Integrated Care Board Meeting Agenda (Open Session)

Thursday 09 May 2024 09:00-12:15

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

"Every person enjoying their best possible health and wellbeing"

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

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

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

	Item	Presenter	Type *(For Assurance, Decision, Discussion or Information)*	Enc.	Time
	Introductory items				
1.	Welcome, introductions and apologies	Kathy McLean	-	-	09:00
2.	Confirmation of quoracy	Kathy McLean	-	-	-
3.	Declaration and management of interests	Kathy McLean	Information	✓	-
4.	Minutes from the meeting held on: 14 March 2024	Kathy McLean	Decision	✓	-
5.	Action log and matters arising from the meetings held on: 14 March 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.	Joint Forward Plan: Annual Refresh	Lucy Dadge	Decision	✓	09:30
9.	Joint Capital Resource Use Plan	Stuart Poynor	Decision	✓	09:50
10.	VCSE Alliance Report	Daniel King	Discussion	✓	10:00
	Delivery and system oversight				
11.	Health Inequalities Statement	Dave Briggs	Assurance	✓	10:20

	Item	Presenter	Type *(For Assurance, Decision, Discussion or Information)*	Enc.	Time
12.	Delivery Plan for Recovering Access to Primary Care	Dave Briggs	Assurance	✓	10:40
13.	Quality Report	Rosa Waddingham	Assurance	✓	11:00
14.	Service Delivery Report	Mandy Nagra	Assurance	✓	11:15
15.	Finance Report	Stuart Poynor	Assurance	✓	11:30
	Governance				
16.	Committee Highlight Reports: • Strategic Planning and Integration Committee • Quality and People Committee • Finance and Performance Committee • Audit and Risk Committee	Committee Chairs	Assurance	✓	11:40
17.	Board Assurance Framework	Lucy Branson	Assurance	✓	12:55
	Information items *The following items are for information and will not be individually presented. Questions will be taken by exception.*				
18.	2024/25 Internal Audit Plan	-	Information	✓	-
	Closing items				
19.	Risks identified during the course of the meeting	Kathy McLean	Discussion	-	12:10
20.	Questions from the public relating to items on the agenda	Kathy McLean	-	-	-
21.	Any other business	Kathy McLean	-	-	-
	Meeting close	-	-	-	12:15

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
11 July 2024, 09:00-12:30	Rushcliffe Arena, Rugby Road, West Bridgford, NG2 7YG
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

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/05/2024
Paper Title:	**Declaration and management of interests**
Paper Reference:	ICB 24 003
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		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	Primary Integrated Community Service (PICS) - provider of local health services in the Nottinghamshire area	Director	✓				01/07/2022	31/10/2023	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 PICS.
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 decision-making.
LIM, Dr Kelvin	Primary Care Partner Member	Alike Ltd (GP private practice)	Business owner (business has been inactive since 2018 and is in the process of being liquidated)	✓				01/07/2022	Present	N/A (business is in the process of being liquidated)

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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.
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.

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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.
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 discussions and decisions (including procurement activities) relating to services that could be provided by Kathy McLean Ltd.
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.

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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.
MCLEAN, Kathy	ICB Chair	NHS England	Lay Advisor	✓				01/07/2022	18/12/2023	This interest will be kept under review and specific actions determined as required.
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.
POYNOR, Stuart	Director of Finance	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable

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ROBINSON, Paul	NHS Trust and NHS Foundation Trust Partner Member	Sherwood Forest Hospitals NHS Foundation Trust	Chief Executive	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangement) relating to services that are currently, or could be, provided by Sherwood Forest Hospitals NHS Foundation Trust.
SULLIVAN, Amanda	Chief Executive	Hillview Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
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.

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UNDERWOOD, Catherine	Local Authority Partner Member	Nottingham City Council	Corporate Director of People	✓				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 Nottingham City Council
UNDERWOOD, Catherine	Local Authority Partner Member	Ruddington Medical 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 decision-making.
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.
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

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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.
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

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NAGRA, Mandy	Interim System Delivery Director	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable

Appendix B

Nottingham and Nottinghamshire

Managing Conflicts of Interest at Meetings

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

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

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

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

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

Integrated Care Board (Open Session)
Unratified minutes of the meeting held on
14/03/2024 10:00-13:00
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
Caroline Maley	Non-Executive Director
Stuart Poynor	Director of Finance
Paul Robinson	NHS Trust/Foundation Trust Partner Member
Amanda Sullivan	Chief Executive
Jon Towler	Non-Executive Director
Rosa Waddingham	Director of Nursing
In attendance:	
Katy Ball	Service Director, Nottinghamshire County Council (on behalf of Melanie Williams)
Lucy Branson	Associate Director of Governance
Sarah Collis	Chair, Healthwatch Nottingham and Nottinghamshire (for item ICB 23 098)
Philippa Hunt	Chief People Officer
Professor Daniel King	Voluntary, Community and Social Enterprise Alliance Chair
Maria Principe	Director System Analytics and Intelligence Unit (for item ICB 23 100)
Sabrina Taylor	Interim Chief Executive, Healthwatch Nottingham and Nottinghamshire (for item ICB 23 098)
Sue Wass	Corporate Governance Officer (minutes)
Apologies:	
Ifti Majid	NHS Trust/Foundation Trust Partner Member
Melanie Williams	Local Authority Partner Member
Catherine Underwood	Local Authority Partner Member

Cumulative Record of Members' Attendance (2023/24)

Name	Possible	Actual	Name	Possible	Actual
Kathy McLean	6	6	Stuart Poynor	6	5
Marios Adamou	6	6	Paul Robinson	6	4
Dave Briggs	6	5	Amanda Sullivan	6	6
Lucy Dadge	6	6	Jon Towler	6	5

Name	Possible	Actual	Name	Possible	Actual
Stephen Jackson	6	6	Catherine Underwood	6	4
Kelvin Lim	6	6	Rosa Waddingham	6	5
Ifti Majid	6	2	Melanie Williams	6	3
Caroline Maley	6	6			

Introductory items

ICB 23 091 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.

A particular welcome was extended to Katy Ball, who was attending the meeting on behalf of Melanie Williams. It was noted that Melanie had been appointed to the role of Association of Directors of Adult Social Services (ADASS) President for 2024/25. In line with this, it has been agreed that a nominated deputy will attend meetings when Melanie needs to give apologies. A deputy is currently being identified and this will be confirmed at the next meeting.

The Chair asked the Board to note that the ICB had a renewed focus on compliance with the public sector website accessibility regulations, which had certain requirements regarding the format of published information, including Board papers, and members may notice some changes in how papers were now presented.

ICB 23 092 Confirmation of quoracy

The meeting was confirmed as quorate.

ICB 23 093 Declaration and management of interests

It was confirmed that no interests had been identified in advance of the meeting and no further interests were noted. The Chair reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

ICB 23 094 Minutes from the meeting held on: 11 January 2024

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

ICB 23 095 Action log and matters arising from the meeting held on: 11 January 2024

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

A written briefing had been provided on the Green Plan as requested. The Board welcomed the additional information but noted that it did not completely answer the request that had been made, which was to confirm whether the ICB was able to measure progress towards meeting the target of 80% carbon net zero by 2028.

It was further noted that this was a key area of focus for the ICB in relation to its role as an anchor organisation and in meeting the fourth aim regarding social and economic development. As such, a further progress report would be scheduled for the Board during 2024/25.

Action: Stuart Poynor to confirm whether the ICB is able to measure its progress towards meeting the target of 80% carbon net zero by 2028.

Leadership

ICB 23 096 Chair's Report

Kathy McLean highlighted the following points from her report:

a) It was felt timely to reflect on the extremely challenging year experienced by both the ICB and wider health and care partners. Of necessity there had been a greater focus on operational delivery, and while this would need to continue into next year, it would also be critical to ensure the right balance with transformational matters in order to build a more sustainable system. This would include having to make brave decisions together with partners.

b) The ICB's aim was to support colleagues in the delivery of safe care and thanks were given to everyone working in public services across Nottingham and Nottinghamshire for their continued hard work to ensure the delivery of safe services.

c) It was stressed that every effort must be made to improve services for the future and with this in mind, the Integrated Care Strategy was being reviewed to ensure that it continued to meet the needs of the local population. The next Integrated Care System (ICS) Partners Assembly would take place on 22 April, which would be a welcome opportunity to hear from interested members of the public, wider partners, and representatives of the voluntary sector on how they see delivery being achieved.

d) The imminent inaugural election for the East Midlands Mayor and the establishment of the Combined Authority would also provide a welcome opportunity to work more closely with colleagues in Derby and Derbyshire.

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

ICB 23 097 Chief Executive's Report

Amanda Sullivan presented the item and highlighted the following points:

a) On behalf of the Executive Team, thanks were given to ICB staff members who had taken the time to complete the 2023 NHS Staff Survey. Although it had been positive to see that the ICB's approach to flexible working and the focus on equality, diversity and inclusion priorities had been well received, the results reflected the increasing pressures and complexity of work that many staff were experiencing. The Executive Team is committed to addressing the challenges identified through the development of an action plan to deliver real change for staff.

b) The Chancellor had recently announced measures relating to the NHS in his Spring Budget. Revenue funding would remain largely flat and capital funding was unchanged. However, there would be additional investment in digital and tech-related investments, aimed at boosting productivity. It was anticipated that the final NHS England Priorities and Operational Planning Guidance for 2024/25 would now be published imminently.

c) The Secretary of State for Health and Social Care had announced a special review into mental health services at Nottinghamshire Healthcare NHS Foundation Trust (NHT). This would be undertaken by the Care Quality Commission and would also address wider issues identified by their recent inspection reports. The Board was asked to note that the ICB, in its system leadership role, will work alongside NHS England Midlands colleagues to ensure that the appropriate support and challenge is offered to NHT during their work to improve services.

d) The joint NHS England, Department of Health and Social Care plan to recover and reform NHS dentistry was welcomed, although there were clear workforce constraints in its implementation. Earlier in the year the Board had supported the expansion of fluoridation in Nottinghamshire and reference in the Plan to the health benefits of this would strengthen our system's case.

The following points were made in discussion:

e) Jon Towler, as Chair of Remuneration Committee, asked members to note that the Committee had been concerned by the results of the Staff Survey, which showed levels of deterioration in a number of

critical areas. The Committee would oversee progress on the development and implementation of an Executive-owned action plan.

f) Discussing the Independent Review of Greater Manchester Mental Health NHS Foundation Trust, members queried whether the ICB would be taking forward the recommendation to review the level of mental health expertise it had in its oversight arrangements. In response, it was noted that the ICB was currently developing a new role within its quality team and that there was already a level of clinical expertise in this area within the Medical Directorate. The Chair urged members to read the full report and confirmed that some Board time would be protected during 2024/25 to review the system's ambition for mental health services.

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

Sarah Collis and Sabrina Taylor joined the meeting at this point.

Health inequalities and outcomes

ICB 23 098 Healthwatch Nottingham and Nottinghamshire Report

Amanda Sullivan welcomed to the meeting Sarah Collis and Sabrina Taylor, who were in attendance to present their report. By way of introduction, it was stated that the ICB, and the former Clinical Commissioning Groups, had enjoyed a positive relationship with Healthwatch colleagues over many years, and the insights that Healthwatch brought were very much valued.

Sarah Collis and Sabrina Taylor went on to highlight the following points:

a) Healthwatch had a unique role to ensure that the patient voice was heard in all aspects of health and social care services. They had good connections within communities and were a conduit between citizens and statutory organisations, able to hold them to account.

b) The organisation had two main roles, one to be that link between communities and organisations, the other to provide independent scrutiny of services and raise concerns.

c) There had been significant change since the formation of Healthwatch, with a greater complexity of the health and social care landscape and a greater complexity of need. There was still work to do to reach voices that were not heard and new ways of engaging with local people were always being explored.

d) Healthwatch was a small team with a limited budget, it was important to ensure their role was maximised and to ensure that the voice of the citizen was heard within organisations.

The following points were made in discussion:

e) Noting that the County Council was developing a new Joint Strategic Needs Assessment around the prevention agenda, Katy Ball saw this as an opportunity to have a conversation about how Healthwatch could input to this, which was welcomed.
f) Healthwatch's support to test the efficacy of strategies was also discussed.
g) There was a discussion regarding the value of Healthwatch to provide early indications of when services were starting to struggle, with the example of care homes being used.
h) As it was noted that Healthwatch had no legal powers to compel organisations to implement their recommendations, a better connection with the ICB's quality oversight was required to enable the ICB to address issues earlier; it was agreed further discussion on this point would be taken forward. This would also include how to ensure that Healthwatch reports were more visible through quality governance processes and to the Board. It was also highlighted that Healthwatch reports could provide a valuable source of external assurance for the Board Assurance Framework
i) Daniel King observed that it would be beneficial to raise Healthwatch's profile among the Voluntary, Community and Social Enterprise Alliance members, which was welcomed.

The Board **noted** the report, and thanked Sarah and Sabrina for attending the meeting.

Action:

- **Rosa Waddingham to work with HealthWatch colleagues to define their role in supporting the ICB's awareness and response to emerging quality concerns.**
- **Lucy Branson 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).**

At this point, Sarah Collis and Sabrina Taylor left the meeting

ICB 23 099 Nottingham and Nottinghamshire Integrated Care Strategy: Annual Refresh

Lucy Dadge presented the item and highlighted the following points:

a) The Integrated Care Partnership (ICP) approved Nottingham and Nottinghamshire's Integrated Care Strategy on 13 March 2023. Subsequent work had focussed on ensuring collective ownership and understanding the approach to oversee delivery of the Strategy.

b) The Strategy was being delivered by the Nottingham City and Nottinghamshire County Health and Wellbeing Boards through the implementation of their Joint Local Health and Wellbeing Strategies, and by NHS partners through delivery of the NHS Joint Forward Plan.

c) At its 6 October 2023 meeting, the ICP had agreed to commence a light touch review of the Integrated Care Strategy at the end of the first year of delivery, the result of which would be presented at its meeting on 22 March 2024.

d) Following discussion with partners, the key proposed changes included an increased focus on children and young people and on frailty, with a recommendation that the ICP continued to focus on the three guiding principles of the strategy: prevention, equity, and integration; and understanding how partners collectively adhered to and contributed to these principles.

e) Key actions for the year ahead were to strengthen oversight arrangements; further describe and refine the principles of prevention, equity, and integration; make the link between the priorities of the Integrated Care Strategy and the Integrated Care System Outcomes Framework; and further develop the Target Operating Model for the Integrated Care System, which would describe how the Strategy will be delivered through neighbourhood, place, and system working.

The following points were made in discussion:

f) Members welcomed the proposed re-focus, noting the balance to be achieved to ensure that Boards were sighted on progress on the delivery of the strategy without adding further bureaucracy to what was already a complex operating environment.

g) Members queried the differential approach by the Place Based Partnerships. It was noted that as the health needs and administrative landscape in the county were very different, activity was more at a neighbourhood level.

h) Members noted the need for all partners to own the Strategy, to ask themselves what their role was and what was in their gift to change. There needed to be a common understanding and language. There was discussion regarding whether the Strategy was seen as separate to operational planning; it was agreed that it should be more integral to ensure Boards had more visibility.

i) Members discussed how progress would be tracked and how the impact of the Strategy would be measured. It was suggested that the development of a maturity model could support this issue; this would be fed into upcoming ICP discussions.

The Board **noted** the report and confirmed its support for the refreshed Integrated Care Strategy for Nottingham and Nottinghamshire.

At this point, Maria Principe joined the meeting.

ICB 23 100 Population Health Management (PHM) Outcomes Framework

Dr Dave Briggs presented the item, supported by Maria Principe, and highlighted the following points:

a) The ICB's Strategic Analytical Intelligence Unit had led an initiative to develop a comprehensive dashboard and framework dedicated to monitoring the health outcomes of the population, which sought to provide a method to evaluate the effectiveness of health and care services delivered to communities.

b) The approach had concluded with the launch of the Population Health Management (PHM) Outcomes Dashboard, now accessible on the system's SharePoint portal. This tool was crucial for assessing health indicators such as life expectancy, premature mortality, and healthy life expectancy, and for addressing inequalities in health outcomes, experiences, and access.

c) By analysing a wide range of indicators, including patient satisfaction, mortality, readmission, and complication rates, the initiative aimed to identify areas needing improvement, base decisions on solid evidence, and optimise resource utilisation to better meet the diverse needs of the population.

d) Further development was needed to complete the dashboard fully and work would continue. Moving forward, focus would now shift to defining outcome ambitions and principles with partners.

The following points were made in discussion:

e) Members commended the work that had taken place to develop the Dashboard but sought to understand how this would be translated into a high-level outcomes framework that the Board could track on a regular basis. A wide-ranging discussion ensued and the lack of a strategic framework was recognised as a gap, and it was agreed that an outcomes framework, with supporting metrics, needed to be developed at pace.

f) In terms of the population health management approach, Dave Briggs stated that for 2024/25 there would be a focus on frailty, and it was suggested that this be presented to a future Board session, which was agreed.

The Board **noted** the report.

Action:

- **Dave Briggs and Lucy Dadge 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.**
- **Lucy Branson to schedule time within the Board's annual work programme to focus on the population health management approach to frailty.**

Maria Principe left the meeting at this point.

Assurance and system oversight

ICB 23 101 Quality Report

Rosa Waddingham presented the item and highlighted the following points:

a) The report provided a summary of compliance against targets required for 2023/24, and the actions and recovery timeframes for those targets currently off track.

b) Significant oversight remained on adult learning disability and autism inpatient performance, and actions to support recovery were showing an improved position; however, the year-end target was unlikely to be met.

c) The Care Quality Commission's Section 29A warning notices that had identified areas of concern at Nottingham University Hospitals NHS Trust (NUH) had recently been lifted following sustained improvement. Maternity services were no longer rated as inadequate;

however, the Trust remained in the Maternity Support Pathway to ensure improvements were sustained.

d) At NHT, Care Quality Commission reports on acute wards for adults of working age and psychiatric intensive care units and wards for older people with mental health problems, had been published with an inadequate rating overall for both areas. Formal oversight arrangements were being put in place by the ICB jointly with NHS England to support the Trust to make the necessary improvements.

e) Pressures in emergency and urgent care remained, predominantly at NUH. To support the system risk relating to potential harm across the non-elective pathway, a new risk had been added that focused more closely on emergent concerns of 'failing to meet new response times for category two ambulance response due to demand'.

f) Sustained focus on the recovery of initial health assessment rates for looked after children had resulted in improvement in the number of completed assessments rising from 50% in quarter two to 84-88% in quarter three.

g) Nottingham CityCare Partnership had been placed on enhanced surveillance following a review of community services and an improvement plan had been put in place. A deep dive report was scheduled for a future meeting of the Quality and Performance Committee.

The following points were made in discussion:

h) Regarding workforce metrics, the Chair noted that overall workforce numbers were not reducing and welcomed a strategic discussion on the subject scheduled for the May Board meeting.

i) Board members noted the enhanced quality oversight of Nottingham CityCare Partnership, and the substantive appointment of a new Director of Nursing was welcomed.

The Board **noted** the report.

ICB 23 102 Finance Report

Stuart Poynor presented the item and highlighted the following points:

a) At the end of month ten, the system was showing a deficit position of £119.4 million, which was a deterioration in the previously reported position due to NHT declaring that they would be unable to deliver against their target forecast by a further £12.5 million.

b) The ICB continued to forecast a £6.8 million deficit position, which was in line with the re-forecast previously agreed with NHS England, and there was confidence that the forecast would be met, albeit the deficit would create a cost pressure for the next financial year.

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) Stephen Jackson, Chair of the Finance and Performance Committee, noted that the Committee had examined the origin of NHT's late reporting of its deficit and had concluded that recent events had played a part; however, the backloading of the forecast for reducing out of area placements had also been a significant contributory factor. Despite the enormous amount of work on mitigations, the Committee could only give a low level of assurance.

The Board **noted** the report.

ICB 23 103 Service Delivery Report

Stuart Poynor presented the item and highlighted the following points:

a) The report provided a summary of compliance against targets required for 2023/24, and the actions and recovery timeframes for those targets currently off track.

b) A further round of industrial action had taken place since the last report and industrial action continued to be a key constraint on delivery of healthcare within the system, impacting elective and non-elective pathways.

c) Discharge pressures continued to impact the front door of the emergency department, and performance against the four-hour Accident and Emergency waiting time standard and ambulance handover times remained areas of concern.

d) A strong focus remained on the volume of long waiting patients, with the recent industrial action making it difficult to meet planned trajectories.

e) The Out of Area Placement target was unlikely to be met, with 32 patients in placement against a target of zero.

f) An improvement plan was in place for recovery of access to Talking Therapies.

The following points were made in discussion:

g) Members queried whether the year-end four-hour Accident and Emergency waiting time standard would be achieved. It was noted that there was confidence that it would be achieved at SFH, but not at NUH.

h) Members challenged why targets continued to be missed despite there being recovery plans in place. The issue of pockets of poor culture and behaviour within provider organisations that continued to impact on performance were discussed, and assurance was given that they were being addressed.

The Board **noted** the report.

ICB 23 104 Committee Highlight Reports

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

Jon Towler, Marios Adamou, Stephen Jackson and Caroline Maley, presented the report and highlighted the following points:

a) Strategic Planning and Integration Committee members continued to review many programmes of work for Board approval, including the process to secure sustainable opening hours for the Urgent Treatment Centre at Newark Hospital, planning for the Urgent Treatment Centre at NUH, and the approach to the refresh of the Joint Forward Plan. Looking ahead the Committee would be overseeing potential risks relating to the next delegation of services from NHS England and scrutinising planning timelines for large contracts.

b) Quality and People Committee members had noted limited assurance in progress towards compliance with several key quality domains and a focussed report had been received in relation to NHT. Members had been assured of the progress made on the implementation of the Nottinghamshire Special Educational Needs and Disabilities Partnership's Improvement Programme and for primary medical services; but had placed limited assurance on delivery of the ICS People Plan.

c) Finance and Performance Committee members had discussed the financial position of the ICB and wider system, along with the operational performance issues currently being experienced. Limited assurances were agreed in all areas. The Committee had also

examined health inequalities relating to maternal and infant mortality and the restoration of elective services and received adequate assurance regarding delivery of the Digital Notts Strategy.

d) Audit and Risk Committee members had received assurance on the ongoing programme of in-depth discussions with ICB executives on the strategic risks in their areas, noting the need, as the ICB moved forward, to seek further external assurances and evidence that the plans that had been put in place were working. There was concern that there were several outstanding reports from the Internal Audit function, including the system audit on financial controls, as there had been an expectation that this would be concluded sooner.

e) Remuneration Committee members had reviewed a range of workforce metrics for the ICB, including the recent staff survey results, as mentioned earlier in the meeting; an overall adequate level of assurance had been agreed.

The following points were made in discussion:

f) Noting that a rating of limited assurance had been assigned to the ICS People Plan, the Chair highlighted that the key would be to ensure re-deployment of the existing workforce, rather than growing it.

g) Following a request, it was confirmed that the 2024/25 Internal Audit Plan would be brought to the May meeting for information.

The Board **noted** the reports.

Action: Lucy Branson to include the 2024/25 Internal Audit Plan on the agenda for the May Board meeting.

ICB 23 105 Emergency Preparedness, Resilience and Response Annual Report

Lucy Dadge presented the item and highlighted the following points:

a) The report provided assurance on the Emergency Preparedness, Resilience and Response (EPRR) activities undertaken to ensure the ICB is adequately prepared to respond to major and business continuity incidents.

b) The ICB had self-assessed itself as partially compliant with national EPRR Core Standards, a position which had been verified by NHS England. Actions to achieve full compliance had been incorporated into a work programme for 2024/25.

c) As part of the ICB's role as a Category One responder, it had a duty to assess the compliance of other NHS providers. The ICB also worked with other public service providers through the Local Health Resilience Partnership.

d) The report provided further detail on compliance with training and exercise activities.

The Board **noted** the report.

Information items

ICB 23 106 Board Work Programme 2023/24

This item was received for information.

Closing items

ICB 23 107 Risks identified during the course of the meeting

Members queried whether the enhanced surveillance status of Nottingham CityCare Partnership was adequately covered by registered risks. It was noted that this was reflected in the risk relating to quality assurance.

The risk of possible industrial action by GPs was also discussed. It was noted that this was due for consideration at the next meeting of the Strategic Planning and Integration Committee.

ICB 23 108 Questions from the public relating to items on the agenda

There were no questions from members of the public.

ICB 23 109 Any other business

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

Date and time of next Board meeting held in public: 09 May 2024 at 9:00 (Chappell Room)

ACTION LOG from the Integrated Care Board meeting held on 14/03/2024

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Closed – action completed	09/11/2023	ICB 23 064: Quality report	To add a focused report on the system's ambition for mental health services (for all ages) to the Board's work programme.	Lucy Branson	09/05/2024	See agenda item 6 – This month's Chair's Report includes the proposed work programme for the Board for 2024/25. A Board seminar session on mental health services has been scheduled for December 2024.
Closed – action completed	11/01/2024	ICB 23 080: Joint Forward Plan: delivery and oversight arrangements	To include an update on the work of integrated neighbourhood teams as part of the scheduled update on the 2024/25 refresh of the Joint Forward Plan.	Lucy Dadge	28/03/2024	Presented at the extra-ordinary Board meeting on 28 March.
Closed – action completed	11/01/2024	ICB 23 082: Committee highlight reports	To present a progress report on delivery of the ICS People Plan to the Board in May 2024, following the scheduled session at the ICS Reference Group in April 2024.	Rosa Waddingham	09/05/2024	See agenda item 6 – This month's Chair's Report includes the proposed work programme for the Board for 2024/25. A Board seminar session on the people plan has been scheduled for June 2024, which will follow an ICS Reference Group discussion on this topic in May. A formal progress report will be

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
						presented to the Board in September.
Closed – action completed	14/03/2024	ICB 23 095: Action log	To confirm whether the ICB is able to measure its progress towards meeting the target of 80% carbon net zero by 2028.	Stuart Poynor	09/05/2024	This was discussed by the Finance and Performance Committee on 24 April, where it was confirmed that it is not possible to accurately measure this target for the ICB at the current time.
Open – on track	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	Not yet due.
Open – on track	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	Not yet due.
Open – on track	14/03/2024	ICB 23 100: Population Health	To lead on the development of a strategic outcomes framework, with supporting	Dave Briggs/ Lucy Dadge	12/09/2024	Not yet due – an interim update on progress in defining the outcomes to be delivered by the

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
		Management (PHM) Outcomes Framework	metrics, to enable the Board to track the impact of the Integrated Care Strategy through the Joint Forward Plan.			Joint Forward Plan is included in this meeting's papers, at agenda item 8.
Closed – action completed	14/03/2024	ICB 23 100: Population Health Management (PHM) Outcomes Framework	To schedule time within the Board's annual work programme to focus on the population health management approach to frailty.	Lucy Branson	09/05/2024	See agenda item 6 – This month's Chair's Report includes the proposed work programme for the Board for 2024/25. A Board seminar session on frailty has been scheduled for October 2024.
Closed – action completed	14/03/2024	ICB 23 104: Committee highlight reports	To include the 2024/25 Internal Audit Plan on the agenda for the May Board meeting.	Lucy Branson	09/05/2024	On this agenda at item 18; to be received for information, without presentation. Questions will be taken by exception.

Key:

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

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/05/2024
Paper Title:	**Chair's Report**
Paper Reference:	ICB 24 006
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:

A: Integrated Care Strategy stakeholder briefing
B: Board Annual Work Programme 2024/25

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. Welcome to the first of my Board updates of the new financial year. I continue to be grateful to all colleagues who have helped us to navigate a very challenging winter period with pressures felt particularly within our urgent and emergency care (UEC) system and in General Practice. The frontline teams and operational and commissioning managers supporting their work are increasingly taking a whole-pathway and whole-population view of the pressures felt in UEC and I hope that this will continue as we move into what it usually a slightly quieter period. I know that the report and recommendations on our approach to UEC from the national Getting It Right First Time (GIRFT) team are already starting to have an impact, which is good news.
2. I am pleased that the ICB was able to deliver on its commitments in terms of the financial position to the end of March 2024. This was no small feat so I would like to record my thanks and those of the Board for all the work that went into this.
3. The challenge from a financial position gets no easier for 2024/25 and as I have been consistently saying for a number of months, we have to get on top of this and start to make the systemic changes needed to address our underlying challenge. We need to act now to get to system-wide balance by end of March 2026 and this will require the whole-hearted commitment of everyone in the ICB and also from partners.
4. Linked to our need to deliver on our commitments on both the financial position and operational delivery, I am pleased to welcome Mandy Nagra to the ICB as interim System Delivery Director for an initial six months. Joining from NHS Birmingham and Solihull ICB and with a wealth of experience from other systems, Mandy will support the delivery of joint working across the directorates and with partners across health and care, ensuring that clinical, contractual, pathway, performance, and operational expertise and system delivery is brought together.
5. As previously mentioned, I have now taken up the role of Chair at NHS Derby and Derbyshire ICB and look forward to our two ICBs working together on joint areas of interest over the coming months and years. This of course links to the new political construct in our area, the Combined County Authority and Mayor, more on which below.
6. I have now also taken up my position as Chair of the NHS Confederation ICS Network Board. The Board is made of up of ten members who, together, ensure representation from both ICSs and the Local Government Association (LGA), and bring tremendous skills and experience. I am intending to ensure

that the great work we are delivering in Nottingham and Nottinghamshire gets the national attention it deserves and also use the Network to bring new and innovative ideas from other systems here.

7. This is the last formal Board meeting for two of our members and so I want to record my thanks, and those of the Board, to Stuart Poynor, Director of Finance and Catherine Underwood, Local Authority Partner Member. Stuart has been the ICB's Director of Finance since our establishment and also that of the former Clinical Commissioning Groups. Stuart has made a great impact on the Nottingham and Nottinghamshire system over a number of years and we will miss his advice and contributions. I would like to thank Stuart for his hard work and for helping to steer the local health system through some challenging times. We have all benefitted from Stuart's breadth of experience and guidance. Stuart will leave the ICB early in July and will be instrumental in setting our course towards financial recovery in the coming weeks and months.

8. Catherine has also been a member of the Board since July 2022 and leaves her role as Corporate Director for People at Nottingham City Council at the end of June. We have benefitted from Catherine's deep knowledge of her sector and areas of responsibility and from her championing of the people of Nottingham City. She leaves with our very best wishes.

Developing Our System

9. At the end of April, I was delighted to speak at our latest ICS Partners Assembly at the John Fretwell Centre near Mansfield. Welcoming nearly 200 representatives from across our partners, our general population, stakeholders and other interested parties. It was a really vibrant and valuable discussion and I was pleased to be able to share updates on how we are progressing on our Integrated Care Strategy and NHS Joint Forward Plan. The highlight for me though, was hearing from a number of projects from within our ICS who are really embracing our strategic principles of prevention, equity and integration. We heard from among others, one of the family mentors within the Small Steps, Big Changes Programme – this story really was a standout example of how we are harnessing a deep knowledge and understanding of our communities with a tailored and prevention-first approach to improving the lives of those in communities most at risk of experiencing health inequalities.

10. It was great to see so many members of the voluntary, community and social enterprise (VCSE) sector at the Assembly and I am very much looking forward to hearing more from the Chair of the Alliance, Professor Daniel King, later on in the meeting today. Our vibrant and diverse VCSE sector is a real strength and I am consistently delighted to see the impact of VCSE organisations when I am visiting our Places and Neighbourhoods.

11. One of the things that we updated on at the Assembly was the refresh of our system's Integrated Care Strategy. I'm pleased that the updated Strategy has now been signed off by partners and endorsed by the Integrated Care Partnership at its 22 March 2024 meeting and can be found here: https://healthandcarenotts.co.uk/wp-content/uploads/2021/05/Integrated-Care-Strategy-2023_27-2024-refresh.pdf. Through the discussions to update the Strategy we received overwhelming support for continuing to work towards our vision of every person enjoying their best possible health and wellbeing, as well as for our aims and principles. Appendix A provides greater detail for stakeholders.
12. Later in our meeting today we will be discussing the consequent update of our NHS Joint Forward Plan in light of this refreshed Integrated Care Strategy.
13. Away from strategy refreshes and conferences, I have been once again prioritising my time in meeting frontline staff who are on with delivering our integrated care ambitions and in particular, I wanted to mention the work being done by Nottingham City East Primary Care Network who I had the pleasure of spending a morning with recently.
14. The On Day Service, based at St Ann's Valley Centre, serves the population of the Primary Care Network (PCN). The purpose of the service is to create extra urgent same day GP appointments based in a central hub that practices can utilise if they are at full capacity. It is a really good example of the Practices in the PCN working together, supported by good IT access and also partnership working with the ICB. 62% of the residents within this PCN live in areas that are defined as the most deprived 20% in England. The PCN is also ethnically diverse, over one third of the resident population is from a black and ethnic minority background, which is more than double the England average, and 23 languages are spoken. Evaluation of the service is underway but it is expected to have reduced attendances at the Urgent Treatment Centre on London Road and supported practices to be more resilient and responsive to their patients.
15. Other meetings of note include ongoing conversations with Non-Executive Directors from across the system, but in particular Nottinghamshire Healthcare NHS Foundation Trust in light of the quality concerns identified by the Care Quality Commission. I have also met with our MPs or their representatives alongside the ICB's Chief Executive as part of our regular interactions with elected members, and I was pleased to join the ICB's all-staff monthly briefing in April.

Looking Forward

16. By the time that this report is received by the Board, we will know the outcome of the East Midlands Combined County Authority Mayoral election, identifying the leader of this new Combined Authority for Nottingham, Nottinghamshire,

Derby and Derbyshire for the next four years. Both ICBs will be prioritising engagement with the new Mayor and the Combined Authority with a particular focus for Nottingham and Nottinghamshire being the strategic development approach for Tomorrow's Nottingham University Hospitals Trust programme, which is currently underway.

17. Finally, as I note above, delivery on our financial and operational plans for the year 2024/25 is a critical 'must-do' and I note that we are already over ten percent of the way through the year. I know that colleagues within the ICB and across the system are working very hard on developing and delivering the plans we need to have in place to achieve expectations, and the Board will want to support and challenge that work as we move forward.

Board Work Programme

18. A key aspect of my role as Chair of the ICB is to ensure the Board is effective, focussed on key responsibilities and delivering against statutory duties, regulations and agreed strategies. Good governance practice dictates that Boards should be supported by an annual work programme that sets out a coherent cycle of business for the next year of meetings. The annual work programme is a key mechanism to ensure the full breadth of the Board's role can be discharged, balancing agenda time appropriately between key strategic priorities and ensuring appropriately timed governance oversight, scrutiny and transparency, while making best use of the work of the Board's committees.

19. A work programme for 2024/25 has been developed that aims to build on progress made by the Board over the past year and that takes into consideration the output from the recent assessment of Board effectiveness. This will be used to steer agenda planning; however, we will keep this under review throughout the year as our arrangements continue to evolve and embed, and in light of any changes to national timeframes for planning requirements.

20. The work programme is provided for information and feedback at Appendix B; this has been cross-referenced to the strategic risks set out within the Board Assurance Framework for 2024/25.

21. For this year, we are proposing a number of Board seminars. These informal sessions will be used for in-depth reviews of our strategic direction in a range of key areas. It is proposed that colleagues from our Place-Based Partnerships, the Provider Collaborative at Scale and HealthWatch be invited to these sessions to enrich discussions. The proposed topics are detailed in the work programme.

22. Also set out in the work programme are the proposed topics for our ICS Reference Group meetings in 2024/25.

19 April 2024

Dear colleagues,

Nottingham and Nottinghamshire Integrated Care Strategy

On 6 October 2023, the Integrated Care Partnership (ICP) agreed to commence a light touch review of the Integrated Care Strategy at the end of the first year of delivery. Our approach has been directed by updated guidance from Department of Health and Social Care on the preparation of Integrated Care Strategies.[1]

All ICS partners supported in the refresh of the strategy, for which the ICP are grateful, and a version of the strategy was presented to the ICP at their 22 March 2024 meeting. We received enormous support for continuing to work towards our vision, *every person will enjoy their best possible health and wellbeing,* as well as for our aims and principles.

We're writing to confirm that the ICP approved the refreshed Integrated Care Strategy for 2024/25 with the changes summarised as:

- Refreshed Foreword from the Chair and Vice Chairs.
- Strengthened wording and proposed re-ordering of the 14 priorities with an emphasis on babies, children and young people, frail older people and long-term conditions.
- A shorter document focussed on the priorities and actions, with much of the background information referenced to the strategy published in March 2023.
- Updated case studies for the four aims of the strategy to demonstrate examples of progress from the last year.

The latest version of the Strategy can now be found on our website: https://healthandcarenotts.co.uk/integrated-care-strategy/

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[1] https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies

Nottingham and Nottinghamshire Integrated Care System
healthandcarenotts.co.uk

We are writing to you as the Chair and Vice Chairs of the ICP to thank you all for your contributions, feedback and support in the development of the refreshed strategy. As we move into this next year, we would ask that as ICS partners, you consider the refreshed Integrated Care Strategy and how your organisation or partnership can contribute to the delivery of the strategy.

Next Steps

The ICP have endorsed work to strengthen the oversight and reporting arrangements for the Integrated Care Strategy over the coming months.

Partners are considering the optimal approach to ensure regular development and oversight of delivery of the Integrated Care Strategy. The opportunity for a Strategy Oversight Group is being considered to collectively understand progress with delivery, key risks, and issues arising across partners organisations, and to ensure the ongoing development of the Strategy throughout the year. Approaches to oversight of the Integrated Care Strategy will give due regard to existing reporting approaches for both Joint Health and Wellbeing Strategies and the NHS Joint Forward Plan and be clear about the added value.

It is proposed that an annual report on delivery of the Integrated Care Strategy is produced from 2024/25 onwards.

A practical framework that articulates how we will deliver our ambitions for prevention, equity and integration will be developed. This will describe the ways in which partners will work to meet these principles, describing tangible actions that can be monitored and assessed for impact.

A Population Health Management Outcomes dashboard has been developed by the System Analytics Intelligence Unit. Work is progressing in Q1 2024/25 to confirm outcome targets/ambitions that reflect the refreshed Strategy and associated delivery plans.

Your ongoing support and leadership as we move to the next phase of work continues to be enormously important and appreciated. We look forward to continuing to work with you all to translate our vision into action for the benefit of the people of Nottingham and Nottinghamshire.

Best wishes,

Kathy, Linda and John

Dr Kathy McLean OBE
Chair of the Integrated Care Partnership
Chair, NHS Nottingham and Nottinghamshire

Cllr Linda Woodings
Vice Chair of the Integrated Care Partnership
Chair of Nottingham City Health and Wellbeing Board

Cllr John Doddy
Vice Chair of the Integrated Care Partnership
Chair of Nottinghamshire Health and Wellbeing Board

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Appendix B

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	07 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
VCSE Alliance Report	✓	-	-	-	-	-	Strategic risk 9	See note 6

Agenda item (See Annex 1 for purpose and content)	09 May	11 Jul	12 Sep	07 Nov	09 Jan	13 Mar	Link to BAF	Notes
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

Agenda item (See Annex 1 for purpose and content)	09 May	11 Jul	12 Sep	07 Nov	09 Jan	13 Mar	Link to BAF	Notes
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: • Proactive care and long-term conditions management • System risk management and risk appetite	-	-	-	✓	-	-	-	-	-
Board Seminar: • Population health management approach to frailty • Primary care (primary medical services and pharmacy, optometry and dental services)	-	-	-	-	✓	-	-	-	-

Topic	11 Apr	30 May	13 Jun	16 Sep	10 Oct	12 Dec	16 Dec	13 Feb	17 Mar
Board Seminar: • Mental health • 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

<table>
<tr><th>No.</th><th>Agenda item</th><th>Purpose</th></tr>
<tr><td>1.</td><td>Introductory items</td><td>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.</td></tr>
<tr><td>2.</td><td>Chair's Report</td><td>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.</td></tr>
<tr><td>3.</td><td>Chief Executive's Report</td><td>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.</td></tr>
<tr><td>4.</td><td>Joint Forward Plan and Outcomes Framework</td><td>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.
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.</td></tr>
<tr><td>5.</td><td>Joint Capital Resource Use Plan</td><td>To present the Joint Capital Resource Use Plan for approval (prepared with partner NHS trusts and NHS foundation trusts).</td></tr>
</table>

No.	Agenda item	Purpose
		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.
6.	**VCSE Alliance Report**	To receive a report summarising the work of the Nottingham and Nottinghamshire VCSE Alliance.
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. 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.

No.	Agenda item	Purpose
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.
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.

No.	Agenda item	Purpose
		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 Committee, Quality and People Committee, Strategic Planning and Integration Committee, Audit and Risk Committee, Remuneration Committee**	To present an overview of the work of the Board's committees to provide assurance that the committees are effectively discharging their delegated duties 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

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/05/2024
Paper Title:	**Chief Executive's Report**
Paper Reference:	ICB 24 007
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.

The report also includes items for formal ratification following the exercise of the Board's emergency powers for urgent decisions. Updated terms of reference for the Integrated Care Partnership are also presented for approval.

Recommendation(s):

The Board is asked to:
- **Note** this item for information.
- **Ratify** the urgent decisions made during March and May 2024 using the Board's emergency powers.
- **Approve** the proposed amendments to the Integrated Care Partnership's terms of reference.

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

Appendices:

A: Integrated Care Partnership terms of reference

Board Assurance Framework:

Not applicable to this report.

Report Previously Received By:
The proposed amendments to the Integrated Care Partnership's terms of reference were considered and endorsed by the Integrated Care Partnership at its 22 March 2024 meeting.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Chief Executive's Report

Use of emergency powers for urgent decisions

1. The Board's urgent decision-making powers (as defined in the ICB's Standing Orders) are exercised when necessary due to exceptional circumstances. The following urgent decisions, which have been made since the last meeting in line with arrangements agreed by the Board, are now presented for formal ratification:

   a) **2024/25 Operational and Financial Plans** – Following discussion at meetings of the Board on 14 march and the Finance and Performance Committee on 21 March, the Chair and Chief Executive approved the submission to NHS England of the high-level 2024/25 Operational and Financial Plans. Following further discussion at the Finance and Performance Committee on 24 April, the Chair and Chief Executive approved the final submission to meet the deadline of 2 May 2024.

      The final plans have been shared with Board members separately. The ICB and our NHS Trust partners are required and committed to meet these plans and to recover the system financial position.

   b) **2024/25 ICB Opening Budgets** – Following endorsement at the Finance and Performance Committee on 21 March, the Chair and Chief Executive approved the ICB's opening budgets for 2024/25, in line with the agreed financial plan.

Review of the Integrated Care Partnership's terms of reference

2. Section 116ZA of the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Care Act 2022), requires upper tier Local Authorities and Integrated Care Boards (ICBs) to establish Integrated Care Partnerships (ICPs) as equal partners. In July 2022, the Nottingham and Nottinghamshire ICP was established as a joint committee of Nottingham City Council, Nottinghamshire County Council and NHS Nottingham and Nottinghamshire ICB, with updated terms of reference subsequently confirmed in November 2022. Since its establishment, the ICP has met five times in its role as 'guiding mind' of the Integrated Care System; developing and publishing an Integrated Care Strategy for Nottingham and Nottinghamshire and reviewing its early impact.

3. On 22 March 2024, the ICP met and considered its terms of reference in light of its initial period of operating, to ensure their ongoing fitness for purpose. As a result, no material amendments are proposed, with the ICP's purpose, principles of working, membership, chair and vice-chair arrangements, and meeting frequency all felt to be appropriate and working well. A small number of

minor changes were proposed; these relate to providing greater clarity on the difference between the ICP and the Health and Wellbeing Boards and the removal of references that are specific to the ICP's first period of operation.

4. The Board is asked to approve the updated terms of reference, which are attached with tracked changes at Appendix A

5. The terms of reference will also be presented to the full council meetings of Nottingham City Council on 13 May and Nottinghamshire County Council on 16 May. Once approval has been granted by all statutory organisations, the updated terms of reference will be formally published.

NHS England Oversight Framework 2023/24 quarter 3 review

6. 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 3 position. It has been agreed that the ICB will remain in segment 3 of the Framework, based in the main, on the financial position across the system and the level of support required across several performance challenges.

Review into mental health services at Nottinghamshire NHS Healthcare Trust

7. Since our last Board meeting, the report into Nottinghamshire Healthcare NHS Foundation Trust by the Care Quality Commission, commissioned by the Secretary of State for Health and Social Care under Section 48 of the Health and Social Care Act (2008), has been published, in part. While the strand of the report related to the care of Valdo Calocane is expected in June, published last month were the reports on the quality and safety of Nottinghamshire Healthcare NHS Foundation Trust services and an assessment of the improvements made at Rampton Hospital.

8. As I reported to the last meeting, the ICB has an important role to play as system leader to support the oversight of improvements needed at NHT, and we continue to work with the Trust to ensure that quality and safety concerns are fully addressed as rapidly as possible. A tailored, intensive support programme has been put in place with the Trust, focussing on the issues that need to be addressed to achieve rapid and sustainable improvement.

9. The ICB and NHS England Midlands colleagues have established a joint Improvement Oversight and Assurance Group which brings together all relevant parties to ensure that the appropriate support and challenge is offered to NHT during their work to improve services.

2024 Covid-19 vaccination campaign

10. Following the Government's acceptance of advice from the Joint Committee on Vaccination and Immunisations, the 2024 campaign commences from 15 April. Eligible cohorts are adults aged 75 or over, residents in care homes for older adults, and individuals aged six months or over who are immunosuppressed.
11. In line with NHS England's Strategy 'Shaping the Future of NHS Vaccination and Immunisation Services', the ICB has been working with system partners to develop a local plan for all vaccination requirements to ensure services are convenient to access and tailored to the needs of local people, supplemented by targeted outreach projects to increase uptake in underserved populations.

East Midlands Cancer Alliance

12. On 1 April 2024 staff working with the East Midlands Cancer Alliance transferred from NHS England to the ICB. Although based with the ICB, they will continue to cover the whole East Midlands region. The team works to improve the experience of care and cancer outcomes for local communities. They work with GP practice teams, hospital teams, cancer clinicians, commissioning teams, public health teams and community teams. Transferring to the ICB will allow the team to work more closely with one of their major cancer services providers, Nottingham University Hospitals NHS Trust.

NHS England's delegation of 59 specialised services

13. On 1 April 2024, the ICB also took on delegated responsibility from NHS England for the commissioning of 59 specialised services. This is part of a national policy direction to bring the commissioning of services closer to local populations. The first phase came into effect on 1 April 2023, with the ICB taking on responsibility for the commissioning of pharmacy, optometry and dental services. The expected outcome of this policy is to improve the quality of services by joining up pathways, enabling the better planning of services and to reduce health inequalities.
14. Joint arrangements have been agreed between the 11 Midlands ICBs for delivery of the delegated functions through the expansion of the existing East Midlands and West Midlands Joint Committees. The further delegation of additional specialised services is scheduled for 2025/26.

Care Quality Commission assessments of Integrated Care Systems

15. The Care Quality Commission (CQC) has announced that there will be a short delay to the commencement of their assessments of Integrated Care Systems to allow them to refine their approach.

16. The CQC has been piloting their assessment approach with Birmingham and Solihull ICS and Dorset ICS and has undertaken an evaluation of their methodology. In particular they have been working with NHS England on their strengthened approach to performance evaluation and rating of the ICB elements of the Integrated Care System.
17. Following government approval of their methodology, the CQC will publish their pilot reports, pilot evaluation and updated guidance ahead of starting their assessments.

Health and Wellbeing Board updates

18. The Nottinghamshire County Health and Wellbeing Board met on 13 March and 17 April 2024. The meetings received an update report on 'the Building Blocks of Health Ambition Two: healthy and sustainable places' and approved Joint Strategic Needs Assessments on food insecurity and carers. The papers for these meetings are published on Nottinghamshire County Council's website here: https://www.nottinghamshire.gov.uk/dms/Committees/tabid/62/ctl/ViewCMIS_CommitteeDetails/mid/381/id/548/Default.aspx.
19. The Nottingham City Health and Wellbeing Board met on 27 March 2024. The meeting received a delivery update on the Joint Health and Wellbeing Strategy and a report on race health inequalities. 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.

Healthwatch Annual Report 2022/23

20. Healthwatch has recently published their annual report for 2022/23, which provides a valuable overview of the key issues and emerging trends affecting health and social care services both nationally and locally. The report highlights three themes that Healthwatch call on organisations to focus on, arguing that if these are not addressed there is a risk that a two-tier health system will arise:
    a) Making the NHS easier to navigate
    b) Tackling health inequalities
    c) Building a patient-centred culture
21. At our last Board meeting in March, we had a very useful discussion with the Chair and Chief Executive of Nottingham and Nottinghamshire Healthwatch on how we could work more closely together to engage with communities and identify and address emerging quality and safety issues with our services at an earlier stage.

22. The full annual report can be found here: https://www.healthwatch.co.uk/report/2024-03-14/value-listening-our-annual-report-2022-23#Download

Martha's Rule

23. Thirteen-year-old Martha Mills died from sepsis at King's College Hospital, London, in 2021, due to a failure to escalate her to intensive care and after her family's concerns about her deteriorating condition were not responded to promptly.

24. In February 2024, NHS England announced the roll out of a patient safety initiative to provide patients and their families 24-hour, seven-day access to a rapid review from an independent critical care team if they are worried about their or a loved one's condition.

25. Further to this announcement the first phase of the implementation of Martha's rule is being rolled out from April 2024 and expressions of interest for the recruitment of the first 100 provider sites are being processed. This first phase will be an opportunity to help the NHS to devise and agree a standardised approach to Martha's Rule. An announcement around the successful sites is scheduled be made during May.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/05/2024
Paper Title:	**Nottingham and Nottinghamshire NHS Joint Forward Plan 2024/25**
Paper Reference:	ICB 24 008
Report Author:	Joanna Cooper, Assistant Director of Strategy Sarah Fleming, Programme Director for System Development
Report Sponsor:	Lucy Dadge, Director of Integration
Presenter:	Lucy Dadge, Director of Integration

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

Summary:

In line with NHS England guidance, there is a requirement to annually refresh the Nottingham and Nottinghamshire ICB Joint Forward Plan (JFP) [1] (https://healthandcarenotts.co.uk/integrated-care-strategy/joint-forward-plan/).

A report was provided to Board on 11 January 2024 where the approach to the development of a refreshed document was approved. The Board was further updated on progress at its 28 March 2024 meeting, including the updated guidance from NHS England issued on 20 March 2024 to advise that the JFP is to be published by end of June 2024.

The plan has been developed in collaboration with system partners and citizens during February to April to ensure there is system support for the JFP as our collective plan. The final draft JFP is presented for approval.

Work continues to map the JFP deliverables to the ICS Outcomes Framework to ensure there is a clear line of sight from deliverables to improved outcomes. A JFP Delivery Group has been established to provide oversight for the delivery of the Plan. Board will receive bi-annual updates to support assurance of delivery and outcomes.

Recommendation(s):

The Board is asked to:

- **Approve** the 2024/25 NHS Joint Forward Plan.
- **Note** progress with defining the outcomes to be delivered by the Joint Forward Plan.
- **Note** the developing delivery and oversight arrangements.

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,

[1] https://www.england.nhs.uk/long-read/guidance-on-updating-the-joint-forward-plan-for-2024-25/

How does this paper support	the ICB's core aims to:
	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.
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: Final draft Nottingham and Nottinghamshire NHS Joint Forward Plan.
Appendix 2: Draft JFP Delivery Plan Outcomes
Appendix 3: Oversight governance

Board Assurance Framework:

This paper provides assurance in relation to the management of the following ICB strategic risks:

- Risk 1: Transformation (Making Tomorrow Better for Everyone) – Effective system working may not transform (reform) and improve services to address health inequalities and ensure best possible future health outcomes within available resources.
- Risk 2: System Resilience (for Managing Today) – Working effectively across the system may fail to address the current levels of demand across primary, community and secondary care.

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.

Nottingham and Nottinghamshire NHS Joint Forward Plan 2024/25

Refresh and review of the NHS Joint Forward Plan 2024/25

1. The 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. NHS England issued updated guidance on 20 March 2024 to advise that the JFP is to be published by the end of June 2024 to take into consideration the timeline for the development of NHS Operational Plans.
3. The JFP refresh has been supported by a working group consisting of NHS Directors of Strategy, Directors of Public Health, the Provider Collaborative at Scale and Place Based Partnership programme and clinical leads to ensure the plan continues to reflect the system's ambitions and supports the principle of subsidiarity.
4. All ICS partners have been engaged in the development of the JFP. Formal feedback has been received from 75 sources. Key points to note are:
    a) Both Nottingham City Health and Wellbeing Board (HWB) and Nottinghamshire County HWB have considered the JFP, with County holding a specific workshop discussion. Both HWBs have confirmed statements of support that the JFP takes into account its feedback and provides commitment to the Joint Health and Wellbeing Strategy.
    b) NHS providers have undertaken organisation specific approaches to engaging with their own Boards or Committees to consider the JFP and provided feedback to the Plan.
    c) The refresh was informed by the service user and citizen insights report received by the Integrated Care Partnership at their 6 October 2023 meeting[2].
    d) A survey was developed and shared with a broad range of stakeholders including citizens to give them opportunity to share their thoughts on the emerging content of the JFP. The survey received 118 responses.
    e) NHS England provided feedback on the JFP stating that the draft plan reflects the priorities of the NHS in Nottingham and Nottinghamshire and articulates the collective response to addressing them over the coming years. Key success includes good evidence of system working, demonstration of integration, positive approach to addressing inequalities and co-design of services, recognition that innovative approaches are

[2] ICP-06.10.23.pdf (healthandcarenotts.co.uk)

being implemented such as Virtual Wards, and excellent reference to children in care and care plan development work.

f) There has been broad support for the plan including the aims, ambitions and principles as the right direction of travel for the system. All partners are supportive of a stronger focus on delivery of the JFP with a clear delivery plan, programmatic approach and robust approach to demonstrating impact.

g) Following Board discussion, a summary of what delivery of the JFP means for patients has been included.

5. All feedback has been reviewed and incorporated as appropriate following an assessment by the relevant programme leads, recognising the balance between content detail and maintaining focus/brevity within the plan. Review of the feedback received to date suggests no significant amendment to the JFP presented. A record of the feedback received and how this has been reflected in the plan is available on request.

6. The final draft plan is included in Appendix 1 for agreement.

Confirming outcomes to demonstrate impact of delivery

7. A stocktake of delivery of the year one plans in 2023/24 was presented to Board in January and March to demonstrate key areas of delivery. This stocktake will evolve with the development of a bi-annual report of progress against both milestones and outcomes.

8. Work is progressing to confirm the outcomes and supporting metrics that will monitor progress. An initial draft is outlined in Appendix 2 for the four priority areas in the JFP.

9. Further work will be undertaken in Q1 2024/25 to confirm the outcomes related to the NHS JFP deliverables and develop the necessary specificity of intended benefit and ambition and associated monitoring metrics. This will be shared with the ICB's Strategic Planning and Integration Committee in July and Board in September.

10. The work undertaken to date has identified that some components of the JFP are enabling activities that do not necessarily have associated data or will require further work to provide greater definition of the intended benefit.

11. The approach will align with the Population Health Management Outcomes dashboard developed by the System Analytics Intelligence Unit (SAIU) to ensure that outcomes can be measured in a timely and robust way, and to identify gaps in data availability and frequency of reporting.

12. Where gaps in data availability are identified, SAIU will provide an assessment of the feasibility of new data collection and associated timescales.

13. Monitoring of outcomes will be undertaken by the relevant Programme Board with collective oversight undertaken by the JFP Delivery Group.

Delivery and oversight arrangements

14. The JFP provides detailed expectations in relation to the delivery of NHS programmes and initiatives over the next five years that will, in combination, transform the way we work together and how/where we focus our collective efforts and resources.

15. Further engagement with system partners has been undertaken since the Board was updated in January regarding the oversight arrangements required to have a programmatic approach to delivery of the JFP. This is summarised in Appendix 3.

16. A JFP Delivery Group has been established to provide a structure and programme through which the JFP can be delivered and to ensure collective ownership for delivery of the plan by all NHS organisations. The focus will be two-fold:

    a) Delivery of milestones: understanding progress with planned milestones from Programme Boards and understanding the risks for other programmes due to delays in implementation.

    b) Delivery of outcomes: monitoring the impact of the JFP on population outcomes.

17. The key duties of the group include:

    a) Ensure that NHS Joint Forward Plan priorities are clearly articulated with responsibility for delivery assigned and system outcomes confirmed.

    b) Manage interdependencies between different programmes of work including understanding the impact that actions taken in one part of the system has on other parts.

    c) Oversee the development of a reporting approach that ensures there is clarity over delivery whilst not replicating existing performance reporting where that is deemed effective.

    d) Receive recommendations on clinical transformation from the Clinical and Care Professional Leadership Group and align efforts and resource accordingly.

    e) Propose the most appropriate delivery vehicle for NHS Joint Forward Plan priorities.

    f) Ensure there is a clear link to relevant system performance groups to ensure delivery of the JFP and in year performance is clearly understood and managed.

g) Promote and champion integrated ways of working within the Nottingham and Nottinghamshire ICS system, as well as regionally and nationally.

18. The group will take into consideration the emerging oversight arrangements for the delivery of the Integrated Care Strategy to avoid duplication and to ensure that there is not a gap in our collective understanding of delivery. The first meeting will take place on 23 May 2024.
19. Place Based Partnerships (PBP) are members of the group recognising their role in the delivery of the JFP with leadership for areas including prevention, addressing inequalities in children and adults, frailty, and long-term condition management with a focus on specific cohorts and neighbourhoods.
20. PBP leadership of Integrated Neighbourhood Working is recognised as integral to transformation with Primary Care Networks playing a key role in the design and development of local approaches to achieve system outcomes.

Next Steps

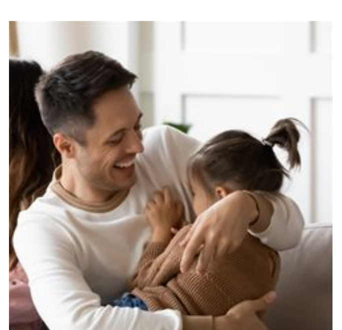
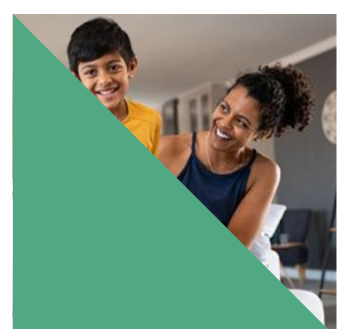
21. Following approval, the plan will be published on the ICS website.
22. Work will be undertaken in Q1 to confirm the outcomes that will be achieved by successful delivery of the JFP, clearly mapped to the deliverables.
23. The metrics that will provide the short- and medium-term monitoring of progress will be confirmed working with the SAIU to ensure robust data is available to programme leads to track delivery.
24. The JFP Delivery Group will ensure that there is collective ownership of delivery by all NHS Organisations. The group will coordinate bi-annual reports on delivery of the JFP. The first report to Board will be provided in September 2024.

Joint Forward Plan: Annual Refresh

Appendix 1

3 May 2024

NHS
Nottingham and
Nottinghamshire

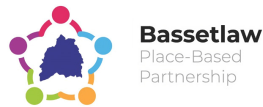
Chappell Room, 09:00-09/05/24

Nottingham and Nottinghamshire NHS Joint Forward Plan 2024/25

2024 - 2028

Our NHS Joint Forward Plan for Nottingham and Nottinghamshire has been developed with our NHS statutory partners.

The plan has also been developed with our wider stakeholder community. Special thanks to the following partners for their support including the VCSE Alliance and Citizens Intelligence Advisory Group.



This plan builds on the version published in June 2023. It sets out how we will work differently, where we want to be in five years and how we will get there.

Section	Description	Pages
Section 1. Our approach	Sets out how the NHS will reposition the component parts of our system and how the NHS will work with partners across Nottingham and Nottinghamshire and regionally. Outlines links to national policy and strategic thinking. Describes specifics in terms of how we will achieve equity, prevention and integration and our overall approach to ensuring delivery of the four statutory aims of the Integrated Care Board (ICB).	Pages 8 - 14
Section 2. Our health needs	Describes our outcomes baseline and where we are now.	Page 15
Section 3. Our care delivery	Identifies programmes/initiatives including NHS commitments, Integrated Care Strategy deliverables and the four key clinical priorities for the system. Specifies year-on-year expectations, with year-on-year milestones, aligned to Operational Plan deliverables for the first year.	Pages 16 - 18
Section 4. Our delivery commitments	Detail on how the NHS will operate in relation to the enablers in the Integrated Care Strategy. This includes, for example, workforce, digital, estates, working with people and their local communities, our evidence-based approach and focus on outcomes. Considers our delivery approaches (Place Based Partnerships, Provider Collaborative, Primary Care Networks) and system enabling mechanisms (including the ICB Operating Model, research and innovation, productivity and performance improvement, social and economic development, quality improvement and environmental sustainability).	Pages 19 - 41
Appendices and Glossary	The section includes the opinions of our two Health and Wellbeing Boards on the extent to which the Joint Forward Plan addresses the priorities outlined in the two Joint Health and Wellbeing Strategies and meets the commitments of the Integrated Care Strategy.	Pages 42 - 46

Chappell Room, 09:00-09/05/24

Foreword from our Chief Executives

At the start of our second year of our Joint Forward Plan we have taken the opportunity to reflect on progress. This version of the plan, reinvigorates our approach to 2024/25 and sets out our high-level plans for 2028/29.

We continue to be committed to our collective ambition to improve the health and wellbeing of our local population. Our Integrated Care Partnership, acting as the 'guiding mind' of the Nottingham and Nottinghamshire Integrated Care System, published its Integrated Care Strategy 2023-27 in March 2023, which has subsequently been reconfirmed in March 2024.

This Strategy describes our ambition, challenges and intended achievements to ensure that every person will enjoy their best possible health and wellbeing.

This ambition is testament to the hard work and dedication of our staff who continue to work tirelessly across all our NHS and partner organisations to deliver safe and high-quality health and care services to the people of Nottingham and Nottinghamshire and beyond.

We continue to face challenges in converting this ambition into action. Recruitment and retention of staff remains a priority and demand for services continues to rise. We continue to seek to recover services following the pandemic. Covid-19 highlighted underlying health inequalities across our communities and clear opportunities to improve healthy life expectancy and life chances for those who are most disadvantaged. We now face additional challenges with an increased focus on establishing a sustainable financial position to deliver best value for our population.

This five-year Joint Forward Plan has two specific and interlinked aims:

1. To recover NHS core services and make them sustainable.
2. To show how the NHS will support the delivery of our Strategy by shifting resource from treatment to prevention, focusing on those communities where need is greatest and integrating services around people and their communities.

We are determined to stay on course to deliver the ambitions of the Strategy. The Plan provides more detail as to 'how' we will deliver the Strategy, the approach we will take and the specific interventions that we will implement in order to meet our collective ambition over the next five years.

In delivering the Strategy we will retain the three strategic principles of:

PREVENTION, EQUITY and INTEGRATION.

We remain committed to focussing on preventing people becoming ill, reducing the impact of ill health and empowering people to manage their illness themselves. We will reduce health inequalities across our population and we will promote equity.

Our partnership working with our local authorities, public and voluntary sector organisations, our population and communities continues to evolve and strengthen. We will build on the momentum of our Joint Health and Wellbeing Strategies to tackle the wider determinants of health and support people to live healthier lives.

Our approach is to embed these three principles as 'the way we work'.

This first year saw the development of the Health Inequalities Innovation Fund to redeploy investment and resources into services to support prevention, earlier detection and interventions that impact on population health. Funding has been allocated across 9 schemes relating to three themes of Severe Multiple Disadvantage (SMD), Integrated Neighbourhood Working and Best Start in Life. We remain committed to our plan to develop this fund and will build on what we have learnt during the first year.

Our teams are being empowered to ensure every contact counts and encourage all voices to be heard in how we respond to our current challenges, as well as co-create our health and care services of the future. Through our Place based working, training has been delivered to frontline staff to enable them to better support citizens and their families.

We have established frameworks to embed our approach to equity:

- Population Health Framework that will be used together with the Systems Analytic Intelligence Unit (SAIU) approach.
- ICS Social Value Procurement Policy setting out how we will gain efficiencies from our combined purchasing power, and support sustainability and social value in our communities.

SAIU continues to develop data packs and dashboards for system clinical priorities to inform our approach. We have focussed on developing strong foundations for collaborative working at neighbourhood, Place, system and regional level. Our approach to Integrated Neighbourhood Working is emerging to enable teams to be more integrated, developing proactive care to prevent ill health and helping people stay healthier at home for longer. We have been scaling up personalised care planning working with those with lived experience and local communities development of a co-production toolkit. We will actively seek out voices that are seldom heard so that all may contribute to building our transformed system.

Over the next five years, these changes will result in a significant cultural shift in the way we work together and a radical overall transformation of the system in which we work.

Our NHS organisations are committed to delivery of key national expectations. This plan continues to be a primary reference point for future strategic and planning decision making. The plan provides detail on how we will continue to improve and meet or exceed national standards in relation to elective care recovery, patient waiting times, access to primary care and other services. Nottingham and Nottinghamshire performs well compared to certain national indicators and we reconfirm our commitment to remain one of the best performing systems in the East Midlands region, if not nationally.

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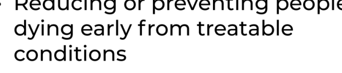
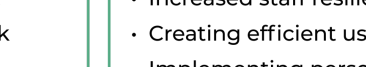
What will delivery of our Joint Forward Plan mean for our community?

Figure 3.

	For People	For Staff	For NHS Organisations	For Partners
Promoting Prevention	• Earlier detection of disease • Reduced likelihood of future ill health or current ill health worsening • Empowered to work with staff to develop services and solutions based on need and real-life experiences 	• Helping people to stay healthier for longer • Promoting a more holistic approach to patient care • Ensuring physical and mental health needs are addressed 	• Avoiding future use of services, ensuring services are available for those that need them when they need them most 	• Developing closer working relationships and reducing duplication across organisations • Supporting effective use of resources
Promoting Equity	• Supporting those with severe multiple disadvantage to have improved life chances • Ensuring all voices are heard • Promoting inclusion, valuing diversity 	• Making sure all patients have equal opportunity to benefit from the services they provide • Valuing all our staff and supporting them 	• Reducing or preventing people dying early from treatable conditions • Making better use of resources to benefit more people 	• Enabling better access to non-NHS services that support personalised care • Enabling all our community to fulfil their potential
Promoting Integration	• Reducing the need to engage with multiple NHS staff about the same issue • Being supported on non-medical matters that are important to the individual • Promoting more seamless care across clinical and non-clinical support services 	• Promoting multi-disciplinary team working and continuity of care • Making Every Contact Count • Staff feel empowered to work differently 	• Creating streamlined care pathways • Increased staff resilience • Creating efficient use of estates • Implementing personalised care 	• Making it easier to do business with the NHS • Greater recognition of the value of non-NHS services in supporting health and wellbeing • Building community resilience

Chappell Room, 09:00-09/05/24

Chappell Room, 09:00-09/05/24

Reflecting on key successes from 2023/24

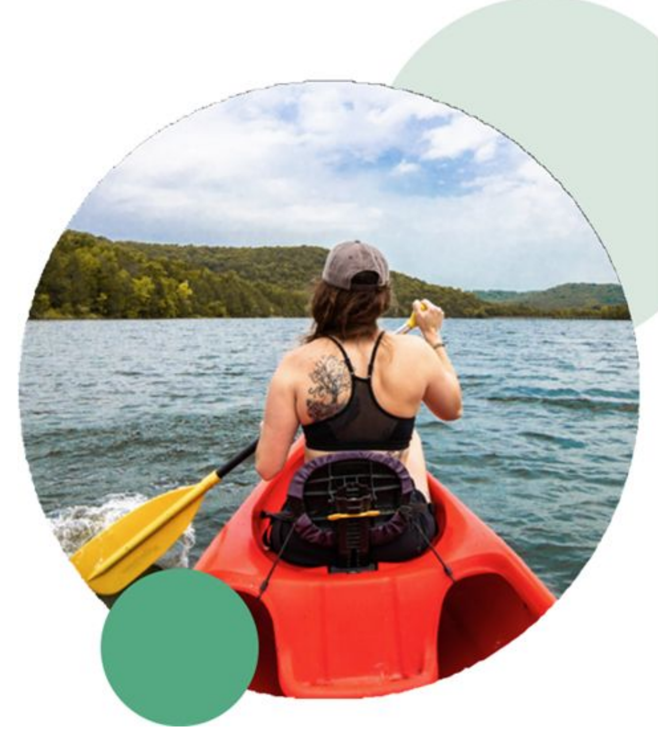
As we start this new year and refreshed plan, we want to take the opportunity to thank our staff for their hard work over the last year. A selection of our achievements are shared below, which demonstrate the strong platform that we have developed for the coming year to further embed PREVENTION, EQUITY and INTEGRATION.

Place Based Partnerships (PBPs) are continuing to develop approaches to Integrated Neighbourhood Working that bring partners and communities together to develop effective support and services tailored to local need.	The ICS was awarded Vanguard Status for NHS Scaling People Services. Three priority areas have been confirmed: Staff Wellbeing; Portability and Passporting including a collaborative approach to flexible staffing; a review of outsourced HR contracts including Employee Assistance Programme.	PCNs are hosting the Workingwell employment advice service within surgery. The service encourages patients struggling to find or stay in work due to a health condition to gain support.
Sherwood Forest Hospitals (SFH) Phoenix Team, a nationally recognised maternity tobacco dependence treatment service, has helped over 200 families to achieve a smokefree birth.	The Targeted Lung Health Check programme has expanded into Nottingham City building on the success of the programme in Mansfield and Ashfield. The ICB has recorded the highest national uptake rate for the programme. Further expansion is planned in 2024 and 2025 with full ICS coverage by 2027.	Partners have signed the Armed Forces Covenant as we we acknowledge and understand that those who serve or have served in the Armed Forces, and their families, should be treated with fairness and respect.
Through the Health Inequalities Innovation and Investment Fund, the ICS is providing wrap around care across Nottingham and Nottinghamshire for those who are facing Severe Multiple Disadvatage (SMD).	Initial stage of the Better Care Fund (BCF) review is now complete. The output will inform commissioning decisions and has identified potential areas to scale up collaborative commissioning including prevention, urgent care, mental health and children and young people.	Virtual wards to support patients who would otherwise be in hospital have been established across the ICS. 181 virtual ward beds across 23 specialties were operational as of 18th December 2023 providing monitoring and support to people in the place they call home.
South Nottinghamshire PBP held an Integrated Neighbourhood Working event in July bringing together more than 80 people to consider how to create healthy and sustainable neighbourhoods. This is now being progressed in the four areas with the highest level of health inequalities: Arnold Town, Cotgrave, Eastwood Town and Hucknall Town.	Nottingham City identified cardiovascular disease as a PCN priority. A review was undertaken using data from the System Analytics Intelligence Unit (SAIU) focused on avoidable deaths, clinical conditions, lifestyle factors and the wider determinants of health. A programme has been initiated offering interventions such as personalised exercise and diet plans and access to classes, a targeted media campaign and providing patients with resources to support healthy lifestyles.	Supporting frail and/or older people with underlying conditions to stay well, remain independent and avoid unnecessary admissions to hospital in the short term. Partners are working together to jointly develop the same day emergency care pathway to prevent hospital admissions and keep people at home.
SFH introduced new pathways of MRI head, magnesium, lumbar punctures and developing same day ultrasound for deep vein thrombosis into its dedicated medical unit. The Unit has 25 recliners and sees an average of 60 patients per day equating to 37% of patients admitted via emergency methods who were discharged same day.	Bassetlaw PCN are carrying out targeted work to improve uptake of screening by Women in a deprived area. This includes walk-in cervical cytology for Polish women on Saturdays, advertised by Polish leaflets and posters, with a community and voluntary sector interpreter on site. 20 people attended the first session with 17 screened. Further sessions are planned.	Doncaster and Bassetlaw Teaching Hospitals (DBTH) launched a landmark partnership with Retford Oaks Academy and became the second 'Foundation School in Health' in UK, bolstering the relationship between education and health across the region.

Since our first plan was published in July 2023, organisations in Nottingham and Nottinghamshire continue to work in a challenging environment. Of note are that:

- Local people and organisations continue to face financial challenges. The rising cost of living is impacting on households and businesses, including health and care staff and services. We are working across our system for the provision of core NHS and social care services, and our partnerships can help align our public sector approach to the rising cost of living.
- Increasing workforce costs are also impacting on the financial sustainability of the health and care services that we provide.
- The pressure of ongoing industrial action continues to impact on health and care services, including our waiting lists and resilience of our staff. Getting back on track with waiting times and access to emergency care, is a top priority for the NHS. We have a track record of successful collaboration during times of pressure on our health and care system, and partners continue to work together to support citizens and staff. We have a whole system response structure to ensure that essential services are maintained.
- Some of our services aren't being delivered to the standards that we would expect for the people of Nottingham and Nottinghamshire. This plan outlines key actions that we will be taking to improve the quality of services and outcomes in population health and healthcare.
- A new Combined East Midlands Authority has been created after a £1.14 billion devolution deal was agreed by the four upper tier councils of Derbyshire County Council, Nottinghamshire County Council, Derby City Council and Nottingham City Council in November 2022. Devolution provides opportunities to improve the economic, social and environmental wellbeing of the people who live and work in the area including:
  - Local control over a range of budgets like the Adult Education Budget, so we can use the money to meet the needs of people in our communities.
  - Local powers to tackle challenges that are specific to our area and harness its true economic potential, for the benefit of everyone who lives and works here.
  - Working more effectively on a larger scale across council boundaries, further strengthening partnership working across and between our counties and cities.

We remain confident that a continued focus on our four NHS focus areas is the right thing to do for local people. Our plan sets a clear direction for health and care services in Nottingham and Nottinghamshire.



NHS Focus Areas

1. Prevention: Reduce physical and mental illness and disease prevalence
2. Proactive management of long-term conditions and frailty
3. Improve navigation and flow to reduce emergency pressures
4. Timely access and early diagnosis for cancer / planned care

ACHIEVING: PREVENTION | EQUITY | INTEGRATION

Chappell Room, 09:00-09/05/24

Introduction

Our Nottingham and Nottinghamshire Integrated Care Partnership has developed an **integrated care strategy** for our system, with the expectation that collaboration across all partners will deliver four core aims, and that delivery of these will be guided by three underlying principles:

1. Improve outcomes in population health and healthcare	**2. Tackle inequalities** in outcomes, experiences and access	**3.** Enhance **productivity and value for money**	**4.** Support broader **social and economic development**

We now have to translate this intent into action – encouraging local people, neighbourhoods, communities, staff, Place Based Partnerships and system partners to all play their part. This Joint Forward Plan acts as the NHS delivery commitment for all NHS organisations within the Nottingham and Nottinghamshire Integrated Care System (ICS), with intentions in line with our two Joint Health and Wellbeing Board Strategies for the city and county.

This Plan sets out the role that NHS partners will play in collaboration with our wider system partners in delivering our Strategy as well as the national expectations set out by NHS England. We want to be ambitious – we trust the passion, experience and commitment of our staff to enable us to be brave in the changes we intend to introduce or accelerate.

We recognise that our communities face huge challenges and that we need to ensure every public pound, and all our combined effort, is focused on helping every person within Nottingham and Nottinghamshire to enjoy their best possible health and wellbeing.

We want to emphasise in this Plan how, by acting as an NHS team within our ICS, we will address the challenges of today as well as tomorrow. We outline the changes that our system will take over the next five years to ensure we have sustainable services by working differently, co-producing these changes with children, young people and adults, and being courageous in our approach. Our delivery plan responds directly to the priorities identified within our Strategy.

Further detail on our system, the approach to our JFP and ambition is outlined in the first version of our NHS Joint Forward Plan available on our website: healthandcarenotts.co.uk

Our agreed 14 Integrated Care Strategy Priorities
We will support babies, children and young people to have the best start in life with their health, development, education and preparation for adulthood.
We will support babies, children, young people and adults with the greatest needs (the 20% most deprived, those in vulnerable or inclusion groups and those experiencing severe multiple disadvantage).
We will focus on health, wellbeing and education for children and young people to help improve employability and life chances for future generations.
We will support frail older people with underlying conditions to maintain their independence and health.
We will focus and invest in prevention priorities, like tobacco, alcohol, healthy weight, oral health and mental health, to support independence, prevent illness, poor birth outcomes and premature death from heart attack/stroke/ cancer/ chronic obstructive pulmonary disease (COPD), asthma and suicide.
We will 'Make Every Contact Count' (MECC) for traditional areas of health, for example mental health and healthy lifestyle and incorporate signposting to other services like financial advice which support people to improve their health and wellbeing.
We will establish a single health and care recruitment hub.
We will adopt a consistent system-wide approach to quality and continuous service improvement.
We will bring our collective data, intelligence and insight together.
We will align our Better Care Fund programme to our strategic priorities.
We will make it easier for our staff to work across the system.
Use our collective funding and influence to support our local communities and encourage people from the local area to consider jobs in our organisations.
We will add social value as major institutions in our area.
Work together to reduce our impact on the environment and deliver sustainable health and care services.
Underlying principles guiding our delivery **Prevention is better than cure** **Equity in everything** **Integration by default**

Chappell Room, 09:00-09/05/24

Building our integrated approach

Working and behaving differently to deliver maximum impact

We want to transform the way our system works, to improve the lives of the people it serves. Our integration approach is widespread, taking in all levels, including colleagues within existing NHS organisations and the development of our four Place Based Partnerships (PBPs), working alongside system-level transformational programmes. Our PBPs will be characterised by empowered local teams working together across upper and lower tier councils. PBPs will be supported to work with our Primary Care Networks (PCNs) and develop integrated neighbourhood working (sometimes in the form of multi-disciplinary teams). Focus for these teams will be where population health intelligence suggests it would be most impactful, either in terms of improving health and wellbeing outcomes and/or improving cost-effective use of our collective resources. Ongoing evaluation and system level assurance mechanisms will enable us to refine and adapt these approaches as well as rapidly spread good practice and learning.

Our system model (see Figure 1) shows how our various partners 'lock' into our shared integrated system approach. The triangle of inter-dependency is strong, with all partners and elements of our system playing their role in delivering change based on the platform of the Integrated Care Partnership and the Integrated Care Strategy. The three strategic principles of **Prevention, Equity and Integration** remain the basis for this platform.

The benefits of this approach will be:

- Transformational change driven and owned by people closer to where people live.
- Interventions co-designed with a better understanding of the context within which people live – interventions more sensitive to local need and therefore more impactful and cost efficient.
- Relationships across partners and with communities are stronger and better able to use local resources – for example, creating innovation through integration/ combined posts/shared knowledge and skills transfer.
- More direct communication channels – professionals get to the right person/ organisation more quickly to resolve the problem. Informal and formal mechanisms of engagement expand opportunities to make appropriate professional connections.
- PBPs offering a way to drive local transformational change initiatives working in collaboration with system level experts, in areas such as public health, clinical and social care.

Evolving our integrated operating model

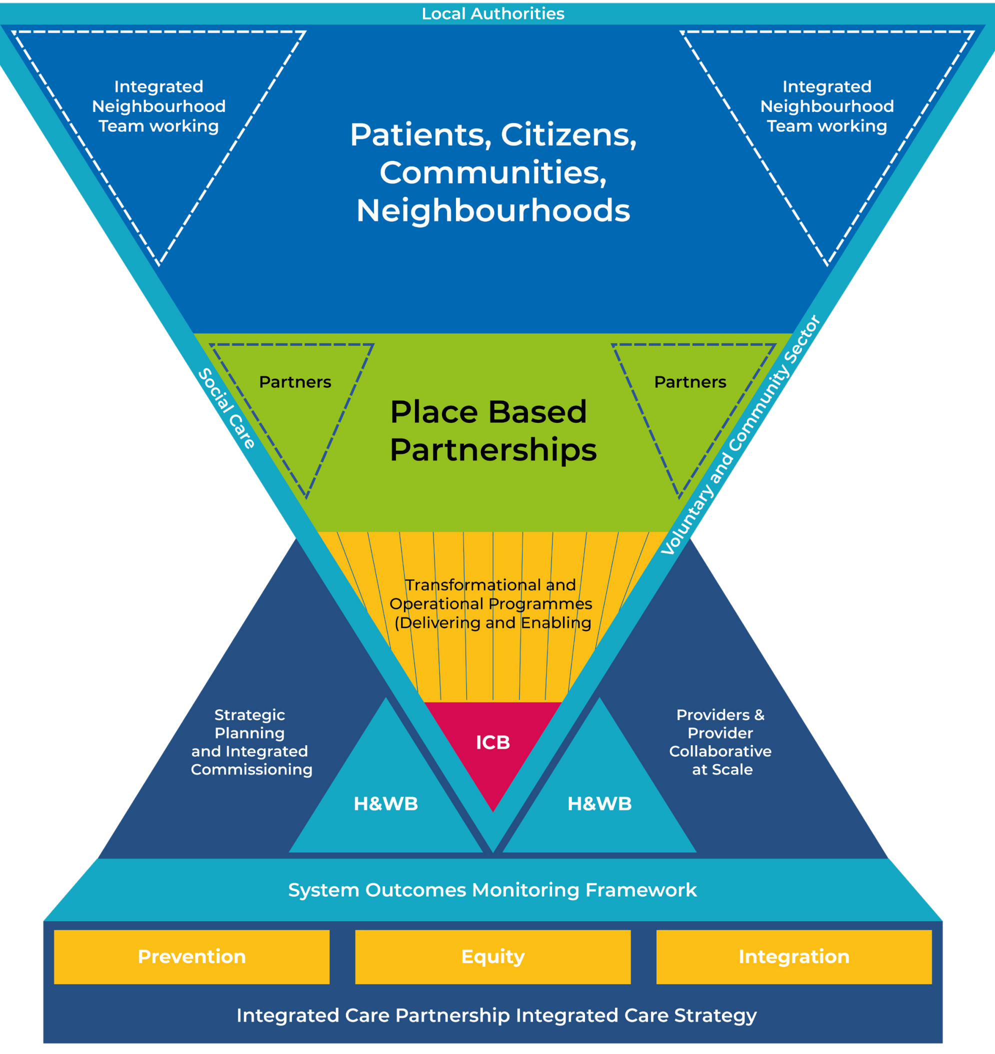


Figure 1.

Building our integrated approach

Delivering through improved prevention, reducing health inequalities and promoting equity

Our Plan is built on the shared commitment of all local NHS leaders to create conditions for success. We value our staff and recognise the significant contribution they can bring to finding creative solutions to the challenges we face. The NHS partner organisations, with local people and our communities, are well placed to ensure a sustainable health and care system that improves the long-term health and wellbeing of the people we serve. We share this motivation with our partners across our local authorities, wider public sector and our voluntary and community services.

We will achieve our future system by creating incentives for change. These areas include changes in focus, funding, structure, process and culture across our organisations, teams and individual staff members.

We will continue to deliver on national performance and delivery standards.

NHS Focus Areas

	NHS Focus Areas	ACHIEVING		
1	Prevention: Reduce physical and mental illness and disease prevalence	PREVENTION	EQUITY	INTEGRATION
2	Proactive management of long-term conditions and frailty			
3	Improve navigation and flow to reduce emergency pressures			
4	Timely access and early diagnosis for cancer / planned care			

Delivering today while preparing to meet the challenges of tomorrow

"Prevention, population health management and reducing health inequalities are not a distraction from the immediate priorities: indeed, they are the key to sustainable solutions to those immediate performance challenges." Hewitt Report 2023.

In Nottingham and Nottinghamshire, we know that in a decade there will be a 38% increase in people aged over-85 years living in poor health. By seeking to reduce the growth in demand for costly hospital and specialist skills, unnecessary duplication across services and reducing inappropriate use of all services, we can shift resources into prevention initiatives that reduce demand in later years. We will do this while still maintaining safe and effective support for people when they need it. Alongside this, we recognise that babies, children and young people (aged up to 18 years) make up 20% of our population but 100% of our future. By investing in our services for all ages, across physical and mental health, using evidence and population health intelligence to prioritise where we can make the greatest impact, we will accelerate prevention of future ill health, reduce health inequalities and achieve improvement in health inequity.

Data tells us there are four areas which will significantly contribute to sustaining services today and create the conditions for meeting demand tomorrow. Making the significant impact required needs all NHS organisations to consolidate our collective effort over the next five years.

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Key areas of focus in 2024/25

In this section we have summarised NHS transformational expectations in line with our strategic principles. We have included proposed changes to our financial regime and the way we reinvest our resources. This will ensure a financially sustainable system, now and in the future. These commitments recognise that by focusing more on prevention we will generate longer term cost efficiencies that will enable future reinvestment. By promoting equity, we will provide everyone with the opportunity to have improved health and wellbeing (physical and mental). By promoting integration, we will significantly reduce waste and inefficiencies, creating future opportunities for reinvestment.

Prevention	Equity	Integration	How we will use our resources differently
Develop our focus on children and young people and Women's Health across all Places	All partners will embed the Population Health Framework and approaches to tackling inequity in Women's Health	Improve navigation and flow to reduce emergency pressures	Developing plans to return the NHS system to financial sustainability
Proactive management of long-term conditions and frailty with development of care pathways that support people to stay well at home for longer	Continued support to eliminate waits of over 65 weeks for elective care, with a focus on reducing Did Not Attends and responding to barriers to access and experience	Workforce aligned to places through integrated neighbourhood working to address health inequalities	Reprioritisation of funding/resources on prevention
Collective focus across our system on a minimum of two Joint Health and Wellbeing Strategy prevention priorities	Continued roll out of the Health Inequalities Investment Fund to target resources to specific population needs	Developing multi-disciplinary personalised care plans and active case finding for those at greatest need to support their health, care and independence needs	Ongoing system review of opportunities for reinvestment based on invest to save and value-for-money principles

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Key areas of focus in 2024/25 - our success factors

The Integrated Care Board (ICB) has led the development of an ambitious and credible 2024/25 NHS operational plan which covers the whole population of Nottingham and Nottinghamshire. The plan supports delivery of the local priorities set out in the Integrated Care Strategy and the refreshed NHS Joint Forward Plan.

It also supports delivery of the national priorities as set out in the NHS England 2024/25 Priorities and Operational Planning Guidance, published on 27th March 2024. This confirms that the overall priority for the NHS in 2024/25 remains the recovery of core services and productivity following the COVID-19 pandemic. To improve patient outcomes and experience the NHS is expected to:

1. Maintain collective focus on the overall quality and safety of services, particularly maternity and neonatal services, and reduce inequalities in line with the Core20PLUS5 approach.
2. Improve ambulance response and A&E waiting times by supporting admissions avoidance and hospital discharge and maintaining the increased acute bed and ambulance service capacity that systems and providers committed to put in place for the final quarter of 2023/24.
3. Reduce elective long waits and improve performance against the core cancer and diagnostic standards.
4. Make it easier for people to access community and primary care services, particularly general practice and dentistry.
5. Improve access to mental health services so that more people of all ages receive the treatment they need.
6. Improve staff experience, retention and attendance.

This should be underpinned by system wide transformation, including the integration and streamlining of care to deliver evidenced-based approaches to prevention, self-care and the effective management of frail older people and those living with long-term conditions. Alongside this the NHS must continue to drive improvements in productivity and operational effectiveness, improve Digital maturity and support delivery of the NHS Long Term Workforce Plan.

The NHS England 2024/25 Priorities and Operational Planning Guidance includes 32 detailed national objectives listed in the table opposite. The ICS is expecting the final version of the NHS operational plan to be compliant with the majority of these national objectives. In the few areas where there remains a challenge to meet the national objective the ICS will continue to push hard for achievement in year.

Partners have agreed ambitious financial plans for 2024/25 in response to significant financial sustainability challenges across the system. These plans include an ambitious 6% efficiency requirement to be delivered through a combination of system transformation and organisational efficiency programmes. Even with such ambitious plans the ICS is unable to meet the national objective to deliver a balanced net system financial position for 2024/25 and is therefore non-compliant in this area.

The final version of the NHS operational plan was approved by ICS Partners and the ICB Board by 2nd May 2024 before submission to NHS England for review and approval which is expected during May.

National NHS Objectives for 2024/25

Area	Objective
Quality and patient safety	Implement the Patient Safety Incident Response Framework (PSIRF)
Urgent and emergency care	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025
Urgent and emergency care	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25
Primary and community services	Improve community services waiting times, with a focus on reducing long waits
Primary and community services	Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
Primary and community services	Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels
Elective care	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)
Elective care	Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%
Elective care	Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25
Elective care	Improve patients' experience of choice at point of referral
Cancer	Improve performance against the headline 62-day standard to 70% by March 2025
Cancer	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026
Cancer	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
Maternity, neonatal and women's health	Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment
Maternity, neonatal and women's health	Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities
Mental health	Improve patient flow and work towards eliminating inappropriate out of area placements
Mental health	Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0–25 compared to 2019)
Mental health	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery
Mental health	Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025
Mental health	Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025
People with a learning disability and autistic people	Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025
People with a learning disability and autistic people	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12–15 under 18s for every 1 million population
Prevention and health inequalities	Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025
Prevention and health inequalities	Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025
Prevention and health inequalities	Increase vaccination uptake for children and young people year on year towards WHO recommended levels
Prevention and health inequalities	Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people
Workforce	Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions
Workforce	Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors
Workforce	Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan
Use of resources	Deliver a balanced net system financial position for 2024/25
Use of resources	Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25

Key system changes over the next 5 years aligned to our three principles are:

PRINCIPLES	2024/25	2025/26	2026/27	2027/28	2028/29
Prevention	Collective focus across our system on a minimum of two Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs (one of these addressing healthy behaviour choices). Population health intelligence will guide collaboration with our communities and across partners to maximise this impact, for example, including consideration of wider determinants of health, as well as inter-relationship with promoting equity. Development of care pathways that support people to stay well at home for longer. Development of 'virtual wards' to enable people to be cared for at home/within their communities safely. Evidence based review of system prevention offer to reshape and integrate services. Ongoing development of plans for each of the clinical priorities and identification of priorities based on population need to inform future investment decisions Develop our focus on children and young people and Women's Health across all Places.	Collective focus across our system on a minimum of three Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs (one of these addressing healthy behaviour choices). Defining outcomes and targeted approach to the five clinical areas for adults and children and young people based on health equity assessments. Targeted approach to inclusion health groups through Place Based Partnerships. Build on falls prevention services at a Place level.	PBPs will implement a minimum of four Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs and Place resources. All new starters to complete Make Every Contact Count training as part of induction by March 2026.	PBPs will implement a minimum of four Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs and Place resources. 90% of frontline care staff completed Make Every Contact Count training.	An improvement in healthy life expectancy and life expectancy from birth from 2018-20 baselines. PBPs will implement a minimum of four Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs and Place resources. 80% carbon net zero by 2028-32.
	Building on existing Joint Health and Wellbeing Strategy and delivery plans, to agree prevention approaches across health and care pathways. Improving children and young people outcomes and mental health needs will be evident in all Plans over the five years. Through integration and using the skills and resources across the system and Place, and in particular with the support of the VCSE sector and communities, we will gradually accelerate action that moves population need away from treatment. Impact on equity considered for all prevention initiatives.				
Equity	The ICB will continue to provide a dedicated £4.5m fund to support improvements in health inequalities and equity, which will be aligned to financial sustainability and ICS priorities. Funding has been committed to support the continuation of 9 programmes across the system.	The Health Inequalities and Innovation Fund will increase by a further £4.5m.	This fund will increase by a further £9m.	This fund will increase by a further £9m.	This fund will increase to accumulate to circa £30-35m.
	Development of new health inequalities dashboard and corresponding reporting. Adopt the principle of 'proportionate universalism' in future transformation, service redesign and in the context of funding allocations across the partnership so that resources are deployed according to need rather than historic allocation.	Metrics and performance reporting to represent activity in relation to population need (aligned with allocations formula). Framework for evaluating the impacting of funding allocations in relation to proportionate universalism. Alignment with Health and Wellbeing Board evaluation according to population need. We recognise that a whole population approach is required and that our opportunities relate to the sum of all the parts of the system. Each partner has a role to play in impacting on equity.			
	All partners will embed the Population Health Framework and approaches to tackling inequity in Women's Health.	Ongoing oversight of delivery of our agreed transformation initiatives/commitments across Places, primary care, community and acute sectors.			
	Embed parity of esteem for physical and mental health needs across all policy areas (including maintaining a focus on dementia). Review waiting lists and access criteria against deprivation level criteria, ethnicity and disability data and convert into a clear action plan.				
	Co-production toolkit embedded. Covid-19 recovery for CYP in closing the gaps in physical, education and health needs	Ongoing oversight of co-production approach as part of Integrated Care Strategy commitments. Roll-out of training offer.			

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Key system changes over the next 5 years aligned to our three principles are:

PRINCIPLES	2024/25	2025/26	2026/27	2027/28	2028/29
Integration	Through the Core20+5 Accelerator programme, defining a quality improvement approach to impacting on health inequalities. Ongoing development of PBPs Place plan outlining delivery of interventions to address key priorities, including Core 20+5 (adults and children and young people) and Joint Health and Wellbeing Strategies. Maturing of the provider collaborative. Ongoing implementation of the Primary Care Strategy. Integrated commissioning function and quality and market management functions established.	Based on identified local and system priorities, PBPs will develop integrated neighbourhood teams to curb demand growth, focusing on keeping people out of hospital wherever possible.	Based on local and system priorities identified by the System Analytics and Intelligence Unit, PBPs will develop integrated neighbourhood teams to curb demand growth, focusing on the prevention agenda.		
	Embedding of system monitoring and delivery assurance framework for the ICP Strategy and JFP. Continued development of an agreed inclusive approach to annual JFP refresh.	Ongoing system level assurance and delivery oversight of the ICS Integrated Care Strategy and Joint Forward Plan.			
	Developing multi-disciplinary personalised care plans and active case finding for those at greatest need (Severe Multiple Disadvantage) to support their health, care and independence needs.				
	Ongoing system level leadership, assurance and delivery oversight with governance that reflects system working. Development of a system level project management office to support oversight.				
How we will use our resources differently	Developing and implementing plans to return the NHS system to financial sustainability. Reprioritisation of funding/resources on prevention through the Health Inequalities and Innovation Fund, moving from treatment services to prevention services to address system priorities, for example, proactive care and management of long term conditions.	We will create financial headroom to provide resilience for safe and quality services. Recurrent investment in prevention where it will have the greatest value, recognising the valuable contribution across all partners (NHS, statutory and non-statutory) and through our structures (with an annual investment uplift dependent upon affordability and return-on-investment assessment).			
	Continued implementation of the Better Care Fund with specific reference to supporting PBP plan delivery and delivery of the three guiding principles. Ongoing assurance of use of Better Care Fund to maximise investment to achieve delivery of the ICP Integrated Care Strategy, Joint Forward Plan and Joint Health and Wellbeing strategies.				
	Development of equity framework that demonstrates the opportunity to impact on access patient experience and outcomes across interventions including the re-distribution of resources.			Equity framework refined and model tested in relation to the distribution of financial resources.	Equity frameworks embedded across all activities that provide a strong universal approach with resources targeted to need.
	Ongoing system review of opportunities for reinvestment based on invest to save and value-for-money principles. Redistribution of efficiency savings and/or growth funds to those areas of greatest prevention and equity opportunity, to shift health and wellbeing outcomes at a population level. Anchor organisations continue to progress with development of opportunities to advance social value, leveraging the NHS opportunity to contribute to wider social and economic development. We will accelerate our research programmes, including service evaluation and audit. We will use population health data, best practice guidance and research evidence to inform the choices and decisions we make. We will work together with our population, Nottingham's universities and our local National Institute for Health and Care Research infrastructure to inform this approach.				

The stark differences between our PCN/neighbourhoods

We know that many people in Nottingham and Nottinghamshire could be living longer, healthier, happier lives than they currently do – as explained in our Integrated Care Strategy and Joint Health and Wellbeing Strategies for Nottingham and Nottinghamshire. Further details are available in the first version of our NHS Joint Forward Plan available on our website: healthandcarenotts.co.uk

We continue to monitor key indicators of health and wellbeing through our System Analytics and Intelligence Unit (SAIU) dashboards. The below shows a snapshot of population health from last year. We have made progress in some areas, however, we recognise that we are early on our journey of embedding the new approach set out in this plan.

As NHS partners we remain committed to improving inequalities and supporting our system vision set out in the Integrated Care Strategy to ensure that ***every person will enjoy their best possible health and wellbeing.***

Period

202312

The stark differences between our PCN / neighbourhoods

		Deprivation	Risk Factors			Long Term Conditions								System Outcomes		
PCN Neighbourhood	No of patients	IMD decile	Obesity	Current Smoker	Hyper-tension	Diabetes Type 2	COPD	Heart Failure	Stroke	CHD	Cancer	Serious Mental Illness	Severe Frailty	Emergency Admissions	Avoidable deaths	Median age of death
BACHS	62,523	2.4	223.5	182.6	186.3	81.5	33.5	18.0	17.0	38.5	41.2	10.2	12.5	7,991	331.1	77
Clifton & Meadows	34,703	2.5	224.6	185.1	184.6	75.7	32.6	15.2	18.4	39.0	40.6	9.1	7.0	8,190	326.5	83
Bulwell & Top Valley	46,657	2.6	236.9	197.5	178.8	71.4	33.6	14.7	17.0	37.2	44.7	9.6	7.1	8,453	331.5	80
Radford & Mary Potter	46,123	2.7	187.0	185.1	184.9	107.9	24.2	11.1	16.1	43.9	36.0	15.2	15.9	8,391	373.9	74
Nottingham City East	67,001	3.0	186.0	185.1	162.0	73.8	29.3	14.1	16.6	34.9	41.0	13.5	11.9	7,889	385.9	76
Bestwood & Sherwood	55,189	3.5	195.6	156.0	153.1	64.0	21.1	12.9	15.9	34.0	42.2	10.1	7.8	7,361	295.3	80
Ashfield North	51,441	3.9	259.0	164.2	167.6	68.7	25.8	16.4	14.7	37.2	47.7	7.6	9.3	7,760	320.2	80
Mansfield North	59,386	4.1	239.2	154.1	169.0	65.9	26.1	10.3	13.5	36.3	44.4	5.9	10.9	7,291	299.3	79
Rosewood	51,595	4.1	218.5	178.9	151.0	64.2	27.1	12.1	13.8	37.0	42.5	7.6	9.6	7,556	289.8	80
Ashfield South	40,684	4.3	254.3	156.4	153.5	65.9	26.0	10.6	14.2	34.2	44.1	6.5	6.9	7,258	308.3	79
Byron	38,993	4.5	226.5	141.2	155.0	61.1	23.6	11.5	14.9	33.3	47.5	5.2	17.5	7,659	284.5	81
Newgate Medical Group	30,091	4.6	233.2	176.2	143.2	65.7	30.5	12.5	12.5	29.7	42.3	5.7	8.8	6,109	296.5	80
Larwood & Bawtry	37,762	5.1	229.9	136.2	161.3	67.2	30.9	19.0	15.2	34.1	45.5	6.8	14.6	6,507	245.6	80
Retford & Villages	58,166	5.3	229.6	133.6	147.8	57.0	23.5	10.7	12.1	29.1	44.2	5.3	10.3	5,402	227.4	82
Sherwood	63,570	5.3	234.3	141.8	164.4	62.3	23.7	12.3	14.0	36.7	45.7	5.8	10.6	6,958	229.4	81
City South	39,013	5.6	166.3	109.8	151.7	56.7	17.0	9.1	12.9	34.4	43.2	6.6	6.5	6,841	211.6	82
Eastwood/Kimberley	37,859	5.9	223.4	120.5	151.7	56.3	20.5	15.3	14.2	32.7	47.4	5.7	8.2	6,985	232.5	80
Synergy Health	36,068	5.9	213.3	146.2	151.1	53.0	18.3	10.7	15.3	30.7	47.5	7.6	15.1	6,701	263.2	81
Newark	79,263	6.0	192.9	138.0	145.3	50.1	15.8	11.1	12.3	29.7	49.2	5.4	7.8	5,663	236.7	81
Stapleford	22,320	6.1	223.8	137.0	163.8	58.2	21.6	12.8	11.9	30.4	44.8	5.8	4.3	6,709	219.8	80
Arnold & Calverton	34,110	6.5	202.3	122.2	144.5	49.3	17.4	9.5	15.3	30.0	47.1	6.7	9.3	6,387	204.4	83
Arrow Health	39,660	6.6	182.6	115.7	143.9	46.6	15.1	9.9	12.8	28.5	46.2	6.4	5.9	6,357	204.3	82
Beeston	49,691	7.4	175.5	107.3	147.7	51.8	16.4	12.2	13.7	28.8	47.5	7.1	11.2	6,160	221.9	84
Rushcliffe North	42,464	8.5	179.8	97.1	136.0	39.5	14.8	9.1	12.2	27.5	46.9	3.6	5.0	6,010	159.2	83
Rushcliffe Central	52,890	8.8	135.2	67.6	133.0	41.7	10.9	9.6	12.1	27.0	47.4	5.7	5.0	5,090	182.6	83
Rushcliffe South	43,567	9.0	172.2	87.3	135.9	39.5	11.1	9.5	12.2	25.9	46.4	3.6	3.9	5,301	165.9	84
Unity	46,871	5.3	110.0	63.6	143.6	41.1	12.8	9.5	8.4	21.1	38.9	3.6		3,422	118.8	68.5

Bassetlaw Place
Nottingham City Place
South Nottinghamshire Place
Mid Nottinghamshire Place

Unity's population is almost entirely university students and is presented separately due to its atypical population demographics.

IMD value is the **index of multiple deprivation** (calculated based on weighted average of registered patients' Lower Super Output Areas declines as per GP Repository for Clinical Care).

COPD = Chronic obstructive pulmonary disease
CHD = Congestive heart disease

Most deprived PCN neighbourhood
Least deprived PCN neighbourhood

Case Study

One version of the truth data to support hospital discharge Teams from health and social care have worked together to create a 'one version of the truth' discharge dataset that all partners agree is accurate. This data supports collaboration and data-informed practice across the wards and the multi-disciplinary Transfer of Care Hubs in managing the timely, safe and appropriate discharge of older people once they are well enough to leave hospital and return home. It has supported better practice and decision making and more people are now going directly home in a shorter time, leading to people spending 20,000 fewer days a year in a hospital bed at one of our acute hospitals.

The work is being rolled out across all three acute hospital sites in the ICS and is viewed as national best practice, with NHS England and the Department of Health and Social Care featuring the project in their national workshops to consider new metrics for hospital discharge.

Delivering the right care at the right time

Our opportunities for targeting joint efforts to achieve maximum impact

The population health profile of Nottingham and Nottinghamshire highlights the need to prioritise certain actions within the health and care system to address our collective challenges. Prevention measures are crucial as the area faces a higher prevalence of long-term medical conditions, particularly in the most deprived areas. Conditions such as COPD, stroke, heart failure, heart disease, diabetes, asthma and mental health conditions have higher prevalence rates among the most deprived parts of the population. Avoidable deaths in the under-75 age group are primarily attributed to cancer, circulatory, and respiratory conditions, with heart disease, lung cancer, COPD, and stroke being the leading causes.

Emergency pressures are significant within the healthcare system, as evidenced by the high percentage of emergency admissions and bed days relating to the over-65 age group. Issues with management of patient flow in and out of hospitals contribute to longer stays for patients once admitted, despite stable emergency department activity.

The relationship between deprivation and healthcare resource utilization is evident, with individuals in the most deprived areas generally incurring higher healthcare costs per head of population. This has been shown for both in-hospital emergency costs and out-of-hospital spending. Given the clear correlation between age and use of healthcare resources, the projected increase in the older age group by 2033 creates an urgency to take action now.

Reducing planned care waiting list times is critical and we must address the disproportionate impact of waits on children and young people. Long waits before accessing planned care can have life-long consequences on the development of children and young people, impacting their ability to access education and lead full and active lives.

The table below shows the key targeted interventions that will be delivered over the next five years through our Place Based Partnerships, Provider Collaborative and via greater integrated team working.
These interventions focus on the need to reduce illness and disease prevalence, encourage proactive management of long-term conditions to avoid crises/escalation of care, improve navigation and flow to reduce emergency pressures, and reduce planned care waiting lists.

The contribution of ‘enabling’ interventions is further outlined on pages 22-41.

The overall impact on our four aims will be to:

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Enable people to stay well, safe and independent at home for longer. Providing the right care in the right place in the right time.	Ensure services are co-designed and targeted based on shared understanding of health and care needs.
Enhance productivity and value for money	**Support broader social and economic development**
Ensure more efficient use of services and funding by reducing duplication, avoiding waste and addressing inefficient pathways and interventions. Early detection and effective management in order to reduce disease progression/severity and subsequently save resources.	Invest in our community assets and promote more non-clinical support for local people. Enable people to better manage their own health and wellbeing and access support to remain or access work, training and education and make sustainable healthy behaviour changes.

Delivering the right care at the right time

Our opportunities for working differently to achieve maximum impact: high level delivery commitments and success factors

<table>
<tr><th>System interventions</th><th>2024/25</th><th>2025/26</th><th>2026/27</th><th>2027/28</th><th>2028/29</th></tr>
<tr><td rowspan="2">Prevention: reduce physical and mental illness and disease prevalence</td><td colspan="2">Development of targeted case finding specifically focused on population health needs across Places and system priorities, for example, frailty, severe multiple disadvantage, obesity.

Based on identified local and system priorities, PBPs will develop integrated neighbourhood teams to curb demand growth, focusing on keeping people out of hospital wherever possible.</td><td colspan="3">People with multiple long-term conditions receive targeted support in a co-ordinated way with personalisation of care and individualisation of targets. Programme of universal interventions to promote prevention, for example, alcohol, ongoing smoking cessation, obesity (adults and children).</td></tr>
<tr><td colspan="2">System-wide approach to personalised care planning across all sectors (acute, community and primary).
Implement structured education programmes.</td><td colspan="3">Embed personalised care for all.
Expand structured education and learning events consistently across Places and long-term conditions.
Development of shared learning opportunities across primary/community and secondary care.</td></tr>
<tr><td rowspan="2">Proactive management of long-term conditions and frailty to support early identification and avoid unnecessary escalation</td><td colspan="2">Develop PBP focus on tackling the quality of care in frailty that would be supported by the whole system and its partners.
Identify the frailty cohort of focus based on data which indicates where resources are being over utilised and where care could be provided more appropriately.
Reinvigorate the Practice Pack model at a Practice, PCN and Place.
Frailty same-day emergency care embedded.
Asthma diagnosis tools embedded within primary care for children and young people.
Increase immunisation and screening uptake for 'at risk' groups.</td><td colspan="3">Working with PBPs to implement joined up frailty pathways across the system. Embed personalised care and advanced care planning for all.
Achieve Clinical Design Authority frailty ambitions.
Increase rates of annual reviews for children and young people with asthma to support self management plans.</td></tr>
<tr><td colspan="5">Understand the opportunities for aligned resources and incentives at a PCN and neighbourhood level, and review ICB support e.g. medicines optimisation and Clinical Design Authority.
Deliver Primary Care Strategy and integrated approach to Long Term Conditions Management with a focus on the top five health conditions for the population.
Continued identification of physical health issues in people with a serious mental illness thorough physical health checks to ensure proactive management in this group who do not routinely access physical health services. PBPs will support integrated Place plans which address people's physical, mental and social needs (noting that 30% of people with a long-term condition also have a common mental health disorder).</td></tr>
<tr><td rowspan="7">Improve navigation and flow to reduce emergency pressures in physical and mental health settings</td><td colspan="5">Embedded integrated neighbourhood team working across community teams. Prioritise those cohorts/pathway development where data indicates there is greatest opportunity for impact at both Place and system level, for example, frailty, respiratory, hypertension, CVD.</td></tr>
<tr><td>Further develop social prescribing model across all Places/care navigation across primary care, aligned with Make Every Contact Count approach.</td><td colspan="4">Ongoing development of communications and information resources to support awareness of service offers to local people and staff – resources co-designed with users of services, focusing on achieving improved equity across the population.</td></tr>
<tr><td colspan="5">Virtual wards fully established and meeting target activity levels. Integrated care pathways with social care established for specific cohorts.</td></tr>
<tr><td>Develop a co-located urgent treatment centre at QMC to reduce demand on A&E.
Deliver medically safe for transfer plan target and develop trajectory for years 2 to 5.</td><td colspan="4">Embed improvements in length of stay and flow across all acute settings</td></tr>
<tr><td colspan="5">Expand our same-day emergency care offer across hospitals ensuring direct access for all professionals and implementing new data requirements.</td></tr>
<tr><td colspan="5">Transform our P2 and P3 offer to improve patient flow for patients who are medically safe for transfer. and reduce length of stay in P2 beds.</td></tr>
<tr><td colspan="5">Develop an urgent care coordination hub which will act as a single point of access for health professionals</td></tr>
<tr><td rowspan="2">Timely access and early diagnosis for cancer and elective care</td><td colspan="3">Continued support to eliminate waits of over 65 weeks for elective care.
Elective hubs and clinical diagnostic centres established (Newark, City, Mansfield).
Expansion of targeted lung health, breast cancer screening, community prostate clinics and community liver surveillance programmes.
Identify the top 5 specialities with the longest waits for CYP elective care. Differentiating waits and preoperative care for children and young people where development is disproportionately affected compared to adults.</td><td colspan="2">Ongoing delivery and development of prevention initiatives.</td></tr>
<tr><td colspan="5">Roll-out personalised care, optimise integrated care pathway and referrals. Maximise productivity and make best use of workforce, for example, shared workforce plans, staff digital passports and Making Every Contact Count.</td></tr>
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What will delivery of our Joint Forward Plan mean for patient care?

1 Prevention: reduce physical and mental illness and disease prevalence

- Prioritise prevention and early intervention to effectively reduce the incidence and impact of diseases and costly treatments (including planned care) on our health and care system, leading to long-term cost savings and enhanced health outcomes for our population.
- People supported to lead healthy behaviours and maintain good health from birth and for as long as possible, including education to support self-care.
- Services are commissioned in an integrated way across health, education, social care, public health and housing, improving the experience of care for the population and optimising outcomes.
- Achieve an efficient and effective healthcare system, that optimises the workforce available to us, directing resources to where they are most needed.
- Embracing technology and innovation to enhance the tools available increasing productivity for our workforce.
- Adopting digital solutions in an inclusive way (primary care and community) to improve efficiency, accessibility and patient outcomes.

2 Proactive management of long-term conditions and frailty

- Case finding and screening programmes will target population groups where there are inequalities in uptake to support early detection of long-term conditions in line with our Core20PLUS5 approach.
- Priority for cohorts where population health management data indicates there is greatest opportunity for impact at both Place and system level, for example, frailty, respiratory, hypertension, CVD.
- People with multiple long-term conditions will be supported in a co-ordinated way with personalisation of care and individualisation of targets.
- Staff will be trained to support the complexity of needs of people with long-term conditions and to manage different diseases providing an opportunity to up-skill staff across specialisms.
- We will make every contact count ensuring people are supported for both their physical and mental health needs.
- Integrated neighbourhood team working will promote proactive care co-ordination for the management of long-term conditions – creating a ‘team of teams’ that wraps care around people.
- We have services and pathways in place that allow people to receive the care they require in the right place, first time.
- System working and collaboration with system partners to transform medicines use to improve the health and wellbeing of our population.

3 Improve navigation and flow to reduce emergency pressures in both physical and mental health settings

Flow into the hospital

- People know how and when to access urgent and emergency care services when they need it.
- We have services in place to support people who have urgent care needs to be cared for at home for both their physical and mental health needs.
- People who need to use 999 or our hospitals in an emergency are transferred to the hospital and seen in a timely manner.
- We have services and pathways in place that allow people to receive the care they require in the right place, first time.

Flow into the hospital

- People are treated and supported in hospital to a point when they are medically stable. They will be transferred to a place for their ongoing care/rehab needs and longer term support if required.
- Discharge planning starts on admission (or pre-admission where possible).
- Discharge teams are integrated and work seven days-a-week.
- People are assessed for their longer term needs once they are discharged and not before.
- Only those that need hospital care that cannot be provided at home are admitted into a hospital bed, with the remainder going home the same day on same day/community/virtual ward pathways.
- Physical and mental health services are integrated.

Flow out of the hospital

- Multi-disciplinary transfer of care hubs are established at each hospital and operational seven days-a-week.
- People go home, or to a place that is suitable for the support they require, on the day they are medically safe to do so.
- A culture of trusted assessment is embedded across all organisations.
- Virtual wards are established and embedded across the ICS.
- For people in an acute mental health bed, community provision, appropriate housing and supported living will support prevention of admission and timely discharge.
- Community rehabilitation supports people to maximise their recovery in their own homes.

Preventing readmissions

- Integrated Neighbourhood Teams support people to remain at home and manage their health and wellbeing.
- Our population health management approach supports us to identify those most in need.
- Comprehensive care planning for our most vulnerable patients to keep them well and/or at home in a crisis.

4 Timely access and early diagnosis for cancer / planned care

- Cancer and planned care waiting times are within national performance requirements.
- Local people have equitable access based on need with appropriate choice of provider.
- Shared decision making, people offered options to avoid unnecessary procedures and acute intervention with conservative treatment considered at an early stage closer to home.
- Prioritisation of waiting lists includes clinical risk, health equity, population need. Consideration of the specific needs of children and young people and ensuring parity of esteem for physical and mental health.
- Elective hubs are in place, underpinned by best practice in productivity.
- Shared workforce plans and staff retention, support in place.
- Community diagnostic hubs established and GP direct access enabled.
- Expansion of targeted lung health programme starting this year and completed in 2025-26.
- Breast cancer – implementing community-based breast screening in areas of low uptake.
- Prostate cancer – implementing community-based clinics with high incidence – Afro-Caribbean communities.

Place Based Partnerships, provider collaboration and system programmes

How we will do things differently: our delivery methods

We are seeking to make big changes in the way we operate as a system. There are three main transformational ways that will enable this over the next five years and beyond. These are Place Based Partnerships (PBPs), our Provider Collaborative(s) and ICS programmes. These will work in harmony with our partners to achieve both the delivery of the Joint Forward Plan and national policy expectations. In order to deliver our system ambitions, we know that we need to think about how we set ourselves up as a system, ensuring that we have clarity of the roles of the different components of our system in delivering our ambitions. Work is underway to develop a system operating model which will start to map out where we think that different functions will sit across our system in the future. We have a number of developing structures or parts within our system, including Place Based Partnerships and Provider Collaboratives.

By encouraging and supporting our PBPs and Provider Collaboratives to be radical, we have the opportunity to empower local frontline health and care professionals, working within statutory and non-statutory bodies, to implement transformational change which both supports system priorities and the things which matter most to their local communities. Our system programmes will continue to ensure high-level implementation of change where this makes sense in order to achieve population and system-level outcomes.

At a Place level, Integrated Neighbourhood Teams (INTs) and the integrated neighbourhood working approach (INW) will be integral to this transformation. Our PCNs will play a key role in the design and development of these approaches, aligned to the ethos and approach of the Community Transformation Programme. This will enable focus on population health management-identified specific disease/condition cohorts within a Place footprint (for example, diabetes, COPD) as well as cohorts that are geographically focused (such as those living in the most deprived communities/neighbourhoods). PBPs are able to map existing assets, understand their relative importance to local communities, engage with their populations with greater reach and develop co-designed opportunities sensitive to local community characteristics. Front-line coordination, relationship building, local knowledge and direct understanding of patient need can all combine to create a highly effective coalition able to make better use of our scarce resources.

PBPs will develop Place plans aligned to the Integrated Care Strategy priorities and which address identified opportunities to address the wider determinants of health and the Core20+5 health inequality priorities for both children and adults. Place Plans will also support delivery of NHS priorities, such as urgent/same day care demand and long-term condition management with a focus on specific cohorts and neighbourhoods, based on system intelligence.

The ICB will support overall system maturity by developing and enabling PBPs and the provider collaborative at scale to accelerate towards greater maturity; to ‘pull’ for greater levels of responsibility and appropriate and proportionate levels of resources, and provide assurance of delivery of agreed commitments. The development of resourcing and assurance frameworks will be accelerated in year one.

There is significant work underway to strengthen provider collaboration and develop provider collaboratives across our system, encouraging Trusts to do things together where it makes sense. We have a number of collaboratives in existence which either span our ICS area, or work across broader areas e.g. the East Midlands. Some of these collaboratives focus on particular service areas and others are geographical based collaborations. The range of work being undertaken in these collaboratives spans clinical pathways and corporate services and we hope that as they continue to evolve, their role in our system will strengthen. Our Provider Collaboratives will continue to mature in a way that enables our provider organisations to work more intimately and collaboratively on key areas in order to secure sustainable local services. Provider collaboratives may form organically to address specific needs, such as local collaboration between primary and community organisations and general wellbeing support within our Places.

Nottingham and Nottinghamshire ICS health partners will work with existing provider collaboratives across the Midlands to optimise local benefits for local people. For example, opportunities for further collaboration at scale with other ICBs will be considered such as elective recovery and urgent care networks. In appraising options, particular importance will be placed on those with faster and improved access to care, incorporating consideration of health inequalities and equity.

We believe that genuine and meaningful integration of our services and collaboration between all partners will be transformational if we are prepared to collectively create the conditions, and culture for co-operation to become the norm.

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Productivity and efficiency - our financial savings approach

Achieving more within our resource constraints

Through the pandemic, efficiency schemes and expectations were stood down as we focused on maintaining high quality services that met the changing needs of our population. Ongoing challenges in respect to workforce, industrial action and the impact on population health has meant we have struggled to regain the performance and productivity required.

The system has seen a 20% increase of staff in post since March 2020 without a commensurate increase in activity levels. To achieve the best outcomes for our population, we need to use existing resources in the most effective way, regaining our collective focus on reducing waste and increasing productivity.

In 2023/24 the system spent more than the resources available leading to a financial deficit. Plans are under development to deliver the ambition of financial balance and recurrent financial sustainability within 2 years.

The scale of deficit will require continued focus on financial and workforce control in every organisation, alongside productivity improvement, efficiency and transformation. To drive this, we have a system-wide approach to transformation across 8 system programmes and 10 areas of financial opportunity.

The analysis, using peer benchmarks, has identified £148m to £350m of potential savings deliverable over the medium term. The identified opportunities are in areas of strategic importance and are expected to lead to performance, quality, access and experience benefits in addition to the financial benefit. These opportunities are being used to support the development and implementation of system-wide detailed delivery plans.

Our Joint Forward Plan commits us to achieving this, with an accelerated focus on driving cost effectiveness and efficiency over the next five years to ensure all our collective resources are focused on achieving the maximum health and wellbeing gains for our population.

Our productivity and efficiency framework comprises three elements:

Clinical transformation

Our population health management approach of prioritising prevention and improving proactive management of long-term conditions, improving navigation and flow, and reducing planned care waiting lists will ease the operational burden on our hospitals. This will reduce the need for additional capacity in busy periods and excess premium staffing costs.

Workforce productivity

Our workforce and associated costs have increased significantly in recent years, while activity levels have remained broadly flat. We will look to develop a deeper understanding of loss in productivity through the pandemic, which will enable decisions on how we can increase future activity and improve outcomes within existing workforce levels. Alongside this, our integrated approach to recruitment and retention will place less reliance on expensive agency costs.

Operational efficiency

We will maintain robust processes to manage budgets to ensure best value of the public pound. A single system approach to exploring and delivering efficiency opportunities. We will use benchmarking analysis and national tools (such as Getting It Right First Time) to implement best practice. There is a particular focus on areas of collaboration and integration between partners - more efficient use of our collective estate, back office functions, procurement and medicines management.

In our approach we make use of relevant productivity guidance and recommendations from NICE.

Our summary delivery plans

High level commitments across our key programme areas that will deliver or enable the four aims and three strategic principles of our ICP Integrated Care Strategy, while continuing to meet national policy expectations.

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Primary care including GPs, Community Pharmacy, Dental and Optometry	26	Strategic estates	36
Mental health	27	Digital, Data and Technology	37
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Finance

Current state: Our challenges

- **Underlying financial deficit** – all NHS partners within the system carry underlying deficits, annually managed through non-recurrent means. This has worsened in 2023/24 due to inflationary pressures and continuing workforce growth above funded levels.
- **Productivity and efficiency** – through the pandemic, efficiency schemes and expectations were stood down and since then system partners have struggled to get the same efficiency as we have had previously. The system has seen a 20% increase of staff in post since March 2020 without a commensurate increase in activity. The plan needs to reflect how we use these increased staffing levels to deliver improved performance and higher levels of productivity.
- **Shape of spend** – the system strategy is based on shifting costs by investing in preventative services and providing care closer to home. This has not been seen in reality with continuing growth in acute hospital services due to continuing urgent care pressures.
- **Capital availability** – system capital funds are scarce and have historically been used to support business as usual maintenance and replacement, relying on national funds to support larger strategic priorities. This has led to some local priorities remaining unfunded for some years.

Future state: Our ambition

- **Financial sustainability** – return to financial balance in year two and achieve recurrent financial balance by end of year three through improved productivity and efficiency, and transformation of services to ease the burden on urgent care services. This will provide improved services for local people and staff and allow for future investment in ICS priorities.
- **Productivity and efficiency framework** – we will implement a framework that will ensure delivery of productivity and efficiency opportunities. The framework looks at clinical transformation, workforce productivity and operational efficiency. Further detail can be found on page 20.
- **Investment in prevention and tackling health inequalities** – £4.5m recurrently invested in health inequalities in 2023/24. Funded schemes remain in place. Additional investment paused in 2024/25 to focus on affordable financial position. Ambition remains to grow this investment further in future years alongside a focus prioritising existing resources to support prevention and equity.
- **Capital resources used to support strategic aims** – ensure a considerable proportion of the system capital envelope is used to support agreed strategic priorities, improving services and providing better outcomes, access and experience for staff and local people.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Financial sustainability	Reduced deficit; Improving recurrent underlying deficit (2024/25–2025/26)	Deliver in year balance	Deliver recurrent financial balance. Create headroom to provide resilience. (2026/27–2028/29)			✔		✔
Investment priorities	Embed and evaluate impact of 2023/24 investment	Increasing in investment in prevention and equity (2025/26–2028/29); 0.4% cumulative	0.6% cumulative	1.0% cumulative	1.4% cumulative	✔	✔	✔
Capital investment	Increasing capital usage to support strategic aims (2024/25–2028/29); Min. 10%	Min. 15%	Min. 20%	Min. 25%	Min. 25%		✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Financial balance will be achieved by greater investment in prevention, providing care closer to home and less pressure on our urgent care services. Ultimately leading to improved outcomes, access and experience.	Explicit focus on investment to drive equity in our most deprived communities through the Health Inequalities and Innovation Fund.
Enhance productivity and value for money	**Support broader social and economic development**
Through improved service productivity and using our resources more effectively.	Targeted investment, alongside system partners, in prevention and wider determinants of health to keep people well for longer.

Place Based Partnerships

Current state: Our challenges

- Low healthy life expectancy has significant consequences for individuals, communities and services.
- Pressures of 'day job' across all partners, with low capacity and resilience in the primary and community workforce promotes focus on transactional, not transformational change.
- 'Today' challenges consume capability to develop and implement 'tomorrow' solutions relating to prevention and ill health avoidance.
- Pressures on primary care limit the capacity for PCNs to deliver population health management identified opportunities.
- Voluntary sector infrastructure, capacity and resilience is significantly reduced.
- Balancing NHS national/regional/ICB priorities and those generated by non-NHS PBP partners within current Place based resource constraints.
- The ability to create a cultural shift from a paternalistic approach to one where communities are empowered to make the changes themselves.
 Lack of trust in services by our communities; particularly in areas of high deprivation and among minority communities.
- Historical commissioning decisions which impact on service delivery do not always reflect current population health needs post-pandemic and due to cost of living crisis.
- Lack of system clarity on the vision and opportunities for the delegation of responsibilities to Place
- Need for recurrent funding streams to facilitate sustainable Place-based transformation activities beyond existing ICB investment in place-based teams.
- Organisational silos inhibit progress on integrated public sector estates solutions.

Future state: Our ambition

- We will see a reduction in health inequalities through transformation of services informed through community insight, co-production and sensitive to local population health needs.
 We will have coordinated communications. We will move from community engagement to community empowerment and asset-based approaches in all we do. Our community and voluntary sector will be strong and sizeable, maximising community assets to create resilient communities which can support self care.
- We will maximise our social value capacity to address wider determinants of health.
- The 'Place focused' workforce will have shared purpose/values and feel supported working in the PBP, professional pride and enthusiasm in all they do, built around a unified focus on population health management, strength-based approaches and genuine co-production working alongside the people we serve.
- We will have truly integrated teams following a successful roll-out of integrated neighbourhood working across voluntary and statutory services including primary, community and secondary care services, maximising our skill sets.
- PBPs will hold increased level of delegated responsibility for delivery with appropriate resources.
- We will maximise joint commissioning opportunities, particularly around primary and secondary prevention and with our local authority partners.
- Our transformation of services will be sustained through long term investment in evidenced based services with reduced reliance on short-term funding and pilots.
- Our service delivery will maximise use of community buildings and assets.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Workforce aligned to the place and values to address health inequalities.	Support the workforce to work in a geographical footprint across organisational boundaries aligned to integrated neighbourhood working.	Work with partners to understand what it would take for the workforce to deliver personalised, Strengths based trauma informed care within the MECC principles.	Build on areas of good practice to spread and embed the cultural change required.			✔	✔	✔
Implementation of Partnership Place Plans and PBP maturity.	Collaborative leadership of neighbourhood model embedded. PCN active participation in INTs, maximising skills and capabilities across PCNs and partners.	Place focused individuals from across partners identifying as 'one team'.	Ongoing development and rollout - review of Place impact and spread of learning. Evaluation in partnership with Academic Health Science Network/ universities.	Neighbourhood working fully embedded. Ongoing review and development of PBP role, function and impact.		✔	✔	✔
We will maximise joint commissioning opportunities, particularly around primary and secondary prevention and with our local authority partners.	Identify areas where similar services are commissioned and explore opportunities for alignment Use the Better Care Fund review to support this process	Understand the differences between services to ensure the maintenance of specialist aspects and reduce duplication of provision. Alignment of the offers to support the experience of the person using the service.	Jointly commission a preventative service with local authority partners.	Review the impact of a jointly commissioned service on the people accessing it , the productivity and financial resources.		✔	✔	✔
Development and maturity of Place to enable functions to be delivered at Place and neighbourhood level.	Place responsibilities and assurance models established. Recurrent transformational resources established.	Fully delegated responsibilities and performance oversight/ assurance arrangements embedded.	Ongoing review and development of PBP role, function and impact.				✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Ensuring a focus on population health need through informed interpretation of data and community insight.	Enabling a 'place and neighbourhood' first approach with local partner and community expertise, and currently under-served populations informing delivery.
Enhance productivity and value for money	**Support broader social and economic development**
Ensure service delivery is as local as possible and joined up across partner organisations to optimise public spend.	Bringing together partners around a broad approach on health and wellbeing with a focus on addressing the wider determinants.

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Place supported action on Frailty and Proactive Care

Current state: Our challenges

- Frailty is a common medical condition that is frequently associated with ageing. Over the next 20 years there will be a significant increase in frail people in our ICS.
- The Nottingham and Nottinghamshire system has identified frailty as one of the system priorities where our resources are currently significantly committed and an area of high growth in spend.
- The cost of frailty is not just financial. It is a cost to our people, our quality of care, our services.
- The electronic frailty index shows that across the 65 and over population at PCN level:
  - People identified as Fit varies from 31% - 52%
  - People identified with Mild Frailty varies between 28% and 33%
  - People identified with Moderate Frailty varies between 12% and 21%
  - People identified with Severe Frailty varies between 10% - 18% (excluding Bassetlaw)
- 21.5 % of the following two areas accounts for all over 65 emergency admissions (2019)
  - 7,800 admissions for falls, Injuries and fractures equating to approximately 70,000 bed days.
  - 5,100 Flu and pneumonia emergency admissions equating to 43,000 bed days.
- People classed with severe frailty are 5.9 times more likely to have a flu and pneumonia admission than those people not classed with severe frailty.
- The 65 and over population living alone are 8.8 times more likely to be admitted to hospital than those not living alone.
- People with dementia are predicted to be 8.2 times more likely to be admitted into hospital.
- Having multiple co-morbidities has a significant impact on the odds of having hospital admissions.
- Priority areas:
  - CVD (Heart Failure, Stroke, CHD, hypertension)
  - Respiratory(COPD/Pneumonia)
  - Cancer
  - EoL
  - Frailty/Dementia/Falls

Future state: Our ambition

- Our population is supported to age well, maximising support across health services, Local Authority and the VCSE.
- A reduction in health inequalities across our most vulnerable populations.
- EoL care plans in place for those in the last 12 months of life.
- Experience end of life according to their personal and individual wishes.
- Our population receive expert co-ordinated management of LTCs.
- Our population will be supported to address health improvement with targeted prevention advice and support.
- The population feel supported and empowered to recover and regain their independence in their own home with dignity.
- Our population will have shared decision-making to make important choices about the right care and treatment.
- Reduce inappropriate admissions to hospital.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Develop a Place focus on tackling the quality of care in frailty: - Understanding the challenge and focus. - Information, intelligence, and evidence base. - Ageing well: preventative approaches. - A reinvigorated approach to proactive care – embedding an MDT approach as standard.	Reinvigorate the Practice Pack model with a focus on frailty Focus on indicators that suggest quality of patient experience / outcomes could be improved Data from other system partners - E.g., social care/acute trusts. Consider General Practice protected time/resource. Review data to map prevalence and identify predominant condition clusters. Approaches will be focused on increased risk stratification and preventative strategies targeting underlying risk factors .	Build on falls prevention services at a Place level. Engage with VCSE and maintain community development models. Tackling loneliness – loneliness collaborative. Develop neighbourhood working models across PCNs and neighbourhoods with focus on prevention/ageing well. Agree approach for engagement with General Practice. Review current provision of services to support MDT provision.	Continuous development and refinement.				✔	✔
Focus on patients with multiple long term conditions.	Local action to test new approaches to the delivery of long term condition management in primary and community care. Align where possible to the Integrated Neighbourhood Working approach.	Review ICB support e.g. medcines and Clinical Design Authority. Understand the opportunity for aligned resources and incentives at a PCN and neighbourhood level.	Continuous development and refinement.				✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Ensuring a focus on population health need through informed interpretation of data and community insight.	Enabling a 'place and neighbourhood' first approach with local partner and community expertise, and currently under-served populations informing delivery.
Enhance productivity and value for money	**Support broader social and economic development**
Ensure service delivery is as local as possible and joined up across partner organisations to optimise public spend.	Bringing together partners around a broad approach on health and wellbeing with a focus on addressing the wider determinants.

Primary Care Networks

Current state: Our challenges

- Pressures on primary care limit the capacity for PCNs to deliver population health management identified opportunities.
- Capacity and demand in primary care are challenging.
- Workforce pressures growing across primary care, impacting on resilience across the PCNs.
- In order to manage current challenges, different models of care are being tested by developing new roles through the national Additional Roles Reimbursement Scheme (ARRS) and through system clinical transformation programmes.
- Estates for the growing workforce and community-based delivery of care is restricting delivery.
- A review of current estate and needs for future delivery has been undertaken and plans are being developed to address challenges, maximising the available estate as flexibly as possible.
- Need to work with other providers such as Community Pharmacy with significant communication barriers between the various parties

Future state: Our ambition

- Delivery of our Primary Care Strategy supporting resilient/vibrant primary care practices as part of PCNs.
- PCNs across Nottingham and Nottinghamshire continue to mature allowing them to be in a positive position for leading the ongoing implementation of Integrated Neighbourhood Teams (INTs).
- ‘ Team of teams’ to evolve from PCNs with a sense of shared ownership for improving the health and wellbeing of the population with our partners across the system, thus strengthening outcomes for local people, workforce resilience and productivity.
- Integrated Neighbourhood Teams and INT working will deliver a model of care that takes a holistic approach to supporting the health and wellbeing of a community (re-aligning the wider health and care system to a population-based approach, including aligning secondary care specialists to neighbourhood teams). This approach will see a reduction in health inequalities through transformation of services informed through community insight and co-production.
- To continue with the work started with Community Pharmacy visits to integrate Community Pharmacy into PCNS – this includes starting up a working party with representatives from all stakeholders

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
PCN maturity to support INTs.	System leadership development.	Opportunities and cultural change.	Continuous development.			✔	✔	✔
‘Team of Teams’: common purpose and shared endeavour.	PCN active participation in INTs maximising skills and capabilities across PCNs and partners.	Implement process improvement. Development of continuous improvement cycles.	Embed INT working.	Development opportunities.		✔	✔	✔
Integration of secondary care into INTs.	Identify opportunities in line with population needs.	Secondary care working within INTs.	Embed INTs.	Development opportunities.		✔	✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Targeted approach based on community needs making every contact count through integrated working.	Enhanced services in the community with a focus of those in greatest need, delivered within the community closer to where people live.
Enhance productivity and value for money	**Support broader social and economic development**
Working together to enhance productivity and resilience across the system and its communities reducing duplication.	Wider system working that will maximise opportunities across partners and deliver sustainable health and care services.

Primary Care including GPs, Community Pharmacy, Dental and Optometry

Current state: Our challenges

- On-the-day demand impacts ability to focus on people with long-term conditions, escalations and continuity of care.
- Contracting model can be a barrier to innovation / transformation.
- Increasing complexity in patients means more timely access to specialist advice and guidance is required.
- Recruitment and retention challenges causing additional pressure on workforce.
- Opportunities for primary care at scale model not fully realised.
- Lack of communication with public about new roles in primary care impacts on ability to 'see right professional at right time'.
- Challenges with capacity to enable longer consultation times for people with complex needs.
- Movement of services from secondary care to primary care requires appropriate shift in resourcing
- Most deprived neighbourhoods tending to experience greatest access challenges.
- National capitation funding not necessarily reflective of need.
- Estates constraints hinder primary care service delivery.
- Ensuring integration of pharmacy, dental and optometry contracts and services including Pharmacy First.

Future state: Our ambition

- Our ICB will be a national exemplar in new models of working between the ICB, Place Based Partnerships and primary care providers.
- To improve on-the-day triage demand and signposting to most appropriate professional.
- Evolve contracting model where relevant to encourage / reward innovation while also delivering national contract requirements.
- Multi-disciplinary team with wider participation of roles working as part of integrated neighbourhood team working approach.
- Improved recruitment and retention and increase in new roles.
- Improved understanding among public / patients about roles and capability of primary care professionals
- Resource allocation based on a deeper understanding of assessed need, 'proportional universalism' where discretionary funding allows.
- Real time access to advice and guidance, enabled by technology and decision support mechanisms.
- Full implementation of improved access plans and associated GPIT schemes.
- Future primary care provision across all providers remains high quality and sensitive to local population needs.
- 'One public estates' approach becomes business as usual at a Place and system level to meet needs of providers and their communities.
- Regular uptake of Pharmacy First and other Community Pharmacy services to increase access as part of Primary Care Access Recovery Plan (PCARP).

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	27/28	28/29	Prevention	Equity	Integration
Implementation of primary care strategy. Delivery primarily through Place-based teams working with subject leads at a system level.	Work progressing on priority area of General Practice chapter of Primary Care Strategy. Development of Community Pharmacy chapter. Commence engagement work on dentistry and optometry chapters. ICB Primary care estates strategy completed.	Promote learning and sharing of new ways of working. Implementation of Estates Strategy. Finalise dentistry and optometry chapters.	Develop primary care workforce modelling and response. Promote research.	Development opportunities		✔	✔	✔
Improve primary care access.	All practices achieve NHSE Delivery Plan for Recovering Access expectations. Acceleration of secondary/primary care interface working to support long term condition and frailty management, promote referral optimisation, pathway efficiencies. Local support programme in place for practices focused on identified development opportunities. Development of Integrated Neighbourhood Team working. Improve patient comms to support awareness of local service offer/new ways of working.		Ongoing delivery of NHSE PCN directed enhanced service/delivery plan expectations.			✔	✔	✔
Supporting primary care resilience.	Embed benefits of PCN investment e.g. care navigation training, funding for additional roles (ARRS), online consultation, cloud-based telephony, use of NHS App. Tailored working with practices to understand specific resilience challenges.	Review locally enhanced services to promote focus on reduced HI and equity/promote practice. Place resources allocation proportionate to practices within highest areas of deprivation/need.	Ongoing review of primary care opportunities for collaborative working. Development of integrated team approaches to prevention programmes, for example, vaccinations.			✔	✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
A resilient and vibrant primary care is fundamental to population health management.	Primary care is fundamental to addressing health inequalities and equity.
Enhance productivity and value for money	**Support broader social and economic development**
Technology as well as pathway reviews will realise value-for-money.	Primary care workforce is a significant contributor to our local economic development in terms of staff, as well as enabling communities and people to remain economically active.

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Mental health

Current state: Our challenges

- Waiting times remain too long for access to assessment with hidden waits between services where specific mental health services/organisations operate in silos.
- Pathways are not always clear, do not provide local early support and intervention to reduce escalation, maintain independence in the community and reduce the need for acute services.
- Mental and physical health and wellbeing and social needs are inextricably linked, however services operate in silos and do not recognise interdependencies which support the whole person.
- In addition to meeting and improving performance on all national standards (business as usual).

Future state: Our ambition

- Sustainable local community care model of delivery that aims to optimise people's independence by holistically addressing their physical, mental health and social needs and intervening before people reach crisis point.
- Through integrated care, and better communication between services and those receiving services, people will be cared for in the most appropriate setting for their need. There will be a reduction in avoidable and unplanned admissions to hospital for people with mental health needs, through partners working collaboratively to meet people's needs.
- Through workforce education, we will make every contact count for areas which have been traditionally health focused, incorporating signposting to other services such as financial advice, employment advisors, housing advice and social prescribers to enable people to improve their overall health and wellbeing.
- People will be empowered and supported to self-care, with support from within their communities, maximising the use of community assets.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Prevention, inpatient, discharge joint working.	Deliver Mental Health Inpatient Strategy Review of phase one implementation. Develop and agree timescale for phase two implementation. Develop plan for years three-to-five transformation. Maintain performance for Adult and Children and Young People services/pathways meeting Long Term Plans standards.		Review phase two actions. Deliver plans for phase three priorities.			✓	✓	✓
Seamless pathways and provision from increased community provision through to acute and social care, addressing physical and mental health needs.	Develop Place-based prevention models aligned to community transformation. Implementation of phase one priorities.	Review pilot area and learning, agree roll-out and implementation for years two-to-five.	Ongoing review and refinement ensuring a continuous quality improvement approach.			✓	✓	✓
Reviewing waiting times and building on workforce models to utilise all sectors including the voluntary sector.	Recovery Action Plan in place to improve performance and focus on integration at a place level Reduce waiting times to services Implement Adult Avoidant Restrictive Food Intake Disorder scoping pathway Implement Community Rehabilitation Pathway Increase and embed psychological therapy service delivery		Implementation of improvement plan, monitoring impact and ensuring infrastructure to enable continuous quality improvement.	Ongoing review and refinement ensuring principles embedded in all new pathway development.		✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
PCN and Place-level support and early intervention to reduce escalation. Develop joint and seamless pathways of care which support the whole person, both physical and mental health issues. Support building resilient communities and people to prevent mental health illness in the first place.	Tailored local support developed utilising information on population needs. Improving life expectancy of people with severe mental illness through improvements in mental health/physical health integration and support. Improving the mental wellbeing of patients with physical health needs including long-term conditions.
Enhance productivity and value for money	**Support broader social and economic development**
Maximising investment that has been made into mental health services over last five years, ensuring services are delivering to meet people's needs. Develop more local integrated provision with services provided in the least acute setting aligning health and social care provision, with acute mental health services only accessed by those who need it. Prevent acute mental health admissions and reduce length-of-stay where admission is appropriate through increased fit for purpose community support.	Increase the number of people with severe mental illness in employment. Increase ability of people with severe mental illness to live independently in the community through appropriate housing and wraparound support.

Maternity, babies, children and young people

Current state: Our challenges

- Covid-19 pandemic has disproportionally affected the development, physical and mental health of babies, children and young people. Rates of obesity are rising in childhood, increasing short-term and lifelong negative impact on health outcomes.
- Significant health inequalities exist in maternity & neonatal care meaning worse outcomes for women & babies from minority ethnic groups.
- Access to health services for the most vulnerable groups of babies, children and young people is disjointed and inequitable.
- Numbers of children and young people experiencing signs of mental disorders are increasing.
- Children and young people (aged 0-25) with Special Educational Needs and Disabilities (SEND) are not always identified, assessed or able to access services in a timely way.
- Engagement of children and young people in decisions about their needs and health care is not systematised.
- Transitions between children and young people services and adult services are improving but remain difficult for many.

Future state: Our ambition

- Children, young people and their families continue to co-produce service improvement and transformation across the system and participate in decision-making about their individual plans and support.
- All health service planning incorporates prevention for under-25s, where there are modifiable factors
- Be child friendly. Children and young people's needs are identified accurately and assessed in a timely and effective way. Achievement of UNICEF child friendly recognition.
- Children and young people are well prepared for their next steps, achieve desired outcomes, have supportive and successful transitions into adulthood.
- Children and young people are valued, involved in decision-making about their lives, visible and included in their communities.
- Every woman and birthing person from minority ethnic groups has a safe and positive birthing experience in the place of their choosing.
- Optimise opportunities for laying a firm foundation for good mental health of children and young people through evidence-based support in the first 1001 days of a child's life.
- Families, babies, children and young people are able to access seamlessly delivered support including those at end of life, children in care, those who are neurodiverse, risk of obesity, require sleep support, meeting speech language and communication needs.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	27/28	28/29	Prevention	Equity	Integration
Focus on the under-fives to have the maximum preventative impact.	Co-design new pathways with system partners for healthy lifestyles and infant mental health. All Maternity and Neonatal staff have been trained in Cultural Competency and Safety.	Focus on early identification with PCNs and at Place. Review impact to outcomes of training. Develop appropriate local data & intelligence driven interventions.	New pathways embedded. Costs saved reviewed and outcome measures refined.			✓	✓	✓
Reduce inequity of services in maternity and for children and young people.	Implement a Single Point of Access (SPA) for all Children and Young People with healthy weight concerns.	New models of care negotiated and commence.	Maintain and review impact of service.			✓	✓	✓
	Delivery of the system maternity equity action plan. Delivery of the children and young people Core20+5 framework. Implementation of multi-agency models of care embedding thrive model for children and young people with mental health outcomes.					✓	✓	✓
Achieving improved outcomes for vulnerable children and young people, including those who are looked after or with SEND.	To scope and design effective joint commissioning for Speech and Language Therapy, Occupational Therapy, sensory approach, and sleep. Reducing waiting times, increase in quality and minimise duplication of offers. Joint data SEND dashboard shared across local authority and health. Reduce waiting times for Initial Health and Review Assessments for Children in Care.	95% of patients waiting for therapy services to continue to receive treatment within 18 weeks of referral.	Work with children and system partners to reduce inequity of outcomes from baseline set in year two.	Maintain and review impact of service.		✓	✓	✓
Improved outcomes for women and babies.	Continued implementation of the three-year maternity and neonatal delivery plan, including the embedding of Ockenden recommendations, with all system partners.					✓	✓	✓
	Implement maternity and neonatal voices partnership model to enable effective coproduction.	Review the impact and ongoing needs based on the evidence from the enhanced model.					✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Focus on babies, children and young people at the earliest stage of prevention and intervention improves outcomes over people's lives.	Inequity of service offer perinatally and for babies, children and young people, is addressed through local, personalised and streamlined services.
Enhance productivity and value for money	**Support broader social and economic development**
Investment in prevention and early intervention at the earliest opportunity in people's lives delivers the highest returns on investment.	Children and young people who are happy, healthy and have the best start in life are more productive and economically secure as adults.

Reducing emergency pressures in mental and physical health settings

Current state: Our challenges

- People are assessed for their long-term needs in hospital.
- People spend too long in our hospitals.
- People arrive at the emergency department and are admitted to hospital when their needs could have been met in the community.
- People often have to navigate several services before they reach the one that is most suitable for their needs.
- Our teams and pathways are not always integrated.
- We do not have seven-day working across all services.
- We have inequity of service provision across the ICS.
- We have delays in transferring people from one service to another.

Future state: Our ambition

Flow into the hospital

- People know how and when to access urgent and emergency care services when they need it.
- We have services in place to support people who have urgent care needs to be cared for at home for both their physical and mental health needs.
- People who need to use 999 or our hospitals in an emergency are transferred to the hospital and seen in a timely manner.
- We have services and pathways in place that allow people to receive the care they require in the right place, first time.

Flow through the hospital

- People are treated and supported in hospital to a point when they are medically stable. They will be transferred to a place suitable to their ongoing care / rehab needs and plan for longer term support if required.
- Discharge planning starts on admission (or pre-admission where possible).
- Discharge teams are integrated and work seven days-a-week.
- People are assessed for their longer term needs once they are discharged and not before.
- Only those that need acute care that cannot be provided at home are admitted into a hospital bed, with the remainder going home the same day on same day/community/ virtual ward pathways.
- Physical and mental health services are integrated.

Flow out of the hospital

- Multi-disciplinary transfer of care hubs comprising professionals from all relevant services (such as health, social care, housing, and the voluntary and community sector) are established at each hospital and operational seven days-a-week.
- People go home, or to a place that is suitable for the support they require, on the day they are medically safe to do so.
- A culture of trusted assessment is embedded across all organisations.
- Virtual wards are established and embedded across the ICS.
- For people in an acute mental health bed, community provision, appropriate housing and supported living will support prevention of admission and timely discharge.
- Community rehabilitation supports people to maximise their recovery in their own homes.

Preventing readmissions

- Integrated Neighbourhood Teams support people to remain at home and manage their health and wellbeing.
- Our population health management approach supports us to identify those most in need.
- Comprehensive care planning for our most vulnerable patients to keep them well and/or at home in a crisis.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Develop a co-located urgent treatment centre at the QMC.	Mobilise front door streaming and triage process, workforce and pathways.	NHSE Designation of UTC.	Implementation, monitoring and evaluation.					✔
Virtual wards.	Mobiilse step up virtual wards and procure remote monitoring technology		Further expansion where appropriate and monitoring of benefits and impact				✔	✔
Transform our P2 and P3 offer.	Recommission P2 and P3 beds based on vision and scope agreed in 22/23. Reduce LOS in P2 beds. Mobilise new service offer	Embed new P2/P3 offer. Monitoring of benefits and impact.	Implementation, monitoring and evaluation.				✔	✔
Develop an urgent care coordination hub.	Integrate UCR and the UCCH. Roll out and embed phase 1 of the UCCH plan. Develop IT solutions for direct booking and electronic transfer of records.	Add pathways to UCCH offer as per mobilisation plan. Monitoring of benefits and impact	Add pathways to UCCH offer as per mobilisation plan. One single number for all health and care professionals. Monitoring of benefits and impact				✔	✔
Expanding the same day emergency care offer.	Mobilising surgical SDEC. Ensuring direct access to SDEC for all professionals. Implementing the new data set for SDEC	Implementation, monitoring and evaluation.					✔	✔
Development of Integrated Neighbourhood Team (INT) working.	Establish routine engagement opportunities for clinical interface between secondary/ primary clinicians.	Embedded INT working across community teams for priority cohorts identified through population health data to avoid admission / prevent re-admission.				✔	✔	✔
Social prescribing and care navigation.	Develop care navigation model aligned with Making Every Contact Count (MECC).	Ongoing development of communications and information resources co-designed with users of services with a focus on achieving improved equity.				✔	✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare

Supporting more people to remain in their own homes and reducing time spent in hospital.

Tackle inequalities in outcomes, experiences and access

Commissioning services across the ICS and reviewing and transforming historical pathways while providing more personalised care.

Enhance productivity and value for money

Providers working collaboratively and in integrated teams to make best use of system resources.

Support broader social and economic development

Supporting more people to remain at home for longer with improved functional outcomes.

Early cancer diagnosis and planned care

Current state: Our challenges

- Long backlogs of patients waiting for cancer and routine planned care with an over-reliance of non-NHS providers.
- Patients may deteriorate while waiting for routine care and may enter the system via the emergency department.
- Potential inequity of access to some cohorts of the population.
- Workforce challenges across our acute providers. Our elective care capacity in acute hospitals can be compromised when there are surges in urgent care demand.
- There are long waiting times for diagnostic tests which can cause unnecessary delays in diagnosis.

Future state: Our ambition

- Cancer and elective waiting times are within national performance requirements.
- Local people have equitable access based on need with appropriate choice of provider.
- Shared decision making, patients offered options to avoid unnecessary procedures and acute intervention with conservative treatment considered at an early stage closer to home.
- Prioritisation of waiting lists includes clinical risk, health equity, population need. Consideration of the specific needs of children and young people and ensuring parity of esteem for physical and mental health.
- Elective hubs are in place, underpinned by best practice in productivity.
- Shared workforce plans and staff retention; support in place.
- Community diagnostic hubs established and GP direct access enabled.
- Expansion of targeted lung health programme completed in 2025-26.
- Breast cancer – implementing community-based breast screening in areas of low uptake.
- Prostate cancer – implementing community-based clinics with high incidence – Afro-Caribbean communities.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Reduce elective backlogs.	To 65 weeks maximum. Identify the top 5 specialities with the longest waits for CYP elective care	To 52 weeks maximum.	Meet national operational performance targets.			✓	✓	
Reduce cancer backlogs	Meet all cancer standards as defined in operational performance requirements and enable earlier diagnosis (maintain faster diagnosis standards).					✓	✓	
	· Lung health programme · Breast cancer screening · Community prostate clinics · Community Liver Surveillance		Expansion of targeted lung health programme complete.		Monitoring and evaluation.	✓	✓	
Establish Elective Hubs and Clinical Diagnostic Centres (CDCs)	Complete roll out of Newark elective Hub (opened November 2023) Implement GIRFT principles Complete Phase 1 and phase 2 City elective hub roll out	Complete City elective hub phase two. Commence City elective hub phase three. Opening of Mansfield and Nottingham CDCs.	Expansion of CDCs pending confirmation of national funding.			✓	✓	
	· Roll-out personalised care and optimise integrated health. Maximise pathways and productivity. · Make best use of workforce shared workforce plans and staff digital passports. · Implement Make Every Contact Count across teams and integrated care supporting improved patient care/ increase efficient care provision. · Systematise the incorporation of prevention, reducing health inequalities and improving equity across all pathways of care in the management of waits, patient pathway redesign. · Refine referral optimisation between primary care and acute providers to enable access to alternatives to face to face appointments, reduce outpatient attendance and Do Not Attends.					✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Earlier diagnosis and care closer to home.	Taking a more personalised approach to care with shared decision making and optimising health prior to elective procedures.
Enhance productivity and value for money	**Support broader social and economic development**
Making best use of our estate and workforce.	Enabling timely access to elective care and maximising health.

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Quality improvement

Current state: Our challenges

- No collective framework to utilise quality improvement (QI), transformation and how this relates to system efficiencies or performance delivery.
- Mixed QI approaches exist within the system and partners with no central understanding of interdependencies for the impact.
- No collective understanding within the system to enable developing levels of expertise and skills to undertake QI in conjunction with local needs or involvement with the population.
- No clear evidence of co-production principles/ opportunities with patients/clients/families and how this informs the priorities for QI.
- Benchmarking and aim correlation for QI does not always align with data insights from our current data collection schedules.
- Existing quality challenges do not directly link to programmes of QI with measurable outputs.
- Limited learning within the system to enable the adoption and spread of QI inventions where appropriate and embed improvement into the management systems and processes.

Future state: Our ambition

- QI, transformation and efficiencies impacts are understood within the system which drives improvement decision making in a shared vision.
- Systematised QI learning and programmes platform accessible within the system allowing for individual system partners priorities with understanding of collective population benefits.
- QI approaches occur within the system and partners with scoping, supporting levels of expertise to undertake QI are clearly defined and understood to deliver locally.
- System and clinical leadership align to enable and embed ethos that QI is a 'second job'.
- Co-production continues to be a tenet of all QI programmes and this informs QI priorities.
- System agility and agreed QI responses to emerging quality challenges with known measurable outputs becomes 'normalised'.
- Shared and spread learning of evidence-based, high impact improvements, to be embedded into improvement management systems and processes.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
System scoping to enable the preconditions to allow the shaping of a shared purpose and vision related to quality improvement initiatives.	Build consensus and shared vision by scoping and reporting using the framework of NHS IMPACT and feedback of system partners.	Monitor and adjust to align with feedback.	Monitor and adjust to align with bench-marking programme as system position collectively matures.			✔		✔
System understanding of the investment of people and culture supported by leadership behaviours to enable system levels of expertise and skills to undertake QI.	Informed system approaches to systematic QI building on population engagement networks with ICS QI enablers. supported by leadership behaviours to enable system	Adoption of the NHS IMPACT approach within QI communities approach by Q4 2024-25.	Monitor and adjust as improvements are embedded into management systems and processes approach by Q4 2026-27. This can be evidenced by system programmes of work responding to locality needs. Individual system partners have developed shared understanding of whole approaches to improvement learning and sharing which is visible.			✔	✔	✔
System has an understanding of building improvement capacity and capabilities including benchmarking programme.	Alignment of ICS data insights leading to processes to support QI learning capacity and capabilities.	Evidence base developed with local population to inform priorities and links to alignment of capacity and capabilities to undertake.	Progress check. Use QI programme developments to redefine or reprioritise year three to five year ambitions.	Progress check against QI programme activities to inform and adjust priorities . System demonstrates alignment of QI programmes, individual organisations and across sectors		✔	✔	✔
ICS commitment of co-production informs the current QI work.	Reaffirm arrangements for population engagement whilst working towards embedding improvements into management systems and processes.	Create core co-design and co-production within all aspects of QI programmes. Update priorities around management systems and processes	Monitor and adjust to align feedback of QI programmes and projects impacts.	Monitor and adjust as system position collectively matures.		✔	✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Targeting systematic QI interventions based on system health outcomes, co-designed with local people representation and clinical leadership, underpinning the commitment to continuous improvement.	Data and people insights will shape and inform QI system priorities to enable interventions to address place population needs.
Enhance productivity and value for money	**Support broader social and economic development**
Improvements in quality reduce costs and improve outcomes.	Supporting greater integrated system learning from QI programmes that can be utilised for adopt/spread interventions.

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Personalisation

Current state: Our challenges

- Year on year the system has met and/or exceeded the Long-Term Plan targets.
- Initiatives to embed personalised care approaches are tested and expanded, but not at scale and embedded as business as usual.
- Our workforce does not always have the tools it needs to deliver personalised care.
- Personalised care approaches are not routinely included in commissioning and contracting activity.
- People are not offered a personalised conversation, based on what matters to them, they have to repeat their story and are not always empowered to share decision making.
- Personalised care initiatives do not receive the investment needed as part of the prevention agenda

Future state: Our ambition

- Personalised Care is scaled up and shifts to business as usual.
- Personalised Care approaches are fully understood, scaled up and embedded by system partners, in programmes, commissioning and pathway redesign and at Place.
- The workforce are trained and skilled to deliver personalised care.
- Personalised care approaches are considered in all commissioning and contracts to ensure funds are invested to support people in a way that works for them, rather than the traditionally commissioned 'one size fits all' approach.
- People only need to tell their story once and the focus of the conversation is 'what matters to them and what's important to them'.
- Personalised care is a core function that we fund as part of prevention and equity approaches.

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Implement Universal Personalised Care (UPC) embedding and scaling social prescribing, supported self-management, personalised care and support planning and personal health budgets in all system areas.	• Priority areas to embed personalised care are finalised with a System wide UPC Plan in place, system owners and leads agreed. • Agree UPC local targets, owned and shared across Place and programmes of work. • System leads are supported to understand which UPC approaches are relevant and need to be embedded in their plans and how to measure the impact to people. • Develop a knowledge share approach based on the system needs and prioritised to most impactful areas. • Review the team support offer to the system, including Co-production, and its impact from the work in 23/24. • Run an 'It's Ok to Ask' internal and external (public) Communications plan.	• Review the impact, learn and scale up across the agreed areas. Continue to measure progress and impact. • Embed personalised care in commissioning and contracting. • Adopt the personalised care section of the NHS Contract. • Sharing and learning with other ICBs on their approach to contracting. • Deliver ongoing internal and external communications plan.	Quality Assurance of Personalised Care in contracts, including assurance that PHB's are offered to all with a legal right to have and expanded.			✓	✓	✓
Social prescribing and community based support.	Continuation of Green Social Prescribing with system focused deliverables, and implementation of Maternity Link Worker. Expand on the learning to date, focus on cost-benefit analysis, health inequalities, data tracking through the pathway and building models for sustainable funding.	System learning, impact, cost savings and sustainable models. Stronger evidence and models on tracking users and joining up data	Progress check and use evidence to redefine or reprioritise year ambitions.			✓	✓	
Develop and embed a system culture to deliver personalised care and a trained and skilled workforce.	Create a System network of Personalised Care Champions/ Ambassadors. Workforce Charter and Commitments adopted by partners.	• Phased training plan developed to incorporate primary and secondary care workforce. • Maintain and review impact of training on staff, skills and outcomes. • Develop appropriate data & local intelligence driven interventions to continue to embed cultural change				✓	✓	

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare

Personalised care is all about working with people, as equal partners, to achieve outcomes, based on what matters to them.

Tackle inequalities in outcomes, experiences and access

Making healthcare more personalised is one way to target health inequalities This ensures care and support is shaped to individual need and supports equity so that care makes sense to people and focuses on what really matters in their lives.

Enhance productivity and value for money

Personalised care is a proactive, strength-based approach, by working with people as equal partners and focussing on what matters to them, sharing their story on an 'About Me' we shift from being reactive and reduce waste and duplication.

Support broader social and economic development

Supporting people in a holistic way has an impact on their individual social and economic circumstances and impacts wider society.

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Working with people and their local communities

Current state: Our challenges

- While we have a strong foundation of listening to and working with our population and have made good progress of embedding this into our system forums, this is not consistent and not fully implemented.
- We have made good progress in moving from an episodic approach based around service change proposals to a continuous listening programme but this needs more work to be shared across the whole system.
- The opportunity presented by the formation of the ICP and our even closer working with local authority and other partners needs to be fully maximised to the benefit of the NHS and our population.
- We are not maximising the assets that all of our partners have across the whole health and care system and and have not yet fully realised the opportunities we have through our ICP to hear regularly from our population to feed into our decision-making arrangements.
- The embedding of our co-production approach requires a significant culture change for our staff across the system.

Future state: Our ambition

- Our citizen Intelligence approach is fully embedded across all system partners. 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.
- Co-production is embedded as default across the system - people with lived experience have an equal voice in all aspect of service development and change. These population insights are jointly gathered by all NHS and wider partners and freely available to all organisations within our system and also our residents.
- We consistently measure and monitor satisfaction with the health and care services we deliver and feedback on where we can do better or build on positive examples. This guides our focus.
- Staff know how to share their insights on how services can be better tailored for our population and how to signpost local people to get involved in improving their services.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Insights hub.	Co-design new hub model with partners		Implementation.				✔	✔
Citizens panel	Evaluation of panel and development of mechanisms at Place	Recruit additional 800 panel members	Evaluation and agree rollout			✔	✔	
Co-production	Ongoing oversight of all co-production activity as part of Integrated Care Strategy commitments.					✔	✔	
	Review and roll-out of training offer.	Evaluation Roll out Co-Production Toolkit				✔	✔	
VCSE Alliance.	Expand membership, including to to faith groups					✔	✔	✔
ICP and ICB reports	Ongoing annual and periodic reports						✔	✔
Service change	Support the Strategic Development activity for the Tomorrow's NUH programme.						✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Services will be better tailored for our population and access will be streamlined, leading to better outcomes.	We will use insights from our population to prioritise areas where we need to focus our attention, especially in times of budget challenges for the NHS and Local Authorities
Enhance productivity and value for money	**Support broader social and economic development**
By working together across all partners, we can gather intelligence once for the benefit of everyone. Co-production with people who use services will lead to improvement based on need and experience to support value for money.	Leveraging existing assets such as Nottingham's universities will have wider benefits on the economic and social development of our area.

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Safeguarding

Current state: Our challenges

- Partnership working on safeguarding and promotion of the health and welfare of children, young people and adults. We need to effectively work together to meet the future challenges of improving resilience across the system.
- Learn from local and national safeguarding rapid reviews, child safeguarding practice reviews and Safeguarding adult reviews including Domestic Homicide Reviews to improve outcomes.
- Develop a systems approach to capturing the Voice of the Child/Young person to improve the experiences in all areas of care
- This is an emerging speciality that requires development across the children's safeguarding partnerships and safeguarding adult boards.
- We need to support parents and carers to provide the best possible care for their children - preparing young people for adulthood.
- Lack of specialist provision for domestic abuse survivors within primary care.
- Increasing numbers of referrals into the domestic abuse Multi-Agency Risk Assessment Conference.
- Appropriate access and identification of asylum seekers and survivors of trafficking and modern slavery.
- Child sexual exploitation and abuse across the system and increase in contextualised safeguarding.
- The ICB meeting their statutory duties for looked-after-children health assessments.
- Listening and responding to children and young people and adult victims and survivors of child abuse to guide how services are delivered.
- Assessing and authorising within the community – in patients' best interest and least restrictive options. Deprivation of Liberty Safeguards not fully embedded across community teams.
- Children being cared for in inappropriate settings.
- Implementing the new duties around serious violence and the Domestic Abuse Act 2021 within the ICB and prepare for future duties in the Victims and Prisoners Bill.
- Developing data to evidence safeguarding assurance across the system.
- Identifying the emerging themes and gaps within the system and partnerships.

Future state: Our ambition

- The ICB Safeguarding Children team will work to deliver the plan across the system and in conjunction with the local agendas for safeguarding children and young people.
- Survivors of domestic abuse are identified and appropriate support provided.
- Survivors of modern slavery and trafficking identified within the system and appropriate support given.
  Those who lack capacity within the community are supported to make decisions and live their lives with the appropriate care and support.
- The ICB is a valued contributor to the Violence Reduction Partnership and meets our Serious Violence Duties.
- We have reliable data which supports the identification of emerging themes and gives assurance around statutory duties being met across the system.
- Ensure there is safeguarding connectivity across the ICS with the NHS agenda.
- We will work with partners across the ICS and other areas to ensure children and young people are in the most appropriate setting, receiving the right services at the right time, to improve outcomes.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Children and young people will receive the right care, in the right setting, at the right time.	Influence the development of D2N2 appropriate care settings for children and young people.					✔	✔	✔
Develop and enhance transitional safeguarding.	Development of transitional safeguarding.					✔	✔	✔
Embedding a trauma-informed approach across the system.	Establishing a data informed approach. Revisiting and defining locally the NHS role in the Serious Violence Duty and Domestic Abuse Act 2021.	Fully integrated approach with primary care for domestic abuse that includes children as victims. Refine process for survivors of child sexual exploitation and abuse.	Data dashboard implemented	Ongoing developments towards model of integrated, data informed approach.	Fully integrated, data informed approach.	✔		✔
Working with our partners to improve outcomes for children in local authority care.	Children leaving care will have a comprehensive leaving care plan.	Processes embedded for children in care/looked after children to have their health assessments completed in a timely way.				✔	✔	✔
Support provided to adults in the community.	Identify Mental Capacity Act cohort, risk profile and proceed in the patients' best interests and least restrictive option.	Develop process of early identification of potentially restrictive care plans in the community and progress via appropriate Court of Protection route. Identify children with special educational needs and disabilities transitions cases requiring deprivation of liberty safeguards. Develop mechanism for early identification of fully-funded adult and pre-18 cases for quick response to application of the Mental Capacity Act/Court of Protection.				✔	✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare

Support at system and place to embed a proactive safeguarding approach and aid early detection and intervention. This will aim to reduce the impact on people's physical and mental health. It will aim to help reduce adverse childhood experiences that go on to impact on health and socio-economic outcomes throughout people's lives.

Tackle inequalities in outcomes, experiences and access

Specialist local support that uses data intelligence and local knowledge of the population will improve the outcome of people, for example, those experiencing abuse and trauma and also restrictions upon their liberty.

Enhance productivity and value for money

Early recognition and responding appropriately to safeguard and promote the welfare of people across the system. This will assist in individuals going into crisis and/or requiring hospitalisation or a 'significant response'.

Support broader social and economic development

Improving resilience with the system, developing the workforce and promoting trauma-informed culture will aim to reduce all types of abuse, serious violence and responding to individual human rights.

Workforce

Current state: Our challenges

- Workforce numbers and related pay bill costs are potentially the largest rate limiting factors in our ability to deliver the ICS strategy and improve health outcomes for our population.
- Workforce planning is short term and driven by operational targets, which does not address the medium to longer term need for strategic workforce and education planning as set out in the Long Term Workforce Plan and is not informed by population health projections.
- There is no longer workforce transformation funding from Health Education England.
- Post-covid recovery and waiting lists pressures are additional challenges, with workforce productivity remaining lower than pre-pandemic.
- Sustained Industrial action increase costs due to Locum and agency cover and impact quality and continuity of care.
- Organisations interventions to attract high demand staff groups have a negative impact on system staff and adds to cost pressures

Future state: Our ambition

- The system 'one workforce' will consist of the right number of people, to meet demand and improve health outcomes, working at the right location to deliver the treatment and care our populations deserve, with the skills and training to support prevention as well as treatment to enable the population to stay healthy and at a cost that is affordable.
- Organisations will collaborate to move to a 'one workforce approach' recognising that the future workforce will want to have flexible rewarding careers within a system that recognises and develops talent and is representative of the population of Nottingham and Nottinghamshire.
- Digital technology will be an enabler to flexibility and resourcing on a systems footprint not an organisational one.
- There will be multiple entry points to employment, supporting all levels of academic and physical ability, to create meaningful and fulfilling opportunities for all that desire a career in health and care.
- The financial pressures exacerbated by workforce availability will be reduced by system partners working together on solutions to ensure that we are to utilise our existing workforce efficiently.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Establish ICS people and culture plan and delivery process.	Establishing a sustainable delivery team.	One workforce becomes a reality.	Population health needs drive plans.	Aligned public health, education and training, and workforce plan.		✓	✓	✓
Resourcing including retention.	System attraction and retention approach, including local pipeline.	Expand digital solutions.	Operational system recruitment hub.	Review evaluate and further consolidate.		✓	✓	✓
Strategic workforce planning.	Work with partners on a common Strategic Workforce Plan approach.	Establish a common approach to productivity measurement.	Further support service transformation.	Review evaluate and seek further opportunities.		✓	✓	✓
Delivering the future of human resources.	Fully utilise digital passport.	Develop rotational placements across providers.	Establish core HR working including primary care.	Review evaluate and seek further opportunities.		✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
A skilled and present workforce is better able to deliver improved health and healthcare outcomes including prevention and equity via Make Every Contact Count.	A workforce representative of our diverse communities is better able to understand and address their needs. Our workplaces supported to be smoke free.
Enhance productivity and value for money	**Support broader social and economic development**
Better planning, resourcing and retention will reduce temporary worker costs and improve quality and care.	Supporting multiple entry points to employment for all levels of academic and physical ability supports social and economic development, and renumerate equitably.

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Strategic estates and shared infrastructure

Current state: Our challenges

- Across our ICS partner organisations, we have in excess of 800 buildings, in varied condition. Ageing estate negatively impacts our net zero strategy
- There is limited co-ordination of maintenance and utilisation of our estate capacity.
- Some of our newer/better quality estate is not being fully used, and utilisation across all our estate is not well understood.
- Locations of services is mainly historic, rather than being situated where it is most needed.
- Since the Covid-19 pandemic, the move to hybrid or virtual working means we need less corporate capacity across our ICS.
- Annual capital funds are insufficient.
- There are significant challenges with some estate Backlog of maintenance issues increasing across all providers.

Future state: Our ambition

- Services are located based on need rather than historic arrangements, promoting sustainable travel.
- Co-location of complementary services wherever possible.
- Our newer/better quality estate is fully utilised.
- Create a combined estate which is fit for purpose, big enough to cope with fluctuating demand, but no bigger than necessary.
- We have a clear pipeline of buildings/land for disposal.
- The cost of premises management is kept to a minimum.
- All our buildings are as carbon-efficient as possible.
- National Rehabilitation Centre (NRC) opportunities are maximised.
- Tomorrow's NUH has been successfully navigated through consultation phase, business case approvals and reconfiguration work has begun.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Develop an ICS infrastructure strategy.	Finalise our strategy, including a system wide, prioritised list of Estates and Infrastructure Schemes	Increase utilisation of system estates capacity against agree metrics.	Year three delivery.	Year four delivery.	Year five delivery.			✔
Rationalise our ICS estate.	Gather detailed baseline, agree assessment and prioritisation process.	Hand back or dispersal of properties.	Hand back or dispersal of properties.	Hand back or dispersal of properties.	Hand back or dispersal of properties.		✔	✔
Support 'One public sector estate' approaches.	Encourage the collective consideration of estates needs and solutions across Places – working across statutory and non-statutory partners to find efficiencies in the use and adaptation of estates to promote integrated neighbourhood team working and primary care resilience.							✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Support high quality environments for staff and local people, optimising the opportunity for delivery of services that improve outcomes.	Understanding our total ICS estate allows us to make better decisions about sighting services in the most appropriate places for local people.
Enhance productivity and value for money	**Support broader social and economic development**
Ensuring our quality estate is used most productively, allowing us to release estate that is costly to maintain, and prevent capital investment in additional capacity.	Support estates development which contributes to social value within communities and across the system.

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Digital, Data and Technology

Current state: Our challenges

- Patient-facing digital assets are disjointed and used in silos, which provides inequitable access to health and care services. Technology enabled care to support remote monitoring/remote consultations/virtual wards is limited to pilots or relatively small-scale use in specific teams/organisations. Social care data is not available on the individual – often gets missed as clinical data is prioritised. Data between social care and health still disjointed.
- Data is not held or collected in all digital assets which limits the utilisation of rich data sources to enable intelligence-based decision-making. Where data is held in a digital asset, there are no consistent standards applied.
- Organisations do not have a fully digitised electronic patient record, digitisation does exist but often there are multiple systems which hold patient data in one organisation.
- While information sharing across digital assets has improved, clinical data is often not available to the clinician or professional from one organisation to another to enable them to provide the right care, in the right place.
- Moving to a digital approach to access can exacerbate health inequalities when people do not have access to digital or the skills.
  Significant skills gaps exist across our workforce which means that digital assets cannot be exploited to the full benefit.

Future state: Our ambition

- Deliver the Digital Notts Strategy 2023-28 - https://prezi.com/view/WAlBPVywyhc231fdWMlx/
- Develop our patient-facing digital services - we will empower and enable our population to have greater control over their health and care by providing them with access to their digital health and care record so that they can self-manage and access key information and services.
- Support intelligent decision-making - use data to better understand the health and care needs of our local population, helping to focus and tailor resources where they have the most impact. Design and target interventions to prevent ill-health, and to improve care and support for people with ongoing health conditions.
- Recognising key factors helps us to adapt future local services to improve the overall health of the population.
- Digitise our services to support the frontline - our workforce will have access to effective and efficient digital assets and infrastructure to enable them to provide the best health and care services.
- Utilising digital assets such as electronic patient records, electronic prescribing, medicine administration systems and automation technologies to reduce burdensome processes, for example, log-in standardisation.
- Enable interoperability across the system - our population will receive the right care at the right time, always.
- By providing health and care providers with access to key information about the person, reduces unnecessary diagnostics, treatment and enables efficient access to health and care services.
- Support our population and workforce through digital inclusivity - our population and workforce are given access to support, training and equipment to enable them to use digital assets to benefit their health and wellbeing or deliver effective care services.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Patient facing digital services.	Increase digital correspondence. Scale eMeet and Greet. Improve access to services through digital.	Expand the use of technology enabled care to support remote monitoring. Explore opportunities around an Internet of Things (IoT) platform.	Digital care planning, expand record access; deploy robotics process automation and Artificial Intelligence (AI) technology.	Personalised approach to health and care services through digital technology. AI technology to increase productivity.	Digital contact becomes the default route for health and care services. Smart homes.	✔	✔	✔
Support intelligent decision making.	Infrastructure to enable data to be used. Develop a data standards approach to improve data quality.	Ensure PHM approach supported. Establish Secure Data Environment for Research.	Embed a systematic approach to developing and monitoring system outcomes.	Augment artificial intelligence and human skills in designing care services. Secure Data Environment for Research embedded.	Augment artificial intelligence and human skills in designing care services.	✔	✔	✔
Digitise frontline services.	Electronic prescribing and drug administration. Review assets and utilisation	Staff enabled to work across any location and integrate care across residential settings.	Electronic patient record deployment in Acute Care. Implement services in line with procurement frameworks held via the Digital Services for Integrated Care catalogue.			✔	✔	✔
Interoperability.	Notts Care Record data baselined	Single health and care record available to all staff with all key organisations onboarded.	Notts Care Recorded embedded.	Further developments in the application including regional sharing, enhanced functionality and features		✔	✔	✔
Digital inclusivity.	Training, access and support. Support the community through VCSE grants	Role of Digital Champions, Digital Carers and Digital Inclusion Co-ordinators to be established.	Develop a model to enable a roving workforce across digital specialty roles	Develop new pipeline talent to address skills gaps across digital..	System workforce development programme.	✔	✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Improved access to services, ability to target services more effectively and reduce inequality.	Provide people with the tools and skills they need to access health and care service, increase patient satisfaction through improved access and services, keep people independent at home for longer.
Enhance productivity and value for money	**Support broader social and economic development**
Utilise technologies to remove time consuming activities such as administrative and chasing around for information to enable care to be provided, reduce did-not-attends, and improve patient flow.	Reduce net carbon footprint through reduced travel and reduction in unnecessary face-to-face appointments, less paper, increase employability through digital skills training.

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Greener NHS / sustainability

Current state: Our challenges

- We have a comprehensive ICS Green Plan, approved by the ICS board and ICB Board in 2022. This plan builds on the individual plans/ strategies of our health and care partners.
- Organisations have strong plans and stakeholder buy-in and are delivering well within the confines of their organisation, and we are now starting to amplify learning gained at a system-level.
- The trajectory to carbon net zero cannot be achieved without the buy-in of clinicians and service users.
- Subject matter expertise and clinical capacity for designing sustainable care models, and supporting population health and involvement, has been limited.
- While we have many delivery initiatives, we are not currently able to make accurate measurements of the impact they are having on carbon emissions.

Future state: Our ambition

- Our carbon net zero journey is clinically-led, managerially delivered.
- We become the first ICS to set up a sustainability faculty, supporting clinicians and managers early in their careers to make a difference.
- Healthcare and the councils work as one to deliver their net zero targets.
- We work across ICS and public sector boundaries when we identify opportunities.
- Local people are empowered – they know the steps they can take to reduce their own footprints - and take hem.
- Local people travel more 'actively'; relying less on cars, preferring walking, cycling or taking public transport instead.
- All our sites (where possible) have green spaces supporting wildlife and biodiversity, and supporting the wellbeing of local people and staff.
- Staff are empowered to make changes and reduce waste in their own work areas.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Deliver our ICS Green Plan.	Deliver three-plus objectives per programme.	Refresh/refine ICS Green Plan. Deliver three-plus objectives per programme.	Deliver three-plus objectives per programme.	Deliver three-plus objectives per programme.	Refresh/refine ICS Green Plan. Deliver three-plus objectives per programme.	✔	✔	
Securing and embedding clinical/ professional leadership and design for sustainable services.	Expand Faculty for Sustainability to include other clinical and managerial student placements	Staff across all organisations are empowered to make changes, reducing waste in their work.	Faculty for Sustainability embedded and Years 4 and 5 priorities defined.	Implementation, monitoring and evaluation		✔	✔	✔
Achieve national NHS Net Zero targets.	Continue with delivery - strengthen with primary care focus.	Refine delivery to ensure annual objectives are covered.		Achieve 80 net zero for NHS footprint emissions. Refine delivery to ensure annual objectives are covered.	Refine delivery to ensure annual objectives are covered.	✔	✔	

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Supporting healthier environments that reduce the likelihood of disease onset or exacerbation, for example, respiratory-related conditions such as asthma caused by poor environmental conditions.	Those with higher levels of deprivation are more greatly affected by global warming, air pollution. Tackling the sources of these provides a better quality of life for local people.
Enhance productivity and value for money	**Support broader social and economic development**
Almost all forms of waste reduction support both carbon reduction and saving money, providing better value for the public pound.	Many carbon net zero initiatives have the added benefits of health promotion and/or mental wellbeing.

Medicines optimisation

Medicines are the most common therapeutic intervention, the second highest area of NHS spending after staffing costs, and are associated with a high degree of clinical and financial risk.

Current state: Our challenges

- Between 5 to 10% of all hospital admissions are medicines-related and around two-thirds of these admissions are preventable.
- 30 to 50% of the medicines prescribed for long-term conditions are not taken as intended.
- Investment in medicines to optimise health outcomes and reduce hospital admissions is not maximised.
- Processes to reduce medicines harm need to be embedded through system working.
- Current working practices and systems do not facilitate reduction in medicines waste.
- Lack of interoperability between clinical systems in organisations increases the risk of harm from medicines.
- Pharmacy workforce pressures in all sectors constantly challenge the delivery of system ambitions to transform and optimise medicines use.

Future state: Our ambition

- A quality and safety culture around the use of medicines will be embedded in our system with ownership from all system partners.
- Improvement in outcomes associated with the use of medicines through reducing harm, improving patient access, shared decision making and personalised care.
- Reduction in unwarranted clinical variation, health inequalities and equitable access relating to medicines use will improve outcomes, using population health management and prescribing data to identify need.
- System working and collaboration to transform medicines use to improve the health and wellbeing of our population. Ensure the efficient use of resources and support the greener NHS agenda.
- Pharmacy workforce development (pharmacists, pharmacy technicians working in hospitals, community pharmacies, health and justice, ICB, mental health trust) to attract and retain staff.
- Education and training to develop career pathways and specialist roles.
- Investment in medicines, digital technology and workforce to improve quality of life and outcomes, and reduce hospital admissions through use of medicines. Active partnership in new models of care such as virtual wards.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Medicines across the system.	Finalise and publish ICS medicines optimisation strategy. Strengthen system leadership. Integration of clinical services in Community Pharmacy to build Primary Care capacity. Improve communication and sharing of information about medicines use.	System integration of all pharmacy services, improving equity through development of system-wide solutions.				✔	✔	✔
Medicines commissioning.	Strengthen Area Prescribing Committee capacity. Streamline system working. Develop contracts. Further develop contractual principles and governance for prescribing.	Integration of specialised medicines commissioning. Invest in expertise to support the evolving genomic medicines agenda.				✔	✔	✔
Medicines safety and quality.	Antimicrobial stewardship. Safe prescribing and reducing medicines harm. Reduction in inappropriate polypharmacy. Focus on improvement in the National Oversight indicators.	Patient Safety Incident Response Framework implementation across secondary care and primary care. System oversight of national patient safety alerts. Co-produced Medicines Safety Plans with PCNs.				✔	✔	✔
Medicines finance.	Develop ICS system medicines and prescribing efficiency plans.	Shared learning and collective responsibility - system ownership of the pharmaceutical cost (system £) Ensure medicines expenditure is fully accounted for in new service developments. ICS medicines waste reduction initiatives				✔	✔	✔
Pharmacy workforce development.	Strengthen established Pharmacy Workforce Faculty and develop 3-year plan to Train, Retain and Reform workforce	Develop system working for pharmacy placements for students.	System pharmacy education programme.			✔	✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
System working and collaboration with system partners to transform medicines use to improve the health and wellbeing of our population.	Identification and reduction in unwarranted clinical variation in medicines use to improve outcomes and ensure equitable access to the right care, at the right time, in the right place.
Enhance productivity and value for money	**Support broader social and economic development**
Through strategic medicines oversight and planning, ensure maximum benefit is gained from investment in medicines use.	Optimising health through appropriate medicines use enables communities and people to remain economically active. Reduction in medicines waste and promotion of greener medicines choices positively contributes to reduction in the net carbon footprint.

Research

Current state: Our challenges

- Better aligning the research that is undertaken and the research strengths, expertise and infrastructure of the ICS to the principles and priorities of the Integrated Care Strategy.
- Equity of access to place-based research opportunities with research being delivered where population need is greatest, with people from more diverse and under-served communities shaping, involved in and participating in research.
- Embedding research into everyday practice through opportunities for the workforce to be involved in research as part of their usual roles or to develop a research career.
- Systematically using the evidence from research to inform decision making.

Future state: Our ambition

- Partners from across sectors working together, including NHS providers, Local Authorities, VCSE Alliance, University of Nottingham, Nottingham Trent University, the local National Institute for Health and Care Research (NIHR) infrastructure and Health Innovation East Midlands.
- A collaborative, integrated and equitable approach to health and care research that aligns with the needs and priorities of the Integrated Care Strategy.
- The benefits and impact of research are maximised to continually improve population health and wellbeing outcomes, high quality joined up care and reduce inequalities.
- To attract, develop and retain a sustainable research workforce providing opportunities to lead and be involved in research that is embedded into everyday practice. Optimising integration as a means of undertaking research across the system and with all partners.
- Research is wrapped around what we do with an embedded evidence-informed approach. There is a strengthened alignment of research findings to shape interventions for mutual benefit and opportunities.
- A culture of evidence-based practice including the ability to test, learn and evaluate across the ICS.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Develop an ICS research strategy.	ICS Research Strategy agreed. Plan and mechanisms in place to operationalise it.	Continued implementation of Research Strategy with partners				✔	✔	✔
Better align research to the ICS strategy.	Build a pipeline of research projects.	Develop ongoing mechanisms to support awareness of and engagement with research activity across the system including integrated delivery of research studies.				✔	✔	✔
Increasing the diversity of those involved in research.	Complete Research Engagement Network Programme and develop sustainability plan.	Implementation and monitoring of plan delivery.					✔	

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Research, and the use of evidence from research, improves outcomes.	Research informs greater understanding of inequalities and how to tackle them.
Enhance productivity and value for money	**Support broader social and economic development**
Utilising the evidence from research enhances productivity and value for money.	Research brings investment into anchor institutions supporting economic prosperity.

Supporting social and economic development

Current state: Our challenges

- Supporting social and economic development is the fourth aim of the ICS.
- NHS Trusts, as anchor organisations, have already established programmes in support of this agenda.
- The ICB established an Anchor Champions Network (ACN) in 2022 comprising of ICB, Trusts, Provider Collaborative, local authorities (public health and economic development) and Place Based Partnerships.
- Individual ICS partners and Place Based Partnerships, as Anchors, have well established programmes in place.
- ICS priorities for 2023/24 focussed on People, Procurement, Net Zero and Estates and have been delivered through relevant system groups with support through the ACN. Place Based Partnerships continue to support residents around Financial Resilience.
- The ICS has continued to make good progress on this agenda in the context that many of our resources are focussed on immediate operational and financial pressures.
- An ICS wide workshop was held in September 2023, facilitated by the NHS Confederation, to stretch our thinking and identify 2024/25 priorities. This identified three broad themes (1) Employment, Skills and Health (2) Health as an Investment (3) Community Anchor Principle which will be progressed from 2024/25.

Future state: Our ambition

- The ICS will continue to be an active partner in the Universities for Nottingham Civic Agreement, Midlands Engine and will strengthen links with D2N2 to understand how we can better support wider social and economic development.
- Employment, Skills and Health – Building on the successful Individual Placement Support Programme the ICS has bid to be a WorkWell Vanguard, a health led programme to support people into work, remain in work and thrive in the workplace. Place Based Partnerships coordinated partners to develop the bid, which if successful will be implemented through 2024/25 and 2025/26, underpinned by an ICS Health and Work Strategy.
- Health as an Investment – Place Based Partnerships will confirm Health as an Investment priorities and actions which will be co-produced in line with Community Anchor Principles and jointly delivered through Integrated Neighbourhood Working (INW) models in priority neighbourhoods.
- Priorities established in 2023/24 around Net Zero, Procurement and Estates will continue to progress through ICS delivery groups.

SUMMARY of what we intend to do over the next 5 years

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Network: Maintain a vibrant ICS Anchor Champions Network (ACN) to define and facilitate delivery of ICS priorities.	Facilitate delivery of priorities through established system groups and partnerships. Define Year 2 strategic priorities.	Facilitate delivery of priorities through established system groups, and partnerships. Define Year 3 strategic priorities.				✓	✓	✓
Partnerships: Strengthen ICS contribution to key strategic partnerships for social and economic development.	Active role in Midlands Engine Health and Life Sciences Board. Active role in UfN Civic Agreement and support key work programmes e.g. diverse employment. Forge new partnerships e.g. D2N2.	Active role in existing partnerships. Continue to forge new partnerships.				✓	✓	✓
Facilitate delivery of key annual priorities	Develop Health and Work Strategy. Implement WorkWell. Identify Health and an Investment Priorities. Procure for Social Value. Continue to support local people with Financial Resilience.	Continue to support health and wellbeing and financial wellbeing programmes.				✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Promotes focus on the wider determinants of health including employment, training and economic development.	Encourages economic regeneration and growth which will impact directly or indirectly on inequalities.
Enhance productivity and value for money	**Support broader social and economic development**
Collaboration across partners will contribute to generation of efficient and effective use of anchor organisational and collective resources.	Actions are aligned to the fourth aim of the Integrated Care Strategy.

Appendices

Contents:

A. How we developed the strategy / engagement

B. Statements of support from the Health and Wellbeing Boards

C. Glossary of terms

Integrated Care Strategy

The Integrated Care Strategy published in March 2023 has its origins in the Joint Health and Wellbeing Strategies for Nottingham and Nottinghamshire and, as such, should be seen as both complementary to, and building upon, the aims set out in those documents.

As part of developing the strategy, we listened extensively to the public, patients and stakeholders to check that it reflected the hopes, needs and aspirations of local people and their communities.

The engagement programme included desk research of previous engagement and strategies within the system, stakeholder meetings, presentations at existing forums, public events and a survey. In total, just under 750 individuals were involved in a range of activities, between October and November 2022. Activities included:

- Targeted meetings with key stakeholders, including voluntary, community and social enterprise sector leaders, Healthwatch Nottingham and Nottinghamshire and local elected representatives.
- The October 2022 ICS Partners Assembly, which bought together 161 system stakeholders, carers, service users, patients and citizens.
- The annual Nottinghamshire County Council Shadow event, which was attended by more than 250 children and young people, including young adults with learning disabilities.
- Two virtual public events, which were attended by 48 individuals.
- A survey for people to provide their views on the emerging strategy, which received 206 responses.
- Discussions among ICS partner organisations and Place Based Partnerships during November and early December 2022.
- An ICP workshop on 9 November 2022.

The Integrated Care Partnership reviewed and refreshed the strategy for March 2024. This process included engaging Health and Wellbeing Boards and partner organisations.

NHS Joint Forward Plan

As described earlier, the JFP acts as the NHS delivery commitment for all NHS organisations within the Nottingham and Nottinghamshire ICS.

In developing the initial plan in 2023, we further engaged with public, patients and stakeholders. The engagement programme built on engagement for the Integrated Care Strategy and included stakeholder meetings, presentations at existing forums, public events and a survey. In total, just under 800 individuals were involved in a range of activities, between May and June 2023. Activities included:

- Targeted meetings with key stakeholders, including voluntary, community and social enterprise sector leaders, Healthwatch Nottingham and Nottinghamshire and local elected representatives.
- Specific workshop and/or meeting discussions with the two Health and Wellbeing Boards to ensure that the plan was aligned to the strategy.
- Hosting the second Nottingham and Nottinghamshire ICS Partners Assembly in May 2023, which was attended by more than 120 system representatives.
- Listening to and gathering insights from across our Place Based Partnerships.
- A survey for patients, local people and staff, which received 168 responses.
- Discussions with NHS organisations' board members and further established partner forums during May and June 2023.
- An engagement report on how we have engaged with people and communities has been produced.

In refreshing the plan for 2024 activities included:

- Targeted meetings with key stakeholders as outlined above.
- Specific workshop and/or meeting discussions with the two Health and Wellbeing Boards to ensure that the plan was aligned to the strategy.
- Listening to and gathering insights from across our Place Based Partnerships.
- A survey for patients, local people and staff, which received 104 responses.
- Discussions with NHS organisations' board members and further established partner forums during February and March 2024.

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Nottingham City Health and Wellbeing Board

The Nottingham Health and Wellbeing Board is satisfied that the NHS Joint Forward Plan for Nottingham and Nottinghamshire takes full account and outlines the ICB's contribution to the delivery of the Integrated Care Strategy. We welcome the strong commitment and connectivity to the Joint Local Health and Wellbeing Strategy.

Nottinghamshire County Health and Wellbeing Board

The Nottinghamshire Health and Wellbeing Board is satisfied that the NHS Joint Forward Plan for Nottingham and Nottinghamshire has taken account of its feedback, and the plan clearly articulates the ICBs commitment and contribution to the delivery of the Nottinghamshire Joint Health and Wellbeing Strategy.

Health	The state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity.	Integrated Care Partnership (ICP)	ICPs are a critical part of ICSs and the journey towards better health and care outcomes for the people they serve. ICPs provide a forum for NHS leaders and local authorities to come together with important stakeholders from across the system and community. Together, the ICP generates an integrated care strategy to improve health and care outcomes and experiences for their populations, for which all partners will be accountable.
Health inequalities/ Health inequities	Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.	Integrated Care System (ICS)	In an ICS, NHS organisations in partnership with local councils and others take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve. Statutory ICS arrangements include: • an Integrated Care Partnership, the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS • an Integrated Care Board, bringing the NHS together locally to improve population health and care. Within ICSs, it is expected that several place-based partnerships will be agreed. Four place-based partnerships have been agreed in our system.
Integrated Neighbourhood Team	INTs are where people can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.”	Healthy life expectancy	The length of time a person spends in good health – in other words not hampered by long term conditions, illnesses or injuries.
Neighbourhood	The smallest and most local area that services are organised at.	Life expectancy	The average number of years that someone can expect to live.
Primary care network (PCN)	Local collaboration of GP practices, usually covering 30,000 to 50,000 people, working towards integrated primary and community health services.	Place Based Partnerships (PBP)	Place-Based Partnerships are collaborative arrangements that have been formed across the country by the organisations responsible for arranging and delivering health and care services in a locality or community. They involve the NHS, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities (people who use services, their representatives, carers and local residents).

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System Analytics and Intelligence Unit (SAIU)	The SAIU brings together and develops existing ICB and ICS workforce with the purpose of delivering: • Population intelligence to support planning and strategy. • Analytical intelligence that spans the entire commissioning cycle. This includes capacity and demand modelling, population health management, and quantifying and evaluating the value of transformational initiatives. • Oversight of regional, national benchmarking data, as well as insight, contextual analysis and comparative information to support the interpretation of local data to improve quality of care and outcomes for our population. • Embedding an analytical approach to health inequalities which underpins all outputs. • Utilising best practice evidence-based interventions and new models to develop improved quality outcomes for our population. The SAIU is an independent team within the ICS that operates across the system.	Provider Collaborative at Scale	Partnership arrangements involving two or more trusts (NHS Trusts or Foundation Trusts) working at scale across multiple places, with shared purpose and effective decision-making arrangements, to: • Reduce unwarranted differences and inequality in health outcomes, access to services and experience • Improve resilience (for example, by providing mutual aid) • Ensure that specialisation and consolidation occur where this will provide better outcomes and value. The Nottingham and Nottinghamshire Provider Collaborative at Scale is between Nottinghamshire Healthcare NHS Foundation Trust, Sherwood Forest Hospitals NHS Foundation Trust, Nottingham University Hospitals NHS Trust, Doncaster and Bassetlaw NHS Teaching Hospitals Foundation Trust and East Midlands Ambulance Service NHS Trust, with an initial focus on programmes within the themes of people and culture and corporate services.
Outcomes	Change in health and wellbeing as a result of an intervention or action, either by an individual (exercising more), community (starting a running group) or organisation (creating more green spaces for people to exercise in).	Universities for Nottingham Civic Agreement	Partners have agreed as anchor institutions for Nottingham and Nottinghamshire a commitment to work together ensuring a joined up approach across several themes, including: • Economic prosperity • Educational opportunity • Environmental sustainability • Health and wellbeing which includes attracting the world's most talented clinicians and healthcare workers to the area, training and retaining local talent to develop their careers in Nottingham and Nottinghamshire; and maximising the economic opportunities provided by the strong local health and life sciences sectors.

Appendix 2

Joint Forward Plan

Delivery Plan Outcomes

DRAFT in development

Our collective system focus

Ambitions

Overarching Ambitions of the Integrated Care Strategy		
Improving Healthy Life Expectancy	**Improving Life Expectancy**	**Reducing Health Inequalities**
An improvement in years of healthy life expectancy at birth from the baseline for 2018-2020 - yet we acknowledge that this may well require a longer timeframe than five years.	An improvement in years of life expectancy at birth from the baseline for 2018-2020 - yet we acknowledge that this may well require a longer timeframe than five years.	A reduction in life expectancy gap (measured in years) between those living in the most and least deprived areas of the ICS from 2018-2020 baseline.

Baseline (years) **Source: OHID Fingertips**	**Healthy Life Expectancy**	**Improving Life Expectancy**	**Reducing Health Inequalities (gap)**
Nottingham City	57.1 (females) 57.4 (males)	81.0 (females) 76.6 (males)	7.6 (females) 8.4 (males)
Nottinghamshire County	60 (females) 62.4 (males)	82.6 (females) 79.5 (males)	7.7 (females) 9.3 (males)

Key System Outcomes

Strategic Aims

- **Improve outcomes** in population health and healthcare
- **Tackle inequalities** in outcomes, experiences and access
- Enhance **productivity and value for money**
- Support broader **social and economic development**

Principles

- Prevention is better than cure
- Equity in everything
- Integration by default

Outcomes

Improve outcomes in population health and healthcare

- Increase in life expectancy
- Increase in healthy life expectancy
- Reduction in average number of years spent in poor health
- Early identification and early diagnosis
- Reduction in premature mortality
- Reduction in potential years of life lost
- Reduction in illness and disease prevalence
- Stabilisation of the rising rates of obese and overweight children in Year 6
- Reduction in avoidable and unplanned admissions to hospital
- Reduction in avoidable and unplanned admissions to care homes
- Improvement in carer reported quality of life score

Tackle inequalities in outcomes, experiences and access

- Improvement in educational attainment
- Improvement in birth outcomes
- Increase in the proportion of people reporting high satisfaction with the services they receive
- Increase in the proportion of people reporting their needs are met
- Increase in the number of people that report having choice, control and dignity over their care and support
- Increase in quality of life for people with care needs
- Increase in appropriate and effective care for people who are coming to an end of their lives
- Increase in number of people being cared for in an appropriate care setting
- Narrow the gap in the onset of multiple morbidities between the poorest and wealthiest sections of the population
- Increase in appropriate access to primary and community-based health and care services
- Increase the number of people who have the support to self-care and self-manage and improve their health and wellbeing

Enhance productivity and value for money

- A workforce representative of our local population
- Sustainable teams with skill mix designed around our population and mechanisms to deploy them flexibly to respond to care & support needs
- Increase in skills, knowledge and confidence to take every opportunity to support people to self-care and take a flexible, holistic approach to people's needs with a strong focus on prevention and personalised care
- Population health approach embedded across all of our organisations to support people to manage their health and wellbeing
- Financial control total achieved

Support broader social and economic development

- Increase in the total use and appropriate utilisation of our estate
- Increase in the % of health and care workforce under the age of 25 years
- An increased proportion of the population with health conditions who are supported back into work
- Achieve carbon net zero by 2040

Delivering the right care at the right time

JFP focus areas

Prevention: we will reduce physical and mental illness and disease prevalence

Proactive management of long-term conditions and frailty to support early identification and avoid unnecessary escalation

Improve **navigation and flow** to reduce emergency pressures in physical and mental health settings

Timely access and early diagnosis for cancer and elective care

Priority 01	Prevention: reduce physical and mental illness and disease prevalence.

Outcomes		
Outcomes	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

Key Deliverables	Metrics
Development of targeted case finding specifically focused on population health needs across Places and system priorities, for example, frailty, severe multiple disadvantage, obesity.	Under 75 mortality rate all causes Mortality rate from causes considered preventable Suicide rate Reduced emergency admissions for people with 3+ Long Term Conditions (LTCs) (COPD, Cancer, CVD, Respiratory, Frailty) Reduction in adult smoking prevalence Reduction in admissions due to alcohol
Based on identified local and system priorities, PBPs will develop integrated neighbourhood teams to curb demand growth, focusing on keeping people out of hospital wherever possible.	Predictors of long-term conditions (age-adjusted) Gap in the employment rate between those with a long-term health condition and the overall employment rate % of people who have three or more emergency hospital admissions during the last 90 days of life Adjusted social care quality of life – impact of social care services Health related quality of life for older people
System-wide approach to personalised care planning across all sectors (acute, community and primary).	People referred for self-management support, health coaching and similar interventions Self-reported wellbeing (people with a low satisfaction score) Hospital admissions as a result of self-harm (10-24 years) Number of people completing an assessment tool Number of people who benefit from community signposting/social prescribing
Implement structured education programmes	Ambition that everyone newly diagnosed with Type 1 or Type 2 diabetes should be offered education within 12 months: • Number of people referred to education programme • Number of people attending education programme • Number of people who have completed education programme

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Priority 02	Proactive management of long-term conditions and frailty to support early identification and avoid unnecessary escalation.

Outcomes	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

Key Deliverables	Metrics
Develop PBP focus on tackling the quality of care in frailty that would be supported by the whole system and its partners. Identify the frailty cohort of focus based on data which indicates where resources are being over utilised and where care could be provided more appropriately	Reduced emergency admissions for people with 3+ LTCs (Frailty)
Reinvigorate the Practice Pack model at a Practice, PCN and Place.	Enabling activity to support delivery
Frailty same-day emergency care embedded.	Reduced emergency admissions for people with 3+ LTCs (Frailty)
Asthma diagnosis tools embedded within primary care for children and young people.	Asthma prevalence 0-19
Increase immunisation and screening uptake for 'at risk' groups	Investment and Impact Fund (IIF) 'at-risk' data Data for Screening – Bowel, Breast and Cervical (links to cancer metrics)
Deliver Primary Care Strategy and integrated approach to Long Term Conditions Management with a focus on the top five health conditions for the population.	Reduced emergency admissions for people with 3+ LTCs (Frailty)
Continued identification of physical health issues in people with a serious mental illness thorough physical health checks to ensure proactive management in this group who do not routinely access physical health services.	Severe Mental Illness (SMI) Patients aged 15+ with all 6 Physical Health Checks completed

Priority 03	Improve navigation and flow to reduce emergency pressures in physical and mental health settings.	
Outcomes	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)

Deliverables	Metrics
Action	**Short and medium term**
Embedded integrated neighbourhood team working across community teams. Prioritise those cohorts/pathway development where data indicates there is greatest opportunity for impact at both Place and system level, for example, frailty, respiratory, hypertension, CVD.	Reduction in emergency admissions >5yrs (physical and mental health) Reduced emergency admissions for people with 3+ LTCs (Frailty)
Further develop social prescribing model across all Places/care navigation across primary care, aligned with Make Every Contact Count approach	People referred for self-management support, health coaching and similar interventions Self-reported wellbeing (people with a low satisfaction score) Number of people completing an assessment tool Number of people who benefit from community signposting/social prescribing
Virtual wards fully established and meeting target activity levels. Integrated care pathways with social care established for specific cohorts	Number of virtual ward beds Utilisation of virtual ward capacity
Develop a co-located urgent treatment centre at QMC to reduce demand on A&E. Deliver medically safe for transfer plan target and develop trajectory for years 2 to 5.	Reduction in emergency admissions >5yrs (physical and mental health) Reduced emergency admissions for people with 3+ LTCs (Frailty)
Expand our same-day emergency care offer across hospitals ensuring direct access for all professionals and implementing new data requirements.	Reduction in emergency admissions >5yrs (physical and mental health) Reduced emergency admissions for people with 3+ LTCs (Frailty)
Transform our P2 and P3 offer to improve patient flow for patients who are medically safe for transfer. and reduce length of stay in P2 beds.	Reduced bed days / length of stay
Develop an urgent care coordination hub which will act as a single point of access for health professionals.	Reduced bed days / length of stay

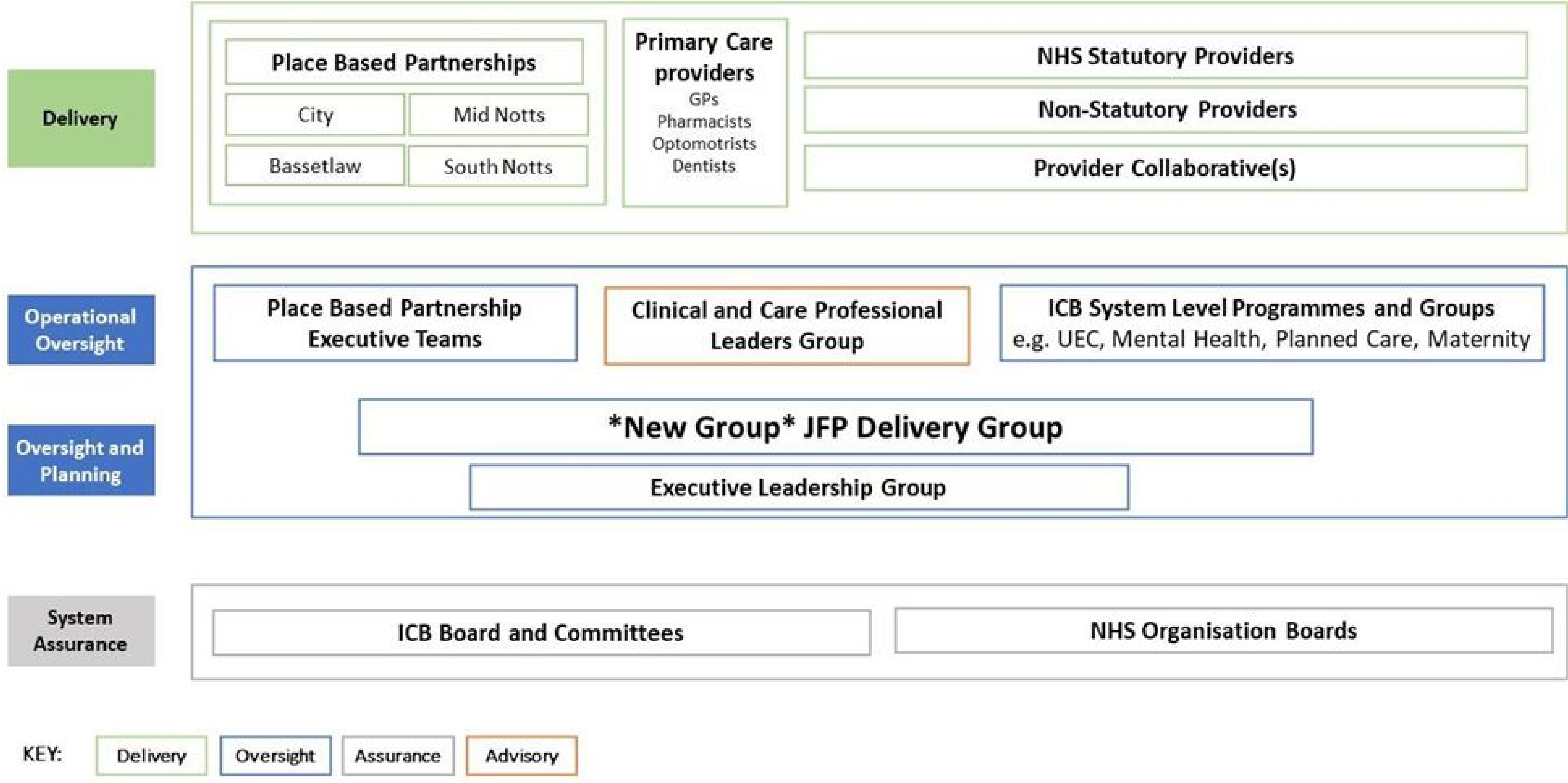
Priority 04	Timely access and early diagnosis for cancer and elective care.	
Outcomes	Increase in life expectancy Increase in illness-free life expectancy Reduction in average number of years spent in poor health Improve Early Cancer diagnosis	Reduction in avoidable premature mortality Increase in the 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

Deliverables	Metrics
Action	**Short and medium term**
Continued support to eliminate waits of over 65 weeks for elective care	Reduce people waiting 65 weeks to 0 by September 2024.
Elective hubs and clinical diagnostic centres established (Newark, City, Mansfield).	Increased diagnostic tests.
Expansion of targeted lung health, breast cancer screening, community prostate clinics and community liver surveillance programmes.	Number of screening tests being undertaken
Identify the top 5 specialities with the longest waits for CYP elective care. Differentiating waits and preoperative care for children and young people where development is disproportionately affected compared to adults	Number of children waiting Waiting times
Roll-out personalised care, optimise integrated care pathway and referrals. Maximise productivity and make best use of workforce, for example, shared workforce plans, staff digital passports and Making Every Contact Count	Number of people who have a personal health budget % of patients that have been identified and involved in shared decision making People referred for self-management support, health coaching and similar interventions Self-reported wellbeing (people with a low satisfaction score) Number of people completing an assessment tool Number of people who benefit from community signposting/social prescribing

JFP focus areas **Summary of outcomes**

Outcome	Ambition	Priorities contributing to outcome	Current	Source
Increase in life expectancy	TBC	1, 2, 3, 4	81.2 years (stable) Nottingham 80.5 (females), 75.8 (males); Nottinghamshire 82.6 (females), 78.8 (males) (decreasing)	2023, PHM Outcomes SID18 2020-2022 OHID Fingertips
Increase in illness-free life expectancy	TBC	1, 2, 3, 4	Measure being developed	
Reduction in average number of years spent in poor health	TBC	1, 2, 3, 4	Measure being developed	
Improve early cancer diagnosis	75% by 2028 (national target: NHS Long Term Plan)	1, 2, 4	Percentage of cancers diagnosed at Stages 1&2: Nottingham 53.6% (stable), Nottinghamshire 56.1% (stable)	2021, OHID Fingertips
Reduction in avoidable premature mortality (under 75)	TBC	1, 2, 3, 4	Under 75 mortality rate from causes considered preventable 3-year range: 257.5 (stable)	2021-2023, PHM Outcomes SID18
Reduction in infant mortality	50% reduction by 2025 (national target: DHSC)	1	Infant mortality rate: Nottingham 5.5, Nottinghamshire 4.6 (trend not available)	2020-2022, OHID Fingertips
Reduction in suicides	Decrease by 2028 (national target: DHSC)	1, 2, 3, 4	Suicide rate: Nottingham 8.9, Nottinghamshire 10 (trend not available)	2020-2022, OHID Fingertips
Stabilisation of the rising rates of obese and overweight children in Year 6	50% reduction by 2030 (national target: DHSC)	1	Nottingham 43.6 (increasing), Nottinghamshire 35.9 (increasing)	2022/23, OHID Fingertips
Increase in the proportion of people reporting high satisfaction with the services they receive	TBC	1, 2, 3, 4	Experience of A&E services: NUH 83%, SFH 82% and DBH 77% Experience of making a GP appointment fairly good or very good: Nottingham 72%, Nottinghamshire 73%	2020, PHM Outcomes SID06 2020/21, PHM Outcomes SID06
Increase the number of people who have the support to self-care and self-manage and improve their health and wellbeing	TBC	1, 2, 4	32,086 personalised care and support plans in place (new and reviewed)	2022/23, PHM Outcomes SID12

Appendix 3: Oversight arrangements



Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/05/2024
Paper Title:	**2024/25 Capital Resource Use Plan**
Paper Reference:	ICB 24 009
Report Author:	Marcus Pratt, Programme Director for System Finance
Report Sponsor:	Stuart Poynor, Director of Finance
Presenter:	Stuart Poynor, Director of Finance

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

Summary:

The National Health Service Act 2006, as amended by the Health and Care Act 2022 (the amended 2006 Act), requires ICBs and their partner trusts to:

- prepare a plan setting out their planned capital resource use before the start of each financial year.
- publish the plan and give a copy to their Integrated Care Partnership, health and wellbeing boards and NHS England.

For 2024/25 the guidance has been amended to coincide with operational planning timescales. Agreement and publication of the Joint Capital Resource Use Plans (JCRUP) are required by 30 June 2024.

Systems have the flexibility to determine their Plan's scope, as well as how it is developed and structured, and as a minimum the Plan needs to describe how capital is contributing to ICB's priorities and delivering benefits to patients and healthcare users.

The published plan aims to provide transparency for local residents, patients, NHS health workers and other NHS stakeholders on the prioritisation and expenditure of capital funding by ICBs to achieve their strategic aims. This aligns with ICBs' financial duties to not overspend their allocated capital and to report annually on their use of resources.

The enclosed plan has been prepared by the ICB and its NHS trust partners. It is fully aligned with the system's 2024/25 operational plan.

The Finance and Performance Committee endorsed the Plan at their meeting on 24 April and will oversee its delivery in year.

Recommendation(s):

The Board is asked to **approve** the Joint Capital Resource Use Plan.

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 capital resources and delivery of the plan within allocated funds, 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:
A: Joint Capital Resource Use Plan

Board Assurance Framework:

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

- Risk 2: System Resilience (for Managing Today) – Working effectively across the system may fail to address the current levels of demand across primary, community and secondary care.
- Risk 10: Financial Sustainability – Establishing a shared culture of financial stewardship may not ensure financial sustainability across the system.
- Risk 11: Allocation of Resources – Failure to establish robust resource allocation arrangements across the system (revenue and capital).
- Risk 12: Digital Transformation – Failure to deliver digital transformation and establish effective system intelligence solutions.
- Risk 13: Environment Sustainability – Failure to effectively deliver on the green plan.

Report Previously Received By:
The ICB Finance and Performance Committee

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Appendix A

Joint capital resource use plan – 2024/25

REGION	Midlands
ICB / SYSTEM	Nottingham and Nottinghamshire ICS

Introduction

The ICS has been working within a system-wide capital envelope since 2020/21. The ICS is provided with an annual capital resource envelope for use across the 3 provider organisations (Nottingham University Hospitals, Sherwood Forest Hospitals and Nottinghamshire Healthcare), and is expected to plan and deliver capital expenditure within available resources.

The Nottinghamshire estate contains a mixture of older poor condition building and newer estate. The older estate, notably at Queens Medical Centre, Nottingham City Hospital and Rampton Hospital, requires extensive maintenance and as such, the system is recognised as having one of the highest backlog maintenance requirements in the country.

Coupled with capital required to support service continuity pressures and strategic priorities the requirements for capital funds across our provider organisations are significantly higher than funding available.

In recent years the capital envelope has been mainly used to address operational priorities on an annual basis such as equipment replacement, IT upgrades and backlog maintenance priorities. The envelope is also supported where possible by the disposal of assets. Larger strategic priorities have tended to be funded by targeted national funding as it becomes available.

The system holds a capital database to provide a granular understanding of capital plans and expenditure that would support proactive management of the capital programme and forward planning.

The following broad approach to the allocation and prioritisation of funds has been agreed within the system for planning: -

- Agree prior year precommitments are the first call on the capital envelope. This includes any slippage or unexpected cost increases.
- Approximately 50% of capital envelope to be used to address operational priorities using an agreed assessment of need across the provider organisations.

Appendix A

- National funding to be used to support strategic priorities where possible.
- Remaining funding to be used to addressed larger strategic schemes – prioritised at a system level.

Assumed Sources of Funding for 2024/25

The table below shows the expected sources of capital income for NHS partners in 2024/25. The system has been successful in bidding for several funding sources from outside of the operational capital envelope.

NHS England have announced further digital and technology funding in the 2024 spring budget. The details of this funding have not yet been announced. The system expects to bid for funding from this pot to support system digital strategies.

£17.8m of funding has been confirmed to support net zero commitments in 2024/25. This is grant funding from the Public Sector Decarbonisation Scheme (PSDS) and for accounting purposes is treated as revenue income and expenditure. The system continues to seek public sector funding for works required to test feasibility and/or meet net zero targets, including Low Carbon Skills Funding and Public Sector Decarbonisation funding.

Planned sources of income for 2024/25 capital plans	2024/25 Plan £000
System Envelope - Operational Capital Providers	86.0
Maternity & Neonatal Redesign Programme	2.5
ICB Operational Capital	2.0
Total Operational Capital	**90.5**
City Hospital Theatres & Elective Ward (Targeted Investment Fund)	6.0
Community Diagnostics Centres (CDC)	25.9
New Hospital Programme (National Rehabilitation Centre)	55.1
New Hospital Programme (Tomorrow's NUH)	0.5

Appendix A

Impact of International Financial Reporting Standard (IFRS16)	11.2
Residual Interest	4.5
Frontline Digitisation - Electronic Patient Records	11.6
Urgent Care Capacity	0.5
Increasing Diagnostic Capacity	1.7
Total Capital Resources Available	**207.4**

Overview of Ongoing Scheme Progression

Nottingham University Hospitals

NUH are expecting £143.2m capital resource for 2024/25 primarily driven by the significant ring fenced PDC spend relating to the National Rehabilitation Centre (NRC), and completion of the Community Diagnostic Centre (CDC). There is a further £18.3m relating to donations and grant funded spend including next stage of the Public Sector Decarbonisation Scheme (PSDS), to give a total capital programme of £161.5m.

Significant schemes in the 2024/25 plan include:

- The National Rehabilitation Centre (NRC) at Stanford Hall Rehabilitation Estate, a 70-bed clinical facility which will be a purpose-built rehabilitation centre anticipated to open Spring 2025
- The creation of a Community Diagnostic Centre in Nottingham city centre. This is a Nationally approved scheme to be completed in 24/25 with spend of £21.9m in 24/25. Total scheme costs £25.0m.
- Completion of the second phase of development to create a Ring-fenced Elective Hub on the City Campus; Targeted Investment Fund (TIF) project of £19.1m.
- Develop a compliant inpatient and tertiary cancer Endoscopy facility on D floor at QMC, to support improvements to patient care, patient safety and the workforce in multiple parts of the current pathway, £10.0m.
- Completion of Mechanical Thrombectomy, with electrical infrastructure support at City Hospital.
- Ongoing BAU spend has been restricted to £14m on estates, medical equipment and ICT to facilitate the extent of pre-commitments going in to 2024/25.

Sherwood Forest Hospitals

Appendix A

Significant schemes in the 2024/25 plan include:

- The creation of a Community Diagnostic Centre (CDC) in Mansfield. This is a Nationally approved scheme started in 2022/23 due to be completed in 24/25 with funding of £530m in 24/25. The Nottingham and Nottinghamshire ICS programme seeks to reduce health inequalities as evidence has shown that residents who live in high areas of deprivation are more likely to experience poorer health outcomes. Total scheme costs £22.51m.
- Ongoing implementation of an Electronic Patient record system, expenditure of £4.5m planned in 2024/25 as part of the NHS Frontline Digitisation programme. This will be a key enabler of the ambition to develop the single summary health and care record across the Integrated Care System (ICS) and will be a core data source for the development of the Population Health Management capability.
- Business as usual replacement of aged medical and I.T equipment to ensure continuity of service provision £7.46m.
- Construction of new build MRI facilities with a forecast expenditure of £12m across two years 2024 – 2026.

Nottinghamshire Healthcare

NHT are expecting £31.3m capital resource for 2024/25 inclusive an allocation of £16m from the system capital envelope.

Significant schemes in the 2024/25 plan include:

- The Electronic Patient Record frontline digitation programme. This is funded nationally by PDC to the value of £7m.
- The implementation of the crisis telephony system linked directly to 111 to support patients in crisis (£0.49m).
- Millbrook eradication of dormitories project that is scheduled to be finalised in Feb 2025. (£11.9m)
- High voltage infrastructure work at Rampton (£2.1m) and an upgraded Perimeter Intrusion Detection System (PIDS) at Rampton Hospital at (£1.5m)

Risks and Contingencies

Given current economic and supply chain issues, increased costs for planned schemes are a significant risk to in-year delivery. To address this system partners have instigated enhanced business case scrutiny, tight management of scheme specifications and firm cost control as schemes progress.

Appendix A

In addition, the following organisation specific risks have been recognised within the plan.

Nottingham University Hospitals

- The Trust has over £400m of critical infrastructure back log maintenance.
- The Board has committed to spending up to £10m over a 3-year period to address fire related risks. 2024/25 will be year 2 of 3.
- The Trust has nearly £30m of red rated medical equipment replacement requirements.
- The two main campuses, QMC and City, are capacity constrained from an electricity perspective which may lead to a critical infrastructure failure.
- The Trust has two Cath Labs which are past end of life and, if unaddressed, would prevent the Trust from being able to deliver electro physiology.
- The Trust is having to review its commitment to previously approved multi-year schemes that support rolling replacement of clinical need due to insufficient funding availability.

Sherwood Forest Hospitals

- Specific risks exist in relation to Community Diagnostic Centre, in relation to recruitment of staff to ensure operational deliverability on completion in 24/25, and in relation to national building and engineering price inflation, which needs to be managed within the overall quantum of capital costs as the build progresses.
- The SFH EPR case is subject to formal approval of the 24/25 capital, following a formal tender exercise for the preferred supplier. Full business case currently being prepared following approval by the Department of Health of the outline business case in 2023/24.

Nottinghamshire Healthcare

- Specific risks exist in relation to the seclusion suites at Arnold Lodge and Block A and B at Rampton Hospital which were not possible to address within the capital resources available.
- Availability of capital funding to address additional safety issues at NHT secure hospitals.

Appendix A

Business Cases in 2024/25.

A system business case was agreed for Electronic Patient Records across all 3 providers, which enables record sharing within and across providers and is a key element of our frontline digitisation strategy. NUH have implemented this in 2023/24 with SFH and NHT using national funds to commence implementation in 2024/25.

The system also continues to develop the business case for Tomorrow's NUH as part of the New Hospitals Programme. This will see the reconfiguration of approximately one third of the QMC campus providing modernised acute services to our community. A case for the provision of the Day Nursery Project has commenced and will pick up the Data Centre in June and Multi Story Car Park (MSCP) Full Business Case from October.

The CDC at Mansfield Community Hospital has been approved with and is under implementation as is the CDC in Nottingham City Centre. This will be part of the new Broadmarsh Development alongside other health and wellbeing services. Both schemes are expected to be operational from March 2025.

The system has had a particular focus on eradication of mental health dormitories. This has 3 elements locally:

- Sherwood oaks has been completed and is operational.
- Millbrook business case under implementation and to be completed in February 2025.
- Cherry Ward is the final phase with a business case under development and planned to be submitted in 2024/25. Further national funding for this is being scoped.

Net Zero

In 2023/24, NUH received the second year of a PSDS grant of £21.7m towards completion of the replacement of windows at QMC and beginning work to remove steam as the main transfer of heat around the buildings. The new solution will use a low temperature hot water system from both Combined Heat & Power (CHP) and ground source heat pumps. This requires the construction of a new energy centre at QMC, which has begun using a further grant from PSDS of £22.3m in 2023/24. This grant continues into 2024/25, with a further £17.8m to complete the energy centre, moving a significant way to reducing the use of gas towards heating at QMC.

Appendix A

Primary Care Capital

The ICB receives a ring-fenced capital allocation of c. £2m each year to invest in I.T. replacement and small premises improvements in primary care (general practice). Based on estates strategies from legacy organisations and the recent Primary Care Network Estates Toolkit, the ICB has several agreed primary care priorities. However, the cost of implementation is unaffordable within the size of the capital envelope provided. There are currently no sources of national funding prioritised for primary care, however business cases are being developed in anticipation of future funding.

Priority areas include:

- Hucknall (Cavell) – 3 practice new build health and wellbeing hub
- Eastwood and Giltbrook – 2 practice new build
- East Leake – large single practice new build
- Newark – single practice new build
- Beeston – single practice new build, site identified

In addition to these there are several major housing developments planned across Nottingham & Nottinghamshire that will require increased primary care provision:

- Fairham Pastures – land south of Clifton 3000 dwellings, reserve site requested for primary medical facility
- Chetwynd Barracks, Chilwell (and Toton sidings) - up to 4,500 dwellings, reserved site requested for primary medical facility
- Tollerton/Bassingfield – 4,000 dwellings reserved site being requested for primary medical facility

Emerging priorities for new build/major expansion have also been identified in the following areas which are now being developed further:

- Radcliffe on Trent
- Strelley/Aspley area
- Burton Joyce
- Edwinstowe/Ollerton

Appendix A

Cross System Working

As described above, the capital funding provided to the Nottingham & Nottinghamshire system is for use by the 3 provider organisations that form part of the ICS. However, East Midlands Ambulance Service and Doncaster and Bassetlaw Hospitals are key service providers within the system and require capital resources to support service pressures and operational priorities. The capital funds for these providers are routed through other ICBs. However, through system forums the N&N ICB is party to decision making for capital funds. This is particularly true for capital required to support emergency care capacity and elective/diagnostic recovery.

Capital Planning & Prioritisation

In prioritising operational capital, the system considers the following factors:

- Addressing operational risk such as estates infrastructure risk, equipment replacement requirements and IT upgrades/replacement.
- Supporting national programme capital using local funds.
- Capital requirements to support larger strategic priorities.

In 2024/25, system partners have several pre-commitments that require funding from the operational capital envelope. Much of these pre-commitments arise from nationally funded schemes. Due to timing of available funds, inflation or changes in scope, local capital funding has been required to supplement the capital funds provided.

In addition, the system envelope will be used to invest £9m in a new MRI scanner at King's Mill Hospital. This has left a smaller share of funding to support operational risk areas in 2024/25.

To support longer-term capital planning, the system has developed a long list of strategic priorities that it is looking to drive forward as part of its wider strategy. The Strategic Estates Group have agreed prioritisation criteria alongside the development of our ICS Infrastructure Strategy (Annex B). This strategy will look to ensure best value from existing assets, which may lead to disposals in some areas (notably corporate estate). To ensure plans are in place from 2024/25 the system is developing a 3-year rolling capital programme with prioritised developments from this long list.

NHS

Appendix A

Annex A – Nottingham & Nottinghamshire ICS 2024/25 CAPITAL PLAN

2024/25	CDEL	ICB £'m	NUH £'m	SFH £'m	NHT £'m	Total FY Plan £'m	Narrative on the main categories of expenditure
Provider	Operational Capital		57.5	15.0	16.0	88.5	This includes a separate £2.5m allocation for MNR. This funding is to support business as usual e.g., backlog maintenance and supports a number of other large & national schemes i.e., Digital, Targeted Investment Fund, Mental Health including Dormitories.
ICB	Operational Capital	2.0				2.0	The ICB capital plans relate to GP IT £0.9m, primary care premises developments/improvements £1.0m & ICB IT £0.1m.
	Total Operational Capital	**2.0**	**57.5**	**15.0**	**16.0**	**90.5**	
Provider	Impact of IFRS 16		1.9	2.3	7.0	11.2	These plans relate to equipment and premises leases and car lease schemes.
Provider	Upgrades & New Hospital Programmes		55.6	0	0	55.6	These plans relate to the National Rehabilitation Centre development & TNUH.

Appendix A

NHS

2024/25	CDEL	ICB £'m	NUH £'m	SFH £'m	NHT £'m	Total FY Plan £'m	Narrative on the main categories of expenditure
Provider	National Programmes (diagnostics, Front line digitisation, Mental Health, Targeted Investment Fund)		28.2	9.8	7.6	45.6	Targeted Investment Fund to support Elective Recovery £6m, Electronic Patient Record/Frontline digitisation £11.6m, Urgent Care Capital – Mental Health Crisis Phone - £0.5m, Community Diagnostic Centres, £25.9m
Provider	Other (technical accounting)		0.0	3.8	0.7	4.5	This relates to the technical adjustment relating to residual interest.
	Total system CDEL	**2.0**	**143.2**	**30.9**	**31.3**	**207.4**	

Chappell Room, 09:00-09/05/24

Appendix A

NHS

Annex B – Nottingham & Nottinghamshire ICS Infrastructure Strategy capital prioritisation criteria

Assessment Area	Assessment Criteria	Assessment Detail	Weighting
Integrated Care Strategy principles and aims	Improved outcomes in population health and healthcare	A key aim of the IC strategy is to maximise the opportunities for improving people's health and wellbeing, schemes that have a clear link to the quality of services and population health management should be prioritised.	19%
	Move to prevention or early intervention	A guiding principle of the IC strategy is prevention is better than cure. Investing in prevention and early intervention initiatives could reduce costs over the long-term.	
	Health equity	A key aim of the IC strategy is to tackle inequalities in health outcomes, experiences and access. Investments targeting the most disadvantaged groups would align with this aim.	
	Integration of / collaboration between services	Integration by default is another guiding IC strategy principle. Investments enabling greater integration between organisations across the ICS and collocation of services support this principle. Scheme proposal should include clear evidence of joint planning with ICS partners.	
	Broader social responsibility	The IC strategy commits to using resources to support broader social and economic development, including creating opportunities for young people locally e.g., employment and training opportunities.	
Transforming Services	Enhancing value for money	We have a duty to ensure funding received for health and care is used efficiently. Infrastructure and Estate investments that enhance service value for money, demonstrate cost savings and have a positive return on investment should be prioritised. Quantifiably managing demand against agreed baselines, within existing / reduced resources can also be considered i.e., pressure mitigation.	29%

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Assessment Area	Assessment Criteria	Assessment Detail	Weighting
	Accessibility of services	Scheme: •reduces waiting times or improved access to care •supports principles of right place, right care, right time •reduces travel times for local residents •is on good public transport links and/or supports active travel •is in an area expecting population growth / increasing demand •aligns to Digital Notts Strategy objectives	
	Net zero	We have committed to reducing environmental impact Scheme: • is targeted at net zero carbon • identifies opportunities to improve staff/patient travel sustainability • reduces volumes of residual waste • improves renewable energy performance	
Service Resilience	Operational resilience	Scheme proposal includes evidenced improvement in service resilience e.g., scheme: •manages demand pressures •includes adaptations required due to climate change •enhances power resilience at key sites. •Supports recruitment and retention.	20%
	Improves Productivity	We have a duty to ensure funding received for health and care is used efficiently. Infrastructure and Estate investments that that have a focus on improving productivity and the performance of services should be prioritised.	

Appendix A

NHS

Assessment Area	Assessment Criteria	Assessment Detail	Weighting
	Improving utilisation of estate	Reduces void risk and associated cost. Scheme optimises the use of estates and is evidencing ongoing affordability. Reduces corporate space. Creates opportunities to reduce overall estates running costs.	
Risk Management	Back log maintenance	Scheme reduces organisations backlog maintenance liabilities and addresses critical backlog issues.	18%
	Estate safety and compliance	Scheme addresses space that does not currently meet NHS standards from statutory/mandatory compliance perspective and delivers safer health care premises.	
Deliverability	Financially viable	Scheme capital outlay and ongoing revenue budget requirement is financially viable, ideally with an identified source of funding or self-generating capital receipt and no additional revenue requirements.	14%
	Clear and reasonable delivery route and timetable	Detailed plan with clear key achievable milestones that meet deadline for delivery or scheme, with strong project management capabilities and appropriate Governance. Digital technology requirements available to support. Strong evidence of comprehensive stakeholder engagement and high degree of support, and discussion of issues arising.	

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/05/2024
Paper Title:	**Nottingham and Nottinghamshire Voluntary, Community and Social Enterprise (VCSE) Alliance**
Paper Reference:	ICB 24 010
Report Author:	Prema Nirgude, Head of Insights and Engagement
Report Sponsor:	Amanda Sullivan, Chief Executive
Presenter:	Professor Daniel King, Chair of the Nottingham and Nottinghamshire VCSE Alliance

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

Summary:

In June 2021, the NHS England Integrated Care System Design Framework[1] set the expectation that Integrated Care Board (ICB) governance and decision-making arrangements support close working with the Voluntary, Community and Social Enterprise (VCSE) sector as a strategic partner in shaping, improving and delivering services, and developing and delivering plans to tackle the wider determinants of health.

By April 2022, ICBs were expected to have developed a formal agreement for engaging and embedding the VCSE sector in system-level governance and decision-making arrangements, ideally by working through a VCSE Alliance to reflect the diversity of the sector. These arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level.

Our VCSE sector partners are also key to the effective delivery of the collective system approach to working with people and communities. VCSE organisations engage with communities that the ICB may not hear from, because of their independence from the statutory sector and their strong position within communities providing support, advice and guidance.

The purpose of this paper is to provide an update on the establishment of the Nottingham and Nottinghamshire VCSE Alliance, how the Alliance continues to support the delivery of the Integrated Care Strategy and further opportunities that will strengthen our partnership with the sector.

Recommendation(s):

The ICB Board is asked to:

- **Note** the progress made in establishing and embedding the VCSE Alliance within Nottingham and Nottinghamshire Integrated Care System and also the next steps.
- **Discuss** how the VCSE sector could be further embedded within the health and care system.

[1] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	The work of the VCSE Alliance 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: VCSE Alliance Terms of Reference Appendix 2: Current VCSE Alliance membership Appendix 3: Programmes of work supported by the VCSE Alliance Appendix 4: Delivering the Integrated Care Strategy: Case studies

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.

Nottingham and Nottinghamshire Voluntary, Community and Social Enterprise (VCSE) Alliance

Background and context

1. The Voluntary, Community and Social Enterprise (VCSE) sector is referred to in many ways, for example, Civil Society, the Third Sector, and the Voluntary and Community Sector. The VCSE sector is the current 'catch all' term that includes any organisation that are:
   a) Independent of government and constitutionally self-governing, usually with an unpaid voluntary management committee (at least half).
   b) Value-driven – they exist for the good of the community, to promote social, environmental or cultural objectives in order to benefit society as a whole, or particular groups within it.
   c) Not run for financial gain – they re-invest any surpluses to further the positive impacts and opportunities they create for the community.
2. The type of groups that make up the sector includes charities (registered and unregistered), community groups, community interest companies, friendly societies, social clubs, many sports clubs, churches and other faith groups, and voluntary organisations.

Codesign and establishment of the VCSE Alliance

3. Nottingham and Nottinghamshire VCSE Alliance is made up of:
   a) Local representatives of national and regional VCSE organisations working countywide to provide services to citizens.
   b) A collective of the local Community and Voluntary Services (CVSs) and other infrastructure organisations which operate in Nottingham and Nottinghamshire.
4. This means that the VCSE Alliance draws in both smaller VCSE organisations via their CVS 'umbrella' organisations, as well as the local representatives of larger charities. This two-pronged approach ensures the voice of smaller community organisations isn't lost against those of bigger providers and means they can all have real influence at system level, working towards the consistent aim of improving health and well-being outcomes for residents. It also means that smaller organisations with limited resources are able to be part of the Alliance through their CVS without committing to an unmanageable burden of meetings. This model was co-designed with a small cohort of VCSE organisations prior to the establishment of the Integrated Care System and ICB on 1 July 2022.

5. The VCSE Alliance's role is to act as a central communication point between the NHS and VCSE sector, facilitating a two-way dialogue and channelling insights to support the health and wellbeing of local communities (see the Alliance's Terms of Reference at Appendix 1). Beyond this, the Alliance aspires to amplify the sector's voice, engage with ICS governance, collaborate effectively, and demonstrate the unique value of the VCSE sector.
6. The first formal meeting of the VCSE Alliance took place on 4 October 2022 with members from 15 different VCSE organisations in attendance. To date, there are 102 members from 69 different VCSE organisations (see Appendix 2) who meet virtually every two months.
7. Early in the establishment of the Alliance, members agreed that an Independent Chair should be recruited and remunerated to lead the group. This approach was endorsed by the ICB Executive Team, and a sub-group of Alliance members coproduced the role description and recruitment process. Professor Daniel King was appointed as Chair of the VCSE Alliance in April 2023. The Chair of the Alliance is a formal member of the system's Integrated Care Partnership and is an advisory member to the ICB's 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.
8. 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[2], glossary of terms and introductory videos, to support current and future members. Tailored resources will continue to be produced based on the specific needs of members.

Activities undertaken by the VCSE Alliance

9. The work of the Alliance is broad and agile, as requirements and opportunities emerge. Some selected examples (with further details at Appendix 3) of how the Alliance has contributed over the first 18 months of its work include:
    a) Supporting the development of the Integrated Care Strategy.
    b) Developing an intelligence and insights framework.
    c) Securing funding from NHS England to map and develop a Research Engagement Network across Nottingham and Nottinghamshire

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

Impact of the VCSE Alliance

10. The VCSE Alliance has had several positive benefits and impacts since its inception:

    a) Enabled the voices of communities that may not engage with statutory services to influence the Integrated Care Strategy and NHS Joint Forward Plan.

    b) Raised the profile of the VCSE sector within Nottingham and Nottinghamshire ICS.

    c) Provided a platform for VCSE organisations to spread awareness of their services using the ICB's reach.

    d) Provided a dedicated space for a diverse range of VCSE colleagues with an interest in health, care and the wider determinants of health to meet, collaborate and work better together as a sector.

    e) Provided training to increase knowledge about the ICB, ICS and process for commissioning which has enabled meaningful conversation.

Delivering the Integrated Care Strategy

11. This section sets out the value of the VCSE sector in delivering the Integrated Care Strategy, focussing on the principle of integration (see Appendix 4) and opportunities for achieving this by default. Additionally, it discusses the several practical measures that could support the VCSE sector to continue to be a key delivery partner of the Integrated Care Strategy.

The value of the VCSE sector

12. The VCSE Alliance believe that the sector has long been aligned to the three principles and four aims of the Integrated Care Strategy, and there is now an opportunity to continue to work as part of the wider health and care system in a more developed way. However, for the VCSE sector, the challenge lies in transforming the ambition into a tangible reality, particularly when faced with tight resource constraints.

13. The VCSE sector has long been recognised for its ability to work in a highly integrated and collaborative manner, setting high standards for holistic and person-centred approaches to addressing the needs of citizens. One of the key strengths is the sector's adaptability and responsiveness to (often unprecedented) challenges, which is grounded in understanding and connected with diverse communities and building trust.

14. The VCSE sector's commitment to inclusion and equity in everything is another notable aspect of its integrated approach. By actively involving people,

communities, service users and various stakeholders in decision-making processes, the sector ensures that interventions are not only responsive but also reflective of the diverse perspectives and needs within the community. This inclusive approach enhances the sector's ability to address the social determinants of health and well-being, acknowledging that a comprehensive understanding of the community's context is crucial for effective service delivery.

15. Moreover, the VCSE sector in Nottingham and Nottinghamshire can demonstrate strengths in building networks and establishing connections between different organisations, community groups, and service providers. This interconnectedness can promote information-sharing, resource pooling, and the dissemination of best practice, facilitating a more cohesive and efficient response to supporting people and communities.

Challenges for the VCSE sector

16. Detailed discussions with members of the VCSE Alliance have identified a number of challenges to the full delivery of the sector’s ambitions in supporting the system’s Integrated Care Strategy these include:

    a) Short-term contracts and funding in the VCSE sector introduce uncertainty regarding ongoing/future investment, staffing and the ability to deliver.

    b) The reliance on short-term funding exacerbates the challenges faced by some VCSE organisations in providing the necessary quantitative and qualitative data for robust monitoring of activities and outcomes.

    c) Short-term funding often neglects to cover the core costs of VCSE organisations.

    d) Nottingham City Council has recently proposed a “reduction of contribution to voluntary and charity sector through area-based grants”. This proposal could have a significant impact on the role of the VCSE sector in their support to community development and tackling health inequalities.

    e) The lack of understanding of the commissioning process both within the VCSE sector and the NHS.

Ambitions and opportunities for the VCSE Alliance and wider sector

17. The VCSE sector brings substantial value, impact, and savings to health and care system. Becoming a strategic partner in transformation and commissioning processes is a key aspiration, moving away from being perceived as a transactional provider or only a route to engagement with underserved communities.

18. Enabling communities, including communities of interest, to influence what is commissioned by the ICB is an important goal. This involves creating a partnership that prevents individuals from falling through gaps in provision, enabling every citizen to enjoy their best possible health and wellbeing. By raising the profile of the VCSE Alliance at the ICB's Board and in other system-wide forums and establishing closer ties between VCSE organisations and decision-makers, there is an opportunity to shape the strategic direction of Nottingham and Nottinghamshire ICS.
19. Ongoing engagement between the ICB and the VCSE sector is crucial for a better understanding of the sector's value. The aim is to reach a point where the VCSE is seen as an equal partner and to work together more cohesively.

Next steps for the VCSE Alliance

20. The next steps for development of the Alliance include:
    a) Increasing the number and diversity of members. The Hewitt Review[3] made several references to voluntary, community, faith and social enterprise (VCSFE) organisations. The VCSE Alliance membership currently does not include faith organisations so there is now a focussed effort on expanding the membership of our VCSE Alliance to include faith groups operating within Nottingham and Nottinghamshire.
    b) Partnership working with Assura plc and the National Association for Voluntary and Community Action. Assura will be making an investment of £75,000 into Nottingham and Nottinghamshire ICS to fund the work of grassroots community organisations working directly with communities to support their health and wellbeing.
    c) Continuing to engage with the Third Sector Commissioning Group. Led by Nottinghamshire Healthcare NHS Foundation Trust, this group was established to enable a more constructive relationship between NHS Commissioners and the VCSE sector to coproduce a shared understanding of what good commissioning looks like. The group also aims to transform how the VCSE Alliance builds social value and is productive not only for the Commissioners and the VCSE organisations but also the communities and places the organisations operate in as well. VCSE Alliance members will continue to feed into the group.
    d) Continuing to support the refresh of the Integrated Care Strategy and Joint Forward Plan.
    e) Review of internal processes. The Chair of the VCSE Alliance does not have capacity to attend all meetings where a VCSE representative is requested and is actively working towards establishing internal processes

[3] The Hewitt Review: an independent review of integrated care systems - GOV.UK (www.gov.uk)

to distribute the responsibility more effectively. ICB and ICS colleagues are asked to communicate their requirements as early as possible to support forward planning.

f) Establishing a Nottingham and Nottinghamshire Insight Hub. The Hub will be a key resource for capturing and reporting community intelligence that includes findings drawn from all system partners including statutory sector, VCSE, Healthwatch, citizens' panel and networks at Place and neighbourhood level. It will also draw in data and insights created and published from outside our system, e.g., census data, ONS reports and wider public sector focussed reports and research. All of this will be captured and recorded in a database (to be developed over time) enabling a systematic record of what we know about certain communities or geographies. VCSE Alliance members will be encouraged to share insights and also highlight what data and information held by health services would support them with grant applications, development of services etc.

21. 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 and continues to demonstrate a positive impact on people and communities.

Appendix 1: VCSE Alliance Terms of Reference

1. Context and purpose

In the guidance from NHS England (NHSE) which underpins the development of Integrated Care Systems (ICS) there is a requirement for them to support the development of an Alliance through which voluntary, community, and social enterprise organisations (VCSE) across a geographical area can bring the insights of the sector to support the health and wellbeing of the communities served by the ICS, as a system partner.

All system partners are committed to consistently listening to, and collectively acting on, the experience and aspirations of local people and communities through the Integrated Care Board and Integrated Care Partnership and will work to:

1. Have a deep understanding of all the people and communities it serves.
2. Capture the insights and diverse thinking of people and communities to enable the ICB and ICP to tackle health inequalities and the other challenges faced by health and care systems.
3. Bring fresh opportunities to strengthen work with people and communities, building on existing relationships, networks and activities.

The purpose of the VCSE Alliance is to enable every citizen to enjoy their best possible health and wellbeing by bringing together local representatives of national and regional VCSE organisations working countywide to provide services to citizens and infrastructure organisations. The VCSE Alliance will act as a single point of contact to enable the generation of citizen intelligence from the groups and communities that they work with. This intelligence and insight will be shared across the ICB and ICS to ensure that the experiences and views of citizens are considered in the design and delivery of health and care services, enabling a two-way flow of information. Furthermore, where citizen intelligence has influenced changed, this will be shared back with citizens. If citizen intelligence has not resulted in a change, the rationale for this will be clearly stated to citizens.

The VCSE Alliance will be an essential part of how the system operates at all levels. This will include involving the sector in governance structures and system workforce, population health management and service redesign work, leadership and organisational development plans.

2. Ambition:

- To act as one of primarily mechanisms to represent the voice of citizens, sharing intelligence and insights about the health and care needs and aspirations of local people.
- To amplify the voices of citizens who do not traditionally engage with statutory services.
- To engage and embed the sector within the Integrated Care System governance and decision-making structures.

- To strengthen the voice of the VCSE sector within the ICS, building on partnership working across all layers of the system.
- To optimise the value the sector can bring to the health and wellbeing of their communities through greater collaboration across ICS partners.
- To evaluate and measure our impact as a sector and deliver the best outcomes for patients.

3. Vision and Values

- Open and inclusive. All VCSE organisations within the Nottingham and Nottinghamshire ICS can be part of the Alliance and have their voice heard in it.
- Independent – the Alliance will demonstrate its independence of the statutory sector.
- Be as local as possible - recognise the importance of the four Places within the ICS
- Equality and fairness - Welcome and work to hear the voices of our diverse and ethnic communities.

4. Objectives

- Act as the main point of contact, facilitate two-way flow of communication between the NHS and VCSE sector, encourage collaboration, co-design and transformation.
- Join up intelligence – giving VCSE organisations better access to data and 'market intelligence' and vice versa.
- Provide a central point for reporting and feedback against national developments and regional priorities using intelligence from local communities and residents.
- Act as the main point of contact for leadership of the sector to liaise with commissioners and other stakeholders encouraging dialogue, co-design and collaboration.
- Join up intelligence – giving VCSE organisations better access to data and 'market intelligence' and vice versa.
- Enable small voluntary organisations to act equal partners within the VCSE Alliance.
- Build capacity within the sector through joint applications for investment.
- Use shared data to identify emerging trends from across the wider VCSE sector that the VCSE Alliance represents and influence key decision makers across the ICS or place for the benefit of the sector.

5. Benefits/Outcomes/Impact

- Raise the profile, increase understanding, and promote the value of working collaboratively with the VCSE sector on the health and wellbeing of communities, on NHS services, health inequalities, prevention, population health management, social prescribing etc.

- Identify new opportunities and to align opportunities through grant funding and social investment with statutory partners.
- Explore opportunities to demonstrate impact, value, benefits that the VCSE sector can bring, collaboratively across the wider VCSE sector using the available evidence, data and intelligence to best use to support the overall sector development and to achieve the vision.
- Support infrastructure through peer advice, support and development.
- Identify, promote and share peer learning, training and capacity building to; ensure all members workforce are in a strong position to meet future demands, improve the quality and sustainability of services for people living in specified location.

6. Membership

Membership of the VCSE Alliance will be inclusive of NHS, Healthwatch, local representatives of national and regional VCSE organisations working countywide to provide services to citizens and infrastructure organisations. All VCSE organisations within the Nottingham and Nottinghamshire ICS can be part of the Alliance.

Other members may also be co-opted for a specific purpose for a limited period of time.

VCSE Alliance members may review membership at any time in order to add value for the benefit of the sector and the VCSE Alliance as a whole. This process will be fair and transparent and agreed by the VCSE Alliance members.

7. Chairing arrangements

An Independent Chair will be recruited.

Should the Chair be unable to attend a meeting the membership will agree a substitute chairperson from the attendees for that meeting only.

8. Quorum and voting arrangements.

As the VCSE is not a decision-making body, quoracy does not impact on its business. The Chair will determine if a meeting should be convened in the event of a high number of apologies.

9. Frequency of meetings

The VCSE Alliance will meet once every two months and meetings will take place virtually and/or at accessible venues across Nottingham and Nottinghamshire.

To support access, virtual working through email links and telephone conference calls will be used where appropriate. Extraordinary meetings will be arranged as required.

10. Requirements of the VCSE Alliance and its membership

VCSE Alliance members will be expected to:

a) Be well informed about the health issues affecting service users/the local population.
b) Undertake preparation for meetings.
c) Share learning experiences and feedback from VCSE Alliance meetings to the organisations/sector they represent.
d) Be a role model and ambassador with a positive, collegiate approach.
e) Bring challenge to the ICS in the role of ‘critical friend’.
f) Contribute to a work plan to ensure that the VCSE Alliance has clear aims and objectives to support the work of the ICS and its priorities.

If any member is not in a position to attend a meeting, then an appropriate deputy should be sent.

11. Conduct of business

An agenda and supporting papers will be distributed at least 5 days before meetings. The agenda will be agreed with the Chair prior to the meeting.

Administrative support will be provided by the ICB Engagement Team.

Meetings held virtually will be recorded for the purposes of assisting with production of accurate minutes of the meeting and will be deleted upon completion of the minutes.

12. Code of Conduct for Members

‘Know how’ and Intellectual Property

Members of the VCSE Alliance will respect the ‘know how ‘and intellectual property rights of its members, partners and third parties. VCSE Alliance members will not use any shared information or data for commercial advantage or to the financial or commercial detriment of the original supplier of the information.

Fair Dealing

Members of the VCSE Alliance will not take unfair advantage of or injure anyone through manipulation, concealment, abuse of privileged or confidential information, misrepresentation of material facts, fraudulent behaviour or any other unfair dealing practice.

Integrity

Members of the VCSE Alliance will act with highest degree of integrity, honesty, diligence, responsibility and in accordance with applicable laws.

Confidentiality

Members of the VCSE Alliance will adhere to the confidentiality requirements of the ICS. Any information shared in confidence, or any information believed to be of a confidential nature should not be disclosed. It is the responsibility of the author or speaker to be explicit around the status of information shared.

13. Declarations of Interest

At the beginning of each meeting, VCSE Alliance members will be required to declare any personal interest if it relates specifically to a particular issue under consideration. Any such declaration shall be formally recorded in the minutes for the meeting in accordance with the provisions set out in the ICS's policy.

14. Reporting Responsibilities

The VCSE Alliance will have a direct link into the ICS Citizen Intelligence Advisory Group and its work will support the delivery of citizen insights to the Integrated Care Partnership and the Integrated Care Board. The Chair of the VCSE Alliance will attend both forums to represent citizens and the sector.

15. Review of Terms of Reference

The Terms of Reference will be reviewed at least annually.

Appendix 2: Current VCSE Alliance membership

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

Organisation	Organisation category
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

Appendix 3: Programmes of work supported by the VCSE Alliance

Supporting the development of the Integrated Care Strategy

The VCSE sector is one of the partnerships crucial for supporting the delivery of the strategic objectives of Nottingham and Nottinghamshire Integrated Care System.

The VCSE Alliance played a pivotal role in shaping and enhancing the Nottingham and Nottinghamshire Integrated Care Strategy and NHS Joint Forward Plan development through their active engagement and valuable feedback to ICB Strategy Leads at five meetings for the Strategy and three for the Joint Forward Plan. Their participation brought a diverse range of perspectives from the VCSE sector, enriching the dialogue and ensuring a comprehensive approach to strategic system planning. The VCSE Alliance's contributions significantly strengthened the framework of the Strategy, aligning it more closely with the needs and aspirations of the communities in Nottingham and Nottinghamshire. The importance of the Alliance is referenced in the Strategy:

“The voluntary, community and social enterprise (VCSE) Alliance will be an essential part of how the system operates at all levels. This will include involving the sector in how we govern and run the system, how we use data and insights to better understand our population, and how we intend to re-design services.”

Developing an intelligence and insights framework

The VCSE Alliance has led on a co-designed framework for gathering citizen intelligence and insight. The framework will help us understand and theme the information that VCSE organisations hold, allowing us to explore the trends in our population and help highlight the gaps in service and how to resolve them. A Framework Subgroup came together to focus on a clinical priority and understand the intelligence held by VCSE Alliance members. Frailty and Proactive Care were chosen as the first focus.

Using the data described in the Population Health Management Deep Dive Report into Ageing Well[4], the Subgroup developed ten questions to explore with VCSE Alliance members. Some of the key themes and recommendations included:

- Increasing support for older people involves applying multi-agency working, providing referrals to social prescribers, promoting support groups and improving access to financial advice and mental health support.
- Addressing transportation issues in rural areas is crucial, including support for community transport schemes and improving access to emergency medical services.
- Increasing awareness and access to services through information campaigns and community outreach.

[4] Nottingham & Nottinghamshire ICS - System Analytics Intelligence Portal - PHM Ageing Well Deep Dive- April 2021.pdf (sharepoint.com)

- Implementing strategies to prevent falls and injuries among the elderly including promoting mobility programmes and facilitating multi-agency referrals.
- Utilising technology can greatly improve access to healthcare and social care, requiring support and education for digital literacy is key.
- Adapting local healthcare systems, supporting carers, addressing social isolation, and innovative dementia care are all flagged.

Whilst this work has been initiated and led by the VCSE Alliance, to support the triangulation of intelligence the ICB Engagement Team reached out to others within our ICS with an interest in Frailty and Proactive Care to gain their insight and strengthen the recommendations. This included the ICB Population Health Management Team, the ICS Ageing Well Team, East Midlands Academic Health Science Network (now known as Health Innovation East Midlands), and the ICB Research and Evidence Team.

This work has informed the Mid-Nottinghamshire Place Plan, and future work will be undertaken with the Community Transformation Team on upcoming frailty projects. The report was also shared with the Nottingham and Nottinghamshire Integrated Care Partnership in October 2023, as part of a wider Citizen Insight report[5].

Research Engagement Network Funding

In October 2023, Nottingham and Nottinghamshire Integrated Care System was awarded just under £100k to help us increase diversity in research participation through community engagement.

The NHSE funding will help us to:

- Map existing research engagement initiatives to provide a clear overview of current activities.
- Develop a community researcher capacity building programme, building on existing community champions programmes and networks.
- Establish a Knowledge Exchange Hub that outlines key principles to guide future community engagement for research.

The ultimate objective is to support the development of improved infrastructure to enable research engagement and mutual understanding to empower more equitable and balanced research experiences. Job descriptions and person specifications for the project roles have been developed and shared with the VCSE Alliance, and the project team comprises Alliance member organisations. The development of a successful bid and the formation of a programme team comprised of four VCSE colleagues and two NHS colleagues shows strong potential for joint working on other similar opportunities.

[5] Integrated Care Partnership Insight Report - NHS Nottingham and Nottinghamshire ICS - NHS Nottingham and Nottinghamshire ICS (healthandcarenotts.co.uk)

Appendix 4: Delivering the Integrated Care Strategy: Case studies

Case study:
Supporting families with the cost of living

In November 2022 a leaflet was created to support families with cost of living. The partners involved in its development included Bassetlaw Community and Voluntary Service, Bassetlaw District Council, Citizens Advice, Bassetlaw Warm Spaces and Bassetlaw Place-Based Partnership.

Signposting, useful links and advice were all included in the leaflet, which was delivered to every single address in Bassetlaw (51,458 households) and shared on mailing lists and Facebook pages.

"The distribution of the leaflet both online and via the post has ensured that the information on support available was accessible to the population of Bassetlaw.

This has been a result of the collaborative efforts of local partners working together. By working together, we have strengthened partnerships and reduced the negative impact of the cost of living on the health of local people."

If you are struggling with the cost of living this winter, there are people and organisations in Bassetlaw that can help. Here are some important contact details.

There is lots of support available...
...to help with money worries, energy bills and advice about financial support and benefits checks.

Bassetlaw Community and Voluntary Service
01909 476 118 | www.bcvs.org.uk/costofliving
Citizens Advice Bassetlaw
01909 498 888 | www.bassetlawca.org.uk
Bassetlaw District Council
01909 533 533 | www.bassetlaw.gov.uk/costofliving
Bassetlaw Action Centre
01777 709650 | www.bassetlawactioncentre.org.uk

If you need support with your mental health...
Support is available 24 hours a day, seven days a week.
Mental health crisis number: 0808 196 3779
For more places of support: www.healthandcarenotts.co.uk /bassetlawhealth

Warm Spaces
Warm Spaces are warm, safe places in Bassetlaw where residents can expect a friendly and inclusive welcome.
01909 476 118 | www.bcvs.org.uk/warmspaces
01909 533 533 | www.bassetlaw.gov.uk/costofliving

Bassetlaw Food Bank
Before you can be given a food parcel, we need to understand your circumstances and the number of people in your household. Contact Bassetlaw District Council to ask about this.
01909 533 533 | bassetlawfoodbank.org/
Bassetlaw Foodbank also run a mobile community shop where you can buy fresh food and essentials at affordable prices. View locations at: bassetlawfoodbank.org/communityshop

Food Hubs in Bassetlaw
A collection of Food Hubs allows anyone to fill a bag with food for £3. You don't have to be referred for this service.
01909 476 118 | www.bcvs.org.uk/foodhubs

Case Study: BAME wig project

Feedback from patients at Nottingham University Hospitals NHS Trust showed that that no black hairdressers were on the list of eligible suppliers of wigs for patients suffering from alopecia due to cancer treatment.

The Black Asian Minority Ethnic Shared Governance Council worked closely with Sistas Against Cancer, a Nottingham based community support group that offers peer support to anyone affected by cancer or anyone supporting someone with cancer. They approached Nottingham Hospitals Charity for funding to purchase appropriate wigs and scarves for trial.

The project initially started off for BAME patients experiencing hair loss following chemotherapy, however the service now carters for all patients experiencing hair loss regardless of ethnicity. As of September 2023, 70 patients have accessed the trichologist services (providing scalp care).

Case study: Changing Futures

The Changing Futures programme stands as a great example of how a partnership made up of interconnected services and groups boost the strength of the entire system they sit within.

Ran by the Nottingham City Place-Based Partnership, Changing Futures brings together partners from health, local government, and the voluntary sector to provide a co-ordinated response to the needs of people who experience Severe and Multiple Disadvantage (SMD).

The combination of challenges facing people experiencing SMD, creates great difficulties in providing care that is effective. Public services working with people facing SMD often struggle to meet their needs as they are predominantly set up to deal with single issues.

This is why operating in an integrated way across multiple sectors is vital for this work. Putting in effort and resources to help one aspect of a person’s life can be undermined by shortcomings in other areas.

After steady growth, carrying on from the achievements of Opportunity Nottingham, Changing Futures has recently seen a leap forward in its development, with multidisciplinary teams across the health, social care, voluntary, and criminal justice sectors being able to grow.

Through work done by Changing Futures, specialist SMD workers are now deployed into statutory services to provide clear and helpful guidance for working with people experiencing SMD. This has created a knowledge base in wider services and is directly improving some of the most vulnerable lives in Nottingham.

The acceleration of progress made by Changing Futures is partly linked to having the programme manager being employed within Nottinghamshire Healthcare Trust which has helped cement the bridge between the Trust and the programme.

The co-location and embedding of NHS staff into VCSE sectors help decision making become more impactful through understanding the needs of programs and services. This in turn provides insights into “boots on the ground” who are helping to tackle issues facing communities.

Strong and impactful insights right from the source within communities deeply aligns with the mission of the VCSE Alliance at large. In turn then, the success of the Changing Futures programme highlights the power of working at system level instead of as individual partners.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/05/2024
Paper Title:	**Nottingham and Nottinghamshire Response: NHS England Statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)**
Paper Reference:	ICB 24 011
Report Author:	Bryony Smith, Health Inequalities Project Manager Hazel Buchanan, Associate Director Health Inequalities and Clinical Strategic Programmes
Executive Lead:	Dave Briggs, Medical Director
Presenter:	Dave Briggs, Medical Director

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

Summary:
On 27 November 2023, NHS England published a Statement setting out a description of the powers available to NHS bodies to collect, analyse and publish information and how these powers should be exercised in connection with health inequalities. In defining the requirements for the Statement, NHS England has provided a list of metrics that ICBs and NHS trusts must report on. The Nottingham and Nottinghamshire Statement supports a number of duties, or powers, of the ICB that should enable and inform collection, analysis and publication of information on inequalities. The Statement is part of the annual reporting processes and will be referenced within and sit alongside the ICB's Annual Report.

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

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	Good quality, robust data enables the NHS to understand more about the populations we serve. It enables NHS bodies to identify groups that are at risk of poor access to healthcare, poor experiences of healthcare services, or outcomes from it, and deliver targeted action to reduce healthcare inequalities. The Statement and duty to report information on health inequalities will encourage better quality data, completeness and increased transparency.
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: Nottingham and Nottinghamshire Response: NHS England Statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)

Board Assurance Framework:

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

- Risk 1: Transformation (Making Tomorrow Better for Everyone) – Effective system working may not transform (reform) and improve services to address health inequalities and ensure best possible future health outcomes within available resources.
- Risk 2: System Resilience (for Managing Today) – Working effectively across the system may fail to address the current levels of demand across primary, community and secondary care.

Report Previously Received By:

This Statement has been discussed by the Finance and Performance Committee in April 2024.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Nottingham and Nottinghamshire Response: NHS England Statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)

Introduction

1. On 27 November 2023 NHS England published a statement setting out a description of the powers available to NHS bodies to collect, analyse and publish information and how these powers should be exercised in connection with health inequalities. The Nottingham and Nottinghamshire Statement (Appendix 1) is intended to align with annual reporting processes and will sit alongside the ICB's Annual Report.
2. The Nottingham and Nottinghamshire Statement therefore supports a number of duties or powers of the ICB that should enable and inform collection, analysis and publication of information on inequalities. Trusts and foundation trusts are also required to produce a Statement and the work of the System Analytics and Intelligence Unit supports them in this regard and allows for alignment across the NHS system.
3. The first Statement focuses on a specific number of data indicators that align with NHS England's five priority areas for health inequalities, outlined in the planning guidance, and Core20PLUS5 approach[1], which is a national NHS England approach to inform action to reduce healthcare inequalities for adults and children and young people, at both national and system level. The approach defines a target population – the most deprived 20% of the national population – and identifies five focus clinical areas requiring accelerated improvement. The metrics are also intended to help understand and improve health access, experience and outcomes.
4. The Statement metrics provide a framework for ICB reporting on health inequalities and have been supplemented with locally defined indicators. This has been achieved through the expertise of the Strategic Analytics and Intelligence Unit and incorporated into a health inequalities dashboard that will continue to evolve as we enhance our reporting across access, experience and outcomes.

ICB duties and powers

5. The Nottingham and Nottinghamshire Statement supports the following duties or powers of the ICB, which enable and inform collection, analysis and publication of information on inequalities.

[1]More information can be found here: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/.

a) The core general duty to arrange healthcare services to meet reasonable requirements for the people for whom it is responsible (section 3 of the NHS Act 2006) and the associated commissioning power (section 3A of the NHS Act 2006). It is the view of NHS England that the arrangement of healthcare services includes understanding the needs of the population that the ICB is responsible for, any barriers to access and the effectiveness of services. In commissioning services, ICBs must act consistently with the NHS Mandate (sections 3(4) and 3A(4) of the NHS Act 2006). The NHS Mandate for 2023 refers to addressing "health disparities", which are analogous to "health inequalities" referenced in the NHS Act 2006 and this Statement.

b) The power to do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of any of its functions (section 2 of the NHS Act 2006) – this duty, in conjunction with the core commissioning duty described above and the functions listed below, is likely to provide the key statutory foundation for processing information.

c) The duty to exercise functions (among other things) efficiently and effectively (section 14Z23).

d) The duty (jointly with NHS trusts and NHS foundation trusts) to produce a forward plan annually (section 14Z52), including in particular addressing the needs of children and young people and those who are the victims of abuse.

e) The responsibility (jointly with upper tier local authorities) to produce joint strategic needs assessments, and health and wellbeing strategies, and to have regard to them, under section 116 and section 116A of the Local Government and Public Involvement in Health Act 2007.

f) The duty, as a member of an integrated care partnership, to produce, publish and keep under review an integrated care strategy, under section 116ZA of the Local Government and Public Involvement in Health Act 2007.

g) The duty of an ICB to have regard to reducing inequalities in the exercise of functions (in section 14Z35 of the NHS Act 2006), including by reference to access and outcomes.

h) Public involvement duties and promotion of patient involvement (sections 14Z36 and 14Z45 respectively).

i) The duty, in the exercise of its functions, to facilitate or promote research into matters relevant to the health service, and the use in the health service of evidence obtained from research (section 14Z40).

j) Duties to have regard to the wider effects of decisions, including in inequalities issues (section 14Z43 of the NHS Act 2006).

k) General duties under the public sector equality duty in section 149 of the Equality Act 2010, and the specific duties to create and report equalities information further to the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

Health inequalities indicators

6. The Statement includes an overview of the Nottingham and Nottinghamshire demographic profile that has been built from the Joint Strategic Needs Assessment (JSNA) JSNA Dashboard[2]. The demographic information within the JSNA is extensive and supports with a population health management approach and based on an understanding of local needs and disparities.
7. The health inequalities indicators identified by NHS England support the ICB's understanding and drive to improve access, experience and outcomes specific to health inequalities. NHS England has also outlined the alignment of the metrics in informing the NHS England five priority areas for addressing health inequalities (restoring NHS services inclusively, mitigating against digital exclusion, ensuring datasets are complete and timely, accelerating preventative programmes, strengthening leadership and accountability) and the Core20PLUS5 approach.
8. The indicators and supporting information demonstrate Nottingham and Nottinghamshire's robust capabilities to collect and analyse data, identify health disparities, which are analogous to health inequalities, and to take action.

Conclusion

9. The Nottingham and Nottinghamshire Statement is a comprehensive document demonstrating our adherence to duties to collect, analyse and publish information in connection with health inequalities. In producing the Statement, the ICB has developed a robust health inequalities dashboard that supports ongoing monitoring across the NHS England five priority areas for health inequalities and the Core20PLUS5 approach. The dashboard will continue to evolve as we further develop our understanding of access, experience and outcomes in the context of health inequalities.
10. The Statement will be a publicly available document published alongside the ICB's Annual Report.

[2] https://app.powerbi.com/view?r=eyJrIjoiNDgzZTMyZmEtMzYyZS00NTY4LWFjMGMtZDg4NmQ2MjFmZDIzIiwidCI6ImQ2M2ZjZDg2LTlkYTctNGI4OS04OTA3LWU3NjE3MjY2YmNhZiJ9.

Nottingham and Nottinghamshire Response: NHS England Statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)

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Introduction

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Deprivation and ethnicity are two key drivers of inequality and often affect a person's ability to access healthcare, their outcomes when receiving a diagnosis or treatment for a condition and their experiences of settings when receiving care.

Evidence shows these elements are more likely to be negative when compared to people accessing care living in the least deprived areas. There are also other population groups who may have additional complexities which also increase their risk of health inequalities such as learning disabilities or those with severe and multiple disadvantage.

To drive forward the NHS focus on health inequalities, NHS England published a Statement on Information on Health Inequalities in November 2023. The Statement set out a description of the powers available to relevant NHS bodies to collect, analyse and publish information. NHS England has a statutory duty to conduct an annual assessment of Integrated Care Boards (ICBs) including the extent to which they have fulfilled their statutory obligations regarding health inequalities, adhering to this Statement supports this annual statement.

Nottingham and Nottinghamshire Integrated Care Board (ICB) and Integrated Care System (ICS) recognise that good quality, robust data enables the NHS and wider system partners to understand more about the populations we service. The ICB and ICS are supported by a Strategic Analytics Intelligence Unit that has the skills and expertise to allow for effective reporting and analysis to identify groups that are at risk of poor access to healthcare, have poor experiences or outcomes from care and as a result take targeted action to reduce health inequalities.

NHSE have provided a list of key metrics for monitoring that are the focus of the Statement. The metrics align with the national five strategic health inequality priorities alongside the clinical areas in the Core20+5. Actions are supported by the Nottingham and Nottinghamshire Joint Forward Plan.

Ongoing the data and information provided in this Statement will be used by the ICS to shape and monitor improvement activity to further reduce healthcare inequalities, fulfilling the Statement's aim to help drive improvement in the provision of good quality services.

Nottingham and Nottinghamshire Population Profile

Nottingham and Nottinghamshire Integrated Care System (ICS) is a partnership between organisations across the NHS and Social Care. The ICS supports health and wellbeing, active communities and ensures high quality joined up care, when needed, for local people. The ICS is home to 1,170,475 people across the City and the County, 20% of which are children and young people (Census Data 2021).

18% of the population are aged 65 and over. The majority of this age group live in the county areas. Over the last 18 years there has been an increase in total population numbers across the ICS. However there has been a larger increase in older age groups and a decrease in the number of births.

80% of the Nottingham and Nottinghamshire population are from a White British ethnicity. People from an Asian heritage are the second largest ethnicity group in Nottingham and Nottinghamshire, making up around 6% of the overall population. 6% of the ICS population are from a White Other group, 4% are from Black African/Caribbean heritage, 3% are from a mixed heritage and 1% are from other ethnic groups.

The ethnic makeup of each district varies across the system and Nottingham City is privileged to be rich in its ethnic diversity, with around 46% of the City population being from ethnic groups other than White British. 15% of the City population are from an Asian heritage, 10% are from Black African/Caribbean heritage, 8% are from White other groups, 6% are from a mixed heritage and 3% are from other ethnic groups.

Despite the many positives of living in Nottingham and Nottinghamshire, there are also challenges which may unfairly affect certain population groups within society, leading to poorer health outcomes often described as health inequalities. Deprivation and ethnicity are two of the main drivers of these inequalities.

Nottingham City, Mansfield and Ashfield fall into the 20% most deprived districts in England. 55% of Nottingham City and 15% of the county population live in the 20% most deprived areas in England. People from ethnic minority groups are also overrepresented in areas of higher deprivation. Ethnicity can also increase the risk of developing certain conditions too such as Type 2 Diabetes and high blood pressure. We know deprivation can contribute to the risk of poorer outcomes however, additional barriers and risks may face some minority ethnic groups which can worsen inequalities.

People in the most deprived areas of Nottingham and Nottinghamshire are more likely to develop long term conditions at a younger age and live in poor health for longer. The life expectancy difference is around 8 years less for those in the most deprived areas of the ICS compared the least deprived areas. The average life expectancy of the ICS is also lower than the England average by up to 3 years for males and 2 years for females, life expectancy is consistently worse across the ICS

for males. Nottingham City ranks in the lowest 25% of districts in England for life expectancy for both men and women.

The disparities between men and women continue when looking at years spent in good health, also known as healthy life expectancy. Although women may live longer, they are living in poorer health for longer and at a younger age than men across the ICS. On average, women in Nottingham City will spend 70% of their life in good health compared to 75% for men, both figures are lower than the England averages of 77% for women and 80% for men. Rates in the county are similar to the England averages but still reflect the disparities between men and women.

Poor healthy life expectancy not only decreases quality of life but also has wider reaching economic consequences for the local system. If people become ill at a younger age it can increase the risk of economic inactivity, creating losses for the local economy in addition to increased costs incurred by the NHS.

Data for this section has been taken from the Nottingham and Nottinghamshire Joint Strategic Needs Assessment Dashboard which can be accessed here: JSNA Dashboard

Condition Prevalence Across the ICS

Table 1 provides an overview of the stark differences between Primary Care Networks (PCNs) across the system and provides context to our interpretation of the data. The PCNs are listed in order of deprivation, PCNs with the highest levels of deprivation to the lowest. The table shows that where deprivation is high, long term condition prevalence and risk factors are higher. We also can see that emergency hospital admissions and avoidable deaths are higher and median age of death is lower. The colour red indicates higher prevalence or worse outcomes.

Table 1

Period

202403

The stark differences between our PCN / neighbourhoods

		Deprivation	Risk Factors: age-adjusted prevalence per 1,000 people			Long Term Conditions: age-adjusted prevalence per 1,000 people								Age-adjusted rates per 100,000 people		Life expectancy in Years	
PCN Neighbourhood	No of patients	IMD Quintile	Obesity	Current Smoker	Hyper-tension	Diabetes Type 2	COPD	Heart Failure	Stroke	CHD	Cancers	Serious Mental Illness	Severe Frailty	Emergency Admissions (1+ bed days length of stay)	Avoidable deaths	Life expec. at birth (M)	Life expec. at birth (F)
Clifton & Meadows	34,703	1	230.3	183.6	185.9	76.1	33.0	14.8	18.5	38.3	40.9	9.0	6.8	8,190	326.5	78.5	80.1
Radford & Mary Potter	46,123	1	187.7	182.6	184.9	106.7	23.8	12.0	16.4	43.3	35.7	15.1	16.9	8,391	373.9	76.6	83.0
Bulwell & Top Valley	46,657	1	240.7	196.9	180.7	71.0	34.1	14.6	17.1	36.4	45.0	9.7	6.9	8,453	331.5	78.6	80.9
BACHS	62,523	1	227.6	180.2	187.1	81.8	33.0	17.9	17.0	38.8	41.0	10.1	13.3	7,991	331.1	78.5	80.9
Nottingham City East	67,001	1	188.4	183.9	162.5	73.7	29.3	14.2	16.7	35.1	40.6	13.5	12.3	7,889	385.9	75.5	81.7
Newgate Medical Group	30,091	2	235.0	174.3	146.6	66.0	30.3	12.8	12.4	29.6	41.8	5.8	11.0	6,109	296.5	78.6	83.7
Ashfield South	40,684	2	255.9	155.6	153.7	65.9	25.8	10.9	14.6	34.4	44.4	6.8	7.0	7,258	308.3	77.4	80.4
Ashfield North	51,441	2	260.2	162.5	168.9	68.3	25.8	16.6	14.6	36.7	48.5	7.3	9.1	7,760	320.2	77.1	82.2
Rosewood	51,595	2	220.8	176.8	152.6	64.7	27.4	11.9	13.8	37.0	42.7	7.4	9.3	7,556	289.8	79.1	82.8
Bestwood & Sherwood	55,189	2	199.9	154.7	154.2	64.3	21.4	12.9	15.9	33.5	42.6	9.8	7.7	7,361	295.3	78.1	82.9
Mansfield North	59,386	2	241.3	151.7	171.2	66.5	26.2	10.5	13.4	36.2	44.3	5.9	10.5	7,291	299.3	79.3	82.0
Larwood & Bawtry	37,762	3	231.9	134.7	164.8	67.0	31.0	19.5	15.1	33.7	45.9	6.9	13.8	6,507	245.6	79.2	82.9
Byron	38,993	3	230.4	139.6	156.8	61.3	23.6	11.6	14.8	33.0	47.6	5.1	17.3	7,659	284.5	77.9	80.5
City South	39,013	3	170.1	109.1	152.4	56.9	16.9	8.8	12.8	34.1	43.0	6.5	6.9	6,841	211.6	82.2	84.0
Retford And Villages	58,166	3	232.9	132.8	149.7	57.0	23.4	11.0	12.0	28.6	44.2	5.3	10.0	5,402	227.4	79.8	84.4
Sherwood	63,570	3	235.8	140.6	167.1	62.7	23.8	12.5	13.9	36.4	46.0	5.9	9.6	6,958	229.4	79.7	81.5
Stapleford	22,320	4	225.5	135.3	164.2	58.1	21.5	12.6	12.0	29.9	44.7	5.8	4.4	6,709	219.8	81.0	86.1
Synergy Health	36,068	4	214.8	145.2	152.2	53.5	18.6	11.1	15.5	30.7	47.6	7.9	14.4	6,701	263.2	80.5	83.1
Eastwood/Kimberley	37,859	4	225.0	120.7	153.8	56.4	20.2	15.1	14.5	32.3	47.8	5.5	7.6	6,985	232.5	80.4	85.4
Arrow Health	39,660	4	185.1	115.6	146.0	46.4	15.2	10.0	12.7	28.2	46.6	6.5	5.7	6,357	204.3	81.6	85.0
Newark	79,263	4	195.2	136.5	147.4	50.2	15.8	11.2	12.4	29.7	49.2	5.2	7.8	5,663	236.7	80.5	84.3
Arnold & Calverton	34,110	5	203.0	120.7	145.5	49.2	17.3	9.2	15.2	29.9	47.0	6.7	9.3	6,387	204.4	79.6	84.2
Rushcliffe North	42,464	5	181.2	96.2	137.7	39.6	14.7	9.0	12.2	27.5	47.2	3.8	5.5	6,010	159.2	81.3	84.2
Rushcliffe South	43,567	5	174.8	86.2	137.4	39.4	11.0	9.5	12.1	25.6	46.8	3.7	4.2	5,301	165.9	83.7	84.8
Beeston	49,691	5	177.3	106.6	149.1	51.4	16.6	12.3	13.6	28.6	47.6	7.2	11.1	6,160	221.9	79.9	82.8
Rushcliffe Central	52,890	5	136.2	66.7	134.6	41.4	10.7	9.9	12.0	27.0	47.6	5.4	5.3	5,090	182.6	79.6	86.3
Unity (Nottm)	46,871	3	111.0	64.6	142.9	41.4	13.4	10.0	7.9	20.4	38.7	3.6		3,422	118.8		86.1

Bassetlaw Place
Nottingham City Place
South Nottinghamshire Place
Mid Nottinghamshire Place

Unity's population is almost entirely university students and is presented separately due to its atypical population demographics.

IMD value is the **index of multiple deprivation** (calculated based on weighted average of registered patients' Lower Super Output Areas declines as per GP Repository for Clinical Care).

COPD = Chronic obstructive pulmonary disease
CHD = Congestive heart disease

Most deprived PCN neighbourhood
Least deprived PCN neighbourhood

Chappell Room, 09:00-09/05/24

Impacting on Health Inequalities

Health inequalities are differences in the status of people's health, but the term can also be used to refer to differences in the care that people receive and the opportunities they have to lead healthy lives. Both can contribute to health status and can be impacted by wider societal influences and barriers[1].

When assessing differences in health care, we need look at three areas; access, experience and outcomes and reducing barriers and disparities that can contribute to, or reduce health inequalities.

- Access to healthcare: Access to healthcare refers to the availability of services that are timely, appropriate, easy to get to and use, and sensitive to user choice and need. Barriers such as location of services, affordability of transport, work commitments, caring responsibilities, health literacy or language barriers, may affect ability to access healthcare. Some factors may be more likely to negatively impact those in the most deprived areas and people from minority ethnic groups. Access to services can be measured by monitoring uptake of services and referrals.

- Experience of using healthcare services: Previous experiences when accessing healthcare or interacting with medical professionals can affect engagement with treatments and future use of services. Poor experience when using just one element of the healthcare system may prevent a person seeking help at the right place and right time in the future. Different social groups may have systematically different experiences within the services that they use, including in terms of the quality of care they receive and whether they are treated with dignity and respect. Monitoring patient feedback and listening to those with lived experience are key in helping healthcare systems drive forward positive, patient-centred change which in turn will help reduce health inequalities. Embedding personalised care approaches is a key ambition of the ICS, enabling people to become more involved with their care and decision making.

- Patient Outcomes: Worse health outcomes occur when people have limited access to health care, experience poorer-quality care and practise more risky health-related behaviours. People from the most deprived areas are more likely to have the poorest outcomes, with a life expectancy up to 8 years lower than those in the least deprived areas. People from minority ethnic groups may also experience poorer outcomes when accessing services. Enabling preventative healthcare, equitable access to health services and coproducing services with people with lived experienced are some ways in which overall outcomes could be improved.

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[1] What are health inequalities? 2022 What Are Health Inequalities? | The King's Fund (kingsfund.org.uk)

Utilising data from the indicators included in this Statement can help the system to identify disparities in access to services and patient's outcomes, highlighting where change is needed. Equitable approaches focussed on improving outcomes will allow a focus on those population groups where need and risk is higher, ensuring resources are distributed in the most effective way. Examples of how we are driving improvement in health inequalities across access, experience and outcomes have been included where possible within this Statement.

How do we Measure Deprivation?

We measure deprivation by using Index of Multiple deprivation quintiles. The index of multiple deprivation (IMD) quantifies deprivation of an area by using multiple indicators across seven domains, including income, crime rates, employment levels, educational attainment and living environment to establish an overall deprivation score across all the districts in England. The overall scores are then ranked and then divided into 5 quintiles. Quintile 1 includes the 20% most deprived areas nationally, whereas quintile 5 includes the 20% least deprived areas in England. We have used this breakdown of quintiles when assessing data by deprivation to understand if there are differences in outcomes between the most and least deprived areas.

Elective Care

A. The Data

Elective care covers a broad range of non-urgent services usually delivered in a hospital setting such as, diagnostic tests and scans, outpatient care, surgery and cancer treatment. The COVID-19 pandemic has had a significant impact on the delivery of elective care, meaning that more patients are now waiting longer for treatment than they were before the pandemic began. Elective restoration is one of the five strategic NHS Health Inequality Priorities.

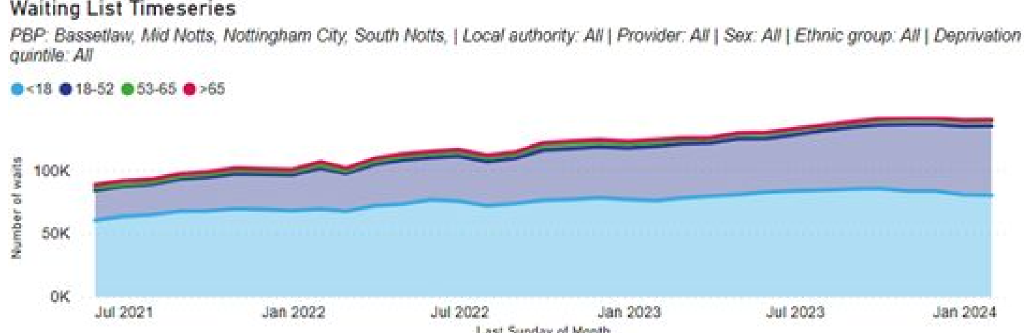
The impact of waiting longer for treatment on individuals, their families and carers is wide ranging and can increase the risk of poorer outcomes following intervention.

1. Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks – by deprivation and ethnicity.

In January 2024 there were 139,704 treatments on the waiting list for GP registered patients in Nottingham and Nottinghamshire. 3.5% of waits were over 52 weeks. The waiting list has grown steadily since July 2021 but has stabilised since September 2023, changes in the waiting list over time can be viewed in figure 1. The number of waits over 52 weeks reached a peak in November 2022 of 6,175 and although fluctuations have occurred, this has decreased overall to 4,958 (January 2024).

23% of waits in the recorded data below had an unknown ethnicity, which is the largest ethnic group after White. Although the waiting profile is similar to expectations based on the recorded ICB population, this hampers our understanding of variation in long waits between ethnic groups. The Data Quality section of this Statement refers to the accuracy and completeness of patient demographics recorded in Secondary Care, including the Waiting List Minimum Data Set (WLMDS).

Figure 1: Waiting list time series as of January 2024



27% of the overall waiting list population are within the 20% most deprived populations which is line with population expectations.

Locally there are no statistically significant differences in the proportion of waits which are more than 52 weeks by deprivation quintile. There are no statistically significant differences in the proportion of waits which are more than 52 weeks by ethnic group. Figures 2 and 3 detail the breakdown of the waiting list by deprivation and ethnicity.

Figure 2: Waiting list by deprivation as of January 2024

Waiting List Breakdown for the Last Sunday of January 2024

PBP: Bassetlaw, Mid Notts, Nottingham City, South Notts, | Local authority: All | Provider: All | Sex: All | Ethnic group: All | Depriv...

Weeks waiting	<18		18-52		53-65		>65		Total	
Deprivation quintile	Waits	%	Waits	%	Waits	%	Waits	%	Waits	%
1	21,337	56.7%	14,958	39.7%	1,072	2.8%	265	0.7%	37,632	100.0%
2	15,511	57.3%	10,567	39.0%	781	2.9%	210	0.8%	27,069	100.0%
3	16,210	58.5%	10,560	38.1%	747	2.7%	214	0.8%	27,731	100.0%
4	13,192	58.3%	8,684	38.4%	602	2.7%	164	0.7%	22,642	100.0%
5	13,885	56.7%	9,805	40.0%	648	2.6%	151	0.6%	24,489	100.0%
Total	80,135	57.4%	54,574	39.1%	3,850	2.8%	1,004	0.7%	139,563	100.0%

Figure 3: Waiting list by ethnicity as of January 2024

Waiting List Breakdown for the Last Sunday of January 2024

PBP: Bassetlaw, Mid Notts, Nottingham City, South Notts, | Local authority: All | Provider: All | Sex: All | Ethnic group: All | Depriv...

Weeks waiting	<18		18-52		53-65		>65		Total	
Ethnic group	Waits	%	Waits	%	Waits	%	Waits	%	Waits	%
Asian	2,450	55.4%	1,811	41.0%	129	2.9%	30	0.7%	4,420	100.0%
Black	1,533	54.8%	1,155	41.3%	86	3.1%	22	0.8%	2,796	100.0%
Mixed	1,212	58.4%	796	38.4%	53	2.6%	13	0.6%	2,074	100.0%
Other	1,440	56.0%	1,054	41.0%	65	2.5%	11	0.4%	2,570	100.0%
Unknown	17,894	56.4%	12,719	40.1%	905	2.9%	226	0.7%	31,744	100.0%
White	55,606	57.9%	37,039	38.6%	2,612	2.7%	702	0.7%	95,959	100.0%
Total	80,135	57.4%	54,574	39.1%	3,850	2.8%	1,004	0.7%	139,563	100.0%

2. Age standardised activity rates with 95% confidence intervals for elective and emergency admissions and outpatient, virtual outpatient and emergency attendances

Age standardised rates illustrate that emergency admission rates are significantly higher for the most deprived quintiles and white ethnic groups, however elective admission rates for the most deprived groups are lower than expected. This indicates potential barriers to accessing preventative care across the system within this cohort, resulting in exacerbation of conditions requiring emergency care.

Elective rates of admission by deprivation and ethnicity are shown in figure 4. Emergency rates of admission and emergency attendance are provided within the Urgent Care Section.

Figure 4: Age standardised rates of Elective Admissions by deprivation and ethnicity.

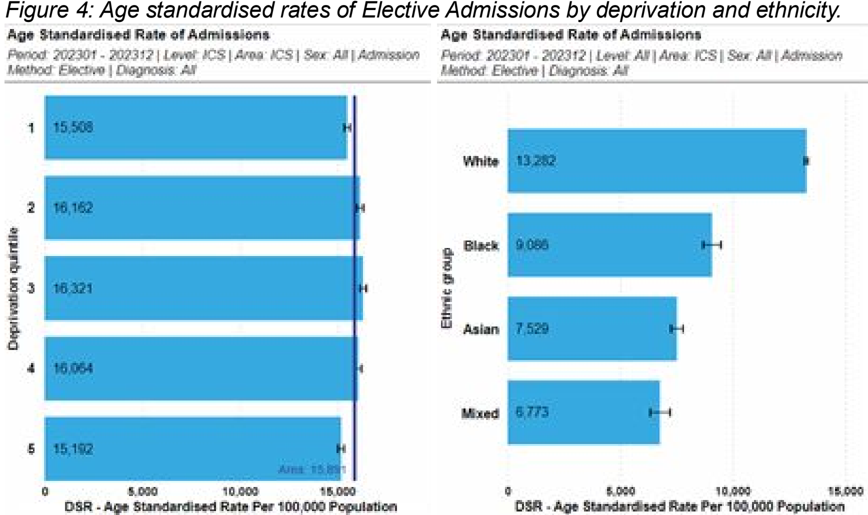
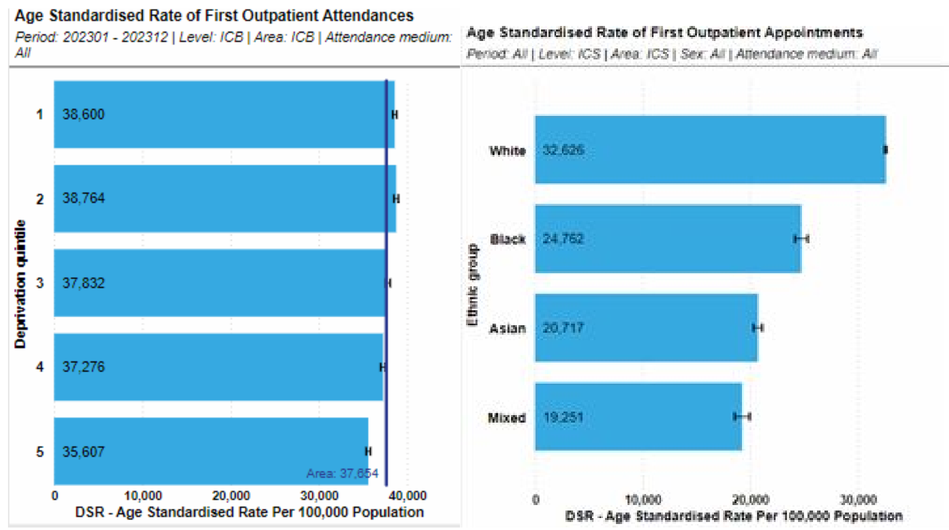


Figure 5 below shows there is a higher age standardised rate of first outpatient appointments completed in the most deprived populations. However, there is also a clear relationship between deprivation and the Do Not Attend (DNA) rate for out-patients. Those in the most deprived quintile were more than twice as likely to not attend an appointment compared to those in the least deprived quintile. Outpatient appointment rates are significantly higher in the White population than other ethnic groups. Rates in the White population were around 1.3 times higher than for the Black population and 1.6 times higher than for the Asian population, also shown in figure 5.

Figure 5: Age standardised rates of First Outpatient Appointments by deprivation and ethnicity

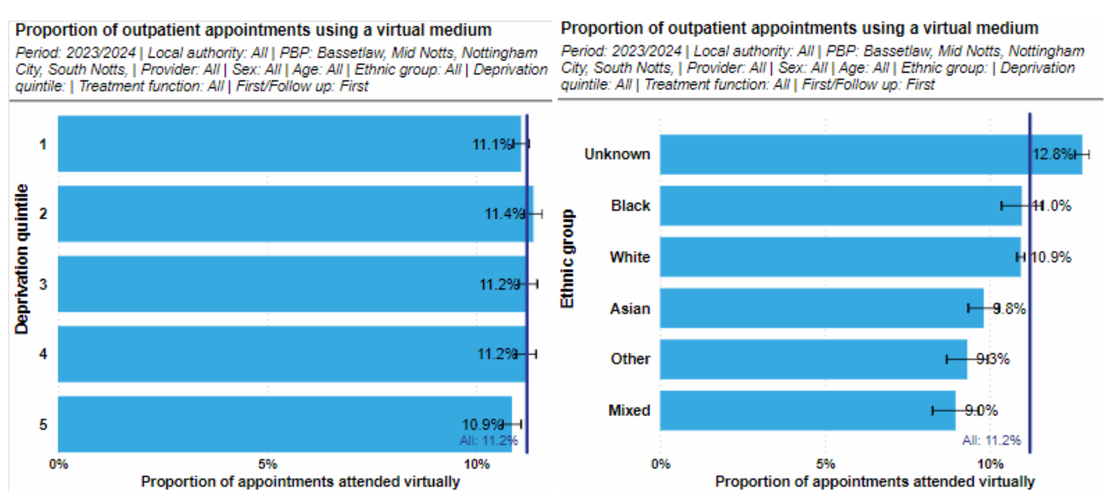


In 2023 a total of 53,077 first outpatient appointments were attended virtually by the Nottingham and Nottinghamshire ICS population. This equates to an age standardised rate of 4,308 appointments per 100,000 population.

Figure 6 details rates of virtual outpatient attendances by deprivation and ethnicity in 2023/24. Rates are similar across all IMD quintiles except quintile 5 (least deprived quintile) which is lower. Although virtual appointments have helped to increase access to healthcare for some, care must be taken for those at risk of digital exclusion which is one of the five NHS five strategic health inequality priorities. Risk factors for digital exclusion include age, ethnicity and deprivation.

Figure 6 also demonstrates that those from an unknown ethnic group were significantly more likely to attend a first outpatient appointment using a virtual medium than those of other ethnicities. It should be noted that age-standardised rates for outpatient appointments are subject to the same issues with ethnicity coding as admissions and other secondary care-based indicators.

Figure 6: Age standardised rates of Virtual Outpatient Appointments by deprivation and ethnicity 2022/23

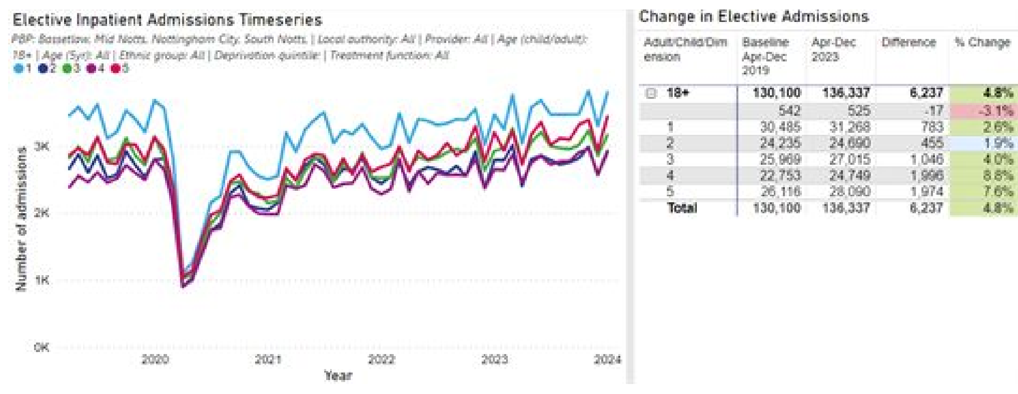


3. Elective activity vs pre-pandemic levels for under 18s and over 18s

Across both age groups, elective inpatient admissions increased by 4.8% between 2019 and 2023. For adults, the biggest increases were seen in IMD quintiles 4 and 5, the least deprived quintiles, as shown in figure 7.

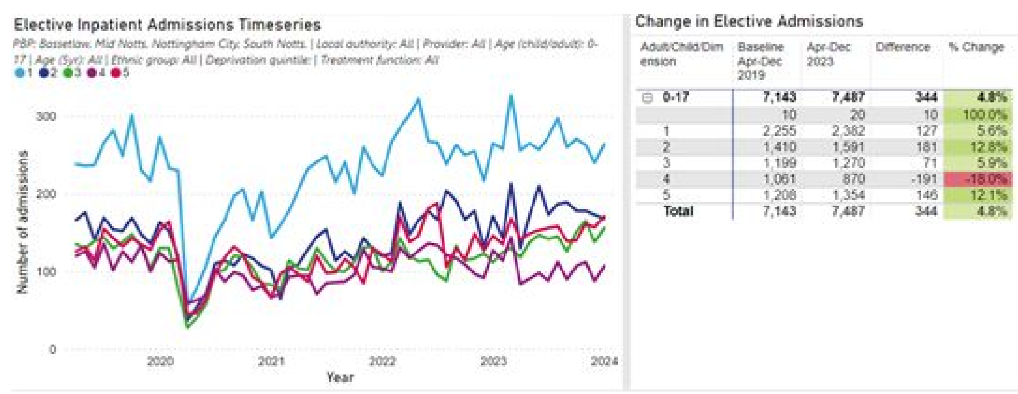
Conversely, for under 18s, admissions for quintile 4 decreased by 18%. The largest increases in under 18 elective inpatient admissions were seen in IMD quintiles 2 and 5 (figure 8). Figures 9 and 10 detail the changes in ethnicity between the two age categories. For both, the largest increases were seen in the Asian population, with a 23% and 32% increase in admissions for over 18s and under 18s respectively. In adults there was a decrease of 0.2% in admissions for the White population and in children a 13% decrease for those of an unknown ethnicity.

Figure 7 Adult (18+) Elective admissions time series by deprivation Apr 2019 – Dec 2023



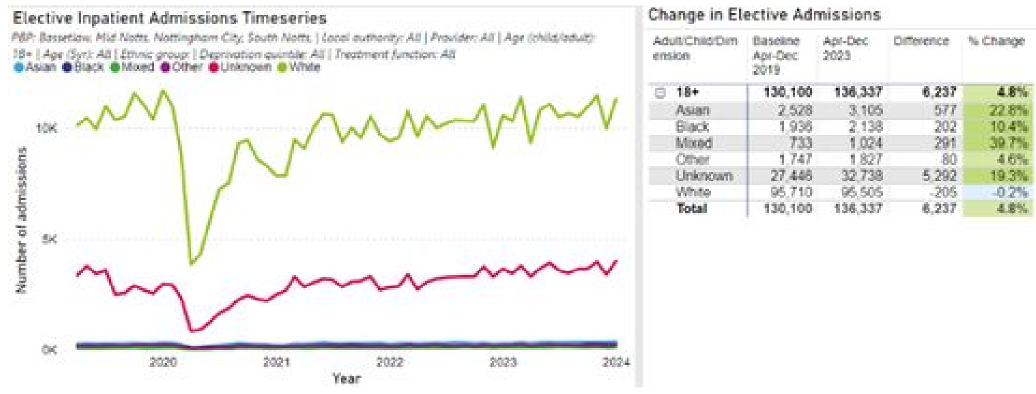
Adult/Child/Dimension	Baseline Apr-Dec 2019	Apr-Dec 2023	Difference	% Change
18+	**130,100**	**136,337**	**6,237**	**4.8%**
	542	525	-17	-3.1%
1	30,485	31,268	783	2.6%
2	24,235	24,690	455	1.9%
3	25,969	27,015	1,046	4.0%
4	22,753	24,749	1,996	8.8%
5	26,116	28,090	1,974	7.6%
Total	130,100	136,337	6,237	4.8%

Figure 8 0-17 Elective admissions time series by deprivation April 2019 – Dec 2023



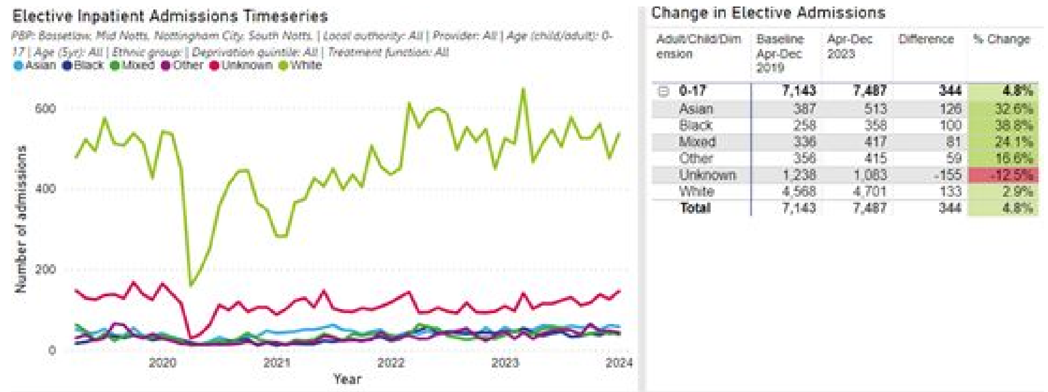
Adult/Child/Dimension	Baseline Apr-Dec 2019	Apr-Dec 2023	Difference	% Change
0-17	**7,143**	**7,487**	**344**	**4.8%**
	10	20	10	100.0%
1	2,255	2,382	127	5.6%
2	1,410	1,591	181	12.8%
3	1,199	1,270	71	5.9%
4	1,061	870	-191	-18.0%
5	1,208	1,354	146	12.1%
Total	7,143	7,487	344	4.8%

Figure 9 Adult (18+) Elective admissions time series by ethnicity April 2019 – Dec 2023



Adult/Child/Dimension	Baseline Apr-Dec 2019	Apr-Dec 2023	Difference	% Change
18+	**130,100**	**136,337**	**6,237**	**4.8%**
Asian	2,528	3,105	577	22.8%
Black	1,936	2,138	202	10.4%
Mixed	733	1,024	291	39.7%
Other	1,747	1,827	80	4.6%
Unknown	27,446	32,738	5,292	19.3%
White	95,710	95,505	-205	-0.2%
Total	130,100	136,337	6,237	4.8%

Figure 10 0-17 Elective admissions time series by ethnicity April 2019 – Dec 2023



Adult/Child/Dimension	Baseline Apr-Dec 2019	Apr-Dec 2023	Difference	% Change
0-17	**7,143**	**7,487**	**344**	**4.8%**
Asian	387	513	126	32.6%
Black	258	358	100	38.8%
Mixed	336	417	81	24.1%
Other	356	415	59	16.6%
Unknown	1,238	1,083	-155	-12.5%
White	4,568	4,701	133	2.9%
Total	7,143	7,487	344	4.8%

B. Impacting on Health Inequalities

Elective and emergency care admission rates can highlight inequalities prevalent throughout the healthcare system in relation to access and outcomes. The data above indicates that people from more deprived populations are more likely to use emergency care routes and are less likely to be admitted for elective care which may highlight issues in access to preventative care.

Actions are ongoing across the system to reduce waiting lists and the number of long waiters. Nottingham University Hospital Trust (NUH) has utilised artificial intelligence software to help increase appointment attendance by predicting likelihood of DNA based on demographics, appointment timings and other additional factors. Proactive contact is then initiated, improving communications if appointments need to be rearranged or cancelled.

In order to help improve patient outcomes on the elective care pathway, a risk stratification process has been outlined, increasing support and intervention for those with more complex needs. Fixed term funding enabled a digital pre-op assessment project at Sherwood Forest Hospitals (SFH) to support early screening and triage. Improving pre-treatment optimisation aims to help increase access to care whilst improving experiences and outcomes for patients.

SFH have also worked with Primary Care to enable data sharing between GP practices and the acute trust in relation to preventative patient care. A particular use of this sharing is to identify and invite current smokers to smoking cessation service to improve a persons' preparedness for surgery which in turn can reduce the risk of cancellations and delays.

Steps are being taken across the system to embed personalised care approaches such as shared decision making within elective care pathways across the trusts to further improve patient experience during treatment.

Urgent and Emergency Care

A. The Data

Urgent and emergency care services provide a critical role in healthcare, often treating people with serious or life threatening injuries or illnesses which cannot be treated in Primary Care or in the community. National data shows that people living in the most deprived areas are 1.7 times more likely to attend A&E than those in the least deprived areas[2]. Evidence shows that people who are socially excluded underuse some services, such as primary and preventative care, and often rely on emergency services such as A&E when their health needs become acute. This results in missed opportunities for preventive interventions, serious illness and inefficiencies, and further exacerbates existing health inequalities[3].

This section of the Statement includes metrics on emergency attendances and emergency admissions into hospital, previously mentioned in the elective care section.

1. Adult (18+) Age standardised activity rates with 95% confidence intervals for emergency admissions

The rate of emergency admissions is significantly higher for those in IMD quintile 1, which are the most deprived populations. Figure 14 below shows that rates for this group are higher than the ICB average, those in IMD quintile 5 (least deprived populations) have the lowest rates of emergency admission as shown in figure 11.

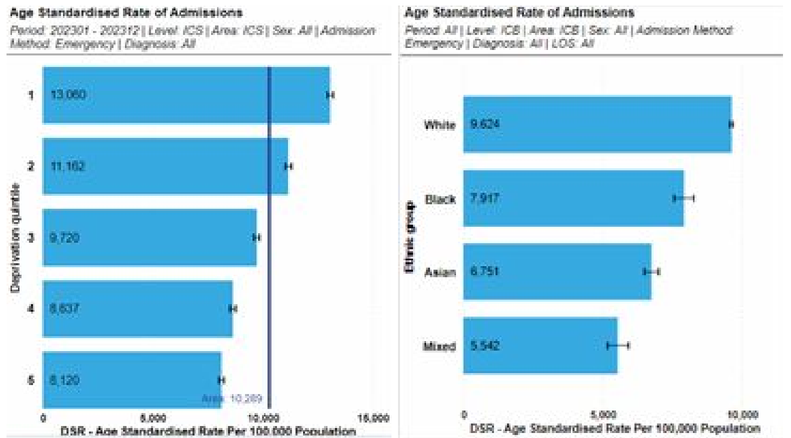
The three most common reasons for emergency admission for the ICS are injury/poisoning/other consequence of external causes, respiratory illness and circulatory illness, all of which have a preventative element. Admission rates for all 3 areas are higher from IMD quintile 1, however the largest disparity is seen in respiratory admissions where 36% of admissions for respiratory illness come from IMD quintile 1 compared to 18% from IMD quintile 5.

Figure 11 also shows that rates of emergency admissions are statistically significantly higher in the White population than other ethnic groups. Rates in the White population were 1.2 times higher than for the Black population and 1.4 times higher than for the Asian population.

[2] Inequalities in Accident and Emergency department attendance, England: March 2021 to March 2022 Inequalities in Accident and Emergency department attendance, England - Office for National Statistics (ons.gov.uk)

[3]Inclusion Health: Applying all our health 2021 Inclusion Health: applying All Our Health - GOV.UK (www.gov.uk)

Figure 11: Age standardised rates and count of Emergency Admissions by Deprivation and ethnicity

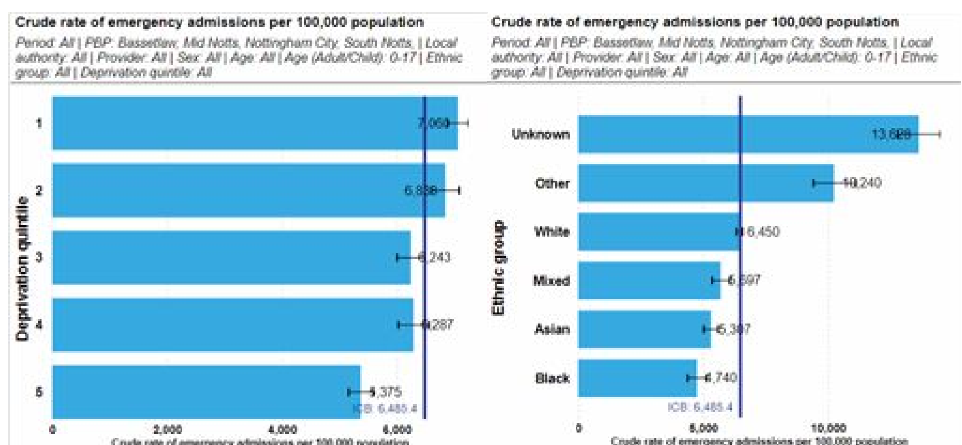


2. Emergency Admissions for Under 18s

Emergency admissions for under 18s are higher in the two most deprived IMD quintiles, but particularly in quintile 1, the 20% most deprived populations (figure 12). The three most common reasons for emergency admission in ages 0-17 are; respiratory illnesses, infectious and parasitic diseases and injury/poisoning/consequence of other external causes. Rates for admission are higher for all 3 conditions in IMD quintile 1, however the biggest disparity is for respiratory illnesses where 41% of admissions are from IMD quintile 1, compared to 17.5% from IMD quintile 5, least deprived populations.

Figure 12 also highlights emergency admissions by ethnicity where rates are higher in those from other and unknown ethnic groups. This potentially highlights issues in ethnicity recording and data quality. Although unknown ethnicity is a valid code, it can reduce accuracy of analysing data by ethnicity and hamper understanding disparities in admission The Data Quality section of this Statement refers to the accuracy and completeness of patient demographics recorded in Secondary Care.

Figure 12: Crude rate of Emergency Admissions by deprivation and ethnicity

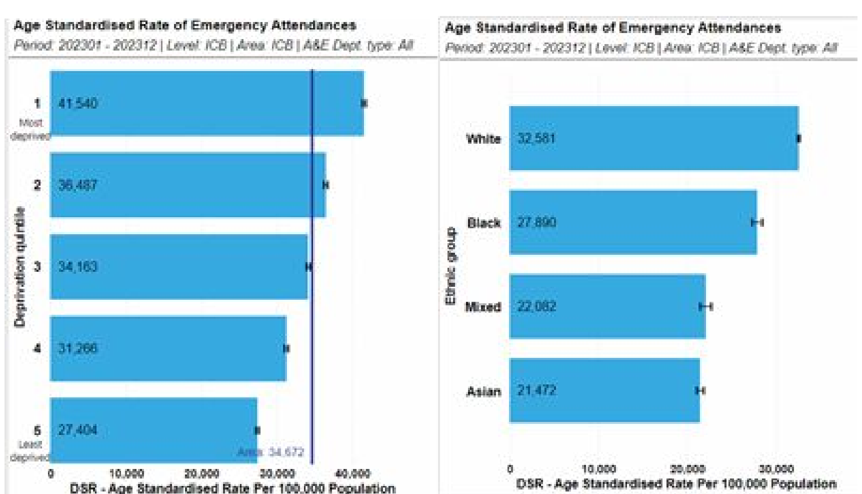


3. Age standardised rate of emergency attendances at emergency departments

The rate of attendances at an emergency department is significantly higher in the most deprived quintile compared to all other quintiles. Rates of emergency attendances are 1.5 times higher in the most deprived quintile compared to the least deprived quintile.

By ethnic group, rates of emergency attendances are highest in the White population. Rates are lowest in the Mixed and Asian population. Like other secondary care indicators, rates for emergency attendances may be distorted by higher numbers of attendances with an 'Unknown' ethnicity. Figure 13 below shows rates of attendances by deprivation and ethnicity.

Figure 13: Age standardised rate of emergency attendances by deprivation and ethnicity



B. Impacting on health inequalities

Whilst we are able to obtain data on attendances and admissions, further work is required to understand the impact of health inequalities on the population attending Urgent and Emergency Care settings who are not admitted to hospital. The system is working to understand how emergency attendances equate to emergency admissions, particularly within inclusion health groups. This can help us to understand the demographics of this cohort, the care they are receiving alongside potential barriers to healthcare for the condition for which they attended.

The ICB conducted analysis in October 2023 on High Frequency Users (HFU) and High Intensity Users (HIU) of Urgent and Emergency Care. HFU refers to patients who have had 2+ unplanned admissions and been prescribed 10+ medications in the last 12 months. HIU refers to patients with 10 or more Emergency Department Attendances and / or Emergency Admissions in the last 12 months. There were 1,325 patients defined as HFU and 1,900 defined as HIU.

Within both cohorts, around a quarter of patients were within IMD quintile 1 and the majority of patients were from a White ethnic group. The analysis also investigated whether patients could attend their GP practices, potential health risks and other

social factors such as homelessness and interactions with other services. Understanding this data enables us to explore targeted support as well as potential barriers impacting on admission rates from these groups and help improve access to primary and preventative care.

The ICS data helps us to understand who our high intensity and high frequency users are. The data has been presented to stakeholders through a health inequalities stakeholder workshop. The workshop explored gaps in the data, perspectives from Primary Care, examples of best practice and enabled attendees to discuss new ways of working across the system to provide enhanced support to these patients. Emerging themes will be collated and used to drive forward change within the system in 24/25.

Admissions for respiratory illnesses for the most deprived populations are double the rate of the least deprived populations. COPD, Flu and Pneumonia are the highest contributors to admission rates for lower respiratory tract infections.

Reducing hospital admissions in patients with COPD is a key metric of the Core20Plus5 approach to reducing health inequalities, alongside increasing flu and covid vaccines for these patients. Work is ongoing to help increase diagnosis and treatment of COPD in areas of high need and deprivation. There is an annual drive to increase flu and covid vaccinations in this cohort which saw a 12% increase in March 2024 compared to March 2023. By increasing diagnosis, improving management of the condition and mitigating against risks, it is hoped that condition exacerbations will decrease and reduce the need for hospital admission.

Respiratory

A. The Data

Immunisation is one of the most cost-effective public health interventions, ensuring coverage is not only high overall, but also within underserved communities is essential for disease control and elimination strategies. Immunisation against respiratory illnesses such as flu and covid, particularly in groups who have additional risk factors for illness, can prevent the worsening of existing health conditions and prevent hospital admissions. Respiratory illnesses are currently the second highest reason for emergency admissions for people living in the most deprived populations.

1. Uptake of covid and flu vaccinations by age and demographic

Vaccination rates for both covid and flu are the lowest across Black, Mixed, Asian and Other ethnic groups and for those in the most deprived IMD quintiles. Rates increase across all ethnic groups in the least deprived quintiles, although uptake remains lower than White ethnic groups. This data is shown below in figures 14, 15 and 16.

Figure 14 The proportion of eligible patients aged 18+ with a flu vaccination by deprivation

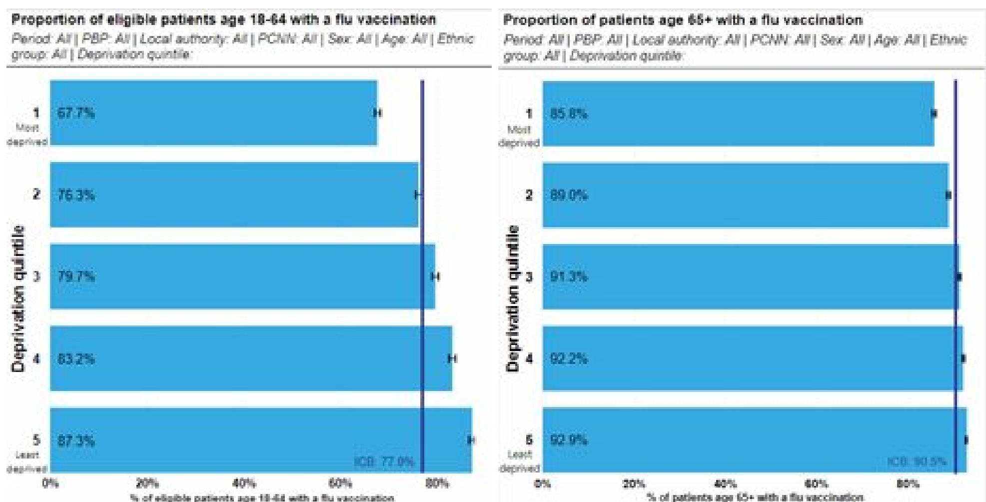


Figure 15 The proportion of patients aged 18+ with a flu vaccination by ethnicity

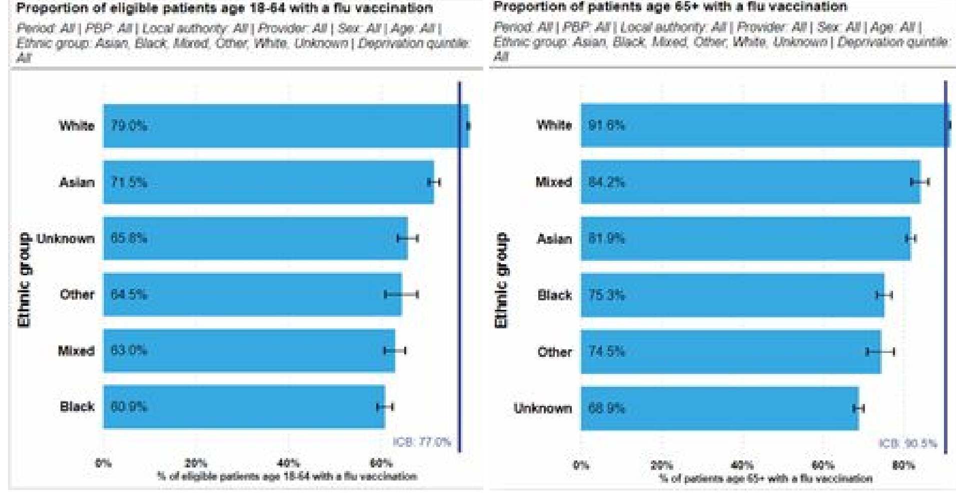
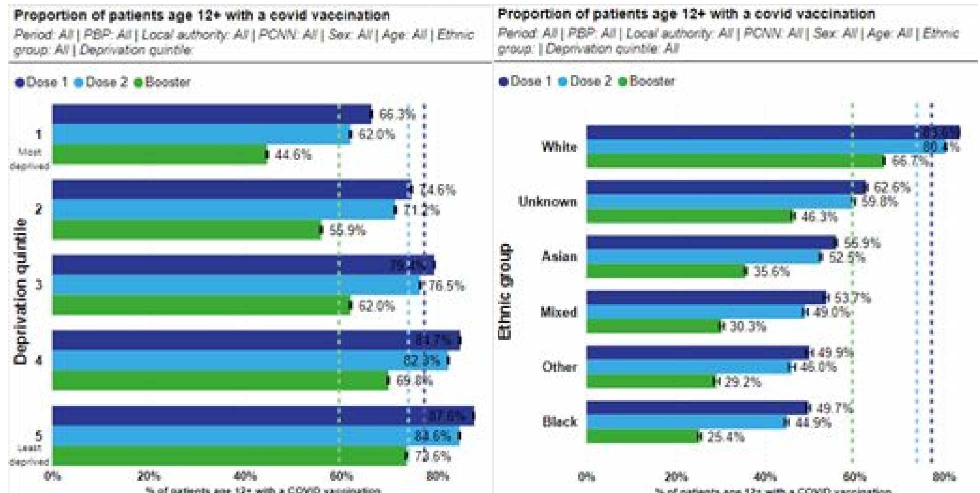


Figure 16 The proportion of patients aged 12+ with a Covid vaccination by deprivation and ethnicity



B. Impacting on Health Inequalities

Vaccination data can provide intelligence in relation to barriers to accessing healthcare more generally. Groups with lower vaccination uptake are groups also more likely to have poorer outcomes and experiences in other aspects of healthcare. Exploring and improving barriers to access in these cohorts could improve health outcomes in other areas.

Work undertaken during the Covid-19 pandemic period helped to increase uptake of vaccination within certain ethnic groups and communities where large variations in Covid-19 vaccination status were seen. The use of a vaccination bus was nationally recognised and enabled a flexible approach to vaccination, creating access points within community locations where uptake was low. In addition to this over 2000 vaccines were delivered by creating pop up clinics in faith settings and community venues utilised by a diverse range of residents. The Community Champions organised by Nottingham City Council played a crucial role in improving acceptance of the vaccine amongst hesitant communities and increasing levels of trust between healthcare and residents.

The learning from these approaches has been invaluable and has enabled the ICS to think differently when providing services to residents. Working with community champions, community leaders and bringing care closer to the community through flexible approaches remain key ways we distribute health messages across a range of conditions and influence how we deliver care across the system.

Mental Health

A. The Data

Mental health problems can affect anyone and have a significant effect on the lives of individuals, their families, communities and wider society. Research in 2018 found

that over the course of a week, 1 in 6 adults had experienced a common mental health disorder, such as anxiety[4].

People with severe and enduring mental illness are at greater risk of poor physical health and reduced life expectancy compared to the general population. Patients with severe mental illness (SMI) on average have a life expectancy 15-20 years shorter than the general population[5]. Smoking rates within this population are over 40% nationally, which is much higher than the national smoking rate of 12.9% in the general population.

People experiencing poor mental health may be less likely to be in employment, experience social isolation and live in poor quality housing or in a less safe area. Children who experience poor mental health may have poorer education attainment and school attendance and may be at an increased risk of worsening mental and physical health into adulthood. These factors may increase the risk of health inequalities an individual may face.

1. Overall number of severe mental illness (SMI) physical health checks

It is estimated that for people with SMI, 2 in 3 deaths are from physical illnesses that could be prevented. Major causes of death in people with SMI include chronic physical medical conditions such as cardiovascular disease, respiratory disease, diabetes and hypertension. Physical health checks provide opportunity to spot the signs of these conditions early as well as valuable contact with a health professional. Monitoring of SMI Physical Health Checks also forms part of the Core20 Plus 5 national approach to reducing health inequalities and places a focus on improving uptake across ethnic minority groups.

Annual health checks completed in the ICS are increasing by yearly comparison, 1045 more checks were completed in the financial year 2023/24 than in 2022/23. Figure 17 shows the breakdown of completed SMI checks by deprivation and by ethnicity. A lower proportion of checks have been completed in people from IMD quintile 1 (the most deprived populations). Across ethnicity, those from Black, Mixed, other and unknown ethnic groups are less likely to have a completed check than those from White ethnic groups. Those of Asian heritage have a similar completion rate to White.

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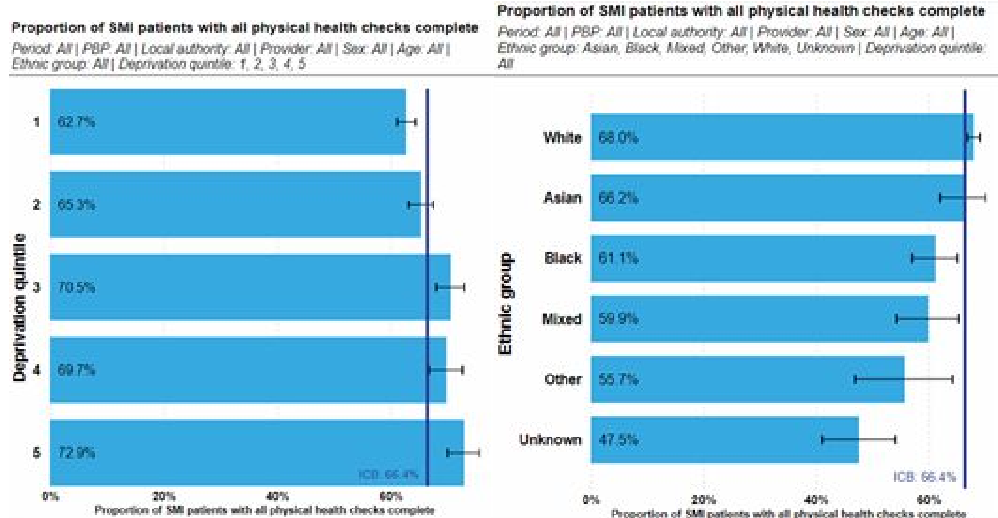
[4] Health matters: reducing health inequalities in mental illness (2018) Health matters: reducing health inequalities in mental illness - GOV.UK (www.gov.uk)

[5] Severe mental illness (SMI) and physical health inequalities: briefing (2018) Severe mental illness (SMI) and physical health inequalities: briefing - GOV.UK (www.gov.uk)

Figure 17 The rate of patients with an SMI Health check by deprivation and ethnicity



B. Impacting on Health Inequalities

The Physical Health Check SMI Local Enhanced Service (LES) was introduced in 2021 for 2 years and provided additional resource to Primary Care to enable more comprehensive SMI Health Checks to be completed and follow up interventions to be provided. Due to the success of the LES, the ICB has extended the scheme until 2026. For 2024-2026, 98% of GP practices in the ICS have signed up to the LES.

Nottingham City has the lowest completion rate of SMI Health Checks, yet has a higher proportion of SMI patients. This is also an area of high deprivation and high ethnic diversity within the ICS. An equitable approach has been applied to Nottingham City in the allocation of staffing resources to help increase the number of checks completed.

Nottingham City are also piloting a peer support offer to enable increased access to physical health interventions for people with SMI to address the needs identified in the annual physical health check, such as lifestyle interventions and cancer screenings.

2. Rates of total Mental Health Act detentions

A. The Data

Figure 18 shows the count of detentions under the mental health act by deprivation decile, taken from the national data set; Mental Health Act Statistics, Annual Figures 2022-2023[6]. The highest number of detentions are within the two most deprived categories. However, this data refers to count only we are therefore unable to analyse if these levels differ from expectations based on wider population data. We are therefore unable to decipher under or overrepresentations within population groups. In the short term, this data should be interpreted with caution, however it is a

[6] Mental Health Act Statistics Annual figures 2022-23 Mental Health Act Statistics, Annual Figures, 2022-23 - NHS England Digital

long term aim of the ICB to work with trusts to establish data sharing processes to enable awareness and deeper understanding of this data.

Figure 18 The count of detentions under the Mental Health Act by deprivation 2022-2023.

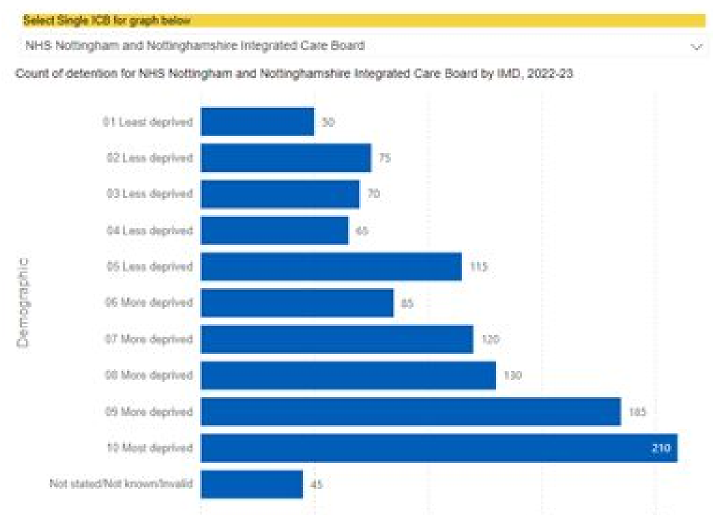
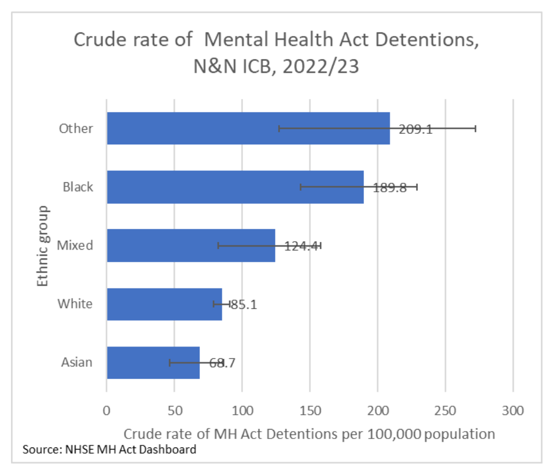


Figure 19 shows the crude rate of Mental Health Act detentions by ethnicity, the data used to create this chart is taken from the national data set, Mental Health Act Statistics Annual Figures 2022-23. The chart shows that there is a higher rate of detentions of those from Other and Black ethnic groups in comparison to those from a White or Asian ethnic group. However, this data should be interpreted with caution as crude rates do not help us to understand if there is under or over representation between population groups. In addition there are further complexities surrounding interpretation of this data; age, severity and the point of contact with the system can be contributing factors impacting on restrictions used and are not reflected in this data set. It is the longer-term aim of the ICB to continue working with Trusts to help interpret and understand this data in a standardised way which will help to identify any disparities more clearly. This will also allow us to identify any additional factors contributing to these disparities, such as point of access to the system, which could highlight further inequalities regarding access and experience.

Figure 19 The crude rate of detentions under the Mental Health Act by ethnicity



3. Rates of restrictive interventions

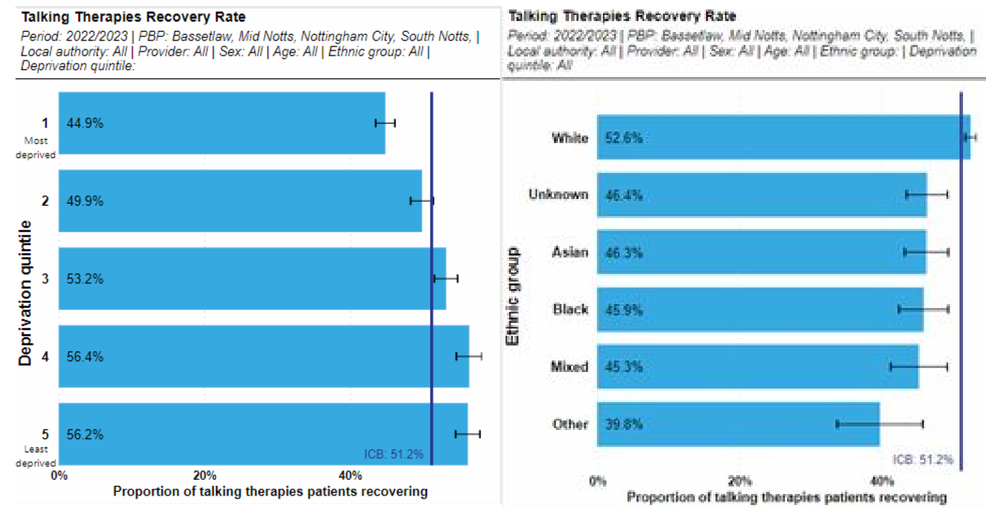
Availability of data in relation to restrictive interventions is limited via the NHS England restrictive interventions dashboard. The count of patients who experience a restrictive intervention is higher amongst people from a White ethnic group, however the age standardised rate is currently unavailable in order for the ICB to understand disparities within this data.

The ICB is committed to working with the trusts in order to further understand disparities in restrictive interventions for future Statements.

4. NHS Talking Therapies Recovery

Talking therapies are psychological treatments for mental and emotional problems like stress, anxiety and depression. The Talking Therapy recovery rate for the ICS is currently 51.2% which is above the national target of 50%. Figure 25 shows that although the count of people in recovery for talking therapies is higher in the most deprived areas, the rate of recovery in comparison to those in the least deprived areas is lower. The recovery rate amongst ethnic minority groups is also lower than White ethnic groups as detailed in figure 20.

Figure 20 The rate of talking therapies recovery by deprivation and ethnicity.



B. Impacting on Health Inequalities

In 2022, Nottingham CVS employed a community engagement co-ordinator, funded by the ICB, with the aim to increase awareness of mental health and improve access to Talking Therapies amongst adults from South Asian and other ethnic groups in Nottingham via a community centric approach. Over 200 residents attended sessions from a range of diverse ethnicities. Specialised sessions were also created

for women, refugees/asylum seekers, older age groups to help encourage diversity and inclusion.

The sessions highlighted that in some South Asian languages, there isn't a word for mental health. They also highlighted other barriers to accessing services by people within these communities. The findings were used to help promote mental health and talking therapies in a different way using a co-designed health intervention approach. Targeted community sessions were initially used, followed by attendance at wider events and engagement with group and community leaders.

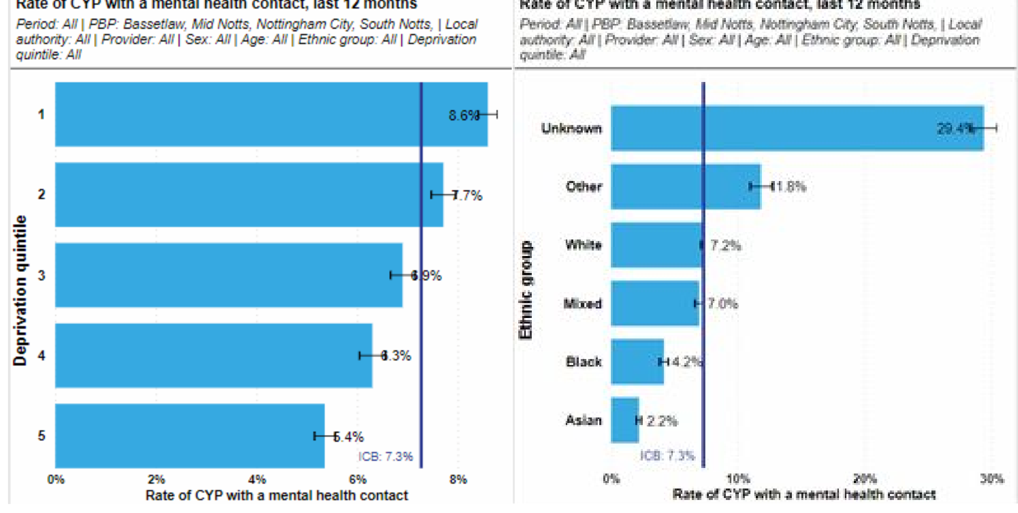
Within Nottingham and Nottinghamshire there is now one Talking Therapies service creating easier access for patients whilst also allowing for resources to be targeted based on population need. Cultural competency is a key priority for the provider of Talking Therapies, with community engagement roles within the service aiming to increase awareness of mental health, increase service uptake and experience from communities where referral rates are low, including those from different ethnic groups, people from LGBT communities and elderly people.

5. Children and Young People's (CYP) Mental Health Access

A. The Data

Figure 21 provides the rate of CYP who had contact with a mental health service in the last 12 months by deprivation and ethnicity. This shows rates are higher than the ICB average in the most deprived IMD quintile and lower than average in the least deprived quintiles. The high numbers of contacts with 'Unknown' or 'Other' ethnicity make comparisons by ethnic group difficult. However, where ethnicity is known, Black and Asian CYP appear to have a significantly lower rate of contact with mental health services.

Figure 21 Rate of CYP with a mental health first contact in the last 12 months, by deprivation and ethnicity



B. Impacting on Health Inequalities

In 2023 Nottingham City Council and Nottinghamshire County Council published the Children and Young People's Mental and Emotional Health Services in Nottingham and Nottinghamshire: Health Equity Audit. The audit reviewed equity of access to, uptake of and outcomes for service users of CYP emotional and mental health services across the population and made recommendations for improvement, particularly in areas of high deprivation and within minority ethnic groups.

Cancer

A. The Data

Cancer is one of the leading causes of the inequality in life expectancy across Nottingham and Nottinghamshire, contributing between 18-21% of the life expectancy gap between the most and least deprived areas. Breast, prostate, lung and bowel cancers are the most common cancers in the UK, however around a fifth of all cancer deaths are from lung cancer. Around 38% of cancers are estimated to be preventable, with many cases attributed to lifestyle factors such as smoking, obesity, alcohol consumption, and poor diet[7]. There may also be occupational risks which could increase the risk of cancer.

Populations with higher deprivation often have higher prevalence of cancer risk factors. These populations may also be less aware of symptoms of cancer and report more barriers to seeking help, participation in screening programmes is lower and there are higher proportions of cancer diagnosed through routes with worse survival outcomes[8].

1. Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex

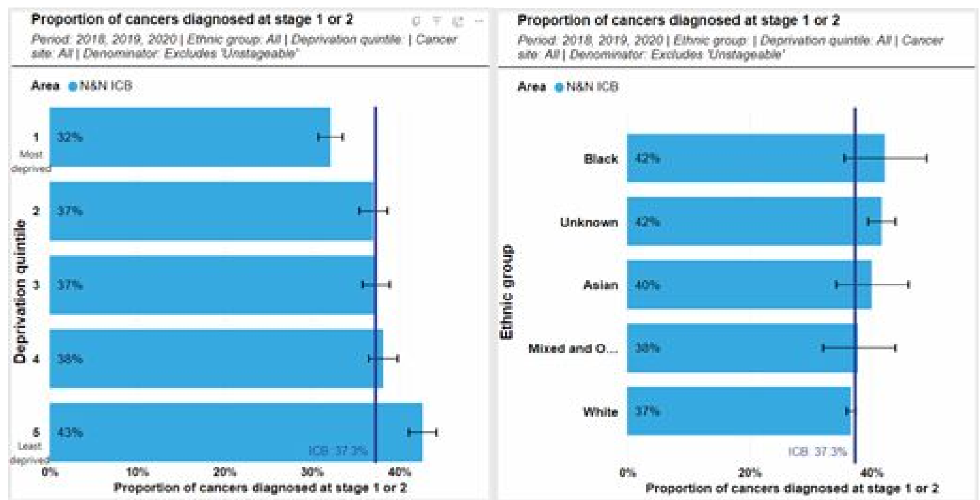
Data on cancer diagnosis is limited locally. The latest available national data published in 2021 shows the ICB below attainment is below the national target of 75% of cancers diagnosed in stage 1 or 2. The proportion of diagnosed cancers at stage 1 or 2 by deprivation and ethnicity is detailed in figure 22.

The most recent available data broken down by deprivation quintile shows those living in the most deprived quintile are around 10 percentage points less likely to have been diagnosed in the early stages of cancer compared to those living in the least deprived quintile. There are no statistically significant differences between ethnic groups where the ethnicity is known.

[7]Cancer statistics UK Cancer Statistics for the UK (master-7rqtwti-hreqyzlibi4ac.uk-1.platformsh.site)

[8] Cancer in the UK 2020: Socio-economic deprivation Cancer in the UK 2020: socio-economic deprivation (cancerresearchuk.org)

Figure 22 Proportion of stageable cancers diagnosed at stage 1 or 2 by deprivation quintile and ethnicity



B. Impacting on Health Inequalities

Although the ICB is unable to access more detailed data currently, efforts are ongoing to improve cancer diagnosis staging through targeted screening programmes.

Mansfield and Nottingham City are two areas piloting the Targeted Lung Health Check Programme, aiming to increase earlier diagnosis of lung cancer in at risk populations, uptake to date has been high. Data from Mansfield and Ashfield between April 2021 and November 2023 has so far shown:

- 110 cancers were diagnosed with staging data available for 82% of cases.
- 62% of Lung Cancer diagnosed via the programme have been at Stage 1 or 2.

The Nottingham City project is undertaking work with Homeless stakeholders to make the Lung Health Checks accessible to the Homeless community. The programme is due to be expanded into Sherwood in May 24.

The ICS is piloting a self-referral project in Nottingham City. Patients with Lung Cancer symptoms can by-pass GP appointment and access a telephone triage service. Patients at high risk receive rapid access to diagnostics.

Routine screening for breast, bowel and cervical cancer present opportunities for earlier cancer diagnosis. Uptake for screening is lower for all three programmes in Nottingham City than all other in the ICS. The ICS is working with NHSE to improve Breast Screening uptake in areas with low uptake (specifically Nottingham City), learning from the Targeted Lung Health Check Programme. This includes increasing mobile scanning in community locations and targeted Communications and Engagement work. The women’s health hub project is exploring barriers to Breast Screening uptake in women with SMI in Newgate where Breast Screening uptake is at 35%, half the target ambition.

The ICS is working in collaboration with Macmillan to fund Cancer Co-ordinators within Primary Care in locations with lowest screening uptake rates.

The ICS is working with NUH, East Midlands Cancer Alliance and Cancer Research UK to understand the variation in bowel screening uptake rates and completion of FIT tests for symptomatic patients. Analysis shows variation by deprivation and ethnicity. A behavioural scientist is working with specific communities to understand the barriers and agree targeted interventions.

Two community diagnostics hubs are planned for Mansfield and Nottingham City which will aim to increase access to tests to support cancer pathways and diagnosis, alleviating pressures on primary and secondary care. The centres have been specifically sited in locations which will improve access to diagnostics for populations with greatest health inequalities. The diagnostic centres are due for completion Spring/Summer 2025.

Cardiovascular Disease (CVD)

A. The Data

CVD is an umbrella term for conditions which affect the heart and circulatory system. CVD is one of the leading causes of the gap in life expectancy between the least and most deprived across Nottingham and Nottinghamshire. Nottingham City has the 2nd highest rate of CVD mortality in under 75s across England, with 131 per 100,000, over double the rate in the Rushcliffe. Ethnicity can also increase the risk of developing some CVD conditions, Black African/Caribbean or South Asian ethnic groups are two ethnic groups which may have an increased risk of development.

Hypertension is the leading preventable risk factor for CVD development and mortality. The risk of hypertension development is higher in areas of deprivation. People from Black African/Caribbean ethnic groups are also more likely to develop hypertension[9] and are also disproportionally more likely to live in areas of high deprivation in the ICS[10].

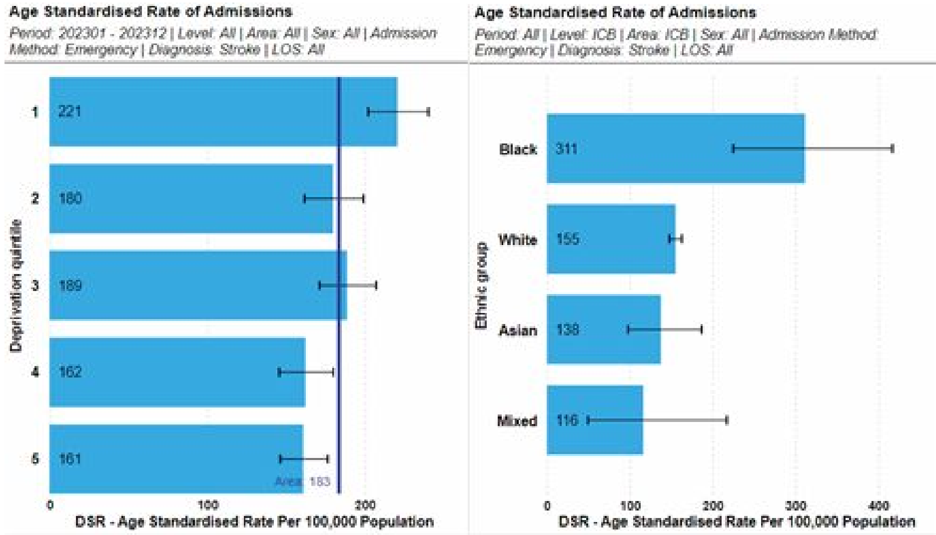
1. Stroke rate of non-elective admissions (per 100,000 age, sex standardised)

Stroke is a form of CVD. Figure 23 below shows the age standardised admissions for Strokes across the ICS by deprivation and ethnicity. Rates of admission are higher in the most deprived populations and are lowest in the least deprived populations. Nottingham City has the highest age-standardised rate of stroke across the ICS, at 217 per 100,000 people. The lowest rates are in Bassetlaw at 152.5 per

[9] Public Health England 2017, Health matters: combating high blood pressure https://www.gov.uk/government/publications/health-matters-combating-high-blood-pressure/health-matters-combating-high-blood-pressure

100,000. Data also shows rates of admission are significantly higher in people from a Black African/Caribbean heritage.

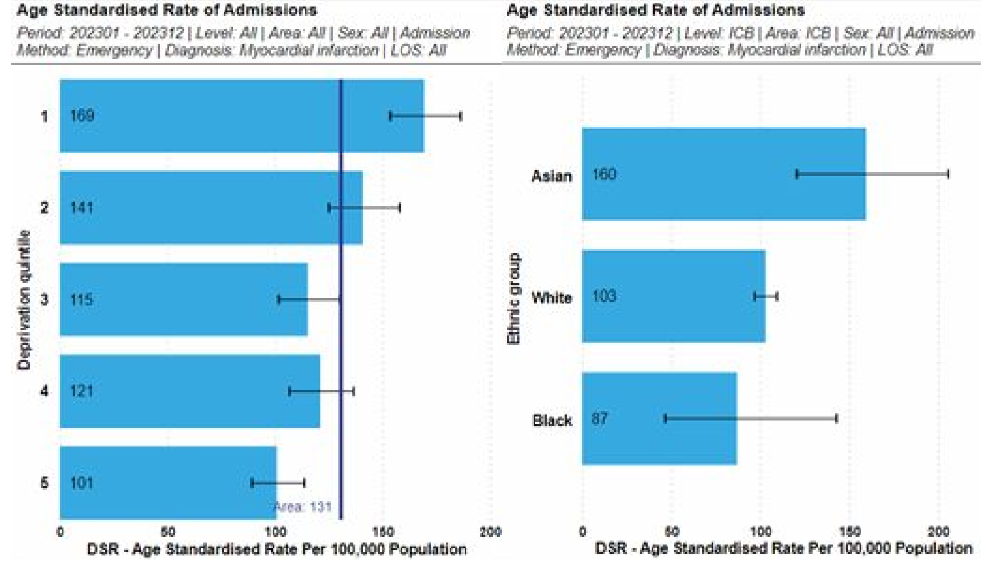
Figure 23 Age standardised rates for non-elective stroke admission by deprivation and ethnicity Jan 2023 – Dec 2023



2. Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)

Myocardial infarction is also a form of CVD. Figure 24 shows that age standardised admissions for myocardial infarction are significantly higher in people from the most deprived populations and lower from those in the least deprived populations. Ethnicity data also in figure 24, shows the age-standardised rate of admissions are higher for those from an Asian heritage.

Figure 24 Age standardised rates for non-elective myocardial infarction admission by deprivation and ethnicity Jan 2023 – Dec 2023

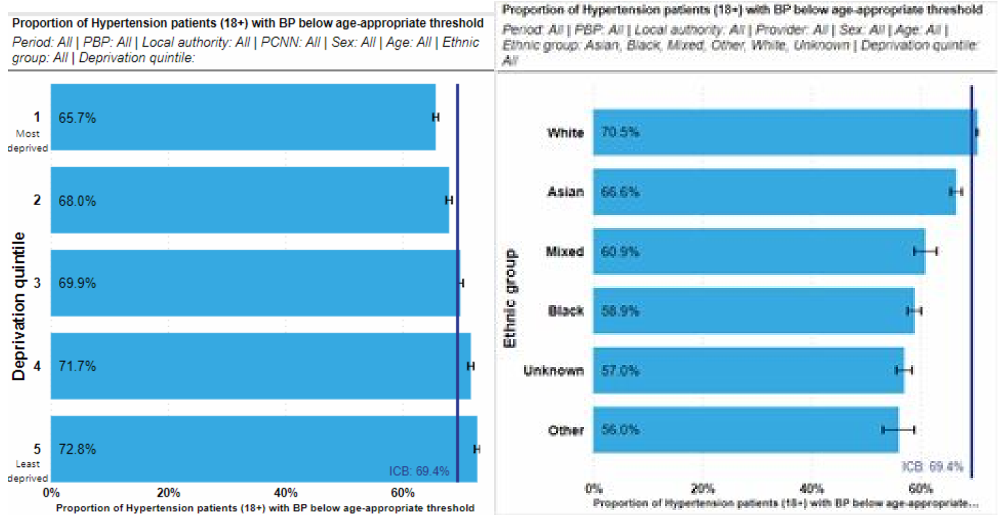


3. Percentage of patients aged 18 or over with GP recorded hypertension, in whom the last blood pressure reading in the preceding 12 months is below age-appropriate treatment thresholds (indicator of optimal condition management)

Hypertension (high blood pressure) is the leading modifiable risk factor for CVD development. A blood pressure reading within age-appropriate thresholds for people diagnosed with hypertension is an indicator of optimal management of the condition. In the long term, optimal management will improve patient outcomes, reducing the risk of heart attacks, strokes and other complications resulting from high blood pressure.

Across the ICS older adults and females are more likely to be within these thresholds, indicating better management within these groups. However, those from the most deprived areas are less likely to be within these thresholds as highlighted in figure 25. This could lead to an increased risk of serious illness from the effects of having high blood pressure in these cohorts. People from White ethnic groups are more likely to reach these thresholds, those from Black, Mixed Ethnicities and Asian ethnic groups less likely to meet these targets, also shown in figure 25.

Figure 25 Percentage of hypertensive patients with their latest blood pressure reading within age appropriate thresholds by deprivation and ethnicity



4. Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy

Across the ICS 60% of patients aged over 18 with a QRISK score of >20% are on lipid lowering therapy. However in the age group 25-84 (a cohort monitored within national CVD key performance indicators) attainment is 74% against a 65% target. Figure 26 shows that a higher proportion of eligible patients from the most deprived

quintile are on lipid lowering therapy, and therefore being treated. Treatment rates are lower in less deprived areas. Figure 26 also shows Asian patients are the most likely within this cohort to be on lipid lowering therapy. Between the other main ethnic groups there are no statistically significant differences.

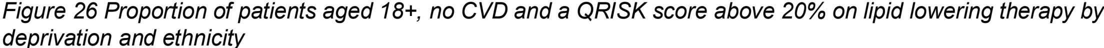
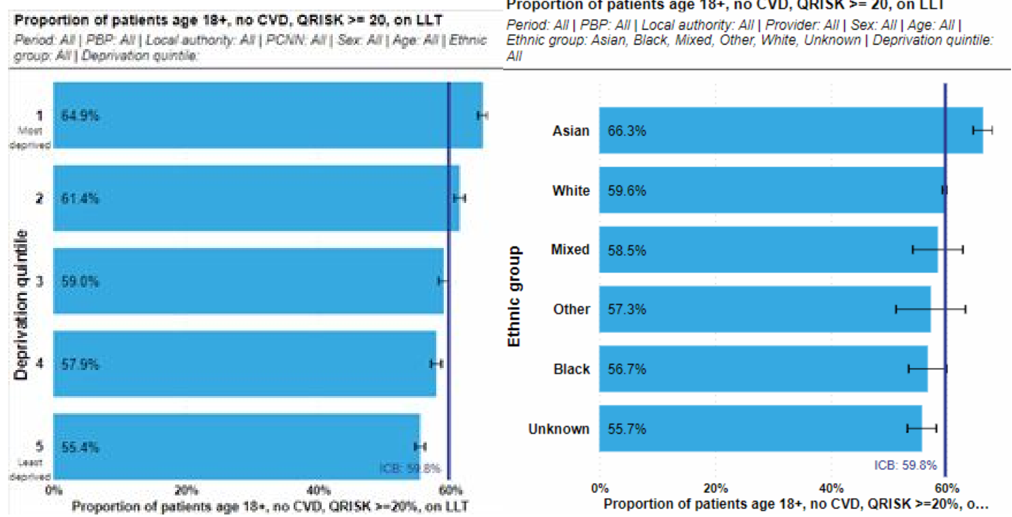


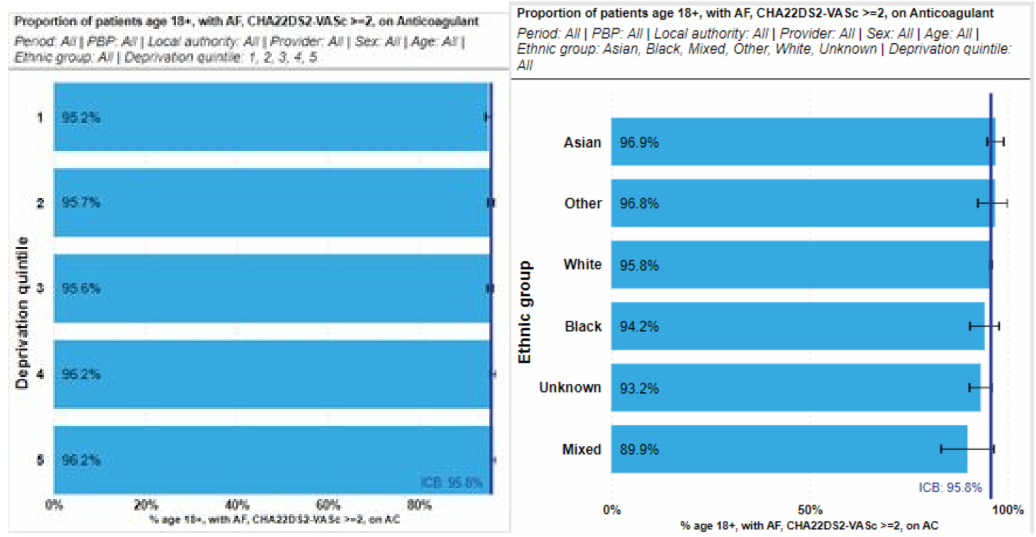
Figure 26 Proportion of patients aged 18+, no CVD and a QRISK score above 20% on lipid lowering therapy by deprivation and ethnicity



5. Percentage of patients aged 18 or over with GP recoded atrial fibrillation and a record of CHA2DS2-VASc Score of 2 or more who are currently treated with anti-coagulation drug therapy

Figure 27 shows the percentage of people within this cohort on anticoagulation drug therapy across deprivation quintiles and ethnic groups. The data shows there are no statistically significant differences across all deprivation quintiles when it comes to this cohort. There are no statistically significant differences by ethnic group.

Figure 27 Percentage of patients aged 18+ with Atrial Fibrillation and a record of CHA2DS2-VASc score 2 or more treated with anti-coagulation drug therapy by deprivation and ethnicity



B. Impacting on Health Inequalities

There are various projects ongoing across the ICS to help prevent CVD and remains a focus of the Long-Term Conditions strategy. The ICS relaunched a CVD steering group in Mar 2024 to help drive forward innovation in identifying areas for early intervention and prevention. A Stroke Delivery Group and Hypertension Task and Finish Group are in the process of being established.

From February 2023 to February 2024, the ICS took part in the NHS England Core20 Accelerator Site Programme in collaboration with The Institute for Healthcare Improvement. The focus of the programme was CVD and in particular the hypertension pathway. The programme set out an ambition that *"By December 2028, the proportion of people dying before aged 75 of CVD in the most deprived areas of Nottingham and Nottinghamshire will reduce (per 100,000), becoming more similar to those in the least deprived areas".*

The programme enabled small scale test and learn opportunities to take place across the ICS. In 2023, the Health Inequalities and Innovation Fund awarded funding to support the detection of hypertension in at risk communities, particularly those from IMD quintile 1 and people from a Black African/Caribbean heritage to support this work.

In August 2023 a Clinical Senate was convened to explore the multifaceted nature of CVD. The Senate identified a set of high-level recommendations that can be adopted across the system. These recommendations are intended to serve as guiding principles, fostering a cohesive approach to CVD care while acknowledging the importance of tailoring interventions to individual localities and their unique patient demographics. Key metrics from the Senate have been incorporated into a dashboard to track progress of the recommendations and inform targeted work.

In October 2023, the ICB System Analytics and Intelligence Unit published a series of reports into CVD and the associated conditions. These reports provide a deep dive analysis of the populations at risk of the various CVD conditions, admission rates to hospital and potential interventions to help inform understanding of the condition.

Diabetes

A. The Data

Type 1 Diabetes is an autoimmune condition where the body cannot produce insulin and cannot be prevented. Differently, with Type 2 Diabetes the body can still produce insulin, however it is unable to produce enough insulin or the insulin produced by the body is not working well enough for optimal health[11]. Type 2 diabetes can be prevented through lifestyle factors, with obesity being the main driver in development of the condition. The risk of development also increase with age, family history,

[11] Differences between type 1 and type 2 diabetes [Differences between type 1 and type 2 diabetes | Diabetes UK]

ethnicity (South Asian and Black African/Caribbean ethnic groups have a higher risk). Type 2 diabetes is often more prevalent in areas of higher deprivation where people may be more likely to experience lifestyle risk factors associated with its development. Across the ICS, 30.5% of the Type 2 diabetic population are from IMD quitile 1, the most deprived quintile.

Diabetes can weaken the body's immune system which can increase the risk of poorer outcomes from ill health. The consequences of uncontrolled diabetes are also severe and can be life changing, for example developing chronic kidney disease or requiring limb amputation.

1. Variation between percentage of people with Type 1 and Type 2 Diabetes receiving all 8 care processes.

The 8 care processes are key health markers identified by NICE Guidance for the treatment of diabetes and are an importance factor in ensuring positive patient outcomes and preventing complications associated with the condition. The 8 care processes should be checked annually, for patients with type 1 diabetes this is usually within a hospital setting, for patients with type 2, this is often managed within primary care. Figure 28 shows the variation in completed 8 care processes for type 1 and type 2 diabetics by deprivation. There is a clear correlation between deprivation and achieving all 8 care processes for Type 2 diabetes with those in the least deprived quintile 1.4 times more likely to achieve all eight than those in the most deprived quintile. Figure 29 shows this by ethnicity.

Figure 28 Percentage of people with all 8 care processes complete for Type 1 vs Type 2 Diabetes by deprivation quintile (last 12 months)

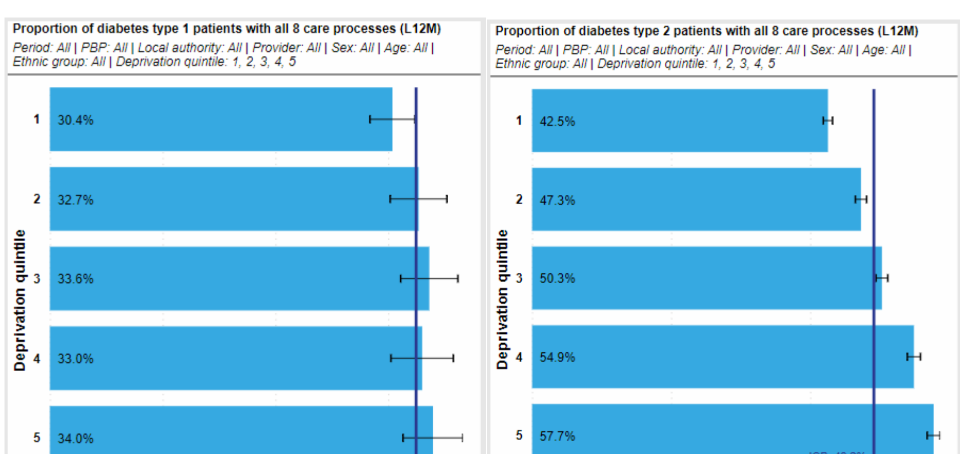
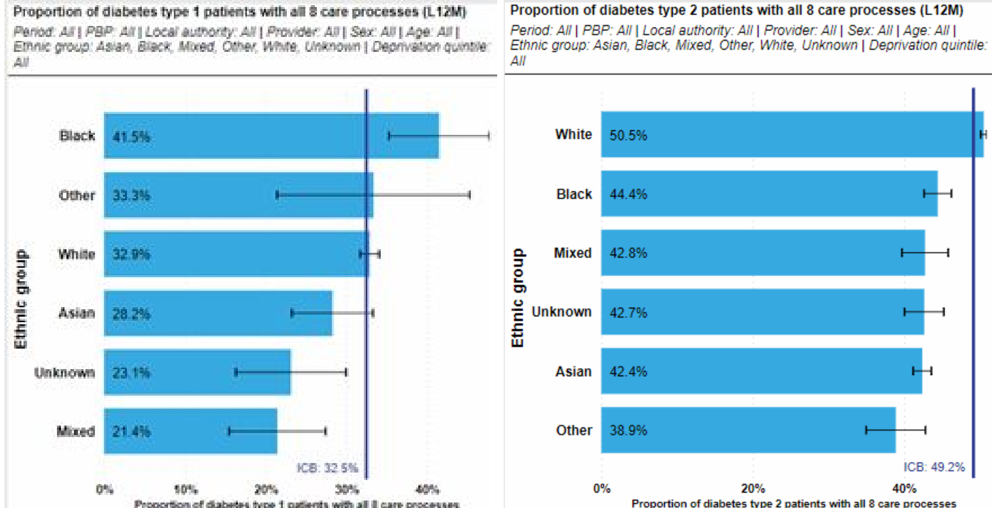


Figure 29 Percentage of people with all 8 care processes complete for Type 1 vs Type 2 Diabetes by ethnicity (last 12 months)



B. Impacting on health inequalities

In 2022, a system wide Diabetes Local Enhanced Service (LES) was issued across the ICS with the aim of standardising diabetes care in Primary Care and bringing in line equality of service across the historic CCG area offers. The LES aims to increase the percentage of 8 care processes completed. An extension of the LES has been granted for financial years 2024 – 2026.

In addition to the LES, an additional equity payment was granted for 2023-2025 to practices where 40% or more of the practice population resided within IMD quintile 1. The payment was designed following feedback from local GP practices in the most deprived areas and their ability to sign up to the LES due to the additional complexities faced in their registered population. Practices partaking were required to submit an action plan of how they intended to use the funding to target patients in the most deprived cohorts.

To date the LES has shown that for Type 2 Diabetics;

- The percentage of patients who have received all 8 care processes has increased by 8%, compared to results in 2021/22 when no LES was in place. The largest improvements have been for patients living in Nottingham City.
- The percentage of foot checks completed has increased by 10% and Urine Albumin/Creatinine Ratio Checks have increased by 7%.The largest improvements have been for patients living in Nottingham City and Mid-Notts. Both are areas of high deprivation, areas which did not previously have a LES but are areas with highest rate of admissions and spend on Chronic Kidney Disease and diabetic foot disease.
- A reduction in variation of the 8 Care Processes across the 113 GP Practices signed up to the LES in 2022/23 compared to 2021/22 when there was no LES in place.

In relation to other areas of diabetes care, the ICS is adhering to NICE Guidance in relation to accessibility of Continuous Glucose Monitoring (CGM). CGM assists with blood glucose control, optimal blood sugar management is a crucial factor in reducing the risk of diabetes complications. It is a key clinical area of the Core20Plus5 approach for children and young people to ensure access to CGM is improved for those in the most deprived areas. The adherence to NICE Guidance will help to assist access to this.

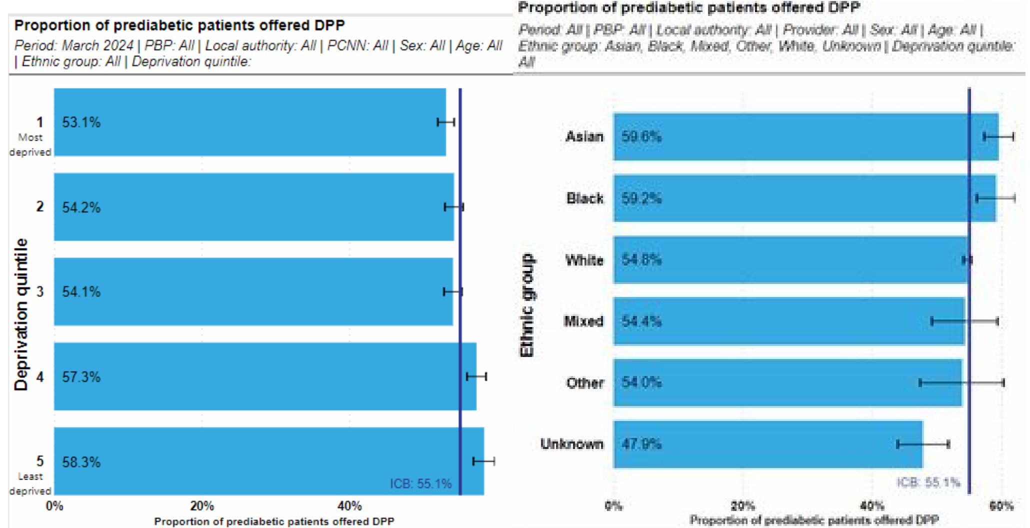
2. Variation between percentage of referrals to the National Diabetes Prevention Programme from the most deprived quintile and percentage of Type 2 Diabetes from the most deprived quintile

A. The Data

The National Diabetes Prevention Programme (NDPP) identfies people at risk of Type 2 diabetes and offers the opportunity to take part in 9 month lifestyle programme with the aim to prevent the condition developing.

Overall, 55% of eligible patients across the ICS have been reffered to the NDPP. Figure 30 shows the offer rates are lower than the ICS average from IMD quintile 1 but are higher from IMD quintile 5, the least deprived population. A higher of eligible patients are referred to the diabetes prevention programme from Asian and Black ethnic groups.

Figure 30 Percentage of people at risk of Type 2 Diabetes referred to the NDPP by deprivation and ethnicity



B. Impacting on health inequalities

Targetted promotion of the NDPP has been undertaken to help increase uptake, particulalry amongst at risk communities. Promotional vidoes have been developed and are avaliable Arabic, Farsi, Kurdish, Polish, Romanian, Tigrigna and Urdu. Closer working with local communities has been a key element of raising awareness of the programme. Collaborative working with partners has allowed for awareness

sessions to take place in community venues and religious settings in some of the most deprived areas of the ICS.

ICB Governance has also approved a new project to help improve information sharing to enable identification of and contacting eligible patients. This will allow us to target GP Practices and PCN's that are low referrers and in areas of high deprivation and across minority ethnic groups.

Smoking Cessation

A. The Data

It is estimated 16% of the Nottingham and Nottinghamshire population aged 18+ are current smokers. This is worse than the England average and places the ICS within the 6th highest smoking rates in England. The most deprived districts of the ICS, Mansfield and Nottingham City have the highest smoking rates, both within the top 10 highest rates in England with over 21% of the population current smokers.

Smoking is the leading cause of health inequalities and accounts for half of the difference in life expectancy between the most and least affluent communities in England[12].

NHS partners are members of the Nottingham and Nottinghamshire Smoking and Tobacco Alliance, led by Public Health. The Alliance brings together partner organisations including Nottingham City Council and Nottinghamshire County Council, to work towards eliminating smoking and tobacco-related harm, creating a smoke-free generation for Nottingham and Nottinghamshire by 2040.

The Alliance has published the Nottingham and Nottinghamshire Smoking and Tobacco Long Term Vision which confirms a clear and shared ambition to see smoking amongst adults reduced to 5% or lower by 2035 as well as ensuring those born in 2022 remain smoke free by their 18th birthday to help create a smoke-free generation. There are four key delivery themes of the vision:

a) Helping vulnerable people quit smoking: A particular focus on more deprived communities, those in social housing, working in manual and routine jobs, those with poor mental health and those with multiple needs such as homelessness.
b) Effective regulation of tobacco products
c) Reducing exposure to second hand smoke
d) Prevention and engagement with children and young people

Key actions within each of the four areas and can be viewed within the vision Statement here: 43.114-Smoking-and-Tobacco-Control-Vision.pdf (mynottinghamnews.co.uk)

[12] Smoking and Health Inequalities 2019 ASH-Briefing_Health-Inequalities.pdf

1. Proportion of adult acute inpatient settings offering smoking cessation services

100% of adult acute inpatient settings offer smoking cessation services across Nottingham and Nottinghamshire.

Smoking tobacco is linked to just over 500,000 hospital admissions each year, with smokers being 36% more likely to be admitted to hospital than non-smokers. Smoking tobacco is linked to over 100 different conditions. Stopping smoking results in an improved response to cancer treatments, faster recovery after surgery, fewer exacerbations of cardiovascular disease, slower decline in lung function, lower pharmacotherapy costs and a beneficial impact on long-term levels of depression and anxiety. Increasing access to tobacco treatment services whilst in hospital can help improve quit rates, continued support in the community following discharge is also an important part of the pathway to ensure continued positive outcomes for patients.

2. Proportion of maternity inpatient settings offering smoking cessation services

100% of maternity inpatient settings offer smoking cessation services across Nottingham and Nottinghamshire.

Smoking is also the single greatest modifiable risk factor for poor outcomes in pregnancy. The harms associated with smoking relate not only to the mother but also to the unborn child, where we see a doubling of the likelihood of stillbirth and tripling of the likelihood of sudden infant death[13]. Smoking rates are higher amongst those in the most deprived areas. The service offer aims to help pregnant people who smoke set quit dates to reduce risks during pregnancy.

B. Impacting on Health Inequalities

After receiving early implementer funding, Sherwood Forest Hospitals Foundation Trust (SFHT) have a comprehensive programme for reducing smoking at the time of delivery. Along with an evidenced based service delivery model, the programme utilised NICE Guidance in relation to helping pregnant people stop smoking and use of incentives in the form of shopping vouchers to help encourage this. The team also provided emotional support and nicotine replacement therapies to aid people to quit smoking. The number of people who set quit dates during the pilot period doubled. Around 79% of those identified as smokers in the pilot were also from the 40% most socio-economically deprived areas, 58% were from the 20% most deprived.

On the pilot commencement, 18% of pregnant people were classed as smokers at the time of delivery in SFHT, one of the highest rates in England. The most recent data available to the ICS indicates the current smoking at time of delivery at SFHT is

[13] Tobacco Dependency Programme 2019 NHS England » Tobacco dependency programme

now 12.9%, a decline of 6 percentage points, just one percentage point reduction in the smoking rate equates to an annual saving to the Trust of around £100,000.

Results from the programme have also shown;
88% of participants were smoke-free at birth
83% of participants were still smoke-free 6 weeks postnatal
18% of homes became entirely smoke-free

An evaluation found the combination of support offered via the programme to be effective and highlights the efficacy of an incentive scheme, complemented with support from clinicians and the significance of knowledge exchange and collaboration between stakeholders in healthcare.

Although not noted specifically as a requirement of the statement, the ICS has smoking cessation service available in 100% of Mental Health Inpatient Settings. The service will provide tobacco dependence advice and treatment in a secondary care setting. This will include a systematic identification of smoking status on admission and opt-out referral to the 'in-house' Tobacco Dependency Service. Support will continue upon discharge with community mental health teams working closely with hospital teams, assisting the patients to reach a 12 week quit rate. Smoking rates among people with a mental health condition are significantly higher than in the general population and there is a strong association between smoking and mental health conditions.

Oral Health

A. The Data

Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable. Almost 9 out of 10 hospital tooth extractions among children aged 0 to 5 years are due to preventable tooth decay and tooth extraction is still the most common hospital procedure in 6 to 10 year olds, according to data up to 2019[14]. Data also shows that children in the most deprived populations have more than twice the level of tooth decay than those in the least deprived areas.

1. Tooth extractions due to decay for children admitted to hospital aged 10 and under (number of admissions)

The overall number of children admitted as inpatients to hospital tooth extractions in Nottingham and Nottinghamshire is relatively small, with between 100 and 150 extractions each year. In 2022/23, two thirds of extractions where for children living in the Bassetlaw PBP or corresponding local authority. Because numbers are so low, there is no statistically significant variation by deprivation or ethnicity, the data is available in figures 31 and 32.

Figure 31 Rate and count of tooth extraction admissions in under 10s by deprivation quintile

[14] Child oral health: applying All Our Health 2022 Child oral health: applying All Our Health - GOV.UK (www.gov.uk)

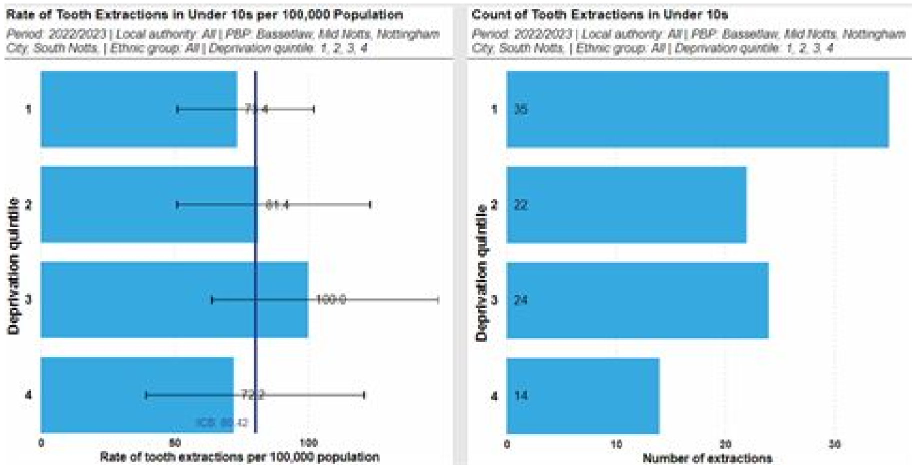
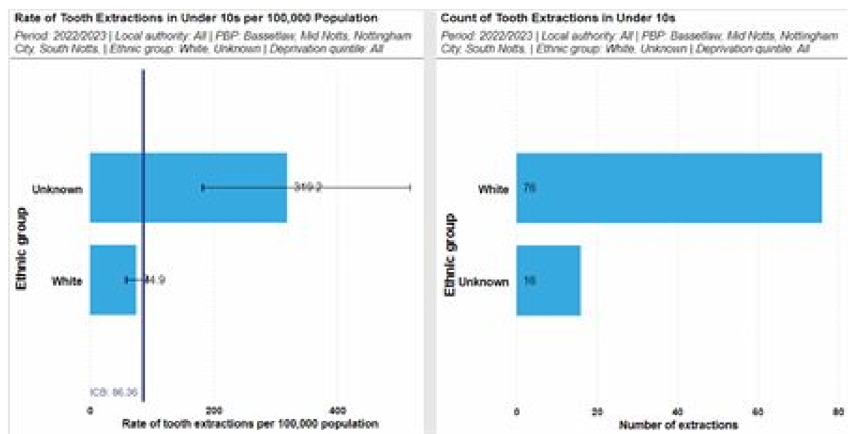


Figure 32 Rate and count of tooth extraction admissions in under 10s by ethnicity



B. Impacting on Health Inequalities

Water fluoridation is a safe and effective population intervention, which involves the controlled adjustment of fluoride to a public water supply to an optimum level for reducing tooth decay (1parts per million). It works by helping to prevent bacteria in the mouth from producing acid that attacks the enamel on tooth surfaces and also helps to restore and strengthen the surface enamel on teeth. It is effective in both children and adults. 22% of Nottingham and Nottinghamshire residents have access to fluoridated water however, the vast majority of the ICS does not – as such this has the potential to exacerbate inequalities in oral health.

To improve the oral health of local children and adults and prevent health inequality, Nottingham City County and Nottinghamshire County Council, with the endorsement of the ICB and Integrated Care Partnership have been working in partnership to seek the expansion of water fluoridation across the ICS area. In January, the two councils, along with health partners, submitted a formal letter to the Secretary of State for Health and Social Care requesting the expansion of water fluoridation across the whole of Nottingham and Nottinghamshire. The formal request is now being reviewed by the Secretary of State. If it is agreed to consider expanding water fluoridation locally, there would be a phase of exploratory work and public

consultation before a decision is made whether to proceed with implementation. This is long term piece of work and a resolution is not expected imminently.

People with Learning Disabilities and Autistic People

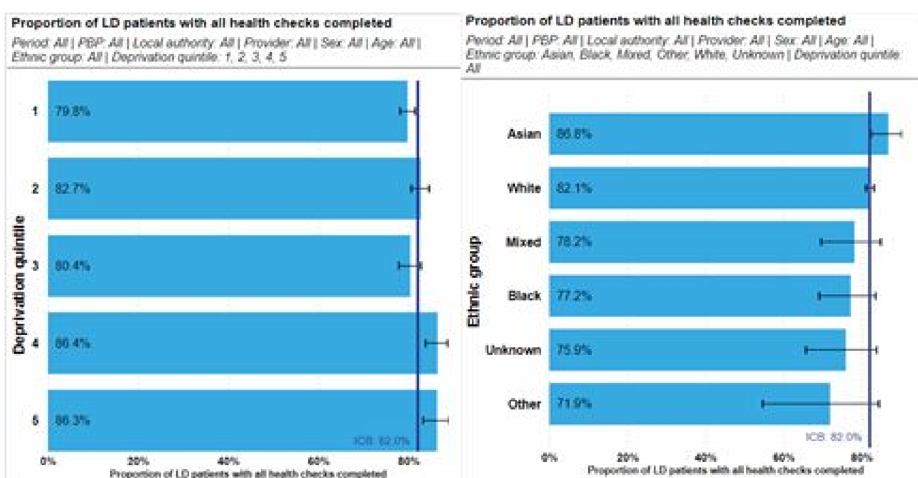
A. The Data

Health Inequalities are evident in people with Learning Disabilities, with the average life expectancy around 20 years less in this population group, further data indicates that 49% of deaths in this group were from avoidable causes[15]. Annual health checks enable contact with a health professional to spot early signs of illness and prevent conditions worsening.

1. Learning disability annual health checks

In the ICS Overall, 82% of people with a learning disability have had an annual health check completed in the previous year. The rate of checks is lower in the most deprived IMD quintile as shown in figure 44. While the percentage of checks completed is also below the ICS average for a number of ethnicity categories, these differences are not statistically significant. Those in younger age categories (below age 33) also have a lower rate of checks than older age categories.

Figure 33 Rate of completed learning disability health checks by deprivation and ethnicity.



2. Adult mental health inpatient rates for people with a learning disability and autistic people

The latest national data set available for this states that there were 45 in patient mental health stays for people with learning disabilities and autistic people in December 2023 and 50 at the end of January 2024 for Nottingham and Nottinghamshire ICB. Data is unavailable to show the breakdown of admissions by deprivation and ethnicity.

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[15] Learning disability - applying All Our Health (2023) Learning disability - applying All Our Health - GOV.UK (www.gov.uk)

B. Impacting on Health Inequalities

A pilot undertaken between 2022-2023 increased the percentage of checks of LD Checks completed across ethnic minority groups across Nottingham City as data showed uptake was lower amongst non-white groups. Using personalised approaches, new locations for the completion of checks and different methods of communication, some population groups saw up to an 83% increase in checks completed. Black, Asian and Mixed ethnic groups saw a 33-43% increase in the number of checks completed. This pilot demonstrates the impact increasing access to checks through new methods can improve uptake in populations and in turn contribute to improved outcomes within populations experiencing additional barriers.

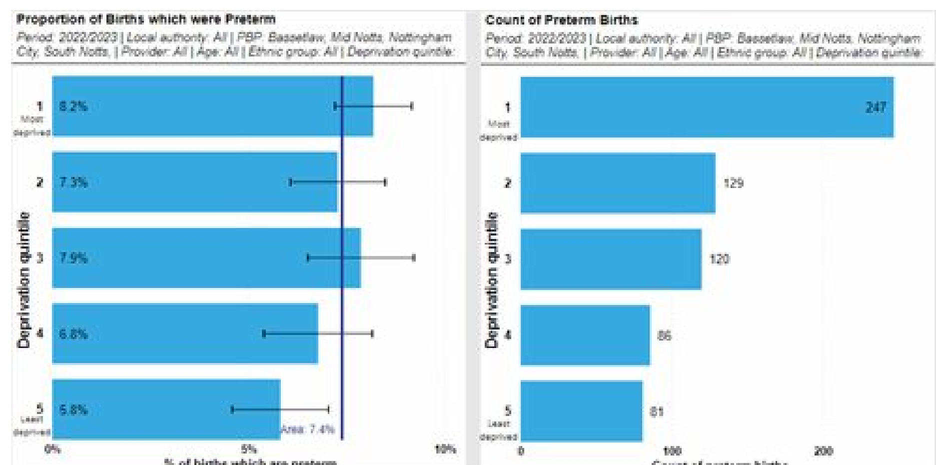
Maternity and Neonatal

1. Pre-term births under 37 weeks

A. The Data

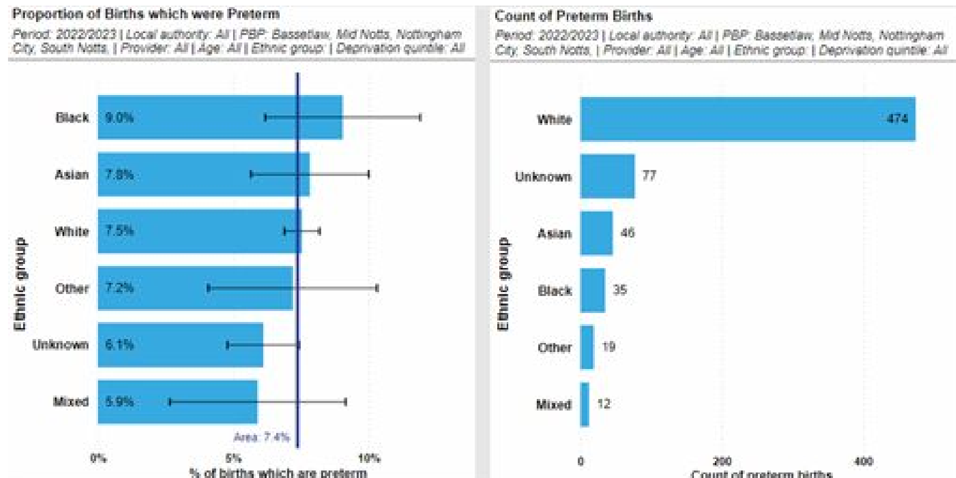
As shown in Figure 39, those in the most deprived IMD Quintile have the highest count of pre-term births, and are 1.4 times as likely to have a preterm birth than those in the least deprived quintile. Pre-term births by ethnic group are presented in Figure 40, however numbers of pre-term births are too small to show statistically significant differences. Complications from premature birth remains one of the three main causes for infant mortality in the UK[16]. The Marmot Review 2010 stated that one quarter of all deaths under the age of one would potentially be avoided if all births had the same level of risk as those to women with the lowest level of deprivation[17].

Figure 34 Rate and count of preterm births by deprivation



[16]Infant mortality and health inequalities 2023 CBP-9904.pdf (parliament.uk)
[17] The Marmot Review 2010 fair-society-healthy-lives-full-report-pdf.pdf (instituteofhealthequity.org)

Figure 35 Rate and count of preterm births by ethnicity



B. Impacting on Health Inequalities

The NHSE 3-Year Delivery Plan for Maternity & Neonatal Services, published in March 2023, aims to make care safer, more personalised, and more equitable. A key theme in the plan is “Listening to women and families with compassion which promotes safer care.” One of the recommendations from The Nottingham and Nottinghamshire Maternity and Neonatal Voices Partnership (MNVP) is also to engage with families from ethnic minority communities when developing new services/updating existing services. To support this, it was agreed to add capacity and resource into the local MNVP provision with a new team of volunteers and ICB staff to be recruited.

In Q1-Q2 2023, the Local Maternity Neonatal System established a health inequalities working group which explored initiatives to support a more equitable maternity system. Following on from the group sessions, additional on-demand - language and communication support services are now in place via CardMedic and Maternity & Neonatal Link Worker roles are being explored. Link Workers will provide individualised support to expectant parents who have difficulty communicating with their midwife and other health professionals in a flexible and innovative way. Link workers will provide support to develop a personalised care & support plan that sets out their decisions about their care and wider health needs.

NUH have streamlined all their patient information leaflets for maternity to ensure they are up to date, accurate and fit for purpose. All the leaflets are available in the Badgernet resource library for and will also sit on their internet page for maternity, where they can be downloaded in multiple languages with a voice over in native language option using a ReciteMe tool button.

The LMNS Neonatal Steering Group was established in 2023 to develop seamless, responsive, and multidisciplinary Neonatal services built around the needs of newborn babies and the involvement of families in their care. The local vision is that high quality neonatal care will be delivered to improve outcomes for all families, providing safe, expert care as close to their home as possible, and keeping the

mother and baby together while they need care. The Neonatal Voices Lead is a key member of this group and is working with the wider MNVP to gather feedback and experiences from the diverse population using services via a new survey published in May 2024 that will inform service development across maternity and neonatal services.

Preterm Birth Clinic Leads have been recruited at both SFH & NUH (April 2024). The clinics are mandated by NHSE in support of the Long-Term Plan ambition to achieve 50% reduction in perinatal morbidity and mortality by 2025, through bespoke care for those identified at risk of preterm birth. The existing clinic at NUH will be developed and a new clinic set up at SFH to increase capacity across the system for optimising care for those at risk of pre-term birth. Care immediately after birth will be also optimised using nationally recommended clinical adjuncts to support reduction in the incidence of brain injuries acquired during or shortly after birth for preterm babies.

NUH utilised a share of national funds for improving equity and diversity to appoint a community engagement matron which supports the aims of the delivery plan and findings from the MVP. Key priorities were agreed for the inclusivity task force (interpreting services; cultural awareness training; engagement with local minority ethnic community groups; workforce diversity; antenatal forums in different languages). The aim of this role and task force is to reduce barriers for maternity service users which in turn will improve outcomes and experiences for those who may otherwise have more negative experiences. Progress is reported through the Trust to prevent silo working.

Sherwood Forest Hospitals Phoenix Team incentive scheme – a joint project funded by the LMNS, the Trust and the Nottingham Business School. Details of which are provided within the smoking cessation section.

There is further Partnership working through a Public Health & Child Death Overview Panel (CDOP). The process for learning from the death of a child is managed through the statutory framework of the CDOP[18] which involves strong local partnerships across health, social care, safeguarding and police.

Data Quality

The data used in this Statement has been take from the suggested NHS England data sources as well as local primary and secondary care data available.

Efforts have been taken to ensure data sources are complete and valid. Data Quality is part of Contract and/or Information review meetings led by Contracting Teams. Data quality issues are raised and discussed as part of these meetings, usually when problems are identified.

However, it should be noted that within ethnicity coding, “Not Stated” is considered a valid code, in addition the category “other” may also be used incorrectly for example in instance’s when ethnicity is not stated or unconfirmed. This may result in an

[18] https://nottinghamshirescb.proceduresonline.com/p_unexp_death_ch.html

inaccurate picture of ethnicity. Despite this, ethnicity coding is improving and training is available for staff regarding when and how to use coding to prevent errors.

Impact of ethnicity coding quality on the calculation of rates from secondary care data

The population denominators used for indicators presented here are based on the Nottingham and Nottinghamshire ICB GP-registered population. Ethnicity coding in the GP-registered population is generally near-complete, with only 5% of patients having an unknown ethnicity, either because they have declined to share their ethnicity or it hasn't been recorded.

Secondary care data sources, such as SUS and the Waiting List Minimum Dataset, tend to have a significantly higher proportion of 'Unknowns', often between 10 and 25%. Additionally, the number of patients in secondary care data sources with an 'Other' ethnicity is substantially higher than would be expected for the GP-registered population.

When crude or age-standardised rates are calculated with a secondary care data source as the numerator and the GP population as the denominator this produces a distorting effect when viewed by ethnicity due to the mismatch between the numerator and denominator: Rates for the 'Unknown' and 'Other' populations appear to be excessively high, and rates in smaller ethnic groups (Asian, Black, Mixed), for which missing a small number in the numerator has a greater effect, are likely depressed.

Crude and age-standardised rates based on secondary care data should be interpreted with caution when broken down by ethnic group. For age-standardised rates, 'Unknown' and 'Other' ethnic groups have been omitted.

For further information, please see the below tables which detail the Nottingham and Nottinghamshire GP Population breakdown by ethnicity and the validity of ethnicity coded within secondary provider trusts.

Nottingham and Nottinghamshire ICB GP-registered population by ethnicity

Ethnic Group	% of population	Count of population
White	76.5%	970,984
Asian	8.8%	112,278
Unknown	5.2%	66,489
Black	4.1%	52,860
Mixed	3.4%	43,537
Other	1.7%	21,660

Ethnicity coding validity for Nottingham and Nottinghamshire Secondary Care providers ethnicity coding validity

The chart below details the percentage of patients with a valid ethnicity code for Secondary Care Providers in comparison with the national average. All providers in

the ICS are exceeding national averages. The below information is correct as of January 2024.

Provider	Dataset	% Valid Ethnicity Coding	National Average
NOTTINGHAM CITYCARE PARTNERSHIP	CSDS	91%	79.50%
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	CSDS	82%	79.50%
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	APC	84%	79.50%
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	APC	91%	79.50%
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	APC	95%	79.50%
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	APC	97%	79.50%
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	OP	85%	79.50%
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	OP	97%	79.50%
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	OP	94%	79.50%
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	OP	96%	79.50%
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	MH	95%	79.50%

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/05/2024
Paper Title:	**Delivery Plan for Recovering Access to Primary Care**
Paper Reference:	ICB 24 012
Report Author:	Esther Gaskill, Deputy Associate Director Primary Care
Report Sponsor:	Dave Briggs, Medical Director
Presenter:	Dave Briggs, Medical Director

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

Summary:

NHS England published the 'Delivery Plan for Recovering Access to Primary Care' on 9 May 2023. The plan included the requirement for all ICBs to develop a system-level primary care access improvement plan. The Nottingham and Nottinghamshire plan was presented to the Board in November 2023.

The plan sets out the actions being taken across the four key national commitments:

1. Empowering patients to manage their own health.
2. Implementing modern general practice access.
3. Building capacity.
4. Cutting bureaucracy.

This report provides an update on progress to date with implementation of plan and the actions being taken to ensure delivery within required timescales.

Recommendation(s):

The Board is asked to **receive** the report for asurance.

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

How does this paper support the	ICB's core aims to:
	Practice to support that need, building social capital within local areas.

Appendices:
A: Summary of progress made against each of the main actions between November 2023 and April 2024

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 1: Health Inequalities and Outcomes – Failure to adequately address health inequalities and improve health outcomes for the population of Nottingham and Nottinghamshire. • Risk 2: System Resilience (for Managing Today) – Working effectively across the system may fail to address the current levels of demand across primary, community and secondary care. • Risk 6: Quality Improvement – Failure to maintain and improve the quality of services.

Report Previously Received By:
Progress kept under review by the Strategic Planning and Integration Committee.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Delivery Plan for Recovering Access to Primary Care

Background

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

Delivery oversight

5. The Primary Care Strategy Delivery Group has operational oversight of the PCAIP. The Group meets monthly and is chaired by the ICB's Chief Executive, with representation including Primary Care Network (PCN) clinical directors, the Local Medical Council, transformation leads for workforce, estates and digital, and ICB leads for primary care commissioning, contracting and quality.

6. The Group agreed four initial priority areas from the ICB's Primary Care Strategy, one of which was improving access to primary care services.
7. A task and finish group has been established to oversee the access pillar and implementation of the PCAIP. Actions and timescales for delivery have been identified for each access component so that there are clear measurements for assessing delivery.
8. Metrics have been developed by the System Analytics and Intelligence Unit (SAIU) to support monitoring delivery of the PCAIP. A PCAIP dashboard facilitates this and ensures ICB officers, PCNs and practices can review the access data which includes:
    a) GP Appointment Data:
        - % of same day appointments
        - % of appointments booked within 2 weeks
        - % of face-to-face appointments
        - % of GP appointments and
        - % of Did Not Attend (DNA)
    b) Digital / on-line data:
        - % practices with online appointments booking
        - % patients enabled for repeat prescriptions online
        - % patients with prospective online records access
    c) Patient experience data:
        - Family and Friends Test submission and scores
    d) Community Pharmacy:
        - % practices referring to community pharmacy consultation service
9. The quality of the data continues to develop, hence firm conclusions cannot be made around access to appointments. This is recognised as an issue nationally. SAIU colleagues are working with the NHS England regional team to develop reporting quality.
10. The 2024/25 GP Contract will be amended to require practices to provide data on eight additional telephony metrics through a national data extraction. These eight metrics are:
    a) Call volumes
    b) Calls abandoned
    c) Call times to answer
    d) Missed call volumes

e) Wait time before call abandoned

f) Call backs requested

g) Call backs made

h) Average call length time

Implementation progress

11. The following table provides a Red (minimal progress), Amber (moderate progress), Green (good progress) rated summary of progress to date against the key commitments in the PCAIP.

Key Commitments	Deliverable	Progress Rating	Comments / Rational
Empowering Patients	Self-referral pathways	Green	self-referral options for 5 out of 7 pathways in place
	Community pharmacy services	Green	Pharmacy first launched, blood pressure and contraception services expanded
Modern General Practice Access	Digital telephony and online tools	Green	100% GP practices with online tool in place and digital telephony by 2025
	National GP Improvement Programmes (GPIP)	Green	126% take up of share of allocated places by NHS England
	Local GPIP	Red	No local programme in place (see paragraph 21)
	Support Funding	Amber	£250,000 allocated, practices to be encouraged to continue to apply for funding throughout 2024/25.
	Training	Amber	Care Navigation, Digital Lead training undertaken, to be further supported as/when available
Capacity	Additional Roles Reimbursement Scheme (ARRS)	Green	ARRS continuing to increase with number of roles to be widened in 2024/25
Reducing bureaucracy	Primary – secondary care interface	Green	Development plans in place national benchmark assessment tool completed

12. Appendix A provides a summary of progress made against each of the main actions between November 2023 and April 2024.

Empowering patients

Self-referral pathways

13. Self-referral routes for a number of services, have been expanded. Developments and achievements include:

    a) Introduction of self-referral options for five out of seven pathways determined by NHS England, with ongoing work to introduce self-referral to audiology and wheelchair services.

    b) Current scoping of an online self-referral hub for Nottingham and Nottinghamshire that consolidates the self-referral offer for both citizens and professionals. This would be greater than the 7 pathways defined by NHS England.

    c) Exceeding the indicative target set by NHS England: the baseline being 282 self-referrals, the target being 422 self-referrals and the November 2023 data being 648 self-referrals undertaken.

Expansion of community pharmacy services

14. The delivery plan for recovering access to primary care includes relaunch / implementation of several Community Pharmacy services which aim to increase access to GP surgeries through directing patients with simpler conditions to pharmacies.

15. Pharmacy First launched on 31 January 2024 and includes seven new clinical pathways as well as incorporating the existing Community Pharmacy Consultation Service (CPCS). These pathways have both a walk in and referral mechanism and pharmacists can supply a prescription only medicine if appropriate. In Nottingham and Nottinghamshire, as of 31 March 2024, there are 219, over 95%, of community pharmacies registered to provide the service.

16. The Blood Pressure service, which includes case finding and referral from the GP surgery has been expanded so that all suitably trained members of the Community Pharmacy team can now provide the service. In 2023, 37,068 blood pressure checks were undertaken by Community Pharmacy in Nottingham and Nottinghamshire.172 pharmacies are currently offering the service.

17. The Oral contraception service has expanded to include both initiation and continuation of oral contraception. General practice can now refer any patient to this service. Locally there are 44 pharmacies registered for the service. A regional webinar with presentations from specialists and local pharmacists took place in November to help increase confidence in signing up and delivering this service.

Modern general practice access

Digital telephony

18. Significant progress has been made in supporting the 17 practices that were on an analogue system to implement a new cloud-based telephony system. 69 practices are being assisted to move to an improved cloud-based telephony system. All Nottingham and Nottinghamshire practices will meet the requirement to be using a cloud-based telephony system by 2025.

Use of digital services integrated care products (online tools)

19. All practices now have an online consultation tool in place and are at various stages in enabling patients to have access to both administrative requests (for example, a repeat prescription request) and medical requests (for example, asking for an appointment). Over the last eight months there has been a 47% increase in the volume of online consultations completed with approximately 22,000 per month being completed. Progress is monitored through the PCAIP implementation group and practices are being supported to increase availability for patients.

20. The ICS's digital strategic direction is to have the NHS app as the front door. At the end of March 2024, 54% of the Nottingham and Nottinghamshire population have the NHS app, with 4,500 new registrations being added each month (6% annual increase). Over 80,000 repeat prescriptions are being ordered via the app each month, with an estimated time saved of 30 seconds per repeat prescription. Work continues to increase uptake of the NHS app with events taking place locally to promote digital confidence and support increased take up of app services.

Uptake and participation in General Practice Improvement Programmes

21. 32 practices have completed or are undertaking the national intensive and intermediate support programmes. This is a 126% take up of share that was originally allocated by NHS England. The participation is well spread across Place-Based Partnerships (PBPs), with a number of practices working in high areas of deprivation and need taking part.

Local hands-on support to practices

22. Due to the need to identify financial savings in 2023/24, the funding allocated to develop a local support offer to practices via the Primary Care System Development Funding has been withdrawn. Any practice wishing to access support has been able to do so through one of the national support programmes. The local support programme offer will be reviewed once the allocation of primary care development funding for 2024/25 is confirmed.

Transition cover and transformation support funding

23. To date over 30 practices have approached the ICB for transformation support funding to enable them to prepare for implementation of elements of a modern general practice access model. Approximately £250,000 has been allocated for:
    a) Sessional GPs for a limited period (to enable practice GPs to prepare for implementation).
    b) Support from experienced peers (to support the practice in readiness for implementation).
    c) Additional sessions, for a limited period, from current practice staff, clinical or non-clinical (to prepare for implementation).
    d) Additional training e.g., care navigator training for all reception staff to enable full implementation of the new access model.
24. Practices are able to continue to apply for funding (an average of £13,500 per qualifying practice) throughout 2024/25. Additional communication to ensure practices are fully aware of this, know how to access it and what it can be used for will be circulated in the coming weeks.

Training: care navigation

25. Approximately 330 individuals have attended Care Navigation training provided by the Nottingham Alliance Training Hub (NATH) or through completing NHS England's national programme.
26. Practices will continue to be supported to meet their identified training needs around care navigation through development of a local training session that will be delivered by NATH during 2024/25.

Digital and transformation leads

27. The twelve-month Digital and Transformation Lead Development Programme delivered by NHS England has been specifically designed to equip individuals in the Digital and Transformation Lead ARRS role with the core skills to be able to lead transformational change. Of the 18 Digital and Transformation Leads in post, five are taking part in the programme. Additional leads will be supported to participate should further cohorts be announced for 2024/25.

Access improvement

28. All PCNs developed a Capacity and Access Improvement Plan in 2023. 70% of the associated Capacity and Access Payment has been paid by NHS England to PCNs during 2023/24 without any conditions. The remaining 30% payment will be allocated following assessment of achievement against improvement criteria developed by the ICB including:
    a) Improved patient survey results (local survey)
    b) Increased use of the Family and Friends Test and score

c) More consistent GP Appointment Data reporting

29. Specific examples of improving access at Place level include Nottingham City East PCN On Day Service: extra urgent same day appointments are available at a central hub within St Ann's Valley Centre that practices can utilise if they are at full capacity. This service is operationally managed by Nottingham City GP Alliance and operates for five days a week with appointments undertaken by a GP. Practices are extremely supportive of the service and patient feedback has been positive.

30. In South Nottinghamshire a project to improve access to urgent and routine appointments and continuity of care for frail, elderly patients who are frequent attenders and housebound patients is underway. The aim is also to support staff morale/retention, reduce workload and fatigue for all staff groups. Patients in the above cohorts are able to have a code assigned which indicates the healthcare professional reviewing them feels they would benefit from continuity of care. Several benefits have been identified to date including:

    a) GPs benefitting from the time to address holistic issues for identified patients.

    b) Patients reporting positive experiences of more time, increased information and resolution of long-standing issues not resolved during previous contacts.

    c) Carers living with housebound patients included in reviews to address unmet needs.

31. In Bassetlaw, the Worksop Integrated Team (A PCN hub jointly operated by two Worksop PCNs) has helped primary care tackle urgent presentations (there is no urgent care centre or walk in centre available in Bassetlaw).

32. The hub provides Emergency Department streaming and works to an Acute Respiratory Infection (ARI) hub model but is not limited to respiratory presentations. It has enabled practices to focus on chronic, complex patients including running a frailty pilot. The hub has offered a total of 3,096 appointments since its launch in August 2023 (120 per week).

33. This is mirrored by a hub at Retford Hospital operated by Retford and Villages PCN, which was established in September. This offers approximately 600 appointments per month.

Capacity

Using full Additional Roles Reimbursement Scheme (ARRS) budget

34. The PCN ARRS has continued to increase during 2023/24. Approximately 646 whole time equivalent staff are currently employed within Nottingham and Nottinghamshire PCNs through this scheme in a number of different roles.

35. The number of reimbursable roles is to be widened in 2024/25, and role restrictions removed. Throughout 2023/24 PCNs have been supported to use their full ARRS budget and report an accurate complement of staff using the National Workforce Reporting Service portal.

Reducing bureaucracy

Improve primary-secondary care interface

36. ICB colleagues have been working closely with secondary care providers over the last two years to improve relationships and the interface between general practice and secondary care. The focus has been on wider system working, reducing duplication, acknowledging each other's roles and communication. Development plans to continue to progress this joint work are in place and will be brought together through completion of NHS England's recently circulated assessment tool. This will also support identification of areas for further development.

37. Interface work with East Midlands Ambulance Service (EMAS) is also underway, with a local GP Fellow involved in collaborating on improvement of communication to a GP following an EMAS patient attendance and maximising population health management opportunities.

Register with a GP surgery service

38. Practices have been supported to sign up to NHS England's new online 'Register with a GP service' through regular communications and signposting to examples of where implementation has been successful. The service aims to reduce GP practice processing time and digitises and standardises registration. Over 40 practices are currently signed up and this will increase as it becomes a contractual requirement for 2024/25.

Communication plan

39. A system communication plan to support patient understanding of the new ways of working in general practice, including digital access, multidisciplinary teams and wider care available has been developed. A variety of ICB and partner channels have been used to promote key messages to our audiences, including websites, social media, print and broadcast media, stakeholder communications, TeamNet and the intranet. Key milestones for 23/24 have included:

    a) Creation of new Pharmacy webpages

    b) Launch of Pharmacy First campaign across all platforms

    c) Creation of new ARRS video assets to increase patient awareness

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

40. For 2024/25, a refreshed communications plan to reflect NHS England's and local priorities is being prepared. This will include:
    a) An aim to increase self-referrals by creating a new portal on the ICB's website
    b) Continued promotion of Pharmacy First services
    c) Improve public awareness of the care navigator role
    d) Promotion of the online 'Register with a GP service'
    e) Promotion of use of 111 by phone and online
    f) Increase awareness of impact of Did Not Attends (DNAs).

Risks and issues

41. General Practice resilience is challenged across many practices, impacting on staff health and wellbeing, and operational delivery. The ICB's Primary Medical Services Support and Assurance Groups aim to provide a systematic 'early warning system' that provides an opportunity to support practices at risk of being unsustainable. This is limited by the information providers choose to share with the ICB and constrained by the level of support that can be offered by the ICB when a practice is struggling.
42. The relationship the ICB has with GPs is different to that of predecessor Clinical Commissioning Groups (CCGs). This is a risk to delivery of the PCAIP and Primary Care strategy due to disengagement from GP colleagues which is heightened by the recent 2024/25 GP Contract publication. Despite the creation of mitigating actions such as the creation of forums for GP/ICB engagement (e.g., One Voice Forum, Place based Partnership meetings, Primary Care Strategy Group) there remains a reported 'disconnect' practices experience from the ICB.
43. The 2024/25 GP contract has not been agreed with the BMA GP Committee and is likely to be imposed. The BMA are balloting GPs on whether to take further action (such as 'work to rule'), including industrial action.
44. The uplifts in the value of the GP contract are significantly below inflation and the 10% increase in the minimum wage from April 2024, which is also likely to filter through to other pay bands. This increases the risk of financial viability for practices and the potential for contract hand backs as well as disengagement from Local Enhanced Services. This could lead to an increase in financial pressure on the ICB as well as deplete ICB capacity to find alternative commissioning solutions.

Next steps

45. NHS England published an update to the Delivery Plan in April 2024. This includes a summary on progress to date and the key milestones for 2024/25.

46. The Primary Care Strategy Group will continue to oversee the implementation of the PCAIP through a programmatic approach that includes consideration of any future developments or contractual requirements. The Strategic Planning and Integration Committee will scrutinise delivery in-year, and a further update is scheduled for the Board in November, along with a refreshed plan in line with updated guidance.

Appendix A

PCAIP Action	November 2023 Position	April 2024 Position
Expand self referral routes (falls services, musculoskeletal services, audiology for older people including loss of hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services)	Five of the seven pathways for implementing self-referral already had self-referral pathways in place. For the remaining two pathways (Audiology and Wheelchairs services) discussions due to take place	Work underway to introduce self-referral to audiology and wheelchair services Exceeding the indicative target set by NHS England: the baseline being 282 self-referrals, the target being 422 self-referrals and the November 2023 data being 648 self-referrals undertaken
Expand Community pharmacy services (oral contraception and blood pressure services)	156 pharmacies providing the blood pressure service 44 pharmacies registered for the oral contraception service.	In 2023, 37,068 blood pressure checks were undertaken by Community Pharmacy.172 pharmacies currently offering the service The Oral contraception service has expanded to include both initiation and continuation of oral contraception. General practice can now refer any patient to this service. Still 44 pharmacies registered for the service Pharmacy First launched on 31 January 2024 and includes seven new clinical pathways. As of 31 March 2024, there are 219, over 95%, of community pharmacies registered to provide the service
Digital telephony – Sign up practices ready to move from analogue to digital telephony	111 already Cloud Based 17 analogue	Significant progress in supporting the 17 practices that were on an analogue system to implement a new cloud-based telephony system. 69 practices being assisted to move to an improved cloud-based telephony system. All practices will meet the requirement to be using a cloud-based telephony system by 2025
Use of digital services integrated care products (online tools)	A small number of practices identified as having tools that did not meet the national requirements	All practices now have an online consultation tool in place. Over the last eight months there has been a 47% increase in the volume of online consultations completed with approximately 22,000 per month being completed

PCAIP Action	November 2023 Position	April 2024 Position
Uptake and participation in national GPIP	Nine practices signed up to intermediate / intensive GPIP programmes	32 practices have completed or are undertaking the national intensive and intermediate support programmes
Local hands-on support to practices	A local programme was in development	The funding allocated to develop a local support offer to practices via the Primary Care System Development Funding has been withdrawn. Any practice wishing to access support has been able to do so through one of the national support programmes. The local support programme offer will be reviewed once the allocation of primary care development funding for 2024/25 is confirmed
Transition cover and transformation support funding	£0 support funding allocated	Approximately £250,000 allocated for: • Sessional GPs for a limited period • Support from experienced peers • Additional sessions, for a limited period, from current practice staff • Additional training e.g., care navigator training
Training	114 individuals undertaken care navigation training	330 individuals have attended Care Navigation training provided by the Nottingham Alliance Training Hub (NATH) or through completing NHS England's national programme Of the 18 Digital and Transformation Leads in post, 5 are taking part in the national training programme
Access Improvement	Capacity and Access Improvement Plan developed by all PCNs	Review of progress against plans using CAIP 30% assessment criteria underway
Using full ARRS budget	Approximately 600 whole time equivalent staff employed	Approximately 646 whole time equivalent staff employed
Improve primary-secondary care interface	Providers across primary care, community service, mental health and secondary care	Work ongoing, development plans in place. National

PCAIP Action	November 2023 Position	April 2024 Position
	working together to improve patients' experience of transitions of care between providers	benchmark assessment tool completed

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/05/2024
Paper Title:	**Quality Report**
Paper Reference:	ICB 24 013
Report Author:	Diane-Kareen Charles, Deputy Chief Nurse and Director of Quality. Nicola Ryan, Deputy Chief Nurse Operations and Delivery Philippa Hunt, Chief People Officer
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 includes progress and exception reports for areas of concern covering quality and workforce, including the following areas of enhanced oversight:

- **Learning Disability and Autism:** There remains significant challenges to delivery and the impact on the care experience for service users. As of end March 2024 there are 45 adult inpatients, therefore not achieving the year-end target of 37.
- **Nottinghamshire Healthcare NHS Foundation Trust:** Following publication of the Section 48 report a jointly chaired Improvement Oversight and Assurance Group was established in March 2024. NHT has now moved into a Recovery Support Programme and NHS Oversight Framework Level 4. The Trust has shared a developing integrated improvement plan to align with themes and risks.
- **Nottingham University Hospitals NHS Trust:** Whilst there have been improvements in the oversight areas of leadership and maternity, significant financial challenge remains. There is evidence of sustained attention to alleviating pressure in the Urgent and Emergency Care pathway and considerable assurance in relation to the continued improvement around maternity services.
- **Urgent and Emergency Care:** A Rapid Quality Review was held in March 2024 with all system partners, chaired by the ICB Chief Nurse, with the agreement of key actions to take forward.

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

Recommendation(s):

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

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	Provides an overview of current performance in relation to quality across the ICB.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	Provides an overview of current performance in relation to finance across ICB quality domains.

How does this paper support	the ICB's core aims to:
Help the NHS support broader social and economic development	Provides an overview of current performance in relation to workforce across ICB quality domains.

Appendices:

None.

Board Assurance Framework:

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

- Risk 1: Transformation (Making Tomorrow Better for Everyone) – Effective system working may not transform (reform) and improve services to address health inequalities and ensure best possible future health outcomes within available resources.
- Risk 2: System Resilience (for Managing Today) – Working effectively across the system may fail to address the current levels of demand across primary, community and secondary care.
- Risk 6: Quality Improvement – Failure to maintain and improve the quality of services.
- Risk 7: People and Culture – Failure to ensure appropriate capacity and capability within the local workforce..
- Risk 9: Safeguarding – Failure to safeguard children and vulnerable adults in accordance with legislative and statutory frameworks and guidance.

Report Previously Received By:

Previously reviewed by the Quality and People Committee.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Quality Report

Executive summary

1. In line with the ICS Escalation Framework (contained in the Nottingham and Nottinghamshire ICB Operating Framework) areas of quality and safety are classified as 'Escalated', 'Enhanced', 'Further Information Required' or 'Routine'.
2. There are no areas of escalated risk (serious, specific risk to delivery or quality identified, including where there is a need to act rapidly to protect patients or staff). However, a rapid quality review in relation to the Nottingham University Hospitals NHS Trust's (NUH) urgent and emergency care pathway was undertaken on 19 March 2024 in response to an escalation of risk. Detail on this is included below.
3. Areas of enhanced oversight where delivery or quality concerns have been identified are learning disability and autism, urgent and emergency care (UEC) pathway, maternity, providers subject to National Quality Board intensive or enhanced surveillance, special educational needs and disabilities, looked after children, children and young people, and vaccinations.

Nottinghamshire Healthcare NHS Foundation Trust (NHT)

4. Following publication of the Section 48 report and the establishment of a jointly chaired Improvement Oversight and Assurance Group in March 2024. NHT has now moved into a Recovery Support Programme and NHS Oversight Framework Level 4.
5. A developing Integrated Improvement Plan shared by the Trust in March 2024**,** includes five programmes of work aligned to Trust-wide themes and risks. A final version is expected to be completed by the end of April 2024 with support from NHS England.
6. The Trust has received a further Prevention of Future Deaths (regulation 28 Coronial and investigation Regulations) report resulting from an inquest held in March 2024. The Trust will respond to the Coroner within the allocated timeframe with actions planned or taken in response to the findings. Monitoring of active prevention of future deaths reports are undertaken at the NHT internal weekly Serious Incident Review Group, which is attended by a representative of the ICB's quality and safety team.

Nottingham University Hospitals NHS Trust (NUH)

7. NUH is challenged to provide safe and high-quality care in response to regulatory requirements due to sustained operational pressures in all settings

and exacerbated by financial constraints and workforce issues including resource, culture, and staff wellbeing.

8. The operational inflow pressures in the Emergency Department remain persistently high, with increasing concern about harms for patients who are receiving care in unconventional care spaces. Quality insight visits by the ICB quality team continue to monitor the position.

9. Discussions continue between senior leadership colleagues within the ICB, Urgent Emergency Care (UEC) NUH and the East Midlands Ambulance Service NHS Trust, focusing on emerging quality concerns relating to handover delays**.**

10. The quality oversight focus is now on the progress of improvement activities and plans into ‘business as usual,’ supporting this transition moving forward. NUH colleagues show commitment to this approach and are engaged with system activities including System Quality Group; Patient Safety Incident Response Framework implementation; and the Local Maternity and Neonatal System.

Nottingham CityCare Partnership (Community Interest Company)

11. As reported at the last meeting, a strategic transformation and improvement plan is now in place following the output of the external review of community services. Some progress has been made between the ICB’s quality team and operational colleagues at Nottingham CityCare around actions identified. This includes advice and guidance with Patient Safety Incident Response Framework activities, and support with a local community services development scheme.

12. Communications with Nottingham CityCare have been clear about the level of oversight, and a formal notification of enhanced oversight has been issued, noting that current contracting and performance conversations have also flagged areas where quality may be impacted.

Sherwood Forest Hospitals NHS Foundation Trust (SFH)

13. The Trust has received a Prevention of Future Deaths (regulation 28 Coronial and investigation Regulations) requirement in relation to a case of Necrotising Fasciitis. With support from system partners the stipulated required policy has been created and shared across the system.

14. The Trust has also received two Prevention of Future Deaths (regulation 28 Coronial and investigation Regulations) requirements in relation to paediatric care in the Emergency Department in December 2022. The Coroner has taken the unusual step of flagging these concerns directly with the ICB, and we are

working with the Trust and the urgency and emergency care team to ensure that the appropriate learning for the Trust and system are embedded.

15. The Trust's Quality Committee has ratified the new Clinical Services Strategy (2024-29), which reflects the Integrated Care Strategy and NHS Joint Forward Plan. The Trust's strategy is built on four principles – start well; live well; age well; die well – with a clear focus on personalised care and continuous quality improvement.
16. Sepsis identification processes and management are being reviewed by the Emergency Department team and the Trust wide sepsis group, in response to the recent publication of updated National Institute for Health and Care Excellence (NICE) guidance or 'Martha's Rule.' There are challenges to compliance, which are acknowledged by the national team and an 'early adopter' programme has been launched to support learning and embedding.

Learning disability and autism

17. The Learning Disability and Autism (LDA) programme remains in enhanced oversight. This is in recognition of the significant challenges to delivery and the impact on the care experience for service users.
18. The ongoing focus remains on adult inpatient performance, with monthly NHS England system performance meetings in place and a local system inpatient summit. As of end March 2024 there are 45 adult inpatients, we therefore missed the year-end target of 37, by being eight patients over target.
19. Ongoing challenges persist with the movement of secure inpatients; the impact of system financial controls on workforce; the increased risk of inappropriate admissions (lack of appropriate community placements) and delays to Nottingham City Council agreeing new funding for packages due to their financial position.
20. The Dynamic Support Risk Register (DSR) process has helped to avoid admissions from the community as well as identify those patients that are not progressing through the 12-point plan. These patients are now following the agreed lack of progress escalation policy and are scrutinised at oversight meetings.
21. During quarter four 2023/24 the Oliver McGowan mandatory training pilot approach continues, with discussions underway to extend the pilot if required, to mitigate against any slippage to delivery and sustainability.

Urgent and Emergency Care (UEC)

22. A Rapid Quality Review was held in March 2024 with all system partners, chaired by the ICB's Director of Nursing. Key actions were agreed including the

development of ‘safe today’ metrics associated with the minimum standards of care, and a time frame for improvement activity based on these findings.

23. The Urgent and Emergency Care (UEC) Board retains oversight of performance, quality and safety across the pathway, and the terms of reference will be updated to ensure that quality and safety issues receive equal exposure and review, with actions owned by UEC Board members.

Maternity

24. The Local Maternity and Neonatal (LMNS) incident review panel will transition in line with Patient Safety Incident Response Framework (PSIRF) to a learning and improvement forum once all current serious incidents reported on the STEIS system have been closed.
25. The dashboard development project continues, and an update was provided to the Local Maternity and Neonatal (LMNS) Executive Partnership Board in March 2024. The first phase of the dashboard migration to PowerBI is underway and will be available in late April 2024.
26. NUH announced a resumption of the 24-hour home birth service on 27 March 2024, almost two months earlier than anticipated. This positive move reflected the team’s commitment to driving improvement in this service and meeting women’s needs.
27. Both SFH and NUH continue to work towards full Saving Babies Lives Care Bundle Version Three compliance. Both have recently completed their third submission of evidence and compliance at both trusts has risen – NUH are now 81% compliant and SFH 90% compliant.
28. A bereavement counselling service level agreement with ‘Petals’ has been written to offer additional support to the system, including support for fathers and families with early baby loss.

Special Educational Needs and Disabilities (SEND)

29. The Nottinghamshire local SEND Priority Action Plan was received positively by the SEND Improvement Board, and a Deep Dive session with the Department for Education (DfE) and NHS England took place 19 March 2024.
30. Nottinghamshire SEND Strategy Stakeholder Events have concluded, with the agreement of outcome focused measures for the local area partnership which will now inform the development of the SEND Strategy.
31. A regional workshop to develop a Self-Evaluation Framework will have representation from the local area partnership. The outcome of this evaluation will inform preparations for a reinspection.

32. Nottingham City local strategic partnerships have been advised to anticipate a joint SEND local area inspection this year. Work undertaken collaboratively following the learning from the County Inspection will help inform planning.

Looked After Children (LAC)

33. NUH is now reporting no backlog of children and young people (CYP) waiting for an Initial Health Assessment, which is a priority for the recovery plan.
34. Key performance indicators and a new reporting schedule are being updated by the ICB contracting team, to ensure that data is available to the ICB in a timelier way. DBH is reviewing their data collection process and clinic capacity to ensure the statutory timeframe is met to provide the ICB with quarter three 2023/24 indicators.
35. NUH and the City Council have completed an Initial Health Assessment mapping exercise to reduce delays and improve system working, as identified at the City Improvement Board. An action plan has been developed and shared with key partners. A follow up meeting to review actions will take place in April 2024. Learning will be shared in the LAC Service Improvement Forum and cascaded to the LAC Assurance Group.

Children and Young People (CYP)

36. Numbers of CYP presenting with complex behavioural, mental health and autism related needs continue to increase. The annual report into CYP in inappropriate settings will be completed at the start of quarter one 2024/25 and the outcomes will be shared.
37. This is acknowledged as a national challenge and local actions have been developed to mitigate the risk, including weekly system meetings with both local authorities, acute hospitals, Child and Adolescent Mental Health Services (CAMHS) and the ICB. This has improved working relationships and understanding of legal and organisational boundaries and expedites more efficient escalation in the system.
38. Transition is a national priority and scoping work continues across the ICS with a view to an ICS wide Transition Group, including children’s and adult services. An updated NICE Quality Standard was published December 2023, which will be benchmarked in quarter four 2023/24 to identify the current position in Nottingham and Nottinghamshire.
39. The County Youth Justice Joint Inspection resulted in a "good" outcome. The existing plans to improve mental health provision and speech, language and communication services were accepted as positive. The progress of these plans requires joint funding commitment from both local authorities.

Vaccinations – Enhanced Oversight

40. Vaccination rates are currently at 82% for second dose Measles, Mumps, Rubella (MMR) at five years. This is significantly below the World Health Organisation elimination target of 95%.
41. System Task and Finish groups have been established to work through the established Measles Elimination Plan, focusing on using local population data and GP level data to support a more targeted approach to immunisation and vaccination management through the Primary Care Networks (PCNs).
42. A measles outbreak management desktop review exercise took place on 6 March 2024 to test the system's response. Overall, the exercise showed the agreed roles and actions worked, and the gaps identified are being addressed through the measles outbreak management task and finish group.

Workforce

43. The workforce position of the NHS providers shows a decrease in total workforce of 82.7 whole time equivalent (wte), driven by a decrease in substantive and agency wte, mainly in NUH. Our total workforce position moved -0.04% (- 12.9 wte) closer to plan. Our substantive staff position improved by -0.49% (-152 wte) towards plan. The agency performance aspect is overseen by the Financial and Performance Committee given the impact on the system financial position.
44. Overall, vacancies remain static at 6.7%. Turnover remains static at 11%, 2.2% below plan. Lower levels of sickness absence compared to plan supports staff availability across the NHS providers, sickness having decreased to 5.37%, 1.3% below plan. The highest categories for sick leave, remain as mental health and musculoskeletal linked to fatigue and burnout.
45. Recovery post covid of returning to routine appraisals supporting career and personal development that informs on capability and helps in the retention of our workforce has been seen but not consistently across the NHS Providers. None are meeting the target of 95% but are in a range of 81% - 88% achieved.
46. Recovery post covid of returning to compliance on all mandatory training requirements has been seen in all NHS Providers however, only SFH is achieving the target of 90%. An approach to make mandatory training consistent across the NHS providers within staff passports has been developed, now part of the Scaling Up of People Services Vanguard delivery, which when implemented, makes the training portable when staff move organisations and reduces the duplication of having to repeat training. The initial focus on this by NHS England is with Training Doctors, supporting improved experience of this cohort of staff.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/05/2024
Paper Title:	**Service Delivery Report**
Paper Reference:	ICB 24 014
Report Author:	Sarah Bray, Associate Director of Performance and Assurance Rob Taylor, Deputy Director of Performance and Assurance
Report Sponsor:	Stuart Poynor, Director of Finance and Performance
Presenter:	Mandy Nagra, Interim Service Delivery Director

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 - Elective and Diagnostic waits
- Planned Care - Cancer 62 Day Backlog
- Mental Health – Inappropriate Out of Area Placements
- Mental Health – Talking Therapies
- Community – Waiting Lists

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

Recommendation(s):

The Board is asked to **receive** 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 including lengths of waits
Enhance productivity and value for money	Provides information in relation to productivity and volumes of activity being undertaken across the system
Help the NHS support broader social and economic development	Addressing long waits, ensuring patients with high clinical needs are seen quickly and supporting patients to 'wait well' while tackling long waits, will support patients to return to work where possible.

Appendices:
None.

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 1: Health Inequalities and Outcomes – Failure to adequately address health inequalities and improve health outcomes for the population of Nottingham and Nottinghamshire. • Risk 2: System Resilience (for Managing Today) – Working effectively across the system may fail to address the current levels of demand across primary, community and secondary care. • Risk 6: Quality Improvement – Failure to maintain and improve the quality of services. *(in the context of performance delivery)*

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.

Service Delivery Report

Executive summary

1. There is significant focus on four-hour accident and emergency department performance within the system. Granular plans have been developed to enable monitoring at a daily frequency, which includes four hour and twelve-hour breach thresholds. Performance against these plans is tracked daily with more comprehensive discussion taking place within the newly formed weekly System Oversight Group A - Delivery.
2. As previously reported, the ambulance turnaround times in the emergency department deteriorated during winter at Nottingham University NHS Hospitals Trust (NUH) due to challenges in timely outward flow, rather than increases in attendance volumes. Industrial action has further complicated efforts to support crowded clinical areas, with patients being moved to base wards or held by East Midlands Ambulance Service (EMAS), worsening ambulance turnaround. The position has improved into April.
3. The position for long waiting elective patients is improving within the system with nine 78-week waiters forecast for the end of April and elimination of all 65-week waiters by September. Both providers are working to refine plans to significantly reduce the volume of 52-week waiters by March 2025. There have also been reductions in the backlog of cancer patients, which are described in more detail below.
4. Demand for inpatient mental health beds continues to be high, with services reporting increased acuity of patients presenting for support. 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. Nottinghamshire Healthcare NHS Foundation Trust (NHT) is focusing on internal flow improvements to reduce long lengths of stay and facilitate discharges to increase in area capacity and improve patient experience. As part of the operational planning process, a plan has been developed to eliminate inappropriate out of area placements by March 2025. Early improvements are being seen in local April data.
5. The table overleaf 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 2024. The plan for March 2024 is included to enable current performance to be viewed alongside the year end ambition.

Key performance metric summary

Programme Area	Key Metric	Metric Basis	Latest data period	Plan	Actual	Variance	Plan March 2024	SPC Variation[1]	IPR Page No.
Urgent Care	Total A&E Attendances	Provider	Mar-24	35,181	35,597	416	35,181	Common Cause Variation	48
Urgent Care	A&E 4hr % Performance (All types)	Provider	Mar-24	76.1%	62.7%	-13.3%	76.1%	Common Cause Variation	51
Urgent Care	A&E 12 Hour Waits	Provider	Mar-24	0	534	534	0	Common Cause Variation	51
Urgent Care	Hospital Handover Delays >60 minutes	Provider	Mar-24	0	1,432	1,432	0	Special Cause Concerning High	51
Urgent Care	Ambulance Total Hours Lost	Provider	Mar-24	0	3,622	3,622	0	Special Cause Concerning High	51
Urgent Care	No. Patients utilising Virtual Ward	Population	Mar-24	253	202	-51	253	Special Cause Improving High	49
Urgent Care	Number of MSFT > 24 Hours	Provider	Mar-24	136	290	154	136	Special Cause Concerning High	49
Urgent Care	Length of Stay > 21 days	Provider	Mar-24	395	425	30	395	Common Cause Variation	49
Planned Care	104 Week Waiters	Provider	Feb-24	0	1	1	0	Common Cause Variation	-
Planned Care	78 Week Waiters	Provider	Feb-24	0	33	33	0	Special Cause Improving Low	53
Planned Care	65 Week Waiters	Provider	Feb-24	749	903	154	596	Special Cause Improving Low	53
Planned Care	62 Day Backlog	Provider	Feb-24	371	373	2	335	Common Cause Variation	56
Planned Care	Cancer 28 Day Faster Diagnosis	Provider	Feb-24	78.5%	80.2%	1.6%	77.6%	Common Cause Variation	56
Planned Care	Op Plan Diagnostics 6-week Performance	Provider	Feb-24	25.1%	29.6%	4.5%	22.9%	Special Cause Improving Low	57
Mental Health	Inappropriate Out of Area Placement Bed Days	Population	Jan-24	0	805	805	0	Special Cause Concerning High	60
Mental Health	NHS Talking Therapies - Entering Treatment (3mth)	Population	Feb-24	8,425	7,060	-1,365	8,425	Common Cause Variation	60
Mental Health	NHS Talking Therapies - >90 Days 1st & 2nd Treatment	Population	Feb-24	10.0%	45.0%	35.0%	10.0%	Special Cause Concerning High	60
Mental Health	SMI Health Checks	Population	Mar-24	7,029	6,137	-892	7,029	Special Cause Improving High	70
Mental Health	CYP Eating Disorders - Routine	Population	Feb-24	95.0%	71.0%	-24.0%	95.0%	Special Cause Concerning Low	62
Mental Health	CYP Eating Disorders - Urgent	Population	Feb-24	95.0%	89.0%	-6.0%	95.0%	Special Cause Concerning Low	62
Primary Care	Primary Care - % book 2 Weeks	Population	Feb-24	85.0%	76.9%	-8.1%	85.0%	Common Cause Variation	64
Community	Community Waiting List (0-17 years)	Provider	Feb-24	1,831	2,308	477	1,831	Special Cause Concerning High	64
Community	Community Waiting List (18+ years)	Provider	Feb-24	7,725	7,833	108	7,725	Special Cause Improving Low	64

[1] 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 six 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.

Chappell Room, 09:00-09/05/24

Urgent care

6. Latest published data for March shows a stable position for virtual wards at 202 beds, which is below the plan of 253 beds. The ICB is now fourteenth from bottom nationally with 19.4 beds per 100,000 registered population (the aggregate England position is 23.1 per 100,000). The occupancy level increased from 66.8% in February to 69.3% in March. The operational plan submitted on 2 May 2024 includes a plan of 236 beds by March 2025.

7. Discharge pressures continue to impact the front door emergency department as reported through the high levels of people waiting over twelve hours in accident and emergency departments and high volumes of delays in handover from Ambulances into emergency departments. However, the position has shown improvement from February to March.

8. At the NUH emergency department, the volume of patients attending and arriving by ambulance remains stable, however timely outward flow from the emergency department remains challenging and has been subject to delays. The high occupancy of the Queens Medical Centre ‘majors’ unit has impacted ambulance handover performance. Demand pressures have increased at (Sherwood Forest Hospitals NHS Foundation Trust (SFH) during February 2024 through to April 2024.

9. In March 2024, there were 2,703 handover delays over 30 minutes, of which 1,432 were above 60 minutes. Of the 60-minute delays, 1,417 were at NUH and 15 were at SFH. In March, there were 3,622 hours lost through ambulances waiting to handover patients to hospitals in Nottinghamshire, which significantly limits the capacity of EMAS to respond to calls within a timely manner. Provider Improvement Plans have been developed and are tracked through Urgent and Emergency Care Board. Work continues to focus on conveyance and the flow through to emergency departments. The Nottinghamshire ICS Ambulance Hospital Handover Improvement Group has the responsibility for the identification and resolution of key challenges and issues in the ambulance hospital handover processes.

10. Accident and emergency four-hour performance for the system overall remains a significant area of concern. It is a key national performance standard and can be a broader indicator of efficient and effective flow of patients through an emergency care system. There is significant focus on accident and emergency performance at NUH. Some early improvements are noted following daily focus and adjustments to service arrangements to respond to drivers of performance (e.g., staffing shift arrangements), which includes action taken by the acute and type three (minor injury) attendance providers.

11. Within the system there remains a high volume of patients that have been declared medically safe for transfer and have a delayed discharge from a

hospital setting. The March position was 290 patients against a plan of 136 patients. This is very similar position to the February position of 288 patients.

12. Within the Nottinghamshire system it is recognised that home care capacity is a significant constraint with other system capacity often used to help decongest the acute provider; this is often out of alignment with the ‘home first’ principles. At system-level there is a System Discharge Board in place to enable focus on addressing these issues, with a focus on right-sizing bedded capacity for the medium term.

Planned care

13. As part of the planning process, providers modelled for 596 patients to be waiting 65 weeks or more by the end of March 2024 excluding any impact of Industrial action. The position at the end of March was 580 which includes the impact of industrial action.
14. 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 has a stretch ambition to eliminate 65-week waiters by the end of June 2024. Providers have advised that they will only be able to eliminate 65-week waiters in some specialties by the end of June.
15. The April forecast for 78-week waiters was nine patients waiting across the two providers at the end of the month. The forecast for the end of May is that no patients will be waiting beyond 78 weeks for elective treatment.
16. The backlog of cancer patients waiting 62 days or more remains significantly above the planned level but is reducing gradually. The position at the end of March 2024 was a backlog volume of 373 patients for SFH and NUH combined against a plan of 335.
17. The total volume of patients waiting for diagnostics and those waiting more than six weeks (the diagnostic backlog) reduced in February when compared to the January position. However, the backlog of patients waiting longer than six weeks remains above planned levels at 7,434 against a plan of 6,420 patients. Echocardiography, MRI, and CT remain the key drivers of the position, due to having a high volume of patients waiting over six weeks at system level.
18. The community diagnostic centres will be key to delivering long term sustainable reductions in waiting times for patients. ‘Accelerated’ activity is being delivered onsite in Mansfield with NOUS, echo, and phlebotomy modalities. ‘Accelerated’ MRI mobile capacity is in place at the Nottingham site, which is planned to deliver 7,500 additional MRI scans in 2024/25.
19. 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 Diagnostic Board, which includes tracking of the position against the recovery trajectories.

Mental health

20. Areas which consistently fail the target, and which are unlikely to achieve the targeted levels have improvement plans in place to progress towards delivery. These include Talking Therapies Access, out of area placements, severe mental illness health checks, perinatal access, and children and young people eating disorders.

21. Talking Therapies has been an area of concern for which an improvement plan is in place for recovery of access by quarter four, however this is unlikely to be achieved. The volume of patients entering Talking Therapies services remains below plan, however, have reported significant improvements since April 2023. The waiting time for a talking therapy first appointment has reduced and now 96% of patients receive their appointment within the six-week standard, which significantly exceeds the 75% standard. Improvements are required for patients waiting more than 90 days between their first and subsequent treatments.

22. The Talking Therapies provider has implemented a marketing and engagement plan, activities for quarter four included marketing campaigns utilising social media, billboards as well as Talking Therapies conferences. There was also further working with other organisations such as employers, Active Notts, Care Homes and universities to increase awareness and referrals into the service.

23. The routine referrals for the Children and Young People Eating Disorders Service are not achieving the 95% compliance standard; however patient volumes are small and therefore have a significant impact on the overall level of achievement. Each patient is reviewed to confirm cause of delay, and in each case the position has related to patient choice, through either school exams, holidays, work experience placements for example. Investment plans have been agreed to increase capacity to achieve the waiting time standards. This will include a service offer to support children and young people presenting with Avoidant Restrictive Food Intake Disorder.

24. The volume of out of area placements remains at a high level, with 805 bed days currently being placed outside of the local area. 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.

25. Work is taking place with ICB and NHT colleagues to develop a detailed action plan, which will eliminate out of area placements by March 2025, which includes securing additional local capacity and improving local flow. Local data indicates that early improvements are being made.

Primary care

26. The volume of GP Appointments in February was 19% above the planned level. The percentage of appointments held face to face was stable 68% in February. In February, 77% of appointments were offered within two weeks, which is a very similar to January position of 76%.
27. 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.

Community care

28. The community waiting list for adults has increased from the January position of 7,601 patients to 7,833 patients in February and is above the plan of 7,725 patients. One of the community providers identified an under-reporting issue with the January snapshot, which was subsequently corrected in time for the February data submission. However, the longer-term trend is a reduction in the volume of adult waiters. The children and young people waiting list has increased from the January position of 2,196 to 2,308 patients in February and remains above planned levels.
29. Across both community providers, the largest waiting list is for the Musculoskeletal service, which has 1,806 patients waiting. There are 60 adult patients and three children waiting more than 52 weeks across all services. The largest cohort with patients waiting more than 52 weeks is Nursing and Therapy support for continence, with 39 patients. Increasing referrals are coming into the autism spectrum disorder services and Neuro-developmental services.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/05/2024
Paper Title:	**Finance Report**
Paper Reference:	ICB 24 015
Report Author:	Marcus Pratt, Programme Director for System Finance Michael Cawley, Operational Director of Finance
Report Sponsor:	Stuart Poynor, Director of Finance
Presenter:	Stuart Poynor, 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 twelve; the report draws out the key messages for the Board.

ICB position

- Revenue finance – £6.8 million deficit outturn position. The £6.8 million deficit is in line with the re-forecast agreed with NHS England.
- The efficiency target of £66.0 million has been delivered, albeit with a reliance on non-recurrent solutions.
- The ICB has delivered its remaining financial duties and targets, including not exceeding the capital resource limit and remaining within the running cost allowance.

NHS system position

- Revenue finance – £113.7 million outturn deficit position.
- This deficit represents a £20.9 million adverse variance against the 2023/24 H2 (October 2023-March 2024) reset plan. £12.5 million relates to Nottinghamshire Healthcare NHS Foundation Trust's declared outturn at month ten and a further £8.4 million due to Community Diagnostic Centre Funding not being received.
- Capital finance – capital expenditure is £0.8 million less than the system allocation provided.

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

Recommendation(s):

The Board is asked to **receive** the report for assurance regarding the year-end financial position.

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

How does this paper support	the ICB's core aims to:
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 10: Financial Sustainability – Establishing a shared culture of financial stewardship may not ensure 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

ICB financial position

1. The ICB has delivered a £6.8 million deficit on its revenue position, in line with the agreed position with NHS England. The primary drivers of the adverse position are price increases associated with primary care prescribing (£21.4 million), alongside costs and activity pressures in continuing health care (£17.8 million) and section 117 aftercare (£8.0 million). In addition, estates have overspent by £2.4 million, again driven by unbudgeted price pressures.
2. Those pressures are partially offset by underspends on GP contracting (£9.7 million), dental services (£15.5 million) and a favourable variance on the efficiency reserve (£19.5 million).
3. The efficiency target of £56.0 million plus the additional £10.0 million has been achieved with a small over delivery, with a final outturn of £66.2 million. £41.8 million of the outturn has been delivered with non-recurrent efficiencies and £24.4 million has been delivered recurrently.
4. The ICB has achieved its other financial duties of staying within the capital resource limit, not exceeding the allowable cash bank balance as of 31 March, remaining within the running cost allowance and delivering on the mental health investment standard (MHIS) requirement.

NHS system financial position

5. The ICB's reported position, in aggregate with the three NHS trusts for Nottingham and Nottinghamshire (which the ICB has principal responsibility for financial allocation purposes), form the NHS system financial position.
6. The system is reporting a final year-end outturn of £113.7 million deficit, against the break-even annual plan. The in-month position comprises a £3.0 million deficit. The in-month deficit is driven by an income reversal for the year of £8.5 million relating to Community Diagnostic Centres (CDC): the two acute providers have been assuming this income from NHS England throughout the year and have now been advised that this will not be received. Outside of this one-off issue, the system has experienced a £5.5 million surplus in month twelve alone, the majority due to non-recurrent savings and benefits.
7. The system agreed a 2023/24 H2 reset plan of a £92.9 million deficit. This has been missed by £20.9 million. £8.5 million is due to the CDC income shortfall and a further £12.5 million at Nottinghamshire Healthcare NHS Foundation Trust (NHT).
8. The key drivers of the NHT adverse variance are the cost of private mental health beds and agency usage in mental health and offender health. The

quality concerns faced by the organisation have slowed the ability to deliver savings and the stretching H2 recovery plans, especially where investment has been essential in key areas such as Rampton and offender health services. The Trust has also had to take urgent direct actions, where care has fallen below accepted levels and this has led to the suspension of a large number of staff in mental health acute hospitals, with the consequence of not being able to drive down agency spend as planned.

9. Key elements of the drivers of the month twelve position are efficiency delivery shortfall, inflationary pressures and increases in pay run rates above planned levels. These can be quantified as follows:

    a) External factors including prescribing and continuing health care pressures (ICB), inflation and pay award shortfalls – £64 million.

    b) Planned actions not delivered including mental health subcontracted beds and urgent and emergency care escalation beds, efficiencies, planned income shortfalls (including CDC) and Elective Recovery Fund shortfall – £24.5 million.

    c) Unfunded workforce and pay increases arising from increasing run rates compared to 2022/23 – £25.2 million.

10. Efficiency delivery for the year is reported as £176.8 million, which is £15.9 million adverse to plan. 56% of the efficiency has been delivered non-recurrently, with recurrent delivery being £70.7 million adverse to plan.

11. The system remains committed to delivering financial sustainability. Ambitious plans are in development for 2024/25. Delivery will require a continued focus on financial control, efficiency, productivity and transformation. The system financial recovery group, comprising system Chief Executives and Directors of Finance, continues to meet weekly to oversee this work ensuring pace and focus.

Capital

12. The system has been allocated a capital envelope of £100.6 million in 2023/24 for capital expenditure across the three NHS trusts and a further £2.4 million relating to the ICB. A further £13.0 million of additional capital allocation has been provided to support the impact of the accounting standard IFRS16 with external bodies, taking the total capital envelope to £116.0 million.

13. At month twelve, total spend against the capital envelope including the impact of IFRS16, is £115.4 million, an underspend of £0.8 million. £0.7 million of this relates to the ICB, partly due to an increase of £0.4 million to the envelope in month twelve. Including national programme funding, system partners have committed capital expenditure of £209.8 million in 2023/24.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/05/2024
Paper Title:	**Committee Highlight Reports**
Paper Reference:	ICB 24 016
Report Author:	Committee Secretariat
Report Sponsor:	ICB Committee Chairs
Presenter:	ICB Committee Chairs

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

Summary:

This report presents an overview of the work of the Board's committees since the last Board meeting in March 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.

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.

Recommendation(s):

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

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	The Board's committee structure has been designed to provide assurance to the Board that statutory duties and responsibilities in line with the core aims are being effectively discharged.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

A: Highlight Report from the Strategic Planning and Integration Committee
B: Highlight Report from the Quality and People Committee
C: Highlight Report from the Finance and Performance Committee
D: Highlight Report from the Audit and Risk Committee
E: 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:	4 April 2024 and 2 May 2024
Committee Chair:	Jon Towler, Non-Executive Director

Assurances received:

Item	Summary	Level of assurance
1. Preventative Care and Long-Term Conditions Management Transformation Programmes	Members received and discussed a progress update on the priorities, achievements and challenges in relation to long-term condition management and the approach to transformation, with a focus on cardiovascular disease (including stroke), diabetes, respiratory disease and plans in line with the Joint Forward Plan. Members noted that the current challenges in relation to financial and workforce resource presented an opportunity to drive forward transformational change without layering on additional services. Discussion took place around resource allocation, actions that could be taken across the system to become more sustainable and the optimisation of digital support. Members agreed that a further update should be scheduled later in the year to provide an update on the identified opportunities for different delivery vehicles to progress key elements of the programme.	**Partial**

Other considerations:

Decisions made:
The Committee: a) Approved the 2023/24 Strategic Planning and Integration Committee Annual Report 2023/24. b) Approved the 2024/25 Strategic Planning and Integration Committee Annual Work Programme 2024/25.

Chappell Room, 09:00-09/05/24

Decisions made:

c) Ratified an urgent decision taken on 27 March 2024 via the Committee's urgent decision-making powers. This was to approve a contract award to the Nottinghamshire Hospice for Hospice at Home, Bereavement Support, and Day Therapy services in South Nottinghamshire and a contract variation to the existing contract with Nottinghamshire Hospice for the Hospice at Home service in Mid-Nottinghamshire.

d) Ratified an urgent decision taken on 8 April 2024 via the Committee's urgent decision-making powers to approve the award of an Alternative Provider Medical Services (APMS) contract for the provision of Primary Medical Services at the Windmill Practice.

e) Endorsed the Integrated Care System Research Strategy and recommended it to the Board for approval. Members requested that the next update on research provide examples of how research was being implemented and embedded across the system.

Matters of interest:

The Committee also received and discussed:

a) A progress update on work being undertaken to scale up collaborative commissioning between the ICB, Nottingham City Council and Nottinghamshire County Council. In particular, members discussed the time it would take to identify areas of mutual benefit and the pace of progress in terms of evolving governance, legal arrangements and potential barriers to further opportunities. Members requested that the next update address these factors specifically, as well as the progress and impact of delivery through Place Based Partnerships linked to the Integrated Care Strategy outcomes, and any challenges to delivery, particularly because of the financial environment.

b) A summary of the discussions, decisions, challenges, and risks considered by the Primary Medical Services Contracting Panel since the disestablishment of the Primary Medical Services Contracting Sub-Committee in July 2023. The Committee will receive an update on contingency planning around the 2024/25 GP Contract in July 2024.

c) The draft three-year mental health inpatient strategic plan and provided feedback for inclusion in the final submission due on 30 June 2024.

d) The draft Nottingham and Nottinghamshire NHS Joint Forward Plan 2024/25. This had been refreshed as part of an integrated approach to planning and would be submitted to the May 2024 meeting of the ICB Board for approval. Members discussed the importance of defining the outcomes to be delivered by the Joint Forward Plan. It was agreed that a timeline for the development of a high-level strategic dashboard with agreed metrics and baseline data should be developed through the Joint Forward Plan Delivery Group.

Decisions made:
e) An update on the strategic development approach to the Tomorrow's Nottingham University Hospital (TNUH) programme. The programme governance arrangements had been redesigned to create a Programme Board which would focus on the delivery of the core programme and enabling works for the capital scheme, and a separate Partnership Board whose focus would be on the strategic development aspects of TNUH. Positive discussions around the opportunities for the wider socio-economic developments had taken place with Nottinghamshire County Council, Nottingham City Council and the Universities at the Nottingham Programme Management Board, and the East Midlands Combined County Authority would be engaged once the Mayoral election had concluded. f) The log of all investment, disinvestment and contract awards (healthcare services) made during the year (2023/24). The findings from a local lessons learnt exercise on the Provider Selection Regime would be presented to a future meeting of the Committee. Members noted that a number of contractual discussions had been resolved as part of the 111 contract award to DHU Healthcare. g) An update on proposals around Locked Rehabilitation Services. h) Comprehensive updates on the risks relating to the Committee's remit. i) The outcome of its effectiveness review 2023/24 and supported the actions identified to enhance the current arrangements.

Appendix B: Quality and People Committee Highlight Report

Meeting Dates:	20 March 2024 and 17 April 2024
Committee Chair:	Marios Adamou, Non-Executive Director

Assurances received:

Item	Summary	Level of assurance
1. Quality Oversight Report	Members received the Quality Oversight Report at both meetings and concluded on each occasion that the assurance provided was limited. Whilst a number of satisfactory quality areas were noted within the reports, the ratings were agreed due to areas in the system under enhanced surveillance and the two providers currently in National Oversight Framework (NOF) segment four (Nottingham University Hospitals NHS Trust and Nottinghamshire Healthcare NHS Foundation Trust (NHT)). Members were advised that Nottingham CityCare Partnership and the ICB were working together to have a clear agreed action plan to move from enhanced surveillance into a more positive assurance space. The ICB has formally notified CityCare of the escalation, the concerns that initiated this, and the next steps to improve quality. A further quality review meeting is planned for April and an update would be provided to members at the committee's next meeting. In terms of ensuring quality, members expressed concern about the overall quality of community services; particularly since both providers, NHT and CityCare, were under heightened scrutiny. It was requested that future reports provide assurance around this specifically.	**Limited**
2. Nottinghamshire Healthcare NHS Foundation Trust (NHT)	At the April 2024 meeting, members were presented with a report focused on NHT. The report offered an update on the progress made in developing action plans subsequent to the Section 48 review and the establishment of the Integrated Oversight and Assurance Group (IOAG).	**Limited**

Item	Summary	Level of assurance
	In particular, members questioned the ICB's confidence in achieving the required actions. It was noted that NHT had appointed an Improvement Director, which combined with ongoing support and constructive challenge (including that provided via the weekly oversight meetings), provided some assurance in respect of this. The limited assurance rating was applied to reflect that whilst action plans were being formulated and initial actions implemented, this process was still in its early stages with no evidence of delivery to date.	
3. System Quality Framework	Members received an update on progress on the development of the system Quality Framework and the work being performed with partners to define 'quality' in the Nottingham and Nottinghamshire System and ensure alignment across quality strategies. Members welcomed the update but requested further information as to how the ICB was delivering against its own objectives. It was agreed that the next scheduled update would provide this. Partial assurance was applied to reflect that the system work was clearly progressing but had not yet concluded.	**Partial**
4. Learning Disabilities and Autism (LDA) Deep Dive	The report aimed to provide assurance on the progress and performance of Learning Disability and Autism (LDA) plans and targets. For the 2023/24 period, the target for adult inpatients was initially set at 27. However, at the beginning of the year, there were 49 adults in inpatient settings, leading to an adjustment of the target to 37. Forecasts indicated that by 31 March 2024 there would be 42 adult inpatients, surpassing the revised target by five patients. Throughout 2023/24, there was an increase in the number of patients receiving late diagnosis of Autism while undergoing treatment within adult mental health inpatient settings. Discussions with Regional NHS England (NHSE) had taken place regarding the adult inpatient target for 2024/25, resulting in agreement to adjust the local target	**Partial**

Item	Summary	Level of assurance
	from the national standard of 27 to 32. Despite this adjustment, performance data would indicate the ICB's failure to meet the national target of 27. The partial assurance rating specifically pertained to the quality assurance related to this group of patients and did not reflect performance against targets.	
5. Maternity Services, health outcomes and LMNS Deep Dive	Members received this report, which provided a review and comparison of data related to perinatal morbidity and mortality from a national (UK) and local system perspective. With regard to ethnicity and deprivation factors and the associated outcomes, it was agreed that there was an aspiration to significantly improve the position. The availability of this data provided the opportunity to change practices to improve maternity equity. Action would be required to impact on the reduction of current rates. The LMNS dashboard would be expanded to include equity data and members agreed that this should be escalated to the ICB Board when available. The limited assurance rating stressed the need to observe the impact of actions, as evidenced by data, over an extended timeframe.	**Limited**
6. ICB Equality Objectives and Equality Improvement Plan	Members received a report on progress on the ICB's statutory duties in relation to the Public Sector Equality Duty (PSED). It was confirmed that the ICB had met its statutory duties in this regard. During discussion, members raised a particular concern regarding the apparent lack of action taken in relation to racism in Primary Care. Assurance was provided that specific actions would be identified to mitigate this, with delivery monitored by the ICB's Equality, Diversity and Inclusion Steering Group. The Committee applied a rating of 'adequate' assurance to the report, in recognition of the achievement of statutory duties and delivery to date, against the Plan.	**Adequate**
7. Urgent and Emergency Care System Rapid Quality Review –	In response to heightened concerns regarding Urgent and Emergency Care (UEC) performance at NUH, a paper was received detailing the findings from a rapid quality	**Limited**

Item	Summary	Level of assurance
Nottingham University Hospitals NHS Trust (NUH)	review conducted in March 2024. The review specifically examined the quality aspects of the UEC pathway and pinpointed three key areas for improvement. Members enquired about the structured approach to enhancing quality and were informed that it aligned with the Quality Framework, which mirrored the NHS Impact framework and methodologies. Subsequently, there was a discussion on the monitoring of the UEC action plan, during which members were informed that progress with actions would be overseen by the System Quality Group and the UEC Delivery Board. This oversight aimed to ensure attention was given to quality and outcomes of care in the UEC pathway. Members suggested that the UEC Delivery Board consider broadening its membership to include a representative from primary care (general practice), which would facilitate the consideration of changes in the UEC pathway in relation to their impact on general practice. Further discussion focused on the work commissioned by the ICB to address clinical behaviours at NUH. It was agreed to share the review framework with members to provide insight and assurance. The rating of limited assurance was specifically attributed to the quality within the UEC pathway, rather than the overall performance of UEC.	
8. Patient Experience Annual Report 2023/24	The report provided assurance regarding the ICB's adherence to its statutory duty regarding managing complaints, and how any learning from complaints had been identified and translated into actions. Going forward, members agreed that more frequent reporting on complaints was needed, along with clearer reporting on lessons learnt. The Committee agreed a rating of 'adequate' assurance, which recognised the ICB's compliance with statutory obligations but reflected a need for clearer reporting in some areas in future reports.	**Adequate**

Other considerations:

Decisions made:
a) In April 2024, members approved both the Committee Annual Report for 2023/24 and the Committee Annual Work Programme for 2024/25. b) Members approved the Equality Delivery System (EDS) submission to NHS England, as well as its publication on the ICB's website.
Information Items and Matters of interest:
The Committee also: a) Reviewed identified risks relating to its areas of responsibility. b) In March 2024, members were presented with the outcome report from its committee effectiveness review and the actions identified to enhance current arrangements. c) Received a paper describing the approach to develop the 2024/25 People Plan. The 2024/25 Operational Plan placed increased emphasis on integrating the people delivery plan into the overarching operational planning process, acknowledging the interconnection between workforce management and expenditure. Ongoing focus would be directed towards minimising agency costs and exploring options to streamline the substantive workforce.

Appendix C: Finance and Performance Committee Highlight Report

Meeting Dates:	21 March 2024 and 24 April 2024
Committee Chair:	Stephen Jackson, Non-Executive Director

Assurances received:

Item	Summary	Level of assurance
1. System Finance Report and Recovery Plan (M11 and 12)	Discussion at both meetings centred on the factors influencing the adverse system position. Despite the agreement with NHSE as part of the H2 reset plan, its objectives were not met by year-end. The deficit of £92.8 million had further deteriorated by £21 million. Within this £21 million, £12.5 million was attributed to NHT, with the remainder stemming from anticipated income for Community Diagnostic Centres (CDCs) that did not materialise.	**Limited**
2. ICB Finance Report and Recovery Plan (M11 and 12)	The ICB reported a financial deficit of £6.795 million for the 2023/24 financial year. Although falling short of achieving a break-even position, the ICB successfully contained its overspend within the forecasted deficit of £6.8 million, as agreed with NHSE during the H2 reset.	**Limited**
3. ICB Service Delivery Performance Report	In both March and April, members received reports detailing areas of risk and improvement. While certain concerns were highlighted, there was notable progress in several areas. A significant emphasis was placed on monitoring the four-hour Accident and Emergency (A&E) performance within the system, with detailed plans in place for daily tracking. Progress was reported with long-waiting elective patients, with three patients waiting 78 weeks by the end of April 2024. Plans would be put in place to eliminate 65-week waiters by September 2024. Reductions in the backlog of cancer patients were also reported.	**Limited**

Item	Summary	Level of assurance
	The overall 'limited' assurance rating considered both the partial assurance regarding sustained improvements and the insufficient assurance in specific performance areas, notably at NUH and NHT.	
4. NHS England Statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)	The Nottingham and Nottinghamshire statement provided comprehensive evidence of the ICB's commitment to fulfilling its duties to collect, analyse and disseminate information related to health inequalities. In producing the statement, the ICB had developed a robust Health Inequalities dashboard to support ongoing monitoring across the NHSE five priority areas for health inequalities and the Core20PLUS5 approach. The statement would be made available and published alongside the Nottingham and Nottinghamshire ICB Annual Report.	**Full**

Other considerations:

Decisions made:
a) Members endorsed the March and April Operational Planning submissions for approval by the Chair and Chief Executive utilising emergency powers. Board members were invited to both meetings to take part in reviewing the submission. The deficit position improved from £116m in the March submission to £105.8m in April. Plans assumed a 5% efficiency target. Whilst approving the submissions members were cognisant of the significant challenges to delivery faced by the system in 2024/25. In addition, the system would be required to produce plans to reach break-even in 2025/26. b) Members endorsed the ICB's 2024/25 Financial Plan and Opening Budgets and recommended them for approval by the Board (at its extra-ordinary Board meeting on 28 March 2024), noting that plans were subject to confirmation by NHSE. c) In April 2024, members approved both the Committee Annual Report for 2023/24 and the Committee Annual Work Programme for 2024/25.
Matters of interest:

a) In March 2024, members were presented with the outcome report from its committee effectiveness review and the actions identified to enhance current arrangements.
b) Members received updates in March and April on the production of the 2024/25 Joint Capital Resource Use Plan. Guidance had been amended to coincide with operational planning timescales, and plans were required to be approved and published by 30 June 2024.
c) The operational risk report was presented in both March and April 2024. Notably, the April 2024 report introduced new risks pertinent to the 2024/25 period. These risks specifically addressed financial concerns and challenges associated with the implementation of the Operational plan, as well as the overall financial standing of the ICB.

Appendix D: Audit and Risk Committee Highlight Report

Meeting Dates:	27 March 2024
Committee Chair:	Caroline Maley, Non-Executive Director

Assurances received:

Item	Summary	Level of assurance
1. Board Assurance Framework Targeted Assurance Report – Finance Directorate	Members had an in-depth discussion with the Finance Director regarding the strategic risks 'owned' in this area, which included assurance on the control environment and the work being undertaken to address any gaps in control or assurance. The Committee recognised that despite continued efforts, the risk relating to financial sustainability was rated as high and remained some way from its target score. Although the control environment had continued to develop, the Committee acknowledged that the management of the risk was also largely dependent on individual partners' control environments.	**Partial**
2. Internal Audit Report Personalised Care – Social Prescribing	The ICB's internal audit function had examined the effectiveness of the governance structure that supported social prescribing and had provided an opinion of 'limited assurance'. The Committee was advised that although the programme had exceeded targets, elements of its governance had fallen down in its transition from a transformation project into 'business as usual'. Assurance was provided to members that the strengthening of governance processes was being taken forward, as recommended in the report.	**Limited**
3. Policy Management Framework	This report provided assurance that the process for reviewing the ICB's corporate policies was being managed effectively. Following scrutiny, members approved extensions to several policies on the proviso that no further extensions would be granted.	**Adequate**

Other considerations:

Decisions made:
The Committee approved the Internal Audit Plan for 2024/25 and the Counter Fraud Plan for 2024/25.
Matters of interest:
a) Members received a briefing on a 'loss', which under the ICB's Standing Financial Instructions, was of a value that had been approved by the ICB's Chief Executive and Director of Finance. b) The receipt of an early draft of the Corporate Governance Report, which formed part of the ICB's Annual Report and Accounts 2023/24, had been welcomed and was reviewed. The Committee also received the Interim Head of Internal Audit Opinion, which would form part of the draft annual report submission in April 2024. c) Good progress was noted on actions to ensure the completion of the 2023/24 Counter Fraud Plan. d) The ICB's achievement of the 2022/23 Mental Health Investment Standard was noted. e) As part of the rolling programme of committee effectiveness, members discussed the findings of their self-assessment review and agreed that, in general, the Committee was operating effectively. f) The Committee reviewed its Annual Report 2023/24, which demonstrated how it had discharged its duties during this period.

Appendix E: Current high-level operational risks being oversighted by the Board's committees

Risk Ref.	Risk Description	Current Score	Responsible Committee
ORR105	Continued over-reliance on non-recurrent (one-off) funds / mitigations by the NHS Nottingham and Nottinghamshire ICB to temporarily offset recurring (year on year) pressures may result in further deterioration in the ICB's recurrent underlying financial position for 2023/24.	**High** 20 (I4 x L5)	Finance and Performance Committee
ORR106	There is a potential risk that NHS Nottingham and Nottinghamshire ICB may not meet its statutory financial duties for 2023/24.	**High** 20 (I4 x L5)	Finance and Performance Committee
ORR107	There is a potential risk that the Nottingham and Nottinghamshire system, as a collective, may not meet its agreed year-end financial position outlined within the 2023/24 financial plan. As well as potential reputational risks for the ICS, this may significantly impact the extent to which the system is able to create financial 'headroom' to focus on the transformation of services.	**High** 20 (I4 x L5)	Finance and Performance Committee
ORR108	Continued over-reliance on non-recurrent mitigations to manage the Nottingham and Nottinghamshire system's 2023/24 financial position may result in further deterioration in the system's underlying financial position (UDL). The UDL may also be impacted by non-delivery of required 'cash releasing' productivity, efficiency, and transformation plans.	**High** 20 (I4 x L5)	Finance and Performance 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
ORR177 (NEW)	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)	Finance and Performance Committee
ORR178 (NEW)	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
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	**High** 15 (I5 x L3)	Finance and Performance Committee

Risk Ref.	Risk Description	Current Score	Responsible Committee
	result in patients not receiving timely diagnosis or treatment due to necessary equipment not functioning or patient records being unavailable.		
ORR145	Due to a continued period of sustained pressure, further organisational change and cost reductions, there is a risk of increased sickness absence and reductions in NHS Nottingham and Nottinghamshire ICB staff productivity alongside staff feeling disconnected or disengaged.	**High** 16 (I4 x L4)	Human Resources Executive Steering Group
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** 20 (I4 x L5)	Quality and People Committee
ORR191 (NEW)	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
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 (NEW)	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

Risk Ref.	Risk Description	Current Score	Responsible 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
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. This may also result in additional pressure on an already constrained urgent and emergency care service.	**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 (NEW)	If insufficient availability of mental health inpatient beds continues, there is a risk that individuals may face delayed or inadequate treatment or be transferred for care in an 'out of area' setting, which may result in increased distress, potential harm to themselves or others, or a higher likelihood of crisis situations.	**High** 16 (I4 x L4)	Quality and People Committee
ORR171 (NEW)	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
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 (NEW)	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	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee

Risk Ref.	Risk Description	Current Score	Responsible Committee
	community service transformation. This may result in future population needs not being made and/or anticipated efficiencies not materialising.		

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/05/2024
Paper Title:	**Board Assurance Framework – Biannual Update**
Paper Reference:	ICB 24 017
Report Author:	Siân Gascoigne, Head of Corporate Assurance Lucy Branson, Director of Corporate Affairs
Report Sponsor:	Rosa Waddingham, Director of Nursing
Presenter:	Lucy Branson, Director of Corporate Affairs

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

Summary:

The purpose of this paper is to present the final position of NHS Nottingham and Nottinghamshire ICB's 2023/24 Board Assurance Framework for scrutiny and comment. The paper highlights several key messages for the Board from reference to the Assurance Framework in terms of controls, assurances and identified gaps. It also sets out progress with actions to move the strategic risks towards their target scores. The Assurance Framework has been scrutinised in-depth by the Audit and Risk Committee via Executive-led Targeted Assurance Framework Reports, received in October 2023 and January, February and March 2024.

This paper also presents the proposed strategic risks for 2024/25 for review; subject to Board approval, these strategic risks will be used as the basis for developing the full 2024/25 Board Assurance Framework.

Recommendation(s):

The Board is asked to **receive** the latest version of the 2023/24 Board Assurance Framework for assurance and **approve** the proposed strategic risks to enable the full development of the 2024/25 Board Assurance Framework.

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	The Board Assurance Framework is a structured way of identifying and mapping the main sources of assurance in support of the achievement of the ICB's four aims.
Tackle inequalities in outcomes, experience, and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

A: Board Assurance Framework roles and responsibilities and full business cycle

Appendices:

B: 2023/24 Board Assurance Framework

Board Assurance Framework:

This paper presents the fully populated Board Assurance Framework, which outlines the controls and assurances across all the ICB's strategic risks.

Report Previously Received By:

Board Assurance Framework updates have been presented to the May and November 2023 meetings of the Board and the October 2023 and January, February and March 2024 meetings of the Audit and Risk Committee.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Board Assurance Framework – Biannual Update

Introduction

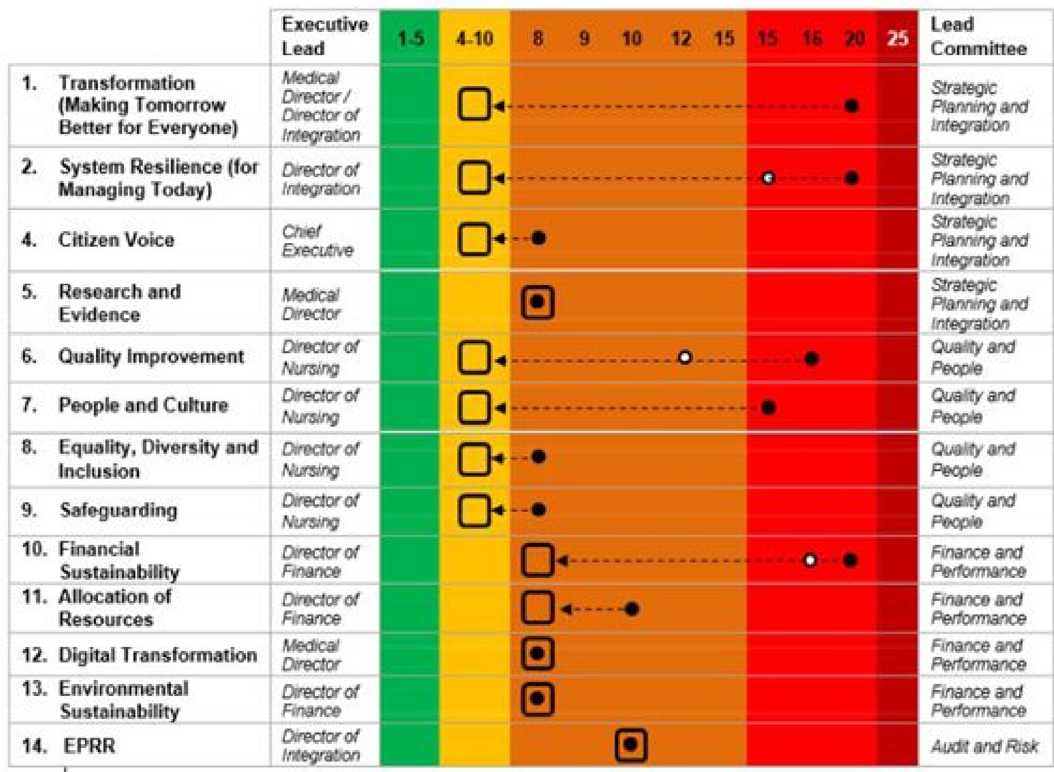
1. The ICB's strategic risk management processes are centred on the Board Assurance Framework, which is a structured way of identifying and mapping the main sources of assurance in support of the achievement of the ICB's core aims/objectives. The Assurance Framework provides the Board with confidence that what needs to be happening is happening in practice. More specifically it enables the Board to:
    a) Gain a clear and complete understanding of the control environments that have been established to manage its strategic risks.
    b) Consider the types of assurance currently obtained and whether they are effective and efficient.
    c) Identify areas where controls have yet to be fully established or where existing controls are failing (i.e., control gaps), and consequently, the risks that are more likely to occur.
    d) Identify areas where assurance activities are not present or are insufficient (i.e., assurance gaps), or where assurances may be duplicated or disproportionate.
2. The Board Assurance Framework also plays a key role in informing the production of the Chief Executive's annual Governance Statement (included within the ICB's Annual Report) and is the main tool that the Board should use in discharging its overall responsibility for ensuring that an effective system of internal control is in place. Roles and responsibilities and the full business cycle for the Board Assurance Framework is set out for information at Appendix A.
3. The purpose of this paper is to present the final position of NHS Nottingham and Nottinghamshire ICB's Board Assurance Framework for scrutiny and comment. This builds upon previous updates provided to the ICB Board during May and November 2023.
4. This paper also presents the ICB's proposed strategic risks for review and approval, which will form the basis for the 2024/25 Board Assurance Framework.

NHS Nottingham and Nottinghamshire ICB's Board Assurance Framework

5. The Board Assurance Framework is structured around 13 strategic risks to achieving the ICB's four core aims. The fully populated Framework is provided at Appendix B. This is introduced by an explanation of how to navigate the document and includes a summary of how each risk aligns to the ICB's four core aims (at Annex 1 of the Board Assurance Framework document).

Summary of key messages

6. The following diagram presents a summary 'heat map' of the Board Assurance Framework, reflecting discussions with the Executive Team during April 2024. It is important to remember that the ICB's strategic risk profile is expected to be high due to the nature of the risks contained within the Board Assurance Framework (i.e., if their impact rating is not high or very high, then it is questionable whether they should be classified as strategic risks to the organisation).



Note: Black dots represent the current scores for each risk and white dots indicate where scores have changed since last reported. The squares indicate the target scores for each risk, in line with the ICB's risk appetite statement. The arrows show the movement in current risk scores, as well as the distance from the current risk score to the target risk score.

7. The following key points are highlighted for the Board's attention:

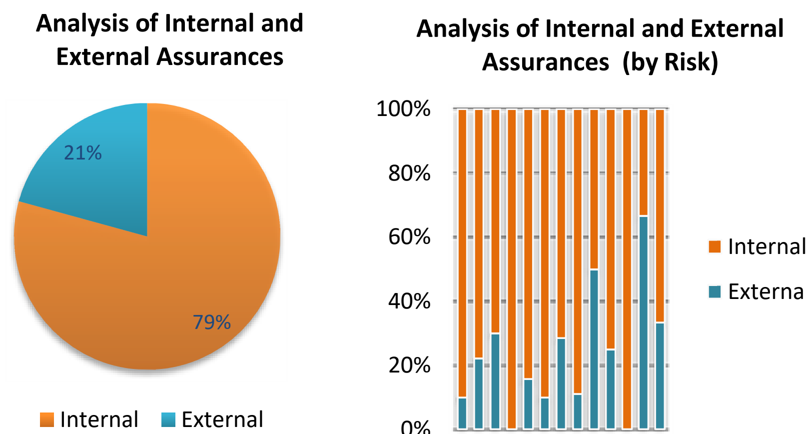
   a) While four risks are at their target risk score, there has been an increase in risk score for three strategic risks since last presented to the Board in November 2023 (risks relating to system resilience, quality improvement financial sustainability), which aligns to the reported position in these areas in separate papers to the Board at this meeting. Six strategic risks remain some way from their target risk score.

   b) A good level of control continues to be in place across the 13 strategic risks. Controls have continued to strengthen since the Assurance

Framework was previously presented to the Board, with strategies, plans and frameworks being established, alongside the embedment of system co-ordinating functions. Progress has been made across the majority of the previously identified 'gaps'; however, it is recognised that due to the nature of some of these, they will continue to evolve to address local, regional and national challenges. Actions relating to 'gaps' in control are often complex and multifaceted and require a strategic approach to strengthen the control environment of the system-focussed strategic risks; this will support collective implementation and delivery of system and ICB-led plans for 2024/45 onwards.

c) A wide range of assurances have been received throughout 2023/24 by the Board and its committees, across all of the ICB's strategic risks. The robustness of assurances has evolved in-year to ensure they provide the level of assurance required; however, it is recognised that in some instances, further work is required. Many 'positive' assurances have been received to date that controls are operating as expected; albeit that significant areas of challenge are also being reported, which can be demonstrated by the number of 'live' operational risks within the ICB's Operational Risk Register (and outlined against each strategic risk within the BAF).

d) A review of the internal and external assurances set out within the Assurance Framework has been completed, as illustrated below. As a reminder, internal assurances are classed as any that are produced by the ICB, or system partners, and external assurances relate to parties that are independent to the ICB and its partners (e.g., regulators, internal and external audit providers). Currently, 21% of assurances across the ICB's strategic risks are external.



e) A key theme that the Audit and Risk Committee has identified is the need for further external assurances to be sought in relation to the management of the ICB's strategic risks. This has been considered when developing

the 2024/25 internal audit plan, with planned audits scheduled in relation to quality oversight, provider selection, digital transformation, clinical and care professional leadership and delivery of the people plan.

Interim Head of Internal Audit Opinion

9. 360 Assurance (the ICB's internal audit provider) has recently published its interim Head of Internal Audit Opinion for 2023/24. This is a formal assessment of the effectiveness and adequacy of the ICB's internal controls, risk management processes and governance arrangements. A specific area of focus is the robustness of the ICB's strategic risk management processes, which are operated via the Board Assurance Framework.

10. 360 Assurance has provided a 'significant assurance' opinion in relation to the ICB's strategic risk management and Board Assurance Framework, with no recommendations made during the in-year or year-end assessments. The level of scrutiny and challenge of the Board Assurance Framework was positively referenced.

2024/25 Board Assurance Framework – Strategic Risks

11. Early work has been completed to define the strategic risks that will form the basis of the 2024/25 Board Assurance Framework. These have been considered and developed through a session with the Executive Management Team in March and subsequently at the recent Board development session in April.

12. The proposed strategic risks for 2024/25 have moved away from a focus on the ICB's key statutory duties, to a focus on delivery of the ICB's key priorities, which in turn, closely align with the key challenges faced by the system. This is in recognition of the progress of the previous 21-month period to set-up and establish the ICB and the need to now focus on delivery. It also enables the Board Assurance Framework to drive the Board's annual work programme more explicitly.

13. Nine strategic risks are proposed, which span across the three key areas outlined within the ICB's priorities (managing today, making tomorrow better and developing the ICS). They can also be 'mapped' to the ICB's five objectives (the four purposes of the ICS, alongside the system leadership role of the ICB).

14. The ten proposed strategic risks for 2024/25 are:

Strategic risk	Risk owner
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.	Director of Integration

Strategic risk	Risk owner
2. **Primary care** - Failure to reduce unwarranted variation and improve access to primary medical services and pharmacy, optometry and dental (PODs) services.	Medical Director
3. Financial sustainability - Failure to achieve financial sustainability across the system.	Director of Finance
4. Quality improvement - Failure to systematically improve the quality of healthcare services.	Director of Nursing
5. Service transformation - Failure to identify and/or deliver service transformation to address health inequalities and improve outcomes.	Director of Integration
6. Workforce - Failure to utilise the system workforce effectively and ensure a sustainable workforce for the future.	Director of Nursing
7. Digital transformation - Failure to drive forward digital transformation and utilise system intelligence solutions to address health inequalities and improve outcomes.	Medical Director
8. Infrastructure and net zero - Failure to work effectively as a system to a sustainable infrastructure to deliver high-quality and efficient care and the net zero commitment.	Director of Finance
9. ICB operating model - Failure to develop and embed a robust ICB operating and workforce model to enable delivery of strategic goals and statutory duties.	Chief Executive
10. Culture and leadership – Failure to orchestrate positive system culture and leadership to drive effective partnership working.	Chief Executive

Next steps and timeline

15. Subject to Board agreement of the ICB's proposed strategic risks, work will be completed with the Executive risk owners to fully develop the Board Assurance Framework. This will be presented to the Board at its November 2023 meeting, in line with the bi-annual reporting schedule.

16. Targeted Board Assurance Framework reports (scheduled for the October and December 2024 and February and March 2025 meetings of the Audit and Risk Committee) will provide an update on progress against all identified actions and enable the Committee to continue its review and scrutiny of the design and operation of the Board Assurance Framework.

17. As a reminder, the unitary Boards of each statutory NHS Trust partner within the ICS, will continue to maintain their own individual Board Assurance Frameworks, as relevant to the roles and responsibilities of their organisations and their Boards' requirements. However, prior to presenting the fully populated Board Assurance Framework to the Board (in November 2024), an alignment exercise will be undertaken in relation to the strategic risks contained with NHS Trusts' Board Assurance Frameworks. This will be taken forward by the ICS Risk Management Network.

Appendix A: Board Assurance Framework (BAF) roles and responsibilities and full business cycle

BAF Roles and Responsibilities

Board	Has ultimate responsibility for risk management and as such, needs to utilise the Board Assurance Framework to be satisfied that internal control systems are functioning effectively.
Audit and Risk Committee	Has delegated responsibility for risk management and receives assurance that the ICB has robust operational and strategic risk management arrangements. The Committee specifically comments on the fitness for purpose of the Board Assurance Framework and has a role in securing independent assurances.
Board Committees	Scrutinise assurances in relation to the strategic risks for which they are the ‘lead’ committee and escalate levels of assurance to the Board (via routine highlight reports).
Executive Directors	Ensure a robust control framework is in place to mitigate their respective strategic risks within the BAF to drive delivery of the ICB’s core aims and objectives.
Governance Team	Develops Board and Committee annual work programmes (which outline planned assurances in line with Board and Committee duties) and co-ordinates the population of the ICB’s BAF, in conjunction with the Executive Team. The Team also provides risk management expertise to establish and support the ICB’s strategic risk management arrangements.

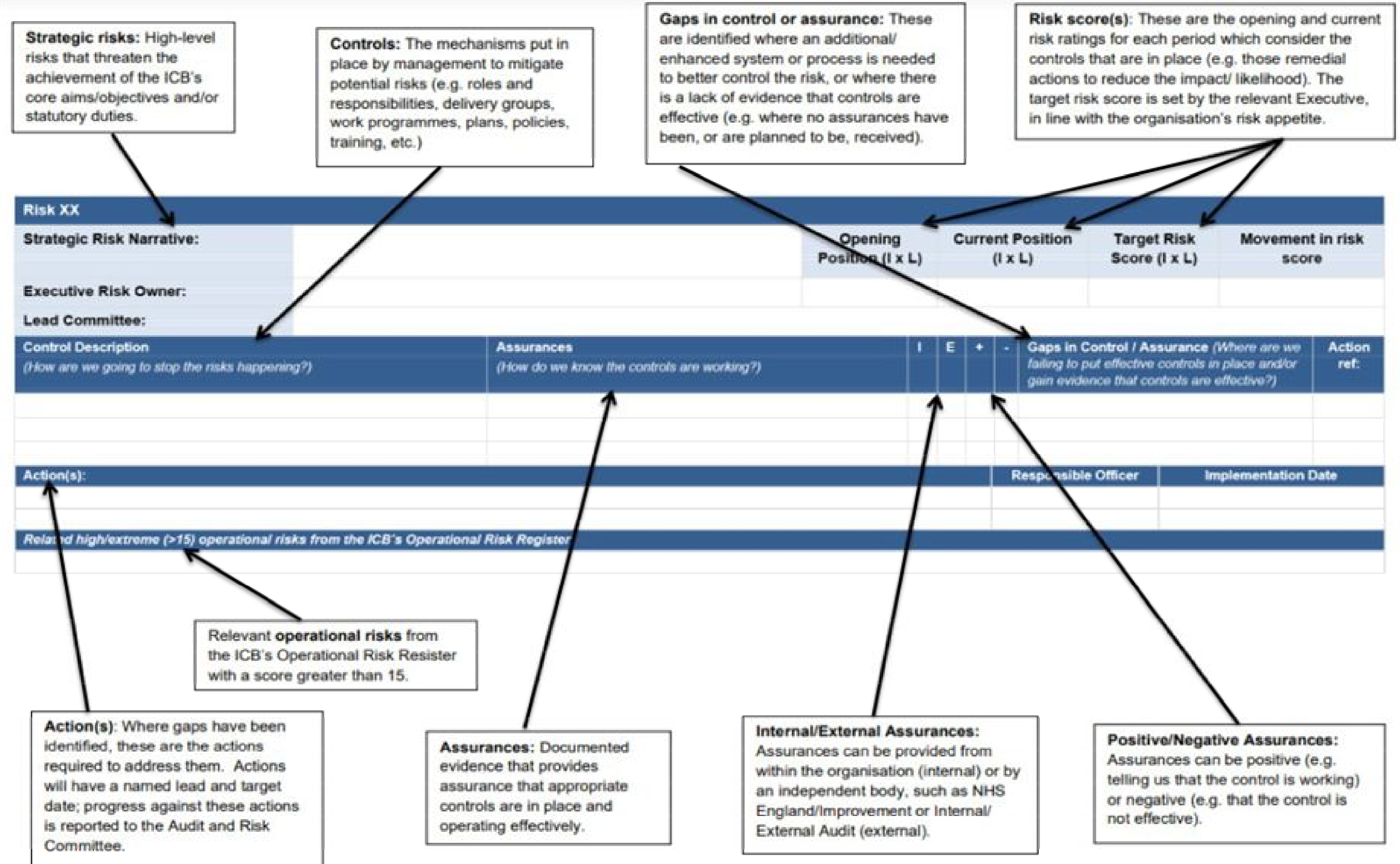
2024/25 BAF Full Business Cycle

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Board: BAF biannual reviews	-	✓	-	-	-	-	-	✓	-	-	-	-
Audit and Risk Committee: Targeted assurance reports	-	-	-	-	-	✓	-	✓	-	✓	-	✓
Board Committees: Receipt of assurances	✓	✓	✓	✓	-	✓	✓	✓	-	✓	✓	✓
BAF Quarterly Reviews: 1:1 reviews between the Head of Corporate Assurance and relevant Executive	✓	-	-	-	✓	-	✓	-	✓	-	✓	-

Board Assurance Framework

May 2024

How to navigate the Board Assurance Framework



Risk 1 and 3 – Transformation (Making Tomorrow Better for everyone)					
Strategic Risk Narrative:	Effective system working may not transform (reform) and improve services to address health inequalities and ensure best possible future health outcomes within available resources.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Medical Director / Director of Integration	High (5 x 3)	High (5 x 4)	Medium (4 x 2)	↔
Lead Committee:	Strategic Planning and Integration Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Joint Forward Plan (JFP), which sets out how the ICB and its local NHS partners will work differently across the next five years to improve the health, care and wellbeing of local communities and reduce health inequalities. The JFP describes how the ICB and its local NHS partners will contribute towards the delivery of the: **a)** **Integrated Care Strategy**, which outlines how the ICS will improve health and care outcomes and experiences across three themes of prevention, equity and integration; and b) **Joint Local Health and Wellbeing Strategies (Nottingham City and Nottinghamshire County)**, which set out the vision, priorities and action agreed by the Health and Well-being Boards to improve the health and wellbeing of the population. The Integrated Care Strategy, Joint Local Health and Wellbeing Strategies and JFP are based on the population health and care needs as described by the **Nottingham City and Nottinghamshire County Joint Strategic Needs Assessments**.	Updates on Joint Forward Plan development and oversight and delivery arrangements to SPI Committee (December 2022, January to July 2023 and September 2023, and March 2024). Update on Joint Forward Plan Delivery to the Board (January 2024)	✓ ✓		✓ ✓		None identified.	
Role of the System Analytics and Intelligence Unit (SAIU) in relation to the **Population Health Management (PHM) programme** and **ICS Outcomes Framework**.	PHM Approach: System Development Update to the SPI Committee (October 2022 and May 2023). An integrated approach to Population Health Management Outcomes Monitoring updates to the Board (May, Sept 2023 and March 2024)	✓ ✓		✓ ✓		To revamp the ICS Outcomes Framework in light of the Integrated Care Strategy and Joint Forward Plan.	1.10
Establishment of system delivery 'vehicles', including: a) **Primary Care Networks**, collective partnerships of providers working together differently to achieve closer integration of services at neighbourhood level. b) **Place-Based Partnerships**, collective partnerships with a role of driving transformation at a local and neighbourhood level. c) **Provider Collaborative at Scale**, a collective partnership of the NHS trusts across Nottingham and Nottinghamshire, working together at scale to benefit the population.	System development updates: Approach to delivering community and primary care transformation through thriving places and provider collaboration to the SPI Committee (November 2022, March, and November 2023). Rolling programme of Place Based Partnerships and Provider Collaborative updates to the Board (January, March, May, July, September, and November 2023).	✓ ✓		✓ ✓		To establish appropriate targeted operating model with system delivery 'vehicles' and establish associated commissioning arrangements.	1.11
The role and remit of System Programme Boards in relation to the oversight and delivery of transformation programmes; these include:	Rolling programme of transformation updates to the Board (September, October, November 2022, and January 2023).	✓ ✓		✓ ✓	✓ ✓	To take appropriate action following system forums self-assessment work *(as discussed at*	1.12

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
a) **Ageing Well Programme Board**, which oversees delivery of the Community Services Transformation Programme. b) **Mental Health Programme (Transformation) Executive Board.** c) **Primary Care Strategy Delivery Group**. d) **Planned Care Board**, which exists to oversee transformational changes in the provision of planned care, cancer and diagnostic services across the ICS. e) **Urgent and Emergency Care (UEC) Board**, which oversees transformation across the non-elective pathway. f) **Special Educational Needs and Disabilities (SEND) Improvement Board**. g) **Children and Young People Board**. h) **Learning Disability and Autism (LDA) Transformation Board**; and i) **Local Maternity and Neonatal (LMNS) Transformation Board**. The above are also supported by a number of system delivery oversight groups, which includes an **ICS Health Inequalities (HI) and Prevention Oversight Group** and an **ICS Performance Oversight Group.** As well as clinical and care professional groups, which includes the **ICS Clinical and Care Professional Leadership Group** and the role of the **Clinical Design Authority's (CDA)**.	Rolling programme of Delivery of Service Transformation updates to the SPI Committee (November 2022, January, July, September, October, November and December 2023, February, and March 2024). Thematic Service Delivery and Health inequalities Reporting to the Finance and Performance Committee (monthly from April 2023). 2022/23 Internal Audit Review – Health Inequalities *(Advisory).*	✓	✓	✓ ✓	✓	*the ICB Board Development Session in October 2023).* To clarify the role of the ICS HI and Prevention Oversight Group.	1.13

Action(s):	Responsible Officer	Implementation Date
Action 1.6 To establish robust oversight and accountability arrangements to ensure delivery of the Joint Forward Plan.	Director of Integration	Complete
Action 1.10 To revamp the ICS Outcomes Framework in light of the Integrated Care Strategy and Joint Forward Plan.	Medical Director	~~March 2024~~ July 2024
Action 1.11 To establish appropriate targeted operating model with system delivery 'vehicles' and establish associated commissioning arrangements.	Director of Integration	~~March 2024~~ July 2024
Action 1.12 To take appropriate action following system forums self-assessment work *(as discussed at the ICB Board Development Session in October 2023).*	Chief Executive	Superseded*
Action 1.13 To clarify the role of the ICS HI and Prevention Oversight Group in light of the establishment of the Integrated Care Strategy Steering Group and System Transformation Group.	Medical Director	Superseded*

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
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.
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.

**Actions superseded by the work being undertaken by the Interim System Delivery Director to fully review the operational and transformational system groups.*

Risk 2 - System Resilience (for Managing Today)					
Strategic Risk Narrative:	Working effectively across the system may fail to address the current levels of demand across primary, community and secondary care.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Integration	High (5 x 4)	High (5 x 4)	Medium (4 x 2)	⇧
Lead Committee:	Strategic Planning and Integration Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Role and remit of the **ICS System Oversight Group**, whose members have collective accountability for the operational performance of the ICS, and which is underpinned by the **Nottingham and Nottinghamshire ICB Operating Framework.**	Integrated Performance Report (IPR) presented to the Board (bi-monthly). Service Delivery Scorecard and Exception Reporting to the Finance and Performance Committee and Quality and People Committee (monthly). NHS Oversight Framework Assessment (quarterly and annually).	✓ ✓ 	 ✓	✓ ✓ ✓	✓ ✓ ✓	To undertake a review of the ICS operating model to support alignment and consistency of system forums (superseded by actions 1.12 and 1.13).	2.5
Delivery of the **2023/24 Operational Plan**, alongside the development of 2024/25 Operational Planning.	Integrated Performance Report (IPR) presented to the Board (bi-monthly). Service Delivery Scorecard and Exception Reporting to the Finance and Performance Committee and Quality and People Committee (monthly). Routine Operational Planning updates to the Finance and Performance Committee (monthly from Oct 2023). NHS Oversight Framework Assessment (quarterly and annually)	✓ ✓ ✓ 	 ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	See actions relating to risk 1 and 3 *(Making Tomorrow Better for Everyone)*	
The role and remit of System Programme Boards in relation to the operational delivery; these include: a) **Urgent and Emergency Care (UEC) Board**, which leads on overall system resilience for both in and out of hospital care. b) **Ageing Well Programme Board**, which oversees delivery of the three national priorities (Anticipatory Care, Enhanced Health in Care Homes and Urgent Community Response. c) **Mental Health Programme Executive Board,** which exists to oversee delivery of mental health transformation across the ICS. d) **Primary Care Strategy Delivery Group**, with responsibility for overseeing delivery of the Primary Care Strategy and the Primary Care Access Recovery Plan (PCARP).	Integrated Performance Report (IPR) presented to Board (bi-monthly). Urgent and Emergency Care (incl. Winter Planning) and Primary Care delivery updates to the Board (July, November, and December 2023). Service Delivery Scorecard and Exception Reporting to the Finance and Performance Committee and Quality and People Committee (monthly). Rolling programme of Delivery of Service Transformation updates to the SPI Committee (November 2022, January, July, September, October, November and December 2023, February, and March 2024). NHS Oversight Framework Assessment (quarterly and annually)	✓ ✓ ✓ ✓ 	 ✓ ✓	✓ ✓ ✓ ✓ ✓	✓ ✓ ✓ ✓ ✓	See actions relating to risk 1 and 3 *(Making Tomorrow Better for Everyone)*	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
e) **Planned Care Board**, which exists to oversee delivery of the system's elective recovery plans and the establishment of **Elective Hubs.** The above are also supported by several system delivery oversight groups, as well as daily System Calls. Role and remit of the **Demand and Capacity Group,** supported by the Bed Modelling 'Task and Finish' Group.	2023/24 Internal Audit Review – System-wide Discharge Management (*scheduled Q1 2024/25*).						
Establishment of external System Development Support for Resetting UEC, Demand, Capacity and Flow	NHS Oversight Framework Assessment (quarterly and annually) 2023/24 Internal Audit Review – System-wide Discharge Management (*scheduled Q1 2024/25*).		✓ ✓	✓	✓	None identified.	
Establishment of a **System Co-ordination Centre (SCC)**; the purpose of which is to ensure the safest and highest quality of care possible for the entire population across every area by balancing the clinical risk within and across all health and care settings. **Operational Pressures Escalation Level (OPEL) Framework** across both primary and secondary care providers.	NHS Oversight Framework Assessment (quarterly and annually)		✓	✓	✓	None identified.	
Primary Care Networks, collective partnerships of providers working together differently to achieve closer integration of services at neighbourhood level. **Place-Based Partnerships**, a collective partnership with a role of driving local delivery of prevention services at a local (Primary Care Network) and neighbourhood (Integrated Neighbourhood Team) level. **Provider Collaborative at Scale**, a collective partnership of the NHS trusts across Nottingham and Nottinghamshire, working together at scale to benefit the population.	System development updates: Approach to delivering community and primary care transformation through thriving places and provider collaboration to the SPI Committee (November 2022, March, and November 2023). Rolling programme of Place Based Partnerships and Provider Collaborative updates to the Board (January, March, May, July, September, and November 2023).	✓ ✓		✓ ✓		See actions relating to risk 1 and 3 *(Making Tomorrow Better for Everyone)*	

Action(s):	Responsible Officer	Implementation Date
Action 2.5 To undertake a review of the ICS operating model to support alignment and consistency of system forums.	Chief Executive	Superseded (by actions 1.12 and 1.13)
Action 2.7 To develop an implementation plan following the PA Consulting diagnostic work.	Director of Integration	Complete
Action 2.8 To implement the new 2023/24 Operational Pressures Escalation Level (OPEL) Framework.	Director of Integration	Complete

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
None (see quality related risks at Risk 6).

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Risk 4 - Citizen Voice					
Strategic Risk Narrative:	Failure to effectively work in partnership with citizens and communities.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Chief Executive	Medium (4 x 3)	Medium (4 x 2)	Low (3 x 2)	⟺
Lead Committee:	Strategic Planning and Integration Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	I	E	+	-	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
ICS Working with People and Communities: Citizen Intelligence Strategy 2022-2025, which outlines the vision and principles to ensure that citizens are at the heart of the ICS, as well as the role of the: a) **Citizen Intelligence Advisory Group,** which brings together Healthwatch Nottingham and Nottinghamshire, representatives from our four Places, local authorities and the Voluntary, Community and Social Enterprise sector; to ensure citizen intelligence and insight informs the commissioning of health and care services. b) **ICS Engagement Practitioners Forum**, which brings together representatives from Healthwatch Nottingham and Nottinghamshire, NHS Trusts, Local Authorities, universities, Community and Voluntary sector and Place Based Partnerships; enabling system partners working with people and communities to work collaboratively, share resources, knowledge and expertise and maximise existing knowledge and insights. c) **Voluntary, Community and Social Enterprise Alliance,** which forms a formal part of our ICS; with representatives from various organisations across Nottingham and Nottinghamshire, with an aim to encourage partnership working and putting the voice of people and communities at the heart of what we do.	Working with People and Communities Updates to the SPI Committee (June, September 2023 and March 2024). Healthwatch: Shaping the future of health and social care report to the Board (March 2024) Citizen stories reporting to the Board (periodic) Working with People and Communities Annual Report to the Board (pending) 2023/24 Internal Audit Review – Citizen involvement and Co-production (significant assurance).	✓ ✓	 ✓ ✓	✓ ✓ ✓		None identified.	4.3
Co-production Strategy, which outlines system's approach to engaging with citizens in the development and improvement of services, as well as the role of the ICB Strategic Coproduction Group.	Transformation Personalisation Care and Co-production update to the ICB Board (Jan 2023). Working with People and Communities Updates to the SPI Committee (June, September 2023 and March 2024). 2023/24 Internal Audit Review – Citizen involvement and Co-production (significant assurance).	✓ ✓	 ✓	✓ ✓ ✓		See 6.3	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Establishment of the ICB's **Public Involvement and Engagement Policy,** which sets out mechanisms to undertake meaningful involvement and engagement in the development, implementation and review of health and care policies and services across Nottingham and Nottinghamshire.	Working with People and Communities Updates to the SPI Committee (June, September 2023 and March 2024).	✓		✓		None identified.	
	2023/24 Internal Audit Review – Citizen involvement and Co-production (significant assurance).		✓	✓			
ICB's Equality, Diversity and Inclusion (EDI) Policy, which outlines the requirement to meaningfully engage with people from all protected characteristic and disadvantaged groups. **Equality, Diversion and Inclusion Action Plan 2023-25,** which outlines ICB and System-facing objectives to ensure EDI related statutory duties are met.	Equality, Diversity and Inclusion Action Plan 2023-25 Update to the Q&P Committee (April 2023 and March 2024).	✓		✓		See action 8.4 (*implementation of action plan*)	
	Equality, Diversity and Inclusion Annual Report to the Board (pending)	✓					
	Thematic Health Inequalities reporting to the Finance and Performance Committee (Sept 2023, January and April 2024)	✓		✓			
Equality and Quality Impact Assessment (EQIA) processes, outlined within the ICB's Strategic Decision-Making Framework.	Ad-hoc business cases reported via SPI Committee.	✓		✓		See 8.3.	

Action(s):	**Responsible Officer**	**Implementation Date**
Action 4.3 To develop the Overall Strategy for Working with People and Communities (which combines the Citizen Intelligence Strategy and the Co-production Strategy).	Chief Executive	Superseded

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
None.

Risk 5 - Research and Evidence					
Strategic Risk Narrative:	Failure to effectively facilitate and promote research and utilise evidence to inform decision-making.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Medical Director	Medium (4 x 3)	Medium (4 x 2)	Medium (4 x 2)	⟺
Lead Committee:	Strategic Planning and Integration Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Joint Forward Plan (JFP), which sets out how the ICB and its local NHS partners will work differently across the next five years to improve the health, care and wellbeing of local communities and reduce health inequalities. The JFP describes how the ICB and its local NHS partners will contribute towards the delivery of the **Integrated Care Strategy**. The **Integrated Care Strategy** describes that an 'evidenced based approach' is key in the delivery of the four strategic aims. Research is a key element of the **Joint Forward Plan;** with year one focusing on the development of an ICS Research Strategy and better alignment of research to ICS commissioning.	Updates on Joint Forward Plan development and oversight and delivery arrangements to SPI Committee (December 2022, January to July 2023 and September 2023, and March 2024). Update on Joint Forward Plan Delivery to the Board (January 2024)	✓ ✓		✓ ✓		None identified.	
ICS Research Strategy (in development), to support delivery of the Integrated Care Strategy and Joint Forward Plan. A Senior Research Strategy Manager from the University of Nottingham (funded by the NIHR Clinical Research Network East Midlands) is working with the ICB's Head of Research and Evidence to take forward this work for the system. **ICS Research Partners Group,** which promotes a collaborative approach to health and care research across the system. Role and remit of the **ICB's Research Strategy Group**, which is a GP-led forum which oversees arrangements to promote, develop and increase research activity and research capacity and culture building within the ICB, Primary Care Networks and GP practices. ICB commissioned **Knowledge and Library Service** (from Sherwood Forest Hospitals NHS Foundation Trust),	Promotion of Research and Use of Evidence updates to the SPI Committee (February and October 2023 and *April 2024 (pending))*. Annual Assurance Report: Promotion of Research and Use of Research Evidence to the ICB Board *(pending)*.	✓ ✓		✓ ✓		None identified.	5.2

Action(s):	**Responsible Officer**	**Implementation Date**
Action 5.2 To develop processes to ensure that knowledge and evidence from research systematically influences business cases (which will be supported by the appointment of a Senior Evidence Fellow)	Medical Director	~~April 2023~~ April 2024
Action 5.3 To develop an ICS Research Strategy to support delivery of the Integrated Care Strategy and Joint Forward Plan.	Medical Director	Complete

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
None.

Risk 6 - Quality Improvement					
Strategic Risk Narrative:	Failure to maintain and improve the quality of services. *For 2023/24, this specifically includes the need to improve the quality of maternity and Learning Disabilities and Autism services.*	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Nursing	High (5 x 4)	High (4 x 4)	Low (3 x 2)	⇧
Lead Committee:	Quality and People Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Joint Forward Plan (JFP), which sets out how the ICB and its local NHS partners will work differently across the next five years to improve the health, care and wellbeing of local communities and reduce health inequalities. The JFP describes how the ICB and its local NHS partners will contribute towards the delivery of the **Integrated Care Strategy**. Quality improvement and personalisation are key elements of the **Joint Forward Plan;** with year one focusing on the development of a system definition of quality improvement (QI), establish system reporting and then benchmark and monitor.	Updates on Joint Forward Plan development and oversight and delivery arrangements to SPI Committee (December 2022, January to July 2023 and September 2023, and March 2024). Update on Joint Forward Plan Delivery to the Board (January 2024) NHS Oversight Framework Assessment (quarterly and annually).	✓ ✓	✓	✓ ✓ ✓	✓	See actions relating to risk 1 and 3 *(Making Tomorrow Better for Everyone)*	
Role and remit of the **ICS System Oversight Group**, whose members have collective accountability for the operational performance of the ICS, and which is underpinned by the **Nottingham and Nottinghamshire ICB Operating Framework.**	Integrated Performance Report (IPR) presented to the Board (bi-monthly). Service Delivery Scorecard and Exception Reporting to the Quality and People Committee (monthly). NHS Oversight Framework Assessment (quarterly and annually).	✓ ✓	✓	✓ ✓ ✓	✓ ✓ ✓	None identified.	
System Quality Framework (formally known as Strategy) 2023/24, supported by a delivery plan, the purpose of which is to develop and embed a robust quality improvement framework across system partners.	System Quality Framework updates to the Quality and People Committee, (June and Oct 2023 March 2024).	✓		✓		None identified.	
Role and remit of the **System Quality Group**, which exists to drive quality improvement collaboratively and proactively. It includes '7 minute' learning sessions at each meeting which relate to various quality improvement initiatives. This is supported by system sub-groups which include, but are not limited to, safeguarding (including LAC and SEND), infection prevention and control, immunisations and vaccinations, patient safety, social care and personalisation.	Service Delivery Scorecard and Exception Reporting to the Quality and People Committee (monthly).	✓		✓		None identified.	
Establishment of the **System Quality Outcome Dashboard** (supported by the SAIU), supported by the development of quarterly **Quality Risk Profiles** which are co-produced with NHS	Service Delivery Scorecard and Exception Reporting to the Quality and People Committee (monthly).	✓ ✓		✓ ✓	✓ ✓	None identified.	

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Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
system partners and support requirements of the National Quality Board.	System Provider Risk Profiles reporting to the Quality and People Committee (quarterly).						
Implementation of the **Patient Safety Incident Response Framework (PSIRF),** which sets out the systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This includes the establishment of Patient Safety Specialists and Patient Safety Partners to support the implementation of PSIRF and the production of **PSIRF Policy**.	Patient Safety Incident Response Framework (PSIRF) implementation: Focused ICB and System review update to the Quality and People Committee (May and October 2023). Patient Safety Incident Response Framework (PSIRF) Development Session with the ICB Board (Dec 2023).	✓ ✓		✓ ✓		None identified.	6.5 6.6
NHSE Improving Patient Care Together (IMPACT) Self-Assessment, the purpose of which is to help systems, providers and partners understand where they are on their quality improvement journey and identify improvements needed.	NHSE IMPACT Self-Assessment presented to NHS England and ICB Executive Management Team.	✓		✓		None identified.	
Role and remit of the **Nottingham and Nottinghamshire Local Maternity and Neonatal System (LMNS) Executive Partnership Board,** which is overseen by the System Quality Group and supported by: • **LMNS Perinatal Surveillance Quality Group (PSQG).** • **LMNS Serious Incident (SI) Panel.** • **LMNS Quality Outcomes Dashboard Sub-group (DSG)** Role and remit of the **Maternity Voices Partnership (MVP).** Role and remit of the **Regional Quality Oversight Group.** Role and remit of the **Regional Perinatal Quality Surveillance Group.** Regional LMNS oversight and performance meetings with NHS England.	Service Delivery Scorecard and Exception Reporting to the Quality and People Committee (monthly). Exception report LMNS Programme Assurance Update to the Quality and People Committee (April 2023). Donna Ockenden inquiry updates to the Executive Management Team (ad-hoc) and to ICB Board (via Chief Executive reports). Maternity Services, health outcomes and LMNS 'deep dive' presented to the Quality and People Committee (March 2024).	✓ ✓ ✓ ✓		✓ ✓ ✓ ✓		None identified.	
Role and remit of the **Nottingham and Nottinghamshire Learning Disability & Autism (LDA) Executive Partnership Board,** which is overseen by the System Quality Group and supported by: • **LDA Operational Delivery Group (ODG).** • **Crisis and admission prevention steering group.** • **Discharges and community capacity steering group.** • **Living and ageing well working steering group.** • **Children and young people steering group.** Regional LDA oversight and performance meetings with NHS England.	Service Delivery Scorecard and Exception Reporting to the Quality and People Committee (monthly). Learning Disability and Autism (LDA) 'deep dive' presented to the Quality and People Committee (March 2024)	✓ ✓		✓ ✓	✓		
The ICB's quality framework and commissioning processes, which include a range of nursing, quality and safeguarding statutory	System Quality and People Oversight Reporting to the Quality and People Committee (monthly).	✓		✓	✓	None identified.	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
duties (e.g., Safeguarding, Infection Prevention and Control, Complaints).	2023/24 Internal Audit Review – Complaints (significant).		✓	✓			
Equality and Quality Impact Assessment (EQIA) processes, outlined within the ICB's Strategic Decision-Making Framework.	Ad-hoc business cases reported via SPI Committee.	✓		✓		None identified.	
Co-production Strategy, which outlines system's approach to engaging with citizens in the development and improvement of services, as well as the role of the ICB Strategic Coproduction Group.	Transformation Personalisation Care and Co-production update to the ICB Board (Jan 2023).	✓		✓		See 6.3	
	Working with People and Communities Updates to the SPI Committee (June, September 2023 and March 2024).	✓		✓			
	2023/24 Internal Audit Review – Citizen involvement and Co-production (significant assurance).		✓	✓			
ICB Complaint's Policy, which sets out the organisation's approach to handling complaints and concerns about commissioned services, ensuring that 'lessons are learnt' and improvements made as a result of issues raised.	System Quality and People Oversight Reporting to the Quality and People Committee (monthly).	✓		✓	✓	None identified.	
	2023/24 Internal Audit Review – Complaints (significant).		✓	✓			

Action(s):	Responsible Officer	Implementation Date
Action 6.4 To finalise and publish the ICB's Patient Safety Incident Response Framework (PSIRF) Policy.	Director of Nursing	Complete
Action 6.5 To implement the Patient Safety Incident Response Framework (PSIRF).	Director of Nursing	Complete

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR166 If ambulance handover times at acute trusts increase and cause delayed ambulance arrival in the community, there is a risk of potential harm to citizens who are waiting for an ambulance, which may lead to further deterioration of their condition.
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.
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.
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.
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.
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
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.
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.
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.

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
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.
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. This may result in future population needs not being made and/or anticipated efficiencies not materialising.

Risk 7 - People and Culture					
Strategic Risk Narrative:	Failure to ensure appropriate capacity and capability within the local workforce.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Nursing	High (5 x 4)	High (5 x 3)	Low (3 x 2)	⟺
Lead Committee:	Quality and People Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Joint Forward Plan (JFP), which sets out how the ICB and its local NHS partners will work differently across the next five years to improve the health, care and wellbeing of local communities and reduce health inequalities. The JFP describes how the ICB and its local NHS partners will contribute towards the delivery of the **Integrated Care Strategy**. Workforce is a key element of the **Joint Forward Plan;** with year one focusing on the establishment of an ICS people and culture plan and delivery process, retention of shortage skill areas and strategic workforce planning. The ambitions for people and culture outlined in the Joint Forward Plan informed the four priorities for 2023/4. 1. Developing a system people and culture function. 2. One workforce - supported by the scaling up vanguard. 3. Supporting inclusion and belonging for all, creating a great experience for staff; and 4. Agency reduction. Delivery of the **NHS People Plan,** whose purpose is to ensure that that Nottingham and Nottinghamshire ICS has the right staff, with the right skills, values and behaviours to deliver high-quality services now and in the future.	Updates on Joint Forward Plan development and oversight and delivery arrangements to SPI Committee (December 2022, January to July 2023 and September 2023, and March 2024).	✓		✓		See actions relating to risk 1 and 3 *(Making Tomorrow Better for Everyone)*	
	Update on Joint Forward Plan Delivery to the Board (January 2024)	✓		✓			
	Nottingham and Nottinghamshire ICS People Plan: Strategic Delivery Update to the Board (Sept 2023).	✓		✓			
	10 People and Culture Outcomes Dashboard presented to the Quality and People Committee (June 2023).	✓		✓			
	Nottingham and Nottinghamshire Integrated Care System People Plan: Update to the Quality and People Committee (Sept 2023).	✓		✓			
	ICS People Plan: Delivery Update to Quality and People Committee (November 2023).	✓		✓			
	Integrated Care System People Plan stocktake to the Quality and People Committee (February 2024).	✓		✓			
	Operational People Delivery Plan 2024/25 update to the Quality and People Committee (March 2024).	✓		✓			
	System Quality and People Oversight report to the Quality and People Committee (monthly).	✓		✓	✓		
	NHS Oversight Framework Assessment (quarterly and annually).		✓	✓	✓		
Establishment and embedment of the **System People and Culture Function,** as described below: a) **ICB People and Culture Team**: this team will play a fundamental role in the Running Cost Allowance work and the Operating Model and is an ICB focussed team. b) **People and Culture, Programmes and Assurance Team:** this is a system partnership with reporting and assurance	Nottingham and Nottinghamshire ICS People Plan: Strategic Delivery Update to the Board (Sept 2023).	✓		✓		None identified.	
	10 People and Culture Outcomes Dashboard presented to the Quality and People Committee (June 2023).	✓		✓			
	Nottingham and Nottinghamshire Integrated Care System People Plan: Update to the Quality and People Committee (Sept 2023).	✓		✓			

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
processes in place, with a focus on the oversight of the delivery of the ICS People priorities and long-term plan. c) **ICS People and Culture Delivery Team:** to enable the ICS to develop a "One Workforce" approach, that delivers the ICS Strategy, Joint Forward Plan and ambitions of the Provider Collaborative. and includes a partnership approach to delivery including the ICB, three providers, Nottingham City and Nottinghamshire County Councils, Primary Care and Voluntary Care Sector(s).	ICS People Plan: Delivery Update to Quality and People Committee (November 2023). Integrated Care System People Plan stocktake to the Quality and People Committee (February 2024). Operational People Delivery Plan 2024/25 update to the Quality and People Committee (March 2024). System Quality and People Oversight report to the Quality and People Committee (monthly).	✓ ✓ ✓ ✓		✓ ✓ ✓ ✓	 ✓		
Establishment of the **System People and Culture Steering Group,** whose collective membership oversees delivery of the NHS People Plan, which is supported by the: a) **ICS People and Culture Delivery Group,** whose role and remit includes oversight and delivery of the ICS People and Culture Plan. This is supported by the **ICS Health and Well-being Steering Group**; and b) **ICS Planning, Performance and Risk Group,** whose role and remit includes the oversight and delivery of the ICS Workforce Plan. This is supported by the **Agency Reduction Group, Workforce Intelligence Group (WIG)** and **Technical Workforce Planning Group.** The role and remit of the **Primary Care Strategy Delivery Group**, which oversees the delivery of the workforce workstream of the **Primary Care Strategy**.	Nottingham and Nottinghamshire ICS People Plan: Strategic Delivery Update to the Board (Sept 2023). 10 People and Culture Outcomes Dashboard presented to the Quality and People Committee (June 2023). Nottingham and Nottinghamshire Integrated Care System People Plan: Update to the Quality and People Committee (Sept 2023). ICS People Plan: Delivery Update to Quality and People Committee (November 2023). Integrated Care System People Plan stocktake to the Quality and People Committee (February 2024). Operational People Delivery Plan 2024/25 update to the Quality and People Committee (March 2024).	✓ ✓ ✓ ✓ ✓ ✓		✓ ✓ ✓ ✓ ✓ ✓		None identified.	
Scaling Up People Services – NHS England Vanguard Project, which has three key aims: a) Improve the ease of people movement across the Provider Collaborative, addressing as many blockers to movement as possible. b) Improve the health wellbeing of staff across the Provider Collaborative c) Address our agency spend by collaborating on our flexible workforce to improve our temporary workforce capacity.	Nottingham and Nottinghamshire ICS People Plan: Strategic Delivery Update to the Board (Sept 2023).	✓		✓			

Action(s):	**Responsible Officer**	**Implementation Date**
Action 7.3 To establish and embed the System People and Culture Function, which includes the System People and Culture Group and supporting governance structures, including working alongside the Provider Collaborative.	Director of Nursing	Complete
Action 7.4 To embed workforce as a routine item across all relevant system programmes/boards.	Director of Nursing	Complete

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
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.

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
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.
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.

Risk 8 - Equality, Diversity and Inclusion					
Strategic Risk Narrative:	Failure to comply with the general and specific Public Sector Equality Duties.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Nursing	Medium (4 x 3)	Medium (4 x 2)	Low (3 x 2)	↔
Lead Committee:	Quality and People Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
ICB's Equality, Diversity and Inclusion (EDI) Policy which sets out how the organisation meets its statutory responsibility to comply with the Public Sector Equality Duty of the Equality Act 2010 (and associated Regulations) and how the ICB will work to achieve good equality performance outcomes. Establishment of an **Equality, Diversity and Inclusion Action Plan 2023-25,** which outlines ICB and System-facing objectives to ensure EDI related statutory duties are met. The role and remit of the **Equity, Inclusion and Human Rights Steering Group,** with responsibility for the oversight and delivery of the Equality, Diversity and Inclusion Action Plan.	Equality, Diversity and Inclusion Action Plan 2023-25 updates to the Quality and People Committee (April 2023 and March 2024). Public Sector Equality Duty and NHS EDS Briefing paper to the Quality and People Committee (November 2023). Equality, Diversity and Inclusion Annual Report to the Board (pending) Government Digital Service Review, which focussed on the accessibility of the ICB's website in line with the associated regulations (The Public Sector Bodies Accessibility Regulations 2018). Review by the Equality and Human Rights Commission Review of the ICB's compliance with the PSED.	✓ ✓ ✓	✓ ✓	✓ ✓ ✓ ✓		To implement actions identified within the Equality, Diversion and Inclusion Action Plan 2023-25.	8.4
Key ICB business activities where due regard to the general public sector equality duty is required include: • Assessing the health needs of our population. • Public engagement and communications. • Procurement and contract management. • Recruitment and selection; and • Cultural competence.	Public Sector Equality Duty and NHS EDS Briefing paper to the Quality and People Committee (November 2023). Review by the Equality and Human Rights Commission Review of the ICB's compliance with the PSED.	✓	✓	✓ ✓		None identified.	
The ICB's compliance with (or working toward the principles of) the: • NHS Accessible Information Standard. • NHS Workforce Race Equality Standard (WRES). • The NHS Workforce Disability Equality Standard (DES).	Equality, Diversity and Inclusion Action Plan 2023-25 updates to the Quality and People Committee (April 2023 and March 2024).	✓		✓		None identified.	
Establishment of robust **Equality and Quality Impact Assessment (EQIA)** processes which monitor the effectiveness of arrangements in place for the completion of equality impact assessments when planning, changing or removing a service, policy or function; these are overseen by the **EQIA Panel**.	Ad-hoc business cases reported via SPI Committee.	✓		✓		None identified.	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
The requirement for all ICB staff to undertake mandated **Equality and Diversity training** on a three-yearly basis.	Mandatory Training Compliance Reports to the Audit and Risk Committee (bi-annually).	✓		✓		None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 8.4 To implement actions identified within the Equality, Diversion and Inclusion Action Plan 2023-25.	Director of Nursing	March 2025
Action 8.5 To establish the Executive-led ICB Human Resources Group.	Director of Nursing	Complete

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
None.

Risk 9 - Safeguarding					
Strategic Risk Narrative:	Failure to safeguard children and vulnerable adults in accordance with legislative and statutory frameworks and guidance	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Nursing	Medium (5 x 2)	Medium (4 x 2)	Low (3 x 2)	↔
Lead Committee:	Quality and People Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Establishment of a suite of corporate policies which describe the ICB's compliance with legislative and statutory frameworks, including the: a) **ICB's Safeguarding Policy** (incorporating PREVENT and Safeguarding Training and Supervision), which describes how the ICB discharges its safeguarding responsibilities for commissioning health services. b) **ICB's Policy for Managing Allegations and Concerns,** which describes the processes to be followed if an employee or those who act in the capacity of employees may pose a risk to a child, young person or an adult in need of safeguarding. c) **ICB's Mental Capacity Act (MCA) 2005 Policy** which outlines the duties placed on health and social care staff and how various processes within the MCA should be followed.	Service Delivery Scorecard and Exception Reporting to the Quality and People Committee (monthly). System Quality and People Oversight Reporting to the Quality and People Committee (monthly). Annual reports Nottinghamshire and Nottingham Safeguarding Children Partnerships to the Quality and People Committee (October 2023). Nottingham and Nottinghamshire Safeguarding Adult Boards Annual Reports to the Quality and People Committee (October 2023). Learning Disability and Autism (LDA) 'deep dive' presented to the Quality and People Committee (March 2024). NHS England Safeguarding Commissioning Assurance Tool submissions (quarterly).	✓ ✓ ✓ ✓ ✓	✓	✓ ✓ ✓ ✓ ✓ ✓		None identified.	
Role and remit of the **ICB Safeguarding Assurance Group (SAG)**, whose members have operational responsibilities for ensuring delivery of the ICB's statutory safeguarding duties; supported by the **ICB Chief Nurse and Safeguarding Professionals Meeting**, which facilitates the prompt escalation of safeguarding concerns and issues. Routine safeguarding assurance processes, such as the completion of Section 11 Audits, Serious Case Reviews, Domestic Homicide Reviews and Multi Agency Audits. Designated and Named Professionals in line with the Royal College of Nursing (RCN) Intercollegiate guidance.	Service Delivery Scorecard and Exception Reporting to the Quality and People Committee (monthly). System Quality and People Oversight Reporting to the Quality and People Committee (monthly). Annual reports Nottinghamshire and Nottingham Safeguarding Children Partnerships to the Quality and People Committee (October 2023). Nottingham and Nottinghamshire Safeguarding Adult Boards Annual Reports to the Quality and People Committee (October 2023). NHS England Safeguarding Commissioning Assurance Tool submissions (quarterly).	✓ ✓ ✓ ✓	✓	✓ ✓ ✓ ✓ ✓		None identified.	
The ICB is statutory partner of the **Local Safeguarding Adults Boards** and **Multi Agency Public Protection (MAPPA) Strategic Management Board** (City and County); as well as having a statutory membership on the **Children's Partnership Boards** (City and County).	Annual reports Nottinghamshire and Nottingham Safeguarding Children Partnerships to the Quality and People Committee (October 2023).	✓ ✓		✓ ✓		None identified.	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
	Nottingham and Nottinghamshire Safeguarding Adult Boards Annual Reports to the Quality and People Committee (October 2023).						
The ICB is a statutory partner of the **Nottinghamshire SEND Partnership Improvement Board,** which has been established to oversee the CQC improvement actions needed.	Deep Dive - Nottinghamshire Joint local area SEND Inspection outcome to the Quality and People Committee (June 2023). Nottinghamshire SEND Partnership Improvement Programme – Progress Update to the Quality and People Committee (January 2024).	✓ ✓		✓ ✓		To address actions identified within the SEND inspection of Nottinghamshire Local Area Partnership.	9.1
Role and remit of the **Nottingham and Nottinghamshire Learning Disability & Autism (LDA) Executive Partnership Board,** which is overseen by the System Quality Group and supported by: • **LDA Operational Delivery Group (ODG).** • **Crisis and admission prevention steering group.** • **Discharges and community capacity steering group.** • **Living and ageing well working steering group.** • **Children and young people steering group.** Role and remit of the **LDA Expert by Experience Group.** Role and remit of the **Regional Quality Oversight Group.** Role and remit of the **Regional Partnership Group.** Independently chaired **SEND Improvement Board.**	Service Delivery Scorecard and Exception Reporting to the Quality and People Committee (monthly). Learning Disability and Autism (LDA) 'deep dive' presented to the Quality and People Committee (March 2024)	✓ ✓		✓ ✓	✓		
The requirement for all ICB staff to undertake mandated **level 1 Safeguarding** on a three-yearly basis.	Mandatory Training Compliance Reports to the Audit and Risk Committee (bi-annually).	✓		✓		None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 9.1 To address actions identified within the SEND inspection of Nottinghamshire Local Area Partnership.	Director of Nursing	May 2024

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
None.

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Risk 10 - Financial Sustainability					
Strategic Risk Narrative:	Establishing a shared culture of financial stewardship may not ensure financial sustainability across the system.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Finance	High (4 x 5)	High (4 x 5)	Medium (4 x 2)	⇧
Lead Committee:	Finance and Performance Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Role and remit of the **ICS Directors of Finance Group**, whose members have collective accountability for the financial performance of the ICS. This is supported by the **ICS Financial Recovery Group,** with responsibility for overseeing delivery of the financial plans across the NHS partners within the ICS. The above are also supported by the **Operational (Deputy) Finance Directors Group**, as well as daily and weekly **ICS Chief Executives** and **Directors of Finance** meetings.	Finance Reports to the Board (bi-monthly).	✓		✓		None identified.	
	Routine System Finance and Financial Recovery updates to the Finance and Performance Committee (monthly).	✓			✓		
	2022/23 Internal Audit Review - HfMA Financial Sustainability (Advisory).		✓	✓			
	NHSE Financial Performance, Controls and Governance: NHS Partner self-assessment (Sept 2023)		✓	✓			
	2023/24 Internal Audit Review - ICS NHS Partners System Financial Control (to assess the effectiveness of the Standard and Financial Controls, as outlined in NHSE' Financial Performance, Controls and Governance letter) *(pending)*		✓				
	NHS Oversight Framework Assessment (quarterly and annually).		✓		✓		
Development and delivery of the **Joint Medium-term Financial Plan,** which supports overall delivery of the five-year Joint Forward Plan. The Plan is developed in line with the: a) **ICS Finance Framework,** which sets out the rules which govern the way finances are managed within the ICS (as identified as best practice by the HfMA); and b) **ICS Financial Planning Principles.**	Routine Operational and Financial Planning updates to the Finance and Performance Committee (monthly from Oct 2023); including the ICS Financial Planning Principles (Sept 2022 and Feb 2024).	✓		✓		To develop the Joint Medium-term Financial Plan.	10.1
	Routine Operational and Financial Planning updates to the Board, including opening budgets and capital resource use planning (September 2022, March 2023 and *March 2024 (pending)*).	✓		✓			
	2022/23 Internal Audit Review - HfMA Financial Sustainability (Advisory).		✓	✓			
	NHSE Financial Performance, Controls and Governance: NHS Partner self-assessment (Sept 2023)		✓	✓			
	2023/24 Internal Audit Review - ICS NHS Partners System Financial Control (to assess the effectiveness of the Standard and Financial Controls, as outlined in NHSE Financial Performance, Controls and Governance letter) *(pending)*		✓				
	NHS Oversight Framework Assessment (quarterly and annually).		✓		✓		
Role and remit of the **ICS System Oversight Group**, whose members have collective accountability for the operational performance of the ICS, and which is	Finance Reports to the Board (bi-monthly).	✓		✓		None identified.	
	NHS Oversight Framework Assessment (quarterly and annually).						

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
underpinned by the **Nottingham and Nottinghamshire ICB Operating Framework.**		✓	✓	✓	✓		
Delivery of the **2023/24 Operational and Financial Plan**, including delivery of performance targets which may have financial implications.	Finance Reports to the Board (bi-monthly). Routine System Finance and Financial Recovery updates to the Finance and Performance Committee (monthly). Service Delivery Scorecard and Exception Reporting to the Finance and Performance Committee (monthly). NHS Oversight Framework Assessment (quarterly and annually)	✓ ✓ ✓	 ✓	✓ ✓ ✓	 ✓	None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 10.1 To develop the Joint Medium-term Financial Plan to support delivery of the Joint Forward Plan.	Director of Finance	~~April 2023~~ July 2024

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR105 Continued over-reliance on non-recurrent (one-off) funds / mitigations by the NHS Nottingham and Nottinghamshire ICB to temporarily offset recurring (year on year) pressures may result in further deterioration in the ICB's recurrent underlying financial position for 2023/24.
ORR106 There is a potential risk that NHS Nottingham and Nottinghamshire ICB may not meet its statutory financial duties for 2023/24.
ORR107 There is a potential risk that the Nottingham and Nottinghamshire system, as a collective, may not meet its agreed year-end financial position outlined within the 2023/24 financial plan. As well as potential reputational risks for the ICS, this may significantly impact the extent to which the system is able to create financial 'headroom' to focus on the transformation of services.
ORR108 Continued over-reliance on non-recurrent mitigations to manage the Nottingham and Nottinghamshire system's 2023/24 financial position may result in further deterioration in the system's underlying financial position (UDL). The UDL may also be impacted by non-delivery of required 'cash releasing' productivity, efficiency, and transformation plans.

Risk 11 - Allocation of Resources		Opening Position (I x L)	Current Position (I x L)	Target Risk Score (I x L)	Movement in risk score
Strategic Risk Narrative:	Failure to establish robust resource allocation arrangements across the system (revenue and capital).				
Executive Risk Owner:	Director of Finance	High (5 x 3)	Medium (5 x 2)	Medium (4 x 2)	⟺
Lead Committee:	Finance and Performance Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	I	E	+	-	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
Role and remit of the **ICS Directors of Finance Group**, whose members have collective accountability for the financial performance of the ICS. This is supported by the **ICS Capital Sub-Group,** which is responsible for ensuring a collaborative approach to capital and that capital investment is prioritised and used effectively. The **ICS Financial Recovery Group** also has a role in relation to any revenue investment decisions.	Routine Operational and Financial Planning updates to the ICB Board, including opening budgets and capital resource use planning (September 2022, March 2023 and *March 2024 (pending)*). NHS Oversight Framework Assessment (quarterly and annually).	✓	 ✓	✓ ✓		None identified.	
Board approved **Joint Capital Resource Plan**, which is prepared with partner NHS trusts and NHS foundation trusts and provides transparency to stakeholders on the prioritisation and expenditure of capital funding. The Plan is developed in line with the: c) **ICS Finance Framework,** which sets out the rules which govern the way finances are managed within the ICS (as identified as best practice by the HfMA); and d) **ICS Financial Planning Principles.**	Bi-monthly Joint Capital Resources Planning progress updates to the Finance and Performance Committee (June, Oct 2023, January and *March 2024 (pending)*). NHS Oversight Framework Assessment (quarterly and annually).	✓	 ✓	✓ ✓		None identified.	
Development of the **ICS Infrastructure Strategy,** which will align with service strategies and support future investment prioritisation. This work is being overseen by **ICS' Infrastructure Strategy Steering Group.**	Estates and Infrastructure updates to the Finance and Performance Committee, including Strategic Estates and Primary Care Estate (November 2023 and *May 2024 (pending)*).	✓		✓		To develop the ICS Infrastructure (previously known as Estates) Strategy.	11.2

Action(s):	Responsible Officer	Implementation Date
Action 11.2 To develop the ICS Infrastructure (*previously known as Estates*) Strategy.	Director of Finance	~~December 2023~~ May 2024

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
None.

Risk 12 - Digital Transformation					
Strategic Risk Narrative:	Failure to deliver digital transformation and establish effective system intelligence solutions.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Medical Director	High (4 x 4)	Medium (4 x 2)	Medium (4 x 2)	⟺
Lead Committee:	Finance and Performance Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Joint Forward Plan (JFP), which sets out how the ICB and its local NHS partners will work differently across the next five years to improve the health, care and wellbeing of local communities and reduce health inequalities. Digital is a key element of the Joint Forward Plan. *Year 1 priorities relate to digital correspondence access, electronic patient records and supporting infrastructure, and the expansion of digital inclusion co-ordinator roles.* The JFP describes how the ICB and its local NHS partners will contribute towards the delivery of the **Integrated Care Strategy**, which outlines how the ICS will improve health and care outcomes and experiences across three themes of prevention, equity and integration. In particular, *the importance of building on our successful data, analytics, information and technology (DAIT) approach in delivery of the four strategic aims.*	Updates on Joint Forward Plan development and oversight and delivery arrangements to SPI Committee (December 2022, January to July 2023 and September 2023). Update on Joint Forward Plan Delivery to the Board (January 2024).	✓ ✓		✓ ✓		See action 1.6 relating to risk 1 and 3 *(Making Tomorrow Better for Everyone)*	
Digital Notts Strategy (2023 to 2028), which is underpinned by five programmes: • Public Facing Digital Services. • Digital and Social Inclusion. • Frontline Digitalisation. • Interoperability (Shared Care Records); and • Supporting Intelligent Decision Making.	Digital Transformation: Strategic Progress Update to the ICB Board (January and November 2023). ICS Digital Strategy 2023-2028 Overview to ICB Development Session (October 2023). Digital, Data and Technology Strategies updates to the Finance and Performance Committee (February, July, September 2023 and January 2024).	✓ ✓ ✓		✓ ✓ ✓		To strengthen assurance reporting in relation to delivery of the Strategy.	12.5
ICS Data, Analytics, Information and Technology (DAIT) Strategy Group and supporting delivery group structure, which includes the **ICS Digital Executive Group**.	Digital Transformation: Strategic Progress Update to the ICB Board (January and November 2023). Digital, Data and Technology Strategies updates to the Finance and Performance Committee (February, July, September 2023 and January 2024).	✓ ✓		✓ ✓		None identified.	
Primary Care Digital Steering Group, which exists to develop, support and implement the necessary IT infrastructure within primary care.	Digital, Data and Technology Strategies updates to the Finance and Performance Committee (February, July, September 2023 and January 2024).	✓		✓		None identified.	
Primary Care Information Technology Strategy (2021-2026) which sets out the strategy for IT services and functionality for	Digital, Data and Technology Strategies updates to the Finance and Performance Committee (February, July, September 2023 and January 2024).	✓		✓		To revisit the Primary Care IT Strategy in light of the new overarching ICS Primary Care Strategy.	12.4

Chappell Room, 09:00-09/05/24

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
primary care and will support delivery of the **Primary Care Access Recovery Plan (PCARP).**							
Role of the System Analytics and Intelligence Unit (SAIU) in relation to the **Population Health Management (PHM) programme** and **ICS Outcomes Framework**.	PHM Approach: System Development Update to the SPI Committee (October 2022 and May 2023). An integrated approach to Population Health Management Outcomes Monitoring updates to the Board (May and September 2023)	✓ ✓		✓ ✓		See action 1.10 relating to risk 1 and 3 *(Making Tomorrow Better for Everyone)*	

Action(s):	**Responsible Officer**	**Implementation Date**
Action 12.4 To revisit the Primary Care IT Strategy in light of the new overarching ICS Primary Care Strategy *(completed via the ICS Primary Care Strategy, Estates and Digital Plan on a Page).*	Medical Director	Complete
Action 12. 5 To strengthen assurance reporting in relation to delivery of the Digital Notts Strategy.	Medical Director	Complete

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR 090 If the 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.
ORR 084 If organisations within the ICS 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.

Risk 13 - Environment Sustainability					
Strategic Risk Narrative:	Failure to effectively deliver on the green plan.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Finance	Medium (4 x 3)	Medium (4 x 2)	Medium (4 x 2)	⇔
Lead Committee:	Finance and Performance Committee (*Highlight Reports from the Committee to the ICB Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	I	E	+	-	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Nottingham and Nottinghamshire ICS Green Plan (2022 to 2025), which outlines the specific actions and priority interventions for achieving carbon net zero to lay the foundation to deliver carbon emission reductions through the delivery of sustainable health and care services.	Twice-yearly Environment Sustainability updates to the Finance and Performance Committee and ICB Board (July 2023 and January 2024).	✓		✓		None identified.	
Role and remit of the **ICS Net Zero / Green Steering Group,** whose members have collective accountability for delivery of the ICS' Green Plan.	2022/23 Internal Audit Review – Environmental sustainability governance (significant assurance).		✓	✓			
	NHS Oversight Framework Assessment (quarterly and annually).		✓	✓			

Action(s):	**Responsible Officer**	**Implementation Date**
None.		

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
None.

Risk 14 - Emergency Preparedness, Resilience and Response					
Strategic Risk Narrative:	Failure to be adequately prepared to respond to major and/or business continuity incidents.	**Opening Position (I x L)**	**Current Position (I x L)**	**Target Risk Score (I x L)**	**Movement in risk score**
Executive Risk Owner:	Director of Integration	Medium (5 x 2)	Medium (5 x 2)	Medium (5 x 2)	⇔
Lead Committee:	Audit and Risk Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
ICB's Emergency Preparedness, Resilience and Response (EPRR) Policy, which outlines how the ICB complies with its statutory responsibilities and EPRR obligations, planning and responding to a major incident and or a business continuity incident.	EPRR Annual Report to the Board (January 2023 and March 2024). Routine EPRR and business continuity updates to the Audit and Risk Committee (November 2022, May and June 2023, January 2024 and *pending in May 2024*). 2022/23 Internal Audit Review – EPRR and Business Continuity Planning (Significant). 2023/24 EPRR Core-Standards statement of assurance submission to NHSE (Partially compliant, 77% to 83%)	✓ ✓ ✓	 ✓ 	✓ ✓ ✓ ✓		None identified.	
Board approved **ICB's Incident Response Plan and Business Continuity Plan** which describe the systems and processes that will be followed when responding to major incidents, significant disruptions and emergencies in line with the Civil Contingencies Act.	2022/23 Internal Audit Review – EPRR and Business Continuity Planning (Significant). Routine EPRR and business continuity updates to the Audit and Risk Committee (November 2022, May and June 2023, January 2024 and *pending in May 2024*).	 ✓	✓ 	✓ ✓		None identified.	
ICB's On-Call Handbook / Action Cards (and rota) which ensure a robust and consistent approach to the implementation of on-call arrangements.	2022/23 Internal Audit Review – EPRR and Business Continuity Planning (Significant). Routine EPRR and business continuity updates to the Audit and Risk Committee (November 2022, May and June 2023, January 2024 and *pending in May 2024*).	 ✓	✓ 	✓ ✓		None identified.	
ICB representative on the Local Health Resilience Partnership (LHRP) and **Local Resilience Forum (LRF).**	2023/24 EPRR Core-Standards statement of assurance submission to NHSE (Partially compliant, 77% to 83%)		✓	✓		None identified.	
NHIS Cyber Security Strategy which outlines compliance with the 10 Steps to Cyber Security and NHIS ISO 27001 accreditation. **NHIS Cyber Assurance Programme Board** and **Cyber Assurance Delivery Group, which is** attended by ICB representatives and has	Routine Information Governance Assurance Reports to the Audit and Risk Committee (November 2022, June 2023, January 2024, and *scheduled June 2024*). 2022/23 Internal Audit Review – Data Security and Protection Toolkit (Substantial - NHSE Opinion). 2023/24 Internal Audit Review *pending in Q1, 2024/25.*	✓ 	 ✓	✓ ✓		None identified.	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
operational oversight responsibility regarding implementation of the cyber strategy.							
ICB Information Security Policy, which defines security measures applied through technology and encompasses the expected behaviour of those who manage information within the organisation. **ICB's Information Governance Steering Group**, which has operational oversight responsibility for information governance, including policy implementation.	Routine Information Governance Assurance Reports to the Audit and Risk Committee (November 2022, June 2023, January 2024, and *scheduled June 2024*). 2022/23 Internal Audit Review – Data Security and Protection Toolkit (Substantial - NHSE Opinion). 2023/24 Internal Audit Review *pending in Q1, 2024/25.*	✓	 ✓	✓ ✓		None identified.	

Action(s):	Responsible Officer	Implementation Date
None.		

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
None.

Annex 1: Alignment of BAF Strategic Risks to ICB Aims (Objectives)

Strategic Risks *(What could prevent us from achieving our strategic aims/objectives and statutory duties?)*	To improve outcome in population health and healthcare.	To tackle inequalities in outcomes, experience and access.	To enhance productivity and value for money.	To help the NHS support broader social and economic development.
Risk 1 and 3: Health Inequalities and Outcomes – Effective system working may not transform (reform) and improve services to address health inequalities and ensure best possible future health outcomes within available resources.	✓	✓	✓	✓
Risk 2: System Resilience (for Managing Today) – Working effectively across the system may fail to address the current levels of demand across primary, community and secondary care.	✓	✓	✓	
Risk 4: Citizen Voice – Failure to effectively work in partnership with citizens and communities.	✓	✓		✓
Risk 5: Research and Evidence – Failure to effectively facilitate and promote research and utilise evidence to inform decision-making.	✓	✓		✓
Risk 6: Quality Improvement – Failure to maintain and improve the quality of services.	✓	✓		
Risk 7: People and Culture – Failure to ensure sufficient capacity and capability within the local workforce.	✓	✓	✓	
Risk 8: Equality, Diversity and Inclusion – Failure to comply with the general and specific Public Sector Equality Duties.		✓		
Risk 9: Safeguarding – Failure to safeguard children and vulnerable adults in accordance with legislative and statutory frameworks and guidance.	✓			
Risk 10: Financial Sustainability – Establishing a shared culture of financial stewardship may not ensure financial sustainability across the system.			✓	✓
Risk 11: Allocation of Resources – Failure to establish robust resource allocation arrangements across the system (revenue and capital).	✓	✓	✓	✓
Risk 12: Digital Transformation – Failure to deliver digital transformation and establish effective system intelligence solutions.	✓	✓	✓	
Risk 13: Environment Sustainability – Failure to effectively deliver on the green plan.				✓
Risk 14: Emergency Preparedness, Resilience and Response – Failure to be adequately prepared to respond to major and/or business continuity incidents.	✓			

Impact ↑					
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Serious	3	6	9	12	15
2 Moderate	2	4	6	8	10
1 Minor	1	2	3	4	5
Likelihood →	1 Rare / Almost Impossible	2 Possible	3 Likely	4 Very Likely	5 Almost Certain

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/05/2024
Paper Title:	**2024/25 Internal Audit Plan**
Paper Reference:	ICB 24 018
Report Author:	Claire Page, Client Manager, 360 Assurance
Report Sponsor:	Stuart Poynor, Director of Finance
Presenter:	-

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

Summary:
The Plan, approved by the ICB's Audit and Risk Committee at its March meeting, was developed through discussions with the ICB's Executive Management Team, the Director of Corporate Affairs, Audit and Risk Committee members, and with the Nottinghamshire system audit committee chairs in relation to system wide reviews. It reflects the ICB's objectives and priorities and includes several reviews that are deemed 'core' and/or are mandated, being undertaken either on an annual or cyclical basis. Other reviews are risk-based.

Recommendation(s):i
The Board is asked to **note** the 2024/25 Internal Audit Plan for information.

How does this paper support the ICB's core aims to:	
Improve outcomes in population health and healthcare	Internal audit work provides assurance to the ICB on its framework of governance, risk and control. It reflects the ICB's objectives and priorities, and supports improvement.
Tackle inequalities in outcomes, experience and access	
Enhance productivity and value for money	
Help the NHS support broader social and economic development	

Appendices:
N/A

Board Assurance Framework:
This paper provides assurance in relation to the management of all ICB strategic risks.

Report Previously Received By:
N/A

Are there any conflicts of interest requiring management?
No

Is this item confidential?
No

NHS Nottingham and Nottinghamshire ICB

2024/25 Internal Audit Plan

20 March 2024

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Introduction

This is your draft 2024/25 Internal Audit Plan, cross-referenced with the Counter Fraud plan where applicable for joint delivery.

Your draft Internal Audit Plan has been developed to meet your assurance requirements. It reflects your objectives and priorities, provides assurance and supports improvement, is fully compliant with Public Sector Internal Audit Standards (PSIAS) and provides for an annual Head of Internal Audit Opinion. We will take a flexible approach and will keep the workplan under review throughout the coming year.

The Plan does not cover all identified key risks in the audit universe, reflecting prioritised allocation of internal audit resources through discussions with ICB officers. The Audit and Risk Committee should acknowledge this limitation when approving the Plan, which is drafted based on available internal audit resources advised by the Director of Finance.

Summary plan:

This table summarises your 2024/25 Internal Audit Plan. The full Plan is provided at Appendix A1.

Ref.	Audit	Indicative Phasing*	Days	Assurance or Advisory
Governance and risk management				
1	Head of Internal Audit Opinion	Q1-4	15	Assurance
2	Governance and risk management	Q4	15	Assurance
Financial management				
3	Financial ledger and reporting	Q3	15	Assurance
4	Financial systems	Q2	20	Assurance
Commissioning and primary care				
5	Delegated direct commissioning	Q4	15	Assurance

Ref.	Audit	Indicative Phasing*	Days	Assurance or Advisory
6	Provider Selection Regime	Q2	16	Assurance
Information management and technology (IM&T) and digital				
7	Data security and protection toolkit (DSPT)	Q1	15	Assurance
8	Delivering Digital Transformation	Q2	18	Assurance
Quality and citizen involvement				
9	Quality management arrangements	Q1/2	22	Assurance
People management				
10	Framework for clinical and care professional leadership	Q2	17	Assurance
11	Delivering the People Plan	Q2/3	17	Assurance
System wide review				
12	To be determined	TBD	8	Advisory
Management				
13	Management, action tracking and contingency	All	57	
TOTAL			**250 days**	

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Post payment verification (PPV)				
14	PPV		40	Advisory
TOTAL			**40 days**	

** Quarters have been allocated where specifically requested. Other audits will be balanced across the year to align with client requirements and resource availability.*

Draft 2024/25 Internal Audit Plan

Engagement with executive officers and Audit and Risk Committee

In producing this draft Plan we have reviewed key documents and held meetings with the following stakeholders:

- Director of Finance regarding system-wide reviews
- Nottinghamshire system Audit Committee Chairs on 29 January
- Associate Director of Corporate Governance and Operational Director of Finance on 9 February
- Director of Integration on 22 February
- Audit and Risk Committee members on 28 February
- Executive Management Team on 4 March.

We understand that you are part of a wider system and there is increasing emphasis on system-wide collaboration and engagement with system partners. As part of our engagement with you we have discussed any assurance needs that reflect your system oversight and leadership role.

As part of our engagement process so far we have identified the following you:

- the following major ‘projects’ are to be undertaken in the next 12 months:
  - replacement of general ledger
  - review and update of Integrated Care Strategy
  - delegation from NHS England of commissioning of additional services
- you expect to receive the following third party assurances over the next 12 months:
  - NHS England annual ICB assessment
  - service auditor reports
- the organisational structure including any subsidiaries, hosted services, shared working arrangements etc and their assurance arrangements:

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- HR functions provided by Arden and GEM CSU – contract management arrangements reviewed as part of staff support audit in 2023/24
- partner in Nottinghamshire ICS – system wide review included in the Plan
- host of staff supporting the delivery of joint primary care functions on behalf of East Midlands ICBs – annual audit of delegated primary care functions self certification.

Planning process

We undertake a risk assessment to ensure your plan is focused on your key risks and which:

- ensures appropriate coverage to meet the requirements of the Public Sector Internal Audit Standards
- facilitates the Audit and Risk Committee in discharging its responsibilities in relation to governance, risk management and control
- supports achievement of strategic objectives.

We will continue to take a flexible approach to delivery of your plan. Even once the plan is agreed, we will continue to scan your local and national risks and agree any proposed changes to the plan through the Audit and Risk Committee, as appropriate. We will also take into account any third party assurances received.

The process is outlined in the table below:

Stage 1
Mandated

- Ensures adherence to the PSIAS over a three year cycle. Supports your AGS and legislative and regulatory requirements.
- Core review assessment completed and provided in the three year strategic plan (Appendix B). Reviews due for 2024/25 not included by the organisation are highlighted in section A2.1.

Stage 2
Risk based

- Uses our wider understanding to identify a prioritised list of sector risks and considers your BAF risks.
- The plan in Appendix A1 is mapped to your BAF and any BAF risks not covered by reviews in the plan are highlighted in A2.2.

Stage 3
High level audit universe

- Considers potential areas for review across your organisation. This does not present an assurance map or include all auditable units. We also consider any other requests made.
- As part of the planning process we have considered coverage against the High Level Audit Universe. Please see Appendix C.

The output of this risk assessment process informs the proposed annual plan. Appendix A summarises your proposed 2024/25 annual plan. The strategic internal audit plan is presented in Appendix B.

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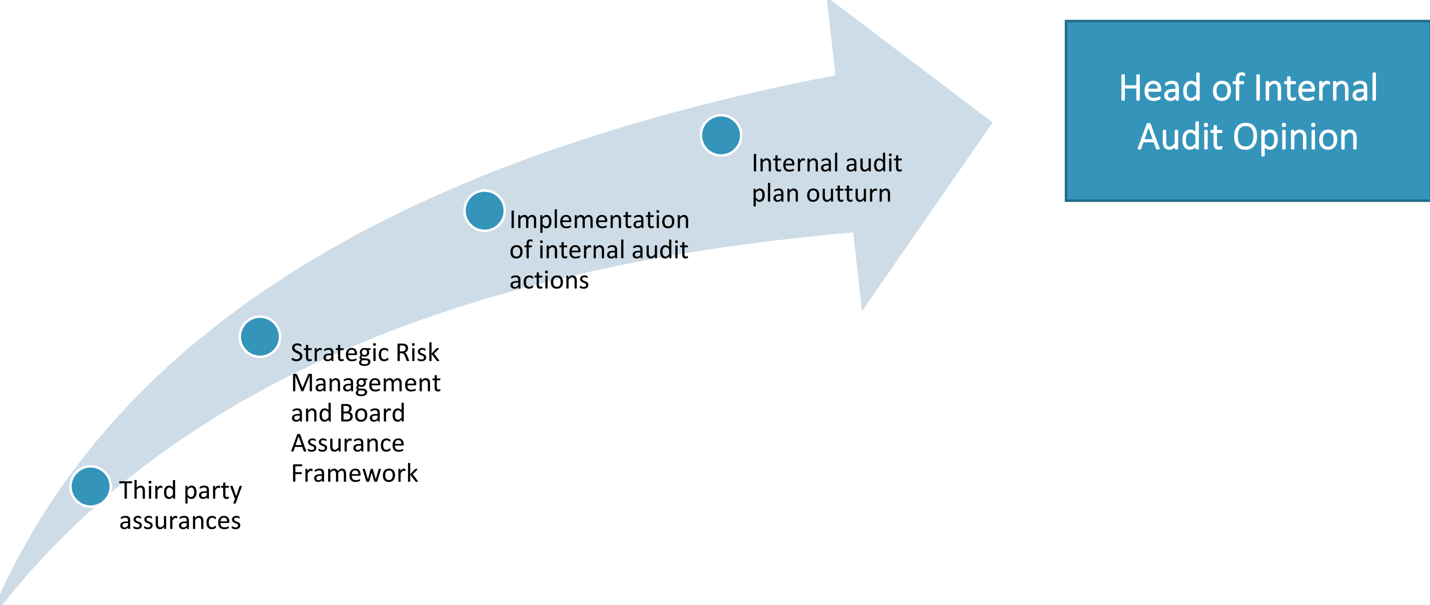
Statutory requirements

Head of Internal Audit Opinion

Our planning process is designed to meet the requirements of the Head of Internal Audit Opinion Statement and to support your Annual Governance Statement, including ensuring the risk management processes in place are well designed and operating as intended.

Our year-end Head of Internal Audit Opinion will be based on the findings of our annual work programme, and consider the four areas outlined in the diagram below. The Head of Internal Audit opinion levels are available to view in full on our website.



Public Sector Internal Audit Standards

The Plan is compliant with the PSIAS. Our Internal Audit Charter is included in Appendix D to demonstrate how we align to your internal audit requirements.

Post Payment Verification (PPV)

Post Payment Verification checks provide assurance that the amounts paid to Primary Care in respect of activity-based claims are correct and that the systems and processes in place are such that future claims will be accurate.

Traditionally, this service has focused on GP Practice Directed Enhanced Services (DESs) and Local Enhanced Services (LESs).

With further delegation of responsibilities from NHSE, we are also able to undertake these PPV checks on behalf of ICBs for:

- Dentistry
- Ophthalmology
- Pharmacy.

We also provide assurance in relation to the Quality Outcomes Framework (QOF) and undertake list cleansing exercises.

In 2023/24, we are undertaking PPV checks for the ICB that include validating claims made by primary care contractors for the delivery of Direct Enhanced Services in respect of Minor Survey Incisions/Excisions.

Although not formally part of the Internal Audit Plan, the PPV service we deliver provides an independent assurance in respect of payments made to primary care contractors and is, therefore, included in this document for information. A proposed level of 40 days has been included for PPV work in 2024/25.

Conclusion

The Audit and Risk Committee has been delegated responsibility by the Board to approve the Internal Audit Plan for the ICB. The Committee must be satisfied with the planned coverage and take into account other sources of independent assurance. The Plan has been developed on the basis of 235 internal audit days being delivered during the year.

We seek approval from the Audit and Risk Committee for our proposed Plan. We will continue to horizon scan and liaise with executive officers to ensure the Plan remains relevant to the rapidly changing environment in which you operate.

We work in partnership with the ICB to deliver this Plan and continue to seek efficiencies in the way we work. Cooperation of ICB officers is essential to support the timely delivery of our Plan.

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Appendix A1 – Your Internal Audit Plan and indicative phasing for 2024/25

Ref.	Audit and nominated lead officer	BAF reference[1]	Days*	Indicative phasing*	Outline scope	Assurance or Advisory
Governance and risk management						
1	***Head of Internal Audit Opinion*** (Chief Nurse/Associate Director of Governance)	All	15	Q1-4	To undertake a comprehensive annual work programme to test the Board Assurance Framework to support our year-end Head of Internal Audit Opinion statement.	Assurance Core - annual
2	***Governance and risk management*** (Chief Nurse/Associate Director of Governance)	Risk 6 – Quality improvement Current score = 12 Target score = 4	15	Q4	Outline scope to be agreed following the conclusion of the current ongoing self-assessment processes (Board and committee effectiveness and partnership governance).	Assurance Core - annual
Financial management						
3	***Financial ledger and reporting*** (Director of Finance)	Risk 10 – Financial sustainability Current score = 16 Target score = 8	15	Q3	To review the key financial ledger controls and financial reporting arrangements for the new IFSE ledger due to be implemented during the year.	Assurance Core - cyclical
4	***Financial systems*** (Director of Finance)	Risk 10 – Financial sustainability Current score = 16 Target score = 8	20	Q2	To review key financial systems on a three year cyclical basis. For 2024/25 these will be: • accounts receivable • treasury and cash management.	Assurance Core - annual

[1] BAF information February 2024

Ref.	Audit and nominated lead officer	BAF reference[1]	Days*	Indicative phasing*	Outline scope	Assurance or Advisory
					Audit and Risk Committee members proposed a review of payments to GPs.	
Commissioning and primary care						
5	**Delegated direct commissioning** (Director of Integration)	Risk 1/3 - Transformation (making tomorrow better for everyone) Current score = 20 Target score = 8	15	Q4	From 1 April 2023, NHSE delegated responsibility to all ICBs for all pharmaceutical, general ophthalmic and dental services. As part of the financial delegation checklist, ICBs were required to include an audit in plans for 2023/24 and an annual audit is expected for future years.	Assurance NHSE mandated
6	**Provider Selection Regime** (Director of Integration)	Risk 1/3 - Transformation (making tomorrow better for everyone) Current score = 20 Target score = 8	16	Q2	To assess compliance with the ICB's Procurement and Provider Selection Policy in relation to the procurement of healthcare services, including processes for the publication of transparency notices and consideration of provider representations which are new requirements under the Provider Selection Regime regulations.	Assurance Risk-based
Information management and technology (IM&T) and digital						
7	***Data Security and Protection Toolkit (DSPT)*** (Chief Nurse/Associate Director of Governance)	Risk 12 – Digital transformation Current score = 8 Target score = 8	15	Q1	To complete in Q1 to inform the 2023/24 Toolkit submission as at 30 June 2024. The overall objective is to assess the effectiveness of your data security and protection environment as assessed through	Assurance Core and NHSE mandated

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Ref.	Audit and nominated lead officer	BAF reference[1]	Days*	Indicative phasing*	Outline scope	Assurance or Advisory
					the Data Security and Protection Toolkit. The scope of the audit is determined by NHSE.	
8	**Delivering Digital Transformation** (Medical Director)	Risk 12 – Digital transformation Current score = 8 Target score = 8	18	Q2	To assess the extent to which effective arrangements are in place to progress delivery of the digital priorities set out within the Digital Notts Strategy 2023-2028. New area of responsibility for ICB, and therefore to provide assurance this function has been appropriately established.	Assurance Risk-based
Quality and citizen involvement						
9	***Quality management arrangements*** (Chief Nurse)	Risk 6 – Quality improvement Current score = 12 Target score = 4	22	Q1/2	To cover Patient Safety Incident Response Framework (PSIRF) and risk response/ escalation. To assess how the ICB is fulfilling its responsibility to establish and maintain structures to support a coordinated approach to oversight of patient safety incident response in all the services within the system. To review compliance with the National Guidance on Quality Risk Response and Escalation in Integrated Care Systems.	Assurance Core

Ref.	Audit and nominated lead officer	BAF reference[1]	Days*	Indicative phasing*	Outline scope	Assurance or Advisory
People management						
10	***Delivering the People Plan*** (Chief Nurse/Chief People Officer)	Risk 7 – People and culture Current score = 15 Target score = 6	17	Q1/2	To assess the extent to which effective arrangements are in place to progress delivery of the priorities set out within the People Plan. This is a new area of responsibility for the ICB and, therefore, to provide assurance this function has been appropriately established.	Assurance Core
11	**Framework for clinical and care professional leadership** (Chief Nurse/Chief People Officer)	Risk 7 – People and culture Current score = 15 Target score = 6	17	Q2	To assess the extent to which the NHSE guidance 'Building strong integrated care systems everywhere' has been addressed. This is a new area of responsibility for the ICB and, therefore, to provide assurance this function has been appropriately established.	Assurance Risk-based
System wide review						
12	Topic to be determined		8	TBD	Various topics have been suggested by system partners which are being discussed.	Advisory
Management, action tracking, and contingency						
13	Management	N/A	30	Q1-4	For management of the ICB's internal audit service, including:	N/A

Ref.	Audit and nominated lead officer	BAF reference[1]	Days*	Indicative phasing*	Outline scope	Assurance or Advisory
					• production of the Strategic Internal Audit Plan and annual work programme • continual review and update of the Internal Audit Plan to ensure it meets the needs of the organisation • provision of ad hoc advice and support regarding internal control and governance issues • quality management • progress reports to the Audit and Risk Committee and Director of Finance • liaison with External Audit • attendance at Audit and Risk Committee, client progress meetings, and other meetings as required. *This section is in accordance with requirements of the PSIAS.*	
14	Action tracking	N/A	12	Q1-4	To follow up agreed actions in all audit reports using the online tracker, Pentana.	N/A
15	Events and benchmarking papers	N/A	3	Q1-4	Annually we provide training and development sessions for Audit Committee members and governance leads and a series of benchmarking papers.	N/A

Ref.	Audit and nominated lead officer	BAF reference[1]	Days*	Indicative phasing*	Outline scope	Assurance or Advisory
16	Contingency	N/A	12	Q1-4	Contingency is used to cover the following: • changes to audit assignments that could not have been reasonably foreseen • facilitate additional work where required or scope increases • where we experience delays in obtaining evidence and/or receiving responses to queries • where meetings are cancelled and we prepared and/or travelled to client sites • in line with our KPIs where we do not receive agreement to terms of reference and agreement to draft reports in a timely manner. In addition, spare contingency can be to allow ICB-identified risk issues to be accommodated in-year. *This section is in accordance with requirements of the PSIAS.*	N/A
TOTAL			**250 days**			

Post Payment Verification (PPV)						
17	PPV	All	40	TBC	To be confirmed with ICB's PPV lead.	Advisory
TOTAL			**40 days**			

** Quarters have been allocated where specifically requested. Other audits will be balanced across the year to align with client requirements and resource availability.*

Appendix A2 – Exclusions from the Internal Audit Plan 2024/25

A2.1 The following core audits are due for review in 2024/25 but not included in the Plan

Core review	Reason for non-inclusion in the Plan
Policy management framework	Undertaken on a cyclical basis. Not considered a priority for 2024/25.

A2.2 Principal risks in Assurance Framework not covered by reviews in the Plan

Principal risk	Current risk score	Reason for non-inclusion in the Plan
Risk 4: Citizen Voice – Failure to effectively work in partnership with citizens and communities.	8	2022/23 review provided significant assurance.
Risk 5: Research and Evidence – Failure to effectively facilitate and promote research and utilise evidence to inform decision making.	8	Not considered a priority given BAF risk score.
Risk 8: Failure to comply with the general and specific Public Sector Equality Duties.	8	Not considered a priority given BAF risk score.
Risk 9: Safeguarding – Failure to safeguard children and vulnerable adults in accordance with legislative and statutory frameworks and guidance.	8	Not considered a priority given BAF risk score.
Risk 13: Environment Sustainability – Failure to effectively deliver on the green plan.	8	2022/23 review provided significant assurance.
Risk 14: Emergency Preparedness, Resilience and Response – Failure to be adequately prepared to respond to major or business continuity incidents.	10	2022/23 review provided significant assurance.

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A2.3 Areas requested by Audit and Risk Committee members or ICB officers which have not been included in the Plan

Area	Reason for non-inclusion in the Plan
System PMO	This is still considered to be at an early stage and audit not appropriate at the current time.

Appendix B – Five year strategic audit plan 2022-2027

Ref.	Audit	2022/23	2023/24	2024/25	2025/26	2026/27
Governance and risk management						
1	Governance and risk management	X	X	X	X	X
2	System-wide review	X	X	X	X	X
3	Policy management framework				X	
4	Partnership working				X	
5	Management of conflicts of interest		X			
6	Data quality and performance management framework				X	
Financial management						
7	Financial ledger and reporting	X	X	X		
8	Financial systems	X	X	X	X	X
9	Budget setting, reporting and monitoring				X	
Commissioning and primary care						
10	Healthcare procurement and contract management	X				
11	Primary care contracts					
12	Personalised care and support		X			X

Ref.	Audit	2022/23	2023/24	2024/25	2025/26	2026/27
13	Delegated direct commissioning		X	X	X	X
14	Provider Selection Regime			X		
Information management and technology (IM&T) and digital						
15	Data security and protection toolkit	X	X	X	X	X
16	Delivering Digital Transformation			X		
17	Cyber governance					X
Quality and citizen involvement						
18	Quality management arrangements			X		
People management						
19	People agenda – Delivering the People Plan			X	X	X
20	Framework for clinical and care professional leadership			X		
21	Staff wellbeing		X			

Appendix C – High Level Audit Universe

The Internal Audit Universe aims to 'give a more detailed indication of the range of activities that an internal audit plan may include'. This list is not meant to be exhaustive and should not be used as a checklist; rather that the universe gives an idea of the issues that may be considered when the internal audit plan is being discussed.

Internal Audit	Coverage in five year strategic plan
Governance and risk management	
Strategic governance	2024/25
Operational governance	
Place governance/risk management (system leadership)	
Integrated Care Strategy (system leadership)	
Partnership working (system leadership)	
Risk management	2024/25
Management of conflicts of interest	2023/24
Fit and proper persons test	
Complaints	
Data quality and performance management (system leadership)	

Internal Audit	Coverage in five year strategic plan
Financial management	
Financial ledger and reporting	2024/25
Financial systems	Annual
Financial controls – NHSE (system leadership)	2023/24
Financial management (system leadership)	
Business planning (system leadership)	
Better Care Fund and Section75	
GP payments	2024/25 - PPV
Direct payments	
Individual funding requests	
Capital programme and business case approval (system leadership)	

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Internal Audit	Coverage in five year strategic plan
Freedom to speak up	
Environmental governance	2022/23
Health inequalities/population health management (system leadership)	2022/23
EPRR and business continuity	2022/23
Commissioning and primary care	
Procurement and contract management	
Personalised care and support	
Delegated direct commissioning	Annual
Primary Care Networks	
Provider selection regime	2024/25
Enhanced services	
CQC/NICE compliance	
Performance monitoring/management/reporting	

Internal Audit	Coverage in five year strategic plan
Estates, supply chain and commercial strategies	
Use of consultancy	
IM&T and digital	
DSPT	Annual
Cyber security	2026/27
IM&T strategy	2024/25
IT service management, asset management and strategy	
Data Protection Act, GDPR	
New system implementation	
Desktop/PC maintenance	
Firewalls, data leakage and encryption	

Internal Audit	Coverage in five year strategic plan
QIPP	
Healthcare pathway redesign	
Commissioning support units	
Quality and citizen involvement	
Incidents	
Patient, carer and resident engagement	
Clinical safety/alerts, monitoring and improvement	
Prescribing and medicines management	
Safeguarding (adults and children)	
Delivery of transformation programmes (system leadership)	

Internal Audit	Coverage in five year strategic plan
Mobile device management	
Artificial intelligence	
People	
People plan (system leadership)	2024/25
Health and wellbeing	2023/24
Equality, diversity and inclusion	
Appraisals	
Mandatory and job specific training compliance	
Agency staffing	
HR systems and ESR	
Absence management	
Organisational development	

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Appendix D – 360 Assurance Charter 2023/24

This Charter sets out the purpose and authority of, and responsibility for, internal audit, consistent with the Core Principles for the Professional Practice of Internal Auditing, Definition of Internal Auditing, the Code of Ethics, and the Public Sector Internal Audit Standards (April 2017). This Charter should be read in conjunction with our Service Level Agreement/Contract.

Definitions
Internal auditing Internal audit is an independent and objective assurance and consulting activity that is guided by a philosophy of adding value to improve the operations of the organisation. It helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of the organisation's risk management, control, and governance processes. **Standards** The Standards are principles-focused, mandatory requirements applicable to the planning, management and delivery of our internal audit services to each client. 360 Assurance has specific quality processes to ensure compliance with all detailed requirements set out in the standards and any additional local quality requirements agreed with the client. **Board** The highest level of governing body charged with the responsibility to direct and/or oversee the activities and management of the organisation. Typically, this includes an independent group of directors/lay members. In the absence of this group, the 'board' may refer to the head of the organisation. **Senior Management** The most senior staff of the organisation reporting to the accounting or accountable officer, ie Executive Team. **Chief Audit Executive/Head of Internal Audit** This is the Director of 360 Assurance.

Purpose and mission

The purpose of internal audit is to provide independent, objective assurance and consulting services designed to add value and improve the organisation's operations. The mission statement for internal audit per the PSIAS is 'to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight'.

Standards of professional practice

360 Assurance's provision of internal audit to each client will follow the principles set out in the Code of Ethics contained in the Public Sector Internal Audit Standards 2017 (PSIAS). Our staff are required to follow the rules of conduct laid down in the Code of Ethics as well as related 360 Assurance guidance and professional requirements of any professional body to which the auditor belongs. 360 Assurance applies ongoing processes to prevent and detect breaches of the Code of Ethics; any identified breaches will be referred by the Director of 360 Assurance to the Audit and Risk Committee.

The Standards are principles-focused, mandatory requirements applicable to the planning, management and delivery of our internal audit services to each client. 360 Assurance has specific quality processes to ensure compliance with all detailed requirements set out in the standards and any additional local quality requirements agreed with the client, ensuring the principles of integrity, objectivity, confidentiality and competency are applied and upheld.

Authority

The director of 360 Assurance is ultimately responsible for the delivery of the client's audit plan in line with the service level agreement. To achieve this they are assisted by a designated client lead. The director of 360 Assurance and client lead will be suitably qualified and experienced. Any change of client lead will be discussed with the Audit and Risk Committee/Director of Finance. Other internal audit staff will be suitably qualified and/or experienced, in line with agreement regarding skill mix through the service level agreement/contracting process.

360 Assurance will have unrestricted access to communicate and interact with the Chief Executive, Chair of the Board and Chair of the Audit and Risk Committee, including in private meetings without management present.

360 Assurance will work with the whole of the executive team who will support us in delivering the Internal Audit Plan and work from the Plan will be reported directly to the Audit and Risk Committee.

Authority is granted by the client for full, free and unrestricted access by 360 Assurance to any and all of its records, physical properties and personnel relevant to any function under review, for example care records and staff information. All client employees will assist internal audit in

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fulfilling its function. 360 Assurance will not be responsible or liable if information material to our task is withheld and concealed from us or wrongly represented to us.

The Board has agreed the objectives for the Internal Audit function. These are expressed through standing documents and Audit and Risk Committee Terms of Reference.

The ICB's standing documents state the following in relation to Internal Audit:

3.1.5 Internal audit will review, appraise and report upon policies, procedures and operations in place to:

(a) Establish and monitor the achievement of the organisation's objectives.

(b) Identify, assess and manage the risks to achieving the organisation's objectives.

(c) Ensure the economical, effective and efficient use of resources.

(d) Ensure compliance with established policies (including behavioural and ethical expectations), procedures, laws and regulations.

(e) Safeguard the organisation's assets and interests from losses of all kinds, including those arising from fraud, irregularity or corruption.

(f) Ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes.

3.1.6 The Head of Internal Audit will provide to the Audit and Risk Committee:

(a) A risk-based plan of internal audit work, agreed with management and approved by the Audit and Risk Committee, that will enable the internal auditors to collect sufficient evidence to give an opinion on the adequacy and effective operation of the organisation.

(b) Regular updates on the progress against plan.

(c) Reports of management's progress on the implementation of action agreed as a result of internal audit findings.

(d) An annual opinion based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This opinion is used by the Chief Executive to inform their annual Governance Statement and by NHS England as part of its performance management role.

(e) Additional reports as requested by the Audit and Risk Committee.

3.1.7 Whenever any matter arises during the course of internal audit work, which involves, or is thought to involve, irregularities in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately. If the Director of Finance is thought to be involved in an irregularity, then this should instead be reported to the Chief Executive.

3.1.8 The Head of Internal Audit will normally attend Audit and Risk Committee meetings and has a right of access to the Chair of the Audit and Risk Committee and the ICB Chair and Chief Executive.

3.1.9 The Head of Internal Audit reports to the Audit and Risk Committee and is accountable to the Director of Finance. The reporting system for internal audit will be agreed between the Director of Finance, the Audit and Risk Committee and the Head of Internal Audit and will comply with the guidance on reporting contained in the Public Sector Internal Audit Standards.

(Standing Financial Instructions, July 2022)

The Audit and Risk Committee Terms of Reference state the following in relation to Internal Audit:

The Committee will approve arrangements for the provision of internal audit services.

The Committee will ensure that there is an effective internal audit function established by management that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, ICB Chief Executive, ICB Chair and the Board. This will be achieved by:

i) Considering the provision of the internal audit service and the costs involved; ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.

j) Reviewing and approving of the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the ICB (as identified in the Board Assurance Framework).

k) Considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.

l) Monitoring the effectiveness of internal audit and completing an annual review.

(Terms of Reference, July 2022)

The size of the internal audit programme will be based on the organisation's risk appetite. The Internal Audit Plan and its content are owned by the Audit and Risk Committee.

360 ASSURANCE

Independence and Objectivity

360 Assurance will seek to ensure the independence and objectivity of our personnel engaged in the provision of the services. You will be made aware of any relationships that, in our professional judgement, may reasonably be thought to impinge on our independence and the objectivity of the personnel involved in the provision of the services. This is essential in order to reach impartial and unbiased judgements in the reporting of the services.

The head of internal audit will disclose to the Audit and Risk Committee any interference and related implications in determining the scope in internal auditing, performing works and/or communicating results.

Scope of internal audit activity

The scope of internal audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management processes, systems of internal control and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. PSIAS recommend it includes:

- reviewing the reliability and integrity of financial and operating information and the means used to identify, measure, classify, and report such information
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations and reports and whether the organisation is in compliance
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets
- reviewing and appraising the economy and efficiency with which resources are employed
- reviewing operations or programmes to ascertain whether results are consistent with established objectives and goals and whether the operations or programmes are being carried out as planned
- reviewing specific operations at the request of the Audit and Risk Committee or management, as appropriate
- monitoring and evaluating the effectiveness of the organisation's risk management system.

Documents and information given to internal audit during a review will be handled in the same prudent and confidential manner as by those employees normally accountable for them.

Responsibility

Annually, the client lead will submit to senior management and the Audit and Risk Committee a Plan for the forthcoming year. The annual planning process will identify strategic risk-based and key internal control systems reviews for consideration and will be aligned to the objectives and priorities of the organisation, any reviews not prioritised will be identified. Any significant deviation from the formally approved Plan will be communicated to senior management and the Audit and Risk Committee for approval.

360 Assurance will work with the whole of the executive team who will support us in delivering the Plan, and will report on work from the Plan directly to the Audit and Risk Committee.

On an operational basis the client lead will report to the client's lead contact, normally the director of finance.

Audit work is carried out for the client only unless it is agreed during the planning stage that the audit will involve third parties.

360 Assurance will ensure all Plan engagements are completed, including the establishment of objectives and scope, the assignment of appropriate and adequately supervised resources and the documentation of work programmes and testing results. Following the conclusion of each audit we will confirm our findings in writing which will be issued by the client lead. Management have an opportunity to formally respond to each report and detail the corrective action taken, or to be taken, in regard to the specific findings and recommendations raised; responses should include allocated responsibility and timeframes for anticipated completion of each action and an explanation for any recommendations not addressed.

The client will be responsible for notifying 360 Assurance of any reasons for delays in planned work with sufficient notice and also ensuring that information requested is provided in a timely manner. Other than in exceptional circumstances, clients should provide requested information, evidence and responses to audit enquiries within 5 working days.

Follow up arrangements are in place to ensure that management implement corrective actions within specified timeframes. 360 Assurance shall be responsible for providing assurance over the appropriateness of management's monitoring of actions to address recommendations.

Individual assurance assignments provide audit opinions based upon a sound methodology and using accepted best practice. Where, in the opinion of 360 Assurance, an issue arises which requires the urgent attention of the client, the matter will be reported to the Director of Fiannce without delay.

Our risk matrix, audit review and overall Head of Internal Audit opinions are available to view in full on our website.

360 ASSURANCE

Consulting services

Internal audit services to the organisation may consist of Assurance services and/or Consulting services. Assurance services involve the internal auditor's objective assessment of evidence to provide an independent opinion or conclusions regarding an entity, an operation, a function, a process, system, or other subject matter. The results of Assurance reviews will be regularly reported to the Audit and Risk Committee. Consulting services are advisory in nature and are generally performed at the specific request of the client. 360 Assurance will seek approval from the Audit and Risk Committee *prior* to the commencement of any significant Consulting services. Work is considered significant if it exceeds 20% of the annual audit fee.

Any Consulting services will, in line with the Public Sector Internal Audit Standards, be limited to reviews that aim to improve governance, risk management and control. When performing Consulting services, the internal auditor will maintain objectivity and will not take on management responsibility. We will apply appropriate management arrangements to ensure that any conflict is avoided if we were to undertake any non-internal audit activities and these will be dealt with in an open and transparent manner.

External Audit liaison

360 Assurance will liaise with the client's current external auditors and will provide information, explanations and working papers that support our reports to assist them in their evaluation of the work carried out. This liaison with the external auditors enables the client to maximise the value of the total audit effort. This close liaison will provide the client's external auditors the opportunity to:

- comment on the overall Annual Internal Audit Plan
- comment on the scheduling of reviews
- examine audit working papers/files and associated draft and final reports for individual reviews.

Any external auditor or other reviewer of work undertaken as part of the services will need to draw their own conclusions from the work as it will have been undertaken and concluded on by 360 Assurance for its own purposes.

Performance of Internal Audit service

Performance of the service provided will be assessed in line with the agreed key performance indicators, which are included within the service level agreement/contract.

360 Assurance undertakes a programme of quality monitoring to ensure that audits are delivered in line with the Audit Manual, which reflects extant professional requirements.

360 Assurance will engage in an independent review in line with the Public Sector Internal Audit Standards and notify the client of any quality assurance and improvement programme developed as a consequence.

Role of Internal Audit in fraud related work

360 Assurance will have sufficient knowledge to evaluate the risk of fraud and the manner in which it is managed by the organisation. The potential for the occurrence of fraud and how the organisation manages fraud risk will be considered. There is a protocol in place with the client's Counter Fraud provider to review internal audit requirements where a fraud has arisen or to report any potential fraud issues to Counter Fraud where such issues arise.

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