NHS
Nottingham and Nottinghamshire

Integrated Care Board Meeting Agenda (Open Session)

Thursday 11 July 2024 09:00-11:50

Rushcliffe Arena, Rugby Road, West Bridgford, NG2 7YG

"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: 09 May 2024	Kathy McLean	Decision	✓	-
5.	Action log and matters arising from the meetings held on: 09 May 2024	Kathy McLean	Discussion	✓	-
	Leadership and operating context				
6.	Chair's Report	Kathy McLean	Information	✓	09:05
7.	Chief Executive's Report	Amanda Sullivan	Information	✓	09:15
	Strategy and partnerships				
8.	Outcomes Framework	Maria Principe	Discussion	✓	09:30
9.	Research Strategy	Dave Briggs	Decision	✓	09:45
10.	Working with people and communities	Rosa Waddingham/ Prema Nirgude	Assurance	✓	10:05
	Delivery and system oversight				

	Item	Presenter	Type *(For Assurance, Decision, Discussion or Information)*	Enc.	Time
11.	Meeting the public sector equality duty	Rosa Waddingham/ Philippa Hunt	Assurance	✓	10:25
12.	Quality Report	Rosa Waddingham	Assurance	✓	10:45
13.	Service Delivery Report	Mandy Nagra	Assurance	✓	11:00
14.	Finance Report	Marcus Pratt	Assurance	✓	11:15
	Governance				
15.	Committee Highlight Reports: • Strategic Planning and Integration Committee • Quality and People Committee • Finance and Performance Committee • Audit and Risk Committee	Committee Chairs	Assurance	✓	11:30
	Information items *The following items are for information and will not be individually presented. Questions will be taken by exception.*				
16.	NHS Nottingham and Nottinghamshire Integrated Care Board Constitution (October 2024)	-	Information	✓	-
17.	2024/25 Board Work Programme	-	Information	✓	-
	Closing items				
18.	Risks identified during the course of the meeting	Kathy McLean	Discussion	-	11:45
19.	Questions from the public relating to items on the agenda	Kathy McLean	-	-	-
20.	Any other business	Kathy McLean	-	-	-
	Meeting close	-	-	-	11:50

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
12 September 2024, 09:00-12:30	Rushcliffe Arena, Rugby Road, West Bridgford, NG2 7YG
14 November 2024, 09:00-12:30	Chappell Meeting Room, Arnold Civic Centre, Arnot Hill Park, Arnold, NG5 6LU
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

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Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	11/07/2024
Paper Title:	**Declaration and management of interests**
Paper Reference:	ICB 24 024
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.
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.

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
DADGE, Lucy	Director of Integration	Mid Nottinghamshire and Greater Nottingham Lift Co (public sector)	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Valley Road 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.
DADGE, Lucy	Director of Integration	Nottingham Schools Trust	Chair and Director			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	Lilya Lighthouse Education Trust Limited	Trustee		✓			01/12/2023	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration	NEMS Community Benefit Services Ltd	Chief Executive	✓				01/10/2024	Present	To be excluded from all commissioning activities and decision making (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by NEMS Community Benefit Services Ltd.
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.

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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).
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.

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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.
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.
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.
MALEY, Caroline	Non-Executive Director	Village Health 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.
MCLEAN, Kathy	ICB Chair	University Hospitals of Derby and Burton NHS Foundation Trust	Trust Chair	✓				01/07/2022	30/04/2024	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	NHS Providers Board	Trustee		✓			01/07/2022	01/05/2024	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NEMS Healthcare Ltd	Partner is a shareholder				✓	01/07/2022	11/04/2024	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.
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.
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.

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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.
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 spaces.	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	Care Quality Commission (CQC)	Specialist Advisor (temporary appointment supporting the ICS inspections pilot)		✓			09/10/2023	31/03/2024	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.

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
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

Appendix B

NHS
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Managing Conflicts of Interest at Meetings

1. A conflict of interest is defined as a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.
2. An individual does not need to exploit their position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur. In fact, a perception of wrongdoing, impaired judgement, or undue influence can be as detrimental as any of them actually occurring. It is important to manage these perceived conflicts in order to maintain public trust.
3. Conflicts of interest include:
    - Financial interests: where an individual may get direct financial benefits from the consequences of a commissioning decision.
    - Non-financial professional interests: where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their reputation or status or promoting their professional career.
    - Non-financial personal interests: where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit.
    - Indirect interests: where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision.
    - 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
09/05/2024 09:00-12:15
Chappell Room, Civic Centre, Arnot Hill Park

Members present:

Dr Kathy McLean	Chair
Professor Marios Adamou	Non-Executive Director
Dr Dave Briggs	Medical Director
Lucy Dadge	Director of Integration
Stephen Jackson	Non-Executive Director
Dr Kelvin Lim	Primary Care Partner Member
Ifti Majid	NHS Trust/Foundation Trust Partner Member
Stuart Poynor	Director of Finance
Paul Robinson	NHS Trust/Foundation Trust Partner Member
Amanda Sullivan	Chief Executive
Jon Towler	Non-Executive Director
Catherine Underwood	Local Authority Partner Member
Rosa Waddingham	Director of Nursing
Melanie Williams	Local Authority Partner Member

In attendance:

Lucy Branson	Director of Corporate Affairs
Hazel Buchanan	Associate Director Health Inequalities and Clinical Strategic Programmes (for item ICB 24 011)
Joanna Cooper	Assistant Director of Strategy (for item ICB 24 008)
Sarah Fleming	Programme Director for System Development (for item ICB 24 008)
Philippa Hunt	Chief People Officer
Professor Daniel King	Voluntary, Community and Social Enterprise Alliance Chair
Mandy Nagra	Interim Director of System Delivery (for items ICB 24 014 and ICB 24 015)
Sue Wass	Corporate Governance Officer (minutes)

Apologies:

Caroline Maley	Non-Executive Director

Cumulative Record of Members' Attendance (2023/24)

Name	Possible	Actual	Name	Possible	Actual
Kathy McLean	1	1	Stuart Poynor	1	1
Marios Adamou	1	1	Paul Robinson	1	1
Dave Briggs	1	1	Amanda Sullivan	1	1
Lucy Dadge	1	1	Jon Towler	1	1
Stephen Jackson	1	1	Catherine Underwood	1	1

Name	Possible	Actual	Name	Possible	Actual
Kelvin Lim	1	1	Rosa Waddingham	1	1
Ifti Majid	1	1	Melanie Williams	1	1
Caroline Maley	1	0			

Introductory items

ICB 24 001 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.

Following the discussion at the last meeting regarding the nomination of a deputy for Melanie Williams at times when she will be unable to attend Board meetings, her deputy had been confirmed as Guy Van Dichele, the County Council's Interim Director of Adult Services.

ICB 24 002 Confirmation of quoracy

The meeting was confirmed as quorate.

ICB 24 003 Declaration and management of interests

Stephen Jackson asked the Chair to be aware of his connection with several voluntary and community sector organisations referenced in the report at agenda item ICB 24 010. It was agreed that as this was a discussion paper, this declaration was for transparency purposes and did not require management.

No further 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 24 004 Minutes from the meeting held on: 14 March 2024

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

ICB 24 005 Action log and matters arising from the meeting held on: 14 March 2024

Three actions from the previous meeting remained open and on track for completion. All other actions were noted as completed.

Regarding the action relating to the carbon net zero target, members noted there was a need to understand the steps being taken to get to the point of being able to measure it. It was agreed that this would be included in the next scheduled update against the Green Plan to the Finance and Performance Committee.

Action: Stuart Poynor to include commentary on understanding the steps being taken to get to the point of being able to measure the 80% carbon net zero by the 2028 target as part of the next scheduled update against the Green Plan to the Finance and Performance Committee.

Leadership

ICB 24 006 Chair's Report

Kathy McLean highlighted the following points from her report:

a) This was the Board's first meeting of the new financial year and thanks were given to colleagues within the Nottingham and Nottinghamshire system for their continued hard work and support in navigating an extremely challenging period.

b) The recent announcement of the election results for the new East Midlands Mayor provided an excellent opportunity for joint working with Derby and Derbyshire to maximise benefits; and Kathy as Chair of both ICBs looked forward to working closely with Claire Ward, the successful candidate.

c) The Chair noted that she had recently taken up a position as Chair of the NHS Confederation Integrated Care System Network Board, which would afford more opportunities to share ideas and experiences from other systems.

d) This was the last formal meeting for two members of the Board, Catherine Underwood, and Stuart Poynor. On behalf of the Board, the Chair thanked them both for their valuable and insightful contributions.

e) The third Partners Assembly, held in April, was a useful opportunity to connect with colleagues and stakeholders and share the refreshed Integrated Care Strategy. A recent visit to the On Day Service at St Ann's Valley Centre had been a great demonstration of the Strategy in practice.

f) The Board's 2024/25 work programme had been appended to the report for information and feedback.

The following points were made in discussion:

g) Discussing the work programme, members agreed that the Board's focus on mental health services should be brought forward.

The Board **noted** the Chair's Report for information.

Action: Lucy Branson to update the Board work programme for 2024/25 to bring forward the discussion on mental health services.

ICB 24 007 Chief Executive's Report

Amanda Sullivan presented the item and highlighted the following points:

a) The Board was asked to ratify the approval of the 2024/25 operational plans and opening budgets, the Chief Executive asked the Board to note that discussions with NHS England remained ongoing, as the plans were not financially compliant. It was hoped that a final position would be agreed soon. The ICB would work hard to bring the system back to financial balance by March 2026.

b) At the most recent meeting of the Integrated Care Partnership, their terms of reference had been reviewed and no material changes were made. The Board was asked to approve the minor changes proposed. The terms of reference would also be presented for approval at the full council meetings of Nottingham City Council and Nottinghamshire County Council.

c) Since the last meeting, the report into Nottinghamshire Healthcare NHS Foundation Trust by the Care Quality Commission had been published in part. The ICB continued to support the oversight of the required improvements within the Trust.

d) The 2024 Covid-19 vaccination campaign had been launched. The ICB had been working with system partners to develop a local plan for all vaccination requirements to ensure services were convenient to access and tailored to the needs of local people, supplemented by targeted outreach projects to increase uptake in underserved populations.

e) Joint arrangements had been agreed between the 11 East Midlands ICBs for the delivery of 59 specialised services delegated from NHS England on 1 April 2024, which would be exercised through the expansion of the existing joint committee arrangements. It was noted that Kathy McLean had recently taken over as interim chair of the East Midlands Joint Committee.

f) Staff working with the East Midlands Cancer Alliance had transferred their employment from NHS England to the ICB on 1 April 2024.

The following points were made in discussion:

g) Querying the transfer of the Cancer Alliance, members sought to understand the implications for the ICB. It was noted that the ICB's role was as a host employer, which differed to other areas where NHS England commissioning functions had been delegated. The Alliance had its own governance and was funded nationally. The intention of the move was to bring the Alliance services closer to the delivery services.

h) It was confirmed that in terms of ICB staffing structures, the Alliance sat within the Medical Directorate; however, it was agreed to clarify the ICB's oversight responsibilities as host.

i) Members queried what the delegation of the 59 specialised services would mean for the system. It was noted that this was a national policy direction designed to join up pathways.

j) Members queried how the ICB would maximise and measure the impact of this, and for future proposed delegation of services. It was noted that although oversight was through the East Midlands Joint Committees, the ICB should also ensure progress was kept under review to ensure outcomes in Nottingham and Nottinghamshire were being met. This would be overseen by the Strategic Planning and Integration Committee.

k) Members noted that a review of the Care Quality Commission had been announced part of the Cabinet Office's Public Bodies Review programme. The Department of Health and social Care had appointed Penny Dash, Chair of NHS North West London ICB, to lead the review.

The Board:

- **Noted** the Chief Executive's Report for information.
- **Ratified** the urgent decisions made during March and May 2024 using the Board's emergency powers.
- **Approved** the proposed amendments to the Integrated Care Partnership's terms of reference.

Action: Dave Briggs to present a report to the Strategic Planning and Integration Committee to clarify the oversight arrangements for the East Midlands Cancer Alliance.

At this point, Joanna Cooper and Sarah Fleming joined the meeting.

Strategy and partnerships

ICB 24 008 Joint Forward Plan: Annual Refresh

Lucy Dadge introduced the item and welcomed to the meeting Joanna Cooper and Sarah Fleming, who were in attendance to support the item:

a) In line with NHS England guidance there was a requirement to refresh the Joint Forward Plan on an annual basis. Following the report to the January 2024 Board meeting outlining the approach to the refresh, the plan was presented for approval prior to the requirement for it to be published by 30 June 2024.

b) The plan had been developed in collaboration with system partners and citizens during February to April to ensure there was system support for the plan. There had been broad support for the plan including the aims, ambitions, and principles, as the right direction of travel for the system. All partners were supportive of a stronger focus on delivery.

c) It was noted that both Nottingham City and Nottinghamshire County Health and Wellbeing Boards had provided statements of support.

d) The refreshed plan had been considered by the ICB's Strategic Planning and Integration Committee and as a result language within the plan had been refined in terms of the level of specificity to enable monitoring of delivery.

e) Work was progressing to confirm the outcomes and supporting metrics that would monitor progress of the plan, which would align with the Population Health Management Outcomes dashboard, developed by the System Analytics Intelligence Unit. This was scheduled to be shared with the ICB's Strategic Planning and Integration Committee in July 2024 and Board in September 2024.

f) A Joint Forward Plan Delivery Group had been established to provide a structure and programme through which the plan would be delivered and to ensure collective ownership for delivery by all NHS organisations.

The following points were made in discussion:

g) On behalf of the Board, the Chair thanked everyone who had worked on the plan for their hard work.

h) Melanie Williams assured the Board that this was very much a joint piece of work by all partners and that the focus on children and young people was welcomed. The challenge moving forward was to ensure system leaders kept a focus on the strategic and long terms aims of the plan within a very challenging financial and operational climate.

i) Members agreed that the only solution to achieving sustainable improvements in services and financial balance would be to achieve the aims within the plan. This would entail agreeing the best use of resources and removing duplication, rather than incremental investment. Cultural and behavioural change was required.

j) Ifti Majid noted that mental health services were very much influenced by national policy and requested that reference should be made in the final plan to the 'right care, right person' approach, which was agreed.

k) Discussing the importance of agreeing metrics, population outcomes and ownership, the Board wanted to be assured that this piece of work was in development and requested that a report be brought to the July 2024 meeting to provide an outline of the high-level outcomes for each strategic area. It was noted that health inequalities should be embedded in the metrics.

The Board:

- **Approved** the 2024/25 NHS Joint Forward Plan subject to the inclusion of reference to the 'right care, right person' approach.
- **Noted** progress with defining the outcomes to be delivered by the Joint Forward Plan and the developing delivery and oversight arrangements.

Action: Lucy Dadge to present the proposed strategic outcomes framework, with supporting metrics, to the July 2024 Board meeting.

ICB 24 009 Joint Capital Resource Use Plan

Stuart Poynor presented the item and highlighted the following points:

a) There was a requirement for the ICB and partner NHS trusts to prepare and publish an annual plan setting out their planned capital resource. The Joint Capital Resource Use Plan was presented for approval ahead of the deadline for submission of 30 June 2024.

b) The majority of the allocation was set aside for prior year precommitments in the first instance, and for operational priorities, which comprised approximately 50% of the plan. Remaining funding was allocated to be used to address larger strategic schemes

prioritised at a system level. National funding would be used to support strategic priorities where possible.

The following points were made in discussion:

c) Stephen Jackson, Chair of the Finance and Performance Committee, asked the Board to note that the Committee had scrutinised the plan at its April 2024 meeting and found it to be a pragmatic document. However, much of the detail within it was driven by practical requirements such as maintenance and there was a question as to whether it could fully respond to strategic priorities. This was noted as a potential risk given that some local allocations had been required to be used on national services, such as Rampton Hospital.

d) It was noted that the risks within this plan would need to be considered in parallel with the developing Infrastructure Strategy, which was scheduled for presentation at the next Board meeting.

e) Members queried allocations for primary care. It was noted that primary care estate development opportunities were being considered but would be funded through primary care revenue allocations.

The Board **approved** the Joint Capital Resource Use Plan.

ICB 24 010 Voluntary, Community and Social Enterprise Alliance Report

Professor Daniel King presented the item and highlighted the following points:

a) In June 2021, the NHS England Integrated Care System Design Framework had set the expectation that ICB governance and decision-making arrangements should support close working with the Voluntary, Community and Social Enterprise (VCSE) sector as a strategic partner in shaping, improving, and delivering services.

b) The report provided an update on the establishment of the Nottingham and Nottinghamshire VCSE Alliance, how the Alliance supported the delivery of the Integrated Care Strategy and proposed further opportunities that would strengthen the ICB's partnership with the sector.

c) Professor King had been appointed as the Chair of the Alliance. It had been a steep learning curve engaging with numerous organisations, each with their own differing structures, maturity, and size. It was an ongoing challenge to ensure that all members were well placed to contribute to the Alliance. However, good foundations

had been laid and the report described activities where the Alliance had supported the development of the Integrated Care Strategy.

d) Alliance members had also benefited from a raised profile and the sharing of good practice.

e) However, significant challenges remained relating to difficulties in securing funding and short-term contracts, which led to uncertainty for staff and capacity for organisations to fully engage, with an example given of cyber security issues. In order to unlock the potential value of the VCSE as a partner organisation there was a need for it to be seen as an equal partner.

The following points were made in discussion:

f) On behalf of the Board the Chair thanked Professor King for his leadership of the Alliance, noting that a move from 15 to over 100 members was a significant achievement.

g) Members discussed the challenges of short-term funding solutions for the sector and agreed the need to better understand the contribution of the sector to the ICS strategic aims.

h) The need for the ICB to understand how the sector wants to be engaged with was also noted, with a view to establishing a long-term partnership.

i) Some good examples were noted of how the sector contributed to several areas of the ICB's work, including Special Educational Needs and Disabilities and Learning Disabilities and Autism.

j) Members discussed the mutual benefit of establishing a knowledge exchange between the VCSE sector and other statutory ICS partners.

k) Professor King noted that the challenge of resourcing the sector was a constant, with hidden costs, for example management time. Engagement was a resource intensive activity and there was a need to ensure communication was not just one way.

l) The Chair noted that the discussion had raised several challenging questions and practical considerations and asked for the VCSE Alliance to bring an update in these areas later in the year.

The Board **noted** the report.

Action: Lucy Branson to add a further report from the VCSE Alliance to the Board work programme for 2024/25.

At this point Hazel Buchanan joined the meeting.

Delivery and system oversight

ICB 24 011 Health Inequalities Statement

Dr Dave Briggs presented the item, supported by Hazel Buchanan, and highlighted the following points:

a) In November 2023, NHS England published a statement setting out a description of the powers available to NHS bodies to collect, analyse and publish information on health inequalities and how these powers should be exercised. In defining the requirements, NHS England had provided a list of metrics that ICBs and NHS trusts must report on.

b) The report presented the ICB's Statement, which was a comprehensive document demonstrating the ICB's adherence to requirements.

c) In producing the Statement, the ICB had developed a robust health inequalities dashboard that supported ongoing monitoring across the NHS England five priority areas for health inequalities and the Core20PLUS5 approach. It included a demographic profile of the Nottingham and Nottinghamshire area and supported the population health management approach, based on an understanding of local needs and disparities. The dashboard would continue to evolve.

d) The analysis of the data demonstrated that health inequalities in some areas were widening, for example cardiovascular mortality rates. Actions in priority areas were aligned with the Joint Forward Plan and the focus for the coming year was on hypertension.

The following points were made in discussion:

e) Members queried whether waiting lists for elective care were being managed in line with health inequalities principles. It was noted that this was an area of work being addressed by ensuring robust coding practices.

f) Discussing when benefits from a focus on hypertension would be seen, it was noted that the data should indicate an improving position from earlier interventions over the coming two to three years.

g) Members urged the ICB to use best practice and engage the whole system to ensure maximum impact in areas such as vaccinations, screening, and smoking cessation in the most deprived communities.

h) The need to ensure health inequalities was not seen as a separate subject matter was emphasised and members were reminded that a

future ICS Reference Group meeting would be used to discuss this further.

The Board **noted** the report.

At this point Hazel Buchanan left the meeting.

ICB 24 012 Delivery Plan for Recovering Access to Primary Care

Dr Dave Briggs presented the item and highlighted the following points:

a) The report provided an update on progress with the implementation of the primary care access improvement plan.

b) There were four key areas in the plan; empowering patients; implementation modern general practice access; building capacity; and cutting bureaucracy. The report detailed progress against each area and noted that delivery was overseen by the Primary Care Strategy Delivery Group and the Strategic Planning and Integration Committee.

c) Self-referral pathways for several services had been expanded; community pharmacy services had been expanded; and significant progress had been made to implement cloud-based telephony systems.

d) Progress had been slower than expected in three areas, including the local support offer to practices, as funding had been withdrawn.

e) Risks to the plan were noted as potential GP disengagement with the plan, exacerbated by the publication of the 2024/25 GP Contract.

The following points were made in discussion:

f) Whilst it was clear from the report that there was good progress in several areas, it was noted that the metrics regarding numbers of appointments, when compared to other ICB areas did not compare favourably. Members queried whether this plan was making a positive difference to patients. It was noted that there was a local coding issue with some practices, which was being addressed, and GP practices were performing much better than the metrics indicated.

g) Members noted that the pandemic had created a material change in demand. Practices had responded to this and had increased capacity and flexibility. It was suggested that the articulation of what ‘good looks like’ would help to measure impact; and for good practice to be disseminated consistently. It was agreed that there needed to be a

better understanding of whether the ICB was meeting the needs of patients.

h) It was agreed to explore this topic in more detail at a Board seminar, scheduled for October 2024.

The Board **noted** the report.

ICB 24 013 Quality Report

Rosa Waddingham 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) The end of year target for adult learning disability and autism inpatient performance had not been met. At the end of March 2024, there were 45 adult inpatients against a target of 37. A slightly higher target than the national target had been agreed for 2024/25, which was challenging but deliverable. Focus would remain on extending the Oliver McGowan mandatory training pilot in areas where required.

c) Nottingham City local strategic partnerships had been advised to anticipate a joint Special Educational Needs and Disabilities local area inspection this year. Work undertaken collaboratively following the learning from the County inspection would help inform planning.

d) Performance concerns relating to looked after children's health assessments had been raised and issues would be escalated through safeguarding and nursing routes.

e) Regarding workforce, the Vanguard for the Midlands Region for the Scaling Up People Services Programme would transfer to the Provider Collaborative for the delivery phase.

f) The Board was asked to note the work being undertaken in partnership with Nottinghamshire Healthcare NHS Foundation Trust, and with Nottingham University Hospitals NHS Trust on maternity services and accident and emergency care to recover services.

The following points were made in discussion:

g) Marios Adamou, Chair of the Quality and People Committee, asked the Board to note that the Committee had received several reports that members had taken limited assurance from and had requested further assurance on the impact of actions taken to improve the quality and safety of services.

h) Members queried whether there was an agreed system workforce plan. It was confirmed that there was a plan in place; however, this would be subject to change as system efficiency plans developed. A refresh of the strategic ICS People Plan was also in progress and would be discussed further at the board's seminar session in June.

The Board **noted** the report.

At this point Mandy Nagra joined the meeting.

ICB 24 014 Service Delivery Report

Mandy Nagra presented the item and highlighted the following points:

a) Over the past six weeks there had been a focus on balancing oversight and support with giving providers the time and space to deliver. A new weekly oversight meeting had been established to provide a space for a single conversation on performance and to track delivery. The focus was on maximising capacity and mutual aid across the system. A demonstrable recovery in key targets had been noted.

b) As part of the operational planning process, a plan had been developed to eliminate inappropriate out of area mental health inpatient placements by March 2025. Early improvements were being seen in local data for April 2024.

c) Likewise, the April 2024 forecast for 78-week waiters was nine patients on the waiting lists across the two providers. The forecast for the end of May 2024 was that no patients would be waiting beyond 78 weeks for elective treatment.

d) The backlog of cancer patients waiting 62 days or more remained significantly above the planned level but was reducing gradually. This required a continued focus by the system to eradicate.

The following points were made in discussion:

e) Discussing the continued challenges around out of area placements, members queried whether assurance could be taken that the improvement was sustainable. It was noted that the key difference was that patients were able to be identified earlier in the pathway. However, although much work had been undertaken to achieve this, there was a need to also take into account placements in private providers. The agreed trajectory was zero by September 2024.

f) Members challenged how the backlog of cancer patients would be addressed. It was noted that there were plans at tumour site level; although diagnostic, workforce and surgery capacity continued to impact on some areas. Work continued to bring together collective resource and the East Midlands Cancer Alliance was keen to be involved.

g) Members requested that future service delivery reports should more clearly describe plans, issues and outcome trajectories for key metrics, which was agreed.

The Board **noted** the report.

ICB 24 015 Finance Report

Stuart Poynor presented the item and highlighted the following points:

a) At the end of month 12, the NHS system had a deficit position of £113.7 million, representing an adverse variance of £20.9 million from the 2023/24 reset plan. This had been driven in the main by Nottinghamshire Healthcare NHS Foundation Trust declaring that they would be unable to deliver against their target forecast and expected Community Diagnostic Centre funding not being received.

b) The ICB ended the year with a £6.8 million deficit position, which was in line with the re-forecast previously agreed with NHS England.

c) There continued to be a strong focus on mitigating actions to ensure that the position did not deteriorate further.

The following points were made in discussion:

d) Members queried the robustness of efficiency planning for the year ahead. It was noted that planning had commenced earlier, with a greater focus on developing a more sustainable plan. However, the 5% efficiency target would be challenging, and there were still gaps to fill, but the NHS system was in a better position than in previous years.

The Board **noted** the report.

At this point Mandy Nagra left the meeting.

Governance

ICB 24 016 Committee highlight reports

The report presented an overview of the work of the Board's committees since its last meeting in March 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.

No further points were raised by Committee Chairs further to those raised under items ICB 24 13, 14 and 15.

The Board **noted** the reports.

ICB 24 017 Board Assurance Framework

Lucy Branson presented the item and highlighted the following points:

a) The Board Assurance Framework provided a mechanism to manage strategic risks in a structured way by identifying and mapping the main sources of assurance in support of the achievement of the ICB's core aims/objectives. The report presented the latest position of the ICB's Board Assurance Framework for scrutiny and comment.

b) Since last reported in November 2023, four risks had reached their target score; however, three risks related to system resilience, quality improvement and financial sustainability had increased in score, which reflected discussions during the course of the meeting so far.

c) A good level of control continued to be in place, with new working arrangements, strategies, plans, and frameworks being established.

e) Progress had also been made on addressing the previously identified 'gaps' in control; however, it was recognised that many of the 'gaps' related to the complex delivery of system-led plans.

f) A key theme that the Audit and Risk Committee had identified was the need for further external assurances to be sought and this had been taken into consideration when developing the 2024/25 internal audit plan.

g) The ICB's Internal Audit function had provided a 'significant assurance' opinion in relation to the ICB's strategic risk management arrangements.

h) Early work has been completed by the Executive Team to define the strategic risks that would form the basis of the 2024/25 Board Assurance Framework. These were set out in the paper for Board consideration.

The following points were made in discussion:

i) Members queried the level of consistency of strategic risks between the ICB and partner NHS Trusts; this was confirmed and it was highlighted that a full alignment exercise was being completed via the ICS Risk Management Network.

j) In discussion it was agreed that care needed to be taken when abbreviating the strategic risks, so as not to lose the focus on health inequalities.

The Board **noted** the report for assurance and **approved** the 2024/25 strategic risks.

Information items

ICB 24 018 2024/25 Internal Audit Plan

This item was received for information.

Closing items

ICB 24 019 Risks identified during the course of the meeting

Members queried whether a new risk should be raised regarding the potential consequence of the ICB not adequately engaging with the VCSE sector. It was agreed to discuss this in further at a future meeting of the Strategic Planning and Integration Committee.

Action: Lucy Branson to explore potential risks relating to engagement with the VCSE sector for discussion at a future meeting of the Strategic Planning and Integration Committee.

ICB 24 020 Questions from the public relating to items on the agenda

No questions had been received prior to the meeting:

ICB 24 021 Any other business

Paul Robinson asked members to note that he would be taking a period of planned sick leave and in his absence David Selwyn, the Sherwood Forest Hospitals NHS Foundation Trust's Medical Director would be acting as Chief Executive. A deputy for the ICB's Board meetings would be

identified. Following the announcement of the East Midlands mayoral elections, Claire Ward would be stepping down from her post as Chair of the Trust, and as an interim measure, Graham Ward, the current Vice Chair would take over this responsibility.

No other business was raised, and the meeting was closed.

Date and time of next Board meeting held in public: 11 July 2024 at 09:00 (Rushcliffe Arena)

NHS
Nottingham and Nottinghamshire

ACTION LOG from the Integrated Care Board meeting held on 09/05/2024

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Closed – action completed	14/03/2024	ICB 23 098: Healthwatch Nottingham and Nottinghamshire Report	To work with HealthWatch colleagues to define their role in supporting the ICB's awareness and response to emerging quality concerns.	Rosa Waddingham	11/07/2024	Discussed at a meeting between Rosa Waddingham, Sabrina Taylor and Sarah Collis. HealthWatch colleagues will now be routinely invited to attend the ICS System Quality Group and will report into this forum any concerns or emerging concerns regarding the quality of services. The ICB's Quality Directorate has also established regular informal touchpoint meetings with HealthWatch to support the sharing of insights and emerging themes.

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Closed – action completed	14/03/2024	ICB 23 098: Healthwatch Nottingham and Nottinghamshire Report	To establish mechanisms for ensuring visibility of HealthWatch reports within the ICB's Board and Committee arrangements (including as external assurances within the Board Assurance Framework).	Lucy Branson	11/07/2024	The ICB's Communications and Engagement Team will ensure that HealthWatch Report findings are presented to the Board as part of Board seminar sessions and other strategy or Executive updates. Relevant committees will also receive HealthWatch reports in line with their Annual Work Programmes.
Closed – action completed	14/03/2024	ICB 23 100: Population Health Management (PHM) Outcomes Framework	To lead on the development of a strategic outcomes framework, with supporting metrics, to enable the Board to track the impact of the Integrated Care Strategy through the Joint Forward Plan.	Dave Briggs/ Lucy Dadge	12/09/2024	See agenda item 8.
Closed – action completed	09/05/2024	ICB 24 005: Action Log	To include commentary on understanding the steps being taken to get to the point of being able to	Stuart Poynor	29/05/2024	See agenda item 15 – presented to the Finance and Performance

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
			measure the 80% carbon net zero by the 2028 target as part of the next scheduled update against the Green Plan to the Finance and Performance Committee.			Committee at its 29 May 2024 meeting.
Closed – action completed	09/05/2024	ICB 24 006: Chair's Report	To update the Board work programme for 2024/25 to bring forward the discussion on mental health services.	Lucy Branson	11/07/2024	See agenda item 17 – brought forward to October 2024.
Closed – action completed	09/05/2024	ICB 24 007: Chief Executive's Report	To present a report to the Strategic Planning and Integration Committee to clarify the oversight arrangements for the East Midlands Cancer Alliance.	Dave Briggs	04/07/2024	See agenda item 15 – presented to the Strategic Planning and Integration Committee at its 4 July 2024 meeting.
Closed – action completed	09/05/2024	ICB 24 008: Joint Forward Plan Annual Refresh	To present the proposed strategic outcomes framework, with supporting metrics, to the July 2024 Board meeting.	Lucy Dadge	11/07/2024	See agenda item 8.
Closed – action completed	09/05/2024	ICB 24 011: VCSE Alliance Report	To add a further report from the VCSE Alliance to the Board work programme for 2024/25.	Lucy Branson	11/07/2024	See agenda item 17 – added for November 2024.
Closed – action completed	09/05/2024	ICB 24 019: Risks identified during the	To explore potential risks relating to engagement with the VCSE sector for discussion at a future meeting of	Lucy Branson	11/07/2024	Meeting scheduled during July 2024 to explore potential risks, which are

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
		course of the meeting	the Strategic Planning and Integration Committee.			scheduled for discussion at the 5 September 2024 meeting of the Strategic Planning and Integration Committee.

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)

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	11/07/2024
Paper Title:	**Chair's Report**
Paper Reference:	ICB 24 027
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. By the time this report is being discussed we will know the result of the UK General Election. I look forward to working closely and collaboratively with the duly elected Members of Parliament for our area and also to understand the new Government’s proposals and approach for the NHS and social care. It was notable how prominent health and care were in the election campaign and this underlines for me how critical it is that we continue our focus on delivering access to the high-quality care that our population expects.
2. As I mentioned last time, we now also know that Claire Ward has been elected Mayor of the East Midlands and that the new Combined County Authority is starting to take shape. I have written to Claire to ask for a meeting as soon as possible to discuss our joint priorities for population health, noting the Combined Authority’s powers over economic development, training and skills, transport, housing and many other of the wider determinants of health. I look forward to updating the Board further in due course.
3. A few weeks ago marked the one-year anniversary of the tragic killings of Barnaby Webber, Grace O’Malley-Kumar and Ian Coates in Nottingham. The ICB continues to stand with other partners in Nottingham in offering their deepest sympathies to the families of those victims. As the Board knows, we have, since that time, been supporting Nottinghamshire Healthcare NHS Foundation Trust to ensure that quality and safety concerns identified in the wake of the attacks are fully addressed as rapidly as possible. We anticipate the final section of the Care Quality Commission’s section 48 report into the care of the perpetrator of the attacks, and also NHS England’s Independent Mental Health Homicide Review, will both be published in the coming weeks and we will work with the relevant agencies to address the recommendations made.
4. As we enter into the second quarter of the financial year, I will emphasise again to the Board the criticality of delivering on our financial commitments for 2024/25 and for the development of plans to address our NHS system’s underlying financial position by March 2026. It was great therefore to be able to discuss the approach we will take to this with the ICS Reference Group at the very end of May and to secure the commitment of partners to our proposed approach to moving to financial balance across our NHS system. We also heard at this meeting the initial plans for the work of the Provider Collaborative, whose initial workplan will not only deliver more integrated and higher-quality services for our population but will also contribute to our efficiency ambitions.

Developing our system

5. In recent weeks I have continued my programme of visits to see the delivery of our Integrated Care Strategy on the ground. Most recently I have been to see some excellent work at Bassetlaw Hospital where the two local Primary Care Networks (PCNs) have worked together to stream urgent appointments into hospital where required and to offer additional capacity for more routine appointments where appropriate. The integrated and high-trust way of working between the PCNs, the hospital, the mental health trust and other partners is what makes this service really have impact – including the ability for GPs to directly add into the patient record of all patients, no matter which practice they are registered with.

6. At Bassetlaw Hospital I was also lucky enough to have a look behind the scenes of the construction of the new Emergency Village – a really impressive £17 million capital development which will increase the size of the Emergency Department and provide more accessible same day services, so we can get patients to where they need to be to receive the best care more quickly.

7. As the Board is aware, I am now Chair of the NHS Confederation ICS Network and as part of that I was delighted to speak to the Health and Social Care Journal and share my perspective on the role of ICBs in health and care systems. As set out in the resultant article, I am clear that the whole-population and holistic approach that ICBs can bring to the conversation is a critical one – if there was to be a “carve-up” of responsibilities, fragmenting that overall oversight of a population’s health outcomes and the services required then that would, in my view, be detrimental.

8. In that interview I also highlight the widening gap in healthy life-expectancy being seen across England and so it is excellent that we have an update today on our agenda on our Outcomes Framework where we will track progress on this issue, and also that we are receiving the Annual Report on Working with People and Communities, setting out how we strive to hear from groups and populations who may be at risk of experiencing health inequalities.

9. Again, as part of my role with NHS Confederation, I was pleased to chair last month a session at the annual ConfedExpo conference in Manchester. The session heard from colleagues leading a project developed between the Confederation, the Universities of Stirling and Southampton, and Newton, which has helped to better understand the barriers to delivering the shift towards preventative models of health and care that are being experienced at both a system and local level. Through focussing on this sort of activity and celebrating success where it occurs, we can make the incremental progress we need to achieve our strategy.

Governance and leadership

10. In line with recent Board discussions, NHS England has confirmed approval of our application to vary our Board's composition, as set out within the ICB's Constitution. The approved changes will increase the membership of our Board by one further non-executive member and one further executive member. The additional executive member will see the portfolio of the current Director of Integration being split across two new roles – a Director of Strategy and System Development and a Director of Delivery and Operations. This will bring the Board's total membership to 17 members, which still enables the Board to be of an appropriate size to facilitate effective decision-making and allows for an appropriate balance of roles and perspectives to be maintained.

11. These changes to the ICB's Constitution, as approved by NHS England, will be enacted from 1 October 2024, allowing the period from now up to this time to focus on successful recruitment into these new Board roles. The revised Constitution that will be in place from 1 October is shared with the Board for information as part of this pack of papers.

12. Prior to the new Board membership being enacted, a review of committee memberships will be completed to reflect the new roles and responsibilities. The outcome of this work will be presented for Board approval in due course.

13. I have spent considerable time over the last few weeks conducting appraisals for our Chief Executive and Non-Executive Directors, as part of our preparation for the year ahead. I know that the ICB's objectives are now therefore clearly threaded into the performance plans of our Executive team and that our Non-Executive Directors are appropriately prepared to hold colleagues to account for delivery. Following conclusion of this process, I am pleased to report the re-appointments of Jon Towler and Stephen Jackson for further terms of office as Non-Executive Directors, with Jon continuing to support me as my Vice-Chair.

14. I am also pleased to report that sine we last met, Paul Robinson's Board membership has been confirmed for a further two-year term, following his joint nomination by the ICB's NHS Trust and Foundation Trust partners. Paul will continue to bring an informed view of hospital, urgent and emergency care services to the work of the Board. We are awaiting nominations for the role of Local Authority Partner Member, following Catherine Underwood's retirement.

15. Finally in terms of our leadership arrangements, the ICB has recently finished its first annual 'Fit and Proper Person Test' assessment for each individual Board member, following the publication of the Fit and Proper Person Test Framework for board members in August 2023. I am pleased to report that all Board members have been confirmed as 'fit and proper' following the annual process, and this outcome was communicated to NHS England by the deadline of 28 June 2024.

Looking forward

16. I am pleased that we have now launched the second Health and Care Awards for our Integrated Care System, building on last year's very successful event – nominations are now open for projects and initiatives which deliver on our Integrated Care Strategy and on our four aims as an Integrated Care System. Further details can be found here: https://healthandcarenotts.co.uk/integrated-care-strategy/celebrating-success/health-and-care-awards/.

17. As I set out above, we now have a new Government with new priorities and ambitions to which we will need to respond. The thoughts of colleagues may also be starting to turn towards summer holidays, and I do hope that everyone gets a chance to take a well-earned rest. But this rest must be in the context of returning in the autumn with a renewed vigour to deliver on our Integrated Care Strategy priorities of prevention, integration and equity and the necessity of securing financial balance for our NHS system.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	11/07/2024
Paper Title:	**Chief Executive's Report**
Paper Reference:	ICB 24 028
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:
None.

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

Publication of the ICB's Annual Report and Accounts

1. The ICB's Annual Report and Accounts for the period 1 April 2023 to 31 March 2024 has been published following approval by the Audit and Risk Committee.

2. The report provides key organisational details and the audited financial statements in line with the Department of Health and Social Care reporting requirements. The requirements include an assessment of performance during the reporting period, details as to how key statutory duties have been discharged and a governance statement that describes how governance, risk management and decision-making arrangements have operated over the year. The report can be found here: https://notts.icb.nhs.uk/wp-content/uploads/sites/2/2022/04/Final-ARA-2023-24-26.06-KPMG_UNSigned-for-web.pdf.

3. The ICB will be holding its Annual Public Meeting at 2pm on 12 September 2024, at the Wheelers Suite, Meadow Lane, Nottingham, NG2 3HJ.

NHS Nottingham and Nottinghamshire ICB Enforcement Undertakings

4. At its May 2024 meeting, Board members agreed to accept NHS England's proposed enforcement undertakings (in connection with NHS England's functions under the National Health Service Act 2006, as amended), with regard to the Nottingham and Nottinghamshire NHS system's financial sustainability, risk of non-compliance with expenditure limits and controls, and significant growth in workforce costs. It has been agreed that the ICB's Finance and Performance Committee will scrutinise arrangements for ensuring delivery of the ICB's statutory financial duties, and joint financial planning duties with its partner NHS Trust and NHS Foundation Trusts and provide assurance to the Board or raise any specific areas of concern for immediate Board attention. The full letter from NHS England can be found here: https://notts.icb.nhs.uk/about-us/what-we-spend-and-how-we-spend-it/.

NHS Oversight Framework 2023/24 – quarter four review

5. The NHS Oversight Framework provides a consistent approach to oversight of ICBs and NHS Trusts. Organisations are segmented into four categories dependent on their support needs. NHS England has recently written to the ICB to confirm the Quarter four position. It has been agreed that the ICB will remain in segment three of the Framework, based in the main, on the financial position across the NHS system and the level of support required across several

performance challenges, including cancer care, diagnostics, urgent and emergency care, adult inpatient learning disability and autism numbers, and out of area mental health inpatient placements. NHS England will continue to work with the ICB to review the segmentation drivers, plans to address the key issues underpinning the segmentation, support needs, and how we work together.

NHS Oversight and Assessment Framework 2024/25

6. NHS England has recently undertaken a consultation on an updated NHS Oversight and Assessment Framework. The updated Framework aims to respond to feedback for a greater clarity of roles and responsibilities, use of a broader range of short and medium term outcome measures, less subjectivity in measuring success and the adoption of a more mature relationship in supporting organisations to improve. The final document is scheduled to be published later in 2024. The draft document can be found here: https://www.engage.england.nhs.uk/consultation/nhs-oversight-and-assessment-framework/

Industrial action

7. A further round of industrial action was taken by junior doctors from 27 June to 2 July 2024. This is the eleventh period of action since the dispute commenced and the first since February 2024. As with previous periods of planned disruption, a warning of potential disruption was issued to the public, asking for their support by using services appropriately. Our system response structure, which brings operational and emergency preparedness resilience and response leads together into a System Control Centre, was also used to ensure that essential services were maintained.

Cyber security

8. In recent weeks, the healthcare system in London and the Southeast was hit by a cyber-attack affecting pathology laboratory systems provided by an agency called Synnovis. The attack had significant impact on pathology test results and consequently patient care. Whilst the incident has not directly impacted patients in Nottingham and Nottinghamshire, it is important for us to realise that cyber security has had to become a way of life in the NHS. Whilst we can never be able to remove the risk of attack or incident completely, we can ensure we are doing everything we can to mitigate risks and to have appropriate business continuity plans in place should an incident occur.

9. In mitigation, the NHS nationally offers support, guidance, and assurance against known cyber threats. NHS England works with the National Cyber

Security Centre to provide bespoke advice and solutions to NHS organisations across the country. There is a national Cyber Associates Network to disseminate threat levels, risk profiles and practical support where necessary. In Nottingham and Nottinghamshire there is a similar structure, with all local health and care organisations actively participating in the Nottinghamshire Cyber Associates Network. A system-wide desk top exercise has recently been undertaken, organised by NHS England with Emergency, Preparedness, Resilience and Response (EPRR) colleagues, the outcome of which has fed into a local action plan co-ordinated by the ICB's EPRR Team.

10. Dr Dave Briggs, Medical Director, acts as the ICB's Senior Information Risk Owner (SIRO), providing executive leadership to our cyber security arrangements, which are overseen by the Audit and Risk Committee. For 2023/24, the ICB has confirmed full compliance with the requirements of the Data Security and Protection Toolkit and an Annual SIRO Report is scheduled for presentation to the Board later in the year.

11. Everyone in the health and care system has a role to play in mitigating potential attacks. As such, I ask that all board members and staff ensure they are personally up to date on the cyber security elements of their mandatory training. Knowing what to do in the event of being personally targeted could help stop the detrimental impact of a cyber-attack.

Maintaining focus and oversight on quality of care and experience in pressurised services

12. Following the recent Channel 4 documentary focusing on the Emergency Department at the Royal Shrewsbury Hospital, NHS England has written to all ICBs and NHS trusts asking every organisation to assure themselves that they are working with their system partners to do all they can to maintain high standards of quality of care within pressurised services.

13. NHS England acknowledges and commends the continuing hard work of colleagues during the continuing sustained pressure on services and in sometimes difficult circumstances, but states that all patients deserve to be treated with dignity and respect. Specifically, the letter asks every Board across the NHS to assure themselves that they are working with system partners to do all they can to:

    a) Provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence.

    b) Maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility on.

14. The letter goes on to stress that fundamental standards of quality must be adhered to, wherever a patient is receiving care. Corridor care, or care outside of a normal cubical environment, must not be considered the norm – it should only be in periods of escalation and with Board level oversight at trust and system level, based on an assessment of and joined up approach to managing risk to patients across the system (through the OPEL framework). Where it is deemed a necessity – whether in Emergency Departments, acute wards or other care environments – it must be provided in the safest and most effective manner possible, for the shortest period of time possible, with patient dignity and respect being maintained throughout and clarity for all staff on how to escalate concerns on patient and staff wellbeing.

15. The letter notes that whilst these pressures are most visible in Emergency Departments and acute services, they are also wider issues which need whole-system responses, including local authorities, social care and primary and community services. There is therefore a shared responsibility to ensure that quality (patient safety, experience, and outcomes) is central to the system-level approach to managing and responding to significant operational pressures. To this end, all ICS partners should individually and jointly assure themselves that:

    a) Their organisations and systems are implementing the actions set out in the Urgent and Emergency Care Recovery Plan year 2 letter[1].

    b) Basic standards of care, based on the Care Quality Commission's fundamental standards[2], are in place in all care settings.

    c) Services across the whole system are supporting flow out of Emergency Departments and out of hospital, including making full and appropriate use of the Better Care Fund.

    d) Executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance[3].

    e) There is consistent, visible, executive leadership across the Urgent and Emergency Care pathway and appropriate escalation protocols in place every day of the week at both trust and system level.

    f) Regular non-executive director safety walkabouts take place where patients are asked about their experiences in real time and these are relayed back to the Board.

[1] PRN01288_i_Urgent-and-emergency-care-recovery-plan-year-2-building-on-learning-from-2023-24-May-2024.pdf (england.nhs.uk)
[2] The fundamental standards - Care Quality Commission (cqc.org.uk)
[3] B1231-board-assurance-framework-for-seven-day-hospital-services-08-feb-2022.pdf (england.nhs.uk)

Sexual safety in healthcare – organisational charter

16. In November 2023, I reported that the ICB had signed NHS England's organisational charter for sexual safety in healthcare. As a signatory to this charter, the ICB is committed to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace. I can confirm that all three acute trusts within our system are now also signed up to the Charter and we continue to work collaboratively through our nursing teams to support an ICS approach.

Health and Care Awards 2024

17. Aimed at celebrating best practice in line with the aims and principles of our Integrated Care Strategy, this year's Awards are now open for nominations. Categories include health inequalities, prevention, value for money and partnership awards. To recognise an individual or service for their valuable contribution within our healthcare system, follow this link: https://healthandcarenotts.co.uk/integrated-care-strategy/celebrating-success/health-and-care-awards/. The closing date for nominations is 5pm on 27 August.

Health and Wellbeing Board updates

18. The Nottinghamshire County Health and Wellbeing Board met on 22 May 2024. The meeting received an update report on ambition three of the Health and Wellbeing Strategy 'everyone can access the right support to improve their health.' The papers for this meeting are published on Nottinghamshire County Council's website here: https://www.nottinghamshire.gov.uk/care/health-and-wellbeing/health-and-wellbeing-board.

19. The Nottingham City Health and Wellbeing Board met on 29 May 2024. The meeting received a Joint Strategic Needs Assessment profile on people seeking asylum, refugees and people refused asylum, a report on the Nottingham and Nottinghamshire Suicide Prevention Charter and Suicide Prevention and Self-Harm Strategy, an update on the Health and Wellbeing Strategy, and an update from the Nottingham City Place-based Partnership. 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.

Recent leadership appointments

20. In May, Nottingham City Council's Full Council appointed a new Leader, Councillor Neghat Khan and Councillor Ethan Radford as Deputy Leader.

21. A new lead member for Adult Social Care and Health was also appointed, Councillor Pavlos Kotsonis. Councillor Kotsonis' portfolio covers adult social care and public health. He will be the Chair of the Nottingham City Health and Wellbeing Board. On behalf of the Board, I would like to thank Councillor Linda Williams, who previously served in this role, for her work as Deputy Chair of the Nottingham and Nottinghamshire Integrated Care Partnership. Councillor Kotsonis will also take this role, jointly with the Chair of the Nottinghamshire County Health and Wellbeing Board.

22. Mel Barrett, the Chief Executive of the City Council, has announced he is leaving to start a new role as Chief Executive of Metropolitan Thames Valley Housing, and on behalf of the Board I also thank him for his support and wish him well in his new venture.

23. Nottinghamshire County Council has also made some changes in its political leadership. Councillor Matt Barney has stepped down from the position as Cabinet Member for Adult Social Care and has been replaced by Councillor Jonathan Wheeler. Councillor Wheeler has moved across from his role as Chair of the Health Scrutiny Committee and Councillor Roger Jackson has taken this post. Cllr John Ogle has also taken over as Chair of the Adult Social Care and Public Health Select Committee. Councillor John Doddy has stepped down from his role as Chair of the Health and Wellbeing Board and notification of his replacement will be made following the Full Council meeting on 18 July.

Publication of the infected blood inquiry final report

24. Following the publication of the final report from the infected blood inquiry, NHS England issued a public apology and wrote to all ICBs and NHS trusts setting out next steps and what colleagues are being asked to do to support those affected, and to reassure current patients who need these products of the safety of the current NHS blood and blood products supply. In her letter, Amanda Pritchard, Chief Executive of NHS England, noted that the report only came about because people spoke up and reiterated that freedom to speak up is vital in improving patient safety and the safety and treatment of colleagues. The full report can be found here: https://www.england.nhs.uk/long-read/publication-of-the-infected-blood-inquiry-final-report/.

Speech from Amanda Pritchard, NHS England Chief Executive

25. On 12 June 2024, Amanda Pritchard gave a speech at the NHS ConfedExpo conference, looking back to the founding principles of the NHS, recent achievements, and current challenges. The key messages were:

    a) Together, an incredible amount has been achieved over the last year; however, it has been a tough year for colleagues and we do not always

get things right. We are still recovering from Covid, and still not delivering the level of service we would want to for patients.

b) There are big challenges on the horizon, with an ageing population, growing need for care, and a shrinking working age population to pay for it.

c) These challenges require us to reimagine how we do things – such as how we strengthen primary and community care and keep people out of hospital wherever possible so that we can both give patients a better experience, and also achieve better outcomes with the funding available.

d) There are key opportunities to do this now that we have never had before – most importantly the Long Term Workforce Plan, the continued development of our technology and digital offer and systems like the Federated Data Platform, and the ever-maturing relationships at system and place levels.

e) There are also things we need to do to ensure we can take advantage of those opportunities, including strengthening management and leadership, giving colleagues the tools they need to create the fastest improving healthcare system in the world, and backing innovative new ways of doing things.

f) But we should be clear we cannot do this alone. As well as requiring investment in estates, and action on public health and social care, there are wider issues we need to grasp as a society to avoid the NHS being an expensive safety net, such as how we address rising obesity and the mental health impacts of problem gambling.

26. The full speech can be found here: https://www.england.nhs.uk/events/highlights/amanda-pritchard-speech-june-2024/.

Health Survey for England 2022 (part one)

27. Part One of the Health Survey for England monitors trends in the nation's health. Part Two is used to estimate the proportion of people in England who have health conditions, and the prevalence of risk factors and behaviours associated with certain health conditions. The surveys provide regular information that cannot be obtained from other sources. Part One has recently been released and features adults' health related behaviours and drinking habits and children's health and behaviours. Key findings include:

a) Current cigarette smoking has declined steadily from 27% in 1993 to 13% in 2022.

b) Adults living in the most deprived areas were more likely to smoke cigarettes (21%) than those living in the least deprived areas (9%).

c) In 2022, 9% of adults currently used e-cigarettes. Current cigarette smokers were more likely to use e-cigarettes compared with those who have never smoked cigarettes.

d) The proportion of children aged eight to 15 who have ever tried a cigarette decreased from 19% in 1997 to 3% in 2022.

e) In 2022, 12% of children aged eight to 15 had ever used an e-cigarette or vaping device.

f) 22% of adults participated in less than 30 minutes of moderate or vigorous physical activity a week.

g) 29% of adults ate five or more portions of fruit and vegetables per day, and 7% ate no fruit or vegetables.

h) 19% of children aged five to 15 ate the recommended five or more portions of fruit and vegetables a day.

i) A higher proportion of men (32%) than women (15%) drank at levels that put them at increasing or higher risk of alcohol-related harm (over 14 units in the last week).

j) The proportion of children aged eight to 15 who had ever drunk alcohol fell from 45% in 2003 to 14% in 2022.

k) In 2022, 34% of 13 to 15 year olds reported ever having drunk alcohol, compared with 2% of 8 to 12 year olds.

28. The full report can be found here: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	11/07/2024
Paper Title:	**Defining the Joint Forward Plan Population Health Outcomes**
Paper Reference:	ICB 24 029
Report Author:	Sarah Fleming, Programme Director for System Development Maria Principe, Director – Clinical Effectiveness and Transformation
Executive Lead:	Lucy Dadge, Director of Integration
Presenter:	Maria Principe, Director – Clinical Effectiveness and Transformation

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

Summary:

The NHS Joint Forward Plan (JFP) was refreshed for 2024/25 and signed off by Board on 9 May 2024. This paper presents the proposed population outcomes that will be achieved by successful delivery of the JFP. This recognises that the NHS contribution to the achievement of outcomes does not sit in isolation from actions taken by other system partners including public health and social care, and also the social and economic factors that are beyond the immediate influence of NHS partners.

It is proposed that the ambition of the JFP is confirmed as returning to pre-pandemic outcomes, recognising the impact of the pandemic on operational delivery of key access targets and the associated influence on outcomes.

The JFP Delivery Group has now been established and will oversee delivery of the outcomes.

Recommendation(s):

The Committee is asked to **discuss** the proposed outcomes and ambition to be achieved through delivery of the NHS Joint Forward Plan.

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	The Joint Forward Plan sets out a transformed approach to system working based on the key strategic principles of prevention, equity and integration. These principles inform the key programmes/interventions that are expected to drive improved outcomes for the population through a better understanding of local population need, the development of locally sensitive support and services, and through greater collaboration between NHS partners as well as wider system partners.
Tackle inequalities in outcomes, experience and access	The Plan describes the NHS approach to ensuring that local population need is understood, and that support and service provision is tailored to this need.

How does this paper support	the ICB's core aims to:
Enhance productivity and value for money	Key drivers for productivity and value for money are described in the JFP, along with the contribution each programme / initiative will make.
Help the NHS support broader social and economic development	The approach to social economic development is set out the in the JFP.

Appendices:
Appendix 1: Joint Forward Plan Outcomes

Board Assurance Framework:
Not applicable

Report Previously Received By:
Reports have been provided to the Board and the Strategic Planning and Integration Committee at its previous meetings.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Defining the Joint Forward Plan Population Health Outcomes

Background

1. The Joint Forward Plan (JFP) has been reviewed and refreshed as part of an integrated approach to planning, incorporating the five-year JFP, three-year financial opportunities and 2024/25 operational planning.
2. In line with the Integrated Care Strategy priority to *bring our collective data, intelligence and insight together* a set of outcomes has been developed to monitor delivery of the JFP. The approach draws on the ICS Outcomes Framework agreed in 2019. Analysis has been undertaken to propose an ambitious, but achievable level of ambition for each of the outcomes, using national targets where available and applying a local methodology for all other outcomes.

Confirming the outcomes to demonstrate impact of delivery

3. A suite of outcomes has been identified that monitors progress with delivery of the JFP. These cover the four aims of the Integrated Care System. This is shown in Appendix 1.
4. Baselines have been provided for each outcome along with current performance and direction of travel.
5. The outcomes consider standardised rates which take into account changes to the population as well as absolute numbers. This approach is effective for monitoring population outcomes but is not effective for monitoring financial impact which will only be achieved by a change in absolute numbers.
6. It is proposed that the level of ambition be to return each outcome to pre-COVID levels. This aligns with the national focus on recovery from the pandemic for areas such as primary care and elective waiting times. This sets a challenging ambition recognising the impact that wider determinants of health have had in the last four years. Using this as an ambition means we can use local and more timely data.
7. The Strategic Planning and Integration Committee discussed and supported the approach and proposed levels of ambition its 4 July meeting.

Understanding the impact of evidence-based interventions on outcomes

8. The outcomes proposed to monitor impact of the JFP recognise that delivery of is achieved by the collective efforts of system partners, and this it is rarely possible to attribute delivery to a single intervention.

9. It is therefore important to ensure that interventions are evidence based wherever possible and that we continue to evolve a system response to delivering agreed outcomes. Joint Strategic Needs Assessment and Clinical Senate reviews provide system opportunities to ensure decision making is evidence based.
10. Assumptions will need to be made using proxy measures where there is a time lag between interventions and impact e.g., an increase in early identification of cancer will contribute to improved ten-year survival rates, and therefore illness-free life expectancy.

Next steps

11. The JFP Delivery Group has been established and will focus on the delivery of outcomes across all workstreams as well as the strategic direction for transformation including the role of Place Based Partnerships and provider collaboratives.
12. The Delivery Group will ensure that each workstream is clear about the outcomes it is aiming to achieve and identifies the performance and process measures that provide an understanding of impact in the short to medium term.
13. The System Analytics Intelligence Unit (SAIU) is finalising a JFP outcomes dashboard to share with system partners to ensure a common view of JFP outcomes, quality and performance across the ICS.
14. We will continue to build the evidence base into our JFP deliverables to ensure we understand the contribution made by programmes.
15. The JFP will continue to be developed to ensure that there is clarity over the deliverables and the outcomes they will achieve.
16. The Strategic Planning and Integration Committee will receive a further update report on this work at its 5 September meeting, ahead of the scheduled report to the Board on 12 September.
17. Complementary to this, further work is taking place to confirm a set of outcomes for the Integrated Care Strategy. Bi-annual reporting on outcomes and delivery of the 14 priorities will be presented to the Integrated Care Partnership at its September 2024 meeting.

Appendix 1: Joint Forward Plan Outcomes

Table showing how Joint Forward Plan focus areas contribute to ICS level outcomes.

Priority 01: Prevention: reduce physical and mental illness and disease prevalence.	**Priority 02: Proactive management of long-term conditions and frailty to support early identification and avoid unnecessary escalation**	**Priority 03: Improve navigation and flow to reduce emergency pressures in physical and mental health settings.**	**Priority 04: Timely access and early diagnosis for cancer and elective care.**
• Increase in life expectancy • Increase in illness-free life expectancy • Reduction in average number of years spent in poor health • Improve early cancer diagnosis • Reduction in avoidable premature mortality • Stabilise obesity in Year 6 children • Increase in the proportion of people reporting high satisfaction with the services they receive • Increase the number of people who have the support to self-care and self-manage and improve their health and wellbeing	• Increase in life expectancy • Increase in illness-free life expectancy • Reduction in average number of years spent in poor health • Reduction in avoidable premature mortality	• Increase in life expectancy • Increase in illness-free life expectancy • Reduction in average number of years spent in poor health • Reduction in avoidable premature mortality • Increase in the proportion of people reporting high satisfaction with the services they receive • Reduction in Hospital Emergency admissions to hospital (Length of Stay 1+ bed-days) • Reduction in Hospital Emergency admissions for COPD, Cancer, CVD, Falls, Alcohol (including same-day discharges)	• Increase in life expectancy • Increase in illness-free life expectancy • Reduction in average number of years spent in poor health • Improve Early Cancer diagnosis • Reduction in avoidable premature mortality • Increase in the proportion of people reporting high satisfaction with the services they receive • Reduction in Hospital Emergency admissions to hospital • Reduction in Hospital Emergency admissions for Cancer

Table showing Joint Forward Plan outcomes mapped to the Integrated Care Strategy strategic aims

Aim	Indicator	Baseline Figure	Latest Figure	Change	Statistical Significance	Baseline Period	Latest Period	Indicator Description
Improve Outcomes in Population health and healthcare	ICS Life Expectancy - Female	82.8	83.0	0.2	No Difference	2019	2023	Life expectancy at birth (years)
	ICS Life Expectancy - Male	80.1	79.5	-0.6	Lower	2019	2023	Life expectancy at birth (years)
	ICS Multi-morbidity Free LE - Female							Work in progress
	ICS Multi-morbidity Free LE - Male							Work in progress
	ICS Avoidable Deaths - Female	194.2	201.5	7.3	No Difference	2017 - 2019	2021 - 2023	Age Standardised Rate per 100,000 registered population
	ICS Avoidable Deaths - Male	284.5	313.9	29.4	Higher	2017 - 2019	2021 - 2023	Age Standardised Rate per 100,000 registered population
	ICS Avoidable Deaths - Total Numbers	7,245	8,098	853	N/A	2017 - 2019	2021 - 2023	Count of Avoidable Deaths
	Infant Mortality - Nottingham	6.7	4.9	-1.8	No Difference	2019	2023	Crude Rate per 1,000 Births
	Infant Mortality - Nottinghamshire	3.6	3.9	0.3	No Difference	2019	2023	Crude Rate per 1,000 Births
	ICS Suicides - Rates	9.2	10.0	0.8	No Difference	2017 - 2019	2021 - 2023	Age Standardised Rate per 100,000 registered population
	ICS Suicide - Total Numbers	292	331	39.0	N/A	2017 - 2019	2021 - 2023	Count of Suicide Deaths
	Early Cancer Diagnosis - Nottingham	50.3%	53.6%	3.2%	No Difference	2020	2021	% Cancers diagnosed at stage 1 & 2
	Early Cancer Diagnosis - Nottinghamshire	50.4%	56.1%	5.7%	Higher	2020	2021	% Cancers diagnosed at stage 1 & 3

Aim	Indicator	Baseline Figure	Latest Figure	Change	Statistical Significance	Baseline Period	Latest Period	Indicator Description
Tackle inequalities in outcomes, experiences and access	ICS - Year 6 Prevalence of Obesity	21.6%	24.1%	2.6%	Higher	2019/20	2022/23	Year 6 prevalence of obesity (including severe obesity)
	Average Attainment 8 score - Nottingham	45.3%	42.7%	-2.6%	Lower	2019/20	2022/23	Average Attainment 8 score
	Average Attainment 8 score - Nottinghamshire	50.8%	46.4%	-4.4%	Lower	2019/20	2022/23	Average Attainment 8 score
	School Readiness - Nottingham	60.3%	63.3%	3.0%	No Difference	2021/22	2022/23	School readiness: percentage of children achieving a good level of development at the end of Reception
	School Readiness - Nottinghamshire	66.8%	67.4%	0.6%	No Difference	2021/22	2022/23	School readiness: percentage of children achieving a good level of development at the end of Reception
	ICS - Overall patient experience of GP Practice	84.4%	71.8%	-12.5%	Lower	2019	2023	% Patients who had a good overall experience of GP Practice
	Overall Experience of Inpatient Services - DBH	8.0	8.1	0.1	No Difference	2019	2022	Total Trust Mean Score
	Overall Experience of Inpatient Services - NUH	8.1	8.0	-0.1	No Difference	2019	2022	Total Trust Mean Score
	Overall Experience of Inpatient Services - SFH	8.3	8.4	0.1	No Difference	2019	2022	Total Trust Mean Score
	Overall Experience of A&E - DBH	8.1	7.5	-0.7	No Difference	2018	2022	Total Trust Mean Score
	Overall Experience of A&E - NUH	8.0	7.4	-0.6	No Difference	2018	2022	Total Trust Mean Score
	Overall Experience of A&E - SFH	8.4	8.0	-0.3	No Difference	2018	2022	Total Trust Mean Score

Aim	Indicator	Baseline Figure	Latest Figure	Change	Statistical Significance	Baseline Period	Latest Period	Indicator Description
	ICS - Patients on EoL with ReSPECT Form	52.8%	70.9%	18.1%	Higher	May-2022	May-2024	% Patients on GP EoL Register with a recorded ReSPECT Form
	ICS - LD Patients with Annual Health Check	68.3%	81.6%	13.3%	Higher	Jan-2023	May-2024	% Patients 14+ on GP LD Register with an Annual Health Check
	ICS - SMI Patients with 6 Physical Health Checks	37.2%	62.5%	25.3%	Higher	Mar-2020	May-2024	% Patients on GP SMI Register with all 6 Health Checks
	Smoking Prevalence (QOF) - Nottingham	19.4%	17.2%	-2.2%	Lower	2019/20	2022/23	Smoking prevalence in adults (15+) - current smokers (QOF) %
	Smoking Prevalence (QOF) - Nottinghamshire	16.0%	14.3%	-1.7%	Lower	2019/20	2022/23	Smoking prevalence in adults (15+) - current smokers (QOF) %
Productivity and value for money	ICS Emergency Admissions with 1+ LOS (Rate)	7,577	6,380	-1,197	Lower	2019/20	2023/24	Age Standardised Rate per 100,000 registered population
	ICS Emergency Admissions with 1+ LOS (Number)	86,991	76,951	-10,040	N/A	2019/20	2023/24	Count of emergency spells with length of stay of 1 or more bed-days (1+ LOS)
	ICS Emergency Admissions - Bed Days (Number)	615,978	675,966	59,988	N/A	2019/20	2023/24	Count of emergency spells bed-days
	ICS Emergency Admissions for Alcohol (Rate)	110.2	93.3	-16.9	Lower	2019/20	2023/24	Age Standardised Rate per 100,000 registered population (all length of stay, including 0 LOS)
	ICS Emergency Admissions for Cancer (Rate)	295.5	248.4	-47.1	Lower	2019/20	2023/24	Age Standardised Rate per 100,000 registered population

Aim	Indicator	Baseline Figure	Latest Figure	Change	Statistical Significance	Baseline Period	Latest Period	Indicator Description
								(all length of stay, including 0 LOS)
	ICS Emergency Admissions for COPD (Rate)	246.0	198.2	-47.8	Lower	2019/20	2023/24	Age Standardised Rate per 100,000 registered population (all length of stay, including 0 LOS)
	ICS Emergency Admissions for CVD (Rate)	1,138.6	1,044.5	-94.2	Lower	2019/20	2023/24	Age Standardised Rate per 100,000 registered population (all length of stay, including 0 LOS)
	ICS Emergency Admissions Frailty-related (Rate)	2,249.0	1,699.8	-549.3	Lower	2019/20	2023/24	Age Standardised Rate per 100,000 registered population (all length of stay, including 0 LOS)
Support broader social and economic development	Workforce demographics							SAIU exploring what data are available
	% of health and care workforce under the age of 25 years							SAIU exploring what data are available
	Total use and appropriate utilisation of our estate							SAIU exploring what data are available
	Carbon footprint							SAIU exploring what data are available

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	11/07/2024
Paper Title:	**Integrated Care System Research Strategy**
Paper Reference:	ICB 24 030
Report Author:	Rachel Illingworth, Head of Research and Evidence
Executive Lead:	Dr Dave Briggs, Medical Director
Presenter:	Dr Dave Briggs, Medical Director

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

Summary:

Population health and care research embedded in health, care and community settings is essential for improving population health, wellbeing, joined up care and reducing inequalities. Research underpins all advances in health and care and is the basis for evidence-based practice.

Research and the use of evidence from research are enablers for the four aims of Integrated Care Systems (ICS). Integrated Care Boards (ICB) must, in the exercise of their functions, facilitate or otherwise promote research on matters relevant to the health service and the use in the health service of evidence obtained from research.

An Integrated Care System (ICS) Research Strategy has been developed collaboratively through extensive engagement with partners involving over 100 people and groups, plus a review of relevant local and national strategies. It aligns to the Integrated Care Strategy.

Our ICS research vision is for an integrated and supportive research environment, clearly aligned with system priorities, that ensures improved outcomes and reduced health inequalities for our local population, and efficiencies for our health and care system. The research strategy contains four pillars: population, workforce, system and implementation. The five-year strategy sets out our ambition and enables us to harness our collective strengths and build on opportunities to work together in an integrated and effective way to drive and develop research and increase the implementation of the outcomes of research for the benefit of the population, workforce and system.

An operational plan is being developed which will include what we will do and how we will measure the progress and impact of the strategy.

Recommendation(s):

The Board is asked to **approve** the ICS Research Strategy

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	Research and the use of evidence from research is essential to transform services, increase quality of care and improve outcomes.
Tackle inequalities in outcomes, experience and access	Research informs greater understanding of inequalities and how to reduce them. By ensuring that all communities are able to be actively involved in

How does this paper support	the ICB's core aims to:
	population health and care research and that research is more representative of our diverse and underserved communities, everyone can benefit from research and a reduction in inequalities.
Enhance productivity and value for money	Utilising the evidence from research enhances productivity and value for money. The ICS creates the opportunity for integrated research delivery across partners, increasing flexibility of workforce and recruitment to studies while reducing bureaucracy and improving research productivity and value for money.
Help the NHS support broader social and economic development	Research brings investment into anchor institutions supporting wider economic prosperity.

Appendices:
Appendix 1 - ICS Research Strategy 2024-29

Board Assurance Framework:
Not applicable.

Report Previously Received By:
The ICS Research Strategy was considered by the Strategic Planning and Integration Committee on 2 May 2024. The Committee endorsed the Strategy and recommended it to the Board for approval.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Integrated Care System Research Strategy

Introduction

1. In 2023 the Nottingham and Nottinghamshire Integrated Care Partnership set out its vision in an Integrated Care Strategy “Every person will enjoy their best possible health and wellbeing”. Research has a key part to play in delivering this vision cost-effectively and supports the Integrated Care System (ICS) to deliver on its four key aims.
2. The ICS Research Strategy aligns to the Integrated Care Strategy.
3. Our ICS research vision is for an integrated and supportive research environment, clearly aligned with system priorities, that ensures improved outcomes and reduced health inequalities for our local population, and efficiencies for our health and care system.
4. The research strategy has been developed through extensive engagement throughout the ICS plus a review of relevant local and national strategies. This led to the four pillars of the research strategy: population, workforce, system and implementation.
5. The ICS starts from a strong research position and the ICS Research Strategy sets the vision and ambition to harness our collective strengths to collaborate effectively and efficiently together so that everyone in our population and workforce can benefit from research.

Integrated Care Board, Integrated Care System and Research

6. The Health and Care Act 2022 set legal duties for Integrated Care Boards (ICB) regarding research and evidence. ICBs must in the exercise of their functions, facilitate or otherwise promote research on matters relevant to the health service and the use in the health service of evidence obtained from research.
7. NHS England will assess ICBs for the discharge of these duties.
8. In March 2023, NHS England published guidance for Integrated Care Systems on maximising the benefits of research[1] recognising the opportunity for systems to embed research within health and care for the benefit of the population. The guidance encouraged ICSs to develop a research strategy that aligns to their Integrated Care Strategy recognising the benefits of working together, combining expertise and resources to foster and deploy research and innovations.

[1] NHS England » Maximising the benefits of research

Why is research important?

9. Research leads to improvements in clinical and care practice, reduces the cost of health and care, leads to a healthier population and supports a happier workforce. Population health and care research embedded in health, care and community settings is essential for improving population health, wellbeing, joined up care and reducing inequalities.

10. Evidence shows clinically research active hospitals have better patient care outcomes and not just for research participants.[2] Research provides professional development opportunities for the workforce, attracting and retaining people. It also brings investment into anchor institutions supporting wider economic prosperity. The utilisation of evidence from research informs understanding of the needs of the population, how to meet those needs, improve outcomes, reduce inequalities and tackle the challenges in ICSs.

What is our current position in the ICS?

11. There is an existing vibrant research ecosystem in the ICS, as demonstrated in our ICS Research Infrastructure Mapping Report November 2022, and by the data presented below.

12. The mapping of our ICS health and care research activity, expertise, interests and infrastructure by the ICS Research Partners Group chaired by the ICB's Head of Research and Evidence was cited as an example of best practice in NHS England's ICS research guidance (paragraph 8 above). The mapping enabled our ICS to see its research capabilities, strengths, expertise and areas of synergy and opportunities for collaboration to align to its needs and priorities and also gaps for future development, recognising that organisations are at different stages of research development.

13. The extent of involvement in National Institute for Health and Care Research (NIHR)[3] portfolio research studies in the ICS is a key indicator however it is important to note that this does not include all research of importance and relevance to the ICS for example research related to the building blocks of health.

14. The NIHR portfolio includes a wide range of research studies including clinical, public health and social care research delivered in a range of settings. Key priorities are research addressing complex health and care challenges, research taking place in areas where need is greatest and ensuring our diverse and underserved communities are able to shape and participate in research so that it is representative of these communities, and everyone can benefit.

[2] Embedding a research culture | NIHR
[3] National Institute for Health and Care Research | NIHR

15. During 2023-24, 31,500 people in Nottingham and Nottinghamshire participated in 538 unique NIHR research studies. 53% of these people were recruited from the three NHS trusts, 45% from primary care and 2% from other settings. The total number of people participating in NIHR portfolio research in our ICS has increased from 17,000 participants three years ago.
16. In 2023-24 our ICS had the highest number of people participating in NIHR research studies from the five ICSs in the East Midlands as well as the highest number when analysed by sector: trust, primary care and other settings. Our ICS also had the highest number of unique NIHR research studies.
17. When comparing the number of people participating in NIHR portfolio research in 2023-24 across the Midlands (East and West) Region, our ICS was second for both the number of people participating in NIHR portfolio research in trusts and primary care. Birmingham and Solihull ICS were highest for trusts and Staffordshire and Stoke on Trent ICS for primary care.
18. The number of people participating in primary care research in our ICS has increased over five years from 1,500 in 2019-20 to over 14,000 in 2023-24, with 76% of all GP practices taking part in at least one NIHR research study during the last financial year. The largest increase has been in Mid Nottinghamshire where the number of people participating in primary care research increased by over the last 12 months from 740 – 4,200 people.
19. This increase in primary care research activity across the ICS and particularly in Mid Nottinghamshire has demonstrated the impact of the ICB Primary Care Research Champions (a GP and Practice Manager) and the Mid-Nottinghamshire Research Team (a collaboration between a GP, Senior Primary Care Research Nurse and Head of Research and Innovation at Sherwood Forest Hospitals NHS Foundation Trust). There has been a focus on equity of access for the people of Mid Nottinghamshire where historically there have been fewer opportunities to participate in research.
20. The Primary Care Research Champions were awarded the Judges Special Recognition Award at the NIHR Clinical Research Network East Midlands Research Awards in March 2024. They were commended for their impact, team working, building relationships, engagement, leadership and focusing on underserved communities. The Mid Nottinghamshire Research Team were also finalists in the Outstanding Achievement by a Team Award category.
21. The ICS therefore starts from a strong base and provides new opportunities to achieve even more together, through working as a research system, than it is possible to achieve as individual organisations.

Why do we need an ICS Research Strategy?

22. Having an ICS research strategy sets a collective vision and ambition for the system. It enables us to build on the existing opportunities and harness our collective strengths to work together in an integrated and effective way to drive and develop research and increase the implementation of the outcomes of research. This will enable everyone in our population and workforce to benefit.

Our engagement approach

23. A Senior Research Strategy Manager from the University of Nottingham (funded by the NIHR Clinical Research Network East Midlands) was seconded for six months to work with the ICB's Head of Research and Evidence to collaboratively develop the research strategy with ICS partners.

24. Over 100 people and groups participated in the consultation between September 2023 and March 2024. These included people from a wide range of health and care professions, roles and settings from across ICS partners and wider stakeholder organisations including both local universities and the NIHR. People from all four Places of the ICS, the ICS Clinical and Care Professional Leadership Group and the Clinical Cabinets were involved.

25. The collaborative participation in the development of the strategy underlines the strong base of research expertise and enthusiasm that exists across the system.

26. The ICS Research Strategy was endorsed by the ICB's Strategic Planning and Integration Committee in May 2024 who recommended it to the Board for approval.

What are we aiming to achieve?

27. We have four areas of priority related to population health and care research that form the pillars of our research strategy:

    a) Population – We will undertake research to improve the health and care outcomes and reduce the health inequalities of our local population.

    b) Workforce – We will support our workforce to drive and deliver research in a culture where research is everyone's business.

    c) System – We will maximise the collective capabilities and strengths of the system through collaboration and shared infrastructure.

    d) Implementation – We will increase the implementation of research outcomes that are shown to improve health and care.

28. These pillars represent the opportunities to work together and harness our collective strengths to collaborate collectively and efficiently together so that everyone in our population and workforce can benefit from research.

Implementation and impact

29. An engagement and opportunities report has been written from the information gathered during the strategy development phase. This is informing an operational plan which will build on the NHS Joint Forward Plan. The operational plan will include what we will do and how we will measure the progress and impact of the strategy.
30. Further funding has been received from the NIHR Clinical Research Network East Midlands to fund another secondment to support the implementation of the strategy in 2024-25.
31. Alongside the well-established ICS Research Partners Group chaired by the Head of Research and Evidence at the ICB, a more senior ICS Research Leaders group is being set up which will be chaired by an ICB Deputy Medical Director. This group will develop, lead, champion and support the implementation of a research and evidence led ICS including oversight of the research strategy. The group will monitor and address via joint action, those factors that could affect, constrain, block or influence the successful implementation of the above.
32. The ICS Research Strategy will be presented to the ICS Reference Group in December 2024.

Integrated Care System
Nottingham & Nottinghamshire

Nottingham and Nottinghamshire ICS Research Strategy

2024-29

Executive summary

This research strategy sets out our ambition for research in the Nottingham and Nottinghamshire Integrated Care System (ICS) for the next five years.

In 2023, our ICS set out its vision in an Integrated Care Strategy "Every person will enjoy their best possible health and wellbeing". Research has a key part to play in delivering this vision cost-effectively, as outlined in the Nottingham and Nottinghamshire NHS Joint Forward Plan:

Research can:

- **Improve clinical and care practice**
- **Reduce the cost of health and care**
- **Lead to a healthier population**
- **Support a happier workforce**

We have a very vibrant research ecosystem in our ICS, with all partners involved in research. This research strategy was developed through consultation with over 100 individuals and groups across the ICS. These included stakeholders from a variety of settings [1], from a range of professions [2] and from a wide geographical area [3]. The collaborative participation in the development of this strategy underlines the strong base of research expertise and enthusiasm that exists across our system.

Through these discussions, we identified four pillars that this strategy will address:

Population **Workforce** **System** **Implementation**

These pillars represent the opportunities to work together to drive, develop and improve research in our system, so that everyone in our population can benefit; everyone who works in health and care can benefit; and we harness our collective strengths to collaborate effectively and efficiently together.

Alongside this strategy, we are developing an operational plan which will set out the specific actions to be taken to deliver the aims.

This research strategy is for people of all ages: adults, young people and children, the workforce that supports them and the delivery of services provided for them.

The development of this strategy was funded by the NIHR Clinical Research Network East Midlands.

[1] *Hospitals, GP surgeries, community care, care homes, at home, pharmacies, dental surgeries, opticians, pre-hospital care*

[2] *Doctors, nurses, midwives, allied health professionals, clinical psychologists, pharmacists, optometrists, dentists, public health, social workers, advanced clinical practitioners, commissioners, academics and research managers*

[3] *The four Places of the ICS: Nottingham City, South Nottinghamshire, Mid Nottinghamshire, Bassetlaw.*

Why is research important?

Research is essential in providing the evidence needed to continually improve population health and wellbeing, provide high quality joined up services, contribute to a net zero health and care system and reduce health inequalities. From the improvement of clinical and care practice to the reduction in the cost of healthcare and the wellbeing of the workforce, research offers enormous opportunities for solutions to today's challenges.

Improving clinical and care practice

Through research, new and better ways are found to prevent, diagnose and treat health problems for our population.

Research can:

- Transform services, increase quality of care and improve outcomes.
- Increase patient satisfaction and quality of life.
- Increase safety and save lives.

Reducing the cost of health and care

Against a backdrop of acute budgetary pressures, research supports enhanced productivity and value for money.

Research can:

- Provide evidence of the benefits of more cost-effective treatments and interventions.
- Reduce resources spent on unnecessary or ineffective treatments, interventions and care.
- Improve efficiency of health and care delivery.

> **"Research is the single most important way in which we improve our healthcare."**
>
> *Department of Health and Social Care* [4]

Healthier population

Research shows that good health is dependent on a wide range of factors linked to the environments in which we grow, live and work.

Research can:

- Inform greater understanding of inequalities and how to tackle them.
- Identify measures to strengthen the building blocks of good health.
- Help understand how people engage with health and care services so that we can better meet the needs of our diverse and underserved populations.

Happier workforce

In a health and care system with workforce pressures, we know that staff satisfaction is higher among staff who are involved in research.

Research can:

- Help organisations to recruit and retain staff.
- Contribute to workforce wellbeing through greater job satisfaction.
- Enhance the skills of the workforce and support continuous improvement.

What do we mean by research?

Research is about generating new knowledge that could lead to changes to treatments, policies or care. It provides the data to inform evidence-based practice and policies.

It includes a broad range of topics, for example:

- Clinical research into the discovery and development of medical treatments.
- Evaluation and development of care models and pathways.
- Research into methods of diagnosing, monitoring and predicting health.
- Social care research into how to improve people's lives and help them live well.
- Public health research into population health issues, prevention of ill health and reduction of health inequalities.
- Management research into efficiency of delivering health and care.

Research can be any size or scale: from a short project with local application, to a multi-million-pound programme with global application.

Activities related to research

Research is one of a range of ways we can improve health and care. Related activities which may lead to research or stem from research include:

- **Audit** evaluates practice against standards or criteria to ensure adherence of care against evidence-based guidelines and best practices.
- **Quality improvement** processes identify areas of care which can be improved to achieve better patient outcomes.
- **Development** is the application of research to create prototypes or pilot schemes.
- **Innovation** refers to the development and implementation of new ideas, technologies, and processes that improve the quality and efficiency of health and care services.
- **Evaluation** uses measurement and analysis to learn how well a service or intervention is achieving its outcomes, to assess its value.

Involvement in research

Anyone in the health and care sector, in any profession or role, can play a part in research. They may

- Lead their field and be a principal or co-investigator on a project.
- Identify areas where research could be beneficial and advise and support researchers.
- Play a role in recruiting people to research studies or delivering research.
- Collect or analyse data for projects.
- Promote or help explain research to the public.

Research in our ICS

In our ICS, we have a thriving research ecosystem where research takes place across all our health and care settings and where our universities provide a wealth of research expertise, facilities and centres of excellence. Over the years, we have developed supportive research networks and there are good examples of collaboration between partners. Nonetheless, we can improve.

With the creation of the ICS, we have the opportunity to further integrate our research across our partners, benefiting from our combined expertise, resources and infrastructure and increasing the implementation of research evidence into practice.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	**Nottingham Trent University**	**University of Nottingham**
East Midlands Ambulance Service NHS Trust	**Nottingham University Hospitals NHS Trust**	**Primary care providers of NHS Services**
NHS Nottingham and Nottinghamshire Integrated Care Board	**Nottinghamshire County Council**	**Care homes**
Nottingham CityCare Partnership	**Nottinghamshire Healthcare NHS Foundation Trust**	**Voluntary and community sector organisations**
Nottingham City Council	**Sherwood Forest Hospitals NHS Foundation Trust**	**Commercial companies**

Organisations undertaking health and care research within our ICS

Research in our ICS *continued*

Our research infrastructure

Our research infrastructure has benefitted from significant investment from the National Institute for Health and Care Research (NIHR), charities, Research Councils, place-based funds and industry, as well as from the government, the NHS and universities. This represents a huge opportunity for all partners to use these joint major assets.

- Biodiscovery Institute
- NIHR HealthTech Research Centre in Mental Health
- The Institute of Mental Health
- NIHR HealthTech Research Centre in Rehabilitation
- Medical Technologies Innovation Facility
- Nottingham Clinical Trials Unit
- National Rehabilitation Centre
- NIHR Public Health Intervention Responsive Studies Team Light
- NIHR Nottingham Biomedical Research Centre
- NIHR School for Primary Care Research
- NIHR Nottingham Clinical Research Facility
- Sir Peter Mansfield Imaging Centre

Examples of major health and care research facilities and centres of excellence

Research and innovation support

We can also draw on the expertise available from local and regional organisations and services. These offer support along the research pathway to ensure our research has the best chance of success in its design, delivery and in its translation to use in practice.

- Centre for Healthcare Equipment and Technology Adoption
- NIHR Applied Research Collaboration East Midlands
- Health Innovation East Midlands
- NIHR Clinical Research Network East Midlands
- Medilink Midlands
- NIHR Research Support Service *(regional hub)*

Research and innovation support organisations and services

Partnerships

In addition to the expertise and infrastructure within our ICS, we have partnerships with organisations regionally and nationally which can support and enhance our local capabilities.

Our priorities

Our vision

In five years' time, our ICS will have an integrated and supportive research environment, clearly aligned with system priorities, that ensures improved outcomes and reduced health inequalities for our local population, and efficiencies for our health and care system.

The pillars of our research strategy

Through consultation with over 100 individuals and groups across the ICS, and informed by national and local strategies and plans related to population health and care research, we have identified four areas of priority that form the pillars of our research strategy.

Population

We will undertake research to improve the health and care outcomes and reduce the health inequalities of our local population.

Workforce

We will support our workforce to drive and deliver research in a culture where research is everyone's business.

System

We will maximise the collective capabilities and strengths of the system through collaboration and shared infrastructure.

Implementation

We will increase the implementation of research outcomes that are shown to improve health and care.

Pillar 1: **Population**

We will undertake research to improve the health and care outcomes and reduce the health inequalities of our local population.

We will

- Ensure that our local population benefits from research, by co-producing research that focuses on their health and care needs.
- Widen participation in research to involve the communities with greatest need, and across the many different health and care settings.
- Work together to prioritise and support research that focuses on preventing poor health and strengthening the building blocks of good health.

We recognise that research benefits from the involvement of patients, carers, service users and community members. We will help researchers engage effectively with these groups and with the wealth of population data, to understand their needs and co-produce studies that are meaningful to them. We will also focus on co-producing research that supports the Integrated Care Strategy and Core20Plus5 [1] priorities within our ICS.

There are significant health inequalities across our population. We recognise that those with the worst health are least likely to be involved in research studies, yet participation in research is shown to improve health outcomes and helps engage patients in their own healthcare. We will focus on widening participation in research studies, including NIHR portfolio studies, overcoming the barriers that we have identified, to enable equity of access, so that all communities can benefit from research.

Most health and care research is targeted at treating people who are already ill. We will put an emphasis on prioritising and supporting research that focuses on prevention of ill health. We will work with partners across the system, including those with responsibility for the building blocks of good health, on research to reduce or delay the need for health and care services.

How this pillar supports the Integrated Care Strategy aims and principles

The Population pillar addresses “Prevention is better than cure” and “Equity in everything” and particularly tackles the ICS aims “Improving outcomes” and “Tackling inequalities” by “Working with people and their communities”

[1] Core20PLUS5[10] is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level.

Pillar 2: **Workforce**

We will support our workforce to drive and deliver research in a culture where research is everyone's business.

We will

- Develop a research culture by growing a shared understanding by the health and care workforce of how research can improve quality and outcomes so that it can be embedded in care.
- Build the capacity and capability of the workforce to participate in research, providing equitable and inclusive opportunities to include research as an integral part of working life.
- Develop research-involvement career pathways in all professions to support staff motivation, recruitment and retention.

We know that health and care staff want to participate in research: whether that is driving research programmes as research leaders, identifying opportunities for improved care and seeking solutions, or supporting patients' participation in studies.

We recognise that only some of the workforce has the opportunity to be involved in research and that the benefits of research are not always understood. We will build a culture where research participation is encouraged at all levels, where research is visible and that successes are celebrated, however small. We will ensure we learn the lessons where things haven't worked.

In the context of operational and workload challenges, we will work with leaders to recognise research as productive time and develop the capability of the workforce through proportionate training.

Research involvement is widely acknowledged to motivate the workforce and provide an incentive for recruitment and retention. We will work with managers across all health and care settings and for all professions to identify ways that people can build research into their career.

How this pillar supports the Integrated Care Strategy aims and principles

The Workforce pillar addresses "Equity in everything" and "Integration by default" and particularly tackles "Enhance productivity and value for money" by "Supporting our workforce"

Pillar 3: **System**

We will maximise the collective capabilities and strengths of the system through collaboration and shared infrastructure.

We will

- Develop system-wide leadership and improve working practices for collaborative research that addresses system priorities.
- Create streamlined governance to overcome barriers to collaboration and to maximise use of the entire ICS research infrastructure and services.
- We will work towards a technological method to safely access and utilise patient data for research.

We know that for this strategy to be effectively delivered we need to work together so the opportunities can be realised. Our system-wide Research Leadership Group will drive a positive research culture from the top, lead the changes and develop the capacity to address our priorities.

There is a breadth and depth of capability and research infrastructure across the system. We recognise that this is not available to everyone in the system and that sometimes reaching agreement on governance issues can create barriers in delivering research. We will work together to improve the ways that we collaborate and work in an integrated way, from our resources (workforce, equipment and services) to our processes and governance, to make research more efficient and effective for all partners.

Across the system there is a wealth of data about the health of our population. Safe access to and utilisation of this data is crucial to be able to undertake the research which will lead to a healthier population. This will be met through the ICS Digital Notts delivery programme. We will bring together the different partners to develop a streamlined approach to information governance for research.

How this pillar supports the Integrated Care Strategy aims and principles

The System pillar addresses “Integration by default” and particularly tackles “Enhance productivity and value for money” by “Having the right enabling infrastructure”.

Pillar 4: **Implementation**

We will increase the implementation of research outcomes that are shown to improve health and care.

We will

- Systematically use evidence from research to inform the choices and decisions we make.
- Make it easier for the workforce to discover the findings of research and how these could be used to improve health and care outcomes.
- Enable all partners to identify shared health and care challenges to inform research priorities that will generate evidence for implementation.

While evidence from research is used to inform practice across our system, we recognise that we do not yet do this systematically. We will build the use of evidence from research into our decision making so that our population and workforce routinely benefits from the best available evidence.

To commission and deliver cost-effective services and care, decision makers and the workforce need easy access to the latest research findings and be able to identify how they can be applied to improve the health outcomes of the populations they serve. We will work with the research community to improve the communication of research so that its benefits are easier to find and understand, to maximise successful implementation.

Across the system, we understand our local population health and care challenges through our data and our workforce who may have ideas about how to meet these challenges through research. We will work with the research community to focus and collaborate on these priorities.

How this pillar supports the Integrated Care Strategy aims and principles

The Implementation pillar particularly tackles “Enhance productivity and value for money” through an “Evidence based approach, whilst encouraging innovation” and a “Focus on outcomes and impact to ensure we’re making a difference”.

Next steps

This strategy sets out our system's priorities for the next five years. We recognise the current operational and financial pressures that the system is under and we are mindful that any plans to deliver this ambitious strategy will exist within this difficult context.

But it is important that we make progress and continue to deliver the strategy throughout the five years, especially as research can help resolve some of the pressing issues.

We are not starting from scratch. Many of the partners in our system have their own research strategies and there is a wealth of activity already happening, with excellent examples of best practice which can be shared between our partners. The extensive consultations that took place in the development of the strategy highlighted the enthusiasm and willingness of many people to share their knowledge and support the other organisations in our system.

There are also conversations in national bodies for different professional groups and strategies for national priorities which focus on many of the same issues as our pillars. We will harness the activities that are taking place in these national organisations and seek to identify how these can be implemented locally.

In recognising the value of working as a system to achieve our research goals, we have also received many ideas and suggestions for how we should work better together and what plans we could put in place.

An operational plan is now in development and activities will be prioritised in discussion with system partners.

Thank you to everyone who gave their time to contribute to the development of this strategy.

References

The following publications informed the development of this strategy:

Local strategies and plans

1. Nottingham and Nottinghamshire Integrated Care System Integrated Care Strategy 2023-27
2. Nottingham and Nottinghamshire NHS Joint Forward Plan 2023-27
3. Digital Notts Strategy 2023-28

National strategies and plans

4. Saving and Improving Lives: The Future of UK Clinical Research Delivery - GOV.UK
5. NIHR Best Research for Best Health: The Next Chapter June 2021
6. NHS England: Maximising the benefits of research: Guidance for integrated care systems
7. NHS Long term plan
8. A plan for digital health and social care - GOV.UK
9. Commercial clinical trials in the UK: the Lord O'Shaughnessy review - final report - GOV.UK
10. NHS England - Core20PLUS5 – an approach to reducing healthcare inequalities

Strategies and plans for workforce and settings

11. NIHR Clinical Research Network Primary Care Strategy 2022
12. NHS England Making research matter: Chief Nursing Officer for England's strategic plan for research 2021
13. Royal College of Nursing Research Strategy 2024-27
14. NHS England: Chief Midwifery Officer for England's strategic plan for research 2023
15. NHS Health Education England: Allied Health Professions' Research and Innovation Strategy for England 2022
16. NHS Long Term Workforce Plan
17. Report of a UK survey of pharmacy professionals' involvement in research
18. Research Strategy 2020-2025 - College of Optometrists
19. NHS England: Centre for Advancing Practice Multi-professional Practice-based Research Capabilities Framework 2024

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	11/07/2024
Paper Title:	**Working with People and Communities Annual Report**
Paper Reference:	ICB 24 031
Report Author:	Alex Ball, Director of Communications and Engagement Prema Nirgude, Head of Insights and Engagement Dave Bradley, Strategic Quality and Transformation Manager
Executive Lead:	Amanda Sullivan, Chief Executive Rosa Waddingham, Director of Nursing
Presenter:	Rosa Waddingham, Director of Nursing Prema Nirgude, Head of Insights and Engagement

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

Summary:

NHS commissioning organisations have a legal duty under the NHS Act 2006 to 'make arrangements' to secure that individuals to whom services are being or may be provided and their carers/representatives are involved when commissioning services for NHS patients. For ICBs, this duty is outlined in section 14Z45 of the NHS Act 2006.

To fulfil the public involvement duty, the arrangements must provide for the public to be involved in:

a) the planning of services
b) the development and consideration of proposals for changes which, if implemented, would have an impact on the manner or range of services, and
c) decisions which, when implemented, would have such an impact.

On 14 February 2023, NHS England published guidance[1] on how ICBs should describe their work with people and communities in the context of discharging their public involvement legal duties. No updated guidance has been published since.

The guidance states the following content should typically be included in an ICB Working with People and Communities Annual Report:

a) Governance and assurance information.
b) Demonstration of how the ICB's strategy on working with people and communities is being put into practice.
c) An illustration of how insight and data have been used by the ICB to inform its work with people and communities.
d) Evidence that equality and inclusion principles were considered when working with diverse communities.
e) Demonstration of how the ICB has worked with partner organisations.
f) Sharing learning and good practice examples.
g) Communications, social media and marketing.
h) Future planning.

[1] NHS England » ICB annual reports and working with people and communities: Guidance

Summary:
The content of the Nottingham and Nottinghamshire ICB Working with People and Communities Annual Report is aligned with the guidance from NHS England. Given the wide range of requirements to include in the Annual Report, Nottingham and Nottinghamshire ICB includes a brief synopsis of how the legal public involvement duty has been discharged in the ICB's main Annual Report and Accounts, with a link to the Working with People and Communities Annual Report. The Nottingham and Nottinghamshire ICB Working with People and Communities Annual Report aims to provide assurance on how the ICB has discharged its legal duties on public involvement and consultation, setting out the ways that we have worked with people and communities from 1 April 2023 to 31 March 2024.

Recommendation(s):
The ICB Board is asked to **receive** the 2023/24 Working with People and Communities Annual Report.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	Our approach to Working with People and Communities 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:
Appendix 1: Working with People and Communities Annual Report

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 4: Citizen Voice – Failure to effectively work in partnership with citizens and communities.

Report Previously Received By:
Strategic Planning and Integration Committee endorsed the report at its meeting on 6 June 2024.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Appendix 1

NHS
Nottingham and Nottinghamshire

Working with People and Communities

Annual Report

April 2023 – March 2024

Nottingham and Nottinghamshire Integrated Care Board

Table of Contents

1 Foreword

As we reflect on the past year, we are proud to present our second *Working with People and Communities Annual Report*, highlighting the progress and achievements of NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) in this important area. We have built on the foundations established last year, enhancing our ability to listen to our population and ensuring that health and care services are delivered in a way that meets their needs.

July 2023 marked the 75th anniversary of the NHS, a milestone that reminds us of the enduring commitment to health and care that underpins our work. The needs and aspirations of the population today are transformed from those at the NHS's establishment in 1948 and so it is more vital than ever that we listen and hear from our population to ensure that the services we deliver meet their expectations.

We have made significant strides towards listening to and working with our population in an integrated way, aiming to achieve the best possible health and care outcomes for all 1.1 million citizens of Nottingham and Nottinghamshire.

As set out in our Strategy for Working with People and Communities, we have continued our focus on both Citizen Intelligence and Coproduction – joining up our work where appropriate but respecting the differences between those two disciplines. By expanding our Voluntary, Community and Social Enterprise (VCSE) Alliance and the Engagement Practitioners Forum we have enhanced our methods for gathering citizen intelligence and insights. These efforts further strengthen our relationships with local partners, organisations, and citizens.

The full report includes detailed accounts of our various projects and activities. The report highlights several key initiatives have significantly enhanced our understanding of how people and communities interact with our health and care services, enabling us to improve them for the future.

Your comments on how we can do even better in achieving and feeding back on our work are always welcome. We look forward to hearing your thoughts and hope you find this report impactful and inspiring.

Please get in touch using the contact details included in this report.

Alex Ball

Director of Communications and Engagement

This report highlights our duty as an Integrated Care Board to engage honestly and openly with the citizens of Nottingham and Nottinghamshire to help us shape and commission services together.

It also recognises the value we place on actively listening to everyone’s shared experiences and perspectives, that then allows us to create something tangible together. We know through the initiatives outlined within this report that what results is much more creative and far richer than taking any single approach or opinion. Then we develop the best conditions for designing services that are effective, efficient, accessible and improve experiences.

Coproduction must be how we approach every element of our work - service redesign, transformational change and patient safety. Coproduction must become the way we work together as partners across our system, listening to respecting and acting upon the voices of people with lived experience, service users, our population, and professionals.

We welcome your feedback and invite you to engage in continuous discussions, for ways for us to improve.

Rosa Waddingham

Chief Nurse

2 Introduction

2.1 About us

NHS Nottingham and Nottinghamshire Integrated Care Board is responsible for commissioning (planning and buying) healthcare services that meet the needs of local people. To do this well we have to ensure the voice of our citizens is at the heart of what we do, so that we can understand the health problems that affect people living in Nottingham and Nottinghamshire, and commission services that will deliver the most benefit to these populations.

The ICB also has a 'convening' role for the Nottingham and Nottinghamshire Integrated Care System (ICS), to support the collaborative and joint working of all partners within the ICS. This means working jointly with partners including the Local Authorities, the Voluntary, Community and Social Enterprise sector, and other anchor institutions within our area, to deliver on the ICS's strategic ambitions. Consequently, whilst much of the work described in this report relates to the work of the ICB, it also has a bearing on – and relevance to – the wider work of the ICS.

We serve a population of just over 1.1m people, covering urban and rural areas. We have some of the country's most deprived communities, and there are significant health inequalities between our most affluent and most deprived areas.

Our goal is to ensure that everyone living in Nottingham and Nottinghamshire has the best possible health and wellbeing they can. To achieve this, we work alongside our partners and our communities to provide people with access to quality healthcare, as well as reducing the health inequalities that exist today.

2.2 Our statutory duties

The main duties on NHS bodies to make arrangements to involve the public are set out in Section 14Z45 of the National Health Services Act 2006, as amended by the Health and Care Act 2022:

"The integrated care board must make arrangements to secure that individuals to whom the services are being or may be provided, and their carers and representatives (if any), are involved (whether by being consulted or provided with information or in other ways):

a) in the planning of the commissioning arrangements by the integrated care board,
b) in the development and consideration of proposals by the integrated care board for changes in the commissioning arrangements where the implementation of the proposals would have an impact on:
   - *the manner in which the services are delivered to the individuals (at the point when the service is received by them), or*
   - *the range of health services available to them, and*

c) *in decisions of the integrated care board affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact."*

The ICB requires assurance that the legal duties for public involvement are being delivered effectively, and that the Working with People and Communities Strategy is being delivered in line with statutory guidance[1].

The report covers our activity for the period 1 April 2023 – 31 March 2024.

[1] NHS England » Guidance on working with people and communities

3 Our commitment to working with people and communities

The ICB is committed to putting people at the heart of all that we do by consistently listening to, involving, and collectively acting on, the experience and aspirations of local people and their communities. This is clearly set out in our Constitution and supported by our Public Involvement and Engagement Policy which describes the ICB's approach to ensure public involvement and engagement in the development, implementation, and review of health and care policies and services across the statutory organisation.

The two system-wide strategies for citizen intelligence and coproduction forms our collective system approach to working with people and communities. The Director of Communications and Engagement and Chief Nurse jointly lead on the two elements of our overall and the importance which is placed upon this work is underlined by the fact that both of these roles report directly to the Chief Executive.

One of the ICB's Board Committees (Strategic Planning and Integration (SPI) Committee) has responsibility for scrutinising arrangements for public involvement and consultation in line with the ICB's statutory responsibilities. This includes overseeing the development and delivery of the ICB's Working with People and Communities Strategy, ensuring the diversity of the population is effectively considered, including those who experience the greatest health inequalities as well as reviewing and scrutinising how people's voices and experiences across providers and partners are coordinated and heard. The SPI Committee regularly reports to the Board on progress on this work.

3.1 Overview

Our Strategy for Working with People and Communities is formed of two key elements, that are closely aligned and complementary but are different disciplines with different techniques and arrangements:

- Citizen Intelligence[2]. A process of actively listening to citizens to understand their experiences of health and care services to enable a focus on areas that need improvement or changes. An ongoing cycle of activities that generate genuine citizen insights to guide the work of transformation and commissioning.
- Coproduction[3]. A way of working that includes people who use health and care services, carers, and communities in equal partnership; and which does this at the earliest (and all) stages of service design, development, and evaluation.

This is underpinned by our Public Involvement and Engagement Policy[4].

3.2 Our principles

The principles that guide the work of Nottingham and Nottinghamshire are based on the ten principles set out by NHS England:

1. We will work with, and put the needs of, our citizens at the heart of the ICS.
2. We will prioritise reaching out to those communities affected by inequalities who are less likely to be heard.
3. We will use community development approaches that empower people and communities, making connections to social action.

[2] Working with people and communities strategy (healthandcarenotts.co.uk)
[3] Nottingham and Nottinghamshire ICB Coproduction Strategy 2022 to 2024
[4] https://notts.icb.nhs.uk/wp-content/uploads/sites/2/2022/04/ENG-001-Public-Involvement-and-Engagement-Policy-v1.2.pdf

4. We will work with Healthwatch and the voluntary, community and social enterprise sector as key transformation partners.
5. We will redesign models of care and progress system priorities in partnership with staff, people who use health, care and support services and unpaid carers.
6. We will understand our community's experience and aspirations for health and care.
7. We will systematically capture and report community intelligence that includes findings drawn from a citizen's panel, VCS partners, statutory sector partners and networks at Place and neighbourhood level.
8. We will use insight gathered through a range of engagement approaches to inform decision-making.
9. We will develop a culture that enables good quality community engagement to be embedded.
10. We will systematically provide clear and accessible public information about vision, plans, progress and outcomes to build understanding and trust amongst our citizens.

The work outlined in this report is aligned to these principles.

3.3 Citizen Intelligence

Our framework for generating qualitative and quantitative citizen intelligence involves a number of mechanisms of equal value, ensuring we are fully inclusive and have a strong focus on health inequalities, enabling the involvement of people and communities. For example:

- We scope and review existing research, data, and evidence to ensure we are maximising what we know and identifying gaps in our knowledge.
- Our targeted engagement work helps us to bridge the gap in our understanding of people and communities' health and care needs and aspirations. Some examples include the work that we've done on the Integrated Care Strategy and Tomorrow's NUH.
- We meet regularly with our Health Scrutiny Chairs, MPs and Councillors which helps us hear the concerns and aspirations of communities in a systematic way.
- We work closely with our Place Based Partnerships to understand trends based on geography and to understand who uses services, what views we have already heard, which voices may be missing and how to reach those groups.
- Our Voluntary, Community and Social Enterprise (VCSE) Alliance and other forums outlined in this report allow us to hear from those who are experiencing the greatest health inequalities.
- We use forums like the ICS Partners Assembly to hear directly from our citizens and their representatives and feed these insights into our Integrated Care Partnership.
- We use appropriate routes to reach our population, including our Citizen Panel, targeted surveys, public meetings, social media and the traditional media – following a principle of 'going to where people are' rather than expecting them to come to us.
- We also operate on an open and collaborative basis, sharing and disseminating our findings and those of other partners organisations.

3.4 Coproduction

The ICB is committed to embedding coproduction into all elements of system design and delivery, including commissioning activity, transformation, and improvement; and to empower and enable both professionals and people with lived experience to work alongside each other in a meaningful way.

Coproduction and co-design have been incorporated within the ICB System Quality Framework which is guiding Nottingham and Nottinghamshire system partners across health and social care to align and develop a single approach to quality through a single quality framework. This will enable priorities and strategies within individual partners to be aligned in a way that is meaningful for the Nottingham and Nottinghamshire populations.

Our coproduction approach is strengthened through the connections and relationships built with our local health, local authority, voluntary sector partners and people with lived experience enables best practice and system experience to be the foundation of the way we work in partnership.

During 2023/24, the ICB coproduction activity was focused on building the initial infrastructure and resources needed to enable and empower teams to reflect on how they can bring a coproduction approach into their existing involvement approaches, working to develop an effective and impactful routine approach to coproduction in the ICB in alignment with the wider system.

4 Governance and assurance

This section describes the structures and processes that support working with people and communities, including the responsible leads, and how working with people and communities happens at different layers across the Nottingham and Nottinghamshire system.

4.1 Nottingham and Nottinghamshire ICB arrangements

Progress on the delivery of the Working with People and Communities strategy is formally reported to the ICB Board through our SPI Committee. The Working with People and Communities Annual Report will be presented to the ICB Board in July 2024.

The roles and responsibilities of different governance structures that support working with people and communities, including responsible leads can be found below:

Role	Responsibility
ICB Board	The ICB Board has overall accountability for public involvement and engagement, including the Working with People and Communities Strategy. They also have responsibility for ensuring that the views of the public are appropriately considered in decision making.
Strategic Planning and Integration Committee	The Strategic Planning and Integration Committee is responsible for assuring the ICB Board in regard to its statutory duties for patient and public involvement.
Director of Communications and Engagement Chief Nurse	The Director of Communications and Chief Nurse have joint responsibility for sponsoring the ongoing development and implementation of the Working with People and Communities Strategy. They also oversee the teams that supports the organisation in its duties and ambitions to work with and hear from people and communities.

4.2 Coordinating how we listen to people and communities

4.2.1 Citizen Intelligence Advisory Group (CIAG)

The CIAG ensures that all proposals to change and improve healthcare services in Nottingham and Nottinghamshire are developed with appropriate and sufficient citizen and

service user involvement and citizen intelligence and insights from patients, staff, carers, and public that tell us what matters to them influence decision making.

The membership of the group consists of experts in the fields of research, insight, and engagement working across the system. All four Places have a representative to bring local perspective and challenge to the discussion.

4.2.2 ICS Engagement Practitioners Forum

The ICS Engagement Practitioners Forum is a platform for all system partners working with people and communities to work collaboratively, share resources, knowledge and expertise and maximise existing citizen insight.

Since its inception, the membership of the Forum has expanded, bringing together representatives from over 35 organisations across our ICS (see Appendix 1). This includes health and care colleagues, Local Authority officers, VCSE organisations, Office of the Police Crime and Commissioner, NHS Trusts, and Healthwatch Nottingham and Nottinghamshire. More recently the Lead Governors from Nottinghamshire Healthcare Foundation Trust, Sherwood Forest Hospitals Trust, and Doncaster and Bassetlaw Hospitals Trust have also joined the forum, further strengthening how we hear the needs of local people and communities.

Over the last twelve months, members have focussed on sharing and triangulating citizen insight. This supported the development of a wider Citizen Insight report, which was shared with the Nottingham and Nottinghamshire Integrated Care Partnership in October 2023. Members have further supported the generation of citizen insight by facilitating discussions at the ICS Partners Assembly.

An NHS Futures Platform Space has been developed by the ICB Engagement Team to support members of the Engagement Practitioners Forum to share ideas and information outside of the scheduled two-monthly meetings.

4.2.3 Voluntary, Community and Social Enterprise (VCSE) Alliance

Nottingham and Nottinghamshire's Voluntary, Community, and Social Enterprise (VCSE) sector plays a crucial role in the ICB’s approach to working with people and communities. The VCSE Alliance, now fully integrated into strategic decision-making processes, has 102 members, representing a 57% increase since 2022/23. To date, we have representation from 69 different organisations. This includes representation from both the ‘umbrella’ CVS organisations, who support the small and medium sized members of the sector, and also larger regional and national organisations such as Canal and River Trust, Dementia UK, NSPCC, Parkinson’s UK, SHE UK and Sustrans (see Appendix 2).

The Alliance is establishing itself as an integral part of the way that the system works – acting as a sounding board, a voice for marginalised communities, and a source of new ideas and initiatives.

In April 2023, Professor Daniel King was appointed as Chair of the VCSE. The Chair of the Alliance is a formal member of the Nottingham and Nottinghamshire ICP and is an advisory member to the ICB Board, further underlining the importance that is being placed on working with this sector through these connections into the formal governance meetings of the system.

Over the last 12 months, there has been a focus on ensuring that all VCSE Alliance members have a clear understanding of the local health and care landscape. In response to this, a range of resources have been developed, including a dedicated webpage[5], glossary of terms, and introductory videos to support current and future members. In February 2024, the VCSE Alliance received the first presentation in a rolling series to learn from other local systems and how their VCSE Alliances are operating. Tailored resources will continue to be produced based on the specific needs of members.

The Alliance's activities in 2023/24 have included supporting the Integrated Care Strategy's development, securing funding from NHS England to map and develop a Research Engagement Network across Nottingham and Nottinghamshire and developing an insights and intelligence framework (see section 6.1.2).

The VCSE Alliance has continued to evolve since its inception in July 2022. The work carried out by the VCSE Alliance and sector is fully aligned to the principles and aims within the Integrated Care Strategy. Positive impacts of the VCSE Alliance include enabling community voices to influence strategies, raising the profile of the sector, and providing a dedicated space for collaboration.

4.2.4 ICB Strategic Coproduction Group

The Strategic Coproduction Group was launched in 2023, representing a fresh initiative for the ICB. It was recognised that there would be challenges in establishing the group but doing so it would be of great benefit for the organisation.

Membership of the group included people with lived experience who had an interest or past experience in taking part in coproduction across the system, and Officers leading on coproduction working in system partner organisations.

Members of the Strategic Coproduction Group brought valuable insights from their experiences with project coproduction in various organisations as well as huge learnings in the challenges in developing an authentic and honest relationship between lived experience members with professionals and partners across our system.

The constructive challenge of how the group formed, its purpose and function allowed us the opportunity to reflect and develop our course. This constructive criticism has been instrumental in helping us refine and expand our coproduction efforts.

We absolutely recognise the value that Strategic Coproduction brings to our System and are committed to ensuring its role in supporting the embedding of coproduction.

During 2024, we will engage and listen to what our population, lived experienced representatives and system partners tell us about their views, ideas and challenges for Strategic Coproduction. These themes will then be used to shape a reset of the Strategic Coproduction Group.

4.2.5 ICB Coproduction Network

The development of a new coproduction network has been ongoing during 2023/24. The Network is a further pillar that creates a partnership to provide knowledge, tools and peer support for all system professionals who are engaged in coproduction. This is to continue to build the momentum to embed coproduction across our system.

[5] Voluntary, Community and Social Enterprise (VCSE) Alliance - NHS Nottingham and Nottinghamshire ICS - NHS Nottingham and Nottinghamshire ICS (healthandcarenotts.co.uk)

The aims for the network are to:

- Encompass a wide-ranging membership, open to anyone across the system.
- Create a network virtual space to share insight and approaches about coproduction, maximising the spread of best practice and avoiding duplication.

Refining the focus on system requirements pertaining to coproduction, along with broader discussions on coproduction methodologies involving system partners, colleagues, and individuals with lived experiences, has pinpointed a distinct purpose for the network. This purpose revolves around fostering relationships and facilitating the exchange of information regarding coproduction, thereby linking individuals interested in collaborative production with ongoing coproduction initiatives.

Whilst this is being developed the Coproduction Newsletter acts as a method of showcasing and sharing coproduction activity and the Coproduction Directory of Teams enables people to be able to reach out to other people who are coproducing to seek direct insight and advice.

4.2.6 ICS Partners Assembly

The ICB coordinates on behalf of the system a twice-a-year public conference which we call the Partners Assembly. This attracts more than a hundred voluntary sector leaders, patient and citizen representatives, civic partners, and others. The Assembly has been used to explore topics and approach for the system's Integrated Care Strategy and also the ICB's Joint Forward Plan. Reports and fundings from the Assembly are shared widely, including to the Integrated Care Partnership and the ICS Reference Group. Further details about the work of the ICS Partners Assembly can be found in section 6.1.

5 Putting our Working with People and Communities Strategy into practice

This section describes some of the key work programmes that has taken place in partnership with people and communities.

5.1 Citizen intelligence (Neighbourhood): Patient Participation Groups

The ICB Engagement Team remains committed to supporting Patient Participation Groups (PPGs), emphasising the valuable contributions they offer to GP Practices. To do this, we have:

- Developed and produced a toolkit[6], in partnership with Mid-Nottinghamshire VCSE infrastructure organisations, to share with GP Practices to grow and enhance their PPGs.
- Delivered a presentation to Practice Managers via the Local Medical Committee, showcasing the benefits of PPGs and to offer further support as needed.
- Had conversations with Practice Managers and GP Practices, supporting them to continue to evolve their PPGs.
- Attended a PPG Awayday with Belvoir PPGs in May 2023 to share information about the wider engagement structures of the ICS and ICB and how the work of PPGs feeds into our wider approach for working with people and communities.

5.2 Citizen intelligence (Place): Newark Urgent Treatment Centre listening exercise

Newark Hospital's Urgent Treatment Centre (UTC) is currently open between 9.00am-10.00pm. These opening hours had been in place on a temporary basis since March 2020,

[6] PPG Resource Pack - Updated July 2023 (icb.nhs.uk)

when the impact of the Covid-19 pandemic exacerbated existing issues with safely and sustainably staffing the Centre.

Between 4 September and 17 October 2023, a listening exercise commenced to gather people's views on Newark Hospital's UTC opening hours, and the wider Out of Hours Urgent Care services in the area. A range of different engagement methods were used to engage with patients, staff, and the public to understand their views. In total, 1,932 individuals participated by either completing an online survey, paper survey, attending public meetings, attending an engagement event/focus group, and/or providing a response to the promotion of the engagement on social media. After closing the engagement activity, the gathered data were analysed and an engagement report[7] was produced demonstrating the full findings of the listening exercise and presenting a number of evidence-based recommendations.

In November 2023, an options appraisal exercise took place across two half-days which was attended by a number of system partners. The full list of proposed options presented for consideration were drawn from the evidence supporting the Case for Change and feedback from the listening exercise.

In March 2024, the ICB Board met and approved the future opening hours of the Newark UTC. The UTC will open between 8am – 10.30pm (last patient admitted at 9.30pm) seven days a week, offering an extended window for patients to access essential healthcare services.

It was clear that throughout the process of developing a long-list, short-list and preferred option for the future opening hours of the UTC, the ICB carefully considered the feedback from the listening exercise and responded to the local population's preferences for their health services.

The listening exercise activities which have supported the development of the insights and report into the options appraisal decision making process have been supported by the pre-existing Citizen Intelligence arrangements and in turn have further developed and enhanced those arrangements. This includes:

a. Through previous activity to work more closely with Governors of the Foundation Trusts, the ICB was able to secure the detailed input from one of Sherwood Forest Hospitals NHS Foundation Trust's (SFH) Governors into the Option Appraisal Process.
b. Prior to commencing the listening exercise, monthly informal meetings took place with the Chair of Nottinghamshire Health Scrutiny Committee to discuss the approach and methods. They shared their local insights, advising on accessible community locations with good public transport links and parking to hold face-to-face public meetings. They also shared various contacts to allow further engagement to take place with key community groups who may access the UTC.
c. Alongside the informal conversations with the Chair of Nottinghamshire Health Scrutiny Committee, we have also continued to lead the formal process of involvement with Nottinghamshire Health Scrutiny Committee. These two-way discussions have allowed us to hear the concerns of Newark citizens in a systematic way,

[7] Newark Urgent Treatment Centre report V6 - English (icb.nhs.uk)

d. The ICB Engagement Team has been able to strengthen existing relationship with system partners and community groups. During the listening exercise we worked closely with Maternity Voices Partnerships, local dementia groups, children centres and Newark and Sherwood District Council. We worked in partnership with the Volunteering Team at SFH who supported in handing out surveys and returning these to us.
e. New relationships have been developed with groups in and around the Newark and Sherwood Area, including Newark and Southwell Rotary Club, churches, children's play groups and mental health support groups.
f. The ICB Engagement Team, working with the Engagement Practitioners Forum, is considering how we continue to engage and involve the local communities in Newark and the surrounding area, with a specific focus on working with children and young people on how they access health services. This may include expansion of the Citizens Panel to Mid-Nottinghamshire.

5.3 Citizen Intelligence (System): Policy alignment - Female sterilisation

On 1 July 2022, the two clinical commissioning groups (CCGs), Bassetlaw CCG and Nottingham and Nottinghamshire CCG merged to form NHS Nottingham and Nottinghamshire Integrated Care Board (ICB). Efforts have been made to harmonise policies for equal healthcare access.

While most policies were integrated without changes, a disparity existed within the Access to Female Sterilisation policy. The former Bassetlaw CCG had no specific rules for approving this procedure, whereas the former Nottingham and Nottinghamshire CCG required patients to try an Intrauterine Device (IUD) (e.g., a Mirena coil) for one year before considering sterilisation. National Institute for Clinical Excellence guidance[8] encourages patients to consider all possibilities for long-acting reversible contraception (LARC) prior to being referred for permanent sterilisation.

The removal of the mandatory IUD trial could potentially benefit patients in specific diverse communities who do not believe in, or hold reservations about, the use of IUDs. Moreover, survivors of sexual abuse and trauma (such as Female Genital Mutilation) might consider the utilisation of an IUD to be invasive and unsuitable. In addition, increasing the choice and accessibility of LARC and sterilisation services could play a role in reducing unwanted pregnancies or the need for terminations arising from unwanted pregnancies.

To address the disparity between the policies and align with national guidance, a recommendation was made to remove the mandatory trial period and instead propose that patients "explore all suitable contraceptive options before considering sterilisation."

On 5 July 2023 the ICB launched an online survey to obtain feedback and comments around the proposed change to the female sterilisation policy. We specifically wanted to hear from patients who would have an interest in this policy change. Therefore, it was disseminated to relevant groups such as the Maternity and Neonatal Voices Partnership, SHE UK, Heya and Nottingham Women's Centre amongst others.

[8] Scenario: Female sterilization (tubal occlusion) | Management | Contraception - sterilization | CKS | NICE

The majority of survey respondents supported the change to the sterilisation policy, mostly citing support due to bodily autonomy and patient choice therefore the main recommendation was to remove the requirement for patients to trial the IUD for 12 months.

Many noted that it is vital there is sufficient high-quality and timely information regarding contraception and sterilisation so that patients and clinicians can be confident they are making an informed choice. Therefore, it is vital to ensure that there is appropriate information and advice for patients exploring this treatment. Both recommendations were implemented in the new policy from 1 November 2023.

5.4 Citizen Intelligence (System): Wheelchair Services across Nottingham and Nottinghamshire

The Community Care Transformation Team approached the ICB Engagement Team, requesting support, guidance, and advice for reviewing services offered to wheelchair users across Nottingham and Nottinghamshire. The ICB Engagement Team assisted in gathering feedback from patients, citizens, and professionals to identify areas for improvement and highlight what is already working well.

Two online surveys were produced: one for patients, citizens and carers and a separate one for professionals. Two online focus groups took place, together with site visits to the current providers to understand more about the current service offer through conversations with staff.

Findings and recommendations aligned with the following themes:

• Efficiency of wheelchair services • Personalised care • Positive attitude and capability of staff • Consistency of servicing, maintenance, and assessments • Accessibility of wheelchair services	• Inequity of wheelchair services • Information sharing and education about wheelchair services • Integration of wheelchair services within the wider Nottingham and Nottinghamshire system.

The insights gathered are currently being collated and will form the basis of a number of recommendations to inform how the service is designed and delivered in the future.

5.5 Coproduction (System): Home Births Listening Event

The Coproduction Team facilitated a Home Births Listening Event for Nottingham University Hospitals NHS Trust (NUH) in July 2023, organised in response to a request from a parent who had attended a previous event. They wanted a chance to speak with the NUH Maternity Leadership Team in a safe space and share how the inability of NUH to accommodate their preferred birth setting had affected them.

Attendees of the Listening Event included the Nottingham Home Births Group, any parents and families who had chosen to have a home birth, and people who had chosen to have a home birth but were unable to. The event offered different ways for people to share their experiences, including one to one meetings with senior leaders and creative ways of sharing their feelings including written reflections, drawing and poetry.

The insight and experience captured during this event is being used to inform the development of a new home birth service and the recruitment of a dedicated team.

5.6 Citizen Intelligence (System): Winter survey

In October 2023, Nottingham and Nottinghamshire ICB launched its winter survey to understand how the public are using health services in the area. The responses from 415 individuals showed that:

- There is a good understanding of local healthcare services and people broadly know which services to use for the need that they have.
- People are mainly using NHS 111 and Urgent Treatment Centres (UTCs) for urgent but non-emergency conditions and using GP services to check and discuss symptoms they have.
- 61% who used the UTC rated their experience 3.7 out 5 (5 = excellent, 1 = poor).
- People are now aware of the wide range of illness and conditions that can be treated in pharmacies, and they are happy with the services provided to them there.
- About 90% were aware that NHS 111 can offer advice and guidance on where to go for treatment and even booking them an appointment if needed.
- While 79% said they know which NHS service to use if they needed help, 35% felt that the NHS services available in Nottingham and Nottinghamshire will be able to treat them/their family at the right time if help is needed. It is recognised that public perception and trust may have been influenced by ongoing industrial action throughout 2023/24 and also whilst the survey was live.

The survey findings informed the delivery of the 2023/24 Winter Communications Campaign and established a baseline for future surveys. Conducting this survey annually will help identify trends and changes over time.

5.7 Coproduction (System): Personalised Care

Personalised care represents a new relationship between people, professionals and the health and care system. It provides a positive shift in power and decision making that enables people to have a voice, to be heard and be connected to each other and their communities. The Universal Personalised Care Model[9] tells us how and what we need to do to deliver this shift by bringing together six, evidence-based components.

Coproduction is a key enabler to scaling up personalised care. My Life Choices[10] have the knowledge skills and confidence to work in partnership with the system to embed it, ensuring we focus on ‘what matters to people’.

Some members get involved in national work, contributing to various groups and committees, and bringing the skills, knowledge and experiences developed My Life Choices and our local work:

- NHS Assembly, contributing to the NHS in England at 75 Priorities for the Future report.
- NHSE group embedding coproduction as default for quality improvement.
- NHSE working in partnership with people and communities coproduction group.
- NHSE Primary Care and Community Health Services strategic co-production group.

[9] NHS England » Universal Personalised Care: Implementing the Comprehensive Model
[10] My Life Choices - NHS Nottingham and Nottinghamshire ICB

- Lived Experience Partners and Coach / Mentors within the Voices for Improvement Programme of National Voices.

Some members have also worked with system partners on key workstreams:

- Working with Nottinghamshire County Council, Nottingham City Council, NHS Nottingham and Nottinghamshire ICB to co-produce the Joint Carers Strategy 2023 – 28.
- Involvement in the review of jointly funded integrated personal budgets working in partnership to develop a strategy, framework, and process.
- Working in partnership with the Medicines team to develop over 42 self-care meds leaflets, along with being part of a personalised care weight management and health inequalities project.

6 How we've used insight and data

This section describes some examples of how we've used different sources of insight (aligned to our Citizen Intelligence framework) to understand people's needs and inform decision making.

6.1 Developing the NHS Joint Forward Plan and refreshing our Integrated Care Strategy

The Nottingham and Nottinghamshire Integrated Care Partnership (ICP) has developed an Integrated Care Strategy[11] to improve health and care outcomes and experiences for local people (2023 – 2027). The Strategy has been developed for the whole population using the best available evidence and data, covering health and social care, and addressing the wider determinants of health and wellbeing. In addition to developing the Strategy, the ICP is also responsible of overseeing the implementation of the Strategy and its refreshing. To support the annual refresh of the Strategy and to ensure ongoing consideration of the needs of people and communities, the ICP:

a) Engages with a wider assembly of partners, at least once a year, comprising people who rely on care and support, unpaid carers, the full range of social care and NHS providers, the voluntary and community sector, and local professional committees.
b) Will also receive reports on insights gained from service users and citizens.

Each NHS organisation in the country was required to produce an NHS Joint Forward Plan following the creation of their system's Integrated Care Strategy. The Joint Forward Plan sets out the organisation's contribution to the delivery of the Integrated Care Strategy.

6.1.1 Involving partners

One approach for the ICP to engage with the wider assembly partners is via the ICS Partners Assembly. The ICS Partners Assembly is a bi-annual gathering of organisations and individuals who have an influence and interest in the health and care of the region's population.

The second ICS Partners Assembly was held in May 2023 and attended by 113 system stakeholders, carers, service users, patients, and citizens. This Assembly aimed on involving

[11] https://healthandcarenotts.co.uk/wp-content/uploads/2021/05/Integrated-Care-Strategy-2023_27.pdf

citizens in the development of the NHS Joint Forward Plan for Nottingham and Nottinghamshire and help with refreshing the Strategy.

The overarching themes from the insight at the ICS Partners Assembly can be broken down into eight key areas:

1. Integration and collaboration
2. Community engagement and empowerment
3. Effective communication and information exchange
4. Prevention and focus on wider determinants of health
5. Resource allocation and funding coordination
6. Person-centred care
7. Workforce development as a system
8. Utilising existing knowledge and learning

This Partners Assembly has enabled our citizens to be involved in creating the Joint Forward Plan, made their voice heard, and strengthened the trust between the system, staff working within the system, and people and communities:

"I found the Partners Assembly really useful in terms of the opportunity to network with people from across the system, particularly patient reps and frontline colleagues who I wouldn't necessarily come into contact with in my day to day working life. It's great to be able to get together face to face and have those conversations and get perspectives from across the system, and see where the work we do in the ICB has an impact in the health and care system."

In addition to the Partners Assembly, between May and June 2023, targeted meetings with the VCSE Alliance and Citizen Intelligence Advisory Group took place complemented by a survey which gathered 168 responses. In total, just over 300 people were involved in the development of the NHS Joint Forward Plan and refresh of the Integrated Care Strategy.

6.1.2 Development of the Citizen Insight Report

The ICB Engagement Team produced the first Citizen Insight Report[12], which was presented to the ICP on 6 October 2023. The report included:

1. Census data, to describe what our population looks like, including a summary of population changes.
2. A summary of all recent activity involving working with people and communities across our system.
3. Deep dive on key topics to include:
    - ICS Partners Assembly (15th May 2023)
    - Frailty (VCSE Alliance led write up)
    - Race health inequalities (maternity and mental health access)
    - The impact of the cost of living crisis on people and communities

The report contained several conclusions and recommendations for discussion and, as it was the first report of its kind, feedback on how to strengthen future reports was welcomed. The Chair and members welcomed the rich collection of information contained within the report, noting the need to connect back to the feedback in the actions the system needed to take.

[12] Integrated Care Partnership insight report - English (healthandcarenotts.co.uk)

This report to the ICP demonstrates the strength of working together as a system to ensure that we have the widest possible angle lens on the needs of our population and communities. The report draws from a very diverse range of sources including existing census and public polling data, qualitative discussions and research led by the VCSE sector, service-change led engagement and much more. The report and discussion help to support the ambition for the ICP to be the "guiding mind" of the system. The production of the report also demonstrates the value of ICB colleagues acting as system coordinator and leader, acting on behalf of our whole population rather than through a narrow organisational or geographic lens.

By embedding a regular report of insights and intelligence into the "guiding mind" of the system at the appropriate points of refresh of the Integrated Care Strategy it is anticipated that this will help to deliver a citizen intelligence-led approach to the system's strategic thinking.

7 Equality and inclusion when working with our diverse communities

This section describes the principles that enable us to effectively hear from the diverse communities living in Nottingham and Nottinghamshire. It also provides some examples of how we have proactively reached out to groups who are most often excluded from (or less represented in) health services and involvement opportunities, such as people from inclusion health groups, people with a learning disability and people whose first language is not English.

7.1 Equality and inclusion principles

We tailor our engagement methods and messages according to the needs of our communities to maximise opportunities to hear from the diverse people living in Nottingham and Nottinghamshire. We make sure that our meetings and events are designed to meet the needs of individuals and communities and enhance access and participation. For example, we source British Sign Language (BSL) and language interpreters at events, provide easy read versions of documents as well as providing information in other languages.

7.2 Targeted Lung Health Check Programme

In April 2021, a Targeted Lung Health Check programme started in Mansfield and Ashfield and expanded to Nottingham City in January 2023. Under the programme, those aged 55-74, who are current smokers or have ever smoked, receive an invitation for an initial telephone lung health assessment. Following the assessment, a patient may be invited to attend one of the mobile lung health check units that are equipped with a mobile CT scanner. The aim of this programme is to identify lung cancers at an earlier stage when there is more chance of curative treatment.

To make the programme accessible to as many people and communities as possible, the mobile units are sited in different community locations within Nottingham and Nottinghamshire, and all communication materials are translated into the nine most spoken languages across Nottingham and produced in easy read format. The team works proactively to build up local knowledge of an area to identify the most convenient community locations and target specific community groups.

To gather an understanding of each Primary Care Network area the team liaise with professionals who have a deep understanding of local communities, including: Social Prescribing Link Workers, Resident Development Officers, and Community and Voluntary Service Development Workers. These conversations have supported the ICB to consolidate

understanding about the local population, areas of deprivation, languages spoken, and “tried and tested” engagement methods that will support people and communities to engage with the programme.

To directly engage with individuals, events in the local community have been attended, to share information, answer questions, and gather feedback on programme materials. This included outdoor theatre events for families, local markets, health events at culturally specific community venues, libraries, and local support groups for people living with long-term conditions. The programme is also widely promoted on local radio stations, public transport and social media channels. The team also link with GP practices, councils, charities, and faith centres to gain valuable local insight to shape the communication and engagement strategy and reduce barriers to participating. Feedback from the ICB’s Citizens Panel supported the development of the invitation letters.

More recently, the team have been working with the Severe Multiple Disadvantage Group in Nottingham to understand any barriers people with mental health difficulties, substance misuse, homelessness, and offending may have to accessing lung health checks. This includes exploring opportunities to hold a one-day drop-in clinic which would follow a more accessible process, being a drop in clinic rather than a booked telephone and scan appointment. Following a conversation with Emmanual House to understand how best to engage people experiencing homelessness, one of the barriers identified was citizens not being registered with a GP practice. In response to this, a leaflet explaining how to register with a GP was produced.

So far, over 30,000 people have been invited and over 10,000 scans performed. The programme has achieved a 74% uptake rate to the service, the highest in the country. 120 cancers have been diagnosed through the programme. 60% of these cancers have been diagnosed at an earlier stage and 70% have a curative treatment plan.

As a result of the teams’ hard work in delivering this programme, they won the ICS Health and Care Award for Health Inequalities at the System’s inaugural awards ceremony in October 2023. The award judges were impressed by the work carried out to make the lung health checks accessible to those communities who need them.

Stakeholder mapping continues to take place, together with establishing new relationships with community groups and networks. This has allowed communication to be delivered to our diverse and ethnic communities to promote this key programme of work, and the Engagement Practitioners Forum and VCSE Alliance have supported this. These two forums along with data around uptake rates continue to support the targeted engagement work on this programme.

Translated materials have been produced so that ethnic communities are able to understand what the programme is about and whether they are eligible. A translation plug in tool has also been installed to the dedicated Nottingham Lung Health Check website which allows users to translate the whole website into their preferred language.

7.3 Accessibility Working Group

This year saw the inception of a new Accessibility Working Group, born out of a shared vision among ICB colleagues. Their aim is to champion ongoing enhancements in accessibility practices, ensuring that coproduction and broader engagement materials align with local and national guidance, as well as adhere to standards such as the Accessible Information Standard, the Public Sector Equality Duty, and the Equality Act 2010. This group

serves as a resource hub, offering expertise and guidance on crafting accessible information. Membership of this group included engagement, coproduction and personalised care colleagues with experience and insight in equality, diversity and inclusion.

The group shared have shared valuable information and expertise on enhancing the accessibility of various resources, online meetings, and in-person events, consolidating this wealth of knowledge within the Coproduction Toolkit.

8 Demonstration of how the ICB has worked with partner organisations

This section describes some examples of how we have worked with partners to design services collaboratively and times when the ICB have gone to groups to listen and find out what matters to them.

8.1 Nottingham and Nottinghamshire Maternity and Neonatal Voices Partnership (MNVP)

Nottingham and Nottinghamshire MNVP is an independent team made up of women, birthing persons and their families, providers (who deliver services such as midwives and doctors), the ICB, Local Authority, representatives from public health and social care, and VCSE organisations. This section describes how the MNVP uses citizen insights to drive service improvement and how a coproduction approach is at the forefront of developing a new MNVP model.

8.1.1 Using citizen insights to improve services

Our MNVP includes a team of passionate MNVP volunteers who represent and reach out to local women, birthing persons and their families to gather feedback on their experiences.

Our local MNVP are asked to do a ‘15 steps’ visit to our hospital providers each year and report back to the system. The idea is to enable a small team of people to explore different healthcare settings through the eyes of those who use them and their relatives/carers.

In May 2023, the 15 steps visit to our local providers (Sherwood Forest Hospitals NHS Foundation Trust (SFHT) and Nottingham University Hospitals Trust (NUH) led to a number of recommendations, which have been actioned or are in progress.

- Enhance the ambiance buy purchasing artwork for the walls (NUH). Diverse art work is being chosen with MNVP input.
- Make better use of the currently underutilised noticeboards (NUH). Notice boards have been refreshed and will continue to be monitored and updated.
- Find alternative spaces for partners to make and drink and store food as the current room is being repurposed, rather than remove the option (SFH). There is now a suitable alternative for partners to store their personal refreshments.
- Ensure noticeboards display relevant and up to date information, and set up an MNVP area on the notice board (SFH). There is a notice board for MNVP updates.
- The neonatal unit needs a secure lock to be fitted to the first set of doors to the unit for safety (SFH). A request for a lock has been made.

The MNVP also gather feedback on a regular basis from maternity and neonatal service users through an online survey. This information is then analysed, themed and shared with NUH and SFH through a feedback report to take action on. Recent insights and action taken include:

- Parents are still affected by their experiences during Covid pandemic. The Trusts advised that parents are able to self-refer for a birth reflections sessions to discuss their experiences.
- Clear/accessible information for parents with additional needs, such as l learning disabilities (LD) and autism spectrum disorder (ASD), was requested. A service user review of information was agreed. It was also decided to explore the integration of maternity-related case studies into staff online training modules for LD and ASD.

8.1.2 Coproducing a new MNVP model

Hearing the voices of women and families is a requirement of NHS England's Three-Year Delivery Plan for Maternity and Neonatal Services[13]. The plan clearly sets out key responsibilities for Maternity and Neonatal Providers and ICBs are as follows:

- Involve service users in quality, governance, and coproduction when designing and planning delivery of maternity and neonatal services.
- Commission and fund MNVPs, to cover each trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
- Remunerate and support MNVP leads, and ensure that an annual, fully funded workplan is agreed and signed off by the MNVP and the ICB.
- Ensure service user representatives are members of the LMNS Board.

To meet these requirements, additional capacity and resource into the local MNVP provision was agreed. We have applied a coproduction approach to developing our new model. With a 50/50 split of professionals and service users working in collaboration, we have scoped the requirements locally for a new model, finalised role descriptors, planned governance structures and ways of working and developed our new Mission Statement 'Championing the voices of service users to improve maternity and neonatal experiences'.

We have continued our ethos of coproduction and engagement with a smaller working group being established which includes MNVP volunteers, ICB colleagues and professionals who meet on a regular basis to support the implementation of the new model.

8.2 Speech, Language and Communication Needs services for children and young people

Significant system-wide scoping and recent SEND inspections in Nottinghamshire County revealed that current service models may not be meeting local needs. During November – December 2023, the ICB Engagement Team, together with the Children and Young People's Commissioning and Transformation Team undertook targeted engagement with parents, carers and professionals, including school staff and Speech and Language Therapists (SLT).

A total of 236 parents/carers and professionals shared their views via a survey, telephone interviews, attending online focus groups or sharing feedback at community groups.

Key findings highlighted a desire for increased face to face support and closer collaboration between SLT services and schools. Challenges identified include difficulties navigating the system, long waiting times, and communication gaps. While staff were praised, overall perceptions of the service were negative.

[13] NHS England » Three year delivery plan for maternity and neonatal services

The recommendations from this report[14] will be utilised to support how speech, language and communication needs services for children and young people in Nottingham and Nottinghamshire are improved and how they are designed in the future.

8.3 Building relationships with the universities

Full-time university students constitute approximately 1 in 7 of the population of Nottingham[15], highlighting their considerable importance as a community for the ICB to engage with. In addition, a new programme was launched by the two universities, which aims to put community knowledge and experience at the core of research.

Over the course of 2023/24, we have actively pursued the establishment of new relationships with the University of Nottingham and Nottingham Trent University. This section described how we have worked with the universities to understand what is important to students and support the community-led research agenda.

8.3.1 University of Nottingham engagement events

The ICB Engagement Team have established a good relationship with Students' Union at the University of Nottingham, and were invited to four events during 2023:

- Three Open Day events in June, July and September 2023: Engaging with prospective students and their families.
- Freshers Day in September 2023: Engaging with current students, both home and international students.

Over the four events, the Engagement Team:

- Spoke to over 500 individuals about health and wellbeing services available in Nottingham and Nottinghamshire.
- Shared information about Choosing Well and how to access mental health support.
- Responded to enquires around health and wellbeing services available at the University, including the services offered at Cripps Health Centre and support available for diabetic students.

The Freshers Day event was particularly beneficial as we were able to speak to international students, many of whom were unfamiliar with the NHS and local health services. We were able to:

- Answer questions about how to access NHS services.
- Support students to download and access the NHS App.
- Provide information about vaccinations that are offered in the UK.

8.3.2 Co(l)laboratory

Co(l)laboratory is a pioneering new programme supported by Nottingham Trent University, the University of Nottingham, and the Universities for Nottingham partnership. The programme aims to bring together researchers, community-focused organisations, and local citizens to deliver meaningful change for the people of Nottingham and Nottinghamshire. It is an eight-year-long, £5.1m project, funded by the Research England Development Fund, Co(l)laboratory will engage local citizens, organisations, and communities in setting the

[14] Engagement-report-SLCN-services-for-children-and-young-people-Final.pdf (icb.nhs.uk)
[15] Population - Nottingham Insight

agenda for research at their local universities, conducting those research projects, and empowering communities to lead local change.

Over the next eight years, Co(l)laboratory will train 50 Ph.D. students, deliver 30 community events, provide 25 paid 'Citizen Scientist' research placements, support 15 community projects, and produce a national blueprint for how to support Ph.D. candidates to develop as future civic leaders.

Working in partnership with the University of Nottingham Business School and Nottingham Trent School of Social and Political Science, the ICB Engagement Team co-authored a research proposal titled "Promoting direct democracy in the NHS in Nottingham and Nottinghamshire". This proposal was selected as one of the projects[16] for the inaugural cohort of students, who started their Ph.D. journey in April 2023.

9 Sharing learning and good practice examples

This section describes successful programmes and initiatives that have been delivered by Nottingham and Nottinghamshire ICB.

9.1 Supporting the ICS to work effectively with people and communities

This section outlines the training initiatives and resources we've developed and implemented to enhance the system's effectiveness in engaging with people and communities.

9.1.1 Coproduction Week 2023

The ICB took part in National Coproduction week for the first time in 2023. Coproduction week is a national celebration of coproduction created by the Social Care Institute for Excellence (SCIE)

The Coproduction team curated a weeklong set of events for colleagues and people with lived experience, with contributors from across the system including our local authority partners along the national theme of Coproduction in the Real World. This included talks on Coproduction with an Equality and Diversity focus, training and resources created on subjects relating to the theme including how to facilitate a public meeting, coproduction for service improvement and how to capture lived experience insight by creating a digital story.

9.1.2 Coproduction Toolkit and support resources

Over 2024/25, several training requirements were identified to ensure that staff and people with lived experience felt comfortable and confident to engage in coproduction activity:

- Basic skills that are essential for any involvement work (engagement or coproduction) including planning, project management, facilitation skills, presentation skills, working with the public, feedback and communication for involvement projects, reflection and reporting for involvement.
- An introduction to coproduction – what it is and how to apply it to existing work
- Creating documents, tools, and other resources by people with Lived Experience aims to assist those who have not previously participated in coproduction activities to understand the requirements, their role and challenges involved.
- Dedicated training on how to work with people with lived experience, what it means to coproduce and share power.

[16] Promoting direct democracy in the NHS in Nottingham and Nottinghamshire - Co(l)laboratory (ufncollaboratory.ac.uk)

The Coproduction Team developed and launched the Coproduction Toolkit on the NHS Futures platform. This is a central resource for national and local guidance on coproduction approaches. The content on the toolkit has been designed to support everyone, from those who are new to the coproduction approach, to individuals who have been coproducing for a while.

In addition, the Coproduction Team have directly been involved in delivering training sessions on the following aspects of coproduction over the year:

- What coproduction is and how it can be delivered.
- Explaining how coproduction approaches apply at strategic, project and personal levels.
- “Golden Skills for Coproduction” – planning and delivering coproduction meetings and sessions.
- Using technology for coproduction.

A new bi-monthly coproduction newsletter has been introduced, designed to raise the profile of coproduction and promote coproduction activity that is happening locally so that people can participate if they wish to. There has been one edition of the newsletter so far and feedback has been positive. The newsletter has a system audience and the content included in each edition will feature articles to raise the profile of coproduction, help build understanding of what coproduction is and the impact that coproduction can have. Anyone who is involved in coproduction or has insight about coproduction projects they have been involved in can submit an article for inclusion. Each edition will be evaluated against any feedback received so that it can be continually improved so it meets the needs of the system.

A system-wide distribution list for coproduction has been compiled, with the aim of improving the ease of circulating best practice and communicating across the system. It is also a method of circulating the Coproduction Newsletter. People and teams working across Nottingham and Nottinghamshire can utilise the coproduction newsletter and network as a platform to promote upcoming projects and broaden engagement.

9.1.3 Engagement with elected members

We have continued to regularly and proactively brief (both verbally and in writing) Members of Parliament on system wide topics. We have also continued to lead the formal process of involvement with the Health Scrutiny Committees (HSC) as well as continuing an informal dialogue with the HSC Chairs and Vice-Chairs. These two-way processes have allowed us to hear the concerns of constituents in a systematic way.

The May 2023 elections bought extensive change to the membership of the Nottingham Health and Adult Social Care Scrutiny Committee. To support new Committee members, representatives from the Nottingham and Nottinghamshire ICB delivered an informal session in July 2023, to introduce new members to the ICS and ICB, and explain its role and remit in readiness for scrutiny of items from September 2023.

On 1 April 2023, ICBs became responsible for commissioning pharmacy, general ophthalmic and dental (POD) services. Given the significant interest in access to dentistry, representatives from the ICB Engagement Team delivered a training session to dental colleagues on how to effectively engage with HSCs. This was well received by delegates:

"The engagement support provided was incredibly insightful. It enhanced my awareness of the committee's role and fostered self-awareness in participating members, equipping them to address questions in a politically neutral manner."

9.2 Community Care Transformation Programme

The aim of the Community Care Transformation Programme (CCTP) is to plan for and deliver a future sustainable model of community care provision to optimise people's independence by addressing physical and mental health and social needs, delivering care to meet the needs of the Nottingham and Nottinghamshire population. It is being delivered via two phases to support this change:

- Phase One: Integrated Neighbourhood Working
- Phase Two: Specialist Community Support

9.2.1 Case Study 1: My Support Network

Phase One has carried out Integrated Neighbourhood Working via 'Local Design Teams', a group of people who represent the local community and the services that support it. These teams aim to co-produce solutions to the needs of local people, while improving integration between care services.

> "Wouldn't it be great if there was a way to share details about all the community contacts and friends and family supporting me in my care – everything in one place." - 39-year-old 'Andy', who has complex health needs.
>
> "As professionals we could save time searching for information and reducing pressure on the person to provide information" - so they are not having to repeat their story every time – A health professional.

The Local Design Team engaged with the system's workforce and local citizens to co-produce a solution to these things by developing the 'My Support Network' document[17]. This document is held in the citizen's home and holds key information about them and their current treatment plans, including details about the services involved in their care.

'My Support Network' has changed ways of working for the better, by improving integration between Integrated Care System partners, and within NHS services. It has drawn positive feedback from local people and workforce, including:

- People felt confident that services supporting them have the right information to support their holistic physical health and emotional wellbeing through multi-disciplinary teams' engagement.
- It reduced the amount of time professionals spend in handover, allowing them more time to support people and make a real connection with them.
- It reduced the amount of time the citizen spent conveying information about their care to teams in Health and Social Care, allowing them to feel actively listened to, and a trusted connection developed.

9.2.2 Case Study 2: Health and Wellbeing Event on Bellamy Road Estate

Phase Two looks at Specialist Community Support: community services and wider support available for citizens to improve their health and manage their long-term conditions. This support might be delivered by health services, local authorities, the community and voluntary sector, a person's own community or support network, or themselves via supported self-care or self-management.

[17] My Support Network - NHS Nottingham and Nottinghamshire ICB

Via a Diabetes-focused 100-day Improvement Cycle, accessible education and support for all was identified as a focus for the group. This was also supported by themes from engagement with citizens, carers, and health professionals across Nottingham & Nottinghamshire. A focus group was developed in collaboration with Mansfield Community and Voluntary Service and Mansfield District Council, to provide citizens who lived on and close to Bellamy Road Estate with support in their community.

On 14 February 2024, a health and wellbeing event was held at Trowell Court Community Centre on Bellamy Road Estate. 36 residents attended, as well as services that were requested by residents. Services included information on dental hygiene, personalised care, blood pressure, diabetes prevention/education, mental health, and disability support.

Positive feedback from local residents who attended the event included:

- “Thank you for listening to us and providing what we wanted”.
- “Great event with an opportunity to support getting information from services I didn’t know about.”

Providers who attended the event also shared:

- “Excellent opportunity to engage with other providers. I had some useful conversations particularly with the Learning Disability nurses and the Community Champions.”
- “Residents have long term health conditions but don't know much about them, or how they could make some lifestyle changes to help, they haven't been given that information when given a diagnosis, or if they have it wasn't in a way that they could understand it.”

Learning from the event will inform the development of a common blueprint to support accessible education and support for all, across all of Nottinghamshire.

10 Communications, social media and marketing

This section describes some of our communications activity that has supported the ICB’s work with people and communities.

10.1 Overview

We believe that a key enabler of our work is building and maintaining an ongoing relationship with people and communities, enabling a two-way dialogue. This includes:

- Producing regular newsletters for system partners, so that they are aware of the work that is being done in this area.
- Producing a monthly stakeholder update.
- Sharing final reports with those who were involved in generating citizen intelligence as part of bespoke programmes of work, including direct distribution and publication on our website.
- Proactively briefing and updating (both verbally and in written form) Members of Parliament.
- Informally meeting with the Chairs of Nottingham Adult Health and Social Care Committee and Nottinghamshire Health Scrutiny Committee monthly.
- Providing regular verbal and written updates to Healthwatch.

10.2 Mental Health Campaign

Communications work in Mental Health has focused on raising awareness of, and signposting to, the different services people can access for their own needs or those of

someone they care about. The ICB commissions many mental health services which can be accessed without a GP appointment.

The campaign involved:

- Paid for social media which reached in excess of 200,000 people and the information was shared more than 2,000 times
- Promotional materials displayed in GP practices, sports groups, grassroots sporting and community groups
- Advertising with LGBTQ+ groups
- Engagement with local community groups
- Production of a colourful, pocket-sized fold-out leaflet which details services and contact details.

10.3 MMR Vaccination Campaign (January 2024 onwards)

Following a number of outbreaks of measles across the country, NHS Nottingham and Nottinghamshire ICB, along with local authority public health teams, stepped up planning and activity to increase the uptake of measles in the city and county.

Planning meetings were established, which were attended by partners from across the system including public health, school aged immunisation services, universities, primary care, outreach teams and acute settings. The ICB communications team worked closely with UKHSA, Nottingham City Council and Nottinghamshire County Council's communications teams to make sure all activity was aligned and shared in the same way. This collaborative response created a joined-up approach to tackling the issue.

Key inputs included:

- Joined-up letters being sent to nurseries and schools with detailed information about what to do in an outbreak and how to communicate with parents.
- Local recall of under 5s which complimented the national recall of 6-11 year olds.
- Engagement with pharmacies and primary care so they shared the messaging on screens, in waiting rooms and with patients.
- Engagement with universities and colleges with leaflets being distributed to students.
- Internal campaign to check vaccination of staff and encouraging them to get vaccinated.
- Working with local media to create coverage and provide interviews and broadcast opportunities.
- A web page was created which was the hub of all information for partners and the public.
- A suite of material was used across the system such as posters, social media assets, leaflets, audio cards.
- Translated materials shared with community and voluntary sector as well as outreach teams and district councils.
- Outreach work was carried out in areas of low uptake in the city and county.
- Pop-up clinics were established by locality teams who contacted patients directly.

As a result, we have seen an increase in the percentage of children aged 5 that have had 2 doses of the MMR vaccination since the campaign began. (We are still awaiting national quarterly data which will provide mor information on the uptake).

10.4 Pharmacy First

We've worked with local pharmacies to promote a wide range of new services which they now provide, which previously would only have been available from GPs. This includes oral contraception, blood pressure checks for over 40s and Pharmacy First – treatments for seven common conditions, including sore throats, UTIs, ear infections and insect bites. There's been significant, on-going public facing and system-wide comms activity to highlight these services, including:

- New Pharmacy area on the ICB website
- Social media using national NHS England and Community Pharmacy England messaging as well as locally produced assets
- Regular messages, information and asset sharing with GP Practices
- Media activity, using local case studies, including broadcast, print articles and columns.

10.5 GP Access

We continue to promote improved access to GP appointments, highlight investment in increased capacity and encourage patients to choose wisely from the wide range of care options available. This work has included a mixture of local and national comms and comms materials, promoting services including the ARRS roles, care navigators, the NHS app, NHS 111, urgent treatment centres and Pharmacy First.

We are currently working on a refresh of the Primary Care Access Communications Plan, in line with national NHS England priorities.

11 Future planning

This section presents an outline of key activity planned for the next financial year.

11.1 Citizen intelligence

A significant amount of work has been undertaken during 2023/34 to actualise the ambition that our starting point for all consideration of how we deliver services starts with insights from our population on what services they value, how they want to access them and how they are best delivered. However, there is still more to do and during 2024/25, we will:

- Launch our Insights Hub, initially as a "minimum viable product" and thereafter continually increasing the number of reports uploaded that captures community intelligence, including findings drawn from all system partners including statutory sector, VCSE, Healthwatch, citizens' panel and networks at Place and neighbourhood level. We also aspire to maximise the number of system partners who are accessing the Hub.
- Continue to deliver insight reports on citizen and service user intelligence and insight to the Integrated Care Partnership.
- Deliver reports on citizen and service user intelligence and insight to the SPI Committee and ICB Board on specific issues, linked to the work programme.
- Expand the Citizens' Panel to Mid-Nottinghamshire, increasing the number of members.
- Continue to develop and embed the VCSE Alliance. Our focus will be on expanding the membership particularly including the Faith sector.

- Review the role and remit of the CIAG, VCSE Alliance and Engagement Practitioners Forum to ensure there is no duplication of efforts across these groups.
- Deliver formal public consultations for major service change programmes as required.
- Continue to produce and collate resources that enable the generation of citizen intelligence.
- Strengthen our relationships with the Derby and Derbyshire ICB Engagement Team by sharing good practice and exploring opportunities for collaboration.

11.2 Coproduction

We will continue to embed the coproduction approaches and tools that have been created, while working to identify areas where further tools or enhancements are required as our coproduction activities mature.

We will work with system partners to understand how we develop a view of the quality and the impact of Coproduction activities, through a richer understanding of both the empirical and experiential measures.

We will review the role and remit of the Coproduction Strategic Group Forum to ensure there is no duplication of efforts across the wider engagement and practitioners groups.

Planning is already underway for how the Nottinghamshire ICB will celebrate and use the opportunity of the 2024 National Coproduction week. The week is following a theme of #Whatsmissing. The focus of the week is about diversity in coproduction and increasing the representation of all of our communities and citizens in coproduction.

The Nottingham and Nottingham ICB Coproduction Strategy runs until the end of this year. Work will be undertaken to refresh the strategy.

12 Working with People and Communities: How to get involved

It is important for us to hear people's comments, ideas and suggestions about health and care services in Nottingham and Nottinghamshire, so we know what we're doing well and where we could do better.

Please visit our website to find out how people and communities can get involved in the work of Nottingham and Nottinghamshire ICB or call or text 07385 360071.

13 Appendices

13.1 Appendix 1: Engagement Practitioners Forum: organisations represented

Organisation
Alzheimer's Society
Ashfield District Council
Ashfield Voluntary Action
Bassetlaw Community and Voluntary Service
Bassetlaw Place-Based Partnership
British Liver Trust
Deep End Group (GP Practices in Nottingham City)
Digital Notts
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Health Innovation East Midlands
East Midlands Ambulance Service
Gedling Borough Council
Healthwatch Nottingham and Nottinghamshire
Mansfield Community and Voluntary Service
Mid Nottinghamshire Place-Based Partnership
Newark and Sherwood Community and Voluntary Service
NHS Nottingham and Nottinghamshire Integrated Care Board. Representatives from the following teams are in attendance: • Engagement • Coproduction • Research
Lead Governors of behalf of: • Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust • Nottinghamshire Healthcare NHS Foundation Trust • Sherwood Forest Hospitals NHS Foundation Trust
Nottingham City Council
Nottingham CityCare
Nottingham Community and Voluntary Service
Nottingham Trent University
Nottingham University Hospitals Trust (including Research Team)
Nottinghamshire County Council
Nottinghamshire Healthcare Trust
POhWER
Police and Crime Commissioners Office
Rushcliffe Community and Voluntary Sector
Self Help UK
Sherwood Forest Hospitals NHS Foundation Trust
Talking Therapies Service
University of Nottingham

13.2 Appendix 2: VCSE Alliance: organisations represented

Organisation	Organisation category
Active Health Coach	Sports/Fitness
Active Partners Trust	Sports/Fitness
Age UK Nottingham and Nottinghamshire	Older people
Al-Hurraya	Community
Alzheimer's Society	Health condition
Ashfield Voluntary Action	Community
Autism East Midlands	Supporting Autistic families
Autistic Nottingham	People with Autism
Bassetlaw Action Centre	Community, Older people, disabilities
Bassetlaw Citizens Advice	Legal, debt, consumer, housing
Bassetlaw CVS	Community
British Liver Trust	Health condition
Broxtowe Women's Project	Women's Charities
Canal & River Trust	Charity to improve waterways
Children's Bereavement Centre	CYP, bereavement, mental health
Citizens Advice Nottingham and District	Advice on debt, housing, jobs, legal
Dementia UK and Admiral Nursing	Health condition
Diversify Education and Communities	Primary Education
Double Impact Services and Cafe Sobar	Drug and Alcohol Support
Enable	Drug and Alcohol Support
Framework	Homelessness
Health Alliance Group (BHAG) CIC	BAME
Healthwatch Nottingham and Nottinghamshire	Health and social care
Himmah	Tackling poverty, racism and educational inequalities
Homestart Nottingham	CYP
Improving Lives	Mental Health Care
Ladybrook Enterprise	Community centre
Mansfield Citizens Advice	Legal, debt, consumer, housing
Mansfield CVS	Community
My Sight	Supporting Blind people
Newark and Sherwood CVS	Community
NHS Nottingham and Nottinghamshire ICB	Healthcare
Nottingham City Council	Local Authority
Nottingham Citycare Partnership	Healthcare provider
Nottingham Counselling Service	Counselling
Nottingham CVS	Community
Nottingham Focus on Wellbeing	Mental Health
Nottingham Mencap	Disabilities charity
Nottingham Muslim Women's Network	Faith Group
Nottingham Trent University	Education

Nottingham Women's Centre	Women's Charities
Nottinghamshire Community Dental Services CiC	Dental care for disadvantaged groups
Nottinghamshire Deaf Society	Health condition
Nottinghamshire Disabled People's Movement	Disabilities
Nottinghamshire Hospice	Health & social care
Nottinghamshire Mind	Mental Health Support
NSPCC	CYP
Opus music	Music Support Group
P3	Community Services
Parkinson's UK	Disabilities
Place2Be	Improving children and young people's health
POhWER	Disability and Vulnerability Support
Rainbow Parents Carer Forum	SEND parent/carer support
Royal Air Forces Association	Military
Royal Voluntary Service	Volunteering
Rural Community Action Nottinghamshire	Community
Rushcliffe CVS	Community
Self Help UK	Self help
SHE UK	Sexual abuse, exploitation and violence
Sherwood and Newark Citizen Advice Bureau	Legal, debt, consumer, housing
SSBC (Small Steps Big Changes)	Children and young people support
Stroke Association	Health condition
Sustrans (sustainable transport)	Sustainable transport
The Centre Place - LGBT+ Service Nottinghamshire	LGBT+
The Helpful Bureau	Older people, disabilities
The Pythian Club	Sporting Community
The Toy Library	Community
Trussell Trust	Food banks

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	11/07/2024
Paper Title:	**Annual Equality Diversity and Inclusion Report 2023/24**
Paper Reference:	ICB 24 032
Report Author:	Gemma Waring, Head of Human Resources and Organisational Development
Report Sponsor:	Rosa Waddingham, Director of Nursing
Presenter:	Rosa Waddingham, Director of Nursing Philippa Hunt, Chief People Officer

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

Summary:

The Equality Diversity and Inclusion (EDS) Annual Report meets the ICB's statutory duty under the Equality Act 2010 to report on performance against the ICB's equality objectives on an annual basis.

The report provides information on workforce demographics against protected characteristics in comparison to the population of Nottingham and Nottinghamshire, in order to provide context for the report. In addition, the report provides an overview of the legal and statutory frameworks that the ICB is required to adhere to.

It outlines the progress that the ICB has made against the equality objectives, specifically highlighting:

- Equality Objectives Progress
- Equality Delivery System
- Equity in Maternity and Neonatal Services
- Strengthening our Equality and Quality Impact Assurance (EQIA) process.

The report also highlights the focus of the ICB equality diversity and inclusion work in 2024/25:

- Equality Objectives
- Race Health Equalities Maturity Matrix
- Inclusive Leadership
- Freedom to Speak Up
- Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

Recommendation(s):

The Board is asked to **receive** the Equality Diversity and Inclusion Annual Report for assurance.

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	The Equality Diversity and Inclusion Annual Report does not directly contribute to the improvement of health outcomes for our population but does provide an overview of monitoring mechanisms and reflection of our

How does this paper support	the ICB's core aims to:
	current practice and is a statutory requirement under the Equality Act 2010.
Tackle inequalities in outcomes, experience and access	The Equality Diversity and Inclusion Annual report does not directly contribute to the tackling of health inequalities in outcomes, experience or access for our population but does provide an overview of monitoring mechanisms and reflection of our current practice and is a statutory requirement under the Equality Act 2010.
Enhance productivity and value for money	The Equality Diversity and Inclusion Annual Report will not directly impact productivity or value for money but as a statutory requirement could aid us in the identification in best practice, removal of duplication and areas for improvement that could indirectly enhance productivity.
Help the NHS support broader social and economic development	The Equality Diversity and Inclusion Annual report does not directly contribute to supporting broader social and economic development but does provide an overview of monitoring mechanisms and reflection of our current practice and is a statutory requirement under the Equality Act 2010.

Appendices:

A: ICB Annual Equality and Inclusion Assurance Report April 2023-March 2024

Board Assurance Framework:

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

- Risk 6: Sustainable workforce – Failure to utilise the system workforce effectively and ensure a sustainable workforce for the future.

Report Previously Received By:

The report was presented to the Quality and People Committee at its May 2024 meeting.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Annual Equality Diversity and Inclusion Report 2023/24

Overview

1. The ICB has a duty to comply with equalities legislation and statutory requirements. These include the Equality Act 2010, Human Rights Act 1998, Public Sector Equality Duty, Equality Delivery System (EDS), Workplace Disability Equality Standard (WDES) and Race Equality Standard (WRES), and Gender Pay Gap.
2. The ICB has fulfilled its duties under the above legislative and statutory requirements as of 31 March 2024.

NHS Equality Delivery System

3. The ICB completed the EDS for the first time in 2023/24. This requires the ICB to self-assess itself against a set number of criteria.
4. Overall, the ICB rated itself as '*developing*' in all three domains: commissioned/ provided services; workforce health and well-being; and inclusive leadership.

Commissioned/ provided services

5. Whilst there has been work undertaken to understand differential access, experience and satisfaction with services, there are developing tools such as the Racial Equity Matrix, our Equality and Quality Impact Assurance (EQIA) process and developing health equity audits will continue to support the ICB's understanding and oversight of this.
6. Health equity, health inequality and population health metrics form a core part of the ICB's oversight, but again, understanding and response to these in commissioning activity and plans needs more focus.

Workforce health and well-being

7. The ICB is working hard to understand the needs of its workforce and implement meaningful changes. Gaps and where improvements are needed are understood and acknowledged. This is why a rating of '*developing*' had been given. The ambition is to improve the scores on all outcomes during 2024/25.

Inclusive leadership

8. The ICB recognises the foundations are in place; however, further work needs to be done to embed true inclusive leadership across the organisation.

Workforce diversity

9. The ICB is on a journey to a truly diverse workforce that is representative of the places we serve. The ICB is representative of wider place populations in some protected characteristic groups; however, in others there are significant disparities:

    a) **Sex:** The populations of Nottingham and Nottinghamshire are almost 50% male and 50% female. However, the ICB workforce is 75% female. Whilst this is similar to other healthcare organisations, this is not representative of the populations we serve.

    b) **Disability:** The populations of Nottingham and Nottinghamshire are around 20% disabled; however, 6.4% of the ICB workforce have declared a disability. 77% have declared they do not have a disability, but a large number (16%) have not declared.

    c) **Race and Ethnicity:** The ICB workforce is 81% white British, with 13% stating they are from a non-white British background. 6% have not declared. However, Nottingham and Nottinghamshire is around 85% white British, and 15% non-white British. Therefore, the ICB's racial and ethnicity diversity is similar to the population.

    d) **Sexual Orientation:** There are a significant number of ICB colleagues who have not declared their sexual orientation (22%). This makes comparisons difficult with the wider Nottingham and Nottinghamshire populations. Of those that have declared, around 4% have declared gay, lesbian, or other sexual orientation, with 74% declaring straight/ heterosexual. This compares to just over 3% of the Nottingham and Nottinghamshire population and 89% of the Nottingham and Nottinghamshire population respectively.

10. The above statistics show part of the story, with over representation of some groups in lower pay bands compared to senior leadership roles. The ICB has work to do to support an equitable workforce at all levels.

Equality objectives

11. The ICB's Equality Objectives for 2023-2025 have continued to be actioned, with oversight through the Equality, Inclusion, and Human Rights Steering Group. Work will commence later this year to fully review and overhaul the Equality Objectives to ensure they remain relevant and up to date from April 2025 onwards.

Appendix A

Nottingham and Nottinghamshire Integrated Care Board

Annual Equality and Inclusion Assurance Report

April 2023 to March 2024

This document can be made available in large print and in other languages by request to the ICB's Communications and Engagement Team:

This document can be made available in large print and in other languages by request to the ICB's Communications and Engagement Team:

Este documento puede estar disponible en letra grande y en otros idiomas solicitándolo al Equipo de Comunicaciones y Participación del LPI:

Dokument ten może zostać udostępniony dużą czcionką oraz w innych językach na żądanie Zespołu ds. Komunikacji i Zaangażowania ICB:

应 ICB **沟通和参与**团队的要求，可提供本文件的大字版和其他语言版本：

یہ دستاویز بڑے پرنٹ اور دوسری زبانوں میں ICB کی کمیونیکیشنز اینڈ اینگیجمنٹ ٹیم کی درخواست کے ذریعے دستیاب کرائی جا سکتی ہے:

يمكن إتاحة هذه الوثيقة بطباعة كبيرة وبلغات أخرى بناءً على طلب يقدم إلى فريق الاتصالات والمشاركة التابع للبنك الدولي:

Email: nnicb-nn.comms@nhs.net

Website: https://notts.icb.nhs.uk/

Contents

Section 1: Welcome

1. Introduction

NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) was established on 1 July 2022 under the Government's Health and Care Act 2022.

The ICB recognises and values the diverse needs of the population we serve, and we are committed to embedding equality, diversity, inclusion and human rights considerations into all aspects of our work including policy development, commissioning processes and employment practices.

Our ambition, over the next few years, is to make a real difference to citizens' health and wellbeing, quality of service delivery and use of resources.

Our philosophy is to build on what is working well and to act as one system, rather than a collection of organisations.

Whilst we still have considerable work to do, we believe we can enable each and every citizen to enjoy their best possible health and wellbeing.

The equalities information presented in this report represents the ICB's progress in incorporating equality, diversity, and inclusion into all aspects of its work. The publication of this report and the information contained within demonstrates compliance with the Public Sector Equality Duty, and the requirement to publish equality information annually.

This report sets out:

NHS Nottingham and Nottinghamshire ICB's commitment to equality, diversity and inclusion.
Evidence of our 'due regard' to the Public Sector Equality Duty.
Progress made against the ICB's equality objectives.
Future planning.

2. Legal Duties

The Equality Act 2010 requires us to demonstrate compliance with the Public Sector Equality Duty.

The Public Sector Equality Duty places a statutory duty on the ICB to address:

- Eliminating unlawful discrimination, harassment and any other conduct prohibited by the Equality Act.
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it.
- Foster good relations between people who share a protected characteristic and people who do not.

The ICB also has a specific duty under the Public Sector Equality Duty to complete the following actions:

- Publish information to demonstrate their compliance with the Equality Duties, at least annually.
- Set equality objectives, at least every four years.

NHS employers are mandated by NHS England to show compliance of the Public Sector Equality Duty via Equality Delivery System (2022).

The Equality Delivery System helps NHS organisations improve the services that they provide for their local communities and provide better working environments, free from discrimination, for those who work in the NHS, whilst meeting the requirements of the Equality Act (2010). The Equality Delivery System is an evidence-driven accountable improvement tool for NHS organisations in England – in active conversations with patients, public, staff, staff networks and trade unions – to review and develop their services, workforces, and leadership.

NHS England also require NHS providers to publish evidence against the Workforce Race Equality Standard and the Workforce Disability Equality Standard on an annual basis. The Workforce Race Equality Standard and Workforce Disability Equality Standard are not currently mandated returns for ICBs, but we will be publishing our position for both standards for 2023/24 onwards.

Details of the wider legislation the ICB must adhere to is detailed in Appendix A.

3. Our Organisation

The ICB is committed to having a workforce that is representative of the population we serve within Nottingham and Nottinghamshire. Having a representative workforce enables the organisation to have a diverse range of experiences that positively impact our commissioning decisions.

We recognise that there is much more that the organisation can do to attract and retain applicants from diverse communities, as well as retaining and improving experiences for our existing workforce.

The ICB encourages staff to self-declare their diversity information at the point of recruitment and via our Electronic Staff Record self-service. We acknowledge that there is more we can do to help staff feel comfortable in declaring their diversity information.

The following section provides the demographic detail of the ICB in comparison to our local population as of 31 March 2024. Where declared numbers are relatively low, to avoid potential identification of individuals we have clustered protected characteristics together. We have not been able to report on marital status and pregnancy due to the current low reported numbers. We are unfortunately not able to

report on gender reassignment as staff are not currently able to select this option on the Electronic Staff Record.

Sex – The ICB's sex profile is typically representative of the NHS with 75% female and 25% males. The 2021 Census information for Nottingham and Nottinghamshire residents informs that 50.2% is female and 49.8% is male.

Disability – The ICB is committed to supporting all staff and applicants who have a disability. We are a Disability Confident employer and aim to support all staff with reasonable adjustments in the workplace to ensure that they are able to work to their full potential.

Currently only 6.4% of the ICB's workforce have declared that they have a disability, 77.2% have declared that they do not have a disability and 16.4% have not declared their status.

We know from the 2021 Census that 19.5% of the Nottingham and Nottinghamshire population are living with a disability as defined within the Equality Act.

Ethnicity – The ICB's workforce ethnicity profile is predominantly White at 81%. Staff from an ethnically diverse background (non-White British) is currently 13%. 6% of staff have not declared their ethnicity to the organisation.

From the 2021 Census we know that the proportion of the Nottingham and Nottinghamshire population from an ethnically diverse background is currently 14.6%, with 85.4% stating that they are White.

Within Nottingham City the ethnicity mix is much more diverse with 42.7% stating they from a non-white British background.

Religion – The ICB collects our workforce's self-declared religions and beliefs. For the purposes of this report, to protect individuals from potentially being identified, we have categorised religions with smaller representations together.

The table below shows the ICB workforce religion and beliefs in comparison to the data collected from the 2021 Census for residents of Nottingham and Nottinghamshire.

We recognise that we have a high proportion of our workforce that have not declared a religion or belief. We have committed to working with our Staff Networks to understand this trend with all protected characteristics.

Religion	ICB	Nottingham and Nottinghamshire Census 2021
Christianity	37%	43%
Atheism/No religion	21%	44%
Other religions	10%	7%
Not declared	32%	6%

Sexual Orientation – The table below details the sexual orientation profile of our ICB workforce in comparison to the resident population of Nottingham and Nottinghamshire from the 2021 Census information.

We acknowledge that we have a high percentage of our workforce who have not declared their sexual orientation. We have committed to working with our Staff Networks to understand this trend with all protected characteristics.

Sexual Orientation	ICB	Nottingham and Nottinghamshire Census 202
Straight/ Heterosexual	74.04%	89.3%
Gay or Lesbian	1.28%	1.4%
Other sexual orientation	2.56%	1.8%
Not declared	22.12%	7.5%

Section 2: Measuring Equality and what we have achieved

4. Measuring Equality

The ICB has established robust governance processes to monitor our equality performance throughout the year.

Our Equality, Inclusion and Human Rights Steering Group develops, populates and reviews the progress against the EDI (Equality, Diversity and Inclusion) Action Plan and the Equality Delivery System before submitting to the ICB's Quality and People Committee, a committee of the ICB Board, for formal monitoring and approval.

The following are examples of how we measure equality within the ICB.

NHS England High Impact Action

The High Impact Actions have been developed by NHS England as part an EDI improvement plan to support the Long-Term Workforce Plan.

The High Impact Actions will improve the culture of our workplaces and experiences of our workforce and to improve recruitment and retention of diverse talent. The High Impact Actions also support the achievement of the following strategic EDI outcomes:

- **Address discrimination**, enabling staff to use the full range of their skills and experience to deliver the best possible patient care.
- **Increase accountability of all leaders** to embed inclusive leadership and promote equal opportunities and fairness of outcomes in line with the NHS Constitution, the Equality Act 2010, and the Messenger Review.
- **Support the levelling up agenda** by improving EDI within the NHS workforce, enhancing the NHS's reputation as a model employer and an anchor institution, and thereby continuing to attract diverse talents to our workforce.
- **Make opportunities for progression equitable**, facilitating social mobility in the communities we serve.

The High Impact Actions should be developed and implemented in partnership with trade union colleagues and in collaboration with local staff networks.

The High Impact Actions are:

Action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

Action 3: Develop and implement an improvement plan to eliminate pay gaps.

Action 4: Develop and implement an improvement plan to address health inequalities within the workforce.

Action 5: Implement a comprehensive induction, onboarding and development programme for internationally recruited staff.

Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Gender Pay Gap

The gender pay gap measures the difference between average (median) hourly earnings of men and women, usually shown by the percentage men earn more than women.

Since 2017/18, public and private sector employers with 250 or more employees have been required annually to publish data on the gender pay gap within their organisations. Organisations must report the data to the Government, who then publishes it.

The ICB published our Gender Pay Gap information in February 2024.

Ethnicity Pay Gap

The ethnicity pay gap shows the difference in the average pay between all Black, Asian and minority ethnic staff in a workforce and all White staff.

Ethnicity pay reporting is voluntary, many employers already report on their ethnicity pay data.

Workforce Race Equality Standard

Implementing the Workforce Race Equality Standard is a requirement for NHS commissioners and NHS healthcare providers.

NHS providers and commissioners are required to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation.

During 2023/24 ICBs were not formally required to submit their Workforce Race Equality Standard data to NHS England for inclusion in national analysis.

Workforce Disability Equality Standard

The Workforce Disability Equality Standard is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.

During 2023/24 ICBs were not formally required to submit their Workforce Disability Equality Standard data to NHS England for inclusion in national analysis.

What we have achieved

At the start of the year the ICB developed some equality objectives that we felt would align with our ICB objectives and purpose to improve the health and wellbeing of our citizens and improve the working experience of all our employees.

The following sections detail what we have progressed against our objectives and other key achievements over the last 12 months.

5. Equality Objectives

The ICB has a duty under the Public Sector Equality Duty: Specific Duty Two, which requires public bodies and organisations to publish at least one Equality Objective every four years.

The ICB currently has nine equality objectives with a two-year Action Plan (April 2023 to March 2025).

The ICB has made good progress against its overarching Equality Objectives. Several objectives set in April 2023 have been completed. The Head of EDI, in consultation with the identified leads, has added new actions where all the specific actions have been completed for an objective. This ensures that work continues, and we strive for the best service and outcomes for our diverse population.

The ICB published its Annual Equality Objectives and Action Plan in March 2024.

6. Equality Delivery System

> The Equality Delivery System is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, whilst meeting the requirements of the Equality Act 2010. The Equality Delivery System was developed by the NHS, for the NHS, taking inspiration from existing work and good practice.

Implementation of the Equality Delivery System is a requirement on both NHS commissioners and NHS providers.

The Equality Delivery System Report is designed to give an overview of the organisation's most recent Equality Delivery System implementation and grade.

The ICB has undertaken a self-assessment of the Equality Delivery System domains for the first time in 2023/24. The Equality Delivery System three domains are detailed below – with specified outcomes within each domain:

Domain 1: Commissioned or provided services

1A: Patients (service users) have required levels of access to the service
1B: Individual patients (service user's) health needs are met

1C: When patients (service users) use the service, they are free from harm
1D: Patients (service users) report positive experiences of the service

Domain 2: Workforce health and well-being

2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment, and physical violence from any source
2D: Staff recommend the organisation as a place to work and receive treatment

Domain 3: Inclusive leadership

3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed
3C: Board members, system, and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients

The Equality Delivery System Report requires the organisation to score their evidence under each outcome and provide an overall score for each Domain. The ICB has assessed as 'developing' across all domains.

The ICB published our Equality Delivery System self-assessment in April 2024.

Equity in Maternity and Neonatal Services

The MBRRACE-UK report about maternal and perinatal mortality shows worse outcomes for those from Black, Asian and Mixed ethnic groups and those living in the most deprived areas. Black women are four times more likely to die in childbirth than White women, those from mixed backgrounds are three times more likely and those from Asian backgrounds are twice as likely.

In addition, the NHS People Plan highlights *"…where an NHS workforce is representative of the community that it serves, patient care and…patient experience is more personalised and improves".* If equity for mothers and babies is to improve, so must race equality for staff.

Therefore, the main aims of our Local Maternity and Neonatal System (LMNS) Equity Plan are to improve:

- equity for **mothers and babies** from Black, Asian and Mixed ethnic groups and those living in the most deprived areas
- race equality **for staff**

Locally, we will also be looking to improve equity in maternity for other protected characteristics including (but not limited to) disability, mental health and autism.

Good health in pregnancy significantly influences a baby's development in the womb which in turn, influences long-term health and educational outcomes. By giving every child the best start in life we will help them fulfil their health, wellbeing and socioeconomic potential.

The ICB has published the Local Maternity and Neonatal System High-Level Equity Strategy

Increased commissioning focus on equity through a strengthen Equality, Quality Impact Assessments

A key priority has been to enable commissioning managers to focus on equity and to do this through the Equality, Quality Impact Assessments (EQIA).

To support understanding and completion of the EQIA, the ICB has developed a Standard Operating Procedure along with consultation panels that consist of subject matter experts to help and support the commissioning process. EQIAs are seen as 'live' documents, and as such, are required to be revisited at key stages of any project development and implementation, particularly following the conclusion of any engagement and consultation activities to inform decision-making.

Section 3 Future Planning

The ICB recognises that we are on a journey to develop and improve our equality, diversity and inclusion practices. This section details the delivery commitments we have made to be achieved within the next year.

Equality Objectives

In January 2024, the ICB met with the Equality and Human Rights Commission to review the content and accessibility of the EDI information available on the ICB's external website.

The feedback was positive; however, they did identify some areas of focus for the future. The key area of focus was to review our Equality Objectives. They identified that our current objectives were more of a list of tasks and would benefit from being reworked to become SMART (Specific, Measurable, Achievable, Relevant, and Time-Bound).

The Equality, Inclusion and Human Rights Steering Group have committed to completing this in the first quarter of 2024/25.

We will also be reviewing the objectives during 2024 to establish new objectives which are streamlined and aligned to the work detailed in this section. Using tools such as the maturity matrix and health inequalities dashboard to help set measurable progress indicators.

Race Health Equalities Maturity Matrix

With the objective of challenging the deep-rooted structural racism that exists within parts of the health and care system, the main focus of the programme has been on the development and roll out of the Race Health Inequalities Maturity Matrix. Co-produced between health and care partners and community leaders in Nottingham, the matrix is now supporting over 30 organisations in Nottingham and Nottinghamshire to address structures and process that contribute to the exacerbation of health inequalities experienced in minority ethnic communities.

Communities of practice have been established to support organisations to embed the matrix across the organisation often focusing on organisational processes, commissioning cycles, team or service or policy development.

The Maturity Matrix has a clear focus on seven Domains and with four self-assessment outcomes:

- Community Engagement
- Inclusive Decision Making
- Representative Workforce
- Equality Impact Assessments
- Accountable Leadership
- Data and Evidence
- Financial Investment

Assessments scoring:

- Emerging
- Developing
- Maintaining
- Thriving

The ICB had a board development session with the developers of the tool, where they looked at the Matrix to gain insightful reflection of where individuals and the organisation sit withing that matrix.

Following this a number of next steps were agreed:

- The Board would be undertaking a full and considered Maturity Matrix self-assessment.
- The Board is likely to adopt Accountable Leadership as its priority area following this review and discussions at the board development session.
- The priority development area will be linked to the organisation EDI objectives.

- The framework and learning from it will support the development of personal equity objectives for board members during appraisals.
- Promoting further roll out across the ICB to support team and individual development and equity objectives.

Inclusive Leadership

Each board member will have an equity objective set during the appraisal process which will be linked into the work being done in relation to maturity self-assessment.

NHS England have developed a Leadership Competency Framework for Board Members that has an EDI domain embedded within the framework. The competency framework details that leaders should be:

- Promoting equality and inclusion and reducing health and workforce inequalities.

The framework measures the equality competency through four domains:

- I contribute as a leader
- I assess and understand
- I recognise and champion
- I personally….

The framework's appraisal process will be launched in Autumn 2024, and we have committed to reviewing this and adopting it into our appraisal practice. In addition, all staff are also supported to develop an equity objective with this being an integrated element in our appraisal form.

This work will be further strengthened by additional development sessions in 2024/25 for our Board members.

Freedom to Speak Up (FTSU)

In June 2022, NHS England and the National Guardian's Office published an updated Freedom to Speak Up guide and improvement tool to support organisations with delivering a speaking-up culture for their workers.

The ICB opted to appoint a part-time FTSU Guardian to provide staff routes to speak up. Their initial focus over the coming 12 months will be building relationships internally with HR, Network Chairs and Trade Union colleagues and reviewing the trends within our 2023 National Staff Survey results in order to triangulate trends and themes within the organisation.

The Nottingham and Nottinghamshire system is developing an FTSU network of which the ICB's Guardian will be a member. The Network will allow learning to be shared and allow them to identify areas of commonality across the organisations.

In addition, the ICB will be developing the offer for Primary Care, signing up to and attending NHS E learning events to share best practice from other areas.

NHS England » Integrated care boards, integrated care systems and Freedom to Speak Up

Workforce Race Equality Standard and Workforce Disability Equality Standard

During 2023/24 the ICB has collated the data for both Workforce Race Equality Standard and Workforce Disability Equality Standard workforce indicators and developed an action plan that has been reviewed and approved internally.

As an ICB we have not yet published this information but have committed to do so during 2024/25.

Appendices

Appendix A – Summary of the legislative framework for equality

Equality Act 2010	The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. It replaced previous anti-discrimination laws with a single Act, making the law easier to understand and the strengthening protection in some situations. It sets out the different way in which its unlawful to treat someone. The Equality Act 2010 defines the 9 protected characteristics as the following: Age Disability Gender reassignment Marriage and civil partnership Pregnancy and maternity Race Religion and belief Sex Sexual orientation
Modern Slavery Act 2018	The Modern Slavery Act 2018 will give law enforcement the tools to fight modern slavery, ensure perpetrators can receive suitably severe punishments for these appalling crimes and enhance support and protection for victims. It received Royal Assent on Thursday 26 March 2015. The act will: • consolidate and simplify existing offences into a single act. • ensure that perpetrators receive suitably severe punishments for modern slavery crimes (including life sentences). • enhance the court's ability to put restrictions on individuals where it's necessary to protect people from the harm caused by modern slavery offences. • create an independent anti-slavery commissioner to improve and better coordinate the response to modern slavery. • introduce a defence for victims of slavery and trafficking. • place a duty on the secretary of state to produce statutory guidance on victim identification and victim services.

	• enable the secretary of state to make regulations relating to the identification of and support for victims. • make provision for independent child trafficking advocates. • introduce a new reparation order to encourage the courts to compensate victims where assets are confiscated from perpetrators. • enable law enforcement to stop boats where slaves are suspected of being held or trafficked. • require businesses over a certain size to disclose each year what action they have taken to ensure there is no modern slavery in their business or supply chains.
Health and Social Care Act 2012	The Kings Fund provides a succinct summary of the Health and Care Act 2012. The Heath and Care Act introduced significant reforms to the organisation and delivery of health and care services in England. The main purpose of the Heath and Care Act is to establish a legislative framework that supports collaboration and partnership-working to integrate services for patients. Among a wide range of other measures, the Act also includes targeted changes to public health, social care and the oversight of quality and safety.
Human Rights Act 1998	The Human Rights Act 1998 sets out the fundamental rights and freedoms that everyone in the UK is entitled to. It incorporates the rights set out in the European Convention on Human Rights (ECHR) into domestic British law. The Human Rights Act came into force in the UK in October 2000. The Act sets out your human rights in a series of 'Articles'. Each Article deals with a different right. These are all taken from the ECHR and are commonly known as 'the Convention Rights'. The Equality and Human Rights Commission provides more information on the Human Rights Act 1998 and provides details of the Articles.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	11/07/2024
Paper Title:	**Quality Report**
Paper Reference:	ICB 24 033
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 progress reporting for 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 includes exception reporting for areas of enhanced oversight, as per the ICB's escalation framework (included for information at Appendix one):

- Nottingham CityCare
- Paediatric Audiology Services in Doncaster and Bassetlaw Teaching Hospitals (DBH), Learning Disability and Autism,
- Urgent and Emergency Care
- Maternity
- Special Educational Needs and Disabilities
- Looked After Children
- Children and Young People
- Vaccinations
- Infection Prevention and Control

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

The reporting period is 01-31 May 2024.

Recommendation(s):

The Committee 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.

How does this paper support	the ICB's core aims to:
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 1. 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 delivery has been reported through the ICB Quality and People Committee

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Quality Report

Trusts for which the ICB has responsibility based on the NHS Oversight Framework (NOF)

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.

Mitigation

2. The Improvement Oversight Assurance Group oversees actions being taken by NHT to address and mitigate risks to ensure sustained delivery of safe services.
3. ICB and NHT ‘Safe Now’ meetings with shared reporting and metrics are used to assess progress against the more immediate safety challenges. These metrics are also aligned with the Trust’s internal action plans and verification processes.
4. Representatives of the ICB attend the Trust’s Improvement Board and associated workstreams to triangulate data and actions.

Assurance

5. Extensive governance arrangements, including oversight from the ICB, regional and national NHS England teams have been put in place. These are currently being updated and will be shared at the next Board meeting.
6. A buddying system between Broadmoor, Ashworth and Rampton High Secure facilities is supporting cultural change.
7. A ‘Safe Now’ dashboard supports immediate actions for safety and improvement, with appropriate escalations. This will become part of routine ward to board escalation pathways as it is embedded.
8. The NHT-led thematic review of homicides to support learning and improvement programmes continues across the Trust.

Horizon Scanning

9. The Care Quality Commission (CQC) is expected to undertake regular inspections of services across the Trust. Publication of the final part of their report, commissioned by the Secretary of State under Section 48 Health and Social Care Act (2008), and other inspections related to the care of Valdo Calocane, are likely to be published in the late summer.

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

10. Nottingham University Hospitals NHS Trust (NUH) remains in a challenged position in providing safe and high-quality care in response to regulatory requirements.
11. The operational flow pressures in the Emergency Department (ED) remain persistently high.

Mitigation

12. The Board Assurance Framework (BAF) score in relation to the delivery of safe high quality patient care is being reviewed by NUH.
13. Weekly discussions continue between senior leadership colleagues within the ICB, Urgent Emergency Care (UEC), NUH and the East Midlands Ambulance Service NHS Trust (EMAS), focusing on emerging quality concerns relating to handover delays.
14. The Improvement Oversight Assurance Group held in May 2024 reported sustained positive progress against maternity improvements and well led aspects. However, the financial position is less robust, and it is anticipated that exit from National Oversight Framework Segment Four (NOF 4) will not occur before Quarter One 2025/2026, this is dependent on financial recovery and segmented criteria discussions with NHS England.

Assurance

15. Trust maternity oversight has been refreshed with clear leadership by the Chief Nurse of the internal escalations around neonatal and maternity services. The ICB, Local Maternity and Neonatal System (LMNS) and our maternity and neonatal voices partners (MNVP) are all part of that oversight.
16. The CQC visited Trust maternity services in an unannounced inspection in June and feedback is awaited.

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

Risk

17. Sherwood Forest Hospitals NHS Foundation Trust (SFH) received two Prevention of Future Deaths notices in April 2024, requiring formal response by the end of May 2024.

Mitigation

18. The Trust has a rapid quality improvement plan which follows four workstreams, including actions from Prevention of Future Deaths (PFDs) including staffing, escalation and leadership.

19. This improvement plan includes new ways of working, increasing leadership visibility and changes to the estate, which release capacity to further develop the actions needed. Sepsis and escalation of the deteriorating patient remain a key focus for Trust-wide improvements.

20. Unannounced peer reviews have highlighted some improvements, and the ICB continues to support with insight safety visits and peer reviews where needed.

Assurance

21. The early evidence of insights from the Trust Patient Safety Incident Response Oversight Group is being seen to lead to learning and improvement initiatives.

Areas under Enhanced Oversight, as per the Oversight Framework

Nottingham CityCare (Community Interest Company) – Enhanced Oversight

Risk

22. 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.

Mitigation

23. CityCare has accepted support from the ICB Quality Team to undertake caseload review next steps, prioritisation and quality surveillance and actions taking place to operationalise the outcome of reviews. Equality, Quality, and Impact Assessments (EQIAs) will be reconsidered to include wider quality and equity considerations of operational activity and relevant mitigations. An enhanced assurance Key Lines of Enquiry (KLOE) summary response was presented at the May 2024 System Quality Group.

Assurance

24. A Monthly Quality Review meeting is in place to track progress against the agreed quality actions. The ICB Quality Team is attending CityCare's accountability meetings to ensure appropriate internal responses to the concerns, and to triangulate information.

Horizon Scanning

25. All Nottingham CityCare out of hospital contracted services are describing activity over planned levels, excluding Musculoskeletal Physiotherapy and Occupational Therapy Service. Paediatric Continence and Dietetics, and Continuing Healthcare (CHC) are showing significantly higher levels of activity. This is being monitored for the impact on quality.

Doncaster and Bassetlaw Teaching Hospitals Paediatric Audiology Services

Risk

26. Paediatric Audiology Services in Doncaster and Bassetlaw Teaching Hospitals (DBH) remain challenged during the response to a serious incident managed by South Yorkshire ICB, as the lead commissioners.

27. An additional risk has arisen in the implementation of the new IT system, all follow up appointments have been cancelled, which has created longer waiting times for paediatric and adult services.

Mitigation

28. No child will be discharged from the service while DBH look to understand the number of children affected and the impact on this service. A standard operating procedure has been shared from a national template and ratified for use within the service under the guidance of the external clinical specialists.

Assurance

29. Duty of Candour has been undertaken and a Patient Safety Incident Investigation has been commissioned in response to the identified harms from the case study review.

30. The Service Level Agreement to fund a 5-year review of all records was taken to the DBH Board for agreement during April. There is a pool of clinical specialists that have been identified and will support the review.

31. Fortnightly incident management meetings continue to track the actions agreed. Mitigations with support from clinical experts have allowed for the service to provide an effective and safe provision of care whilst training and estates actions continue.

Horizon Scanning

32. The delayed access to paediatric audiology services may result in long term impacts on individuals who are affected and lead to increased access to a range of services over their lifetime.

Learning Disability and Autism (LDA) – Enhanced Oversight

Risk

33. Ongoing risks remain around adult inpatient numbers, with the end May 2024 position being 44 against a target of 42, and a challenging target of having no more than 32 adults in inpatient beds by the end of March 2025.

Mitigation

34. The partnership has developed a number of admission avoidance strategies including the adult and children and young people Dynamic Support registers and a range of ICS wide measures are in place to expedite discharges.

Assurance

35. The Learning Disability and Autism (LDA) Board retains oversight of performance, quality and safety across the pathway. Quarterly performance meetings with NHS England regional colleagues continue. LDA summits are taking place monthly with additional scrutiny from the ICB interim Chief Delivery Officer in June 2024.

Horizon Scanning

36. The local system is observing an increase in adults and children and young people within mental health settings who are receiving a diagnosis of Autism Spectrum Disorder who then, in turn, are classed as ‘admissions’ into the LDA system, which is in line with the national trend.

Urgent and Emergency Care (UEC) – Enhanced Oversight

Risk

37. Quality and patient safety concerns remain as a result of delays and extended waits for patients on the UEC pathway. Whilst NUH remains under significant scrutiny due to performance issues, there is wider impact felt by system partners, including SFH.

Mitigation

38. Partners have collaborated to identify specific safety and quality concerns on the UEC pathway (specifically ED) at NUH.
39. The May 2024 System Quality Group received an update on the actions from the March 2024 Rapid Quality Review.
40. Findings from visits indicate that whilst the department at Queens Medical Centre (QMC) remains busy and often overcrowded, frequent reviews occur, and departmental oversight is robust and organised.
41. The Getting It Right First Time (GIRFT) team continue to meet NUH on a monthly basis to review progress against their recommendations following their visit in March 2024.
42. When required, and by agreement, ambulance diversions to SFH take place to mitigate overcrowding issues.

Assurance

43. The UEC Board retains oversight of performance, quality and safety across the pathway and the ICB’s UEC team monitor performance data daily.

Horizon Scanning

44. Planning was undertaken for the upcoming Junior Doctors strike announced for July 2024 to cover all aspects of the UEC pathway including community services to limit potential or actual impact.

Maternity – Enhanced Oversight

Risk

45. Due to issues with understanding data requirements, system interoperability and data sharing, there is a risk the system may not be able to measure effectively its impact and demonstrate results, value, and performance.

Mitigation

46. The LMNS and maternity commissioning teams are mapping the nationally mandated programmes of work, including targets and predicted outcomes, against LMNS funding investment. The LMNS Project Management Office team is conducting a similar exercise for the transformation programme 2024/25.

47. Additionally, the LMNS Project Management Office team are organising a face-to-face oversight and assurance panel to take stock of progress on the three-year plan deliverables and develop an action plan to aid further progression.

Assurance

48. It is anticipated that the narrative exercise described above will support migration onto the LMNS dashboard as part of its ongoing development.

49. NUH is reporting positive progress in achievement of their Maternity Improvement Plan objectives (199 out of 236 actions are now complete).

Special Educational Needs and Disabilities – Enhanced Oversight

Risk

50. Capacity challenges to deliver on improvements and prioritise the Special Educational Needs and Disabilities (SEND) agenda, leading to inconsistent experiences and outcomes for children and young people with SEND.

Mitigation

51. Both Nottingham and Nottinghamshire SEND Partnership Assurance Improvement Groups are working collaboratively with partners across the system, including parent carers and young people to co-produce the undertaking of a Self-Evaluation Framework.

52. The Nottinghamshire local area SEND partnership continues to deliver on the Priority Action Plan to deliver improvements and are preparing for a stocktake in June 2024, to be undertaken by the Department for Education and NHS England regional advisors.

Assurance

53. Clear arrangements are in place for shared and robust oversight and monitoring of SEND arrangements and will report via the established governance routes to escalate risks and provide assurance to Executive leadership.
54. The Department of Education and NHS England are undertaking continuous monitoring and providing advice and support with regular keeping in touch meetings with both local authorities.

Horizon Scanning

55. The Nottingham City SEND Partnership is participating in a SEND Peer Challenge programme in September 2024.
56. Ofsted and CQC inspectors are expected to return to Nottinghamshire to undertake a monitoring visit to review progress of improvements following the inspection outcome in October 2023.
57. The Nottinghamshire SEND Strategy and Nottingham and Nottinghamshire ICS Integrated Joint Commissioning Strategy will be published July 2024.

Looked After Children – Enhanced Oversight

Risk

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

Mitigation

59. Demand and capacity reviews, which have allowed providers to use existing capacity to best effect, have allowed us to increase capacity.
60. Named Doctors for Looked after Children are now in post in all Initial Health Assessment health providers. NUH is recruiting additional Community Paediatricians.
61. New Initial Health Assessment Key Performance Indicator metrics are now in place and reported by all Initial Health Assessment health providers.

Assurance

62. Overall waiting times for Initial Health Assessments have reduced and waiting times for Review Health Assessments show an improved position compared to 2022/2023 numbers.

Horizon Scanning

63. Following completion of the Ofsted inspection at Nottinghamshire County Council, the report and any recommendations relating to Children in Care and Care Leavers is expected.

64. NHT is expected to start reporting updated Review Health Assessments Key Performance Indicator in quarter three 2024/2025.

Children and Young People Services – Enhanced Oversight

Risk

65. The management of children and young people presenting with significant emotional dysregulation and self-harming behaviours into acute hospitals, who are then managed in inappropriate settings, is an increasing risk.

Mitigation

66. A weekly system meeting is attended by the acute trusts, the ICB, Child and Adolescent Mental Health Services and both local authorities to escalate children and young people who are in inappropriate settings.

67. Cross system pathways have been designed to support this cohort of children and young people and work continues to progress this, but it has not been adopted by all trusts.

68. There is a project across Derby and Derbyshire and Nottingham and Nottinghamshire to progress four, two bedded units as step down provision.

Assurance

69. Improved communication and relationships across Nottingham and Nottinghamshire provide greater understanding of risks, challenges and resolutions available.

Vaccinations – Enhanced Oversight

Risk

70. Pertussis (whooping cough) - If low uptake rates for maternal vaccinations persist, alongside an increase in circulation of pertussis in the general population, there is a risk of adverse health outcomes for the infant population of Nottingham and Nottinghamshire.

71. Measles - If low uptake rates for the Measles, Mumps and Rubella (MMR) vaccination persist, there is a risk measles cases will increase.

Mitigation

72. A pertussis task and finish group has been implemented to take forward actions to increase uptake of the vaccination. Actions are being taken across the trusts (maternal vaccination) and in primary care (infant vaccinations) to reach out to and provide opportune vaccinations.

73. Increasing the uptake of the MMR vaccination is a priority. The area of highest risk is NG7, and work is underway to target the schools in NG7 as well as offering additional clinics and outreach in this area.

Assurance

74. The pertussis task and finish group reports into NHS England as vaccinations commissioner, and into the Health Protection Board.

75. Measles is supported by an incident management team chaired by UK Health Security Agency.

Infection Prevention Control – Enhanced Oversight

Risk

76. There is limited change in Healthcare Associated Infection (HCAI) performance.

77. HCAI thresholds for 2024/25 have not been issued but are not expected to change, these will be hard to achieve.

Mitigation

78. The regional Infection Prevention Control (IPC) lead supports concerns that HCAI targets are not achievable in the current climate of long waits in ED and high bed occupancy. Work is ongoing to maintain IPC compliance within ED and areas supporting patients receiving care in corridors.

79. NUH has implemented their Patient Safety Incident Response Plan following reporting of a MRSA BSI in April 2024. Following clinical review, no trust learning was identified.

Assurance

80. Improvement has been noted at SFH with all HCAI targets met in April 2024. With little change at NUH, assurance remains limited.

81. IPC Board Assurance Frameworks remain in use across all providers and mechanisms for monitoring actions are in place.

Horizon Scanning

82. An IPC system review will identify local determinants associated with Gram-Negative BSI and may identify areas for targeted system prevention work.

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.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	11/07/2024
Paper Title:	**Service Delivery Report**
Paper Reference:	ICB 24 034
Report Author:	Sarah Bray, Associate Director of Performance and Assurance Rob Taylor, Deputy Director of Performance and Assurance
Report Sponsor:	Marcus Pratt, Acting Director of Finance
Presenter:	Mandy Nagra, Interim Director of Service Delivery

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 2023/24. The report describes the key drivers behind performance and actions being taken to address areas of concern in all service delivery performance areas.

Areas of particular concern identified as low assurance and high risk for delivery include:

- Urgent Care – 4 Hour and 12 Hour waits.
- Urgent Care – Ambulance Handover Delays.
- Planned Care - Diagnostic waits.
- Planned Care - Cancer 62 Day Backlog.
- Mental Health – Out of Area Placements.
- Community – Waiting Lists.

Areas of improvement are being made, which include:

- Urgent Care – hospital flow has improved.
- Urgent Care – virtual wards continue to increase capacity.
- Planned Care – zero 104 waits, on track for zero 78 weeks in June 2024.

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

Recommendation(s):

The Committee 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

How does this paper support	the ICB's core aims to:
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:

-

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. *(in the context of performance delivery)*

Report Previously Received By:

The report elements have been previously reported to the Finance and Performance Committee and discussed through the System Oversight Group.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Service Delivery Report

Executive summary

1. Junior doctors in England staged a five-day strike from 27 June to 1 July 2024. At the System Oversight Group A - Delivery (SOG A) on 18 June the system's NHS trusts provided assurance that industrial action planning was progressing well and no immediate concerns to delivery had been identified. The trusts have worked to minimise the volume of outpatient appointments that are cancelled and limit the impact upon urgent care and cancer services.
2. There continues to be significant focus on four-hour Accident and Emergency (A&E) performance within the system. Granular plans have been developed to enable monitoring at a daily frequency, which include four-hour and twelve-hour breach thresholds. Performance against these plans is tracked daily with more comprehensive discussion taking place within the weekly SOG A meeting.
3. Improvements have been seen in the four-hour wait performance at Nottingham University Hospitals NHS Trust (NUH), with the Trust achieving local plans in April and May. However, there are challenges in achieving consistent performance above 98% within four hours for Eye Casualty. Ambulance turnaround had been improving but has faced challenges recently due to staff rota fill and unplanned absences in key areas including respiratory, acute medicine and the Emergency Department.
4. Ambulance arrival volumes and attendance volumes at Accident and Emergency at Sherwood Forest hospitals NHS Foundation Trust (SFH) are high and can be volatile, which materially impacts the consistency of performance delivery at the Trust. The Trust is working with East Midlands Ambulance Service (EMAS) to identify the causes of the growth in ambulance arrivals.
5. The position for long waiting elective patients is improving within the system and the forecast is for the elimination of 78- and 65-week waiters by the end of June and September 2024 respectively. The volume of long waiters in Ear Nose and Throat at NUH is a challenge and the Trust is working to review and improve the productivity of the service.
6. Performance in the 28-day Faster Diagnosis Standard (FDS) continues be strong for both providers. There have also been reductions in the backlog of cancer patients, but this remains a challenging area for NUH, particularly for the Urology tumour site.
7. Out of Area Placements for mental health patients has been an area of focus for the system, as the position continued to increase through to the end of 2023/24. Local reporting indicates significant improvement being made over recent weeks, reducing from 52 patients in April to 21 patients on latest data, which is ahead of the improvement plan for 2024/25.

Key Performance Metric Summary

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 March 2025	SPC Variation	IPR Page No.
Urgent Care	Total A&E Attendances	Provider	May-24	35,324	37,027	1,703	35,574	Special Cause Concerning High	44
Urgent Care	A&E 4hr % Performance (All types)	Provider	May-24	69.6%	68.9%	-0.7%	78.0%	Common Cause Variation	47
Urgent Care	A&E 12 Hour Waits	Provider	May-24	0	527	527	0	Common Cause Variation	47
Urgent Care	Hospital Handover Delays >60 minutes	Provider	May-24	0	1,205	1,205	0	Special Cause Concerning High	47
Urgent Care	Ambulance Total Hours Lost	Provider	May-24	0	3,037	3,037	0	Special Cause Concerning High	47
Urgent Care	No. Patients utilising Virtual Ward	Population	May-24	202	240	38	236	Special Cause Improving High	45
Urgent Care	Number of MSFT > 24 Hours	Provider	May-24	351	318	-33	347	Special Cause Improving Low	45
Urgent Care	Length of Stay > 21 days	Provider	May-24	410	353	-57	430	Common Cause Variation	45
Planned Care	104 Week Waiters	Provider	Apr-24	0	0	0	0		-
Planned Care	78 Week Waiters	Provider	Apr-24	0	10	10	0	Special Cause Improving Low	-
Planned Care	65 Week Waiters	Provider	Apr-24	554	507	-47	0	Special Cause Improving Low	49
Planned Care	62 Day Backlog	Provider	Apr-24	-	407	--	344	Common Cause Variation	52
Planned Care	Cancer 28 Day Faster Diagnosis	Provider	Apr-24	76.5%	77.3%	0.7%	78.1%	Common Cause Variation	52
Planned Care	Op Plan Diagnostics 6-week Performance	Provider	Apr-24	69.6%	68.2%	-1.3%	84.1%	Special Cause Concerning High	53
Mental Health	Inappropriate Out of Area Placement Bed Days	Population	Mar-24	0	1,325	1,325	0	Special Cause Concerning High	56
Mental Health	NHS Talking Therapies - Entering Treatment (3mth)	Population	Apr-24	-	7,150	-	-	Common Cause Variation	55
Mental Health	NHS Talking Therapies - >90 Days 1st and 2nd Treatment	Population	Apr-24	10.0%	63.2%	53.2%	10.0%	Special Cause Concerning High	55
Mental Health	SMI Health Checks	Population	May-24	4,050	5,945	1,895	4,371	Special Cause Improving High	56
Mental Health	CYP Eating Disorders - Routine	Population	Mar-24	95.0%	80.0%	-15.0%	95.0%	Special Cause Concerning Low	58

Programme Area	Key Metric	Metric Basis	Latest data period	Plan	Actual	Variance	Plan March 2025	SPC Variation	IPR Page No.
Mental Health	CYP Eating Disorders - Urgent	Population	Feb-24	95.0%	89.0%	-6.0%	95.0%	Special Cause Concerning Low	58
Primary Care	Primary Care - % book 2 Weeks	Population	Apr-24	81.0%	74.9%	-6.1%	90.0%	Common Cause Variation	-
Community	Community Waiting List (0-17 years)	Provider	Apr-24	-	3,432	-	-	Special Cause Concerning High	60
Community	Community Waiting List (18+ years)	Provider	Apr-24	-	7,750	-	-	Special Cause Improving Low	60

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). 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.

Urgent care

8. In May, the system achieved 68.9% performance for four hour waits against a plan of 69.6%. NUH achieved 65.9% against a plan of 64.0%, with SFH delivering 73.4% against a plan of 76.0%.

9. NUH has had two consecutive months of achieving the operational plan target for all accident and emergency attendance types (1,2 and 3). However, challenges remain on type 1 attendances and remain ahead of the plan. Note that a Type 1 department is a major emergency department that provides a consultant-led 24-hour service with full facilities for resuscitating patients, for example patients in cardiac arrest. Type 1 departments account for most attendances. Type 2 departments are consultant-led facilities but for specific conditions, for example, eye conditions or dental problems. Type 3 departments treat minor injuries and illnesses.

10. The performance of Eye Casualty (Type 2) is a concern and work is being carried out to identify the underlying causes of the service being unable to consistently achieve the 98% target. The Type 1 majors four-hour performance is significantly influenced by ambulatory majors and have long waits to be seen. A review of the Urgent Treatment Unit is taking place, which will expose the elements that require change. The volume of patients waiting 12 hours from arrival is reducing and was marginally above plan in May (2.3% of attendances against a plan of 2.0%) but there are broader challenges with the pace at which patients move through the Majors Department. Performance is ahead of plan, but work is being carried out with focus on non-admitted patients, as this should deliver further improvements. NUH has clear plans that identify actions and timescales. They have segmented pathways to identify the component parts that require intervention and have clear data driven actions. Cultural change is progressing with the four-hour target, but to culturally embed it will take time after many years of non-delivery and the trial of new targets.

11. Latest published data for May shows an improved position for virtual wards at 240 beds, which is above the plan of 202 beds. The ICB places 18th of 42 nationally with 18.9 beds per 100,000 registered population (the aggregate England position is 19.5 per 100,000). The occupancy level increased from 69.9% in April to 84.6% in May. The operational plan submitted on 21 March 2024 includes a plan of 236 beds by March 2025.

12. Improvements in discharge levels have been seen at NUH over previous months, averaging over 300 per day and in reporting over 400 discharges on two occasions in the most recent weeks data (w/e 16/06/24).

13. A deep dive meeting has been held due to lack of improvement in patient flow at NUH, despite reductions in bed occupancy and Medically Safe for Transfer patients. There are capacity constraints between 4pm and 11pm, which impact ambulance arrivals during this period and NUH is developing operational

actions to address these pressures. Performance is being impacted by unplanned staffing absences in key areas. Boarding support work “getting ready for your next patient” is being led by the Chief Nurse.

14. In May 2024, there were 2,532 delays over 30 minutes, of which 1,205 were above 60 minutes. Of the 60-minute delays, 1,205 were at NUH and 0 were at SFH. There were 3,037 hours lost through ambulances waiting to handover patients to hospitals in Nottinghamshire in May in excess of the 30 minutes expected (15 mins pre and 15 mins post-handover time), this significantly limits the capacity of EMAS to respond to calls within a timely manner.

15. The handover clock starts when the ambulance wheels stop in the patient offloading bay and the ‘Red at hospital’ button is pressed on the Mobile Data Terminal. Where a patient is handed over directly from the conveying crew to hospital staff, the operational handover clock stop is when clinical handover has been fully completed and the patient has been physically transferred onto hospital apparatus. Handover times exceeding the 30 minutes are aggregated to generate the total number of lost hours from handovers.

16. In May 2024, the Queen’s Medical Centre (QMC) reported 2,799 lost hours from handover delays – this is the highest reported figure of the 27 reporting hospitals in the Midlands. QMC’s reported lost hours account for over 21% of the total EMAS reported lost hours for May (12,807). However, this is an improvement on the April position where QMC lost hours made up over 23% total. As a County, Nottinghamshire reported 3,306 lost hours, which was the second highest volume within the region, below Lincolnshire, and accounting for over 25% of total EMAS reported lost hours (26% in April).

17. Within the system, there remains a high volume of patients that have been deemed as not meeting the necessary criteria to reside in the hospital and eligible for discharge. The May position was 318 patients against a plan of 351 patients. At system-level there is a System Discharge Board in place to enable focus on addressing these issues, with a focus on Pathway 2 and Pathway 3 right-sizing bedded capacity for the medium term.

Planned care

18. At the end of April 2024, there were 10 patients waiting 78 weeks or more across the two providers (8 at NUH and 2 at SFH). The latest forecast states that by the end of June there will be zero 78-week waiters within the system.

19. There were 507 patients over 65 weeks at the end of April (367 at NUH, 140 at SFH) against a plan of 554. The most recent unvalidated data presented indicates that NUH did not achieve the May plan (108 away from trajectory – Ear, Nose and Throat Department challenges are the main cause). SFH achieved the May plan position and are on track to achieve June plan.

20. Both providers are planning to eliminate waits of 65 weeks or more by September 2024, which is in line with the NHS England planning requirement. The NHS England regional team have a stretch ambition to eliminate 65-week waiters by the end of June 2024. Providers have advised that they will be able to eliminate 65-week waiters in some specialties by the end of June, but not all.
21. There were 4,818 patients waiting over 52 weeks at the end of April against a plan of 5,095. The most recent unvalidated data indicates that NUH are slightly behind their May plan (3,576 patients v 3,570 plan) with SFHT ahead of May position (1,161 patients v 1,280 plan).
22. The backlog of cancer patients waiting 62 days or more remains above the planned level but is reducing. The 62-day backlog volume continues to be a challenge at NUH but has reduced by 13 patients from last week to 284 patients and is achieving the local trajectory. Urology remains the largest backlog at 132 patients. The Trust is working to achieve the fair shares target of 233 patients by September.
23. NUH is sourcing additional locum consultant capacity with funding through the Cancer Alliance, which should be in place within two weeks. The Trust is also considering how additional capacity at Northampton may be able to be utilised. The Trust is also employing East Midlands Cancer Alliance funding to drive improvements within the lower gastrointestinal pathways.
24. The total volume of patients waiting for diagnostics and those waiting more than six weeks (Diagnostic Backlog) reduced between March and April by 416 patients. The backlog remains above planned levels at 9,363 against a plan of 7,540 patients. Echocardiography, MRI and Audiology are key drivers of the position due to having a high volume of patients waiting over six weeks at system level.
25. SFH delivered against plan for April, May and confident for June. There are risks relating to Cystoscopy, where demand and related waiting list have increased, however validation work has been carried out to mitigate the growth. NUH was marginally behind their trajectory in May (66.8% within 6 weeks v 69% plan). However, improvements are being seen around MRI, CT, Sleep Studies and Echocardiography.
26. The largest backlog within the system relates to Echocardiography at SFH with 2,530 patients from a total waiting list of 3,733 patients in April. This is a significant challenge and will take time to reduce. The Trust have insourcing providers in place, which have contributed to improvement seen from April to May. There are also enhanced overtime payment rates agreed for Trust staff to encourage take up of over time sessions. Mutual aid is in place from NUH for 30 scans per month. As a longer-term solution, SFH is training newly recruited staff through a three-year programme to increase Echo capacity in future.

27. There is significant variation in the volume of patients waiting, and waiting times by modality, and provider level within the system. Detailed review of performance is undertaken at the System Oversight Group, which includes tracking of the position against the recovery trajectories.

Mental health

28. 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.

29. The waiting time for a Talking Therapy first appointments within 6 and 18 weeks are achieving their respective standards in April 2024. In April, 97.5% of patients received their 1st treatment within 6 weeks. The waiting time between the first and second treatment remains an area of focus for the provider with 63% of patients waiting more than 90 days compared to a plan of 10%. Weekly improvement meetings are being held with the provider, with a weekly improvement trajectory being developed and agreed.

30. 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. A ‘deep dive’ is being undertaken to understand how to mitigate likelihood of these exceptions. Recovery trajectories are being developed for 2024/25.

31. The volume of out of area placements remains at a high level, with 1,325 bed days being placed outside of the local area for March 2024. Local data indicates an improving position during quarter one 2024/25 and being ahead of improvement plans. The reporting basis changes to number of patients for 2024/25. 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.

32. A detailed action plan has been developed to eliminate out of area placements by March 2025. This is tracked in detail weekly via the System Oversight Group. The latest data shows 23 patients placed in inappropriate Out of Area Placements against a plan of 34. This has reduced from a high of 52 patients in April. The latest data details there are five appropriate placements and 72 sub contracted beds being utilised, which has increased due to pro-active repatriation of patients from out of area.

Primary care and community services

33. Total GP Appointments in April were 16.6% above the planned level. The percentage of appointments held face to face has decreased from 68.9% in March to 68.5% in April 2024, with 74.9% of appointments offered within two weeks, which is a slight reduction from 76.9% reported for March.

34. Monthly monitoring against the access metrics is included within the Place based Primary Care Support and Assurance Group meetings and will progress opportunities to support improvement at practice level. Engagement work is being undertaken with specific GP Practices, where it has been identified that there is a coding issue with how the 14-day appointments are being captured. There is high confidence that were this to be corrected, the system would report delivery against the 85% expected position.

35. The community waiting list for adults has decreased from the March position of 9,299 patients to 7,750 in April.

36. Reporting in 2023/24 was limited to Nottinghamshire Healthcare NHS Foundation Trust (NHT) and CityCare, however this has been expanded to include relevant services from NUH and SFH for 2024/25, which provides a more complete position of the volume of patients waiting. As a result, the Children and Young People waiting list has increased from the March position of 2,422 to 3,432 in April 2024. An additional 1,227 patients (1,007 at NUH, 220 at SFH) have been added to the position, whilst the volume of patients waiting for services at CityCare and NHT have reduced by 217 patients overall (Increase of four at CityCare and reduction of 221 at NHT).

37. The plan for the volume of 52 week wait Children and Young People waiting for community services for 2024/25 details material increases from 60 patients by the end of quarter one to 118 by quarter four. In April, there were 22 Children and Young People patients waiting over 52 weeks, of which 19 were waiting at NUH, 3 were at NHT and 0 at CityCare at SFH. The 19 patients at NUH are waiting for the Community Paediatric service and the remaining three are waiting for Occupational Therapy, Physiotherapy and Speech and Language Services.

38. During the planning process, NHT had described the pressures around capacity in the Autism and speech and language therapy pathways, but an increased volume of 52-week waiters is not being seen. Further work is required with the provider to understand the modelling assumptions and the rationale for the significant growth forecast for the year.

39. The 52 week wait plans for adults reduce from 89 patients in quarter one to 65 in quarter four. The reduction is based on recovery improvement plans that the provider was developing for a range of services with performance challenges. In April, there were 99 Adults waiting more than 52 weeks for community services in Nottinghamshire. Of these, 83 were NHT and 16 were CityCare.

Almost half (48) of these patients are waiting for Continence/Colostomy services. The next largest group were 37 patients waiting for podiatry or podiatric surgery across CityCare and NHT.

NHS Oversight Framework

40. As of 21 May 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 across ICB areas are:

    a) Accident and Emergency (4 Hours)

    b) Out of Area Placements

    c) Diagnostic Waits (6 weeks)

    d) Cancer 62 days against fair shares

    e) GP Appointments (14 days)

41. All areas except for GP Appointments are currently areas of weekly focus within the newly established System Oversight Group (A) – Delivery, which is led by the ICB's System Delivery Director. Primary care delivery will be brought within the remit of the group. The focus for improvement is to evidence delivery at quarter one against the operational improvement plans submitted for 2024-25. The aims within the plan were as follows:

    a) **Accident and Emergency 4 Hours** – deliver as a system to achieve the 78% standard by March 2025.

    b) **Out of Area Placements** – deliver zero placements by March 2025

    c) **Diagnostic Waits (6 weeks)** – the plans did not deliver to the national expectation of 95% of patients waiting less than 6 weeks, however, did plan for improvements through the year to deliver 85% SFH and 82% NUH.

    d) **Cancer 62 days against fair shares** – plans submitted were to deliver to fair shares at NUH by the end of May 2025. This will be difficult to achieve due to specific issues with the urology pathway for which regional and national support and input has been requested.

    e) **GP Appointments (14 days)** – the plans were to achieve the 85% target by March 2024. It is understood that there is a coding issue within certain practices which is artificially deflating the current performance to below 85%, and the system would deliver to target if all practices were coding activity correctly. A specific piece of work is being undertaken with certain practices to address this.

42. There is a quarterly responsibility for the ICB to provide assessment recommendations for local providers to inform and support the formal

assessments undertaken by NHS England as part of their regulatory responsibilities. The output of the National Oversight Framework (NOF) assessments has now been received from NHS England, which has finalised the assessments as follows for Quarter 4 2023-24.

a) ICB – NOF Assessment Level 3 (Q3 - NOF 3) – finance and learning, disabilities and autism performance.

b) NUH – NOF Assessment Level 4 (Q3 – NOF 4) – this now relates to finance. Previously the level 4 related to maternity, however sufficient progress had been made to recommend movement to NOF 3.

c) NHT – NOF Assessment Level 4 (Q3 – NOF 3) – this has deteriorated due to the significant quality challenges facing the organisation.

d) SFH – NOF Assessment Level 2 (Q3 – NOF 2).

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	11/07/2024
Paper Title:	**Finance Report Month Two**
Paper Reference:	ICB 24 035
Report Author:	Clare Hopewell, Assistant Director of System Finance Ian Livsey, Deputy Director of Financer Ben Taylor, PMO Operations Manager
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 NHS system at the end of month two; the report draws out the key messages for the Board.

NHS System:

Due to the timing of the final June 2024/25 plan submission, month two reporting to NHS England was reduced in scope, so there is limited data available in some areas.

The NHS system has reported a £38.5m deficit at month two, which is £3.7 million adverse to plan against the submitted May plans. The position includes £18.1 million of efficiency. Throughout this report the variances reported relate to the plan submitted in May 2024.

The NHS system subsequently re-submitted plans on 12 June 2024. This reduced the annual NHS system deficit from £105.8 million to the agreed Revenue Financial Plan Limit of £100.0 million. In addition, NHS system partners rephased plans, improving the month two position to nil variance.

There are high levels of risk in the plan submitted, particularly around the delivery of the required efficiency target of £251 million with tighter control and grip measures and governance arrangements put in place to support delivery. There are also risks around the delivery of the elective recovery plan and in the 2024/25 NHS contract negotiations that are on-going and not yet finalised.

The NHS system has had a £8.2 million deduction to their capital envelope, due to the planned deficit position, which will be challenging to deliver against the NHS system priorities and requirements in its capital programme.

ICB:

The ICB is reporting a £17.8 million forecast deficit position in line with plan. The year-to-date position is also in line with plan at a £3.9 million deficit. At this stage of the year there is limited data on which to base the financial position, however, Continuing Healthcare and Section 117 costs are above plan and will be key areas to control during the year.

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 report elements have been previously reported to the Finance and Performance Committee.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Finance Report

NHS system key messages

Indicator Measure	2024/25 Plan (June)	2024/25 Plan (May)	2024/25 YTD Plan (May)	YTD Actuals	YTD Variance	RAG (YTD)
Financial Sustainability (variance from b/e)	-100.0	-105.8	-34.9	-38.5	-3.7	Red
Pay Spend	-1,846.6	-1,845.1	-318.6	-316.1	2.5	Green
Agency Spend v Plan	-52.3	-52.3	-9.3	-8.5	0.8	Green
Agency Spend v Ceiling	-63.5	-63.5		-8.5		
WTE (Provider) – 24/25 Plan as at end March 25	33,369	33,947	34,611	34,091	520	Green
Financial Efficiency v Plan	257.0	251.1	19.9	18.1	-1.8	Red
Recurrent Efficiencies	201.5	178.0	12.5	12.6	0.1	Green
Achievement of MHIS	217.8	217.3	not	reported	at	M2
Capital Spend v System Envelope (excl. IFRS16)	80.3	88.5	13.9	11.6	-2.3	Red

1. The NHS system has a reported £38.5 million spend at month two, which is £3.7 million adverse to plan against the May plans submitted. The NHS system had resubmitted plans in June 2024, which is a break-even position at end of May year-to-date. Throughout this report the variances reported relate to the plan submitted in May 2024.
2. The £3.7 million variance to plan relates solely to Nottinghamshire Healthcare NHS Foundation Trust (NHT), with the main driver being non-delivery of year-to-date efficiency plans (relating to phasing of unidentified savings which have been reprofiled for final plans).

By Organisation £'m	YTD Plan	YTD Actuals	YTD Variance	2024/25 Plan (May)	2024/25 Plan (June)
NUH	-18.7	-18.7	0.0	-51.6	-51.6
SFH	-7.2	-7.2	0.0	-14.0	-14.0
NHT	-5.0	-8.7	-3.7	-16.5	-16.5
N&N ICB	-3.9	-3.9	0.0	-23.6	-17.8
TOTAL	**-34.9**	**-38.5**	**-3.7**	**-105.8**	**-100.0**

3. **Plan re-submission**: The NHS system re-submitted plans on 12 June 2024, which reduced the annual NHS system deficit from £105.8 million to the agreed Revenue Financial Plan Limit of £100.0 million. In addition, NHS system partners rephased plans, improving the month two position to nil variance.
4. **Debt**: £46.4 million will be added to the NHS system's cumulative debt, which will need to be repaid in future years.
5. **Workforce**: Staff costs are £2.5 million underspent across the NHS system at month two with whole time equivalents (WTEs) being 520 WTEs lower than plan. Agency spend is £8.5 million which is £0.8 million under the May year to date plan. Agency plans are £11.2 million below the agency cap and across the NHS system represent 2.8% of the total pay bill.
6. **Efficiencies**: The year-to-date month two position includes £18.1 million of efficiency. All organisations within the NHS system continue to work up financial recovery plans as the risk on the delivery of the efficiency plan target of £251.2 million (May plans) and £257 million (June plans) remains high.
7. **Financial Risk**: In addition to efficiency delivery, there are also risks around the delivery of the elective recovery plan and in the 2024/25 NHS contract negotiations that are on-going and not yet finalised.
8. **Governance and Oversight**: The 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 NHS system Financial Recovery Group which scrutinises and oversees the efficiency and finance position on a weekly basis. The ambition remains to have 100% identified efficiency by the end of June and where gaps and unmitigated risk remains, to consider further options for delivery.
9. **Capital Envelope**: For the June re submission, the revised financial regime relating to 2024-25 revenue performance has an impact on available capital allocations to the NHS system. Based on the NHS system's £100m deficit position, the NHS system has had £8.2 million deducted via a fair share allocation from the original NHS system capital allocation of £88.5 million (revised envelope in May plans £80.3 million).
10. This will have a real impact on the NHS system being able to utilise capital monies to support the capital schemes already expected to be delivered in 2024/25 and will require close monitoring and prioritisation by the NHS system provider collaborative to ensure delivery within the revised envelope.
11. Spend year-to-date against the revised NHS system capital envelope of £80.3 million, is £11.6 million; and against the total capital department expenditure limit plan of £199.2 million, is £19.9 million.

ICB key messages

Key financial Performance Indicator	Target	Year to Date	Forecast
Deliver Planned Surplus/Deficit	£17.8m deficit full year	£3.9m deficit (on plan)	£17.8m deficit
Deliver Income and Expenditure Breakeven	Breakeven	£3.9m deficit	£17.8m deficit
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 ‹£2.02m	On target	On target
Deliver Efficiency Target	Deliver £68.5m	On target	On target

12. The ICB is reporting a £17.8 million forecast deficit position in line with plan. The year-to-date position is also in line with plan at a £3.9 million deficit. At this stage of the financial year, the ICB has limited information on which to base certain aspects of the reported position (for example, limited prescribing data). As such an element of caution is required in interpreting the month two position. Notwithstanding this, Continuing Healthcare and Section 117 costs are above plan and will be key areas to control during the year.
13. Underspends on delegated services of GP contracts and pharmacy, optometry and dental are currently forecast, offsetting overspending areas.
14. The overall efficiency target of £68.5 million is currently forecast to be delivered. Risk-adjusted delivery is at £51.0 million (74%), with the remaining £17.5 million currently being scoped by saving leads. Identified savings have increased by £7.1 million since month one. Year to date delivery is £3.9 million (5.6%).
15. The 2024/25 savings and efficiency governance process is fully in operation. This process includes a strengthened structure in reviewing and delivering efficiency requirements across the organisation, including Financial Recovery Panels, Financial Recovery Meetings, increased awareness to teams led by executive team members and weekly finance meetings.
16. Significant risk exists in delivering the planned £17.8 million deficit, with key risks being delivery of the efficiency programme, continuing healthcare costs and prescribing costs. At this stage of the year there is £18.9 million worth of unmitigated risk in addition to the planned deficit.

17. The ICB has utilised £487.0 million or 16.6% of its 2024/25 of its cash draw down requirement of £2,935.0 million. This compares to an expected utilisation of 16.7%. The cash balance held at 31st May was £0.10 million compared to a maximum target balance of £2.80 million.
18. The ICB met all its Better Payment Practice Code targets of paying at least 95% by value and volume of invoices within 30 days for the end of the reporting period.
19. The ICB capital programme of £2.0 million is currently forecast to be spent in full.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	11/07/2024
Paper Title:	**Committee Highlight Reports**
Paper Reference:	ICB 24 036
Report Author:	Committee Secretariat
Report Sponsor:	ICB Committee Chairs
Presenter:	ICB Committee Chairs

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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 May 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 ICB committees have a responsibility to oversee risks relating to their remit, ensuring that their discussions are reflective of the risks identified and that robust management actions are being taken in response. As such, all committee meetings have risk as a standing agenda item.

As requested at the Board's meeting in May 2024, previous levels of assurance have been included where applicable.

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

Appendices:
C: Highlight Report from the Finance and Performance Committee D: Highlight Report from the Audit and Risk Committee E: 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:	**6 June 2024 and 4 July 2024**
Committee Chair:	**Jon Towler, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
Mental Health, Learning Disability and Neurodiversity Specialist Treatment / Funding Requests Panel Annual Report	The Annual Report for the Mental Health, Learning Disability and Neurodiversity Specialist Treatment / Funding Requests Panel provided an overview of the activity of the Panel during the period 1 April 2023 – 31 March 2024. During this time, three cases had been reviewed and supported and assurance was provided that robust monitoring was undertaken to ensure that services/treatments were improving outcomes and to inform future decision making.	**Full**	**Full** *Awarded at the meeting held on 1 June 2023.*
Individual Funding Request Panel and Prior Approval Process Annual Report	The Annual Report for the Individual Funding Request (IFR) Panel and Prior Approval Process Annual Report, which covered the period 1 April 2023 to 31 March 2024, was received. The report provided a comprehensive overview of the activity received by the IFR team in relation to IFR and prior approval requests. Members noted that all IFRs underwent a robust pre-screening process, and of the 50 IFRs submitted in 2023/24, only two were presented to the IFR Panel.	**Full**	**Adequate** *Awarded at the meeting held on 1 June 2023.*
Working with People and Communities Annual Report	Members received a comprehensive report, covering the period 1 April 2023 to 31 March 2024, describing how the ICB had discharged its legal duties regarding public involvement and consultation and the ways that the ICB had worked with people and communities.	**Full**	**Full** *Awarded at the meeting held on 1 June 2023.*

Item	Summary	Level of assurance	Previous level of assurance
	The purpose and value of several groups established to support the citizen intelligence and coproduction agendas was discussed. Prior to publication, members requested that additional detail be included to set out the actions taken to increase awareness of the full range of urgent and emergency care services.		

Other considerations:

Decisions made:
The Committee: a) Approved the process for decision making in relation to National Institute for Clinical Excellence Technology Appraisals (TAs). This was subject to the refinement of the escalation process and the addition of the ICB's duty to involve the public in planned service change, including public engagement and consultation (as appropriate). Members also endorsed several recommendations regarding compliance with TAs related to semaglutide for obesity, COVID medicines for severe symptoms and hybrid closed loop for type 1 Diabetes. b) Approved the updated IFR Commissioning Policy which had been refreshed with support from the Public Health Consultants from the Local Authorities. c) Approved the Healthcare Contributions to Adult Care Packages Commissioning Policy. The impact of the policy will be closely monitored and a review of the arrangements will be undertaken in six months. d) Approved a direct Alternative Provider Medical Services contract award to The Practice Surgeries Ltd for the Broad Oak Medical Practice under the Provider Selection Regime Process C for the period 1 January 2025 to 31 December 2029. e) Approved the spend associated with the 2024/25 urgent and emergency care capacity fund and the health element of the adult social care discharge fund that was associated with the Better Care Fund. f) Approved the Three-year Mental Health Inpatient Strategic Plan for Adult Services. The Committee will receive delivery progress updates on a six-monthly basis. g) Approved the Public Involvement and Engagement Policy.

h) Endorsed the Nottinghamshire Special Educational Needs and/or Disabilities Joint Commissioning Strategy (2024-2027) which will go on to Nottinghamshire County Council for final approval, prior to publication. Delivery plans for the four priorities identified within the plan will be shared with the Committee in due course.

i) Endorsed the Nottinghamshire local area Special Educational Needs and/or Disabilities Strategy (2024-2027) prior to being presented to the Nottinghamshire County Council for final approval. The endorsement was subject to the development of specific actions for each priority area, which will clearly describe how improvements will be achieved.

j) Endorsed the approach being taken to identify financial efficiencies and savings and a risk-based approach to deliver financial undertakings through an overall efficiency programme.

Matters of interest:

The Committee also received and discussed:

k) A progress update on the development and delivery of the Primary Care Strategy, noting that the current focus was on primary medical services and the delivery of key ambitions to support ongoing local primary care resilience and to meet national policy objectives.

l) An update on progress with the 12 strategic commissioning reviews being carried out where approval had been given for contract extensions and direct contract awards to incumbent providers.

m) The proposed approach, population outcomes and ambition to be achieved through successful delivery of the NHS Joint Forward Plan (JFP). System partners were supportive of the proposed outcomes and had been engaged through the JFP Delivery Group. The JFP population outcomes would be presented to the ICB Board in July 2024.

n) An update on the current context of proposed collective action by primary medical services providers including key risks, potential impact and next steps to support risk mitigation. A further update would be provided to the Committee in September 2024.

o) A business case that provided a high-level summary of the proposed changes to commissioned services to be implemented in 2024/25, in support of the financial recovery plan. The need for pace was emphasised along with the importance of following the appropriate governance processes for decision making.

p) Comprehensive updates on the risks relating to the Committee's remit. Following discussions, several risk scores would be reviewed to ensure that they were representative of the current position.

q) The Log of Investment, Disinvestment, Procurement and Contract Award Decisions (Healthcare) 2024/25.

r) A report on the East Midlands Cancer Alliance oversight arrangements.

Appendix B: Quality and People Committee Highlight Report

Meeting Dates:	**15 May 2024 and 19 June 2024**
Committee Chair:	**Marios Adamou, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous reported level of assurance
Quality Oversight Report	Members received the Committee's routine quality oversight report at both meetings, detailing the quality status of providers where the ICB has principal responsibility for system oversight purposes and areas of quality under enhanced surveillance. In particular, discussions focussed on Nottingham CityCare and ongoing efforts to address quality issues. Members were advised that work was progressing; with the ICB's Quality Team actively involved and more contractual conversations taking place where appropriate. Members noted that the numbers in relation to Learning Disabilities and Autism (LDA) patients remained static. This highlighted the difficulties posed by the complexity of needs versus the requirement to achieve national targets. This was increasingly being highlighted as a conversation that needs progressing at a national level. Members also queried whether transformational changes were happening regarding looked after children and were advised that a system children's transformation board was being established to pursue the required change. It was suggested that the Committee schedule a report for a future meeting to demonstrate what was happening across children's pathways. Members also queried the outputs of recent quality visits to Nottingham University Hospitals NHS Trust (NUH) and were advised that these had	**Limited**	**Limited** *Awarded at the meetings held on 20 March and 17 April 2024.*

Item	Summary	Level of assurance	Previous reported level of assurance
	focused on the Urgent and Emergency Care Pathway and had shown that collaboration and working relationships were improving. Discussions regarding Nottinghamshire Healthcare NHS Foundation Trust (NHT) provided assurance that week on week improvements were being monitored via 'safe now' metrics, and although the pace of change was slower than desired, improvement was evident. At its meeting in June, members received the full NHT Action Plan for discussion (see section 'information items and matters of interest).		
Measles Plan	In January 2024, the UK Health Security Agency (UKHSA) declared a national incident following a surge in measles cases across the UK. Whilst Nottingham and Nottinghamshire had not seen an increase in cases, the decline in measles vaccination uptake was similar to areas with the most confirmed cases, with the lowest rates in Nottingham City, Mansfield, Worksop, and Newark. Upon reviewing the plan, members concluded that the assurance provided was adequate. The primary concerns raised during the discussion focused on the metrics and the measurement used to monitor the plan's effectiveness. The absence of an outbreak in Nottingham and Nottinghamshire was seen as evidence of the plan's effectiveness; however, the transient nature of the population necessitates constant oversight of initiatives to improve vaccination uptake.	**Adequate**	*Assurance level not previously applied.*
People and Culture Annual Report	Members received a report summarising the work of Integrated Care System (ICS) delivery partners regarding the objectives in the ICS People and Culture Delivery Plan for 2023/24. The main request from members was for a People Plan with clearly defined deliverables for 2024/25 to enable measurement and	**Limited**	*Assurance level not previously applied*

Item	Summary	Level of assurance	Previous reported level of assurance
	assessment of the actions' impact. Members also sought assurance about the Provider Collaborative's ability to fulfil its responsibilities. Whilst members acknowledged that the report provided a comprehensive summary of the activities conducted during 2023/24, a limited assurance rating was applied due to insufficient information about the effectiveness and impact of actions and the absence of measurable outcomes.		
Equality, Diversity and Inclusion (EDI) Annual Report	Members received the statutory report for assurance before its publication on the ICB's website. The general consensus was that there should be a stronger focus on actively engaging in EDI conversations at Board level going forward. This should be supported by broader equality objectives and the agreement of measurable outcomes to assess the embedding of the EDI maturity matrix. Whilst members felt the report provided adequate assurance, they requested that future assurances include more detail regarding the nine equality objectives.	**Adequate**	*Assurance level not previously applied*
ICB Patient Safety Incident Response Framework (PSIRF)	The report focused on the ICB's roles and responsibilities concerning the PSIRF. Members reviewed the information and discussed the red, amber, and green ratings for providers, concluding that the system was performing as expected at this stage. In this first year of implementation, the focus was on embedding the framework, which would be followed by analysis of outputs and lessons learned. The adequate assurance rating related to the PSIRF processes implemented over the last year, although members requested to see how this was translating into improvements for patients in future updates.	**Adequate**	*Assurance level not previously applied*

Item	Summary	Level of assurance	Previous reported level of assurance
Safeguarding Report - Children	Members received a comprehensive report of performance against the ICBs statutory Safeguarding duties with regard to children. The report was complemented by further context and verbal assurances from the Chief Nurse and members applied full assurance to the report.	**Full**	*Assurance level not previously applied*
Care Homes and Home Care Report	The report provided an overview of the care sector, encompassing both Care Homes and Home Care, and highlighted key risks associated with international recruitment, service suspensions, and their impact on the availability of Care Home beds and Home Care services. Members felt that whilst the report was descriptive, it lacked context and was not clear on purpose. Further information to help members in this regard was shared following the meeting and it was agreed that the next report (due in November 2024) would provide more detail around the ICB's statutory responsibilities and performance against headline key performance indicators. It was agreed that the lack of necessary detail in the report required an assurance level of limited.	**Limited**	*Assurance level not previously applied.*
Medicines Optimisation – Quality and Safety in Social Care Annual Report 2023/24	This report complimented the Care Homes and Home Care report and provided comprehensive information that led members to apply an adequate assurance rating. Members were assured of the processes in place, with the only gap in assurance being the feedback loop in terms of demonstrating learning from issues.	**Adequate**	*Assurance level not previously applied.*
Delivery of 2024/25 Workforce Plan	Members reviewed the 'month one' system workforce report, following a detailed discussion at the previous meeting around the Committee's requirements for reporting this year. Members accepted that the information	**Partial**	*Assurance level not previously applied.*

Item	Summary	Level of assurance	Previous reported level of assurance
	available for this first month was limited, therefore assurance was agreed as partial.		

Other considerations:

Decisions made:
The Committee: a) Approved the modern slavery statement 2024/25 for publication on the ICB's website. b) Approved the ICB Corroborative Statements to be inserted into Quality Accounts for: NUH, NHT and Sherwood Forest Hospitals NHS Foundation Trust (SFH).
Information Items and Matters of interest:
The Committee: c) Received the latest iteration of the NHT action plan, which led to discussion about assurance in relation to governance arrangements. It was agreed that more detailed updates on delivery were required and that discussions would take place outside of the meeting to schedule these at appropriate points. d) Received an update on development of the System Quality Framework. Members asked for the objectives within the strategy to be Specific, Measurable, Achievable, Relevant and Time bound (SMART). e) Reviewed identified risks relating to its areas of responsibility. The number of risks remained high and it was agreed that members should periodically review the risk register as the first item on the agenda. f) Members were provided with a verbal update outlining the intention with regard to development of the People Plan, noting that this would also be the subject of the upcoming board development session.

Appendix C: Finance and Performance Committee Highlight Report

Meeting Dates:	**29 May 2024 and 26 June 2024**
Committee Chair:	**Stephen Jackson, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
2024/25 System and ICB Finance Report (M2)	Members received the report and were advised that the achievement of efficiencies remained the greatest risk to delivery of the financial plan, which had resulted in partner organisations enhancing their efficiency governance and oversight arrangements. 90% of the £257m efficiency requirement had been identified, though some plans were still in their early stages. This left a risk-adjusted gap of £100m. To bridge the gap, more focus was needed to develop the initial schemes, identify additional internal efficiencies in all organisations and to collaborate with providers to find further opportunities to reduce spending. Members were assured that all efforts would consider the impact on service delivery and quality. Members expressed concern about the current position and the slow progress in developing achievable, credible plans. Consequently, members agreed to escalate this to the ICB Board meeting on 11 July 2024, asking for a paper to be taken explaining how the system plans to deliver the £257 million efficiency target, including addressing the £100 million risk-adjusted gap.	**Limited**	**Limited** *Awarded at the meetings held on 21 March 2024 and 24 April 2024.*
Service Delivery Report and Operational Plan 2024/25 Delivery (M2)	In May and June 2024, members received reports highlighting areas of improvement and challenges. Additionally, in June, they received an update from the Interim Director of System Delivery on actions taken to promote rapid improvement. This report covered key delivery areas such as Cancer, Electives, Value Weighted Activity, Diagnostics, Urgent and Emergency Care,	**Partial**	**Limited** *Awarded at the meetings*

Item	Summary	Level of assurance	Previous level of assurance
	Mental Health, Primary Care, and Learning Disabilities and Autism. It detailed the progress against the Operational Plan 2024/25, actions taken, planned actions, and their impact. Members welcomed the report, acknowledging the improvements and recognising the areas needing continued focus. They noted that weekly oversight arrangements would need to remain in place for the foreseeable future. The overall rating improved from limited to partial, reflecting the sustained improvements and increased confidence in plans to enhance performance further.		*held on 21 March 2024 and 24 April 2024.*
Thematic Health Inequalities Review – Respiratory Conditions	Chronic Obstructive Pulmonary Disorder (COPD) was a key focus area in the Core20+5 initiative due to its significant impact on health inequalities. In Nottingham and Nottinghamshire, 2.1% of the population, approximately 26,000 individuals, had a recorded diagnosis of COPD. Respiratory diseases were the third highest cause of avoidable deaths in individuals under 75. The COPD diagnosis rate was increasing annually and was projected to grow by 26% over the next 20 years. Discussion focused on the priority need to improve access to and rates for Spirometry. This was discussed in the context of the financial sustainability opportunities plan which aimed to introduce measures that would lead to a reduction in emergency admissions. The rating of partial assurance was given in recognition of the need to significantly improve access to Spirometry services.	**Partial**	*Assurance level not previously applied.*
ICS Green Plan	Members received periodic updates about implementation of the ICS Green Plan. This report showed that the system performed well relative to other systems in the Midlands.	**Partial**	**Adequate** *Awarded at the meeting*

Item	Summary	Level of assurance	Previous level of assurance
	Members discussed the priority areas for focus during 2024/25, noting that to date reductions had resulted from de-carbonisation of the national grid rather than from local actions. It was evident that achieving the 80% net zero target by 2028 would not be feasible. The next phase of work would focus on identifying achievable goals, areas for progress, and identifying stakeholders to drive initiatives forward.		*held on 26 July 2023.*

Other considerations:

Decisions made:
a) Members approved funding for the re-provision of the Gotham Branch Surgery. Additionally, the ICB would continue to plan for a medical facility on the Fairham Pastures site for the longer-term growth.
b) Members approved the expansion of clinical space and car parking by the Sherwood Medical Partnership, Clipstone.
Matters of interest:
c) Members received a verbal update on development of the ICS Infrastructure Strategy. The final strategy would be subject to ICB Board approval.
d) The Operational Risk Register was considered as the first item of business on the June 2024 agenda. This led to a wide-ranging discussion focused on risks related to service delivery and the identification of new risk associated with cash flow and relationship management.
e) Members received a report on Population Health Management Outcomes – avoidable deaths under 75. Whilst provided as a report for information, members were concerned about the deterioration in outcomes, leading to discussion about the need to develop a Long-Term Conditions (LTC) delivery plan. It was noted that there may be an investment decision required via the Strategic Planning and Integration Committee.

Appendix D: Audit and Risk Committee Highlight Report

Meeting Dates:	**16 May 2024 and 19 June 2024**
Committee Chair:	**Caroline Maley, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
Bi-annual Risk Management Arrangement Update	The report provided an update on the work being undertaken to embed strategic and operational risk management arrangements within the ICB. The Committee approved non-material changes to the ICB's Risk Management Policy, noting that proposed changes to risk appetite reflected how the ICB and system had operated in practice. Although the systems and processes underpinning risk management arrangements were robust, arrangements, particularly within the system, continued to evolve.	**Adequate**	**Full** *Awarded at the meeting held on 23 October 2023.*
Use of Emergency Powers for Urgent Decisions	The Committee reviewed the six urgent decisions that had been undertaken since the last report in October 2023 using the emergency powers permitted via the ICB's Standing Orders and the committees' terms of reference. Members were satisfied with the rationale for using the powers.	**Full**	**Full** *Awarded at the meeting held on 23 October 2023.*
Health and Safety Year End Report	An annual report on the embedment of arrangements across the ICB to meet health and safety requirements was received by the Committee. As the ICB is classified as a 'low risk' organisation, with staff being predominantly office or home based, focus in this area related to the health, safety, and welfare of its	**Full**	**Full** *Awarded at the meeting*

Item	Summary	Level of assurance	Previous level of assurance
	workforce. Members considered the governance in this area to be proportionate to the level of risk and gave a rating of full assurance.		*held on 13 June 2023.*
Financial Stewardship	The report provided an update on the ICB's key financial arrangements. The Committee noted that procurement card usage and agency spend continued to be proactively managed. The Committee was also the Committee provided with details of all instances where competitive tendering requirements had been waived during the financial year 2023/24.	**Adequate**	**Adequate** *Awarded at the meeting held on 3 January 2024.*
Emergency Preparedness, Resilience and Response (EPRR) Report	The report provided an update of work towards achieving full compliance against NHS England' EPRR core standards. The ICB had been rated as partially compliant at the beginning of the year. The Committee were assured that work to improve compliance rates were being undertaken, with full compliance expected by the end of quarter two.	**Adequate**	**Adequate** *Awarded at the meeting held on 3 January 2024.*
Information Governance	Members were assured to the arrangements established within the ICB to ensure compliance with the requirements of the Data Security and Protection Toolkit (DSPT) and to report on the ICB's position ahead of the year-end (2023/24) submission by 28 June 2024. An Internal Audit check on the ICB's self-assessment had concluded, with an overall 'substantial' opinion.	**Full**	**Adequate** *Awarded at the meeting held on 3 January 2024.*

Item	Summary	Level of assurance	Previous level of assurance
Statutory and Mandatory Training Compliance	The Committee reviewed ICB's current statutory and mandatory training compliance figures and the processes in place to monitor and improve compliance rates. Overall, compliance rates remained high.	**Adequate**	**Full** *Awarded at the meeting held on 3 January 2024.*

Other considerations:

Decisions made:
a) The Committee approved the Annual Report and Accounts for the ICB for the period 1 April 2023 to 31 March 2024 for onward submission to NHS England ahead of the deadline of 28 June 2024. The Committee also endorsed the signing of the letter of representation, which stated compliance with accounting and auditing standards. These approvals followed scrutiny of the External Audit report of the accounts; third party assurance reports; and the Head of Internal Audit Opinion report, which had provided an overall rating of 'significant assurance'. The External Audit opinion was 'unqualified'.
b) The Committee approved the Counter Fraud Functional Standard Return for 2023/24. All components in the self-assessment had been rated as compliant.
c) The Committee approved its work programme for 2024/25.
Matters of interest:
d) The Committee received a report on the outcome of the effectiveness reviews of all committees and the actions that had been identified to enhance existing arrangements, concluding that the reviews had demonstrated that all committees were operating effectively, members were supportive of the action plan and the proposals for the coming year's review.
e) The ICB's Counter Fraud function's Annual Report 2023/24 was received.

Decisions made:
f) Members received an update on progress of the Internal Audit Plans. Two of the three remaining advisory reports for 2023/24 had been issued and one report for the Data Security and Protection Toolkit from the 2024/25 Internal Audit Plan had been received, which provided ‘substantial assurance’.

Appendix E: Current high-level operational risks being oversighted by the Board's committees

Risk Ref.	Risk Description	Current Score	Responsible Committee
ORR084	If organisations within the Nottingham and Nottinghamshire system are unable to access IT systems, 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** 15 (I5 x L3)	Audit and Risk Committee
ORR090	If the Nottingham and Nottinghamshire system does not have sufficient system partner 'buy in' and capacity to engage with and deliver 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
ORR178	If Nottingham and Nottinghamshire system workforce productivity is not improved, due to cultural and operational challenges, there is a risk to the financial sustainability of the system. This may also impact service delivery.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR145	If there continues to be sustained pressure, further organisational change and ICB cost reductions, there is a risk of increased sickness absence and reductions in staff productivity alongside staff feeling disconnected or disengaged with the ICB.	**High** 16 (I4 x L4)	Human Resources Executive Steering Group
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.	**High** 20 (I4 x L5)	Quality and People Committee
ORR024	If Nottingham University Hospitals NHS Trust (NUH) do not have the capacity to make improvements in a timely manner (following CQC visits), the quality of services provided may not meet optimal care standards resulting in poor patient experience and adverse health outcomes for the population of Nottingham/shire.	**High** 16 (I4 x L4)	Quality and People Committee
ORR061	If demand outstrips the system's capacity to promptly treat cancer, people may wait longer for treatment, which may lead to poor patient outcomes and experience. This risk is further exacerbated by industrial action.	**High** 16 (I4 x L4)	Quality and People Committee

Risk Ref.	Risk Description	Current Score	Responsible Committee
ORR077	If sustained levels of significant pressure on health and social care services continues, due to high levels of demand there is risk of moral injury, staff sickness, exhaustion and 'burn out'. This relates to health, social care and primary medical services provider 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, patients may stay in inpatient settings longer than necessary. 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 (NEW)	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
ORR101	If pressures on elective activity persist, due to capacity constraints and non-elective demand, there is a significant risk that planned care waiting times will increase further. This may in turn present a risk of patient deterioration and deconditioning (physical or cognitive functions), leading to increased levels of morbidity and mortality. This risk is further exacerbated by industrial action	**High** 16 (I4 x L4)	Quality and People Committee
ORR142 (NEW)	If staffing levels are reduced, at times of workforce industrial action, this may result in risk to the delivery of services across the system.	**High** 16 (I4 x L4)	Quality and People Committee
ORR154	If we fail to prioritise prevention across the health and social care system, there is a risk of missed opportunities to avoid unnecessary admissions and keep individuals well in their communities.	**High** 16 (I4 x L4)	Quality and People Committee
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.	**High** 16 (I4 x L4)	Quality and People Committee
ORR167	If there are delays across the urgent and emergency care pathway, there is a risk of patient deterioration and deconditioning (physical or cognitive functions) within hospital settings, which may lead to increased levels of morbidity and mortality.	**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

Risk Ref.	Risk Description	Current Score	Responsible 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 Nottingham and Nottinghamshire 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, resulting in ineffective use workforce that does not align with population health needs.	**High** 16 (I4 x L4)	Quality and People Committee
ORR023	If Nottingham University Hospitals NHS Trust (NUH) do not have the capability to make improvements in a timely manner following CQC recommendations, the quality of maternity services provided may not meet optimal care standards resulting in poor patient experience and adverse health outcomes for the population of Nottingham/shire.	**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
ORR192	If resources at Nottinghamshire Health 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.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	11/07/2024
Paper Title:	**ICB Constitution**
Paper Reference:	ICB 24 038
Report Author:	Lucy Branson, Director of Corporate Affairs
Executive Lead:	Rosa Waddingham, Director of Nursing and Governance
Presenter:	-

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

Summary:

As referenced in paragraph 11 of the Chair's Report on this agenda.

Recommendation(s):

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

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:

A: ICB Constitution.

Board Assurance Framework:

-

Report Previously Received By:

-

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

NHS Nottingham and Nottinghamshire Integrated Care Board

CONSTITUTION

Version	Effective Date	Changes
1.0	1 July 2022	First version constitution on establishment of the ICB.
1.1	10 November 2022	Housekeeping amendments to 1.4.7(f), 3.2.4, 3.2.7, 7.1.1 and Appendix 1, as directed by NHS England.
1.2	1 October 2024	To reflect an increase in the number of Ordinary Members of the Board; one further non-executive member and one further executive member. Changes to 2.2.2(a), 2.2.2(b), 2.2.3(f), 2.2.3(j), 2.2.3(k) and 3.8.1, 3.12, 3.12.1 and 3.12.3.

Contents

1. Introduction

1.1 Background/ Foreword

1.1.1 NHS England has set out the following as the four core purposes of Integrated Care Systems:

(a) Improve outcomes in population health and healthcare.

(b) Tackle inequalities in outcomes, experience and access.

(c) Enhance productivity and value for money.

(d) Help the NHS support broader social and economic development.

1.1.2 The Integrated Care Board will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

(a) Improving the health of children and young people.

(b) Supporting people to stay well and independent.

(c) Acting sooner to help those with preventable conditions.

(d) Supporting those with long-term conditions or mental health issues.

(e) Caring for those with multiple needs as populations age.

(f) Getting the best from collective resources so people get care as quickly as possible.

1.1.3 In Nottingham and Nottinghamshire, the Integrated Care Partnership will form the 'guiding mind' for the Integrated Care System in creating an integrated care strategy that will set out how the assessed needs of its area are to be met by the Integrated Care Board, NHS England and relevant local authorities. The Integrated Care Board will pay due regard to this integrated care strategy when exercising its functions.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Nottingham and Nottinghamshire Integrated Care Board (referred to in this constitution as "**the ICB**").

1.3 Area covered by the Integrated Care Board

1.3.1 The area covered by the ICB (referred to in this constitution as "**the ICB Area**") is coterminous with the District of Ashfield, District of Bassetlaw, Borough of Broxtowe, Borough of Gedling, District of Mansfield, District of Newark and Sherwood, City of Nottingham and Borough of Rushcliffe.

1.4 Statutory framework

1.4.1 The ICB is established by order made by NHS England under powers in the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022 ("**the 2006 Act**").

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29 of the 2006 Act). This constitution is published on the ICB's website at www.notts.icb.nhs.uk.

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both duties and powers. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

(a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act).

(b) Exercising its functions effectively, efficiently, and economically (section 14Z33 of the 2006 Act).

(c) Duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014).

(d) Adult safeguarding and carers (the Care Act 2014).

(e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35 of the 2006 Act).

(f) Information law (for instance, data protection laws, such as the UK General Data Protection Regulation, the Data Protection Act 2018, and the Freedom of Information Act 2000).

(g) Provisions of the Civil Contingencies Act 2004.

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:

(a) Section 14Z34 of the 2006 Act (improvement in quality of services).

(b) Section 14Z35 of the 2006 Act (reducing inequalities).

(c) Section 14Z38 of the 2006 Act (obtaining appropriate advice).

(d) Section 14Z40 of the 2006 Act (promoting research).

(e) Section 14Z43 of the 2006 Act (having regard to the wider effect of decisions).

(f) Section 14Z45 of the 2006 Act (public involvement and consultation).

(g) Sections 223GB to 223N of the 2006 Act (financial duties).

(h) Section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61 of the 2006 Act).

1.5 Status of this constitution

1.5.1 The ICB was established on 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its constitution by reference to this document.

1.5.2 This constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.

1.5.3 Changes to this constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this constitution may be varied in accordance with the procedure set out in this paragraph. The constitution can only be varied in two circumstances:

(a) Where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved.

(b) Where NHS England varies the constitution of its own initiative (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the constitution is as follows:

(a) The Chair or Chief Executive may periodically propose amendments to this constitution.

(b) All proposed amendments shall be considered and endorsed by the Board of the ICB in line with its procedures for making decisions (as set out in the ICB's Standing Orders), prior to an application being made to NHS England to vary the constitution.

(c) Proposed amendments to this constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related documents

1.7.1 This constitution is also supported by a number of documents, which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to this constitution and form part of it for the purpose of the provisions set out at 1.6 of this constitution and the ICB's legal duty to have a constitution:

(a) **Standing Orders** – which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

1.7.3 The following do not form part of this constitution but are required to be published:

(a) **Scheme of Reservation and Delegation (SoRD)** – sets out those decisions that are reserved to the Board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with this constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

(b) **Functions and Decisions Map** – a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decisions Map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

(c) **Standing Financial Instructions** – which set out the arrangements for managing the ICB's financial affairs.

(d) **Governance Handbook** – this brings together all the ICB's governance documents, so it is easy for interested people to navigate. It includes (but is not limited to):

  (i) The above documents (a) to (c).

  (ii) Terms of reference for all committees and sub-committees of the Board that exercise ICB functions.

  (iii) Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to one or more other body (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body); or to a joint committee of the ICB and one or more of those organisations in accordance with section 65Z6 of the 2006 Act.

  (iv) Terms of reference of any joint committee of the ICB and one or more other body (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

  (v) The up-to-date list of eligible providers of primary medical services as referenced at 3.6.2 of this constitution.

(e) **Key policy documents** – which should also be included in the Governance Handbook or linked to it – including (but not limited to):

  (i) Standards of Business Conduct Policy, which incorporates the ICB's policy and procedures for the identification and management of conflicts of interest.

  (ii) Policy for public involvement and engagement.

2. Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in part 3 of this constitution.

2.1.2 Further information about the individuals who fulfil these roles can be found on the ICB's website at www.notts.icb.nhs.uk.

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this constitution as **"the Board"** and members of the ICB referred to as **"Board Members"**) consists of a Chair, a Chief Executive, and at least three Ordinary Members.

2.1.4 The membership of the ICB (the Board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 NHS England Policy requires the ICB to appoint the following additional Ordinary Members: three executive members, namely a Director of Finance, a Medical Director, and a Director of Nursing; and at least two non-executive members.

2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as **"Partner Members"**) are nominated by the following, and appointed in accordance with the procedures set out in part 3 of this constitution:

(a) NHS trusts and NHS foundation trusts who provide services within the ICB Area and are of a prescribed description.

(b) The primary medical services (general practice) providers within the ICB Area and are of a prescribed description.

(c) The local authorities which are responsible for providing social care and whose areas coincide with or include the whole or any part of the ICB Area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the Board, they are not to act as delegates of those sectors.

2.2 Board membership

2.2.1 The ICB has five Partner Members:

(a) Two from the NHS trusts and NHS foundation trusts who provide services within the ICB Area.

(b) One from the primary medical services (general practice) providers within the ICB Area.

(c) Two from the local authorities that provide social care and whose areas coincide with the ICB Area.

2.2.2 The ICB has also appointed the following further Ordinary Members to the Board (which are in addition to those set out at 2.1.5 and 2.1.6 of this constitution):

(a) Three non-executive members.

(b) Two executive members, namely a Director of Strategy and System Development and a Director of Delivery and Operations.

2.2.3 The Board is therefore composed of the following members:

(a) Chair.

(b) Chief Executive.

(c) Two Partner Members – NHS trusts and NHS foundation trusts.

(d) One Partner Member – providers of primary medical services.

(e) Two Partner Members – local authorities.

(f) Five Non-Executive members:

(i) One to be Chair of the Audit and Risk Committee.

(ii) One to be Chair of the Remuneration Committee.

(iii) Three further Non-Executive members.

(g) Director of Finance.

(h) Medical Director.

(i) Director of Nursing.

(j) Director of Strategy and System Development.

(k) Director of Delivery and Operations.

2.2.4 The Chair will exercise their function to approve the appointment of the Ordinary Members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The Board will keep under review the skills, knowledge, and experience that it considers necessary for members of the Board to possess (when taken together) in order for the Board to effectively carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular participants and observers at meetings of the Board

2.3.1 The Board may invite specified individuals to be Participants or Observers at its meetings to inform its decision-making and the discharge of its functions as it sees fit.

2.3.2 Participants will receive advanced copies of the notice, agenda and papers for Board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting, but may not vote.

2.3.3 Observers will receive advanced copies of the notice, agenda and papers for Board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

2.3.4 Participants and/or observers may be asked to leave the meeting by the Chair in the event that the Board passes a resolution to exclude the public as per the Standing Orders.

3. Appointments process for the Board

3.1 Eligibility criteria for Board membership

3.1.1 Each member of the ICB must:

(a) Comply with the criteria of the Fit and Proper Person Test.

(b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles).

(c) Fulfil the requirements relating to experience, knowledge, skills, and attributes set out in the relevant role specification.

3.2 Disqualification criteria for Board membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a Board member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted:

(a) In the United Kingdom of any offence.

(b) Outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any health service body.

3.2.6 A person whose term of appointment as the chair, a member, a director, or a governor of a health service body, has been terminated on the grounds:

(a) That it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office.

(b) That the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings.

(c) That the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest.

(d) Of misbehaviour, misconduct, or failure to carry out the person's duties.

3.2.7 A Health Care Professional or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practice or any alleged fraud, the final outcome of which was:

(a) The person's suspension from a register held by the regulatory body, where that suspension has not been terminated.

(b) The person's erasure from such a register, where the person has not been restored to the register.

(c) A decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded.

(d) A decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

(a) A disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002.

(b) An order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under:

(a) Section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities).

(b) Section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State for Health and Social Care.

3.3.2 In addition to the criteria specified at 3.1 of this constitution, this member must fulfil the following additional eligibility criteria:

(a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

(a) They hold a role in another health or care organisation within the ICB Area.

(b) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(c) They are an employee of the ICB, or a person seconded to the ICB.

3.3.4 The term of office for the Chair will be three years and the total number of terms a Chair may serve is three terms.

3.4 Chief Executive

3.4.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England

3.4.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

3.4.3 Further to the criteria specified at 3.1 of this constitution, the Chief Executive must fulfil the following additional eligibility criteria:

(a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.4.4 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(b) Subject to the provisions set out at 3.4.3(a) of this constitution, they hold any other employment or executive role.

3.5 Partner Member – NHS trusts and NHS foundation trusts

3.5.1 These Partner Members are jointly nominated by the NHS trusts and NHS foundation trusts which provide services for the purposes of the health service within the ICB Area and meet the forward plan condition or (if the forward plan condition is not met) the level of services provided condition, as prescribed in regulations:

(a) Sherwood Forest Hospitals NHS Foundation Trust.

(b) Nottingham University Hospitals NHS Trust.

(c) Nottinghamshire Healthcare NHS Foundation Trust.

(d) East Midlands Ambulance Services NHS Trust.

(e) Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust.

3.5.2 These members must fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be the Chief Executive or relevant Executive Director of one of the NHS trusts or NHS foundation trusts within the ICB Area.

(b) One member must be able to bring an informed view of hospital, urgent and emergency care services.

(c) The other member must have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

3.5.3 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(b) They are an employee of the ICB, or a person seconded to the ICB.

3.5.4 These members will be appointed by the Chief Executive, subject to the approval of the Chair.

3.5.5 The appointment process will be as follows for each of these Partner Member roles:

(a) **Joint nomination:** When a vacancy arises, each eligible organisation listed at 3.5.1 of this constitution will be invited to nominate an individual who meets the required criteria for the role (as set out at

3.5.2 and 3.5.3 of this constitution). Eligible organisations may choose to nominate an individual from their own organisation or from another eligible organisation listed at 3.5.1 of this constitution. There is no requirement for every eligible organisation to nominate an individual.

All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, specifying a date for responses to be provided. The list will be adopted on the specified date and taken forward to step (b) below if the eligible organisations have expressly confirmed the list or provided no response.

Should no individuals be nominated, or if a majority of the eligible organisations do not agree the list, then the nomination process will be re-run until sufficient nominations are received and/or agreement is reached.

(b) **Assessment, selection and appointment:** The agreed list of jointly nominated individuals will be considered by a panel convened by the Chief Executive. The panel will assess the suitability of the nominees against the requirements of the role as set out at 3.5.2 and 3.5.3 of this constitution. If there is more than one suitable nominee, then the panel will select the most suitable for appointment. Should no individual be eligible for appointment following assessment, then the nomination process at 3.5.5(a) of this constitution will be repeated.

(c) **Approval:** The individual identified as most suitable for appointment will then be subject to approval by the Chair before taking up their role on the Board.

3.5.6 Except as provided for at 3.5.8 of this constitution, the normal term of office for these Partner Members will be two years.

3.5.7 There is no limit to the number of terms of office that can be served by an individual, whether consecutively or otherwise; however, no individual will have the right to be automatically reappointed, as the appointment process set out at 3.5.5 of this constitution will be followed at the end of each term of office.

3.5.8 Normal terms of office may be varied at the discretion of the Chair, based on the ICB's requirements at the time of appointment and to facilitate Board continuity.

3.6 Partner Member – providers of primary medical services

3.6.1 This Partner Member is jointly nominated by the providers of primary medical services for the purposes of the health service within the ICB Area and that are primary medical services contract holders responsible for the

provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility. The list of relevant providers of primary medical services for this purpose is published as part of the ICB's Governance Handbook. The list will be kept up to date but does not form part of this constitution.

3.6.2 This member must fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be a registered medical practitioner, performing primary medical services for one of the providers set out at 3.6.1 of this constitution.

3.6.3 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(b) They are an employee of the ICB, or a person seconded to the ICB.

3.6.4 This member will be appointed by the Chief Executive, subject to the approval of the Chair.

3.6.5 The appointment process will be as follows:

(a) **Joint nomination:** When a vacancy arises, individuals that meet the required criteria for this role (as set out at 3.6.2 and 3.6.3 of this constitution) may nominate themselves for this role. All self-nominations must be seconded by at least one of the eligible organisations described at 3.6.1. There is no requirement for every eligible organisation to nominate an individual.

All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, specifying a date for responses to be provided. The list will be adopted on the specified date and taken forward to step (b) below if the eligible organisations have expressly confirmed the list or provided no response.

Should no individuals be nominated, or if a majority of the eligible organisations do not agree the list, then the nomination process will be re-run until sufficient nominations are received and/or agreement is reached.

(b) **Assessment, selection and appointment:** The agreed list of jointly nominated individuals will be considered by a panel convened by the Chief Executive. The panel will assess the suitability of the nominees against the requirements of the role as set out at 3.6.2 and 3.6.3 of this constitution. If there is more than one suitable nominee, then the panel will select the most suitable for appointment. Should no

individual be eligible for appointment following assessment, then the nomination process at 3.6.5(a) of this constitution will be repeated.

(c) **Approval:** The individual identified as most suitable for appointment will then be subject to approval by the Chair before taking up their role on the Board.

3.6.6 Except as provided for at 3.6.8 of this constitution, the normal term of office for this Partner Member will be three years.

3.6.7 There is no limit to the number of terms of office that can be served by an individual, whether consecutively or otherwise; however, no individual will have the right to be automatically reappointed, as the appointment process set out at 3.6.5 of this constitution will be followed at the end of each term of office.

3.6.8 Normal terms of office may be varied at the discretion of the Chair, based on the ICB's requirements at the time of appointment and to facilitate Board continuity.

3.7 Partner Members – local authorities

3.7.1 These Partner Members are jointly nominated by the local authorities whose areas coincide with, or include the whole or any part of, the ICB Area. Those local authorities are:

(a) Nottingham City Council.

(b) Nottinghamshire County Council.

3.7.2 This member will fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be the Chief Executive or hold a relevant executive level role of one of the bodies listed at 3.7.1 of this constitution or be a member of one of these bodies if deemed most appropriate.

(b) One member must be able to bring a perspective of the social care needs and health and wellbeing characteristics of people and communities living in an urban city area.

(c) The other member must be able to bring a perspective of the social care needs and health and wellbeing characteristics of people and communities living in market towns and rural areas.

3.7.3 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(b) They are an employee of the ICB, or a person seconded to the ICB.

3.7.4 These members will be appointed by the Chief Executive, subject to the approval of the Chair.

3.7.5 The appointment process will be as follows for each of these Partner Member roles:

(a) **Joint nomination:** When a vacancy arises, each eligible organisation listed at 3.7.1 of this constitution will be invited to nominate an individual who meets the required criteria for the role (as set out at 3.7.2 and 3.7.3 of this constitution). Eligible organisations may choose to nominate an individual from their own organisation or from another eligible organisation listed at 3.7.1 of this constitution. There is no requirement for every eligible organisation to nominate an individual.

The eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, specifying a date for responses to be provided. The list will be adopted on the specified date and taken forward to step (b) below if the eligible organisations have expressly confirmed the list or provided no response.

Should no individuals be nominated, or if the eligible organisations do not agree the list, then the nomination process will be re-run until sufficient nominations are received and/or agreement is reached.

(b) **Assessment, selection and appointment:** The agreed list of jointly nominated individuals will be considered by a panel convened by the Chief Executive. The panel will assess the suitability of the nominees against the requirements of the role as set out at 3.7.2 and 3.7.3 of this constitution. If there is more than one suitable nominee, then the panel will select the most suitable for appointment. Should no individual be eligible for appointment following assessment, then the nomination process at 3.7.5(a) of this constitution will be repeated.

(c) **Approval:** The individual identified as most suitable for appointment will then be subject to approval by the Chair before taking up their role on the Board.

3.7.6 Except as provided for at 3.7.8 of this constitution, the normal term of office for these Partner Members will be three years.

3.7.7 There is no limit to the number of terms of office that can be served by an individual, whether consecutively or otherwise; however, no individual will have the right to be automatically reappointed, as the appointment process set out at 3.7.5 of this constitution will be followed at the end of each term of office.

3.7.8 Normal terms of office may be varied at the discretion of the Chair, based on the ICB's requirements at the time of appointment and to facilitate Board continuity.

3.8 Non-Executive members

3.8.1 The ICB will appoint five Non-Executive members.

3.8.2 These members will be appointed and approved by the Chair.

3.8.3 These members will fulfil the eligibility criteria set out at 3.1 and the following additional eligibility criteria:

(a) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit and Risk Committee.

(b) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee.

(c) Have a connection to (such as living or working in) the ICB Area.

3.8.4 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

(b) They hold a position or office in another health or care organisation that provides services within the ICB Area.

(c) They are an employee of the ICB, or a person seconded to the ICB.

3.8.5 Except as provided for at 3.8.7 of this constitution, the normal term of office for a Non-Executive member will be three years and the total time able to be served is nine years in total.

3.8.6 The Chair may approve the re-appointment of an individual to the role of Non-Executive member for further terms of office up to the maximum number of years able to be served, subject to demonstration of continuing competence through a satisfactory annual performance appraisal. No individual will have the right to be automatically re-appointed.

3.8.7 Normal terms of office may be varied at the discretion of the Chair, based on the ICB's requirements at the time of appointment and to facilitate Board continuity.

3.9 Director of Finance

3.9.1 This member will fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

(b) Be a qualified accountant with full professional membership.

3.9.2 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

3.9.3 This member will be appointed by the Chief Executive, subject to the approval of the Chair.

3.10 Medical Director

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

(b) Be a registered medical practitioner.

3.10.2 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

3.10.3 This member will be appointed by the Chief Executive, subject to the approval of the Chair.

3.11 Director of Nursing

3.11.1 This member will fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

(b) Be a registered nurse.

3.11.2 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

3.11.3 This member will be appointed by the Chief Executive, subject to the approval of the Chair.

3.12 Director of Strategy and System Development and Director of Delivery and Operations

3.12.1 These members will fulfil the eligibility criteria set out at 3.1 of this constitution and the following additional eligibility criteria:

(a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.12.2 Individuals will not be eligible if:

(a) Any of the disqualification criteria set out at 3.2 of this constitution apply.

3.12.3 These members will be appointed by the Chief Executive, subject to the approval of the Chair.

3.13 Vice-Chair

3.13.1 Subject to 3.13.2 of this constitution, the Chair will appoint a Non-Executive member as Vice-Chair. Any such appointment will be for a period not exceeding the remainder of the individual's term as a Non-Executive member, as specified on appointment.

3.13.2 Any Non-Executive member appointed as Vice-Chair may resign at any time from the office of Vice-Chair by giving notice in writing to the Chair. In the event of a resignation, the Chair may appoint another Non-Executive member as Vice-Chair in accordance with the provisions set out at 3.13.1 of this constitution.

3.13.3 Where the Chair has ceased to hold office, or where they are unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be. References to the Chair in this constitution and the ICB's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice-Chair.

3.14 Deputy Chief Executive

3.14.1 Subject to paragraph 3.14.2 of this constitution, the Chief Executive will appoint an Executive Director as Deputy Chief Executive subject to approval of the Chair.

3.14.2 Any Executive Director appointed as Deputy Chief Executive may resign at any time from the office of Deputy Chief Executive by giving notice in

writing to the Chief Executive and Chair. In the event of a resignation, the Chief Executive may appoint another Executive Director as Deputy Chief Executive in accordance with the provisions of paragraph 3.14.1 of this constitution.

3.14.3 Where the Chief Executive has ceased to be employed, or where they are unable to perform their duties as Chief Executive owing to illness or any other cause, the Deputy Chief Executive shall act as Chief Executive until a new Chief Executive is appointed or the existing Chief Executive resumes their duties, as the case may be. References to the Chief Executive in this constitution and the ICB's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation shall, so long as there is no Chief Executive able to perform those duties, be taken to include references to the Deputy Chief Executive.

3.15 Board members: removal from office

3.15.1 Arrangements for the removal from office of Board Members is subject to the relevant terms of appointment and application of the relevant ICB policies and procedures.

3.15.2 With the exception of the Chair, Board Members shall be removed from office if any of the following occurs:

(a) They no longer fulfil the requirements of their role or become ineligible for their role as set out in this constitution, regulations or guidance.

(b) They fail to attend three consecutive Board meetings (except under extenuating circumstances, such as illness).

(c) They fail to uphold the Seven Principles of Public Life (known as the Nolan Principles) or have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; and seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise.

(d) They are subject to disciplinary proceedings by a regulator or professional body.

3.15.3 Board Members may be suspended pending the outcome of an investigation into whether any of the matters set out at 3.15.2 of this constitution apply.

3.15.4 Executive Directors (including the Chief Executive) will cease to be Board Members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

3.15.5 The Chair of the ICB may only be removed by NHS England, subject to the approval of the Secretary of State for Health and Social Care.

3.15.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

(a) Terminate the appointment of the ICB's Chief Executive.

(b) Direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.16 Board members: terms of appointment

3.16.1 With the exception of the Chair and Non-Executive members, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published on the ICB's website and any guidance issued by NHS England or other relevant body. Remuneration for the Chair will be set by NHS England. Remuneration for Non-Executive members will be set by a Non-Executive Director Remuneration Panel. The Non-Executive Director Remuneration Panel will operate under terms of reference agreed by the Board and published in the ICB's Governance Handbook.

3.16.2 With the exception of the Chair and Non-Executive members, other terms of appointment will be determined by the Remuneration Committee.

3.16.3 Terms of appointment of the Chair will be determined by NHS England. Terms of appointment of the Non-Executive members will be determined by the Non-Executive Director Remuneration Panel.

3.17 Specific arrangements for appointment of Ordinary Members made at establishment

3.17.1 Individuals may be identified as "Designate Ordinary Members" prior to the ICB being established.

3.17.2 Relevant nomination procedures for Partner Members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the requirements set out at 3.5 to 3.7 of this constitution.

3.17.3 Any appointment and assessment processes undertaken in advance of establishment to identify Designate Ordinary Members should follow, as far as possible, the processes set out at 3.5 to 3.12 of this constitution. However, a modified process, agreed by the Chair, will be considered valid.

3.17.4 On the day of establishment, a panel consisting of the Chair, Chief Executive and the ICB's governance lead will appoint the Ordinary Members who are expected to all be individuals who have been identified as designate appointees pre ICB establishment. The Chair will approve these appointments.

3.17.5 For the avoidance of doubt, the arrangements set out at 3.17.1 to 3.17.4 of this constitution are only valid in relation to the appointments of the initial Ordinary Members and all appointments post establishment will be made in accordance with 3.5 to 3.12 of this constitution.

4. Arrangements for exercising functions

4.1 Good governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England.

4.1.2 The ICB has a Standards of Business Conduct Policy, which sets out the standards and public service values that members of the Board and its committees must follow whilst undertaking ICB business. The Standards of Business Conduct Policy is published on the ICB's website.

4.2 General

4.2.1 The ICB will:

(a) Comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations.

(b) Comply with directions issued by the Secretary of State for Health and Social Care.

(c) Comply with directions issued by NHS England.

(d) Have regard to statutory guidance including that issued by NHS England.

(e) Take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England.

(f) Respond to reports and recommendations made by local Healthwatch organisations within the ICB Area.

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with the requirements set out at 4.2.1(a) to 4.2.1(f) of this constitution, documenting them as necessary in this constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

(a) Any of its Board Members or employees.

(b) A committee or sub-committee of the Board.

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other body (another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other prescribed body), subject to regulations. Other ICBs, NHS England, NHS trusts and NHS foundation trusts may also arrange for their functions to be exercised by or jointly with the ICB, subject to regulations. Where the ICB and any one or more other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6 of the 2006 Act). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5, section 65Z6, or section 75 of the 2006 Act, the Board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a Scheme of Reservation and Delegation (SoRD), which is published in full on the ICB's website at www.notts.icb.nhs.uk.

4.4.2 Only the Board may agree the SoRD and any amendments to the SoRD may only be approved by the Board on the recommendation of the Chair or Chief Executive.

4.4.3 The SoRD sets out:

(a) Those functions that are reserved to the Board.

(b) Those functions that have been delegated to individuals or to committees and sub-committees.

(c) Those functions delegated to, or by, one or more other body, or to be exercised jointly with one or more other body, under sections 65Z5, 65Z6 and 75 of the 2006 Act.

4.4.4 The ICB remains accountable for all its functions, including those that it has delegated. All those with delegated authority are accountable to the Board for the exercise of their delegated functions.

4.5 Functions and Decisions Map

4.5.1 The ICB has prepared a Functions and Decisions Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decisions Map is published on the ICB's website at www.notts.icb.nhs.uk.

4.5.3 The map includes:

(a) Key functions reserved to the Board of the ICB.

(b) Commissioning functions delegated to committees and individuals.

(c) Commissioning functions delegated under sections 65Z5 and 65Z6 of the 2006 Act to be exercised by, or jointly with any one or more body (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body.

(d) Functions delegated to the ICB (for example, from NHS England).

4.6 Committees and sub-committees

4.6.1 The Board may appoint committees and arrange for its functions to be exercised by such committees. Committees may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees, if empowered to do so by the Board.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the Board, or by the relevant parent committee in the case of sub-committees. All terms of reference are published in the ICB's Governance Handbook.

4.6.4 The Board remains accountable for all functions, including those that it has delegated to committees and sub-committees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB, will be required to:

(a) Report regularly to the Board (or parent committee in the case of sub-committees) to provide assurance that they are effectively discharging delegated responsibilities.

(b) Review their effectiveness on at least an annual basis.

4.6.5 Any committee or sub-committee established in accordance with the provisions set out at 4.6 of this constitution may consist of, or include, persons who are not Board Members or employees.

4.6.6 All individuals appointed as members of committees and sub-committees that exercise ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the individual's involvement with the private healthcare sector or otherwise.

4.6.7 All members of committees and sub-committees are required to act in accordance with this constitution, including the ICB's Standing Orders, as well as the ICB's Standing Financial Instructions and any other relevant ICB policies.

4.6.8 The following committees will be maintained:

(a) **Audit and Risk Committee:** This committee is accountable to the Board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The Audit and Risk Committee will be chaired by the Non-Executive member listed at paragraph 2.2.3(f)(i) of this constitution. The Chair of the ICB cannot chair or be a member of the Audit and Risk Committee.

(b) **Remuneration Committee:** This committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB. The Remuneration Committee will be chaired by the Non-Executive member listed at paragraph 2.2.3(f)(ii) of this constitution. The Chair of the ICB cannot be chair of the Remuneration Committee but can be a member. The Chair of Audit and Risk Committee cannot chair or be a member of the Remuneration Committee.

4.6.9 The Board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 of this constitution, the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other body as defined by the 2006 Act (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body), subject to regulations.

4.7.2 All delegations made under these arrangements are set out in the ICB's Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the 2006 Act will be set out in a delegation agreement which defines the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation agreements made under this provision will be reserved to the Board.

4.7.4 The Board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation agreements, summaries of which will be published in the ICB's Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5. Procedures for making decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of Standing Orders which describe the processes that are employed to undertake its business. They include procedures for:

(a) Conducting the business of the ICB.

(b) The procedures to be followed during meetings.

(c) The process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the Board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and form part of this constitution.

5.2 Standing Financial Instructions

5.2.1 The ICB has agreed a set of Standing Financial Instructions (SFIs), which set out the arrangements for managing the ICB's financial affairs (associated delegated limits of financial authority are set out in the Scheme of Reservation and Delegation).

5.2.2 A copy of the SFIs is published on the ICB's website at www.notts.icb.nhs.uk.

6. Arrangements for conflicts of interest management and standards of business conduct

6.1 Conflicts of interests

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual 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 interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has an agreed policy and procedures for the identification and management of conflicts of interest; these are incorporated within the ICB's Standards of Business Conduct Policy, which published on the ICB's website at www.notts.icb.nhs.uk.

6.1.3 All Board, committee and sub-committee members, and employees of the ICB, will comply with the ICB's policy and procedures on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this constitution and the ICB's policy and procedures for the identification and management of conflicts of interest.

6.1.6 The Board will appoint a Conflicts of Interest Guardian from its non-executive members to further strengthen scrutiny and transparency of ICB's decision-making processes. In collaboration with the ICB's governance lead, their role is to:

(a) Act as a conduit for anyone with concerns relating to conflicts of interest.

(b) Be a safe point of contact for employees or workers of the ICB to raise concerns in relation to conflicts of interest.

(c) Support the rigorous application of the principles and policies for managing conflicts of interest.

(d) Provide independent advice and judgment where there is any doubt about how to apply conflicts of interest policies and principles in individual situations.

(e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions, the ICB will abide by the following principles for managing conflicts of interest to ensure they are handled with integrity and probity, in an open and transparent way:

(a) Conducting business appropriately: decision-making will be geared towards always meeting the statutory duties of the ICB; ensuring that needs assessments, engagement and consultation mechanisms, commissioning strategies and provider selection procedures are robust and based on expert professional advice.

(b) Being proactive, not reactive: seeking to identify and minimise the risk of conflicts of interest at the earliest possible opportunity, for instance by:

(i) Considering potential conflicts of interest when appointing individuals to the Board or other decision-making committees; clearly distinguishing between those individuals who should be involved in formal decision taking, and those whose input informs decisions.

(ii) Ensuring individuals receive proper induction and training so that they understand their obligations to declare their interests.

(iii) Establishing and maintaining the register of interests and agreeing in advance how a range of possible situations and scenarios will be handled, rather than waiting until they arise.

(c) Assuming that individuals will seek to act ethically and professionally: ensuring there are prompts and checks to identify when conflicts occur, supporting individuals to exclude themselves appropriately from decision-making.

(d) Being balanced and proportionate: identifying and managing conflicts, preserving the spirit of collective decision-making wherever possible, and not expecting to eliminate conflicts completely.

(e) Transparency and sound record keeping: clearly documenting the rationale for decision-making so that an audit trail of actions taken is evident and able to withstand scrutiny.

(f) Creating an environment and culture where individuals feel supported and confident in declaring relevant information and raising concerns.

6.3 Declaring and registering interests

6.3.1 The ICB maintains a register of the interests of:

(a) Board Members.

(b) Members of the Board's committees and sub-committees.

(c) Its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act, the register of interests is published on the ICB's website at www.notts.icb.nhs.uk.

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 of this constitution must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the register as per 6.3.1 of this constitution.

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.3.7 Interests (including offers/receipt of gifts and hospitality) of decision-making staff will remain on the published register for a minimum of six months. In addition, the ICB will retain a record of historic interests (including offers/receipt of gifts and hospitality) for a minimum of six years after the date on which they expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the relevant ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of business conduct

6.4.1 Board Members, members of the Board's committees and sub-committees and employees will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should:

(a) Act in good faith and in the interests of the ICB.

(b) Follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles).

(c) Comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct Policy.

7. Arrangements for ensuring accountability and transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Meetings and publications

7.2.1 The ICB will comply with the Public Bodies (Admission to Meetings) Act 1960, as set out at Standing Order 4.11, including admission to meetings held in public and publication of associated papers and minutes.

7.2.2 Annual accounts will be externally audited and published.

7.2.3 A clear complaints process will be published.

7.2.4 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.2.5 Information will be provided to NHS England as required.

7.2.6 This constitution and the ICB's Governance Handbook will be published as well as other key documents, including but not limited to:

(a) All ICB policies, including those relating to conflicts of interest.

(b) Registers of interests.

7.2.7 The ICB will publish a plan, produced with partner NHS trusts and NHS foundation trusts, at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will:

(a) Explain how the ICB proposes to discharge its duties under:

(i) Sections 14Z34 to 14Z45 of the 2006 Act (general duties of integrated care boards).

(ii) Sections 223GB and 223N of the 2006 Act (financial duties).

(b) Set out any steps that the ICB proposes to take to implement the joint local health and wellbeing strategies to which it is required to have regard under Section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

(c) Set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25.

(d) Set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

7.3 Scrutiny and decision making

7.3.1 Five Non-Executive members will be appointed to the Board (including the Chair) and all Board and committee and sub-committee members will comply with the Nolan Principles of Public Life and meet the criteria described in the Fit and Proper Person Test.

7.3.2 Healthcare services will be arranged in a transparent way, and decisions around which organisations provide services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.3.3 The ICB will comply with the requirements of the NHS Provider Selection Regime, including complying with existing procurement rules until the provider selection regime comes into effect.

7.3.4 The ICB will take all reasonable steps to comply with local authority health overview and scrutiny requirements.

7.4 Annual report

7.4.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

(a) Explain how the ICB has discharged its duties under sections 14Z34 to 14Z45 and 14Z49 of the 2006 Act (general duties of integrated care boards).

(b) Review the extent to which the ICB has exercised its functions in accordance with its plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan) of the 2006 Act.

(c) Review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised).

(d) Review any steps the ICB has taken to implement any joint local health and wellbeing strategies to which it is required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

(e) Include a statement of the amount of expenditure incurred by the ICB during the financial year in relation to mental health and a calculation of the proportion of the expenditure incurred by the ICB during the financial year that relates to mental health. An explanation of the statement and calculation must be provided.

8. Arrangements for determining the terms and conditions of employees

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines, and appoint staff on such terms and conditions as it determines.

8.1.2 The Board has established a Remuneration Committee which is chaired by a Non-Executive member other than the Chair or Audit and Risk Committee Chair.

8.1.3 The membership of the Remuneration Committee is determined by the Board. No employees may be a member of the Remuneration Committee, but the Board ensures that the Remuneration Committee has access to appropriate advice by:

(a) Expert human resources advisors attending meetings to support the Remuneration Committee in discharging its responsibilities.

8.1.4 The Board may appoint independent members or advisers to the Remuneration Committee who are not members of the Board.

8.1.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the Board are published in the Governance Handbook.

8.1.6 The duties of the Remuneration Committee include:

(a) Setting the remuneration, allowances and other terms of appointment for members of the Board, except for the Chair and non-executive members.

(b) Setting any allowances for members of committees or sub-committees of the Board, who are not members of the Board.

8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9. Arrangements for public involvement

9.1.1 In line with section 14Z45(2) of the 2006 Act, the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

(a) The planning of the commissioning arrangements by the ICB.

(b) The development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them.

(c) Decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act, the ICB and its partner NHS trusts and NHS foundation trusts will make appropriate arrangements to consult with the ICB's population when preparing or revising their joint five-year plan. Public consultation will be completed in accordance with the ICB's policy for public involvement and engagement.

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities:

(a) Putting the voices of people and communities at the centre of decision-making and governance.

(b) Starting engagement early when developing plans, feeding back to people and communities how engagement has influenced activities and decisions.

(c) Understanding the needs, experience and aspirations of people and communities for health and care, using engagement to find out if change is having the desired effect.

(d) Building relationships with excluded groups – especially those affected by inequalities.

(e) Working with Healthwatch and the voluntary, community and social enterprise sector as key partners.

(f) Providing clear and accessible public information about vision, plans and progress to build understanding and trust.

(g) Using community development approaches that empower people and communities, making connections to social action.

(h) Using co-production, insight and engagement to achieve accountable health and care services.

(i) Co-producing and redesigning services and tackling system priorities in partnership with people and communities.

(j) Learning from what works and building on the assets of all health and care partners – networks, relationships, activity in local places.

9.1.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.5 These arrangements include:

(a) The creation, implementation and evaluation of a system-wide strategy for engaging with people and communities, to be reviewed at least every three years.

(b) The establishment of a Citizen Intelligence Advisory Group to ensure the Board is supported in discharging the duties set out in 9.1.1.

(c) Having a Board approved policy for public involvement and engagement, which will require the ICB to:

(i) Be clear about who is being engaged, the possible options, the engagement process, what is being proposed and the scope to influence.

(ii) Ensure that engagement takes place in a suitable timeframe to allow decisions to be genuinely influenced by feedback received.

(iii) Adapt engagement activities and methods to meet the specific needs of different patient groups and communities.

(iv) Keep the burden of engagement to a minimum to retain continued buy-in to the process by people and communities.

(v) Ensure that responses to engagement exercises are carefully analysed with clear feedback provided to participants, which set out the decision made and the influence the results of the engagement exercise had on the final decision.

Appendix 1: Definitions of terms used in this constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
ICB Board	Members of the ICB.
ICB Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this constitution.
Committee	A committee created and appointed by the ICB Board.
Sub-Committee	A committee created and appointed by and reporting to a committee.
Integrated Care Partnership	The statutory joint committee for the ICB Area established by the ICB and each responsible upper tier local authority whose area coincides with or falls wholly or partly within the ICB Area.
Ordinary Member	The Board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the Board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 of this constitution, having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB Area and are of a prescribed description. • The primary medical services (general practice) providers within the ICB Area and are of a prescribed description. • The local authorities which are responsible for providing social care and whose area coincides with or includes the whole or any part of the ICB Area.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
Health Care Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

Appendix 2: Standing Orders

1. Introduction

1.1.1 These Standing Orders have been drawn up to regulate the proceedings of NHS Nottingham and Nottinghamshire Integrated Care Board ("**the ICB**") so that the ICB can fulfil its obligations as set out largely in the National Health Service Act 2006 ("**the 2006 Act**"), as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022. They form part of the ICB's Constitution.

1.1.2 These Standing Orders should be read alongside the ICB's constitution, Standing Financial Instructions and Scheme of Reservation and Delegation, which together describe the ICB's governance framework.

1.1.3 These Standing Orders set out the:

(a) Arrangements for conducting the business of the ICB.

(b) Procedures to be followed during meetings of the Board of the ICB ("**the Board**") and its committees and sub-committees.

2. Amendment and review

2.1.1 These Standing Orders are effective from the date the ICB is established.

2.1.2 These Standing Orders will be reviewed on an annual basis or sooner if required.

2.1.3 Amendments to these Standing Orders will be made in line with the procedure set out at section 1.6 of the ICB's constitution.

2.1.4 All changes to these Standing Orders will require an application to NHS England for variation to the ICB constitution and will not be implemented until the constitution has been approved.

3. Interpretation, application, and compliance

3.1.1 Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB's constitution and as per the definitions in Appendix 1.

3.1.2 These Standing Orders apply to all meetings of the Board, including its committees and sub-committees unless otherwise stated. All references to Board are inclusive of committees and sub-committees unless otherwise stated.

3.1.3 All members of the Board, members of committees and sub-committees and all employees should be aware of these Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.1.4 In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the ICB's governance lead, will provide a settled view which shall be final.

3.1.5 All members of the Board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible. If the Chief Executive is responsible for the non-compliance, then this should instead be reported to the ICB's lead for governance.

3.1.6 If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification and the Audit and Risk Committee for review.

4. Meetings of the Board

4.1 Calling meetings

4.1.1 Meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Board will normally meet no less than six times per year. Terms of reference for committees and sub-committees will specify the required frequency of meetings.

4.1.2 In normal circumstances, each member of the Board will be given not less than one month's notice in writing of any meeting to be held. However:

(a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.

(b) Members of the Board may request the Chair to convene a meeting by notice in writing signed by not less than one third of the Board Members, specifying the matters they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board Members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the Board, specifying the matters to be considered at the meeting.

(c) In emergency situations, the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

(d) A failure to give notice in accordance with the above requirements shall not invalidate a decision otherwise taken in accordance with these Standing Orders.

4.1.3 In accordance with Public Bodies (Admission to Meetings) Act 1960, a public notice of the time and place of meetings open to the public, and how to access the meetings, all be given by posting it at the offices of the ICB and electronically on the ICB's website at least three clear days before the meeting, or if the meeting is convened at shorter notice, then at the time it is convened.

4.2 Chair of a meeting

4.2.1 The Chair of the ICB shall preside over meetings of the Board.

4.2.2 If the Chair is absent or is disqualified from participating by reason of a conflict of interests, then the Vice Chair will preside. If both the Chair and Vice Chair are absent or disqualified from participating, then a Non-Executive member of the Board (other than the Chair of the Audit and Risk Committee) shall be chosen by the members present, or by a majority of them, and shall preside.

4.2.3 The Board will appoint a Chair to all committees that it has established. Chairs of sub-committees will be appointed by the relevant parent committee. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2 Except where the emergency provisions apply (as provided for in Standing Order 4.1.2(c)), the agenda and supporting papers will be circulated to all members of the Board at least five calendar days before the meeting.

4.3.3 Agendas and papers for meetings open to the public will be published electronically in advance of the meetings on the ICB's website at www.notts.icb.nhs.uk.

4.4 Petitions

4.4.1 Where a valid petition has been received by the ICB, it shall be included as an item for the agenda of the next meeting of the Board in accordance with the process set out within the ICB's Governance Handbook.

4.5 Nominated deputies

4.5.1 With the permission of the Chair, the Executive Directors and Partner Members of the Board may nominate a deputy to attend a meeting of the Board that they are unable to attend. Deputies may speak, but not vote, on their behalf, and will not count towards the quorum unless Standing Order 4.7.2(c) applies.

4.5.2 Any nomination of a deputy must be made in writing to the Chair in advance of the meeting, confirming that the individual nominated to deputise fulfils the requirements of the role and is not disqualified. Ad-hoc deputy arrangements are not permitted. The decision of the Chair (or in their absence, the person presiding over the meeting) regarding authorisation of nominated deputies is final.

4.5.3 Terms of reference for committees and sub-committees will specify the extent to which nominated deputies are allowed.

4.6 Virtual meetings

4.6.1 The Board may meet virtually using telephone, video and other electronic means when necessary. Where a virtual meeting is convened, the usual process for meetings of the Board will apply, including those relating to the quorum (as set out in Standing Order 4.7) and those relating to meetings being open to the public and representatives of the press (as set out in Standing Order 4.11).

4.6.2 Virtual attendance at in-person meetings will be permitted at the discretion of the Chair.

4.7 Quorum

4.7.1 The quorum for meetings of the Board will be five members, including:

(a) The Chair of the meeting and one further Non-Executive Director.

(b) The Chief Executive or the Director of Finance.

(c) The Medical Director or the Director of Nursing.

(d) One Partner Member.

4.7.2 For the sake of clarity:

(a) No person can act in more than one capacity when determining the quorum.

(b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interests, shall no longer count towards the quorum.

(c) An officer in attendance for an Executive Director in accordance with Standing Order 4.5.1 may only count towards the quorum if they have formal acting up status.

(d) A failure to comply with the above requirements as to quorum shall not invalidate a decision otherwise taken in accordance with these Standing Orders.

4.7.3 For all committees and sub-committees, the details of the quorum for these meetings and the status of any nominated deputies are set out in the appropriate terms of reference.

4.8 Vacancies and defects in appointments

4.8.1 The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate. Where helpful, the Board may draw on third party support such as peer review or mediation by NHS England.

4.9.2 Generally, it is expected that decisions of the Board will be reached by consensus. Should this not be possible, then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

(a) All members of the Board who are present at the meeting will be eligible to cast one vote each.

(b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.

(c) For the sake of clarity, any participants or observers at the meeting (in accordance with section 2.3 of the ICB's constitution) will not have voting rights.

(d) A resolution will be passed if more votes are cast for the resolution than against it.

(e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.

(f) No resolution will be passed if it is unanimously opposed by all the Executive Directors present or by all the Non-Executive Directors present.

(g) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

4.9.3 Decision-making arrangements for committees and sub-committees will be set out within the appropriate terms of reference.

Emergency powers for urgent decisions

4.9.4 In the case of urgent decisions and extraordinary circumstances, every attempt will be made for the Board to meet virtually. Where this is not possible Standing Orders 4.9.5 and 4.9.6 will apply.

4.9.5 The powers which are reserved or delegated to the Board, may for an urgent decision be exercised by the Chair and Chief Executive subject to every effort having made to consult with as many members of the Board as possible in the given circumstances.

4.9.6 The exercise of such powers by the Chair and Chief Executive will be reported to the next formal meeting of the Board for formal ratification and to the Audit and Risk Committee for review of the reasonableness of the decision to use emergency powers.

4.9.7 Decision-making arrangements set out within committee and sub-committee terms of reference will specify the extent to which urgent decisions can be taken in extraordinary circumstances.

4.10 Minutes

4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4 Where providing a record of a meeting open to the public, the minutes shall be made available to the public.

4.11 Admission of public and representatives of the press

4.11.1 In accordance with the Public Bodies (Admission to Meetings) Act 1960, meetings of the Board, and meetings of committees that are comprised entirely of Board Members or at which all Board Members are present, at which public functions are exercised, will be open to the public. There is no requirement for meetings of the Remuneration Committee or the Audit and Risk Committee to be open to the public.

4.11.2 The Board may resolve to exclude the public and representatives of the press from a meeting, or part of a meeting, where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960, as amended or succeeded from time to time.

4.11.3 The Chair (or in their absence, the person presiding over the meeting) shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press, such as to ensure that the Board's business can be conducted without interruption or disruption.

4.11.4 As permitted by section 1(8) of the Public Bodies (Admissions to Meetings) Act 1960 (as amended from time to time), the public and representatives of the press may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5 Matters to be dealt with at a meeting following the exclusion of the public and representatives of the press shall be confidential to the members of the Board.

4.11.6 Members of the Board and any regular participants or employees of the ICB in attendance will not reveal or disclose the contents of papers or minutes marked as 'confidential' or 'private' outside of the Board, without the express permission of the Board. This prohibition will apply equally to the content of any discussion during the Board meeting that may take place on such papers or minutes.

5. Suspension of Standing Orders

5.1.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended at any meeting of the Board by the Chair (or the person presiding over the meeting), provided that a majority of members present, including at least one executive member and one non-executive member, are in favour of suspension.

5.1.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.1.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit and Risk Committee for review of the reasonableness of the decision to suspend Standing Orders.

6. Execution of documents

6.1 Custody of seal, sealing of documents and register of sealings

6.1.1 The ICB will have a common seal for executing certain documents, as required by legislation.

6.1.2 The seal will be kept by the ICB's lead for governance in a secure place.

6.1.3 The seal swill be affixed in the presence of two officers of the ICB, to include either the Chief Executive or the Director of Finance, and shall be attested by them.

6.1.4 An entry of every sealing will be made and numbered consecutively in a register provided for that purpose.

6.1.5 A report of all sealings will be made to the Board, or a committee nominated by the Board, at least annually.

6.2 Execution of a document by signature

6.2.1 Where any document will be a necessary step in legal proceedings on behalf of the ICB, it will, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any other executive member of the Board.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	11/07/2024
Paper Title:	**Board Annual Work Programme 2024/25**
Paper Reference:	ICB 24 037
Report Author:	Lucy Branson, Director of Corporate Affairs
Executive Lead:	Kathy McLean, Chair
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								
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
Joint Capital Resource Use Plan	✓	-	-	-	-	✓	Strategic risk 3 and 8	See note 5

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
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
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
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 ~~and long-term conditions management~~ • System risk management and risk appetite	-	-	-	✓	-	-	-	-	-
Board Seminar: • ~~Population health management approach to frailty~~ • Mental health • Primary care (primary medical services and pharmacy, optometry and dental services)	-	-	-	-	✓	-	-	-	-
Board Seminar: • ~~Mental health~~ • Population health management approach to frailty	-	-	-	-	-	✓	-	-	-

Topic	11 Apr	30 May	13 Jun	16 Sep	10 Oct	12 Dec	16 Dec	13 Feb	17 Mar
• Working with people and communities									
ICS Reference Group: • Planning for 2025/26 (operational and joint forward plans)	-	-	-	-	-	-	✓	-	-
Development Session: • Board effectiveness/ maturity	-	-	-	-	-	-	-	✓	-
ICS Reference Group: • Social and economic development • 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 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).
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 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 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