Integrated Care Partnership Meeting Agenda (Open Session)

Friday 16 December 2022 14:00 – 15:30

The Council Chamber, County Hall, West Bridgford, Nottingham, NG2 7QP

"We will enable each and every citizen to enjoy their best possible health and wellbeing."

Principles:

- We will work with, and put the needs of, our **citizens** at the heart of the ICS.
- We will be **ambitious** for the health and wellbeing of our local population.
- We will work to the principle of **system by default**, moving from operational silos to a system wide perspective.

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.

	Item	Presenter	Type	Time
Introductory items				
1.	Welcome, introductions and apologies	Kathy McLean	Verbal	14:00
2.	Confirmation of quoracy	Kathy McLean	Verbal	
3.	Declaration and management of interests	Kathy McLean	Paper	
4.	Minutes from the meeting that took place on the 13 October 2022	Kathy McLean	Paper	
5.	Action log and matters arising from the meeting that took place on the 13 October 2022	Kathy McLean	Paper	
Items for approval				
6.	Initial Integrated Care Strategy for Nottingham and Nottinghamshire	Lucy Dadge	Paper	14:10
Items for information				
7.	Revised terms of reference for Nottingham and Nottinghamshire Integrated Care Partnership	Lucy Branson	Paper	15:10
Closing items				
8.	Questions from the public relating to items on the agenda	Kathy McLean	Verbal	15:20
9.	Any other business	Kathy McLean	Verbal	

Date and time of next meeting held in public: 17 March 2023 at 14:00 (The Council Chamber, County Hall, West Bridgford, Nottingham, NG2 7QP)

Meeting Title:	Integrated Care Partnership
Meeting Date:	16/12/2022
Paper Title:	**Declaration and management of interests**
Paper Reference:	ICP 22 010
Report Author:	Lucy Branson, Associate Director of Governance, NHS Nottingham and Nottinghamshire ICB
Report Sponsor:	Kathy McLean, Chair of the Integrated Care Partnership (and ICB Chair)
Presenter:	Kathy McLean, Chair of the Integrated Care Partnership (and ICB Chair)
Recommendation(s):	The Integrated Care Partnership is asked to **RECEIVE** this item.

Summary:

The Integrated Care Partnership (ICP) is 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 ICP from any perception of inappropriateness in its decision-making and assuring the public that the use of taxpayers' money is free from undue influence.

ICP members must ensure that they always comply with their organisational/ professional codes of conduct and details of the declared interests for members of the ICP are attached at Appendix A. Members are 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.

A protocol for managing conflicts of interest at meetings of the ICP is attached at Appendix B.

An assessment of members' interests has been performed against the meeting agenda and the outcome is recorded in the section below on conflicts of interest management.

How does this paper support the Integrated Care System's core aims to:	
Improve outcomes in population health and healthcare	It is essential that the Integrated Care Partnership (ICP) 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 ICP'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 support broader social and economic development	As above.

Appendices:
Appendix A: Register of Declared Interests for members of the ICP. Appendix B: Protocol for managing conflicts of interests at meetings of the ICP.

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

• The ICP has made arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the ICP will be taken and seen to be taken without being unduly influenced by external or private interests.

• 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	ICP Membership Role	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
ATKINSON, Dr Nicole	Clinical Director, South Nottinghamshire Place Based Partnership	Nottingham West Primary Care Integrated Community Services (PICS) GP federation	Practice is a member	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ATKINSON, Dr Nicole	Clinical Director, South Nottinghamshire Place Based Partnership	Primary Integrated Community Services (PICS) Ltd	Partner	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ATKINSON, Dr Nicole	Clinical Director, South Nottinghamshire Place Based Partnership	Eastwood Primary Care Centre	Partner	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
BRIGGS, David	Medical Director, NHS Nottingham and Nottinghamshire ICB	British Medical Associaton	Member		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration, NHS Nottingham and Nottinghamshire ICB	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, NHS Nottingham and Nottinghamshire ICB	Nottingham Schools Trust	Chair and Trustee			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration, NHS Nottingham and Nottinghamshire ICB	Care Workers Union	Director (not remunerated)			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration, NHS Nottingham and Nottinghamshire ICB	Cleaners Union	Director (not remunerated)			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DODDY, Cllr John	Chair of the Nottinghamshire Health and Wellbeing Board	Hickings Lane Medical Centre	General Medical Practitioner	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DODDY, Cllr John	Chair of the Nottinghamshire Health and Wellbeing Board	Nowenigma Ltd	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DODDY, Cllr John	Chair of the Nottinghamshire Health and Wellbeing Board	Clayfields House Secure Unit	Employed to provide medical care	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
GRIBBIN, Jonathan	Director of Public Health, Nottinghamshire County Council	Cornerstone Chuch	Director			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
GRIBBIN, Jonathan	Director of Public Health, Nottinghamshire County Council	Nottingham University Hospitals NHS Trust	Spouse is a Consultant in Obstetrics				✓	01/07/2022	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
LAUGHTON, Jane	Chief Exectuive Officer, Healthwatch Nottingham and Nottinghamshire	Active Partners Trust	Director/Trustee (not remunerated)		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LAUGHTON, Jane	Chief Exectuive Officer, Healthwatch Nottingham and Nottinghamshire	Nottingham University Hospitals NHS Trust	Spouse is employed as a Consultant				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MAY, Anthony	Chief Executive, Nottingham University Hospitals NHS Trust (Representative of the Nottingham and Nottinghamshire Provider Collaborative at Scale)	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable

Name	ICP Membership Role	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
MCGREGOR-RILEY, Dr Victoria	Locality Director, Bassetlaw Place Based Partnership	Sheffield Teaching Hospitals NHS Foundation Trust	Spouse employed as a consultant surgeon				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCGREGOR-RILEY, Dr Victoria	Locality Director, Bassetlaw Place Based Partnership	Doncaster Bassetlaw Hospitals NHS Foundation Trust	Partner Governor on the Trust Board		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	University Hospitals of Derby and Burton NHS Foundation Trust	Trust Chair	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	Treetops Hospice	Spouse is a trustee of Treetops Hospice				✓	01/07/2022	30/06/2022	Interest expired - no action required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	Kathy McLean Limited- Private limited company to offer health related advice	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	Barts Health NHS Trust (London)	Non-Executive Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	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	Chair, NHS Nottingham and Nottinghamshire ICB	Care Quality Commission (CQC)	Occasional Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	Public Sector Consultancy	Senior Clinical Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	NHS England	Lay Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	NEMS Healthcare Ltd	Spouse is shareholder				✓	01/07/2022	30/06/2022	Interest expired - no action required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	NHS Providers Board	Trustee		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	Nottingham City GP Alliance	The University of Nottingham Health Service is a member	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	The University of Nottingham Health Service (UNHS), which provides primary care services under a GMS contract, is	Executive Partner	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	UNICOM Healthcare LLP, which provide non-GMS primary care services	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	NEMS Healthcare Ltd	Shareholder	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	NEMS Healthcare Ltd	Wife is shareholder				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	The University of Nottingham Health Service (Cripps Health Centre)	Partner	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	Local Authority	Cripps Practice provide contraceptive and sexual health services under national agreements	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	Overdale and Breaston Practice in Derbyshire	Wife is GP partner	✓			✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

Name	ICP Membership Role	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
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	Unity Primary Care Network	The University of Nottingham Health Service (Cripps Health Centre) is a member		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
REDFERN, Andrew	Chief Exexutive, Framework Housing Association	Derbyshire County Cricket League	Executive Committee Member			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
REDFERN, Andrew	Chief Exexutive, Framework Housing Association	Christian Projects Development Trust	Treasurer and Trustee			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
SACCO, Volt	Chief Executive Officer, Fosse Healthcare	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
SEBELIN, Jules	Chair of the Nottingham and Nottinghamshire Voluntary, Community and Social Enterprise Alliance	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
SHERRATT,Donna	Race Health Inequalities Programme Lead, Nottingham City Place-Based Partnership	Nottingham CityCare Partnership	Employee	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
UNDERWOOD, Catherine	Corporate Director for People Services, Nottingham City Council	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
WILLIAMS, Cllr Adele	Chair of the Nottingham City Health and Wellbeing Board	Co-operative Party	Member	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WILLIAMS, Cllr Adele	Chair of the Nottingham City Health and Wellbeing Board	Sherwood Ward	Councillor, Deputy Leader and Portfolio Holder for Finance	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WILLIAMS, Cllr Adele	Chair of the Nottingham City Health and Wellbeing Board	Labour Party	Member	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WILLIAMS, Cllr Adele	Chair of the Nottingham City Health and Wellbeing Board	D2N2 Infrastructure and Investment Board	Member	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WILLIAMS, Cllr Adele	Chair of the Nottingham City Health and Wellbeing Board	Foresight Group LLP	Member	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WILLIAMS, Cllr Adele	Chair of the Nottingham City Health and Wellbeing Board	Greater Nottinghamshire Rapid Transit Limited	Member	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WILLIAMS, Melanie	Corporate Director for Adult Social Care and Health, Nottinghamshire County Council	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable

Appendix B: Protocol for managing conflicts of interest at meetings of the Nottingham and Nottinghamshire Integrated Care Partnership

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 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 decision.
    - Non-financial professional interests: where an individual may obtain a non-financial professional benefit from the consequences of a 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.
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 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 Partnership (Open Session)
Unratified minutes of the meeting held on:
Thursday 13 October 2022 15:00 – 17:00
Committee Room, Loxley House

Members present:	
Kathy McLean (Chair)	Chair of NHS Nottingham and Nottinghamshire ICB
Dave Briggs	Medical Director, NHS Nottingham and Nottinghamshire ICB
Lucy Dadge	Director of Integration, NHS Nottingham and Nottinghamshire ICB
Cllr. John Doddy (Joint Vice-Chair)	Chair of the Nottinghamshire Health and Wellbeing Board
Jonathan Gribbin	Director of Public Health, Nottinghamshire County Council
Lucy Hubber	Director of Public Health, Nottingham City Council
Jane Laughton	Chief Executive Officer, Healthwatch Nottingham and Nottinghamshire
Victoria McGregor-Riley	Locality Director, Bassetlaw Place Based Partnership
Dr Hugh Porter	Clinical Director, Nottingham City Place Based Partnership
Andrew Redfern	Chief Executive, Framework Housing Association
Volt Sacco	Chief Executive Officer, Fosse Healthcare
Jules Sebelin	Chair of the Nottingham and Nottinghamshire Voluntary, Community and Social Enterprise Alliance
Donna Sherratt	Race Health Inequalities Programme Lead, Nottingham City Place-Based Partnership
Amanda Sullivan	Chief Executive, NHS Nottingham and Nottinghamshire ICB
Catherine Underwood	Corporate Director for People Services, Nottingham City Council
Cllr. Adele Williams (Joint Vice-Chair)	Chair of the Nottingham City Health and Wellbeing Board
Melanie Williams	Corporate Director for Adult Social Care and Health, Nottinghamshire County Council
In attendance:	
Alex Ball	Director of Communications and Engagement, NHS Nottingham and Nottinghamshire ICB
Lucy Branson	Associate Director of Governance, NHS Nottingham and Nottinghamshire ICB
Fiona Callaghan	Locality Director, South Nottinghamshire Place Based Partnership (on behalf of Dr Nicole Atkinson)
Joanna Cooper	Assistant Director, Nottingham and Nottinghamshire Integrated Care System
Tim Guyler	Assistant Chief Executive, Nottingham University Hospitals NHS Trust (on behalf of Anthony May)
Mark Wightman	Director of Strategy and Reconfiguration, NHS Nottingham and Nottinghamshire ICB
Sue Wass	Corporate Governance Officer, NHS Nottingham and Nottinghamshire ICB
Apologies:	
Nicole Atkinson	Clinical Director, South Nottinghamshire Place Based Partnership

Anthony May	Chief Executive, Nottingham University Hospitals NHS Trust (Representative of the Nottingham and Nottinghamshire Provider Collaborative at Scale)

Introductory items

ICP 22 001 Welcome, introductions and apologies

Kathy McLean welcomed members to the inaugural meeting of the Integrated Care Partnership. A round of introductions was undertaken and apologies were noted as above.

Regarding membership, the Chair asked members to note that Hayley Barsby had recently stepped down from her role within the Mid-Nottinghamshire Place-Based Partnership and the process to identify a replacement representative was underway. The partner nomination from Nottingham City Council was also awaited.

ICP 22 002 Confirmation of quoracy

The meeting was confirmed as quorate.

ICP 22 003 Declaration and management of interests

No interests were declared in relation to any item on the agenda. The Chair reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

Items for discussion

ICP 22 004 Role and responsibilities of the Integrated Care Partnership

Lucy Branson presented the item and highlighted the following points:

a) The Nottingham and Nottinghamshire Integrated Care Partnership (ICP) had been established as a joint committee of Nottingham City Council, Nottinghamshire County Council and NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) in July 2022. The report described the role and responsibilities of the ICP, as detailed in its terms of reference, and presented the agreed meeting schedule for 2022/23.

b) The primary role of the ICP would be to lead on creating an Integrated Care Strategy and Outcomes Framework to reduce health inequalities and improve health and care outcomes and experiences for its population. In doing so, the ICP would act as the ‘guiding mind’ of the local health and care system, providing a forum for NHS leaders and local authorities to come together with important stakeholders from across the wider system and communities.

c) The ICP would be governed by a set of principles and ways of working, which were based on a combination of what was deemed important by local stakeholders, together with national expectations.

d) In addition to formal meetings, a wider assembly of partners was being established to enable wider engagement in, and co-production of, the Integrated Care Strategy and Outcomes Framework. The Partners Assembly would meet at least once per year and would comprise people who rely on care and support, unpaid carers, the full range of social care and NHS providers, and the voluntary and community sector. The first Partners Assembly event would be held in October.

e) At the time of approving the ICP's terms of reference, it was recognised that they would need further refinement pending the receipt of guidance and advice, particularly in relation to the ICP's decision-making arrangements as a joint committee in the context of the new legislation. This had now been now received, and work was ongoing to update the terms of reference accordingly. It was anticipated that no material amendments would be required.

f) The full council meetings of both local authorities and the Board of the ICB would be presented with the updated terms of reference at their scheduled meetings in October and November 2022, which once approved, would be circulated to members for information.

The following points were made in discussion:

g) Members welcomed the opportunity to work together in a more formal setting, which provided the flexibility to build integrated care pathways at the local level.

The Integrated Care Partnership:

- **RECEIVED** the report on the role and responsibilities of the Integrated Care Partnership

ACTION: Lucy Branson to circulate the updated terms of reference for the Integrated Care Partnership once approved.

ICP 22 005 Developing an Initial Integrated Care Strategy for Nottingham and Nottinghamshire

Lucy Dadge, Mark Wightman, Lucy Hubber, Jonathan Gribbin and Alex Ball presented the item and highlighted the following points:

a) The report detailed the proposed approach to the development of the Integrated Care Strategy within a challenging national timeline of December 2022.

b) Nottingham and Nottinghamshire had a strong foundation of integrated working from which to draft the Strategy. This was an opportunity to drive transformational change to tackle deep-rooted health inequalities through a more joined up approach to preventative and personalised health and social care.

c) The context for the Strategy and the relationship between the key system strategies was described. The foundation of the Integrated Care Strategy would be the existing health and wellbeing strategies and the joint strategic needs assessments (JSNAs).

d) The challenges across Nottingham and Nottinghamshire regarding health inequalities and the key principles of the local authorities' health and wellbeing strategies were explained.

e) The proposed aims and ambitions of the Integrated Care Strategy were described and the principles of equity, prevention and integration were proposed as the framework upon which to build the Strategy.

f) Key enablers for the delivery of the Strategy and examples of proposed actions were highlighted, which had been discussed at a recent workshop held with system leaders.

g) The proposed approach to ensuring that citizens were involved in the development of the Strategy was detailed. This process comprised a desk top exercise, an on-line survey, and public events. The Partners Assembly would hold its inaugural meeting on 25 October 2022 and would provide a forum to 'test' the content of the proposed strategy.

Lucy Hubber and Jonathan Gribbin left the meeting at this point

The following points were made in discussion:

h) Members queried the role of placed-based partnerships and how they were resourced. It was noted that they were not currently statutory bodies, more broad partnerships, principally resourced by staff from the NHS and local authorities to connect with local care providers to foster more integrated services at the local level. A framework was currently being developed, with the ambition for joint planning and commissioning activities as the partnerships matured.

i) Members noted that there were several best practice initiatives already taking place at the local level, which could be taken forward at scale by the Strategy.

j) Members were supportive of the presentation of the Strategy's aims using short term, medium term, and long-term ambitions; but noted the need to begin working on the foundations for long term ambitions at the same time as tacking short term aims.

k) Members discussed the need for a strong focus on workforce, both as a key enabler to the aims of the strategy and as a driver of wider economic development within Nottingham and Nottinghamshire.

l) It was acknowledged that the Strategy was not aiming to be all encompassing and would aim to focus on a small number of ambitions, which would make a positive impact.

m) Members welcomed the proposed approach to citizen involvement and queried how the voices of people and communities who were likely to be under-represented in traditional engagement activities would be heard. It was noted that targeted work would be needed to address this, and agreement was reached that this would be considered in the delivery of the engagement work.

n) Members noted that an initial Integrated Care Strategy would be presented for consideration and approval at the next meeting in December and that draft versions would be shared for shaping ahead of this, including at a workshop session scheduled in November.

The Integrated Care Partnership:

- **ENDORSED** the proposed approach to developing the Nottingham and Nottinghamshire Integrated Care Strategy.

ACTION: Alex Ball to ensure the voices of people and communities who are likely to be under-represented in traditional engagement activities are targeted in the development of the Integrated Care Strategy.

Closing items

ICP 22 006 Questions from the public relating to items on the agenda

No questions were raised.

ICP 22 007 Any other business

No other business was raised.

Date and time of next meeting held in public: 16 December 2022 at 14:00 (The Council Chamber, County Hall, Nottingham)

ACTION LOG for the Integrated Care Partnership meeting held on 13/10/2022

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Closed	13.10.22	Role and responsibilities of the Integrated Care Partnership (ICP 22 004)	To circulate the updated terms of reference for the Integrated Care Partnership once approved.	Lucy Branson	16.12.22	See item 7 on the agenda for the 16 December 2002 Integrated Care Partnership meeting.
Closed	13.10.22	Developing an Initial Integrated Care Strategy for Nottingham and Nottinghamshire (ICP 22 005)	To ensure the voices of people and communities who are likely to be under-represented in traditional engagement activities are targeted in the development of the Integrated Care Strategy	Alex Ball	16.12.22	See item 6 on the agenda for the 16 December 2002 Integrated Care Partnership meeting.

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 Partnership
Meeting Date:	16/12/2022
Paper Title:	**Initial Integrated Care Strategy for Nottingham and Nottinghamshire**
Paper Reference:	ICP 22 013
Report Author:	Joanna Cooper, Assistant Director, NHS Nottingham and Nottinghamshire Integrated Care Board
Report Sponsor(s):	Lucy Dadge, Executive Director of Integration, NHS Nottingham and Nottinghamshire Integrated Care Board
Presenter(s):	Mark Wightman, Director of Strategy and Reconfiguration, NHS Nottingham and Nottinghamshire Integrated Care Board Alex Ball, Director of Communications and Engagement, NHS Nottingham and Nottinghamshire Integrated Care Board Lucy Hubber, Director of Public Health, Nottingham City Council Jonathan Gribbin, Director of Public Health, Nottinghamshire County Council
Recommendation(s):	The Integrated Care Partnership is asked to **REVIEW** and **APPROVE** the initial Integrated Care Strategy for Nottingham and Nottinghamshire

Summary:

At the Integrated Care Partnership on 13 October, the approach for developing the Integrated Care Strategy was approved, along with the proposed involvement and engagement approach for developing the strategy. This paper sets out work to date to develop the strategy. The initial strategy and design options are appended to this report.

Work has continued to develop the strategy which has been co-produced with a wide range of ICS partners. The initial strategy has also been informed by the legislative requirements, statutory guidance and policy.

The strategy and design options are presented for the Integrated Care Partnership to review and approve.

How does this paper support the Integrated Care System's core aims to:	
Improve outcomes in population health and healthcare	The Integrated Care Strategy is fundamental to meeting the four core aims.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help support broader social and economic development	As above.

Appendices:
Appendix A provides the initial Integrated Care Strategy for Nottingham and Nottinghamshire. Appendix B provides design options which have been developed for the Strategy.

Report Previously Received By:
The initial Integrated Care Strategy set out within this paper has been shared with ICS partner organisations for their thoughts and comments. .

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Initial Integrated Care Strategy for Nottingham and Nottinghamshire

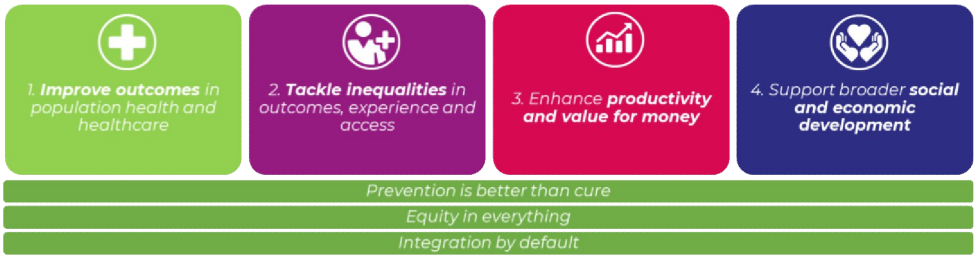
Introduction and context

1. In line with guidance from the Department of Health and Social Care, by December 2022 the Nottingham and Nottinghamshire Integrated Care Partnership (ICP) will generate an Integrated Care Strategy. This strategy will improve health and care outcomes and experiences for its populations, for which all partners will be accountable.

2. The proposed contents of Nottingham and Nottinghamshire's Integrated Care Strategy were presented to the ICP at its meeting on 13 October to discuss and shape. For reference, the meeting papers can be found here: ICP-Agenda-and-Paper-13102022 At the meeting, ICP members discussed and endorsed the proposed approach to developing the Nottingham and Nottinghamshire Integrated Care Strategy.

Developing the Integrated Care Strategy

3. Work has continued to develop the content. The Integrated Care Strategy Steering Group have continued to input and develop the content, working within the four national aims for ICSs, which are underpinned by our local principles to improve integration, prevention and equity across the system.



4. Within each aim, specific priorities have been identified and the strategy describes the approach, actions and ambitions for these priorities.

5. People, communities and system partners have been involved the developing the priorities, which have been tested in a number of forums through a variety of methods as the strategy has been developed.

6. The strategy has benefited from the involvement of people and communities in previous strategies and transformation proposals – as agreed at the October meeting the insights from this historical and foundational work has been fed into the strategy development.

7. In addition to this desktop research input, around 750 people have fed in directly to the strategy through a variety of activities which included:

   a) Targeted meetings with key stakeholders, including Voluntary,

Community and Social Enterprise sector leaders, Healthwatch Nottingham and Nottinghamshire and local elected representatives.

b) The ICS Partners Assembly, which bought together 161 system stakeholders, carers, service users, patients and citizens.

c) The annual Nottinghamshire County Council Shadow event, which was attended by over 250 children and young people, including young adults with learning disabilities.

d) Two virtual public events, which were attended by 48 individuals.

e) A survey for people to provide their views on the emerging strategy, which received 206 responses.

f) ICS partner organisations and Place Based Partnerships during November and early December.

g) An ICP workshop on 9 November.

8. A report summarizing the feedback from citizens and local Healthwatch has been published and is available here Integrated-care-strategy_engagement-report_final1.pdf (healthandcarenotts.co.uk)

9. The initial Integrated Care Strategy is appended to this report for the ICP to review and approve alongside design options for the strategy.

Recommendations and next steps

10. The initial strategy in Appendix A is presented to the ICP at its meeting on 16 December to DISCUSS and APPROVE ready for publication following the meeting in line with the guidance from the Department of Health and Social Care.

11. It is proposed that the strategy is formally launched by the end of January 2023 at the latest to inform the Integrated Care Board's first Five Year Forward Plan. This launch will include further work being undertaken to define ambitions where this is possible, and designed versions of the strategy in different formats, such as a public facing version of the strategy.

12. Worked examples of the design for the initial strategy are shown in Appendix B for ICP members to DISCUSS and APPROVE the preferred design.

Integrated Care System
Nottingham & Nottinghamshire

Nottinghamshire County Council
Nottingham City Council
NHS

Nottingham and Nottinghamshire Integrated Care System

Initial Integrated Care Strategy 2023-27

Presented to the Integrated Care Partnership on 16 December 2022

Contents

Foreword

The Nottingham and Nottinghamshire Integrated Care System (ICS) brings together partner organisations from across health and care with a renewed focus on providing joined up services and improving the lives of all people who live and work in the city and county.

We know that many people in Nottingham and Nottinghamshire could be living longer, healthier, happier lives than they currently do. To address this, our ICS health and care partners have agreed that we will work together to ensure that 'every person will enjoy their best possible health and wellbeing'. That is our vision, and this Integrated Care Strategy will guide us as we seek to deliver that vision over the next five years.

This strategy is being presented against a backdrop of very challenging times as we seek to recover from the pandemic and cope with the cost-of-living crisis, issues which have both had a huge impact on people's health and wellbeing. This strategy sets out a way forward as to how we can best improve services, access, outcomes, experiences and, critically, tackle health inequalities.

It is built on a series of important principles - placing a greater emphasis on supporting wellbeing and preventing ill health; ensuring equity in our approach to supporting people and their communities; and seeking to better integrate services – and we have made significant progress in each over the last few years. However, there is much more to do.

Over the next five years, we will:

- Reframe health and wellbeing as an asset, not a cost. We recognise that without good health and wellbeing, life becomes infinitely harder for people from all backgrounds
- Increase investment in wellness, as well as sickness, and focus resources in such a way that frail older people are supported to remain independent in their own home and reduce our current reliance on hospital and social care
- Focus on children and young people - they are the future and everything that we can do to support them to make a healthy start in life is an investment that benefits us all
- Recognise that while our services are 'universal', access to them is not and where inequity in access or outcomes exists, we will seek to rectify it
- Use data and intelligence to help us understand issues better, like smoking and obesity. We will tailor and personalise support for people, so that they feel empowered to make healthy changes in areas that are important to them
- Work together on the basis of what is best for our population, best for our system and best for our organisation, *in that order* and, in doing so, enable our staff to work across the system in genuinely integrated ways
- Make careers in health and care an attractive option for all, especially our young people, so that our workforce is representative of the people we serve

- Spend our money wisely, recognising the challenged economic circumstances and we will seek to support local business when we are buying goods and services
- Be honest, transparent and accountable for delivering what we set out in this strategy and we will be the first ICS to report progress in ways that puts health and wellbeing on a par with finance, wealth and productivity.

With the ICS now in place, and with an enhanced sense of partnership working throughout all agencies, across the city and county, we must embrace this opportunity to improve the health and wellbeing of our population, to make a difference through our combined resource and working in new and innovative ways.

[Editorial/design note: sign-off with pictures of chairs and vice-chairs]

Plan on a page

This is the five-year strategy of the Nottingham and Nottinghamshire Integrated Care System (ICS). Figure 1, below, summarises our vision, key aims, guiding principles and our approach to delivery.

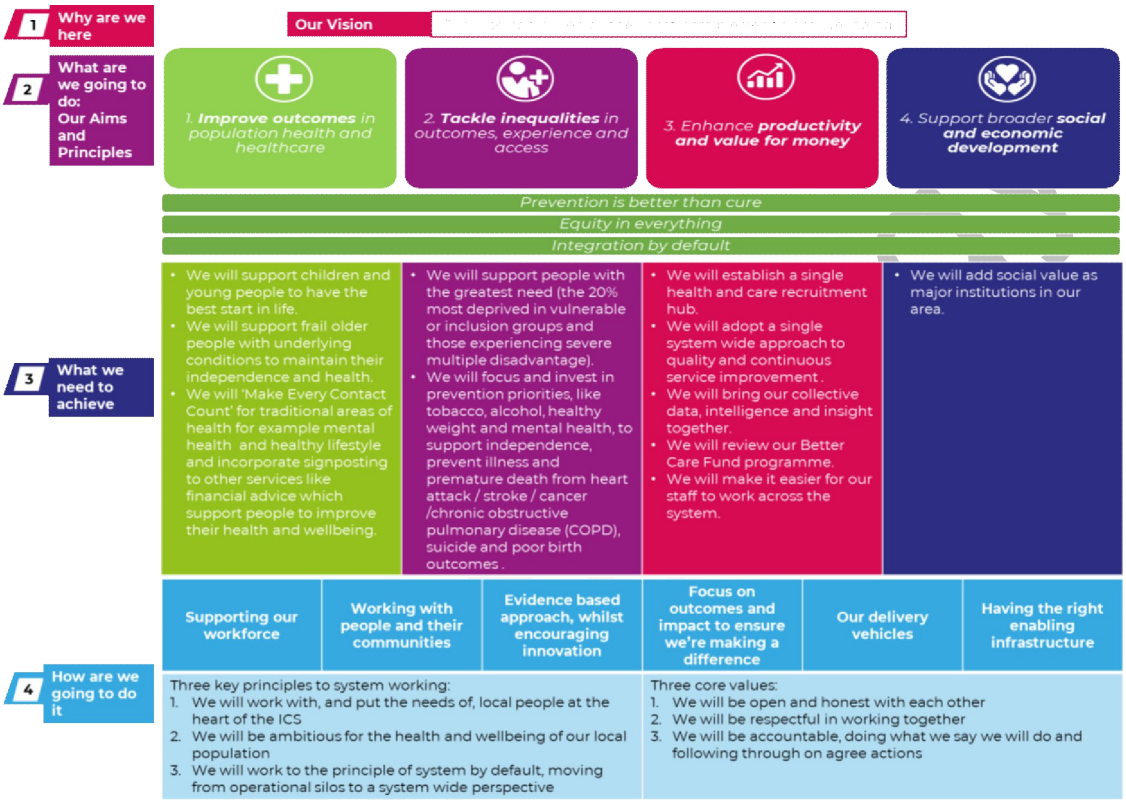


Figure 1: Overview of the Nottingham and Nottinghamshire ICS Strategy

[Note to design: re-work diagram to fill portrait layout page.]

Executive summary

Background

In July 2022, the Nottingham and Nottinghamshire Integrated Care System (ICS) became one of 42 ICS partnerships set up across the country. Our ICS brings together local health and care organisations to improve population health and healthcare, tackle unequal outcomes, experience and access, enhance productivity and value for money and help local organisations to support broader social and economic development. This is the first strategy produced by the ICS and is set to run for five years. The strategy has been produced following extensive engagement with local people and communities and key stakeholders and is based on existing work, such as the two local Joint Health and Wellbeing Strategies. This version, produced December 2022, is intended to set out our initial position and we expect refinements prior to publication of the final document in early 2023.

Strategic principles

The strategy is based on three guiding principles.

Principle 1: Prevention is better than cure

There is a saying that 'prevention is better than cure'. We know that finding a health problem early or helping people know when to ask for help can mean that:

- People need less treatment
- We can stop more serious illness
- We can stop diseases getting worse.

By focusing on prevention, we can make sure we use our limited resources most efficiently and improve people's health and wellbeing. For the ICS, this means taking action now at all levels of the system to identify how we can build a preventative approach into service delivery. This includes acknowledging that the building blocks for good health sit outside the GP's room and hospital ward and are influenced by other factors such as where we are born, grow, live work and age. There are many opportunities to integrate prevention and these wider social factors into our everyday thinking about health and care which will improve people's health and wellbeing in the most effective and efficient way.

Principle 2: Equity in everything

We believe that a 'one size fits all' method for what we do across health and care can create barriers and exclude certain groups of people, ultimately impacting on the needs of the population and demand across the system. The principle of equity recognises that not all people have equal health and care access, experience or indeed outcomes. This strategy sets out that for some people and communities more support and resource might be required to achieve similar outcomes to others.

Principle 3: Integration by default

In past years, different health and care organisations have developed their plans in relative isolation of one another, leading in some cases to fragmented services. Local people have told us that they want joined up and seamless services. By making collaboration between all the workforce and teams the normal way of working, and by harnessing our resource and ingenuity, we can re-shape services to become more integrated, treating the 'whole person'.

Strategic aims

Aim one: Improve outcomes in population health and healthcare

From birth through to end-of-life, and every contact with services inbetween, we want to maximise the opportunities for improving people's health and wellbeing. Babies, children and young people make up 20% of our population (ages 0-18 years)[1] and we want to support children and young people to have the best start in life. Those aged 65 years and over make up less than one in five (19%) of the Nottingham and Nottinghamshire population[2]. However, many of our population experience a greater number of years spent in ill health than seen on average for England and as a result are more likely to experience multiple long-term conditions that increase their risk of hospital admission. We want to support older people to stay well, remain independent and, where preventable, reduce admissions to hospital.

Aim two: Tackle inequalities in outcomes, experiences and access

Our second aim is to tackle inequalities in health outcomes, experiences and access – and increase equity (fairness in approach) for the people of Nottingham and Nottinghamshire. We will aim to support people in greater need (those living in the 20% most deprived areas, in vulnerable or inclusion groups and those experiencing severe multiple disadvantage). We will focus and invest in prevention priorities, like tobacco, alcohol, healthy weight and mental health, to support people's independence, prevent illness and premature death from heart attack, stroke, cancer, chronic obstructive pulmonary disease (COPD), suicide and poor birth outcomes.

Aim three: Enhance productivity and value for money

We have a duty to ensure that we make the very best use of the funding received for health and care. Our strategy sets out a range of focus areas that should result in better value, improved ways of working and, in turn, better support for local people. This includes seeing organisations working closer together, removing traditional organisational barriers, and a drive to improve the quality of services.

Aim four: Support broader social and economic development

The ICS partner organisations employ 70,000 people and have a combined spend on goods and services of £3.6 billion. How and where that money is spent, how we support our local communities, encourage people from the local area to consider jobs in our organisations and how we offer employment opportunities for all are

areas where partners can increase the ‘social value’ of what we do. We also want to make sure that we are doing all that we can to reduce our impact on the environment and deliver sustainable health and care services.

How we will organise ourselves to deliver the strategy

Oversight and ongoing review of the strategy is owned by the Nottingham and Nottinghamshire Integrated Care Partnership (ICP), which brings together NHS, social care, public health and independent and third sector providers. The ICP is a statutory committee jointly formed between the local NHS Integrated Care Board and upper-tier local authorities (Nottingham City Council and Nottinghamshire County Council). All partners – NHS, local government, the voluntary, community and social enterprise sector, and other agencies linked to the ICS – will have a role to play in implementing the strategy. There are a number of formal partnerships which will support the delivery of the strategy including Health and Wellbeing Boards, Place-Based Partnerships, Provider Collaboratives at Scale and the Voluntary, Community and Social Enterprise Alliance.

How we will deliver the strategy

Our staff are at the centre of our ambition for integration to deliver better care and support to local people. We are working across the ICS to take a ‘one workforce’ approach, inclusive of all staff involved in supporting local people’s health and wellbeing. This will enable us to make the most of skills and talent across our system, building integrated teams with the adaptability and capacity to support prevention and deliver person-centred care.

All system partners are committed to putting people at the heart of all that we do by consistently listening to, involving and collectively acting on, the experience and aspirations of local people and their communities. Implementation of the strategy will therefore be under-pinned by a process of co-production. This will become the default position for how we will work with people as equal partners at all stages of the design, development and commissioning of health and care services and support.

Strategy evaluation

In order to ensure a positive impact is being made, monitoring of the strategy will be achieved through an ICS outcomes framework. This framework looks at how we measure progress against our aims – how we listen to the views of our population, how services are being delivered and how we assess the state of people’s health and wellbeing.

Introduction to the strategy

The national context

Our integrated care system (ICS)[3] [4] is a partnership of organisations that has come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in Nottingham and Nottinghamshire. This is the first integrated care strategy produced by our system.

Our integrated care system

Our ICS has two statutory elements:

- Integrated Care Board (ICB) – a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services. The ICB works to deliver the ICS outcomes with partners from across our system

- Integrated Care Partnership (ICP)[5] - a statutory committee formed between the NHS Integrated Care Board and upper-tier local authorities. The ICP will bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population.

With a combined annual budget of £3.6 billion for the commissioning and provision of health and care services, the partners collaborate at:

- A 'neighbourhood level' through 23 primary care networks (PCNs) covering populations between 30,000 and 50,000

- At a 'place level' through four Place-Based Partnerships (PBPs): Bassetlaw, Mid Nottinghamshire, Nottingham City, and South Nottinghamshire. Each PBP serves a population of about 120,000-350,000 people and leads the detailed design and delivery of integrated services across their localities and neighbourhoods. These involve the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners

- Through 'provider collaboratives at scale' which bring NHS providers together to achieve the benefits of working at scale across multiple places to improve quality, efficiency and outcomes and address unwarranted variation and inequalities in access and experience across different providers

- At a whole 'system' (ICS) level

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.

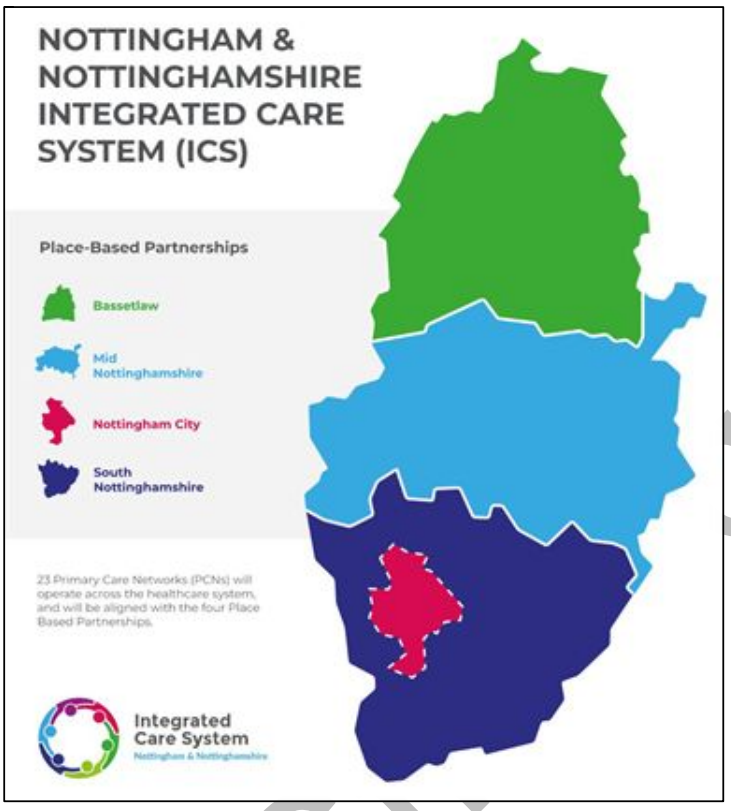


Figure 2: Place areas of the Nottingham and Nottinghamshire ICS

Our family portrait - Nottingham and Nottinghamshire Integrated Care System (ICS)						
Nottingham City PBP 396,000 population	South Nottinghamshire PBP 378,000 population		Mid Nottinghamshire PBP 334,000 population		Bassetlaw PBP 118,000 population	
8 PCNs	6 PCNs		6 PCNs		3 PCNs	
NHS Nottingham and Nottinghamshire Integrated Care Board (ICB)						
Nottingham University Hospitals NHS Trust	Sherwood Forest NHS Foundation Trust		Doncaster and Bassetlaw NHS Foundation Trust			
Nottinghamshire Healthcare NHS Foundation Trust (mental health, learning disability and autism)						
Nottingham CityCare Partnership (community provider)			Nottinghamshire Healthcare NHS Foundation Trust (community provider)			
111 and NEMS						
East Midlands Ambulance NHS Trust						
Nottingham City Council (Unitary)	Nottinghamshire County Council					
	Broxtowe Borough Council	Gedling Borough Council	Rushcliffe Borough Council	Ashfield District Council	Mansfield District Council	Newark & Sherwood District Council	Bassetlaw District Council
Voluntary and community sector input	Voluntary and community sector input		Voluntary and community sector input		Voluntary and community sector input	

Figure 3: The structure of the Nottingham and Nottinghamshire ICS

[Note to design: request to re-draw diagram so organisations match up to PBPs and councils, and move VCSE higher up.]

The health and wellbeing of our population

We know that many people in Nottingham and Nottinghamshire could be living longer, healthier, happier lives than they currently do. Here is an illustration of the scale of need and poor health in the local communities of Nottingham and Nottinghamshire:

[Design note: produce infographic from information below. Editorial note: some statistics have source information but not all. References need adding to data below.]

- More than 50,000 people in Nottingham and Nottinghamshire of working age who are 'economically inactive' have long term health problems[6]
- Across Nottingham and Nottinghamshire, 36,684 children live in relative low-income families, including over a quarter of those living in Nottingham City
- Nottingham and Bassetlaw both have significantly higher proportions of children in year six who are overweight (40.8% and 38.4% respectively)[7]
- Compared to national figures, both Nottingham and Nottinghamshire have significantly higher prevalence of babies born to mothers who were smoking at the time of delivery (13 % and 12.6%)[8]
- On average, women living in Nottingham can expect to live 57.5 years in good health, compared to 60 years for women in Nottinghamshire. This is lower than the England average of nearly 64 years
- Life expectancy for men is significantly lower than England in Ashfield, Mansfield and Nottingham, at between 76.6 and 78.2 years
- Among those aged 65 years and over, the proportion of people identified as having moderate frailty varies between 12% and 21%, and severe frailty between 10% and 18%, varying across Nottingham and Nottinghamshire
- Black and Asian people died from Covid-19 at significantly higher rates than White groups in the East Midlands, illustrating the structural inequalities faced by some groups[9]
- More than 65% of adults across Nottingham and Nottinghamshire are overweight or obese
- More than 11,000 hospital admissions and more than 4,500 preventable deaths each year in our ICS are caused by smoking[10]
- Data over the past two years shows one in six young people aged 6-19 years now has a probable mental health disorder[11]
- Compared to other systems, we have a high prevalence of obesity, diabetes, chronic kidney disease and coronary heart disease.[12]

More detailed information on local health needs and inequalities is included in the Joint Strategic Needs Assessments (JSNAs) which inform the work of the Health and Wellbeing Boards in Nottingham and Nottinghamshire. They are available on Nottingham Insight[13] and Nottinghamshire Insight[14].

The Joint Health and Wellbeing Strategies for Nottingham[15] and Nottinghamshire[16] summarise health needs and describe their agreed priorities for partnership working.

Strategy engagement with people and communities

This strategy has its origins in the Joint Health and Wellbeing Strategies for Nottingham[17] and Nottinghamshire[18] and, as such, should be seen as both complementary to, and building upon, the aims set out in those documents.

We have listened extensively to the public, patients and stakeholders during production of the strategy to check that it reflected the hopes, needs and aspirations of local people and their communities.

The engagement programme included desk research, 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. A full engagement report has been produced[19].

Guiding principles

Our Integrated Care Strategy is built on three guiding principles:

1. Prevention is better than cure
2. Equity in everything
3. Integration by default

Principle 1: Prevention is better than cure

There is a saying that 'prevention is better than cure'. We know that finding a health problem early or helping people know when to ask for help can mean that:

- People need less treatment (for example, immunisation can stop serious illnesses like meningitis)
- We can stop more serious illness (for example, changes in diet and weight-loss can reduce the risk and, in some cases, reverse the need for medications for type 2 diabetes or heart disease)
- We can stop diseases getting worse (for example, physical activity rehabilitation programmes to help people recover after a heart attack).

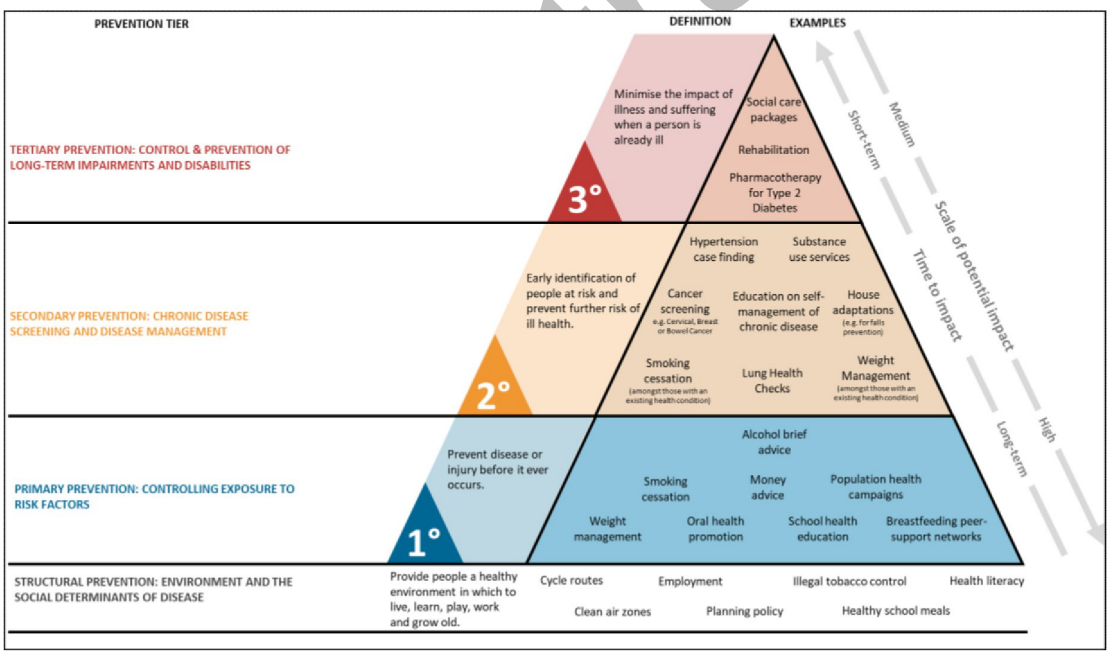


Figure 4: How different levels of prevention can improve health and wellbeing outcomes for people and help reduce or delay the future need for health or care services.

By focusing on prevention, we can make sure we use our limited resources most efficiently and improve people's health and wellbeing.

For the ICS, this means taking action now at all levels of the system to identify how we can build a preventative approach into service delivery. We know that health is

affected by more than healthcare provision. It is also influenced by other factors such as where we live; what we eat; how many family members and friends we have nearby to support us; if we work; or how much time we spent in education. Acknowledging that the building blocks for good health sit outside the GP's room and hospital ward is key in our approach to influencing health and care needs; there are many opportunities to integrate prevention and these wider social factors into our everyday thinking about health and care.

For this strategy, the ICS will focus on:

- Prioritising prevention across the health and social care system
- Moving the NHS from a 'treatment only' to a health and wellbeing service
- Considering how social care can intervene earlier to support people to remain healthy and independent for as long as possible
- Making sure the local organisations play a full role in supporting building and increasing 'social value' and strengthening communities, as well as helping families and carers in supporting an individual's independence, health and wellbeing.

Principle 2: Equity in everything

Equity has been adopted as a core guiding principle of the ICS, recognising that a 'one size fits all' method for what we do across health and care can create barriers and exclude certain groups of people, ultimately impacting on the needs of the population and demand across the system.

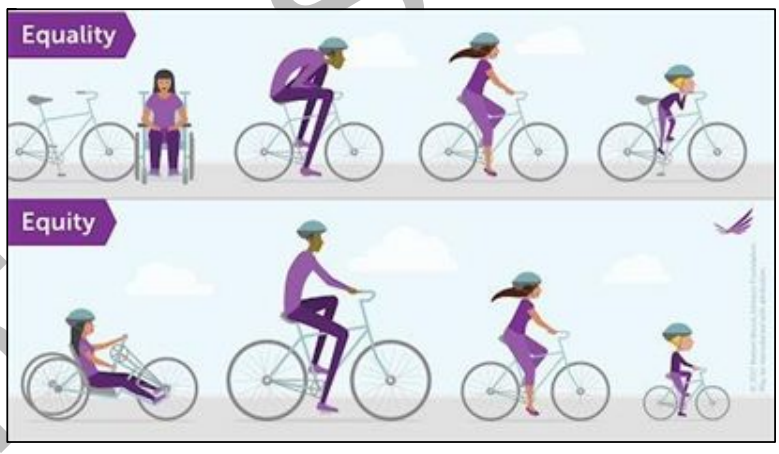


Figure 5: The difference between equality and equity. Source: Robert Wood Johnson Foundation (Better Bike Share, 2017)

It is important to be clear by what we mean by 'equity' as the word is often used interchangeably with 'equality', although they have different meanings. Equality means ensuring that everyone has the same opportunities and receives the same treatment and support. Equity is about tailoring the approach to people's needs, in order to make things fair.

Our strategy on tackling inequity will be based on an approach called ‘proportionate universalism’, as set out by Sir Michael Marmot in a national review into health inequalities[20]. This means that actions must be universal (in keeping with the founding principles of the NHS) but with a scale and intensity that is proportionate to the level of disadvantage need. ‘Proportionate universalism’ aims to improve the health and wellbeing of the whole population, while simultaneously seeking to improve the health and wellbeing of the most disadvantaged fastest.

Principle 3: Integration by default

Many of our organisations and teams will be serving the same communities and the same individuals, but in many instances, they will be doing it independently of one another. This leads to situations for people with multiple health and care needs having different agencies visiting for support at different times during the day. This is not in the best interests of local people or our workforce and teams. We want to support our workforce and teams to work in a more integrated way to ensure that local people have care that is joined up around them.

Achieving integration will depend on a culture of collaboration, bringing together:

- Our communities, who will help shape the delivery of services to meet their needs
- NHS services, including primary care, community, mental health and hospitals
- Local authority services, including social care, public health, housing and planning
- The voluntary and community sector involved in health and care as well as supporting broader determinants of health
- And supporting a more joined up response alongside other public services such as schools, police, fire and job centres.

Strategic aims

Aim one: Improve outcomes in population health and healthcare

Our priority: We will support children and young people to have the best start in life.	
What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will support children and young people to have the best start in life by: • Prioritising the first 1,001 critical days including implementing recommendations from the Ockenden Review[21] to equitably transform our maternity services • Develop multidisciplinary family hubs to support the holistic needs of children and families • Tackling the impact of Covid-19 on our children, with a particular focus on emotional health and wellbeing and school readiness, including speech and language support • Delivering our six physical health transformation programmes, with a particular focus on developing a system approach to childhood obesity • Recognising young carers at the earliest opportunity and ensuring that appropriate person-centred support is in place following a needs-led, strengths-based and personalised conversation • Prioritising those children at greatest need.	• A reduction in the proportion of women smoking at time of delivery • An improvement in breastfeeding prevalence at six-to-eight weeks after birth with 6 in every 10 women is still breastfeeding at *[outcome to be completed]* • A stabilisation of the rising rates of obese and overweight children in year six from *[date to be included]* baseline. • An improvement in school readiness: percentage of children achieving a good level of development at the end of reception • A reduction in *[figure]* per 100,000 hospital admissions as a result of self-harm, Nottingham and Nottinghamshire • An increase in access to children and young people mental health services (one contact) annual plan

Our priority: We will support frail older people with underlying conditions to maintain their independence and health.	
What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.

We will focus on supporting frail and/or older people with underlying conditions to stay well, remain independent and avoid unnecessary admissions to hospital in the short term. This will include: • Using risk stratification to identify, screen and categorise those people at greatest risk of frailty and admission to hospital • Developing multi-disciplinary personalised care plans for those at greatest need to support their health, care and independence needs • Seeking parity of esteem for mental and physical health needs including a focus on dementia • Prioritising secondary and tertiary prevention (including social care, falls prevention, home adaptations, and technology) to delay disease progression and maintain independence for as long as possible • A system review of hospital discharge and reablement pathways to get people back to their place of home as quickly and independently as possible. This includes implementing the Local Government Association recommendations on transfer of care, one shared data set and culture • Recognising carers of all ages at the earliest opportunity, and ensuring that appropriate person-centred support is in place following a needs-led, strengths-based and personalised conversation • Further improving infection prevention and control practice and reducing antimicrobial resistance to reduce the likelihood and impact of hospital acquired infections.	• A 5% reduction in emergency hospital admissions over the next 5 years compared with an unmitigated growth scenario • A reduction in the rate of emergency admissions due to falls in people aged 65 and over (rate per 100,000) • An increase in the proportion of people who feel they have control over their daily life • An increase in the proportion of adults in contact with secondary mental health services living independently, with or without support • An improvement in the proportion of frail and/or older people discharged home • A reduction in the proportion of patients in hospital that are medically fit for discharge • An increase in proportion of people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services (effectiveness of the service and offered the service) • An increase in the proportion of carers who reported that they had as much social contact as they would like • An increase in carer reported quality of life score • A reduction in hospital acquired infections. *[Measurement details to be added]*

Our priority: We will 'Make Every Contact Count' (MECC) for traditional areas of health, for example, mental health and healthy lifestyles, and incorporate signposting to other services like financial advice which support people to improve their health and wellbeing.	
What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will ensure that all health and care staff understand the building blocks of health and health inequalities, and are competent and confident to deliver brief interventions on a range of prevention topics to support people's wellbeing. This will include: • Developing a Making Every Contact Count[22] (MECC) framework for action across ICS organisations • Developing a flexible approach to MECC training and support that will be owned and tailored by the different services across the ICS. This will be linked to health literacy, better three conversations and strengths-based approaches • Embedding MECC training into the personal development plans and appraisals of all health and care staff, with consideration that MECC becomes mandatory training • Clarifying signposting and referral mechanisms into prevention services, collaborating with local health and wellbeing services • Prioritising brief interventions for those of greatest need.	• MECC framework developed and agreed at the ICP • All health and care staff have completed local, high quality bespoke MECC training to build their confidence and competence in delivering health and wellbeing advice • An increase in MECC conversations across the system • An increase in referrals into prevention services.

Aim two: Tackle inequalities in outcomes, experiences and access

Our priority: We will support people with the greatest need (the 20% most deprived, in vulnerable or inclusion groups and those experiencing severe multiple disadvantage).	
What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will prioritise the areas and population groups of most need, including those living in the most deprived areas, those in vulnerable or inclusion groups and those experiencing severe multiple disadvantage. This will involve embedding a 'proportionate universalism'[23] approach, delivering a core service to our people, but tailoring the scale and intensity to the level of need. This will include: • Delivering the priorities of the adult and children and young people NHS England Core20Plus5[24] frameworks • Equitable access to immunisation and screening and health checks, including those for people with severe mental health and learning disabilities • Identifying and addressing the 'care gap' in effective anticipatory care and secondary prevention interventions that are not completed, to provide a holistic, personalised approach to care, prioritising those most in need • Embedding a trauma informed approach across the system • Delivering the priorities of the NHS Mental Health Implementation Plan and adopting the reforms to the Mental Health Act • Reviewing progress of the local Transforming Care programme • Focusing on populations including those with severe mental illness, homelessness, domestic abuse, severe multiple disadvantage, financial vulnerability, multiple or life limiting illness, BAME groups, and	• An improvement in years of healthy life expectancy from *[insert date]* baseline – yet we acknowledge that this may well require a longer timeframe than five years • A reduction in life expectancy gap (measured in years) between the most and least deprived areas of the ICS from *[insert date]* baseline • An improvement in access to, experience of and outcomes from services for those at greatest need (split where appropriate by 20% most deprived areas, ethnicity, age, gender, disability etc) • A reduction in non-elective activity through proactive management of long-term conditions (split where appropriate by 20% most deprived areas, ethnicity, age, gender, disability etc.) • *[Insert figure]* of staff attending trauma informed approach training • At least 75% of people aged 14 or older with a learning disability will have had an annual health check (NHS Long Term Plan[25]) • An increase in the number of people with learning disabilities, autism or mental health needs in paid employment • An increase in the number of people with learning disabilities, autism or mental health needs in settled accommodation.

people with learning disabilities and/or autism.	

Our priority: We will focus and invest in prevention priorities, like tobacco, alcohol, healthy weight and mental health, to support independence, prevent illness and premature death from heart attack, stroke, cancer, chronic obstructive pulmonary disease (COPD), suicide and poor birth outcomes.	
What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will prioritise equitable investment in prevention across the ICS, focusing on the key priorities of the two local Joint Health and Wellbeing Strategies. This will include: • Creating an Inequalities and Innovation Investment Fund to tackle the top prevention priorities for local people, including tobacco, alcohol, healthy weight and mental health • Agreeing to adopt the principle of 'proportionate universalism' in future funding allocations across the partnership so that resources are deployed according to need rather than historic allocation • Completing an evidence-based system review of the prevention offer and operating model to reshape and integrate services.	• A commitment to increasing the proportion of spend on prevention • Best start in life indicators (as highlighted earlier) • A smokefree generation by 2040 ensuring that we take an equitable approach to working with our most vulnerable groups. • A reduction in alcohol-related hospital admissions (split by deprivation where possible) • A reduction in the percentage of adults (aged 18-plus) classified as overweight or obese (split by deprivation where possible) • A reduction in suicide rate

Aim three: Enhance productivity and value for money

Our priority: We will establish a single health and care recruitment hub.	
What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will explore opportunities to develop a single health and care recruitment hub. This is likely to include: • Leading on joint recruitment, enabling deployment and sharing of staff to respond to service needs. This could include benchmarking and exploring opportunities across the ICS and the wider D2N2 Local Enterprise Partnership • Completing work to explore opportunities to address parity issues for care workers across the system.	• Provider collaborative at scale partners working together from April 2023. By April 2024, the model may be expanded to include wider partners for selected shared staff groups, such as care support workers and nurses • Workforce is more reflective of our local population (split by deprivation, age, ethnicity, gender and disability) • A reduction in ICS health and care vacancy rate • An increase in the number of jointly employed health and care posts • An increased proportion of the population with health conditions who are supported back into work.

Our priority: We will adopt a single system-wide approach to quality and continuous service improvement.	
What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will adopt a single system-wide approach to quality and continuous service improvement, exploring opportunities and aligning where practicable.	• *[Figure here]* staff trained in system-wide quality and improvement approach by quarter four 2022-23 • System ambitions (prevention, equity and integration) embedded into all staff performance development reviews.

Our priority: We will bring our collective data, intelligence and insight together.	
What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.

We will collaborate on our collective data, intelligence and insight. This will include: • Creating a common view of outcomes, quality and performance across the ICS • Looking for opportunities for alignment across the system to support service planning and integration • Developing 'one version of the truth' through agreed system metrics and dashboards • Developing a pipeline for the next generation of data, intelligence and insight workforce across the system.	• Development of a collaborative virtual intelligence system across the ICS • An agreed ICS outcomes framework, with associated dashboards, that is used to identify priorities across the system • A reduction in vacancies across data, intelligence and insight posts across the system.

Our priority: We will review our Better Care Fund programme.	
What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will ensure our Better Care Fund[26] programme is meeting the needs of local people and aligned with the ambition of this strategy.	• Completed review of the Better Care Fund programme by March 2023

Our priority: We will make it easier for our staff to work across the system.	
What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will make it as easy as possible for staff to work across different teams and organisations. This will include: • Establishing jointly employed head of commissioning posts for Ageing Well and Living Well, and head of quality and market management • Further developing the Memorandum of Understanding for mutual aid between organisations • All NHS providers being registered to utilise the digital staff passport to support movement of staff between organisations • Developing a rotational scheme to support allied health professionals to move between sectors (NHS	• Recruited head of commissioning posts for Ageing Well and Living Well, and head of quality and market management • Signed Memorandum of Understanding for mutual aid between organisations • All NHS organisations signed up to and using the digital staff passport • Rotation scheme for allied health professionals operational by April 2023 • System-wide partner review completed by *[date]* • Integrated discharge hubs implemented • Integrated commissioning function and a quality and market

providers, primary care and social care) • Establishing an integrated commissioning function and a quality and market management function across the ICB/ICS – to be agreed • Developing integrated discharge hubs to encourage an integrated approach to service delivery • Completing a system-wide partner review • Reviewing data sharing agreements to ensure staff have access the information they need to deliver the best care.	management function established across ICB/ICS – to be agreed • Streamlined, appropriate information sharing in place.

Aim four: Support broader social and economic development

Our priority: We will add social value as major institutions in our area	
What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.

We will use our role as large public sector organisations that are linked integrally to place, people and communities (anchor institutions[27]), to go beyond normal service delivery. We will use our resources and influence to maximise social, economic and environmental impacts (social value[28]) to improve the building blocks of health and reduce inequalities. Collectively, we have the potential to leverage our size and strengths to deliver greater benefits. This will include:
 	
• Building on the work of local authorities to align the social value approach across the system
• Strengthening the ICS Anchor Champions Network to explore how we maximise support for social and economic development through the collective work of anchor institutions and the ICS delivery groups
• Implementing the University of Nottingham Civic Agreement[29] as our mission for anchor institutions across the ICS and D2N2 Local Enterprise Partnership
• Reducing our environmental impact by delivering our ICS Green Plan
• Putting actions in place to support local people with the rising cost of living, including signposting to relevant support services and fair reimbursement for skills.
	• University of Nottingham Civic Agreement approved across all ICS organisations
	• Agreement for the ICS Anchor Champions Network on specific targets for April 2023 including:
	  ○ *[Insert figure]* of all contracts and sub-contracts awarded are with local businesses/providers
	  ○ An increase above baseline for small and medium-sized enterprises procurement
	  ○ An increase in the utilisation of the apprenticeship levy[30]. One additional local apprentice/entry level post per £x million spend (measured through Nottingham Jobs)
	  ○ An increase above baseline tenders that include environmental impact assessments
	  ○ Embed healthy places policy (smokefree place, food charter)
	  ○ An increased weighting of social value in all procurements
	• Organisations achieving carbon net zero[31] by *[insert date]*
	• An increase in the proportion of our buildings and spaces used to support communities
	• A reduction in staff sickness and absence rates.

How we will deliver the strategy

Supporting our workforce

For our strategy to be successful it will necessarily mean that many of our colleagues and teams will need to adapt the way that they work. This will require an approach which prioritises the needs of the population first, then the system, and then the employing organisation.

We are working across the ICS to take a 'one workforce' approach, inclusive of all staff involved in supporting local people's health and wellbeing. This will enable us to make the most of skills and talent across our system, building integrated teams with the adaptability and capacity to support prevention and deliver person-centred care. In line with this, we will review our People and Culture Strategy[32] to ensure that it meets the ambitions of the Integrated Care Strategy.

We will support our staff and teams in:

- Improving how we best make use of colleagues' skills and capability to make services better. We will lead the process of co-designing and developing an integrated workforce development plan, including developing new roles and new ways of working, built around population health modelling (gaining insights from analysing data). This will ensure our workforce is deliberately designed and developed to meet current and future health and care needs.

- Establishing a workforce representative of our population. Our aspirational goal is to have a workforce that reflects the communities we serve. Our equality, diversity and inclusion (EDI) leads will work collaboratively to support our people and culture programmes and to embed EDI principles and practice into all aspects of planning and delivery. We will continue to grow and develop our EDI Partnership Group and staff networks (race equality, disability and sexual identity) to provide support for existing staff. We will challenge inequity in all its forms across the ICS to foster a sense of belonging and in return broaden participation and engagement.

- Expanding CARE4Notts Health and Care Careers Academy to support people into work. CARE4Notts provides a single point of access to promote health and care careers, delivering information, advice and guidance, focusing on schools and colleges, young people and growing the future talent pipeline to ensure our teams reflect the diversity of our local population. We also have a Foundation School in Health, a partnership between Doncaster and Bassetlaw Teaching Hospitals and Retford Oaks Academy. We will continue to progress apprenticeship routes into clinical and non-clinical roles and a system approach to support diverse and inclusive work placements. We recognise the social value and impact within our local communities to better enable, develop and provide career opportunities to those who are under-represented, due to existing processes within securing and further career development.

- Embedding organisational development, culture and quality improvement. In, October 2022, we established our new system People and Culture function. Working with local health and care partners, we will set our vision and objectives, supported by a collection of measurable outcomes for improvement. System strategic areas include equality, diversity and inclusion, health and wellbeing, organisational development, leadership and talent management, training and education, and quality improvement.

Working with people and their communities

We are keen to further improve our work with the people and communities we serve by:

- Co-producing services alongside local people as equal partners to understand what matters to them. All system partners are committed to putting people at the heart of all that we do by consistently listening to, involving and collectively acting on, the experience and aspirations of local people and their communities. We will embed co-production as the default position for how we will work with people as equal partners at all stages of the design, development and commissioning of health and care services and support

- Further information on the approach to be taken is available in the Working with People and Communities Strategy[33].

- Embedding a true system culture into the way that we work. Culture and leadership development will be appropriately invested in and supported as a health and care system. We will attract, develop and retain our workforce through a demonstration of behaviours, style and technical capability. We will develop leadership capability and capacity by designing culture transformation and leadership programmes that are inclusive and outcome focused. Our interventions will be underpinned by collaborative leadership development, and where networks and spaces are created to support connectivity, conversations and act as a safe space to build and nurture relationships.

- Embedding personalised care and social prescribing. We will increasingly shift from a reactive, professional-led, illness-focused ‘medicalised’ approach, towards a proactive, strength-based, partnership and holistic care approach.

Evidence-based approach

We want to work together to embed an evidence-based continuous improvement approach. This will include:

- Building on our successful data, analytics, information and technology (DAIT) approach. Further information on how we will progress areas such as digital information, systems and services is contained in our DAIT strategy[34].

- Accelerating our research programmes, including service evaluation and audit. We will use evidence from research 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. We support the ambition to become an Academic Health Science Centre which combines excellence in research, education and care.

- Developing a system-wide approach to quality improvement. Our partner organisations have committed to working together to build on our current System Quality Strategy[35] by incorporating principles and approaches from this to form a system-wide delivery plan..

Focus on outcomes

In order to ensure we are making an impact, monitoring delivery of the strategy will be achieved through the ICS outcomes framework. This framework is built from system outcomes relevant to each aim, which are measured by a set of metrics that apply across all that we do - service delivery, service change, transformation, people and culture. Through our System Analytics and Insight Unit, we will develop a way of measuring people's health and wellbeing at neighbourhood, place and system level, using a 'Gross Domestic Wellbeing'[36] measurement. This will be supported by feedback from our population about what is and is not working for them.

Our delivery organisations and partnerships

In addition to the Integrated Care Partnership, there are a number of formal partnerships which will support the delivery of the strategy. These include:

1. Health and Wellbeing Boards - statutory committees of Nottingham City and Nottinghamshire County Councils respectively, with membership across public health, social care, children's services, the NHS and local Healthwatch.

2. Place-Based Partnerships - formed by organisations responsible for arranging and delivering health and care services in a locality or community. They include the NHS, local government and providers of health and care services, including the voluntary, community and social enterprise sector, and people and communities.

3. Provider collaboratives at scale – delivering benefits of mutual aid working across a wider footprint, both within places and between places.

4. Primary care – GP practices, multi-disciplinary teams and primary care networks (groups of GP practices and others working together) implementing the Primary Care Strategy[37].

5. Voluntary, Community and Social Enterprise Alliance - formally embedded within the ICS. The Alliance will engage and embed the sector within the system governance and decision-making structures. 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 as a single point of contact, to generate citizen intelligence from the groups and communities that they work with.

Enabling infrastructure

To implement the strategy, we will be reliant on the enabling support of:

- Finance - the challenges to public sector financing mean that the strategy will need to be delivered within our organisations' resources. How we use our funding will be a key enabler to the delivery of the strategy. As statutory organisations we will develop a set of guiding principles, in line with our ambitions for Nottingham and Nottinghamshire, to inform how our resources are used, achieving value for money and ensuring budgets are balanced.

- Estates - our ICS Estates Transformation Programme aims to complete the SHAPE database (capturing all public estate) so our baseline position is clear. Our ICS has identified the development of its next estates strategy as one of the key deliverables to support achieving our strategic ambitions. This will be developed on the basis of 'one public estate' so we deliver integrated care at place, using our estate in the most efficient ways.

- Sustainability – partner organisations have already agreed a Green Plan for the system to support the NHS achieve its commitment to becoming carbon neutral by 2040 and support the ambition set by Nottingham City Council for Nottingham to be the first carbon neutral city in the UK, with a target of net zero emissions by 2028. Our ICS Green Plan 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.

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[6] https://www.nomisweb.co.uk/home/profiles.asp

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[10] https://ash.org.uk/resources/smokefree-nhs/briefings-for-integrated-care-systems

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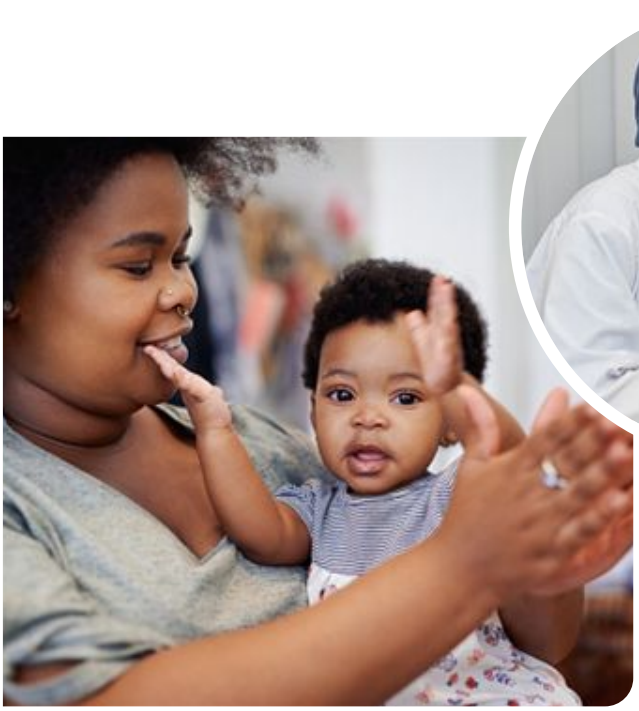
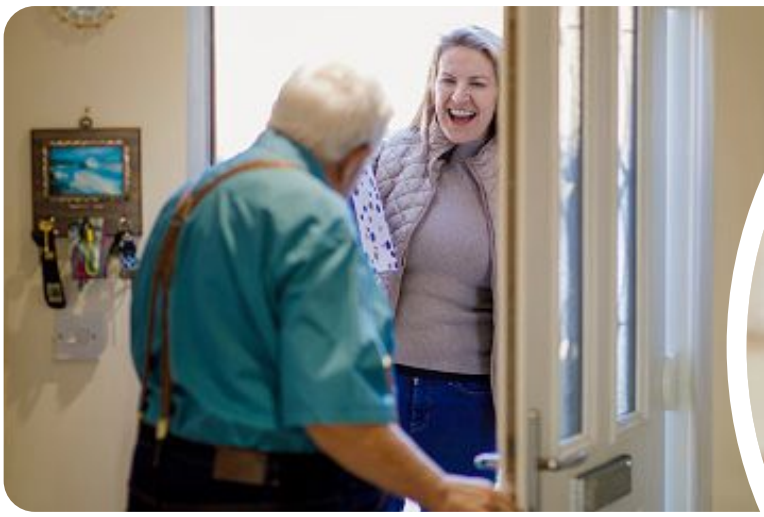
APPENDIX B

Integrated Care System
Nottingham & Nottinghamshire





Integrated Care Strategy

Nottinghamshire County Council
Nottingham City Council
NHS

Integrated Care System
Nottingham & Nottinghamshire

Every person will enjoy their best possible **health** and **wellbeing**

Integrated Care Strategy

Nottinghamshire County Council

Nottingham City Council

NHS

ICS Principles and Values

There is a history of strong partnership working in Nottingham and Nottinghamshire. For a number of years the ICS has operated as a non-statutory partnership bringing together public health, general practice and primary care, acute hospitals, community and mental health services, social care and wider partners - including housing - to better serve population needs and achieve quality and sustainable care through our collective endeavours.

The partners have signed up to a set of principles and values which define how we will work together.

Principles

- We will work with and put the needs of local people at the heart of the ICS.
- We will be ambitious for the health and wellbeing of our local population.
- We will work to the principle of system by default, moving from operational silos to a system wide perspective.

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.

The key partners and how we are structured:

We have already reflected on the fact that for most of our collective history NHS organisations have acted independently of one another and in turn independently of Local Government and Social Care, despite often serving exactly the same people.

This will not change overnight but it will nonetheless change as individual parts of the NHS increasingly cohere and reach a better understanding of one another and of their colleagues in local government.

This is crucial to the success of the partnership especially when we consider that if we want to improve people's health and wellbeing we must recognise that there are more factors in play than just healthcare; health is affected by many things – housing, unemployment, financial stress, domestic abuse, poverty and lifestyle choices. This is something that we need to look at through a partnership between the NHS, local government, and the voluntary sector.

With that context in mind here is how we are currently structured:

Each Integrated Care System has two statutory elements:

- Integrated Care Partnership (ICP) - a statutory committee formed between the NHS Integrated Care Board and upper-tier local authorities. The ICP will bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population.
- Integrated Care Board (ICB) – a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services. The ICB works to deliver the ICS outcomes with partners from across our system.

With a combined annual budget of over £3 billion for the commissioning and provision of health and care services, the partners collaborate at:

- A 'neighbourhood level' through 23 primary care networks (PCNs) covering populations on the whole of between 30,000 and 50,000
- At a 'place level' through four Place-Based Partnerships (PBPs): Bassetlaw, Mid Nottinghamshire, Nottingham City, and South Nottinghamshire. Each PBP serves a population of ~120,000-350,000 people and lead the detailed design and delivery of integrated services across their localities and neighbourhoods. These involve the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners.
- Through 'provider collaboratives at scale' which bring NHS providers together to achieve the benefits of working at scale across multiple places to improve quality, efficiency and outcomes and address unwarranted variation and inequalities in access and experience across different providers.
- At a whole 'system' (ICS) level

Our family portrait - Nottingham and Nottinghamshire Integrated Care System (ICS)							
Nottingham City PBP 396,000 population	South Nottinghamshire PBP 378,000 population		Mid Nottinghamshire PBP 334,000 population		Bassetlaw PBP 118,000 population		
8 PCNs	6 PCNs		6 PCNs		3 PCNs		
NHS Nottingham and Nottinghamshire Integrated Care Board (ICB)							
Nottingham University Hospitals NHS Trust	Sherwood Forest NHS Foundation Trust			Doncaster and Bassetlaw NHS Foundation Trust			
Nottinghamshire Healthcare NHS Foundation Trust (mental health, learning disability and autism)							
Nottingham CityCare Partnership (community provider)			Nottinghamshire Healthcare NHS Foundation Trust (community provider)				
111 and NEMS							
East Midlands Ambulance NHS Trust							
Nottingham City Council (Unitary)	Nottinghamshire County Council						
	Broxtowe Borough Council	Gedling Borough Council	Rushcliffe Borough Council	Ashfield District Council	Mansfield District Council	Newark & Sherwood District Council	Bassetlaw District Council
Voluntary and community sector input	Voluntary and community sector input		Voluntary and community sector input		Voluntary and community sector input		

Integrated Care System
Nottingham & Nottinghamshire

Integrated Care Strategy

Nottinghamshire County Council

Nottingham City Council

NHS

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- At a whole 'system' (ICS) level

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Meeting Title:	Integrated Care Partnership
Meeting Date:	16/12/2022
Paper Title:	**Revised terms of reference for Nottingham and Nottinghamshire Integrated Care Partnership**
Paper Reference:	ICP 22 014
Report Author:	Lucy Branson, Associate Director of Governance, NHS Nottingham and Nottinghamshire ICB
Report Sponsor:	Kathy McLean, Chair of the Integrated Care Partnership (and ICB Chair)
Presenter:	Lucy Branson, Associate Director of Governance, NHS Nottingham and Nottinghamshire ICB
Recommendation(s):	The Integrated Care Partnership is asked to **RECEIVE** this item.

Summary:

The Nottingham and Nottinghamshire Integrated Care Partnership (ICP) was established as a joint committee of Nottingham City Council, Nottinghamshire County Council and NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) in July 2022.

At the time of approving the Integrated Care Partnership's terms of reference, it was recognised that these would need further refinement following the receipt of guidance and advice, particularly in relation to decision-making arrangements as a joint committee in the context of the new legislation. This has now been received and a small number of amendments to the terms of reference have been approved at meetings of the Nottingham City Council on 31 October 2022, the ICB Board on 10 November 2022 and the Nottinghamshire County Council on 24 November 2022. The revised terms of reference are attached at Appendix A; these are presented with tracked changes for ease of reference.

How does this paper support the Integrated Care System's core aims to:	
Improve outcomes in population health and healthcare	The Integrated Care Partnership (ICP) is established to further the four core aims.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help support broader social and economic development	As above.

Appendices:

Appendix A: Revised terms of reference for Nottingham and Nottinghamshire Integrated Care Partnership.
Appendix B: List of nominated ICP members.

Report Previously Received By:

The revised ICP's terms of reference were approved by the Full Council meetings of both Local Authorities and by the Board of the ICB during October and November 2022.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

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Nottingham and Nottinghamshire Integrated Care Partnership

Terms of Reference

1. Description/ status	The Nottingham and Nottinghamshire Integrated Care Partnership ("**the ICP**") is a joint committee of NHS Nottingham and Nottinghamshire Integrated Care Board**,** Nottingham City Council and Nottinghamshire County Council ("**the Statutory Organisations**"), established in accordance with Section 116ZA of the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Care Act 2022). The ICP will act as the 'guiding mind' of the Nottingham and Nottinghamshire Integrated Care System (ICS) and is authorised to operate within these terms of reference, which set out its purpose, membership, authority and reporting arrangements. The ICP will not duplicate the work of the Nottingham City and Nottinghamshire County Health and Wellbeing Boards. ICP members will champion and act as ambassadors of effective partnership working for local population benefit.
2. Purpose	a) The primary purpose of the ICP is to produce an Integrated Care Strategy and Outcomes Framework for Nottingham and Nottinghamshire, setting out how the assessed health and social care needs identified by the Nottingham and Nottinghamshire Joint Strategic Needs Assessments (JSNAs) are to be met by the Statutory Organisations or NHS England, in line with their respective commissioning responsibilities. b) In preparing the Integrated Care Strategy, the ICP will: i) Involve Nottingham and Nottinghamshire Healthwatch and the people who live and work in Nottingham and Nottinghamshire. ii) Consider the extent to which health and social care needs could be met more effectively through arrangements for pooled budgets, joint commissioning and integrated delivery under

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	section 75 of the NHS Act 2006 (as amended). iii) Have regard to the mandate published by the Secretary of State for Health and Social Care under section 13A of the NHS Act 2006 (as amended). iv) Have regard to any further guidance issued by the Secretary of State for Health and Social Care. c) The ICP may also include within the Integrated Care Strategy its views on how arrangements for the provision of health-related services in its area could be more closely integrated with arrangements for the provision of health services and social care services in the area. d) To support the development of the Integrated Care Strategy, the ICP will engage with a wider assembly of partners, at least once a year, comprising people who rely on care and support, unpaid carers, the full range of social care and NHS providers, the voluntary and community sector, local professional committees (e.g. optical and pharmaceutical committees), the Office of the Police and Crime Commissioner, etc. e) The ICP will review the impact of the Integrated Care Strategy, focusing on improving outcomes in population health and healthcare, tackling inequalities in outcomes, experience and access, enhancing productivity and value for money and supporting broader social and economic development. f) The ICP will also receive reports on insights gained from service users and citizens. g) The ICP will consider the extent to which the Integrated Care Strategy needs to be revised on receipt of an updated JSNA.
3. Principles	The following principles will be used to guide the work of the ICP: a) Focus on improving equity of outcomes for people, including improved health and wellbeing, supporting people to live more independent lives, and reduced inequalities. b) Support the triple aim (better health and wellbeing for everyone, better care for all and efficient use of the

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	collective resource). c) Enable consistent standards and policy across the ICS (strategically sound) whilst allowing for different models of delivery in accordance with diverse populations served (locally sensitive). d) Ensure all delivery mechanisms (e.g. primary care networks, place-based partnerships and provider collaboratives at scale) are equally respected and supported, in line with the principle of subsidiarity. e) Champion co-production and inclusiveness throughout the ICS. f) Put at the forefront the experience and expertise of professional, clinical, political and community leaders, and promote strong clinical and professional system leadership. g) Create a learning system, fostering a culture of innovation, bravery, ambition and willingness to learn from mistakes. h) Optimise the role of health and care as anchor organisations within the local community. i) Utilise existing networks, groups, and governance structures, including staff forums and insights gained from place and neighbourhood engagement. j) Come together under a distributed leadership model and commit to work together equally. k) Accountable to one another and the public including through transparency and building trust.
4. Membership	The membership of the ICP will be comprised as follows: *Nottingham City Council:* a) Elected Member Representative who is the Chair of the Health and Wellbeing Board b) Corporate Director for People Services c) Director of Public Health for Nottingham d) Two further partner members nominated by Nottingham City Council ~~City Partner to be identified~~ ~~City Partner to be identified~~ *Nottinghamshire County Council:* e) Elected Member Representative who is the Chair of

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	the Health and Wellbeing Board f) Corporate Director, Adult Social Care and Health g) Director of Public Health for Nottinghamshire h) Two further partner members nominated by Nottinghamshire County Council ~~County Partner to be identified~~ ~~County Partner to be identified~~ *NHS Nottingham and Nottinghamshire Integrated Care Board:* i) Chair of the Integrated Care Board j) Chief Executive k) Director of Integration l) Medical Director m) Representative of the Nottingham and Nottinghamshire Provider Collaborative at Scale *Other:* n) Representative of Healthwatch Nottingham and Nottinghamshire o) Chair of the Nottingham and Nottinghamshire Voluntary, Community and Social Enterprise Alliance p) Representative of the Bassetlaw Place-based Partnership q) Representative of the Nottingham City Place-based Partnership r) Representative of the Mid-Nottinghamshire Place-based Partnership s) Representative of the South Nottinghamshire Place-based Partnership
5. Chair and vice-chair arrangements	The ICP will be Chaired by the Chair of NHS Nottingham and Nottinghamshire Integrated Care Board. The Chairs of the Nottingham City and Nottinghamshire County Health and Wellbeing Boards will act as joint Vice-Chairs of the ICP.
6. Substitutes	Members are permitted to nominate a suitable substitute to attend a meeting of the ICP on their behalf should they be unable to attend themselves. Members are responsible for fully briefing any nominated substitutes. Substitutes need to be confirmed in writing to the Chair of

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	the ICP ahead of the meeting.
7. Quorum	The quorum will be seven members, including at least one member from each of the Statutory Organisations. Nominated substitutes will count towards the quorum. Members (or nominated substitutes) will not count towards the quorum if attending remotely. If any member (or nominated substitute) of the ICP has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may only proceed on an informal basis and no decisions may be taken.
8. Decision-making arrangements	It is expected that at the ICP's meetings, decisions will be reached by consensus ~~and a vote will not be required.~~ ~~If consensus cannot be reached and if timeframes allow, then the item will be re-scheduled for discussion at the next meeting of the ICP. Otherwise, decisions will be taken by simple majority.~~ Should this not be possible, then a vote of the ICP's members will be required, the process for which will be as follows: a) All members of the ICP (or nominated substitutes) who are present at the meeting will be eligible to cast one vote each. Members attending remotely will not be eligible to vote. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote. b) A decision will be passed if more votes are cast for it than against it. c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the ICP will have a casting vote. Any decisions taken will be recorded in the minutes of the meeting.
9. Conflicts of interest	A register of the declared interests of ICP members will be maintained and published. In advance of any meeting of the ICP, consideration will be given as to whether conflicts of interest are likely to arise in

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	relation to any agenda item and how they should be managed. At the beginning of each meeting of the ICP members 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 declarations will be formally recorded in the minutes for the meeting. The Chair of the ICP will determine how any declared interests should be managed. ICP members must ensure that they comply with their organisational/ professional codes of conduct at all times.
10. Meeting arrangements	The ICP will meet at least twice per year. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair in consultation with the Vice-Chairs. At least five clear working days' notice will be given when calling meetings. Remote attendance at meetings will be permitted at the discretion of the Chair. Meetings of the ICP shall be open to the public unless considering exempt information. The ICP is subject to the same requirements of openness and transparency as other meetings of the Statutory Organisations. As such, agendas and supporting papers, including ratified minutes of meetings, will be published. A protocol will be published separately for members of the public to set out arrangements for submitting questions to meetings of the ICP.
11. Secretariat	Secretariat support will be provided to the ICP by NHS Nottingham and Nottinghamshire Integrated Care Board. Agendas will be agreed by the Chair in consultation with the Vice-Chairs prior to each meeting. Any items to be placed on the agenda are to be sent to the secretary no later than ~~nine~~ ten clear ~~calendar~~ working days in advance of the meeting. Items that miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas and supporting papers will be circulated no later

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	than five clear working days before each meeting. Minutes will be taken at all meetings and will be ratified by agreement of the ICP at the following meeting.
12. Reporting arrangements	The ICP must: a) Publish its Integrated Care Strategy (and any revised strategies). b) Provide a copy of its Integrated Care Strategy (and any revised strategies) to the Statutory Organisations.
13. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. An early review of these terms of reference may be required during the ICP's first year of operation, as arrangements across the Nottingham and Nottinghamshire Integrated Care System evolve. Any proposed amendments to the terms of reference will be submitted to the Statutory Organisations for ratification.
14. Date approved	~~July~~ November 2022

Appendix B – List of nominated ICP members

Nottingham City Council nominated members	Cllr. Adele Williams	Chair of Nottingham City Health and Wellbeing Board
	Catherine Underwood	Corporate Director for People Services, Nottingham City Council
	Lucy Hubber	Director of Public Health, Nottingham City Council
	Donna Sherratt	Nottingham City Place-Based Partnership Race Health Inequalities Programme Lead
	To be confirmed	*Nottingham City Partner*
Nottinghamshire County Council nominated members	Cllr. John Doddy	Chair of Nottinghamshire Health and Wellbeing Board
	Melanie Williams	Corporate Director, Adult Social Care and Health
	Jonathan Gribbin	Director of Public Health, Nottinghamshire County Council
	Andrew Redfern	Chief Executive, Framework Housing Association
	Volt Sacco	Chief Executive, Fosse Healthcare
NHS Nottingham and Nottinghamshire ICB nominated members	Dr Kathy McLean	Chair of NHS Nottingham and Nottinghamshire ICB
	Amanda Sullivan	Chief Executive, NHS Nottingham and Nottinghamshire ICB
	Lucy Dadge	Director of Integration, NHS Nottingham and Nottinghamshire ICB
	Dr Dave Briggs	Medical Director, NHS Nottingham and Nottinghamshire ICB
	Anthony May	Chief Executive, Nottingham University Hospitals NHS Trust (Representative of the Nottingham and Nottinghamshire Provider Collaborative at Scale)
Other members	Jane Laughton	Chief Executive Officer, Healthwatch Nottingham and Nottinghamshire
	Jules Sebelin	Chair of the Nottingham and Nottinghamshire Voluntary, Community and Social Enterprise Alliance
	Victoria McGregor-Riley	Locality Director, Bassetlaw Place-based Partnership
	Dr Hugh Porter	Clinical Director, Nottingham City Place-based Partnership
	Dr Nicole Atkinson	Clinical Director, South Nottinghamshire Place-based Partnership
	To be confirmed	*Mid-Nottinghamshire Place-based Partnership representative*