NHS Frimley Integrated Care Board

Agenda – Meeting in Public

Tuesday 19 March 2024 – between 11.30 and 12.30

Online via MS Teams

Chair: Priya Singh

The quorum for a meeting will be seven members, including:

a) *Either the Chair or Vice Chair*
b) *Either the Chief Executive or the Chief Finance Officer*
c) *Either the Chief Medical Officer or the Chief Nursing Officer*
d) *At least one non-executive member*
e) *At least one Provider Member*
f) *At least one Practice Member*
g) *At least one Local Authority Member*

Timing	No.	Item	Action	Delivery	Lead
11.30	1.	Welcome, apologies for absence and Chair's introduction	-	Verbal	Chair
	2.	Conflicts of Interest Register and declarations of any interests relating to this agenda	Note	Paper	Chair
	3.	Minutes of the last meeting in Public held on 16 January and matters arising	Approve	Paper	Chair
11.35	4.	Chief Executive Update	Note	Verbal	Fiona Edwards
	5.	Reducing Health Inequalities			
11.40	5.1	Core20Plus	Note	Paper and Presentation	Lalitha Iyer
11.55	5.2	Quality and Safety Report	Note	Paper	Sarah Bellars
	6.	Standing Items			
12.10	6.1	Board Assurance Framework	Note	Paper	Richard Chapman
12.15	6.2	Frimley ICB Integrated Performance Report: • Finance • Performance • Workforce • Quality	Note	Presentation on the Day	Richard Chapman / Sarah Bellars / Caroline Corrigan

Timing	No.	Item	Action	Delivery	Lead
	7.	Close of business			
12.25	7.1	Questions received in advance from members of the Public	Note	Verbal	Chair
12.30	7.2	Any Other Business and Close	-	Verbal	Chair
Date of next meeting in public: 21 May 2024, 11.30 – 12.30					

Job Title	First Name	Last Name	Interest	Description of Interest		Type of Interest		Actions agreed with Line Manager to mitigate conflict
Chief Nursing Officer	Sarah	Bellars	FHFT	Son and Daughter in Law work for FHFT	Declarations of Interest – Other	Indirect	Indirect	Seek the advice of other senior members of the executive and Non-executive team if there is a potential conflict
Non-Executive Member	Ilona	Blue	General Dental Council	Lay Council Member	Declarations of Interest – Other	Non-Financial Professional	Direct	I do not anticipate any direct conflicts of interest as I do not expect the ICB or its audit committee to engage in direct discussions/decisions related to individual dental professionals; or dental education establishments. My role in GDC does not involve any direct decisions about individual professionals as these are handled through independent hearing panels.
Non-Executive Member	Ilona	Blue	Accent Housing Group Limited	Non-executive director	Declarations of Interest – Other	Non-Financial Professional	Direct	I don't anticipate any direct conflicts, but should any discussions arise relating to housing in Frimley I would flag my interest and if necessary recuse myself from any discussions/decisions.
Non-Executive Member	Ilona	Blue	NB Solutions	I am a director (I own 25% and my husband Robert Nichols owns 75%) of NB Solutions. My husband is the sole employee.	Declarations of Interest – Other	Financial	Direct	I do not anticipate any conflicts of interest. NB Solutions' clients could sell into the NHS but my husband would not be directly involved in such commercial arrangements and I do not expect the ICB to be directly engaged with third party suppliers to provider organisations in the patch. My lack of direct involvement in any such commercial arrangements mitigates the risk of conflict.
Non-Executive Member	Ilona	Blue	Defence Equipment and Support, an arms' length body of the MoD	Non-executive member of the Audit and Risk Assurance Committee	Declarations of Interest – Other	Non-Financial Professional	Direct	No conflicts anticipated.
Non-Executive Member	Ilona	Blue	Active Travel England, an executive agency of the Department for Transport	I am a non-executive director and Audit Chair	Declarations of Interest – Other	Non-Financial Professional	Direct	No conflicts anticipated
Non-Executive Member	Ilona	Blue	DOHL, a public corporation of the Department	Interim non-executive director and Audit Chair.	Declarations of	Non-Financial	Direct	No conflicts anticipated
Director for Partnerships and	Emma	Boswell	Registered with a GP practice within the Frimley	Registered with a GP practice within the Frimley CCG boundary	Declarations of	Indirect	Indirect	Declared as potential conflict and will note in relevant conversations
Chief Transformation & Digital Officer	Samuel	Burrows	Eightway Solutions Ltd	My spouse is the owner and operator of the company Eightway Solutions Ltd.	Declarations of Interest – Other	Indirect	Indirect	Sought advice from the Governance team and communicated to Line Manager. Will ensure that if this conflict of interest has the potential to become direct this will be immediately disclosed in order to identify further mitigations.
Chief Finance Officer	Richard	Chapman			Nil Declaration			
Chief People Officer	Caroline	Corrigan			Nil Declaration			
NHS Provider Partner Member from Frimley Health FT	Neil	Dardis	Frimley Health NHS Foundation Trust	I am the CEO and full time employee of Frimley Health NHS Foundation Trust	Declarations of Interest – Other	Non-Financial Professional	Direct	Full declaration - will declare interests on specific ICB business if and when needed in line with COI policy.
Chief Executive	Fiona	Edwards	Care Quality Commission	Executive Reviewer	Declarations of	Non-Financial	Indirect	Only review services in distant geographical areas
Chief Executive	Fiona	Edwards	NHS Confederation	Board Trustee	Declarations of	Non-Financial	Indirect	Will be managed in accordance with policy.
Local Authority Partner Member from Rushmoor Borough Council	Karen	Edwards	Land and Property owned or leased by Rushmoor Borough Council	As an Executive Director of Rushmoor Borough Council there will be occasions when land and property form which the Council would	Declarations of Interest – Other	Indirect	Indirect	Will not participate in any decision which would result in a financial gain or loss where the NHS would become a tenant of the local authority.
Local Authority Partner Member from Rushmoor Borough Council	Karen	Edwards	Land and property from which Rushmoor Borough Council as my employer would receive an income or profit may be under discussion	As an Executive Director of Rushmoor Borough Council with the responsibility for land and property there will be occasions when land and property from which the Council would receive an income or profit may be under discussion.	Declarations of Interest – Other	Non-Financial Professional	Direct	In the event that a land or property transaction comes forward to the benefit of the Council and it is a decision of the Board then I would ensure that proposals were submitted by another officer of the Council and I would not take part in any decision making unless clarifications were helpful and requested.
Non-Executive Member	Paul	Farmer	Frimley ICS	My son works for the Public Affairs agency PLMR. On occasion, he	Declarations of	Indirect	Indirect	
Non-Executive Member	Paul	Farmer	Age UK	I am employed by Age UK as Chief Executive. Age UK is a charity which works with older people. It is federated with independent local	Declarations of Interest – Other	Financial	Indirect	If contracts related to Age UK are discussed, I will recuse myself from discussions.
NHS Provider Partner Member	Alex	Gild	Berkshire Healthcare NHS Foundation Trust	I am Deputy Chief Executive and voting Board member of Berkshire	Declarations of	Non-Financial	Direct	Will declare interests on specific ICB business if and when needed.
Chief Medical Officer	Lalitha	Iyer	Women's Scan Clinic	Director of private scanning company (company listed as Polar	Declarations of	Financial	Direct	Will declare COI and leave meetings if any relevant discussions take place
Chief Medical Officer	Lalitha	Iyer	Farnham Road GP Practice	GP Partner at the surgery	Declarations of	Financial	Direct	Will declare COI and will leave meetings if any relevant discussions take place
Chief Medical Officer	Lalitha	Iyer	Farnham Road GP Practice	The practice is a Provider of care home services. 'Farnham Road Medical Group' has a contract to provide enhanced clinical services to	Declarations of Interest – Other	Financial	Direct	Will declare COI and will leave meetings if any relevant discussions take place
Chief Medical Officer	Lalitha	Iyer	Farnham Road GP Practice	Farnham Road Practice rents space to a community pharmacy, no	Declarations of	Financial	Direct	Will declare COI and will leave meetings if any relevant discussions take place
Chief Medical Officer	Lalitha	Iyer	Globe Management Consultants	I am the Secretary of the company which is pwned by my spouse. I	Declarations of	Non-Financial	Indirect	This company has no dealings with the Health Sector/NHS/CCG
Chief Medical Officer	Lalitha	Iyer	Magna Konserv	I am a Director of this company and have no financial interest or	Declarations of	Non-Financial	Indirect	This company has no dealings with the Health Sector/NHS/CCG
Chief Medical Officer	Lalitha	Iyer	Solutions for Health	I am a Medical Advisor on the Board if Solutions for Health	Declarations of	Non-Financial	Direct	I will declare COI and will leave meetings if any relevant discussions take place
Equality Diversity and Inclusion	Safina	Nadeem	Purple Infusion Ltd	Director of a limited company which provides training to health and	Declarations of	Financial	Indirect	Do no provide any training via company to Frimley ICS
Equality Diversity and Inclusion	Safina	Nadeem	BHA	Trustee for a Charity	Declarations of	Indirect	Indirect	
Primary Care Partner Member	Prash	Patel	Magnolia House	I am a profit sharing GP Partner	Declarations of	Financial	Direct	
Primary Care Partner Member	Prash	Patel	Frimley Health Foundation Trust	I am an employee of the FHFT	Declarations of	Non-Financial	Direct	
Primary Care Partner Member	Prash	Patel	Berkshire Primary Care Ltd	I am the CEO and Medical Director	Declarations of	Financial	Direct	
Primary Care Partner Member	Prash	Patel	Ascot Primary Care Network	I am the Clinical Director of the Primary Care Network under the PCN	Declarations of	Financial	Direct	
Bracknell Forest Council	Grainne	Siggins	Association of Directors of Social Services	Member of ADASS.	Declarations of	Non-Financial	Direct	Declaration was needed, however, membership of ADASS does not present as a risk.
Bracknell Forest Council	Grainne	Siggins	Bracknell Forest Council	Employed as Executive Director of People Services	Declarations of	Financial	Direct	
Bracknell Forest Council	Grainne	Siggins	Association of Directors of Children Services	Member of ADCS	Declarations of	Non-Financial	Indirect	
Frimley ICB Chair	Priya	Singh	Guy's and St Thomas's NHS Foundation Trust	Appointed November 2015 - NED / Deputy Chair	Outside			
Frimley ICB Chair	Priya	Singh	National Council for Voluntary Organisations	Appointed November 2020 - Chair of Board of Trustees	Outside			
Frimley ICB Chair	Priya	Singh	Society for Assistance of Medical Families	Appointed January 2018 - Executive Director	Outside			
Frimley ICB Chair	Priya	Singh	PG Mutual Insurance	Non-Executive Director	Declarations of	Financial	Indirect	Manage in accordance with COI policy.
Clinical Lead Royal Borough of	Huw	Thomas	Claremont and Holyport practice	Partner in the practice	Declarations of	Financial	Direct	Will be managed in accordance with policy
Clinical Lead Royal Borough of	Huw	Thomas	Maidenhead Primary Care Network	Practice is a member of Maidenhead PCN	Declarations of	Financial	Direct	Will be managed in accordance with policy
Clinical Lead Royal Borough of	Huw	Thomas	Frimley Health NHS Foundation Trust	Spouse employed by Trust as Clinical Nurse Specialist	Declarations of	Indirect	Indirect	Will be managed in accordance with policy
Clinical Lead Royal Borough of	Huw	Thomas	East Berkshire Primary Care	Work on sessional basis for East Berkshire Primary Care. EBPC provide	Declarations of	Financial	Direct	Will be managed in accordance with policy
Clinical Lead Royal Borough of	Huw	Thomas	Holy Trinity Primary School, Cookham	Governor at school	Declarations of	Indirect	Indirect	Will be managed in accordance with policy
Clinical Lead Royal Borough of	Huw	Thomas	Royal Borough of WIndsor and Maidenhead	Practice subcontracted to provide opiate substitute prescribing	Declarations of	Financial	Direct	Manage in accordance with policy

Local Authority Partner Member	Rachael	Wardell	Surrey County Council	Executive Director of Children, Families and Lifelong Learning since 07-	Declarations of	Non-Financial	Direct	Will be managed in accordance with the Conflicts of Interest policy.
Local Authority Partner Member	Rachael	Wardell	Become - The Charity for Children in Care and	Trustee and Board Member since September 2019	Declarations of	Non-Financial	Direct	Will be managed in accordance with the Conflicts of Interest policy.
Local Authority Partner Member	Rachael	Wardell	Association of Directors of Children's Services	Member of Professional Association since October 2009 and Chair of	Declarations of	Non-Financial	Direct	Will be managed in accordance with the Conflicts of Interest policy.
NHS Provider Partner Member	Graham	Wareham	Friends of Chambo Seminary	Trustee	Declarations of	Non-Financial	Indirect	No conflict anticipated
NHS Provider Partner Member	Graham	Wareham	Surrey and Borders Partnership NHS FT	Employed as CEO	Declarations of	Non-Financial	Direct	Will excuse if conflict of interest occurs

NHS
Frimley
Integrated Care Board

Minutes of NHS Frimley Integrated Care Board
Held in Public on Tuesday 16 January 2024 from 11.30-12.30
Via Zoom

Chair – Priya Singh

Present:	
Dr Priya Singh	Chair
Fiona Edwards	Chief Executive
Sarah Bellars	Chief Nursing Officer
Richard Chapman	Chief Finance Officer
Caroline Corrigan	Chief People Officer
Dr Lalitha Iyer	Chief Medical Officer
Ilona Blue	Non-Executive Member
Paul Farmer	Non-Executive Member
Dr Prash Patel	Primary Care Partner Member
Dr Huw Thomas	Primary Care Partner Member
Karen Edwards	Local Authority Partner Member
Grainne Siggins	Local Authority Partner Member
Rachael Wardell	Local Authority Partner Member
Neil Dardis	NHS Provider Partner Member
Alex Gild	NHS Provider Partner Member
Graham Wareham	NHS Provider Partner Member
In Attendance:	
Safina Nadeem	Equality, Diversity and Inclusion System Lead
Olly Hemans	Communications and Engagement Manager
Mary-Jane Steijger	Head of Governance
Sam Branscombe	Governance and Committee Support Officer
Tom Allinson	Governnace Manager (secretariat)
Apologies for Absence:	
Sam Burrows	Chief Transformation & Digital Officer
Emma Boswell	Director for Partnerships and Engagement

1.	**Welcome and Apologies for Absence**
	The Chair opened the meeting and welcomed members of the NHS Frimley Integrated Care Board. The meeting was noted to be quorate. Apologies were received as recorded above. Members agreed for the meeting to be recorded. The recording would then be uploaded to the public website along with the meeting papers. Seven members of the public had signed up to attend the meeting. No questions had been received in advance of the meeting.

	Members of the ICB Board's Mirror Board were in attendance.
2.	**Declaration of Conflicts of Interest**
	Members noted the Conflicts of Interest register, and there were no specific declarations made for the contents of the meeting's agenda.
3.	**Minutes of the last meeting in Public held on 21 November 2023, Action Tracker, and matters arising**
	The minutes of the last meeting in public were taken as accurate and approved without further comment. There were no matters arising.
4.	**ICB Chief Executive's Update**
	Fiona Edwards, Chief Executive, gave the verbal update, wishing all present a happy new year and reflecting on the work and challenges being faced across the system. Partnership and collaborative working remained a core theme and vehicle for the Frimley system, as demonstrated by the leadership, culture, and investment into the ICP assembly which had last met in December, and the development of a Mirror Board which represented both an innovation and a progression on Frimley's commitment to creating opportunities and an inclusive environment underpinned by its core values. Acute demand had been high over the winter period to date, and the Chief Executive thanked all staff working to meet the challenge and increase capacity while moving people out of acute care more rapidly. The demand was being driven by usual winter pressures, increase year-on-year, and industrial action. Neil Dardis, the Chief Executive for Frimley Health Foundation Trust, would give an update under item 6 on the agenda. The NHS was also reviewing how it would meet its financial duties going forwards, with the ICB going through a significant restructure and reorganisation. The significant financial challenge was being felt beyond the NHS, and was affecting all System partners, including local authorities. *The Board noted the update.*
5.	**Strategy and Planning**
5.1	**Quality Presentation** Sarah Bellars, Chief Nursing Officer, presented the update on system quality, outlining the following key areas for members of the Board and public present to note: <u>Financial recovery</u> • In November the ICB took extraordinary actions to review the commissioning landscape to pause or to stop programmes which were initially designed to improve access, outcomes and patient flow during the winter period. The quality team were reviewing financial initiatives and providing key assurance and perspective on potential impact on services and planning. • The System Quality Group were confident that any decisions made would not materially contribute to direct harm or patient experience measures but recognised there would be a natural consequence to access, patient outcomes and non-elective flow through the health and care delivery system as a result.

- However, the Group also acknowledge that some of the financial pauses to some services such as mental health could be paused until the end of March but would have a detrimental/negative impact if the financial pause continued into the new financial year.

Quality Hotspot - CAMHS

- Transfer of North East Hampshire Children & Adolescent Mental Health Services (CAMHS) from Sussex Partnership NHS Foundation Trust (SPFT) to Surrey and Borders Partnership NHS Foundation Trust (SABP) by 1st February 2024.
- A due diligence process was completed on the SPFT services to establish the viability of the transfer in principle. Following this, an Executive oversight group was set up, into which reports a weekly Operational Delivery Group, comprising membership from SABP, SPFT, and Frimley ICB. The Operational Delivery Group oversees progress by delegated leads in the following key areas: Communications, Digital, Workforce, Finance, Estates, Contracts, and Clinical Pathways. There was a focus on quality impact across all of these domains.
- The Operational Delivery Group continued to meet weekly, ensuring that any risks to a safe transfer and continuity of service within the agreed financial envelope were documented, escalated, and either resolved or satisfactorily mitigated. The group ensures that all risks are logged, managed and subject to executive oversight. The main areas of focus currently are on transfer of clinical records and migration to SABP electronic clinical systems, workforce TUPE and interim cover, recruitment, estates, and commitments against the service specification. The group was also ensuring timely communications to staff and service users.
- A number of transfer risks had been outlined and mapped.

Quality and Urgent and Emergency Care:

- Maintaining safety in urgent and emergency care, particularly during periods of intense demand, was of paramount importance.
- The Frimley ICB Chief Nursing Directorate was working with the Urgent and Emergency Care Programme Board to develop an evidence-based risk-based tool aligned with the OPEL framework.
- This would support in managing clinical risk during periods of escalating demand, in ensuring that the fundamentals of care are in place to support those within the Emergency Department, alongside assessment of systemic risk associated with Urgent and Emergency Care.

CQC outcomes:

- In May 2023, the maternity services at both Frimley Park Hospital and Wexham Park Hospital were inspected by the Care Quality Commission (CQC) as part of the national maternity services inspection programme.
- The report from CQC was published in September, with both sites rating as overall good. However, with in the safe domain of the inspection, this required improvement on both sites. This related to compliance of training at Frimley Park Hospital and the improvement of staffing levels at Wexham Park Hospital.

The Chair thanked all involved and the System Quality Group for its cross-system engagement and leadership.

The Board noted the update.

5.2 **Provider Selection Regime**

Richard Chapman, Chief Finance Officer, gave the update on the Provider Selection Regime (PSR), which came into effect on 1 January 2024, and which set out new rules for procuring health care services in England for NHSE organisations as well as local authorities.

The paper recommended a procurement approach compliant with the PSR, where the ICB's System Resourcing Group, reporting into the Finance and Performance Committee, would hold delegated responsibility for contracts up to and including £1M per annum. Contracts over £1M per annum would be held directly by the Finance and Performance Committee which included key partner members in its membership.

The ICB had reviewed its procurement approach, and a revised Procurement Policy would be shared with the Board for approval on 20 February 2024. Provider organisations within the system had also been reviewing their processes.

The Board was asked to note the changes in the legal framework for sourcing service providers and the intention to bring a revised Procurement Policy to the February Board meeting.

The Board noted the update.

5.3 **Board Assurance Framework**

Richard Chapman presented the Board Assurance Framework (BAF), which set out the principal risks to the achievement of the ICB's strategic objectives. In so doing, the BAF also served as a primary source of evidence in describing how the ICB was discharging its responsibility for internal control. The BAF further set out the controls in place to manage these risks and the assurances available to support judgements as to whether the controls were having the desired impact. It additionally described the actions to further reduce each risk.

The was is asked to note that three of the four Strategic Objectives continued to remain outside the Risk Appetite and Risk Thresholds previously agreed:

	November 2023	January 2024
Quality	12 Out of risk appetite	12 Out of risk appetite
People	16 Out of appetite	16 Out of appetite
Transformation	16 Within risk appetite	16 Within risk appetite
Financial	16 Out of risk appetite	16 Out of risk appetite

The Board was also asked to note that the principle risk for Hosted POD which sat within the Delivering Work and Transformation Strategic Objective - had been further mitigated from its previous score of 16 and now has a risk score of 6.

The Chief Finance Officer confirmed that the additional controls and mitigations outlined would be reviewed once planning guidance and had been finalised to provide a better picture on their effectiveness.

The Board noted the paper.

6.	**Frimley ICB Integrated Performance Report**
	Richard Chapman and Caroline Corrigan presented the executive summary of the Frimley ICB Integrated Performance Report, highlighting the following key information: • The system deficit at month 8 was given to be £10.6M, constituting an £8.1m adverse variance according to plan. The system was still forecasting to breakeven at year end, but this was reliant on high-risk mitigations. • Performance had been affected by industrial action. The system was responding with additional capacity in primary care and using virtual wards, remote monitoring, and strong community support to alleviate pressure on acute services. • Frimley Health Foundation Trust (FHFT) continued to make significant strides in reducing agency spending on temporary stafing as a percentage of pay, which had decreased to 3.9% in M5 (from 6.7% in M1, 6.7% in M2, 5.6% in M3, and 5.2% in M4). Neil Dardis, FHFT Chief Executive, noted that demand was being compounded by industrial action which was leading to excessive waits at A&E, and apologised to members of the community who had as a result had to wait longer than expected. Much work was going into mitigating the strain and alleviating pressure, as had been outlined elsewhere in the report. The Chief Executive encouraged members of the public to come to A&E in the event of life threatening or urgent needs but to also be aware of the other avenues of care available to them. Lalitha Iyer, Chief Medical Officer, informed the Board and public present that remote monitoring was being embedded positively across all of the ICB's five places. More than 7,000 patients were currently under remote monitoring, which was specifically being offered to patients at high risk within the community. Early deterioration was being picked up, allowing primary care teams to involve themselves early and minimise the risk of hospital admission. Fiona Edwards, Chief Executive for the ICB, outlined that pressures and financial constraints need to be considered together. Pushing forward in one area of the system could create problems elsewhere. UEC Centres and additional beds would need to be considered as part of wider planning discussions in order to successfully mitigate risk. *The Board noted the paper.*
7.	**Questions received in advance from members of the Public**
	None.
8.	**Any Other Business**
	None.
9.	**Close**
	The Chair closed the meeting at 12.30. The date of the next meeting in public was confirmed to be 19 March 2024.

NHS
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Integrated Care Board

FRIMLEY INTEGRATED CARE BOARD

Title of Paper	CORE20PLUS5 - An approach to reducing health inequalities in the Frimley ICS		
Agenda Item	5.1	**Date of meeting**	19 March 2024
Exec Lead	Lalitha Iyer and Sam Burrows		

Purpose	To Approve	☐
	To Ratify	☐
	To Discuss	☒
	To Note	☐

Link to Strategic Objective	Increase healthy life expectancy and reduce health Inequalities.

Executive Summary
Tackling health inequalities are at the heart of our ICS strategy and CORE20PLUS5, covers key aspects and different lenses on health inequalities. Our system strategy – Creating Healthier Communities – has been our primary vehicle for progressing local initiatives which target variation in outcomes for communities or whole-system populations who receive a disparity of health outcome. There is significant overlap between our local approach and the National Programme and the 5 focus areas of the national programme strongly replicate the projects which have been adopted into our ICS strategic ambitions. We will continue to pursue the implementation of our strategic ambitions to ensure that we are meeting both the locally identified needs of our population and contribute to the asks which are made of all ICSs to the CORE20PLUS5 National Programme. CORE20 is based on Index of Multiple Deprivation, and in our ICS, we have opted to focus on deciles 1-4, which accounts for 20% of our ICS population rather than deciles 1-2. This is because our system is less deprived than other parts of the country. There are certain communities who experience particularly pronounced health inequalities and for each 'Plus' group we are ensuring that the gap in unmet need is identified and there is action we can take, that is measurable, to improve their outcomes. The '5' – the five key clinical areas prioritised in the NHS LTP (Maternity, SMI, Chronic Respiratory Disease, Early Cancer Diagnosis, Hypertension Case Finding) requiring accelerated improvement, with the addition of smoking cessation as a thread running through the 5 areas. Stopping smoking has a positive impact in all five clinical areas of focus. Based on the data, insights, and evidence we have gathered from the system partners, the proposed 'PLUS' groups at the system level include Carers and Learning Disabilities for adults, and Children with Learning Disabilities, Young Carers, Children in Care, and Care Leavers for CYP. In addition, race and ethnicity will be a thread running through all 5 clinical areas, CORE20 populations and Plus groups. We aim to work iteratively with Plus groups, where the focus may change over time but in a structured way.

Recommendation	• Adopt the 'plus' populations proposed in this paper for routine consideration and action across the ICS to reduce inequalities in outcomes, access, and experience • CORE20PLUS5 through a race / ethnicity lens to address ethnic inequalities • Set up a system oversight group / Community of improvement to progress delivery, peer support and share learning, best practice and challenges

Please provide details on the impact of following aspects	
Risk and Assurance	Health inequalities represent one of the most profound risks for the various populations we serve.

Equality and Quality Impact Assessment	We are working with a wide range of partners to develop insights from our data to inform our work programmes on health inequalities. Targeting those who have the greatest need and the poorest health and wellbeing outcomes, so that our residents are able to access our services equitably, will improve quality of care.
Patient and Stakeholder Engagement	Community insight and codesign are important, to really test out what works in the ICS. To make a difference on health inequalities, those communities who are most affected need to be central to everything we do. They play a vital role, and we must put communities at the heart of service design and delivery, moving beyond traditional sector silos, focussing on what matters most to them, so that work programmes can be focussed on the right outcomes.
Financial Impact and Legal implications	

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
ICB Senior Leadership Team Meeting	06/02/2024	Approved

CORE20PLUS5

An approach to reducing health inequalities in the Frimley ICS

Purpose of Document

To update the Senior Leadership Team and the Health and Wellbeing Boards in the Frimley ICS geography of Frimley's approach to Reducing Health Inequalities. We are committed to implementing the Core20PLUS5 methodology to help us achieve our ICS' primary strategic objective of reducing health inequalities. Within Frimley, tackling Health inequalities is not seen as a standalone programme, but a golden thread running throughout all our work programmes.

Strategic Context

Addressing health inequalities is the cornerstone of the **Frimley ICS long term strategy**. Our system strategy Creating Healthier Communities has been our primary vehicle for progressing local initiatives which target variation in outcomes for communities or whole-system populations who experience a disparity of health outcome. Our strategy will remain the core way in which we deliver the transformational effort required to achieve this change. An opportunity exists however to create additional rigour with the alignment to national and regional initiatives which will multiply what we are able to achieve through this approach. Health inequalities is not seen as a standalone programme, but a golden thread running throughout all of our work programmes. Our priority will be to ensure we target those who have the greatest need and the poorest health and wellbeing outcomes. The Joint Forward Plan and the NHSE 2023/24 priorities & planning guidance reconfirms the need for action on ambitions set out in the NHS Long Term Plan, continuing to ensure action taken addresses health inequalities and deliver on the CORE20PLUS5 approach.

Background and Policy Context

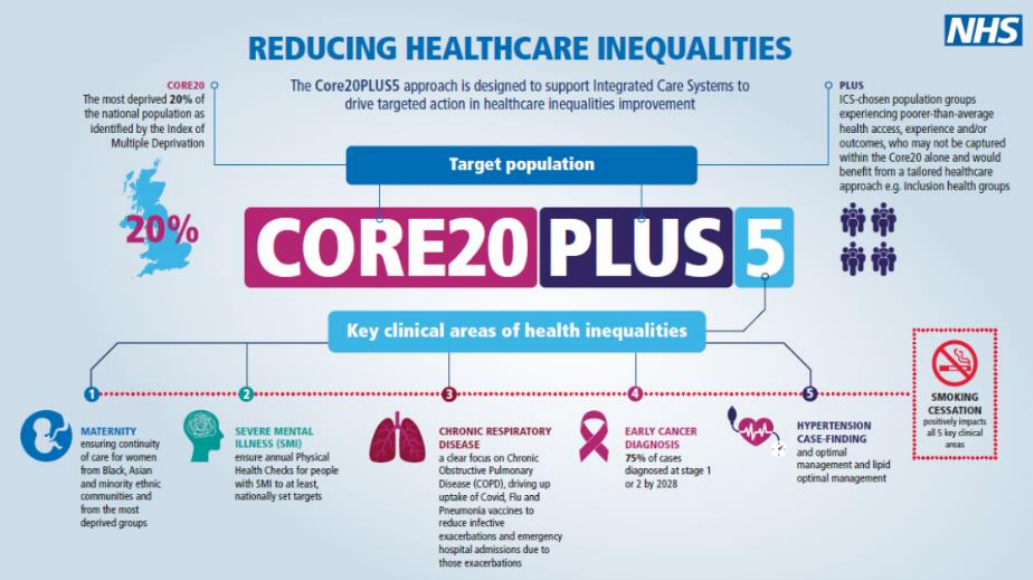
ICSs are expected to understand what their 'Core20PLUS' population is and identify their specific healthcare needs, in order to make informed decisions about how to ensure equitable access, excellent experience and optimal outcomes for these populations. There is strong strategic alignment between this approach and the Frimley ICS Strategic Objective of reducing health inequalities.

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. The approach focuses on 3 core components:

1. The **'Core20'** – a focus on the population in the lowest deprivation quintile, which is meant to pick up and take on the overarching impact of deprivation on access, experience, and outcomes. For our system, we have agreed with the national lead that this would be the 20% of our most deprived, which includes deciles 1-4.
2. The **'Plus'** – an additional focus on local inequalities. ICS chosen cohorts that experience worse than average health experiences, outcomes/and or access (e.g., ethnic minority communities or inclusion health groups) but not captured in the 'Core20' alone.
3. The **'5'** – the five key clinical areas prioritised in the NHS LTP (Maternity, SMI, Chronic Respiratory Disease, Early Cancer Diagnosis, Hypertension Case Finding) requiring accelerated improvement, with the addition of smoking cessation as a thread running

through the 5 areas. Stopping smoking has a positive impact in all the five clinical areas of focus.

CORE20PLUS5 (Adults) summary graphic:



Our Approach

There is significant overlap between our local approach and the National Programme and the 5 focus areas of the national programme strongly replicate the projects which have been adopted into our ICS strategic ambitions. We will continue to pursue the implementation of our strategic ambitions to ensure that we are meeting both the locally identified needs of our population and contribute to the asks which are made of all ICSs to the CORE20PLUS5 National Programme. We anticipate that new opportunities will emerge as the national programme continues to develop which we may want to adopt into our Frimley strategic ambitions. Further, we will ensure that our local initiatives are reported into the national programme team for completeness.

Using our system shared care record enables us to proactively manage patients and target interventions where we see the greatest inequalities. There is significant engagement and momentum around the CORE20PLUS5 strategic approach as a mechanism for reducing health inequalities. The strategy itself defines a CORE20PLUS target population, as well as 5 clinical priority areas (plus smoking cessation) within this population that we want to improve.

We are aiming to drive focused action, and using evaluation to evidence impact we are having, recognising that some of the full effects on health inequalities may take years to realise, but short-term outcomes can be measured to demonstrate impact.

CORE20 is based on Index of Multiple Deprivation, and in our ICS, we have opted **to focus on deciles 1-4,** which accounts for 20% of our ICS population rather than deciles 1-2. This is because our system is less deprived than other parts of the country. Slough has more complexity and residents in lower deciles of the deprivation index. It is therefore envisaged that the focus within Slough might be in 2 tiers with the initial focus being on the population in deciles 2 and below and the next phase be on decile 3 and 4 if required.

There are certain communities who experience particularly pronounced health inequalities and for each 'Plus' group we are ensuring that the gap in unmet need is identified and there is action we can take, that is measurable, to improve their outcomes. There are myriads of health inequalities across the population we serve, therefore a small group with wide representation from across the system, met in May 2023 convened by the ICB Chief Medical Officer, to review and prioritise 'Plus' groups that would improve health and wellbeing and reduce the health inequalities in our communities in an iterative way.

We considered population groups who may be experiencing poorer than average health access, experience and/or outcomes, but who may not be included within the CORE20 and whose needs must be explicitly recognised and met to reduce inequalities. Using both data and experience of our staff and patients to inform these groups. There were a wide range of suggestions, please see below:

Frimley ICS CORE20PLUS5 Approach – Identifying PLUS Groups

Bracknell	NEHF	RBWM	Slough	Surrey Heath	System Insights	East Berkshire PH Teams
Carers	Carers	Veterans	Communications – Language Barriers	Carers (young & adult)	Carers	Depression
Veterans	Veterans	Social Isolation	Asylum Seekers	Veterans	Left Military Service	LD
LD	SMI	Mental Health	Transient populations	LD	LD	Carers
Communications	Refugees and Asylum Seekers		Unregistered Population	Communication - Language Barriers	Requires support to communicate	Ethnic groups with higher risk of disease – All Black, All Asian, White other
Social Isolation	Nepali			Nepali	Social Isolation	People in inclusion group such as those in contact with the Criminal Justice System, people who are homeless; people experiencing or perpetrating Domestic Violence
SMI Homelessness	GRT			GRT	Homelessness	
Care leavers	Cost of living crisis				Refugee and Asylum Seekers	
Dementia					Released from prison	

Based on the data, insights, and evidence we have gathered from the system partners, the 2 'PLUS' groups we would like to propose at a system level are:

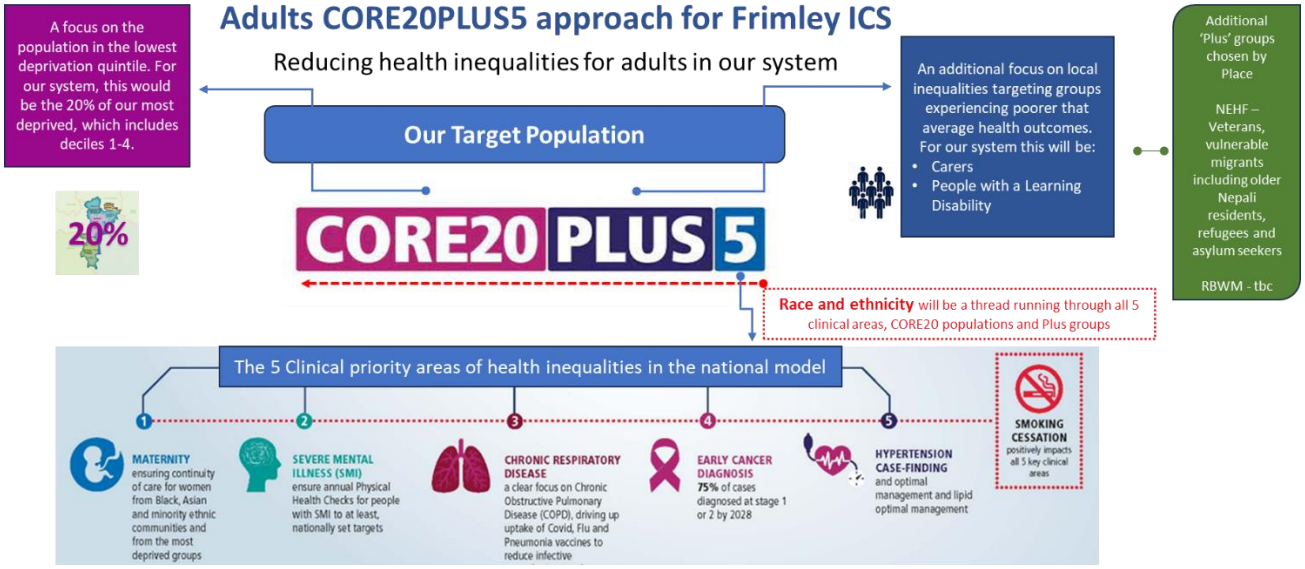
1. **Carers**
2. **Learning Disabilities**

In addition, **race and ethnicity will be a thread running through all 5 clinical areas, CORE20 populations and Plus groups**. Addressing race and ethnicity disparities is fundamental to promoting equity and crucial for reducing healthcare inequalities. Continuing research and evidence, including that from the NHS Race health Observatory, shows disparities in healthcare outcomes and access persist among different racial and ethnic groups. Given the demographics of our population, having race as a running theme will help us address the long term and persistent inequalities faced by our Black and Minority ethnic communities and we can make significant strides in reducing healthcare inequalities and improving health outcomes for all.

Carers and Learning Disabilities will be our 2 Plus groups, for the whole system, working collaboratively with our places and partners to enable meaningful improvement with a view to review in 6 months. The work in other population groups will inevitably continue across system and place in supporting our vulnerable population groups.

Currently it was felt that these 2 groups would benefit most from a further tailored approach to meet their needs. It is envisaged that once this work becomes BAU, other groups may come into focus in an iterative manner. Places and workstreams may wish to focus on other groups in addition and we are committed to evaluating the impact on multiple cohorts as required. Central to this approach will be the ongoing evolution of our collection and analysis of data and intelligence. We will strengthen the 'golden thread' on inequalities throughout all our work.

Proposed CORE20PLUS5 (Adults) Frimley ICS summary graphic:



The rationale for highlighting these 2 plus groups are as follows:

Carers

Unpaid carers play a vital part in ensuring that individuals in need of care continue to experience a good quality of life. It is estimated that 3 in 5 adults in the UK will become an unpaid carer at some point in their lives, and that more individuals will experience giving more than one caring episode. Carers also contribute substantial economic value to society as a whole and it is estimated that carers save the economy £132 billion per year (New Approaches to Supporting Carers Health and Well-Being: evidence from the National Carer's Strategy Demonstrator Sites Programme) Providing unpaid care is nevertheless profoundly challenging and it is often physically and emotionally demanding, with consequences for the carer's own health and wellbeing, and it's crucial that all is done to ensure carers are supported. Carers are more than twice as likely to suffer from poor health compared to people without caring responsibilities, with nearly 21% of carers providing over 50 hours of care, in poor health compared to nearly 11% of the non-carer population (In Poor Health: the impact of caring on health).

There is growing evidence pointing to the adverse impact on the health, future employment opportunities and social and leisure activities of those providing unpaid care, particularly in young carers (Providing unpaid care may have an adverse affect on young carers' general health). Carers attribute their health risk to a lack of support, and 70% of carers come into contact with health professionals, yet health professionals only identify 1 in 10 carers with GPs, more specifically, only identifying 7% (Macmillan Briefing on Carers Issues). Around 66% of carers feel that healthcare staff don't help to signpost them to relevant information or support, and when information is given, it comes from charities and support groups (Commitment for Carers: Report of the findings and outcomes).

There is an increasing prevalence of 'sandwich carers' those looking after young children at the same time as caring for older parents. It can also be used much more broadly to describe a variety of multiple caring responsibilities for people in different generations (Sandwich generation concern is growing). Many young carers remain hidden from sight for a host of reasons, including family loyalty,

stigma, bullying, not knowing where to go for support. Carers may be as young as five years old (Hidden from view: the experience of young carers in England).

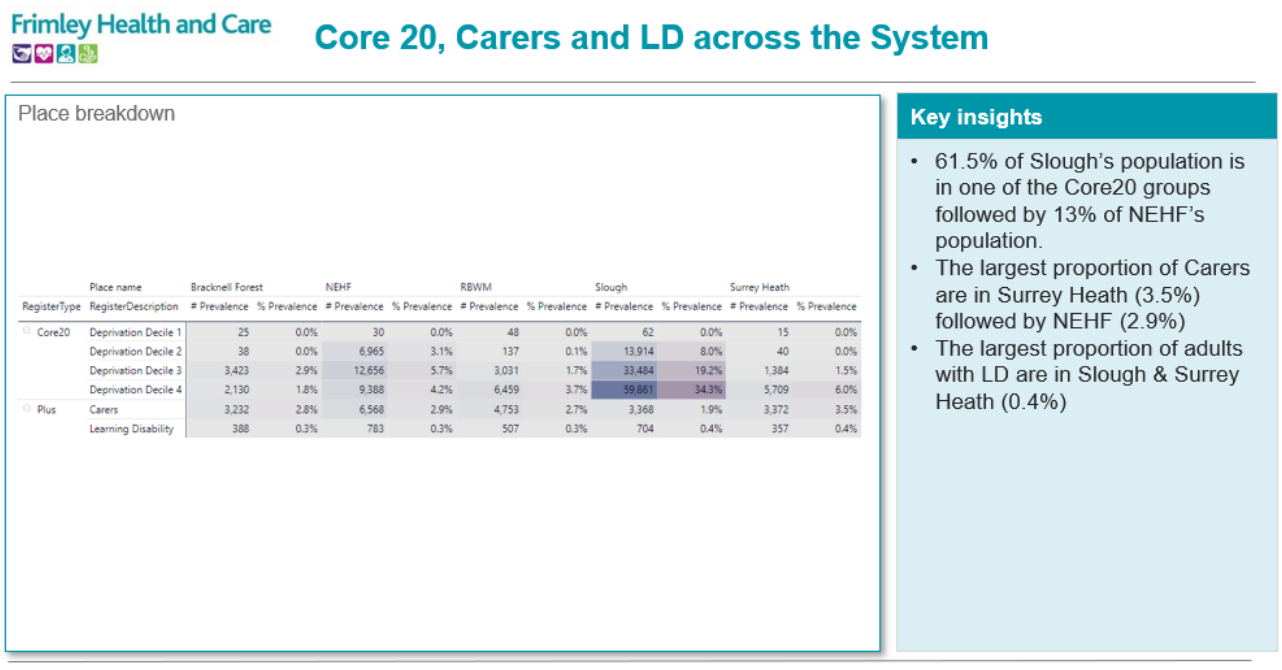
It is estimated from the 2021 Census that in the region of 9% of the population are carers which equates to 76k in Frimley ICS area. It should be noted that the figures represent those individuals who self-identify as carers. Carers UK estimates that the likely figure for carers in the UK is more than double the Census figures which means that in the region of 152k of people in our system are unpaid carers. Carers UK research confirms people do not self-identify until they have been caring for 4 years or more. In addition, we know that amongst our Black, Asian and minority ethnic communities caring is just done, not recognised as needing additional support and often not discussed or considered relevant to their communities.

Learning Disability (LD)

Around 950,000 adults and 300,000 children in England have a LD. People with a LD have worse physical and mental health than people without a LD and are more likely to experience several health conditions. Those with LD have additional healthcare needs beyond that of other inclusion health groups, not least difficulties with communication, leading to suboptimal access, experience, and outcomes.

Compared with the wider population, the average age at death for people with a learning disability is 23 years younger for men, and 27 years younger for women (Learning Disabilities Mortality Review, 2019). Good access to primary care and annual health checks are key in tackling these disparities. Research has shown that, compared with the general population, people with a learning disability were 3 to 4 times as likely to die from an avoidable medical cause of death. Most of the avoidable deaths in people with a learning disability were because timely and effective treatment was not given. The introduction of the Oliver McGowan Mandatory Training to ensure staff working in our system receive LD and autism training is a timely initiative and will raise awareness for those with LD and ensure those with hidden disabilities are given good quality care and get the best support they need.

Data from Connected Care (January 2024) which shows the size of the issue:



	Place name	Bracknell Forest		NEHF		RBWM		Slough		Surrey Heath	
RegisterType	RegisterDescription	# Prevalence	% Prevalence	# Prevalence	% Prevalence	# Prevalence	% Prevalence	# Prevalence	% Prevalence	# Prevalence	% Prevalence
Core20	Deprivation Decile 1	25	0.0%	30	0.0%	48	0.0%	62	0.0%	15	0.0%
	Deprivation Decile 2	38	0.0%	6,965	3.1%	137	0.1%	13,914	8.0%	40	0.0%
	Deprivation Decile 3	3,423	2.9%	12,656	5.7%	3,031	1.7%	33,484	19.2%	1,384	1.5%
	Deprivation Decile 4	2,130	1.8%	9,388	4.2%	6,459	3.7%	59,861	34.3%	5,709	6.0%
Plus	Carers	3,232	2.8%	6,568	2.9%	4,753	2.7%	3,368	1.9%	3,372	3.5%
	Learning Disability	388	0.3%	783	0.3%	507	0.3%	704	0.4%	357	0.4%

It is critical to tackle inequalities within childhood and adolescence in order to prevent disparities later in life, and it's key that the Adults CORE20PLUS5 approach link with the 'Core20PLUS5' model that is specific to children and young people.

It is key that the **5 clinical workstreams** implement work for the plus groups. A lot of the delivery of this approach will be picked up by secondary care so it's vital that they are engaging and contributing to this approach, to improve outcomes in clinical services. We also need to look at how LA services and functions can level up outcomes in the key clinical areas too. This approach will also need to be a standing agenda item on core services/clinical workstreams and Carers and LD groups.

This process is all about learning by doing, and it is important that we extract the learning from this experience of focusing on health and inequalities. Therefore, we need to put a process in place that allows us to come together and share our experiences, which could be through regular learning sets. Through this process we may come across 'wicked problems' and it's vital that we keep a record and learn how to improve the lives of our residents.

It is only by working together, that we can close the health inequality gap and ensure Frimley ICS has: healthier people, communities and healthier futures. We must all ensure we don't inadvertently widen local health inequalities, and that all communities including those who are seldom heard benefit from the activity undertaken.

Governance

- New ICS Strategy adopted in March 2023 which sets a clear frame through the ICP for our shared partner commitment
- All organisations have a responsibility to progress the six strategic ambitions
- Each ambition will work with colleagues across all partners including primary care
- to deliver improvement
- At system level; reporting on, and governance of actions will be through ICB Board and the ICP
- Establish a collaborative working group / community of practice dedicated to synergising the various facets of CORE20PLUS5. This includes bringing together CORE20PLUS5 Ambassadors, Finance Fellows, and Connectors in a shared space for constructive discussions, enabling the exchange of best practices and learnings. We will include key partners, such as Public Health, to amplify the impact of our initiatives.
- At place it will be through the Place Committees and the Health and Wellbeing Boards and Directors of Public Health, as this will be a component of broader work on Health Inequalities

Financial Sustainability

There are large cost savings and health benefits to our system by preventing ill-health and disability, which reduces the need for people to access health and social care. Early detection is likely to produce the greatest benefits and better prognosis for individuals than those diagnosed later, which is likely to cost the system more in treatment as well as serious complications arising that would require more expensive treatments and impact the patient's quality of life.

Inequalities in health can drive demand for health and care services, many of which are funded by the state and sometimes also creating an additional financial burden on individuals. Avoidable

differences between population groups can impact the prevalence of conditions, the willingness of people to seek treatment prior to crisis and the ability to seek or maintain employment. At a time of significant financial pressures on the public finances, a cost of living crisis for individuals and anaemic growth for the UK economy, efforts should be made to address the avoidable factors that contribute to ill health.

There is clear evidence for improving equity and that reducing health inequalities can contribute to an improved financial position. The cost of doing nothing is far more severe and will contribute to higher healthcare costs in the longer term. We know that people from our most deprived communities have a lower life expectancy and exhibit the highest healthcare costs. There is no set rule for what counts as value in a ROI assessment, but financial savings may include time savings (that can be translated into increased revenue) or reductions in appointments, diagnostics, and admissions. Delivering on the CORE20PLUS5 approach is are expected to lead to more improved, equitable, effective, and integrated services that provide needs-led flexible services, and has the potential to reduce length of stay, readmissions, and potentially reduced overall longer-term health and care costs for the system.

Michael Marmot's work that calculated the treatment costs of health inequalities to be in the region of £5.5bn a year. Productivity losses in the economy due to health inequalities amount to £33bn, while a further £32bn a year is spent on higher welfare payments. (Healthy Lives: The Marmot Review). In 2021, the British Red Cross estimated that high intensity usage of A&E, closely associated with health inequalities, cost the NHS £2.5 billion per year. If we optimally manage people's health, we will reduce the incidence of disease and the associated cost of that, to health and social care system of any disability incurred.

Frimley Connected Care data has demonstrated that the rate of admission to hospital is twice as high for residents in the CORE20 population cohort. Given this is one of our most expensive points of delivery within the health and care system, it can be roughly approximated that we are spending twice as much per head of population on residents in the CORE20 cohort. Addressing health inequalities is therefore vital for the future sustainability of our health and care system. All of our teams, including finance officers, have a key role to play as an enabler for this and be part of driving the change that is needed.

The CORE20PLUS5 approach will help us reach our financial sustainability goals because it has the potential to save a significant amount of money in avoidable treatment costs. A significant number of hospital admissions could be avoided if people received help earlier on, before small health challenges turn into crises requiring urgent clinical support. Focussing on prevention is necessary to help reduce the long-term cost of treatment, to slow the growth in demands on our system, making it sustainable for future generations.

Driving Equity: The 'so what'

We aim to deliver Exceptional Healthcare: Equitable Access, Outstanding Experience, and Optimal Outcomes for All. By focusing on health disparities and targeting specific population groups, the ICS aims to improve health outcomes for communities facing significant challenges. The strategy aligns with the national agenda while tailoring initiatives to local needs, as evidenced by the selection of specific deprivation deciles and prioritised clinical areas. Moreover, the inclusion of "Plus" groups such as Carers, Learning Disabilities ensures a comprehensive approach that addresses the diverse needs of the population. The emphasis on iterative, structured approaches reflects a commitment to ongoing improvement and responsiveness to evolving circumstances. Ultimately, the goal is to bridge

gaps in unmet needs and drive measurable improvements in health outcomes for all segments of the population, thereby contributing to the broader objectives of the ICS and CORE20PLUS5 approach.

The overarching goals of our interventions are as follows based on the 5 national clinical priority areas in the CORE20PLUS5 programme:

1. Prioritising continuity of care for women from Black, Asian, and minority ethnic communities as well as those from the most deprived backgrounds, with a focus on implementing safe staffing levels
2. Ensuring that individuals with SMI receive annual physical health checks meeting or exceeding national targets.
3. Increasing uptake of COVID, flu, and pneumonia vaccines in patients with COPD
4. Early cancer diagnosis: Targeting a 75% diagnosis rate at stage 1 or 2 by 2028 to enhance prognosis and treatment outcomes
5. Implementing interventions to optimize blood pressure and to reduce the risk of myocardial infarction and stroke.

The aim of identifying the plus groups is to focus specifically on any differences that may exist in the above outcomes for these groups (those with LD and those who are carers) compared to others in the population and to take tailored action both at system and place level to ensure equality.

We will collaborate closely with our Places, Clinical Leads, as well as Public Health and the five clinical workstreams, to co-create a comprehensive delivery plan for the next 12 months. This plan will be implemented through the Community of Improvement that we will establish to ensure effective coordination and execution.

To maintain a strong focus on measuring and addressing inequalities, we will establish routine monitoring mechanisms. For instance, we will emulate our current practices in the Cardiovascular Disease Prevention Board, which involve continuous assessment, identification of areas requiring improvement, and evaluation of the impact of our interventions. Focusing on priority population groups experiencing health inequalities relating to CVD prevention: People from Asian, mixed, and black ethnic communities, adults with learning disabilities, Carers and targeting communities with low achievement. We have also developed easy reads to further support these communities.

The work is ongoing to ensure the quality and completeness of our data sets, which in turn will inform strategies to enhance outcomes, improve patient experience, and reduce health inequalities. Additionally, we are actively exploring the development of a health inequalities data dashboard to facilitate more actionable insights. We will also explore collaborations with the Anchors Institutions programmes to further enhance outcomes for residents, particularly those residing in the most deprived areas.

Furthermore, we will explore the utilisation of 'The Reasonable Adjustment Flag', a national record integrated into the NHS Spine. This tool enables healthcare professionals to record, share, and access details regarding reasonable adjustments across the NHS, regardless of the individual's treatment location. This initiative aims to enhance accessibility and inclusivity within our healthcare services.

Resources

Five new e-learning modules have been launched to support systems in the implementation of Core2PLUS5. The modules are aimed at anyone with a responsibility or interest in reducing health

inequalities, especially those working to deliver services in the five clinical priority areas. They are available for free on the Health Education England e-learning for health platform.

Recommendations

- Adopt the 'plus' populations proposed in this paper for routine consideration and action across the ICS to reduce inequalities in outcomes, access, and experience – **Carers and LD**
- **CORE20PLUS5 through a race / ethnicity lens** to address ethnic inequalities
- Monitor, evaluate progress and outcomes (data) over time to provide assurance of improvement
- Link to CYP CORE20PLUS5 approach
- Apply the learning from the Covid vaccination programme to Core20PLUS5 by working through community/faith leaders and the VCSE sector who already have relationships with the communities who find our services difficult to access
- Set up a system oversight group / Community of improvement to progress delivery, peer support and share learning, best practice and challenges.

Childrens and young people's CORE20PLUS5 Approach

Proposed CORE20PLUS5 (CYP) Frimley ICS summary graphic (figure 1):

Background

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. This approach includes a focus on two broad population groups: the Core20 who are the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD); and PLUS population groups to be identified at a local level. The Core20PLUS5 approach also includes a focus on 5 clinical areas that require accelerated improvement for Children and Young People (CYP): Asthma, Diabetes, Epilepsy, Oral Health, and

Mental Health. The focus has been decile 1-4 as some areas across the system is less deprived for instance Slough may focus their efforts at decile 2 or 3 and Bracknell Forest decile 3 and largely 4.

Frimley ICB Children and Young Peoples Strategy is a call to action to improve the health and wellbeing of children and young people.

There is a clear case for greater and faster transformation of children's care and services:

- A **quarter** of our population are Children and Young people.
- The pandemic has widened existing health inequalities and worsened the health of our children and young people.
- Poverty and deprivation impact on children's health and the significance of the deep and extended recession that the county faces cannot be underestimated.
- Many of health and care services that we provide to children and young people are struggling to meet demand.

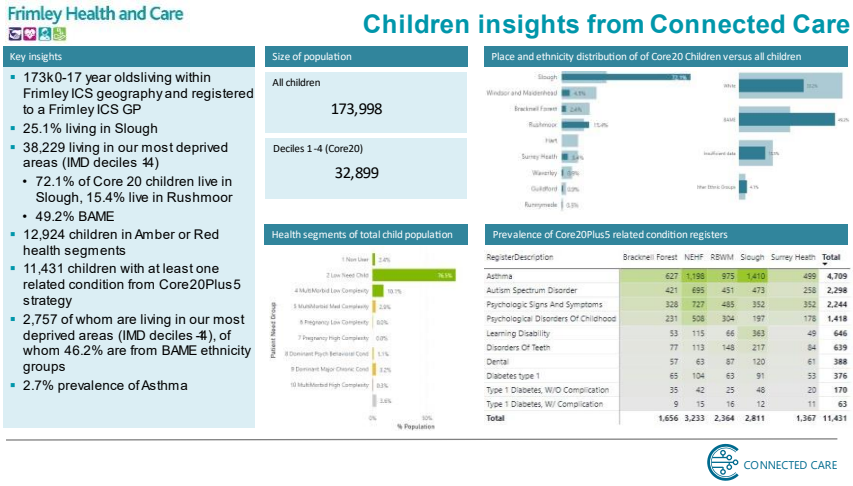
Our strategy comes with optimism about what we can collectively achieve together, we are committed to ensuring this plan succeeds and transforms the lives of children and young people across Frimley. The use of data and insights to proactively target and support those children and families where there is a disparity in health outcomes because of wider determinants.

Our Approach

The selection of CYP PLUS Groups in Frimley ICS have been informed by System-wide meetings and various Place workshop at the GP Council meetings. Following a System meeting with Tracey Faraday-Drake, Director Children & Young People, Learning Disabilities & Autism and team, it was agreed to initially focus on the following PLUS groups; **Children with Learning Disabilities, Young Carers, Children in Care, and Care Leavers** which aligned with the Place assessment, and on the 5 clinical target areas for these groups. In addition to the system plus groups, place based analysis has highlighted additional focus areas that place teams have identified (see above figure 1).

Data

Core20PLUS5 data is available through connected care. Data accessed in October 2023 shows that Children and Young People a quarter of the population Core20Plus Cohort is 11,107 CYP which is just over 45% of population. A race/ethnicity lens will be applied to address ethnic inequalities across all the CORE20Plus5 workstream.



Young Carers

According to the Children's Society there are approximately 800,000 young carers in the UK, available here. The Children and Families Act 2014 amended the Children Act to make it easier for young carers to get an assessment of their needs and to introduce 'whole family' approaches to assessment and support. Local authorities must offer an assessment where it appears that a child is involved in providing care. A 'young carer' is defined as 'a person under 18 who provides or intends to provide care for another person'.

On a national level, in recent years there has been a significant drive to raise the profile of young carers within our communities. Recognition of the value and importance of the caring role has been reflected in government legislation and policies. The Children's Commissioner launched the Big Ask Children's Survey in 2021, available here. In March 2022 it reached out to 6000 young carers who were receiving support across the country to ask them about the impact caring had on their childhood lives, 25% reported mental health difficulties, this compared to 20% reported by children without caring responsibilities. This increased as young carers got older with 47% of 16–17-year-olds reporting mental health difficulties. Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities The approach defines a target population cohort (the most deprived 20% of the population) and identifies '5' focus clinical areas requiring accelerated improvement. This includes improving access rates to children and young people's mental health services for 0–17 year-olds. Young carers are included in the PLUS population groups as warranting specific consideration as illustrated in this paper as a priority for CYP portfolio. More work is to be done with our Primary Care Networks and wider stakeholders to improve data collection and access to services.

Children in Care and Care Leavers

Over the last three years, the Covid-19 pandemic, cost-of-living crisis, and staff shortages and ever-increasing budget constraints in local government have placed enormous pressure on care leavers and severely restricted the support available to them, leaving these young people increasingly struggling to cope, not only with the pressures of accommodation and finances, but also with loneliness and poor mental health. According to the National Youth Advocacy Service, up to 86% of care leavers will experience anxiety and loneliness, with 61% being diagnosed with depression or other mental health conditions which is one of the 5 Clinical priority areas of health inequalities. A 2022 Ofsted survey of children in care and care leavers found that more than a third of care leavers felt they left too early, over a quarter did not meet their personal adviser until they were 18 or older, around a quarter reported they were not at all involved in developing plans about their future, and only around a third had a say in the location they'd like to live in and only a fifth in the type of accommodation. Furthermore, according to Home for Good, care leavers account for 25% of both the homeless and adult prison populations. Of those aged 19-21, 41% were not in education, employment or training (NEET), more than three times higher than the figure for all young people of that age.

Care leavers face specific challenges in relation to gaining full independence as adults. Nationally care leavers are considerably more likely to struggle to find inappropriate housing and secure education, training and employment than other young people for example In March 2023, 14% of 19–21-year-old care leavers in Bracknell Forest were not in suitable accommodation and 43% were not in education, employment or training.

Recommendations

- Adopt the 'plus' populations proposed in this paper for CYP and routine consideration and action across the ICS to reduce inequalities in outcomes, access, and experience. The identified plus groups are **Children with Learning Disabilities, Young Carers, Children in Care, and Care Leavers**
- **CORE20PLUS5 through a race / ethnicity lens** to address ethnic inequalities.
- Monitor, evaluate progress and outcomes (data) over time to provide assurance of improvement.
- Oversight will be through the Children & Young People's boards, including LA CYP boards and our partner ICB CYP board in Surrey Heartlands and HIOW. The workstream will sit within the 'Starting Well' programme of work
- To continue to embed the CORE20PLUS5 framework within Health and Wellbeing Strategy's and Place based Children and Young Peoples Plans.

Frimley Health and Care

Health Inequalities – CORE20PLUS5
March 2024

Dr Lalitha Iyer
Frimley ICB Chief Medical Officer

Frimley Health & Care ICS Strategy

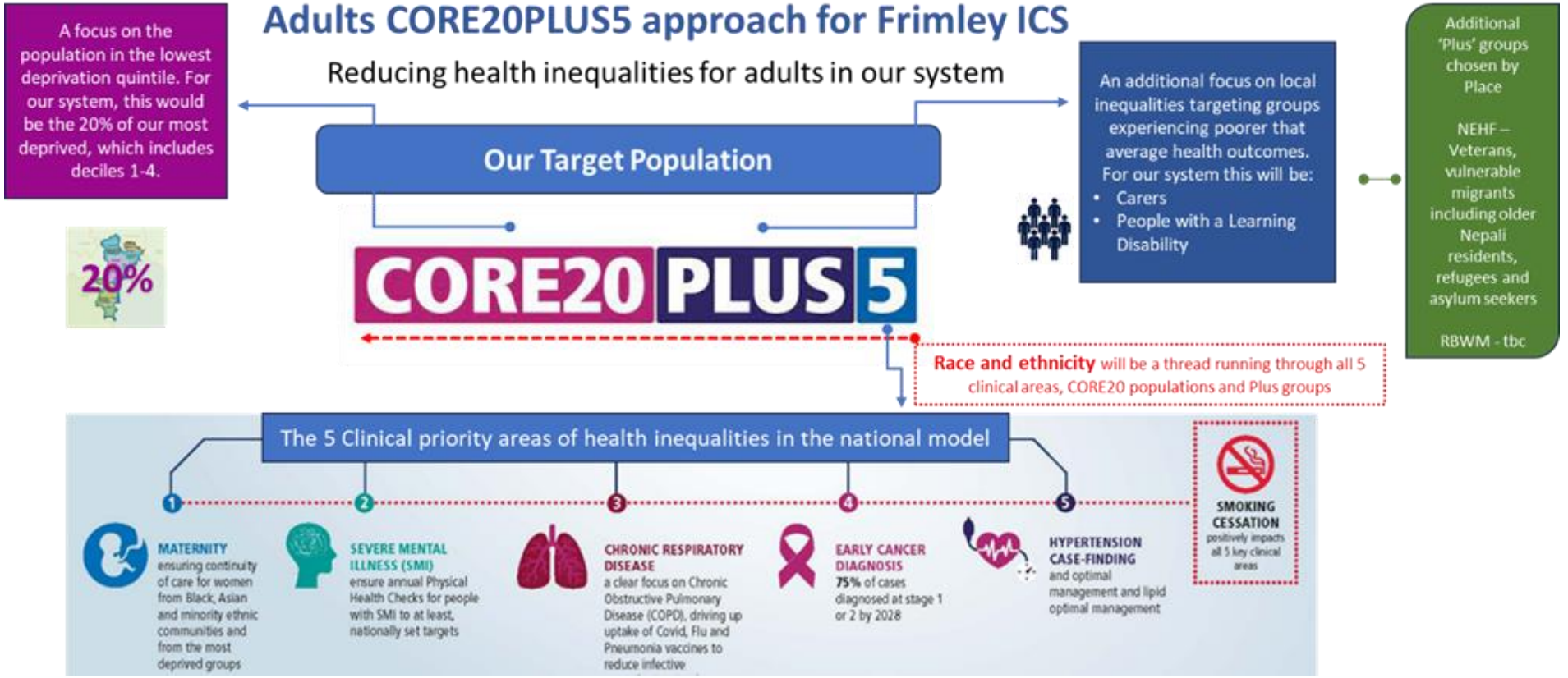
Our ICS goal is to **increase healthy life expectancy** and **reduce health Inequalities**.
We will do this through coordinated actions at system and place.

We are committed to implementing the Core20PLUS5 methodology to help us achieve our ICS' primary strategic objective of reducing health inequalities. Within Frimley, tackling Health inequalities is not seen as a standalone programme, but a golden thread running throughout all our work programmes. Our priority will be to ensure we target those who have the greatest need and the poorest health and wellbeing outcomes.

THE CORE20PLUS5 Approach - Adults

Tackling health inequalities are at the heart of our ICS strategy and CORE20PLUS5, covers key aspects and different lenses on health inequalities.

This is an opportunity to accelerate and augment implementation of the Core20PLUS5 approach, to improve health outcomes



We aim to work iteratively with Plus groups, where the focus may change over time but in a structured way.

Based on the data, insights and evidence we have gathered from system partners, the 2 'PLUS' groups we have agreed at system level are: **Carers and Learning Disabilities**.

In addition, **race and ethnicity** will be a thread running through all 5 clinical areas, CORE20 populations and Plus groups.

THE CORE20PLUS5 Approach – Children and Young People

Frimley ICS summary graphic

The 'PLUS' groups we have agreed at system level are:
Children with Learning Disabilities, Young Carers, Children in Care, and Care Leavers.
In addition, **race and ethnicity** will be a thread running through all 5 clinical areas, CORE20 populations and Plus groups.

Why Carers?

- Unpaid carers play a vital part in ensuring that individuals in need of care continue to experience a good quality of life. It is estimated that **3 in 5 adults** in the UK will become an unpaid carer at some point in their lives

- Providing unpaid care is **challenging and often physically and emotionally demanding**, with consequences for the carer's own health and wellbeing, future employment opportunities and social and leisure activities.

- Carers are more than **twice as likely to suffer from poor health** compared to people without caring responsibilities, with nearly 21% of carers providing over 50 hours of care, in poor health compared to nearly 11% of the non-carer population (In Poor Health: the impact of caring on health).

- 70% of carers encounter health professionals, yet only **1 in 10 carers are identified with GPs**, only identifying 7%

- Around 66% of carers feel that healthcare staff don't help to signpost them to relevant information or support

- Approximately 9% (**76k individuals**) of the Frimley ICS population, are estimated to be carers based on the 2021 Census. Carers UK suggests that the actual number of carers in may exceed double the Census count, indicating around **152k** unpaid carers in our system.

- Research by Carers UK indicates that **individuals often do not recognize themselves as carers** for several reasons. Especially in communities such as **Black, Asian, and minority ethnic groups**, caregiving is often unacknowledged and not seen as needing additional support

Why Learning Disabilities?

There are around **2,739 adults with a Learning Disability in Frimley ICS** 103 are also considered to be Carers

- Compared with the wider population, the average age at death for people with a learning disability is **23 years younger for men, and 27 years younger for women** (Learning Disabilities Mortality Review, 2019).
- Research has shown that, compared with the general population, people with a learning disability were **3 to 4 times as likely to die from an avoidable medical cause of death often because timely and effective treatment wasn't given**
- People with a LD have **worse physical and mental health** than people without a LD and are more likely to experience several health conditions.
- Those with LD have additional healthcare needs beyond that of other inclusion health groups, not least **difficulties with communication, leading to suboptimal access, experience, and outcomes**.
- A larger proportion of patients with a Learning Disability are in more **deprived areas**.
- Good access to primary care and annual health checks are key in tackling these disparities.
- The Oliver McGowan Mandatory Training has been rolled out to staff working in our system and will raise awareness for those with Learning Disabilities and ensure those with hidden disabilities are given good quality care and get the best support they need.

Smoking

Smoking cessation as a thread running through the 5 areas. Stopping smoking has a positive impact in all of the five clinical areas of focus.

NHS Tobacco Dependency Programme

- Commenced the delivery of an In-House In-Patient and Maternity programme at Frimley Health to deliver Tobacco Dependence Treatment in line with the NHS LTP commitments
- For Maternity, a high level maternity model has been agreed with the initial pilot deployed in Slough.
- The inpatient service provides full coverage across the Trust and we are on track to have the impatient service fully established by the end of March 2024.
- The numbers of patients having their smoking status recorded has increased significantly and the Trust are already seeing patients attending hospital months after their initial hospital assessment, who have quit completely
- Frimley Health Smokefree Steering Groups established
- Aligning work to the **CORE20PLUS5** approach as the five clinical areas of focus are all impacted by smoking. Systematically identifying and treating smokers will also support efforts to reduce health inequalities and deliver for the Core20Plus5 populations.

Stopping the start: new plan to create a smokefree generation

Following the Government's announcement, we are working with our Public Health teams to explore the wider smoking pathway, to ensure services are sustainable, taking a whole systems approach to tackling the problem. Although the medicalisation of smoking cessation, in the NHS supports many thousands of smokers, community solutions remain critical in maximising all opportunities, to encourage people to quit, and reaching communities where smoking rates are still too high.

Interventions in North East Hampshire and Farnham Place:

Smoking Cessation and the Targeted Lung Health Checks : Working closely with colleagues in Smoke Free Hampshire and the Surrey and Sussex Cancer Alliance, they have arranged for Smoke Free Hampshire to provide on-site smoking cessation advice to patients attending a screening at the TLHC mobile unit. Smoke Free Hampshire will be co-located with In-Health throughout the screening programme. **In Farnham –** Once a week Smoking Cessation session available in the community centre**.** Smoking Cessation information and advice available in food banks in NEHF.

Carers – Providers accessing Carers hubs to provide smoking cessation advise and support.

Collaboration between PCNs and providers – Smokefree Hampshire joining PCNs in NEHF when they do Outreach.

Smoking Cessation Alliances/ Groups formed across our places to promote a joint approach.

Smokefree Campaigns – Health improvement campaign underway, supporting a number of national campaigns. Community events also taking place across our Places.

Living Well – Hypertension awareness and Reduction

Overview of Initiatives

- Campaign work, running specific campaigns and targeting engagement with groups at higher risk.
- ICS webpage for CVD prevention.
- NHS health checks.
- Digital Weight Management Programme.
- CORE20PLUS5 - hypertension case finding.
- Community hypertension bus pilot.
- Community pharmacy blood pressure (hypertension) service.

Asylum hotel / migrants – During the Health Event at the Asylum Hotel in Aldershot, BP checks were completed on the day and information shared.

We have developed a bespoke webpage
www.frimleyhealthandcare.org.uk/bloodpressure

- AccruRx Florey.
- BP@Home.
- Health Checks at vaccination sites.
- Community hypertension pilot - devices in community
- Omron hypertension plus.
- Lakeside hypertension focussed days.
- 24-hour Ambulatory Blood Pressure monitoring and holter service.

#OneSlough Community Champions network - over 2000 champions. Recently supported hypertension and blood pressure monitoring.

Example Approaches

Frimley Health and Care

A coordinated campaign with supporting resources

Bespoke resources created to provide information in printed, online and video format, with simple, straightforward messaging and advice. Tested with local people whilst in draft form. Designed to link with national and global hypertension awareness campaigns and provided in a comprehensive resource pack to staff and partners for use in their own communities.

GP and clinician based interventions

GPs and local community pharmacies are identifying patients at risk of hypertension (but as yet undiagnosed) and offering a BP check or BP monitor for home readings. Health checks offered at the beginning of the year to those attending vaccination centres.

Community based monitors

Placing monitors in community venues where local people can more easily access them with the support of their community leaders and peers and in a safe, familiar and trusted environment.

Staff support and awareness

Staff encouraged to attend drop in sessions throughout May measurement month and get to know their numbers. Campaigns and resources highlighted throughout staff communications and in staff meetings.

Case study	What we did	Impact
Taking a community approach to tackling high blood pressure – The Hope Hub	The Hope Hub, a registered charity dedicated to preventing and ending homelessness in Surrey Heath Borough and surrounding areas, agreed to host a blood pressure monitor for six weeks, in order to support service user and staff wellbeing, to raise awareness of the dangers of hypertension and encourage service users and staff to take their own readings and get to know their numbers.	Reached vulnerable people High-risk cases identified Created starting point for healthy lifestyle discussions Viewed as a success and monitor now integral in living well programme

Frimley online event – Looking after yourself, a focus on blood pressure we hosted an online public session focused on raising awareness about high blood pressure. We discussed what high blood pressure is, its implications, and most importantly, how people can take control and manage their blood pressure effectively. The session was well received by residents.

You can watch a recording of it here. In addition, there are some valuable resources on our ICS blood pressure page which can be explored here: Blood pressure - Do you know your Numbers?

Learning Disabilities

Focus on improving access and outcomes for people with Learning Disabilities

Utilising a wealth of population health data, Frimley ICS has been able to understand health inequalities for people with a learning disability, and this in turn has helped us focus our efforts to improve the uptake and quality of health checks; support for weight, diet and exercise; prescribing; epilepsy and collaborative working.

Frimley ICB consistently over-achieve against NHS England trajectories on Annual Health Checks.

However, numbers on LD register are relatively low at 0.45% against national average of 0.58% and ambition target of 0.71%.

Good Practice Examples: Aug to Oct 2023

The person chose not to attend her mammogram in 2019, so easy read information was sent, and carers were supported to share this information, leading to person having a mammogram the following year.

The Care Home manager went above and beyond staying with the person when her family were not able to, and enabling end-of-life care at home rather than in a hospice.

BHFT WAM CTPLD maintained involvement even after the patient's move to Slough to ensure continuity of care.

Reasonable adjustments were made by the Ophthalmology and operating teams at Frimley Park Hospital. Hospital accommodated additional needs before, during and after cataract surgery. Family felt the person was treated "like a VIP" and praised the staff's kindness.

The Learning Disabilities Mortality Review (LeDeR) programme was established to support local areas to review the deaths of people with a learning disability, to learn from those deaths and to put that learning into practice. Through this programme we are linking in with other ICSs to learn from best practice.

Carers

Frimley ICS Carers support Steering group established with wide representation. The aim is to share information and promote equitable service across the ICS.

In the workplace – A group was formed to recognise and support working carers. Working Carers are now eligible for carers leave in Frimley.

The **Carers Proactive Pilot was delivered in Surrey Heath** supported by the Health & Wellbeing Coaches. The aim was to understand what support unpaid carers receive and then connect them to communities and support in their local area. Group health and wellbeing sessions to support parents and or carers of autistic children also delivered. Carers Support group sessions at GP Practices have taken place.

Rolled out **Carers awareness training in the acute** –supporting Carers in the Hospital setting - 50 staff members have received training. Lanyards that distinguish staff and volunteers as Carer Support Champions are prominently displayed and widely acknowledged.

Carer Support and Engagement - Better understanding of Carer's needs: We are within a programme of engagement with Carers in NEHF, both adults and young carers, to understand their challenges more and where small changes can be made to support them and reduce barriers to services. So far, we have visited 4 Carers Hubs and have another 4 visits scheduled. Liaising with local colleges, on developing a carers service. The feedback will inform future services. Linking with Healthwatch to identify Carers from ethnic minority communities.

Cancer Screening

Health inequities still exist and many people who require treatment for cancer face barriers whether connected to income, education, geographical location, or other factors that negatively affect access and care.

The Targeted Lung Health Check Programme can identify lung cancer at an earlier stage and often before symptoms become apparent. During 2023 the programme was in Slough, an area selected on the basis of population size, smoking prevalence and late-stage lung cancers and from 26 January 2024 the programme went live in Aldershot where it hopes to see 6500 eligible patients. This programme brings together healthcare teams and providers in order to invite and ensure accessibility to eligible patients – those aged between 55-74 years, who are smokers or former smokers, to this potentially live saving preventative screening. Last year Slough resident, Mr C Walters, told us about his experience:

"As a wheelchair user I always worry when being asked to go somewhere that isn't a hospital as access can be an issue but when I arrived at the lung health check scanner, the staff were very helpful and there was a lift to get me into the machine. In fact, I'd say the staff were excellent!"

In addition, the ICS were praised last year for leading the country in improving GP led **bowel cancer screening** referrals with a higher proportion of people being asked by GPs to use preliminary home testing kits doing so locally than anywhere else in the country

The Cervical Cancer Prevention awareness week shone a light on the fantastic work happening throughout our geography by practice staff and specialist nurses to encourage the uptake of cervical screening. A practice in Farnborough carried out an audit of non-responders which found the biggest age group not attending was women aged 30-32yrs. They took the decision to make available more out of hours (extended access) appointments to see if it would increase access and uptake. They also started a butterfly wall as a visual representation of the number of smears taken in the surgery and encouraged people to write their reflections on the experience. This has been a powerful visual tool to get people talking, leading to partners, family members and friends encouraging others to come in.

NHS
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FRIMLEY INTEGRATED CARE BOARD

Title of Paper	Quality Update – Response to NHS England Letter re: LL		
Agenda Item	5.2	**Date of meeting**	19 March 2024
Exec Lead	Sarah Bellars		

Purpose	To Approve	☐
	To Ratify	☐
	To Discuss	☐
	To Note	☒

Link to Strategic Objective	*See below – please list which Objective this paper relates to here.*

Executive Summary	
The System Quality Group discussed the letter of immediate action from NHSE, following the conviction of Lucy Letby for Killing 6 babies and the attempted murder of seven others. The SRG discussed the importance of our joint responsibilities to respond to the actions and the assurances being sought from our Regional and National NHS England colleagues as well as the public. The Trusts within the system have all responded to the actions and requirements which have been shared at the System Quality Committee and assurances have been gained that these responses have been submitted to NHS England. The ICB has reviewed the correspondence from NHS England. This paper provides assurance to the ICB Board that there are policies and processes in place that enable staff to raise concerns without detriment, and which have Board oversight through regular reporting. The paper also provides other supporting assurance relating to governance, patient safety - confirming the implementation of the PSIRF, medical Examiners and the updated Fit and Proper Persons Framework. The SRG also discussed plans for the implementation of Matha's rule.	
Recommendation	To *Note* the paper.

Please provide details on the impact of following aspects	
Risk and Assurance	The measures described in this report will support safe and appropriate recruitment, systemic mechanisms for identifying and raising concerns.
Equality and Health Impact Assessment	
Patient and Stakeholder Engagement	
Financial Impact and Legal implications	The measures contained within should support know the early identification of risk reducing cost both in terms of error and litigation.

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
System Quality Governance Committee	29th Feb	Approved

Frimley Integrated Care Board (ICB) Response to the letter from NHS England to the NHS following verdict in the trial of Lucy Letby

Frimley ICB and all System Partners have all been shocked and saddened by the appalling crimes that have been reported through the Lucy Letby trial. In the words of the judge, Mr Justice Goss, she acted "in a way that was completely contrary to the normal human instincts of nurturing and caring for babies and in gross breach of the trust that all citizens place in those who work in the medical and caring professions." Our thoughts are with all the families and colleagues who've been affected devastated by these events.

Frimley ICB is committed to ensuring that our primary focus is on patient safety and that staff feel confident to speak up about issues they are concerned about, and that we adhere to the best governance arrangements.

It is important to the ICB to commit to do everything we can to prevent anything like this happening again. A letter received from NHS England on 18th August 2023 (appendix 1) asked NHS Leaders to undertake a number of urgent actions and this report provides the Board with an overview of the:

- All staff have easy access to information on how to speak up.
- Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
- Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
- Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well, with compassion and have access to the right support.
- Boards are regularly reporting, reviewing, and acting upon available data. This includes notifying the ICB of any disclosures made of inappropriate clinical practice which may lead to patient harm, together with a detailed response of actions taken. This should include statutory reporting requirements set in legislation, relating to safeguarding responsibilities, or reports of criminal activity.
- The letter also reminds organisations of their obligations under the Fit and Proper Person requirements.

Immediate Actions

The Chief Nursing Officer at the System Quality Group discussed with all Partners the importance of our joint responsibilities to respond to the actions and the assurances being sought from our Regional and National NHS England colleagues as well as the public.

The Trusts have all responded to the actions and requirements which have been shared at the System Quality Committee and assurances have been gained that these responses have been submitted to NHS England.

Freedom to Speak Up and ICB Responsibilities

Freedom to Speak Up (FTSU) processes were introduced into the NHS in 2016. This was as a result of a number of investigations and concerns raised relating to culture, particularly in NHS Trusts and the way in which those raising concerns were supported and listened to during proceeding inquiries.

When the ICB was established on 1 July 2022 there was a requirement for the ICB to appoint a Freedom to Speak Up Guardian and implement a policy and process for managing concerns which were raised. Frimley ICB do have a Freedom to Speak Up policy and have an established arrangements in place for the raising of concerns.

NHS England have now mandated the adoption of the National Freedom to Speak Up policy by January 2024 and the ICB team are in the process of producing the Policy and associated Standard operating procedures for consideration by the Board at the end of 22 February 2024.

The Freedom to Speak Up role in the ICB is vitally important to ensure safety, excellence, equity, and a route to support our staff. A more open culture encourages learning and improvement which ultimately leads to greater staff satisfaction, performance, and better quality of services for our population. Frimley ICB believe we must support staff feel confidence to speak up, to feel that speaking up will result in change and to feel that speaking up will not result in disadvantage.

On establishment, the ICB appointed Safina Nadeem, in her role as Equality, Diversity and Inclusion Director as the lead for FTSU Guardian. It is an NHSE requirement that this Freedom to Speak Up Guardian is a Board level member of staff to ensure that concerns can be taken directly to the Board if required and so that the individual has sufficient autonomy to enable them to take actions to immediately mitigate any harm.

We ensure all cases brought to the F2SU Guardian are recorded and returns are sent to the NGO quarterly, as required. Since the formation of the ICB we have recorded 16 speak up cases relating to issues such as poor behaviours, unfair processes and culture. The themes of all the cases are presented to the SLT team on a 6 monthly or annual basis. The ICS Board also has oversight of the F2SU cases and themes on an annual basis.

The F2SU Guardians in the ICB have formed a community of practice to share best practice and learning and offer peer support. These meetings are held monthly and led by the ICB F2SU Guardian. The ICB have also formed a network for Guardians, there NEDS and Executive Leads, following the Lucy Letby verdict as a way of sharing any initiatives and learning as well as sharing of resources.

As part of Speak Up Month Up in October, the ICB guardians delivered a workshop on psychological safety which was attended by over 50 people.

Patient Safety Incident Response Framework (PSIRF)

The Lucy Letby case, as well as other inquiries into care of patients in the NHS (Mid Staffordshire, Ockenden and Kirkup reviews) have highlighted the importance of engaging with patients, families, and staff appropriately after a patient safety incident and involving them in any subsequent investigation. The introduction of PSIRF does not affect statutory and professional duty of candour.

PSIRF supports the development of a patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents. Those affected include staff and families in the broadest sense; that is: the person or patient (the individual) to whom the incident occurred, their family and close relations as well as the staff involved. Similarly, PSIRF recognises that staff have important contributions to make about their experience of an incident and the working environment at the time and should be supported and listened to when sharing their accounts.

The framework allows the system to look in detail at cases that previously would not meet threshold for a serious incident investigation or would be considered a 'near miss'. Thus, the system will now be able to review cases where there was no harm, but where there may have been, had a remedial action not been taken.

Frimley ICB continues to work collaboratively with System Partners to ensure a safe adoption and transition to PSIRF, in line with national timeframes.

Martha's Rule

"The first phase of the introduction of Martha's Rule will be implemented in the NHS from April 2024. Once fully implemented, patients, families, carers and staff will have round-the-clock access to a rapid review from a separate care team if they are worried about a person's condition.

Martha Mills died in 2021 after developing sepsis in hospital, where she had been admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to promptly, and in 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier.

In response to this and other cases related to the management of deterioration, the Secretary of State for Health and Social Care and NHS England committed to implement 'Martha's Rule'; to ensure the vitally important concerns of the patient and those who know the patient best are listened to and acted upon". NHSE February 24

This rule commenced following the publication of the assurances from the provider Trusts. It was however discussed at the SQG, at this point in time it is only for acute Trusts. FHFT discussed the measures they have in place already and the plan for further development to comply with full introduction from April 24.

Mortality

The Frimley ICS Mortality Review Group (MRG) was established in 2017 and meets on a quarterly basis. The membership includes System Partners, ICBs, Local Authorities and the Independent Sector. The aims of the group are:

- To promote co-operation and co-ordination between providers in carrying out mortality reviews

- To share learning from reviews across the health and social care economy; this includes learning from providers' internal mortality reviews, from LeDeR reviews, Regulation 28s and from any other informative sources.
- To promote improvement actions emanating from mortality reviews; the group seeks to promote and influence practical improvements across the health economy.

The Mortality Review Group will also have oversight of the Medical Examiner role including community. Frimley ICB have been successful rolling out a pilot of the community Medical Examiner, which is due to be made statutory from the 1st April 2024. We have built strong relationships with the Medical Examiner's Office to ensure transparent and independent concerns are shared. The ICB are responsible for ensuring that learning and improvement from their work is shared at a system level. We have established links to the PSIRF methodology to support further reviews as requested by the findings of the Medical Examiner.

Frimley ICB will continue to monitor the trends and changes in data relating to mortality and harms through this group, with an escalation into our System Quality Group on a quarterly basis or if an urgent matter arises. The System Quality Group is a formal subcommittee of the Frimley ICB Board.

Fit and Proper Person Test for Board Members

On the 2nd of August 2023, NHS England published the Fit and Proper Person Test (FPPT) Framework. The framework is a response to the recommendations made by Tom Kark KC in his 2019 review of the Fit and Proper Person Test (the Kark Review) and also takes account of the requirements of the CQC in relation to directors being fit and proper for their roles.

The revised framework strengthens and reinforces individual accountability and transparency for board members but particularly for the Chair of the Board in relation to the enacting of the framework.

It sets out the additional background checks, including a board member reference template, which will also apply to board members taking on a non-board role. There is a requirement for an annual refresh and for the first time for this to be recorded on Electronic Staff Records so that it is transferable to other NHS Organisation as per of their recruitment processes.

NHS Frimley wrote to all Board members identified as in scope of the new framework in September 2023 setting out the new requirements and how they will be implemented.

NHS Frimley has developed an implementation plan to meet the new framework requirements, a summary is presented in the table below.

Requirements	NHS Frimley	Progress
Notify all board members who the FPPT will apply to and whose details will be included in ESR in advance of the FPPT framework (and standard Board Member Reference) going live on 30th September.	w/c 11th September using the national template write to all Board members with a briefing on FPPT and the privacy notice. This will include confirming that Board Members not currently on ESR (i.e., Partner Members) will have an Off-Payroll Worker ESR record created for governance and audit purposes only (not pay related).	Complete – letters issued w/c 11th September 2023.

From 30th September 2023 use the new Board Member Reference template for references for all new board appointments.	Incorporate requirement into recruitment and onboarding processes.	Complete.
From 30th September 2023 complete and retain locally the new Board Member Reference for any board member who leaves the board for whatever reason and record whether or not a reference has been requested.	This will be overseen by the Chief People Officer and held on the electronic personnel file for the Board and stored securely with the archived Board files.	Complete.
From 30 September 2023 use the Leadership Competency Framework as part of the assessment process when recruiting to all board roles.	Awaiting publication of the LCF. This will be overseen by the Chief People Officer.	Awaiting publication of the LCF. Expected by March 24.
By 31 March 2024 fully implement the FPPT Framework incorporating the LCF and updating the ESR database.	This will be overseen by the Chief People Officer.	In progress.
Incorporate the LCF into annual appraisals of all board directors for 2023/2024 using the board appraisal framework (Q1 24/25).	The process will be overseen by the Chief People Officer.	Awaiting publication of the new board appraisal framework, incorporating the LCF. Expected by March 24.

Conclusion/Next Steps

The ICB has reviewed the correspondence from NHS England. This paper provides assurance to the ICB Board that there are policies and processes in place that enable staff to raise concerns without detriment, and which have Board oversight through regular reporting.

The paper also provides other supporting assurance relating to governance, patient safety - confirming the implementation of the PSIRF, medical Examiners and the updated Fit and Proper Persons Framework.

NHS
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Integrated Care Board

FRIMLEY INTEGRATED CARE BOARD

Title of Paper	Board Assurance Framework (BAF)		
Agenda Item	6.1	**Date of meeting**	19 March 2024
Exec Lead	Rich Chapman, Chief Finance Officer		

Purpose	To Approve	☐
	To Ratify	☐
	To Discuss	☒
	To Note	☒

Link to Strategic Objective	Strategic Objective 3

Executive Summary

The ICB board is asked to review the Board Assurance Framework, noting the updates to the mitigating actions that have been made since the document was last reviewed in January 2024.

The Board agreed the following Risk Thresholds for 23/24 in relation to its approach to the achievement of its five Strategic Objectives.

ICB Strategic Objectives 2023-24:

1. **Strategic Objective A - Our People:** We want to help our employees thrive and be healthy both at work and in their personal lives, while also listening to our workforce to help us achieve our goals as an organisation. We will take actions that create a culture of inclusivity that values our diverse workforce and encourages everyone to contribute to our vision and values.
2. **Strategic Objective B – Improving Outcomes and Reducing Inequalities**: We will work together with our communities and other partner organisations to improve health and care outcomes and experiences for local people, resulting in reduced health inequalities.
3. **Strategic Objective C – Delivering our Work Programme focussed on Transformation and Wider Reform:** We will make sure our organisation stays focused on the delivery of our work programme. Our leaders will oversee our progress and work to improve our approach over time. We will also work closely with our partners and places to make sure we are collectively contributing to wider improvements in public services, reform and transformation.
4. **Strategic Objective D – Data Insights driven by Technology:** We will invest in new technology that can help us provide better care and prevent illness. We will increase the use of data and insights to help us innovate and improve how we provide care and support to our patients and residents.
5. **Strategic Objective E – Financial Sustainability**: We will work to make sure our organisation is financially sustainable in the long term. We will manage our finances carefully and make sure we are providing the best possible value to taxpayers.

The ICB agreed its Risk Appetite Statement and Risk Thresholds for each of the Strategic Objectives and these are summarised below:

Domains	Risk Appetite	Risk Threshold
QUALITY: Clinical quality, safety and patient experience	Cautious	8
PEOPLE: Workforce	Open	12
PERFORMANCE: Operational Performance	Open	12
TRANSORMATION: Innovation and transformation	Seek	16
FINANICAL: Financial risk and value for money	Open	12
REGULATORY: Compliance and regulatory risk	Open	12
REPUTATIONAL: Reputational risks and partnerships	Open	12

The Board is asked to note that since its last meeting, Strategic Objective A1 People has been updated and now sits Within Risk Appetite. Strategic Objective C1 Transformation has also been further mitigated and now sits Within Risk Appetite. Two of the five Strategic Objectives continue to remain outside the Risk Appetite and Risk Thresholds, previously agreed.

	November 2023	January 2024	March 2024
A1 People	16 Out of Risk Appetite	16 Out of Risk Appetite	12 Within Risk Appetite
B1 Quality	12 Out of Risk Appetite	12 Out of Risk Appetite	12 Out of Risk Appetite
C1 Transformation	16 Within Risk Appetite	16 Within Risk Appetite	9 Within Risk Appetite
C2 Transformation	16 Within Risk Appetite	6 Within Risk Appetite	6 Within Risk Appetite
D1 Data & Insights	12 Within Risk Appetite	12 Within Risk Appetite	12 Within Risk Appetite
E1 Financial	16 Out of Risk Appetite	16 Out of Risk Appetite	16 Out of Risk Appetite

Since the last meeting, the Board Assurance Framework has been reviewed by the Intergrated Risk Group, which is made up of executive members of the Finance and Performance Committee and the System Quality Group.

The role of the Integrated Risk Group is to provide an assessment of complex, significant or recurrent risks that are escalated to it via the Corporate Risk Register (comprised of strategic risks 15 ↑) and monitor progress against plans and oversee the mitigation of any significant risks; it is also responsible for providing assurance on the completeness and accuracy of the Board Assurance Framework.

The Board is asked to ***note*** the following summary of key updates:

A1 People	The overall risk score has been further mitigated from 16 to 12 in Q4 and has moved within Risk Appetite.
B1 Quality	No change to overall risk score in Q4.
C1 Transformation	The overall risk score has been further mitigated from 16 to 9 in Q4. New mitigating actions.
C2 Transformation	No change to the overall risk scores in Q4.
D1 Data & Insights	No change to overall risk score in Q4. New mitigating actions.
E1 Financial	No change to overall risk score in Q4. Update to gaps in controls/assurance.

The Board is asked to review and agree its updated Board Assurance Framework.

Recommendation	**The Board is asked to review and agree its updated Board Assurance Framework.**

Please provide details on the impact of following aspects	
Risk and Assurance	
Equality and Health Impact Assessment	
Patient and Stakeholder Engagement	
Financial Impact and Legal implications	

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
Senior Leadership Team	2 January 2024	
Integrated Risk Committee	1 March 2024	

ICB Strategic Objectives 2023-24:

- Strategic Objective 1: We want to help our employees thrive and be healthy both at work and in their personal lives, while also listening to our workforce to help us achieve our goals as an organisation. We will take actions that create a culture of inclusivity that values our diverse workforce and encourages everyone to contribute to our vision and values.
- Strategic Objective 2: We will work together with our communities and other partner organisations to improve health and care outcomes and experiences for local people, resulting in reduced health inequalities.
- Strategic Objective 3: We will make sure our organisation stays focused on the delivery of our work programme. Our leaders will oversee our progress and work to improve our approach over time. We will also work closely with our partners and places to make sure we are collectively contributing to wider improvements in public services, reform and transformation.
- Strategic Objective 4: We will invest in new technology that can help us provide better care and prevent illness. We will increase the use of data and insights to help us innovate and improve how we provide care and support to our patients and residents.
- Strategic Objective 5: We will work to make sure our organisation is financially sustainable in the long term. We will manage our finances carefully and make sure we are providing the best possible value to taxpayers.

NHS Frimley ICB
Board Assurance Framework 2023/24

19 March 2024

The Board Assurance Framework (BAF) sets out the principal risks to the achievement of the ICB's strategic objectives and is a practical means through which the Board can assesses progress against delivery of these. In so doing, the BAF also serves as a primary source of evidence in describing how the ICB is discharging its responsibility for internal control.

The BAF further sets out the controls in place to manage these risks and the assurances available to support judgements as to whether the controls are having the desired impact. It additionally describes the actions to further reduce each risk.

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STRATEGIC OBJECTIVES 2023/24

A	B	C	D	E
Our People	**Improving Outcomes and Reducing Inequalities**	**Delivering our work programme focused on Transformation and Wider Reform**	**Data and Insights driven by Technology**	**Financial Sustainability**
We want to help our employees thrive and be healthy both at work and in their personal lives, while also listening to our workforce to help us achieve our goals as an organisation. We will take actions that create a culture of inclusivity that values our diverse workforce and encourages everyone to contribute to our vision and values.	**We will work together with our communities and other partner organisations to improve health and care outcomes and experiences for local people, resulting in reduced health inequalities.**	**We will make sure our organisation stays focused on the delivery of our work programme. Our leaders will oversee our progress and work to improve our approach over time. We will also work closely with our partners and places to make sure we are collectively contributing to wider improvements in public services, reform and transformation.**	**We will invest in new technology that can help us provide better care and prevent illness. We will increase the use of data and insights to help us innovate and improve how we provide care and support to our patients and residents.**	**We will work to make sure our organisation is financially sustainable in the long term. We will manage our finances carefully and make sure we are providing the best possible value to taxpayers.**
• Co design an ICS People Strategy and associated workplan with Partners across our ICS. This will build upon our work to date, the leadership and culture work through our Frimley Academy, the NHS Long Term Workforce Plan, People Promise and strategic ambitions set out by partners including Skills for Care impacting positively on our workforce • Deliver the ambitions set out in our ICS EDI strategy including supporting our teams and our partners in all aspects of leadership and role modelling a safe environment to raise concerns and take improvement actions. • Develop a specific ICB People strategy and OD plan to ensure our organisation has the capabilities and values to lead and enable our system work	• Embed the Core 20 plus 5 approach in the work of the ICS working jointly with place teams and partners to enable this approach focussing on 20 % of our most deprived population • Deliver the plus 5 clinical programme as outlined in the Core 20 plus 5 approach • We will work with public health and other partners to improve uptake of immunisation and screening programmes • Align policies across the ICS to reduce inequalities • Take a population health management approach to our work so we target our resources and programmes to areas of inequalities • Embed our inclusive approach to engagement/co-production through our People and Communities Strategy	• Develop a shared workplan which clearly sets out the ICBs contribution for both delivery, and leadership of, applicable elements of the ICS Strategy and the Joint Forward Plan. This workplan will demonstrate clarity to the Board on timescales, benefits, risks and issues. • Work with colleagues in Partner organisations to fully explore opportunities for the development of a new system operating framework which maximises the opportunities of greater public sector collaboration in a post Health and Care Act (2022) system architecture. These may include, but not limited to; the development of Place, pan-system shared functions and Provider Collaboratives. • Establish a PMO that ensures we remain focused on our work programme and that we deliver short term priorities as well as our longer term ICS strategic ambitions	• Rapid expansion and deployment of Virtual Care solutions, which includes both Virtual Wards and Remote Monitoring solutions for patients with varying levels of need and acuity. This will be the core plank of our approach to reducing non-elective demand and keeping residents well, for longer, in their own homes. • Continue to develop the Shared Care Record and its capability, focusing on sustainability and scalability by working closely with other health and care systems. • Roll out of our System Insights Platform version 2.0, building on the success of the first version and creating an analytics tool which is usable by clinical and professional leaders across our system to inform better planning, transformation, evaluation and resource allocation	• Develop an aligned financial strategy focused on cost containment and reduction • Implement plans to managing / mitigating growth to ensure flow of income growth for deficit reduction. Utilising a system-first approach to transforming services for the benefit of our population regardless of organisational boundaries. • We will focus on providing defined services and capacity to meet patient needs. • Develop a system wide Business Intelligence function to enable the system to operate with trust, transparency and effective data sharing to do things efficiently and effectively. • Implement our Financial sustainability programme

RISK APPETITE 2023/24

Board Risk Appetite Statement 2023/24

Risk appetite is defined as the amount of risk that we are willing to seek or accept in the pursuit of long-term objectives.

It is key to achieving effective risk management and is agreed by the Board so that that the nature and extent of significant risks we are willing to take in achieving our strategic objectives is understood. It represents a balance between the potential benefits of transformation, the challenges we face, and the threats change inevitably brings.

The Board will review its risk appetite annually or more frequently should the environment we operate in change significantly. The risk appetite sets the threshold for risk against key domains and enables the Board, its Committees and Boards and teams to effectively manage risks.

Risk Statement:

NHS Frimley recognises that long term sustainability of health and care services depends upon managing risks in relation to the delivery of our strategic objectives, and that our relationships with communities, staff and all our partners is key to our success. Our approach to our risk appetite is underpinned by the maturity of our system working .

We believe that no risk exists in isolation and that effective risk management is about finding the right balance between risks and opportunities to deliver our ambitions, to act in the best interests of our communities alongside delivering value for money. Our risk appetite approach recognises the need for risk trade-off conversations, creating a flexible framework within which we can drive transformation, make agile decisions and balance boldness and caution, risk and reward and cost and benefit. It also aims to provide a proportionate approach to risk reducing bureaucracy but ensuring appropriate rigour in our risk management.

We recognise that no health and care is risk free and when balancing risk, we will tolerate some more than others. For example: we will have a cautious approach to risks which impact quality (clinical quality, safety and patient experience) which means we prefer safe delivery options and take decisions that aim to mitigate the level of risk. When driving transformation and innovation we will seek options that have bigger rewards but greater risks to get there, using our risk approach to understand and balance the risk with benefits.

Overall NHS Frimley has an open appetite to take well-considered balanced risks to pursue innovation and opportunities where positive gains can be expected, whilst being confident that through good risk management the threats can be averted.

References**:** Good Governance Institute: Board guidance on risk appetite: 2020; NHSE/I Risk Appetite 2021

The Board has agreed its risk appetite in the following domains for 2023/34:

Domains	Risk Appetite	Risk Threshold
QUALITY: Clinical quality, safety and patient experience	Cautious	8
PEOPLE: Workforce	Open	12
PERFORMANCE: Operational Performance	Open	12
TRANSORMATION: Innovation and transformation	Seek	16
FINANICAL: Financial risk and value for money	Open	12
REGULATORY: Compliance and regulatory risk	Open	12
REPUTATIONAL: Reputational risks and partnerships	Open	12

Risk Appetite	Description
None	We have no appetite for decisions or actions that will impact in anyway - avoid risk at all costs and all decisions taken to remove the risk
Minimal	We are only willing to accept the possibility of very limited risk and will avoid any decisions or actions that may result in heightened risk unless absolutely essential
Cautious	We are prepared to accept the possibility of limited risk. Our preference is for safe delivery options but we are able to tolerate low level risk and uncertainty. Every decision will be with the aim of mitigating the level of risk.
Open	We are willing to consider all potential delivery options and choose while providing an acceptable level of reward. Take a greater degree of risk and tolerate higher uncertainty to achieve a bigger reward.
Seek	We are eager to be innovative and to choose options offering greater rewards but have greater inherent risk. Eager to take on risk to achieve strategic objectives
Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust. Will chose the option with greater reward and will accept any loss as the price for the reward.

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RISK SUMMARY

Strategic Objective A: Our People

BAF REF	Domain	Principle Risk	Risk Owner	System Board/ Assurance Committee	Initial Risk rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
A1	**PEOPLE**	If the ICB does not create a positive working environment that creates a culture of inclusivity that values a diverse workforce, then our people will not feel listened to and included, our people will become disengaged resulting in workforce gaps, unable to attract diverse talent to the ICB leading to a lack of delivery and we will not achieve our goals	Chief People Officer	SLT/Renumeration Committee/System People Board	4	5	20	4	3	12	**Open 12**	**IN**	

Strategic Objective B: Improving Outcomes and Reducing Inequalities

BAF REF	Domain	Principle Risk	Risk Owner	System Board/ Assurance Committee	Initial Risk rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
B1	**QUALITY**	If the ICB is unable to prioritise prevention and population health programmes then the ICB will not be able to put in place the foundations to improve health and care outcomes and in the long term health inequalities will increase resulting in greater pressure on partner organisations, increasing costs, and resulting in poorer outcomes and experiences for the local people.	Chief Medical Officer	System Quality Group / Finance and Performance Committee / ICB Board	5	4	20	4	3	12	**Cautious 8**	**OUT**	

Strategic Objective C: Delivering Our Work Programme: Transformation and Wider Reform

BAF REF	Domain	Principle Risk	Risk Owner	System Board/ Assurance Committee	Initial Risk rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
C1 Risk 1	TRANSFO-RMATION	If the ICB fails to engage key stakeholders in delivering the transformation agenda or commitment to integration is superficial due to operational and financial pressures then some partners will become disengaged from system integration resulting in delays in the reform, transformation and improvements to public services	Chief Transformation and Digital Officer	Transformation and Delivery Board/Finance and Performance/System Quality Group	4	5	20	3	3	9	Seek 16	IN	↓

BAF REF	Domain	Principle Risk	Risk Owner	System Board/Assurance Committee	Initial Risk rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
C1 Risk 2	TRANSFO-RMATION	The responsibility for the development of a shared operating model for the Pharmacy, Optometry and Dentistry (POD) Hub for the SE Region sits with all six ICBs and NHS England, as the delegating body. However, if the Frimley ICB as the host for the Pharmacy, Optometry and Dentistry (POD) function for the SE Region is unable to develop a single shared vision for a distributed leadership model on behalf of all ICBs in the SE Region, then there is a risk that some ICBs in the SE Region may cease to work collaboratively resulting in the potential fragmentation of the Hub model, which will adversely impact on service transformation and operational effectiveness and delivery across the whole of the SE Region. If the other ICBs in the SE Region do not work collaboratively to mitigate this shared risk then there will be a disproportionate adverse impact on the Frimley ICB because it will be unable to deliver on its responsibilities for developing hosted POD services, which will result in the organisation facing reputational, operational and financial risks.	Chief Transformation and Digital Officer		4	4	16	3	2	6	Seek 16	IN	↔

Strategic Objective D: Data and Insights Drive by Technology

BAF REF	Domain	Principle Risk	Risk Owner	System Board/Assurance Committee	Initial Risk rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
D1	TRANSFORMATION	If the ICB fails to resource, work collaboratively towards the priorities in the Digital strategy or ensure effective adoption of digital solutions then the ICB will not be able to maximise the benefits afforded by the advancement of digital and data and this will hinder the advancements in health care and prevention	Chief Transformation and Digital Officer	System Digital Board/Finance and Performance/ System Quality Group	4	4	16	4	3	12	Seek 16	IN	⟷

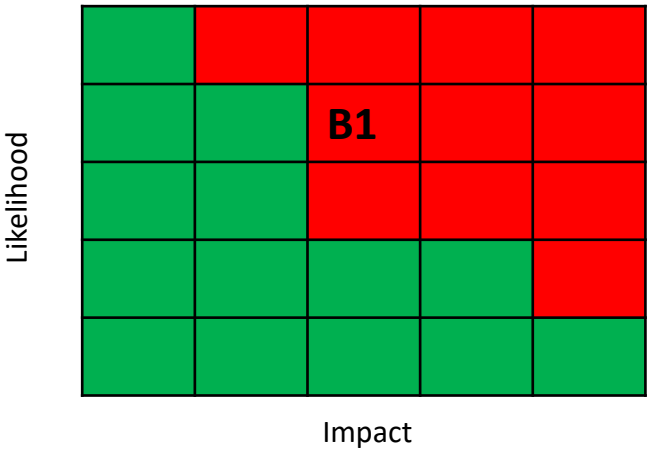
Strategic Objective E: Financial Sustainability

BAF REF	Domain	Principle Risk	Risk Owner	System Board/Assurance Committee	Initial Risk rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
E1	FINANICAL	If we fail to operate within available resources we will cause financial instability and take less VFM decisions leading to poorer outcomes for communities, increasing costs and reputational damage threatening future organisational sustainability	Chief Finance Officer	Finance and Performance	4	5	20	4	4	16	Open 12	OUT	⟷

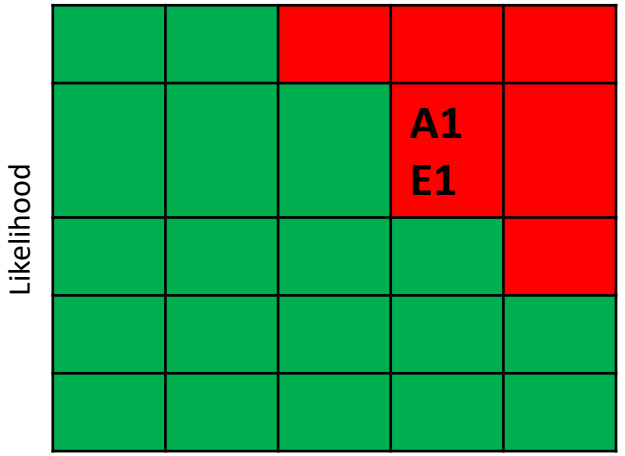
Heat Map

Domains	Risk Appetite	BAF Risk
Quality	*Cautious (8)*	B1
People	*Open (12)*	A1
Performance	*Open (12)*	-
Transformation	*Seek (16)*	C1, D1
Financial	*Open (12)*	E1
Regulatory	*Open (12)*	-
Reputational	*Open (12)*	-

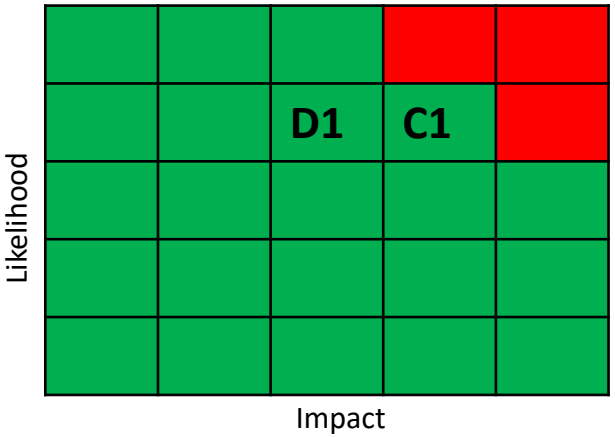
Cautious



Open



Seek



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RISK ANALYSIS

BAF REF:	Strategic Objective:	Principle Risk:	Risk Domain:	Risk Score:
A1	Our People	If the ICB does not create a positive working environment that creates a culture of inclusivity that values a diverse workforce, then our people will not feel listened to and included, our people will become disengaged resulting in workforce gaps, unable to attract diverse talent to the ICB leading to a lack of delivery and we will not achieve our goals	People	12

Risk Owner: Chief People Officer	Assurance Committee: SLT/Remuneration	Date Added to BAF: April 2023

Initial Risk Rating (before mitigation)			Current Risk Rating (after Mitigation)			Risk Appetite	Status (in/out appetite)
I	L	Rating (IxL)	I	L	Rating (IxL)		
4	5	20	4	4	16	OPEN 12	IN

Risk Analysis	Qtr. 1 (23/24)	Qtr. 2 (23/24)	Qtr. 3 (23/24)	Qtr. 4 (23/24)
Current Rating	16	16	16	12

Positive Assurance and Key Controls in Place

- ICS People Board established and has representation across partner organisations and Trade Unions. ICS People Strategy aligned to ICS Joint Forward View. ICS People Board oversighting this work including highlight reporting, engagement plans including alignment with ICB Board Horizons framework.
- EDI strategy and workplan agreed and reporting progress via ICB and system networks and committees.
- PMO reporting to oversight and assure the ICB's governance framework.
- Delivery of key system transformation programmes and indirect approaches such as the HROD Community of Practice and staff engagement networks and opportunities
- Leadership development programmes that are available to partners across the System
- ICB Change Programme Board in place and on track to deliver £4.5m savings
- ICB OD Plan refresh against staff survey results
- ICB Remuneration Committee established, and work plan agreed including oversight of ICB Change Programme

Gaps in Control and/or Assurance

- Data analytics gap due to resourcing issues
- Alignment of system workforce operational plan with finance and activity plans
- Update on redundancy costs for Change Programme due end Q1 2024/25

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update
Analytics resourcing options being progressed via conversation with the ICB's Insights team and partners including CSU and NHSE – Workforce, Training and Education team	31/05/24	CPO	Interim arrangements in place to provide support
Alignment of operational performance oversight with partners and CFO	31/05/24	CPO	Work underway to develop WF reporting specification and plan
Updates through Change Management Programme Board to SLT, RemCom and Board regarding the Change Programme.	31/03/24	CPO	Month update reporting established

BAF REF:	Strategic Objective:	Principle Risk:	Risk Domain:	Risk Score:
B1	Improving Outcome Reducing Inequalities	If the ICB is unable to prioritise prevention and population health programmes then the ICB will not be able to put in place the foundations to improve health and care outcomes and in the long term health inequalities will increase resulting in greater pressure on partner organisations, increasing costs, and resulting in poorer outcomes and experiences for the local people.	Quality	12

Risk Owner: Chief Medical Officer	Assurance Committee: System Quality Group	Date Added to BAF: April 2023

Initial Risk Rating (before mitigation)			Current Risk Rating (after Mitigation)			Risk Appetite	Status (in/out appetite)
I	L	Rating (IxL)	I	L	Rating (IxL)		
5	4	20	4	3	12	CAUTIOUS 8	OUT

Risk Analysis	Qtr. 1 (23/24)	Qtr. 2 (23/24)	Qtr. 3 (23/24)	Qtr. 4 (23/24)
Current Rating	12	12	12	12

Positive Assurance and Key Controls in Place

- Population health approach and health inequality lens in ICS work at system and place, particular focus in the MIMI work
- Our ICS ambitions and ICP strategy
- EHIA within each business case
- EDI director in ICS
- Anticipatory care programme, remote monitoring and proactive management
- Regular links to regional health inequalities group
- Clinical policies review work has begun– SQDG to oversee
- ICS Cardiovascular disease prevention group focussed work to reduce the burden of CV disease morbidity and mortality
- Health and social care partnership (including the VCSE) at place
- Slough and NEHF have increased focus with support from place administrative and clinical leads to tackle health inequalities
- Fuel poverty work in places

Gaps in Control and/or Assurance

- Lack of awareness of usual services (refugees/ asylum seekers)
- Significant system pressures impacting on delivery and recovery
- Digital exclusion
- Language barriers
- Cost of living crisis

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update
Embed Core 20 plus 5 approach with identification of plus groups Deliver improvement in the plus 5 clinical programmes- maternity, SMI, COPD, HT and early diagnosis of cancer	December 2023 for plus groups	Lalitha Iyer	Adult Plus groups identified: carers and LD. Work to agree Paediatric plus groups
Work in places on tackling digital exclusion, Access to NHSE regional expertise, finance and support to facilitate the settlement of refugees and asylum seekers Extended the contracts for interpreting and language services in primary care to ensure adequate communication with the patients	Ongoing	Lalitha Iyer	Work in progress and on track and examples of delivery in places available

BAF REF:	Strategic Objective:	Principle Risk :	Risk Domain:	Risk Score:
C1	Delivering Work & Transformation	If the ICB fails to engage key stakeholders in delivering the transformation agenda or commitment to integration is superficial due to operational and financial pressures then some partners will become disengaged from system integration resulting in delays in the reform, transformation and improvements to public services	Transformation	9

Risk Owner: Chief Transformation Officer	Assurance Committee: Transformation & Delivery Board/F&P and System Quality Group	Date Added to BAF: April 2023

Initial Risk Rating (before mitigation)			Current Risk Rating (after Mitigation)			Risk Appetite	Status (in/out appetite)
I	L	Rating (IxL)	I	L	Rating (IxL)		
4	5	20	4	4	16	SEEK 16	IN

Risk Analysis	Qtr. 1 (23/24)	Qtr. 2 (23/24)	Qtr. 3 (23/24)	Qtr. 4 (23/24)
Current Rating	16	16	16	9

Positive Assurance and Key Controls in Place

- Delivery PMO has been established to ensure that we have a comprehensive baseline of change and transformation programmes occurring across the ICS which contribute to the delivery of the ICS Strategy and / or the NHS Joint Forward Plan
- Triangulation with Allocative Efficiency work and the newly established System Transformation Board to ensure alignment
- System Transformation Board now established and working through its approach to provide impetus for the delivery of change in a relationship led manner

Gaps in Control and/or Assurance

- Variable attendance from system partners at System Transformation Board means that full alignment on system working not yet being realised
- System PMO team has had capacity diverted to implementation of the ICB Change Programme which has limited availability to support this work
- Integrated Care Partnership is a novel construct and there is not yet an emergent consensus on how this statutory joint-committee will prioritise and oversee delivery of the ICS Strategy
- Joint Forward Plan refresh still awaiting approval for Year 2

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update
Ensure Joint Forward Plan refresh is completed to a high quality and approved by 3x NHS organisations	31st July 2024	CTO	New Action
Mitigate PMO capacity through prioritisation and job planning and continue focus on making STB effective	31st July 2024	CTO	New Action

BAF REF:	Strategic Objective:	2nd Principle Risk : HOSTED POD	Risk Domain:	Risk Score:
C2	Delivering Work & Transformation.	The responsibility for the development of a shared operating model for the Pharmacy, Optometry and Dentistry (POD) Hub for the SE Region sits with all six ICBs and NHS England, as the delegating body. However, if the Frimley ICB as the host for the Pharmacy, Optometry and Dentistry (POD) function for the SE Region is unable to develop a single shared vision for a distributed leadership model on behalf of all ICBs in the SE Region, then there is a risk that some ICBs in the SE Region may cease to work collaboratively resulting in the potential fragmentation of the Hub model, which will adversely impact on service transformation and operational effectiveness and delivery across the whole of the SE Region. If the other ICBs in the SE Region do not work collaboratively to mitigate this shared risk then there will be a disproportionate adverse impact on the Frimley ICB because it will be unable to deliver on its responsibilities for developing hosted POD services, which will result in the organisation facing reputational, operational and financial risks.	Transformation	6

Risk Owner: Chief Transformation Officer	Assurance Committee: TBC	Date Added to BAF: October 2023

Initial Risk Rating (before mitigation)			Current Risk Rating (after Mitigation)			Risk Appetite	Status (in/out appetite)
I	L	Rating (IxL)	I	L	Rating (IxL)		
4	4	16	3	2	6	Seek 16	IN

Risk Analysis	Qtr. 1 (23/24)	Qtr. 2 (23/24)	Qtr. 3 (23/24)	Qtr. 4 (23/24)
Current Rating	16	16	6	6

Positive Assurance and Key Controls in Place	Gaps in Control and/or Assurance
Appointment of a POD Director who works for both NHS Frimley ICB and the Collective Established a Resourcing Group with NHS England to manage the funding requirements of the hosting service and any emerging priorities which need resourcing Transformation Board set up at Regional Level co-chaired by ICB Chief Executives and SE Region Chief Executive is successfully overseeing progress	

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update
Establishment of internal control on Internal Management Oversight – Chiefs to have ringfenced time together	Complete	Sam Burrows	Actioned
Development work between POD Leadership Team and NHS England and other ICBs established.	Ongoing	YA	Ongoing

BAF REF:	Strategic Objective:	Principle Risk:	Risk Domain:	Risk Score:
D1	Data and Insights	If the ICB fails to resource, work collaboratively towards the priorities in the Digital strategy or ensure effective adoption of digital solutions then the ICB will not be able to maximise the benefits afforded by the advancement of digital and data and this will hinder the advancements in health care and prevention	Transformation	12

Risk Owner: Chief Transformation Office	Assurance Committee: Digital Board/F&P/System Quality	Date Added to BAF: April 2023

Initial Risk Rating (before mitigation)			Current Risk Rating (after Mitigation)			Risk Appetite	Status (in/out appetite)
I	L	Rating (IxL)	I	L	Rating (IxL)		
4	4	16	4	3	12	SEEK 16	IN

Risk Analysis	Qtr. 1 (23/24)	Qtr. 2 (23/24)	Qtr. 3 (23/24)	Qtr. 4 (23/24)
Current Rating	12	12	12	12

Positive Assurance and Key Controls in Place

- Combination of the Digital Costed Plan, Joint Forward Plan and national strategy give a strong frame for our priority development areas
- Recognising our position as a national leader in this space, we are continuing to leverage our quality and insight to partners inside the system and on a broader geographic footprint
- Financial efficiencies highlighted and identified for 2024/25 without preventing ability to deliver priorities
- Major digital pathway changes (i.e. virtual wards, remote monitoring, etc) are continuing to be developed, implemented and scaled with a view to reducing long term system expenditure on inappropriate acute based care, despite the challenges of funding this work up front.

Gaps in Control and/or Assurance

- Variable system wide attendance at Digital Board is a risk to maintaining alignment across multiple health and care organisations
- Funding model for Connected Care requires a partner led approach with sufficiently robust governance to establishing degree of risk appetite
- Evaluation of digitally led pathway changes or other up front investments in virtual care requires robust evaluation and specific partner oversight controls for examining degree of scaling or exit where appropriate

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update
Working on a financial model to underpin possible new approach on larger footprint	1st October 2024	CTO / CIO	New Action
Continue to identify benefits case for further efficiencies without undermining core delivery function	1st April 2025	CTO / CIO	New Action

BAF REF:	Strategic Objective:	Principle Risk:	Risk Domain:	Risk Score:
E1	Financial Sustainability	If we fail to operate within available resources we will cause financial instability and take less VFM decisions leading to poorer outcomes for communities, increasing costs and reputational damage threatening future organisational sustainability	Financial	16

Risk Owner: Chief Finance Officer	Assurance Committee: Finance and Performance	Date Added to BAF: April 2023

Initial Risk Rating (before mitigation)			Current Risk Rating (after Mitigation)			Risk Appetite	Status (in/out appetite)
I	L	Rating (IxL)	I	L	Rating (IxL)		
4	5	20	4	4	16	OPEN 12	OUT

Risk Analysis	Qtr. 1 (23/24)	Qtr. 2 (23/24)	Qtr. 3 (23/24)	Qtr. 4 (23/24)
Current Rating	16	16	16	16

Positive Assurance and Key Controls in Place

- Robust and effective budgetary control and timely, accurate and complete provision of budgetary intelligence to allow budget holders to take appropriate and effective action to maintain a forecast position which is within the resource envelope delegated to them.
- Focused reporting based on: requirement to manage in-year risk; root cause of variance to plan; exit run rate and underlying position.
- Financial sustainability programme with full executive and Board engagement and embedded within core operating model of the System.
- Dual focus on in year recovery alongside long-term sustainability.

Gaps in Control and/or Assurance

- Financial control performance remains poor, by ISFE metrics. In-housing of CSU capacity is complete but there remain material gaps in capacity and capability while the ICB itself implements it organisational change programme. The remains a requirement for a step-change in financial control environment capability, shift to high-performing financial services function supported by development of financial control competencies organisation-wide.
- Further development and strengthening of financial control regime required, including direct CEO engagement in resource commitment decision making and wider socialisation and utilisation of financial intelligence linked to capacity and performance intelligence.
- Management capacity to deliver transformation alongside day-to-day operational pressures impacting all areas of the system.
- System wide delivery oversight arrangements in their infancy. No current holistic view of delivery of key financial sustainability programmes across the system. Requirement for a single, integrated mechanism to deliver and to provide assurance on the systematic identification and delivery of potential efficiency opportunities.

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update
In-housing SCW CSU Finance and Contracting Team to create a single function	1 February 2024	Debbie Fraser	Work in progress and on track
Additional financial controls implemented as part of the Rapid Turnaround Plan including the implementation of additional non-Pay controls and non-PO, No Pay approaches	Ongoing.	Ollie White	Launched January 2024

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APPENDIX
RISK Matrix

Risk Score Matrix

Likelihood

5	10	15	20	25
4	8	12	16	20
3	6	9	12	15
2	4	6	8	10
1	2	3	4	5

Impact

Low Risk	Medium Risk	High Risk	Significant Risk
1-3	4-8	9-12	15+

Likelihood Score

Likelihood Score		(L)			
Descriptor	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Frequency How often does it/ might it happen	This will probably never happen/ recur	Do not expect it to happen / recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/ recur but it is not a persistent issue	Will undoubtedly happen/ recur, possibly frequently
Probability Will it happen or not? % chance of not meeting objective	<0.1 per cent	0.1-1 per cent	1 -10 per cent	10-50 per cent	>50 per cent

Impact (Consequence) Score

	Consequence score (impact levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Serious	Catastrophic
Impact on the safety of patients, staff or public (physical /psychological harm)	• Minimal injury • requiring no/minimal intervention or treatment. • No time off work	• Minor injury or • illness, requiring minor intervention • Requiring time off work for >3 days • Increase in length of hospital stay by • 1-3 days	• Moderate injury requiring professional intervention • Requiring time off work for 4-14 days • Increase in length of hospital stay by 4-15 days • RIDDOR/agency reportable incident • An event which impacts on a small number of patients	• Major injury leading to long-term incapacity/disability • Requiring time off work for >14 days • Increase in length of hospital stay by >15 days • Mismanagement of patient care with long-term effects	• Incident leading to death • Multiple permanent injuries or irreversible health effects • An event which impacts on a large number of patients
Quality/ complaints/ audit	• Peripheral element of • treatment or service • suboptimal • Informal complaint /inquiry	• Overall treatment or service suboptimal • Formal complaint / • Local resolution • Single failure to meet internal standards • Minor implications for patient safety if unresolved • Reduced performance rating if unresolved	• Treatment or service has significantly reduced effectiveness • Formal complaint/ • Local resolution (with potential to go to independent review) • Repeated failure to meet internal standards • Major patient safety implications if findings are not acted on	• Non-compliance with national standards with significant risk to patients if unresolved • Multiple complaints/ • independent review • Low performance rating • Critical report	• Totally unacceptable level or quality of treatment/ service • Gross failure of patient safety if findings not acted on • Inquest/ombudsman inquiry • Gross failure to meet national standards
Human resources/ Organisational development/ staffing/ competence	• Short-term low • staffing level that temporarily reduces service quality (< 1 day)	• Low staffing level • that reduces the service quality	• Late delivery of key objective/ service due to lack of staff • Unsafe staffing level or competence (>1 day) • Low staff morale • Poor staff attendance for mandatory/key training	• Uncertain delivery of key objective/ service due to lack of staff • Unsafe staffing level or competence (>5 days) • Loss of key staff • Significant numbers of staff not attending mandatory / key training	• Non-delivery of key objective /service due to lack of staff • Ongoing unsafe staffing levels or competence • Loss of several key staff • No staff attending mandatory training key training on an ongoing basis
Statutory duty/ inspections	• No or minimal • impact or breech of guidance/ statutory duty	• Breech of statutory legislation • Reduced performance rating if unresolved	• Single breech in statutory duty • Challenging external recommendations/ improvement notice	• Enforcement action • Multiple breeches in statutory duty • Improvement notices • Low performance rating • Critical reports	• Multiple breeches in statutory duty • Prosecution • Complete systems change required • Zero
Adverse publicity / reputation	Rumors Potential for public concern / media interest Damage to an individual's reputation.	• Local media coverage – short-term reduction in public confidence • Elements of public expectation not being met • Damage to a team's reputation	• Local media coverage – • long-term reduction in public confidence • Damage to a services reputation	• National media coverage with <3 days service well below reasonable public expectation • Damage to an organisation's reputation	• National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) • Total loss of public confidence (NHS reputation)
Business objectives/ projects	Insignificant cost increase/ schedule slippage	• <5 per cent over project budget • Schedule slippage	• 5–10 per cent over project budget • Schedule slippage	• Non-compliance with national 10–25 per cent over project budget • Schedule slippage • Key objectives not met	• Incident leading >25 per cent over project budget • Schedule slippage • Key objectives not met
Finance including claims	Small loss Risk of claim remote	• Loss of 0.1–0.25 per cent of budget • Claim less than • £10,000	• Loss of 0.25–0.5 per cent of budget • Claim(s) between £10,000 and £100,000	• Uncertain delivery of key objective/ Loss of 0.5–1.0 per cent of budget • Claim(s) between £100,000 and £1 million • Purchasers failing to pay on time	• Non-delivery of key objective/ Loss of >1 per cent of budget • Failure to meet specification / slippage • Loss of contract / payment by results • Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	• Loss/ interruption of >8 hours • Minor impact on environment	• Loss/interruption of >1 day • Moderate impact on environment	• Loss/interruption of >1 week • Major impact on environment	• Permanent loss of service or facility • Catastrophic impact on environment
Data Loss / Breach of Confidentiality	Potentially serious breach. Less than 5 people affected or risk assessed as low eg files	• Serious potential breach and risk assessed high eg unencrypted clinical records. Up to 20 people affected	• Serious breach of confidentiality eg up to 100 people affected	• Serious breach with either particular sensitivity eg sexual health details or up to 1000 people affected	• Serious breach with potential for ID theft or over 1000 people affected