

Programme Area	Key Metric	Metric Basis	Latest data Period	Plan	Actual	Variance	Plan Mar-25	SPC Variation	ICB Ranking	IPR Page No.
Community	Community Waiting List (0-17 yrs)	Provider	Aug-24	3806	3974	168	4695	Common Cause		
Community	Community Waiting List (18+ yrs)	Provider	Aug-24	10236	8830	-1406	5888	SC Improving Low		
Community	Community Waiting 52wks+ (0-17 yrs)	Provider	Aug-24	75	5	-70	118	Common Cause	5/42	63
Community	Community Waiting over 52wks+ (18+ yrs)	Provider	Aug-24	80	35	-45	65	Common Cause	22/42	63

To note:
Statistical Process Control (SPC) is an analytical technique that plots data over time. It enables variation that occurs naturally (Common Cause Variation) to be separated from variation that is statistically significant and therefore not due to random chance (Special Cause Variation), which is abbreviated to SC in the table above. The metrics below have been plotted in SPC charts, with the output summarised into the Statistical Process Control column. Special Cause statements indicate where there has been significant movement over the last 6 data points and provide an indication of whether the trend is improving or deteriorating. Common cause variation indicates no material movement away from the mean level.

Service delivery updates

2. The following paragraphs provide a description of the latest performance for urgent care, planned care, mental health, primary care and community services.

Winter plan

3. A different approach to the development of the winter plan has been taken this year. It is much wider than an urgent and emergency care plan, incorporating vaccination plans and all system partners' individual demand and capacity plans.

4. Planning with all system partners commenced at a much earlier stage in the year and confirm and challenge sessions have been undertaken with all system partners to test assumptions and maximise opportunities within their individual plans.

5. The winter plan for 2024 anticipates a significant rise in demand, especially in December, with a 92-bed gap projected despite mitigations, compared to a 37-bed gap in 2023. Although it should be noted that at the commencement of the planning process the bed gap stood at over 300.

6. Seasonal modelling has incorporated historical influenza, COVID-19, and Respiratory syncytial virus (RSV) patterns to predict likely respiratory illness surges. A vaccination programme involving community and roving clinics is underway to minimise disease-related admissions.

7. Acute providers are maximising resources, such as virtual wards and expanded respiratory care, to alleviate bed shortages and reduce emergency admissions where potentially avoidable. Further mitigations include weekend discharges, increased support for care homes, and enhancing community support for high-risk patients with chronic long-term conditions.

8. Financial constraints pose the greatest risk to effective plan implementation, alongside potential impacts from staff shortages and increased demand.

9. Although the plan is comprehensive, it continues to be refined and developed to reflect any new issues and to maximise further opportunities. Notably, work continues to close the remaining bed gap. The bed gap and the delivery of the plan will be monitored by the System Oversight Group, with further scrutiny by the Finance and Performance Committee.

Urgent care

10. **Four hour waits**: In September, the system achieved 70.1% performance for four hour waits against a plan of 72.6%. NUH delivered 67.7% against a plan of 70.0%, with SFH achieving 73.6% against a plan of 76.0%.

11. NUH has new capacity scheduled to come online in the coming months, with Co-located Urgent Treatment Centre moved on 03/10/24 which gives NEMS more clinical space. Beeston Ward (City) is being moved to fully respiratory 04/11/24, Newell Ward (City) will open on 04/12/24 and D56 (QMC) will open in December/January 2025, which will all support with improvement of the four-hour position.

12. **Virtual wards**: For September, an improvement in Virtual Ward bed capacity was reported, with 293 against a plan of 218, but with a decreased occupancy of 52.6% (53.6 % in August). NHS England expectations are that wards and systems will reach 80% utilisation of actual capacity. Latest published data for September shows Nottingham and Nottinghamshire places 15th of 42 nationally with 23 beds per 100,000 registered population (the aggregate England position is 19.8 per 100,000). The operational plan includes a plan of 236 beds by March 2025.

13. **Discharge**: Improvements in discharge levels that were reported previously have been maintained at NUH, which average over 300 per day. The September position for patients that have been deemed as not meeting the necessary criteria to reside in the hospital and eligible for discharge was 216 patients against a plan of 325 patients. At system-level there is a System Discharge Board in place to enable focus on addressing these issues, with a focus on ‘Patient Two’ and ‘Patient Three’ rightsizing bedded capacity for the medium term, which has seen performance achieve plan for two months in a row.

14. **Ambulance handovers**: There had been gradual improvements in ambulance handover performance from April through to August at NUH, which helped drive improvements seen in the wider system position. However, September saw a spike in handover delays, with an increase of 532 (55.7%) 60-minute or more delays from the previous month.

15. In September across both providers there were 2,592 delays over 30 minutes, of which 1,221 were above 60 minutes. There were 3,029 hours lost through ambulances waiting to handover patients to hospitals in Nottinghamshire in September against a plan of 1,896 hours. This is a decline in performance after previously achieving target for two consecutive months. This is largely impacted by an increase again seen at QMC. SFH continues to have swift ambulance handover performance.

Planned care

16. **78 week waits**: In August, there was one patient waiting 78 weeks or more across the two providers at the end of the month. The latest provisional data indicates that by the end of September there were no patients waiting over 78 weeks across the two acute providers.

17. **65 week waits**: There were 577 patients waiting over 65 weeks at the end of August (472 at NUH, 105 at SFH) against a plan of 103. More recent unvalidated data indicates that the providers ended September with 269 patients waiting over 65 weeks against a plan of zero. The main challenges continue around ENT with smaller cohorts of patients in General Surgery at SFH and Allergy Services at NUH.

18. Modelling suggests that that there will be around 200 patients at the end of October waiting 65 weeks or more across the system. Forecasts indicate that the system is expected to achieve the 65 week wait targets of zero by the end of November in all specialties except for ENT. Elimination of 65 weeks is forecast to occur by mid-December.

19. **52 week waits**: There were 4,397 patients waiting over 52 weeks at the end of August against a plan of 3,940. The most recent unvalidated data indicates that NUH and SFH were behind their September plans. NUH had 3,042 patients against a 2,930 plan and SFH had 893 patients compared to plan of 640.

20. Recent provisional data details that the NUH 2 week wait backlog was 249 patients against a plan of 233 at the end of September. Therefore, the ambition to achieve the fair shares was unfortunately not met but good progress had been made in reducing the backlog volume over time. Note that in December 2023, the backlog was 476 patients.

21. Both providers have undertaken analytical modelling work to identify the backlog sizes required to deliver improved and sustained 62-day performance in future. These values will be fed into further modelling taking place within the annual planning round for 2025/26.

22. **Cancer treatments:** The operational plans underpinning the three key Cancer standards of 28 Day Faster Diagnosis Standard, 31-day Diagnosis to Treatment and 62-day Referral to Treatment standards were achieved in August by SFH and NUH.

23. A trajectory for NUH to deliver the required Breast Screening levels of activity has been produced. An additional 1,400 appointments a week will be delivered through additional mammographers, which began in mid-October. NUH will look across all screening areas to understand if they have any wider screening challenges to improve visibility and ensure governance is clear.

24. **Diagnostics**: The total volume of patients waiting for diagnostics and those waiting more than six weeks (diagnostic backlog) reduced between July and

August by 1,225 patients. The backlog remains above planned levels at 9,320 against a plan of 6,374 patients but has reduced by 230 patients from the July position. Activity delivery within the system reduced to 35,171 tests in August, from 35,877 in July, but remained above the planned level. Non-Obstetric Ultrasound, MRI and Echocardiography are key drivers of the position due to having a high volume of patients waiting over six weeks at system level.

25. Echocardiography performance has continued to improve, with 1,872 tests undertaken in September, which was almost double the number of tests undertaken in September 2023 (975). As a result, the volume of six-week waiters has reduced from 1,783 in August to 986 in September. This has led to an increase in six week wait performance of 13.7% in month to achieve the recovery plan.

26. The volume of 13-week waiters is reducing within the system. Provisional data at the end of September highlights NUH has 1,812 patients over 13 weeks against a plan of 678, with SFH having 387 against an operational plan of 387. NUH has a plan to eliminate 13-week waiters by the end of March 2025, with SFH planning to eliminate this by the end of December 2024.

27. There are significant challenges with Audiology at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBH). The service has been heavily limited whilst the trust deals with significant IT, Estates and Staff Training issues. A new IT system has been procured and will be installed by end of February 2025 and by June 2025 all existing data will be migrated to the new system. Discussions with surrounding hospitals are taking place to provide support to improve staff competency. Shadowing will be used going forward to maintain competency until service can be scaled back up. DBH is validating their waiting list to determine clinical priority of patients and will be seeking mutual aid for high priority patients. South Yorkshire ICB will coordinating the independent sector opportunities for the adult cohort when the clinical priority of patients is known.

28. The national guidance changes were implemented in September around the DM01 monthly diagnostics return to enable the data to include surveillance patients. If a patient is due a surveillance test and this does not take place when required, the patient will be transferred to an active waiting list with a waiting time clock start and included in the monthly DM01 return from providers. This change impacted endoscopy, in addition to other modalities.

Mental health

29. As a programme, mental health performs well, with improvements being made across many service areas, and achievements being acknowledged by NHS England for dementia diagnosis.

30. **Talking Therapies**: NHS Talking Therapies delivered against the improvement trajectory for first to second wait in August (44.3% v 60% plan) and are not forecasting to deliver the September plan of 40%, current local data as of 7 October is 43%. The target for October is 30%, current local data is 27%. The improvement plan is to return to 10% by December. The service continues to achieve and exceed the six week (98.5%) and 18 week (99%) waiting time standards.
31. **Children and Young People Eating Disorders**: The routine referrals are not achieving the 95% compliance; however patient volumes are small and therefore have a significant impact on the overall level of compliance. The root cause for underperformance is patient choice and the need for a Consultant Psychiatrist to attend a clinical emergency.
32. **Out of Area Placements**: The volume of out of area placements reduced further during September and into October. Local data indicates there were five Out of Area placements, with a forecast to achieve zero by the end of October. For any patients admitted to an out of area bed (inappropriate or appropriate) there is an out of area case manager who works to repatriate the patients. Nationally there are limited beds available.

Primary care and community services

33. **General Practice**: The volume of total GP Appointments in August was 1.56% below the planned level, with 582,260 appointments against a plan of 591,439. 81.8% of appointments were offered within two weeks in August 2024, which is below the operational plan of 84%.
34. A monthly Primary Care Performance and Delivery Group has been established that monitors delivery against all primary care performance metrics, identifying specific areas of concern and practices which may need specific support for improvement. In addition, contact has been made with identified practices with lower percentage delivery to identify areas of support and review by ICB colleagues.
35. **Community**: The latest published 52 week waiting target data is for August 2024, which details a further reduction in the total volume of 52 week waits from 57 (47 Adult, 10 children and young people) to 40 patients (35 Adult, 5 children and young people). Of the 40 patents, 35 are waiting for services delivered by NHT.
36. Provisional data for September illustrates that the position improves further for NHT from 35 patients to 28 in total (25 Adults, three children and young people). All the Adult patients were waiting for continence services. Further investigation into the three children and young people patients highlights there is one recording error, one patient is to be seen in October, and one has been discharged, therefore the end of October forecast is for zero children and young

people waiting 52 weeks or more at NHT. The Trust is working to eliminate adult waits of more than 52 weeks by the end of December 2024.

NHS Oversight Framework

37. As of 24 October 2024, the system performs well across many metrics and is in the inter quartile range for most metrics, with some areas performing in the upper quartile. The areas of lowest performance are:

    a) Out of Area Placements

    b) GP Appointments (14 days)

    c) Virtual ward - % occupied.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	13/11/2024
Paper Title:	**Finance Report**
Paper Reference:	ICB 24 073
Report Author:	Clare Hopewell, Assistant Director of System Finance Ian Livsey, Deputy Director of Finance
Report Sponsor:	Marcus Pratt, Acting Director of Finance
Presenter:	Marcus Pratt, Acting Director of Finance

Paper Type:							
For Assurance:	✓	For Decision:		For Discussion:		For Information:	

Summary:

This Finance Report focuses on the financial position of the ICB and the Nottingham and Nottinghamshire NHS system and draws out the key messages for the Board at the end of month six.

Nottingham and Nottinghamshire NHS system:
The Nottingham and Nottinghamshire NHS system has a reported a £9.6 million deficit at month six, which is £9.6 million adverse to plan against the June plans. The NHS system has received a non-recurrent allocation at month six for the £100 million deficit plan, with the revised plan now being a break-even position.

The system forecast at month six is in line with the revised break-even position. £7.1 million of the adverse variance is due to the impact of the non-recurrent deficit income relating to the deficit year-to-date phasing, and £1.8 million a shortfall of industrial action income against the industrial action impact. Continuing healthcare costs and prescribing pressures are £10.5 million adverse to plan and efficiency across the system is £4.1 million ahead of plan. Planned efficiencies are profiled to deliver materially more in the later part of the financial year than the first six months.

ICB:
The ICB's financial targets/plan has fundamentally changed this month with the receipt of £17.8 million of non-recurrent deficit support funding (being the ICB's part of the £100 million deficit funding across the system). This now means that the planned deficit becomes a planned breakeven position. The ICB is forecasting to deliver this breakeven position, albeit with an element of unmitigated risk. The year-to-date position is also breakeven.

Key forecast overspending areas include continuing healthcare costs at £6.0 million, prescribing costs at £7.6 million, section 117 costs £1.0 million and non-NHS community contract costs at £0.8 million forecast overspend. Offsetting these overspends is a forecast underspend in reserves.

The overall efficiency target of £68.5 million remains forecast to be delivered in full. That target has been allocated to programme areas and reflected as such in the financial ledger. The full year forecast position is based on agreed savings schemes delivering in full. Risk

Summary:
of non-delivery is captured within the risks and mitigations log. The savings and efficiency governance process to support the efficiency target delivery is in operation.

Recommendation(s):
The Board is asked to **receive** the report for assurance.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	Provides assurance on the effective use of financial resources and delivery of the financial plan, which is fully aligned to improving outcomes in population health
Tackle inequalities in outcomes, experience and access	Provides assurance on the effective use of financial resources and delivery of the financial plan, which is fully aligned to tackling inequalities
Enhance productivity and value for money	Provides direct assurance on the effective use of financial resources
Help the NHS support broader social and economic development	Provides assurance on the effective use of financial resources and delivery of the financial plan, which is aligned to broader social and economic development

Appendices:
None.

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 3: Financial sustainability – Failure to achieve financial sustainability across the system.

Report Previously Received By:
The Finance and Performance Committee has previously considered the report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Finance Report

Nottingham and Nottinghamshire NHS system key messages

Indicator Measure	Year to date Plan	Year to date Actuals	Year to date Var.	Plan/ Ceiling/ Envelope	Forecast outturn	Var.	RAG YTD	RAG Forecast outturn
Financial Sustainability (Variance from break-even)	0.0	-9.6	**-9.6**	0.0	0.0	**0.0**	Red	Green
Pay Spend	-941.3	-944.1	**-2.8**	-1850.9	-1840.5	**10.4**	Red	Green
Agency Spend vs Plan	-26.9	-24.3	**2.6**	-52.4	-47.3	**5.1**	Green	Green
Agency Spend Vs Ceiling		-24.3		-63.5	-47.3	**16.2**		Green
Whole Time Equivalent (Provider) - 24/25 plan as at 31.03.25	34,296	34,044	**252**				Green	
Financial Efficiency Vs Plan	80.5	84.6	**4.1**	257.0	257.0	**0.0**	Green	Green
Recurrent Efficiencies	58.5	58.8	**0.3**	201.5	172.9	**-28.6**	Green	Red
Achievement of Mental Health Investment Standard		108.8		217.8	217.8	**0.0**		Green
Capital Spend Vs System Envelope	41.5	34.0	**-7.5**	91.5	91.5	**0.0**	Green	Green
Elective Recovery Fund Performance	121%	118%	**-3%**	120%	120%	**0%**	Red	Green

1. The NHS system has a reported a £9.6 million deficit at month six, which is £9.6 million adverse to plan against the June plans submitted.
2. The system has received a non-recurrent allocation at month six for the £100 million deficit plan with the revised plan now being a break-even position.
3. The system forecast at month six is in line with the revised break-even position.
4. £7.1 million of the adverse variance is due to the impact of the non-recurrent deficit income relating to the deficit year-to-date phasing and £1.8 million a shortfall of industrial action income against the industrial action impact.

5. Continuing healthcare costs and prescribing pressures are £10.5 million adverse to plan and efficiency across the system is £4.1 million ahead of plan.

6. Planned efficiencies are profiled to deliver materially more in the later part of the financial year than the first six months.

By Organisation £000	Year to date Plan	Year to date Actuals	Year to date Var.	In-month Plan	In-month Actuals	In - month Var.	Total Full Year Plan	Forecast outturn	Var.
Nottingham University Hospitals	0.0	-1.5	-1.5	38.3	39.9	1.7	0.0	0.0	0.0
Sherwood Forest Hospitals	0.0	-0.8	-0.8	12.8	13.3	0.5	0.0	0.0	0.0
Nottinghamshire Healthcare	0.0	-7.3	-7.3	21.7	12.3	-9.4	0.0	0.0	0.0
Nottingham and Nottinghamshire ICB	0.0	0.0	0.0	7.4	7.4	0.0	0.0	0.0	0.0
TOTAL	**0.0**	**-9.6**	**-9.6**	**80.2**	**72.9**	**-7.3**	**0.0**	**0.0**	**0.0**

7. Workforce: Staff costs are £2.8 million underspent across the Nottingham and Nottinghamshire NHS system at month six with whole time equivalents (WTEs) being 252 WTEs lower than plan. Agency spend is £24.3 million, which is £2.6 million under the year-to-date plan. Agency plans submitted in June were £11.2 million below the agency cap and across the Nottingham and Nottinghamshire NHS system 2.8% of the total pay bill agency spend (nationally the NHS is expected to reduce agency spend to a maximum of 3.2% of the 2024/25 total pay bill).

8. Efficiencies: The year-to-date position includes £84.6 million of efficiency. All organisations within the Nottingham and Nottinghamshire NHS system continue to work up financial recovery plans, as the risk on the delivery of the efficiency plan target of £257 million remains high.

9. Debt: as previously reported, £46.4 million will be added to the Nottingham and Nottinghamshire NHS system's cumulative debt, which will need to be repaid in future years.

10. Investigation and Intervention Process: The Nottingham and Nottinghamshire ICS is one of nine NHS systems nationally that has been required to commission a delivery partner to support delivery of the 2024/25 financial plan. The ICB has engaged P.A Consulting to undertake this work. Phase one of this process had focussed on stress-testing plans to identify and quantify the key risks to delivery. Working with Nottingham and Nottinghamshire NHS system partners, the investigation phase has identified further opportunities and high impact interventions to accelerate and support delivery of the financial plan.

11. Financial Risk: In addition to efficiency delivery, there are also risks around growth and price increases relating to continuing healthcare and risks around

pay awards/uplifts, inflationary pressures and urgent and emergency care demand and capacity issues.

12. Governance and Oversight: The Nottingham and Nottinghamshire NHS system has enhanced its efficiency governance and oversight arrangements. All organisations have financial sustainability boards/groups with senior ICB attendance. This feeds into the ICS System Financial Recovery Group, which scrutinises and oversees the efficiency and finance position weekly.

13. System Capital Envelope: As previously reported the Nottingham and Nottinghamshire NHS system submitted a capital plan of £80.3 million (being £8.2 million lower than the original envelope as a consequence of the Nottingham and Nottinghamshire NHS system submitting a deficit financial plan). That plan amount, along with an additional £11.2 million to support the impact of the IFRS16 accounting standard on external bodies, gives a total capital envelope of £91.5 million.

14. Spend year-to-date against the revised Nottingham and Nottinghamshire NHS system capital envelope of £91.5 million is £34 million, and against the total Capital Departmental Expenditure Limit Plan of £199.2 million, is £60 million. The system continues to work together to manage the capital resource spend within the system capital envelope.

15. The difference between total Capital Departmental Expenditure Limit and the system capital envelope relates to schemes funded from national capital programmes. The Capital Departmental Expenditure Limit therefore includes both the system capital envelope and national capital programme funded schemes.

ICB key messages

Key financial Performance Indicator	Target	Year to Date	Forecast
Deliver Planned Surplus/Deficit	Breakeven	Breakeven	Breakeven
Deliver Income and Expenditure Breakeven	Breakeven	Breakeven	Breakeven
Achieve Mental health Investment Standard	Spend in Full	On target	On target
Deliver Better Payment Practice Code Targets	›95% all categories	›95% all categories	›95% all categories
Do not Exceed Capital Allocation	Spend ‹£2.02 million	On target	On target
Do not exceed Running Cost Allowance	Running Cost spend <£19.2 million	On target	On target
Deliver Efficiency Target	Deliver £68.5 million	On target	On target

16. The ICB is continuing to forecast to deliver the amended breakeven target (following the receipt of deficit funding). The year-to-date position is also on plan/breakeven.

17. Key forecast overspending areas continue to be continuing healthcare costs, prescribing costs and acute independent sector costs. Offsetting these overspends is a forecast underspend in delegated services (GP contracts: pharmacy, optometry and dental services) alongside offsetting adjustments in reserves that represent mitigating non recurrent solutions.

18. Following a recent confirm and challenge session, the overall efficiency target of £68.5 million is currently forecast to be delivered in full. That target has now been allocated to programme areas and the full year forecast position is based on those agreed savings schemes delivering in full. Risk of non-delivery is captured within the ICB's risks and mitigations log. As previously reported, the savings and efficiency governance process that support the delivery of the efficiency target is fully in operation.

19. A number of risks exist in delivering the reported position. Delivery of the efficiency target (£12.1 million) and pressures on continuing healthcare, prescribing and section 117 packages (£13.8 million) are the key risks. Total risks are £33.8 million and identified mitigations are £23.6 million arising in a net unmitigated risk of £10.2 million. The ICB continues to look for additional solutions/mitigations to cover off this net risk.

20. The ICB has utilised £1,510 million or 50.4% of its 2024/25 of its cash draw down requirement of £3,043 million. This compares to an expected utilisation of 50.0%. The cash balance held at 30 September was £0.77 million compared to a maximum target balance of £2.95 million.

21. Better Payment Practice Code (BPPC): The ICB met all its BPPC targets of paying at least 95% by value and volume of invoices within 30 days for the end of the reporting period.

22. The ICB capital programme of £2.0 million is currently forecast to be spent in full, with £2.07 million of schemes now identified following review meetings with the ICB officers responsible for the schemes.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/11/2024
Paper Title:	**Board Assurance Framework – Biannual Update**
Paper Reference:	ICB 24 074
Report Author:	Siân Gascoigne, Head of Corporate Assurance Lucy Branson, Director of Corporate Affairs
Report Sponsor:	Rosa Waddingham, Director of Nursing
Presenter:	Lucy Branson, Director of Corporate Affairs

Paper Type:							
For Assurance:	✓	For Decision:		For Discussion:		For Information:	

Summary:

The purpose of this paper is to present the latest position of NHS Nottingham and Nottinghamshire ICB's Board Assurance Framework for scrutiny and comment following approval of the ICB's ten strategic risks in May 2024.

The Assurance Framework has been fully refreshed and updated in conjunction with Executive Director risk owners. The paper highlights several key messages for the Board from reference to the Framework in terms of controls, assurances and identified gaps. It also sets out progress with actions to move the strategic risks towards their target scores by March 2025.

Recommendation(s):

The Board is asked to **receive** this item for assurance, having reviewed the latest position of the Board Assurance Framework.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	The Board Assurance Framework is a structured way of identifying and mapping the main sources of assurance in support of the achievement of the ICB's four aims.
Tackle inequalities in outcomes, experience, and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

A: Board Assurance Framework roles and responsibilities and full business cycle
B: Output of 'gaps' in controls and assurances exercise
C: 2024/25 Board Assurance Framework

Board Assurance Framework:
This paper presents the fully populated Board Assurance Framework, which outlines the controls and assurances across all the ICB's strategic risks.

Report Previously Received By:
Board Assurance Framework updates have been presented to the May and November 2023, and May 2024 meetings of the Board, the April 2024 Board development session, and the October 2023 and January, February and March 2024 meetings of the Audit and Risk Committee.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Board Assurance Framework – Biannual Update

Introduction

1. The ICB's strategic risk management processes are centred on the Board Assurance Framework, which is a structured way of identifying and mapping the main sources of assurance in support of the achievement of the ICB's core aims/objectives. The Assurance Framework provides the Board with confidence that what needs to be happening is happening in practice. More specifically it enables the Board to:

    a) Gain a clear and complete understanding of the control environments that have been established to manage its strategic risks.

    b) Consider the types of assurance currently obtained and whether they are effective and efficient.

    c) Identify areas where controls have yet to be fully established or where existing controls are failing (i.e., control gaps), and consequently, the risks that are more likely to occur.

    d) Identify areas where assurance activities are not present or are insufficient (i.e., assurance gaps), or where assurances may be duplicated or disproportionate.

2. The Board Assurance Framework also plays a key role in informing the production of the Chief Executive's annual Governance Statement (included within the ICB's Annual Report) and is the main tool that the Board should use in discharging its overall responsibility for ensuring that an effective system of internal control is in place. Roles and responsibilities and the full business cycle for the Board Assurance Framework are set out for information at Appendix A.

3. The Assurance Framework is a continuous process, initiated by the identification of the ICB's strategic risks, development of Board and committee annual work programmes and ongoing refresh and review of the ICB's control framework. Therefore, it is important to remember that whilst this paper presents the documented Board Assurance Framework, the process is ongoing throughout the year.

4. The purpose of this paper is to present the latest position of NHS Nottingham and Nottinghamshire ICB's Board Assurance Framework for scrutiny and comment. This builds upon previous updates provided to the Board during May and November 2023 and May 2024.

NHS Nottingham and Nottinghamshire ICB's Board Assurance Framework

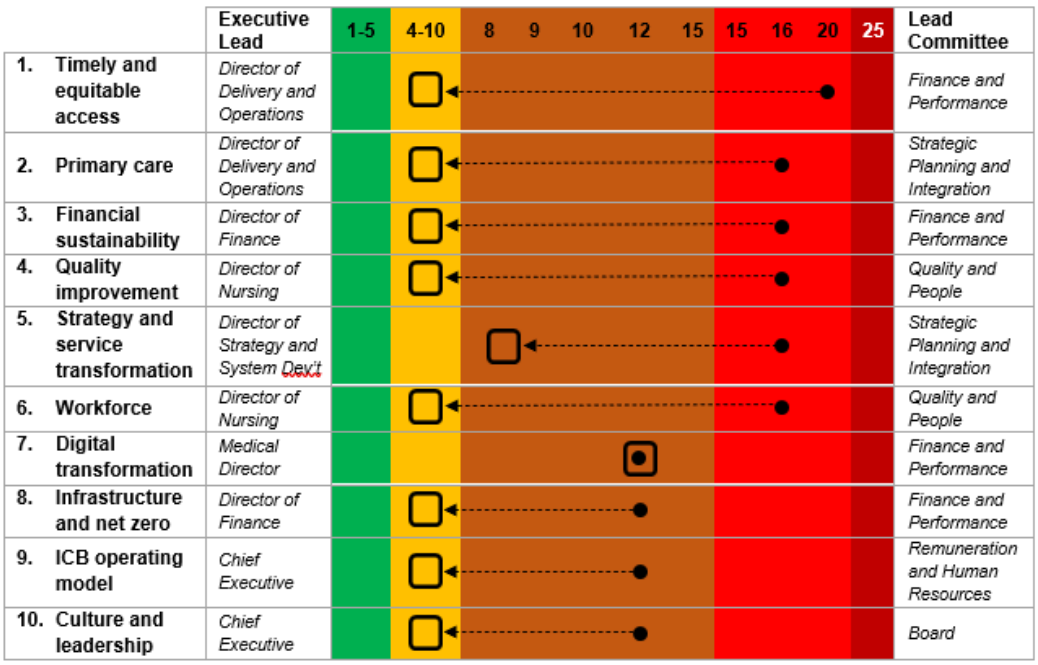
5. The Board Assurance Framework is structured around ten strategic risks to achieving the ICB's four core aims. The fully populated Framework is provided

at Appendix C. This is introduced by an explanation of how to navigate the document and includes a summary of how each risk aligns to the ICB's four core aims (at Annex 1 of the Board Assurance Framework document).

6. As a reminder, the unitary Boards of each statutory NHS partner organisation within the ICS continue to maintain their own individual Board Assurance Frameworks, as relevant to the roles and responsibilities of their organisations and their Boards' requirements. However, work is underway to ensure there is some alignment of key strategic risks across the ICB and its Trust Partners, as appropriate to joint priorities. The ICB's Board Assurance Framework also captures 'system focused' strategic risks, in line with its system oversight and coordination role. It is important to recognise that local authority and other non-NHS partners do not operate Assurance Frameworks in the same way as NHS partners.

Summary of key messages

7. The following diagram presents a summary 'heat map' of the Board Assurance Framework, reflecting latest discussions with the Executive Team during October 2024. It is important to remember that the ICB's strategic risk profile is expected to be high due to the nature of the risks contained within the Board Assurance Framework (i.e., if their impact rating is not high or very high, then it is questionable whether they should be classified as strategic risks to the organisation).



Note: Black dots represent the current scores for each risk. The squares indicate the target scores for each risk, in line with the ICB's risk appetite statement. The arrows show the movement in current risk scores, as well as the distance from the current risk score to the target risk score.

8. The following key points are highlighted for the Board's attention:

   a) Following discussions with Executive leads, the narrative for risks 1 and 9 have been amended. Risk 1 has been expanded to explicitly reference community services *'Failure to ensure timely and equitable access to urgent and emergency care, elective and cancer care,* ***community*** *and mental health services'* and risk 9 has been broadened to enable controls relating to the ICB's organisational culture to be included *'Failure to develop and embed a robust ICB operating and workforce model,* ***with an open, safe and compassionate culture****, to enable delivery of strategic goals and statutory duties'.*

   b) There is one strategic risk at its target risk score (*risk 7, digital transformation and the utilisation of system intelligence solutions*); the remaining nine strategic risks are some way from their target risks scores, with risk 1 (*timely and equitable access*) being the highest scoring risk at 20 (4 likelihood x 5 impact). Target risk scores have been identified in line with the Board's agreed risk appetite levels.

   c) A good level of control is in place across the ten strategic risks. The control framework includes locally developed strategies and plans, alongside ICB and system infrastructure to oversee delivery of these. Various elements of the system are also described within the control framework, including the role of Place-Based Partnerships, Primary Care Networks, Integrated Neighbourhood Teams and the Provider Collaborative at Scale. Reference has also been made to joint governance arrangements, where appropriate to do so.

   d) Review of the Assurance Framework has identified some areas where further work is required to strengthen the control framework. For example, with the introduction of new system forums, there is a need to undertake a comprehensive review of all ICS groups to ensure clarity of purpose and consistency of operations. The need to strengthen oversight of the fourth aim has also been identified (to help the NHS support broader social and economic development).

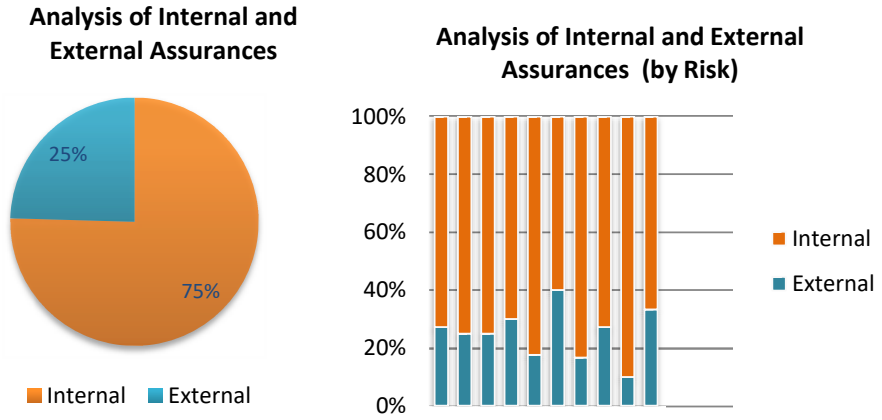
      In addition, work is required to strengthen a number of strategies and plans, such as finalising all chapters of the Primary Care Strategy, enhancing the ICS People Plan and closer alignment of population health needs to resource allocation and capital resource use plans. These are all drawn out as 'gaps' in control within the Framework.

   e) A wide range of assurances have been received by the Board and its committees, to date, across all strategic risks. Many 'positive' assurances have been received that controls are operating as expected; however, there continues to be 'negative' assurances around some of the key strategic risk areas. For example, 'limited' or 'partial' levels of assurance have been given to updates relating to quality, service delivery, workforce

and finance, which are reflective of current risk scores in these areas. It is also important to note that while there may not be 'gaps' identified in relation to controls and assurances for some risks, as robust processes are in place, low levels of assurance remain due to non-achievement of intended outcomes.

f) As expected at this time of year, several assurances are 'pending', meaning that whilst they are scheduled, they have yet to be received by the Board or one of its committees. This includes internal and external assurances, the latter of which are often delivered during the second half of the financial year (such as delivery of internal and external audit plans).

g) A review of the internal and external assurances set out within the Assurance Framework has been completed, as illustrated below. As a reminder, internal assurances are classed as any that are produced by the ICB, or jointly with system partners, and external assurances are those received from parties that are independent to the ICB and its partners (e.g., regulators, internal and external audit providers). Currently, 25% of assurances across the ICB's strategic risks are external, which is considered an acceptable level. In addition, external assurances have been identified across all strategic risks.



Next steps and timeline

9. Actions have been identified in relation to all identified 'gaps' with named responsible officers and clear implementation timelines. An exercise has also been undertaken to ensure any 'gaps' identified from the previous year's Board Assurance Framework have been addressed or reflected for 2024/25. Output from this exercise is provided at Appendix B.

10. Targeted Board Assurance Framework reports (scheduled for the December 2024, February and March 2025 meetings of the Audit and Risk Committee) will provide updates on progress against all identified actions. These reports also

enable the Audit and Risk Committee to review the design and operation of the Board Assurance Framework to ensure it is ‘fit for purpose’ for the ICB.

11. A workshop is scheduled with the Executive Management Team in February 2025 to review the ICB’s strategic risks for 2025/26. These will then be agreed with wider Board members; followed by scheduled Assurance Framework biannual updates to the Board in May and November 2025.

Appendix A: Board Assurance Framework (BAF) roles and responsibilities and full business cycle

BAF Roles and Responsibilities

Board	Has ultimate responsibility for risk management and as such, needs to utilise the Board Assurance Framework to be satisfied that internal control systems are functioning effectively.
Audit and Risk Committee	Has delegated responsibility for risk management and receives assurance that the ICB has robust operational and strategic risk management arrangements. The Committee specifically comments on the fitness for purpose of the Board Assurance Framework and has a role in securing independent assurances.
Board Committees	Scrutinise assurances in relation to the strategic risks for which they are the 'lead' committee and escalate levels of assurance to the Board (via routine committee highlight reports).
Executive Directors	Ensure a robust control framework is in place to mitigate their respective strategic risks within the BAF to drive delivery of the ICB's core aims and objectives.
Governance Team	Develop Board and committee annual work programmes (which outline planned assurances in line with Board and committee duties) and co-ordinate the population of the ICB's BAF, in conjunction with the Executive Team. The Team also provides risk management expertise to establish and support the ICB's strategic risk management arrangements.

2024/25 BAF Full Business Cycle

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Board: BAF biannual reviews	-	✓	-	-	-	-	-	✓	-	-	-	-
Audit and Risk Committee: Targeted assurance reports	-	-	-	-	-	-	-	-	✓	-	✓	✓
Board Committees: Receipt of assurances	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	✓
Executive-led BAF Reviews: 1:1 reviews between the Head of Corporate Assurance and relevant Executive(s)	✓	-	-	✓	-	-	✓	-	-	✓	-	-

Appendix B: Output of 'gaps' in controls and assurances exercise

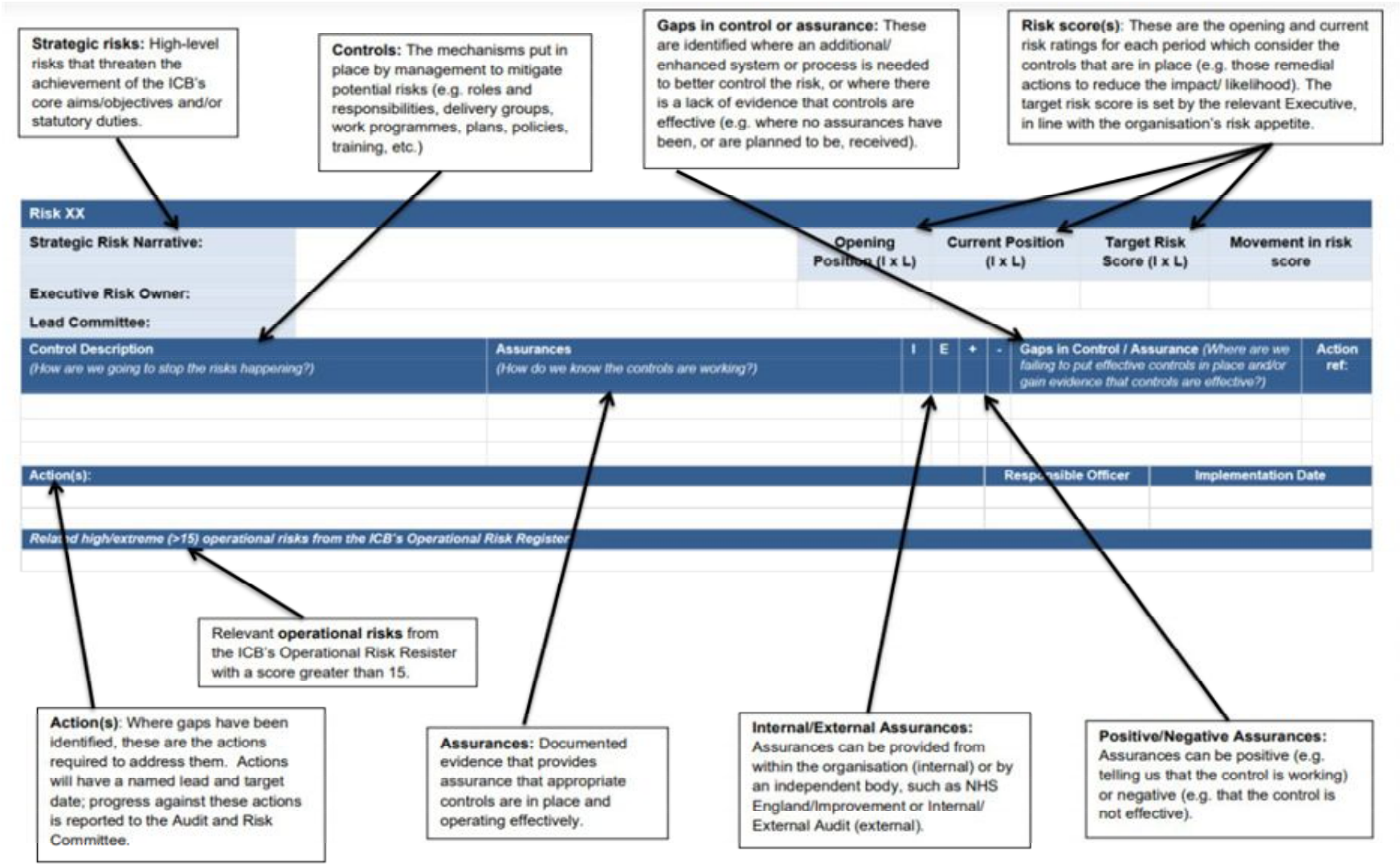
Actions relating to 2022/23 and 2023/24 Board Assurance Framework

(1.10) To revamp the ICS Outcomes Framework in light of the Integrated Care Strategy and Joint Forward Plan.	ICS outcomes framework is in place; its development was overseen by the Strategic Planning and Integration Committee.
(1.11) To establish appropriate targeted operating model with system delivery 'vehicles' and establish associated commissioning arrangements.	Roles of the Provider Collaborative at Scale, Place-Based Partnerships, Primary Care Networks and Integrated Neighbour Teams are explicitly described as controls within the 2024/25 Assurance Framework.
(5.2) To develop processes to ensure that knowledge and evidence from research systematically influences business cases.	ICS Research Strategy has been finalised and published; progress updates in relation to its delivery are received by the Strategic Planning and Integration Committee.
(8.4) To implement actions identified within the Equality, Diversion and Inclusion Action Plan 2023-25.	Equality, Diversion and Inclusion Action Plan is in place and its delivery is overseen by the Quality and People Committee.
(9.1) To address actions identified within the SEND inspection of Nottinghamshire Local Area Partnership.	SEND Improvement Action Plans are in place and their delivery is overseen by the Quality and People Committee.
(10.1) To develop the Joint Medium-term Financial Plan to support delivery of the Joint Forward Plan.	Included in 2024/25 Assurance Framework (see risk 3, action 3.1)
(11.2) To develop the ICS Infrastructure (previously known as Estates) Strategy.	Included in 2024/25 Assurance Framework (see risk 8, action 8.2)

Board Assurance Framework

November 2024

How to navigate the Board Assurance Framework



Risk 1 – Timely and equitable access					
Strategic Risk Narrative:	Failure to ensure timely and equitable access to urgent and emergency care, elective and cancer care, community and mental health services.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Director of Delivery and Operations	High (4 x 5)	High (4 x 5)	Medium (4 x 2)	N/A
Lead Committee:	Finance and Performance Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Cautious*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
2024/25 Operational Plan, which sets out the priorities for healthcare delivery across Nottingham and Nottinghamshire, focusing on improving access, tackling backlogs and meeting key performance targets.	Operational Plan development updates to the Finance and Performance Committee (April 2024 and *pending, January, February and March 2025*)	✓		✓		None identified.	
	Operational Plan delivery updates to the Finance and Performance Committee (June, July and September 2024)	✓		✓	✓		
	Annual Operational and Financial Plan presented to the Board *(*March 2024, and *pending, March 2025)*	✓					
	NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)		✓				
Role and remit of the monthly **ICS System Oversight Group**, whose members have collective accountability for the operational performance of the ICS. This is attended by NHS England. Establishment of the weekly **System Oversight Sub-Group (a),** which is ICB chaired, in line with the ICB's NHS system leadership role, and has responsibility for overseeing delivery of statutory performance targets and delivery of the 2024/25 Operational Plan. NHS Partners are held collectively accountable for performance. Establishment of the **System Transformation Leadership Group**, whose collective membership is responsible for bringing together transformation programmes which support and enable achievement of statutory performance targets.	Service Delivery Reports to the Finance and Performance Committee (monthly)	✓		✓	✓	To undertake a review of ICS system forums to ensure clarity of purpose and naming principles, consistency of operation (as appropriate) and reporting lines.	1.1
	Service Delivery Reports to the Board (each meeting)	✓		✓	✓		
	Rolling programme of 'thematic' Service Delivery reviews to the Finance and Performance Committee (*pending, October and November 2024, and February 2025*)						
	NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)		✓	✓	✓		
The role and remit of System Programme Boards in relation to operational performance and delivery; a) **Urgent and Emergency Care (UEC) Board**, which leads on system resilience and delivery of statutory targets relating to non-elective care across the ICS. b) **Planned Care Board**, which leads on delivery of statutory targets relating to elective care, cancer and diagnostic services across the ICS.	Operational Plan development updates to the Finance and Performance Committee (April 2024 and *pending, January, February and March 20205*)	✓		✓	✓	See action 1.1 To ensure community services are fully embedded within the system oversight and transformation leadership groups.	1.2
	Operational Plan delivery updates to the Finance and Performance Committee (June, July and September 20204)	✓		✓	✓		
	Service Delivery Reports to the Finance and Performance Committee (monthly)	✓		✓	✓		

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
c) **Nottingham and Nottinghamshire Adult and Children's Mental Health Partnership Board** (*being re-established*). d) **Primary Care Strategy Delivery Group,** which oversees primary care delivery via oversight of the Primary Care Access Recovery Plan (PCARP). e) **Community Transformation Group** (*being re-established*). Role and remit of the **Demand and Capacity Group,** supported by the Bed Modelling 'Task and Finish' Group.	Rolling programme of 'thematic' Service Delivery reviews to the Finance and Performance Committee (*pending, October and November 2024, and February 2025*) Service Delivery Reports to the Board (each meeting) NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process) 2023/24 Internal Audit Review – System-wide Discharge Management (*Advisory*).	✓ ✓	 ✓ ✓	 ✓ ✓ ✓	 ✓ ✓		
Daily system calls and **On-call arrangements**, alongside embedment of the **System Co-ordination Centre (SCC)**; the purpose of which is to ensure the safest and highest quality of care possible for the entire population across every area by balancing the clinical risk within and across all health and care settings. **Operational Pressures Escalation Level (OPEL) Framework** across both primary and secondary care providers.	As above.					None identified.	
East Midlands Joint Commissioning Committee (and supporting infrastructure) which is established to ensure delivery of delegated functions.	NHS England delegation update to the SPI Committee *(pending, March 2025)* 2024/25 Internal Audit Review – Delegated direct commissioning *(pending)*	✓	 ✓			To develop routine assurance reporting to the Board on delivery of delegated specialised commissioning functions.	1.3
ICB membership of the **East Midlands Cancer Alliance (EMCA),** whose role is to develop and implement change in line with national priorities; more specifically: • Bringing together influential local decision-makers; • Taking responsibility for directing funding to transform services and care across whole pathways; • Reducing variation in the availability of safe care and treatment for all people with cancer; and • Delivering continuous improvement and reduction in inequality of experience.	Service Delivery Reports to the Finance and Performance Committee (monthly) Service Delivery Reports to the Board (each meeting)	✓ ✓		✓ ✓	✓ ✓	None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 1.1 To undertake a review of ICS system forums to ensure clarity of purpose and naming principles, consistency of operation (as appropriate) and reporting lines.	Chief Executive	March 2025
Action 1.2 To ensure community services are fully embedded within the system oversight and transformation leadership groups.	Director of Delivery and Operations	March 2025
Action 1.3 To develop routine assurance reporting to the Board on delivery of delegated specialised commissioning functions.	Director of Delivery and Operations	March 2025

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR083 If discharges from learning disability and autism inpatient settings are delayed due to lack of available capacity in community-based settings, there is a risk patients may stay in inpatient settings longer than necessary or be cared for in a more restrictive environment than required. This may lead to poor patient experience and adverse health outcomes for the population of Nottingham/shire (System Risk). *ORR092 If the system is unable to provide timely diagnostics, due to increased demand and/or capacity constraints, this may adversely impact patient health outcomes (System Risk).*

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR166 If ambulance handover times at acute trusts increase and cause delayed ambulance arrival in the community, there is a risk of potential harm to citizens who are waiting for an ambulance, which may lead to further deterioration of their condition (System Risk).
ORR170 If insufficient availability of mental health inpatient beds continues, there is a risk that individuals may face delayed or inadequate treatment or be transferred for care in an 'out of area' setting, which may result in increased distress, potential harm to themselves or others, or a higher likelihood of crisis situations (System Risk).
ORR171 If capacity issues continue, there is a risk of not being able to facilitate timely discharge of individuals requiring ongoing mental health support once their medical or physical issues have resolved, which may lead to delays in discharge, potentially exacerbating current challenges across the urgent and emergency care pathway (System Risk).
ORR207 If challenges in the provision and delivery of community mental health services persist, there is risk that these services may not be accessed, or accessed promptly, and/or meet the current and future needs of the population. This may result in worsening health outcomes for citizens across Nottingham/shire. This risk may also result in increased demand on other services as activity may be displaced to other partners within the system (System Risk).

Risk 2 – Primary care					
Strategic Risk Narrative:	Failure to reduce unwarranted variation and improve access to primary medical services and pharmacy, optometry and dental (PODs) services.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Director of Delivery and Operations	High (4 x 4)	High (4 x 4)	Medium (4 x 2)	N/A
Lead Committee:	Strategic Planning and Integration Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Cautious*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Nottingham and Nottinghamshire ICS Primary Care Strategy, which outlines the ICS strategic intention of improving primary medical care resilience and promoting collaborative working with the aim of improving patient care. Improving access in primary care is one of the priority components for delivery. The Strategy is comprised of four chapters, at various stages of development: • Chapter 1 General Practice *(complete).* • Chapter 2 Community Pharmacy *(in development).* • Chapter 3 Community Dentistry *(outstanding).* • Chapter 4 Community Optometry *(outstanding).* **Nottingham and Nottinghamshire ICS Primary Care Access Recovery Plan (PCARP),** which outlines the plan to improve access to primary care services within the region. It aims to improve access to appointments through: • Empowering patients; • Implementing 'Modern General Practice Access'; • Building capacity to enable practices to offer more appointments from more staff; and • Cutting bureaucracy to give practice teams more time to focus on patients' clinical needs.	Primary Care Strategy and Delivery Plan updates to the SPI Committee (June and September 2024 and *pending, November 2024 and February 2025)* Delivery plan for recovering access to primary care updates to the Board (May 2024 and *pending, November 2024)* NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓	 ✓	✓ ✓ ✓	 ✓	To develop and finalise all four chapters of the ICS Primary Care Strategy.	2.1
Role and remit of the monthly **ICS System Oversight Group**, whose members have collective accountability for the operational performance of the ICS. This is attended by NHS England. Establishment of the weekly **System Oversight Sub-Group (a),** which is ICB chaired, in line with the ICB's NHS system oversight role, and has responsibility for overseeing delivery of statutory performance targets and delivery of the 2024/25 Operational Plan. NHS Partners are held collectively accountable for performance. Establishment of the **System Transformation Leadership Group**, whose collective membership is responsible for bringing together	Primary Care Strategy and Delivery Plan updates to the SPI Committee (June and September 2024 and *pending, November 2024 and February 2025)* Delivery plan for recovering access to primary care updates to the Board (May 2024 and *pending, November 2024)* Service Delivery Reports to the Finance and Performance Committee (monthly) Service Delivery Reports to the Board (each meeting) NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓ ✓ ✓	 ✓	✓ ✓ ✓ ✓ ✓	 ✓ ✓ ✓	To ensure primary care is fully embedded within the system oversight and transformation leadership groups.	2.2

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
transformation programmes which support and enable achievement of statutory performance targets.							
Embedment of the ICB chaired **Primary Care Strategy Delivery Group**, whose members have collective responsibility for overseeing delivery of the Primary Care Strategy and the Primary Care Access Recovery Plan (PCARP). This is attended by Place-Based Partnership Clinical Leads and wider primary care and community pharmacist representatives.	As above.					None identified.	
Primary Care Medical Services Contracting Panel, whose role is to manage and oversee the contracting of primary care medical services in Nottingham and Nottinghamshire. This includes responsibility for reviewing and awarding contracts, ensuring that providers are meeting performance and delivery standards.	As above.					None identified.	
Primary Care Networks, who have a role in improving access to local primary medical services by enhancing collaboration and building resilience between individual GP practices across Nottingham and Nottinghamshire.	Primary Care Strategy and Delivery Plan updates to the SPI Committee (June and September 2024 and *pending, November 2024 and February 2025)*	✓		✓		None identified.	
East Midlands Primary Care Tier 3 and Tier 2 joint governance arrangements, which oversee performance and delivery of pharmacy, optometry and dental (POD) services across Nottingham and Nottinghamshire.	NHS England delegation update to the SPI Committee *(pending, March 2025)* PODS/Specialised Commissioning annual update to the Quality and People Committee *(pending, February 2025)* 2024/25 Internal Audit Review – Delegated direct commissioning *(pending)*	✓ ✓	 ✓			To develop routine assurance reporting to the Board on delivery of delegated pharmacy, optometry and dental (POD) services.	2.3

Action(s):	Responsible Officer	Implementation Date
Action 2.1 To develop and finalise all four chapters of the ICS Primary Care Strategy.	Director of Strategy and System Development	March 2025
Action 2.2 To ensure primary care is fully embedded within the system oversight and transformation leadership groups.	Director of Delivery and Operations	March 2025
Action 2.3 To develop routine assurance reporting to the Board on delivery of delegated pharmacy, optometry and dental (POD) services.	Director of Delivery and Operations	March 2025

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:

ORR159 If General Practices, Primary Care Networks, community pharmacy and the ICB do not have appropriate capacity, capability and resources to deliver actions in relation to delivery of ICS Primary Care Strategy and Primary Care Access Recovery Plan (PCARP), expected transformation may not be delivered. This may, in turn, impact on the ability to meet the needs of our population.

ORR179 If insufficient funding allocations and/or uncertainties regarding reimbursement rates continue there may be a risk to the financial sustainability of GP practices. This may increase the likelihood of contracts being 'handed back' and non-delivery of local enhanced services, potentially presenting a risk to access and health outcomes for the local population (System Risk).

ORR182 If GP collective action impacts on partnership working, there may be a risk to primary care engagement which may impact delivery of ICS strategic and transformation programmes. Furthermore, this has the potential to impact on other programmes of work e.g. Elective Recovery programmes if engagement with referral optimisation is affected by collective action (System Risk).

ORR199 As a result of General Practice (GP) participation in collective action, there may be a risk to primary care and community pharmacy service delivery. This may lead to the potential for harm to citizens in terms of management of chronic conditions and urgent medical concerns. Furthermore, this may lead to increased activity at other providers (System Risk).

Risk 3 – Financial sustainability					
Strategic Risk Narrative:	Failure to achieve financial sustainability across the system. *For 2024/25, specific focus is given on meeting the financial undertakings agreed with NHS England for the ICS to 'return to a breakeven financial position by no later than 31 March 2026'.*	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Director of Finance	High (4 x 4)	High (4 x 4)	Medium (4 x 2)	N/A
Lead Committee:	Finance and Performance Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Cautious*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
The **2024/25 ICS Operational and Financial Plan**, more specifically, delivery of performance targets which may have financial implications, such as income relating to elective recovery. Delivery of the **2024/25 ICS Workforce Plan**, which supports financial sustainability by optimising staff allocation, reducing reliance on bank and agency workers and addressing skill shortages.	Annual Operational and Financial Plan presented to the Board *(pending, March 2025)* Annual Financial Plan and Opening Budgets reported to the Finance and Performance Committee (*pending, March 2025*) Finance Report (ICB and ICS) reported to the Finance and Performance Committee (monthly) Finance Report (ICB and ICS) reported to Board (each meeting) System Workforce Plan and delivery updates to the Quality and People Committee (June and July 2024) 2023/24 Internal Audit Review - ICS NHS Partners System Financial Control NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓ ✓ ✓ ✓	 ✓ ✓	 ✓ ✓	 ✓ ✓ ✓ ✓	None identified.	
Delivery of the **Joint Medium-term Financial Plan**, which supports overall delivery of the five-year Joint Forward Plan. The Plan is developed in line with the: a) ICS Finance Framework, which sets out the rules which govern the way finances are managed within the ICS (as identified as best practice by the HfMA); and b) ICS Financial Planning Principles.	As above.					To take a more strategic approach to the Joint Medium Term Financial Plan, ensuring robust resource allocation and prioritisation arrangements are in place.	3.1
Role and remit of the monthly **ICS System Oversight Group**, whose members have collective accountability for the operational and financial performance of the ICS. This is attended by NHS England. Role and remit of the **ICS Directors of Finance Group**, whose members have collective accountability for the financial performance of the ICS, capital and resource allocation, as well as delivery of the Joint Medium Term Financial Plan. Roles and remit of the **ICS System Opportunities Group – Efficiencies and Transformation Delivery** *(formerly known as System Oversight Sub-Group (b))*	As above.					See action 1.1	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
ICS 'grip and control' measures, which are overseen by the **ICS Financial Recovery Group** (FRM). This includes, but is not limited to, weekly scrutiny of progress with financial efficiency programmes and the strengthening of workforce expenditure and vacancy controls. This agenda is supported by regular ICS Chief Executive and Director of Finance meetings. ICB 'grip and control' measures, which are overseen by the **ICB Financial Recovery Meeting**. This includes weekly scrutiny of ICB efficiency programmes, which is in addition to **routine budgetary monitoring and control arrangements** and compliance with ICB standing documents (e.g., the **Scheme of Reservation and Delegation** and **Standing Financial Instructions**).	Finance Report (ICB and ICS) reported to the Finance and Performance Committee (monthly) Finance Report (ICB and ICS) reported to Board (each meeting) Twice-yearly Financial Stewardship Assurance reporting to the Audit and Risk Committee *(pending, December 2024 and May 2025)* Losses and Special Payments Register annual update to the Audit and Risk Committee *(pending, March 2025)* Annual review of the Standing Financial Instructions to the Audit and Risk Committee *(pending, December 2024)* 2024/25 Internal Audit Review – Financial Management *(pending)* 2024/25 External Audit – Year-end financial accounts review *(pending)*	✓ ✓ ✓ ✓ ✓	 ✓ ✓	 	✓ ✓ 	See action 1.1	
The **Project Management Office (PMO) function** within the ICB, which provides support and oversees delivery of programmes which aim to improve operational efficiency and financial performance.	As above.					None identified.	
The ICB's **procurement and contracting functions,** which support financial sustainability by ensuring cost-effective purchasing and efficient allocation of resources, reducing waste and maximising value. Establishment of the **Commissioning Review Group**, whose membership has collective responsibility for ensuring investment and disinvestment commissioning proposals and contract award proposals have appropriate scrutiny in line with the ICB decision-making framework, provider selection regime legislation and statutory guidance.	Provider Selection Regime Assurance report to the Audit and Risk Committee (October 2024) Provider Selection Regime and Provider Accreditation update to the SPI Committee (October 2024) Strategic Commissioning Reviews updates to the SPI Committee (June and July 2024 and *pending, October 2024)* Service Change Review Group updated to the SPI Committee (October 2024) Primary Care Services Contracting Panel reports to the SPI Committee (April 2024 and *pending, November 2024)* Investments, Disinvestments and Contract Awards for Healthcare Services updates to SPI Committee (monthly) 2024/25 Internal Audit Review – Provider Selection Regime *(pending)*	✓ ✓ ✓ ✓ ✓ ✓	 ✓	✓ ✓ ✓ ✓ ✓ 	 	To embed the recently refreshed Commissioning Review Group.	3.2
Provider Collaborative at Scale, a collective partnership of the NHS trusts across Nottingham and Nottinghamshire, working together to streamline services, reduce duplication and share resources, with an aim to lower costs and support financial sustainability and efficiencies.	Provider Collaborative update to the Board *(pending, November 2024)*	✓				None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 3.1 To take a more strategic approach to the Joint Medium Term Financial Plan, ensuring robust resource allocation and prioritisation arrangements are in place.	Director of Finance	March 2026
Action 3.2 To embed the recently refreshed Commissioning Review Group.	Director of Strategy and System Delivery	January 2025

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR195 If NHS Nottingham and Nottinghamshire ICB is unable to identify and implement sustainable recurrent financial efficiency solutions, at pace, there is a risk the ICB's underlying position (UDL) will continue to worsen with impact to the ability to deliver within the ICB's financial resources (ICB Risk).

ORR196 If the Nottingham/shire NHS system, as a collective, does not meet its agreed 2024/25 year-end financial position, there is a risk to the extent to which the system will be able to create financial 'headroom' to invest in services. This may lead to reputational issues and increasing levels of regional and national intervention by NHS England (System Risk).

ORR197 If the Nottingham/shire NHS system, as a collective is unable to identify and implement sustainable recurrent financial efficiency solutions, at pace, there is a risk the collective underlying position (UDL) will continue to worsen, which may significantly impact Nottingham/shire's ability to become a financially sustainable system (System Risk).

Risk 4 – Quality improvement					
Strategic Risk Narrative:	Failure to systematically improve the quality of healthcare services. *For 2024/25, specific focus is being given of improving quality across maternity and learning disability and autism (LDA) services, as well as local secondary care providers under enhanced surveillance.*	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Director of Nursing	High (4 x 4)	High (4 x 4)	Medium (4 x 2)	N/A
Lead Committee:	Quality and People Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Cautious*	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
System Quality Framework (formally known as Strategy), which is supported by a delivery plan, the purpose of which is to develop and embed a robust quality improvement framework across system partners.	System Quality Framework/Strategy updates to the Quality and People Committee (May 2024 and *pending, January 2025)*	✓		✓		None identified.	
System Quality Improvement Approach, which is driven by the **NHSE Improving Patient Care Together (IMPACT) Self-Assessment**; the purpose of which is to help systems, providers and partners understand where they are on their quality improvement journey and identify improvements needed.	As above.					None identified.	
Established infrastructure to *monitor quality improvement of all providers* across the ICS, which includes, but is not limited to: • **'Task and finish' Improvement Oversight and Assurance Groups (IOAG)** for those NHS providers placed in oversight level four; the purpose of which are to help providers recover from significant challenges, ensuring they return to a position where they can deliver safe, effective and financially stable care. • Routine and escalated **quality contract monitoring mechanisms** for those providers where quality concerns are identified (e.g. contract performance notices). • Various forums, whose remits include primary medical services quality improvement, which include the **Primary Care Strategy Delivery Group** and **Primary Care Contracting Panel**; • **East Midlands Primary Care Tier 3** and **Tier 2 joint governance arrangements**, which oversee performance and delivery of pharmacy, optometry and dental (POD) services across Nottingham and Nottinghamshire; and • **East Midlands Joint Commissioning Committee** (and supporting infrastructure) which is established to ensure the quality of specialised services.	Quality Report to the Board (each meeting) Quality Oversight Report updates to each meeting of the Quality and People Committee (monthly) Ad-hoc provider exception reporting and 'deep dives' to the Quality and People Committee (e.g. Nottinghamshire Health NHS Foundation Trust, Section 48 Review, UEC pathway) Primary Medical Services updates to the Quality and People Committee (July 2024 and *pending, January 2025*) Care Homes and Home Care updates to the Quality and People Committee (June 2024 and *pending, November 2024)* PODS/Specialised Commissioning annual update to the Quality and People Committee *(pending, February 2025)* 2024/25 Internal Audit Review – Quality management arrangements *(pending)* 2024/25 Internal Audit Review – Delegated direct commissioning *(pending)* NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓ ✓ ✓ ✓ ✓	 ✓ ✓ ✓	 ✓ ✓	✓ ✓ ✓ ✓ ✓	None identified.	
The ICB's quality framework and commissioning processes, which *monitor quality improvement in line with the ICB's statutory duties*	Safeguarding updates to the Quality and People Committee (quarterly)	✓		✓		None identified.	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
relating to nursing and quality (e.g., safeguarding, infection prevention and control, complaints). This includes implementation of the **Patient Safety Incident Response Framework (PSIRF)**, which sets out the systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The establishment of Patient Safety Specialists and Patient Safety Partners to support implementation of the PSIRF Policy. As well as compliance with the **ICB Complaint's Policy**, which sets out the ICB's approach to handling complaints and concerns about commissioned services, ensuring that 'lessons are learnt' and improvements made as a result of issues raised.	Infection, Prevention and Control annual update to the Quality and People Committee (*pending, November 2024*) Continuing Healthcare, Children's Continuing Care and Personalised Care annual update to the Quality and People Committee (*pending, November 2024*) Patient Safety Incident Response Framework (PSIRF) update to the Quality and People Committee (June 2024 and *pending, February 2025*). Patient Experience and Complaints annual update to the Quality and People Committee (April 2024) 2023/24 Internal Audit Review – Complaints (significant).	✓ ✓ ✓ ✓	 ✓	 ✓ ✓ ✓			
Role and remit of the **System Quality Group**, which exists to drive quality improvement collaboratively and proactively. It includes 'seven minute' learning sessions at each meeting which relate to various quality improvement initiatives. This is supported by system sub-groups which include, but are not limited to, safeguarding (including LAC and SEND), infection prevention and control, care home and home care, immunisations and vaccinations, patient safety, social care and personalisation.	As above.					See action 1.1.	
Role and remit of the **Nottingham and Nottinghamshire Local Maternity and Neonatal System (LMNS) Executive Partnership Board,** which is overseen by the System Quality Group and supported by: **LMNS Perinatal Surveillance Quality Group (PSQG), LMNS Serious Incident (SI) Panel** and **LMNS Quality Outcomes Dashboard Sub-group (DSG)** Role and remit of the **Maternity Voices Partnership (MVP).** Role and remit of the **Regional Quality Oversight Group.** Role and remit of the **Regional Perinatal Quality Surveillance Group.**	Quality Oversight Report updates to each meeting of the Quality and People Committee (monthly) Nottingham and Nottinghamshire Local Maternity and Neonatal System (LMNS) annual update to the Quality and People Committee (October 2024) Regional LMNS oversight and performance meetings with NHSE.	✓ ✓	 ✓	 ✓	✓ ✓	None identified.	
Role and remit of the **Nottingham and Nottinghamshire Learning Disability & Autism (LDA) Executive Partnership Board,** which is overseen by the System Quality Group and oversees the improvement of LDA services across the system, for both adults and children and young people.	Quality Oversight Report updates to each meeting of the Quality and People Committee (monthly) Learning Disability and Autism (LDA) annual update to the Quality and People Committee *(pending, March 2025)* Regional LDA oversight and performance meetings with NHSE.	✓ ✓	 ✓		✓	None identified.	
Establishment of **SEND Partnership Improvement Boards** (with both Nottinghamshire County Council and Nottingham City Council), whose collective membership oversees improvement activity following the Ofsted and Care Quality Commission (CQC) local area inspections.	Quality Oversight Report updates to each meeting of the Quality and People Committee (monthly) Safeguarding updates to the Quality and People Committee (June, Sept 2024 and *pending, January and March 2025)*	✓ ✓		 ✓	✓	None identified.	

Action(s):	Responsible Officer	Implementation Date
None.		

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR191 If Nottinghamshire Healthcare NHS Foundation Trust (NHCT) do not have the capability to make the required quality improvements identified as a result of current quality, staffing and performance concerns and exacerbated by regional and national reviews, there is a risk the quality of services provided may not meet optimal care standards. This may lead to potential risk of harm and poor health outcomes to the population of Nottingham/shire (ICB Risk). *ORR208 If the quality of maternity services does not improve, services provided may not meet optimal care standards. This may result in potential risk of harm (i.e. physical and psychological) and poor patient experience for women, birthing people, their babies, and families (System Risk).* *ORR224 If Nottingham University Hospitals NHS Trust (NUH) fail to sustain improvements made to date following CQC and external recommendations, there is a risk quality of services may decline. This may lead to compromised patient safety and quality of care which could result in poor patient experience and adverse health outcomes for the population of Nottingham/shire (ICB Risk).*

Risk 5 – Strategy and transformation					
Strategic Risk Narrative:	Failure to work collaboratively with Partners to develop robust strategies and plans, and transform services, to address health inequalities and improve outcomes.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Director of Strategy and System Development	High (4 x 4)	High (4 x 4)	Medium (4 x 2)	N/A
Lead Committee:	Strategic Planning and Integration Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Open*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
a) A system wide **Integrated Care Strategy** outlines how statutory partners across the ICS, working with non-statutory partners, patients, people and communities, will improve health and care outcomes. Commitment has been given to achieving a set of ambitions to improve overall health and wellbeing and reduce health inequalities. Partners have agreed to working collaboratively to deliver these ambitions and adhere to three strategic principles of prevention, equity and integration in the design and implementation of interventions and support to people. b) A **Joint Forward Plan (JFP) h**as also been developed across NHS statutory bodes which sets out how the ICB and its local NHS partners will work differently across the next five years to deliver the ICS Integrated Care Strategy. Commitment to the three strategic principles and overall collaborative approach is affirmed in this Plan. c) **Joint Local Health and Wellbeing Strategies (Nottingham City and Nottinghamshire County)**, also set out the vision, priorities and action agreed by the Health and Well-being Boards to improve the health and wellbeing of the population and address issues of inequity and health inequalities. The need for partnership and collaboration across system partners is intrinsic to delivery of these Strategies. The Integrated Care Strategy, Joint Local Health and Wellbeing Strategies and JFP are based on the population health and care needs as described by the **Nottingham City and Nottinghamshire County Joint Strategic Needs Assessments**.	Updates on the oversight and delivery of the Joint Forward Plan to the SPI Committee (May, July and Sept 2024 and *pending, February and March 2025*) Joint Strategic Needs Assessment Prevention Chapter presented to the SPI Committee *(pending, December 2024)* Integrated Care Strategy update to the Board *(pending, Jan 2025)* Joint Forward Plan and Outcomes Framework updates to the Board (May, July and October 2024 and *pending, March 2025)* Health Inequalities Statement to the Board (May 2024) Health Inequalities Statement reported to the Quality and People Committee *(pending)* Rolling programme of health inequalities reviews to the Quality and People Committee *(pending, November 2024, January, and March 2025)* 2022/23 Internal Audit Review – Health Inequalities *(Advisory)* NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	 ✓ ✓	✓ ✓ ✓ ✓ ✓	 ✓	To strengthen oversight arrangements in relation to the fourth aim *(to help the NHS support broader social and economic development).*	5.1
Establishment of the system **Transformation Delivery Group**, whose collective membership is responsible for bringing together transformation programmes which support and enable sustainable achievement of statutory and local performance ambitions. For 2024/25, focus is being given on eight priority transformation areas.	Transformation Programme Delivery updates to the SPI Committee (May 2024 and *pending, February and March 2025)* Primary Care Strategy and Delivery Plan updates to the SPI Committee (June and September 2024 and *pending, November 2024 and February 2025)*	✓ ✓		✓ ✓		See action 1.1, 1.2 and 2.2.	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
	Children and Young People's Mental Health Local Transformation Plan update to the SPI Committee *(pending)*	✓					
The role and remit of System Programme Boards in relation to the transformation and delivery of respective elements of the Joint Forward Plan; a) **Urgent and Emergency Care (UEC) Board,** which oversees transformation across the non-elective pathway. b) **Planned Care Board,** which exists to oversee transformational changes in the provision of planned care, cancer and diagnostic services across the ICS. c) **Nottingham and Nottinghamshire Adult and Children's Mental Health Partnership Board** *(being re-established)*. d) **Primary Care Strategy Delivery Group,** which oversees primary care transformation as outlined in the ICS Primary Care Strategy. e) **Community Transformation Group** (*being re-established*). The above are also supported by several service specific system transformation boards and groups, which include the **Special Educational Needs and Disabilities (SEND) Improvement Board**, **Children and Young People Board**, **Learning Disability and Autism (LDA) Transformation Board** and **Local Maternity and Neonatal (LMNS) Transformation Board**. Delivery of the Joint Forward Plan, in its entirety, is also overseen by the **Joint Forward Plan Delivery Group** (*currently under review*). Role and remit of the **ICS Health Inequalities (HI) and Prevention Oversight Group.** Role and remit of the **ICS Research Group.**	As above. ICS Research Strategy: Progress Updates to the SPI Committee (May and November 2024)	✓		✓		See action 1.1 To revise oversight arrangements in relation to the Joint Forward Plan.	5.2
Establishment and embedment of the **ICS Clinical and Care Professional Leadership Group**, which provides clinical leadership for delivery of the Integrated Care Strategy, associated delivery plans and endorsement of significant service and pathway transformation.	Transformation Programme Delivery updates to the SPI Committee (May 2024 and *pending, February and March 2025)* Ad-hoc commissioning decisions presented to the SPI Committee 2024/25 Internal Audit Review – Framework for clinical and care professional leadership *(pending)*	✓ ✓	 ✓	✓		See action 1.1.	
Establishment and embedment of the **Place Based Partnership (PBP) and Integrated Care Board (ICB) Leads Group,** which maximise the opportunity of PBPs to support delivery of NHS priorities recognising the role of PBPs as local partnerships working across health, care, the voluntary and community sector, and local government to improve population health and wellbeing. The role and remit of **Integrated Neighbourhood Team (INTs),** who support transformation by offering localised, proactive care, promoting interprofessional collaboration and engaging communities	Place Plans update to the SPI Committee (*pending, Nov 2024*) Primary Care Strategy and Delivery Plan updates to the SPI Committee (June and September 2024 and *pending, November 2024 and February 2025)*	✓ ✓		 ✓		See action 1.1.	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
The role of the **Integrated Care Partnership (ICP)** in bringing together key stakeholders from health, social care, public health and the voluntary sector to coordinate and improve health and care services. The **Partners Assembly** within the ICS, which fosters collaboration, sets strategic priorities and drives the integration of health and social care services across Nottingham and Nottinghamshire.	Chair's Report to the Board *(at each meeting)* Chief Executive's Report to the Board *(at each meeting)* NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓	 ✓	 ✓	 ✓	None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 5.1 To strengthen oversight arrangements in relation to the fourth aim (to help the NHS support broader social and economic development).	Director of Strategy and System Development	March 2025
Action 5.2 To revise oversight arrangements in relation to the Joint Forward Plan.	Director of Strategy and System Development	March 2025

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR192 If resources at Nottinghamshire Healthcare NHS Foundation Trust (NHCT) are primarily focused on addressing immediate quality, staffing and performance concerns, there is risk that there may not be sufficient capacity or 'headspace' to deliver mental health and community service transformation. This may result in future population needs not being made and/or anticipated efficiencies not materialising (System Risk). *ORR155 If the transformation of urgent and emergency care services is not prioritised and delivered, there is a risk that limited health and social care resources may not be used most efficiently. This may lead to an inability to meet demand: today and in the future (System Risk).*

Risk 6 – Workforce					
Strategic Risk Narrative:	Failure to utilise the system workforce effectively and ensure a sustainable workforce for the future.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Director of Nursing	High (4 x 4)	High (4 x 4)	Medium (4 x 2)	N/A
Lead Committee:	Quality and People Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Cautious*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Nottingham and Nottinghamshire Five Year ICS People Plan, whose purpose is to ensure that that the ICS has the right staff, with the right skills, values and behaviours to deliver high-quality services now and in the future; this is underpinned by four key ambitions: • A healthy and well workforce; • A fully inclusive and representative workforce; • A right sized, talented, well skilled, educated and trained, affordable workforce; and • A transformed workforce, delivering health and care priorities in new ways and or at different locations.	People Plan updates to the Quality and People Committee (May, June 2024 and *pending, January 2025*). People Plan twice-yearly updates to the Board (Sept 2024 and *pending, March 2025)* 2024/25 Internal Audit Review – Delivering the People Plan *(pending)* NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓	 ✓ ✓	 ✓	✓ ✓ ✓	To further develop and enhance the Nottingham and Nottinghamshire Five Year ICS People Plan.	6.1
Embedment of the **System People and Culture Steering Group,** whose collective membership oversees delivery of the NHS People Plan, with specific focus on transformation, which is supported by the: a) **ICS People and Culture Delivery Group,** whose role and remit includes oversight and delivery of the ICS People and Culture Plan. b) **Workforce Transformation Group**, which focuses on strategic workforce transformation and education planning (long-term workforce plan). c) **ICS Planning, Performance and Risk Group,** which focuses on in-year delivery of the system 'grip and control' opportunities. This is supported by the **Vanguard Steering Group** and **Workforce Intelligence Group (WIG).** The role and remit of the **Primary Care Strategy Delivery Group**, which oversees the delivery of the workforce workstream of the **Primary Care Strategy**.	People Plan updates to the Quality and People Committee (May, June 2024 and *pending, January 2025*). People Plan twice-yearly updates to the Board (Sept 2024 and *pending, March 2025)* ICS 2024/25 Workforce Plan updates to the Quality and People Committee (June, July and September 2024 and *pending, October, November 2024 and January, February and March 2025*). NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓ ✓	 ✓	 ✓ ✓	✓ ✓ ✓ ✓	None identified.	

Action(s):	**Responsible Officer**	**Implementation Date**
Action 6.1 To further develop and enhance the Nottingham and Nottinghamshire Five Year ICS People Plan.	Director of Nursing	January 2025

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR077 If current challenges in the health and social care system continue there is a risk of sustained levels of significant workforce pressures which may lead to sickness, exhaustion, 'burn out' and inability to maintain psychological safety of workforce. This relates to health, social care and primary medical services provider workforce (System Risk).
ORR177 If system workforce planning remains short-term, due to operational and financial challenges, there is risk that it may not address medium to longer term strategic education and planning needs. This may lead to issues with initial workforce supply and ineffective use of workforce. This risk is exacerbated by challenges experienced in getting system data into a single place to support ICS workforce planning and projections (System Risk).
ORR210 As a result of ongoing operational and financial pressures, there is a risk to further deterioration in staff health, wellbeing and morale. This may impact on staff productivity and lead to staff feeling disconnected or disengaged with the ICB. This may, in turn, result in further increases to levels of sickness and vacancies within the organisation (ICB Risk).

Risk 7 – Digital transformation					
Strategic Risk Narrative:	Failure to drive forward digital transformation and utilise system intelligence solutions to address health inequalities and improve outcomes.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Medical Director	Medium (4 x 3)	Medium (4 x 3)	Medium (4 x 3)	N/A
Lead Committee:	Finance and Performance Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Open*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Digital Notts Strategy (2023 to 2028), which is underpinned by five programmes: • Public Facing Digital Services; • Digital and Social Inclusion; • Frontline Digitalisation; • Interoperability (Shared Care Records); and • Supporting Intelligent Decision Making.	Twice-yearly Digital, Data and Technology strategic updates to the Finance and Performance Committee (July 2024 and *pending, November 2024*) Digital, Data and Technology Strategy presented to the Board *(pending, January 2025)* 2024/25 Internal Audit Review – Delivering Digital Transformation *(pending)*	✓ ✓	 ✓	✓		None identified.	
ICS Data, Analytics, Information and Technology (DAIT) Strategy Group and supporting delivery group structure, which includes the **ICS Digital Executive Group**.	As above.					None identified.	
Primary Care Information Technology Strategy (2021-2026) which sets out the strategy for IT services and functionality for primary care and will support delivery of the **Primary Care Access Recovery Plan (PCARP).** **Primary Care Digital Steering Group,** which exists to develop, support and implement the necessary IT infrastructure within primary care.	As above.					None identified.	
Role of the **System Analytics and Intelligence Unit (SAIU)** in relation to the Population Health Management (PHM) programme. The SAIU supports integrated working across ICS data, intelligence and analytical partners to better identify and support the health and care for the population of Nottingham and Nottinghamshire.	Population Health Management Outcomes reported to Finance and Performance Committee (June, July and September 2024) Population Health Management Outcomes reported to the Quality and People Committee *(pending, November 2024)* Hospital Mortality Rates update to the Quality and People Committee *(pending, November 2024)*	✓ ✓ ✓		✓		None identified.	

Action(s):	**Responsible Officer**	**Implementation Date**
None.		

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR084 If organisations within the ICS are unable to access IT systems (i.e. unexpected system outage, successful cyber-attacks or issues with the availability of products and services) they may not be able to conduct core business as usual functions. This may result in patients not receiving timely diagnosis or treatment due to necessary equipment not functioning or patient records being unavailable. It may also result in unfavourable media coverage, reputational damage, and significant cost pressures (System Risk).

ORR090 If the Nottingham and Nottinghamshire system does not have sufficient system partner 'buy in' and capacity (digital workforce and operational workforce) to engage with and deliver digital transformation schemes alongside business-as-usual delivery it may not be possible to progress the System, Primary Care and ICB digital transformation agenda. Additionally, this may lead to missed opportunities in relation to funding available for digital transformation. This risk may be further exacerbated by current financial challenges and GP collective action (System Risk).

Risk 8 – Infrastructure and net zero					
Strategic Risk Narrative:	Failure to work effectively as a system to a sustainable infrastructure to deliver high-quality and efficient care and the net zero commitment.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Director of Finance	Medium (4 x 3)	Medium (4 x 3)	Medium (4 x 2)	N/A
Lead Committee:	Finance and Performance Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Cautious*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Board approved **Joint Capital Resource Use Plan**, which is prepared with partner NHS trusts and NHS foundation trusts and provides transparency to stakeholders on the prioritisation and expenditure of capital funding.	Joint Capital Resource Use Plan reported to the Finance and Performance Committee (April 2024 and *pending, Oct 2024 and March 2025*)	✓		✓		To establish a more strategic approach to the Joint Capital Resource Use Plan, aligning more closely with population health needs.	8.1
	Joint Capital Resource Use Plan updates to the Board (May 2024 and *pending, March 2025)*	✓					
	NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)		✓	✓	✓		
Role and remit of the **ICS Directors of Finance Group**, whose members have collective accountability for the financial performance of the ICS, capital and resource allocation, as well as delivery of the Joint Medium Term Financial Plan. This is underpinned by the role of the **ICS Capital Management Group,** which is responsible for ensuring a collaborative approach to capital and that capital investment is prioritised and used effectively.	Finance Report (ICB and ICS) reported to the Finance and Performance Committee (monthly)	✓			✓	None identified.	
	Joint Capital Resource Use Plan reported to the Finance and Performance Committee (April 2024 and *pending, Oct 2024 and March 2025*)	✓		✓			
	NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)		✓	✓	✓		
Development and implementation of the **ICS Infrastructure Strategy,** which will align with service strategies and support future investment prioritisation. This work is being overseen by **ICS Capital Management Group,** supported by the **ICS Infrastructure Strategy Steering Group.** Development and implementation of the **Primary Care Estates Strategy,** which is supported by individual **Primary Care Network Estate Strategies.**	ICS Infrastructure Strategy updates to the Finance and Performance Committee (May, June and *pending, November 2024*).	✓		✓		To finalise and publish the ICS Infrastructure Strategy. To finalise and publish the Primary Care Estates Strategy.	8.2 8.3
	General Practice Estates Plan updates to the Finance and Performance Committee *(pending, Nov 2024 and March 2025)*	✓					
	ICS Infrastructure Strategy presented to the Board *(pending, January 2025)*	✓					
	NHS England review and assessment of the ICS Infrastructure Strategy *(pending)*		✓				
Nottingham and Nottinghamshire ICS Green Plan (2022 to 2025), which outlines the specific actions and priority interventions for achieving carbon net zero to lay the foundation to deliver carbon emission reductions through the delivery of sustainable health and care services. Role and remit of the **ICS Net Zero / Green Steering Group,** whose members have collective accountability for delivery of the ICS' Green Plan.	Twice-yearly ICS Green Plan updates to the Finance and Performance Committee (May 2023 and *pending, Nov 2024*)	✓			✓	None identified.	
	Green Plan presented to the Board *(pending, January 2025)*	✓					
	2022/23 Internal Audit Review – Environmental sustainability governance (significant assurance).		✓	✓			
	NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)		✓	✓	✓		

Action(s):	Responsible Officer	Implementation Date
Action 8.1 To establish a more strategic approach to the Joint Capital Resource Use Plan, aligning more closely with population health needs.	Director of Finance	March 2025
Action 8.2 To finalise and publish the ICS Infrastructure Strategy.	Director of Finance	March 2025
Action 8.3 To finalise and publish the Primary Care Estates Strategy.	Director of Finance	March 2025

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
No related high/extreme (>15) operational risks currently.

Risk 9 – ICB operating model					
Strategic Risk Narrative:	Failure to develop and embed a robust ICB operating and workforce model, with an open, safe and compassionate culture, to enable delivery of strategic goals and statutory duties.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Chief Executive	Medium (4 x 3)	Medium (4 x 3)	Medium (4 x 2)	N/A
Lead Committee:	Remuneration and Human Resources Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Cautious*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Establishment of the **ICB Operating Model**, which was shared with the Board as part of the rolling-programme of Board seminar sessions.	ICB Operating Model update to the Board (April 2023)	✓		✓		To introduce routine updates relating to the ICB operating model to the Board.	9.1
Development of **ICB annual priorities**, which were shared with the Board as part of the rolling-programme of Board seminar sessions.	ICB Annual Priorities update to the Board (April 2024)	✓		✓		To introduce routine updates relating to delivery of ICB priorities to the Board.	9.2
Review of **ICB Executive portfolios,** ensuring that leadership skills and responsibilities align with, and support delivery of, the ICB's strategic aims and objectives.	Review of Very Senior Manager (VSM) structure update to the Remuneration and Human Resources Committee *(pending, Jan 2025)* Review of clinical leadership remuneration update to the Remuneration and Human Resources Committee *(pending, Jan 2025)*	✓ ✓				None identified.	
Role and remit of the **Executive-led Human Resources Steering Group**, whose collective membership has responsibility for overseeing the development and implementation of the ICB's operating and workforce models.	ICB Workforce Reports to the Remuneration and Human Resources Committee *(pending, October 2024 and January 2025)*	✓				None identified.	
Development of an **ICB Succession Plan**, which ensures a smooth transition of leadership by identifying and preparing individuals to fill critical positions in the event of vacancies.	ICB Succession Plan reporting to the Remuneration and Human Resources Committee *(pending, January 2025)*	✓				To finalise development of the ICB succession plan.	9.3
Development of the **ICB's Values and Behaviours**, with the purpose of enhancing wellbeing through the promotion of positive values and behaviours that foster a supportive and inclusive environment. This is supported by the development and embedment of **Staff Networks** and the **Staff Engagement Group**.	ICB Staff Survey updates to the Remuneration and Human Resources Committee *(pending, January 2025)* National NHS Staff Survey *(pending, February 2025)*	✓	 ✓			None identified.	
The **ICB's Freedom to Speak Up (FTSU) arrangements,** which create a supportive environment where staff can raise concerns without fear of reprisal. These arrangements include access to FTSU guardians, clear reporting processes, and organisational commitment to address concerns in a timely and transparent manner.	ICB Freedom to Speak Up updates to the Audit and Risk Committee *(pending)* ICB Freedom to Speak Up updates to the Board *(pending)* National NHS Staff Survey *(pending, February 2025)*	✓ ✓	 ✓			None identified.	

Action(s):	**Responsible Officer**	**Implementation Date**
Action 9.1 To introduce routine updates relating to the ICB operating model to the Board.	Chief Executive	March 2025
Action 9.2 To introduce routine updates relating to delivery of ICB priorities to the Board.	Chief Executive	March 2025
Action 9.3 To finalise development of the ICB succession plan.	Director of Nursing	March 2025

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
No related high/extreme (>15) operational risks currently.

Risk 10 – Culture and leadership					
Strategic Risk Narrative:	Failure to orchestrate positive system culture and leadership to drive effective partnership working.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Chief Executive	Medium (4 x 3)	Medium (4 x 3)	Medium (4 x 2)	N/A
Lead Committee:	Board			*Cautious*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Embedment of the **ICS Partnership Agreement**, which demonstrates the commitment of the collective leadership across the ICS to work effectively together for the benefit of all communities and residents across Nottingham and Nottinghamshire.	Chair's Report to the Board *(at each meeting)* Chief Executive's Report to the Board *(at each meeting)* NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓	 ✓	 ✓	 ✓	None identified.	
Embedment of **ICS system governance arrangements** which underpin effective partnership working across all partner organisations. This includes all system delivery, clinical leadership and oversight boards and groups, as well as the: – **ICS Reference Group**; – **ICS Non-Executive Directors Network**; – **NHS Governors Forum**; – **ICS Audit Chairs Network**; – **ICS System Risk Management Network**.	2024/25 Internal Audit Review – System Governance Review *(pending)* NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)		✓ ✓	 ✓	 ✓	None identified.	
The role of the **Integrated Care Partnership (ICP)** in bringing together key stakeholders from health, social care, public health and the voluntary sector to coordinate and improve health and care services.	Chair's Report to the Board *(at each meeting)* Chief Executive's Report to the Board *(at each meeting)* NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓	 ✓	 ✓	 ✓	None identified.	
The role of the **Health and Wellbeing Boards (HWBs)** as partnerships between local authorities, the NHS and wider stakeholders, with the purpose of improving the health and wellbeing of the populating of Nottingham and Nottinghamshire.	As above.					None identified.	
The **Universities for Nottingham Civic Agreement**, which sets out a commitment to enhance the economic, social, and cultural life, and the health and wellbeing for the people and place of Nottingham and Nottinghamshire. This is supported by the establishment of an **ICS Anchor Champions Network.**	NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)		✓	✓	✓	To establish assurance reporting relating to ICS anchor institutions.	10.1
Establishment and embedment of the **Primary Care 'One Voice' forum**, which an ICB-led partnership forum with leaders of primary care services (GP and PODs) across Nottingham and Nottinghamshire.	Primary Care Strategy and Delivery Plan updates to the SPI Committee (June and September 2024 and *pending, November 2024 and February 2025)*	✓		✓		None identified.	
Establishment and embedment of the **Place Based Partnership (PBP) and Integrated Care Board (ICB) Leads Group, which** maximise the opportunity of PBPs to support delivery of NHS priorities recognising the	Place Plans update to the SPI Committee (*pending, Nov 2024*)	✓				None identified.	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
role of PBPs as local partnerships working across health, care, the voluntary and community sector, and local government to improve population health and wellbeing.							

Action(s):	**Responsible Officer**	**Implementation Date**
Action 10.1 To establish assurance reporting relating to ICS anchor institutions.	Chief Executive	March 2025

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
No related high/extreme (>15) operational risks currently.

Annex 1: Alignment of BAF Strategic Risks to ICB Objectives/Core Aims

Strategic Risks *(What could prevent us from achieving our strategic aims/objectives and statutory duties?)*	To improve outcome in population health and healthcare.	To tackle inequalities in outcomes, experience and access.	To enhance productivity and value for money.	To help the NHS support broader social and economic development.
1. Timely and equitable access - Failure to ensure timely and equitable access to urgent and emergency care, elective and cancer care, community and mental health services.	✓	✓	✓	
2. Primary care - Failure to reduce unwarranted variation and improve access to primary medical services and pharmacy, optometry and dental (PODs) services.	✓	✓	✓	
3. Financial sustainability - Failure to achieve financial sustainability across the system.	✓	✓	✓	✓
4. Quality improvement - Failure to systematically improve the quality of healthcare services.	✓	✓		
5. Strategy and transformation - Failure to work collaboratively with Partners to develop robust strategies and plans, and transform services, to address health inequalities and improve outcomes.	✓	✓	✓	✓
6. Workforce - Failure to utilise the system workforce effectively and ensure a sustainable workforce for the future.			✓	✓
7. Digital transformation - Failure to drive forward digital transformation and utilise system intelligence solutions to address health inequalities and improve outcomes.	✓	✓	✓	
8. Infrastructure and net zero - Failure to work effectively as a system to a sustainable infrastructure to deliver high-quality and efficient care and the net zero commitment.	✓	✓	✓	✓
9. ICB operating model - Failure to develop and embed a robust ICB operating and workforce model, with an open, safe and compassionate culture, to enable delivery of strategic goals and statutory duties.			✓	
10. Culture and leadership – Failure to orchestrate positive system culture and leadership to drive effective partnership working.	✓	✓	✓	✓

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/11/2024
Paper Title:	**Committee Highlight Reports**
Paper Reference:	ICB 24 075
Report Author:	Committee Secretariat
Report Sponsor:	ICB Committee Chairs
Presenter:	ICB Committee Chairs

Paper Type:							
For Assurance:	✓	For Decision:		For Discussion:		For Information:	

Summary:

This report presents an overview of the work of the Board's committees since the last Board meeting in September 2024. The report aims to provide assurance that the committees are effectively discharging their delegated duties and to highlight key messages for the Board's attention. The report includes the committees' assessments of the levels of assurance they have gained from the items received and any actions instigated to address any areas where low levels of assurance have been provided.

Also included is a summary of the high-level operational risks currently being oversighted by the committees. All committees of the ICB Board have a responsibility to oversee risks relating to their remit and ensure that robust and timely management actions are being taken in mitigation. As such, all committee meetings have risk as a standing agenda item.

Recommendation(s):

The Board is asked to **receive** the report for assurance.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	The Board's committee structure has been designed to provide assurance to the Board that statutory duties and responsibilities in line with the core aims are being effectively discharged.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

A: Highlight Report from the Strategic Planning and Integration Committee
B: Highlight Report from the Quality and People Committee
C: Highlight Report from the Finance and Performance Committee
D: Highlight Report from the Audit and Risk Committee
E: Highlight Report from the Remuneration and Human Resources Committee
F: Current high-level operational risks being oversighted by the Board's committees

Board Assurance Framework:
The Board's committees scrutinise assurances in relation to the strategic risks for which they are the 'lead' committee and escalate levels of assurance to the Board via this consolidated highlight report.

Levels of assurance:	
Full Assurance	The report provides clear evidence that: • Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required.
Adequate Assurance	The report demonstrates that: • Desired outcomes are either being achieved or on track to be achieved; and/or • Required levels of compliance with duties will be achieved; and/or • There are minor weaknesses in control and risks identified can be managed effectively. Unlikely that the achievement of strategic objectives and system priorities will be impaired. Minor remedial and/or developmental action is required.
Partial Assurance	The report highlights that: • Achievement of some outcomes are off-track or mechanisms for monitoring achievement in some areas have yet to be established/fully embedded; and/or • Compliance with duties will only be partially achieved; and/or • There are some moderate weaknesses that present risks requiring management. Possible that the achievement of strategic objectives and system priorities will be impaired. Some moderate remedial and/or developmental action is required.
Limited Assurance	The report highlights that: • Achievement of outcomes will not be achieved or are significantly off-track for achievement; and/or • Compliance with duties will not be achieved; and/or • There are significant material weaknesses in control and/or material risks requiring management. Achievement of strategic objectives and system priorities will be impaired. Immediate and fundamental remedial and/or developmental action is required.

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Appendix A: Strategic Planning and Integration Committee Highlight Report

Meeting Dates:	**03 October and 07 November 2024**
Committee Chair:	**Jon Towler, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. Working with People and Communities Update	The Committee received an update on the work that had taken place during the period 01 April to 30 September 2024 to take forward the system approach to working with people and communities. Work was taking place with the System Analytics and Intelligence Unit to develop ways to measure the value and impact of coproduction and ways to embed the coproduction principles within transformation programmes were being explored. Future reports would provide details of the areas that had been highlighted as a priority for improvement through citizens intelligence, along with an update on if/how the system had responded to the feedback. The potential impact of external factors on the communications and engagement team's capacity was acknowledged. The position would be monitored, and potential resource implications would continue to be assessed.	**Adequate**	**Adequate** *Awarded at the meeting held on 07 March 2024*
2. Implementation of the NHS Provider Selection Regime and ICB Patient Choice Provider Accreditation process	The Committee received an update on implementation of the NHS Provider Selection Regime (PSR) and Patient Choice Accreditation process following their recent introduction.	**Adequate**	**Not applicable**

Item	Summary	Level of assurance	Previous level of assurance
	A number of proactive actions had been undertaken by the ICB working group in readiness for the introduction of PSR, which had placed the ICB in a strong starting position. The PSR/Patient Choice National Panel had reported on three representations since PSR came into force. The points raised in these, and future reports would be considered in future PSR proposals within Nottingham and Nottinghamshire.		
3. ICS Research Strategy: Progress Update	Following approval of the Strategy in July 2024, an update on early progress on the delivery of the Strategy was received. Members were advised that there was enthusiasm across the ICS in driving this, with research and evidence acknowledged as a way forward in addressing some of the current challenges. An ICS Research Leaders Group has also been established comprising senior system leaders. Members welcomed the comprehensive update, discussing the potential for involvement from wider system partners and consideration of any opportunities that could be brought by D2N2. It was agreed that the finalisation of the Research Strategy Delivery Plan in January 2025 would enable more robust assurance around progress.	**Adequate**	**Not applicable**
4. Primary Care Strategy: Progress Update	The report presented progress on the ongoing delivery of the General Practice chapter of the ICB's Primary Care Strategy and the ongoing development of its Community Pharmacy, Optometry and Dental (PODs) chapters. Members were informed that a review of the General Practice Chapter was underway due to recent and predicted contextual changes and that work had been done to ensure alignment of the strategy development areas across all of primary care. Members noted that positive progress had been made across all POD groups, with active engagement underway to ensure the effective co-design of the POD chapters. Members discussed a	**Adequate**	**Not applicable**

Item	Summary	Level of assurance	Previous level of assurance
	number of areas in relation to the report; including capital funding for primary care, where it was agreed that the Finance and Performance Committee should seek further detail as to how the current primary care network estate plans have fed into the ICS Infrastructure Strategy. In conclusion, it was felt that the next scheduled update should focus on PODs and also aim to provide a clearer picture on what was and was not working well in general practice, as it was difficult to assess the current position.		
5. Primary Medical Services Contracting Panel Report	The report provided a summary of the discussions, decisions, challenges, and risks considered by the Primary Medical Services Contracting Panel since last report in April 2024. In particular, members noted the current challenges being overseen by the Panel, which included the financial viability of practices due to the 2024/25 GP contract uplift being significantly below inflation and potential risks around GP Collective Action and practices signing up to deliver local enhanced services. It was confirmed that as independent businesses, potential risks around the impact of the Autumn Budget 2024 were on the Panel's radar. Members agreed the report evidenced the robustness of the Panel's arrangements.	**Full**	**Not applicable**

Other considerations:

Decisions made:
The Committee: a) Approved the Direct Award of a one-year contract, under urgent circumstances rules of the PSR, to commence from 07 October 2024, for the provision of four enhanced supported living beds for the adult inpatient population with learning disabilities and/or autism. In line with the PSR, during the 12-month contract period, the ICB would undertake further market testing.

b) Approved the proposed amendments to the Terms of Reference of the current Service Change Review Group, to be renamed the Commissioning Review Group.

c) Approved ceasing the separate non-weight bearing (NWB) pathway funding, following a service review. Pathway One providers would pick up the NWB activity as agreed through the development of a new Pathway One Service Specification.

Matters of interest:

The Committee also received and discussed:

a) The updated service review process and decision support framework. Ways to engage the Integrated Care System Collaborative Clinical and Care Leadership and Transformation Group in the service review process would be considered and opportunities for integration across the system would be explored.

b) Received an update on the continued work to advance the ICB's Place Based Partnerships (PBP) and place-based working, following the Board's consideration of the maturity of arrangements at its meeting in April 2024. Members were advised of the publication of PBP Place Plans and the development of integrated neighbourhood working, which had progressed well over the last year. Members discussed the importance of ensuring links to the prevention agenda and the increasing national focus on devolvement to places.

c) Comprehensive updates on the risks relating to the Committee's remit.

d) The Log of Investment, Disinvestment, Procurement and Contract Award Decisions (Healthcare) 2024/25.

e) The Committee Annual Work Programme 2024/25 for information. It was noted that due to the increasing need to manage the committee's time flexibly to accommodate ad hoc funding review items, some scheduled items had been re-scheduled to later dates, and some may have to be carried over to the 2025/26 work programme. The work programme would be reviewed to ensure that the committee was discharging its responsibilities.

Appendix B: Quality and People Committee Highlight Report

Meeting Dates:	**18 September and 16 October 2024**
Committee Chair:	**Marios Adamou, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. Nottinghamshire Healthcare NHS Foundation Trust (NHT) – Deep Dive	The report set out the key events in the current context and provided an overview of the robust internal and external assurance and oversight arrangements, along with a progress update on the Section 48 recommendations and the findings from the latest deep dive review undertaken in August 2024. It was noted that limited progress had been made across NHT since the previous deep dive in October 2023. However, there were no signs of deterioration. The organisation was taking a phased approach to improvements, which included the development of the 'safe now' dashboard, the establishment of Rapid Improvement Groups and Boards, and a significant change management process. Members acknowledged that it would take time to embed sustainable improvements throughout the organisation. The Committee would receive a focussed report on homicide reviews and the future management of homicides after the independent homicide review had been published. Members applied an assurance rating of limited, noting that some improvements had been made and there was an increased level of oversight.	**Limited**	**Not applicable**

Item	Summary	Level of assurance	Previous level of assurance
2. Adult Safeguarding Report	The report provided an overview and summary of assurance against the ICB's statutory responsibilities to safeguard adults at risk. The Safeguarding Adults Annual Report 2023/24, which was appended to the report and provided additional detail, would be shared with partners across the Nottingham City and Nottinghamshire Safeguarding Adults Boards.	**Full**	**Not applicable**
3. Nottinghamshire Area Prescribing Committee (APC) Annual Report 2023/24	The Committee received the annual report, which outlined the Nottinghamshire APC's key achievements and challenges, along with a summary of decisions made and their potential financial impact.	**Full**	**Not applicable**
4. Safe Management of Controlled Drugs Annual Report 2023/24	The report detailed how the ICB continued to deliver on its statutory duties related to Controlled Drugs (CDs) through the work of the ICB Medicines Optimisation team during 2023/24. It also detailed how business critical functions were maintained to support medicines safety incidents related to CDs.	**Full**	**Full** *Awarded at the meeting held on 17 January 2024*
5. High-Cost Medicines ICB Annual Report 2023/24	The report detailed the management of ICB commissioned High-Cost Medicines (HCM) within the Nottinghamshire health community and set out the key achievements, risks, and challenges for this area of work during 2023/24.	**Full**	**Not applicable**
6. Quality Oversight Report	Members received the Quality Oversight Report at both meetings and concluded on each occasion that the assurance provided was limited. At the September meeting, members noted the work that was taking place in relation to Special Educational Needs and Disabilities inspections. With regard to the ICB's quality insight visits to Sherwood Forest Hospitals	**Limited**	**Limited** *Awarded at the meeting held on 18*

Item	Summary	Level of assurance	Previous level of assurance
	Foundation Trust, members were advised that these had been positive to date, with further visits scheduled through the winter. It was agreed at the October meeting that future reports would provide a monthly update on the status and quality of Trusts for which the ICB had responsibility based on the NHS Oversight Framework and areas under enhanced oversight, with a quarterly focus on progress.		*September 2024*
7. People and Culture Operational Delivery Plan	Members received updates on progress against the operational workforce plan at both meetings. A quarterly summary of progress against the people provisions of the National NHS objectives for 2024/25 were included within the September report. Members noted that the September report was much improved, and it was helpful to receive the narrative update alongside the metrics. Future reports would be condensed to provide a summary of the current position. At month five, Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust and Nottinghamshire Healthcare NHS Foundation Trust had over performed against the plans for whole time equivalents (WTE) and agency usage. Work was being taken forward to identify the reasons for the pay bill being slightly being above plan. The November report would provide enhanced narrative around the relationship between turnover and WTE reductions including themes around increased turnover and opportunities to drive workforce efficiencies and additional focus around primary and social care workforce. The Committee applied an adequate assurance rating, acknowledging the progress made around delivery against the month five operational workforce plan.	**Adequate**	**Partial** *Awarded at the meeting held on 18 September 2024*

Item	Summary	Level of assurance	Previous level of assurance
8. Progress against the 2023 to 2025 Equality, Diversity and Inclusion (EDI) Action Plan	The report provided a summary of progress against the 2023 to 2025 EDI objectives and action plan. Progress had been variable, with significant delays seen in some areas. The objectives would be refreshed, through a prioritisation exercise, for presentation to the Committee in November 2024. The objectives should be SMART, align to the core aims of the ICB, and focus on the areas that must be delivered by 31 March 2025. The Committee applied an assurance rating of limited, noting that the objectives were too broad, and several actions were significantly delayed.	**Limited**	**Adequate** *Awarded at the meeting held on 20 March 2024*
9. Winter Planning and Emergency Care System Quality Considerations	The report described the ways in which quality had been considered throughout the winter planning process, with all aspects of the plan being considered with a quality lens. It was noted that alignment with the operational workforce plan had also been considered during the development of the winter plan and the ambition around vaccinations and immunisations uptake had been stretched. There was a strong feeling of integration across the ICB quality and urgent and emergency care teams, and work was being taken forward to strengthen collaboration around clinical, quality, and patient safety concerns.	**Adequate**	**Not applicable**
10. Nottingham and Nottinghamshire Local Maternity and Neonatal System (LMNS) Update	The report focussed on responding to the specific requests made by the Committee in March 2024 to demonstrate the impact of actions and projects funded by the LMNS, and to expand the LMNS maternity dashboard to include health inequalities data. The LMNS maternity dashboard was being re-developed into PowerBi and the inclusion of health inequalities data formed part of the development plan. The dashboard was expected to be concluded in 2025/26.	**Partial** *(this related to the targeted work that had taken place following*	**Limited** *Awarded at the meeting held on 20 March 2024*

Item	Summary	Level of assurance	Previous level of assurance
	It had been difficult to quantify the impact of all LMNS actions as key performance indicators had not been built into some of the earlier projects and the impact was often experiential. However, a number of positive outcomes were described within the report and evaluations had been built into a number of LMNS programmes in order to demonstrate the impact on outcomes.	*the deep dive in March 2024)*	

Other considerations:

Decisions made:
The Committee approved the ICB Patient Safety Incident Response (PSIRF) Policy which had been reviewed and updated in line with the previously agreed review date. The updated policy would run for a three-year period, with a review date of September 2027.
Information Items and Matters of interest:
The Committee also reviewed identified risks relating to its areas of responsibility. The number of risks remained high, at 50, with 16 of those risks graded as high risks. A robust confirm and challenge of each live risk on the register had been undertaken, and a new process would be taken forward with the nursing and quality directorate to reiterate the importance of directorate risk logs and to ensure that risks were not escalated unnecessarily. The outputs of the confirm and challenge exercise would be presented to the November 2024 meeting of the Committee. a) Noted the findings of the initial assessments conducted by Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust in response to NHS England's request for Board members across Integrated Care Systems to assure themselves individually and jointly against a number of actions related to urgent and emergency care services. b) Noted the key functions and responsibilities of the ICB regarding medicines management and the schedule of associated reports that would be presented over the next year to enable the Committee to fulfil its delegated duties. c) Received the Quality Integrated Performance Report for information.

Appendix C: Finance and Performance Committee Highlight Report

Meeting Dates:	**25 September and 30 October 2024**
Committee Chair:	**Stephen Jackson, Non-Executive Director (September)** **Jon Towler, Non-Executive Director (October)**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. 2024/25 System and ICB Finance Report (M5 and M6)	Since the last report to the Board, the system had received a non-recurrent allocation of £100 million for the deficit plan, and the revised forecast was for a break-even position at year end. At month six, the system £9.6 million adverse to the year-to-date plan. Delivery of efficiency savings were £4.1 million ahead of plan by month six, and the forecast was for full delivery of the efficiency plan. Pay costs were £2.8 million adverse to plan and other cost pressures indicated a risk to the delivery of the Financial Plan. The ICB's financial target had changed as a consequence of the non-recurrent allocation and was now forecast to achieve a break-even position. The ICB's efficiency plan remained on target. Members discussed areas of overspend and sought assurance that robust governance was in place to ensure that the system's financial plan would be delivered. Levels of confidence in the full delivery of the plan were discussed and tested, given that the most difficult months of the year lay ahead.	**Partial**	**Partial** *Awarded at the meeting held on 31 July 2024.*

Item	Summary	Level of assurance	Previous level of assurance
	The overall partial assurance rating recognised that good progress had been made to date but acknowledged the risks and challenges that remained in achieving the system's and the ICB's financial plans.		
2. Medium term financial plan	Following a directive from NHS England that required the Nottingham and Nottinghamshire NHS to move to breakeven position in 2025/26 and to deliver a financially sustainable position from 2026/27, in September and October 2024, the Committee received reports on the development of the 2025/26 financial recovery plan. Members reviewed the principles, assumptions, and risks that had been discussed with system partners and emphasised that robust grip and control processes needed to remain in place to drive the 2025/26 plan. A rating of partial was applied, recognising that the plan was in its early stages of development.	**Partial**	**Not applicable**
3. Joint Capital Resource Use Plan	The report provided a mid-year update on the delivery of the Nottingham and Nottinghamshire Capital Resource Use Plan and current governance arrangements for the planning and management of system capital. Mid-year projections were forecasting that there was a risk of underspend. Assurance was sought that actions and robust governance were in place to mitigate the risk of underspend. An assurance rating of adequate was applied, recognising the confidence in delivery of the plan.	**Adequate**	**Not applicable**
4. Operational Plan 2024/25 Delivery (M5 and M6) and Service Delivery reports	In September and October 2024, members received reports highlighting areas of improvement and challenges. Continued improvement in overall Cancer performance, waiting lists and mental health out of area placements was noted. Albeit the system did not	**Partial**	**Partial** *Awarded at the meeting*

Item	Summary	Level of assurance	Previous level of assurance
	achieve the NHS England target of zero patients waiting 65 weeks or more by the end of September. After a period of improvement over the summer months, the position regarding Urgent and Emergency Care (UEC) was showing significant deterioration. Members welcomed the report, acknowledging improvement in several metrics. The causes of the deterioration in UEC performance were discussed in depth and members were informed of a range of actions that were being taken forward to mitigate the drop in performance levels. The overall assurance rating remained at partial, recognising good progress to date but acknowledging the risks and challenges that remained in achieving the operational plan.		*held on 31 July 2024.*
5. Winter Planning	The report provided detail of the development of the Winter Plan. Planning had commenced during the summer, with input from all system partners. The aim was to deliver a safe, effective and affordable winter. Noting that the plan would remain under continuing refinement, members sought assurance of governance arrangements for the monitoring of bed capacity over the winter period. Given the comprehensive nature of the plan, an assurance rating of adequate was given.	**Adequate**	**Not applicable**
6. Thematic Health Inequalities Review – Severe mental illness (adults) and mental health (children and young people)	The reviews provided an in-depth analysis on two elements of the approach to improving mental health outcomes, detailing several initiatives that had been mobilised over the past two years. Discussion focused on plans to roll out successful pilot initiatives, learning from best practice and the challenges to the successful delivery of core services.	**Adequate**	**N/A.**

Item	Summary	Level of assurance	Previous level of assurance
	An assurance rating of adequate was provided, given the progress made.		
7. Nottingham and Nottinghamshire Health Inequalities Statement	The Nottingham and Nottinghamshire statement provided evidence of the ICB's commitment to fulfilling its statutory duties to collect, analyse and disseminate information related to health inequalities. This report provided a mid-year update on progress following publication of the first Statement in April 2024, some data in the dashboard had been updated, including GP-based indicators and secondary care-based indicators. New features under development were noted, and an overview of the current disparities affecting the ICB's population was discussed. An assurance rating of adequate assurance, given the progress made.	**Adequate**	**Full** *Awarded at the meeting held on 24 April 2024.*

Other considerations:

Decisions made:
a) Members ratified the award of a non-healthcare contract made as an urgent decision in October 2024, using the Committee's emergency powers, in line with the ICB's Scheme of Reservation and Delegation.
Matters of interest:
a) The Operational Risk Register included 13 risks, with seven rated as high risks. The risks are provided for the Board's information at Appendix F.

Appendix D: Audit and Risk Committee Highlight Report

Meeting Dates:	**09 October 2024**
Committee Chair:	**Stephen Jackson, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
Bi-annual Risk Management Arrangement Update	The report had provided an update on the work being undertaken to embed strategic and operational risk management arrangements within the ICB. The Committee noted that a programme of targeted Executive-led Assurance Framework updates would commence at their next meeting. The report had also provided a detailed analysis of the ICB's current operational risk profile; the processes in place for identifying and categorising risks; and provided an update on the development of system risk management arrangements.	**Full**	**Adequate** *Awarded at the meeting held on 16 May 2024.*
NHS Provider Selection Regime: Annual Monitoring and Reporting Requirements	The report had provided a mid-year update to the Committee regarding its responsibilities for overseeing compliance with the Provider Selection Regime (PSR), noting that the ICB had received only one representation from a provider since January 2024. The Representation Panel had reviewed the case and was satisfied that the ICB had applied the regime correctly, which had subsequently been accepted by the provider. An assurance rating of adequate was provided, pending the review of PSR compliance by the Internal Audit function, as part of this year's Internal Audit Plan.	**Adequate**	**Not applicable**

Item	Summary	Level of assurance	Previous level of assurance
Third Party Assurances Reporting – Complementary User Entity Controls	The report had provided an update on an action agreed at the previous meeting in June relating to the Annual Report and Accounts, to undertake a full review of all audit reports of third-party contractors in order to provide greater assurance that organisations had robust control environments in place. This exercise was noted as best practice by the External Auditor. The Committee applied an assurance rating of adequate at this stage pending the completion of all actions that were being undertaken to strengthen the small number of control weaknesses that had been identified.	**Adequate**	**Not applicable**

Other considerations:

Decisions made:
a) Members endorsed an updated Emergency Preparedness resilience and Response Incident Response Plan and recommended its approval to the Board. b) A system-wide Cyber Security Strategy was endorsed, and the Committee made a recommendation for the Board to approve the Strategy following
Matters of interest:
a) The Committee received an update on the progress of actions agreed following the 2023/24 review of committee effectiveness, noting one action remained outstanding and was due for completion by the end of the calendar year. b) An overview of changes to the NHS audit committee handbook was received. It was noted that the Committee's arrangements remained in line with the mandated requirements and national best practice, however, a small number of actions were agreed to strengthen these further. c) An update on preparations for the introduction of a new NHS finance and accounting system was received.

d) Members received an update on the progress of the 2024/25 Internal Audit Plan and had sought assurance that the plan could be delivered by the end of the financial year.

e) An update on the 2024/25 Counter Fraud Plan was also received

Appendix E: Remuneration and Human Resources Committee Highlight Report

Meeting Dates:	**21 October 2024**
Committee Chair:	**Jon Towler, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
Workforce Report	Members received an update on performance relating to a range of key workforce metrics and provided updates in other key areas of work that were overseen by the executive-led Human Resources Steering Group, including policy approvals and employee relations and engagement matters. Members discussed the possible causes of the rise in sickness rates and asked for a report to be brought to the next meeting on actions being taken to address the increase. Further enhancements to the report were also requested in order for the Committee to seek further assurance in key areas of workforce reporting.	*Not given*	**Partial**
NHS Staff Survey Action Plan	Members received an update on progress of the delivery of the 2023 ICB Staff Survey Action Plan, noting that good progress had been made across all actions within the plan.	*Not given*	**Limited**

Other considerations:

Decisions made:
a) Members approved the publication of the ICB's 2024 Gender and Ethnicity Pay Gap, Workforce Race Equality Standard and Workforce Disability Equality Standard reports.

Decisions made:
b) Members approved pay awards for the Very Senior Managers and Medical and Dentals staff in line with the recent Government commitment following recommendations by the national Review Body on Senior Salaries.
Matters of interest:
a) The Operational Risk Register included five risks, one high and four medium.

Appendix F: Current high-level operational risks being oversighted by the Board's committees

Risk Ref.	Risk Description	Score	Responsible Committee
ORR084	If organisations within the ICS are unable to access IT systems (i.e. unexpected system outage, successful cyber-attacks or issues with the availability of products and services) they may not be able to conduct core business as usual functions. This may result in patients not receiving timely diagnosis or treatment due to necessary equipment not functioning or patient records being unavailable.	**High** 20 (I4 x L5)	Audit and Risk Committee
ORR090	If the Nottingham and Nottinghamshire system does not have sufficient system partner 'buy in' and capacity (digital workforce and operational workforce) to engage with and deliver digital transformation schemes alongside business-as-usual delivery it may not be possible to progress the System, Primary Care and ICB digital transformation agenda.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR195	If NHS Nottingham and Nottinghamshire ICB is unable to identify and implement sustainable recurrent financial efficiency solutions, at pace, there is a risk the ICB's underlying position (UDL) will continue to worsen with impact to the ability to deliver within the ICB's financial resources.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR196	If the Nottingham/shire NHS system, as a collective, does not meet its agreed 2024/25 year-end financial position, there is a risk to the extent to which the system will be able to create financial 'headroom' to invest in services. This may lead to reputational issues and increasing levels of regional and national intervention by NHS England.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR197	If the Nottingham/shire NHS system, as a collective is unable to identify and implement sustainable recurrent financial efficiency solutions, at pace, there is a risk the collective underlying position (UDL) will continue to worsen, which may significantly impact Nottingham/shire's ability to become a financially sustainable system.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR210	As a result of ongoing operational and financial pressures, there is a risk to further deterioration in staff health, wellbeing and morale. This may impact on staff productivity and lead to staff feeling disconnected or disengaged with the ICB. This may, in turn, result in further increases to levels of sickness and vacancies within the organisation.	**High** 16 (I4 x L4)	Remuneration and HR Committee
ORR191	If Nottinghamshire Healthcare NHS Foundation Trust (NHCT) do not have the capability to make the required quality improvements identified as a result of current quality, staffing and	**High** 20 (I4 x L5)	Quality and People Committee

Risk Ref.	Risk Description	Score	Responsible Committee
	performance concerns and exacerbated by regional and national reviews, there is a risk the quality of services provided may not meet optimal care standards. This may lead to potential risk of harm and poor health outcomes to the population of Nottingham/shire.		
ORR077	If current challenges in the health and social care system continue there is a risk of sustained levels of significant workforce pressures which may lead to sickness, exhaustion, 'burn out' and inability to maintain psychological safety of workforce.	**High** 16 (I4 x L4)	Quality and People Committee
ORR083	If discharges from learning disability and autism inpatient settings are delayed due to lack of available capacity in community-based settings, there is a risk patients may stay in inpatient settings longer than necessary or be cared for in a more restrictive environment than required. This may lead to poor patient experience and adverse health outcomes for the population of Nottingham/shire.	**High** 16 (I4 x L4)	Quality and People Committee
ORR092	If the system is unable to provide timely diagnostics, due to increased demand and/or capacity constraints, this may adversely impact patient health outcomes.	**High** 16 (I4 x L4)	Quality and People Committee
ORR166 (NEW)	If ambulance handover times at acute trusts increase and cause delayed ambulance arrival in the community, there is a risk of potential harm to citizens who are waiting for an ambulance, which may lead to further deterioration of their condition.	**High** 16 (I4 x L4)	Quality and People Committee
ORR170	If insufficient availability of mental health inpatient beds continues, there is a risk that individuals may face delayed or inadequate treatment or be transferred for care in an 'out of area' setting, which may result in increased distress, potential harm to themselves or others, or a higher likelihood of crisis situations.	**High** 16 (I4 x L4)	Quality and People Committee
ORR171	If capacity issues continue, there is a risk of not being able to facilitate timely discharge of individuals requiring ongoing mental health support once their medical or physical issues have resolved, which may lead to delays in discharge, potentially exacerbating current challenges across the urgent and emergency care pathway.	**High** 16 (I4 x L4)	Quality and People Committee
ORR177	If system workforce planning remains short-term, due to operational and financial challenges, there is risk that it may not address medium to longer term strategic education and planning needs. This may lead to issues with initial workforce supply and ineffective use of workforce. This risk is exacerbated by challenges experienced in getting system data into a single place to support ICS workforce planning and projections.	**High** 16 (I4 x L4)	Quality and People Committee

Risk Ref.	Risk Description	Score	Responsible Committee
ORR179	If insufficient funding allocations and/or uncertainties regarding reimbursement rates continue there may be a risk to the financial sustainability of GP practices. This may increase the likelihood of contracts being 'handed back' and non-delivery of local enhanced services, potentially presenting a risk to access and health outcomes for the local population.	**High** 16 (I4 x L4)	Quality and People Committee
ORR199	As a result of General Practice (GP) participation in collective action, there may be a risk to primary care and community pharmacy service delivery. This may lead to the potential for harm to citizens in terms of management of chronic conditions and urgent medical concerns. Furthermore, this may lead to increased activity at other providers.	**High** 16 (I4 x L4)	Quality and People Committee
ORR207 (NEW)	If challenges in the provision and delivery of community mental health services persist, there is risk that these services may not be accessed, or accessed promptly, and/or meet the current and future needs of the population. This may result in worsening health outcomes for citizens across Nottingham/shire. This risk may also result in increased demand on other services as activity may be displaced to other partners within the system.	**High** 16 (I4 x L4)	Quality and People Committee
ORR224 (NEW)	If Nottingham University Hospitals NHS Trust (NUH) fail to sustain improvements made to date following CQC and external recommendations, there is a risk quality of services may decline. This may lead to compromised patient safety and quality of care which could result in poor patient experience and adverse health outcomes for the population of Nottingham/shire.	**High** 16 (I4 x L4)	Quality and People Committee
ORR208	If the quality of maternity services does not improve, services provided may not meet optimal care standards. This may result in potential risk of harm (i.e. physical and psychological) and poor patient experience for women, birthing people, their babies, and families.	**High** 15 (I5 x L3)	Quality and People Committee
ORR155	If the transformation of urgent and emergency care services is not prioritised and delivered, there is a risk that limited health and social care resources may not be used most efficiently. This may lead to an inability to meet demand: today and in the future.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee
ORR159	If General Practices, Primary Care Networks, community pharmacy and the ICB do not have appropriate capacity, capability and resources to deliver actions in relation to delivery of ICS Primary Care Strategy and Primary Care Access Recovery Plan (PCARP), expected	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee

Risk Ref.	Risk Description	Score	Responsible Committee
	transformation may not be delivered. This may, in turn, impact on the ability to meet the needs of our population.		
ORR182	If GP collective action impacts on partnership working, there may be a risk to primary care engagement which may impact delivery of ICS strategic and transformation programmes.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee
ORR192	If resources at Nottinghamshire Healthcare NHS Foundation Trust (NHCT) are primarily focused on addressing immediate quality, staffing and performance concerns, there is risk that there may not be sufficient capacity or 'headspace' to deliver mental health and community service transformation. This may result in future population needs not being made and/or anticipated efficiencies not materialising.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	12/09/2024
Paper Title:	**Board Annual Work Programme 2024/25**
Paper Reference:	ICB 24 076
Report Author:	Lucy Branson, Director of Corporate Affairs
Executive Lead:	Rosa Waddingham, Director of Nursing
Presenter:	-

Paper Type:							
For Assurance:		For Decision:		For Discussion:		For Information:	✓

Summary:

The purpose of this item is to provide the Board's Annual Work Programme 2024/25 for Member's information at each meeting.

Recommendation(s):

The Board is asked to **note** this item for information.

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	The ICB's governance arrangements ensure appropriate oversight and decision-making with regard to achievement of the core aims.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

Appendix A – Annual Work Programme 2024/25
Appendix B – Purpose and content of agenda items

Board Assurance Framework:

Not applicable.

Report Previously Received By:

Not applicable.

Are there any conflicts of interest requiring management?

No

Is this item confidential?

No

Appendix A

NHS Nottingham and Nottinghamshire

2024/25 Board Work Programme

"Every person enjoying their best possible health and wellbeing"

Our aims: to **improve outcomes** in population health and healthcare; **tackle inequalities** in outcomes, experiences and access; enhance **productivity and value for money**; and support broader **social and economic development**.

Our guiding principles: **prevention** is better than cure; **equity** in everything; and **integration** by default.

Our core values:

- We will be open and honest with each other.
- We will be respectful in working together.
- We will be accountable, doing what we say we will do and following through on agreed actions.
- We will challenge each other if we fall short of upholding our aims and guiding principles.
- We will work with our population and put their needs at the heart of the ICS.

Agenda item (See Annex 1 for purpose and content)	09 May	11 Jul	12 Sep	14 Nov	09 Jan	13 Mar	Link to BAF	Notes
Introductory items	✓	✓	✓	✓	✓	✓	Not applicable	See note 1
Leadership and operating context								
Citizen Story	-	-	-	✓	✓	✓	Not applicable	-
Chair's Report	✓	✓	✓	✓	✓	✓	Strategic risk 10	See note 2
Chief Executive's Report	✓	✓	✓	✓	✓	✓	Strategic risk 9 and 10	See note 3
Strategy and partnerships								
Joint Forward Plan and Outcomes Framework	✓	✓	✓	-	-	✓	Strategic risk 1, 2, 3, 4, 5	See note 4

Agenda item (See Annex 1 for purpose and content)	09 May	11 Jul	12 Sep	14 Nov	09 Jan	13 Mar	Link to BAF	Notes
Joint Capital Resource Use Plan	✓	-	-	-	-	✓	Strategic risk 3 and 8	See note 5
VCSE Alliance Report	✓	-	-	✓	-	-	Strategic risk 9	See note 6
Research Strategy	-	✓	-	-	-	-	Strategic risk 5	See note 7
Infrastructure Strategy	-	✓	-	-	✓	-	Risk 8	See note 8
Working with People and Communities	-	✓	-	-	-	-	Risk 4, 5 and 9	See note 9
Strategic Commissioning Report	-	-	✓	-	-	✓	Strategic risk 1, 2 and 5	See note 10
Clinical and Care Professional Leadership	-	-	-	✓	-	-	Strategic risk 6, 9 and 10	See note 11
HealthWatch Report	-	-	-	-	✓	-	Risk 4, 5 and 9	See note 12
2025/26 Operational and Financial Plan	-	-	-	-	-	✓	Strategic risk 1, 2, 3, 4, 5	See note 13
2025/26 Opening Budgets	-	-	-	-	-	✓	Risk 3	See note 14
NHS England Delegations	-	-	-	-	-	✓	Strategic risk 9	See note 15
Provider Collaborative at Scale	-	-	-	✓	-	-	Strategic risk 1, 6, 10	See note 28
Delivery and system oversight								
Health Inequalities Statement	✓	-	-	-	-	-	Strategic risk 1, 2, 4 and 5	See note 16
Meeting the Public Sector Equality Duty	-	✓	-	-	-	-	Strategic risk 1, 2, 4, 5 and 6	See note 17
People Plan	-	-	✓	-	-	✓	Risk 6	See note 18
Digital, Data and Technology Strategy	-	-	-	-	✓	-	Risk 7	See note 19
Green Plan	-	-	-	-	✓	-	Risk 8	See note 20
Quality Report	✓	✓	✓	✓	✓	✓	Risk 4	See note 21
Service Delivery Report	✓	✓	✓	✓	✓	✓	Risk 1 and 2	See note 22
Delivery plan for recovering access to primary care	✓	-	-	✓	-	-	Risk 2	See note 23
Finance Report	✓	✓	✓	✓	✓	✓	Risk 3	See note 24
Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity	-	-	-	-	✓	-	Risk 9	See note 29

Agenda item (See Annex 1 for purpose and content)	09 May	11 Jul	12 Sep	14 Nov	09 Jan	13 Mar	Link to BAF	Notes
Governance								
Committee Highlight Reports	✓	✓	✓	✓	✓	✓	All risks	See note 25
Board Assurance Framework	✓	-	-	✓	-	-	Not applicable	See note 26
Closing items	✓	✓	✓	✓	✓	✓	Not applicable	See note 27

Board Seminars and Development Sessions, and ICS Reference Group Meetings:

Topic	11 Apr	30 May	13 Jun	16 Sep	10 Oct	12 Dec	16 Dec	13 Feb	17 Mar
Development Session: • 2024/25 priorities and strategic risks • Governance self-assessments • Race health inequalities maturity matrix • Development of place-based partnerships	✓	-	-	-	-	-	-	-	-
ICS Reference Group: • 2024/25 operational and financial commitments • ICS People Plan	-	✓	-	-	-	-	-	-	-
Board Seminar: • ICS People Plan • Development of the provider collaborative	-	-	✓	-	-	-	-	-	-
~~**ICS Reference Group:**~~ • ~~Health inequalities and proactive care System risk management and risk appetite~~	-	-	-	✓	-	-	-	-	-
Board Seminar: • Mental health	-	-	-	-	✓	-	-	-	-

Topic	11 Apr	30 May	13 Jun	16 Sep	10 Oct	12 Dec	16 Dec	13 Feb	17 Mar
• ~~Primary care (primary medical services and pharmacy, optometry and dental services)~~									
Board Seminar: • Primary care (primary medical services and pharmacy, optometry and dental services) • ~~Population health management approach to frailty~~ • ~~Working with people and communities~~	-	-	-	-	-	✓	-	-	-
ICS Reference Group: • Planning for 2025/26 (operational and joint forward plans) • ICS Research Strategy	-	-	-	-	-	-	✓	-	-
Development Session: • Board effectiveness/ maturity • Preparing for ICB capability assessment	-	-	-	-	-	-	-	✓	-
ICS Reference Group: • Social and economic development • Population health management approach to frailty • ~~Research~~	-	-	-	-	-	-	-	-	✓

Annex 1: Purpose and content of agenda items

No.	Agenda item	Purpose
1.	Introductory items	This section of the meeting will include: • A copy of members' registered interests for consideration and agreement of how any real or perceived conflicts of interest are required to be managed. • The previous meeting's minutes for agreement (and any matters arising). • The Board's Action Log for review.
2.	Chair's Report	To present a summary briefing for Board members of the Chair's reflections, actions and activities since the previous Board meeting. As appropriate, this will include updates on key governance developments, and on an annual basis this will present the Board's Annual Work Programme and include a review of the skills, knowledge and experience of Board members (when taken together) to ensure the Board can effectively carry out its functions.
3.	Chief Executive's Report	To present a summary briefing on recent local and national developments and areas of interest for Integrated Care Boards (ICBs) and the wider Integrated Care System (ICS), along with key updates from system partners, including the Integrated Care Partnership, Health and Wellbeing Boards and the East Midlands Joint Committee. On a quarterly basis, the reports will include the latest segmentation ratings under the NHS Outcomes Framework. The report will include key updates regarding the ICB's workforce on a periodic basis, including NHS staff survey results, freedom to speak up, equality performance and wider workforce indicators. As appropriate, the report may also include specific items requiring approval or for noting by Board members.
4.	Joint Forward Plan and Outcomes Framework	**May 2024** – To present the ICB's Joint Forward Plan for 2024/25 for approval (prepared with partner NHS trusts and NHS foundation trusts) setting out how the ICB will exercise its functions over the next five years. A draft Strategic Outcomes Framework will also be presented for review. **July 2024** – To present the final proposed Strategic Outcomes Framework for approval (action from May meeting). **September 2024** – To present a mid-year strategic delivery update on the key areas that provide the greatest opportunity to improve population health and achieve the ICS principles of principles of integration, equity and prevention, as defined within the Joint Forward Plan. The final Strategic Outcomes Framework will also be presented. **March 2025** – To present a strategic delivery report for 2024/25, which will consider the steps the ICB has taken to implement the Joint Local Health and Wellbeing Strategies. The annual refresh of the Joint Forward Plan for 2025/26 will also be presented for approval. Development and delivery of the plan will be overseen by the Strategic Planning and Integration Committee. The ~~Director of Integration~~ Director of Strategy and System Development is the executive lead for strategic planning.
5.	Joint Capital Resource Use Plan	To present the Joint Capital Resource Use Plan for approval (prepared with partner NHS trusts and NHS foundation trusts). Development and delivery of the plan will be overseen by the Finance and Performance Committee (delivery reports for the Board included in the routine Finance Reports – see 24 below). The Director of Finance is the executive lead for capital planning.

No.	Agenda item	Purpose
6.	VCSE Alliance Report	**May 2024** – To receive a report summarising the work of the Nottingham and Nottinghamshire VCSE Alliance. ~~**November 2024 –** To receive a brief update on the areas identified for further focus (action from May meeting).~~ Follow-up to now be incorporated within the next annual report, to be scheduled for May 2025.
7.	Research Strategy	To present the ICS Research Strategy for approval. This will include a summary of the key achievements in this area since the ICB's establishment. Development and delivery of the strategy will be overseen by the Strategic Planning and Integration Committee. A further strategic delivery update will be scheduled for the Board in 2025/26. The Medical Director is the executive lead for research.
8.	Infrastructure Strategy	To present the ten-year ICS Infrastructure Strategy for approval. **July 2024** – item deferred, now scheduled to be received at the September Board meeting. Development and delivery of the strategy will be overseen by the Finance and Performance Committee. A further strategic delivery update will be scheduled for the Board in 2025/26. The Director of Finance is the executive lead for estates.
9.	Working with People and Communities	To present an annual report on the ICB's arrangements for working with people and communities. This will be reviewed by the Strategic Planning and Integration Committee prior to presentation to Board. The Chief Executive is the executive lead for working with people and communities.
10.	Strategic Commissioning Report	To present relevant updates to the Board regarding developments and decisions across the ICB's commissioning portfolio, including commissioning functions delegated by NHS England to the ICB. The Strategic Planning and Integration Committee will oversee the ICB's strategic commissioning responsibilities during the year. The ~~Director of Integration~~ Director of Delivery and Operations is the executive lead for commissioning.
11.	Clinical and Care Professional Leadership	To present a report on the clinical and care professional leadership arrangements established across the Integrated Care System. The Medical Director is the executive lead for clinical and care professional leadership.
12.	HealthWatch Report	To receive a report summarising the work of HealthWatch Nottingham and Nottinghamshire.
13.	2025/26 Operational and Financial Plan	To present the ICB's operational and financial plans for 2025/26 for approval. Development of the plans will be overseen by the Finance and Performance Committee. Delivery of the 2024/25 plans will be overseen by the Finance and Performance Committee and the Quality and People Committee (delivery reports for the Board included in the routine Quality, Service Delivery and Finance Reports – see 21, 22 and 24 below). The Director of Finance is the executive lead for operational planning and finance.
14.	2025/26 Opening Budget	To present the ICB's 2025/26 opening budget for approval. This will be reviewed by the Finance and Performance Committee prior to presentation to Board. The Director of Finance is the executive lead for finance.

No.	Agenda item	Purpose
15.	**NHS England Delegations**	To present a strategic update in relation to NHS England's ongoing programme of delegating commissioning functions. This will include approval of associated governance arrangements, as appropriate. The Strategic Planning and Integration Committee will oversee developments in-year, including pre-delegation assessments and due diligence. The Chief Executive is the executive lead for the delegation programme.
16.	**Statement on Health Inequalities**	To present an annual statement on health inequalities. This will be reviewed by the Finance and Performance Committee prior to presentation to Board. The Medical Director is the executive lead for health inequalities.
17.	**Meeting the Public Sector Equality Duty**	To present an annual report on the ICB's arrangements for meeting the Public Sector Equality Duty. This will be reviewed by the Quality and People Committee prior to presentation to Board. The Director of Nursing is the executive lead for equality, diversity and inclusion.
18.	**People Plan**	To present a strategic update on the delivery of the ICS People Plan. The Quality and People Committee will oversight in-year delivery. The Director of Nursing is the executive lead for people and culture.
19.	**Digital, Data and Technology Strategy**	To present a strategic update on the delivery of the ICS Digital, Data and Technology Strategy. The Finance and Performance Committee will oversight in-year delivery. The Medical Director is the executive lead for digital and data.
20.	**Green Plan**	To present a strategic update on the delivery of the ICS Green Plan. The Finance and Performance Committee will oversight in-year delivery. The Director of Finance is the executive lead for environmental sustainability.
21.	**Quality Report**	To present quality oversight reports, including performance against key quality targets. This will be reviewed by the Quality and People Committee prior to presentation to the Board. The Director of Nursing is the executive lead for quality.
22.	**Service Delivery Report**	To present performance against the key operational service delivery targets. This will be reviewed by the Finance and Performance Committee prior to presentation to the Board. The Director of Finance and Director is the executive lead for performance management.
23.	**Delivery Plan for Recovering Access to Primary Care**	To present progress updates against the primary care access recovery plan, including a plan refresh in line with 2024/25 planning guidance. The November paper will also include an update on progress in delivering the ICB's Primary Care Strategy. The Strategic Planning and Integration Committee will oversight in-year delivery. The Medical Director and ~~Director of Integration~~ Director of Delivery and Operations are the executive leads for primary care.
24.	**Finance Report**	To present the ICB and wider NHS system financial position, covering revenue and capital, and including delivery updates against financial efficiency plans. This will be reviewed by the Finance and Performance Committee prior to presentation to the Board. The Director of Finance is the executive lead for finance.
25.	**Highlight Reports from the Finance and Performance**	To present an overview of the work of the Board's committees to provide assurance that the committees are effectively discharging their delegated duties

No.	Agenda item	Purpose
	Committee, Quality and People Committee, Strategic Planning and Integration Committee, Audit and Risk Committee, Remuneration Committee	and to highlight key messages for the Board's attention. This includes the committees' assessments of the levels of assurance they have gained from the items received and the actions instigated to address any areas where low levels of assurance have been provided. Also included is a summary of the high-level operational risks currently being oversighted by the committees.
26.	**Board Assurance Framework**	To present themed-year and year-end positions of the Board Assurance Framework. This will include annual approval of the ICB's strategic risks. The Audit and Risk Committee will oversee the strategic risks during the year via focussed updates from each executive director. The Director of Nursing is the executive lead for risk management.
27.	**Closing items**	This section of the agenda at each meeting will be used to share items that are for information only, which will not be individually presented, although questions may be taken by exception at the discretion of the Chair. These will include routine sharing of the Board's Work Programme. The following items will also be shared during the year: • 2024/25 Internal Audit Plan • Senior Information Risk Owner (SIRO) Annual Report • Emergency Accountable Officer (EAO) Annual Report • Learning from the Lives and Deaths of People with Learning Disabilities and Autism (LeDeR) Annual Report This section of the meeting will also include the following verbal items: • Risks identified during the course of the meeting • Questions from the public relating to items on the agenda • Any other business
28.	**Provider Collaborative**	To provide an update on the progress made by the Nottingham and Nottinghamshire Provider Collaborative at Scale.
29.	**Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity**	To provide assurance on the completion of the annual assurance process for 2024/25. The Director of Delivery and Operations is the executive lead for EPRR.