NHS
Nottingham and Nottinghamshire

Integrated Care Board Meeting Agenda (Open Session)
Wednesday 14 May 2025 09:00-12:15
Mansfield Civic Centre, Chesterfield Road, Mansfield NG19 7BH

"Every person enjoying their best possible health and wellbeing"

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

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

Our core values:

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

	Item	Presenter	Type *(For Assurance, Decision, Discussion or Information)*	Enc.	Time
	Introductory items				
1.	Welcome, introductions and apologies	Kathy McLean	-	-	09:00
2.	Confirmation of quoracy	Kathy McLean	-	-	-
3.	Declaration and management of interests	Kathy McLean	Information	✓	-
4.	Minutes from the meeting held on 13 March 2025	Kathy McLean	Decision	✓	-
5.	Action log and matters arising from the meeting held on 13 March 2025	Kathy McLean	Discussion	✓	-
	Leadership and operating context				
6.	Citizen Story: NottAlone all-age mental health website	Rosa Waddingham	Discussion	✓	09:05
7.	Chair's Report	Kathy McLean	Information	✓	09:15
8.	Chief Executive's Report	Amanda Sullivan	Information	✓	09:20
	Strategy and partnerships				
9.	ICS Infrastructure Strategy	Bill Shields	Decision		09:30
10.	Joint Capital Resource Use Plan	Bill Shields	Decision		09:45
11.	Primary Care Strategy	Victoria McGregor-Riley	Decision		09:55

	Item	Presenter	Type *(For Assurance, Decision, Discussion or Information)*	Enc.	Time
	Delivery and system oversight				
12.	Assertive and Intensive Community Mental Health Care Action Plan: Delivery Update	Maria Principe	Assurance	✓	10:15
13.	Service Delivery Performance Report	Maria Principe	Assurance	✓	10:30
14.	Quality Report	Rosa Waddingham	Assurance	✓	10:45
15.	Finance Report	Bill Shields	Assurance	✓	11:00
16.	Population Health Management Report: End of Life Care	Maria Principe	Assurance	✓	11:15
	Governance				
17.	Board Assurance Framework: Bi-annual Update	Lucy Branson	Assurance	✓	11:30
18.	Meeting the Public Sector Equality Duty	Rosa Waddingham	Assurance	✓	11:45
19.	Committee Highlight Reports: • Strategic Planning and Integration Committee • Quality and People Committee • Finance and Performance Committee • Audit and Risk Committee • Remuneration and Human Resources Committee	Committee Chairs	Assurance	✓	12:00
	Information items *The following items are for information and will not be individually presented. Questions will be taken by exception.*				
20.	2024/25 Senior Information Risk Owner Annual Report	-	-	-	-
21.	2024/25 Annual Reports from the Board's Committees	-	-	-	-
22.	2025/26 Internal Audit Plan	-	-	-	-
	Closing items				
23.	Risks identified during the course of the meeting	Kathy McLean	Discussion	-	12:10
24.	Questions from the public relating to items on the agenda	Kathy McLean	-	-	-
25.	Any other business	Kathy McLean	-	-	-
	Meeting close	-	-	-	12:15

Confidential Motion:

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

2025/26 Schedule of Board Meetings:

Date and time	Venue
14 May 2025, 09:00-12:00	Mansfield Civic Centre
09 July 2025, 09:00-12:00	Chappell Room, Arnold Civic Centre
10 September 2025, 09:00-12:00	Mansfield Civic Centre
12 November 2025, 09:00-12:00	To be confirmed
14 January 2026, 09:00-12:00	Rushcliffe Arena
11 March 2026, 09:00-12:00	Rushcliffe Arena

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Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**Declaration and management of interests**
Paper Reference:	ICB 25 003
Report Author:	Jo Simmonds, Assistant Director of Corporate Affairs
Report Sponsor:	Lucy Branson, Director of Corporate Affairs
Presenter:	Kathy McLean, Chair

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

Summary:

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

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

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

Recommendation(s):

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

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

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

Board Assurance Framework:
Not applicable to this report.

Report Previously Received By:
Not applicable to this report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Register of Declared Interests

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

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

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

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

Name	Current position(s) held in the ICB	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To	Action taken to mitigate risk
ADAMOU, Marios	Non-Executive Director	South West Yorkshire Partnership NHS Foundation Trust	Employed as a Consultant Psychiatrist	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	Marios Adamou LTD - providing educational and advisory services	Director	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Marios Adamou Ltd.
ADAMOU, Marios	Non-Executive Director	University of Huddersfield	Visiting Professor			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ADAMOU, Marios	Non-Executive Director	Advance Occupational Healthcare Ltd.	Director	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Advance Occupational Health Ltd.
ADAMOU, Marios	Non-Executive Director	Leeds Becket University	Visiting Professor		✓			16/01/2025	Present	This interest will be kept under review and specific actions determined as required.

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ADAMOU, Marios	Non-Executive Director	Medical Professionals Tribunal Service	Tribunal Member	✓				26/02/2025	Present	This interest will be kept under review and specific actions determined as required.
BRIGGS, David	Medical Director	British Medical Association	Member		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Westinghouse LLC (nuclear energy provider)	Employed as Chief Privacy Officer	✓				01/03/2025	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Westinghouse UK Holdings Limited (UK subsidiary of Westinghouse LLC - nuclear	Named Director		✓			01/03/2025	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Venturezen Limited (UK consultancy company)	Named Director		✓			01/03/2025	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Venturezen Consulting Limited (UK consultancy company)	Named Director		✓			01/03/2025	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Saralistair Limited (UK consultancy company)	Named Director	✓				01/03/2025	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Community Academies Trust (multi academy trust governing schools)	Appointed as a Non-Executive Director			✓		01/03/2025	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Triumph Learning Trust (multi academy trust governing schools)	Appointed as a Non-Executive Director			✓		01/03/2025	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Frolesworth Parochial Church Council	Appointed as a Trustee			✓		01/03/2025	Present	This interest will be kept under review and specific actions determined as required.
BROWN, Gary	Non-Executive Director	Frolesworth Parish Meeting	Appointed as Responsible Financial Officer			✓		01/03/2025	Present	This interest will be kept under review and specific actions determined as required.

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JACKSON, Stephen	Non-Executive Director	Nottingham Business Improvement District (BID) - a business-led,not for profit organisation helping to champion Nottingham.	Non-Executive Chair		✓			01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by BID.
JACKSON, Stephen	Non-Executive Director	Nottingham High School	Governor		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Portland College	Governor		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Marketing Nottingham - A not for profit business and the official place marketing organisation for Nottingham City.	Non-Executive Director		✓			01/07/2022	31/12/2024	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Marketing Nottingham.
JACKSON, Stephen	Non-Executive Director	Derbyshire Health United CIC - A not for profit community interest company providing a range of health service provisions.	Non-Executive Director	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by DHU CIC).
JACKSON, Stephen	Non-Executive Director	Imperial Business Consulting Ltd - a management consultancy business, based in Leicestershire.	Joint Owner and Chief Executive Officer	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Imperial Business Consulting Ltd

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JACKSON, Stephen	Non-Executive Director	Ravenshead Surgery (Abbey Medical Group)	Registered patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
JACKSON, Stephen	Non-Executive Director	Nottingham City Transport	Spouse is a Non Executive Director				✓	01/11/2023	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Nottingham Ice Centre	Spouse is a Non Executive Director				✓	01/11/2023	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Birmingham Women's and Children NHS Foundation Trust	Non-Executive Director	✓				01/10/2024	Present	This interest will be kept under review and specific actions determined as required.
JACKSON, Stephen	Non-Executive Director	Futures Housing Group	Non-Executive Director	✓				01/02/2025	Present	This interest will be kept under review and specific actions determined as required.
LALANI, Mehrunnisa	Non-Executive Director	University Hospitals of Birmingham	Non-Executive Director	✓				01/01/2025	01/04/2025	This interest will be kept under review and specific actions determined as required.
LALANI, Mehrunnisa	Non-Executive Director	British association for counselling and psychotherapy	Fitness to Practice Panel Member	✓				01/01/2025	Present	This interest will be kept under review and specific actions determined as required.
LALANI, Mehrunnisa	Non-Executive Director	Coventry University Group	EDI Strategic Lead	✓				01/01/2025	Present	This interest will be kept under review and specific actions determined as required.
LALANI, Mehrunnisa	Non-Executive Director	Post Office Scandal Research Advisory Group	Member			✓		01/01/2025	Present	This interest will be kept under review and specific actions determined as required.
LALANI, Mehrunnisa	Non-Executive Director	Sara (Leicester) LTD	Consultant	✓				01/01/2025	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Sara (Leicester) LTD.

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LIM, Dr Kelvin	Primary Care Partner Member	Eastwood Primary Care Centre	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
MAJID, Ifti	Mental Health Partner Member	Nottinghamshire Healthcare NHS Foundation Trust	Chief Executive	✓				07/12/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by Nottinghamshire Healthcare NHS Trust
MAJID, Ifti	Mental Health Partner Member	NHS Confederation: BME Leaders Network	Chair		✓			07/12/2022	Present	This interest will be kept under review and specific actions determined as required.
MAJID, Ifti	Mental Health Partner Member	NHS Confederation: Mental Health Network	Board Member and Trustee		✓			07/12/2022	Present	This interest will be kept under review and specific actions determined as required.
MAJID, Ifti	Mental Health Partner Member	Ellern Mede - provider of high intensity children and young people's eating disorder services	Spouse is Managing Director				✓	07/12/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Ellern Mede.
MCGREGOR-RILEY, Dr Victoria	Acting Director of Strategy and System Development	Sheffield Teaching Hospitals NHS Foundation Trust	Spouse employed as a consultant surgeon				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

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MCGREGOR-RILEY, Dr Victoria	Acting Director of Strategy and System Development	GP Practice in Bassetlaw	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
MCGREGOR-RILEY, Dr Victoria	Acting Director of Strategy and System Development	Managers in Partnership	Trade Union Representative (voluntary)			✓		01/09/2022	Present	This interest will be kept under review and specific actions determined as required.
MCGREGOR-RILEY, Dr Victoria	Acting Director of Strategy and System Development	Nottingham University NHS Trust (NUH)	Son employed as a Project Coordinator				✓	04/05/2023	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Kathy McLean Limited- Private limited company offering health related advice	Director	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning
MCLEAN, Kathy	ICB Chair	NHS Employers	Member of the Workforce Policy Board		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	NHS Employers	Chair of the national negotiation committee for Staff and Associate Specialists on behalf of NHS Employers		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Care Quality Commission (CQC)	Occasional Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

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MCLEAN, Kathy	ICB Chair	The Public Service Consultants Ltd (Public Sector Consultancy)	Interim Chair	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by The Public Service Consultants Ltd.
MCLEAN, Kathy	ICB Chair	Oxehealth Ltd (vision-based patient monitoring and management)	Member of the advisory board	✓				01/07/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Oxehealth Ltd.
MCLEAN, Kathy	ICB Chair	NHS Derby and Derbyshire Integrated Care Board	Chair	✓				01/05/2024	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	ICB Chair	Oxehealth Ltd (vision-based patient monitoring and management)	Advisor	✓				01/11/2024	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions
MCLEAN, Kathy	ICB Chair	ICS Network Board, NHS Confederation	Chair	✓				01/04/2024	Present	This interest will be kept under review and specific actions determined as required.
MURPHY, Vicky	Local Authority Partner Member	Nottingham City Council	Corporate Director of Adults Social care, Commissioning and Health	✓				01/11/2024	Present	To be excluded from all commissioning decisions (including procurement activities and contract management
PRINCIPE, Maria	Acting Director of Delivery and Operations	Boho Beauty	Owner	✓				01/10/2024	Present	This interest will be kept under review and specific actions determined as required.
SHIELDS, Bill	Chief Finance Officer	HFMA Financial Recovery Group	Chair		✓			01/04/2025	Present	This interest will be kept under review and specific actions determined as required.

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SHIELDS, Bill	Chief Finance Officer	HFMA ICB CFO Forum	Vice Chair		✓			01/04/2025	Present	This interest will be kept under review and specific actions determined as required.
SULLIVAN, Amanda	Chief Executive	Hillview Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
TOWLER, Jon	Non-Executive Director	Sherwood Medical Practice	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
TOWLER, Jon	Non-Executive Director	Major Oak Medical Practice, Edwinstowe	Family members are registered patients				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	The Conservation Volunteers: a national charity bringing together people to create, improve and care for green spaces.	Chair (Trustee and Director)	✓				01/12/2022	Present	This interest will be kept under review and specific actions determined as required.
TOWLER, Jon	Non-Executive Director	The Conservation Volunteers: a national charity bringing together people to create, improve and care for green spaces.	Fellow director is a senior manager at Everyturn Mental Health				✓	01/12/2022	31/12/2024	This interest will be kept under review and specific actions determined as required.
WADDINGHAM, Rosa	Director of Nursing	NHS Professionals (An NHS staff bank, owned by the Department of Health and Social Care)	Member of the Advisory Board		✓			01/09/2023	Present	This interest will be kept under review and specific actions determined as required.
WADDINGHAM, Rosa	Director of Nursing	Florence Nightingale Foundation (FNF) (A charity supporting Nurses and Medwives to improve patient care)	Chair of the FNF Members' Advisory Group		✓			01/09/2023	Present	This interest will be kept under review and specific actions determined as required.

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WADDINGHAM, Rosa	Director of Nursing	Specsavers	Son is Dispensing Manager at Specsavers, Bingham				✓	01/02/2024	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be provided by Specsavers
WADDINGHAM, Rosa	Director of Nursing	Nottingham Trent University	Honorary Professor		✓			11/11/2024	11/11/2027	This interest will be kept under review and specific actions determined as required.
WILLIAMS, Melanie	Local Authority Partner Member	Nottinghamshire County Council	Corporate Director for Adult Social Care and Health	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by Nottinghamshire County Council
WILLIAMS, Melanie	Local Authority Partner Member	Orchard Surgery	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
The following individuals will be in attendance at the meeting but are not part of the Board's membership:										
BRANSON, Lucy	Director of Corporate Affairs	St George's Medical Practice	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.

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HUBBER, Lucy	Director of Public Health, Nottingham City Council	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
HUNT, Philippa	Chief People Officer	NHS Staff Council	ICB Representative		✓			01/09/2023	Present	This interest will be kept under review and specific actions determined as required.
KING, Daniel	VCSE Alliance Chair	Nottingham Trent University	Employee	✓				06/09/2023	Present	This interest will be kept under review and specific actions determined as required.

Appendix B

NHS
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Managing Conflicts of Interest at Meetings

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

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

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

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

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

Integrated Care Board (Open Session)
Unratified minutes of the meeting held on
13/03/2025 09:00-11:45
Rushcliffe Arena

Members present:

Dr Kathy McLean	Chair
Professor Marios Adamou	Non-Executive Director
Dr Dave Briggs	Medical Director
Gary Brown	Non-Executive Director
Stephen Jackson	Non-Executive Director
Mehrunnisa Lalani	Non-Executive Director
Vicky Murphy	Local Authority Partner Member (up to and including item ICB 24 113)
Maria Principe	Acting Director of Delivery and Operations
Amanda Sullivan	Chief Executive
Jon Towler	Non-Executive Director
Rosa Waddingham	Director of Nursing
Melanie Williams	Local Authority Partner Member (up to and including item ICB 24 114)

In attendance:

Lucy Branson	Director of Corporate Affairs
Andrew Fearn	Chief Digital Officer (for item ICB 24 113)
Sarah Fleming	Programme Director for System Development (deputising for Victoria McGregor-Riley)
Philippa Hunt	Chief People Officer (up to and including item ICB 24 111)
David Johns	Assistant Director of Public Health, Nottingham City Council (up to and including item ICB 24 115)
Daniel King	Voluntary, Community and Social Enterprise Alliance Chair
Andrew Morton	Operational Director of Finance (deputising for Marcus Pratt)
Sue Wass	Corporate Governance Officer (minutes)

Apologies:

Dr Kelvin Lim	Primary Care Partner Member
Ifti Majid	NHS Trust/Foundation Trust Partner Member
Victoria McGregor-Riley	Acting Director of Strategy and System Development
Marcus Pratt	Acting Director of Finance

Cumulative Record of Members' Attendance (2024/25)

Name	Possible	Actual	Name	Possible	Actual
Kathy McLean	6	6	Vicky Murphy[5]	2	2
Marios Adamou	6	5	Stuart Poynor[1]	1	1
Dave Briggs	6	6	Marcus Pratt[2]	5	4
Gary Brown[7]	1	1	Maria Principe[4]	3	2
Lucy Dadge[3]	3	1	Paul Robinson[6]	5	1
Stephen Jackson	6	6	Amanda Sullivan	6	6
Mehrunnisa Lalani[5]	2	1	Jon Towler	6	6
Kelvin Lim	6	5	Catherine Underwood[1]	1	1
Ifti Majid	6	2	Rosa Waddingham	6	6
Caroline Maley[3]	3	2	Melanie Williams	6	3
Victoria McGregor-Riley[4]	3	2	-	-	-

1 – Board membership ceased June 2024
2 – Board membership commenced July 2024
3 – Board membership ceased September 2024
4 – Board membership commenced October 2024
5 – Board membership commenced January 2025
6 – Board membership ceased February 2025
7 – Board membership commenced March 2025

Introductory items

ICB 24 103 Welcome, introductions and apologies

The Chair welcomed members to the meeting of the Board. A round of introductions was undertaken, and apologies noted as above. A particular welcome was extended to Mehrunnisa Lalani and Gary Brown, new non-executive members of the Board.

The Chair reminded members of the principles and core values that the Board should seek to uphold during the course of the meeting.

ICB 24 104 Confirmation of quoracy

The meeting was confirmed as quorate.

ICB 24 105 Declaration and management of interests

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

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

ICB 24 106 Minutes from the meeting held on: 09 January 2025

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

ICB 24 107 Action log and matters arising from the meeting held on: 09 January 2025

Four actions were noted as closed and the remaining actions, which all related to items to be placed on the 2025/26 Board Work Programme, would be completed once the Work Programme had been approved at the next meeting. No other matters were raised.

Leadership and operating context

ICB 24 108 Citizen Story: Best Years Hub

Maria Principe presented the item and highlighted the following points:

a) The report provided an insight into the Best Years Hub, a pilot Ageing Well service launched in June 2024 for residents of Newark and Sherwood, and how it had very much improved the health and wellbeing of Mavis, who cared for her husband with dementia. Prior to using the Hub, and with no social engagements of her own and the constant responsibility of caregiving, Mavis had felt trapped in her home, with little opportunity to relax or engage with others.

b) The background to the Best Years Hub was provided. The service had been funded through a successful bid to the Health Inequalities Investment Fund (HIIF). The bid was led by the Mid-Nottinghamshire Place Based Partnership, aiming to address frailty, social isolation and improve access to health services in a community setting. The Hubs were delivered by Newark and Sherwood Community and Voluntary Service, supported by an integrated team of professionals and volunteers working across health, social care, local authority, community, and voluntary sectors.

The following points were made in discussion:

c) Noting that the funding for the project was non-recurrent, members queried how the impact of the pilot would be evaluated in order to determine whether it should become a core service. It was noted that the ICB was in the process of identifying how best to evaluate the pilot, as it would require both qualitative as well as quantitative evaluation. There was further discussion on the use of best practice evaluation tools, and it was noted that all HIIF funded projects would be subject to a rigorous evaluation.

d) The positive impact in terms of the ICB's prevention priorities from a relatively small investment was noted. It was also emphasised that future plans would need to address equity of provision across the ICB's footprint.

The Board **noted** the report, and on behalf of the Board, the Chair thanked Mavis for sharing her story.

ICB 24 109 Chair's Report

Kathy McLean highlighted the following points from her report:

a) Since the last Board meeting there had been several high-profile changes in national NHS leadership roles, alongside a very recent announcement regarding the abolition of NHS England and significant reductions to ICB management costs. Although there had not yet been time to digest the implications of this announcement, which presented a significant leadership challenge for the ICB, it was important for it not to become a distraction from the ICB's primary responsibility to improve healthcare for the population of Nottingham and Nottinghamshire. Further information would be shared with the Board when available.

b) Referencing a recent visit to Sherwood Forest Hospitals NHS Foundation Trust, the Chair noted the impact that the sad news of Paul Robinson's death had had on the staff. Paul had been a much-valued colleague who had made a significant contribution to the local healthcare system.

c) Attending an event for the Phoenix Fellowship Programme to support GPs, it was heartening to see the enthusiasm in the room and hear about some of the work that had been undertaken within the programme that was having a positive impact on communities.

d) Following confirmation that Bill Shields had been successful in a recent recruitment exercise, it was confirmed that this would be a joint appointment with NHS Derby and Derbyshire ICB for the role of Director of Finance, hosted by NHS Derby and Derbyshire ICB from 1 April 2025. As such, it was necessary to make a non-material amendment to the ICB's Constitution to allow for a secondee to be appointed to the Board. The proposed changes, as set out within the report, would be submitted to NHS England for approval, following endorsement by the Board.

The following points were made in discussion:

e) Regarding the recent announcements relating to NHS reforms, Board members emphasised the need to implement robust arrangements to govern and oversight the ICB's transition to its new operating model. The need to ensure ICB staff were well-supported through the process was also noted as a priority.

The Board:

- **Endorsed** the proposed changes to the ICB's Constitution (as provided at item 16 on the agenda), for onward submission to NHS England for formal approval.
- **Noted** the Chair's report for information.

ICB 24 110 Chief Executive's Report

Amanda Sullivan highlighted the following points from her report:

a) Welcoming the publication of the Independent Mental Health Homicide Review, which examined the case of Valdo Calocane, all recommendations in the Review had been accepted by the ICB and Nottinghamshire Healthcare NHS Foundation Trust. A joint action plan had been drafted and robust oversight arrangements were in place to monitor progress. This included enhanced surveillance on the quality of services and real time metrics. An announcement of how the judge-led public inquiry would operate was awaited. The ICB would support any submissions required to the inquiry.

b) Although the publication date of the Independent Review into Maternity Services at Nottingham University Hospitals NHS Trust (NUH) had been delayed, it was noted that considerable progress had been made and recent patient feedback on the service had been positive.

c) Good progress had also been made on the implementation of an action plan to respond to NHS England's enforcement undertakings with regard to the Nottingham and Nottinghamshire NHS system's financial sustainability, as noted by the Board in May 2024. The action plan, as appended to the report, demonstrated that the majority of the actions had been implemented and embedded.

d) Confirmation that negotiations had concluded on the GP Contract for 2025/26 had been welcomed, which would allow for positive engagement with the sector over the coming year.

e) Attention was drawn to the opening of the new emergency care complex at Bassetlaw Hospital.

The following points were made in discussion:

f) There was a query relating to any potential consequence of the delay in the publication of the Independent Review of Maternity Services. In response it was noted that although it may impact psychologically on those staff involved, NHS England had considered it necessary to include the voices of additional families. Donna Ockenden regularly

released learning from the review to all Local Maternity and Neonatal Systems, who were expected to implement the actions as a priority.

g) Discussing the announcement regarding the delay to the Tomorrow's NUH Programme and noting the reference to a strategic approach to estate improvements, members requested that the Chief Executive consider the leadership arrangements for this area of work.

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

Action: Amanda Sullivan to consider the leadership requirements for strategic estates improvements within the system.

Strategy and partnerships

ICB 24 111 Integrated Care System People and Workforce Plan

Rosa Waddingham presented the item, supported by Philippa Hunt, and highlighted the following points:

a) The Integrated Care System (ICS) People and Workforce Plan was being presented to the Board for approval. This was a two-part plan. Part one related to the NHS People Promise and the ten outcomes-based deliverables, as presented to the Board in September 2024. The second part described a potential workforce trajectory for the medium to long term. This would be developed on an iterative basis, taking into account the Government's national workforce plan, which would be published later in the year, alongside local service transformation priorities.

b) Much work had been undertaken and the Plan had been developed on a collaborative basis. It would provide a practical framework for delivering on the requirements of the health and care service and would be refreshed annually to ensure that it remained relevant in a rapidly changing landscape.

The following points were made in discussion:

c) In response to a query regarding how the Plan supported delivery of the Joint Forward Plan, it was noted that the ICS People and Workforce Plan sat above individual organisational workforce plans to provide a framework to move towards a 'one workforce' system. It was further noted that the People and Workforce Plan needed to be used in conjunction with service transformation plans, which sat under the Joint Forward Plan. Work was underway to better articulate

the workforce planning requirements to deliver service transformation, and this would be reflected in the next refresh of the People and Workforce Plan. Members stressed the importance of undertaking this work at pace and the need for it to be completed well-ahead of the next annual refresh of the plan.

d) Members noted that it was currently an NHS-centric plan. In response, this was acknowledged; however, it was noted that at the present time, a lack of data prevented it from being a whole system plan, but it was the ambition to build in broader workforce planning to include the care sector. Members discussed how this could be an opportunity to help recruit at entry level into integrated neighbourhood teams.

e) Noting that the ICB was moving towards a strategic commissioning role, it was noted that the ICB needed to be the facilitators of changing the way that individual organisations undertook workforce planning.

f) Members queried the realism of the ambition to move 20 per cent of the workforce into community settings in five years, given that clinical pathways also needed to be in place to facilitate the shift from hospital to community settings. It was suggested that the Plan should have yearly targets and outcome measures and have in place robust governance arrangements similar to those used in the oversight of financial plans.

g) In summary, it was agreed that a further iteration of the ICS People and Workforce Plan should be presented to the Board in July 2025; this was required to include the detailed workforce transformation plans, a clearer reference to the intent to broaden its scope to the wider social care workforce, further details of governance oversight arrangements, and clear success measures.

The Board **approved** the ICS People and Workforce Plan.

Action: Lucy Branson to add an update on the further development of the ICS People and Workforce Plan to the Board's Work Programme for its July 2025 meeting.

At this point Philippa Hunt left the meeting.

ICB 24 112 Joint Forward Plan: Year-end Delivery Report and Annual Refresh

Sarah Fleming presented the paper, highlighting the following points:

a) The report provided an update on delivery of the 2024/25 NHS Joint Forward Plan (JFP), along with key milestones, including a high-level assessment of risk to ongoing delivery.

b) It also provided detail on the refresh of the JFP (2025-2030) and its alignment with the proposed refreshed Integrated Care Strategy, which would be considered by the Integrated Care Partnership at its meeting on 24 March 2025.

c) A light touch refresh had been undertaken for both the JFP and Integrated Care Strategy in line with national guidance and in recognition of the proposed publication of the Ten-Year Health Plan in late spring 2025. The paper sought approval of the Nottingham and Nottinghamshire NHS JFP for 2025-2030.

d) The refreshed JFP had been developed by NHS partners. It did not revisit the ambitions and remained consistent with the three national policy shifts of treatment to prevention, analogue to digital, and hospital to community, and reaffirmed commitment to the three system strategic principles of promoting prevention, equity, and integration.

e) The focus of joint work during 2025/26 would be on the design and implementation of transformational priorities under the remit of the System Transformation Delivery Group. This included community transformation, frailty, planned care, urgent and emergency care, digital, workforce, corporate optimisation, estates and facilities, best value, medicines optimisation, and procurement.

The following points were made in discussion:

f) Local authority partner members noted that their leadership teams had welcomed the refreshed Integrated Care Strategy and JFP, as a framework to support their planning priorities.

g) Although it was acknowledged that it was a ‘light touch’ refresh, members considered that JFP lacked specificity, and the narrative was too dense. It was also felt that it needed greater clarity of the actions identified to take forward the key priority areas, linked to outcome measures. It was agreed that these areas would be considered within a revised JFP format at the time of updating it in response to the Ten-Year Health Plan.

h) In discussion, members agreed that it was important that the ICB and its NHS partners were able to clearer see which actions they were responsible for delivering.

i) Governance arrangements for overseeing the delivery of the JFP were queried. It was noted that the system's Transformation Delivery Group was currently overseeing progress, but further work in this area was required to strengthen reporting mechanisms.

j) Members noted the stark differences in health outcomes being experienced by people across the neighbourhoods within the ICS. Following discussion, it was agreed that a routine report would be developed for the Board to update on the population health management actions being taken to address these inequalities.

The Board **noted** progress with delivery of key milestones in the NHS Joint Forward Plan during 2024/25 and **approved** the annual refresh of the NHS Joint Forward Plan for 2025/26, pending a further iteration being developed following publication of the Ten-Year Health Plan.

Action: Maria Principe to prepare a series of population health management reports for inclusion within the Board's work programme for 2025/26, focussed on the health outcome areas where stark differences are being experienced at a neighbourhood-level.

At this point Andrew Fearn joined the meeting.

Delivery and system oversight

ICB 24 113 ICS Digital, Data and Technology Strategy: Delivery Update

Andrew Fearn was in attendance to present the paper, highlighting the following points:

a) The report provided the Board with assurance of progress against the ICS strategic digital priorities and goals set out in the ICS Digital, Data and Technology (DDaT) Strategy, which had been approved at the Board's November 2023 meeting.

b) The overall programme was rated as being on track for delivery and the report presented detail on progress against each of the strategic priorities.

c) The Digital Maturity Assessment had been submitted on 13 May 2024. Whilst included in the report, due to significant changes in the assessment process, it was not recommended to make any year-on-year comparisons.

d) Since the last report, the ICB's internal audit function had completed an audit of the programme's governance and an opinion of 'significant

assurance' had been awarded. All agreed actions were being progressed during 2025.

e) Areas where the programme was behind trajectory were noted as the Shared Care Record and the risk that Nottingham City Council would miss the deadline for going live; and up-scaling frontline digitalisation. Issues relating to securing funding over the medium and longer term were also highlighted.

The following points were made in discussion:

f) Regarding the Digital Maturity Assessment, members queried where the ICB sat nationally, and it was noted it sat in the top quartile.

g) When discussing future funding challenges and whether this left the system vulnerable, a number of mitigations were noted, including the system cyber strategy, cash releasing efficiencies being re-invested, and work with local colleges to enable employment of individuals with the necessary technical skills, rather than utilisation of contractors. The opportunity to undertake further joint working with the Derby and Derbyshire system was also noted as a potential area for efficiencies.

h) Members queried how the digital inclusion programme was delivered. It was noted that there was a dedicated team working on this aspect of the strategy at a neighbourhood level.

i) In response to a query about the use of artificial intelligence (AI), it was noted that it was already being used in clinical settings. The huge potential opportunities presented by AI were recognised; however, there was also a need to bear in mind issues of information governance and cyber security.

j) The Chair closed the item by noting its link to the ICB's strategic risk relating to digital transformation, as detailed within the Board Assurance Framework.

The Board **noted** the report.

At this point Andrew Fearn and Vicky Murphy left the meeting.

ICB 24 114 Quality Report

Rosa Waddingham presented the item and highlighted the following points:

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

b) The Quality and People Committee had scrutinised the action plan based on the learnings for the ICB from the Independent Mental Health Homicide Review, noting that good progress had been made.

c) Although there were some areas still requiring improvement, overall, significant progress had been made to maternity services at NUH.

d) Although enhanced oversight measures continued to be in place at Nottingham CityCare Partnership, again good progress was being made and a forthcoming stocktake of progress by the System Quality Group would agree if enhanced surveillance was still required.

e) Significant progress had been made against the identified priority areas for improvement following a stocktake of the Nottinghamshire local area Special Education Needs and Disability Partnership by the Department of Education and NHS England. The assurance rating for Nottingham City was slightly lower, recognising that robust partnership arrangements had not yet been embedded. However, the appointment of a substantive Corporate Director for Children and Education should help to strengthen the Partnership.

The following points were made in discussion:

f) As chair of the Quality and People Committee, Marios Adamou noted that there was a good level of assurance on actions being taken to improve the quality of services; however, over the long term these needed to be translated into demonstrably improved services.

g) With reference to children and young people with complex needs, members noted that it was difficult to assess the level of the new risks discussed in the report, and how the risks were being managed and mitigated. It was agreed that a more detailed report in this area would be presented to the Quality and People Committee.

The Board **noted** the report.

Action: Rosa Waddingham to present a detailed assurance report to the Quality and People Committee regarding the level of risk and mitigating actions being taken in respect of services for children and young people with complex needs.

At this point Melanie Williams left the meeting, and the Chair noted that the meeting was no longer quorate. As no decisions were required for the remainder of the meeting, it was agreed that discussions would proceed as scheduled.

ICB 24 115 Service Delivery Report

Maria Principe presented the item and highlighted the following points:

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

b) Urgent care performance remained a significant challenge, with the system achieving 57 percent for four-hour accident and emergency waits in January 2025, which was below the target of 76 percent. As ambulance handover performance continued to show an improvement and discharge rates remained positive, the focus of activity was to better understand the increase in activity within accident and emergency departments.

c) Work continued with targeted GP practices to support improvement in the target to offer 87 percent of patients an appointment within two weeks.

d) Significant progress had been made in reducing long waiting times for planned care, with a decrease in 65-week wait volumes. However, achieving the goal of zero 65-week waits remained challenging.

e) Cancer care metrics continued to show notable improvement and overall diagnostic backlogs had reduced significantly, although remained above trajectory.

f) The position on mental health out of area placements continued to improve, with one patient in an out of area placement, against a target of seven.

The following points were made in discussion:

g) As interim chair of the Finance and Performance Committee, Jon Towler asked the Board to note that the Committee had requested an in-depth review of urgent and emergency care non-elective admissions to be brought to its March meeting to understand the root causes of the increase in activity, with a focus on Sherwood Forest Hospitals NHS Foundations Trust's accident and emergency department. Members agreed that further assurance in this area was critical in light of the ICB being nationally ranked 41 of 42 ICBs for this area of performance.

h) Members highlighted that it was difficult to take assurance from the report as insufficient information was provided in relation to the actions being undertaken to address services that were under performing. Actions verbally discussed at the meeting were acknowledged; however, it was agreed that future reports needed to include this information.

i) Responding to a query regarding actions to improve the GP 14-day appointment target, it was noted that actions being taken through the Primary Care Strategy, alongside targeted support for practices, were resulting in improvements; however, this was still work in progress. It was noted that the Finance and Performance Committee would be examining performance in this area at an upcoming meeting.

j) The Chair noted the importance of the ICB being cognisant of whether service users considered that services were improving.

The Board **noted** the report.

Action: Maria Principe to ensure future service delivery reports include a succinct summary of the actions being taken to address areas of poor performance, and to include Statistical Process Control charts to illustrate progress against priority metrics.

At this point David Johns left the meeting.

ICB 24 116 Finance Report

Andrew Morton presented the item and highlighted the following points:

a) At month ten, the NHS system was £18.5 million adverse to plan but remained on forecast to deliver a break-even position at year-end. The primary reason was the impact of the phasing of non-recurrent income. Other drivers of the deficit were the consultant pay award and a shortfall of industrial action income. The system's efficiency plan was slightly behind trajectory but remained on forecast to meet the target.

b) The ICB was reporting a £1.0 million deficit to date; however, the overall year-end forecast remained as break-even, and the efficiency plan remained on forecast.

c) Although there remained a risk to the break-even position, particularly due to planned efficiencies that were backloaded to deliver in the final quarter of the financial year, it was considered to be a manageable risk, as technical non-recurrent actions could be implemented to ensure that the target was met.

The following points were made in discussion:

d) As interim chair of the Finance and Performance Committee, Jon Towler asked the Board to note that following an in-depth review at

the Committee's February meeting, there was an increased level of assurance that financial targets would be met. The Committee had noted that areas of pressure for the 2025/26 financial year would be pay costs and the need to focus on finding recurrent efficiency savings.

e) On behalf of the Board, the Chair thanked all involved for their hard work throughout the year towards what had been an extremely challenging financial target.

The Board **noted** the report.

Governance

ICB 24 117 Committee Highlight Reports

The report presented an overview of the work of the Board's committees since its last meeting in January 2025; it aimed to provide assurance that the committees were effectively discharging their delegated duties and included assessments of the levels of assurance the committees had gained from their work during the period. The report also provided a summary of the high-level operational risks being oversighted by the committees.

The Chair noted that updates from Committee Chairs had already been provided during related discussions under agenda items ICB 24 114, ICB 24 115 and ICB 24 116. Further updates from the Committee Chairs were invited by exception and the following points were highlighted:

a) As chair of the Strategic Planning and Integration Committee, Jon Towler asked the Board to note that the Committee had been overseeing the development of the community pharmacy, optometry and general dental chapters of the Primary Care Strategy. Further work on the strategy was being taken forward in response to the Committee's feedback and the final strategy was due for Board approval in the coming months. The Committee had also received an initial update on the developing role of Integrated Neighbourhood Teams; a further deep dive report on the four proof of concept Integrated Neighbourhood Teams would be received in June 2025.

b) As interim chair of the Audit and Risk Committee, Stephen Jackson asked the Board to note that the ICB's Internal Audit function had provided an opinion of substantial assurance following a recent review of the ICB's governance arrangements.

The following points were made in discussion:

c) Members queried the benefits that had been realised since the ICB had taken on delegated commissioning responsibility for pharmacy, optometry, and dentistry services from NHS England. Following discussion, it was agreed that an assurance report in this area would be scheduled.

The Board **noted** the reports.

Action: Lucy Branson to schedule an assurance report within the Board's work programme for 2025/26 to demonstrate the benefits being achieved by the ICB for pharmacy, optometry and dentistry services since taking on delegated commissioning responsibility from NHS England.

Information items

ICB 24 118 ICB Constitution

This item was received for information.

ICB 24 119 2024/25 Board Work Programme

This item was received for information.

Closing items

ICB 24 120 Risks identified during the course of the meeting

Noting the discussion regarding the recent announcement by the Government of cuts to ICB management costs under item ICB 24 109, new risks would be discussed and registered, as appropriate.

Action: Amanda Sullivan to progress the development of new risks to be added to the ICB's Operational Risk Register relating to the reduction in the ICB's management costs.

ICB 24 121 Questions from the public relating to items on the agenda

No questions had been received.

ICB 24 122 Any other business

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

Date and time of next Board meeting held in public: 14 May 2025 at 9:00 (Mansfield Civic Centre)

NHS
Nottingham and Nottinghamshire

ACTION LOG from the Integrated Care Board meeting held on 13/03/2025

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Closed – Action completed	14.11.2024	ICB 24 064: Experience of autistic people and citizens with a learning disability	To provide the Board with an update on the impact of the Oliver McGowan training to the May 2025 meeting.	Rosa Waddingham	14.05.2025	See agenda item 8.
Closed – Action completed	14.11.2024	ICB 24 071: Quality Report	To schedule a Board seminar early in 2025/26 focused on the community transformation programme and development of integrated neighbourhood teams.	Lucy Branson	31.03.2025	Added to the Board's work programme for 2025/26 – see agenda item 7.
Closed – Action completed	14.11.2024	ICB 24 073: Finance Report	To schedule a Board seminar early in 2025/26 focused on the system's ambition to work differently with VCSE partners through Place-Based Partnerships.	Lucy Branson	31.03.2025	Added to the Board's work programme for 2025/26 – see agenda item 7.
Closed – Action completed	14.11.2024	ICB 24 075: Committee Highlight Reports	To include the actions taken by the ICB following the adoption of the Race Health Inequalities Maturity Matrix within the Annual Equality	Rosa Waddingham	14.05.2025	See agenda item 18.

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
			Diversity and Inclusion Report for 2024/25.			
Closed – Action completed	09.01.2025	ICB 24 088: Chief Executive's Report	To schedule a Board session focussed on integration of health and social care as part of the Annual Work Programme for 2025/26	Lucy Branson	31.03.2025	Added to the Board's work programme for 2025/26 – see agenda item 7.
Closed – Action completed	09.01.2025	ICB 24 089: Healthwatch Report	To present a report on the actions being taken to improve complaints procedures to an upcoming meeting of the Quality and People Committee; to be complemented by a citizen story for a future Board meeting.	Rosa Waddingham	31.03.2025	Added to the Quality and People Committee's work programme for 2025/26, scheduled for consideration at the May 2025 meeting.
Closed – Action completed	09.01.2025	ICB 24 091: Integrated Care System Green Plan Progress Report	To ensure that responses to the points raised regarding system leadership, carbon literacy training, and integrating net zero considerations into 'business as usual' processes are included in the next scheduled Green Plan update to the Finance and Performance Committee.	~~Marcus Pratt~~ Bill Shields	31.03.2025	Added to the Finance and Performance Committee's work programme for 2025/26, scheduled for consideration at the June 2025 meeting.

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Closed – Action completed	13.03.2025	ICB 24 110: Chief Executive's Report	To consider the leadership requirements for strategic estates improvements within the system.	Amanda Sullivan / ~~Marcus Pratt~~ Bill Shields	14.05.2025	To be discussed during agenda item 9.
Closed – Action completed	13.03.2025	ICB 24 111: ICS People Plan	To add an update on the further development of the ICS People and Workforce Plan to the Board's Work Programme for its July 2025 meeting.	Lucy Branson	14.05.2025	Added to the Board's work programme for 2025/26 – see agenda item 7.
Closed – Action completed	13.03.2025	ICB 24 112: Joint Forward Plan	To prepare a series of population health management reports for inclusion within the Board's work programme for 2025/26, focussed on the health outcome areas where stark differences are being experienced at a neighbourhood-level.	Maria Principe	14.05.2025	Added to the Board's work programme for 2025/26 – see agenda item 7.
Closed – Action completed	13.03.2025	ICB 24 114: Quality Report	To present a detailed assurance report to the Quality and People Committee regarding the level of risk and mitigating actions being taken in respect of services for children and young people with complex needs.	Rosa Waddingham	14.05.2025	See agenda item 19.

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Closed – Action completed	13.03.2025	ICB 24 115: Service Delivery Report	To ensure future service delivery reports include a succinct summary of the actions being taken to address areas of poor performance, and to include Statistical Process Control charts to illustrate progress against priority metrics.	Maria Principe	14.05.2025	See agenda item 13.
Closed – Action completed	13.03.2025	ICB 24 117: Committee Highlight Reports	To schedule an assurance report within the Board's work programme for 2025/26 to demonstrate the benefits being achieved by the ICB for pharmacy, optometry, and dentistry services since taking on delegated commissioning responsibility from NHS England.	Lucy Branson	14.05.2025	Added to the Board's work programme for 2025/26 – see agenda item 7.
Closed – Action completed	13.03.2025	ICB 24 120: Risks identified during the course of the meeting	To progress the development of new risks to be added to the ICB's Operational Risk Register relating to the reduction in the ICB's management costs.	Amanda Sullivan	14.05.2025	An initial set of transition risks have been developed. These will be added to the ORR for the next reporting period.

Key:

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

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**Citizen Story: NottAlone all-age mental health website**
Paper Reference:	ICB 25 006
Report Author:	Julie Cuthbert, Head of Communications
Executive Lead:	Rosa Waddingham, Director of Nursing
Presenter:	Rosa Waddingham, Director of Nursing

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

Summary:

This paper provides a citizen's story on how the co-production of the NottAlone website has delivered value to residents across Nottingham and Nottinghamshire.

https://nottalone.org.uk/ is a website sharing local mental health advice and help for people of all ages in Nottingham and Nottinghamshire. If an individual needs advice and help for their own or someone else's mental health, NottAlone can provide information, advice and where to go to get help locally; in person, online or by phone.

Co-production has been a core value at the heart of NottAlone from the very beginning, ensuring that every part of the website, brand and the language used feels right for the people of Nottingham and Nottinghamshire. Groups of local people, some with lived experience of mental health struggles, have contributed through insights and input to the development of the new website and branding.

The NottAlone website is a well-used resource. In March 2025, there were 1,775 site visitors of which 1,479 were new users. The website is being continually monitored and updated and the people involved in the co-production work continue to influence its content.

The paper also covers the future of co-production in mental health.

Recommendation(s):

The Board is asked to **discuss** this item.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	Nottingham and Nottinghamshire NHS Joint Forward Plan (2024 – 2028) has a delivery commitment to improve outcomes for those who experience poor mental health. By continuing to invest in the NottAlone website will be supported to access support earlier, therefore enabling preventative approaches to managing good mental health.
Tackle inequalities in outcomes, experience, and access	NHS Core20PLUS5 (2022) identifies mental health as one of the five focus clinical areas requiring accelerated improvement. Nottingham and Nottinghamshire Integrated Care Strategy 2023 - 2027 (2024) commits the Integrated Care System (ICS) to prioritising mental health

How does this paper support	the ICB's core aims to:
	via delivering the priorities of the NHS Mental Health Implementation Plan. Residents have been involved in co-producing the NottAlone resource to ensure it meets service user need. Further developments to tackle inequalities in outcomes, experience and access arrangements have been agreed with the joint commissioners. These include the development of: • Coordination and promotion of training for professionals • Analysis of website feedback to inform service improvements • Promotion of service waiting times, to support service users in decision making regarding provision • Accessibility developments.
Enhance productivity and value for money	Investing in this low cost website, enables residents, families, and carers to access self-help advice and information and therefore reduces demand on pressured mental health services. Where self-help information is insufficient to meet need the website facilitates accurate signposting to service support. The NottAlone website reports information on usage, which is reviewed to inform website developments.
Help the NHS support broader social and economic development	Emotional and behavioural problems, if left unaddressed, often persist. By continuing to invest in the NottAlone website residents will be supported to access support earlier, therefore enabling preventative approaches to managing good mental health.

Appendices:
None.

Board Assurance Framework:
Not applicable.

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Citizen Story: NottAlone all-age mental health website

Debra’s story

Introduction

1. Debra Dulake played a crucial role in the co-production of the NottAlone website, a project that provides mental health resources and support to all ages. Her involvement spanned from the initial stages to the final implementation, showcasing the importance of patient and public voices in service development.
2. Debra was introduced by the lead project manager who presented the project to the My Life Choices group. My Life Choices is a strategic co-production group that ensures that the voice of people with lived experience is integral to the development and delivery of personalised care, supporting the necessary need for culture change.

Co-production process

3. The co-production process began with a session where members of the My Life Choices group shared their ideas and feedback. Debra then collaborated with the project team to refine these ideas and integrate them into the project. She regularly updated the My Life Choices group during their monthly meetings, ensuring that the wider group remained involved and informed.

Personal motivation

4. Debra's motivation for participating in the project stemmed from her own lived experiences with mental health issues, including depression, post-natal depression, and Post Traumatic Stress Disorder after a traumatic divorce. Debra recognised the importance of holistic health and the need for services to be developed with input from those who have experienced mental health challenges.

Development and testing

5. Debra was actively involved in all stages of the website's development, including the initial planning, procurement, web design, and testing phases. She provided valuable feedback on the website's content, language, and functionality, ensuring that it was inclusive and user-friendly. Her input was instrumental in adapting the language from the children's section to suit adult users.

Impact and legacy

6. The NottAlone website is a well-used resource. In March 2025, there were 1,775 site visitors of which 1,479 were new users. The average time spent on the website was 45 minutes.

7. The website has several user pathways depending on a user's age and their reason for visiting. This was something that was very much at the heart of the development of the new site. Data for March 2025 shows 360 users were visiting to seek information and support for someone else, and 357 visitors were visiting for themselves.

8. The NottAlone website has had an impact, not only in Nottingham and Nottinghamshire but throughout the UK. Debra uses the website as a resource in her role as a helpline advisor for the Patients Association. The success of this project highlights the value of co-production and the importance of involving patients in service development.

Conclusion

9. Debra's involvement in the development of the NottAlone website exemplifies the power of co-production. Her lived experiences, dedication, and collaborative efforts have contributed to the creation of a valuable resource that supports mental health and well-being. This project stands as a testament to the positive outcomes that can be achieved when citizens are actively involved in the development of services.

Debra said: "The co-production for this project worked amazingly from start to finish. It was lovely that I was able to see the whole process.

I was pulled into the whole bigger picture of how these projects are commissioned. I had a yes/no vote on the procurement and was involved in conversations with the web design company as well. We had some really great conversations with the web designers with regards to colours, language, and the flow of the website. And I was also involved in the testing.

They welcomed my feedback, and I do not think there was ever a point where they did not take it on board. Often acknowledging that they had never considered the points I was making but that this aspect was so important. Keeping My Life Choices updated also made it possible for us all to be involved by representation.

People with lived experience need to be part of the process when developing services. The NottAlone adult website is an absolute case in point, which shows how amazingly it works when there is a group of patients involved. Not only for the patients but for the staff who are doing the work.

What was absolutely fundamental is how the relationship was built between staff and myself and how that process was encouraged. I felt listened to and heard, I definitely felt like this was an equal partnership.

Being part of these co-production projects has given me confidence to return to working after eight years. I now work for the Patient's Association as a helpline advisor helping people across the UK. I use the NottAlone website as a resource to signpost people to. I am incredibly proud of the website and my involvement in its development."

The future of coproduction in mental health

10. The Nottingham and Nottinghamshire Adult and Children's Mental Health Partnership Board has identified improving coproduction as one of its three key Board priorities for 2025/26, with the aim of strengthening coproduction with individuals accessing mental health services and their carers at both an individual care level and at a strategic influencing level. A delivery group is in the process of being established to drive and oversee progress. This will be co-chaired by Rosa Waddingham, Director of Nursing, and Richard Falvey, Partners in Mind Expert by Experience.
11. Partners in Mind is an adult mental health co-production group focused on supporting the transformation and commissioning of local mental health and well-being services, and the integration of mental health services across the health and care system through the delivery of the Integrated Mental Health Pathway Strategic Plan 2024/25 – 2026/27. Formed in April 2024, membership of the group includes people with a wide range of lived experience of mental health services.
12. Partners in Mind support a wide range of system transformation work and have two members on the Nottingham and Nottinghamshire Adult and Children's Mental Health Partnership Board to represent the views of people with lived experience at a strategic level.
13. The group is independently supported by Improving Lives, a local mental health Voluntary Sector Organisation, who provide facilitation and support to the group. This provision was co-produced with the Partners In Mind group, who designed the support they required to work effectively and were members of the procurement and selection process.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**Chair's Report**
Paper Reference:	ICB 25 007
Report Author:	Dr Kathy McLean, ICB Chair
Report Sponsor:	Dr Kathy McLean, ICB Chair
Presenter:	Dr Kathy McLean, ICB Chair

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

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

Recommendation(s):
The Board is asked to **note** this item for information.

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

Appendices:
A: Integrated Care Strategy Annual Report B: Board Work Programme 2025/26

Board Assurance Framework:
Not applicable.

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Chair’s Report

Introduction

1. Just before and after the last public meeting of the Board, there were a number of announcements regarding a new approach to the leadership of the NHS nationally and locally. This included some material announcements about the role of ICBs and our management costs.
2. On 1 April 2025, NHS England wrote to all ICBs and NHS Providers[1] setting out the expectations for the 2025/26 plan delivery and also management cost reductions across ICBs and health providers.
3. The Chief Executive will outline in her report the approach that the ICB is taking to delivering this mandate, but I want to describe the arrangements I have asked to be put in place at a Board and Non-Executive level.
4. A long-arranged meeting of the two Boards for Nottingham and Nottinghamshire ICB and Derby and Derbyshire ICB took place on 9 April 2025. The timing did naturally afford the opportunity for the two Boards to consider the content of the communication from NHS England. We reviewed the known detail behind these announcements and also discussed the position to date on joint working between the ICBs. This included reflections and learnings on the development of strategic commissioning functions over recent times.
5. Members of the Boards felt that this initial conversation was both informative and helpful and committed to continuing to build upon this discussion over the months to come.
6. A national working group to develop a ‘Model ICB’ has been convened and I have been able to take part in those conversations as an ICB Chair and as Chair of the NHS Confederation ICB Network. There are further discussions to be held, and it is expected that by the end of May we will be able to be clearer on what the impact of these changes is on teams and roles for the ICB.
7. The ICB has established appropriate executive governance of this change, and I have asked that there is non-executive oversight of this across both ICBs. The Deputy Chair from Nottingham and Nottinghamshire will chair this forum supported by non-executive colleagues from both ICB’s Boards.
8. As we will see later on in the agenda, I am pleased that our system and the ICB itself delivered on the financial expectations for the year ending March 2025. It is a testament to the hard work of teams throughout the ICB and the wider system that we have achieved this with limited impact on the frontline services provided to citizens.

[1] https://www.england.nhs.uk/long-read/working-together-in-2025-26-to-lay-the-foundations-for-reform/

9. As previously discussed, the requirement to achieve financial balance by the end of March 2026 means that we will need to achieve a very similar level of savings for the year ahead of us. The plans that have already been developed across the system give me a high level of confidence in delivering this, but the potential disruption caused by the management cost reductions described above will need to be carefully mitigated against.

Developing our system

10. At the Integrated Care Partnership meeting on 24 March 2025, I was delighted to lead a discussion reflecting on the achievements across the ICS over the last year. The Annual Report produced sets out an inspiring summary of the work of many colleagues across the system, making progress on our four strategic aims. The Annual Report is attached at Appendix A for information.
11. It was also really positive that the ICP approved the 'light touch' refresh of the Integrated Care Strategy. This therefore sets our overall priorities for the coming year. Our collective system focus is on health and work, children and young people, and people living with frailty or complex needs, with the enabling roll out of Making Every Contact Count.
12. This refresh was necessarily light touch given the pending publication of the Government's Ten Year Health Plan, which we expect to see very soon. Receipt of this will enable us to make any material changes to our strategy as required.
13. In early April, I was pleased to spend some time with the Targeted Lung Health Checks team from the ICB who are delivering excellent work in our communities and have detected over 350 cancers to date through careful community engagement and outreach, led by insights and intelligence.
14. I was also pleased to attend a meeting of the South Nottinghamshire Place Based Partnership (PBP) last week, building on the updates we have received from our PBPs at this Board, it was great to see the work discussed there in person. Thanks to Paddy Tipping and the team for inviting me to observe the meeting.
15. I have an exciting programme of visits to our Voluntary, Community and Social Enterprise partners over the coming period and always welcome other suggestions of services and projects that I can spend some time with.
16. I have also made sure to continue to spend time with other Chairs and with our Elected Members from across the system, maintaining connections and supporting the executive teams to deliver on our strategic priorities.
17. Finally, in terms of external partnerships, I was delighted to meet with Claire Ward, Mayor of the East Midlands, and her top team last month. Jointly with the Chief Executives of Nottingham and Nottingham and Derby and Derbyshire

ICBs, we were able to have a very illuminating conversation with Claire about Local Government re-organisation, the role of the ICBs in inclusive growth, in particular the ‘health and work’ agenda, and also explore the role of the Mayor in our Integrated Care Partnerships.

Looking forward

18. We know that the Government will set out its plans for spending and key public sector reforms at the Spending Review, which will conclude on 11 June 2025. Around this time the Ten-Year Health Plan is also expected to be published.

19. These are two key moments for us, alongside the ongoing progress of delivering on the mandate from NHS England regarding management cost reductions. Therefore, by the time of our July Board meeting, we will have greater clarity, and I look forward to discussing with Board members then, or before, if circumstances require it.

20. It is clear that we are now well into a period of significant change. As we navigate through that together, I want to acknowledge the uncertainty it brings and the anxiety it may cause for colleagues within the ICB. Change is never easy, but together I hope that we can face these challenges with resilience and adaptability. I want to place on record my thanks to ICB staff for their dedication – this whole Board recognises that your efforts are invaluable as we move forward with purpose and resolve.

Board matters

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

22. An initial work programme for 2025/26 has been developed that aims to build on progress made by the Board over the past year. This is provided for information and feedback at Appendix B.

23. The work programme will be used to steer agenda planning; however, we will keep this under review as the year progresses, and as our ICB transition arrangements become clearer.

24. I have also continued my practice of observing our committees as they do the ‘heavy lifting’ of assuring and steering the work of the ICB. This has been one of the ways that I have been able to gather input into the appraisal and objective setting process for our Non-Executive Directors, which I am in the process of completing. Now that we have a full complement of non-executives once again, this will help to support the work of the Board and its committees as we move forward into the period of change ahead of us.

Integrated Care Strategy Annual Report

March 2025

Integrated Care System
Nottingham & Nottinghamshire

Supporting a shift towards prevention

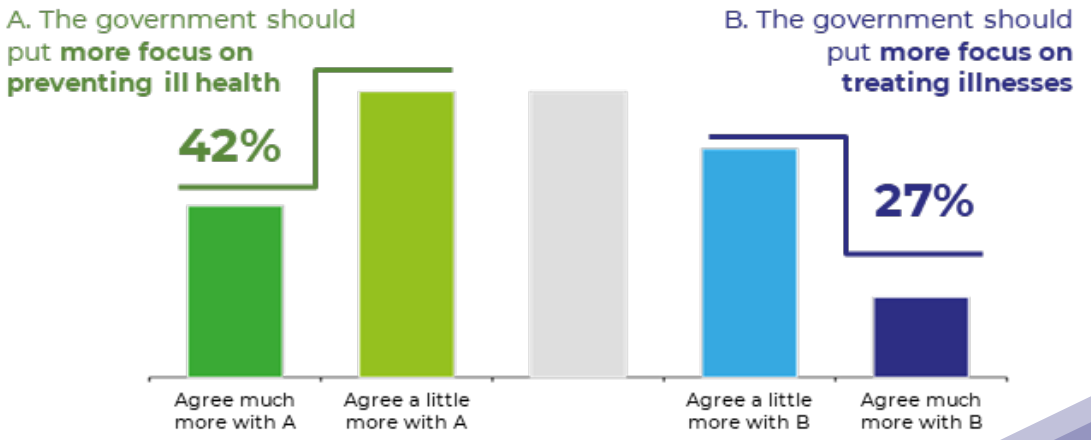
People in our ICS are dying earlier than they should...

...and living with illness and disability longer

Our system has a significant challenge with deprivation...

...and the public want a shift towards prevention

Public survey on what they want from their health and social care system[1]



Source: The Health Foundation / IPSOS Mori

Integrated Care System
Nottingham & Nottinghamshire

Our Integrated Care Strategy

Our Integrated Care Strategy agreed in March 2023 commits us to the four ICS aims and the principles of prevention , equity and integration.
We are committed to maintaining this focus for the people of Nottingham and Nottinghamshire.

Joint Health and Wellbeing Strategy Nottinghamshire County Council

Joint Health and Wellbeing Strategy Nottingham City Council

NHS Joint Forward Plan

Feedback for our stakeholder community

Population health data and intelligence

Our priorities for delivery in 2025/26

Promotion of good work and employment which significantly contributes to overall mental and physical health as well as broader social and economic regeneration

Support for **children and young people** to have the best possible health outcomes, recognising that our children are 20% of our population but 100% of our future

Improving our offer of support to people living with **frailty or complex needs** , recognising this offers opportunity to improve outcomes and promote cost effectiveness of resources.

Continued roll out of Making Every Contact Count across our wider partnership

Prevention is better than a cure

Equity in everything

Integration by default

We are committed to improving outcomes for local people

Our **System Analytics and Intelligence Unit** have developed an interactive dashboard for the ICS Outcomes Framework so that we can monitor the impact of the strategy on outcomes for the population.

Our latest data on high level outcomes for our population show a worsening position, in line with what other areas of the country have seen. However, the latest data shows that the more detailed measures underneath these outcomes are moving in the right direction. Our Integrated Care Partnership remain committed to improving outcomes for local people and recognise that we still have some work to do.

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

Healthy Life Expectancy	Life Expectancy	Health Inequalities
Baseline (2018-2020): **Females** : 57.2 years Nottingham 60.0 Nottinghamshire **Males** : 57.3 years Nottingham 62.4 years Nottinghamshire	Baseline (2018 - 2020): **Females:** 81.0 years Nottingham 82.6 years Nottinghamshire **Males** : 76.4 years Nottingham 79.5 years Nottinghamshire	Baseline (2018-20): **Females** : 7.6 years Nottingham 7.7 years Nottinghamshire **Males** : 8.4 years Nottingham 9.3 years Nottinghamshire
Latest (2021 - 2023) **Females:** 56.8 years Nottingham 59.7 Nottinghamshire **Males:** 57.2 years Nottingham 60.0 years Nottinghamshire	Latest (2021 - 2023): **Females** : 80.6 years Nottingham 82.9 years Nottinghamshire **Males** : 76.2 years Nottingham 78.9 years Nottinghamshire	Data for 2018-2020 are the latest available
Source: Public Health Outcomes Framework	*Source: Public Health Outcomes Framework / Office for Health Improvement and Disparities (OHID) Fingertips*	*Source: Public Health Outcomes Framework* A local methodology is being developed using Patients registered with a GP Practice.

What we've achieved (examples)

1. Improve outcomes in population health and healthcare

Best start
Mental Health Support Teams in Schools continue to expand. Rollout has been targeted to areas of highest need with 55% coverage in schools in the city and 35% of all schools in the county.
The new Young Carers Support Service has supported 534 young carers.

Living well
Since September 2022, hypertension diagnosis across the ICS has increased by 10.4% (August 2024) with over 17,800 new cases diagnosed.
Development of an ICS wide framework for Making Every Contact Count training.

Ageing well
The Best Years Hubs launched in June 2024 in both Newark and Sherwood providing support on managing long-term conditions for those over 65 years.

2. Tackle inequalities in outcomes, experiences and access

Best start
Built collective recognition of the benefit fluoridation will bring for residents, especially Children and Young People.
Health Inequalities and Innovation Fund (HIFF) supported a range of activities, including two new obesity services for children and young people.

Living well
Local Authority commissioned health and wellbeing services have supported over 10,000 people in making positive lifestyle changes (i.e. stopping smoking, losing weight, being more physically active or reducing alcohol consumption).

Ageing well
Severe Mental Illness (SMI) healthchecks commissioned via SMI Locally Enhanced Service (LES) and Health Improvement Workers in place. Exceeded national target by 2% at 62% in 24/25.

3. Enhance productivity and value for money

Development of 'one version of the truth' dashboards for agreed system metrics and outcomes.

Six-day working is in place at Nottingham University Hospitals and Sherwood Forest Hospitals integrated discharge hubs.

System Transformation Delivery Group in place with eleven transformation programmes agreed to support step changes in productivity and efficiency including: community transformation, frailty, planned care, urgent and emergency care, digital/IT, workforce, corporate optimisation, estates and facilities, best value opportunities, medicines optimisation, and procurement.

Key enabling strategies and plans further developed to support ways of working: ICS Workforce Strategy, ICS Research Strategy, ICS Infrastructure Strategy, Medicines Optimisation, Primary Care Strategy, ICS Mental Health

4. Support broader social and economic growth

Working Well – East Midlands Individual Placement and Support in Primary Care service has been established to support people with a disability or physical and mental health issues to find, stay and thrive in employment.

All tenders now have a minimum of 10% weighting on social value.

Evaluation of Social Advice Prescribing Link Workers embedded in three Primary Care Networks showed evidence of substantial financial gain among service users e.g. estimated £380,000.

Food insecurity JSNA profile pack developed to provide recommendations for local action and research.

ICS Green Plan 2022-2025 commitments met.

Partnership with the charity Become to provide a framework for onboarding care experienced young people and to provide training to raise awareness for staff.

Nottingham and Nottinghamshire at our Health and Care Awards 2024: Celebrating our successes

https://healthandcarenotts.co.uk/health-and-care-award-2024-winners-announced/

Health inequalities award:
Broxtowe Learning Disability Collaborative

Equity award:
Swim Sista Swim

Partnership award:
Men at the Edge

Prevention award:
Opportunistic Flu Vaccinations at NUH

Value for money award:
Acute Home Visiting Service for Mid Notts

Best outcome award:
Diabetes Transition and Young Person

Social value award:
Rhubarb Farm Team

Information about all of our shortlisted projects can be found on our website

https://healthandcarenotts.co.uk/integrated-care-strategy/celebrating-success/health-and-care-awards-shortlisted-2024/

Integrated Care System
Nottingham & Nottinghamshire

We continue on our journey of culture change

Prevention is better than a cure

Equity in everything

Integration by default

In 2024 we ran workshops to explore the adoption of our core principles across the system and their understanding by staff from front line to boardroom.

Key Findings:

A shared understanding of the three principles needs to be developed so that we can bring them to life:

Prevention – the workshops highlighted the differences in understanding of 'prevention' as well as the competition and sometimes conflict, between preventing demand and preventing ill-health.

Equity - equity and equality are often used interchangeably however, there is a difference between applying approaches that are equitable or that address inequalities. Support is needed from all partners to take step changes to implement "universal proportionalism" in how we distribute funding to those most in need.

Integration – the workshops highlighted the need to see this as a spectrum rather than absolutes.

Holistic journeys through health and care services need to be promoted e.g. embedding Making Every Contact Count.

The infrastructure and culture to support the three principles need to be embedded in how we work both within organisations and together in partnership e.g. the strategy principles should be embedded in student / new starter training to reach all staff.

Integrated Care System
Nottingham & Nottinghamshire

Our Partners Assembly met on the 3rd February 2025 to discuss the strategy for the coming year

System goals

There was strong support for the System's goals especially prevention and community however many wanted to focus on outcomes and action over high-level theory.

Working together

Delegates highlighted how important it is for organisations to align more effectively, tackle issues and possibilities together and strengthen regional partnerships.

Empowerment

Many agreed that more services should shift from hospitals to community settings, with stronger voluntary sector support and empowered individuals.

Digital

Digital transformation can improve efficiency, but data security, ethical concerns and accessibility should be tackled. Integrated IT systems are key.

Integrated Care System
Nottingham & Nottinghamshire

Our joint work through the Integrated Care Partnership

Continuing to embed our principles of prevention, equity and integration into the ways that we work.

Our City Health and Wellbeing Strategy is being refreshed to ensure that it is reflecting the needs of local people.

Producing Joint Strategic Needs Assessments to understand the challenges that local people face and the services and gaps that we need to address.

NHS partners will continue to work towards delivering our NHS Joint Forward Plan, which has been reviewed and refreshed for 2025/26 to strengthen actions and their impact.

We're expecting a national 10 -year health plan to be published in Spring and we'll work together to make this meaningful for local people.

NHS Nottingham and Nottinghamshire

Appendix B

2025/26 Board Work Programme

"Every person enjoying their best possible health and wellbeing"

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

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

Our core values:

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

Agenda item (See Annex 1 for purpose and content)	14 May	09 Jul	10 Sep	12 Nov	14 Jan	11 Mar	Link to BAF	Notes
Introductory items	✓	✓	✓	✓	✓	✓	Not applicable	See note 1
Citizen Story	✓	✓	✓	✓	✓	✓	Not applicable	See note 2
Leadership and operating context								
Chair's Report	✓	✓	✓	✓	✓	✓	Strategic risk 10	See note 3
Chief Executive's Report	✓	✓	✓	✓	✓	✓	Strategic risk 9 and 10	See note 4
Strategy and partnerships								
Joint Forward Plan (JFP) Outcomes Framework	-	✓	-	-	-	-	Strategic risk 1, 2, 3, 4 and 5	See note 5
Response to Ten Year Health Plan and JFP delivery update	-	-	✓	-	-	-	Strategic risk 1, 2, 3, 4 and 5	See note 6
Update in delivering three strategic shifts: • **Shift 1: Hospital to community.**	-	-	-	-	✓	-	Strategic risk 1, 2, 3, 4, 5, 6 and 7	See note 7

Agenda item (See Annex 1 for purpose and content)	14 May	09 Jul	10 Sep	12 Nov	14 Jan	11 Mar	Link to BAF	Notes
• Shift 2: Analogue to digital. • Shift 3: Treatment to prevention								
Annual Joint Forward Plan refresh	-	-	-	-	-	✓	Strategic risk 1, 2, 3, 4 and 5	See note 8
ICS Infrastructure Strategy	✓	-	-	✓	-	-	Strategic risk 8	See note 9
Joint Capital Resource Use Plan	✓	-	-	-	-	✓	Strategic risk 3 and 8	See note 10
Primary Care Strategy	✓	-	-	-	-	-	Strategic risk 2, 4 and 5	See note 11
ICS Green Plan	-	✓	-	-	-	-	Strategic risk 8	See note 12
ICS People and Workforce Plan	-	✓	-	✓	-	-	Strategic risk 6	See note 13
ICS Quality Strategy	-	✓	-	-	-	-	Strategic risk 4	See note 14
Working with people and communities	-	✓	-	-	-	-	Strategic risk 4 and 5	See note 15
Improvement, learning and innovation (incorporating research)	-	-	-	✓	-	-	Strategic risk 1, 2, 4 and 5	See note 16
Clinical and care professional leadership and involvement	-	-	✓	-	-	-	Strategic risk 6, 9 and 10	See note 17
Report from Nottingham and Nottinghamshire VCSE Alliance	-	-	✓	-	-	-	Not applicable	See note 18
Report from Nottingham and Nottinghamshire Healthwatch	-	-	-	-	-	✓	Not applicable	See note 19
2026/27 Operational Plan (finance, performance, and workforce)	-	-	-	-	-	✓	Strategic risk 1, 2 and 3	See note 20
2026/27 Opening Budgets	-	-	-	-	-	✓	Strategic risk 3	See note 21
Delivery and system oversight								
Quality Report	✓	✓	✓	✓	✓	✓	Strategic risk 4	See note 22
Finance Report	✓	✓	✓	✓	✓	✓	Strategic risk 3	See note 23
Service Delivery/Performance Report	✓	✓	✓	✓	✓	✓	Strategic risk 1 and 2	See note 24
Population Health Management Outcomes	✓	✓	✓	✓	✓	✓	Strategic risk 5	See note 25
Assertive and Intensive Community Mental Health Care Action Plan: Delivery Update	✓	-	-	✓	-	-	Strategic risk 1	See note 26
Delivery of NHS England delegated functions	-	✓	-	-	-	-	Strategic risk 9	See note 27

Agenda item (See Annex 1 for purpose and content)	14 May	09 Jul	10 Sep	12 Nov	14 Jan	11 Mar	Link to BAF	Notes
Statement on Health Inequalities	-	✓	-	-	-	-	Strategic risk 1, 2, 4 and 5	See note 28
Governance and compliance								
Board Assurance Framework	✓	-	-	✓	-	-	All risks	See note 29
Meeting the Public Sector Equality Duty	✓	-	-	-	-	-	Strategic risk 1, 2, 4, 5 and 6	See note 30
Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity	-	-	-	-	✓	-	Strategic risk 9	See note 31
Freedom to Speak Up Report	-	-	-	-	-	✓	Strategic risk 9	See note 32
Committee Highlight Reports	✓	✓	✓	✓	✓	✓	All risks	See note 33
Closing items	✓	✓	✓	✓	✓	✓	Not applicable	See note 34

Board Seminars and Development Sessions:

Topic	11 Apr	13 Jun	10 Oct	12 Dec	13 Feb
• New ICB operating model and required management cost reductions (joint session with NHS Derby and Derbyshire ICB).	✓	-	-	-	-
• Community transformation programme and development of integrated neighbourhood teams. • System ambition to work differently with VCSE partners through Place-Based Partnerships.	-	✓	-	-	-
• Integration of health and social care. • Developing strategic commissioning capability in line with national framework and operating model.	-	-	✓	-	-
• ICB Capability Assessment Framework. • Cyber security.	-	-	-	✓	-
• Operational planning and priorities for 2026/27.	-	-	-	-	✓

Annex 1: Purpose and content of agenda items

No.	Agenda item	Purpose
1.	**Introductory items**	This section of the meeting will include: • A copy of members' registered interests for consideration and agreement of how any real or perceived conflicts of interest are required to be managed. • The previous meeting's minutes for agreement (and any matters arising). • The Board's Action Log for review.
2.	**Citizen Story**	To present a citizen story at the outset of each Board meeting, with the purpose of grounding the following discussions at each meeting in the reality of patient care and putting citizens at the heart of Board decisions. The stories will demonstrate a range of examples of healthcare provision, what matters to people, their experience of healthcare services, learning points and improvement actions.
3.	**Chair's Report**	To present a summary briefing for Board members of the Chair's reflections, actions, and activities since the previous Board meeting. As appropriate, this will include updates on key governance developments, and on an annual basis this will present the Board's Annual Work Programme and include a review of the skills, knowledge, and experience of Board members (when taken together) to ensure the Board can effectively carry out its functions.
4.	**Chief Executive's Report**	To present a summary briefing on recent local and national developments and areas of interest for Integrated Care Boards (ICBs) and the wider Integrated Care System (ICS), along with key updates from system partners and formal partnership arrangements, including the Integrated Care Partnership, Health and Wellbeing Boards and the East Midlands Joint Committee. On a quarterly basis, the reports will include the latest segmentation ratings under the NHS Outcomes Framework. The report will also include key updates regarding the ICB's workforce on a periodic basis, including NHS staff survey results and wider workforce indicators. As appropriate, the report may also include specific items requiring approval or for noting by Board members.
5.	**Joint Forward Plan (JFP) Outcomes Framework**	To present the latest position against the JFP Outcomes Framework for Board assurance. An overview of the requirements of the national Ten-Year Health Plan will also be provided at this time.
6.	**Response to Ten Year Health Plan and JFP delivery update**	To present a refreshed JFP, which sets out the local response to the national Ten-Year Health Plan, for approval. *Note: Development of the refreshed plan will be overseen by the Strategic Planning and Integration Committee.*
7.	**Update in delivering three strategic shifts:** • **Shift 1: Hospital to community.** • **Shift 2: Analogue to digital.** • **Shift 3: Treatment to prevention**	To receive an in-year delivery update on delivery of the JFP, focussed on the three strategic shifts. *Note: Delivery of associated transformation plans will be oversighted by the Strategic Planning and Integration committee and Finance and Performance Committee in-year.*

No.	Agenda item	Purpose
8.	**Annual Joint Forward Plan refresh**	To present the annual refresh of the Joint Forward Plan for 2026/27 for approval. *Note: Development of the refreshed plan will be overseen by the Strategic Planning and Integration Committee.*
9.	**ICS Infrastructure Strategy**	• **May 2025** – To present the ten-year ICS Infrastructure Strategy for approval. • **November 2025** – To receive an in-year assurance report regarding progress in delivery of the strategy. *Note: In-year delivery of the plan will also be overseen by the Finance and Performance Committee.*
10.	**Joint Capital Resource Use Plan**	• **May 2025** – To present the 2025/26 Joint Capital Resource Use Plan for approval (prepared with partner NHS trusts and NHS foundation trusts). • **March 2026** – To present the 2026/27 Joint Capital Resource Use Plan for approval (prepared with partner NHS trusts and NHS foundation trusts). *Note: In-year delivery of the plan will be overseen by the Finance and Performance Committee (updates for Board assurance will be included in the routine Finance Reports and Committee Highlight Reports).*
11.	**Primary Care Strategy**	To present the ICB's Primary Care Strategy for approval. *Note: In-year delivery of the strategy will be overseen by the Strategic Planning and Integration Committee (updates for Board assurance will be included in the routine Committee Highlight Reports).*
12.	**ICS Green Plan**	To present a refreshed ICS Green Plan for approval. *Note: In-year delivery of the plan will be overseen by the Finance and Performance Committee (updates for Board assurance will be included in the routine Committee Highlight Reports).*
13.	**ICS People and Workforce Plan**	• **July 2025** – To present an updated ICS People and Workforce Plan to address the feedback from the Board at its March 2025 meeting. • **November 2025** – To receive an in-year assurance report regarding delivery of the plan. *Note: In-year delivery of the plan will also be overseen by the Quality and People Committee.*
14.	**ICS Quality Strategy**	To present the ICS Quality Strategy for approval. *Note: In-year delivery of the strategy will be overseen by the Quality and People Committee (updates for Board assurance will be included in the routine Quality Reports and Committee Highlight Reports).*
15.	**Working with people and communities**	To receive an annual assurance report on the ICB's arrangements for working with people and communities. This will include progress updates on the delivery of two system-wide strategies for citizen intelligence and coproduction. *Note: The Strategic Planning and Integration Committee will have in-year oversight of these arrangements.*
16.	**Improvement, learning and innovation (incorporating research)**	To receive an annual assurance report on the ICB's arrangements for improvement, learning and innovation. The report will also provide an update on progress in delivery of the ICS Research Strategy. *Note: The Quality and People Committee and Strategic Planning and Integration Committee will have in-year oversight of these arrangements.*

No.	Agenda item	Purpose
17.	**Clinical and care professional leadership and involvement**	To receive an assurance report on the clinical and care professional leadership and involvement arrangements established across the Integrated Care System. *Note: The Quality and People Committee will have in-year oversight of these arrangements.*
18.	**Report from Nottingham and Nottinghamshire VCSE Alliance**	To receive a report summarising the work of the Nottingham and Nottinghamshire VCSE Alliance. *Note: This report is scheduled to follow the Board seminar in June 2025, which will include a focus on working differently with VCSE partners.*
19.	**Report from Nottingham and Nottinghamshire Healthwatch**	To receive a report summarising the work of HealthWatch Nottingham and Nottinghamshire.
20.	**2026/27 Operational Plan (finance, performance, and workforce)**	To present the ICB's operational and financial plans for 2026/27 for approval. *Note: Delivery of the 2025/26 plans will be overseen by the Finance and Performance Committee and the Quality and People Committee (delivery reports for the Board included in the routine Quality, Service Delivery and Finance Reports – see 22, 23 and 24 below).* *Development of the plans will be overseen by the Finance and Performance Committee.*
21.	**2026/27 Opening Budgets**	To present the ICB's 2026/27 opening budgets for approval. *Note: The opening budgets will be reviewed by the Finance and Performance Committee prior to presentation to Board.*
22.	**Quality Report**	To present quality oversight reports, including performance against key quality targets. *Note: The Quality and People Committee will have monthly oversight of these arrangements.*
23.	**Finance Report**	To present the ICB and wider NHS system financial positions, covering revenue and capital, and including delivery updates against financial sustainability and productivity and efficiency plans. *Note: The Finance and Performance Committee will have monthly oversight of these arrangements.*
24.	**Service Delivery/Performance Report**	To receive routine assurance reports regarding the key operational service delivery targets for 2025/26, with a focus on: • Reducing the time people wait for elective care (referral to treatment and cancer waiting time standards). • Improving Accident and Emergency waiting times and ambulance response times. • Improving access to general practice and urgent dental care. • Improving mental health and learning disability care for adults and children and young people. Reports will set out the latest performance, alongside actions being taken to address any areas where required standards are not being met. *Note: The Finance and Performance Committee will have monthly oversight of these arrangements.*
25.	**Population Health Management Outcomes**	To receive a series of population health management updates: • **May 2025** – End of life care • **July 2025** – Dementia care

No.	Agenda item	Purpose
		• **September 2025** – Cancer care • **November 2025** – Planning for winter • **January 2026** – Mental health care • **March 2026** – Excess mortality
26.	**Assertive and Intensive Community Mental Health Care Action Plan: Delivery Update**	To receive an assurance report regarding progress in delivery of the Assertive and Intensive Community Mental Health Care Action Plan. *Note: In-year delivery of the plan will also be overseen by the Strategic Planning and Integration Committee.*
27.	**Delivery of NHS England delegated functions**	To receive an annual assurance report regarding arrangements for meeting the requirements of Delegation agreements in place with NHS England. *Note: This will include assurance regarding the work of the East Midlands Joint Commissioning Committee.*
28.	**Statement on Health Inequalities**	To present the ICB's annual statement on health inequalities. *Note: This will be reviewed by the Quality and People Committee prior to presentation to Board.*
29.	**Board Assurance Framework**	To present in-year and year-end positions of the Board Assurance Framework. This will include annual approval of the ICB's strategic risks. *Note: The Audit and Risk Committee will oversee the strategic risks during the year via focussed updates from each executive director.*
30.	**Meeting the Public Sector Equality Duty**	To receive an annual assurance report on the ICB's arrangements for meeting the Public Sector Equality Duty. *Note: This will be reviewed by the Quality and People Committee prior to presentation to Board.*
31.	**Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity**	To receive an annual assurance report on the ICB's arrangements for EPRR and business continuity. *Note: The Audit and Risk Committee will have in-year oversight of these arrangements.*
32.	**Freedom to Speak Up Report**	To receive an annual assurance report on the ICB's freedom to speak up arrangements. *Note: The Audit and Risk Committee will have in-year oversight of these arrangements.*
33.	**Highlight Reports from the:** • **Strategic Planning and Integration Committee** • **Quality and People Committee** • **Finance and Performance Committee** • **Audit and Risk Committee** • **Remuneration and Human Resources Committee**	To present an overview of the work of the Board's committees to provide assurance that the committees are effectively discharging their delegated duties and to highlight key messages for the Board's attention. This includes the committees' assessments of the levels of assurance they have gained from the items received and the actions instigated to address any areas where low levels of assurance have been provided. Also included is a summary of the high-level operational risks currently being oversighted by the committees.
34.	**Closing items**	This section of the agenda at each meeting will be used to share items that are for information only, which will not be individually presented, although questions may be taken by exception at the discretion of the Chair. These will include routine sharing of the Board's Work Programme. The following items will also be shared during the year:

No.	Agenda item	Purpose
		• 2025/26 Internal Audit Plan • Senior Information Risk Owner (SIRO) Annual Report • Learning from the Lives and Deaths of People with Learning Disabilities and Autism (LeDeR) Annual Report This section of the meeting will also include the following verbal items: • Risks identified during the course of the meeting. • Questions from the public relating to items on the agenda. • Any other business

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**Chief Executive's Report**
Paper Reference:	ICB 25 008
Report Author:	Amanda Sullivan, Chief Executive
Report Sponsor:	Amanda Sullivan, Chief Executive
Presenter:	Amanda Sullivan, Chief Executive

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

Summary:

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

Recommendation(s):

The Board is asked to:

- **Note** this item for information.
- **Ratify** the urgent decision taken at the March 2025 Board meeting using the Chair and Chief Executive's emergency powers.

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

Appendices:

Appendix A: Quarter Four Achievements 2024/25
Appendix B: ICB Workforce Metrics and Demographics

Board Assurance Framework:

Not applicable.

Report Previously Received By:

Not applicable.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Chief Executive's Report

Use of emergency powers for urgent decisions

1. The Board's urgent decision-making powers (as defined in the ICB's Standing Orders) are exercised when necessary due to exceptional circumstances.
2. The March meeting of the Board became non-quorate, due to members needing to leave before it finished. Due to the time-sensitive nature of an item requiring decision at the meeting, the members present agreed that the Chair and the Chief Executive would utilise their emergency powers to enable the decision to be made. The decision was informed by the discussions of executive and non-executive members present at the meeting and is now presented for formal ratification.
3. The decision related to the ICB taking on delegated responsibility for a defined set of specialised acute services and mental health learning disability and autism services from 1 April 2025. The delegated commissioning functions will be delivered via an ICB Collaboration Agreement and overseen by the East Midlands Joint Commissioning Committee. The team of staff working on these functions will be hosted by NHS Birmingham and Solihull ICB from July 2025, working in an integrated way to deliver both the delegated functions and those retained by NHS England.
4. The Chair and Chief Executive approved the delegation arrangements, noting that the associated Delegation Agreement between NHS England and the ICB would be signed by the NHS England Regional Director and the ICB's Chief Executive.

Nottingham and Nottinghamshire NHS Operational and Financial Plans 2025/26

5. As part of the planning process, operational and financial plans for the NHS partners within the Nottingham and Nottinghamshire system were submitted to NHS England by the national prescribed deadline of 27 March 2025, following approval by partner NHS Trust and NHS Foundation Trust Boards, and subsequent approval by the ICB's Board at an extra-ordinary meeting on 26 March 2025.
6. The submitted plan was an ambitious and credible plan, which aimed to deliver all national priorities and success measures, financial balance, the system's local strategic priorities, and the emerging national reform agenda. It confirmed that the ICB would continue to address the underlying financial deficit and the delivery of a £279 million NHS system efficiency requirement.
7. Good progress has been made on the development of efficiency plans to meet this requirement. Robust system governance arrangements have been put in

place, and to date, £267 million has been identified against the £279 million target. Work will continue to improve delivery confidence of these identified plans and build a buffer of schemes to offset any in-year risk. More information is available within the Finance Report later on the agenda for this meeting.

NHS England Publication: Working together in 2025/26 to lay the foundations for reform

8. On 1 April 2025, Sir James Mackey, Chief Executive of NHS England wrote to all ICBs and NHS trusts to provide further detail on the Government's reform agenda for the NHS[1]. The letter highlights the significant progress made in planning for 2025/26 and emphasises a move to a medium-term approach to planning, to be shaped by the Ten-Year Health Plan and the outcome of the Spending Review.

9. The letter also states that ICBs will be central to future plans as strategic commissioners, playing a critical role in realising the ambitions of the Ten-Year Health Plan; however, all ICBs will be required to reduce their management costs by 50%. The letter goes on to stress that in delivering the cost reductions, it will be essential to maintain some core staff, and to maintain or invest in strategic commissioning functions, building skills and capabilities in analytics, strategy, market management, and contracting. The need for ICBs to commission and develop neighbourhood health models is also set out.

10. NHS England will share what they determine is a reasonable running cost per head of the population and ICBs are expected to use a Model ICB Blueprint, which is under development, to create bottom-up plans that are affordable within the reduced running cost envelope for sign off by 30 May 2025, with implementation of plans during quarter three of 2025/26.

11. ICBs are encouraged to expedite these changes as any in-year savings can be used on a non-recurrent basis to address in-year transition pressures or risks to delivery in wider system operational plans. Discussions between NHS England and Government colleagues are ongoing in relation to the costs and approvals of any exit arrangements associated with the staffing reductions.

12. NHS providers have also been requested to reduce their corporate cost growth by 50% by quarter three of 2025/26, with savings reinvested locally to enhance frontline services. The reform programme will also bring together NHS England and the Department of Health and Social Care to create a single aligned centre.

13. There will be an opportunity for Board members to discuss these requirements later in the meeting.

[1] https://www.england.nhs.uk/long-read/working-together-in-2025-26-to-lay-the-foundations-for-reform/.

ICB achievements quarter four 2024/25

14. We are continuing to see a number of positive achievements in our system, and Appendix A provides details of achievements for quarter four of 2024/25. These include the launch of monthly ‘Your Healthy Heart Community Clinics’ in Bestwood and Sherwood Primary Care Network, improved breastfeeding rates in Mid-Nottinghamshire, work to increase lung cancer screening rates in Bassetlaw, and approval to be part of a National Pancreatic Cancer Case finding project. Thank you to all the teams who are working hard to deliver these achievements.

NHS England Oversight Framework: 2024/25 quarter three segmentation

15. The NHS Oversight Framework provides a consistent approach to oversight of ICBs and NHS Trusts. Organisations are segmented into four categories dependent on their support needs. NHS England wrote to the ICB on 17 March 2025 to confirm the outcome of the quarter three review, which is that the ICB will remain in segment three of the Framework. This is based, in the main, on the month nine financial position across the system, alongside the level of support required across several performance challenges. No concern or support needs were identified for system leadership or governance.
16. A new NHS Performance Assessment Framework for 2025/26 is expected to be launched in the near future, aligned to the NHS reform programme.

Public Inquiry into the June 2023 attacks in Nottingham

17. On 22 April 2025, it was announced that Her Honour Deborah Taylor has been appointed by the Lord Chancellor to chair the statutory inquiry into the Nottingham attacks in which Barnaby Webber, Grace O’Malley-Kumar and Ian Coates were tragically killed and three other survivors were seriously injured by Valdo Calocane.
18. The statutory inquiry will have the power to examine all the agencies involved, compel witnesses and establish the facts. The Prime Minister has committed that the inquiry should report within two years. It is intended to be a holistic review to provide recommendations to prevent similar incidents. The full terms of reference will be published in due course.
19. The ICB welcomes this next stage in the establishment of the inquiry and will support the work of HH Taylor in whatever way requested.

ICB workforce update and 2024 staff survey results

20. Key metrics relating to the ICB’s workforce continue to be monitored by the executive-led Human Resources Steering Group and the Remuneration and

Human Resources Committee. Appendix B provides a summary of the information presented to meetings during April 2025, including an illustration of the ICB's workforce demographics.

21. As previously reported, the ICB took part in the national 2024 NHS Staff Survey, achieving a 74% response rate, a slight increase from 2023. The results showed good progress in a number of key areas including good working relationships within teams and with team managers and better than the national average ICB scores in health and wellbeing and personal development domains. However, it highlighted some areas where further action was required, which will form the basis of an action plan focused on four process areas and two areas for executive action:

    a) Improving the quality of appraisals.

    b) Working to support managers and staff create greater control over their work and reduce the need for additional unpaid hours.

    c) Understanding (and taking action) regarding the causes of absence due to work related stress.

    d) Supporting staff with their career progression.

    e) Supporting staff who feel they have experienced bullying and harassment.

    f) In relation to the priority of the ICB to patients and service users, to help staff understand the competing priorities and pressures faced by the ICB and that patient and service users are a priority, even if difficult decisions need making within the ICB and wider system.

22. The staff survey action plan will be co-produced between the Executive Team and staff; this will be delivered via an executive led process within each of their directorates. This will take into consideration the recent announcements regarding the move to a new ICB operating model and the required reduction in management costs.

23. Delivery of the action plan, once finalised, will be overseen by the Remuneration and Human Resources Committee.

National accolade for Sherwood Forest Hospitals NHS Foundation Trust

24. Sherwood Forest Hospitals has been recognised as the best acute NHS Trust to work for in the East Midlands for the seventh year in a row.

25. The 2024 National Staff Survey results showed that 71% of colleagues recommended the Trust as a great place to work, which is 12% higher than the national average.

Strike action

26. Healthcare support workers at Nottingham University Hospitals NHS Trust have taken strike action over pay, primarily due to a dispute over back pay for healthcare assistants who have been performing clinical tasks beyond their designated band two role. The strike action, organised by UNISON, began on 10 April 2025, and continued on 17, 22, and 28 April, with some strikes lasting for 48 hours. These roles include staff employed as emergency department assistants, healthcare assistants, maternity support workers, theatre support workers, and clinical support workers. The Trust has agreed to regrade some staff and provide back pay to August 2021; however, UNISON is unsatisfied with the proposed deal, which does not address back pay for the extended responsibilities performed by staff beyond that date.

27. Our system response structure, which brings operational and emergency preparedness**,** resilience and response leads together, is being used to ensure that essential services are maintained.

Recent leadership appointments

28. At a national level:

    a) NHS England has announced the team who will help lead the organisation's transition into the Department of Health and Social Care[2]. This new team is drawn from the existing executive and the wider NHS on secondment. The roles of Chief Operating Officer and Chief Delivery Officer will no longer exist in the transformation structure, and under the new team there will be two Co-Medical Directors, alongside new posts, a Financial Reset and Accountability Director and Elective Care, Cancer and Diagnostics Director. Regional Directors will report into Sir Jim Mackey as Chief Executive.

29. At a local level:

    a) Sherwood Forest Hospitals NHS Foundation Trust has confirmed two appointments to its Board of Directors following a recent recruitment drive. The Trust's Acting Medical Director, Dr Simon Roe, has accepted the Trust's offer to become its Chief Medical Officer. The Trust has also appointed Simon Illingworth as its Chief Operating Officer. He will join the Trust in July from Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. These appointments follow the extension of Dr David Selwyn's tenure as the Trust's Acting Chief Executive up to the end of March 2026, and Graham Ward, who had been serving as the Trust's Acting Chair since May 2024, has also seen his appointment as the Trust's substantive Chair confirmed for a final term to 25 May 2026.

[2] https://www.england.nhs.uk/2025/03/nhs-england-names-new-executive-team-to-lead-transition/.

b) The new Chief Operating Officer of Nottingham University Hospitals NHS Trust has been named as Andrew Hall. Andrew, who will join the Trust in July, is currently Executive Chief Operating Officer at University Hospitals of Derby and Burton NHS Foundation Trust. Andrew is also currently the Chair of Nottingham Emergency Medical Services (NEMS); he will step down from this role when he joins the Trust.

Update on the Oliver McGowan training programme

30. At its November 2024 meeting, the Board heard powerful citizens stories regarding how autistic people and people with learning disabilities experienced significant health inequalities and how, following the unfortunate death of Oliver McGowan, whose family were not listened to, legislation had been introduced to require all health and care staff working in Care Quality Commission-registered organisations to undertake training on learning disability and autism. At the end of the session, the Chair requested that a progress update on the impact of the training be brought to a future meeting.

31. Since its implementation, the training has seen good progress within the Integrated Care System (ICS). As of the end of 2024/25, the ICS had trained 12% of all staff on Tier 1 training and 9% had also completed Tier 2 training. We are currently working with 15 experts with lived experience who are undertaking co-trainer and facilitator trainer roles. The training sessions have been well-received, with positive feedback highlighting the transformative impact at both professional and personal levels. Staff have reported a deeper understanding of learning disabilities and autism, supporting a change to more compassionate and informed care. Feedback has also highlighted that the interaction with the experts with lived experience is incredibly powerful and key to the difference that the training is making on changes to practice.

32. The programme is currently evaluating the work and impact to date, recognising that it is still in its early stages of delivery. This includes use of feedback and learning from the training sessions delivered to date by the Oliver McGowan Training steering group to understand its local impact, strengths and opportunities.

33. Looking ahead, the ICS remains committed to the continued implementation and expansion of the training to ensure that staff have the right skills and knowledge relevant to their role. Plans are in place to increase the number of training sessions and address any barriers to training, such as the length of the training and capacity constraints due to financial challenges and organisational changes. By continuing with a collaborative and shared learning approach, the ICS aims to drive further progress and ensure that the training reaches and benefits those who need it most.

Appendix A: Quarter Four Achievements

a) All four community pharmacy independent prescribing pathfinder sites are now live and have undertaken over 400 consultations for on-the-day illness between 1 January and 31 March 2025. This is helping to improve patient access to primary care.

b) In January and February 2025, pharmacy services provided the following services to improve patient access to primary care:

- Over 16,000 Pharmacy First consultations of which over 9,600 were seven common condition pathways.
- Over 2,400 oral contraception consultations.
- Over 8,000 blood pressure checks.

c) The ICB's medicines optimisation team has supported the development of the weight loss medication commissioning policy, continued to support prescribers around medication shortages and developed guidance for the discontinuation of insulin products. This is important to support patient safety, offer the best use of evidence-based medicines, offer equity of access to medicines and deliver prescriber support and cost management.

d) The ICB was invited to showcase its health inequalities approach to annual physical health checks for people with severe mental illness (SMI), as part of CORE20plus5, at a recent regional health inequalities forum. This included highlighting the strong system-wide prioritisation of this population, the partnership approach across primary care, Nottinghamshire Healthcare NHS Foundation Trust, and the public health commissioned healthy lifestyle services in delivering health checks and interventions for people with SMI, and the quality improvement approaches partners take to increase uptake and improve experience and outcomes. The system is delivering above the 60% standard for this indicator, meaning more than 60% of patients with SMI have received an annual physical health check over the past 12 months.

e) A co-production model has been agreed to support delivery of the three year Integrated Mental Health Pathway Strategic Plan. The Partners in Mind group was actively involved in the procurement, co-producing the service specification, and undertaking the panel selection to award the contract. Two members of the Partners in Mind group have been selected to be members of the system Adult and Children Mental Health Partnership Board to ensure the voice of experts by experience is heard at a strategic level.

f) Over 700 children and young people joined in with two mental health events ran by NottAlone during Children's Mental Health Week. This showcased local talent and encouraged young people to reflect and build up their resilience by understanding more about mental health and wellbeing.

g) A comprehensive review of Children and Young People's Early Intervention Mental Health Provision across Nottingham and Nottinghamshire has been completed to improve efficiency, delivery and equity in access. This has led to further cross-system working to identify training needs for local workforces and the development of an Early Intervention Network Meeting to improve working relationships and tighten pathways.

h) An expression of interest has been approved to be part of a National Pancreatic Cancer Case finding project. This will involve two Primary Care Networks, Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust. It will target patients with new onset diabetes diagnosis and unexpected weight loss, fast tracking them to receive a CT scan. The aim is to improve the very low early diagnosis rates for pancreatic cancer and therefore survival rates.

i) The System Analytics Intelligence Unit has modelled the local population needs over the next 20 years. This information will be used for the workforce strategy to help ensure that the right skills are available to meet the health and care needs of our population.

j) The ICB successfully commissioned the Perinatal Pelvic Health Service, a national initiative aimed at enhancing the prevention, identification, and treatment of pelvic health issues during pregnancy and up to one year postpartum. This service integrates seamlessly with existing maternity and neonatal services, emphasising education, early intervention, and multidisciplinary collaboration to improve long-term pelvic health outcomes for women.

k) The CardMedic pilot has been extended for an additional year until April 2026. CardMedic is a digital tool designed to improve communication between healthcare staff and patients by addressing language, hearing and cognitive barriers.

l) The lung cancer screening programme in Bassetlaw has delivered over 1,800 24-month scans. Bassetlaw Place-Based Partnership (PBP) has also piloted a non-responder engagement strategy, achieving over 250 additional scans from people who had previously not engaged with the programme.

m) Bassetlaw PBP has been working with South Yorkshire partners and the Bassetlaw Cancer Alliance to target farmers and rural communities with cancer prevention messages in a series of campaigns to increase cancer screening and reduce late-stage presentation rates across those communities.

n) The Bassetlaw place team supported an action planning workshop with Doncaster and Bassetlaw Teaching Hospital aimed at improving access, experience and outcomes for inclusion health groups presenting at Accident and Emergency (A&E). An action group has been created that will support in

making changes to the way patients have access to A&E, GP surgeries and healthcare in general.

o) In Mid-Nottinghamshire, a Listening Line has been developed that enables service users of the Best Years Hubs to keep in touch even if they cannot attend in person, this helps people to feel less isolated knowing they are getting a call from a volunteer.

p) Across the Mid-Nottinghamshire PBP footprint, breastfeeding rates at six to eight weeks after birth are the highest since records began in 2010, with a 10% increase in Ashfield and Mansfield.

q) Across Mid-Nottinghamshire, 1,402 patients with Severe Mental Illness (SMI) have had all six physical health checks completed. This is 63% of all patients with SMI in Mid-Nottinghamshire. The six elements of the annual SMI physical health check are: alcohol consumption status; blood glucose (HbA1c test); blood pressure; body mass index; lipid profile; and smoking status.

r) A number of projects across Mid-Nottinghamshire are underway to address health inequalities. The projects, funded through the ICB's Health Inequalities and Innovation Fund include:

- Frailty prevention – targeting those with severe frailty that are not housebound and live alone to improve outcomes by reducing social isolation.
- Childhood vaccinations and immunisation – delivering nasal flu vaccinations to two to three year olds in a nursery setting.
- Respiratory – delivering asthma outreach services for secondary care services.
- Respiratory – identifying patients aged 65 and over who smoke and have not had a spirometry test in within the past 24 months, to offer a spirometry test.
- Smoking cessation – supporting patients aged 45 and over who are smokers that are not already under smoking cessation services.
- Frailty prevention/end of life – increasing advance care planning/RESPECT in Newark and Sherwood, upskilling of volunteers through the Best Years Hubs interventions.

s) In Nottingham City, the Integrated Neighbourhood Kick-off Events have taken place for Raleigh and Aspire Primary Care Networks in community locations. Both events were a huge success and united local services, groups, and champions to explore how we can work together to improve cardiovascular health and strengthen local support networks.

t) The Bulwell and Top Valley Local Delivery Team has delivered a project to improve the referral pathway for clinicians when referring into any diabetes service. The aim was to streamline the referral process, make it is easier for

clinicians to find relevant diabetes services, save time in consultation, and increase referrals.

u) Monthly ‘Your Healthy Heart Community Clinics’ have been launched in Bestwood and Sherwood Primary Care Network. These involve a multi-disciplinary team approach to engage with patients in a group setting, offering physical checks, group education and health and wellbeing information.

v) In-depth visits have been carried out with six general practices as part of the first phase of the ICB’s clinical end-of-life advanced care planning. Findings revealed differences in outcomes that can be linked back to different approaches and identified best practice that can be used in other settings.

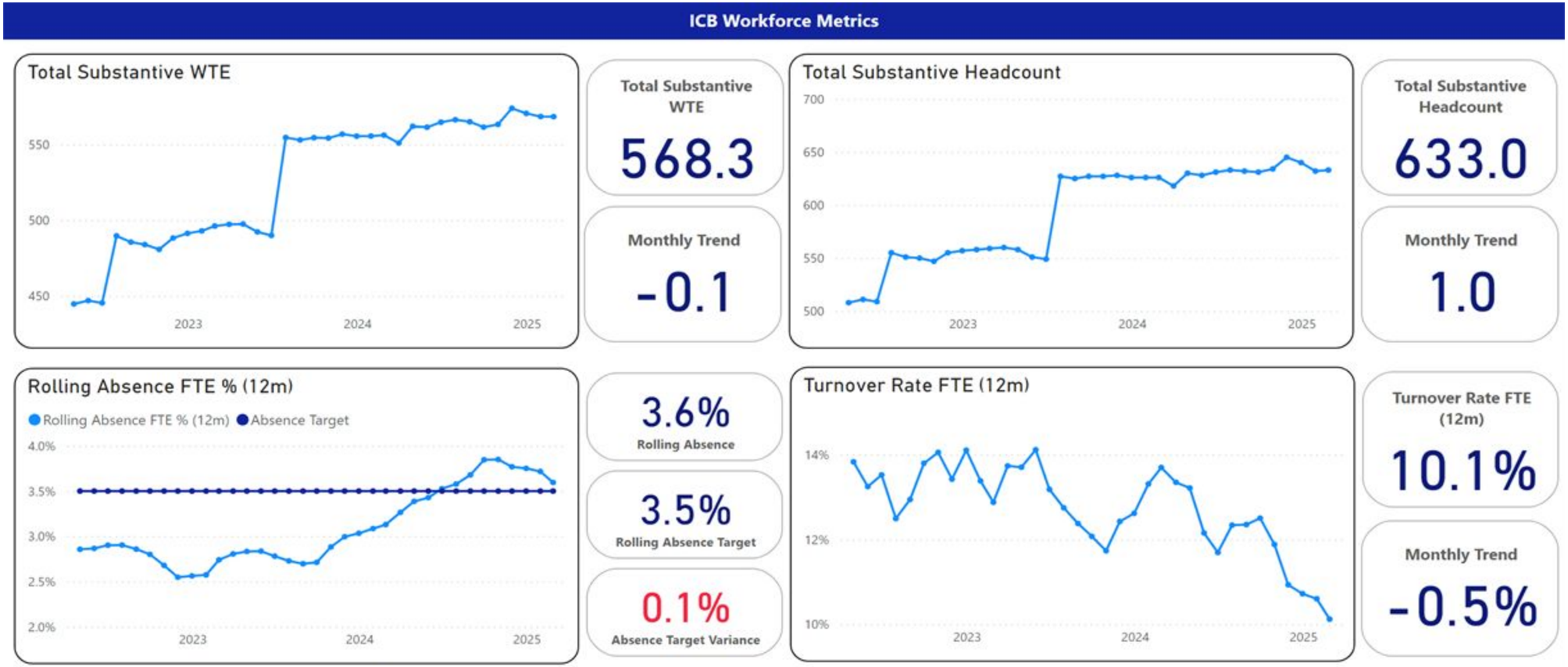
w) Over 140 people attended a conference hosted by Transforming Notts Together. The event brought faith groups, charities, and health professionals together to explore new ways of supporting local communities.

x) Nottingham City Place Based Partnership has started series two of their Health and Wellbeing LIVE video podcast series. These episodes aim to shed light on the work being done across the city to reduce various health issues by conversation leaders across the healthcare network.

y) Nottingham and Nottinghamshire ICS was one of four pilot sites chosen to test the Care Quality Commission’s draft engagement framework to address health inequalities. Feedback was provided by the ICB’s engagement and co-production teams on suggested adaptations and potential application of the framework ahead of its launch in February 2025.

z) The ICB convened partners from the NHS, Local Authorities and the further/higher education sector to develop the wider opportunities for social and economic growth presented by the Tomorrow’s NUH programme. This secured broad buy-in and establishment of a prioritised list of opportunities to maximise the impact of future capital investment and service reconfiguration.

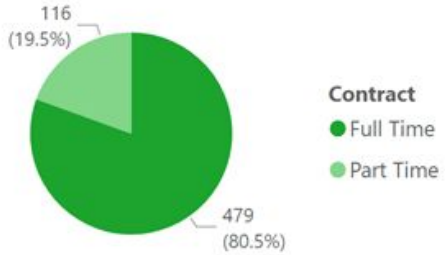
Appendix B: ICB Workforce Metrics and Demographics



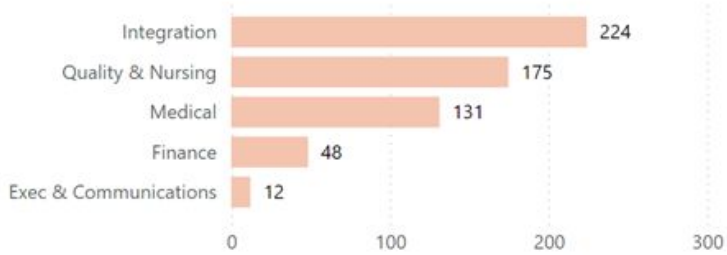
Significant spikes in WTE in July 2022 and in July 2023 equate to the transfer of the Bassetlaw employees at the creation of the ICB and the transfer of POD staff from NHS England. In April 2024, the Cancer Alliance team joined the ICB.

ICB Staff in Post Workforce Demographics

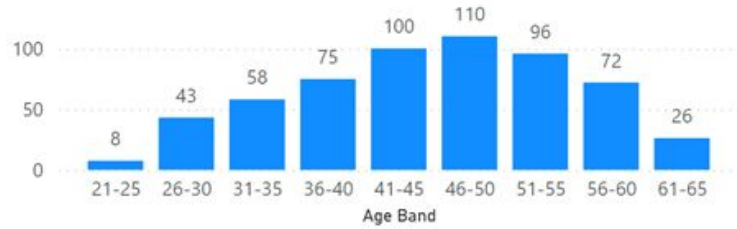
Contract Analysis



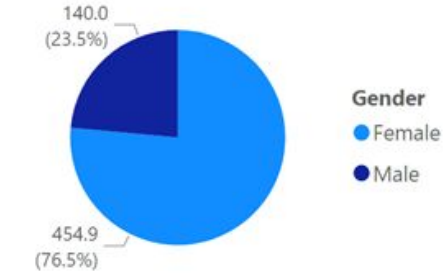
Directorate Group Mix



Age Analysis

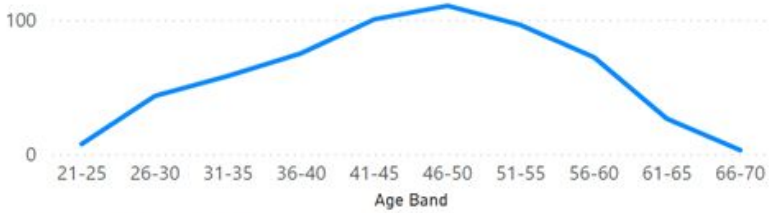


Total Workforce Gender Split

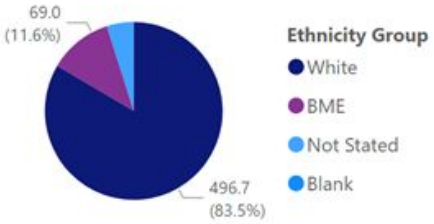


Gender Split across Directorates

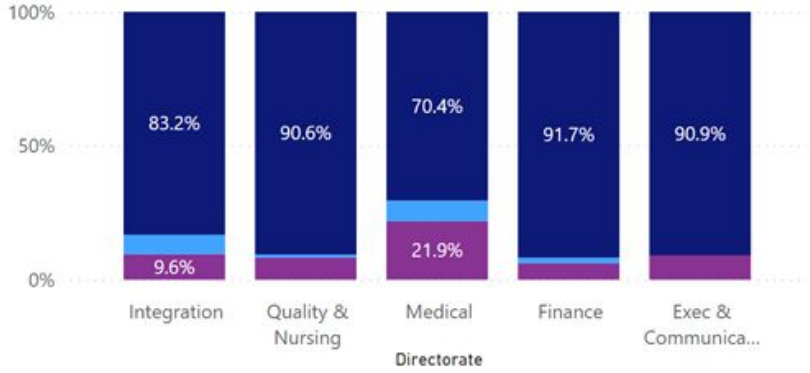
Age Profile Whole Workforce



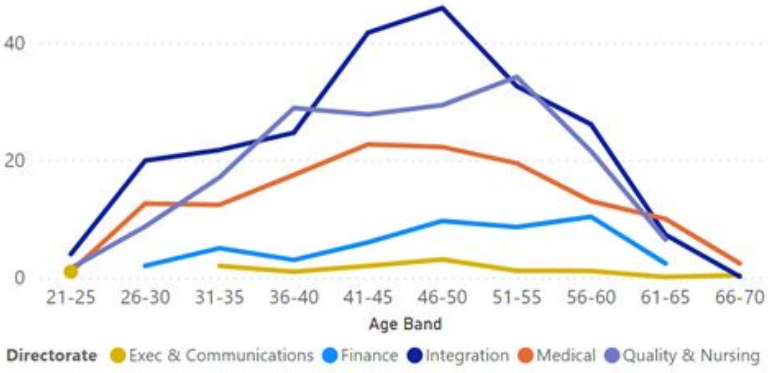
Total Workforce Ethnicity Split



Ethnicity Split across Directorates



Age Profile by Directorate



Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**ICS Infrastructure Strategy**
Paper Reference:	ICB 25 009
Report Author:	Lindsey Sutherland, Programme Director
Executive Lead:	Bill Shields, Director of Finance
Presenter:	Bill Shields, Director of Finance

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

Summary:

The Nottingham and Nottinghamshire ICS Infrastructure Strategy presented for Board consideration, having been reviewed and endorsed by the Finance and Performance Committee on 30 April 2025.

The first draft was submitted to NHS England on 31 July 2024 and has now been amended following feedback.

The Strategy is summarised in the attached report, outlining the baseline infrastructure, strategic priorities, opportunities, and delivery approach.

Recommendation(s):

The Board is asked to **approve** the ICS Infrastructure Strategy.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	Enabling care to be delivered closer to home, based on population need.
Tackle inequalities in outcomes, experience, and access	Enabling care to be delivered closer to home, based on population need
Enhance productivity and value for money	Better use of existing resources reducing the need for additional capital and/or revenue spend
Help the NHS support broader social and economic development	The Infrastructure Strategy requires us to think through how we develop a resilient estates workforce, supporting opportunities to train and employ local people

Appendices:

Appendix 1: Governance for strategy implementation.
Appendix 2: Nottingham and Nottinghamshire ICS Infrastructure Strategy (2024–2039).

Board Assurance Framework:

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

Board Assurance Framework:
• Risk 8: Infrastructure and net zero – Failure to work effectively as a system to a sustainable infrastructure to deliver high-quality and efficient care and the net zero commitment.

Report Previously Received By:
Reviewed and endorsed by Finance and Performance Committee – 30 April 2025

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

ICS Infrastructure Strategy

Executive summary

1. The Nottingham and Nottinghamshire Integrated Care System (ICS) Infrastructure Strategy (2024–2039) presents a unified, long-term vision for the transformation of the health and care infrastructure estate. The strategy is designed to meet the changing needs of a growing and aging population, address systemic health inequalities, reduce carbon emissions, and maximise value from our estate.
2. The Strategy is rooted in the principle of integration by default and aims to reshape infrastructure to enable more accessible, community-based, and digitally enabled models of care. It proposes significant modernisation of assets, while ensuring sustainability and financial stewardship.
3. A critical foundation for this transformation includes:
    a) Prioritisation of care closer to home.
    b) Modernisation of outdated estate, including high-cost and low-efficiency sites.
    c) Adoption of digital tools to reduce physical estate burden.
    d) Commitment to Net Zero by 2040.
4. This Strategy was written before notification of the New Hospital Programme delay was communicated. The new risks posed by delaying the development of Tomorrow's Nottingham University Hospitals will be addressed in the bi-annual delivery plan (see section 5 of the Strategy).
5. Approval is sought from the Board to adopt this Strategy and proceed with implementation planning.

Current infrastructure

6. The Nottingham and Nottinghamshire ICS manages a complex and varied estate comprising 896 public sector sites, with 216 used directly for healthcare delivery. Estate ownership is shared across NHS providers, NHS Property Services, Community Health Partnerships (CHP), and other partners. A major challenge is the estimated £470 million backlog maintenance, which restricts capacity for innovation and transformation.
7. Annual energy costs exceed £53 million, largely driven by inefficient and aging infrastructure.

8. A condition-based assessment categorises 39% of the estate as 'Core' (fit for future use), 47% as 'Flex' (potentially adaptable), and 14% as 'Tail' (unfit for purpose and targeted for disposal). This is summarised in Table 1 below.

Table 1: *Summary of our current estate using categorisation set by NHS England.*

Estate category	% of sites	Description	Action plan
Core	39%	High-quality, fit-for-purpose estate aligned with long-term service needs.	Retain and invest to maximize utilization and support transformation.
Flex	47%	Acceptable condition; potential for improvement or strategic use.	Selective investment or phased divestment depending on location and viability.
Tail	14%	Poor condition, inefficient, or high cost with limited potential.	Exit strategy with service relocation to core or flex sites.

9. Primary care operates across 160 premises, with quality and energy efficiency highly variable. Whilst the majority are classed as core, many are poorly rated for energy performance. The estate faces rising demand due to projected population growth in areas such as Hucknall and Newark, reinforcing the need for targeted investment in modern, integrated care hubs.

10. Nottinghamshire Healthcare NHS Foundation Trust delivers mental health and community services from 79 sites. Key investment priorities include improving facilities at Rampton and Highbury hospitals and completing the national dormitory eradication programme. Sherwood Forest Hospitals NHS Foundation Trust manages three main sites including King's Mill, a part-PFI facility with significant retained estate in need of modernisation. Priorities include sterile services, MRI capacity, and essential utilities upgrades.

11. Nottingham University Hospitals NHS Trust (NUH) operates a large and ageing estate at Queen's Medical Centre and Nottingham City Hospital. Much of this infrastructure is outdated, energy inefficient, and unsuitable for future care models. A major £1.35 billion redevelopment under the Tomorrow's NUH programme is planned to transform acute care delivery, supported by developments such as the National Rehabilitation Centre and new Community Diagnostic Centres.

12. Further estate is managed through NHS Property Services and CHP, including 47 NHS Property Services properties and 13 LIFT buildings. Many of these are underutilised despite being in reasonable condition. Current efforts focus on re-purposing, increasing space utilisation and reducing voids.

13. Finally, the ICS faces a workforce challenge in the estates and facilities function, with over 40% of staff aged 55 or older. Strategic workforce planning,

apprenticeships, and shared service models will be critical to ensuring future delivery capacity.

Strategic priorities

14. Table 2 below summarises the strategic priorities set out within the Strategy:

Table 2: *Strategic priorities that will guide transformation and improvement of our infrastructure.*

Priority area	Key focus areas	Examples/initiatives
Right Place, Right Size, Quality	Match estate to demand; optimise service locations	Service relocation from poor to high-quality buildings (e.g. mental health site transitions, CDC hubs)
Enabling and Innovative	Flexible infrastructure supporting digital transformation	AI diagnostics, remote care, shared clinic spaces, integrated digital systems
Green and Sustainable	Net Zero carbon by 2040; renewable energy and waste reduction	Electric vehicle (EV) charging, solar photovoltaics (PV) installations, decarbonisation plans, joint food/waste programmes with councils
Financial Sustainability	Prioritised capital spend, reduce maintenance costs, maximise utilisation	Dispose tail estate; reinvest in flexible/core estate; align with £1.9 billion required capital plan
Anchor Institution Role	Support local workforce, economic inclusion, regeneration	Apprentice programmes, community-based hubs, place-focused service delivery

Major opportunities identified

15. The Strategy identifies several major infrastructure programmes and investment opportunities:

    a) Tomorrow's NUH Programme: £1.35 billion secured for redeveloping the Queen's Medical Centre and City Hospital sites[1].

    b) Community Diagnostic Centres (CDCs): Planned for Nottingham and Mansfield to increase early detection and reduce hospital demand.

    c) Primary Care Expansion: Targeted investment in high-growth areas (e.g. Hucknall, Newark, Beeston) to develop integrated care hubs.

    d) Digital Transformation: Adoption of AI, remote monitoring, and digital consultations to reduce estate pressure and enhance service access.

[1] On 20 January 2025, the new labour government announced that our new hospital programme would be postponed until 2037-2039. The resulting risks and issues posed by this will be addressed in the bi-annual delivery plan (see section 5 of the Strategy).

e) Net Zero Infrastructure Plan: Installation of solar PV, heat pumps, and EV charging points across all major sites.

f) One Public Estate Integration: Joint planning with councils, fire, and police to enable shared use of public assets.

Delivering the strategy

16. We will work as a system to deliver the Infrastructure Strategy. We will ensure we dovetail and enable delivery of existing strategies and plans agreed across our ICS. Core to delivery is the ICS Strategic Infrastructure Group (see Appendix 1 for the governance structure).

17. Where possible, we will avoid duplication by utilising existing forums to develop and deliver projects.

18. We will prioritise evidence-based decision-making, using data-driven insights to map service demand, identify estate inefficiencies, and develop targeted investment plans.

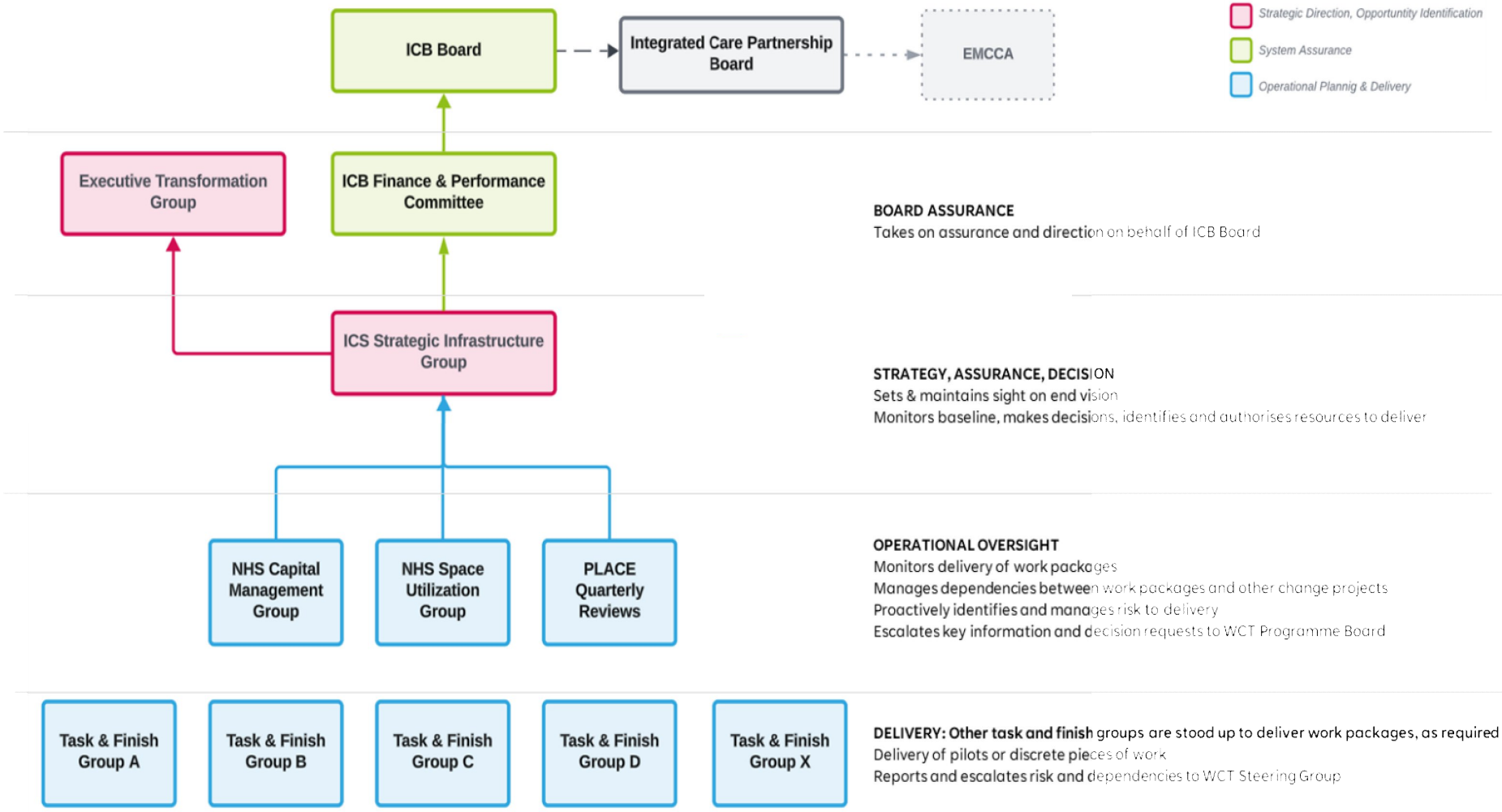
19. Delivery will be structured around key workstreams, focusing on estate optimisation, digital transformation, energy efficiency, and financial sustainability (see summary in table 3).

Table 3: *Summary of delivery and enabling workstream that will shape implementation of the strategy.*

Delivery workstreams	**Enabling workstreams**
Clinical Space – Optimises clinical infrastructure and explores opportunities to drive transformation, such as new primary care models and integrated service delivery.	**Insight –** Uses data and analytics to guide decisions, including clinical modelling, space utilisation, and benchmarking best practices.
Non-Clinical Space – Focuses on operational and workforce transformation through innovative infrastructure use, such as co-located services and automation.	**Investment –** Secures and prioritises funding through a coordinated approach using public, regional, and private investment sources.
Workforce – Develops system-wide infrastructure workforce capacity, supporting shared roles, professional service hubs, and social value through anchor institution principles.	**Procurement –** Creates contractual frameworks that enable system-wide delivery and encourage public-private partnerships.
Operations – Manages estate functions such as facilities management and energy, with a focus on sustainability and local economic benefit.	**Horizon Scanning –** Identifies future innovations and technological trends to ensure infrastructure remains modern and effective.

20. We need to remain clear on how we deliver balance the short to medium term interventions, versus our longer-term strategy. This will be done through the creation of a bi-annual delivery plan covering:
    a) Strategy delivery achievements in last period.
    b) In flight developments.
    c) Operational resilience priorities and pipeline.
    d) Strategy delivery priorities and pipeline.
    e) Prioritisation of operational resilience versus strategic pipeline.
    f) SMART objectives and delivery detailed plan.

Appendix 1: Governance for strategy implementation



Integrated Care System
Nottingham & Nottinghamshire

Nottingham & Nottinghamshire ICS Infrastructure Strategy

2024-2039

Final Draft v1.1

Contents

Integrated Care System
Nottingham & Nottinghamshire

Section 1
Executive Summary & Introduction

We need to think differently about infrastructure

Despite successive governments repeating a vision of health and care services focused on communities rather than hospitals, that vision is very far from being achieved.

Evidence shows that financial and workforce growth is not aligned to the vision, with larger growth in acute hospital sectors than in primary and community sectors.

As a health and social care system we need to address the hierarchies of care, with urgent problems taking priority over longer-term issues.

As our ICS infrastructure professionals, we must support the changing focus of the health and care system towards primary and community health and care across the domains of leadership, culture and implementation, so that each sector is freed up to provide the care that it is best equipped to deliver. As care transformation plans are being developed by others, we can prepare the groundwork enabling rather than dictating clinical delivery. We can identify and communicate potentially innovative changes we can make that would stimulate service transformation, always keeping future flexibility and sustainability at the heart of what we do.

Overview

The Nottingham & Nottinghamshire Integrated Care System (ICS) Infrastructure Strategy (2024-2039) sets out a long-term plan for health and social care infrastructure development. It aims to create a sustainable, efficient, and integrated infrastructure to support high-quality care delivery while addressing population growth, financial constraints, and environmental sustainability.

Key Challenges & Needs

The ICS faces significant challenges, including stark health inequalities driven by deprivation, with certain areas experiencing higher rates of long-term conditions and lower life expectancy. The population is growing and aging, increasing demand for health and social care services and necessitating a shift from hospital-centric care to more community-based models. Financially, there is a £470 million backlog in estate maintenance, and over £1.9 billion in capital investment is needed over the next decade to modernize infrastructure and meet strategic objectives. Additionally, the ICS must work towards achieving Net Zero by 2040, requiring substantial investment in decarbonization initiatives such as renewable energy and improved energy efficiency. Digital transformation is also critical, both for improving service delivery and reducing pressure on physical estates by enabling remote care and AI-driven solutions.

Strategic Priorities

The strategy is built around five core objectives to guide infrastructure development:

1. Right Place, Right Size, Right Quality – Ensuring services are located optimally and operate from safe, efficient buildings.
2. Enabling & Innovative – Supporting transformation through adaptable and future-proof infrastructure, including digital health solutions.
3. Green & Sustainable – Aligning with Net Zero targets by reducing carbon emissions and investing in renewable energy.
4. Financially Sustainable – Maximizing capital investment opportunities and improving cost efficiency.
5. Maximizing the ICS as an Anchor Institution – Leveraging the ICS's role in community development, workforce training, and economic support.

Our Integrated Care System (ICS) is committed to working as a unified network, fostering collaboration across NHS providers, local authorities, and private sector partners to develop innovative solutions that reduce reliance on substandard infrastructure. By aligning resources and expertise, we can modernize estates, optimize space utilization, and ensure that healthcare facilities are fit for purpose, safe, and sustainable.

A key focus is on integrating digital technologies to enhance service delivery, reduce the strain on physical infrastructure, and support more community-based and remote care models. Through strategic investment and shared decision-making, we will phase out outdated buildings, repurpose underutilized estates, and prioritize developments that support high-quality, patient-centered care. By working as one system, we can unlock new funding opportunities, streamline operational efficiencies, and drive transformational change, ensuring our infrastructure meets the evolving needs of our population while remaining financially and environmentally sustainable.

Key Initiatives

To achieve these strategic priorities, the ICS will focus on hospital and community care transformation through major redevelopments like the Tomorrow's NUH programme, which has secured £1.35 billion to improve Nottingham University Hospitals, alongside the expansion of Community Diagnostic Centres (CDCs) in Nottingham and Mansfield.

Upgrades to mental health and community care facilities are needed to improve service delivery, particularly through the elimination of dormitory-style accommodation in mental health hospitals.

Investment in primary care will focus on improving infrastructure in high-growth areas such as Hucknall, Newark, and Beeston, while also integrating AI and digital health solutions to enhance accessibility.

The strategy also prioritizes sustainability by transitioning to renewable energy sources, including solar panels, heat pumps, and electric vehicle infrastructure, with an aim to reduce the £53 million annual energy costs.

Delivery Approach

The strategy outlines a phased implementation with defined milestones from 2024 to 2045, ensuring that investments align with population health needs and system-wide priorities. Governance will be collaborative, involving NHS providers, local authorities, and private-sector stakeholders to achieve maximum impact.

Conclusion

The Nottingham & Nottinghamshire ICS Infrastructure Strategy represents a bold vision for the future of healthcare infrastructure. By modernizing estates, integrating services, leveraging digital innovation, and prioritizing sustainability, the strategy aims to improve health outcomes, enhance patient experience, and ensure long-term financial and environmental sustainability.

What is health and social care infrastructure?

For the purposes of this strategy, 'health infrastructure' means the interconnected and interdependent ecosystem of buildings, equipment and technology which supports the delivery of health services to our population. It is both a key enabler, and a significant overhead.

Infrastructure covers a significant part of how we delivery our services, but we have opted to concentrate on the major elements. It reflects and responds to the vision and strategic priorities set out in our Integrated Care Strategy and NHS Joint Forward Plan.

Poor, inefficient and ineffective infrastructure and buildings not only cost the NHS money, but it has a significant contribution towards poor health outcomes. Without high quality environments, supported by the right workforce, excellent digital systems and medical equipment, we struggle to deliver the quality of care we need for our patients and our population. Furthermore, we cannot start to impact and reduce health inequalities locally without the right infrastructure; an infrastructure that both enables health care delivery and prevents people needing health services in the first place.

Who this document is for

This Infrastructure Strategy provides the framework for a coherent approach to infrastructure management and joint decision making across the ICS and will:

- Assist all Trust staff who are involved in estate related issues to understand the corporate vision and their role in achieving this
- Assist our NHS and public sector partners as we move forward with our ambition to work more collaboratively
- Form the basis for interaction and communication with other key stakeholder groups.

Our ICS Infrastructure Strategy covers

✓ Buildings	× Logistics
✓ Land	× Roads
✓ Utilities	× Transport
✓ Facilities Management	× Equipment used in service provision
✓ Digital Infrastructure	
✓ Integrated Care Board	× Social Care
✓ Primary Care	× Residential or Home Care
✓ Community Care	
✓ Mental Health	
✓ Secondary Care	

Our approach to developing this Infrastructure Strategy

Our ICS Infrastructure Strategy is an NHS focused long term strategy that was developed in partnership with our local councils. It documents the long-term ambitions on how we will work with those partners to create true integrated health and care system infrastructure.

In developing this strategy, we have sought to understand the baseline of our infrastructure; to understand the challenges we face and identify potential opportunities for further exploration.

We have identified the infrastructure requirements to reach the aims and ambitions set out in our existing system strategies, and identified where existing transformational plans will enable us to reduce or change our infrastructure quantum.

Integrated Care System
Nottingham & Nottinghamshire

Section 2
Our ICS Landscape

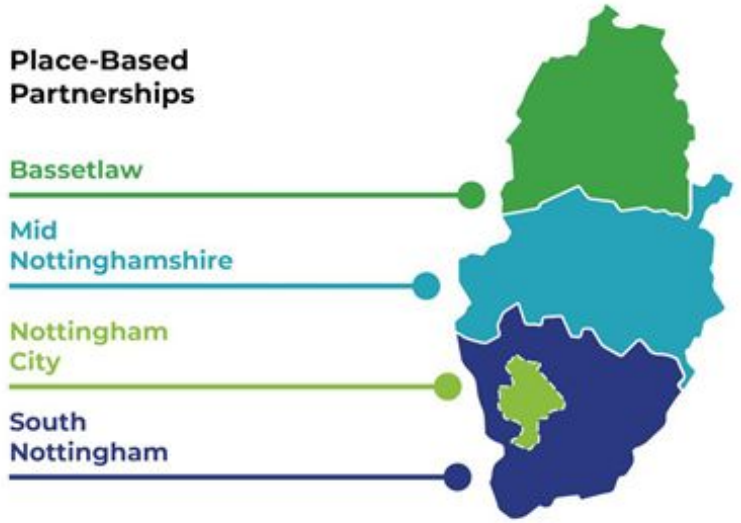
Welcome to Nottingham and Nottinghamshire Integrated Care System. We work together as a system comprising commissioners, NHS and other providers, third sector organisations, and 2 local authorities to provide services to over 1.2 million citizens.

Our ICS is a collective of 139 funded organisations providing health and social care services providing:
Primary care (133 providers)
Urgent and emergency care (6 providers)
Secondary care (2 providers)
Tertiary NHS services (1 provider)
Community care (2 providers)
Mental health services (1 provider)
Public Health (2 providers)
Additionally, more than 150 organisations operate residential homes or providing home care: these are outside the scope of our Infrastructure Strategy.

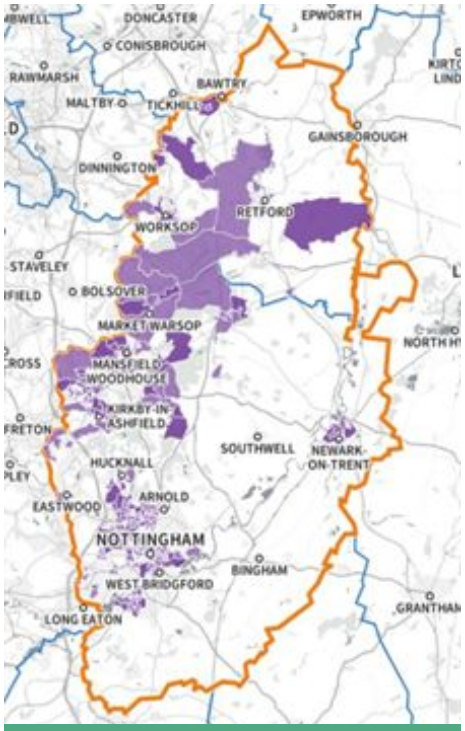
Across our ICS we have some key challenges we must overcome. They are:

- More than 50,000 Nottinghamshire residents are of working age but are 'economically inactive' with long term health problems
- Across Nottingham and Nottinghamshire, almost 37,000 children live in relative low-income families, including over a quarter of those living in Nottingham City
- Nottingham (40.8%) and Bassetlaw (38.4%) both have significantly higher proportions of children in year six who are overweight
- Compared to national figures, both Nottingham (13 %) and Nottinghamshire (12.6%) have significantly higher prevalence of babies born to mothers who were smoking at the time of delivery
- On average, women living in Nottingham can expect to live 57.5 years in good health, compared to 60 years for women in Nottinghamshire. This is lower than the England average of nearly 64 years
- Life expectancy for men is significantly lower than England in Ashfield, Mansfield and Nottingham, at between 76.6 and 78.2 years
- Black and Asian people died from Covid-19 at significantly higher rates than White groups in the East Midlands, illustrating the structural inequalities faced by some groups
- Among those aged 65 years and over, the proportion of people identified as having moderate frailty varies between 12% and 21%, and severe frailty between 10% and 18%, varying across Nottingham and Nottinghamshire
- More than 11,000 hospital admissions and more than 4,500 preventable deaths each year in our ICS are caused by smoking
- Data over the past two years shows one in six young people aged 6-19 now has a probable mental health disorder
- More than 65% of adults across Nottingham and Nottinghamshire are overweight or obese
- Compared to other systems, we have a high prevalence of obesity, diabetes, chronic kidney disease and coronary heart disease

We come together at 3 levels to have the required level of impact with tailoring to need. These are System, Place and Neighbourhood. We have 4 places, and 23 neighbourhoods (PCNs)



Our ICS population varies significantly



MOST deprived 20% of population

LEAST deprived 20% of population

Our geography has stark difference in deprivation.

The Index of Multiple Deprivation (IMD)^

The darker the purple colour, the more deprived the area. Northwest Nottinghamshire has the highest proportion of deprived households, compared to South Nottinghamshire having the least.

Bassetlaw, Nottingham and Nottinghamshire's Index of Multiple Deprivation average score is **23.51** versus the national mean of 21.67. By ranked IMD score, Nottingham was the 10th most deprived area in the UK in 2019.

^Indices of Deprivation 2019: 7 domains.

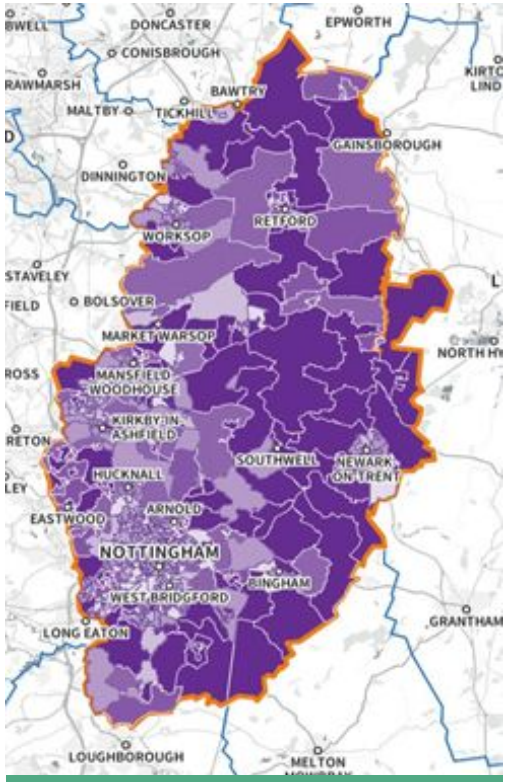
**except cancer where there is a higher incidence in the least deprived neighbourhoods*

Population growth & age profile

We have modelled that the population of Nottingham and Nottinghamshire will grow by 5% over the next 10 years. Over the same period, there will be a 38% increase in people over the age of 85. This growth means we need to fundamentally reconsider how we meet the demands of a growing, more elderly population in terms of health and care needs.

The north-eastern side of the ICS has a higher >65 years population, which will continue as the population ages.

We also know that a high percentage of emergency admissions and bed days relates to the over-65 age group.



Population density over 65 years

We know there is a stark correlation between deprivation and health outcomes; the most deprived having significantly higher incidences of long- term conditions*(see appendix 1).

In 2023, our ICS partners agreed an overarching Integrated Care Strategy to address health and wellbeing, and NHS national and local priorities. The strategy is based on three guiding principles.

Principle 1: Prevention is better than cure
There is a saying that 'prevention is better than cure'. We know that finding a health problem early or helping people know when to ask for help both improve health outcomes.

What this means for our infrastructure
We will need to move away from hospital-centric infrastructure development, investing and/or developing in primary and community care offering capacity to operate prevention activities and services.

We should look at how infrastructure changes can enable easier, faster access for citizens to information and services that help them stay well for longer. This will include digital transformation and adoption of artificial intelligence.

Principle 2: Equity in everything
We believe that a 'one size fits all' method for health and care can create barriers and exclude certain groups of people, ultimately impacting on the needs of the population and demand across the system. The principle of equity recognises that not all people have equal health and care access, experience or outcomes.

Principle 2: What this means for our infrastructure
By understanding our population's health and care needs, we can decide on where to invest and/or develop capacity for service delivery.

We need to ensure our infrastructure caters for those with physical disabilities and those of neurodiversity, and that adopting digital technologies does not further widen the inequity gap.

Principle 3: Integration by default
In past years, different health and care organisations have developed their plans in relative isolation, leading in some cases to fragmented services. Local people have told us that they want joined up and seamless services. By making collaboration between all the workforce and teams the normal way of working, and by harnessing our resource and ingenuity, we can re-shape services to become more integrated, treating the 'whole person'

Principle 3: What this means for our infrastructure
Holistically delivering health and care services will allow us to address interconnectivity of health conditions, and other determinants of health, intervening earlier in disease progression.
Integration should also be about non-physical integration. Sharing contracts, workforce, infrastructure processes and policies should also be our focus.

Section 3

Our Baseline & The need for change

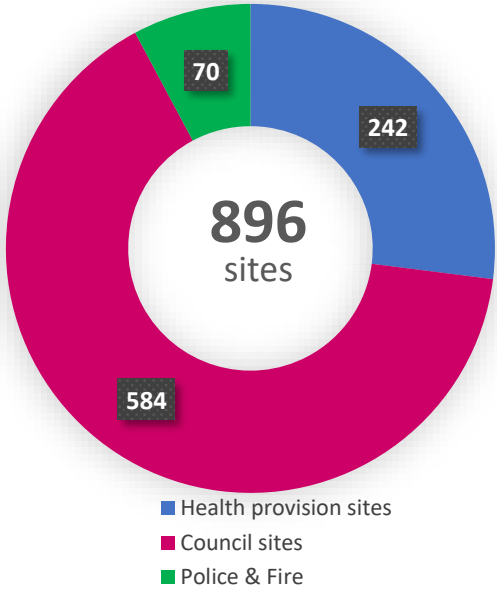
Together, the public estate in Nottingham and Nottinghamshire covers **896** points of provision.

Health care is provided out of **216**.

Primary Care will remain the bedrock of our health system. **9%** premises are poor condition, and **61%** have low to very low energy efficiency

104 of our sites host co-located public sector services.

£470m is the amount we need to address the current backlog maintenance in NHS estate^



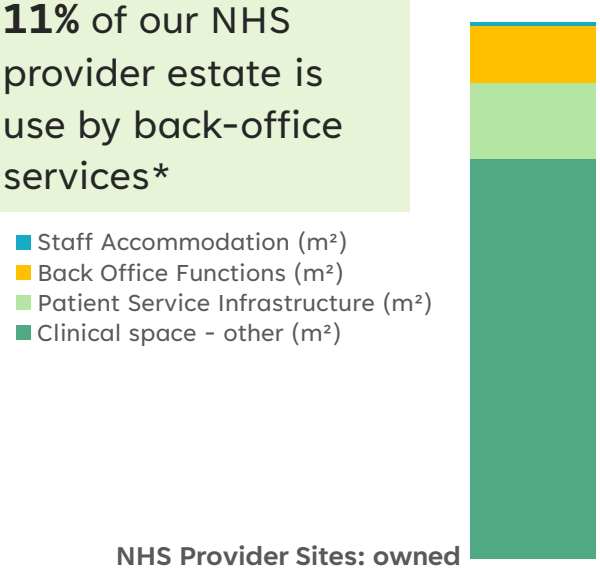
122 sites are managed by NHS property companies

£25.38m is the amount we spend on electricity each year*

£27.16m is the amount we spend on gas each year*

£0.45m is the amount we spend on oil each year*

11% of our NHS provider estate is use by back-office services*



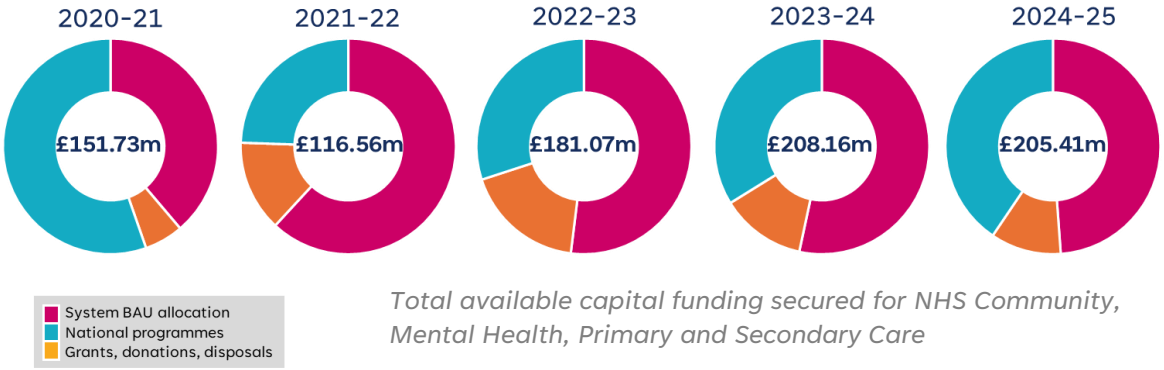
NHS Provider Sites: owned and leased

**taken from ERIC 2022/23 for NUH, SFH, NHCT only*
^ includes ERIC 2022/23 for NUH, SFH, NHCT and Primary Care

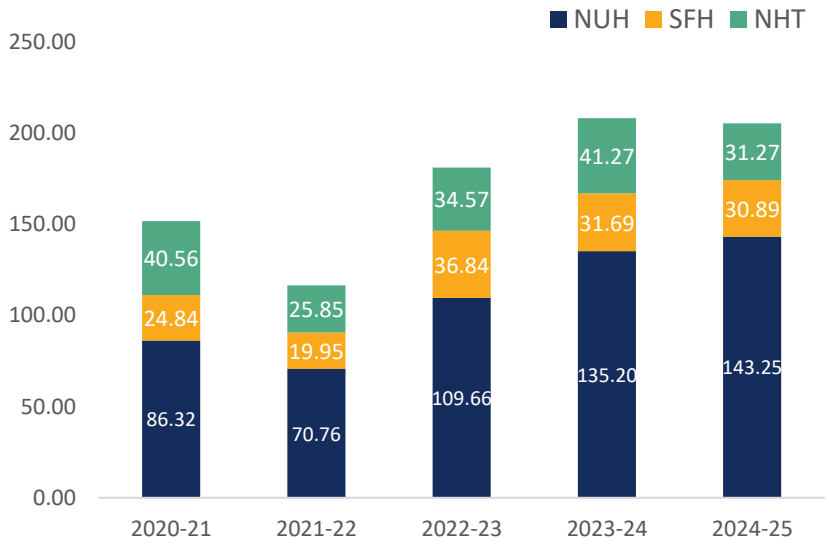
Our ICS Capital funding

The amounts of capital for NHS funding varies each year.

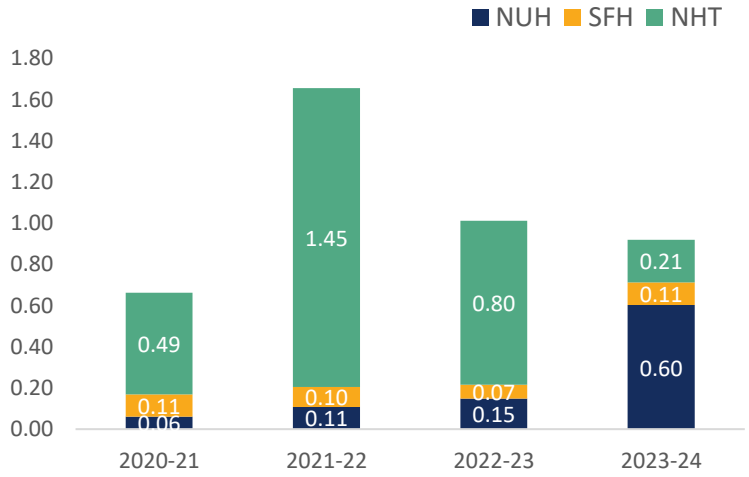
1. **System-level, BAU allocation** to cover day-to-day operational investments (which have typically been self-financed by organisations in integrated care systems (ICS)/STP or financed by the Department of Health and Social Care (DHSC) through emergency loans). This allocation includes funding for Primary Care premises and digital, CIR, high and severe risk RAAC hospitals, diagnostic equipment and COVID-19 responses.
2. **National programme allocation** to cover nationally strategic projects such as already announced and in development and/or construction such as hospital upgrades (STP capital funded schemes) and new hospitals, national technology funding and the continuation of the Mental Health Dormitory Replacement Programme started in 2020/21
3. **Access to public sector grants** such as public sector decarbonisation scheme (PSDS), donations and disposals



Total available capital funding secured for NHS Community, Mental Health, Primary and Secondary Care



Total BAU capital allocation to providers (£'m)



Capital receipts from provider disposals in £'m

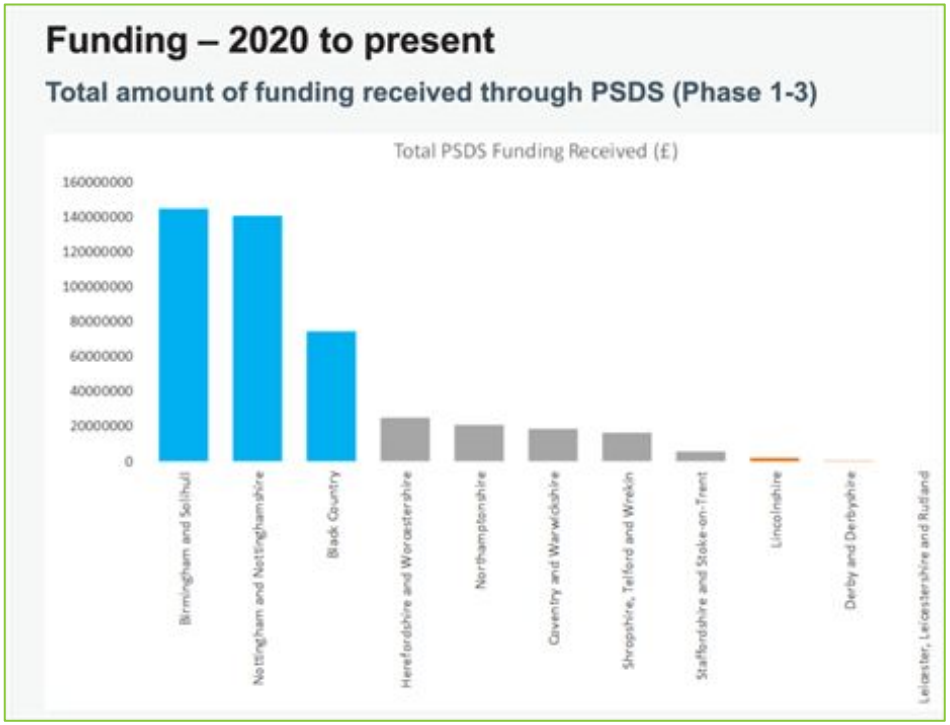
Our Required Capital

Through developing this strategy, we have identified capital requirements likely over a 10-year period. These have been captured in a supplementary excel workbook. The value of capital required for strategic, management of risk, operations, and environmental requirements is in the region of £1.9bn (£2.2bn adjusted for inflation). This excludes Tomorrow's NUH build costs and buy out costs for our PFIs. As part of our ongoing strategy development and delivery, we will consider the cost to, but revenue savings of buying out of PFI at Sherwood Forest Hospitals.

Public Sector Decarbonisation Scheme Funding

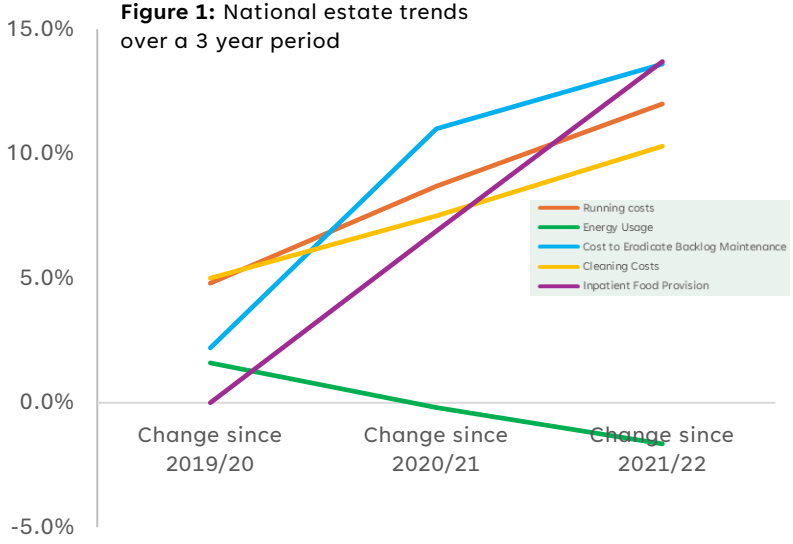
The Public Sector Decarbonisation Scheme supports the aim of reducing emissions from public sector buildings by 75% by 2037, compared to a 2017 baseline, as set out in the 2021 Net Zero and Heat and Buildings strategies. As an ICS we have been very successful in securing PSDS funding. Application is co-ordinated by Salix and to date has been awarded on a first come, first served basis.

The Public Sector Low Carbon Skills Fund provides grants for public sector bodies to put in place a heat decarbonisation plan, providing them with information they need to develop future applications to the Public Sector Decarbonisation Scheme. We recently submitted a bid for LCSF for support to develop decarbonisation plans but where unsuccessful as our application was not deemed 'innovative'.



PSDS Funding Phase	Funding available	Investment period
Phase 4	**1.17bn**	**2024-2028**
Not yet open	-	
Phase 3	**£1.45bn**	**2022-2026**
Nottingham University Hospitals	£40.034m	
Nottinghamshire County Council	£0.156m	
Phase 2	**£75m**	**2021-2022**
None	-	
Phase 1	**£1.00bn**	**2020-2022**
Nottingham University Hospitals	£24.666m	
Nottinghamshire Healthcare Trust	£3.757m	
Nottingham City Council	£1.035m	
Nottinghamshire County Council	£0.402m	

Figure 1: National estate trends over a 3 year period



National Trends

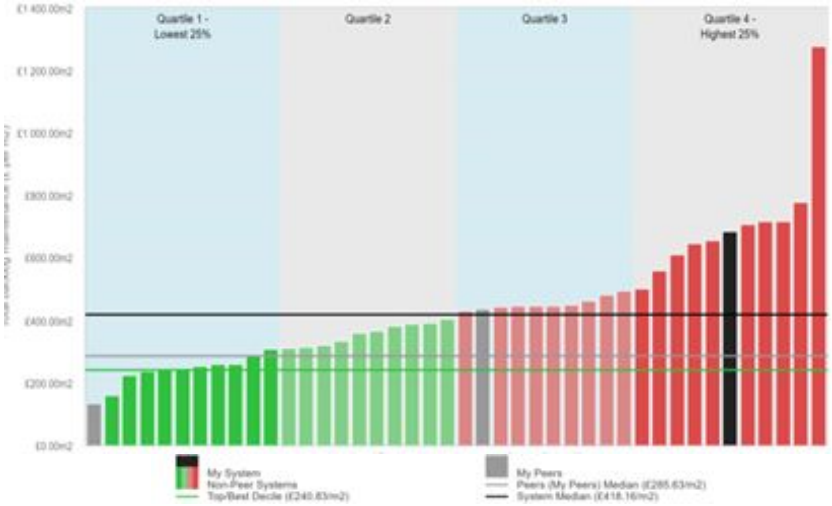
The general trend for cost of provision is upwards. Nationally there has been significant increase in the cost of addressing backlog maintenance and increases in cleaning and inpatient food far exceed general inflation. Figure 1 shows the rate of increases observed nationally.

How Our Backlog Maintenance has Changed

Over a 4-year period, our overall cost to eradicate backlog maintenance has largely remained unchanged (figure 3) despite investment.

There is a danger that all CDEL capital investment we have each year is swallowed up addressing these backlogs limiting our ability to transform. We can partially mitigate this by keep cost efficiency at the core of how we work and disposal of assets we can manage without.

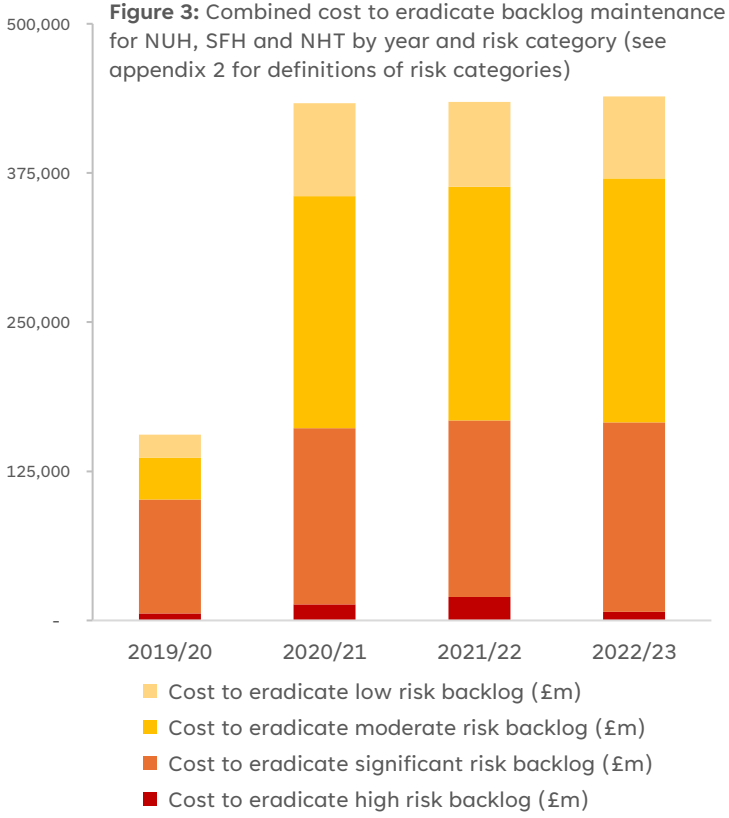
Figure 2: Model System benchmarking of ICS cost to eradicate backlog maintenance per m^2 (includes NUH, SFH, NHT only)



How We Benchmark

As with most ICS', backlog maintenance is a significant financial issue. Of the 42 ICS', we are 9th highest in terms of cost to eradicate backlog maintenance per m^2 (see figure 2). NUH has the 3rd highest backlog maintenance value out of 211 trusts.

Figure 3: Combined cost to eradicate backlog maintenance for NUH, SFH and NHT by year and risk category (see appendix 2 for definitions of risk categories)

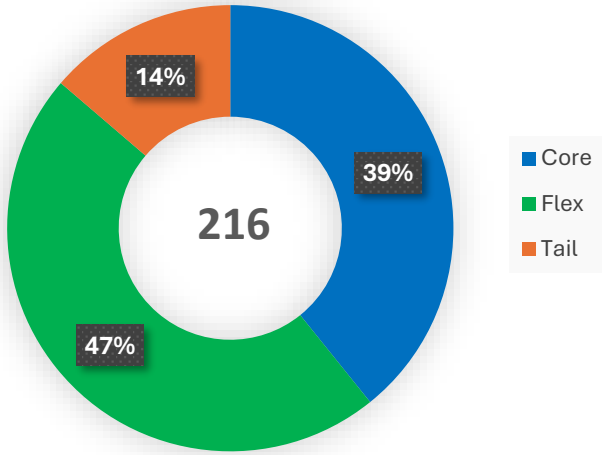


Categorizing our buildings as core, flex or tail

Before we can explore opportunities for change, we needed to strategically categorize our NHS buildings and sites as core, flex or tail.

This involves assessing each by their fit with our wider system strategies, condition, and costs of works or maintenance required.

By doing this, we will be able to develop a system-wide phased pipeline of investment, divestment, and/or transformation requirements.



Core categorized estate: *Good quality, fit for purpose, future proof*

39% of our current health sites are good quality, fit for purpose estate that will continue to be suitable for future provision. We will maximize the utilization within these sites. Where these are NHSPS or CHP, we will work with the property companies to ensure that these buildings are optimized for long- term occupancy. For all sites we will work with the site owner to ensure the estate continues to remain core and supports delivery of our Infrastructure Strategy principles.

Flex categorized estate: *Acceptable quality that could be brought to core rating with investment or providing unique services,*

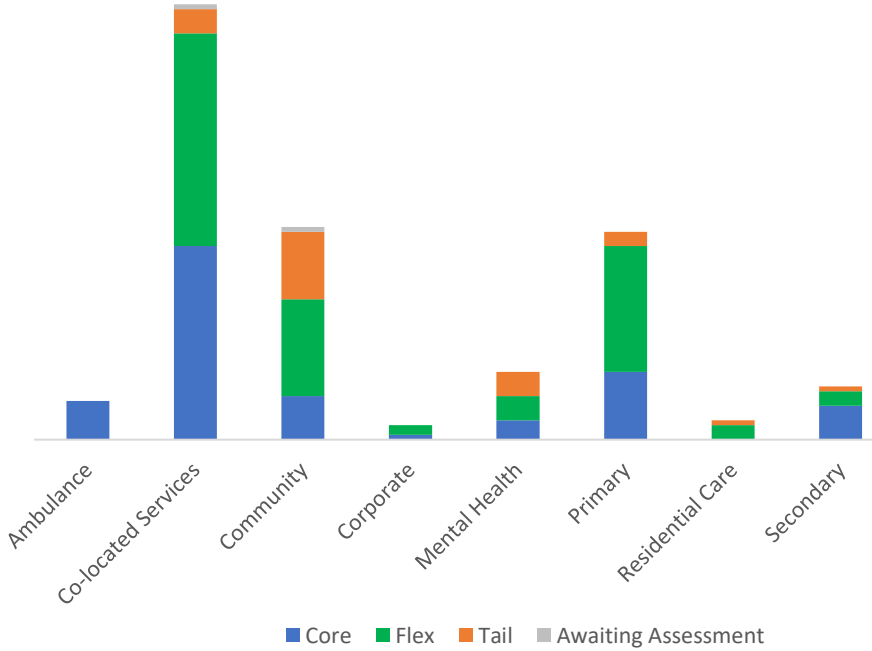
47% of our estate is partially fit for purpose; it is of an acceptable quality and may be able to be adapted.

Flex buildings unsuitable for investment should be phased out, with a plan for an alternative infrastructure solution for each flex building being part of our Infrastructure Strategy delivery plan.

Tail categorized estate: *Poor Quality, not fit for purpose, should be phased out*

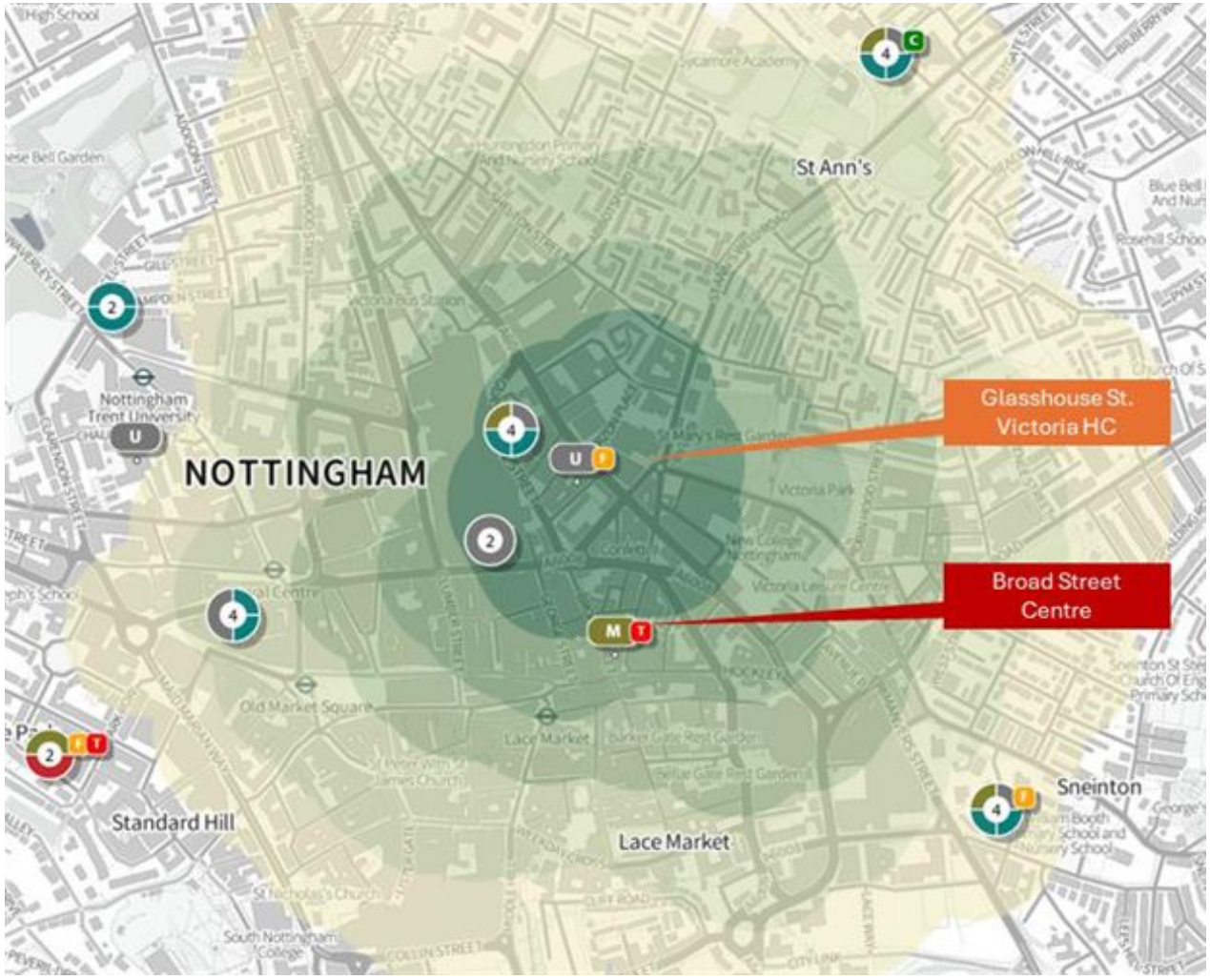
14% of our current health sites are poor quality and unlikely to be improved even with investment. We will phase out the use of our tail buildings, focusing our attention on putting plans in place to provide an alternative infrastructure solution as soon as possible

Categorization of estate by predominant activity at site



Now we have classified our estate as Core, Flex, or Tail we are now starting to examine how well utilized each is. Taking into what patient activity is required in each geographical area, we can explore how we work as a unified system to maximize our most expensive, high-quality estate and where we can start to move services from poor quality estate.

For example, Broad Street Centre, where mental health services are provided, is classified as Tail condition. Within a 3-6 minute walk for the majority of users is Glasshouse Street Victoria Health Centre, a flex premises with lower utilization. A desktop assessment of suitability can then be performed



Overall Energy

We spend in excess of £53m per annum on heating and electricity across NUH, SFH and NHT alone. Decarbonizing our electricity and heating are essential to reach net zero, given energy accounts for 58% of our NHS carbon footprint. Energy contributes similar proportions to our councils' footprints.

	Electrical energy consumption (kWh)	Electrical energy cost (£)
NUH	59,429,423	16,170,603
SFH	29,377,772	6,695,113
NHT	16,434,846	2,520,180
Primary & Community*	Unavailable	1,033,184

** Property Company estate only- includes Citycare and GP leased estate. GP owned estate not included*

Electricity

Until recently all organisations purchased Renewable Energy Guarantees of Origin (REGO) certified renewable energy. The cost of certification for a typical acute trust is more than £300k per annum. Over the course of a year, many NHS organisations have ceased to buy REGO certified energy, either diverting savings into other sustainability projects or using it to ease pressure on the financial bottom line.
Renewable energy across all sites is negligible, but we must address this to reach net zero, and doing so will also save money.

Heating and Other Energy Sources

NHT and NUH have several fossil fuel Combined Heat and Power (CHP) units. CHP is a highly efficient process that captures and utilizes the heat that is a by-product of the electricity generation process. By generating heat and power simultaneously, CHP reduces carbon emissions by up to 30% compared to the separate means of conventional generation via a boiler and power station.

King's Mill site use geothermal capability using the neighbouring reservoir to generate some heating and 90% of cooling.
SFH also run an oil-powered generator and support Sterile Services using oil as the main energy source.
In 2022/23, NHT still had 5 sites reliant on oil fired heating. Work is being undertaken to eradicate these where possible

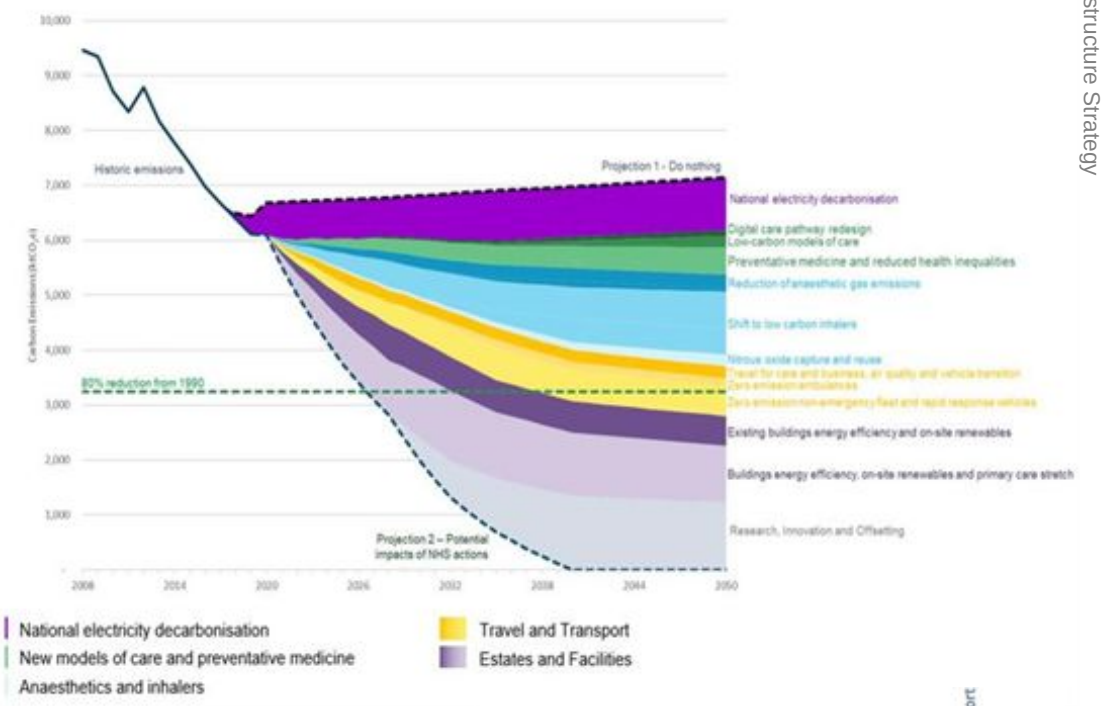
	Gas consumption (kWh)	Gas cost (£)	Oil consumption (kWh)	Oil cost (£)
NUH	212,744,907	21,101,236	206,580	193,865
SFH	33,173,906	2,619,428	1,785,457	216,329
NHT	47,634,397	3,452,705	493,905	43,801
Primary & Community*	Unavailable	640,526	Unavailable	2,073

In July 2022, the Health and Care Act formalized the need for the NHS to become net zero by 2040.

In 2023 our ICS issued our Green Plan. This plan outlined how we would work as a system to reach net zero. In our ICS we have a series of targets to get to net zero. They are:

- Nottingham city Council aims to reach net zero by 2028
- Nottinghamshire County Council aims to reach net zero by 2030
- Our NHS partners need to reach 80% net zero for all emissions within their direct control by 2028-2032
- Our NHS partners must reach net zero for all emissions within their direct control by 2040, and all associated emissions by 2045

A significant proportion of our carbon footprint is associated with infrastructure, especially energy. This is mirrored in our council partners' footprints. Figure 4 shows how the NHS will reach net zero; approximately 40% of this will be achieved by infrastructure changes during the life of this strategy.



NHS Footprint Breakdown

Figure 5

This pie chart shows how the overall national footprint of the NHS is broken down. This includes scopes 1, 2 and 3 emissions and is known as 'Footprint Plus' within the NHS

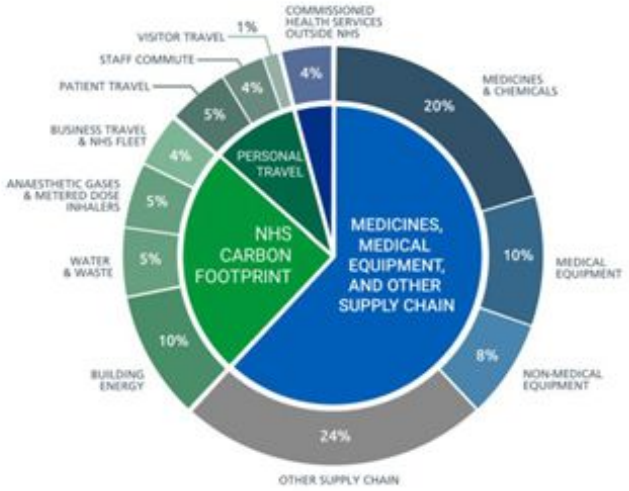
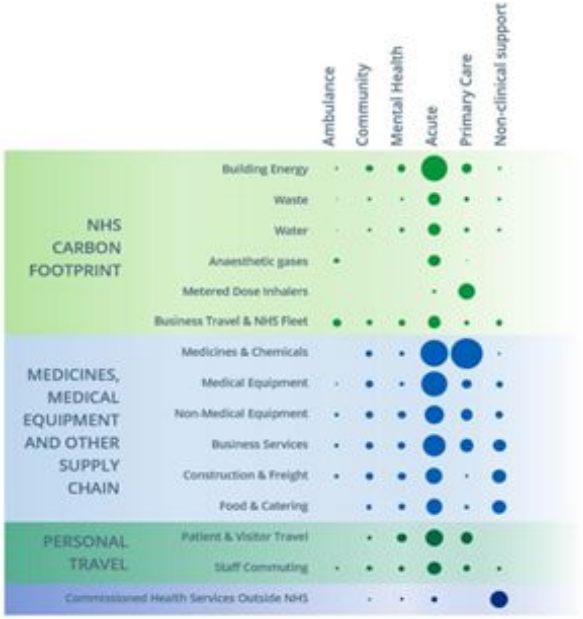


Figure 6

Each care setting for NHS activity dictates the source of carbon emissions and therefore opportunities and challenges of achieving net zero.

For acute providers, energy is by far the greatest emission source, whereas medicines is the greatest for primary care settings.



We will work with our council partners to ensure we maximize delivery where we need to act as a system. We have identified numerous opportunities and will continue to do so, in working as a system in partnership with our councils.

As the NHS we must seek to deliver the following requirements within our infrastructure:

- Have access to energy management expertise (>0.5 FTE) funded from their own resources
- Have access to waste management expertise (>0.5 FTE) funded from their own resources
- Install EV charging infrastructure to support transition of their owned and leased fleet to zero emission vehicles (excluding ambulances) by 2028
- Plan deployment of EV infrastructure by identifying local/ regional grid capacity and work with local network operators and/or local authority to plan for increased capacity where necessary by 2025
- Have a heat decarbonization plan, identifying and prioritizing the phasing out of existing systems
- Utilize the heat decarbonization plans to identify opportunities to increase on-site electricity supply for use in heat pump solutions and EV by 2023/24
- Remove all coal and oil-led primary heating systems by 2028
- Review existing vehicle procurement contracts and develop a standard framework for regional procurement strategies
- Have a system strategy for adaptation.

Renewable or Low Carbon Energy

- Installation of PV panels to generate solar energy – we will explore funding options for this including private investment. This could include solar car park canopies.

- Working with council partners with identified grant funding but limited space available for their own PV panels.
- Ground source heat pump feasibility assessments.
- Explore how/if there are opportunities with Nottingham council on the forthcoming Biomass Powerplant.

Waste Management

- Explore opportunities with our councils on how we will collectively address waste processing.
- Whole system opportunities for food waste reduction initiatives, 'plant first' meal principles, and locally sourced, seasonal produce.

Electrification of Vehicles

- Playing our part in the delivery of the East Midlands Combined Council Authority decarbonization plans.
- Increase power resilience at our acute sites to enable installation of EV charging infrastructure
- ICS system working to enable EMAS to decarbonize/ electrification of their ambulances/fleet.

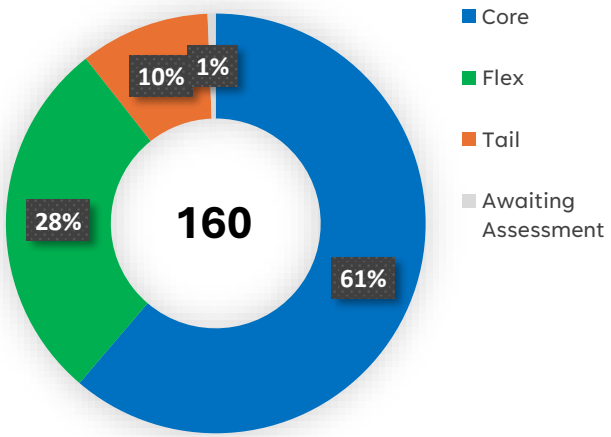
Current Infrastructure

Primary care is, and will remain, the bedrock of our NHS services. Effective functioning of general practice is central to early detection and intervention in people's health and wellbeing.

There are 130 GP practices operating over 160 premises.

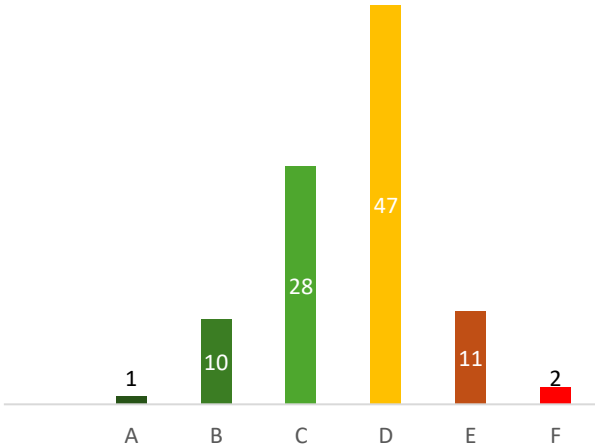
The quality of the general practice estate is highly variable but represents rather more challenge than opportunity. There is a growing backlog maintenance burden across this cohort of premises. There are also needs to meet the demand of population growth.

Total approximate backlog maintenance for Primary Care estate is £12m. Approximately £4m of this is in in Owner-Occupied and Privately-Owned premises. A number of GPs occupy NHS Property Services
estate with has a total backlog maintenance across all properties in our ICS of £8m



General Practice Categorization

Whilst the proportion of 'Tail' GP estate is proportionately low, it must be noted that the energy efficiency of most is far from ideal. This means premises are have higher carbon footprints and are costing more to heat and light.



EPC Energy Rating of General Practice Premises

Key Health Challenges for Primary Care:

- High prevalence of obesity, diabetes, chronic kidney disease and coronary heart disease.
- Nearly one in three people with a long-term physical condition also has a common mental health disorder, most commonly depression and anxiety.
- More than 65% of adults across Nottingham and Nottinghamshire are overweight or obese; both Nottingham and Bassetlaw have significantly higher proportions of children in year six who are overweight.
- More than 11,000 hospital admissions and more than 4,500 preventable deaths each year are caused by smoking.

Primary Care Network Priorities

- PCN Clinical and Estates Strategies completed in 2023 have provided an opportunity to discuss and refine the challenges and opportunities identified by PCNs. Workshop events at 'Place' level have enabled an honest discussion about priorities and has identified some quick wins, such as access to bookable space for practices holding disease specific clinics and conversion of unused space for ARRS staff. This has given PCNs ownership of their strategies and for the ICB a better understanding of the challenges at practice and PCN level from this bottom-up approach.

- The ICB has worked with both property companies to better understand the space utilisation data so that it reflects the situation on the ground and that barriers to accessing this space can be removed. We are anticipating a significant reduction in our NHSPS vacant space through a number of projects we are working on now; and closed café areas in LIFT buildings are being converted into clinical space and areas for community use and social prescribing.

- The PCN strategies aggregated up to ICS level allows the ICB to develop an overarching primary care estates strategy and a pipeline of priorities for the next 10 years. New schemes will be prioritised using the Primary Care Prioritisation matrix national indicator tool alongside consideration of local factors.

- The ICB has identified a number of legacy schemes prioritised by predecessor organisations and areas of significant growth which form the immediate primary care priorities.

PCN Prioritisation Matrix – a national indicator tool

This national indicator tool has been developed with multiple stakeholders across NHS England/Improvement, Department of Health and Social Care, Community Health Partnerships and NHS Property Services. The tool is intended to support prioritisation review and local considerations and factors should also be considered during review.

Adoption of this tool is part of the developing Primary Care Strategy. We are working at place level with health and local authority stakeholders to create development pipelines to address priority areas.

The tool is assesses and assigns a RAG status for each PCN against four key categories. For our Infrastructure Strategy we focus on 'Estate' rather than 'Infrastructure' as the latter refers more to the staff to patient balance.

PCN name	Town/City	Matrix index	Prioritisation theme indices percentiles			
			Health	Demographic	Infrastructure	Estate
Arnold and Calverton	Nottingham	6	58	16	9	1
Arrow Health	Nottingham	18	30	20	11	81
Ashfield North	Nottingham	55	91	79	30	11
Ashfield South	Nottingham	85	80	74	57	58
Aspire	Nottingham	14	16	61	54	4
Bestwood and Sherwood	Nottingham	73	46	84	60	55
Bulwell and Top Valley	Nottingham	61	68	72	57	31
Byron	Nottingham	66	39	86	34	68
City South	Nottingham	14	6	64	55	4
Clifton & Meadows	Nottingham	46	41	69	56	31
Larwood & Bawtry	Worksop	35	77	42	50	9
Mansfield North	Nottingham	95	66	94	94	43
Newark	Nottingham	38	50	56	54	30
Newgate Medical Group	Worksop	67	64	39	89	38
Nottingham City East	Nottingham	73	47	84	61	56
Nottingham West	Nottingham	11	21	4	3	79
Radford and Mary Potter	Nottingham	29	19	90	62	8
Raleigh Healthcare	Nottingham	14	11	62	55	4
Retford and Villages	Newark	54	82	50	52	30
Rosewood	Nottingham	67	34	86	61	57
Rushcliffe	Nottingham	37	35	58	26	69
Sherwood	Nottingham	73	91	44	51	60
Synergy Health	Nottingham	3	35	6	4	16
Unity (Nottingham)	Nottingham	27	12	89	66	4

1. *Health: including disease prevalence ratings against identified key national health inequalities*
2. *Demographic: including indices of multiple deprivation (IMD), life expectancy, ethnic minorities, urban adversity, ageing populations and populations with projected significant shift in population growth*
3. *Infrastructure: including levelling up fund, single handed GPs and/or practices with majority GPs reaching retirement, and patients to staffing ratios*
4. *Estate: including patients to space ratios, staffing to clinical space ratio, age, condition and functionality*

Future model of care

Our local ambitions for integrating primary care respond to and reflect the offer set out in the Fuller report.

Primary care will remain the bedrock of our NHS services being central to transforming people's health and wellbeing outcomes, and to people's experience of health and care services when they need them.

To address increasing complexity of patients, demand on services and constraints of general practice workforce, a new approach will require practices to work with each other in an increasingly integrated way and with other care services in the area.

The future of General Practice requires joining up with other providers (e.g. care homes, consultant advice & guidance, pharmacist, district nurse and others).
Ideally, integrated care team members are co-located, to facilitate communication and collaboration, but where they are not, they need to function as a team even if they're in different locations. This will be enabled by digital connectivity.

Providing intelligent healthcare through an integrated digital ecosystem can support continuous relationships as well as one-off treatments, enable personalized strategies for health and wellness and ultimately AI-enabled preventive strategies. We will look to AI to transform including assisting in disease prediction, pathology diagnosis, clinical decision support and disease management.

Section 4 covers new models of provision that we will explore, ensuring that we build localism into our plans at both place and neighbourhood level.

In essence, or plan for general practice is fewer sites, better utilization, more shared facilities , improved standards and less isolation.

Key Strategic Themes To Shape Future Primary Care
Demand Management and Access Improvement
Low Level Mental Health
Chronic Disease Management and Anticipatory Care
Health Inequalities and Prevention

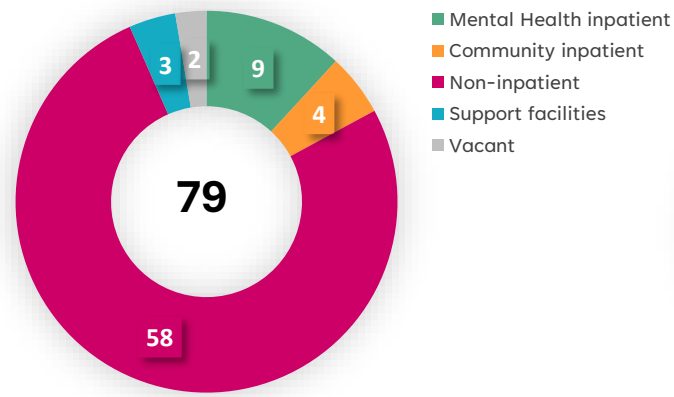
Investment Priorities

1. **Housing development driven priority geographical areas**
   Three major housing developments are in the planning pipeline, all requiring primary care capacity. Work is ongoing with developers to secure primary care facilities. These are:
   - Fairham Pastures –3000 dwellings [c.7k patients]
   - Chetwynd Barracks, Chilwell / Toton Sidings - 4,500 dwellings [c.10.5k patients]
   - Tollerton/Bassingfield – 4,000 dwellings [c.9k patients]

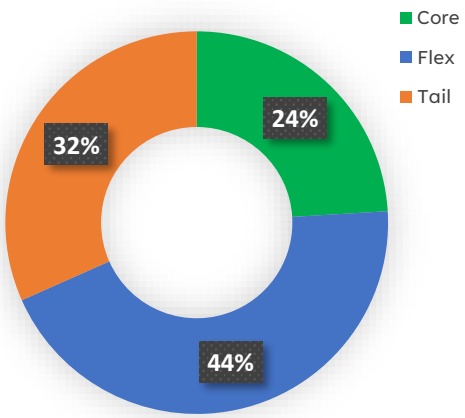
2. **Population growth driven priority geographical areas**
   Creation of capacity through new builds will address estate infrastructure issues, and population growth in the following areas:
   - Hucknall –proposed Cavell site incorporating 3 general practices, and health and wellbeing services
   - Eastwood and Giltbrook
   - East Leake
   - Newark
   - Beeston

3. **Condition driven priority geographical areas**
   - Radcliffe on Trent
   - Strelley/Aspley area
   - Burton Joyce
   - Edwinstowe/Ollerton

Current Infrastructure



NHCT - number of sites



Categorization

Main Sites	Location
Rampton Secure Hospital	Retford
Highbury Hospital	Nottingham
Lings Bar Hospital	Nottingham
Wathwood Hospital	Rotherham
Millbrook Mental Health Unit	Sutton-in-Ashfield
Hopewood	Nottingham
Arnold Lodge	Leicester
Duncan MacMillan House	Nottingham
Sherwood Oaks	Mansfield

Estate Summary

Nottinghamshire Healthcare Trust (NHT) is a combined Community and Mental Health Trust, providing services over a high number of medium to small sites across Nottinghamshire. Mental Health services are provided to the Nottingham city and county, whereas community services are provided to the county. Nottingham City community services are provided by Citycare who provide services from premises managed by NHS PS or LIFT properties.

More than half of their sites provide non-inpatient community services (58 sites). 67% of owned properties classified as tail are community service provision (8 sites).

NHT have a strong track record of working towards Net Zero and using their estate as green spaces for health and wellbeing. They are an active member of the ICS Net Zero programme, offering learning to our other organisations. They have a thriving apprentice scheme for Estates and Facilities staff.

Private Finance Initiative Estate: Highbury Hospital

The original Victorian maternity hospital that sat on the 12-acre Highbury Hospital site was demolished and redeveloped by Walker Healthcare, which also oversees the on-going facilities management, in 2004. The lease runs until 31/01/2039.

Highbury Hospital cares for older people living with a mental health problems or a disability. This includes the Asperger's Service for Nottingham and a wide range of specialist support and care services. It provides residential care for up to 135 people as well as in-patient care and community outreach services.

Nottinghamshire Healthcare Trust Investment Priorities

Millbrook & Highbury Hospital - Dormitory Eradication national programme

In 2020 the Government pledged more than £400 million to eradicate dormitory accommodation from mental health facilities across the country to improve safety, privacy and dignity of patients experiencing mental illness.

Mixed sex accommodation, dormitory style bedrooms with shared bathroom facilities present significant sexual safety risk, provide little access to fresh air and suitable outdoor space.

Eradication works are complete at Sherwood Oaks, construction is underway at Millbrook and Cherry Ward at Highbury is being investigated.

Arnold Lodge Medium Secure Unit (Women's)

Arnold Lodge provides medium secure inpatient services for adults and older people with mental illness and / or personality disorder.

Seclusion and ICU facilities are no longer fit for purpose / environment no longer meets today's requirements in the revised Mental Health Act Code of Practice (2015) and the Care Quality Commission's Guidance on Long Term Segregation (August 2021).

Rampton Hospital – Secure Mental Health Hospital

Rampton Hospital is one of three high security hospitals in England and Wales.

5 services are provided including 3 being on a national basis.

Wards within blocks A and B are no longer fit for purpose with a requirement to re-provide these in their entirety.

Section 3: Secondary Care Infrastructure: Sherwood Forest NHS Foundation Trust

Sherwood Forest NHS Foundation Trust (SFH) delivers a full range of acute services and some community services for approximately 420,000 people across Mansfield, Ashfield, Newark and parts of Derbyshire and Lincolnshire. The Trust occupies 3 main premises. Acute services including 24/7 Emergency Care are provided from King's Mill Hospital in Sutton-in-Ashfield, with an 08:00-22:00 minor injuries service being run from Newark Hospital. Newark Hospital accommodates medical patients that are more clinically stable and is in the process of becoming a 'cold' elective surgery site.

The King's Mill Hospital site houses a significant PFI-funded hospital built in 2006 (lime green on site map below), though there is a similar amount of retained estate.

Mansfield Community Hospital was partially redeveloped as part of the PFI with only a small amount of original estate remaining.

Newark Hospital consists of 8 buildings built between 1881 and 1995.

Retained estate on King's Mill Hospitall site, and the older Newark Hospital carry substantial backlog maintenance burdens. The site plan on the left shows that around half the king's Mill site estate has poor condition
King's Mill retained (PFI) estate backlog maintenance totals of £13.8m. Newark Hospital and Mansfield Community Hospital is under the PFI agreement for backlog.

Sherwood Forest Hospitals NHS Foundation Trust

Private Finance Initiative Buildings

Private Finance Initiative (PFI) properties have been built under a long-term contract between a private party and a government entity where the private sector designs, builds, finances and operates a public asset and related services. PFIs transfer delivery, cost and performance risk to the private sector, protecting the public sector from build delays, cost overruns and poor performance

King's Mill Hospital

New build of over 80,000m^2 built by Skanska in 2004. The lease runs until 2042/43.

The PFI is home to SFH emergency, outpatient, inpatient and diagnostics service. On the KMH site 30% of the floor area is retained estate which includes theatres, wards, education centre, ICT, CSSD and administration

In 2024/25 a settlement agreement is due to be reached that CNH would bring all retained areas up to Condition B in line with Estatecode. The Trust would therefore have no backlog maintenance liability.

The Trust working with our PFI Partners are working towards the green agenda.

Mansfield Community Hospital

Built by Skanska in 2004, the lease runs until 2042/43. The site was partially redeveloped as part of the PFI contract, and a cost recharge mechanism is in place, with SFHFT holding the Project Agreement on behalf of NHS Property Services. NHSPS recharge respective organizations for use of facilities accordingly such as SFHFT.

MCH is now the site of one of our Community Diagnostic Centres (CDC) which will by open in 2025. The CDC occupies 1300m^2 of space (new) as well as including some of the existing MCH rooms such as the old restaurant. The CDC will have a separate lease in place.

Newark Hospital

Skanska as part of the PFI contract are responsible for the maintenance and backlog repairs for the whole of the site.

The site has recently had additional carparking added.

The PFI estate is of the highest quality, and with backlog and Critical Infrastructure Risks (CIR) within retained estate. Sustained investment or removal of legacy infrastructure remains a key priority. The Trust's ambition as part of the settlement deed is the backlog maintenance would transfer across to the PFI contract who will have four years to rectify and bring up to Condition B (Estatecode) except for three buildings.

Magnetic Resonance Imaging

SFH is a significant outlier for the MRI capacity. As demonstrated by Model Hospital benchmarking, SFH has the 4th lowest number / capacity of MRIs per 100k population in England. 2023/24 capacity had a deficit of 2,860 scans to demand, and this will increase to a deficit of 5,065 as demand increases throughout 2024/25. One scanner is end-of-life but is required to run 7 days per week; unsustainable due to breakdowns. In turn this creates pressure on ED flow and length of stay.

Funding for scanners has been identified and £12.4m capital funding has been approved for the works. This is being undertaken through our P22+ Partner.

Car Parking Infrastructure

CNH are investing in ANPR and this is being rolled out in 2024 across all three sites. Survey work is being undertaken to look at long term car parking solutions across the estate and the development of a car park strategy and travel plan.

Areas on KMH site have been identified to facilitate the loss of carparking due to developments such as the magnetic resonance imaging building and the CSSD.

Clinical Sterile Services New Build

Currently Clinical Sterile Services Department (CSSD) is housed in part of KMH retained estates and dates back to 1920s. It is graded at condition DX and has significant building fabric and environmental issues. Estates related failures result in interruption to CSSD operation;

- risk of catastrophic breakdown
- Impact to patient care; service failure leading to surgical cancellation

An options appraisal has been undertaken and further discussions are taking place with NUH as to the location of this build. This area remains outside of the settlement.

Spine Corridor

The link corridor that feeds all trust incoming soft fm supplies and pathology is in a poor state of repair and requires bringing up to Condition B. These works remain outside of the settlement deed and a Trust risk.

Estates related failures result in interruption to clinical delivery which had already occurred for 10 months during 23/24.

There are three strands of work that are being undertaken to ensure that the buildings at SFH are fit for purpose for the foreseeable future. These are the annual lifecycle programme; Investment programme and the work being undertaken following the Centre of Best Practice Surveys.

Lifecycle

Annual lifecycle programme continues to be undertaken investing in all aspects of SFH.

This includes upgrading of the following over the coming years: -

- Fire Alarm Systems
- Medical Gas Pipe Systems Infrastructure
- Ventilation Systems
- Nurse Call
- Replacement of all light fittings (to LED)
- CCTV Upgrades
- Security Access Upgrades
- Water Systems
- Heating infrastructure
- Electrical infrastructure

Investment

Investment from CNH over a period of four years to the retained estate to ensure we have a sustainable estate.

This includes works to the retained areas: -

- Theatres
- X-Ray
- ICU
- Mortuary and Histopathology
- Roofing
- Electrical Switch Panels
- External facades
- Air Handling Units

Centre of Best Practice Surveys

These are surveys being undertaken by specialists to provide detailed analysis of the asset condition and compliance.

Including identification of remedial works required and rectification timeframes

The areas of work include: -

- Fire Survey Works
- Electrical Medical Locations
- Room Data Sheet / Performance Review for all rooms within the PFI

Nottingham University Hospitals NHS Trust

NUH was formed in 2006 following a merger of Nottingham City Hospital and Queen's Medical Centre Trusts. It is now one of the biggest and busiest acute Trusts in England, employing 17,250 staff, with a budget of just over £1.5 billion, 98 wards, and 1927 beds across three main sites.

NUH provides district general health services to over 2.5 million residents in Nottingham, Nottinghamshire and its surrounding communities of Leicester and Lincolnshire. Specialist services are provided to a further 4.5 million people from across the East Midlands, and nationally for some select specialist services.

Queen's Medical Centre

Queen's Medical Centre (QMC), built in the 1970s, houses emergency services including a Major Trauma Centre for the East Midlands, Nottingham Children's Hospital, the University if Nottingham Medical and Nursing Schools, and the Nottingham Treatment Centre (elective surgical services). Premises are in a poor condition, there is significant wastage of energy due to build specifications at the time, and the grid power is at a critical level. A replacement solution is part of the New Hospitals Programme, with around £1.35bn capital investment provisionally secured See slide 27.

Nottingham City Hospital

Nottingham City Hospital is houses in a pre-NHS building circa 1920s. There are less issues with energy wastage, but the age of the estate contributes significantly to the backlog maintenance bill the trust has. Planned Care services are operated here but there is also specific specialty-specific emergency admission routes including for stroke, cardiology, burns, respiratory conditions.

Ropewalk House

Outpatient and hearing services are also provided out of Ropewalk House close to the centre of Nottingham.

Other Points of Provision:

NUH provides services within the community setting at over 30 other sites, though activity tends to be low in these locations.

Tomorrow's NUH – A catalyst for growth

Tomorrow's NUH (TNUH) is part of cohort 2 of the New Hospitals Programme. TNUH will allow the system to develop a wider context, with the TNUH programme at the core stimulating broader estate, strategic and digital development thinking across all health and care settings requirements are being developed strategically with system input.

Our approach to TNUH development will:

- Enable engagement with the new East Midlands Mayor and Combined County Authority, to optimise opportunities for aligning other local investment/regeneration opportunities as well as wider workforce, carbon-zero, transport and public health considerations– potentially leveraging new opportunities and creating a sense of a "whole" greater than the sum of its constituent parts.
- Ensure the outcomes of the Donna Ockenden Review into NUH Maternity Services are iteratively reflected in strategic estates developments.
- Will retain flexibility on elements of the clinical model and estate approach as more details emerge on the national Hospital 2.0 programme.
- Build in future to understand of broader opportunities for the future use of the Medical School building on the QMC campus; whilst ensuring that they can be implemented in tandem with the TNUH development.
- Allow for the maturation of the system's Provider Collaborative and the aspirations for creation of an aligned system capital approach, achieving optimal VFM from all NHS funding sources. Ensure that local authority plans for travel, transport and housing in support of patient access and development of the health and care workforce can be fully aligned – particularly where austerity measures are under consideration.

National Rehabilitation Centre

NUH has been chosen as the provider for national rehabilitation services at the proposed new National NHS Rehabilitation Centre (NRC) on the Stanford Hall Rehabilitation Estate near Loughborough. The NRC will address the current a shortage of specialist rehabilitation beds for in the East Midlands.

The NRC is part of Cohort 2 in the government's New Hospitals Programme and building work is due to be completed and the facility open to patients by mid-2025.

Clinical Diagnostic Centre – Nottingham City

The redeveloped Broadmarsh Shopping Centre will host a CDC, placing it at the heart of the city centre.
With an estimated cost of £25m, this CDC is expected to open in autumn 2025.

Clinical Diagnostic Centre - Mansfield

A derelict building at Mansfield Community Hospital will make way for the new, purpose-built facility. Demolition and building works are due to continue throughout 2024 before the full facility opens in 2025 at an estimated cost of £24m.

Example of existing system working

An ICB led utilisation project in December 2023 identified space within the community hospital which could be assigned to the CDC. This reduced the new build footprint requirement and costs which allowed an early phased launch. The CDC currently offers blood tests (phlebotomy), MRI, echocardiogram and ultrasound with andrology and pulmonary function with X-Ray and CT scans coming to the new facility.

Local Improvement Finance Trust Estate

In our ICS we have 13 buildings funded under the NHS Local Improvement Finance Trust (LIFT) programme. These premises were built to modernize the health estate putting patients' needs at its centre of design and aiming to bring care into the community and out of the acute setting wherever possible, and in areas of high need.

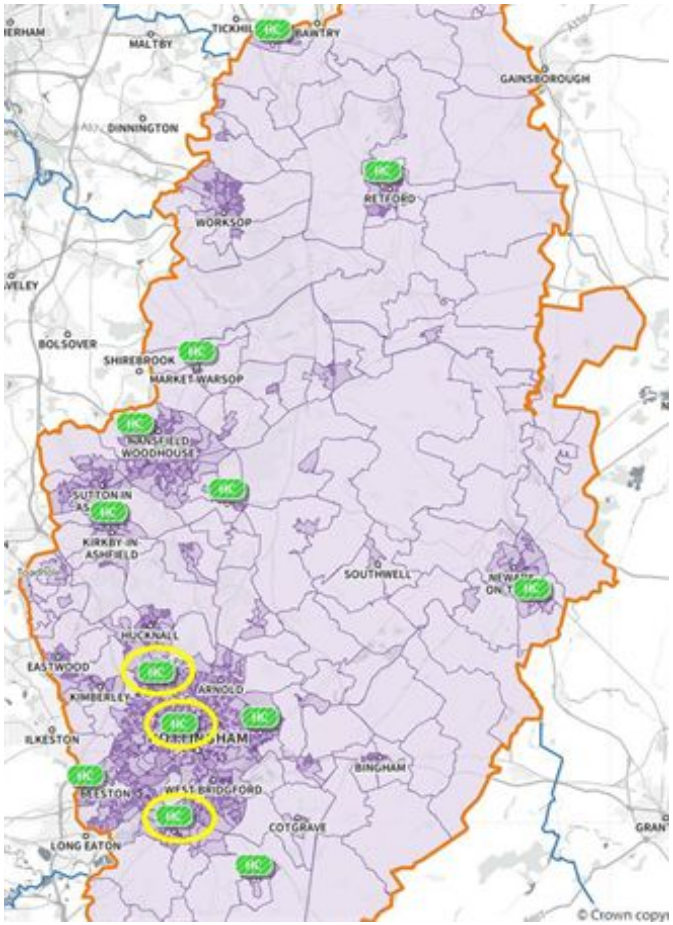
Community Health Partnerships (CHP) hold 40% stakeholder investment in our 13 LIFT buildings, and are head tenants in all properties shown on the map on the right. Nottingham City Council are joint head tenants in the 3 sites circled in yellow. Leases on our LIFT estate expire between 2030 and 2036.

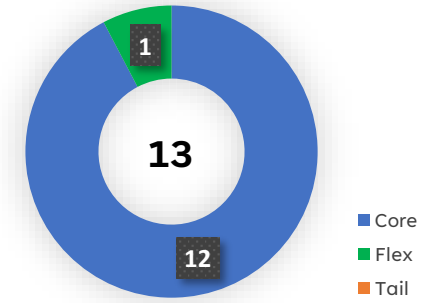
All properties are condition B or above. Backlog maintenance is prevented by planned preventative maintenance, and capital is available annually from the Department of Health separate to our system allocation.

Space within each is a blend of demised (leased) and bookable clinical and non-clinical space.

Utlisation of bookable space averages at 50%. Some sites have void space – the cost of this untaken space sits predominantly with the ICB.

Estate can be re-purposed with moderate ease, and CHP funding can be available for feasibility assessment. Capital funding for re-purposing is also available dependent on prioritisation criteria.





LIFT Properties Categorization

	Place	Head Tennant	Lease Expires	Void (m^2)
Bulwell Riverside	City	CHP & NC	2036	0
Clifton Cornerstone	City	CHP & NC	2030	224
Mary Potter Integrated Joint Access Centre	City	CHP & NC	2033	0
Keyworth Primary Care Centre	South Notts	CHP	2031	96
Park House Health & Social Care Centre	South Notts	CHP	2030	10
Stapleford Care Centre	South Notts	CHP	2030	60
Ashfield Health Village	Mid Notts	CHP	2032	53
Balderton Primary Care Centre	Mid Notts	CHP	2032	0
Bull Farm Primary Care Centre	Mid Notts	CHP	2032	0
Rainsworth Primary Care Centre	Mid Notts	CHP	2032	63
Warsop Primary Care Centre	Mid Notts	CHP	2032	0
Harworth Primary Care Centre	Bassetlaw	CHP	2032	244
Retford Primary Care Centre	Bassetlaw	CHP	2032	13

Priorities

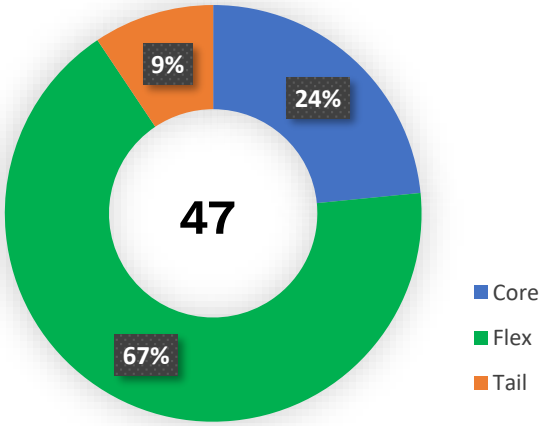
- Increase utilization of bookable space to 75%
- Identify poorly utilized demised areas
- Reduce void space at Clifton Cornerstone, Harworth, Keyworth, Rainworth, Ashfield
- Work creatively with CHP to future proof LIFT sites

NHS Property Services

NHSPS is an NHS property company wholly owned by the Department of Health & Social Care. It manages 2,700 properties nationwide which for Nottinghamshire includes 47 sites and approximately 70,000 sqm (GIA) of accommodation. These sites are occupied by a range of local NHS Providers including GP Practices and NHS Trusts. The types of sites differ, from individual surgery sites to Community Hospitals.

At the time of writing, there are 12 sites which contain vacant accommodation within them, the largest of which being Ashfield Health and Wellbeing Centre (242 sqm), Wollaton Vale Health Centre (148 sqm) and Selston Community Unit (137 sqm).

NHS Property Services: Owned & Immediate Landlord properties

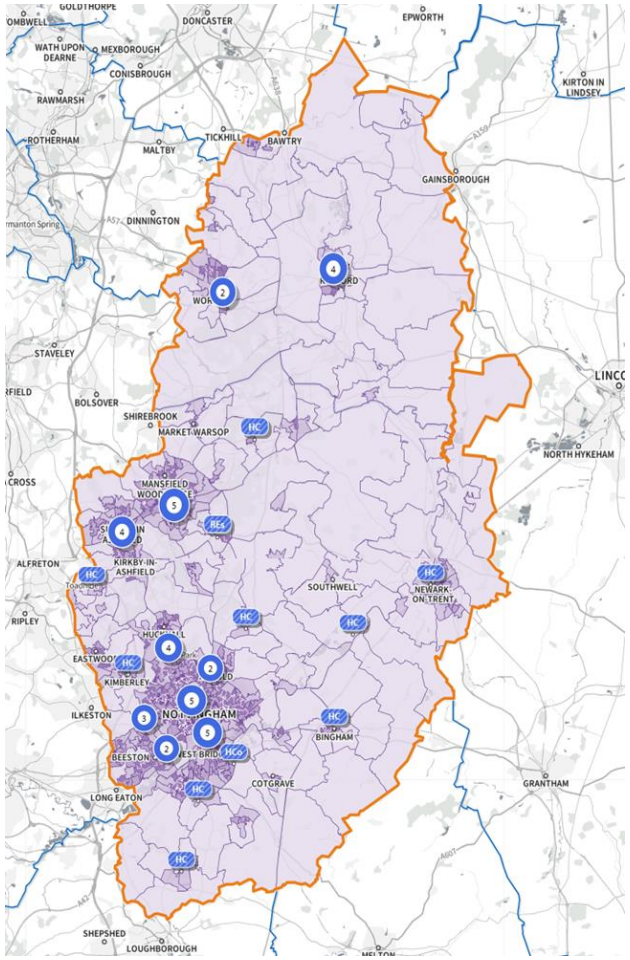


Most of these sites have a strategy in place to reduce vacant space in the near future which could see the total vacant space in the region reduced from circa 1,800 sqm to 1,200 sqm (NIA).

One of the ways in which the ICB and NHSPS are reducing vacant space is by carrying out minor works refurbishment schemes to make spaces more fit for occupation. Three schemes were completed last year, one at Strelley Health Centre and two at Meadows Health Centre.

A number of additional refurbishment schemes have been identified at the following NHSPS properties, which are in the feasibility stage:

- Wollaton Vale
- Victoria health centre
- Sneinton health centre
- Mansfield Woodhouse
- Hucknall Health Centre
- Orchard Centre



Priorities

- Reduce Vacant Space
- Increase utilization of NHSPS Open Space (bookable space platform)
- Agree strategy with ICB around tail estate
- Minor works refurbishment schemes to increase primary care provision

The National Workforce

The c100,000-strong Estates and Facilities Management (EFM) team across England, representing 8% of the NHS workforce, are core to delivery of all NHS services. Every day, the NHS EFM teams across the country, which include cleaners, porters, catering, security, engineering, capital delivery and maintenance staff, work alongside clinicians to ensure patients get the care they need.

There are 300 distinct roles, and the employment arrangements are similarly varied: 66% of people directly employed by the NHS, 27% outsourced to service delivery partners and 7% employed by NHS wholly owned subsidiaries. These are split across Hard Facilities Management (15%), Soft Facilities Management (77%) and Leadership, Management and Support (7%) roles.

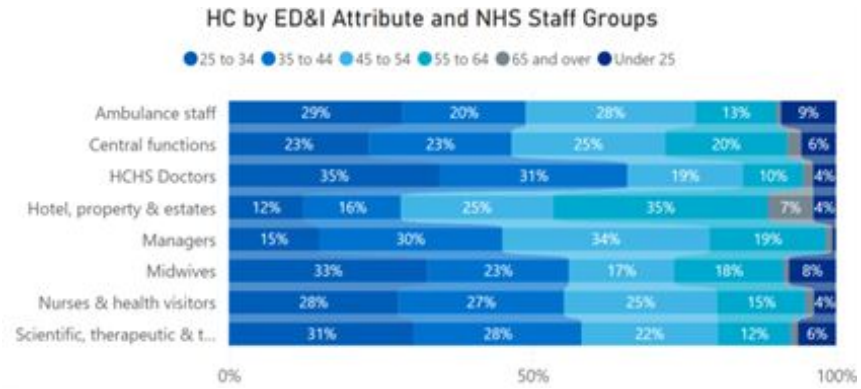
We have some key workforce challenges which need addressing to ensure we have a resilience E&F workforce pipeline for the future. With 41 % of the E&F workforce over 55 years of age and only 3.7% under 25, as well as gender and ethnicity imbalances across our workforce, we need to act now to future proof our workforce and ensure it is representative of the communities we serve.

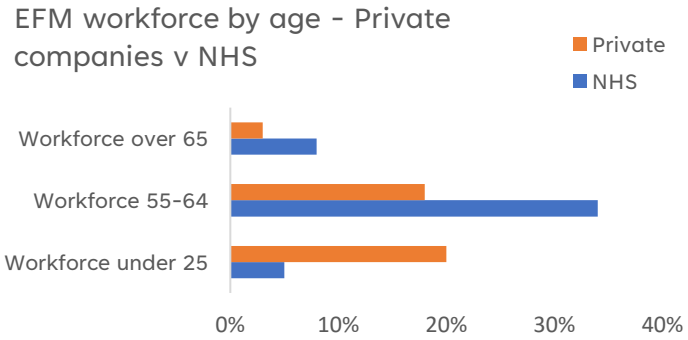
Our Estates & Facilities Workforce

Across our 3 main providers and ICB we employ c.2.3k EFM staff (c.1.9k FTEs). Over 70% of our EFM workforce are AfC band 2.

Comparing NHS staff groups internally we have a significant proportion of our workforce that is over the age of 55

Compared to private companies we have substantially less younger staff. This is a missed opportunity to provide job opportunities for our young people, as they are absorbed by private business such as Boots, Pendragon, Center Parks, and Sports Direct HQ.



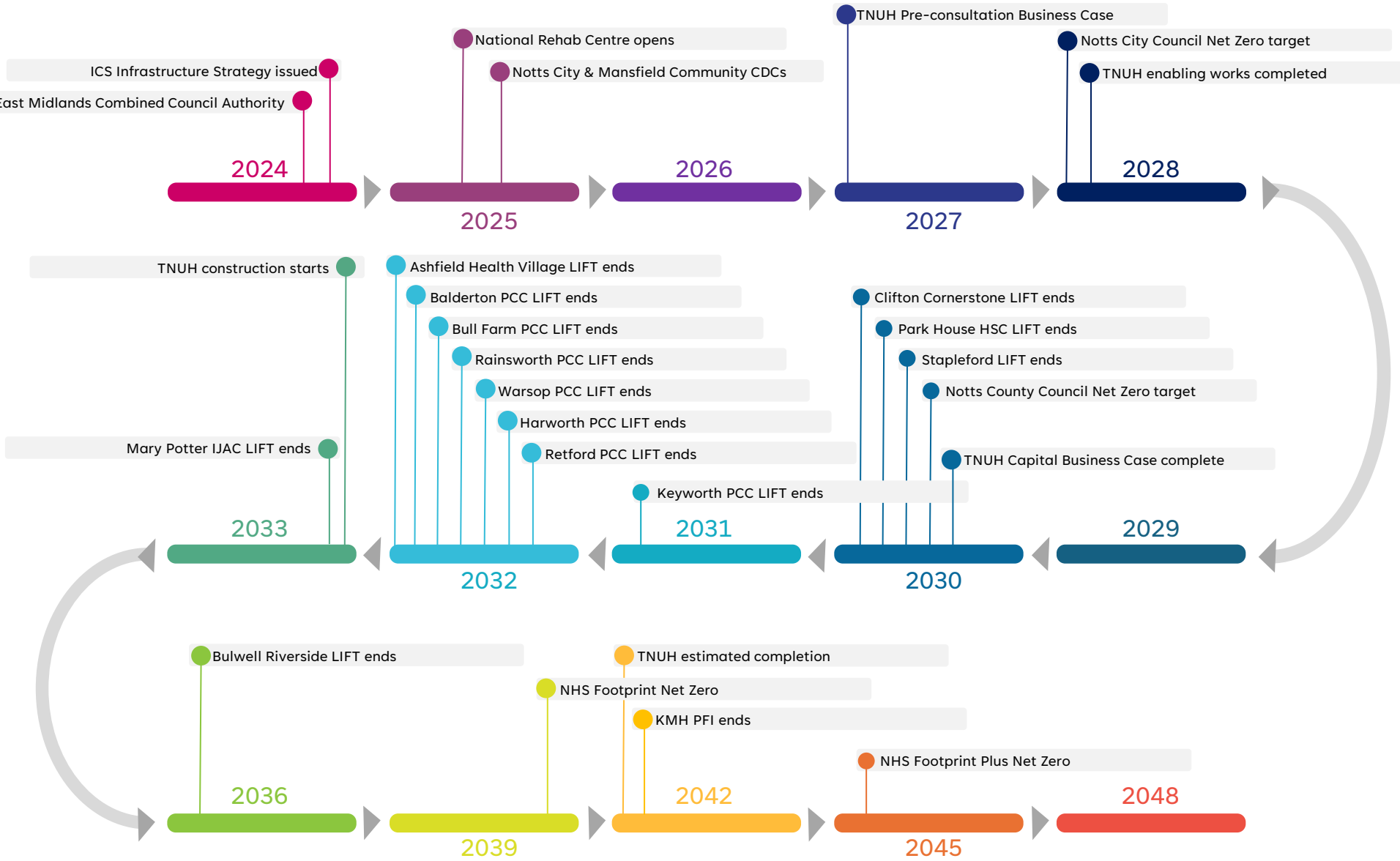


Our Workforce Priorities

We need to align our EFM workforce planning to the nine key actions in the national EFM Workforce Plan. Key priorities to explore are:

1. Compare current apprenticeship programmes being adopted across system partners with a view to harmonizing / creating cross organizational apprentice opportunities
2. Understand the collective need for professional services
3. Appraise options to create a this will inform whether creating a system-wide partnership hub would be feasible
4. Identify opportunities for existing EFM staff to work across providers on a rotational basis
5. Identify opportunities for joint posts as each current post is released

Section 3: Timeline of Key Infrastructure Milestones



Integrated Care System
Nottingham & Nottinghamshire

Section 4

Our Future Infrastructure

Our Vision

We will become a true network of partners, sharing and supporting our collective infrastructure to deliver the best health and care services for our population. We will ensure we use our collective assets to get the best value for the 'public pound'. We future Infrastructure is built on 5 core infrastructure objectives which are:

Right place, right size, right quality **1**		We will operate services from right sized estate in the most appropriate location for service users. Our infrastructure will be ***safe*** and of good quality for all users. We will adhere to our IC Strategy principle of ***Integration by Default***
Enabling and innovative **2**		Our infrastructure ***enables, rather than dictates*** how and what we transform. To often physical constraints have been barriers to change in the past. Digital technology and intelligence will allow us to innovate.
Green and sustainable **3**		Our infrastructure will become ***net zero***, using our green spaces to support health and wellbeing of staff and service users. We will proactively work to ***increase in biodiversity***.
Financially sustainable **4**		Affordable within our current financial envelope and finding new ways to ***deliver productivity*** services efficiently. We will ***proactively seek capital*** funding from sources outside our current envelope
Maximizes our Anchor Institution role **5**		Understanding and ***executing our role*** as anchors within and for our communities, to reduce economic and neighbour inequality.

Section 4: Adopting a One Public Estate approach

We will embrace the "One Public Estate" (OPE) ethos fostering collaboration among all our public sector organisations, including health and care services, police, and fire services. This approach aims to achieve financial and operational efficiencies through shared resources, integrated services, and mutual learning.

The OPE programme, established in 2013, has demonstrated significant benefits of such collaboration. With the involvement of 97% of councils in England and over 650 projects, OPE has supported public sector partners in generating approximately £456 million in capital receipts, saving taxpayers £87.5 million in running costs, creating over 31,000 new jobs, and releasing land for over 19,000 new homes.
The OPE ethos aims to consider all public estate together shaking off traditional service or organisation traditional thinking, to achieve the best value for the public pound.

By working together, public sector organisations can identify opportunities for shared spaces and services, leading to more integrated and customer-focused outcomes.

Within Nottingham and Nottinghamshire our OPE programme has identified opportunities and required feasibility assessments. These are outlined in appendix 3.

Whilst the national OPE programme, lead by Nottinghamshire county Council continues to run, we will adopt the same ethos for how we work within our NHS organisations.

Our Integrated Care Strategy outlines our priorities for clinical transformation.

- ✓ We will focus and invest in prevention priorities, like tobacco, alcohol, oral health, healthy weight, and mental health, to support independence, prevent poor birth outcomes and premature death from heart attack, stroke, cancer, chronic obstructive pulmonary disorder (COPD), asthma and suicide.
- ✓ Support children and young people to make the best start in life.
- ✓ Support frail people retain their independence and health.
- ✓ Make every contact count signposting and intervening earlier.
- ✓ Seek high productivity of clinical assets and workforce.
- ✓ Reduce impact on our environment and deliver sustainable health and care services.

Transformation plans and programmes are outside the scope of this strategy. These will be driven and approved by the ICS Clinical Senate.

It is important that we do not change infrastructure that then inhibits or constrains clinical transformation, but we can still help inform possibilities.

There are 2 significant pieces of infrastructure design that will do that; the New Hospital Programme (NHP) at Queen's Medical Centre, Nottingham University Hospital, and Activity Driven Estates Planning Tool (ADEPT).

The SIG will be involved with and ensure mutuality of all clinical estates modelling.

Activity Driven Estates Planning Tool (ADEPT)

This work is being supported by Community Health Partnerships to deliver a data model on behalf of NHS England.

ICSs within the Midlands are taking part in the second phase of a pilot to develop these data models. The model:

- Takes the baseline estates information on ownership, occupants, size, and overall core, flex or tail status
- Models current and predicted demand for clinical health services
- Indicates gaps in current capacity to manage current and future demand
- Supported by external clinical planners, works with our clinical leaders to develop our transformation interventions
- Models the required space, time and location of required estates capacity, which will then inform wider infrastructure needs

New Hospitals Programme: Tomorrow's NUH

Nottingham University Hospitals NHS Trust has been selected as a New Hospital Programme scheme. A commitment of circa £1.35bn capital investment to re-develop Queens Medical Centre and City Hospitals has been agreed.

A crucial part of the approach to defining what the new hospital will look like is consulting stakeholders, and clinically designing what services need to look like in the future. At the time of writing, early modelling has been completed, and the team developing the business cases will now work through a series of interventions or mitigations to stem ever growing projection of secondary care estate to meet forecast demand for services. All NHP programmes will consider the same interventions.

Clinical leaders will work through the interventions to adjust modelling of required space and design.

Right Place, Right Size, Right Quality 1

If we get this right ...

... we will have provided services mapped to population health and care needs, informed by data intelligence.

... we will have invested in and developed infrastructure to locally 'level-up' and allow service transformation to address inequity across our ICS.

... we will have used our estate to support our system ambitions to provide care closer to home.

... we will have prioritized capital spending across the healthcare pathway rather than continuing the hospital-centric focus.

... we will have operated spaces which are organisationally and functionally agnostic, to promote integrated working and better understanding of issues faced by others.

Enabling & Innovative 2

If we get this right ...

... we will have allowed transformational plans to be free from constrains due to our current infrastructure. Instead, we will have taken the outputs of strategies and plans and collectively worked across all system partners to find estate and infrastructure solutions.

... we will have kept flexibility for future decisions at the heart, evolving and managing our infrastructure.

... we will have embraced digitally-enabled solutions for reducing our infrastructure physical and carbon footprints.

... we will have worked in partnership with each other rather than allowing traditional issues to constrain what we do.

... we will have established and shared best practice and learnt from our previous actions.

Green & Sustainable 3

If we get this right ...

... we will have played a pivotal role in delivering the net zero programmes of our councils, NHS providers and the county.

... we will have moved away from fossil fuel and towards renewable and low-carbon energy generation, exploring initiatives such as covered car park canopies for solar generation.

... with the energy we use, we will have made every kWh of energy count.

... we will have reduced water run-off from our sites.

... we will have used our outside spaces creatively to support health and wellbeing of staff and service users, growing our green social prescribing offer.

... we will have used the land we own to proactively increase biodiversity.

Financially Sustainable 4

If we get this right....

...we will work in partnership across our ICS to prioritise NHS capital investment.

...we will systematically search for and secure capital from outside our NHS CDELs including from public sector grants, programmes and private company investment.

...we will consolidate our estates footprint by using shared clinical and non-clinical space with ICS and other public sector partners.

...we will operate not-for-profit charging of shared infrastructure.

...we will be in the upper quartile of cost per m^2 in NHS properties*.

...we will have achieved economies of scale through consolidating contracts or contracting services from within our ICS partnership.

** Against appropriate peers eg PFI Trusts for SFH*

Maximizes our Anchor Institution role 5

If we get this right ...

... we will have required all infrastructure contractors to meet social responsibility requirements including 15% of workforce being recruited from our local areas.

... we will have supported career progression for those working within our infrastructure sector and offered qualifications through apprenticeships.

... we will have enhanced the benefits to each other before using our public money to the profit of private sector companies.

We will operate services from right sized estate in the most appropriate location for service users. Our infrastructure will be ***safe*** and of good quality for all users. We will adhere to our IC Strategy principle of ***Integration by Default***

Our infrastructure ***enables, rather than dictates*** how and what we transform. To often physical constraints have been barriers to change in the past.
Digital technology and intelligence will allow us to innovate.

Our infrastructure will become ***net zero***, using our green spaces to support health and wellbeing of staff and service users. We will proactively work to ***increase in biodiversity***.

Affordable within our current financial envelope and finding new ways to ***deliver productivity*** services efficiently. We will ***proactively seek capital*** funding from sources outside our current envelope

Understanding and ***executing our role*** as anchors within and for our communities, to reduce economic and neighbour inequality.

Using Our Objectives to Shape Change

As we think what the future will look like if we adhere to these principles, we start to identify initiatives to deliver. From the illustrative examples over the next few pages, we can start to see how delivery is shaped.

Checking back to our principles will be a key part of how we plan and deliver this strategy. See section 5 for more details.

	Principle 1: Right place, right size, right quality	Principle 2: Enabling and innovative	Principle 3. Green and sustainable	Principle 4: Financially sustainable	Principle 5: Maximizing our anchor institution role
Installation of PV Panels (solar)			X	X	
ICS Infrastructure Consultancy		X		X	X
ICS Infrastructure Apprenticeships				X	X
AI Assisted Parking	X	X			
Back Office hub with RPA	X	X	X	X	
ICS Serviced Soft FM Provision	X		X	X	X
Cavell Centre @ Hucknall	X				

Example: Professional Services Hub

Creation of an ICS wide hub providing professional services

It is an integral part of infrastructure management to call on professional expertise from time to time. Most organisations do not use these services frequently enough to warrant substantive employment. Typical consultative services include condition surveying, utilization surveys, business case development.

If we consider the frequency, type and cost of services procured by all system partners it is likely we would hit the scale to justify employing skilled professionals. Funding for these posts could be done jointly, proportionate to likely need. We would expect a reasonable

Benefits:

- ✓ Cost saving.
- ✓ Greater system level insight.
- ✓ Capacity to complete condition surveying in a timely manner.
- ✓ Cross fertilization of good practice.
- ✓ Standardized policies and procedures.

Benefits:

- ✓ Cost saving.
- ✓ Supports achieving net zero carbon trajectories.
- ✓ Better for the local populations than relying on carbon intensive and/or polluting heat generation methods.

Example: Shared energy generation

Installation of PV panels across our estate

Collectively, we have significant roof space to house PV panels allowing solar generation of electricity. Advances in PV technology mean we could be generating a significant proportion of our energy through this renewable method. However, in the NHS, we do not have capital to fund installation. Nottingham City Council has ring-fenced capital funding for PV panel installation but no identified estate space to utilize. Working together we can generate clean, cheap energy.
Alternative funding could be secured from a private investor on a gain share model.

Example: Innovative car parking

Artificial Intelligence assisted car park management^

AI could be used to manage car parking. For example: a service user pre-books a car parking space prior to attending an appointment or visiting an in-patient.

Upon arrival, ANPR recognizes the car, and the system directs the driver to their allocated parking space. ANPR also triggers and sends a welcome message to the person's smart device with instructions on how to find their clinical appointment or the in-patient within the building. On leaving the car park, ANPR feeds back that the space is now free and available to book.

Benefits:

- ✓ Reduced cark parking. requirements allows land to be repurposed, supporting financial sustainability.
- ✓ Improves experience of service users.
- ✓ Reduces congestion thereby reducing emissions.
- ✓ Supports improved productivity.
- ✓ Improved access for blue light services.

^Example at in action:
Manchester University Hospitals NHS Trust ParkingEye

Example: Innovative Back Office Integration

Rightsizing administrative space

Adoption of AI to automate repetitive, high-volume tasks such as recruitment, invoicing and payment. Options to merge back-office functions are supported where appropriate. Shared, flexible administrative spaces available for any system partner to book. A single booking platform such as OpenSpace1, TAP2 or Cloudbooking3 could be used alongside utilization detection systems (eg OccupEye4) to ensure book-and-review capacity at designated sites in Nottingham and across Nottinghamshire. These spaces would be enabled by robust technology solutions for video conferencing and contain collaborative spaces.

Benefits:

- ✓ Repetitive, high volume admin tasks are conducted by RPA faster, freeing up admin time, allowing for teams to be right-sized.
- ✓ Efficient use of a reduced admin footprint, supporting financial sustainability.
- ✓ Heating and lighting energy saved through consolidation of admin estate.
- ✓ Strengthen networks within and across organizational and functional boundaries.

Platforms and systems currently in use in NNICS:
[1]NHSPS properties, [2]CHP properties, [3]ICB, [4]NHCT

We will consider and plan for the different types of infrastructure we need to create at place, taking one-public-estate and integrated approaches to create the infrastructure of the future. We will have a core-built infrastructure, with accommodation provided across integrated hubs, health campuses, on our high streets, in the home and across our communities (from community centres and other community spaces, to supermarkets or pharmacies).

As part of the delivery of this infrastructure strategy, we will appraise new models of primary care provision using all 5 of our infrastructure strategy principles. Below are some opportunities we will consider alongside our traditional general practice:

Changing the Setting: Providing Health Virtually
Our citizens became familiar with this concept during the Covid-19 pandemic, and now a large number of primary care appointments are no longer held in person.
Digital equipment, technology, wearable and other connected devices will be fundamental to support the delivery of effective place-based models of care – improving choice and access for people and enabling more anticipatory care, prevention and self-care.

Changing the Setting: Health on the High Street
Again, our citizens became familiar with this concept during the Covid-19 pandemic.
Our 3rd community diagnostic centre is located in the Broadmarsh Shopping Centre, a regeneration site within Nottingham City. We will build on learning as this becomes operational, looking to amplify benefits and take further opportunities presented by our high streets.

Changing the Setting: Health @ Home
In the future, we will be likely to deliver, and receive, more of our health services at home. Building on the virtual wards and other telehealth services, we will continue to expand models to support people to manage conditions at home to improve health, reduce admissions and to take more control of their own care. Creating the right platforms and systems will be essential, along with consideration and planning around digital inequity.

Changing the Delivery Model: Community Based Hubs
We will consider developing hubs where community and primary care services will come together alongside other health provision (including the out of hospital services that need to be provided locally as part of the new hospitals programme model of care). Such hubs would utilize existing sites rather than new builds.

Section 5
Delivering the Strategy

Delivering our vision

To successfully implement this strategy, our ICS will take a structured and collaborative approach, ensuring that infrastructure transformation is both sustainable and aligned with service needs. We will establish clear leadership and governance frameworks, ensuring all partners from NHS providers, local authorities, to private sector stakeholders, are working towards shared objectives.

Delivery will be structured around key workstreams, focusing on estate optimization, digital transformation, energy efficiency, and financial sustainability.

We will prioritize evidence-based decision-making, using data-driven insights to map service demand, identify estate inefficiencies, and develop targeted investment plans.

A phased implementation approach will guide the transition, balancing short-term improvements with long-term transformation. This will include modernizing primary care facilities, developing integrated community hubs, and strategically consolidating administrative estates to improve efficiency and reduce costs.

To fund these initiatives, we will leverage a mix of NHS capital allocations, public sector grants, and private investment opportunities, ensuring financial sustainability while delivering high-impact improvements.

Maximizing flexibility and adaptability will be crucial, with infrastructure developments designed to support future healthcare models, technological advancements, and evolving patient needs. By working as one system, we will drive innovation, enhance service delivery, and create a high-quality, future-proof health and care infrastructure for Nottingham and Nottinghamshire

Key delivery roles

Executive SRO

Bill Shields, Chief Finance Officer,
Nottingham & Nottinghamshire ICB

- Accountable for the delivery of the ICS Infrastructure strategy
- Setting the strategic direction and ensuring the real business need is being addressed
- Guides overall decision-making across organisations to ensure maximum collaboration and achievement of results

Programme Director

Lindsey Sutherland
Nottingham & Nottinghamshire ICB

- Responsible for the delivery of the strategy
- Determining and managing risks to the programme
- Providing leadership, decision-making support and direction to all organisations to implement the strategy

ICS Strategic Infrastructure Group

This new group will provide steering for programme delivery and monitor results and benefits. Its key role is to:

- Provide a forum for all partner organisations to come together
- Share best practice and create amplification of best practice
- Define the biannual delivery plan
- Prioritise pipelines to balance operational resilience with strategic changes

Governance

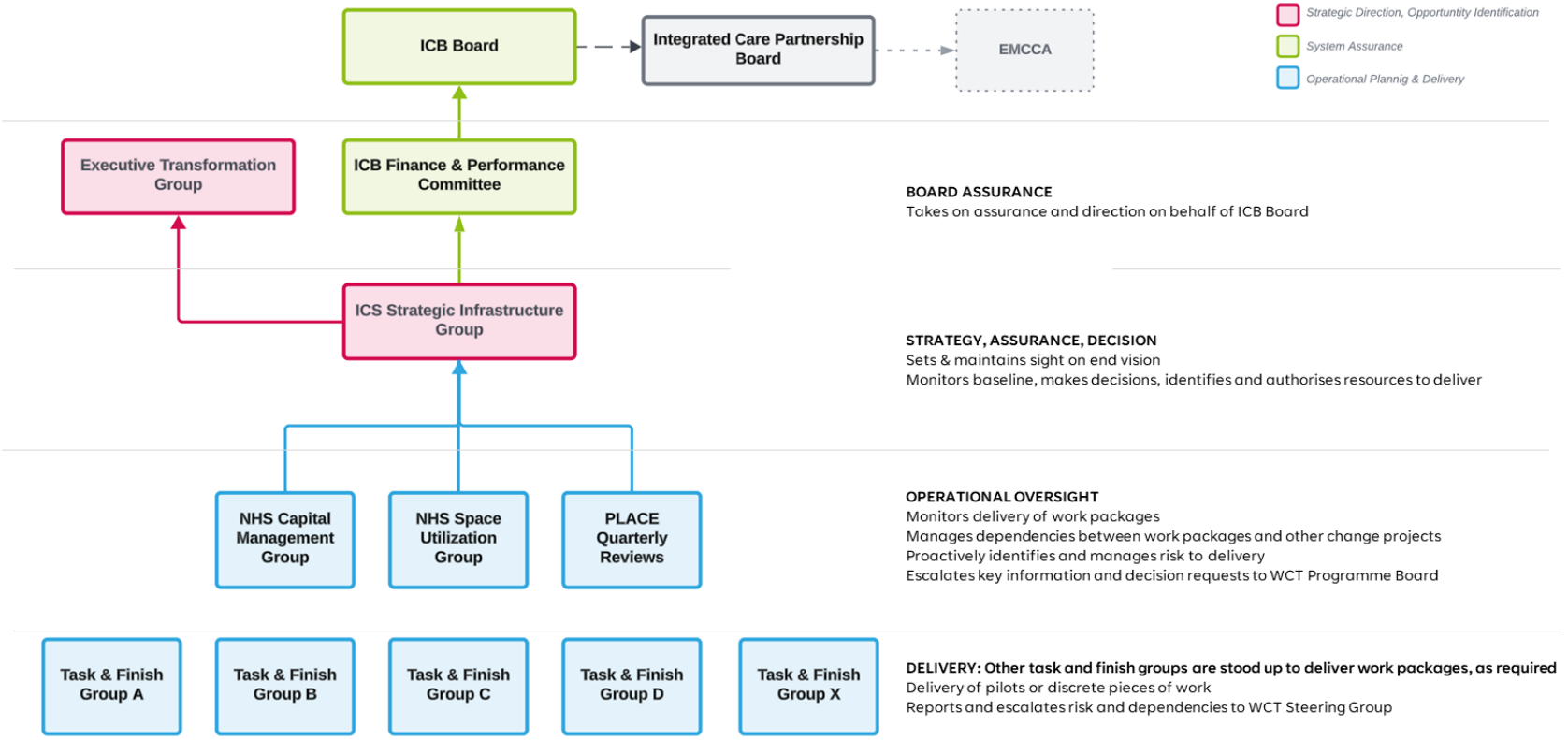
We will work as a system to deliver the Infrastructure Strategy. We will ensure we dovetail and enable delivery of existing strategies and plans agreed across our ICS. Core to delivery is the ICS Strategic Infrastructure Group.

Where possible, we will avoid duplication by utilizing existing forums to develop and delivery projects.

Bi-annual delivery plan

We need to remain clear on how we deliver balance the short to medium term interventions, versus our longer-term strategy. This will be done through the creation of a biannual delivery plan which will document:

- Strategy delivery achievements in last period
- In flight developments
- Operational resilience priorities and pipeline
- Strategy delivery priorities and pipeline
- Prioritisation of operational resilience v strategic pipeline
- SMART objectives & delivery detailed plan

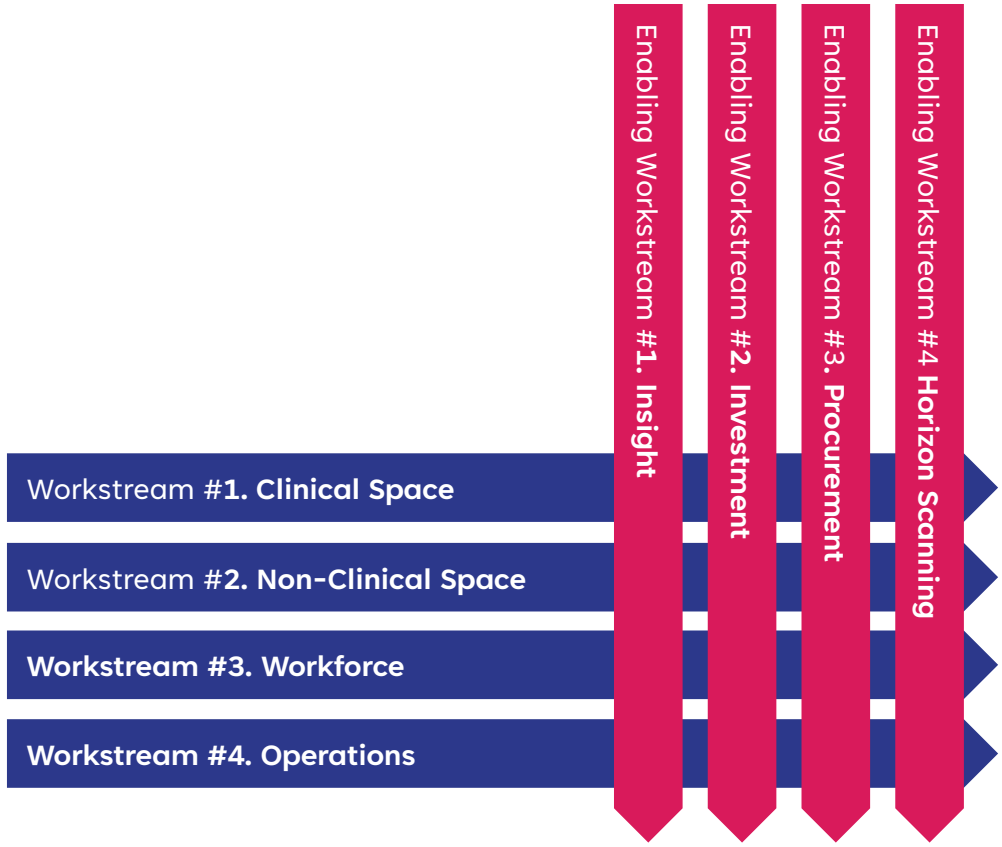


Strategy programme delivery architecture

We will adopt a programme architecture. This architecture serves as a blueprint that guides teams in achieving their objectives while maintaining alignment with organizational goals.

It will be a vital component of successful delivery, enhancing coordination, stakeholder engagement, risk management, and maximize value from constrained resources.

Overall strategy delivery will be driven by 4 delivery and 4 enabling workstreams. Interdependencies between the workstreams and risk will be identified through centralized programme management approach.



Approach

Each workstream will create a blueprint, developing a pipeline of delivery schemes using a Hopper & Pipeline approach (see slide 53).

We will need to appreciate the friction that will inevitably arise between operational priorities and pressing ahead with strategic plans.

We will use weighted prioritization criteria (appendix 4) to help us collectively make decisions about capital spends and resource allocation. Our biannual delivery plan will document our decisions and shape the actions we will take to deliver.

Delivery Workstreams

Delivery of our Infrastructure Strategy will be enabled by 4 key delivery workstreams.

Workstream #1. Clinical Space

Workstream #2. Non-Clinical Space

Workstream #3. Workforce

Workstream #4. Operations

Workstream #1. Clinical Space

Looking at best use of infrastructure for our clinical services. Whilst a clinical strategy or transformation should dictate what infrastructure is required, we could identify opportunities to put forward that may *stimulate* clinical transformation. For example, looking at non-traditional primary care options such as health on the high street.

Clinical modelling will be supported vis the

Workstream #2. Non-Clinical Space

Whilst system transformation should inform what infrastructure is required, we could identify opportunities to put forward that may *stimulate* operational and workforce transformation. For example, co-locating corporate departments alongside adoption of AI and RPA to streamline processes and allow rightsizing of space.

Workstream #3. Workforce

This workstream will look at our collective infrastructure workforce capacity across the system. You will adopt anchor institute principles to benefit our social economy. Aligned to our wider people and culture transformation programme, we will seek to:

- Redesign roles
- Joint recruitment and/or shared posts
- Evaluate the benefits and costs of creating an ICS professional services hub

Workstream #4. Operations

This workstream will encompass all elements in running our estate. It will include utilities and facilities management. You will adopt anchor institute principles to benefit our social economy. We will look to benefit each other before using our public money to profit private companies. The workstream will cover:

- Hard FM
- Soft FM
- Energy generation and contracting

Enabling Workstreams

Delivery of our Infrastructure Strategy will be enabled by 3 key workstreams.

Enabling Workstream **#1. Insight**

Enabling Workstream **#2. Investment**

Enabling Workstream #3**. Procurement**

Enabling Workstream #4**. Horizon Scanning**

Enabling Workstream #1. Insight

All decisions and delivery will be data informed. We will look for best practice and innovative solutions and learn from the experience of others. This workstream encompasses:

- Clinical modelling for future estates requirements*
- Space utilization and condition status
- Creating a single source of truth eg collating PAM, ERIC
- Keeping SHAPE Atlas up to date
- Benchmarking
- Best practice identification in the public sector
- Identifying and monitoring KPIs for strategy delivery

More information on modelling is contained in section 4 under Clinical Requirements.

Enabling Workstream #2. Investment

We will take a systematic, partnership approach to identifying, prioritizing, and securing investment and capital including from

- Community Infrastructure Levy (CIL)
- Section 106
- East Midlands Combined Council Authority devolution funding
- Open Public Estate (OPE)
- Public Sector Decarbonisation Scheme (PSDS)
- Low Carbon Skills Funding (LCSF)
- Private Investment

Enabling Workstream #3. Procurement

Partnership working has in the past been hampered by the lack of suitable contractual mechanisms. Delivery of system opportunities will require structured approach to developing suitable contractual models. For example, how to work with private investors.
This workstream will seek to incentivize partnership working rather than 'who pays' being a barrier.

Enabling Workstream #4. Horizon Scanning

We must dedicate time to identifying future opportunities to improve the way we work. This workstream will consider infrastructure advances in private industry, and emerging technologies that have yet to be adopted.

Other Enabling Inputs

There will be a number of inputs required from other, existing ICS wide programmes such as People & Culture, Digital, Data & Analytics. The central programme management will liaise with these to ensure awareness and support proportional to the scale of the scheme.

** Clinical modelling through ADEPT, and New Hospital Programme*

Creating & Maintaining a Hopper and Pipeline of Programmes

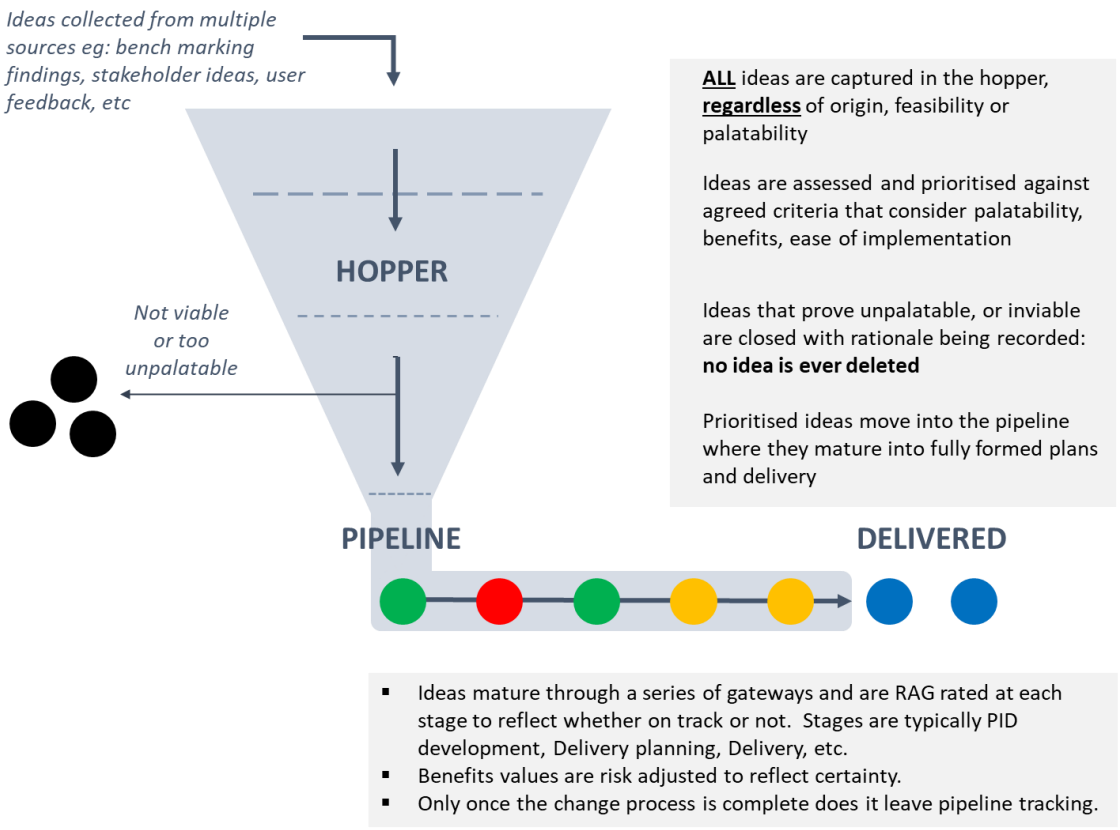
Each of the eight Infrastructure Strategy workstreams will consider what is required to support and deliver the strategy.

All newly identified or existing opportunities, ideas or requirements are captured in the 'hopper', regardless of origin, feasibility, palatability, or priority.

Any investment or infrastructure change hopper entries are then assessed against a set of prioritization criteria previously agreed for our ICS Infrastructure approach (see appendix 3).

Assessment outcomes are ratified by the ICS Strategic Infrastructure Group (SIG) before moving to 'Pipeline' for full scoping of requirements.

On a quarterly basis, the SIG will review the Hopper and Pipeline to ensure we are meeting our infrastructure objectives.



Management of Risk

The SIG will be responsible for 2 types of risks:

1. critical infrastructure risk, and
2. programme delivery risk of this strategy.

Organisation risks will be held and managed through internal risk mechanisms, but we will hold system wide risks on the ICB risk register.

ICB RAID management methodology will be used to proactive identification, management and monitoring of residual risks of either type of risk

Monitoring Strategic Delivery Progress

Each strategy workstream will compile a highlight report prior to each SIG. These will outline progress made, planned activities in the next reporting period and escalations of achievements or problems to inform discussion at the SIG.

Integrated Care System
Nottingham & Nottinghamshire

Section 6
Glossary

Abbreviation	Description
AI	Artificial intelligence
ARRS	Additional roles reimbursement scheme
CDELS	Capital departmental expenditure limits
CHP	Community Health Partnerships
CIL	Community Infrastructure Levy
CIR	Critical Infrastructre Risk
DHSC	Department of Health and Social Care
EMAS	East Midlands Ambulance Service
GIA	Gross internal area
ICB	Integrated Care Board
ICS	Integrated health and social care system
IMD	Indices of multiple deprivation
JFP	Joint Forward Plan (NHS only)
LIFT	Local Improvement Finance Trust
NC	Nottingham City Council
NCC	Nottinghamshire County Council

Abbreviation	Description
NEMS	NEMS Community Benefit Service
NHT	Nottinghamshire Healthcare NHS Trust
NHSPS	NHS Property Services
NIA	Net internal area
NUH	Nottingham University hospitals NHS Trust
OPE	Open Public Estate Programme (National)
PBP	Place based partnerships
PCN	Primary care networks
PFI	Private Finance Initiative
PICS	Primary Integrated Community Services
RAAC	Reinforced autoclaves aerated concreate
RPA	Robotic process automation
S106	Section 106
SFH	Sherwood Forest Hospitals NHS Foundation Trust
SIG	ICS Strategic Infrastructure Group

Section 7
Appendices

Appendix 1: Long term condition incidence per neighbourhood

Taken from NNICS Joint Forward Plan published 2024

		Deprivation	Risk factors (age-adjusted)			Long term conditions (age-adjusted prevalence)								System outcomes		
PCN Neighbourhood	No of patients	IMD decile	Obesity	Current Smoker	Hyper-tension	Diabetes Type 2	COPD	Heart Failure	Stroke	CHD	Cancer	Serious Mental Illness	Moderate/ Severe Frailty	Emergency admissions 1+ length of stay (age-adjusted)	Avoidable deaths (age-adjusted)	Median age of death
BACHS	61,680	2.4	21.5%	16.9%	16.8%	7.9%	3.1%	1.6%	1.6%	3.6%	3.9%	1.0%	3.9%	8,004	355	78
Clifton & Meadows	34,203	2.5	21.6%	17.2%	16.7%	7.2%	3.0%	1.4%	1.7%	3.6%	3.7%	0.9%	2.1%	8,400	329	83
Bulwell & Top Valley	45,878	2.6	22.8%	18.6%	16.4%	7.1%	3.0%	1.3%	1.6%	3.5%	4.1%	0.9%	1.5%	8,227	349	80
Radford & Mary Potter	47,166	2.7	17.5%	17.0%	16.9%	10.4%	2.2%	0.9%	1.4%	4.2%	3.2%	1.5%	4.0%	8,869	429	74
Nottingham City East	65,793	3.0	17.7%	16.9%	14.7%	7.3%	2.7%	1.3%	1.5%	3.3%	3.8%	1.4%	3.4%	7,730	380	76
Bestwood & Sherwood	54,040	3.5	18.7%	13.9%	13.9%	6.2%	1.9%	1.2%	1.5%	3.3%	3.8%	1.0%	2.0%	7,076	296	81
Ashfield North	51,540	3.9	24.6%	15.0%	14.8%	6.4%	2.4%	1.5%	1.4%	3.5%	4.4%	0.7%	1.7%	7,586	323	80
Mansfield North	59,164	4.1	22.9%	13.9%	15.4%	6.3%	2.3%	0.9%	1.3%	3.4%	4.0%	0.6%	2.2%	7,295	326	79
Rosewood	50,717	4.1	20.6%	16.7%	13.6%	6.2%	2.4%	1.1%	1.3%	3.5%	3.8%	0.8%	2.0%	7,291	294	81
Ashfield South	40,460	4.3	24.4%	14.3%	14.0%	6.4%	2.4%	1.0%	1.3%	3.2%	4.0%	0.7%	1.9%	7,312	294	79
Byron	38,408	4.5	21.4%	13.1%	13.9%	6.0%	2.2%	1.0%	1.4%	3.1%	4.3%	0.5%	1.7%	7,496	278	81
Newgate Medical Group	30,076	4.6	21.5%	16.3%	11.6%	6.0%	3.3%	1.1%	1.2%	2.8%	4.0%	0.7%	1.6%	5,917	300	80
Larwood & Bawtry	40,191	5.1	22.3%	13.1%	14.3%	6.6%	3.2%	1.8%	1.4%	3.6%	4.1%	0.7%	3.6%	6,427	251	81
Sherwood	62,794	5.3	22.3%	12.6%	14.8%	6.0%	2.2%	1.0%	1.4%	3.5%	4.2%	0.6%	2.5%	6,726	221	81
Retford and Villages	53,960	5.3	21.7%	11.7%	13.1%	5.4%	1.9%	0.9%	1.1%	2.7%	4.1%	0.5%	2.0%	5,246	207	82
City South	38,198	5.6	15.9%	9.8%	13.9%	5.4%	1.6%	0.8%	1.2%	3.3%	4.0%	0.7%	2.6%	6,975	228	82
Eastwood/Kimberley	37,549	5.9	21.4%	10.9%	13.3%	5.6%	1.9%	1.4%	1.3%	3.1%	4.3%	0.6%	1.8%	6,991	240	81
Synergy Health	30,275	5.9	20.0%	13.0%	13.3%	5.1%	1.7%	0.9%	1.4%	2.9%	4.4%	0.7%	5.5%	6,653	274	81
Newark	78,719	6.0	18.2%	12.5%	13.1%	4.8%	1.4%	1.0%	1.1%	2.8%	4.5%	0.5%	1.7%	5,698	235	81
Stapleford	22,086	6.1	21.7%	12.5%	14.8%	5.8%	1.9%	1.2%	1.0%	3.0%	4.2%	0.6%	1.9%	6,637	233	80
Arnold & Calverton	33,759	6.5	19.0%	11.0%	12.9%	4.9%	1.6%	0.7%	1.4%	2.8%	4.3%	0.7%	2.0%	6,453	203	83
Arrow Health	44,875	6.6	17.9%	11.0%	13.2%	4.8%	1.4%	0.9%	1.2%	2.7%	4.2%	0.6%	1.3%	6,400	219	83
Beeston	49,501	7.4	16.7%	9.9%	13.2%	5.0%	1.5%	1.1%	1.2%	2.7%	4.4%	0.7%	2.4%	6,141	235	84
Rushcliffe North	41,925	8.5	17.5%	8.8%	12.1%	4.0%	1.3%	0.8%	1.2%	2.6%	4.3%	0.3%	1.7%	5,811	163	83
Rushcliffe Central	52,570	8.8	12.9%	6.0%	12.0%	4.2%	1.0%	0.8%	1.1%	2.6%	4.4%	0.6%	1.2%	5,126	171	84
Rushcliffe South	42,646	9.0	16.4%	7.7%	12.2%	4.0%	1.0%	0.9%	1.1%	2.4%	4.2%	0.4%	1.0%	5,169	165	84
Unity	53,068	5.3	9.1%	6.6%	12.9%	3.7%	1.0%	0.7%	1.0%	2.0%	3.6%	0.4%	0.8%	4,182	178	n/a

Key and Notes

- Bassetlaw Place
- Nottingham City Place
- South Nottinghamshire Place
- Mod Nottinghamshire Place

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

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

Most deprived PCN neighbourhood

Least deprived PCN neighbourhood

COPD = Chronic obstructive pulmonary disease
CHD = Congestive heart disease

Risk factors and prevalence data from GP Repository for Clinical Care April 2022
Emergency admissions data from Secondary Uses Service January - December 2022
Avoidable deaths from **Office for National Statistics** (ONS) January 2020 - December 2022
Median age of death from ONS January 2020 - December 2022

Definitions relating to cost to eradicate backlog maintenance

- **Backlog maintenance =** a measure of how much would need to be invested to restore a building to a certain state based on a state of assessed risk criteria. It does not include planned maintenance work (rather, it is work that should already have taken place).

- **High risk =** repairs/replacement to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution.

- **Significant risk =** repairs/replacement so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety.

- **Moderate risk =** repairs/replacement so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety.

- **Low risk =** repairs/replacement to be addressed through agreed maintenance programmes or included in the later years of an Estates Strategy.

Appendix 3: Map of East Midlands OPE opportunities in the delivery pipeline

Map of Delivery

Appendix 3: Projects and opportunities identified from OPE stakeholder engagement carried out in

Regeneration | Health | Health & Social Care Services | Health & Community Services | Health & Housing | Health, Housing & Community Services

Nottinghamshire

Name	Postcode	Type	Top 20% IMD?	Description
Kilton Forest Community Centre	S81 0DA	Health & Community Services		Feasibility Study – service co-location The Community Centre is located adjacent to Larwood Health Centre; the Practice have identified a lack of space and want to explore use of space in the Community Centre, which is owned by Bassetlaw District Council. The proposal is to undertake feasibility work to explore the potential usage, amount of available space, how it could be used by both community and health services. This scheme is dependent upon receiving permission from Bassetlaw District Council for the building to be used in this way / leased moving forward; it is understood that there has been verbal agreement to this effect pending their further confirmation and comments.
Carlton in Lindrick Hub	S81 9AP	Health & Community Services		Feasibility Study – community hub Feasibility work required to explore further development of the Carlton Hub which is running in an existing building on a large Council estate. BDC are already running the Harworth Hub and would like to develop further hubs in locality areas.
Peaks Hill Housing Development	S81 8BS	Health, Housing & Community Services		Feasibility Study – impact on services from new housing development A major new housing development of 1120 new homes is planned for Peaks Hill, a site which is included in the Local Plan; feasibility work is required to understand the potential impact on local services.
Ordsall Hub	DN22 7ND	Health & Housing		Feasibility Study – health hub Feasibility work required to consider the potential provision of a GP surgery within the Ordsall South housing development. Understand there is a building owned by BDC be on a peppercorn rent which could be considered (building to be confirmed), as well as new build options within the development. Desire to provide a GP branch surgery within Ordsall. The facility could include some community services and PCN car service. Capital funding would be required for group 1 and 2 equipment.
Harworth Community Centre	DN11 8JN	Health & Housing		Feasibility Study – affordable housing and community services requirements Feasibility work required to consider the possible extension of the LIFT health centre in Harworth for the provision of community services and also the development of a former school site to develop affordable housing.
Ollerton Hub	HG22 9SZ	Health & Social Care Services		Feasibility Study – service colocation Feasibility work required to explore the possible integration of health services into a community hub, including utilisation study at the existing Ollerton Health Centre, which may have some space.
Nottingham and Nottinghamshire County-wide ARRS Hub	NG1 5LT	Regeneration		Feasibility Study – ARRS Hub Space is in demand to accommodate the newly recruited ARRS staff (Additional Roles Reimbursement Scheme) as part of the growing PCN teams. Feasibility is required to consider the space requirements, possible site locations and funding routes for an admin hub, to move non clinical staff to and free up more clinical space within the existing facilities.
Nottingham and Nottinghamshire Flexible / Bookable Space	NG1 5LT	Regeneration		Feasibility Study – ARRS Space PCNs are facing significant challenges in accommodating their expanding teams, due to recruitment through the ARRS scheme. Feasibility work is required into how more space could potentially be created within existing primary care facilities e.g. with the digitalisation of patient records; combined with research into available bookable spaces and what the processes are for making bookings, along with any improvements which could be made to the system to make this an easy option for use of flexible space.
Kilersick Health Hub	NG5 8BY	Regeneration		Feasibility Study – possible health hub facility Kilersick is an area of inequality and there are concerns about provision and access to health services. Feasibility work is required into existing provision, demand for services and how they may suitably be provided, incorporating service integration.
Eastwood Regeneration	NG16 3AL	Health & Community Services		Feasibility Study – regeneration Feasibility work required to explore how services and public facilities can be improved in the town of Eastwood, particularly as the recent Levelling Up bid was unsuccessful. Eastwood is a former coal mining town which has areas of deprivation and requires investment.

Appendix 4: Investment prioritisation matrix

Weighting	Assessment Area	Assessment Criteria	Assessment Detail
20	Integrated Care Strategy	Improved outcomes in population health and healthcare	A key aim of the IC strategy is to maximise the opportunities for improving people's health and wellbeing, schemes that have a clear link to the quality of services and population health management should be prioritised.
	principles and aims	Move to prevention or early intervention	A guiding principle of the IC strategy is prevention is better than cure. Investing in prevention and early intervention initiatives could reduce costs over the long-term.
		Health equity	A key aim of the IC strategy is to tackle inequalities in health outcomes, experiences and access. Investments targeting the most disadvantaged groups would align with this aim.
		Integration of / collaboration between services	Integration by default is another guiding IC strategy principle. Investments enabling greater integration between organisations across the ICS and collocation of services support this principle. Scheme proposal should include clear evidence of joint planning with ICS partners.
		Broader social responsibility	The IC strategy commits to using resources to support broader social and economic development, including creating opportunities for young people locally e.g. employment and training opportunities.
30	Transforming Services	Enhancing value for money	We have a duty to ensure funding received for health and care is used efficiently. Infrastructure and Estate investments that enhance service value for money, demonstrate cost savings and have a positive return on investment should be prioritised. Quantifiably managing demand against agreed baselines, within existing / reduced resources can also be considered i.e. pressure mitigation.
		Accessibility of services	Scheme: •reduces waiting times or improved access to care •supports principles of right place, right care, right time •reduces travel times for local residents •is on good public transport links and/or supports active travel •is in an area expecting population growth / increasing demand •aligns to Digital Notts Strategy objectives
		Net zero	We have committed to reducing environmental impact Scheme: • is targeted at net zero carbon • identifies opportunities to improve staff/patient travel sustainability • reduces volumes of residual waste

Appendix 4: Map of East Midlands OPE opportunities in the delivery pipeline

...Cont

Weighting	Assessment Area	Assessment Criteria	Assessment Detail
20	Service Resilience	Operational resilience	Scheme proposal includes evidenced improvement in service resilience e.g. scheme: •manages demand pressures •includes adaptations required due to climate change •enhances power resilience at key sites. •Supports recruitment and retention.
		Improves Productivity	We have a duty to ensure funding received for health and care is used efficiently. Infrastructure and Estate investments that that have a focus on improving productivity and the performance of services should be prioritised.
		Improving utilisation of estate	Reduces void risk and associated cost. Scheme optimises the use of estates and is evidencing ongoing affordability. Reduces corporate space. Creates opportunities to reduce overall estates running costs.
20	Risk Management	Back log maintenance	Scheme reduces organisations backlog maintenance liabilities and addresses critical backlog issues.
		Estate safety and compliance	Scheme addresses space that does not currently meet NHS standards from statutory/mandatory compliance perspective and delivers safer health care premises.
10	Deliverability	Financially viable	Scheme capital outlay and ongoing revenue budget requirement is financially viable; ideally with an identified source of funding or self-generating capital receipt and no additional revenue requirements.
		Clear and reasonable delivery route and timetable	Detailed plan with clear key achievable milestones that meet deadline for delivery or scheme, with strong project management capabilities and appropriate Governance. Digital technology requirements available to support. Strong evidence of comprehensive stakeholder engagement and high degree of support, and discussion of issues arising.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**2025/26 Joint Capital Resource Use Plan**
Paper Reference:	ICB 25 010
Report Author:	Clare Hopewell, Assistant Director of Finance and System Efficiency
Report Sponsor:	Bill Shields, Director of Finance
Presenter:	Bill Shields, Director of Finance

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

Summary:

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

- Prepare a plan setting out their planned capital resource use before the start of each financial year (by 1 April).
- Publish the plan and give a copy to their Integrated Care Partnership, Health and Wellbeing Boards and NHS England.

For 2025/26, there is national agreement that publication of the Joint Capital Resource Use Plans (JCRUP) is required by 30 June 2025.

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

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

The enclosed plan has been prepared by the ICB and its NHS Trust partners. The plan is fully aligned with the system's 2025/26 Operational Plan and the final capital plans for 2025/26, which were submitted to NHS England on 30 April 2025 following endorsement by the Finance and Performance Committee at its meeting on 25 March 2025.

Due to the timing of plan submissions for 2025/26 and the on-going process for capital bids into April, not all details in the 2025/26 capital plans were available at the point that the 2025/26 Plan was presented to the Finance and Performance Committee in March.

Therefore, this final 2025/26 Joint Capital Resource Use Plan is being presented to the Board in public in May 2025 for final approval and publication.

Recommendation(s):
The Board is asked to **approve** the 2025/26 Joint Capital Resource Use Plan.

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

Appendices:
Appendix 1: 2025/26 Joint Capital Resource Use Plan

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 3: Financial sustainability – Failure to achieve financial sustainability across the system. • Risk 8: Infrastructure and net zero – Failure to work effectively as a system to a sustainable infrastructure to deliver high-quality and efficient care and the net zero commitment.

Report Previously Received By:
Finance and Performance Committee at its meeting on 26 March 2025.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Appendix 1

Nottingham and Nottinghamshire ICB

Joint Capital Resource Use Plan – 2025/26

Introduction

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

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

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

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

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

2025/26 Capital Departmental Expenditure Limit allocations and sources of funding

The summary table below (see more detailed table in Annex A) shows the expected sources of capital income for NHS partners in 2025/26. The system has been successful in bidding for several funding sources from outside of the operational capital envelope.

The table includes an indicative amount of £36.3 million for Return to Constitutional Standards as advised by NHS England. Following publication of the planning guidance, it has been confirmed that resource has been made available nationally for 2025/26 to support the delivery of a return to constitutional performance standards. Systems have been provided an indicative allocation across Diagnostics, Electives and Urgent and Emergency Care programmes.

2025/26 Capital Departmental Expenditure Limit allocations and sources of funding

Bids have been submitted to NHS England for the indicative amount, and panels were held across NHS England Capital and Programme teams and regions to consider the system schemes and to approve system prioritisation of spend between March and the end of April 2025. In addition, the system submitted bids for potential further funding if any becomes available following the first process against systems' indicative allocations.

Return to Constitutional Standards

Diagnostics - each system has been provided with an indicative total of additional elective waiting list diagnostic activity it needs to deliver in 2025/26 compared to 2024/25 to meet the Referral to Treatment target of 118%. This elective waiting list activity total is broken down by diagnostic modality.

Elective – the Government has committed to achieving the NHS Constitutional Standard that 92% of patients should wait no longer than 18 weeks from Referral to Treatment by the end of this parliament. To deliver the additional activity required to return to the 18-week standard, modelling shows that a combination of additional bed capacity, increased day case rates, and improved planning and utilisation of theatre capacity is needed. This can be supported through investment in elective facilities.

Urgent and Emergency Care - the intent behind the Urgent and Emergency Care funding is to make a meaningful contribution to returning systems and providers back to constitutional standards for Emergency Department 4-hour performance and / or Ambulance Category 2 Response performance.

Mental Health Out of Area Placements (Localising Care)

Bids were submitted to NHS England to assist in reducing one or more of the following:

- Out-of-area placements in Acute Care or Psychiatric Intensive Care Units
- Mental Health Learning Disability and Autism inpatient rehabilitation placements far from home
- Placements outside Natural Clinical Flow in Adult Forensic Medium and Low Secure Services and Children and Young People Inpatient services.

Table 1:

Net Capital Departmental Expenditure Limit 2025/26	Plan £'m
Operational Capital – ICB	**4.6**
Operational Capital – Provider	**86.7**
Sub Total System Operational Capital	**91.3**

Net Capital Departmental Expenditure Limit 2025/26	Plan £'m
Programme National Programme Spend	
Critical Infrastructure Risk	**16.2**
New Hospital Programmes	**4.8**
Digital - Electronic Patient Records	**12.7**
Mental health: reducing Out of Area Placements	**0.8**
Mental health dormitories	**0.6**
National Programme Radiotherapy	**2.4**
Other Adjustments – Provider	**6.4**
Sub Total National Programmes	**43.8**
Return to Constitutional Standards: Diagnostics	**9.2**
Return to Constitutional Standards: Elective	**10.3**
Return to Constitutional Standards: Urgent and Emergency Care	**16.8**
Sub Total Return to Constitutional Standards	**36.3**
TOTAL Capital Departmental Expenditure Limit and ICB capital	**171.4**

Risks and contingencies

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

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

NUH

- NUH has over £440 million of critical infrastructure back log maintenance.
- It has a number of pre-commitments on several major projects going into 2025/26, these will need to be delivered alongside a range of business as usual capital items against a reduced envelope of capital resources available.
- Its Board has committed to spending up to £10 million over a three-year period to address fire related risks. 2025/26 will be year three of three.
- The Trust still has a significant level of red rated medical equipment replacement requirements.

Risks and contingencies

- The two main campuses, Queens Medical Centre and City, are capacity constrained from an electricity perspective, which may lead to a critical infrastructure failure.
- The Trust has two Cath Labs which are past end of life and, if unaddressed, would prevent it from being able to deliver electro physiology.
- The Trust is having to review its commitment to previously approved multi-year schemes that support rolling replacement of clinical need due to insufficient funding availability.

SFH

- Specific risks exist in relation to the Community Diagnostic Centre in relation to recruitment of staff to ensure operational deliverability on completion in 2025/26, and in relation to national building and engineering price inflation, which needs to be managed within the overall quantum of capital costs as the build progresses.
- The SFH Electronic Patient Record case is subject to formal approval of the 2025/26 capital, following a formal tender exercise for the preferred supplier. A full business case currently being prepared following approval by the Department of Health to the outline business case in 2023/24.

NHT

- NHT has £24.5 million of critical infrastructure backlog maintenance.
- The Trust has developed a three-year capital programme to address a proportion of the specific risks.
- All Health and Safety risks of the schemes are being controlled and managed by Digital, Estates, and operational teams.
- Further risks exist in relation to Block A and B at Rampton Hospital, which were not possible to address within the capital resources available given the significant investment required.

Capital planning

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

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

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

- Agree prior year precommitments are the first call on the capital envelope. This includes any slippage or unexpected cost increases.

Capital planning

- Approximately 50% of capital envelope to be used to address operational priorities using an agreed assessment of need across the provider organisations.
- National funding to be used to support strategic priorities where possible.
- Remaining funding to be used to addressed larger strategic schemes – prioritised at a system level.

In 2025/26, system partners have several pre-commitments that require funding from the operational capital envelope. Much of these pre-commitments arise from nationally funded schemes. Due to the timing of available funds, inflation or changes in scope, local capital funding has been required to supplement the capital funds provided.

In addition, the system envelope will be used to invest £9.9 million to complete a new build MRI scanner at King's Mill Hospital. This has left a smaller share of funding to support operational risk areas in 2025/26.

To support longer-term capital planning, the system has developed a long list of strategic priorities that it is looking to drive forward as part of its wider strategy. The Strategic Estates Group have agreed prioritisation criteria alongside the development of our ICS Infrastructure Strategy. This strategy will look to ensure best value from existing assets, which may lead to disposals in some areas (notably corporate estate).

Overview of ongoing scheme progression

NUH

NUH has planned for a total £107.6 million capital resource for 2025/26. This includes the core ICS envelope allocation, along with the specific allocations that cover estates critical infrastructure and constitutional standards. In addition, there is specific Public Dividend Capital funding for the completion of the National Rehabilitation Centre, and confirmation of funding towards a replacement LINAC scanner within radiotherapy. The non Capital Departmental Expenditure spend of £25.5 million relating to donations and grant funded spend including completion of the Public Sector Decarbonisation Scheme gives a total capital programme of £133.1 million.

Significant schemes in the 2025/26 plan include:

- The National Rehabilitation Centre, a 70-bed clinical facility, which will be a purpose-built rehabilitation centre anticipated to open Spring 2025
- The completion of a Community Diagnostic Centre in Nottingham city centre. This is a nationally approved scheme to now be completed early in 2026/27 with significant spend in 2025/26, including an expansion of the original scheme, which is funded by constitutional standards allocations.
- Completion of the second phase of development to create a ring-fenced Elective Hub on the City Campus.

Overview of ongoing scheme progression

- Completion of the compliant inpatient and tertiary cancer endoscopy facility on D floor at the Queens Medical Centre to support improvements to patient care, patient safety, and the workforce in multiple parts of the current pathway.
- Ongoing business as usual spend will need to be managed on estates, medical equipment, and ICT to facilitate the extent of pre-commitments going into 2025/26.

Sherwood Forest Hospitals

Significant schemes in the 2025/26 plan include:

- The completion of a Community Diagnostic Centre in Mansfield. This is a nationally approved scheme started in 2022/23, due to be completed in 2025/26 with planned expenditure of £5.01 million in 2025/26. The Nottingham and Nottinghamshire ICS programme seeks to reduce health inequalities, as evidence has shown that residents who live in high areas of deprivation are more likely to experience poorer health outcomes. National funding received is £22.51 million, and any costs above this will be met through SFH's share of the system envelope.
- Ongoing implementation of an Electronic Patient Record system. Expenditure of £10.67 million is planned in 2025/26 as part of the NHS Frontline Digitisation programme. This will be a key enabler of the ambition to develop the single summary health and care record across the Integrated Care System (ICS) and will be a core data source for the development of the Population Health Management capability.
- Business as usual replacement of aged medical, IT equipment and estates works to ensure continuity of service provision of £5.34 million.
- Construction of new build MRI facilities with a forecast expenditure of £9.90 million across 2025-2027.

Nottinghamshire Healthcare

NHT has planned for £20.2 million capital resource for 2025/26 inclusive an allocation of £13.5 million from the system capital envelope, £2.6 million from estates safety funding, £2 million from national frontline digitation funding, £0.8 million for mental health out of area placements and an indicative plan (funding not yet confirmed) for mental health dormitories of £0.6 million.

Significant schemes in the 2025/26 plan include:

- The Trust's frontline digitisation Electronic Patient Records programme (Digi-Care) representing the second year of implementation (£2 million).
- Blossomwood eradication of dormitories project that is scheduled to be finalised in Sept 2025 (£4.9 million).
- Completion of the high voltage infrastructure work at Rampton (£0.5 million) and an upgraded Perimeter Intrusion Detection System at Rampton Hospital at (£0.9 million).

Business Cases in 2025/26

Electronic Patient Record

All three Providers have business cases approved or being finalised. Implementing or optimising an existing Electronic Patient Record is a key element of the delivery of our ICS frontline digitisation strategy as well as meeting national standards. The roll out of Nerve Centre is underway in NUH, NHT are currently working through a programme of enhancing and optimising the use of SystemOne and Rio and SFH are live with their procurement process with implementation commencing in 2025/26.

Mental Health Dormitories

The system has had a particular focus on the eradication of mental health dormitories. Sherwood Oaks has been completed and is operational with Blossomwood (previously Millbrook) scheduled to be finalised in September 2025. A short form business case has been submitted to NHS England to redesign and improve Cherry Ward (Highbury Hospital) eradicating dormitory accommodation with inpatient wards (the final stage) with national funding to support the project being scoped. This case will also be taken through the system governance processes.

New Hospitals Programme

In January 2025, the outcome of the Government's review of the national New Hospital Programme was announced. The 'Tomorrow's NUH' (TNUH) Programme was part of that review and as a result, the revised start date changed from 2025-2027 to 2037-2039. This represents a significant change for the project leading to the national team advising NUH that all funding associated with TNUH be paused until 2030 at the earliest. This has had an impact on the costs that have been incurred to date, which so far have been shown as an asset in NUH's accounts. This will now have to be impaired, i.e. reduced in value.

Community Diagnostic Centres

Community Diagnostic Centre schemes at Mansfield Community Hospital and in Nottingham City Centre remain in progress. The Mansfield scheme is set for completion during 2025/26 with the Nottingham City Scheme to be completed early in 2026/27. Once operational, the Community Diagnostic Centres will provide additional capacity and greater access to key diagnostic services, aiding the delviery of elective performance.

Cross-system and collaborative working

As described above, the capital funding provided to the Nottingham and Nottinghamshire system is for use by the three provider organisations that form part of the system as well as capital funding for general practice and ICB corporate services.

In addition to this, East Midlands Ambulance Service and Doncaster and Bassetlaw Hospitals are key service providers within the system and require capital resources to support service pressures and operational priorities. The capital funds for these providers are routed through other ICBs. However, via system forums the NNICB is

Cross-system and collaborative working

party to decision making for capital funds. This is particularly true for capital required to support emergency care capacity and elective/diagnostic recovery.

Net Zero carbon strategy, approach, and progress

Overview

The ICS remains fully committed to supporting the NHS England target of achieving net zero carbon emissions. Our strategy, as outlined in the ICS Green Plan, focuses on reducing both direct emissions (NHS Carbon Footprint) and those we can influence (NHS Carbon Footprint Plus). The ICS aims to achieve an 80% reduction in carbon emissions by 2028, with full net zero targeted by 2045. This requires close collaboration with system partners and a structured programme of interventions to embed sustainability across healthcare delivery.

Our ICS Approach

The ICS Green Plan is delivered through a coordinated approach led by the ICB's Programme Director, with senior sponsorship coming from the Chief Finance Officer. A structured programme management approach is in place to track progress and ensure alignment with national net zero targets. The strategy prioritises several key areas, including estates and energy, procurement, clinical service models, travel, and medicines. Estates and energy initiatives focus on heat decarbonisation and energy efficiency improvements across NHS buildings. Procurement efforts are geared toward embedding sustainability into supply chains through the Net Zero Procurement Strategy, ensuring that goods and services align with environmental objectives. Within clinical service models, efforts are being made to reduce waste and emissions, particularly in areas such as anaesthetic gases and medication use. Travel and transport are also critical areas of focus, with the development of a sustainable travel strategy and fleet electrification initiatives aimed at reducing transport-related emissions. Additionally, the ICS is working to reduce nitrous oxide emissions from medical gases and transition to greener inhaler options.

Progress and Challenges

The ICS's approach to delivering a system-wide Green Plan has been commended by NHS England, reflecting strong leadership and collaboration. However, recent carbon footprint quantification has indicated that, despite various initiatives, emissions reductions are not yet sufficient to align with the net zero trajectory. This highlights the need for further targeted interventions to accelerate progress. One of the key challenges faced is securing funding and resources for sustainability projects. The ICS has been successful in obtaining approximately £65 million through the Public Sector Decarbonisation Scheme, but future funding rounds are highly competitive and require rapid responses. Some ICS partners, such as SFH, have raised concerns about having insufficient capacity to apply for these grants effectively.

Key Priorities

Net Zero carbon strategy, approach, and progress

For the coming year, the ICS has identified several key priority areas. Energy decarbonisation remains central, with a focus on expanding heat decarbonisation plans and leveraging available infrastructure funding.

Heat decarbonisation plans are in place for NUH and NHT. The challenge is now to find and secure funding to deliver recommendations made within them. A heat decarbonisation plan is being drafted for SFH funded by the Department of Health and Social Care through the Midlands Net Zero Hub, as bids to secure Low Carbon Skills Funding have been unsuccessful.

We have been fortunate to secure funding for Health Education England Clinical Fellows, one of which has led work to understand and plan replacement of Nitrous Oxide manifolds, a major source of leakage of this potent greenhouse gas. This work enabled our ICS to secure capital funding from NHS England to replace these, saving money, preventing damage to staff health, and moving us towards our net zero targets.

NUH has previously received Public Sector Decarbonisation Scheme grants towards completion of the replacement of windows at the Queens Medical Centre, and removing steam as the main transfer of heat around the buildings. The new solution when complete will use a low temperature hot water system from both Combined Heat and Power and ground source heat pumps. The new energy centre at Queens Medical Centre that is required to operate this will now complete during 2025/26, utilising the residual grant funding and the contribution required from the NUH.

Primary care capital

The ICB receives a ring-fenced capital allocation of circa. £2.5 million each year to invest in IT replacement and small premises improvements in primary care (general practice) and also a new Utilisation and Modernisation Fund of up to £2.1 million in 2025/26, again for small premises improvements in general practice. The ICB summited schemes to NHS England for the Utilisation and Modernisation Fund, which have been supported in principle with final approval expected to be in June 2025. Based on estates strategies from legacy organisations and the recent Primary Care Network Estates Toolkit, the ICB has several agreed major primary care priorities. However, the cost of implementation is unaffordable within the size of the capital envelope provided. There are currently no sources of national funding prioritised for primary care, however business cases are being developed in anticipation of future funding.

Priority areas include:

- Hucknall (Cavell) – three practice new build health and wellbeing hub
- Eastwood and Giltbrook – two practice new build
- East Leake – large single practice new build
- Newark – single practice new build

Primary care capital
• Beeston – single practice new build, site identified. In addition to these there are several major housing developments planned across Nottingham and Nottinghamshire that will require increased primary care provision: • Fairham Pastures – land south of Clifton 3,000 dwellings, reserve site requested for primary medical facility. • Chetwynd Barracks, Chilwell (and Toton sidings) - up to 4,500 dwellings, reserved site requested for primary medical facility. • Tollerton/Bassingfield – 4,000 dwellings reserved site being requested for primary medical facility. Emerging priorities for new build/major expansion have also been identified in the following areas which are now being developed further: • Radcliffe on Trent • Strelley/Aspley area • Burton Joyce • Edwinstowe/Ollerton

Annex A – Nottingham and Nottinghamshire ICS 2025/26 Capital Plan

Status of Funding	2025/26 Capital Plan As of 1 May 2025	ICB £'m	NUH £'m	SFH £'m	NHT £'m	Total £'m	Narrative on the main categories of expenditure
Confirmed	Operational Capital - ICB	2.5				**2.5**	The ICB capital plans relate to GP IT £1.5m and primary care premises developments/improvements £1m.
Supported in principle, approval expected Jun	Utilisation and Modernisation Fund	2.1				**2.1**	The ICB Utilisation and Modernisation fund is for small premises improvements in general practice.
Confirmed	Operational Capital - Provider		57.6	15.5	13.5	**86.7**	This funding is to support business as usual e.g. backlog maintenance and supports a number of other large and national schemes e.g. digital.
	Sub Total System Operational Capital	**4.6**	**57.6**	**15.5**	**13.5**	**91.3**	
Pending approval following NHSE panel	Critical Infrastructure Risk (estates safety)		12.7	0.9	2.6	**16.1**	This funding is intended to mitigate critical infrastructure and safety risks, addressing the poorest quality estates, and ensuring a safe, sustainable environment for healthcare delivery.
Confirmed/awaiting memorandum of understanding (MOU)	Critical Infrastructure Risk (Sub-metering funding)			0.1		**0.1**	These plans relate to a sub-metering project as part of the Commercial Efficiencies Optimisation Programme.
Confirmed	New Hospital Programmes		4.8			**4.8**	These plans relate to the National Rehabilitation Centre development.
Confirmed/MOU in place	Frontline Digital - Electronic Patient Records			10.7	2.0	**12.7**	These plans relate to implementing or optimising an existing electronic patient record system as a key element of the delivery of the ICS frontline digitisation strategy.
Confirmed/awaiting MOU	National Programme Radiotherapy (LINAC)		2.4			**2.4**	This plan relates to replacement machine funded from the national radiotherapy equipment replacement fund.

Status of Funding	2025/26 Capital Plan As of 1 May 2025	ICB £'m	NUH £'m	SFH £'m	NHT £'m	Total £'m	Narrative on the main categories of expenditure
Supported in principle	Mental health: reducing Out of Area Placements				0.8	**0.8**	This relates to supporting reducing inappropriate out-of-area placements for mental health inpatients.
Subject to funding approval	Mental health dormitories				0.6	**0.6**	This relates to the eradication of dormitories from mental health facilities.
Technical Adjustment	Other Adjustments – Provider		0.0	5.7	0.7	**6.4**	This relates to the technical adjustment relating to PFI capital charges e.g. residual interest.
	Sub Total National Programme Spend	**4.6**	**77.5**	**32.8**	**20.2**	**135.1**	
Pending approval following NHSE panel	Return to Constitutional Standards: Diagnostics		9.0	0.2		**9.2**	This includes £2m for completion of the Nottingham City CDC scheme from 2024/25 and £7m for expansion of this community diagnostic centre.
Pending approval following NHSE panel	Return to Constitutional Standards: Elective		9.4	0.9		**10.3**	This includes £6m for completion of the 2024/25 Elective Surgical Scheme at Nottingham City Hospital.
Pending approval following NHSE panel	Return to Constitutional Standards: Urgent and Emergency Care		11.8	5.0		**16.8**	This includes £7m for the new co-located urgent treatment centre at Queens Medical Centre and £5m for new same day emergency care at Queens Medical Centre.
	Sub Total Return to Constitution Standards	**0.0**	**30.2**	**6.1**	**0.0**	**36.3**	
	Total System CDEL and ICB Capital	**4.6**	**107.6**	**38.9**	**20.2**	**171.4**	

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**Nottingham and Nottinghamshire Primary Care Strategy 2025-2030**
Paper Reference:	ICB 25 011
Report Author:	Rachael Rees, Head of Primary Care Network Development
Executive Lead:	Victoria McGregor-Riley, Acting Director of Strategy and System Development
Presenter:	Victoria McGregor-Riley, Acting Director of Strategy and System Development

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

Summary:

This paper presents the final draft of the Nottingham and Nottinghamshire Primary Care Strategy 2025-2030 for Board approval.

This Strategy commits to the delivery of resilient, efficient, and patient-centred care across the four primary care contractor groups. By strengthening integration through the integrated neighbourhood health model, shifting more services from acute to community based provision, considering opportunities for at-scale provision, and prioritising prevention, Nottingham and Nottinghamshire aims to achieve high-quality, accessible, and sustainable primary care that meets the needs of local communities.

Delivery plans have been developed to ensure robust oversight and confidence in delivery of the transformation programme. Clear governance arrangements will provide the focus for monitoring progress supported by a 'live' performance dashboard. This will enable us to respond quickly to off track delivery, and performance challenges, and quickly assess and adapt to developments in national policy.

Recommendation(s):

The Board is asked to **approve** the Primary Care Strategy 2025-2030.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	Sustainable primary care is essential to improving outcomes for the population, as the first point of contact for many people requiring health care and support, as well as preventing illness and addressing escalation of need.
Tackle inequalities in outcomes, experience, and access	Primary care is key to tackling inequalities, through an in depth understanding of local need and awareness of the local support available. In delivering the Strategy, a focus on inequities in access will continue to be identified and appropriately managed.
Enhance productivity and value for money	Delivering optimal access to primary care services supports productivity across the health and care system

How does this paper support	the ICB's core aims to:
	by ensuring people can access care in a timely way based on their needs.
Help the NHS support broader social and economic development	Primary care services are embedded within communities, enabling a comprehensive understanding local demand and need. Working as part of Integrated Neighbourhood Teams enables General Practice, and increasingly the wider primary care sector, to support that need, building social capital within local areas.

Appendices:
Appendix 1 – Nottingham and Nottinghamshire Primary Care Strategy 2025-2030 Appendix 2 – Primary Care Strategy Monitoring and Governance

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

Report Previously Received By:
The Primary Care Strategy was presented to the Strategic Planning and Integration Committee on 3 April 2025

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Primary Care Strategy

Background and policy context

1. The existing Nottingham and Nottinghamshire Primary Care Strategy was developed in 2019 to cover the period 2019-2024. This was primarily focused on General Practice and the emergence of Primary Care Networks.
2. An update was developed during 2023/24 to reflect the changes to primary care delivery following the Covid-19 pandemic, changes to primary care delivery including the Primary Care Access Recovery Plan, new digital advancements, and to reflect national pressures such as the increase in demand and impact on access to General Practice.
3. Other contractor groups have experienced pressures including Community Pharmacy closures and all groups have identified workforce challenges for recruitment and retention.
4. There have also been significant policy changes since 2019 with the introduction of Primary Care Networks, Community Pharmacy Transformation and changes to pharmacy training and education, the General Dental Services Recovery plan and the Fuller Report that introduced the concept of neighbourhood working.
5. More recent NHS policy developments have signalled the drive towards prevention rather than treatment, moving from analogue to digital, and from acute to community-based provision. It is anticipated these three shifts will be further promoted in the NHS 10-Year Plan due for publication in 2025/26.
6. The Primary Care Strategy 2025-2030 has been developed to take account of these national policy development and to maximise the opportunities presented by ensuring a high quality, sustainable primary care offer that meets the needs of local people.

Development of the Strategy

7. The experience of local people in accessing Primary Care services has shaped our strategy as well as being clearly reflected in national policy such as the Primary Care Access Recovery Plan.
8. We are also cognisant of commitments within the recent refresh of our Integrated Care Strategy and NHS Joint Forward Plan. These affirm the critical role of primary care in supporting delivery of transformation programmes over the immediate to medium term to achieve resilient and financially sustainable services for patients that drive improvements in health outcomes, reduce health inequalities, and increase equity.

9. Our engagement approach included workshops with all Primary Care contractor groups during 2024/5. Workshop attendees included the four primary care professions, Primary Care representative bodies (Local Medical Committee, Community Pharmacy Nottingham, Local Ophthalmology Committee, Local Dental Committee), regional specialist leads including the Consultant in Dental Public Health for the Midlands and the Associate Medical Director for Optometry, Local Authority commissioners with responsibility around primary care, and ICB commissioning and contracting leads.
10. The workshops provided an opportunity to co-produce the strategy through a greater understanding of the challenges being experienced, identifying ways to support and improve the delivery of care, and confirming delivery priorities.
11. The strategy vision and priorities have been shared as part of wider engagement with Place Based Partnerships as well as through the System Engagement Forums, Patient Groups, Digital groups, and others. This enabled broader feedback to shape the vision and priorities.
12. Delivery Plans have been developed through the Primary Care Strategy Working groups, the ICB Primary Care Transformation Team, with clinical leadership from the Primary Care Clinical Lead.
13. An Equality Impact Assessment (EIA) has been completed, which recognised an overall positive impact of this strategy implementation.

Primary Care Strategy 2025-2030

14. The strategy reflects the current position of Primary Care across the four contractor groups, and our strategic ambition of improving primary care resilience and promoting collaborative working with the aim of improving patient outcomes. The draft strategy is shown in Appendix 1.
15. The strategy focuses on three key transformational themes:
    a) Resilient and sustainable primary care: ensuring that provision of primary care services through our independent contractors is operationally and financially viable, making the most of opportunities to share functions where this makes sense.
    b) Improve quality of care and patient outcomes: provide a consistent level of service able to meet the needs of the local population and reduce unacceptable or unwarranted variation in the delivery of contractual commitments.
    c) Enhance effective partnership working and integration: there are opportunities to improve outcomes and experience for people through better integration of services, eliminating duplication and waste and promoting more cost effective and efficient delivery models. This applies

both within/across primary care providers but also across primary, community and acute sector providers. Key mechanisms to achieve this will be through the implementation of the Integrated Neighbourhood Health model and a renewed emphasis on shifting appropriate services from acute into community settings at scale where it offers greater cost effectiveness.

16. There are six delivery priorities that support the translation of these transformational themes into practical action:
    a) Prevention and proactive care.
    b) Maintaining resilience.
    c) Improved access.
    d) Integrated Neighbourhood Health.
    e) Increased provider collaboration.
    f) Promoting self-care and management.
17. Each of these priorities has a corresponding Delivery Plan which specifies key actions and associated timeframes. These Delivery Plans incorporate ongoing delivery of national operational standards.

Governance and oversight

18. The monitoring of the delivery against the strategy will be managed through the Primary Care Transformation Delivery Group as detailed in Appendix 2. Quarterly highlight reports for each area of work will be reported to the group. Specific programmes will be presented as part of a series of monthly deep dive topics that require greater investigation, development, and discussion.
19. The strategy will be reviewed against new/emergent national policy, including the Ten-Year Health Plan once published and the Nottingham and Nottinghamshire Pharmaceutical Needs Assessment.
20. Delivery plan metrics will be incorporated into a ‘live’ performance dashboard and updated routinely allowing for robust ongoing performance monitoring. Each delivery intervention will have a named owner so that there is clarity of responsibility for delivery.
21. Data for Optometry and Dental contracting groups remains immature e.g. workforce data, therefore further developmental work will be required in 2025/6 to ensure data completeness and quality. Work with the ICB’s System Analytics and Intelligence Unit and regional colleagues will also continue in 2025/6 to refine data reporting/recording to support more sophisticated monitoring of success factors in year and improve monitoring arrangements.

Risks and issues

22. Key risks to successful delivery of the Strategy in 2025/6 are:

    a) Whilst the GP contract has been agreed for 2025/26, we understand that local practices are still being encouraged to challenge work that they perceive is additional to contractually agreed terms. Similar concerns over nationally negotiated contracts, including payment and/or fees, are apparent across all contractor groups.

    b) Other risks to ongoing resilience and delivery of transformational change include the recent inflationary impact and employer National Insurance contributions, staff health and wellbeing, workforce recruitment and retention, and ongoing increases in levels of demand.

    c) This Strategy has been developed at a time of ongoing system flux, the full impact of this remains unclear. The review of the commissioning function of ICBs and associated reduction in operational costs is likely to reduce the capacity supporting achievement of Delivery Plans.

23. Across all contractors it is recognised there is a need to bolster engagement at a system level as well as operational level of patient care – ensuring our primary care professionals remain fully involved in both the delivery and ongoing co-design and implementation of transformational changes. The ICB will therefore continue to work with clinical and professional leads in 2025/6 to enhance engagement with each contractor group including:

    a) The establishment of the Primary Care Transformation Delivery Group to consider today's operational and performance issues as well as preparing for the future.

    b) ICB leadership representation at Protected Learning Time events.

    c) Within our available resources, provide more targeted support for practices/contractors in meeting their contractual commitments with a more specific support input into those contractors where performance is below expected levels, especially in areas of highest population need.

    d) Exploration of future commissioning and associated funding models that support primary care resilience and full engagement in the development of integrated neighbourhood models.

Next steps

24. Further to consideration and approval by the Board, a public facing Primary Care Strategy summary will be produced for communicating our agreed strategic intentions to a wider stakeholder community.

NHS
Nottingham and Nottinghamshire

Nottingham and Nottinghamshire Primary Care Strategy

2025-2030

Introduction

Amanda Sullivan
Chief Executive
Nottingham and Nottinghamshire
Integrated Care Board

This strategy sets out our vision and roadmap for the future of Primary Care in Nottingham and Nottinghamshire over the next five years. It outlines our intention to accelerate the evolution of our four contractor groups of General Practice, Community Pharmacy, Community Optometry Services, and General Dental Services to meet the needs of local people.

It has been developed in the context of a dynamic environment, with rising patient demand, increasing complexity of needs, pressure for more efficient use of NHS resources, and a shifting workforce landscape. The ongoing review of local government architecture and emerging role of the East Midlands Combined County Authority will also continue to be highly influential in shaping transformational change across our system.

It is within this evolving context that our Primary Care Strategy reimagines our primary care landscape. It outlines the role that GP practices, community pharmacists, optometry and dental services will play within a more integrated health and care system that is characterized by the shift from treatment to prevention, analogue to digital, and hospital to community-based treatment. It describes our commitment to moving beyond traditional structures, using technology to enable proactive, personalised care, fostering collective accountability for population health at scale as well as locally, and organising services around communities by promoting prevention as well as greater integration of service delivery.

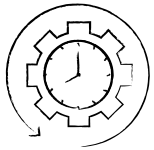
This transformation will continue to rely on the dedication, expertise, and resilience of our primary care teams who remain critical to supporting the health and wellbeing of our population. Our Strategy is founded on their voices alongside that of our patients, people and communities, building on their perspectives of what needs to continue and evolve but also where we can do better for our population to improve outcomes.

This is a pivotal moment for our primary care providers — a time for us to radically redesign our primary care landscape and offer leadership in supporting our staff and teams, as well as our communities, to successfully transition into an exciting future.

Our Vision for primary Care

“A more resilient, efficient, and patient-centred primary care provider sector that meets the needs of our population both now and in the future”.

Our primary care services will be **resilient and sustainable** providing high quality care consistently for our population . It will be modernised through the delivery of three shifts: treatment to prevention, hospital to home, analogue to digital, and through effective workforce planning and development.



There will be **greater consistency of the scope and quality of services,** with less unwarranted variation where not based on assessed population need. Primary care outcomes will focus on reducing health inequalities through an ongoing focus on prevention and tackling inequity.

People will be supported to remain independent for as long as possible through **proactive and personalised care planning.** Primary care teams will target population cohorts using population health intelligence to employ evidence informed interventions.

There will be **greater integration of the community-based workforce** supported by shared training, development and retention initiatives, creating a more flexible and adaptive workforce acting as ‘one team’ irrespective of employing organization.

Primary care services will **be locally accessible**, via multiple routes, that meet the needs of the local neighbourhood population including access to self care and advice.

Primary care professionals will be full and active participants within **Integrated neighbourhood health teams and Place based Partnerships** across Nottingham and Nottinghamshire supporting the co-design and delivery of community based primary care interventions.

There will be **greater public awareness** of the opportunities of support including self care offered by primary care providers, with an expansion of services shifted into a community setting and out of an acute setting where safe and appropriate.

The actions we will take to turn vision into reality

2025/26

- Support our primary care teams to remain resilient.
- Implementation of Integrated Neighbourhood Health Model.
- Improve access to primary care services.
- Support primary care provider collaboration.
- Increase the scope of services provided by primary care providers.
- Improve our awareness of performance of contracts and reduce unwarranted variation.
- Tailored implement plans in place where needed (e.g. dentistry).
- Implement innovative ways of working and support more services to shift from acute into community settings.
- Ensure we have a better understanding of our challenges e.g. primary care workforce data.
- Increase public awareness of primary care services and self care opportunities.

2026/27

- Mature Integrated Neighborhood teams to include a wider range of patient cohorts and input from across health and care.
- Ensure consistency of ‘core’ community offer across the system with identification of warranted/unwarranted variation aligned with population needs.
- Promote workforce retention and training initiatives to embed a ‘one team’ approach.
- Embed more robust performance oversight arrangements of contract holders to ensure we maintain good governance and maximise contract adherence as well as supporting providers to improve.
- Review opportunity for primary care estates as part of One Public Estates approach in partnership with local authorities and NHS partners.
- Assess improving morale of primary care staff and promote their engagement in our transformation journey.

2027/28

- Fully establish digital infrastructure to support same day/urgent and routine oversight of patients in order to manage demand.
- Ensure all practices/Primary Care Networks (PCN) delivering care within consistent model of service offer tailored to achieve improved outcomes and reduced health inequalities.
- Ensure routine appointments are provided within two weeks of request in the format of patient choice.
- Primary care teams fully exploiting AI and digital automation resulting in reduced administrative burden.
- Supported by shared infrastructure across providers and streamlined access routes.
- Fully established provider collaborative model operating across health and care providers, community and acute.
- Fully established integrated training and workforce development model.
- Full system coverage of enhanced pharmacy, dental and optometry services.

2028/29

- Significant shift of resources, staff, and commissioning funding from acute into community-based services from 2025/2026 baseline.
- Urgent care provided by all primary care (all professions) as requested by patients within 48hrs based on clinical need.
- Significant reduction in tooth decay, oral cancer and poor oral hygiene across the system through increase in funded dental care activity.
- Ongoing focus on, and a consistent all system approach, to primary care as active participants in prevention through employment, education, training, activity, smoking cessation, vaccinations etc. resulting in reduced disease prevalence rates and improved outcomes.

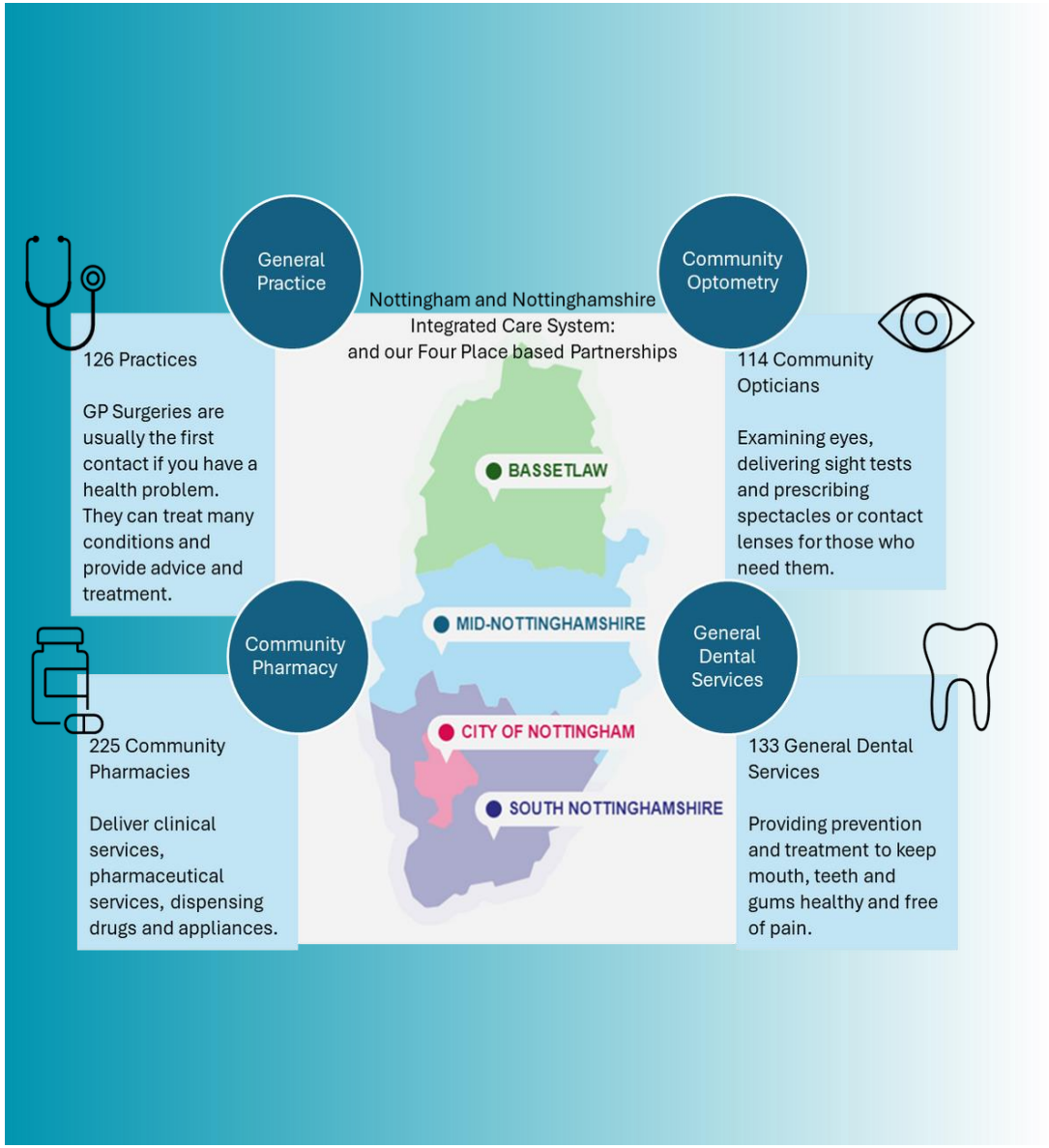
2029/30

- Reduced health inequalities.
- Increase in healthier life expectancy.
- Improvement in primary care staff morale, retention and recruitment.
- Improvement in patient satisfaction with primary care service offer.

What will this mean for local people?

- People will have improved access to their GP with flexible appointment models, which will include advice and guidance from specialists, on-line and face to face consultations. and virtual access.
- People with complex chronic or multiple conditions will have greater access to integrated teams that understand their condition and promote continuity of care, building trusted relationships that better enable personalised care planning.
- People will be able to have access to new technology that will enable them to book appointments online, and access digital support and advice. This will complement existing services offering face to face support to those who need it.
- People will be supported by care navigators who help people access the right care and support services at the right time acting as a guide through the health and social care system.
- People will be able to attend community pharmacy services across Nottingham and Nottinghamshire and receive a consultation for an increasing range of common conditions.
- People will be better informed on how to look after themselves and know where to seek further advice and support to enable them to remain independent and living in their own homes for longer.
- People will be more aware of the community and voluntary services that are available locally to support them to stay well and independent.
- People will be able to have more treatments and consultations with support available, including specialist input, in a local community setting instead of going to hospital.
- People will have access to wider primary care specialist services in the local community, for example specialist optometry services and community pharmacy services.
- People will be more aware of the services and the role of Community Pharmacists, dentists and optometrists within their local community. Access to these services will be tailored to where the need is greatest.
- People will be more aware of what they can do to look after themselves to prevent themselves from becoming unwell and to lead healthier lifestyles.
- People will have opportunities to directly refer themselves into a growing range of diagnostic and treatment services.
- People who have the most complex needs will have more active oversight by a dedicated team that are referred to as an Integrated Neighbourhood Team (INT). This team will be comprised of a wide array of community and specialist health and care professionals who will work together to provide more joined up responses to address the needs of the person.

Our current primary care provider landscape



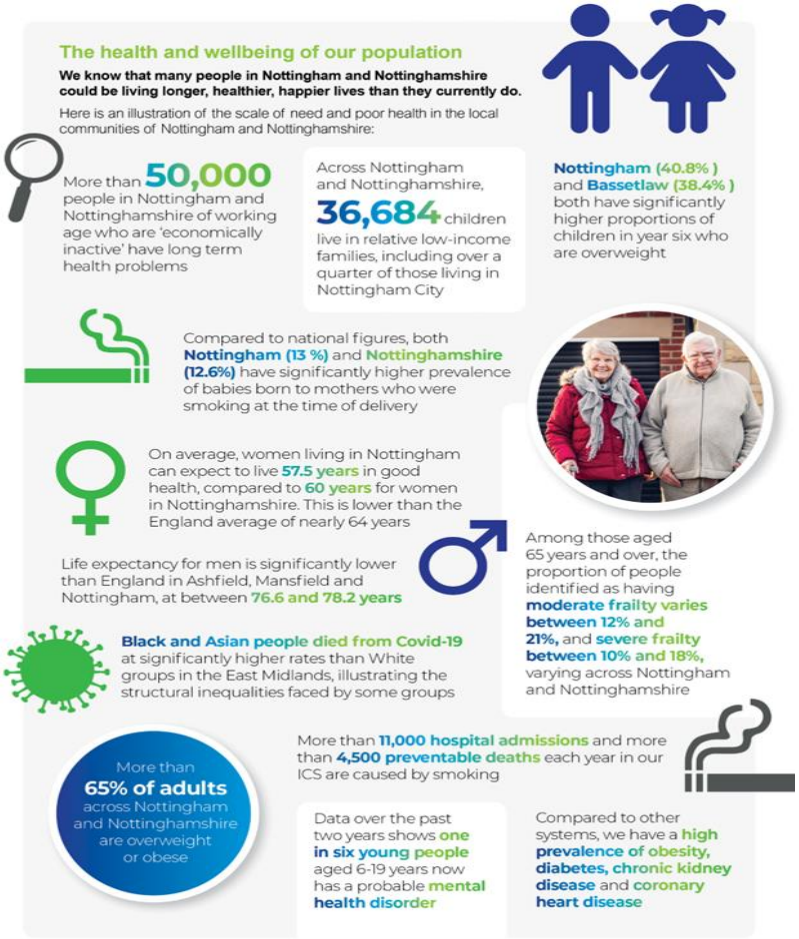
Primary care providers are often the first point of contact for people and provide the vast majority of NHS care to people. Primary care teams are critical to overall sustainability of the local NHS, offering advice, guidance and interventions that often avoid or delay more complex treatment within a hospital environment. We recognise that for this care to continue to meet the needs of people, the provision of primary care services must evolve rapidly over the next 5 years.

Building on what we have achieved

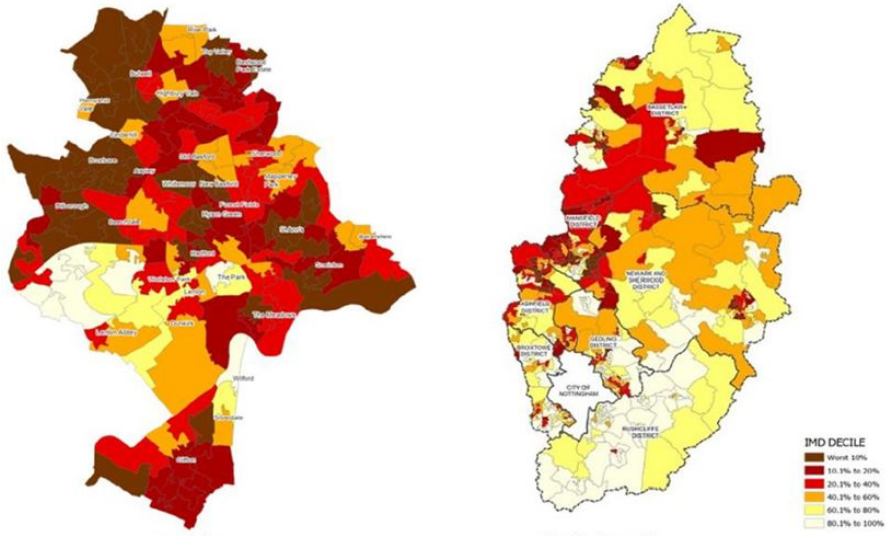
We recognise that primary care is the linchpin of the heath and care system and is central to transforming people's health and well-being outcomes and experience. All four contractor groups have a critical role in reducing inequalities, promoting equity and can also significantly reduce inefficient use of our public sector resources. Examples of where we already do this is outlined below.

- Primary care supports over 1.3m people across Nottingham and Nottinghamshire.
- Primary practices provided 7.8m GP appointments in 2024, an increase of 430,000 from 2023. 69% were face to face. 41% were same day requests.
- Multi-Disciplinary Teams in place supporting people with multiple Long-Term Conditions.
- Practice Nurse, GP Retention leads, and Clinical Ambassadors are supporting local retention and development initiatives. Retention programmes in place providing enhanced development for staff.
- We have 24 Primary Care Networks (PCNs) supporting local communities and providing extended services.
- 95% of Community Pharmacies are signed up to the Pharmacy First scheme providing 7 clinical pathways with 25,262 consultations taking place. 47,911 Blood Pressure checks and 4108 Contraception checks having been completed. (Aug 23- July 24).
- There are 133 General Dental Services providing dental care.
- We are national leaders in the roll out of the NHS App. We had a 54% increase in use last year, making it easier for more patients to access their GP.
- 285,026 NHS Sight tests are completed per year (23/24).
- 112 GP practices are rated at Good or Outstanding by the Care Quality Commission (CQC).
- 95.2% of prescriptions are dispensed using the Electronic Prescription Service, 76.9% of patients have a nominated pharmacy.
- 87% of patients described their experience of using the community pharmacy as good. (GP Survey 2024).
- GP Premises improved across Nottingham and Nottinghamshire enhancing the facilities for patients and opportunities for wider partnership working.
- 74% of patients rated a positive GP experience. (GP Survey 2024).
- 92% felt that they had confidence & trust in the healthcare professional with 91% being involved in the decisions about their care and treatment. (GP Survey 2024).

Our changing population also means we need to change how services are provided



A map of deprivation across our Integrated Care System



To help us understand better where and how we develop primary care services we need to understand what our population health need is. Key facts are:

People are dying earlier than they should be – Nottingham City, Ashfield and Mansfield have significantly higher rates of avoidable and preventable deaths than the England average (and double that in other areas of our ICS).

Inequalities are stark, with inequalities in health reflecting deprivation and social inequalities.

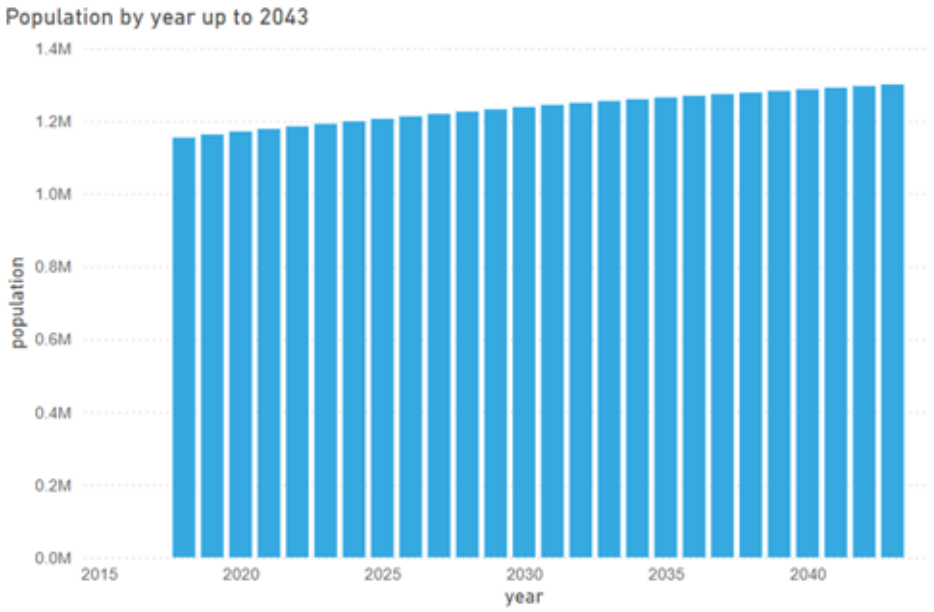
Preventable alcohol and CVD deaths are getting worse.

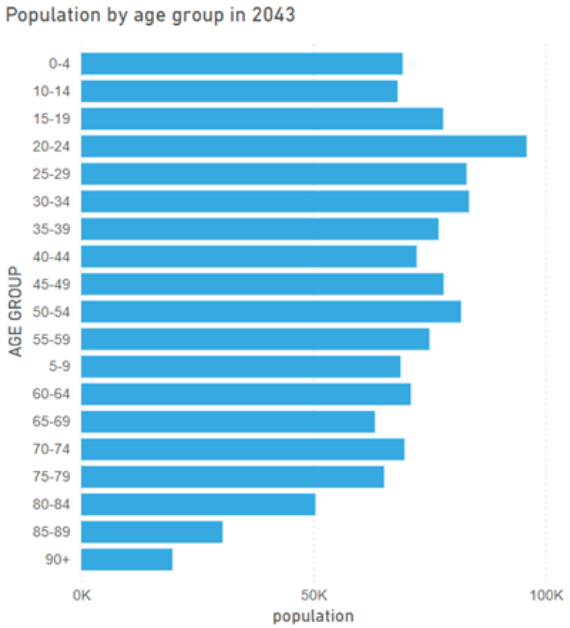
Our children are not as healthy as they should be, childhood obesity remains high.

The number of people accessing some screening programmes is lower than needed.

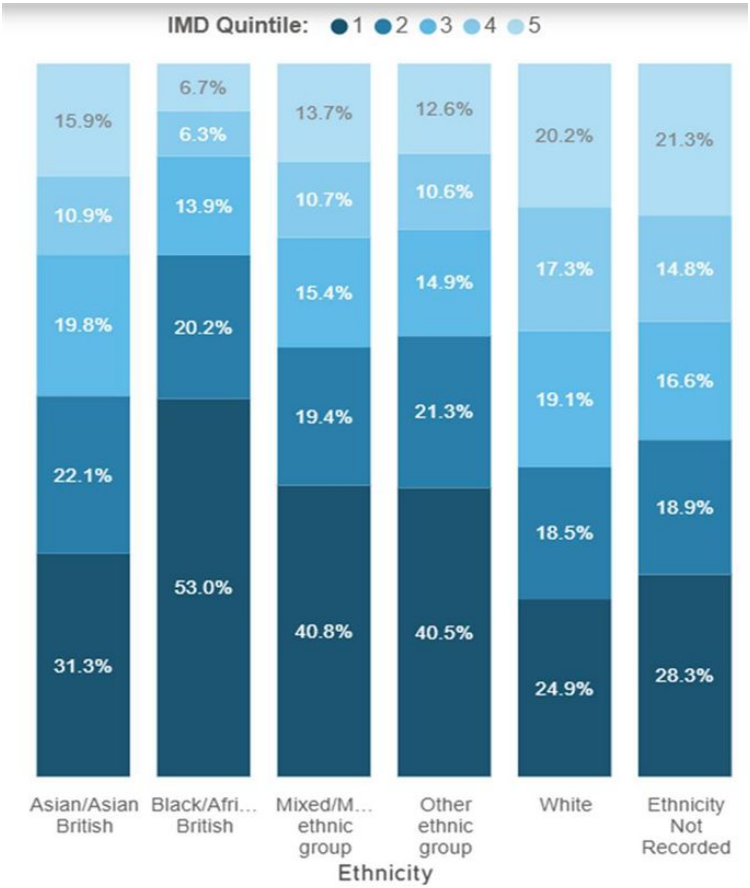
Understanding the impact of our changing population

Our population continues to increase, with people living longer in older age





Data from the SAIU Primary Care Network Dashboard



This chart shows the link between ethnicity and deprivation in Nottingham and Nottinghamshire. 53% of the Black African/Caribbean population lives in the most deprived areas, compared to 25% of the White population.

Data from the SAIU Primary Care Network Dashboard and Census Data 2021

Understanding the impact of ethnicity and deprivation

Understanding ethnicity and deprivation across our community is also crucial for planning services and addressing health inequalities. Some ethnic groups face higher health risks and barriers to accessing care and ethnicity related factors can impact significantly on health outcomes.

Ethnicity	Key Notes
White/White British	Mortality from Cancer, dementia and Alzheimer's is higher in white groups
Asian/British South Asian	Those of South Asian heritage are more likely to develop high blood pressure, cardiovascular disease and diabetes.
Asian/British Chinese	Chinese people have relatively low uptake of health and social care services across the UK.
Black British/African/Caribbean/ Other	Women from black backgrounds are 4x more likely to die in childbirth than white women. Rates of hypertension and diabetes are also higher in black people and mortality rate from strokes and are more likely to have strokes at a younger age. This risk of developing certain cancers (e.g. prostate) can also be higher. Adult and Childhood obesity rates tend to be higher in black ethnicities
Mixed/Multiple Ethnic Groups (Asian/Black/British/ Other)	Those with a mixed ethnicity may still carry the risk factors in developing conditions from their heritage groups. Those from mixed groups have the lowest life expectancy than other ethnicities in the UK> Smoking rates in mixed groups also tends to be higher.
White Gypsy or Irish Traveller	Newark and Sherwood has a higher traveller population than the rest of the country with around 400 pitches in the district alone. The number of pitches across the ICS is set to increase by 193. Travellers are a marginalised group with some of the worse health outcomes, life expectancy 10-15 years lower than the rest of the population. Mental health problems and risk of suicide is higher in this population. Housing education, working conditions and poverty are also pressures for this population.
Other	This other group may represent people from a variety of lesser-known ethnicities who may find it harder to be catered for if they are not represented in the system.

To meet the diverse needs of our population and tackle health inequalities, we will prioritise locating primary care services where they are needed most. We will also continue to drive initiatives focused on preventing ill health, co-designing them with local communities to ensure they are culturally sensitive and make effective use of resources.

Understanding our health inequalities

The table opposite shows our ‘tartan rug’ of health inequalities and the need for us to drive equity across all Primary Care Networks (groupings of GP practices) in Nottingham and Nottinghamshire.

Period: 202412

The stark differences between our PCN / neighbourhoods

PCN Neighbourhood	No of patients	Deprivation: IMD Quintile	Risk Factors: age-adjusted prevalence per 1,000 people: Obesity	Current Smoker	Hyper-tension	Long Term Conditions: age-adjusted prevalence per 1,000 people: Diabetes Type 2	COPD	Heart Failure	Stroke	CHD	Cancers	Serious Mental Illness	Severe Frailty	Age-adjusted rates per 100,000 people: Emergency Admissions (1+ bed days length of stay)	Avoidable deaths	Life expectancy in Years: Life expec. at birth (M)	Life expec. at birth (F)
Raleigh	29,137	1	224.0	181.3	200.0	85.1	33.5	19.0	18.2	39.9	42.7	12.9	14.7	7,784	342.1	79.2	81.0
Radford & Mary Potter	37,520	1	190.0	184.9	198.7	114.0	24.1	14.4	17.5	45.2	35.8	14.4	23.2	7,650	353.0	76.5	82.7
Aspire	39,606	1	224.5	174.8	180.2	83.4	33.6	15.9	16.7	37.2	40.9	9.0	11.8	7,826	328.9	78.0	81.3
Bulwell & Top Valley	47,407	1	242.8	195.5	181.1	71.3	33.5	15.1	17.0	35.0	45.3	10.0	7.2	7,915	331.5	78.6	80.9
Nottingham City East	68,629	1	188.1	180.7	163.7	73.5	28.7	13.7	16.8	34.4	41.7	13.6	13.4	7,318	385.9	75.5	81.7
Newgate Medical Group	30,235	2	236.2	161.5	145.3	67.0	31.0	14.1	12.6	29.4	42.2	7.9	10.0	6,092	296.5	78.6	83.7
Clifton & Meadows	35,048	2	228.7	180.0	188.0	77.4	33.6	14.3	18.8	37.5	41.4	9.7	8.0	7,348	326.5	78.5	80.1
Ashfield North	51,838	2	263.7	158.8	174.4	69.6	25.8	17.8	14.8	36.4	48.9	7.5	8.5	7,783	320.2	77.1	82.2
Rosewood	52,135	2	224.6	173.8	156.2	65.3	28.1	12.4	14.1	36.1	44.0	7.7	8.4	7,546	290.6	79.1	82.8
Bestwood & Sherwood	55,725	2	199.2	151.8	157.1	65.1	22.0	12.9	16.2	32.6	43.8	10.1	8.9	6,200	295.3	78.1	82.9
Mansfield North	59,541	2	240.8	148.0	176.7	67.5	26.1	13.7	13.6	35.8	44.3	5.8	9.5	7,579	300.5	79.3	82.0
Larwood & Bawtry	38,355	3	234.7	128.7	174.3	67.7	30.9	19.9	15.0	33.3	47.5	7.4	11.9	6,207	245.6	79.2	82.9
Byron	39,347	3	234.7	137.4	162.4	61.8	24.3	12.2	14.6	32.9	48.2	6.1	18.3	7,611	284.5	77.9	80.5
City South	39,895	3	165.9	105.3	153.1	57.3	16.9	8.8	12.6	33.0	44.2	7.1	7.2	6,179	211.6	82.2	84.0
Ashfield South	41,038	3	261.6	150.2	156.9	67.5	26.8	11.4	14.7	34.2	46.1	6.7	6.5	7,756	308.3	77.4	80.4
Retford And Villages	59,176	3	237.9	128.2	155.3	58.1	22.9	11.8	12.2	28.1	45.7	5.9	9.1	5,487	227.4	79.8	84.4
Sherwood	64,114	3	238.1	136.4	172.9	64.4	24.3	13.6	13.7	35.6	47.2	5.9	9.4	6,974	229.4	79.7	81.5
Stapleford	22,315	4	230.8	131.3	167.6	58.8	21.9	9.0	12.5	28.9	45.1	6.1	5.2	6,133	219.8	81.0	86.1
Arnold & Calverton	34,303	4	208.2	120.5	146.4	49.3	18.3	8.7	15.7	29.1	47.8	6.8	8.0	5,829	204.4	79.6	84.2
Synergy Health	36,110	4	218.4	143.7	155.1	53.8	18.1	11.7	15.3	30.2	47.9	9.4	20.2	6,396	264.2	80.5	83.1
Eastwood/Kimberley	38,086	4	227.6	118.9	156.7	56.9	20.5	14.7	14.3	32.5	48.3	5.8	7.2	6,299	232.5	80.4	85.4
Newark	79,645	4	200.2	133.3	150.3	51.0	15.4	11.3	12.3	29.7	49.8	5.5	7.1	5,678	236.7	80.5	84.3
Arrow Health	40,161	5	187.5	115.1	148.7	45.5	15.4	9.8	13.0	28.0	47.1	6.6	5.8	5,857	204.3	81.6	85.0
Rushcliffe North	42,913	5	182.9	94.5	140.6	39.5	15.0	9.0	12.3	27.4	47.5	4.1	5.6	4,978	159.2	81.3	84.2
Rushcliffe South	44,505	5	177.1	85.1	139.4	39.4	11.4	9.2	12.5	25.5	47.0	4.3	4.3	4,776	165.9	83.7	84.8
Beeston	50,286	5	182.5	105.8	152.7	51.6	16.8	11.0	14.0	28.1	47.8	7.2	11.0	5,482	221.9	79.9	82.8
Rushcliffe Central	53,346	5	137.7	64.6	138.7	42.0	10.7	9.6	12.4	26.1	48.1	5.6	5.6	4,879	182.6	79.6	86.3
Unity (Nottm)	46,768	4	114.5	64.8	152.8	40.1	10.4	9.2	8.7	20.9	44.5	3.9		3,027	118.8		86.1

Bassetlaw Place
Nottingham City Place
South Nottinghamshire Place
Mid Nottinghamshire Place

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

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

COPD = Chronic obstructive pulmonary disease
CHD = Congestive heart disease

Most deprived PCN neighbourhood
Least deprived PCN neighbourhood
Poor Outcomes
Good Outcomes

Our latest data on high level outcomes for our population show a worsening position, in line with what other areas of the country have seen. However, the latest data shows that the more detailed measures underneath these outcomes are moving in the right direction.

Healthy Life Expectancy

Baseline (2018-2020):
Females: 57.2 years Nottingham
60.0 Nottinghamshire
Males: 57.3 years Nottingham
62.4 years Nottinghamshire

Latest (2021 - 2023)
Females: 56.8 years Nottingham
59.7 Nottinghamshire
Males: 57.2 years Nottingham
60.0 years Nottinghamshire

Life Expectancy

Baseline (2018 - 2020):
Females: 81.0 years Nottingham
82.6 years Nottinghamshire
Males: 76.4 years Nottingham
79.5 years Nottinghamshire

Latest (2021 - 2023):
Females: 80.6 years Nottingham
82.9 years Nottinghamshire
Males: 76.2 years Nottingham
78.9 years Nottinghamshire

Health Inequalities

Baseline (2018-20):
Females: 7.6 years Nottingham
7.7 years Nottinghamshire
Males: 8.4 years Nottingham
9.3 years Nottinghamshire

Data for 2018-2020 are the latest available

Understanding the needs of local communities

General Practice

- Some rural areas require longer travel times to access services and struggle with access generally.
- Nottingham City, Ashfield, and Mansfield have significantly higher rates of avoidable and preventable deaths than the national average — in some cases, double that of other areas within our system.
- Rates of preventable deaths from alcohol-related conditions and cardiovascular disease (CVD) are worsening and continues to vary across communities.
- Childhood obesity remains high, and overall child health is below expected levels.
- Uptake of some screening programmes remains lower than needed with wide variation across our system.
- Challenges in accessing services persist for some populations.

Community Pharmacy

- Pharmacies are well-distributed across Nottingham and Nottinghamshire, with a concentration in areas of higher population density. However, we need to maintain resilience in areas of highest need.
- Most residents can access a pharmacy within 15–20 minutes by car (outside of rush hour), and within 20–30 minutes by public transport.
- In Nottingham City, most residents can access a pharmacy within a 20-minute walk.
- Pharmacies offer a good range of enhanced services, but public awareness of these services is low and we don't have a consistent offer across communities.

Community Optometry Services

- Community optometry services are generally well-distributed, though rural residents may need to travel further.
- Cost concerns often lead some people to delay important eye tests.
- Inequalities in eye health are linked to socioeconomic status, ethnicity, geography, and healthcare access.
- Black, Asian, and minority ethnic groups are at greater risk for conditions such as glaucoma and diabetic retinopathy.
- Research suggests that almost half of those living with sight loss come from economically disadvantaged households.

General Dental Services

- People from disadvantaged backgrounds experience higher levels of oral disease and lower treatment rates.
- Groups at greatest risk include young children, those living in deprivation, people needing care support, smokers, heavy drinkers, inclusion health groups, individuals with chronic conditions, looked-after children, vulnerable families, and older adults.
- Vulnerable groups such as travelers, those in contact with the justice system, looked-after children, and people experiencing homelessness have poorer oral health and face significant barriers to care.
- Limited data exist on oral health disparities across protected characteristics (e.g., ethnicity, religion, sexual orientation, disability), but evidence shows that oral health burdens are highest among the most vulnerable and disadvantaged.

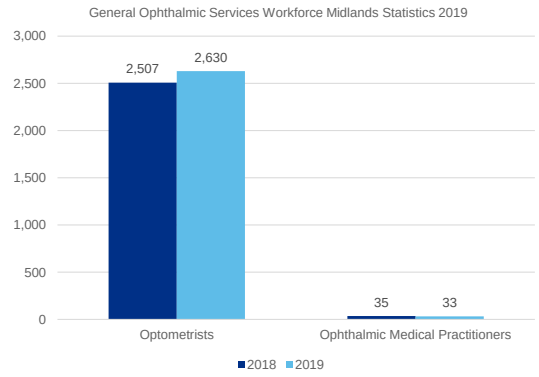
Our Primary Care Workforce:

General Practice and Community Optometry

To meet the changing needs of people and address health inequalities we need to develop a more flexible and integrated primary care workforce. We want to bring providers together, across our health and care provider sectors, to work more collaboratively at a community level. We want them to consider opportunities for sharing their staff, estates and information to enable this to happen. To facilitate this, we will improve our data about our primary care workforce to better understand our skills and capacity gaps. Below is a snapshot of what we currently know.

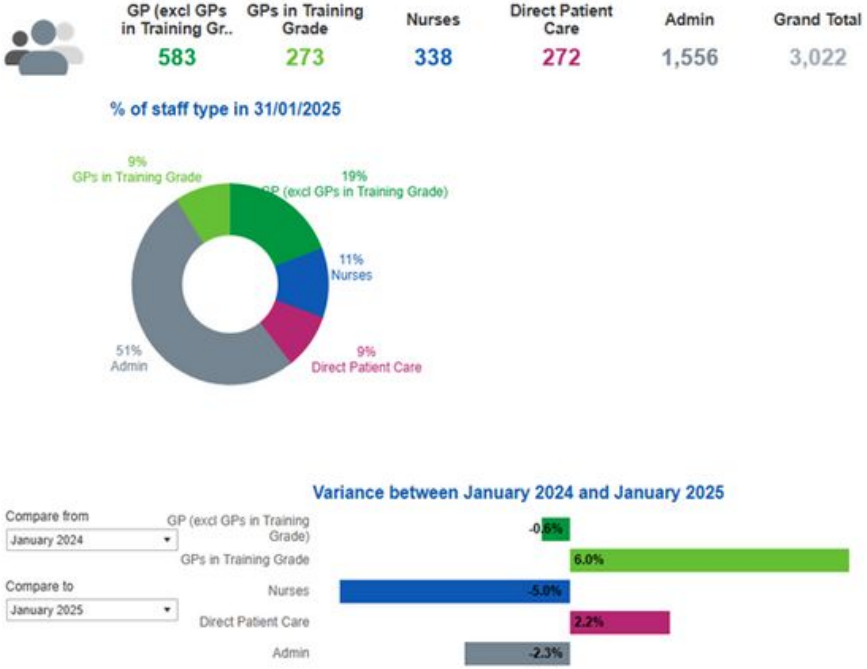
Community Optometry Workforce

- The NHS General Ophthalmic Services Statistics for England 2019 provides analysis based on headcount at a Midlands demographic. This data has not been validated.
- There is no local data available for Nottingham and Nottinghamshire. During 2025/6 we will seek to improve data completeness and quality in respect to our optometry workforce.



General Practice Workforce

- We have seen a shift in the GP workforce moving from being a partner to salaried employment, impacting on the current partnership model which has traditionally provided extensive discretionary effort.
- PCN Additional Roles Reimbursement Staff roles have remained stable through the year, with a slight increase as the 'new GP' role commenced in October 24. This reflects the shift in staff mix at a practice level with fewer GPs but more staff with different skills such as clinical pharmacists, care coordinators, physician associates.
- The greatest reduction in staff has been among Practice Nurses.
- Age profiling of the profession indicates a high portion of the workforce aged 55+ years that could leave the profession within the next 5 years. This means supporting the ongoing retention of more experienced staff will be important – as will supporting existing staff to remain flexible and adaptive to new working environments/ways of working. There are therefore opportunities across our system to promote staff working across traditional working boundaries, especially from acute into community. This will be facilitated by shared learning, recruitment and training initiatives.

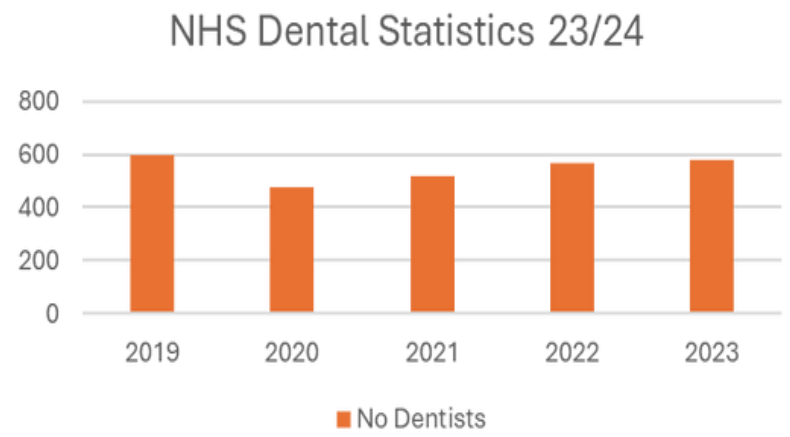


Our Primary Care Workforce:

General Dental Services and Community Pharmacy

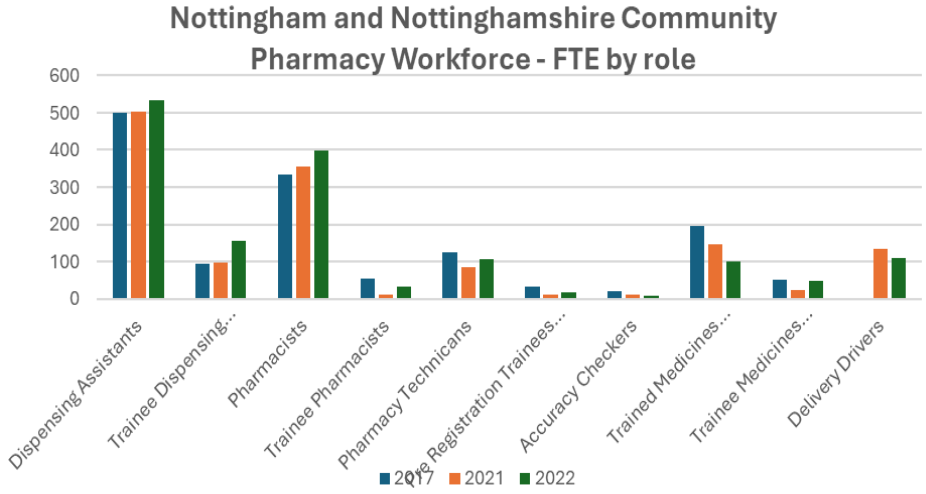
General Dental Services Workforce

- The NHS Dental Statistics for England, 2023/24 provides analysis on workforce and headcount across Nottingham and Nottinghamshire. The accuracy of the data has not been locally validated.
- The data suggests a slight increase of dentists between 2021-2023.
- 80.1% (81.9% England average) of the dentists provide General Dental Services activity. 7.9% provide Personal Dental Services, with 11.9% providing a mix of general and personal services.
- 13% of dentists are 55 years or over which presents a moderate risk of a decline in future capacity without workforce planning/retention considerations.



Community Pharmacy Workforce

- The data for our community workforce is taken from the annual NHS England Community Pharmacy workforce survey (2023).
- The pharmacy sector is in a period of great transformation.
- Between 2017-2022 the pharmacist workforce remained positive within Nottingham and Nottinghamshire, however, there has been a significant impact on the introduction of the Primary Care Network Additional roles position resulting in a shift of professionals moving from community pharmacy into general practice. This has resulted in vacancies and additional pressures being experienced within Community Pharmacy.
- Nottingham and Nottinghamshire has seen a decrease of Pharmacy technicians between 2017-2022 at a time when recent changes to legislation around the roles and responsibilities of pharmacy technicians have relaxed and allowed technicians to act more independently. This development will improve access for patients but will require additional training and supervision support.
- Expansion of the role for Pharmacy Independent Prescribers is also taking place increasing the potential for further growth in the role of community pharmacy in supporting patient care in the future.
- The supply of Designated Prescribing Practitioners (DPPs) continues to be a challenge with Nottingham and Nottinghamshire struggling to meet the required support.



What Primary Care Providers say about local services

A series of workshops highlighted the challenges that are being experienced across our Primary Care providers.

General Practice

- Demand on General Practice continues to rise. GPs and teams are simply seeing more people than ever.
- Continuity of care is not consistently available to patients.
- Workforce retention continues to be a challenge.
- Unsustainable workloads is resulting in burnout.
- The clinical model does not intervene early enough, there needs to be a stronger focus on prevention.
- Finances within General Practice are challenging resulting in Practice Contracts being handed back.
- The partnership model is challenged as a result of increasing numbers of GPs becoming salaried.
- Resources for GP practices are not equitably distributed on the basis of patient need.
- Bureaucratic paperwork takes time away from clinical practice.
- Shift of work from secondary care to primary care impacting on additional workload and no resources to follow.

Community Pharmacy

- Workforce recruitment and retention issues as a result of ARRS model destabilising usual model of community pharmacy workforce.
- Skill mix and funding challenges as an impact of move from prescription to service delivery model.
- Regulations can present challenges to effective working.
- National medicine supply shortages is impacting on relationships with patients and GP practices.
- Financial problems are resulting in pharmacy closures.
- As more people manage their own medication at home, it is expected they will require greater support from community pharmacies.
- Primary Care Networks can involve Community Pharmacy more to maximise opportunities for patient care.

Community Optometry

- Pressing need to streamline pathways so that they work in harmony with clearly defined roles for all providers.
- Underutilisation of Optometrists in Primary Care. Optometrists are not yet recognised or engaged as the first point of contact for eye health issues, despite their expertise.
- There is insufficient engagement and collaboration between/across Primary Care providers, even those working in close proximity.
- The increasing prevalence of age-related conditions is creating a greater need for domiciliary services to cater to people's need.
- Poor communication between primary care, patients, and hospital eye services (HES) is hindering the effectiveness of low vision management, highlighting the need for a more structured and transparent pathway.

General Dental Services

- Access to NHS Dentistry remains a challenge.
- Commissioning of services has remained unchanged and not responsive to patient need.
- Our population continues to access urgent dental services but often demand is heightened due to lack of access to routine care.
- Children continue to experience high levels of oral disease.
- Consistent engagement is lacking across general dental services and patients.
- Increase of oral cancer that means people are having poorer outcomes.
- Workforce challenges are unknown due to lack of data.

What local people and professionals say about primary care services

We have listened to people over the past twelve months. This engagement has comprised:

- Review of patient survey data
- Engagement forums
- Direct patient feedback from Primary Care
- Patient perceptions and wider national feedback.

We have also listened to primary care professionals in a variety of forums:

- Primary Care Strategy workshops
- Direct communication with primary care professionals
- Conversations with colleagues working within primary care
- System and partner meetings.

We have also considered a range of policy and guidance publications including:

- Fuller Stocktake
- NHS Long Term Plan
- NHS Planning Guidance
- NHS Integrated Neighbourhood Health Model Guidance
- Primary Care Recovery Plan
- Community Pharmacy Contractual Framework 2019-2024
- Community Pharmacy Services & specifications
- Pharmacy Needs Assessment
- Dental Recovery Plan
- Oral Health Needs Assessments
- Guidance from professional bodies.

Key messages that have informed our Strategy:

People want better access to primary care services using the form that best suits them e.g. face to face, telephone or virtual, and to be locally available.

People want services to feel more joined up so that professionals involved in their care have access to information about them that reduces the need to re-tell their story.

People want more support to remain independent and stay healthier for longer.

People want more information about which service or professional will best meet their needs at any time in their treatment journey.

People want consistency of provision and not a postcode lottery of care.

Professionals want to support continuity of care, building and maintaining relationships so that care needs might be better met.

Professionals want support to train, recruit and retain staff so that we maintain resilience of local primary care teams, especially in GP practices.

Professionals want more say in the design and delivery of transformation of local services, especially in relation to prevention and shifting services from hospital to community settings.

Professionals want support in managing demand and using data and intelligence so that they can focus on supporting people who would benefit from their expertise the most.

Professionals want to offer more services in fit for purpose environments supported by the most up to date technology.

Moving forward – delivering our vision

A strong, sustainable healthcare system depends on vibrant primary care, rooted in local communities and delivering holistic, patient-centred support across the population. Based on the feedback we have received, and on the data we have about local population needs today and into the future, we think its time to reshape and lead a new era in the delivery of community based primary care services in Nottingham and Nottinghamshire. The transformation of primary care will be intimately connected with the wider transformation of our provider community as part of our integrated health model. We have worked closely with our communities, primary care teams, and system partners to co-design this shared vision for the future — our strategy is therefore shaped by the voices and experiences of those delivering and receiving care as well as our commitment to deliver national primary care operational standards.

By 2030, we intend to achieve:

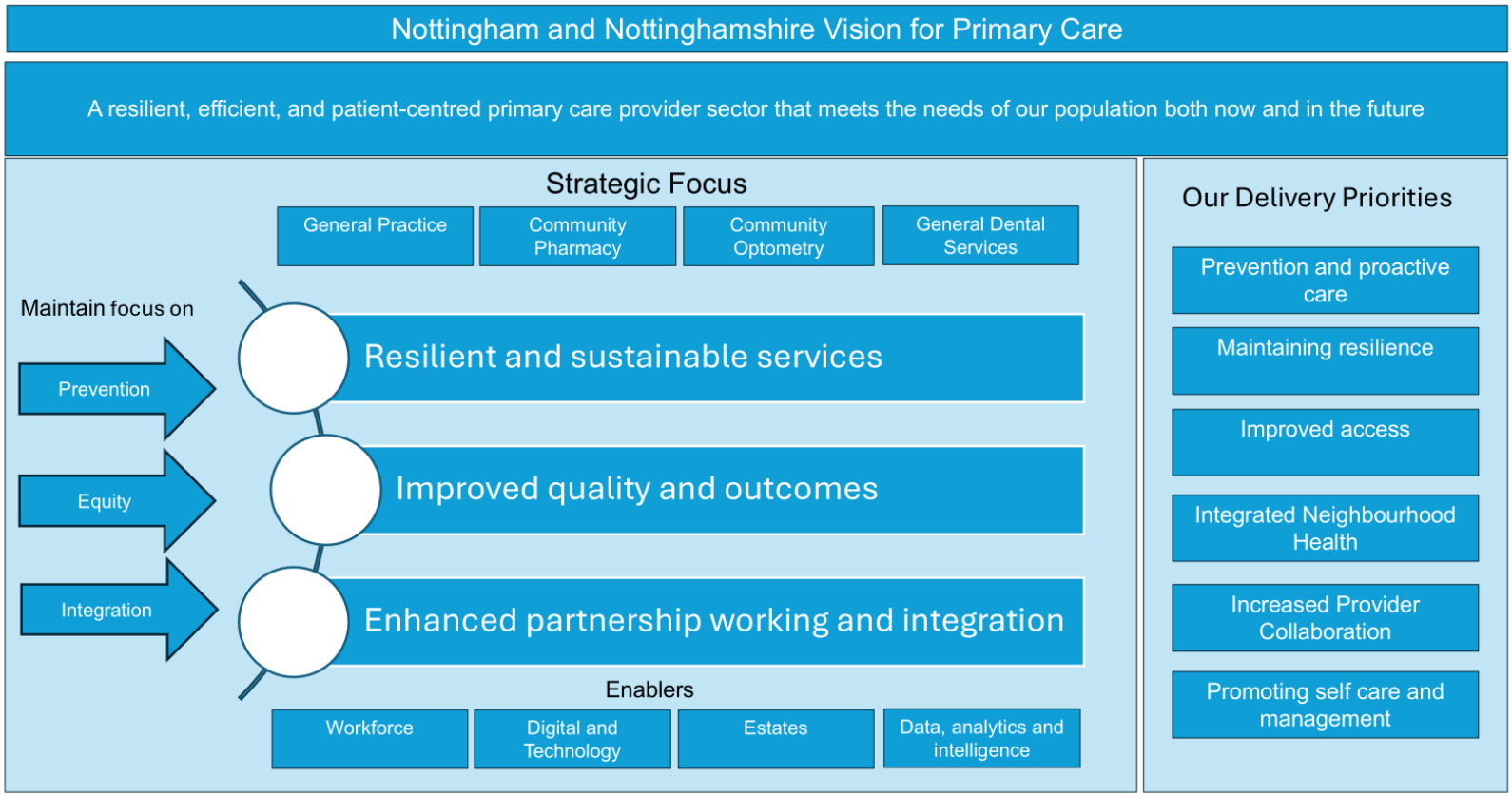
"A more resilient, efficient, and patient-centred primary care provider sector that meets the needs of our population both now and in the future".

To secure this vision we have identified three transformational themes. These are: creating resilient and sustainable services, improving quality and outcomes, and enhancing partnership working and integration. These transformational themes will be achieved through six delivery priorities and associated delivery plans. These will be robustly monitored to ensure we secure the future we are committed to. Supporting the delivery of these transformational themes will also be work to promote one public estate, digital and IT maturity, and joint workforce planning.

Our delivery priorities acting as the building blocks for sustainable transformation of our primary care services

- Promote secondary and tertiary prevention through **proactive and personalised care planning** leading to more cost-effective targeting of resources and improved outcomes.
- **Maintain and promote primary care resilience and sustainability** through extension of community services, new funding models, and the promotion of a unified voice for primary care.
- **Improve access** to primary care services reflecting national delivery commitments as well as local population preferences and needs in order to address health inequalities and reduce inequity.
- **Delivery of the Integrated Neighbourhood Health Model** supporting primary care to undertakes proactive case finding and condition management.
- Promote active engagement and **collaboration of primary care providers** as part of the transformation of our provider landscape.
- Increase public awareness of local support offers within their communities and promote opportunities for **self care and management** of conditions.

Marking our vision a reality: Our Plan on a Page



Delivery Plan 2025/6 – Prevention and Proactive Care

Prevention and proactive care | Maintaining Resilience | Improved access | Delivery of Integrated Neighbourhood Health Teams | Increased Provider Collaboration | Promoting self care and management

Key Actions	Timeline	Success measures
Model of multi-disciplinary discussion of complex cases systematically implemented within primary medical services as part of integrated neighbourhood health model.	Q1-4	• Conduct of MDTs in line with best practice guidance across all Integrated Neighbourhood Teams (March 2026) • Increase in completion of personalised care plans for people identified as frail (trajectories within Frailty Programme) • Increase in recording of RESPECT forms for people on End of Life register (trajectories within Frailty Programme) • Increase in recorded Clinical Frailty Scores (trajectories in Frailty Programme.
Care navigation service in place supporting complex case identification and management.	Q1-2	• Care navigation service procured and mobilised (June 2025).
Increase use of population health management approaches to support case finding, care planning and management for people with high volume/high complex long term conditions (CVD, CHD, respiratory, diabetes, cancer, mental health).	Q1	• Provision of patients via e-Healthscope for GP practice review identifying patients most likely to benefit from further intervention or where gaps in care. Lists to also identify predictive risk of emergency admission (June 2025).
Increase the number of people registered with the NHS App.	Q1-4	• N&N ICS to have the highest rate of NHS App registration in England (March 2026).
Increase in hypertension case finding supporting prevention of exacerbation of illness.	Q1-4	• 1% monthly increase throughout 2025/6.
Increase in Structured Medication Reviews (SMRs) for patients identified as frail/with polypharmacy needs.	Q1-4	• Delivery of agreed trajectory (Frailty Programme/Medicines Optimisation Programme).
Increase in the number of new discharge medicine consultations to reduce readmissions.	Q1-4	• Increase 1% month on month during 2025/6 (March 2026).
Integration of Dental & Medical Needs - ensure that vulnerable people receive support with keeping their mouth clean.	Q1-4	• Work across system to support the importance of (1) brushing their teeth if they need help with personal care and (2) access to toothbrush and toothpaste if they can't afford to buy them, through collaborative and partnership working.

Delivery Plan 2025/6 – Maintaining Resilience

Prevention and proactive care | **Maintaining Resilience** | Improved access | Delivery of Integrated Neighbourhood Health Teams | Increased Provider Collaboration | Promoting self care and management

Key Actions	Timeline	Success Measures
Promote full utilisation of ARRS funding across N&N ICS to develop local skill mix.	Q1-4	• 100% expenditure of available ARRS allocation (March 2026). • Increase in ARRS appointments via GPAD (March 2026).
Implementation of Make Every Contact Count training across all new employees in primary care as part of induction.	Q1-4	• Inclusion of MECC training and awareness in induction programmes for primary care medical services (September 2025). • Inclusion of MECC training and awareness in induction programmes for dentistry, community pharmacy and optometry (March 2026).
Awareness raising and training to support use of National Specialist Pharmacy Service Supply Tool enabling clinicians to be better informed of supply issues and actions.	Q2	• Training completed across all practices (June 2025).
Support for clinical leadership development and inclusion in transformational change initiatives.	Q1-4	• Review of clinical leadership requirements across Place based Partnerships and Neighbourhood Teams (Q1 2025). • Review of Phoenix Programme supporting clinical leadership, retention, training and recruitment (Q1 2025). • Continuation of our senior clinical leadership group in engagement of service/transformational change (2025/6).
Align the development of shared estates and workforce plans with the implementation of the Integrated Neighbourhood Health Model, bringing health and care professionals together to develop a ‘one team’ approach. Primary Care Estates Plans to be reviewed in light of development of same day/urgent Hub and spoke models, clinical delivery models, administrative and training needs and availability of NHS capital investment.	Q1-4	• Develop maturity plans for INTs as they evolve during 2025/6. • Estates and Workforce Plans to be completed by December 2025. • INT Estates Plans and Workforce Plans to be aligned to GP practice plans, system infrastructure/One Public Estates Plans and Workforce Strategy.

Delivery Plan 2025/6 – Improved Access

Prevention and proactive care | Maintaining Resilience | **Improved access** | Delivery of Integrated Neighbourhood Health Teams | Increased Provider Collaboration | Promoting self care and management

Key Actions	Timeline	Success Measures
Improve 14-day GP access through continued delivery of the Action Plan including promotion of best practice appointment coding.	Q1 Q2	• N&N ICB performance achieve national target (85%) or above from March 2025 • Assertive in-reach programme implemented for practices with lower achievement levels to review and revise coding as appropriate (Q1) • Subject to the above, achievement of min 87.6% (from July 2025)
Work with community pharmacy to increase service offer to patients across N&N; prioritisation within areas of highest deprivation.	Q1-4	• Increase in community pharmacists providing Pharmacy First service in most deprived areas (September 2025) across Nottingham and Nottinghamshire (March 2026). • Min 1% monthly increase in community pharmacists providing blood pressure monitoring and contraception services (from Q4 2025/6)
Review and optimise Community Pharmacy Bank Holiday Rota to ensure equitable service access across Nottingham and Nottinghamshire.	Q3	• Revised rota in place (December 2025)
Implementation of Primary Care Access Recovery Plan (PCARP).	Q1-4	• By March 2026: • Min 80% of practices having more than 40% of registrations using national on-line registration service • Min 80% practices implementing Modern General Practice Models (achieving 3 criteria or more) • Improvement in overall Friends and Family Test assessment, submission rate and survey completion rate • Min 80% of practice compliance with website national guidance • Increase of on-line consultation/triage appointments recorded in GPAD

Delivery Plan 2025/6 – Improved Access Continued

Prevention and proactive care | Maintaining Resilience | **Improved access** | Delivery of Integrated Neighbourhood Health Teams | Increased Provider Collaboration | Promoting self care and management

Key Actions	Timeline	Success Measures
Develop community-based pathways for wet age-related macular degeneration (AMD) and eye casualty follow-ups.	Q2-4	• Confirmed revised pathways mobilised (March-April 2026).
Exploration of opportunity for increased role of optometrists in preventative healthcare and early disease detection and treatment in a community setting.	Q1-4	• Confirmed preferred options (June 2025) and revised pathways mobilised (March 2026).
Develop an Eye Health Needs Assessment to identify main priorities for improving eye health, reducing preventable sight loss and reducing inequalities.	Q1-4	• Eye Health Needs Assessment completed (December 2025). • Implementation Plan developed (February 2026). • Mobilisation (March 2026).
Implementation of the Electronic Eye Referral System allowing more appropriate referrals to specialist input.	Q1-4	• Electronic Eye Referral system fully operational (March 2026).
Implementation of the Dental Recovery Plan supporting increased access, urgent care provision and commissioned services.	Q1-4	• Plan deliverables completed in accordance with agreed timelines (June 2025). • Deliver 24,360 unscheduled care appointments (March 26). • Expand commissioning and delivery of UDAs each quarter, commissioning mandatory services to areas of highest need (March 2026). • Recommission urgent dental care services (March 2026). • Expand flexible commissioning through the annual cycle to utilise flexibility within the dental regulations to maximise opportunities to improve dental service provision. (March 2026). • Recommission urgent dental care services by (March 2026).
Implementation of a national community pharmacy independent pathfinder service.	Q3	• Four independent prescribers within Community Pharmacy Independent Pathfinder Programme (December 2025). Minimum of six by March 2026.
Implementation of a Pharmacy Sustainability Dashboard to optimise pharmacy delivery options for people	Q4	• Pharmacy Sustainability Dashboard established (March 2026).

Delivery Plan 2025/6 – Delivery of Integrated Neighbourhood Teams

Prevention and proactive care	Maintaining Resilience	Improved access	**Delivery of Integrated Neighbourhood Teams**	Increased Provider Collaboration	Promoting self care and management

Key Actions	Timeline	Success Measures
Implementation of Integrated Neighbourhood Health model.	Q1-4	• Phase 1: Minimum of 4 INTs – June 2025 • Phase 2: Minimum of 8 INTs – September 2025 • Phase 3: Minimum of 10 INTs – December 2025
Integrated Neighbourhood Health Teams to focus on people with severe or moderate frailty (including with long term conditions), children and young people (CYP) and people experiencing severe multiple disadvantage (SMD). Specific/hyper focussed cohorts defined within the Frailty Programme based on greatest opportunity for population impact and secondary and tertiary prevention.	Q1-4	Phase 1INTs: • Frailty pathway implemented (June 2025) • CYP pathway implemented (September 2025) • SMD pathway implemented (December 2025) Phase 2 INTs: • Frailty pathway implemented (September 2025) • CYP pathway implemented (December 2025) • SMD pathway implemented (March 2026) Phase 3 INTs: • Frailty pathway implemented (December 2025) • CYP pathway implemented (March 2026) • SMD pathway implemented (June 2026)

Delivery Plan 2025/6 – Increased Provider Collaboration

Prevention and Proactive care | Improved workforce integration, retention and training | Improved access | Delivery of Integrated Neighbourhood Health Teams | **Increased Provider Collaboration** | Promoting self care and management

Key Actions	Timeline	Success measures
Develop a single GP Collaborative to create a unified voice for general practice.	Q1-2	• Agreed concordat across all practices (September 2025).
Develop enhanced service proposal/GP Improvement Programme to incentivise GP engagement in Integrated Neighbourhood Health Model and accelerate proactive case finding and management.	Q1-3	• Options appraisal completed • Agreed Enhanced Service Offer mobilised across N&N (June 2025). • Performance oversight of delivery commenced (September 2025).
Dissemination of data packs for practices/Primary Care Networks to support awareness of variation in outcomes to support joint working and learning across practices and identification of opportunities for proactive support to practices by the ICB (PMS Performance Group).	Q1-4	• Implementation of pro-active practice visits to support practices to address unwarranted variation in outcomes (March 2025).
Exploration of opportunities for shared infrastructure across primary medical care services e.g. same day/urgent care, access Hub and Spoke model.	Q1-4	• Identification of opportunities and early mobilisation (March 2026).
Expansion of ‘at scale’ working models for delivery of primary medical services.	Q4	• Review of opportunities for delivery of commissioning ‘at scale’.
Involve Pharmacy, Optometry and Dentistry across all Place Based Partnerships.	Q1-2	• Involve and enhance awareness of Pharmacy, Optometry and Dentistry within Place Based Partnerships (July 2025).
Ensure that we address the needs of the whole population, by considering oral health in the services that support our vulnerable groups. Specifically ensure that vulnerable people receive routine and urgent dental care, as part of their overall care (may involve signposting to services or referral into services such as the Community Dental Service.	Q1	• Agreed process Plan (June) 2025 mobilised by (December 2025).
Confirm approach to develop Dental Strategy One Vision across NHS and Local Authorities.	Q4	• One vision across the system to support commissioning and oral health needs and prevention March 2026. Implementation plan (June 26), Mobilisation (September 2026).
Primary / Secondary care interface enhanced to incorporate Pharmacy, Optometry and Dental Services.	Q2	• PODS active participation within primary / secondary care interface meeting supporting wider working (September 2025).

Delivery Plan 2025/6 – Promoting self care and management

Prevention and Proactive care	Improved workforce integration, retention and training	Improved access	Delivery of Integrated Neighbourhood Health Teams	Increased Provider Collaboration	Promoting self care and management

Key Actions	Timeline	Success measures
Communications campaign to increase public awareness of pharmacy, optometry, dental expertise and services; prioritisation within areas of highest deprivation. Comms to also promote self-care and management and awareness of self-referral pathways. Importance of prevention in managing health and wellbeing (e.g. eye tests reduce risk of falls).	Q1-4	• Completed multi-media comms campaign (December 2025). • Increase in public and professional awareness of optometry's expended role beyond vision correction (sample survey December 2025) • Increase in public and professional awareness of oral health and preventative care and self-referral pathways (sample survey December 2025). Increase in referrals through self-referral (March 2026).
Communications campaign to promote patient ordering of repeat medications allowing 3 – 5 days, supporting hub and spoke model of delivery.	Q3	• Increase in pharmacy on-line prescription requests and reduction in emergency prescriptions issued (December 2026).

Delivering our vision

Our approach for delivery is based on working in partnership across primary care. It recognises the need to work together as a system of good practice and shared solutions and provides an opportunity to collectively shape and influence transformational change.

To successfully deliver the aims and ambitions set out in the document the Primary Care Transformation Group will oversee and support the delivery of this strategy. The group will have a system-wide approach to oversight and governance and our partners who have supported its implementation will all have a key role in supporting its delivery.

Delivery plans have been developed for each of the priority areas, and progress against the delivery plans will be reviewed as part of the Primary Care Transformation Group workstreams, with a view to monitoring the progress of the priorities, providing support and challenge to programme leads in alignment with the desired outcomes, key deliverables and related milestones for each priority area.

In publishing this strategy, we are committing to do all we can to achieve the headline deliverables described therein, wherever possible, via existing resources or from the targeted investments.

Each work programme will have its key requirement of how we measure benefits and see the impact both in terms of hard and soft lived experience, hence continued active focus on the community/engagement investment. Next steps will be to build on the delivery plan and develop detailed proposals with partners involved and provide progress via our governance process with a view to embed the learning and show improvement in key areas through quantitative data but more importantly through lived experiences across our representative patient groups.

NHS Nottingham and Nottinghamshire would like to take this opportunity to thank everyone who has been involved in the development of this strategy and your ongoing support in implementation and driving change.

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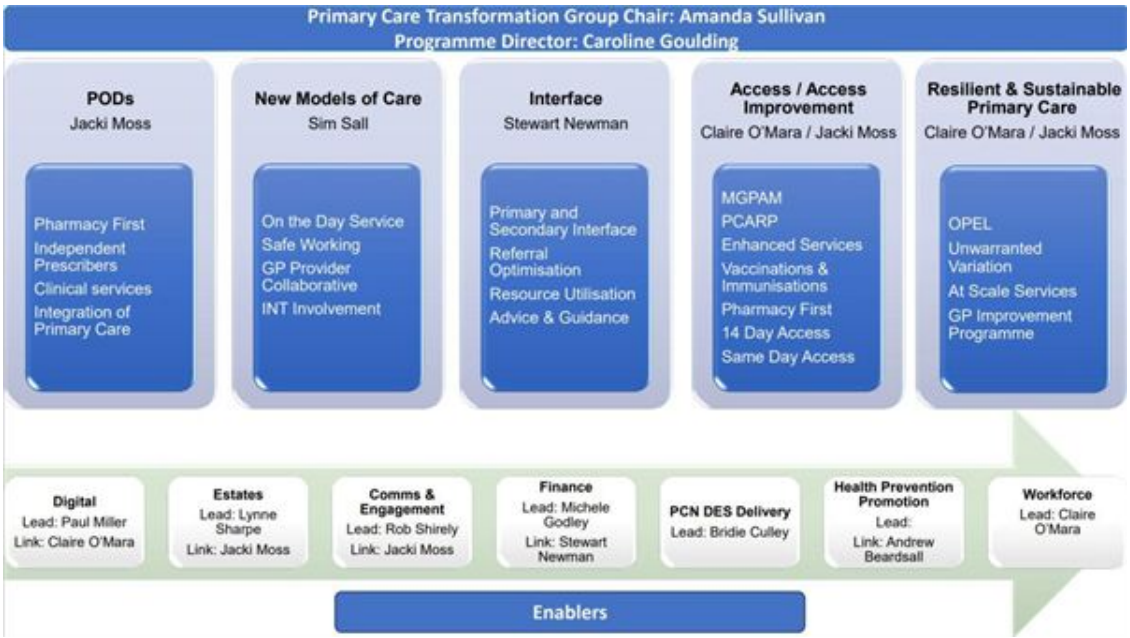
Appendix 2

Primary Care Strategy Governance and Monitoring

The Strategy is the responsibility of the ICB, however, oversight of the delivery of the strategy is discharged to the Primary Care Transformation Board. This board will have a system-wide approach to oversight and governance to oversee and support the delivery. Our partners who have supported its implementation will all have a key role in supporting its delivery.

Delivery plans have been developed for each of the priority areas, and progress against the delivery plans will be reviewed as part of the Primary Care Transformation Board workstreams, with a view to monitoring the progress of the priorities, providing support and challenge to programme leads in alignment with the desired outcomes, key deliverables and related milestones for each priority area.



NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**Assertive and Intensive Community Mental Health Care Action Plan: Delivery Update**
Paper Reference:	ICB 25 012
Report Author:	Kate Burley, Deputy Head of Mental Health Commissioning
Executive Lead:	Maria Principe, Acting Director of Delivery and Operations
Presenter:	Maria Principe, Acting Director of Delivery and Operations

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

Summary:

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

Subsequently, all ICBs were asked to "*Review their community services by Q2 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge.*"

The Nottingham and Nottinghamshire review took place in September 2024 and the outcome of the review, and an improvement action plan was developed and presented to the Board in November 2024. The outcome of the review concluded that the ICB was not assured that the services provided by NHT were able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow up. A Monthly Task and Finish Group was established to oversee the actions and monitor progress. Progress is reported into the NHT Programme Board and into the Improvement Oversight Assurance Group.

Following the publication of the Independent Mental Health Homicide review in February 2025 'Independent investigation into the care and treatment provided to VC', NHS England asked all systems review their Assertive and Intensive Community Mental Health action plans and ensure they address issues identified in the homicide review and present these to a public Board meeting by end of June 2025.

This paper presents on the progress of the Assertive and Intensive Action Plan since the plan was presented to the Board in November 2024.

Progress to date includes a continued focus on safety and quality, ensuring improved oversight of patients requiring assertive engagement. A dashboard has been created from a Safe Now perspective to provide assurance on service delivery, increased oversight of discharges, engagement with carers, and best practice guidelines around

Summary:
medications management. A summary of the overall status of actions is presented below: • Total number of actions: 28 • Number of actions completed:13 • Number of actions in progress but delayed due to delays in the publication of national guidance / national funding announcements: 5 • Number of actions in progress but delayed due to interdependencies with other work taking place in NHT: 10 Some of the delayed actions within the plan are due to requiring further national guidance/standards and confirmation of national investment. To deliver the requirements of the Assertive Engagement caseload and best practice guidelines, the service model will need to be revised to have dedicated staffing focusing only on this pathway and not holding mixed caseloads. The national expectation from NHS England is that systems should continue to focus on the short-term actions with minimal resource implications, which is what the Nottingham and Nottinghamshire Task and Finish Group has been progressing. Next steps include a self-assessment against the latest principles for this care pathway shared by NHS England in April 2025 to identify any additional areas for improvement in the action plan. Stakeholder workshops will take place to shape the core community mental health service and inform redesign of the pathway to ensure the assertive and intensive pathway can be delivered to the best practice guidelines.

Recommendation(s):
The Board is asked to **receive** the report for assurance regarding progress in delivery of the Assertive and Intensive Community Mental Health Care action plan.

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

How does this paper support	the ICB's core aims to:
	symptoms. Part of the model includes Individual Placement and Support (employment support) supporting people to find or maintain employment which in turn can support their recovery.

Appendices:
Appendix A: Summary of Findings from Assertive and Intensive Community Mental Health Review September 2024 Appendix B: Assertive and Intensive Action Plan

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

Report Previously Received By:
Strategic Planning and Integration Committee on 1 May 2025.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Assertive and Intensive Community Mental Health Care Action Plan: Delivery Update

Background and context

1. In March 2024, the Care Quality Commission (CQC) published the first part of a special review into mental health care at Nottinghamshire Healthcare NHS Foundation Trust (NHT) following the conviction of Valdo Calocane in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar, and Barnaby Webber.
2. Subsequently, the 2024/25 NHS Priorities and Operational Planning Guidance asked that all Integrated Care Boards (ICBs) "Review their community services by quarter two 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge."
3. Many people who experience psychosis can receive evidence-based care and treatment enabling them to recover from their psychotic episode and/or be supported to live a life that is meaningful to them alongside the management of ongoing symptoms. However, some people particularly where paranoia is present, struggle to access evidenced-based care and treatment. This can be due to services not being able to meet people's needs, the impact of symptoms including paranoia, or a lack of understanding from the individual that they are unwell. For this group of people, it is critical that mental health services meet the person's needs by adapting their engagement approach, providing continuity of care, and offering a range of treatment options for people experiencing varying intensity of symptoms. People with these needs can be vulnerable to harm from themselves and others; for a very small number of people, relapse can also bring a risk of harm to others.
4. National guidance was published in July 2024: NHS England » Guidance on intensive and assertive community mental health treatment. ICBs were asked to use this to review policies and practices to identify and provide appropriate care to people with severe mental illness who might need intensive and assertive community care. ICBs were asked to confirm if they are assured that services can identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow-up and use the review to identify gaps and barriers to providing good care and report these back to NHS England by 30 September 2024.
5. NHS England was due to publish evidence-based guidance and national standards for high-quality, safe care for people with complex psychosis and paranoid schizophrenia in March 2025 but has been delayed until summer 2025.

6. All systems were asked to submit to NHS England detailed cost estimates and anticipated benefits to quantify funding gaps identified in the review by November 2024 to inform future funding bids in the government spending review process. The national expectation from NHS England is that systems should continue to focus on the short-term actions with minimal resource implications.

7. In February 2025, NHS England published the Independent Mental Health Homicide Review into the tragedies Independent investigation into the care and treatment provided to VC. NHS England requested that all systems review their Assertive Engagement action plans and ensure they address issues identified in the review, including personalised assessment of risk across community and inpatient teams, joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies), multi-agency working and information sharing, working closely with families, and eliminating Out of Area Placements in line with ICB three-year plans. NHS Nottingham and Nottinghamshire ICB and NHT have produced a joint action plan to describe how they are delivering the recommendations from the Homicide review, which can be found here: Independent investigation into care and treatment of Valdo Calocane ICB action plan. The plan was presented to ICB's Quality and People Committee in February 2025 and any actions specific to the Assertive and Intensive Engagement pathway will be taken forward through the Assertive Engagement Task and Finish Group and reported and monitored through the agreed quality oversight arrangements.

Review process

8. As previously reported to Board, the review of assertive and intensive support services provided by NHT took place in September 2024 through a facilitated workshop with partner organisations. Provision was reviewed using an NHS England Maturity Index Self-Assessment Tool. The tool provided a framework to discuss and review the elements of community mental health services that should be in place to provide appropriate assertive outreach and intensive support for people with serious mental illness, and to minimise any risks that may arise and gives an indication of the elements of service that are working well and those that require more development. The findings were presented to the NHT Executive Team and the ICB. A summary of the key findings is presented in Appendix A.

9. Based on the information provided for the review, including the positive developments and improvements made since the special review findings, the ICB was not assured that the services provided by NHT were able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow up. This outcome was reported back to NHS England at the end of September 2024.

Benchmarking

10. National benchmarking from the outcomes of the reviews of Assertive and Intensive Engagement suggested some gaps in provision across all systems across the country, similar to those identified in the local review. Themes included lack of a dedicated function delivering intensive and assertive care, workforce capacity, insufficient data infrastructure, inconsistency in the key elements of care, poor interface across the mental health system and wider partners, lack of local governance and financial pressures.

11. The ICB and NHT are part of a regional NHS England led Task and Finish Group with other systems in the Midlands sharing good practice in improving Assertive Engagement provision. NHS England has recently regionally benchmarked the outputs from systems who completed the Self- Assessment Maturity Index, and this information is being used continue to learn from other systems and inform the local action plan.

Action plan and progress

12. Following the review, an Assertive and Intensive Engagement Improvement Plan was developed during October 2024 to address the gaps highlighted in the self-assessment.

13. Monthly Task and Finish Group meetings have taken place to take forward the actions and monitor progress. Progress is reported into the NHT Programme Board and into the Improvement Oversight Assurance Group. The self-assessment is reviewed on an ongoing basis, including following the Independent Homicide Review, to identify additional actions to address the recommendations from the review. The updated Plan is presented in Appendix B, which provides the headline actions in place.

14. Much of the action to date has focused on safety and quality. This includes the oversight of assertive engagement with patients, confirming operational standards and a standard operating procedure with community teams. Oversight of risk assessments, care plans and contingency planning is ensured, as is line of sight of Assertive Engagement patients waiting for Care Coordination allocation and patients with two or more ‘Did Not Attends’ in the Patient Tracker List Meeting each week. Wider workforce plans such as training are also overseen. A dashboard has been created from a Safe Now perspective to provide assurance on service delivery. Discharges for this group of patients are low, however there has still been increased focus and oversight, ensuring that where discharges are made, they are reviewed by Multidisciplinary Team. A discharge checklist has also been rolled out to support teams in ensuring all elements of a robust discharge are in place.

15. Best practice guidelines for medicines management have been developed and will be signed off by the Trust in April 2025.

16. Actions in the improvement plan are identified as short or longer term, with the longer-term actions requiring further national guidance/standards and confirmation of national investment. To deliver the requirements of the Assertive Engagement caseload, the service model will need to be revised to have dedicated staffing focusing only on this pathway and not holding mixed caseloads. Due to the wider community mental health model being under review, this change will need to be considered as part of that work, which will be designed collectively with stakeholders via workshop events that are currently being planned to take place within the next three months. Community mental health provision has been identified as one of the priorities of the Mental Health Adult and Children Partnership Board, given that it requires a system response, and delivery plans and progress will be through that governance route.

17. One area of concern was in relation to the identification of carers and the wider inclusion of carers / next of kin within patient care planning. The clinical dashboard that has been developed identifies all patients on the pathway that have a carer or significant other involved within their care. Three specific carer, friends and family events have taken place since November 2024 specifically for this patient group to listen and hear their experiences to inform wider pathway improvements. A coproduction model has been agreed to support delivery of the three year Integrated Mental Health Pathway Strategic Plan, with Improving Lives providing coproduction support to the Adult Mental Health coproduction group, Partners in Mind, from 1 April 2025. Two members of the Partners in Mind group have been selected to be members of the system Adult and Children Mental Health Partnership Board to ensure the voice of experts by experience is heard at a strategic level. Wider work has commenced with the NHT Patient Involvement Team to develop a community-based Carer, Friends and Family Strategy.

Next steps

18. The Assertive and Intensive Engagement Improvement Plan will continue to be reviewed and updated on a monthly basis, incorporating the following:

    a) Self-assessment against the latest principles for this pathway shared by NHS England in April 2025 to identify any additional areas for improvement in the action plan.

    b) NHSE's clinically led review of the action plan that was presented to ICB Public Board in November 2024. This was received by the ICB and NHT on 11 April 2025 and will be reviewed in the April Task and Finish Group.

    c) New guidance on the standards of care due to be published in Summer 2025. This guidance will aim to ensure that all people with serious mental illness receive a minimum level of good personalised care and treatment,

and that where care is being delivered across multiple teams or organisations, this care is well coordinated.

d) In line with the wider service developments and to strengthen the current service model to meet the needs of people that require Assertive and Intensive treatment the core service model and clinical pathways require improvement and re-design. This will be designed collectively with stake holders via workshop events which are currently being planned and to take place within the next three months.

19. It is proposed that a further update is presented to the Strategic Planning and Integration Committee in November 2025.

Appendix A: Summary of Findings from Assertive and Intensive Community Mental Health Review September 2024

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

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

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

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

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

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

f) There was good understanding of the legal framework that supports care and treatment. A review of the use of Community Treatment Orders has been completed; the use of Community Treatment Orders has increased since the special review and is currently being benchmarked with other trusts. A Community Treatment Order is an order for supervised treatment in the community with certain conditions, meaning patients can be treated in the community rather than in hospital, but can be returned to

hospital if necessary. The reasons behind the increase are being explored further but is likely to be due to risk when patients are discharged from wards and patients not being discharged from Community Treatment Orders.

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

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

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

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

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

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

Appendix B: Assertive and Intensive Action Plan

1. Function of assertive and intensive case management

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

Action	Lead	Timescale and longer or shorter term plan	Measures	Progress at April 2025
Confirm Assertive and Intensive Community Treatment pathway case list	Operations Manager	04/10/24 Short term	Review of Assertive and Intensive Community treatment lists complete.	**Complete** Clinical dashboard now in place which identifies all patients on this pathway. As of April 2025, 298 patients are on the pathway.
Each Local Mental Health Team to review Assertive and Intensive Community Treatment list against full caseload on an ongoing basis	Operations Manager	30/11/24 Short term	Each Local Mental Health Team confirms Assertive and Intensive Community Treatment List	**Complete** Regular reporting now in place and reviewed monthly in the Focus Group.
Confirm operational standards	Operations Manager	14/10/24 Short term	Proportion of contacts Proportion of Multi-Disciplinary Team Reviews No discharges due to Did Not Attend (DNA) All discharges planned and approved by the Multi-Disciplinary Team X2 DNAs escalated to Associate Director of Operations- Community.	**Complete** Incorporated within the pathway standards below.

Confirm monthly monitoring/reporting (Risk Assessment, Care Plans, Community Treatment Orders, Multi-Disciplinary Team reviews, date last contact)	Operations Manager	04/10/24 Short term	Monitoring reports confirm oversight and monitoring of individual cases.	**Complete** This is captured within the Assertive Engagement focus group attended by teams and clinical leaders.

2. Clinical pathways

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

Action	Lead	Timescale and longer or shorter term plan	Measures	Progress at April 2025
Detail the current Assertive and Intensive Community Treatment pathway within the Local Mental Health Teams Standard Operational Policy and confirm with stakeholders.	Director of Nursing	31/10/24 Short term	Gap analysis Standard Operational Policy in place and shared with stakeholders.	**Complete**
Proposal developed by Task and Finish group for approval and business case (where necessary)	Director of Nursing	15/11/24 Longer term	Operational model agreed and costed	**Complete** Aspirational proposal developed to meet current national standards and costings shared with NHS England to inform resource requirements.

3. Workforce

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

Action	Lead	Timescale and longer or shorter term plan	Measures	Progress at April 2025
Include Assertive and Intensive Community treatment in Local Mental Health Team demand and capacity modelling	Associate Director of Operations	30/09/25* Longer term	Demand and Capacity report approved by NHT Programme Board	**In- progress** Demand and capacity work undertaken for case management but to develop the longer-term model will require understanding of national guidance, which is delayed to Summer 2025, therefore the timescale for completion has been revised to end of September 2025.
Produce comprehensive Multi-Disciplinary Team workforce plan as determined through gap analysis above	Associate Director of Operations	30/09/25* Medium – Longer term	Workforce plan agreed at NHT Programme Board	**In- progress** Workforce plan complete, however awaiting national guidance and confirmation of potential national funding to progress further and timescale revised to reflect this.
Commission specialist training for practitioners working in the pathways (Psychosocial Interventions - PSI)	Associate Director of Operations	31/10/24 Long term	Psychosocial Interventions training provision confirmed, and dates agreed	**Complete** Risk assessment training commenced. PSI purchased and commencing from 20 April 2025, 3 cohorts planned. Wider Training Needs Analysis needs to be linked to the national guidance as above.
Specialist supervision to be provided to Assertive and Intensive Community treatment practitioners	Associate Director of Operations	31/05/25* Short term	Clinical supervision compliance rates Confirmation of Reflective Practice in place	**In- progress** Work commenced with psychological therapy leads across community services to develop new reflective practice group. Ambition to launch from May 2025. This was delayed due to needing to be rolled out across the whole Local Mental Health Team (LMHT) and the resources to do this, due to there not being a bespoke Assertive Engagement Service to target.

Action	Lead	Timescale and longer or shorter term plan	Measures	Progress at April 2025
Caseload norms to be agreed (circa 15) as part of the service model development	Associate Director of Operations	30/09/25* Longer term	To Be Confirmed subject to operational model	**In- progress** As part of the revised service model, caseload norms have been mapped in line with best practice guidelines; however unable to meet this due to merged LMHT offer and generic workforce roles such as Duty, Assessments, other caseload work. This work is interdependent with wider reviews of Community Mental Health resource underway, which is likely to release resource to support this pathway and the timescale has been revised to reflect this work, also pending national guidance. Mental Health Investment Standard will also be reviewed for this.

4. Risk assessment

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

Action	Lead	Timescale and longer or shorter term plan	Measures	Progress at April 2025
Review risk assessment policy, guidance, and best practice	Associate Medical Director	15/11/24 Short term	Revised policy in place	**Complete**

5. Legislation

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

Action	Lead	Timescale and longer or shorter term plan	Measures	Progress at April 2025
Mental Health Law team to review use of Community Treatment Orders, benchmark with other similar Trusts, Reviewed by Clinical Director and Consultant Medical staff and non-medical Approved Clinicians	Deputy Director	31/10/24 Short term	Community Treatment Order report completed and reviewed	**Complete** Data reviewed and no significant concerns or variation.

6. Interface with other services

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

Action	Lead	Timescale and longer or shorter term plan	Measures	Progress at April 2025
Explore with Integrated Care Board and Partners opportunities for closer working arrangements within this care and treatment pathway	Head of Community Transformation	Ongoing, review end of June 2025 Long term	Decision upon partner agencies contribution to this care and treatment pathway	**In- progress** Work commenced to scope out and map system wide interface opportunities with external partners to support coexisting mental health needs with wider partners. Work has also commenced to link with Wraparound Multi-Disciplinary Team for Severe and Multiple Disadvantage to explore this model. Mental Health Partnership Board priority workstream to focus on Community Model will also increase partner engagement in this area.

7. Recovery and personalisation

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

Action	Lead	Timescale and longer or shorter term plan	Measures	Progress at April 2025
Confirm interim care management policy pending guidance on future of Care Programme Approach (CPA)	Head of Community Transformation	30/09/25* Longer term	Care management policy confirmed with staff.	**In-progress** Whilst care plans are co-produced, specific work is happening linked to Patient Reported Outcome Measures for personalised care plans linked to DIALOG PLUS which is a longer-term action due to project plans and scale of rolling this out. Interim plans in place with oversight of care plans via the Assertive Engagement dashboard. Whilst this work is in progress and new personalised care plan being tested the CPA framework remains in place. Further work will progress following receipt of national update on moving away from CPA expected Summer 2025.
Roll out use of outcome measures - e.g. - Bexley, Recovering Quality of Life, Goal Based Outcomes and Dialog+	Head of Community Transformation	30/09/25* Longer term	Monitoring report for Local Mental Health Team as a proxy for Assertive and Intensive Community treatment patients	**In-progress** A plan for embedding outcome measures across all community services is in development but has been delayed due to review of community mental health teams underway and three outcome measures will be in place by a revies date. Testing is currently happening within the assertive engagement patient group to inform wider learning.

8. Meeting the needs of diverse populations

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

Action	Lead	Timescale and longer or shorter term plan	Measures	Progress at April 2025
Review Equality, Diversity, and Inclusion (EDI) data to ensure services are inclusive with patients actively supported to access appropriate interventions e.g., Learning Disability and Autism, Ethnicity, Disability	Director of Nursing	30/11/24 Longer term	Reports on access and use by protected characteristics in place	**Complete** The clinical dashboard now includes key EDI data of which is used to identify specific service access for ethnic minority groups.
Review enablement strategies	Director of Nursing	Ongoing cycle Longer term	Identify any gaps or service deficits	**In- progress** The care group EDI lead is supporting this work to develop the key areas of improvements and focus groups for EDI. Enablement strategies will be developed as part of the wider and longer-term plan. Patient and Carer Race Equality Framework (PCREF) will be one of the main vehicles of change for this work which will include local health-based population data cross referenced to workforce needs to meet the needs of our patients specifically variation of staff differing cultural backgrounds. In line with partnership working specific focused work will draw on listening to feedback from multi-cultural local community groups. Services and leaders to enhance and develop sustained changes to meet the needs of ethnic groups to support and receive care and treatment. Allyship training to be delivered to staff group alongside core EDI training.

9. Medicine management

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

Action	Lead and longer or shorter term plan	Timescale and longer or shorter term plan	Measures	Progress at April 2025
Develop good practice guidelines that promotes adherence	Associate Medical Director	31/05/25* Short term	Best practice guidelines in place	**In- progress** Medication Forum established, bite- sized training on medication agreed for rollout in May 2025, guidelines around medication standards drafted for agreement in April 2025.

10. Experts by experience

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

Action	Lead	Timescale and longer or shorter term plan	Measures	Progress at April 2025
Ensure patient feedback is part of core quality reporting and used to develop and improve services.	Director of Nursing	Ongoing*, review 31/05/25 Longer term	Increased rate of feedback Analysis of feedback in terms of categorisation to indicate quality of service	**In-progress** As of February 2025, there was 64 individual care opinion feedback for community mental health, 52 were positive which equates to 81% however limitations apply to the format or quality of the feedback report that enables key enablers to progress into a category of "very good" therefore as identified above more bespoke work

Action	Lead	Timescale and longer or shorter term plan	Measures	Progress at April 2025
			Patient feedback to form part of business-as-usual quality reporting. Involvement and improvement plans to be developed and completed based on patient feedback and experience coproduced with people with lived experience.	is needed. Key themes from feedback being reported into Quality Oversight Group and into service planning.
Strengthen co-production and engagement with people with lived experience, families, and carers within the model	Director of Nursing	Ongoing*, review June 2025 Longer term	Improved patient and carer experience	**In-progress** Three Carer, friends and family events have taken place since November 2024 specifically for this patient group to listen and hear their experiences to support and aid wider pathway improvements. Wider work has been commenced with Patient Involvement team to develop a community-based Carer, Friends and Family strategy. Coproduction Lead commences in April to support embedding coproduction.

11. Discharge

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

Action	Lead	Timescale and longer or shorter term plan	Measures	Progress at April 2025

Review all Assertive and Intensive Community treatment pathway discharges for assurance	Associate Director of Operations	14/10/24 Short term	Records confirm 100% discharges determined by Multi-Disciplinary Team	**Complete** Internal audit completed which demonstrated compliance, linked to business as usual for ongoing oversight and assurance.
Discharge checklist designed and operationalised across community teams.	Associate Director of Operations	31/06/25* Short term	100% compliance	**In-progress** Quality work has been completed in relation to the design of the discharge checklist for Key Workers to follow if discharging from services. This has been completed (was delayed due to some revisions required and to develop the audit process) and sent to all teams / staff. Next steps will be the oversight by the regular discharge audits to ensure compliance, audit commences from May.

12. Data

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

Action	Lead	Timescale and longer or shorter term plan	Measures	Progress at April 2025
Review prevalence/benchmark data	Deputy Director	10/11/24 Short term	Predictive incidence of people requiring Assertive and Intensive Community Treatment pathway confirmed to contrast with local data	**Complete**
Caseload management tool e.g. Management and Supervision Tool	Deputy Director	31/07/25* Longer term	Agreement to implement appropriate caseload monitoring tool	**In-progress** This has been delayed. It was included in resource requirements costing to NHSE in November and a bid for capital funding has been submitted to NHSE in March 2025, which has been supported in principle and working

Action	Lead	Timescale and longer or shorter term plan	Measures	Progress at April 2025
				through finalising, with implementation expected Summer 2025.

13. Policy variation and control

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

Action	Lead	Timescale and longer or shorter term plan	Measures	Progress at April 2025
Review Discharge and Transfer, and Did Not Attend (DNA) policies to exclude DNA as a reason for discharge for this patient group	Deputy Director	30/09/24 Short term	Policies reviewed and confirmation provided to Integrated Care Board and NHS England	**Complete** Oversight continues via SafeNow processes and within Assertive Oversight group. Reporting to commence going into Business-as-usual quality oversight group monthly for ongoing oversight and assurance.
Review and implement strategies that support access, awareness, and adherence to policies	Deputy Director	31/05/25* Short term	Effective systems to support staff awareness and support. Monitoring at supervision	**In-progress** Delays due to review of governance within NHT which has recently been finalised. Work is underway to consider adherence at core forums such as Quality Oversight Group / Learning from Incidents. Work underway to embed new process of Policy of the Month, updated Induction Pack that will include Must Read Policies and wider changes to agendas at team to Care Unit meetings which will include polices and updates as a standing agenda item.

14. Governance

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

Action	Lead	Timescale and longer or shorter term plan	Measures	Progress at April 2025
Review Clinical Quality and Governance framework, template, and support with Clinical Leads	Associate Director of Operations	31/05/25* Longer term	Consistent model of Quality Governance across all Local Mental Health Teams	**In-progress** This has been delayed due to requiring the completion of Trust wide review of Quality Governance as part of the Trust's Integrated Improvement Plan. This includes quality governance from team to board alongside updated Quality Oversight Groups which will include a quality schedule for Assertive Engagement and operationalised in May.

*Actions within the action plan that have been delayed and have revised dates for completion are marked with a *.*

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**Service Delivery Performance Report**
Paper Reference:	ICB 21 013
Report Author:	Sarah Bray, Associate Director of Performance and Assurance Rob Taylor, Deputy Director of Performance and Assurance
Executive Lead:	Maria Principe, Acting Director of Delivery and Operations
Presenter:	Maria Principe, Acting Director of Delivery and Operations

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

Summary:

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

Urgent care performance remains a significant challenge, particularly with four- and 12-hour performance metrics. Despite improvements in ambulance handover times and hospital flow, the system continues to face substantial pressure due to increased emergency department attendances and staffing shortages. Improvements have been made in March and continued into April. Key actions include extending Same Day Emergency Care (SDEC) opening hours, embedding the Clinical Decision Unit, and investing in additional flow coordinator hours to enhance performance. 'Bridges to delivery' will be discussed at the Performance Oversight Group throughout May.

Whilst there have been improvements in outpatient productivity and transformation, long waiting times for elective procedures and some diagnostics tests persist. The 65-week wait target has not been met, and cancer backlog volumes remain high. Efforts are ongoing to reduce waiting times. Improvement trajectories by specialty, test modality and tumour site will be presented by the trusts to the Performance Oversight Group throughout May and weekly monitoring is in place.

Mental health services have demonstrated positive performance, with improvements across various service areas. Notable achievements include recognition for dementia diagnosis and maintaining low levels of out-of-area placements. An executive level meeting has been scheduled to take place between the ICB and Nottinghamshire Healthcare NHS Foundation Trust to discuss the service delivery approach and reporting of the volume of out of area placements.

Primary care performance has improved compared to the previous year, particularly in dental provision. The proportion of GP appointments offered within two weeks is increasing; however, it remains below planned levels. A targeted group has been established to address issues within larger GP practices and improve overall performance. GP appointment volumes continue to be above plan.

Summary:
Community care faces challenges with increasing waiting times for services, particularly in speech and language therapy. The volume of patients waiting over 52 weeks has increased, and additional capacity is needed to meet current demand levels for speech and language therapy. Progress against the 2025/26 Operational Plan will be provided to the Board from July onwards, due to the time lag in published performance data.

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

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

Appendices:
None.

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

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

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No

Key Performance Metric Summary

The table below displays the key performance indicators for Urgent Care, Planned Care, Mental Health, Primary Care and Community Services. The table includes the latest monthly position against the plan as well as the plan for March 2025. The plan for March 2025 is included to enable current performance to be viewed alongside the year end ambition. ICB Ranking enables comparable performance to be shown across the 42 ICBs (1/42 = top performing). Ambulance ranking is based on the five systems who utilise EMAS services.

Programme Area	Key Metric	Metric Basis	Latest data Period	Plan	Actual	Variance	Plan Mar-25	SPC Variation	ICB Ranking	IPR Page No.
Urgent Care	Total A&E Attendances	Provider	Mar-25	35574	33995	-1579	35574	Common Cause		45
Urgent Care	A&E 4hr % Performance (All types)	Provider	Mar-25	78%	63.9%	-14.1%	78%	Common Cause	38/42	47
Urgent Care	12 hour waits as % of overall attendances	Provider	Mar-25	2%	9.9	7.9%	2%	Common Cause		47
Urgent Care	% Ambulance Handovers > 30 minutes	Population	Mar-25	31.2%	26.1%	-5.1%	31.2%	Common Cause		46
Urgent Care	% Ambulance Handovers > 60 minutes	Population	Mar-25	15.4%	5.5%	-9.9%	15.4%	Common Cause	2/5	46
Urgent Care	Ambulance Total Hours Lost	Provider	Mar-25	1265	1915	650	1265	Common Cause	2/5	46
Urgent Care	Ambulance Cat 2 Mean Response Time	Population	Mar-25	00:22:38	00:31:18	00:08:40	00:22:38	Common Cause	1/5	49
Urgent Care	No. Patients utilising Virtual Ward	Provider	Mar-25	236	198	-38	236	SC Improving High	33/42	48
Urgent Care	Length of Stay > 21 days	Provider	Mar-25	430	378	-52	430	SC Improving Low		
Urgent Care	No Criteria to Reside	Provider	Mar-25	347	266	-80	347	SC Improving Low	22/42	48
Planned Care	78 Week Waiters	Provider	Feb-25	0	3	3	0	SC Improving Low	14/42	
Planned Care	65 Week Waiters	Provider	Feb-25	0	90	90	0	SC Improving Low	17/42	51
Planned Care	52 Week Waiters	Provider	Feb-25	2435	2611	176	2265	SC Improving Low	14/42	51
Planned Care	62 Day Backlog	Provider	Feb-25	288	402	114	283	Common Cause	25/42	
Planned Care	Cancer 28 Day Faster Diagnosis	Provider	Feb-25	78.7%	78.6%	-0.1%	78.1%	Common Cause	30/42	54
Planned Care	Cancer - 62 Day	Provider	Feb-25	63.3%	63.5%	0.2%	70.2%	Common Cause	30/42	54
Planned Care	Cancer - 31 Day	Provider	Feb-25	95.4%	92.3%	-3.1%	96.1%	SC Improving High	26/42	54
Planned Care	Op Plan Diagnostics 6 week Performance	Provider	Feb-25	82.8%	83.3%	0.5%	84.1%	SC Improving High	20/42	55
Mental Health	Inappropriate Out of Area Placement	Population	Mar-25	0	3	3	0	SC Improving Low	23/42	58
Mental Health	NHS TT - >90 Days 1st & 2nd Treatment	Population	Feb-25	10%	13.5%	3.5%	10%	Common Cause		58
Mental Health	NHS TT - Reliable Improvement	Population	Feb-25	67%	70.4%	3.4%	10%	Common Cause		57
Mental Health	NHS Talking Therapies - Reliable Recovery	Population	Feb-25	48%	47.5%	-0.5%	10%	Common Cause		57
Mental Health	SMI Health Checks %	Population	Mar-25	60%	72%	12%	60%	SC Improving High	9/42	59
Mental Health	CYP Eating Disorders - Urgent	Population	Dec-24	95%	100%	5%	95%	Common Cause		60
Mental Health	CYP Eating Disorders - Routine	Population	Feb-25	95%	82%	-123	95%	SC Concerning Low		60
Primary Care	Primary Care - GP Appointments	Population	Feb-25	616808	630787	13979	713967	Common Cause		63
Primary Care	Primary Care - % book 2 Weeks	Population	Feb-25	90%	84.2%	-5.8%	90%	SC Improving High	38/42	63
Community	Community Waiting List (0-17 yrs)	Provider	Feb-25	4063	4702	639	4695	Common Cause		
Community	Community Waiting List (18+ yrs)	Provider	Feb-25	9299	9232	-67	5888	SC Improving Low		

Programme Area	Key Metric	Metric Basis	Latest data Period	Plan	Actual	Variance	Plan Mar-25	SPC Variation	ICB Ranking	IPR Page No.
Community	Community Waiting over 52 wks. (0-17 yrs)	Provider	Feb-25	118	7	-111	118	Common Cause	10/42	64
Community	Community Waiting over 52 wks. (18+ yrs)	Provider	Feb-25	65	4	-61	65	SC Improving Low	11/42	64

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

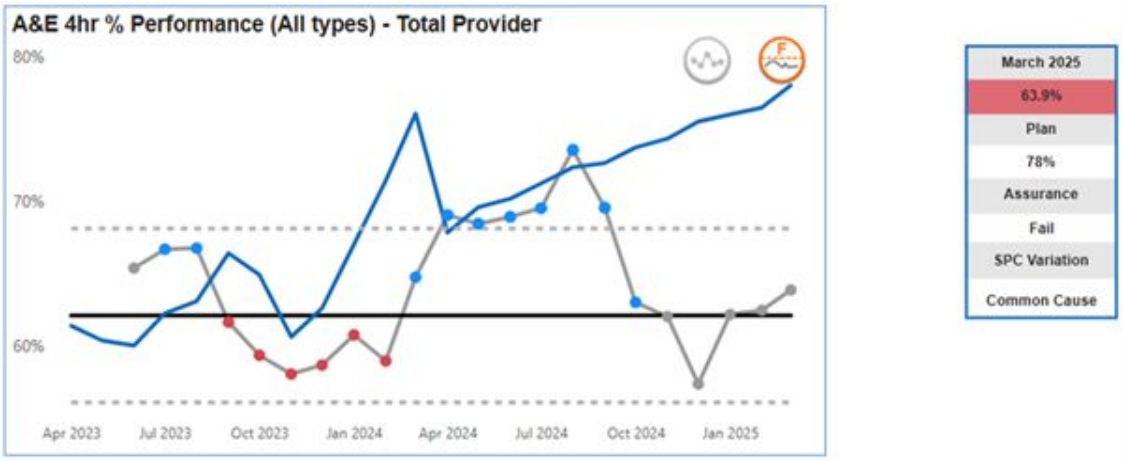
Service Delivery Performance Report

Urgent care

1. **Ambulance handovers:** The 45-minute ambulance handover policy introduced at Nottingham University Hospitals NHS Trust (NUH) in December 2024 continues to deliver measurable operational improvements. Notably, this has enhanced Category Two ambulance response performance across Nottinghamshire and significantly reduced lost hours at the Queen's Medical Centre. In March 2025, the number of ambulance handovers exceeding 60 minutes was very similar to the volume in February, which highlights that despite further improvements being required, the positive progress has been sustained.
2. **Discharge:** The system has consistently met its 'No Criteria to Reside' reduction targets each month since May 2024. In March, the number of patients in this cohort fell from 284 in February to 266, remaining well below both the planned volume and the March 2024 figure of 368.
3. Discharge throughput remains robust. NUH averaged over 352 daily discharges across all care pathways in March, whilst Sherwood Forest Hospitals NHS Foundation Trust (SFH) maintained an average of over 145 daily discharges. Note that pathway one discharges are where the patient can return home with support from health and social care. Pathway zero discharges require no input from health or social care.
4. **Four hour waits:** Emergency Department attendances for Nottingham and Nottinghamshire patients increased by 5.6% in March 2025 in comparison to March 2024. With both NUH and SFH seeing an equivalent increase for the same period. Providers continue to experience spikes in activity at certain points of the day, which is placing additional pressure on the services and leading to challenges in delivery of standards.
5. Four and twelve-hour Emergency Department performance continues to be a significant challenge. Deterioration in the Type Three performance at NUH and SFH has been seen predominantly due to increases in attendance volumes that exceed planned levels. Note that Type Three attendances refer to visits to the Urgent Treatment Centre at Queens Medical Centre, London Road through CityCare, Newark Urgent Treatment Centre and the PC24 service at Kingsmill Hospital. Type Three Newark weekly attendance volumes remain above planning assumptions and staffing is insufficient to achieve 99% for the four-hour standard. Actions are in place to improve performance and NEMS is investing in more flow co-ordinator hours. Rota fill is also improving following improved pay rates for GPs and Advanced Clinical Practitioners. PC24 has seen benefit from additional GP hours each day. There is clear causal link

between performance and additional GP hours. Weekly executive review continues to be in place.

6. In March, the system achieved 63.9% performance for four-hour waits against a plan of 78%. NUH achieved 58.2% against a plan of 78%, with SFH delivering 71.7% against a plan of 78%. As an ICB, Nottingham and Nottinghamshire were 38th of 42 nationally for four-hour performance. The chart below displays the percentage of patients that are admitted, transferred, or discharged within four hours of arrival. The chart includes all patients that attended SFH and NUH emergency departments. Actual performance during January, February and March 2025 has been around the historical mean level of 62%; however, the ambition illustrated by the plan line was to gradually improve and deliver 78% by March 2025.



7. Actions being taken and next steps:

   a) NUH has actions in place for recovery plan.

   b) Injuries perfect week.

   c) Extending Same Day Emergency Care opening hours to 1am from 21 April 2025, which will open other pathways.

   d) Preparation for single front door in May, which will include huddle at 7am for handover. NUH will include EMAS in the front door conversations.

   e) A four-hour taskforce set up with daily breach validation as well as thematic reviews.

   f) NUH identifying options for a similar sized teaching hospital for potential learning around processes to optimise four-hr performance.

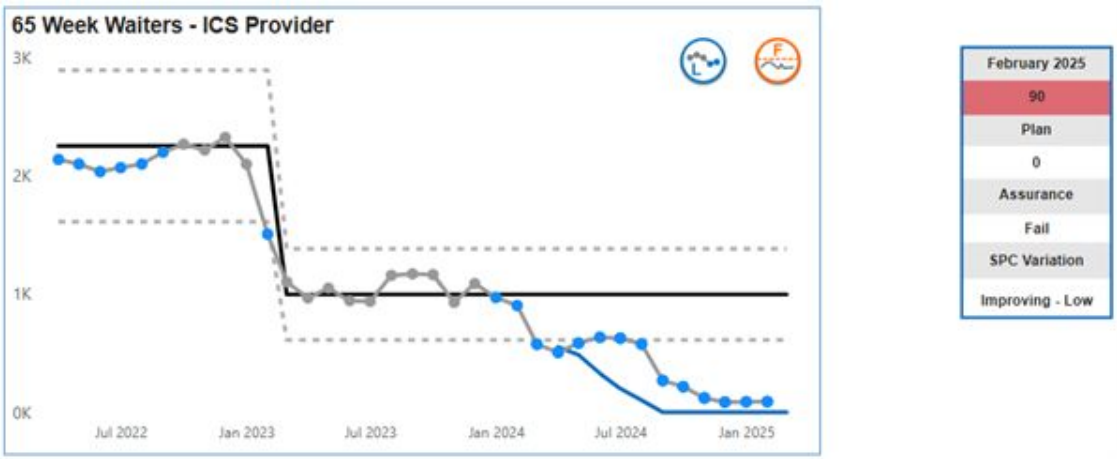
Elective

8. **78 week waits:** The system had zero 78-week waiters at the end of March, and recent data indicates that April will also have zero 78-week breaches.

9. **65 week waits:** NUH reported 61 patients (including 18 corneal transplants) and SFH reported 23 patients at the end of March. The forecast for the end of April is 48 patients at NUH of which 20 are awaiting a corneal transplant and 33 patients at SFH (No corneal transplants).

10. Neither Trust achieved the target in March; NUH 2,307 versus 1,459 plan; SFHT 500 versus 0 plan. Monthly forecasts are now being received on a weekly basis, at NUH the forecast for the end of April is 1,700 and at SFH it is 470 patients.

11. The chart below displays the combined volume of patients waiting 65 weeks or more for treatment at SFH and NUH between April 2022 to February 2025. The chart illustrates the reduction from 507 patients in April 2024 to 90 patients in February 2025. It also shows that during 2024/25, the actual position has largely been behind the ambitious plans set by the system.



12. The 65-week patient volume is not reducing as quickly as required, which is largely due to the challenges in Ear, Nose and Throat and Corneal cohorts. The trusts continue to identify areas of opportunity to support each other where possible, which have centred around Ear, Nose and Throat and Urology. There is also review of patient lists weekly to ensure the longest waiting patients are prioritised equitably across the system.

13. NHS Blood and Transplant has capped eligibility dates for long waiting corneal graft patients, NUH have sourced an alternative provider to support the position, however this will not be funded nationally. There are six additional lists planned for May to deliver extra activity, but the lack of graft material is likely to set the clearance back by at least one month.

14. There are risks to eliminating 65 week waits by the end of May at NUH in Urology. SFH is providing support to NUH where possible for patients of lower clinical complexity. There is a small cohort of patients that require specialist treatment by a renal surgeon who is ill and expected to return mid-May. The Trust expect to clear all specialties apart from Ophthalmology and Urology.
15. Ear, Nose and Throat remains a consistently challenging area locally and across the Midlands, an ENT sub-group is exploring options of a joint waiting list and the possibility to group procedures to drive efficiencies. NUH are to provide a urology recovery plan to the system Performance Oversight Group in May.

Cancer

16. The system did not achieve the plan for February, but actual performance continues to benchmark well when compared to other systems.
17. NUH is forecasting to continue to achieve the Faster Diagnosis Standard metric for March but deliver below plan for the 31-day and 62-day metrics. SFH is forecasting to achieve the Faster Diagnosis Standard of 75% but be below operational plan for 31-day and 62-day metrics.
18. Cancer is an area of concern for the system and individual organisations. A deep dive into the histopathology challenges at SFH took place in March, highlighting the main area of concern being capacity to carry out breast resection reporting due to the large volumes of samples being received, which has increased by 81% year on year.
19. Backlogs have improved at both trusts moving towards the modelled sustainable breach position for 62-day delivery. The backlog at NUH in February was 435 and has reduced to 427 as at 06/04/2025. The backlog at SFH in February was 100 and has reduced to 91 as at 06/04/2025. Reducing the backlog volume is key to sustainable delivery of the 62-day standard.
20. The chart below displays the percentage of patients that begin their cancer treatment at NUH or SFH within 62 days of referral. The chart includes data from April 2022 to February 2025. The latest position is 63.5% against a plan of 63.3%. However, this remains a complex and significant challenge for the system.

21. Cancer Patient Tracking List growth is an area of concern for both trusts, as they are reporting increased conversion rates for breast cancers.

22. SFH has had monies allocated by the East Midlands Cancer Alliance to support with seven-day working and overtime in Histology. Capital funding has been requested to support digital pathology, which will also support Histology improvements and enable joint working across the two main acute trusts. In addition, next steps are to right-size consultant capacity and expand dissection capacity. NUH had a new prostate consultant start in April who will support additional theatre capacity and are also reviewing additional insourcing capacity for urology.

Diagnostics

23. The system is delivering against the six week waits operational plan; however, NUH did not achieve the plan in February and are not forecasting to achieve March. SFH achieved their six week wait plan in February and expect to continue to exceed the plan in March.

24. SFH's position has continued to improve across all modalities. The latest unvalidated performance at 06/04/25 is 93.1% of patients seen within six weeks across all modalities. The equivalent performance for NUH is 76.5%. NUH is forecasting to be below the plan of 82% at the end of March 2025.

25. SFH has reduced the number of 13 week breaches from 1,835 in April 2024 to 10 in March 2025. The equivalent position for NUH is a reduction from 2017 patients waiting over 13 weeks in April 2024 to 246 in March 2025. Reducing the volume of paediatric patients waiting for general anaesthetic MRI remains a large challenge for the trust and they do not expect to clear the backlog until the end of May 2025 at the earliest.

26. The radiology team at NUH is developing plans to address the challenges around Paediatric GA MRI. Options to improve histology (which is underpinning low performance for the SFH cancer position) have received significant focus from the team. Capital bids for digital scanning opportunity have been submitted that will be essential to improve diagnostic and cancer performance. SFH is also exploring options to improve paediatric MRI general anaesthetic sedations through potential charitable funded Kitten scanner.

27. NHS England has ceased the funding of the three MRI accelerator vans within the system for 2025/26. System wide conversations continue around long term funding to enable the diagnostic waiting list to be further reduced and the Route to Treatment position to be appropriately supported; however, a way forward has been agreed for the first quarter to enable activity to continue.

28. Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust is working to improve Audiology staff competency levels, which following successful assessment will enable the trust to step up capacity. Validation of the waiting list backlog of children and your people patients continues, which is being undertaken by subject matter experts from neighbouring providers. Significant progress was reported on in-sourcing efforts and backlog reduction, with the number of adults waiting for hearing aid fittings decreasing from over 780 to 134. Despite ongoing issues with timely coding of adult patients, a plan is being developed to address this issue. Mutual aid and outsourcing efforts continue, with patients being sent to Rotherham and high-risk patients identified and sent for mutual aid. Recovery trajectories are under development for the waiting list and backlog volumes, which build on the input from the intensive support team. When received these will be described within a future iteration of this report. Identification and tracking of harm to patients due to extended waits continues to take place.

Mental health

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

29. **NHS Talking Therapies** did not deliver against the improvement trajectory for first to second waits in February (13.5% v 10% plan) but are forecasting to achieve the March plan of 10%; current local data as at 04/04/2025 is 5%. The service continues to achieve and exceed the six week (97.0%) and 18 week (100%) waiting time standards.

30. **CYP Eating Disorders:** The routine referrals are not achieving the 95% compliance (82% in February); however patient volumes are small and therefore have a significant impact on the overall level of compliance. The root

cause for underperformance is patient choice and the need for a consultant psychiatrist to attend a clinical emergency.

31. **Out of Area Placements:** The number of inappropriate Out of Area Placement observed bed days reported in March 2025 is three against a plan of zero. Local data for 20 April 2025 reported two patients remaining out of area. Discussions are ongoing with colleagues at Nottinghamshire Healthcare NHS Foundation Trust (NHT) to examine the definition of an out of area placement used by the trust to ensure that it aligns to the NHS England guidance and common practice of other similar NHS organisations. There is a risk that differences between the local and national definition of an out of area placement may lead to material increases in the reported volume, relating to local Independent Sector provision. An executive level meeting has been scheduled to take place between the ICB and NHT to discuss the data capture and reporting of the volume of out of area placements.

32. Independent sector beds utilisation saw an increase during January and February, with demand remaining high in March. The latest local data available is showing 76 beds in use. The Trust is reviewing the level of risk around decisions to admit patients to ensure it is appropriate and consistent.

Primary care

33. **Dental:** Performance for 2024/25 improved on 2023/24 for both adults and children's dental provision. The number of Units of Dental Activity (UDA) delivered in 2024/25 (with additional March data yet to be included) were 1,513,215 compared to 1,492,988 UDAs delivered in 2023/24.There is a two-month lag in submitting claims, so performance will be significantly above that seen last year, but this cannot be confirmed until final figures are received during May 2025.

34. **General Practice:** The volume of Total GP appointments in February 2025 was 2.21% above the planned level, with 630,797 appointments against a plan of 616,808. 84.2% of appointments were offered an appointment within two weeks in February 2025, which remains below the operational plan of 90%, however it is continuing to improve towards the national target of 85%.

35. A targeted group has been set up within the ICB to review the latest data, as well as discuss and agree granular actions to improve the 14-day appointment performance. The group are focusing on addressing issues within larger GP practices with lower 14-day performance, as improvements in these areas would have a significant impact on the overall ICB position.

Community care

37. There has been an increase in the volume of patients waiting over 52 weeks for community services, from six patients in January 2025 to 11 in February 2025. Of these, four were Adults and seven were children and young people, all at NHT. NHT has confirmed that all four of the adult breaches were Podiatry recording errors and have been amended. The Trust continues to work with teams to improve data quality.

38. The NHT Speech and Language Therapy service is routinely seeing demand that exceeds capacity. There is an average of 535 referrals per month into the service compared to capacity of 399 slots. The service has calculated that there would need to be around 10 additional therapists to meet the current demand levels. Further action is required to clear the waiting list backlog of around 900 children. Given the combined caseload of new referrals and re-referrals increases month on month, waiting times are increasing. The planning trajectory for 2025/26 indicates that despite efforts to mitigate long waits, the volume of children and young people waiting over 52 weeks will gradually increase. Community waits are also now included in the Performance Oversight Group meeting, which will ensure clarity over the waits and the progress actions which are required.

NHS Oversight Framework

39. As of February 2025, the system performs well across many metrics and is in the inter quartile range for most metrics, with some areas performing in the upper quartile. The areas of lowest performance across ICB areas relevant to the Finance and Performance Committee are:

    a) Accident and Emergency - percentage of patients managed within 4 hours

    b) Inappropriate Out of Area Placements

    c) Diagnostic Waits

    d) GP Appointments (14 days)

40. For 2025/26 the NHS Oversight Framework will be replaced by the NHS Performance and Assurance Framework, where the ICB and Providers will receive separate assessments. As this is finalised and concluded, further information and reporting on the position for the ICB will be included in future reports.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**Quality Report**
Paper Reference:	ICB 25 014
Report Author:	Nursing and Quality Business Management Unit
Executive Lead:	Rosa Waddingham, Director of Nursing
Presenter:	Rosa Waddingham, Director of Nursing

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

Summary:

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

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

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

- Nottingham CityCare Community Interest Company
- Urgent and Emergency Care
- Maternity
- Special Educational Needs and Disabilities
- Looked After Children
- Children and Young People
- Infection Prevention and Control

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

Recommendation(s):

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

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

How does this paper support	the ICB's core aims to:
Help the NHS support broader social and economic development	The mitigations and quality assurance within the report support social and economic development principles.

Appendices:
Appendix 1. Escalation Framework

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

Report Previously Received By:
Quality delivery has been reported through the Quality and People Committee.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Quality Report

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

Reflections on previous month:

1. The Care Quality Commission (CQC) undertook seven assessments of the Trust's core services during March 2025, these included Rampton High Secure Hospital, mental health services for older people wards at Blossomwood Hospital and Highbury Hospital, HMP Lowdham Grange, HMP Fosse Way, Bassetlaw, and John Eastwood Hospices. The CQC has recently published three reports.
    a) Specialist community mental health services for children and young people - following assessment of the quality statement for effective in November 2024, were given a rating of "good" for effective.
    b) Community based mental health services for older people - following assessment of the quality statement for "safe" in November 2024, were given a rating of "good" for safe.
    c) Community health services for adults - following assessment of the quality statement for "safe" in December 2024, were given a rating of "requires improvement" for safe.
2. The Integrated Oversight and Assurance Group met in March 2025 where NHT presented a refreshed Integrated Improvement Plan for 2025/26 with alignment and progress against the Section 48 and Independent Homicide Review recommendations.
3. The Safe Now process (covering adult mental health in-patient settings, community mental health and crisis services) has been expanded to provide oversight of quality, safety, and experience at Rampton High Secure services.
4. The Trust has been involved in a number of high-profile multi-agency inquests during February and March 2025 with media coverage noted.

Monthly exceptions:

5. A visit to Lings Bar Hospital was undertaken by the ICB Quality Team on 28 March 2025 in response to concerns raised through NHS England's Freedom to Speak Up processes. A summary of the visit and assurances about the key lines of enquiry was explored and has been shared with NHS England and the Trust and reflects several areas of ongoing improvement.
6. NHT completed the review of the Crisis Organisation Resolution Evaluation fidelity standards for the crisis service. The report identified key areas for development and service improvement.

New risks:

7. Following the publication of the Independent Homicide Review and announcement of the judicial public inquiry, there remains an ongoing concern relating to the potential for a reduction in provider risk appetite resulting in increased lengths of stay.

Nottingham University Hospitals NHS Trust (NUH) - NHS Oversight Framework Segment Four (NOF 4).

Reflections on previous month:

8. The ICB Quality Team continues to meet regularly with in the Urgent and Emergency Care pathway team alongside visits to the Emergency Department to gain assurance around improvements.
9. Patient flow improvement efforts continue in the Urgent and Emergency Care pathway. March has generally seen sustained improvement in ambulance handover times.
10. Patient care in Temporary Escalation Spaces metrics indicate an average of 69 patients per day experiencing care in non-conventional spaces in the Emergency Department, and an average of 19 patients per day across NUH wards (data up to 27 March 2025).
11. The NUH Breast Screening programme remains subject to a contract performance notice from NHS England and is receiving additional support from NHS England and the ICB to ensure appropriate consideration is given to conducting harm reviews around delays. Funding for new equipment has been secured, which may result in a small increase in delays during installation but will ultimately increase capacity.

Monthly exceptions:

12. March’s Improvement and Oversight Group continued to report a financially challenged position, but the Month 11 position was slightly better than planned, bringing the year-to-date position back on track. A comprehensive Well-led Stocktake was presented outlining the original Recovery Support Programme with progress against these criteria and next steps.

New risks:

13. Additional risks in relation to maternity inquests and prosecutions as detailed in the maternity section.

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

Reflections on previous month:

14. Demand throughout the urgent and emergency care pathways remains high with full capacity protocol enacted when required. Internal actions to address this are on track.
15. Work continues to address issues highlighted by sepsis audits. Some improvements are seen in the recording of overdue observations and live information is being introduced in the emergency department.
16. Development of a forward planner is underway showing quality visits over the next two quarters to support joint working and review with SFH.

Monthly exceptions:

17. A resultant action plan from the Patient Safety Incident Investigation relating to a recent high profile coronial case that concluded with a narrative verdict was reviewed at SFH's patient safety incident review group. Actions are to be strengthened and aligned with the ongoing Emergency Department improvement plans.

New risks:

18. No new risks have been identified.

Nottingham CityCare (Community Interest Company) - Enhanced Oversight

Reflections on previous month:

19. A quality insight visit was completed to CityCare's Urgent Community Response and Virtual Ward Teams in March 2025. These provided useful insights into the role of the community services within the Urgent and Emergency Care Pathways.
20. A joint quality visit to CityCare Adult Diabetes Team was also completed in March 2025, which provided insights into the trial of innovative practices within the service. There was also a commitment to evaluation of the service.
21. The ICB Quality Team met with CityCare to discuss progress with the Joint Action Plan for the Community Nursing Teams and Integrated Care Home Service. They are focussing on high impact actions, but clinical teams face challenges with implementation due to high workload. Reduced capacity in the management team makes timely update of the Joint Action Plan challenging.

Monthly exceptions:

22. The NNICS System Quality Group has asked for further assurance from CityCare following a presentation regarding their Enhanced Quality

Surveillance status to be able to move forward and transition to Routine Oversight.

New risks:

23. CityCare's Paediatric Bladder and Bowel Service is challenged by a high level of demand, compounded by the small workforce has been further impacted by sickness.

Urgent and Emergency Care - Enhanced Oversight

Reflections on previous month:

24. Operational pressures within Urgent and Emergency Care have remained persistent with patients regularly receiving care in spaces such as corridors or cared for in any available spaces on wards, particularly at NUH.
25. Following the implementation of the 45-minute handover protocol at Queen's Medical Centre there has been a significant reduction in pre-handover lost hours, which are showing a special cause improvement across the ICS. However, whilst this has released ambulances back into the community it has not reduced queues to get into the Emergency Department.
26. After Action Reviews continue to be undertaken for people experiencing long delays in the Urgent and Emergency Care pathway, including eight-hour ambulance handover delays and 48- and 72-hour Emergency Department journeys.
27. Urgent and Emergency Care Quality Bellwether Metrics were finalised at the System Quality Group in March and will also go to the Urgent and Emergency Care Board and form part of routine reporting moving forwards.

Monthly exceptions:

28. There are no exceptions to report.

New risks:

29. No new risks have been identified.

Maternity - Enhanced Oversight

Reflections on previous month:

30. The Maternity Incentive Scheme year seven was published on 2 April 2025.
31. The stillbirth rate in Nottingham and Nottinghamshire in February 2025 is the highest it has been in the last two years. Four were reported at each provider. SFH has noticed a gradual increase in the past six months and is therefore undertaking a deep dive into stillbirths that have occurred in the last 12 months. This will be presented through the Local Maternity and Neonatal Service

Perinatal Quality Surveillance Group to facilitate systemwide discussions and shared learning.

32. A three-month extension of the Petals Bereavement Counselling Service was agreed at Local Maternity and Neonatal Service Perinatal Scrutiny and Oversight Board to allow time to explore sustainable funding sources for continuation of the service.

33. The CQC report from a visit undertaken at NUH in June 2024 was published at the end March 2025. Following the inspection of maternity services at Nottingham City Hospital, the CQC identified four breaches of regulation in safe care and treatment. Immediate response and an action plan were put in place at the time.

Monthly exceptions:

34. There are no exceptions to report.

New risks:

35. No new risks have been identified.

Special Educational Needs and Disabilities (SEND) - Enhanced Oversight

Reflections on previous month:

36. Nottingham City Council has appointed a permanent Director of Children's Services, a pivotal role in embedding cultural change and strengthening governance to drive the improvement agenda.

37. The City Council has also appointed a Programme Manager (for six months) to coordinate and strengthen existing governance arrangements, act as the Local Area Nominated Officer for inspection readiness and to support the partnership in responding to requirements.

38. The Nottinghamshire SEND Local Area Partnership participated in a deep dive review by regional SEND advisors (Department of Education and NHS England) to assess the impact of improvement efforts in speech and language therapy, the neurodevelopmental pathway, and Education, Health and Care plan timeliness and quality. Feedback will inform future arrangements.

39. The children and Young People Strategic Commissioning Group has received recommendations to own accountability for driving improvements, in supporting children and young people with medical conditions in education and transport settings.

Monthly exceptions:

40. The Nottinghamshire Local Area SEND Partnership has received indications that Ofsted and the CQC are likely to conduct the planned monitoring visit in

the summer term, in line with the SEND Inspection Framework. In response, partners are accelerating preparation to ensure readiness.

41. Limited oversight of the current position of the Nottinghamshire SEND Priority Area Action Plan has been identified, creating a potential risk to effective progress monitoring.

New risks:

42. Delays in the recruitment of an Associate Designated Clinical Officer for SEND poses a risk to capacity.

Looked After Children (LAC) - Enhanced Oversight

Reflections on previous month:

43. The ICB's Designated Nurse met with NUH to review the updated Initial Health Assessment Transformation Plan.
44. NUH has now recruited a Named Doctor for children in care.
45. NUH expect that Initial Health Assessment recovery will be in place by October 2025. The ICB has requested that NUH demonstrates changes in service delivery.
46. Proposals have been developed collectively with partners in relation to the future model of delivery of the Children in Care Nursing Service, these are now being progressed by ICB commissioners.

Monthly exceptions:

47. There are no exceptions to report.

New risks:

48. No new risks have been identified.

Children and Young People - Enhanced Oversight

Reflections on previous month:

49. There continues to be some extremely complex young people in inappropriate settings including two significantly challenging issues for children and young people from other areas. The increased complexity and lack of available appropriate settings continues to add pressure to the capacity in the ICB for managing the escalation processes.
50. Challenges continue around professional disagreement where children and young people are assessed as detainable under the Mental Health Act but assessed as not requiring an inpatient bed by the Provider Collaborative Enhanced Care Referral Team. A proposal has been taken to the Mental

Health and Learning Disability Funding Panel to align funding decisions for children and young people and adults.

51. Locally, all mitigations that can be in place with current service offers are in place but do not minimise the risks for children and young people where an appropriate setting cannot be found or where a setting is found, but funding is not agreed in a timely way.
52. The confidential incident management process for Sickle Cell Carrier Notification in two Places in the ICB continues to be led by NHS England. The timeframe of the issue is understood, and 316 individuals have been identified as possibly not having received notification of carrier status.
53. Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust Paediatric Audiology Services that provide audiology services for Bassetlaw children and young people continue to be progressing slowly and remains under NHS England incident management processes.

Monthly exceptions:

54. There are no exceptions to report.

New risks:

55. There continues to be risks to ongoing ICB work due to the demand on limited capacity for escalation around children and young people in inappropriate settings.

Infection Prevention Control – Enhanced Oversight

Reflections on previous month:

56. Cases of *Clostridioides difficile* infection (*C difficile*) remain over plan with the majority of cases continuing to be Hospital Onset Hospital Acquired.
57. Improvements continue against thresholds for Escherichia coli Gram negative on bloodstream infections month plans, achieving year-end plan remains challenging. A system Urinary Tract Infection Strategy and task and finish group in place.
58. Respiratory virus cases are reducing across acute and community settings, in line with regional and national reporting.
59. Norovirus cases, whilst on a downward trend, continue in small numbers across acute and community setting causing outbreaks.
60. The investigation of the outbreak of Extended-spectrum beta-lactamase Klebsiella *pneumoniae* on the Neonatal unit at Queens Medical Centre has been closed after no further cases were identified from routine screening. An Infection Prevention Control assurance visit has been made to the new Neonatal Unit.

Monthly exceptions:

61. During March two separate care home outbreaks of invasive Streptococcus pneumoniae were reported to the UK Health Security Agency.

62. One care home outbreak of invasive group A Streptococcal infection was reported in March to the UK Health Security Agency.

New risks:

63. New revised NHS England Healthcare-Associated Infections thresholds that apply from April 2025 were anticipated in March, but these are now delayed.

Appendix 1. Escalation Framework

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

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

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**Finance Report**
Paper Reference:	ICB 25 015
Report Author:	Clare Hopewell, Assistant Director of System Finance Ian Livsey, Deputy Director of Finance
Report Sponsor:	Bill Shields, Director of Finance
Presenter:	Bill Shields, Director of Finance

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

Summary:

System: The system has delivered on its break-even position and has reported a relatively small surplus of £0.1 million, noting that this a draft reported position that will be finalised following external audit scrutiny of the accounts of the ICB and the system's providers.

A re-balancing exercise was undertaken to ensure that, as well the system achieving overall financial balance, each organisation in the system achieved at least financial break-even.

Efficiency delivery is £0.2 million behind plan for 2024/25 with £256.9 million delivered against a total target of £257 million.

ICB: The ICB has delivered on its key financial duties and measures, (noting that this position is still subject to external audit scrutiny).

Delivery is set against the backdrop of the following pressures, as previously reported to Board:

- Consultants pay award pressures.
- Shortfall on income assumptions.
- Mental Health sub-contracted bed costs.
- Pressures in continuing healthcare costs (fast-track reviews) and GP prescribing, urgent and emergency care demand.
- Inflation and pay awards.

Recommendation(s):

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

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

How does this paper support	the ICB's core aims to:
Help the NHS support broader social and economic development	Provides assurance on the effective use of financial resources and delivery of the financial plan, which is aligned to broader social and economic development

Appendices:
Appendix 1: Statement of Comprehensive Net Expenditure Appendix 2: Statement of Financial Position Appendix 3: Statement of Cash Flow

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

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

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Nottingham and Nottinghamshire NHS System:

	Outturn Position £'millions		
Indicator Measure	**Plan/ Ceiling/ Envelope**	**Actuals**	**Variance**
Financial Sustainability (Variance to breakeven)	0.0	0.1	**0.1**
Total Pay Spend	-2,048.1	-2,076.7	**-28.6**
Substantive Spend vs Plan	-1,912.8	-1,920.9	**-8.1**
Bank Spend vs Plan	-82.9	-111.7	**-28.8**
Agency Spend vs Plan	-52.4	-44.0	**8.4**
Agency Spend Vs Ceiling	-63.5	-44.0	**19.4**
WTE (Provider) - 24/25 plan as at 31.03.25	33,369	34,820	**-1,451**
Financial Efficiency Vs Plan	257.0	256.9	**-0.2**
Recurrent Efficiencies	201.5	158.1	**-43.4**
Achievement of MHIS	223.3	223.5	**0.2**
Capital Spend Vs System Env (including IFRS16)	92.2	92.1	**-0.1**
Elective Recovery Fund Performance	119.6%	120.3%	**0.7%**

1. The system has delivered on its breakeven position and has reported a relatively small surplus of £0.1 million, noting that this a draft reported position that will be finalised following external audit scrutiny of the accounts of the ICB and the system's providers.
2. The system received a non-recurrent allocation at month six for the £100 million deficit plan that came with a revised target to breakeven (where previously the target was to deliver a £100 million deficit).
3. The main adverse drivers were consultant pay award pressure, shortfall on income assumptions, sub-contracted bed costs within Mental Health services due to spot purchase acute and psychiatric intensive care unit beds and a shortfall of industrial action income against the industrial action impact.
4. In addition, the ICB has seen pressures in continuing healthcare costs due to fast-track reviews and a continuation of GP prescribing pressures and providers have seen other pressures in inflation and pay awards, urgent and emergency care demand.

5. The breakeven position has been supported by a number of non-recurrent financial recovery actions over and above the delivery on efficiency plans and other planned spend favourable movements e.g. agency, other programme.

By Organisation £'millions (after non-recurrent support)	Plan	Actuals	Variance	In-month Plan	In- month Actuals	In month Variance
Nottingham University Hospitals NHS Trust	0.0	0.1	0.1	0.0	0.0	0.0
Sherwood Forest Hospitals NHS Foundation Trust	0.0	0.0	0.0	2.6	9.7	7.1
Nottinghamshire Healthcare NHS Foundation Trust	0.0	0.0	0.0	0.0	7.0	7.0
NN Integrated Care Board	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	**0.0**	**0.1**	**0.1**	**2.6**	**16.7**	**14.2**

6. **Workforce**: Staff costs are £28.6 million overspent across the system at month twelve with whole time equivalents being 1,451 higher than plan. Agency spend is £44 million, which is £8.4 million under the plan and £19.4 million under the agency ceiling. Bank staff spend is over plan by £28.8 million and substantive staff over plan by £8.1 million.

7. **Efficiencies**: Efficiency delivery is £0.2 million behind the total plan with £256.9 million being delivered against the £257 million plan. Recurrent efficiency delivery is £43.4 million adverse to plan and non-recurrent efficiency delivery £43.2 million favourable to plan.

8. **Investigation and Intervention Process:** The Nottingham and Nottinghamshire ICS was one of nine NHS systems that were required to commission a delivery partner to support delivery of the 2024/25 financial plan. The ICB engaged P.A Consulting to undertake the work. The first phase of the process involved stress-testing plans to identify and quantify the key risks to delivery. Working with NHS system partners and following that investigation phase, further opportunities and high impact interventions were identified to accelerate and support delivery of the financial plan.

9. **Cashflow Position**: The system is facing increasing pressures associated with the management of its cashflow position and is taking actions to mitigate those pressures.

10. **Governance and Oversight**: The NHS system has enhanced its efficiency governance and oversight arrangements. All organisations have financial

sustainability boards/groups with senior ICB attendance. This feeds into the NHS System Financial Recovery Group, which scrutinises and oversees the efficiency and finance position weekly.

11. **Capital Envelope:** The system submitted a capital envelope plan of £80.3 million, which included a deduction of £8.2 million from the initial capital envelope allocation of £88.5 million. The reduction in capital available being one of the implications of the system having a deficit financial plan.
12. The system has been allocated an additional £11.2 million to support the impact of the accounting standard IFRS16 with external bodies. In addition, at month ten, the system received an additional allocation of £0.7 million (over and above original plan) to support the Critical Infrastructure Programme. With these additions, the total capital envelope for 2024/25 is £92.2 million.
13. £92.1 million of the provider capital envelope has been spent in 2024/25 showing a small under spend of £0.1million against the total envelope.
14. The system has spent £197.2 million against its net capital departmental expenditure (£92.1 million against the system envelope and £105.1 million against nationally funded schemes and technical adjustments).
15. The system is monitored against the total system envelope (providers - £92.2 million and ICB - £2.1 million) of £94.3 million.
16. The ICB element of the system capital allocation of £2.1 million is reported in the ICB’s capital section item 22 below.

ICB:

17. The report outlines the provisional financial performance against the key financial targets and indicators for the financial year 2024/25.

18. It should be noted that the actual performance outlined in this report is still subject to external audit scrutiny.

Month 12 financial performance

19. The table below sets out the key financial duties and measures. A comparison to the prior financial year is included.

	2024/25	**£000/%**		**2023/24**	**£000/%**
Duty	**Target**	**Actual**	**Achieved**	**Actual**	**Achieved**
Income and Expenditure					
Expenditure does not exceed income	breakeven	13 surplus	Y	6,795 deficit	N
Cash Balance					
Remain below allowed cash balance	3,155	13	Y	4	Y
Running Costs					
Remain within running cost allowance	22,487	20,890	Y	19,205	Y
Better Payment Practice Code					
Pay NHS invoices by value within 30 days	95%	99.98%	Y	99.98%	Y
Pay NHS invoices by number within 30 days	95%	99.64%	Y	99.67%	Y
Pay non-NHS invoices by value within 30 days	95%	99.74%	Y	99.84%	Y
Pay non-NHS invoices by number within 30 days	95%	99.91%	Y	99.84%	Y
Mental Health Investment Standard					
Deliver the minimum mental health investment	223,290	223,495	Y	208,774	Y

20. Financial Statements (subject to audit) supporting the summarised position can be found in Appendices 1, 2 and 3.

21. The ICB out-turned efficiency delivery of £72.0 million against an efficiency plan of £68.5 million, therefore exceeding the target by £3.5 million.

22. The ICB spent £2.08 million of £2.13 million business as usual capital allocation leaving a small underspend of £0.05 million.

Appendix 1

NHS Nottingham and Nottinghamshire ICB - Annual Accounts 2024-25

Statement of Comprehensive Net Expenditure for the year ended 31 March 2025

	2024-25 £'000	2023-24 £'000
Income from sale of goods and services	(36,900)	(43,949)
Other operating income	(1,967)	(4,731)
Total operating income	**(38,867)**	**(48,680)**
Staff costs	40,020	35,341
Purchase of goods and services	3,245,083	2,679,391
Depreciation and impairment charges	241	222
Provision expense	(612)	(73)
Other operating expenditure	562	808
Total operating expenditure	**3,285,294**	**2,715,689**
Net Operating Expenditure	**3,246,427**	**2,667,009**
Finance income	-	-
Finance expense	11	12
Other Gains & Losses	-	89
Net expenditure for the Year	**3,246,438**	**2,667,110**
Total Net Expenditure for the Financial Year	**3,246,438**	**2,667,110**
Other Comprehensive Expenditure	**-**	**-**
Comprehensive Expenditure for the year	**3,246,438**	**2,667,110**

Appendix 2

NHS Nottingham and Nottinghamshire ICB - Annual Accounts 2024-25

Statement of Financial Position as at 31 March 2025

	2024-25	2023-24
	£'000	£'000
Non-current assets:		
Property, plant and equipment	345	123
Right-of-use assets	996	1,211
Total non-current assets	**1,341**	**1,334**
Current assets:		
Trade and other receivables	24,898	28,584
Cash and cash equivalents	9	2
Total current assets	**24,908**	**28,586**
Total assets	**26,249**	**29,920**
Current liabilities		
Trade and other payables	(104,499)	(109,021)
Lease liabilities	(384)	(305)
Provisions	(169)	(781)
Total current liabilities	**(105,051)**	**(110,107)**
Non-Current Assets plus/less Net Current Assets/Liabilities	**(78,802)**	**(80,187)**
Non-current liabilities		
Lease liabilities	(795)	(1,010)
Total non-current liabilities	**(795)**	**(1,010)**
Assets less Liabilities	**(79,597)**	**(81,197)**
Financed by Taxpayers' Equity		
General fund	(79,597)	(81,197)
Total taxpayers' equity:	**(79,597)**	**(81,197)**

Appendix 3

NHS Nottingham and Nottinghamshire ICB - Annual Accounts 2024-25

Statement of Cash Flows for the year ended 31 March 2025

	2024-25 £'000	2023-24 £'000
Cash Flows from Operating Activities		
Net expenditure for the financial year	(3,246,438)	(2,667,110)
Depreciation and amortisation	241	222
Movement due to transfer by Modified Absorption	-	89
(Increase)/decrease in trade & other receivables	3,686	(7,478)
Increase/(decrease) in trade & other payables	(4,523)	(415)
Provisions utilised	-	(158)
Increase/(decrease) in provisions	(612)	(73)
Net Cash Inflow (Outflow) from Operating Activities	**(3,247,646)**	**(2,674,923)**
Cash Flows from Investing Activities		
Interest Paid/Received	10	-
(Payments) for property, plant and equipment	(248)	(110)
Proceeds from disposal of assets held for sale: property, plant and equipment	-	(89)
Net Cash Inflow (Outflow) from Investing Activities	**(238)**	**(199)**
Net Cash Inflow (Outflow) before Financing	**(3,247,884)**	**(2,675,122)**
Cash Flows from Financing Activities		
Grant in Aid Funding Received	3,248,038	2,675,185
Repayment of lease liabilities	(146)	(63)
Net Cash Inflow (Outflow) from Financing Activities	**3,247,892**	**2,675,122**
Net Increase (Decrease) in Cash & Cash Equivalents	**8**	0
Cash & Cash Equivalents at the Beginning of the Financial Year	**2**	2
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	**10**	**2**

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**Population Health Management Report: End of Life Care**
Paper Reference:	ICB 25 016
Report Author:	Jack Rodber, Chief Analyst Sergio Pappalettera, Senior Analytical Lead Simon Castle, Deputy Director of Cancer, Diagnostics and End of Life Care
Executive Lead:	Maria Principe, Acting Director of Delivery and Operations
Presenter:	Maria Principe, Acting Director of Delivery and Operations

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

Summary:

The Nottingham and Nottinghamshire ICS End of Life Programme Board has the following priorities to improve outcomes for patients in their last year of life:

a) Increase early identification.
b) Increase ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) forms across the ICS.
c) Increase training and education through a Digital Portal.
d) Digital Care Plan – Notts Care Record.

These actions are aiming to achieve the following outcomes:

a) Reduce deaths in hospital.
b) Increase the percentage of preferred place of death.
c) Reduce emergency admissions for end-of-life patients.

We have seen recent improvements in early identification and ReSPECT planning, especially in Nottingham City and Bassetlaw, following targeted work in these areas.

Several opportunities for further transformation have been identified to support further improvements to the key metrics to avoid emergency admissions for end-of-life patients and ensure they die in their preferred place of death. Digital ReSPECT forms and additional capacity in community-based services are seen as key opportunity areas to further improve outcomes.

Recommendation(s):

The Board is asked to **receive** the paper for assurance.

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	The paper describes the priority outcomes we are seeking to improve for people at the end of their life.
Tackle inequalities in outcomes, experience, and access	The paper highlights variation in outcomes for people at the end of their life and the actions being taken to address this variation.

How does this paper support	the ICB's core aims to:
Enhance productivity and value for money	End of life care in an acute hospital setting is expensive and is not desirable from a patient perspective so does not represent the best value care for this cohort.
Help the NHS support broader social and economic development	Not applicable.

Appendices:
Appendix A: Data Sources and Figures

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 1: Timely and equitable access – Failure to ensure timely and equitable access to urgent and emergency care, elective and cancer care and mental health services. • Risk 4: Quality improvement – Failure to systematically improve the quality of healthcare services. • Risk 5: Health inequalities and outcomes – Failure to identify and/or deliver service transformation to address health inequalities and improve outcomes. • Risk 7: Digital transformation – Failure to drive forward digital transformation and utilise system intelligence solutions to address health inequalities and improve outcomes.

Report Previously Received By:
Not applicable.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Population Health Management Report: End of Life Care

Executive summary

1. This paper provides a system wide example of how we are utilising population health management (PHM) data and intelligence to inform and drive key transformational activities. This is the first of a series of deep dives into key areas to inform the Board. This report examines current performance against our shared ambitions and priorities. It is grounded in data, population health intelligence, and aligned with the system-wide direction set out in the Nottingham and Nottinghamshire NHS Joint Forward Plan 2025–2030. The aim is to support transparent, evidence-based improvement in how we care for people in their last year of life.

Intention and strategic direction

2. The Joint Forward Plan outlines a bold vision for end-of-life care built on five core ambitions:

    a) Integrated, Person-Centred Care: Seamless support that respects individual needs and preferences, delivered through collaboration across NHS trusts, hospices, and community services.

    b) Community-Based Support: Shifting the focus away from hospitals, enabling more people to be cared for and die at home or in community settings.

    c) Early Identification and Planning: Proactively identifying people nearing end of life and using tools like ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) to record and honour their wishes.

    d) Collaborative Partnerships: Initiatives such as *End of Life Care Together* demonstrate commitment to multi-agency working across health, social care, and voluntary sectors.

    e) Education and Training: Investing in staff capability to provide skilled, compassionate end-of-life care.

Implementation strategies from the Joint Forward Plan include:

3. In line with the Joint Forward Plan ambition, there are a range of key actions underway that will support the delivery of the core ambitions including:

    a) System-wide adoption of ReSPECT forms.

    b) Early identification of the 1% of people deemed to be in the last year of life.

c) Digital ReSPECT through the implementation of the Notts Care Record.

d) Implementation of an education and training portal for staff, patients, and carers.

Clinical senate

4. The ICB has a well-established End of Life Programme Board, with members from all key sectors. Whilst the ICB has many successes linked to our end-of-life strategy, including significant progress in the metrics, it is recognised that there is still a long way to go before we can definitively say that the Nottinghamshire population can expect to be well supported for all their needs at the end of their life.

5. In September 2024, a clinical senate was convened, bringing together clinical experts and professionals to review and discuss the end-of-life pathway. The senate was broken into three workshops:

   a) Early identification of end-of-life patients, particularly those with non-cancer conditions, younger individuals, men, and those in community settings.

   b) Care Homes: joint work with care homes to make it easier for patients to remain in the care home, when that is their wish, rather than being admitted to hospital.

   c) Anticipatory Medicines: how to improve the availability and use of anticipatory medicines to ensure timely and effective symptom management for end-of-life patients.

6. The Clinical Senate was developed to support the system in developing overarching recommendations across the healthcare system. These recommendations are intentionally broad, providing general guidance adaptable to diverse healthcare settings and contexts. They serve as a compass, directing healthcare providers, policymakers, and stakeholders, fostering innovation, collaboration, and locally relevant interventions.

7. Recognising the diversity within our healthcare system and communities, the recommendations acknowledge variations in patient demographics, socioeconomic conditions, and healthcare infrastructure. They encourage a flexible, locality-driven approach, allowing each programme to develop tailored strategies aligned with its specific needs and characteristics.

8. The recommendations offer a framework for localities to craft their own strategies, promoting collaboration and adaptability among healthcare providers, community organisations, local authorities, and academic institutions in improving end-of-life care.

9. The list of recommendations from the Senate held in September 2024 are available on the System Analytics and Intelligence Unit Portal. The System Analytics and Intelligence Unit Portal also provides various dashboards and reports to monitor key end-of-life metrics.

Progress highlights

10. There are some clear improvements that have been made through working collectively with system partners on the end of life agenda, informed by the data and driven by the End-of-Life Programme Board. The key highlights include:
    a) Identification: the end-of-life register increased from 0.71% (Mar 2024) to 0.76% (Apr 2025) (national average: 0.5%) as a system we have reduced the variation in terms of geography across the Nottingham and Nottinghamshire system with targeted work in the City and Bassetlaw.
    b) ReSPECT forms: Coverage rose from 70% to 76%, with focused work in Nottingham City and Bassetlaw and full implementation of ReSPECT in NUH.
    c) Hospital deaths: Declined from 52% in 2014 to 46% in 2022 and then to 44% in 2024/25. However, there are a higher percentage of deaths in hospital in areas of deprivation, specifically Nottingham City, Ashfield, and Mansfield.
11. The above demonstrates significant progress for our Nottingham and Nottinghamshire residents to ensure that we have the necessary identification in place, with expressed wishes and more people are not dying in an acute hospital setting. The End-of-Life Programme Board has reviewed the reasons for the deprivation factors and is examining ways to re-align and re-allocate capacity to address variation in outcomes.

Using intelligence to drive system change

12. The system is now using integrated, transparent population health data to focus efforts where they are most needed. Dashboards, segmentation models, and shared intelligence tools support transformation programmes to:
    a) Understand variation in outcomes.
    b) Target high-need areas (e.g., Nottingham City, Mansfield, and Ashfield).
    c) Monitor improvement transparently.
13. This data-driven approach is coordinated by a well-established system-wide End of Life Programme Board, which brings system leadership, accountability, and a shared framework for delivery.

Opportunities for further transformation

14. The following opportunities should be explored to accelerate system impact:

    a) Finalise and embed digital ReSPECT and care plans in all settings: Achieving full digital interoperability will enable faster access to critical information during emergencies, improving adherence to patient wishes and reducing inappropriate hospital admissions. Evidence from areas that have implemented digital ReSPECT tools shows improved coordination of care and reductions in avoidable interventions.

    b) Reallocate community end-of-life resources to reflect current population need: Addressing historical funding imbalances by targeting areas with the highest mortality and deprivation will help to reduce variation in outcomes. Data shows that areas with better-resourced community teams experience fewer hospital deaths and greater patient satisfaction.

    c) Expand night-time support and Hospice at Home services: Increasing capacity for out-of-hours care will reduce pressure on urgent care services and help people remain at home during deterioration. National studies highlight the effectiveness of Hospice at Home in enabling timely symptom control and increasing the proportion of home deaths.

    d) Strengthen training and development for frontline staff: A well-equipped workforce is essential to deliver person-centred, high-quality care. Prioritising education in care homes and primary care will help staff recognise end-of-life needs earlier, communicate more effectively with families, and support advance care planning. Local feedback suggests that increased confidence among staff leads to reduced hospital conveyance.

Conclusion

15. With a well-established Programme Board in place, a clear strategic framework, and transparent population health data, Nottingham and Nottinghamshire are now well positioned to continue the transformation in end-of-life care. Whilst improvement has begun, particularly in identification and planning, there is more to do to realise the full ambitions of the Joint Forward Plan. Moving forward, the system should prioritise:

    a) Improving community capacity and access, particularly Hospice at Home and out-of-hours support, to reduce reliance on hospital care.

    b) Delivering full digital integration of ReSPECT and care plans across providers, ensuring real-time, accessible information to support decision-making.

c) Focusing on equitable outcomes, especially in areas of deprivation, by reallocating resources based on population need and strengthening care home support.

Appendix A

Figure 1 – Nottingham and Nottinghamshire GP-registered population deaths in 2024, split by age band and population segment.

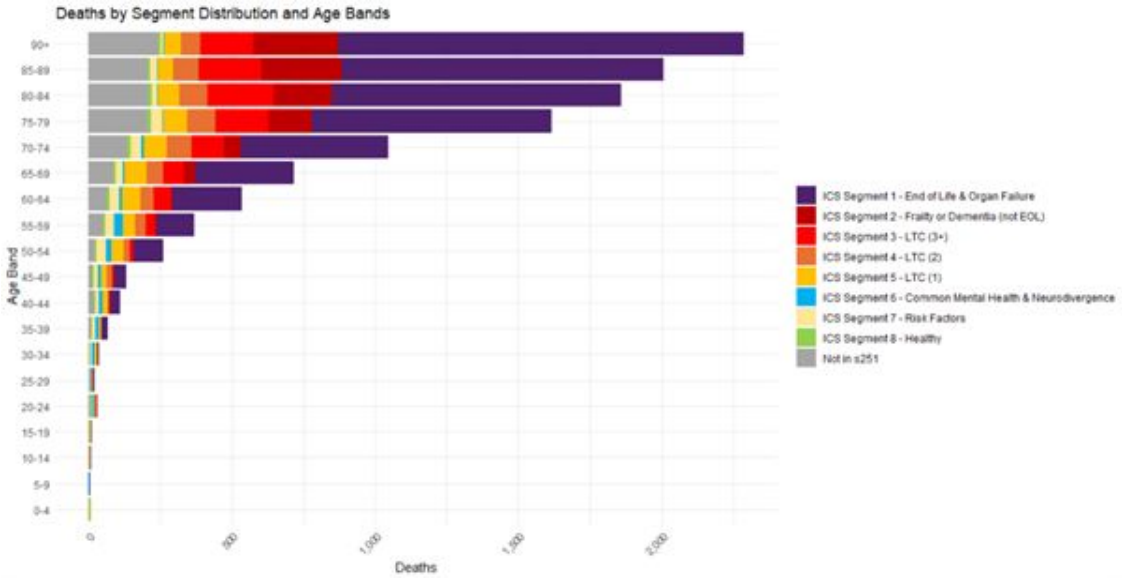


Figure 2 – Percentage of the Nottingham and Nottinghamshire GP-registered population on the End-of-Life register – by ICB and Place, March 2024 to 29 April 2025 (Source: GPRCC)

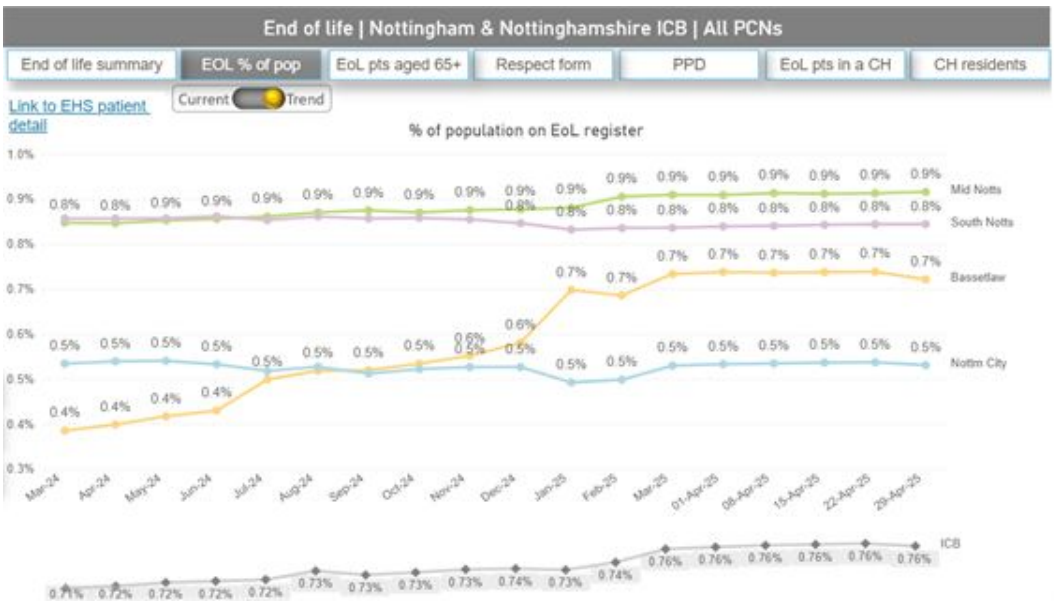


Figure 3 – Percentage of the Nottingham and Nottinghamshire GP-registered population on the End-of-Life register with a ReSPECT form – by ICB and Place, March 2024 to 29 April 2025 (Source: GPRCC)

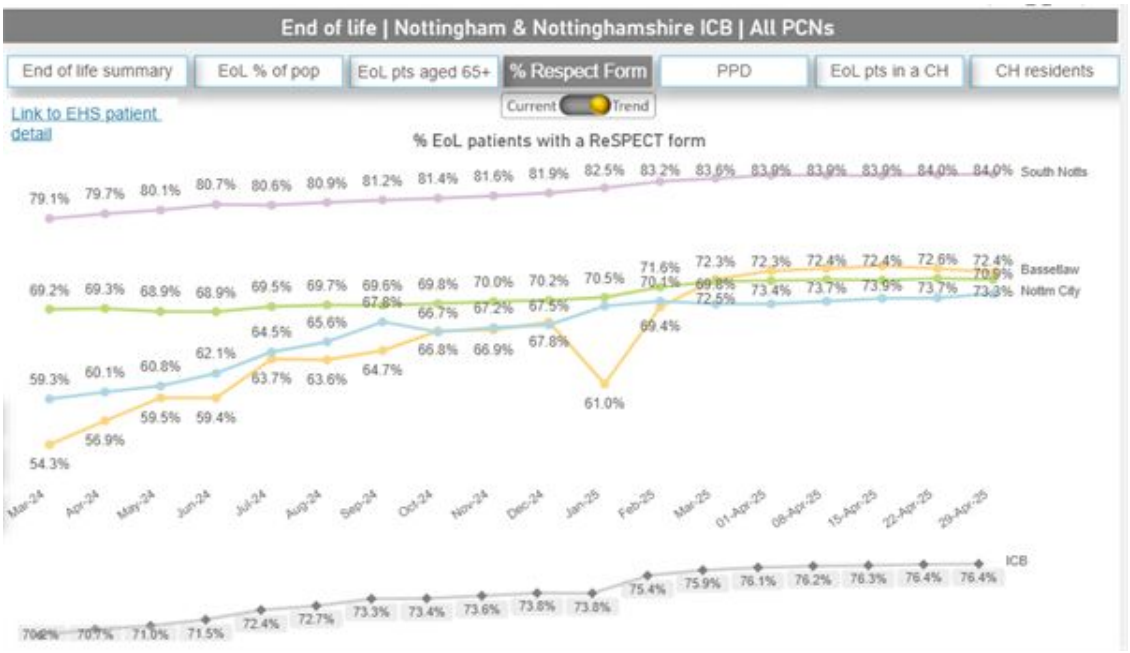


Figure 4 – Percentage of the Nottingham and Nottinghamshire GP-registered population on the end of life register with a preferred place of death recorded – by ICB and Place, March 2024 to 29 April 2025 (Source: GPRCC)

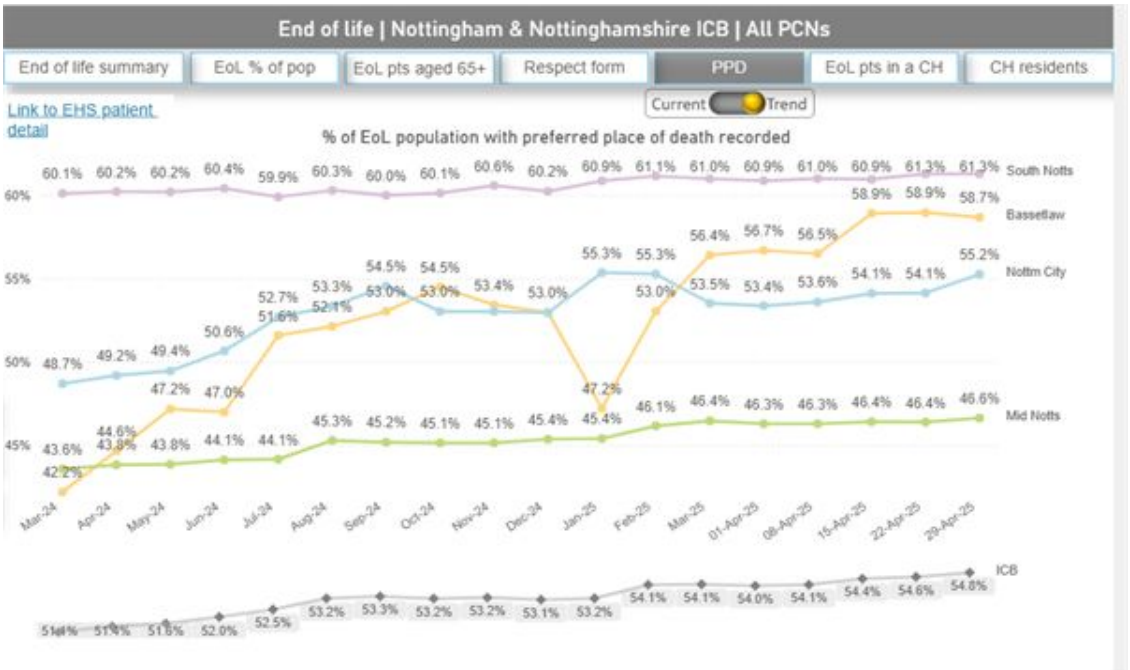


Figure 5 – Nottingham and Nottinghamshire GP-registered population deaths in hospital as a percentage of all deaths – by ICB and Place, April 2024 to March 2025 (Source: ONS)

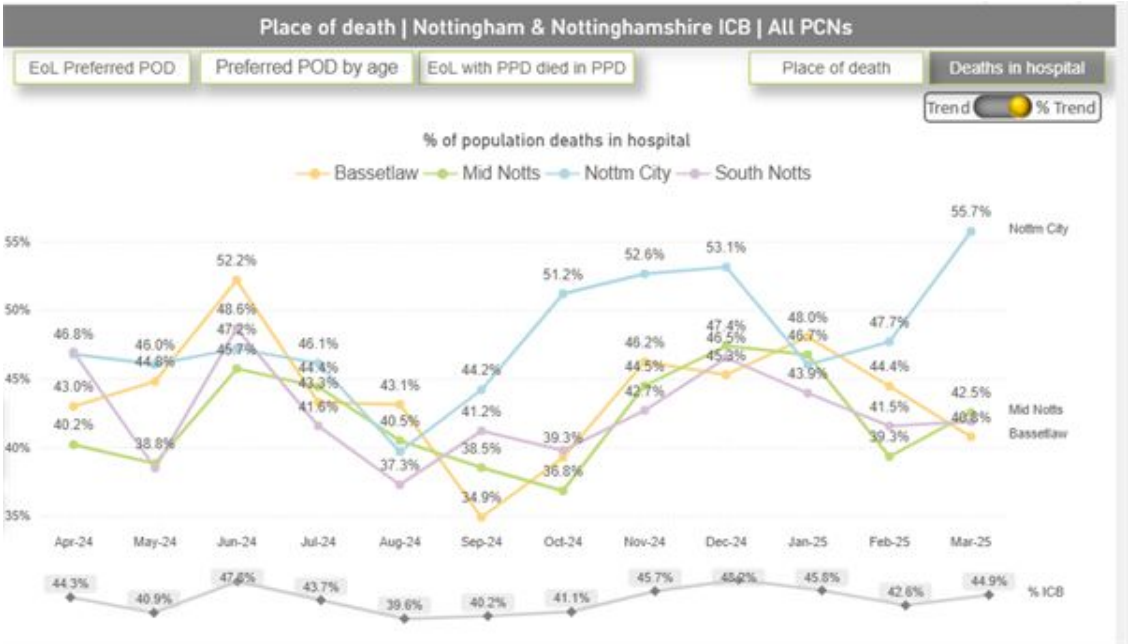
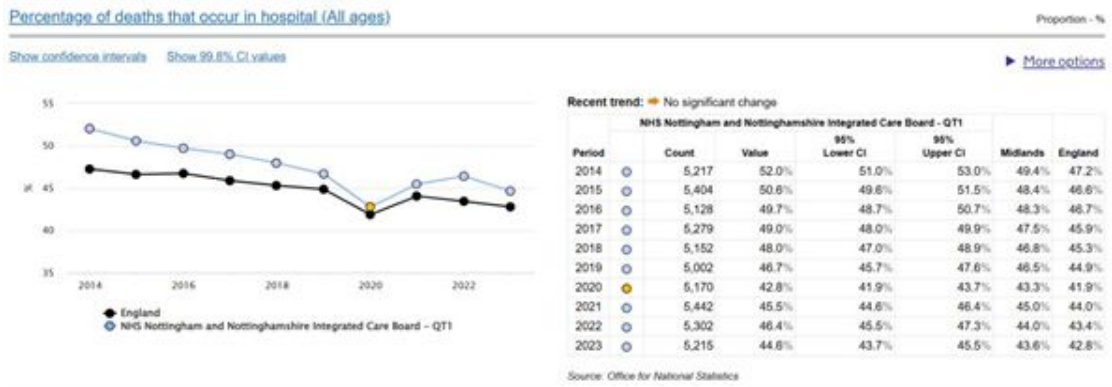


Figure 6 – Nottingham and Nottinghamshire GP-registered population deaths in hospital as a percentage of all deaths compared to England, 2013 to 2022 (Source: Fingertips)



Period		Count	Value	95% Lower CI	95% Upper CI	Midlands	England
2014		5,217	52.0%	51.0%	53.0%	49.4%	47.2%
2015		5,404	50.6%	49.6%	51.5%	48.4%	46.6%
2016		5,128	49.7%	48.7%	50.7%	48.3%	46.7%
2017		5,279	49.0%	48.0%	49.9%	47.5%	45.9%
2018		5,152	48.0%	47.0%	48.9%	46.8%	45.3%
2019		5,002	46.7%	45.7%	47.6%	46.5%	44.9%
2020		5,170	42.8%	41.9%	43.7%	43.3%	41.9%
2021		5,442	45.5%	44.6%	46.4%	45.0%	44.0%
2022		5,302	46.4%	45.5%	47.3%	44.0%	43.4%
2023		5,215	44.6%	43.7%	45.5%	43.6%	42.8%

Figure 7 – Nottingham and Nottinghamshire GP-registered population deaths by Place of Death, April 2024 to March 2025 (Source: ONS)

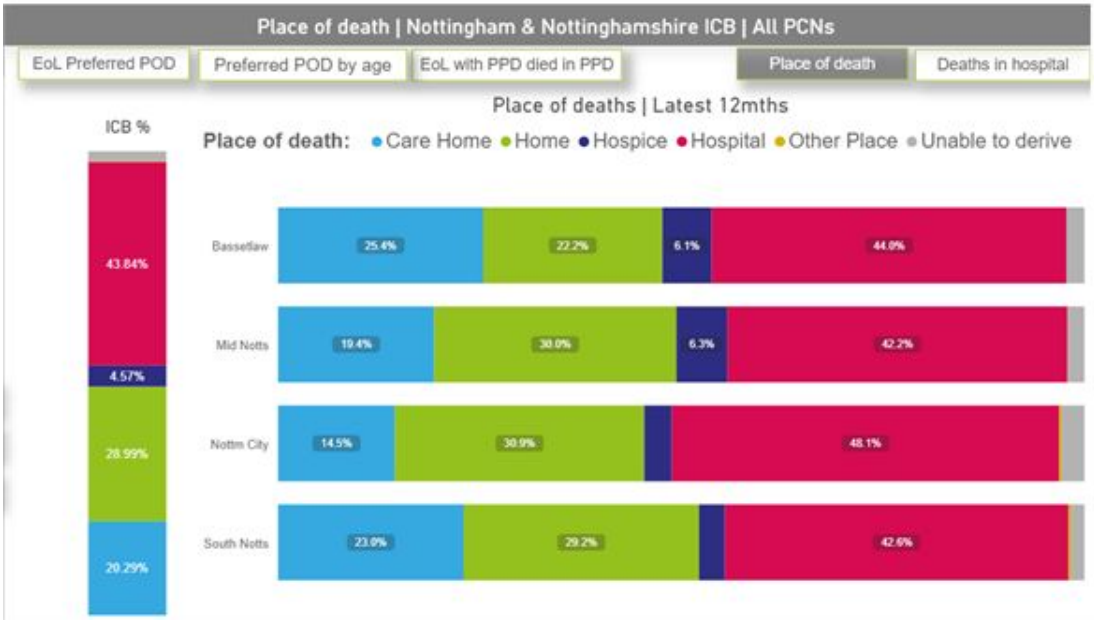


Figure 8 – Rate of emergency admissions with an overnight stay in the last 90 days of life per 1,000 Nottingham and Nottinghamshire GP-registered patients with deaths registered in the period February 2023 to January 2025 (Source: SUS, ONS)

Figure 9 – Rate of emergency admissions with an overnight stay in the last 12 months of life per 1,000 Nottingham and Nottinghamshire GP-registered patients with deaths registered in the period February 2023 to January 2025 (Source: SUS, ONS)

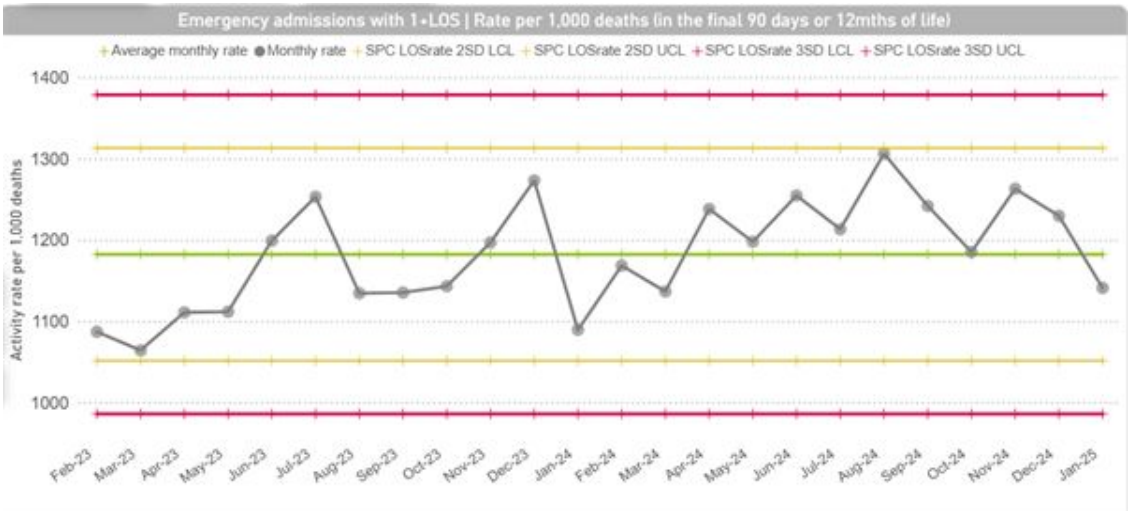


Figure 10 – Nottingham and Nottinghamshire GP-registered population deaths split by the number of emergency admissions in the last 90 days of life, for deaths registered in the period February 2023 to January 2025 (Source: SUS, ONS)

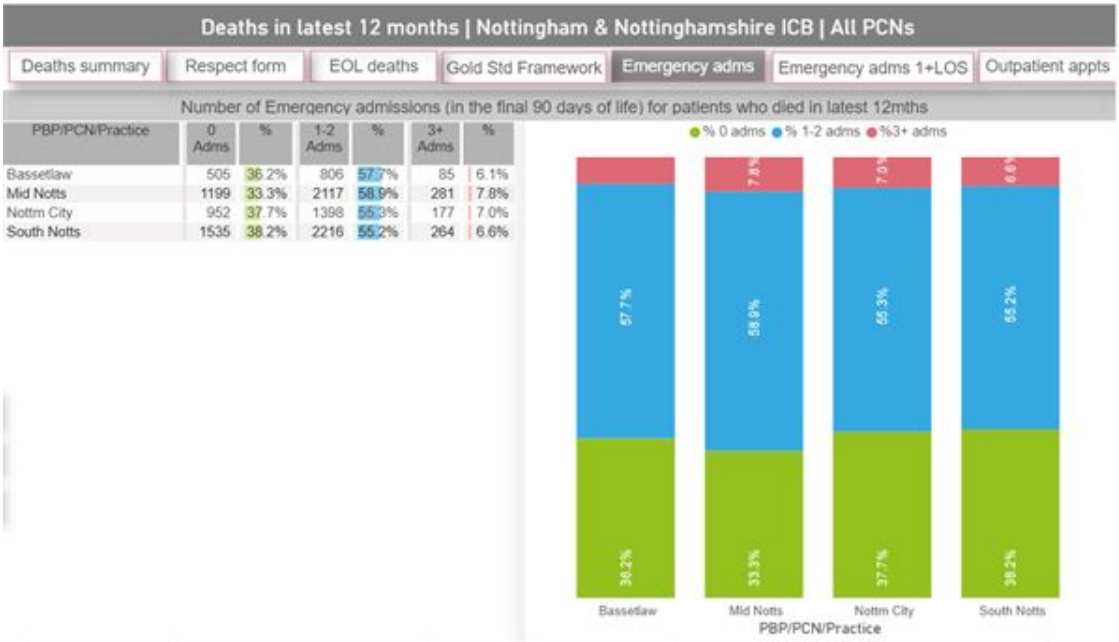
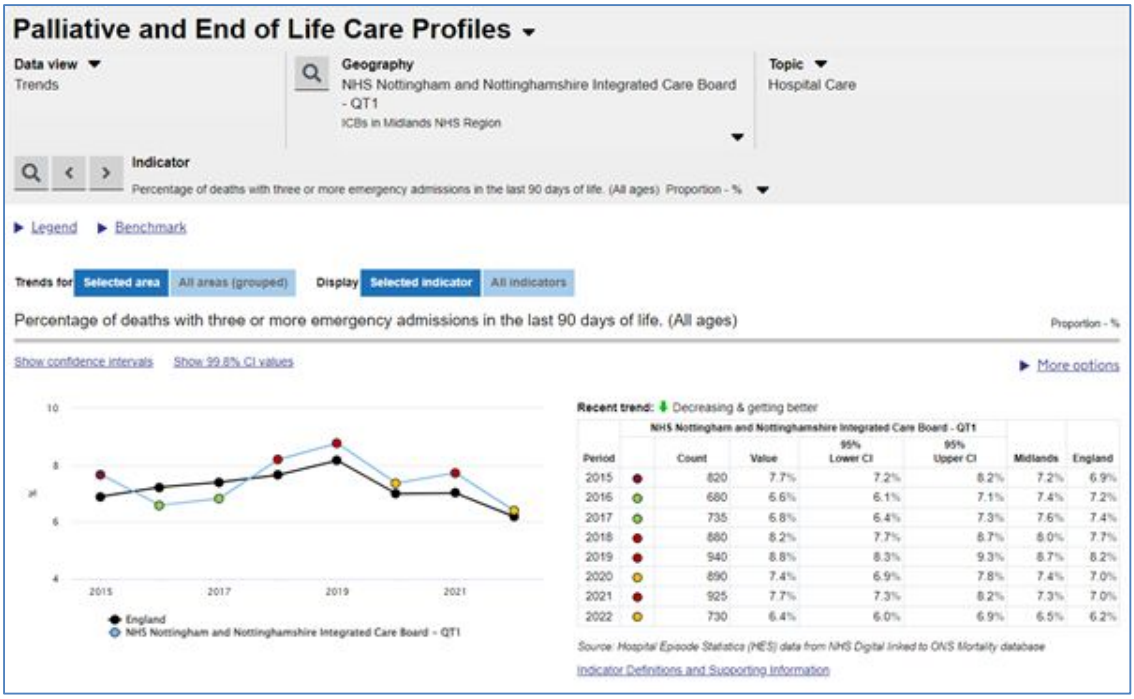


Figure 11 – Nottingham and Nottinghamshire GP-registered population deaths with three or more emergency admissions in the last 90 days of life, 2015 to 2022 (Source: Fingertips)



Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**Board Assurance Framework: Bi-annual Update**
Paper Reference:	ICB 25 017
Report Author:	Siân Gascoigne, Assistant Director of Corporate Affairs Lucy Branson, Director of Corporate Affairs
Report Sponsor:	Rosa Waddingham, Director of Nursing
Presenter:	Lucy Branson, Director of Corporate Affairs

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

Summary:

The purpose of this paper is to present the final position of NHS Nottingham and Nottinghamshire ICB's 2024/25 Board Assurance Framework for scrutiny and comment. The paper highlights several key messages for the Board from the Assurance Framework in terms of controls, assurances and identified gaps across each of the ten strategic risks. The Assurance Framework has been scrutinised in-depth by the Audit and Risk Committee via Executive-led Targeted Assurance Framework Reports, received in December 2024, February, and March 2025.

The paper also seeks Board approval for the continuation of the ICB's current strategic risks into 2025/26, proposing that a full review takes place after the publication of the NHS Ten Year Plan and in light of the new ICB operating model.

Recommendation(s):

The Board is asked to:

- **Receive** the year-end position of the 2024/25 Board Assurance Framework.
- **Approve** the continuation of the current strategic risks as the opening position for 2025/26.

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	The Board Assurance Framework is a structured way of identifying and mapping the main sources of assurance in support of the achievement of the ICB's four aims.
Tackle inequalities in outcomes, experience, and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

A: Board Assurance Framework roles and responsibilities and full business cycle

Appendices:
B: 2024/25 Board Assurance Framework

Board Assurance Framework:
This paper presents the fully populated Board Assurance Framework, which outlines the controls and assurances across all the ICB's strategic risks.

Report Previously Received By:
Board Assurance Framework updates have been presented to the May and November 2024 meetings of the Board and the December 2024 and February and March 2025 meetings of the Audit and Risk Committee.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Board Assurance Framework: Bi-annual Update

Introduction

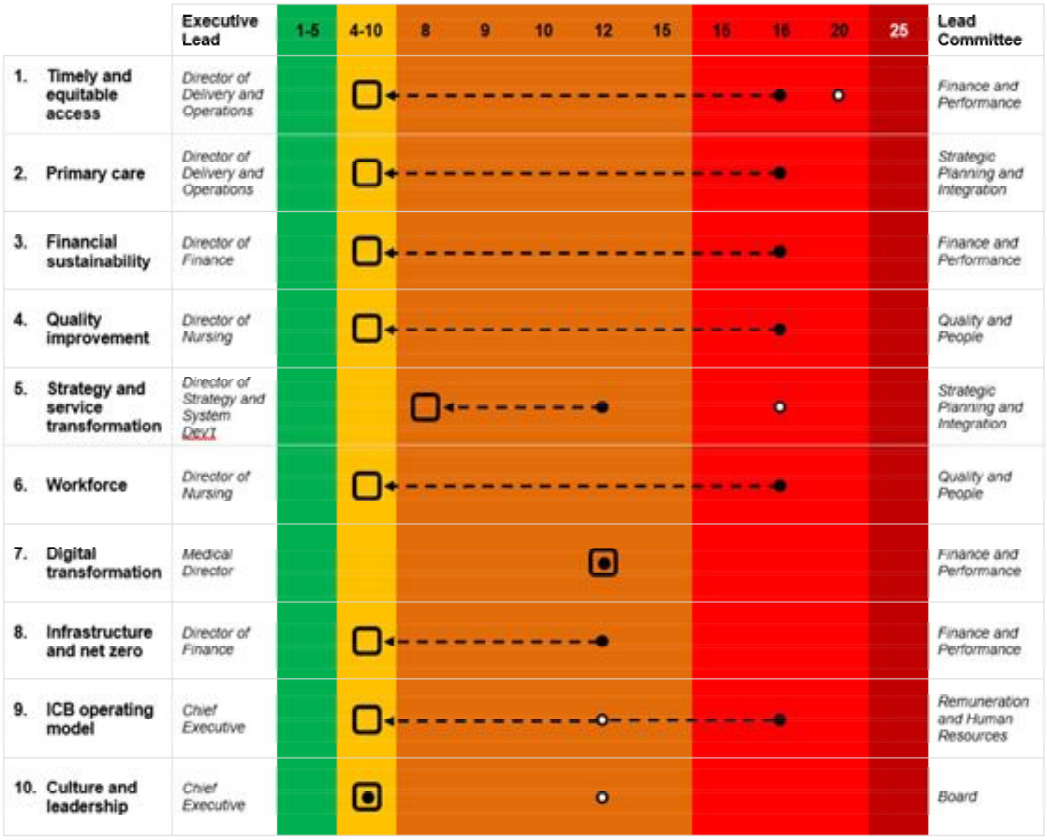
1. The ICB's strategic risk management processes are centred on the Board Assurance Framework, which is a structured way of identifying and mapping the main sources of assurance in support of the achievement of the ICB's core aims/objectives. The Assurance Framework provides the Board with confidence that what needs to be happening is happening in practice. More specifically it enables the Board to:
    a) Gain a clear and complete understanding of the control environments that have been established to manage its strategic risks.
    b) Consider the types of assurance currently obtained and whether they are effective and efficient.
    c) Identify areas where controls have yet to be fully established or where existing controls are failing (i.e. control gaps), and consequently, the risks that are more likely to occur.
    d) Identify areas where assurance activities are not present or are insufficient (i.e. assurance gaps), or where assurances may be duplicated or disproportionate.
2. The Board Assurance Framework also plays a key role in informing the production of the Chief Executive's annual Governance Statement (included within the ICB's Annual Report) and is the main tool that the Board should use in discharging its overall responsibility for ensuring that an effective system of internal control is in place. Roles and responsibilities and the full business cycle for the Board Assurance Framework is set out for information at Appendix A.
3. The purpose of this paper is to present the final position of NHS Nottingham and Nottinghamshire ICB's Board Assurance Framework for scrutiny and comment. This builds upon previous updates provided to the Board during May and November 2024.
4. The paper also seeks Board approval for the continuation of the ICB's current strategic risks into 2025/26, acknowledging that a full review will take place after the publication of the Ten-Year Health Plan and in line with arrangements for transitioning to the new ICB operating model.

NHS Nottingham and Nottinghamshire ICB's Board Assurance Framework

5. The Board Assurance Framework is structured around ten strategic risks to achieving the ICB's four core aims. The fully populated Framework is provided at Appendix B. This is introduced by an explanation of how to navigate the

document and includes a summary of how each risk aligns to the ICB's four core aims (at Annex 1 of the Board Assurance Framework document).

6. The following diagram presents a summary 'heat map' of the Board Assurance Framework, reflecting discussions with the Executive Team during April 2025. It is important to remember that the ICB's strategic risk profile is expected to be high due to the nature of the risks contained within the Board Assurance Framework (i.e. if their impact rating is not high or very high, then it is questionable whether they should be classified as strategic risks to the organisation).



Note: Black dots represent the current scores for each risk and white dots indicate where scores have changed since last reported. The squares indicate the target scores for each risk, in line with the ICB's risk appetite statement. The arrows show the distance from the current risk score to the target risk score.

Summary position of strategic risks

7. **Failure to ensure timely and equitable access to urgent and emergency care, elective and cancer care, and mental health services** – Controls and assurances in relation to this risk continue to be strengthened, which has seen the risk score reduce in-year. A key element of this has been the work to ensure that relevant forums within the system governance architecture have

clarity of purpose and are operating effectively to facilitate collective responsibility and mutual accountability. Most relevant to this risk is the strengthened delivery oversight arrangements of the System Oversight Group, System Transformation Delivery Group and Performance Oversight Group, which has resulted in improved access across a range of services. However, it is recognised that a continued focus on further improvements will be needed to deliver the requirements set out in the 2025/26 Operational Plan.

8. **Failure to reduce unwarranted variation and improve access to primary medical services and pharmacy, optometry and dental (PODs) services** – The score for this risk has remained static during the year; however, the ICB's Primary Care Strategy is now finalised and the role of Integrated Neighbourhood Teams in ensuring equitable access to primary care is progressing well. A primary care dashboard is also now in place, enabling practice-level intelligence to be accessed in support of performance oversight. Further work is required in 2025/26 to fully embed assurance arrangements between the ICB and the East Midlands Joint Commissioning Committee in relation to PODs services.

9. **Failure to achieve financial sustainability across the system** – There has been no change in the score for this risk, in recognition of the financial challenges facing the system in 2025/26, despite the achievement of delivering a balanced position for 2024/25. Financial 'grip and control' mechanisms and oversight arrangements have progressively strengthened during the year, alongside development of a Joint Medium-term Financial Plan. This has resulted in positive progress being made in meeting the requirements of the formal undertakings from NHS England in relation to financial governance and the system's financial sustainability. A continued system-wide focus in this area will be required for 2025/26.

10. **Failure to systematically improve the quality of healthcare services** – Robust controls and assurance arrangements have been established to deliver required quality improvements. These include a range of monitoring, oversight, and escalation mechanisms in line with National Quality Board (NQB) guidance, to ensure required quality standards are met. A range of service specific quality oversight forums are in place, including the Perinatal Scrutiny Oversight Board, Learning Disability and Autism Executive Partnership Board, and Special Educational Needs and Disabilities (SEND) Improvement Boards. Controls have also been strengthened in year through implementation of the Patient Safety Incident Response Framework (PSIRF). However, limited assurance regarding service quality has continued throughout 2024/25, particularly in relation to mental health and maternity services, where joint monitoring of quality concerns with NHS England is in place through Improvement Oversight and Assurance Groups (IOAGs). As such, there has been no movement in score for this risk. Focused quality oversight

arrangements will continue into 2025/26, and an ICS Quality Strategy is in development, which is due for Board approval in July.

11. **Failure to implement robust strategies and plans with system partners to transform services, address health inequalities and improve outcomes** – Controls and assurances in relation to this risk have continued to be strengthened during the year, which has included structured arrangements for the refresh of both the Integrated Care Strategy and NHS Joint Forward Plan (JFP), and the ICB's continued active membership of the Nottingham City and Nottinghamshire Health and Wellbeing Boards. During the year, the JFP Oversight Group has also been re-established, which has a key role in monitoring delivery of the JFP; this will report to the System Transformation Delivery Group twice-yearly from 2025/26 onwards. Work has also been undertaken across individual transformation programme boards to ensure that responsibilities in relation to the delivery of the JFP is clearly articulated within respective terms of reference. This has resulted in the risk score reducing in-year; however, a continued focus on health inequalities remains for 2025/26.
12. **Failure to utilise the system workforce effectively and ensure a sustainable workforce for the future** – The score for this risk has remained unchanged throughout the year; however, the ICS People and Workforce Plan has been recently approved, which sets a clear direction in relation to meeting the NHS People Promise and the ten outcome-based functions the ICB is required to deliver. This will be further developed during early 2025/26 to reflect future workforce transformation requirements. For next year, the focus will be on strengthening assurance arrangements regarding the Plan's delivery.
13. **Failure to drive forward digital transformation and utilise system intelligence solutions to address health inequalities and improve outcomes** – This risk continues to be at its target risk score, reflecting the robust control framework and assurance mechanisms in place. These have been further strengthened in year through establishment of the ICS Cyber Security Strategy and development of an ICS Data and Analytics Strategy. A review of arrangements will be required in 2025/26 in light of the anticipated focus on digital transformation in the forthcoming Ten Year Health Plan.
14. **Failure to work effectively as a system to a sustainable infrastructure to deliver high-quality and efficient care and the net zero commitment** – While the score for this risk has remained unchanged during 2024/25, there has been a focus on strengthening the control environment through development of an ICS Infrastructure Strategy, which is due for Board approval in May. The focus for 2025/26 will turn to assuring the delivery of the Strategy; this will be supported through revised system leadership arrangements, better alignment of the Joint Capital Resource Use Plan and finalisation of the ICB's Primary Care Estates Strategy. Good controls and assurances continue to be in place in

relation to the ICS Green Plan, which will be refreshed in line with national guidance during 2025/26.

15. **Failure to develop and embed a robust ICB operating and workforce model, with an open, safe and compassionate culture, to enable delivery of strategic goals and statutory duties** – For the majority of the year, the control environment for this risk has been robust and assurance arrangements have been improving; however, the recently published 2024 Staff Survey results, coupled with the national announcement regarding the move to a new operating model for ICBs and the requirement for significant reductions in management costs, have signalled the need for revised arrangements. As a result, the score for this risk has recently increased. Early consideration has been given to the governance and programme management requirements for the transition to the new operating model, which will be finalised in the coming weeks once further guidance is published.

16. **Failure to orchestrate positive system culture and leadership to drive effective partnership working** – Controls and assurances for this risk have continued to evolve and mature, which has resulted in the risk moving to its target risk score. During the year, the Board has welcomed wider partners to its seminar sessions, a new ICS Non-Executive Director Network has been established, and positive relationships have been developed with the East Midlands Combined County Authority (EMCCA) and East Midlands Inclusive Growth Commission (IGC). The ICS Partnership Agreement has also been tested at key meetings. Work is planned for 2025/26 to further improve assurance reporting relating to the ICS approach to meeting the fourth aim (NHS support to broader social and economic development).

Analysis of assurances received

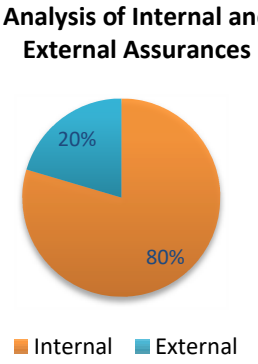
8. During the year, the ICB has received an increased number of assurances, both internal and external.

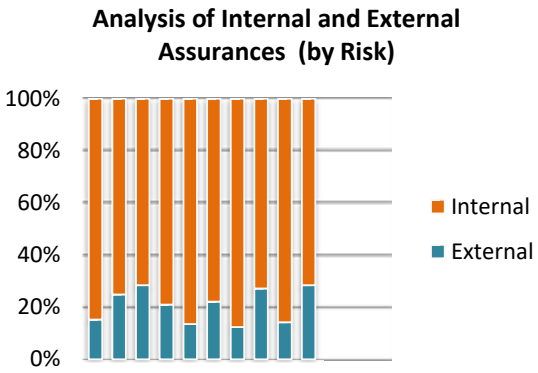
9. Annual Work Programmes are established for the Board and its committees at the start of each year, which are aligned to the Board Assurance Framework, ensuring that robust, ongoing assurances about the effectiveness of controls are received throughout the year. The Board's committees also operate an established process of applying assurance levels (full, adequate, partial, or limited) to the assurance reports they receive, which are escalated through Committee Highlight Reports to the Board and reflected within the Board Assurance Framework.

10. Additional external assurances have been received in-year, as a result of the Audit and Risk Committee's agreement of a number of strategic risk-based reviews within the 2024/25 Internal Audit Plan. These included reviews relating

to delivery of our digital and people plans, implementation of PSIRF, and our arrangements for clinical and care professional leadership.

11. A review of the internal and external assurances set out within the Assurance Framework has been completed, as illustrated below. As a reminder, internal assurances are classed as any that are produced by the ICB, or system partners, and external assurances relate to parties that are independent to the ICB and its partners (e.g., regulators, internal and external audit providers). Currently, 20% of assurances across the ICB's strategic risks are external, which is considered appropriate.





Review of mitigating actions

12. Work has continued throughout the year to address the identified 'gaps' in controls and assurances, with many actions now complete. However, it is important to acknowledge that reductions in risk scores will take time. For example, some of the completed actions focused on reviewing and refining system structures, but the impact of these changes will only become evident once they are fully embedded and have had time to translate into operational improvements.

13. A comprehensive review of mitigating actions to address 'gaps' in controls and/or assurances has been undertaken for all strategic risks. This was an area of focus of Audit and Risk Committee discussions, where confirmation was sought that sufficient actions are in place to support movement from current to target risk scores. This exercise identified a number of additional actions for implementation in 2025/26. The BAF template has also been updated to include a concise progress statement against each individual action.

Interim Head of Internal Audit Opinion

14. 360 Assurance (the ICB's internal audit provider) undertook a review of the Board Assurance Framework during 2024/25. The assessment was undertaken through a 'desktop' review of documentation, interviews with key officers, as

well as observation of Board Assurance Framework discussions at the Audit and Risk Committee and the Board.

15. 360 Assurance provided a ‘significant assurance’ opinion in relation to the Board Assurance Framework review, with no recommendations made. The level of scrutiny and challenge of the Board Assurance Framework was positively referenced.

2025/26 Board Assurance Framework – strategic risks

16. Given the evolving national context and the upcoming ICB transition process, we are not proposing any changes to the Board Assurance Framework at this time. It is proposed that that current strategic risks remain, whilst acknowledging the need for a more in-depth review during quarter two of 2025/26, once the full implications of the Ten-Year Health Plan and new ICB operating model are understood.

17. A high-level review of the current strategic risks has been undertaken with each of the Executive Director risk owners to confirm they remain ‘fit for purpose’ in light of current developments. It was agreed that the strategic risks remain broadly valid, in particular, the risk relating to the ICB’s operating model.

18. The quarter two review process will include Board review of the strategic risks, with a particular focus on the ICB’s risk appetite; specifically, whether the current level of risk tolerance is appropriate in line with local challenges and wider national policy developments.

Appendix A: Board Assurance Framework (BAF) roles and responsibilities and full business cycle

BAF Roles and Responsibilities

Board	Has ultimate responsibility for risk management and as such, needs to utilise the Board Assurance Framework to be satisfied that internal control systems are functioning effectively.
Audit and Risk Committee	Has delegated responsibility for risk management and receives assurance that the ICB has robust operational and strategic risk management arrangements. The Committee specifically comments on the fitness for purpose of the Board Assurance Framework and has a role in securing independent assurances.
Board Committees	Scrutinise assurances in relation to the strategic risks for which they are the 'lead' committee and escalate levels of assurance to the Board (via routine highlight reports).
Executive Directors	Ensure a robust control framework is in place to mitigate their respective strategic risks within the BAF to drive delivery of the ICB's core aims and objectives.
Corporate Affairs Team	Develops Board and Committee annual work programmes (which outline planned assurances in line with Board and Committee duties) and co-ordinates the population of the ICB's BAF, in conjunction with the Executive Team. The Team also provides risk management expertise to establish and support the ICB's strategic risk management arrangements.

BAF Full Business Cycle[1]

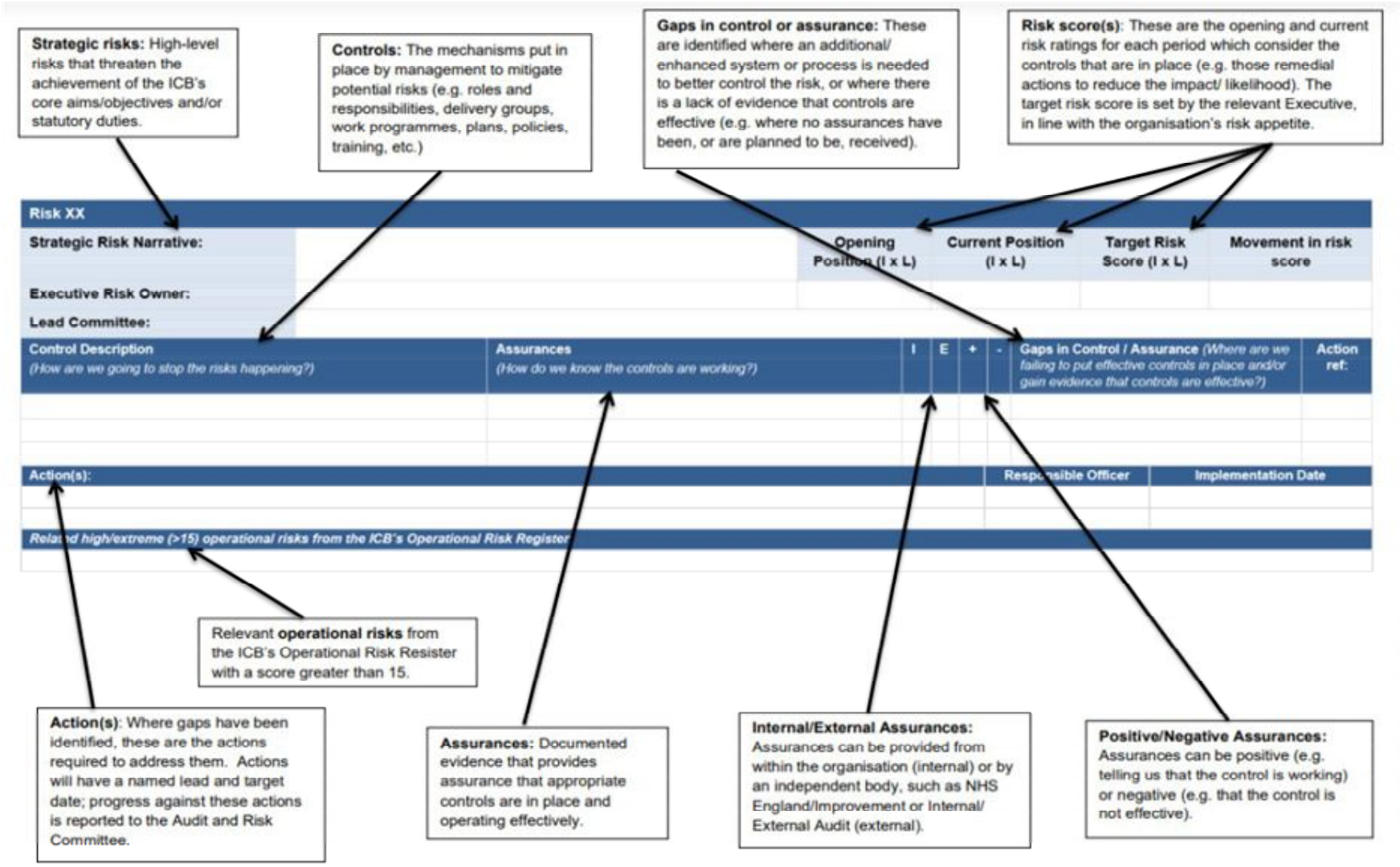
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Board: BAF biannual reviews	-	✓	-	-	-	-	-	✓	-	-	-	-
Audit and Risk Committee: Targeted assurance reports	-	-	-	-	-	-	-	-	✓	-	✓	✓
Board Committees: Receipt of assurances	✓	✓	✓	✓	-	✓	✓	✓	-	✓	✓	✓
BAF Quarterly Reviews: Review by Executive Directors	✓	-	-	✓	-	-	✓	-	-	✓	-	-

[1] This will be adjusted as required during 2025/26, in line with the publication timeframe for the Ten-Year Health Plan and ICB transition arrangements.

Board Assurance Framework

May 2025

How to navigate the Board Assurance Framework



Risk 1 – Timely and equitable access					
Strategic Risk Narrative:	Failure to ensure timely and equitable access to urgent and emergency care, elective and cancer care, community, and mental health services.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Director of Delivery and Operations	High (4 x 5)	High (4 x 4)	Medium (4 x 2)	Decrease
Lead Committee:	Finance and Performance Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Cautious*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Delivery of the **2024/25 Operational Plan**, which sets out the priorities for healthcare delivery across Nottingham and Nottinghamshire, focusing on improving access, tackling backlogs, and meeting key performance targets. Development of the **2025/26 Operational Plan.** Role and remit of the **System Planning Co-ordination Group** (as needed), in relation to development of the Operational Plan.	Operational Plan development updates to the Finance and Performance Committee (April and November 2024, and January, February, and March 2025) Operational Plan and Service Delivery Reports to the Finance and Performance Committee (monthly) Annual Operational and Financial Plan presented to the Board (March 2024 and March 2025) Service Delivery Reports to the Board (each meeting) NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓ ✓ ✓	 ✓	✓ ✓ ✓ ✓ ✓	✓ ✓ ✓	None identified.	
Role and remit of the monthly **ICS System Oversight Group**, whose members have collective accountability for the operational performance of the ICS. This is attended by NHS England. Establishment of the weekly **System Performance Oversight Group (formally System Oversight Sub-Group (a)),** which is ICB chaired, in line with the ICB's NHS system leadership role, and has responsibility for overseeing delivery of statutory performance targets and delivery of the 2024/25 Operational Plan. NHS Partners are held collectively accountable for performance. Establishment of the **System Transformation Leadership Group**, whose collective membership is responsible for bringing together transformation programmes which support and enable achievement of statutory performance targets.	Operational Plan and Service Delivery Reports to the Finance and Performance Committee (monthly) Rolling programme of 'thematic' Service Delivery reviews to the Finance and Performance Committee (November 2024 and January 2025) NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process) 360 Assurance Internal Audit Review – System Governance (Advisory)	✓ ✓	 ✓ ✓	✓ ✓ ✓ ✓	✓ ✓	To undertake a review of ICS system forums to ensure clarity of purpose and naming principles, consistency of operation (as appropriate) and reporting lines.	1.1
The role and remit of System Programme Boards in relation to operational performance and delivery. a) **Urgent and Emergency Care (UEC) Board**, which leads on system resilience and delivery of statutory targets relating to non-elective care across the ICS.	Operational Plan development updates to the Finance and Performance Committee (April and November 2024, and January, February, and March 2025) Operational Plan and Service Delivery Reports to the Finance and Performance Committee (monthly)	✓ ✓		✓ ✓	✓ ✓	See action 1.1 To ensure community services are fully embedded within the system oversight and transformation leadership groups.	 1.2

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
b) **Planned Care Programme Board**, which leads on delivery of statutory targets relating to elective care, cancer, and diagnostic services across the ICS. c) **Nottingham and Nottinghamshire Adult and Children's Mental Health Partnership Board**. d) **Primary Care Strategy Transformation Group,** which oversees primary care delivery via oversight of the Primary Care Access Recovery Plan (PCARP). e) **Community Transformation Group**. f) **Learning Disability and Autism Partnership Board**. Role and remit of the **Demand and Capacity Group,** supported by the Bed Modelling 'Task and Finish' Group.	Rolling programme of 'thematic' Service Delivery reviews to the Finance and Performance Committee (November 2024 and January 2025) Service Delivery Reports to the Board (each meeting) NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process) 2023/24 Internal Audit Review – System-wide Discharge Management (*Advisory*).	✓ ✓	 ✓ ✓	✓ ✓ ✓ ✓	 ✓ 	To establish a Mental Health (MH) Programme Board, to focus on system oversight and performance.	1.4
Daily system calls and **On-call arrangements**, alongside embedment of the **System Co-ordination Centre (SCC)**; the purpose of which is to ensure the safest and highest quality of care possible for the entire population across every area by balancing the clinical risk within and across all health and care settings. **Operational Pressures Escalation Level (OPEL) Framework** across both primary and secondary care providers.	As above.					None identified.	
The role and remit of **Integrated Neighbourhood Team (INTs),** who support equitable access by offering localised, proactive care, promoting interprofessional collaboration and engaging communities.	Rolling programme of 'thematic' Service Delivery reviews to the Finance and Performance Committee (November 2024 and January 2025)	✓		✓		None identified.	
East Midlands Joint Commissioning Committee (and supporting infrastructure) which is established to ensure delivery of delegated functions.	NHS England delegation update to the SPI Committee *(pending)*	✓				To develop routine assurance reporting to the Board on delivery of delegated specialised commissioning functions.	1.3
ICB membership of the **East Midlands Cancer Alliance (EMCA),** whose role is to develop and implement change in line with national priorities; more specifically: • Bringing together influential local decision-makers. • Taking responsibility for directing funding to transform services and care across whole pathways. • Reducing variation in the availability of safe care and treatment for all people with cancer; and • Delivering continuous improvement and reduction in inequality of experience.	EMCA Oversight Arrangements update to the SPI Committee (April 2024)	✓		✓		None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 1.1 To undertake a review of ICS system forums to ensure clarity of purpose and naming principles, consistency of operation (as appropriate) and reporting lines. ***Progress update:*** *Action complete.*	Chief Executive	Complete
Action 1.2 To ensure community services are fully embedded within the system oversight and transformation leadership groups. ***Progress update:*** *Action complete*	Director of Delivery and Operations	Complete
Action 1.3 To develop routine assurance reporting to the Board on delivery of delegated specialised commissioning functions. ***Progress update:*** *Reporting requirements being outlined within the Board and relevant Committee's 2025/26 annual work programmes.*	Director of Delivery and Operations	~~March 2025~~ May 2025
Action 1.4 To establish a Mental Health (MH) Programme Board, to focus on system oversight and performance. ***Progress update:*** *New action.*	Director of Delivery and Operations	July 2025

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
No related high/extreme (>15) operational risks currently.

Risk 2 – Primary care					
Strategic Risk Narrative:	Failure to reduce unwarranted variation and improve access to primary medical services and pharmacy, optometry and dental (PODs) services.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Director of Delivery and Operations	High (4 x 4)	High (4 x 4)	Medium (4 x 2)	None.
Lead Committee:	Strategic Planning and Integration Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Cautious*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Nottingham and Nottinghamshire ICS Primary Care Strategy, which outlines the ICS strategic intention of improving primary medical care resilience and promoting collaborative working with the aim of improving patient care. Improving access in primary care is one of the priority components for delivery. The Strategy is comprised of four chapters. • Chapter 1 General Practice • Chapter 2 Community Pharmacy • Chapter 3 Community Dentistry • Chapter 4 Community Optometry **Nottingham and Nottinghamshire ICS Primary Care Access Recovery Plan (PCARP),** which outlines the plan to improve access to primary care services within the region. It aims to improve access to appointments through: • Empowering patients. • Implementing 'Modern General Practice Access.' • Building capacity to enable practices to offer more appointments from more staff. • Cutting bureaucracy to give practice teams more time to focus on patients' clinical needs.	Primary Care Strategy and Delivery Plan updates to the SPI Committee (June, September and November 2024, and February 2025) Primary Care Strategy presented to the Board *(pending, May 2025)* Delivery plan for recovering access to primary care updates to the Board (May and November 2024) NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓ ✓	 ✓	✓ ✓ ✓	 ✓	To develop and finalise all four chapters of the ICS Primary Care Strategy.	2.1
Role and remit of the monthly **ICS System Oversight Group**, whose members have collective accountability for the operational performance of the ICS. This is attended by NHS England. Establishment of the weekly **System Performance Oversight Group (formally System Oversight Sub-Group (a)),** which is ICB chaired, in line with the ICB's NHS system oversight role, and has responsibility for overseeing delivery of statutory performance targets and delivery of the	Primary Care Strategy and Delivery Plan updates to the SPI Committee (June, September and November 2024, and February 2025) Delivery plan for recovering access to primary care updates to the Board (May and November 2024) Operational Plan and Service Delivery Reports to the Finance and Performance Committee (monthly) Service Delivery Reports to the Board (each meeting)	✓ ✓ ✓ ✓	 	✓ ✓ ✓ ✓	 ✓ ✓	To ensure primary care is fully embedded within the system oversight and transformation leadership groups.	2.2

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
2024/25 Operational Plan. NHS Partners are held collectively accountable for performance. Establishment of the **System Transformation Leadership Group**, whose collective membership is responsible for bringing together transformation programmes which support and enable achievement of statutory performance targets.	NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process) 360 Assurance Internal Audit Review – System Governance (Advisory)		✓ ✓	✓ ✓	✓		
Embedment of the ICB chaired **Primary Care Strategy Transformation Board**, whose members have collective responsibility for overseeing delivery of the Primary Care Strategy and the Primary Care Access Recovery Plan (PCARP). This is attended by Place-Based Partnership Clinical Leads and wider primary care and community pharmacist representatives. Establishment of **Primary Care 'huddles'** and weekly operational calls, focusing on performance and delivery.	As above.					None identified.	
Development of a **Primary Care Dashboard,** providing intelligence of primary care performance and trajectories at ICS, Place and GP Practice-level.	As above.					None identified.	
Primary Care Medical Services Contracting Panel, whose role is to manage and oversee the contracting of primary care medical services in Nottingham and Nottinghamshire. This includes responsibility for reviewing and awarding contracts, ensuring that providers are meeting performance and delivery standards.	As above.					None identified.	
Primary Care Networks, who have a role in improving access to local primary medical services by enhancing collaboration and building resilience between individual GP practices across Nottingham and Nottinghamshire. The role and remit of **Integrated Neighbourhood Team (INTs),** who support equitable access by offering localised, proactive care, promoting interprofessional collaboration and engaging communities.	Primary Care Strategy and Delivery Plan updates to the SPI Committee (June, September and November 2024, and February 2025)	✓		✓		None identified.	
East Midlands Primary Care Tier 3 and Tier 2 joint governance arrangements, which oversee performance and delivery of pharmacy, optometry and dental (POD) services across Nottingham and Nottinghamshire.	PODS/Specialised Commissioning annual update to the Quality and People Committee (April 2025 and *pending)*	✓		✓		To develop routine assurance reporting to the Board on delivery of delegated pharmacy, optometry and dental (POD) services.	2.3

Action(s):	Responsible Officer	Implementation Date
Action 2.1 To develop and finalise all four chapters of the ICS Primary Care Strategy. ***Progress update:*** *Primary Care Strategy due to be presented to the Board at its May 2025 meeting.*	Director of Strategy and System Development	~~March 2025~~ May 2025
Action 2.2 To ensure primary care is fully embedded within the system oversight and transformation leadership groups. ***Progress update:*** *Primary care is now captured within relevant groups' Terms of Reference, including SOG and System Leadership Transformation Group.*	Director of Delivery and Operations	Complete

Action 2.3 To develop routine assurance reporting to the Board on delivery of delegated pharmacy, optometry and dental (POD) services. ***Progress update:*** *Reporting requirements being outlined within the Board and relevant Committee's 2025/26 annual work programmes.*	Director of Delivery and Operations	~~March 2025~~ May 2025

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR159 If General Practices, Primary Care Networks, community pharmacy and the ICB do not have appropriate capacity, capability and resources to deliver actions in relation to delivery of ICS Primary Care Strategy, Primary Care Access Recovery Plan (PCARP) and achievement of NHS England's two-week GP appointment target then expected transformation may not be delivered. This may, in turn, impact on the ability to meet the needs of our population.

Risk 3 – Financial sustainability					
Strategic Risk Narrative:	Failure to achieve financial sustainability across the system.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Director of Finance	High (4 x 4)	High (4 x 4)	Medium (4 x 2)	None.
Lead Committee:	Finance and Performance Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Cautious*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
The **2024/25 Operational and Financial Plan**, more specifically, delivery of performance targets which may have financial implications, such as income relating to elective recovery. Development of the **2025/26 Operational and Financial Plan**. Delivery of the **2024/25 ICS Workforce Plan**, which supports financial sustainability by optimising staff allocation, reducing reliance on bank and agency workers and addressing skill shortages.	Annual Operational and Financial Plan presented to the Board (March 2025) Annual Financial Plan and Opening Budgets reported to the Finance and Performance Committee (March 2025) Finance Report (ICB and ICS) reported to the Finance and Performance Committee (monthly) Finance Report (ICB and ICS) reported to Board (each meeting) System Workforce Plan and delivery updates to the Quality and People Committee (June and July 2024) 2023/24 Internal Audit Review - ICS NHS Partners System Financial Control NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓ ✓ ✓ ✓	 ✓ ✓	✓ ✓ ✓ ✓	 ✓ ✓ ✓ ✓	None identified.	
Delivery of the **Joint Medium-term Financial Plan**, which supports overall delivery of the five-year Joint Forward Plan. The Plan is developed in line with the: a) ICS Finance Framework, which sets out the rules which govern the way finances are managed within the ICS (as identified as best practice by the HfMA); and b) ICS Financial Planning Principles.	As above.					To take a more strategic approach to the Joint Medium Term Financial Plan, ensuring robust resource allocation and prioritisation arrangements are in place.	3.1
Role and remit of the monthly **ICS System Oversight Group**, whose members have collective accountability for the operational and financial performance of the ICS. This is attended by NHS England. Role and remit of the **ICS Directors of Finance Group**, whose members have collective accountability for the financial performance of the ICS, capital and resource allocation, as well as delivery of the Joint Medium Term Financial Plan.	As above. 360 Assurance Internal Audit Review – System Governance (Advisory)		 ✓	 ✓		See action 1.1	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Roles and remit of the **ICS System Opportunities Group – Efficiencies and Transformation Delivery** *(formerly known as System Oversight Sub-Group (b))*							
ICS 'grip and control' measures, which are overseen by the **ICS Financial Recovery Group** (FRM). This includes, but is not limited to, weekly scrutiny of progress with financial efficiency programmes and the strengthening of workforce expenditure and vacancy controls. This agenda is supported by regular ICS Chief Executive and Director of Finance meetings. ICB 'grip and control' measures, which are overseen by the **ICB Financial Recovery Meeting**. This includes weekly scrutiny of ICB efficiency programmes, which is in addition to **routine budgetary monitoring and control arrangements** and compliance with ICB standing documents (e.g., the **Scheme of Reservation and Delegation** and **Standing Financial Instructions**).	Finance Report (ICB and ICS) reported to the Finance and Performance Committee (monthly) Finance Report (ICB and ICS) reported to Board (each meeting) Twice-yearly Financial Stewardship Assurance reporting to the Audit and Risk Committee *(December 2024 and May 2025)* Losses and Special Payments Register annual update to the Audit and Risk Committee (including in Financial Stewardship Assurance Report (December 2024) Annual review of the Standing Financial Instructions to the Audit and Risk Committee *(December 2024)* 2024/25 Internal Audit Review – Financial Management *(Significant)* 2024/25 External Audit – Year-end financial accounts review *(pending)*	✓ ✓ ✓ ✓ ✓	 ✓ ✓	 ✓ ✓ ✓ ✓ ✓	✓ ✓	See action 1.1	
The **Project Management Office (PMO) function** within the ICB, which provides support and oversees delivery of programmes which aim to improve operational efficiency and financial performance.	As above.					None identified.	
The ICB's **procurement and contracting functions,** which support financial sustainability by ensuring cost-effective purchasing and efficient allocation of resources, reducing waste and maximising value. Establishment of the **Commissioning Review Group**, whose membership has collective responsibility for ensuring investment and disinvestment commissioning proposals and contract award proposals have appropriate scrutiny in line with the ICB decision-making framework, provider selection regime legislation and statutory guidance.	Provider Selection Regime Assurance report to the Audit and Risk Committee (October 2024) Provider Selection Regime and Provider Accreditation update to the SPI Committee (October 2024) Strategic Commissioning Reviews updates to the SPI Committee (June, July, and October 2024) Service Change Review Group updated to the SPI Committee (October 2024) Primary Care Services Contracting Panel reports to the SPI Committee (April and November 2024) Investments, Disinvestments and Contract Awards for Healthcare Services updates to SPI Committee (monthly) 2024/25 Internal Audit Review – Provider Selection Regime *(Significant)*	✓ ✓ ✓ ✓ ✓ ✓	 ✓	✓ ✓ ✓ ✓ ✓ ✓ ✓		None identified.	3.2
Provider Collaborative at Scale, a collective partnership of the NHS trusts across Nottingham and Nottinghamshire, working together to streamline services, reduce duplication and share resources, with an aim to lower costs and support financial sustainability and efficiencies.	Provider Collaborative update to the Board (November 2024)	✓		✓		None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 3.1 To take a more strategic approach to the Joint Medium Term Financial Plan, ensuring robust resource allocation and prioritisation arrangements are in place. ***Progress update:*** *Work on the approach continues, in line with the requirements to achieve system financial balance by March 2026.*	Director of Finance	March 2026
Action 3.2 To embed the recently refreshed Commissioning Review Group. ***Progress update:*** *Action complete, Commissioning Review Group in place and meets monthly.*	Director of Strategy and System Delivery	Complete

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR195 If NHS Nottingham and Nottinghamshire ICB is unable to identify and implement sustainable recurrent financial efficiency solutions, at pace, there is a risk the ICB's underlying position (UDL) will continue to worsen with impact to the ability to deliver within the ICB's financial resources. *ORR196 If the Nottingham/shire NHS system, as a collective, does not meet its agreed 2024/25 year-end financial position, there is a risk to the extent to which the system will be able to create financial 'headroom' to invest in services. This may lead to reputational issues and increasing levels of intervention by NHS England.* *ORR197 If the Nottingham/shire NHS system, as a collective is unable to identify and implement sustainable recurrent financial efficiency solutions, at pace, there is a risk the collective underlying position will continue to worsen, which may significantly impact Nottingham/shire's ability to become a financially sustainable system.*

Risk 4 – Quality improvement					
Strategic Risk Narrative:	Failure to systematically improve the quality of healthcare services.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Director of Nursing	High (4 x 4)	High (4 x 4)	Medium (4 x 2)	None.
Lead Committee:	Quality and People Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Cautious*	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Integrated Care System Quality Strategy (Framework Model) 2025-2028, which is supported by a delivery plan, the purpose of which is to develop and embed a robust quality improvement framework across system partners. Establishment of the **System Quality Priorities (ICS Quality Priorities).** Development of **local quality schedules for 2025/2026**, which will seek to embed the reporting and monitoring arrangements for the ICS Quality Priorities and the ICS Quality Strategy.	System Quality Framework/Strategy updates to the Quality and People Committee (May 2024 and April 2025)	✓		✓		To embed 2025/26 local quality schedules to facilitate monitor and delivery of the ICS quality priorities.	4.1
System Quality Improvement Approach, which is driven by the **NHSE Improving Patient Care Together (IMPACT) Self-Assessment**; the purpose of which is to help systems, providers and partners understand where they are on their quality improvement journey and identify improvements needed.	As above.					None identified.	
Established infrastructure to *monitor quality improvement of all providers* across the ICS, which includes, but is not limited to: • **'Task and finish' Improvement Oversight and Assurance Groups (IOAG)** for those NHS providers placed in oversight level four; the purpose of which are to help providers recover from significant challenges, ensuring they return to a position where they can deliver safe, effective, and financially stable care. • Routine and escalated **quality contract monitoring mechanisms** for those providers where quality concerns are identified (e.g. contract performance notices). • Various forums, whose remits include primary medical services quality improvement, which include the **Primary Care Strategy Delivery Group** and **Primary Care Contracting Panel**. • **East Midlands Primary Care Tier 3** and **Tier 2 joint governance arrangements**, which oversee performance and delivery of pharmacy, optometry and dental (POD) services across Nottingham and Nottinghamshire; and	Quality Report to the Board (each meeting) Quality Oversight Report updates to each meeting of the Quality and People Committee (monthly) Ad-hoc provider exception reporting and 'deep dives' to the Quality and People Committee (e.g. Nottinghamshire Health NHS Foundation Trust, Section 48 Review, UEC pathway) Primary Medical Services updates to the Quality and People Committee (July 2024 and January 2025) Care Homes and Home Care updates to the Quality and People Committee (June 2024 and November 2024) PODS/Specialised Commissioning annual update to the Quality and People Committee (April 2025 and *pending)* 2024/25 Internal Audit Review – Quality management arrangements *(pending)* NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓ ✓ ✓ ✓ ✓ ✓	 ✓ ✓	 ✓ ✓ ✓ ✓ 	✓ ✓ ✓ ✓	None identified.	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
• **East Midlands Joint Commissioning Committee** (and supporting infrastructure) which is established to ensure the quality of specialised services.							
The ICB's quality framework and commissioning processes, which *monitor quality improvement in line with the ICB's statutory duties* relating to nursing and quality (e.g., safeguarding, infection prevention and control, complaints). This includes implementation of the **Patient Safety Incident Response Framework (PSIRF)**, which sets out the systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The establishment of Patient Safety Specialists and Patient Safety Partners to support implementation of the PSIRF Policy. As well as compliance with the **ICB Complaint's Policy**, which sets out the ICB's approach to handling complaints and concerns about commissioned services, ensuring that 'lessons are learnt' and improvements made as a result of issues raised.	Safeguarding updates to the Quality and People Committee (quarterly) Infection, Prevention and Control annual update to the Quality and People Committee (November 2024) Continuing Healthcare, Children's Continuing Care and Personalised Care annual update to the Quality and People Committee (*pending)* Patient Safety Incident Response Framework (PSIRF) update to the Quality and People Committee (June 2024 and March 2025) Patient Experience and Complaints annual update to the Quality and People Committee (April 2024) 2023/24 Internal Audit Review – Complaints (significant).	✓ ✓ ✓ ✓ ✓	 ✓	✓ ✓ ✓ ✓ ✓ ✓		None identified.	
Role and remit of the **System Quality Group**, which exists to drive quality improvement collaboratively and proactively. This is supported by system sub-groups which include, but are not limited to, safeguarding (including LAC and SEND), infection prevention and control, care home and home care, immunisations and vaccinations, patient safety, social care, and personalisation.	As above.					To establish local quality improvement groups in conjunction with ICS system partners.	4.2
Role and remit of the **Nottingham and Nottinghamshire Perinatal Scrutiny Oversight Board,** which is overseen by the System Quality Group and supported by: ICS **Perinatal Surveillance Quality Group (PSQG), LMNS Serious Incident (SI) Panel** and **LMNS Quality Outcomes Dashboard Sub-group (DSG)** Role and remit of the **Maternity Voices Partnership (MVP).** Role and remit of the **Regional Quality Oversight Group.** Role and remit of the **Regional Perinatal Quality Surveillance Group.**	Quality Oversight Report updates to each meeting of the Quality and People Committee (monthly) Nottingham and Nottinghamshire Perinatal Scrutiny Oversight Board annual update to the Quality and People Committee (October 2024) Regional LMNS oversight and performance meetings with NHSE.	✓ ✓	 ✓	 ✓ ✓	✓ ✓	None identified.	
Role and remit of the **Nottingham and Nottinghamshire Learning Disability & Autism (LDA) Executive Partnership Board,** which is overseen by the System Quality Group and oversees the improvement of LDA services across the system, for both adults and children and young people.	Quality Oversight Report updates to each meeting of the Quality and People Committee (monthly) Learning Disability and Autism (LDA) annual update to the Quality and People Committee (March 2025) Regional LDA oversight and performance meetings with NHSE.	✓ ✓	 ✓	 ✓ ✓	✓	None identified.	
Establishment of **SEND Partnership Improvement Boards** (with both Nottinghamshire County Council and Nottingham City Council), whose collective membership oversees improvement activity following the Ofsted and Care Quality Commission (CQC) local area inspections.	Quality Oversight Report updates to each meeting of the Quality and People Committee (monthly) Safeguarding updates to the Quality and People Committee (June, July, September 2024, and January 2025)	✓ ✓		 ✓	✓	None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 4.1 To embed 2025/26 local quality schedules to facilitate monitor and delivery of the ICS quality priorities. ***Progress update:*** *New action.*	Director of Nursing	September 2025
Action 4.2 To establish local quality improvement groups in conjunction with ICS system partners. ***Progress update:*** *New action.*	Director of Nursing	July 2025
Action 4.3 To undertake a 'stocktake' of ICB's quality function. ***Progress update:*** *New action.*	Director of Nursing	Q3 2025/26

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR191 If Nottinghamshire Healthcare NHS Foundation Trust (NHCT) do not have the capability to make the required quality improvements identified as a result of current quality, staffing and performance concerns and exacerbated by regional and national reviews, there is a risk the quality of services provided may not meet optimal care standards. This may lead to potential risk of harm and poor health outcomes to the population of Nottingham/shire.
ORR128 If demand and capacity constraints continue, children in crisis or children who are emotionally dysregulated, including those medically fit after a crisis, may be placed in unsuitable clinical settings (e.g. Emergency Departments, children's wards, or S136 suites). This poses risks to the child, other children, and staff. It could also delay treatment beyond NHS England targets and result in children not receiving care and treatment in a timely way. Moreover, these inappropriate placements limit access to appropriate settings for those in need.
ORR207 If challenges in the provision and delivery of community mental health services persist, there is risk that these services may not be accessed, or accessed promptly, and/or meet the current and future needs of the population. This may result in worsening health outcomes for adults and children across Nottingham/shire. This risk may also result in increased demand on other services as activity may be displaced to other partners within the system.
ORR221 If ongoing adverse reports in national and local media continue, there is a growing risk of declining public confidence, which may lead to citizens failing to access appropriate services in a timely manner. This could result in delayed interventions, reduced service effectiveness, and further strain on public resources.
ORR224 If Nottingham University Hospitals NHS Trust (NUH) fail to sustain improvements made to date following CQC and external recommendations, there is a risk quality of services may decline. This may lead to compromised patient safety and quality of care which could result in poor patient experience and adverse health outcomes for the population of Nottingham/shire.
ORR249 If challenges relating to delayed discharge and unavailability of mental health placements (both inpatient and community) continue, there is an increased risk of adults being placed out-of-area and/or in inappropriate care settings. This may cause distress, potential harm, and crisis situations, straining urgent care services and the wider health system. This risk relates to adults including those in acute beds requiring ongoing mental health support once their physical health issues have resolved.
ORR208 If the quality of maternity services does not improve, services provided may not meet optimal care standards. This may result in potential risk of harm (i.e. physical and psychological) and poor patient experience for women, birthing people, their babies, and families.

Risk 5 – Strategy and transformation					
Strategic Risk Narrative:	Failure to implement robust strategies and plans with system partners to transform services, address health inequalities and improve outcomes.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Director of Strategy and System Development	High (4 x 4)	Medium (4 x 3)	Medium (4 x 2)	Decrease
Lead Committee:	Strategic Planning and Integration Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Open*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
a) A system wide **Integrated Care Strategy** outlines how statutory partners across the ICS, collaborating with non-statutory partners, patients, people, and communities, will improve health and care outcomes. Commitment has been given to achieving a set of ambitions to improve overall health and wellbeing and reduce health inequalities. Partners have agreed to working collaboratively to deliver these ambitions and adhere to three strategic principles of prevention, equity and integration in the design and implementation of interventions and support to people. b) A **Joint Forward Plan (JFP)** has also been developed across NHS statutory bodes which sets out how the ICB and its local NHS partners will work differently across the next five years to deliver the ICS Integrated Care Strategy. Commitment to the three strategic principles and overall collaborative approach is affirmed in this Plan. c) **Joint Local Health and Wellbeing Strategies (Nottingham City and Nottinghamshire County)**, also set out the vision, priorities and action agreed by the Health and Well-being Boards to improve the health and wellbeing of the population and address issues of inequity and health inequalities. The need for partnership and collaboration across system partners is intrinsic to delivery of these Strategies. The Integrated Care Strategy, Joint Local Health and Wellbeing Strategies and JFP are based on the population health and care needs as described by the **Nottingham City and Nottinghamshire County Joint Strategic Needs Assessments**.	Integrated Care Strategy update to the Board (January 2025) Progress in delivering the Integrated Care Strategy: Year-end update to the ICP (March 2025) Annual refresh of the Integrated Care Strategy to the ICP (March 2025) Joint Forward Plan (and Refresh) and Outcomes Framework updates to the Board (May, July and October 2024, and March 2025) Updates on the oversight and delivery of the Joint Forward Plan to the SPI Committee (April, May and September 2024, and March 2025) Update on delivery of the Joint Forward Plan to the ICP (October 2024) Joint Strategic Needs Assessment Prevention Chapter presented to the SPI Committee *(pending)* Health Inequalities Statement to the Board (May 2024) Health Inequalities Statement reported to the Quality and People Committee *(pending)* Population Health Management Outcomes reported to the Quality and People Committee *(pending)* Avoidable Mortality and Health Inequalities update to the Quality and People Committee (January 2025) 2022/23 Internal Audit Review – Health Inequalities *(Advisory)* NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	 ✓ ✓	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	 ✓	To develop assurance reporting to the ICP relating to the 4th aim, in alignment with the work of EMCCA and the EM IGC.	5.1
Establishment of the **System Transformation Delivery Group**, whose collective membership is responsible for bringing together transformation programmes which support and enable sustainable achievement of statutory and local performance ambitions. For 2024/25, focus was given on eight priority transformation areas.	Transformation Programme Delivery updates to the SPI Committee (May and December 2024, and February and March 2025) Primary Care Strategy and Delivery Plan updates to the SPI Committee (June, September and November 2024, and February 2025)	✓ ✓		✓ ✓		None identified.	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
This is supported by the recently refreshed **Joint Forward Plan (JFP) Oversight Group,** which oversees delivery of the JFP and monitoring of associated outcomes and leads on co-ordination of the JFP refresh process.	Children and Young People's Mental Health Local Transformation Plan and commissioning updates to the SPI Committee (December 2024 and March 2025)	✓		✓	✓		
The role and remit of System Programme Boards in relation to the transformation and delivery of respective elements of the Joint Forward Plan. a) **Urgent and Emergency Care (UEC) Board,** which oversees transformation across the non-elective pathway. b) **Planned Care Board,** which exists to oversee transformational changes in the provision of planned care, cancer, and diagnostic services across the ICS. c) **Nottingham and Nottinghamshire Adult and Children's Mental Health Exec Partnership Board**. d) **Primary Care Strategy Transformation Group,** which oversees primary care transformation as outlined in the ICS Primary Care Strategy. e) **Community Transformation Programme Board.** The above are also supported by several service specific system transformation boards and groups, which include the **Special Educational Needs and Disabilities (SEND) Improvement Board**, **Children and Young People Board**, **Learning Disability and Autism (LDA) Transformation Board, Perinatal Scrutiny Oversight Board** and **Digital Strategy Oversight Group.** Role and remit of the **ICS Health Inequalities (HI) and Prevention Oversight Group.** Role and remit of the **ICS Research Group.**	As above. ICS Research Strategy: Progress Updates to the SPI Committee (May and November 2024)	✓		✓		None identified.	
Establishment and embedment of the **ICS Collaborative Clinical and Care Leadership and Transformation Group,** which provides clinical leadership for delivery of the Integrated Care Strategy, associated delivery plans and endorsement of significant service and pathway transformation. This is supported by the **Clinical Senate**.	Transformation Programme Delivery updates to the SPI Committee (May and December 2024, and February and March 2025) Ad-hoc commissioning decisions presented to the SPI Committee 2024/25 Internal Audit Review – Framework for clinical and care professional leadership (Moderate)	✓ ✓	 ✓	✓ ✓ ✓	 ✓	None identified.	
Establishment and embedment of the **Place Based Partnership (PBP) and Integrated Care Board (ICB) Leads Group,** which maximise the opportunity of PBPs to support delivery of NHS priorities recognising the role of PBPs as local partnerships working across health, care, the voluntary and community sector, and local government to improve population health and wellbeing. The role and remit of **Integrated Neighbourhood Team (INTs),** who support transformation by offering localised, proactive care, promoting interprofessional collaboration and engaging communities	Place Plans update to the SPI Committee (November 2024 and March 2025) Primary Care Strategy and Delivery Plan updates to the SPI Committee (June, September and November 2024, and February 2025)	✓ ✓		✓ ✓		None identified.	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
The role of the **Integrated Care Partnership (ICP)** in bringing together key stakeholders from health, social care, public health, and the voluntary sector to coordinate and improve health and care services. The **Partners Assembly** within the ICS, which fosters collaboration, sets strategic priorities and drives the integration of health and social care services across Nottingham and Nottinghamshire. The role and remit of the **Integrated Care Strategy Operational Outcomes Group**, which is supported by **the ICS Strategy Working Group**, whose combined responsibility is to develop and maintain an Outcomes Dashboard for monitoring progress in delivery of the Integrated Care Strategy	Chair's Report to the Board *(at each meeting)* Chief Executive's Report to the Board *(at each meeting)* NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓	 ✓	✓ ✓ ✓		None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 5.1 To develop assurance reporting to the ICP relating to the 4th aim, in alignment with the work of EMCCA and the EM IGC. ***Progress update:*** *Align to action 10.6*	Director of Strategy and System Development	~~March 2025~~ September 2026
Action 5.2 To revise oversight arrangements in relation to the Joint Forward Plan. ***Progress update:*** *Action complete.*	Director of Strategy and System Development	Complete

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:

ORR155 If the transformation of urgent and emergency care services is not delivered, there is a risk that limited health and social care resources may not be used most efficiently. This may lead to an inability to meet demand: today and in the future.

ORR159 If General Practices, Primary Care Networks, community pharmacy and the ICB do not have appropriate capacity, capability and resources to deliver actions in relation to delivery of ICS Primary Care Strategy, Primary Care Access Recovery Plan (PCARP) and achievement of NHS England's two-week GP appointment target then expected transformation may not be delivered. This may, in turn, impact on the ability to meet the needs of our population.

ORR192 If resources at Nottinghamshire Healthcare NHS Foundation Trust (NHCT) are primarily focused on addressing immediate quality, staffing and performance concerns, there is risk that there may not be sufficient capacity or 'headspace' to deliver mental health and community service transformation. This may result in future population needs not being made and/or anticipated efficiencies not materialising.

Risk 6 – Workforce					
Strategic Risk Narrative:	Failure to utilise the system workforce effectively and ensure a sustainable workforce for the future.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Director of Nursing	High (4 x 4)	High (4 x 4)	Medium (4 x 2)	None.
Lead Committee:	Quality and People Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Cautious*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Development of the **Planning for the future: transforming the health and social care workforce: the ICS People and Workforce Plan.** The ICS People and Workforce Plan has two distinct parts: i. Part one, **the people plan section**, relates to the NHS People Promise and the ten outcomes-based functions that we must deliver, as presented to the Board in September 2025. ii. Part two, **the workforce plan**, which sets out current challenges, future ambitions and sets a potential workforce trajectory for the next five years, with an illustrative whole time equivalent workforce summary. The workforce transformation plan outlines key workforce challenges, what needs to change and the following priority activities for collaborative system action: • Making the NHS the best place to work. • Improving the leadership culture. • Workforce redesign. • Releasing time for care; and • Growing and training our future workforce. The above will be underpinned by the development of an agreed system-wide approach to measuring and analysing workforce data and performance and aggregating local workforce requirements to support discussions with national bodies on priorities for education, training, and workforce development.	People and Culture Annual Report to the Quality and People Committee (May 2024) People Plan updates to the Quality and People Committee (May 2024) People and Culture Operational Delivery Plan updates to the Quality and People Committee (September, October and November 2024, and January, February, and March 2025) ICS People and Workforce Plan progress update to Quality and People Committee (January and February 2025) ICS People Plan presented to the Board (September 2024) ICS People and Workforce Plan presented to the Board (March 2025) People Plan twice-yearly updates to the Board (Sept 2024 and *pending, March 2025)* 2024/25 Internal Audit Review – Delivering the People Plan (December 2024, 'moderate' assurance) NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓ ✓ ✓ ✓ ✓ ✓	✓ ✓	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	✓ ✓ ✓	To further develop and enhance the Nottingham and Nottinghamshire Five Year ICS People Plan. To establish robust monitoring arrangements to ensure delivery of both part 1 and part 2 of the ICS People and Workforce Plan. To develop processes to incorporate workforce data from all ICS partners, commencing with primary care. To agree a system-wide approach to measuring and analysing workforce data and performance.	6.1 6.2 6.3 6.4
Embedment of the updated system workforce governance arrangements, which includes the: a) **ICS Strategic Workforce Transformation Board (SWTB),** whose role will be to provide the relevant oversight and assurance that workforce growth and transformation ambitions supports the ICS vision for service transformation, efficiency, and care delivery. This is supported by the **Vanguard Steering Group.**	As above.					None identified.	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
b) **ICS Planning, Performance and Risk Group,** which focuses on direct delivery of the agreed work programme by co-ordinating the activities and provide assurance to SWTB on delivery and investment of delegated resources including financial allocations. This is supported by the **Workforce Intelligence Group (WIG)** and **Nottingham and Nottinghamshire ICS People Leads Forum.** c) **ICS People and Culture Insight Group (PCIG)** whose role will be to oversee delivery of the ten ICS outcome based statutory people functions, the people promise and the ICS workforce plan/joint forward plan. The role and remit of the **Primary Care Transformation Group,** which oversees the delivery of the workforce workstream of the Primary Care Strategy.							
ICS 'grip and control' measures, which are overseen by the **ICS Financial Recovery Group** (FRM). This includes, but is not limited to, weekly scrutiny of progress with financial efficiency programmes and the strengthening of workforce expenditure and vacancy controls.	People and Culture Operational Delivery Plan updates to the Quality and People Committee (September, October and November 2024, and January, February, and March 2025)	✓		✓	✓	None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 6.1 To further develop and enhance the Nottingham and Nottinghamshire Five Year ICS People Plan. ***Progress update:*** *Complete, as ICS People and Workforce Plan approved by the Board at its' March 2025 meeting.*	Director of Nursing	Complete
Action 6.2 To establish robust monitoring arrangements to ensure delivery of both part 1 and part 2 of the ICS People and Workforce Plan. ***Progress update****: New action.*	Director of Nursing	July 2025
Action 6.3 To develop processes to incorporate workforce data from all ICS partners, commencing with primary care. ***Progress update****: New action.*	Director of Nursing	September 2025
Action 6.4 To agree a system-wide approach to measuring and analysing workforce data and performance. ***Progress update****: New action.*	Director of Nursing	September 2025

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR212 As workforce planning is based on short term plans set nationally, and due to limitations with access to data, there is a risk the Nottingham/shire system may not have a clear understanding of future NHS workforce requirements. This may lead to inability to identify and implement a sustainable workforce plan, exacerbating the risk to financial stability. *ORR077 If the NHS continues to implement headcount reductions as part of its financial 'grip and control' measures, while social care providers face their own financial and operational pressures, there is a risk of ongoing workforce strain across both sectors. This could result in increased sickness, exhaustion, and burnout, undermining the psychological safety of the workforce across health, social care, and primary medical services providers.* *ORR177 If system workforce planning continues to be set nationally on a short-term basis, and local operational and financial challenges persist, there is risk medium to longer term strategic education and planning needs may not be addressed. This may lead to issues with initial workforce supply and ineffective use of workforce. This risk is exacerbated by challenges experienced in getting system data into a single place to support ICS workforce planning and projections.*

Risk 7 – Digital transformation					
Strategic Risk Narrative:	Failure to drive forward digital transformation and utilise system intelligence solutions to address health inequalities and improve outcomes.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Medical Director	Medium (4 x 3)	Medium (4 x 3)	Medium (4 x 3)	None.
Lead Committee:	Finance and Performance Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Open*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Digital Notts Strategy (2023 to 2028), which is underpinned by five programmes: • Public Facing Digital Services. • Digital and Social Inclusion. • Frontline Digitalisation. • Interoperability (Shared Care Records); and • Supporting Intelligent Decision Making.	Twice-yearly Digital, Data and Technology strategic updates to the Finance and Performance Committee (July 2024 and February 2025) Digital, Data and Technology Strategy presented to the Board (March 2025) 2024/25 Internal Audit Review – Delivering Digital Transformation (Significant)	✓ ✓	 ✓	✓ ✓ ✓		None identified.	
Nottingham and Nottinghamshire ICS Cyber Security Strategy 2024-2030, which is built around the following five 'core' pillars: • Focus on the greatest risks and harms (risk management, asset management and vulnerability management). • Defend as one (identity and access management, logging, and monitoring). • People and culture (engagement and training). • Build secure for the future (architecture and configuration, data security, supply chain security). • Exemplary response and recovery (incident management).	Twice-yearly Cyber strategic updates to the Audit and Risk Committee *(pending)*	✓				None identified.	
ICS Data and Analytics Strategy, which is underpinned by eight foundational elements, which will deliver the vision *'to delivering impactful insights and usable intelligence to drive high quality decision making at all levels.*	Data and analytics updates to the Finance and Performance Committee *(pending)*	✓				None identified.	
ICS Data, Analytics, Information and Technology (DAIT) Strategy Group and supporting delivery group structure, which includes the **ICS Digital Executive Group**.	As above.					None identified.	
Primary Care Information Technology Strategy (2021-2026) which sets out the strategy for IT services and functionality for primary care and will support delivery of the **Primary Care Access Recovery Plan (PCARP).** **Primary Care Digital Steering Group,** which exists to develop, support and implement the necessary IT infrastructure within primary care.	Twice-yearly Digital, Data and Technology strategic updates to the Finance and Performance Committee (July 2024 and February 2025) Digital, Data and Technology Strategy presented to the Board (March 2025) 2024/25 Internal Audit Review – Delivering Digital Transformation (Significant)	✓ ✓	 ✓	✓ ✓ ✓		None identified.	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
Role of the **System Analytics and Intelligence Unit (SAIU)** in relation to the Population Health Management (PHM) programme. The SAIU supports integrated working across ICS data, intelligence, and analytical partners to better identify and support the health and care for the population of Nottingham and Nottinghamshire.	Population Health Management Outcomes reported to Finance and Performance Committee (June, July, and September 2024) Population Health Management Outcomes reported to the Quality and People Committee *(pending)* Avoidable Mortality and Health Inequalities update to the Quality and People Committee (January 2025)	✓ ✓ ✓		✓ ✓		None identified.	

Action(s):	Responsible Officer	Implementation Date
None.		

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:

ORR084 If organisations within the ICS are unable to access IT systems (i.e. unexpected system outage, successful cyber-attacks, or issues with the availability of products and services) they may not be able to conduct core business as usual functions. This may result in patients not receiving timely diagnosis or treatment due to necessary equipment not functioning or patient records being unavailable. It may also result in unfavourable media coverage, reputational damage, and significant cost pressures.

ORR090 If the Nottingham and Nottinghamshire system does not have sufficient system partner 'buy in' and capacity (digital workforce and operational workforce) to engage with and deliver digital transformation schemes alongside business-as-usual delivery it may not be possible to progress the System, Primary Care and ICB digital transformation agenda. Additionally, this may lead to missed opportunities in relation to funding available for digital transformation. This risk may be further exacerbated by current financial challenges.

Risk 8 – Infrastructure and net zero					
Strategic Risk Narrative:	Failure to work effectively as a system to a sustainable infrastructure to deliver high-quality and efficient care and the net zero commitment.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Director of Finance	Medium (4 x 3)	Medium (4 x 3)	Medium (4 x 2)	None.
Lead Committee:	Finance and Performance Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Cautious*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Board approved **Joint Capital Resource Use Plan**, which is prepared with partner NHS trusts and NHS foundation trusts and provides transparency to stakeholders on the prioritisation and expenditure of capital funding.	Joint Capital Resource Use Plan reported to the Finance and Performance Committee (April and October 2024, and March 2025) Joint Capital Resource Use Plan updates to the Board (May 2024 and March 2025) NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓	 ✓	✓ ✓ ✓	 ✓	To establish a more strategic approach to the Joint Capital Resource Use Plan, aligning more closely with population health needs.	8.1
Role and remit of the **ICS Directors of Finance Group**, whose members have collective accountability for the financial performance of the ICS, capital and resource allocation, as well as delivery of the Joint Medium Term Financial Plan. This is underpinned by the role of the **ICS Capital Management Group,** which is responsible for ensuring a collaborative approach to capital and that capital investment is prioritised and used effectively.	Finance Report (ICB and ICS) reported to the Finance and Performance Committee (monthly) Joint Capital Resource Use Plan reported to the Finance and Performance Committee (April and October 2024, and March 2025) NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓	 ✓	 ✓ ✓	✓ ✓	None identified.	
Development and implementation of the **ICS Infrastructure Strategy,** which will align with service strategies and support future investment prioritisation. This work is being overseen by **ICS Capital Management Group,** supported by the **ICS Infrastructure Strategy Steering Group.** Development and implementation of the **Primary Care Estates Strategy,** which is supported by individual **Primary Care Network Estate Strategies.**	ICS Infrastructure Strategy updates to the Finance and Performance Committee (May, June, and July 2024) General Practice Estates Plan updates to the Finance and Performance Committee *(pending)* ICS Infrastructure Strategy presented to the Board (July and September 2024, *pending May 2025)* NHS England review and assessment of the ICS Infrastructure Strategy	✓ ✓ ✓	 ✓	✓ ✓ ✓	✓ ✓ 	To finalise and publish the ICS Infrastructure Strategy. To finalise and publish the Primary Care Estates Strategy.	8.2 8.3
Nottingham and Nottinghamshire ICS Green Plan (2022 to 2025), which outlines the specific actions and priority interventions for achieving carbon net zero to lay the foundation to deliver carbon emission reductions through the delivery of sustainable health and care services. Role and remit of the **ICS Net Zero / Green Steering Group,** whose members have collective accountability for delivery of the ICS' Green Plan.	Twice-yearly ICS Green Plan updates to the Finance and Performance Committee (May and November 2024) Green Plan presented to the Board (January 2025) 2022/23 Internal Audit Review – Environmental sustainability governance (significant assurance). NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓	 ✓ ✓	 ✓ ✓ ✓	✓ ✓	None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 8.1 To establish a more strategic approach to the Joint Capital Resource Use Plan, aligning more closely with population health needs. ***Progress update:*** *Work on the approach continues, in line with the requirements to achieve system financial balance by March 2026.*	Director of Finance	~~March 2025~~ March 2026
Action 8.2 To finalise and publish the ICS Infrastructure Strategy. ***Progress update****: ICS Infrastructure Strategy is completed and due to be presented to the Board at its May 2025 meeting.*	Director of Finance	~~March 2025~~ May 2025
Action 8.3 To finalise and publish the Primary Care Estates Strategy. **Progress update**: *Work remains ongoing to develop the primary care estates strategy; this remains a work in progress.*	Director of Finance	~~March 2025~~ June 2025

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
No related high/extreme (>15) operational risks currently.

Risk 9 – ICB operating model					
Strategic Risk Narrative:	Failure to develop and embed a robust ICB operating and workforce model, with an open, safe, and compassionate culture, to enable delivery of strategic goals and statutory duties.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Chief Executive	Medium (4 x 3)	High (4 x 4)	Medium (4 x 2)	Increase
Lead Committee:	Remuneration and Human Resources Committee (*Highlight Reports from the Committee to the Board on a bi-monthly basis)*			*Cautious*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Embedment of the **ICB Operating Model**, at the time of ICB establishment (July 2022), which was shared with the Board as part of the rolling-programme of Board seminar sessions.	ICB Operating Model update to the Board (April 2023)	✓		✓		To develop new ICB operating model, in line with national policy developments. To establish ICB transitional governance and programme management arrangements. To introduce assurance reporting in relation to the ICB transition.	9.4 9.5 9.6
Delivery of **ICB annual priorities**, which were shared with the Board as part of the rolling-programme of Board seminar sessions.	ICB Annual Priorities update to the Board (April 2024) Assurance reporting of delivery of annual priorities via Committee highlight reports (each meeting)	✓ ✓		✓ ✓	 ✓	None identified.	
Review of **ICB Executive portfolios,** ensuring that leadership skills and responsibilities align with, and support delivery of, the ICB's strategic aims and objectives. Refresh of monthly **Executive and Senior Leadership Team Meetings**; brining senior ICB leaders together face-to-face to strengthening understanding of roles and build relationships.	Proposal for 'refreshed' Executive Team Structure to the Remuneration and Human Resources Committee (May 2024) 'Governance and leadership' update in the Chair's Report to the Board (September 2024)	✓ ✓		✓ ✓	✓	None identified.	
Role and remit of the **Executive-led Human Resources Steering Group**, whose collective membership has responsibility for overseeing the development and implementation of the ICB's operating and workforce models.	ICB Workforce Reports to the Remuneration and Human Resources Committee (October 2024, and January and March 2025)	✓		✓	✓	None identified.	
Development of an **ICB Succession Plan**, which ensures a smooth transition of leadership by identifying and preparing individuals to fill critical positions in the event of vacancies.	ICB Design Principles, including Succession Plan, to the Remuneration and Human Resources Committee (January 2025)	✓		✓		None identified.	
Development of the **ICB's Values and Behaviours**, with the purpose of enhancing wellbeing through the promotion of positive values and behaviours that foster a supportive and inclusive environment. This is supported by the development and embedment of **Staff Networks** and the **Staff Engagement Group**.	ICB Staff Survey updates to the Remuneration and Human Resources Committee (October 2024, and January 2025 and March 2025) NHS Staff Survey results (February 2025)	✓	 ✓	✓ ✓	✓ ✓	None identified.	
The **ICB's Freedom to Speak Up (FTSU) arrangements,** which create a supportive environment where staff can raise concerns without fear of reprisal. These arrangements include access to FTSU guardians, clear	ICB Freedom to Speak Up updates to the Board *(January 2025)*	✓ ✓		✓		None identified.	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
reporting processes, and organisational commitment to address concerns in a timely and transparent manner.	ICB Freedom to Speak Up updates to the Audit and Risk Committee *(pending)* ICB Staff Survey updates to the Remuneration and Human Resources Committee (October 2024, and January and March 2025) NHS Staff Survey results (February 2025)	✓	✓	✓ ✓	✓ ✓		

Action(s):	Responsible Officer	Implementation Date
Action 9.1 To introduce routine updates relating to the ICB operating model to the Board. ***Progress update:*** *Superseded, see action 9.6*	Chief Executive	Superseded
Action 9.2 To introduce routine updates relating to delivery of ICB priorities to the Board. ***Progress update:*** *Complete, as reporting on ICB priorities has been included within the Board and relevant Committees' 2025/26 annual work programmes.*	Chief Executive	Complete
Action 9.3 To finalise development of the ICB succession plan. ***Progress update:*** *Superseded, as talent management and succession planning and part of the design principles of the new ICB operating model (action 9.4)*	Director of Nursing	Superseded
Action 9.4 To develop new ICB operating model, in line with national policy developments. ***Progress update:*** *New action.*	Chief Executive	June 2025
Action 9.5 To establish ICB transitional governance arrangements. ***Progress update:*** *New action.*	Chief Executive	June 2025
Action 9.6 To introduce assurance reporting in relation to the ICB transition arrangements. ***Progress update:*** *New action.*	Chief Executive	July 2025

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR210 If the management of ICB headcount reductions, driven by ICB financial 'grip and control' processes, continues amidst ongoing operational challenges and workforce pressures, there is a risk to deterioration in staff health, wellbeing, and morale. This may impact on staff productivity and lead to staff feeling disconnected or disengaged with the ICB.

Risk 10 – Culture and leadership					
Strategic Risk Narrative:	Failure to orchestrate positive system culture and leadership to drive effective partnership working.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Chief Executive	Medium (4 x 3)	Medium (4 x 2)	Medium (4 x 2)	None.
Lead Committee:	Board			*Cautious*	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Embedment of the **ICS Partnership Agreement**, which demonstrates the commitment of the collective leadership across the ICS to work effectively together for the benefit of all communities and residents across Nottingham and Nottinghamshire.	Chair's Report to the Board *(at each meeting)* Chief Executive's Report to the Board *(at each meeting)* NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓	 ✓	 ✓	 ✓	None identified.	
Board seminar sessions which bring together individuals from across parts of the ICS, which foster collaboration, strengthen leadership capabilities, and promote a shared commitment to positive cultural change.	As above.					None identified.	
Embedment of **ICS system governance arrangements** which underpin effective partnership working across all partner organisations. This includes all system delivery, clinical leadership and oversight boards and groups (**Integrated Care Partnership (ICP), System Oversight Group (SOG) and System Transformation Delivery Group (STDG)**, as well as the: – **ICS Financial Recovery and Planning forums.** – **ICS Non-Executive Directors Network**. – **NHS Governors Forum**. – **ICS Audit Chairs Network**. – **ICS System Risk Management Network**.	2024/25 Internal Audit Review – System Governance Review *(Advisory)* NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)		✓ ✓	✓ ✓	 ✓	None identified.	
The role of the **Integrated Care Partnership (ICP)** in bringing together key stakeholders from health, social care, public health, and the voluntary sector to coordinate and improve health and care services.	Chair's Report to the Board *(at each meeting)* Chief Executive's Report to the Board *(at each meeting)* NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)	✓ ✓	 ✓	✓ ✓ ✓	 ✓	None identified.	
Engagement with the **East Midlands Combined County Authority (EMCCA),** which is key forum in supporting partnership working across Nottingham, Nottinghamshire, Derby and Derbyshire (D2N2); which aligns with the ICS' fourth aim. The work of the **East Midlands Inclusive Growth Commission (IGC)** which will support the development of an **Inclusive Growth Strategy** across D2N2.	Assurance reporting to the ICP (in development)					To develop assurance reporting to the ICP relating to the 4th aim, in alignment with the work of EMCCA and the EM IGC.	10.2
The role of the **Health and Wellbeing Boards (HWBs)** as partnerships between local authorities, the NHS, and wider stakeholders, with the	As above.					None identified.	

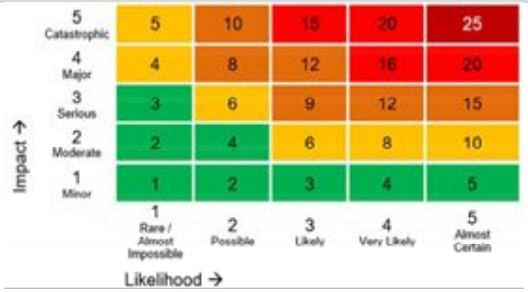
Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
purpose of improving the health and wellbeing of the populating of Nottingham and Nottinghamshire.							
The **Universities for Nottingham Civic Agreement**, which sets out a commitment to enhance the economic, social, and cultural life, and the health and wellbeing for the people and place of Nottingham and Nottinghamshire. This is supported by the establishment of an **ICS Anchor Champions Network.**	NHS Oversight Framework Assessment (quarterly via Quarterly System Review Meeting (QSRM) and annual assessment process)		✓	✓	✓	None identified.	
Establishment and embedment of the **Primary Care 'One Voice' forum**, which an ICB-led partnership forum with leaders of primary care services (GP and PODs) across Nottingham and Nottinghamshire.	Primary Care Strategy and Delivery Plan updates to the SPI Committee (June, September and November 2024, and February 2025)	✓		✓		None identified.	
Establishment and embedment of the **Place Based Partnership (PBP) and Integrated Care Board (ICB) Leads Group, which** maximise the opportunity of PBPs to support delivery of NHS priorities recognising the role of PBPs as local partnerships working across health, care, the voluntary and community sector, and local government to improve population health and wellbeing.	Place Plans update to the SPI Committee (November 2024 and March 2025)	✓		✓		None identified.	
Membership of the **Public Sector Chief Officers Forum** in Nottingham and Nottinghamshire, as part of the Nottinghamshire Local Resilience Forum (LRF). Its primary aim is to coordinate emergency planning and response efforts, ensuring effective multi-agency collaboration to minimise the impact of major incidents and emergencies	Emergency Preparedness, Resilience and Response (EPRR) updates to the Audit and Risk Committee (June and December 2024)	✓		✓		None identified.	

Action(s):	Responsible Officer	Implementation Date
Action 10.1 To establish assurance reporting relating to ICS anchor institutions and the 4th aim. ***Progress update:*** *Superseded, see action 10.2 below.*	Chief Executive	~~March 2025~~ Superseded
Action 10.2 To develop assurance reporting to the ICP relating to the 4th aim, in alignment with the work of EMCCA and the EM IGC. ***Progress update:*** *New action.*	Chief Executive	March 2026

Related high/extreme (>15) operational risks from the ICB's Operational Risk Register:
ORR218 In pursuit of NHS financial efficiencies and operational delivery across the system, there is a risk that relationships may decline (with ICS partners and wider stakeholders). This may lead to deterioration in collaborative efforts, communication breakdowns and wider stakeholder dissatisfaction.

Annex 1: Alignment of BAF Strategic Risks to ICB Objectives/Core Aims

Strategic Risks *(What could prevent us from achieving our strategic aims/objectives and statutory duties?)*	To improve outcome in population health and healthcare.	To tackle inequalities in outcomes, experience, and access.	To enhance productivity and value for money.	To help the NHS support broader social and economic development.
1. Timely and equitable access - Failure to ensure timely and equitable access to urgent and emergency care, elective and cancer care, and mental health services.	✓	✓	✓	
2. **Primary care** - Failure to reduce unwarranted variation and improve access to primary medical services and pharmacy, optometry and dental (PODs) services.	✓	✓	✓	
3. Financial sustainability - Failure to achieve financial sustainability across the system.	✓	✓	✓	✓
4. Quality improvement - Failure to systematically improve the quality of healthcare services.	✓	✓		
5. Strategy and transformation - Failure to implement robust strategies and plans with system partners to transform services, address health inequalities and improve outcomes.	✓	✓	✓	✓
6. Workforce - Failure to utilise the system workforce effectively and ensure a sustainable workforce for the future.			✓	✓
7. Digital transformation - Failure to drive forward digital transformation and utilise system intelligence solutions to address health inequalities and improve outcomes.	✓	✓	✓	
8. Infrastructure and net zero - Failure to work effectively as a system to a sustainable infrastructure to deliver high-quality and efficient care and the net zero commitment.	✓	✓	✓	✓
9. ICB operating model - Failure to develop and embed a robust ICB operating and workforce model, with an open, safe, and compassionate culture, to enable delivery of strategic goals and statutory duties.			✓	
10. Culture and leadership – Failure to orchestrate positive system culture and leadership to drive effective partnership working.	✓	✓	✓	✓



Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**Annual Equality and Inclusion Report 2024/25**
Paper Reference:	ICB 25 018
Report Author:	Gemma Waring, Head of Human Resources and Organisational Development
Report Sponsor:	Rosa Waddingham, Director of Nursing
Presenter:	Philippa Hunt, Chief People Officer

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

Summary:

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

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

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

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

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

- Oliver McGowan Training
- Partners in Mind – Mental Health Co-production
- Inclusive Leadership
- Maternity and Neonatal Voices Partnership

Recommendation(s):

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

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	The Equality Diversity and Inclusion Annual Report does not directly contribute to the improvement of health outcomes for our population but does provide an overview of monitoring mechanisms and reflection of our current practice and is a statutory requirement under the Equality Act 2010.

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

Appendices:

Appendix A: 2024/25 Annual Equality and Inclusion Assurance Report.

Board Assurance Framework:

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

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

Report Previously Received By:

The report has been shared with quality and People Committee members ahead of presentation to the Board.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Annual Equality and Inclusion Assurance Report

April 2024 to March 2025

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

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

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

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

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

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

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

Email: nnicb-nn.comms@nhs.net

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

Contents

Section 1: Welcome

1. Introduction

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

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

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

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

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

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

This report sets out:

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

2. Legal Duties

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

The PSED places a statutory duty on the ICB to address:

- Eliminating unlawful discrimination, harassment and any other conduct prohibited by the Equality Act.

- Advance equality of opportunity between people who share a protected characteristic and people who do not share it.
- Foster good relations between people who share a protected characteristic and people who do not

The ICB also has a specific duty under the PSED to complete the following actions:

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

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

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

NHS England also requires NHS providers to publish evidence against the Workforce Race Equality Standard and the Workforce Disability Equality Standard on an annual basis. The Workforce Race Equality Standard and Workforce Race Equality Standard are not currently mandated returns for ICBs, but we will be publishing our position for both standards for 2024/25 onwards.

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

3. Our Organisation

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

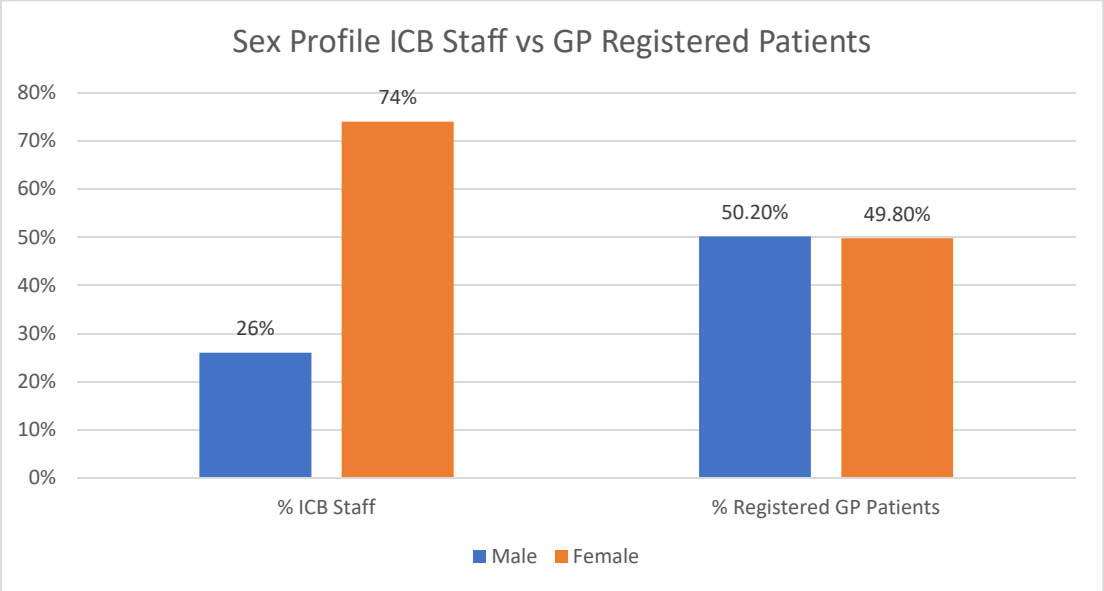
We recognise that there is much more that the organisation can do to attract and retain applicants from diverse communities, as well as retaining and improving experiences for our existing workforce.

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

The following section provides the demographic detail of the ICB in comparison to our local population, using 2021 census data and, where available, our registered GP patient information as of 31 March 2025. Where declared numbers are relatively low, to avoid potential identification of individuals we have clustered protected characteristics together. We have not been able to report on marital status and pregnancy due to the current low reported numbers. We are unfortunately not able to report on gender reassignment as staff are not currently able to select this option with Electronic Staff Record.

Sex – The ICB's sex profile is typically representative of the NHS with 75% female and 25% male. The 2021 Census information for Nottingham and Nottinghamshire residents informs that 50.2% is female and 49.8% is male. These percentages are also mirrored in our registered patient data.

Chart 1.



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

Currently only 9% of the ICB's workforce have declared that they have a disability, 78% have declared that they do not have a disability and 16.4% have not declared their status.

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

Chart 2 provides a visual depiction of the ICB's staff disability status.

Chart 2

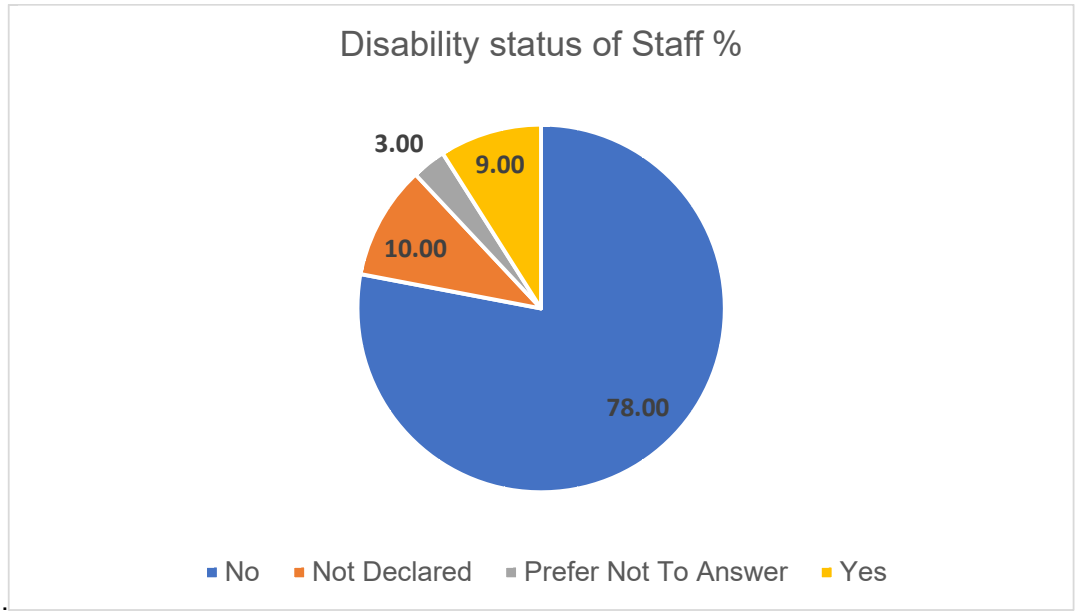


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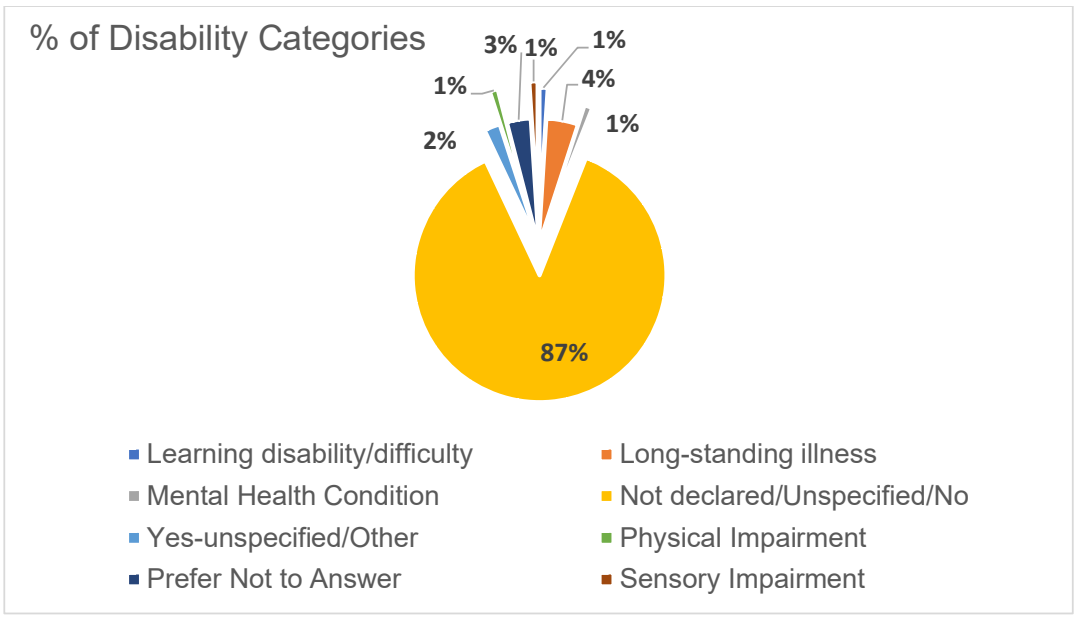
Chart 3 provides a visual depiction of the declared disability categories within the ICB.

Chart 3

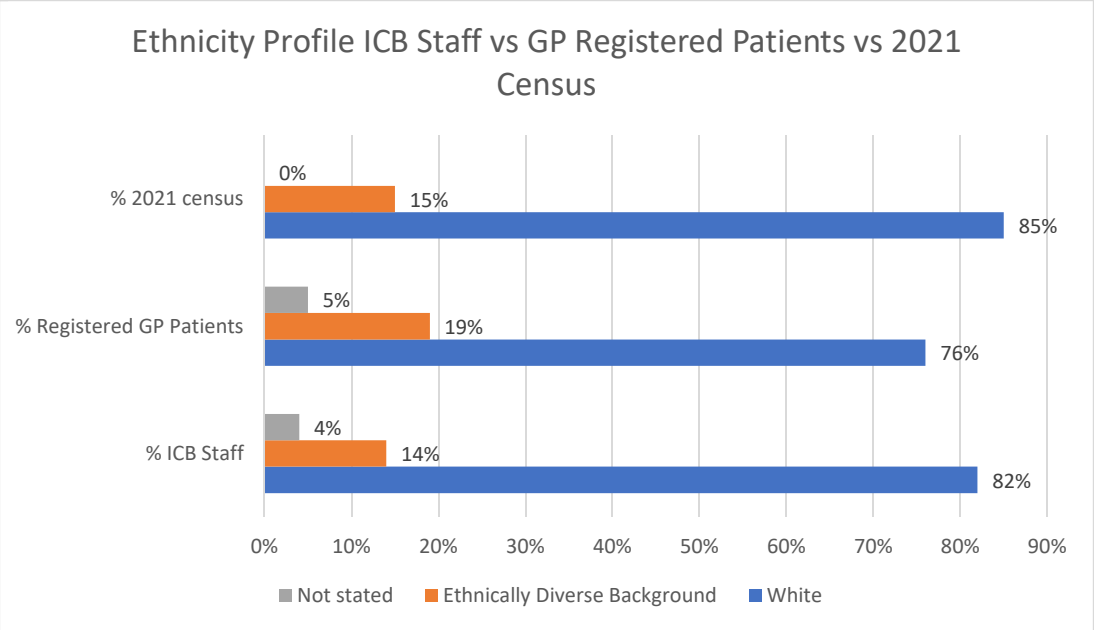


Ethnicity – The ICB's workforce ethnicity profile is predominantly white at 82%. Staff from an ethnically diverse background (non-white British) is currently 14%. 4% of staff have not declared their ethnicity to the organisation.

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

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

Chart 4

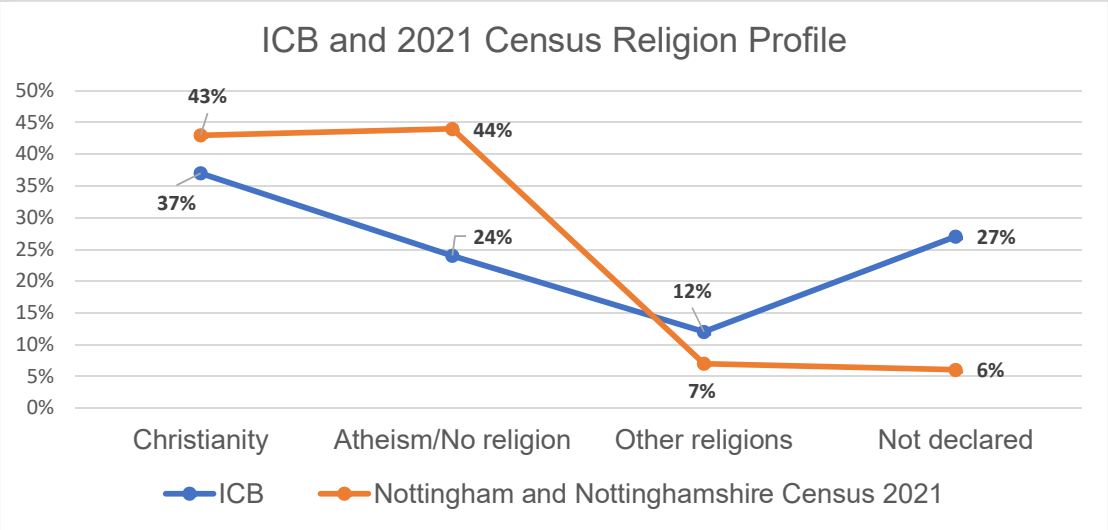


Religion – The ICB collects our workforce's self-declared religions and beliefs. For the purposes of this report, to protect individuals from potentially being identified, we have categorised religions with smaller representations together.

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

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

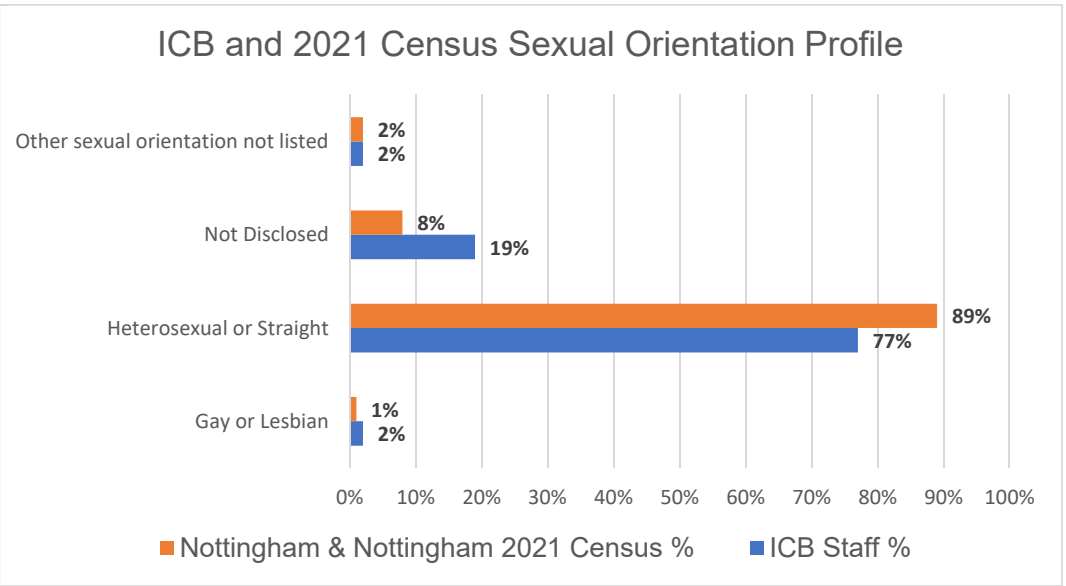
Chart 5



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

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

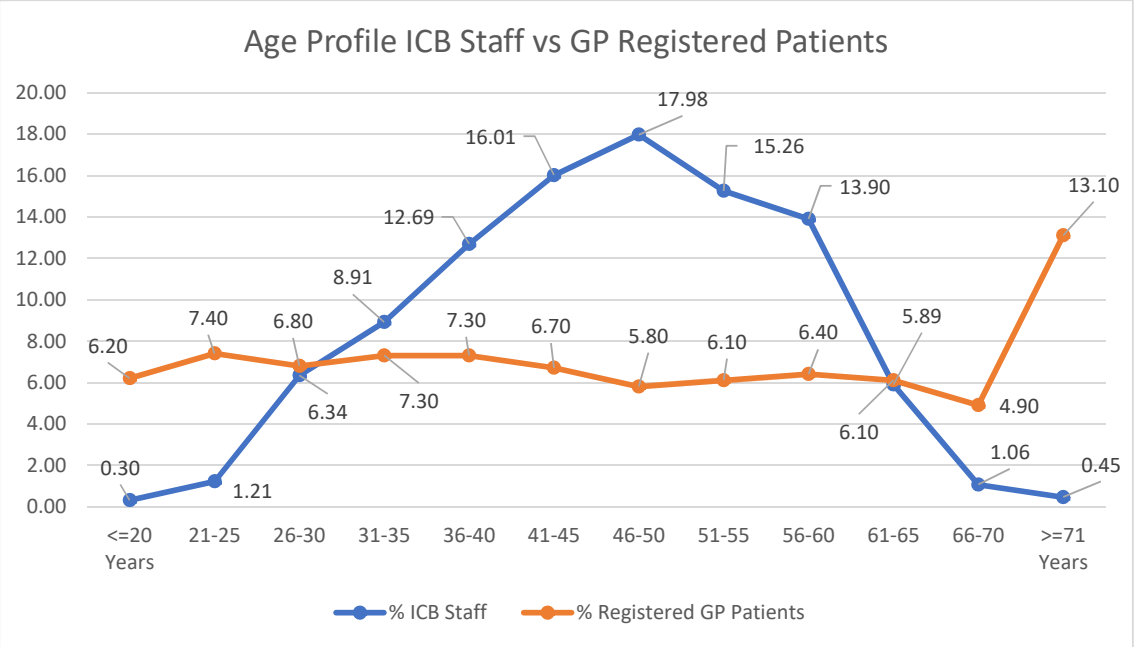
Chart 6



Age Profile

The graph below details the age profile of the ICB in comparison to our registered GP population. The age profile of the organisation is what we would expect with the majority of staff sitting in the middle age ranges. Whereas the GP registered patient data is much more linear until we reach over aged 70 where we see a spike.

Chart 7



Section 2: Measuring Equality and What we have Achieved

4. Measuring Equality

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

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

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

4.1 NHS England High Impact Action

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

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

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

The High Impact Actions are:

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

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

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

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

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

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

During 2024/25 the ICB has completed the Equality and Inclusion Assurance Tool, which allows organisations to rate their performance against the six High Impact Actions.

Table 1

	High Impact 1	High Impact 2	High Impact 3	High Impact 4	High Impact 5	High Impact 6
Nottingham and Nottinghamshire ICB	**Excellent Progress**	**Limited Progress**	**Good Progress**	**Limited Progress**	**Not started / No Progress**	**Limited Progress**

High Impact Action 5 is rated as Not Started/No Progress as the ICB does not undertake international recruitment.

NHS England has reviewed our submission and has identified opportunity areas for the ICB to explore to maintain and improve existing ratings. These are summarised below:

- High Impact Action 1 - Lack of information on how staff stories, lived experiences and staff networks impact decision-making processes, e.g. in formation and monitoring of SMART EDI objectives for Board members
- High Impact Action 3 - Disability Pay Gap report requires collection and analysis to identify gaps in the Trust.

- High Impact Action 4 - Staff Health and Wellbeing offer as well as support in cases of bullying, harassment or discrimination needs development and communication.

4.2 Gender Pay Gap

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

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

The ICB published our Gender Pay Gap information in March 2025.

4.3 Ethnicity Pay Gap

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

Ethnicity pay reporting is voluntary, many employers already report on their ethnicity pay data. The ICB has made the decision to the publish our Ethnicity Pay Gap alongside our Gender Pay Gap in March 2025.

4.4 Workforce Race Equality Standard

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

The NHS Workforce Race Equality Standard ensures that employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. NHS organisations are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation.

2024 Workforce Race Equality Standard Highlights:

- Our ethnic minority representation has remained at 10.8% compared to 26.4% nationally.
- Board representation: 90% white, 10% BME

- Relative likelihood of white candidate being appointed from shortlisting compared to BME candidate: 0.77 for Nottingham and Nottinghamshire ICB against a national average of 1.59 for 2024.
- Percentage of staff experiencing discrimination from managers or other colleagues in the last 12 months is lower than sector average by 1.2% for BME and 6.6% for white staff.
- No BME staff have entered into a formal disciplinary process.

Key priorities:

- To improve equal opportunities for career progression.
- Reducing the experience of harassment, bullying or abuse from patients, relatives or the public.

4.5 Workforce Disability Equality Standard

The NHS Workforce Disability Equality Standard is an NHS wide standard which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.

NHS organisations use the metrics data to develop and publish an action plan.

The Workforce Disability Equality Standard is important, because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

2024 Workforce Disability Equality Standard (WDES) Highlights:

- Our disabled workforce representation has increased to 6.55% compared to 4.9% nationally.
- No disabled staff have entered into a formal capability process.
- Relative likelihood of non-disabled candidates being appointed from shortlisting compared to disabled staff: 0.80 for Nottingham and Nottinghamshire ICB against a national average of 0.99 in 2024.
- Disabled staff saying their employer has made adequate reasonable adjustments to enable them to carry out their work: 85.5% for Nottingham and Nottinghamshire ICB against a national average of 73.4% for 2024.
- Percentage of disabled staff compared to non-disabled staff feeling pressure to come to work despite not feeling well enough: 19.3% for Nottingham and Nottinghamshire ICB against a national average of 27.7% for 2024.

Key priorities:

- To improve equal opportunities for career progression.
- Reducing the experience of discrimination from other colleagues.

What we have achieved

As an ICB we are committed to embedding equality and diversity considerations into all aspects of our work, including policy development, commissioning processes and employment practices. We recognise that equality is about ensuring that access to opportunities is available to all and that no one should have poorer life chances because of the way they were born, where they come from, what they believe, or whether they have a disability. We believe that diversity is about recognising and valuing differences by being inclusive, regardless of age, disability, gender reassignment, marriage or civil partnership status, pregnancy and maternity, race, religion or belief, sex, or sexual orientation.

We are committed to:

- Improving equality of access to health services and health outcomes for the diverse population we serve.
- Building and maintaining a diverse, culturally competent ICB workforce, supported by an inclusive leadership team.
- Creating and maintaining an environment where dignity, understanding and mutual respect, free from prejudice and discrimination, is experienced by all and where patients and staff feel able to challenge discrimination and unacceptable behaviour.

In practice, delivery against these commitments is achieved by ensuring the following actions are undertaken across our business activities:

- Assessing the health needs of our population – We work with Local Authority Public Health colleagues to ensure that Joint Strategic Needs Assessment (JSNA) chapters consider all protected characteristic and other disadvantaged groups to accurately inform equality considerations in our commissioning intentions.
- Public engagement and communications – We engage with people from all protected characteristic and other disadvantaged groups in our population, particularly those whose voices may not be routinely heard, through a range of different mechanisms to ensure that we have the right information to commission the right health services that can be accessed by the people who need them. We also deliver targeted and tailored messaging that reaches the right people more effectively.

- We complete equality impact assessments whenever we plan, change or remove a service, policy or function. These are completed through integrated equality and quality impact assessments (EQIAs) that also incorporate wider quality considerations (patient safety, patient experience and clinical effectiveness). EQIAs are treated as ‘live’ documents and are revisited at key stages of scheme development and implementation, particularly following the conclusion of any patient and public engagement and consultation activities, to inform decision-making.
- We include an assessment of compliance with equality legislation requirements as a routine aspect of all procurement exercises and we use the national NHS Standard Contract, which in its full-length version mandates providers of NHS services to implement the NHS Equality Delivery System, NHS Accessible Information Standard, NHS Workforce Race Equality Standard and NHS Workforce Disability Equality Standard. A range of assurances on compliance with these requirements are incorporated within our routine quality and performance monitoring processes.
- We operate a fair, inclusive and transparent recruitment and selection process and maintain relevant workforce accreditations to help demonstrate that we promote equality of opportunity. We implement the NHS Workforce Race Equality Standard and work to the requirements of the NHS Workforce Disability Equality Standard, and our working environment aims to promote the health and wellbeing of the whole workforce through a suite of human resources policies, which have been assessed from an equality perspective.

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

5. Oliver McGowan Training

Oliver was mildly autistic and had epilepsy and learning difficulties and was treated for a seizure in 2016 and given olanzapine to sedate him.

The 18-year-old from Bristol died in intensive care 17 days later after a rare side effect caused his brain to swell.

The learning disability mortality review (LeDeR) into the death said that if Oliver had been assessed correctly on admission to hospital and staff had read his hospital passport, he may never have needed to be intubated and sedated.

There was a general lack of understanding and acknowledgement of Oliver's autism and how he presented himself when in seizure.

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

Research carried out by Oliver's family and charitable organisations along with findings from reviews suggested that professionals' understanding of autism is very poor.

Oliver's mother has campaigned tirelessly to improve the experience of autistic people within health and social care. Her experience showed that because staff didn't understand autism he was chemically restrained.

Only 11% of autistic adults think hospital doctors understand autism, while 10% believe this for social workers – lack of confidence in professionals. Oliver's family worked with autistic people and people with a learning disability and their families to develop this training.

The evidence from reviews and the determination of Paula McGowan has seen the introduction of mandatory LDA training across Health and social care in England within the Health and Care Act 2022.

The ICB has been working with local providers to facilitate the training across the system. The system has trained approximately 10% of eligible staff. Training figures for the Nottingham and Nottinghamshire system are detailed in the table below:

	Staff number	**Trained to date**	**Trained to date percentage**
ICS Eligible Staff			
Total	41,936	4,310	10%
Tier 1	12,581	1,576	13%
Tier 2	29,355	2,734	9%
ICS Non-Eligible Staff (ICB, Local Authorities, Social Care)			
Total		482	
Tier 1		287	
Tier 2		195	

6. Partners in Mind – Mental Health Co-production

Launched in April 2024, Partners in Mind is a monthly health and social care sector co-production group focused on the integrated mental health pathway programme. Membership of the group includes people with lived experience of using mental health services and co-production staff.

The group was established in response to the integrated mental health programme work which began in January 2025, which mandated a strategic plan for mental health be developed, and the desire to include lived experience insight within that plan.

The group members have a variety of interests and priorities which include access to support for those with learning disabilities and autism, support for people within secondary care including correct amount of bed spaces and therapeutic care offered, psychological education opportunities and talking therapies, suicide prevention, support for carers and in particular parents, children and young people services and support with transition into adult services.

The aims of the group:

- Develop a system wide co-production resource to support the transformation and commissioning of local mental health and well-being services.
- Ensure the delivery of the integrated mental health strategic plan
- Work together with partners on an equal footing around challenging areas of mental health provision including accessing support at the right place and at the right time and adequate provision for secondary care and ensuring people have a place that they call home at discharge.
- Be included and represent the voice of the patient and carers at the heart of change and reviews within mental health and wellbeing services.
- Build relationships and links with stakeholders across the system, including Nottinghamshire Healthcare NHS Foundation Trust.

The group's early impact includes contributing to service commissioning decisions, helping secure a Mental Health Co-production Resource, and lived experience representation on the Mental Health Partnership Board. Members influence projects around secondary care access, therapeutic care, transitions, and suicide prevention, ensuring the voice of lived experience is central to change.

7. Maternity and Neonatal Voices Partnership (MNVP)

The national Maternity and Neonatal Voices Partnership (MNVP) is designed to amplify the voices of women and families and ensure that their insights inform service improvement across maternity and neonatal care. During 2024–2025, our MNVP made significant strides in advancing co-production within this space. It played a key role in shaping responses to the 2024 Care Quality Commission

Maternity Reports, working closely with providers to co-produce improvements based on inspection findings. In addition, the MNVP shared critical insight with the Ockenden review team, ensuring lived experience perspectives contributed to national learning and accountability.

A major focus this year has been expanding engagement with more diverse communities. Targeted work has taken place to improve father inclusivity, establish links with Refugee Roots, and collaborate with the PeriPrem initiative to reduce injury in premature birth. MNVP leads have also built strong relationships with specialist midwives supporting bereavement and vulnerable migrants, ensuring these often-underrepresented voices are heard and influence service design. As a result of these strengthened relationships, the MNVP is now being involved earlier in the development of projects, enabling more meaningful and embedded co-production that is responsive to the needs of all families.

Representation of the MNVP across key governance forums has expanded significantly, demonstrating increased system influence and trust. MNVP members now contribute regularly to the Sherwood Forest Hospitals Perinatal Assurance Committee, the LMNS Neonatal Steering Group, Nottingham University Hospitals' Maternity and Neonatal Redesign Group, Family Hubs, the East Midlands Neonatal Operational Delivery Network Parent Advisory Group, and the Women's Experience Workstream focused on digital maternity records through Badger Notes. This routine inclusion of lived experience in strategic meetings is fostering a more inclusive, transparent, and people-centred approach to service planning and improvement.

Several co-production initiatives have further strengthened the MNVP's impact this year. Advice from MNVP leads has shaped how the system approaches family involvement in the transition from Neonatal Intensive Care to Paediatric wards, including the design of new focus groups to gather direct feedback from families. A refreshed social media strategy and launch of a new website have expanded the MNVP's visibility and reach, with Facebook posts reaching 4.8k people and Instagram profile views climbing to 7.4k, helping raise awareness of the group's work and encourage wider participation.

Volunteer infrastructure has also been enhanced to support sustained involvement. A refreshed set of welcome and onboarding materials for co-production volunteers has been aligned with the ICB's broader approach to Experts by Experience. Volunteers took part in two in-person co-production events at Kingsmill Hospital, contributing to service improvements in triage and transitional care. A dedicated WhatsApp group has been launched to support communication among volunteers, enabling real-time discussion of issues such as antenatal education and digital systems like BadgerNet, which are then escalated to the full MNVP group.

Further work has been done to ensure neonatal feedback is more systematically gathered and acted upon. Increased in-person engagement by MNVP leads at neonatal wards has enabled stronger relationships with families and more

meaningful feedback collection. In addition, MNVP playgroups have been introduced to build trust, give back to the community, and encourage more parents and families to become involved in shaping services.

Collectively, this work illustrates how co-production in maternity and neonatal services has matured over the past year—becoming more embedded, inclusive, and impactful across the system.

8. Equality Objectives

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

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

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

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

9. Equality Delivery System

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

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

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

The Equality Delivery System three Domains are detailed below – with specified outcomes within each domain:

Domain 1: Commissioned or provided services

1A: Patients (service users) have required levels of access to the service
1B: Individual patients (service user's) health needs are met
1C: When patients (service users) use the service, they are free from harm
1D: Patients (service users) report positive experiences of the service

Domain 2: Workforce health and well-being

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

Domain 3: Inclusive leadership

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

The ICB has undertaken the assessment for 2024/25, scoring each sub-section of the Domains in accordance with the following ratings:

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Within Domain 1 the ICB has to select three services for review, the services that have been selected are as follows:

- CardMedic – Improving communication and access to information for Maternity and Neonatal Families to women whose first language is not English
- Development of the paediatric respiratory/asthma diagnosis pathway in Nottingham and Nottinghamshire
- Reducing Health Inequalities for obesity in children and young people within Nottingham and Nottinghamshire

Each subsection of the Domain is scored separately to provide an overall score for the Domain. The Domain scoring for the ICB is detailed in the table below:

Domain	**Overall Domain Score**	**Category**
Domain 1 - Commissioned or provided services	12	Developing
Domain 2 - Workforce health and well-being	5	Underdeveloped
Domain 3 – Inclusive Leadership	3	Underdeveloped
Overall ICB Score	**17**	**DEVELOPING**

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

We have developed an action plan to address the issues identified within Domain's Two and Three and delivery of this will be overseen by the ICB's Quality and People Committee.

Our 2024 annual report did note that it was a key priority to enable commissioning managers to focus on equity. Whilst the Equality Delivery System report is positive about our work in supporting equity, we will continue build upon on our Equality and Quality Impact Assessment process to inform decision-making.

The ICB published our Equality Delivery System self-assessment in April 2025.

Section 3: Future Planning

10. Equality Objectives

We are committed to develop and improve our equality diversity and inclusion practices. This section details the delivery commitments we have made to be achieved within the next year.

The ICB has a duty under the Public Sector Equality Duty and Specific Duties and Public Authorities Regulations 2017 to publish Equality Objectives at least every four years. During 2024/25 the ICB has reviewed our Equality Objectives in order to streamline and make them more accessible.

The ICB's Equality Objectives for 2023 to 2025 are:

1. **Enhance Access and Health Outcomes for Disadvantaged Communities**
Proactively identify and address barriers to healthcare for communities experiencing health inequalities. Work collaboratively with patients, community groups and stakeholders to ensure equitable access to services, reduce disparities in health outcomes, access and improve patient experiences for maternity services across Nottingham and Nottinghamshire

2. **Foster a Diverse and Representative Workforce**
Strengthen recruitment with the aim of widening access and reducing systematic barriers, ensure talent management, development and progression opportunities ensure workforce diversity at all levels within the ICB. Focus on increasing representation across ethnicity and disability to better reflect the communities we serve across Nottingham and Nottinghamshire and create an inclusive and supportive working environment.

3. **Develop a Culturally Competent and Inclusive Workforce**
Equip staff with the knowledge, skills and confidence to foster an inclusive culture that values diversity and promotes equality. Provide ongoing training and initiatives to enhance cultural competence, empower staff to challenge discrimination and drive meaningful change in the organisation's approach to equality, diversity, and inclusion.

The ICB has committed to reviewing the Equality Objectives during 2025 and to have established objectives for 2026 until 2030.

11. Race Health Equalities Maturity Matrix

In 2023/24 the ICB agreed to adopt the Race Health Equalities Maturity Matrix, with the objective of challenging the deep-rooted structural racism that exists within parts

of the health and care system. The matrix has been co-produced between health and care partners and community leaders in Nottingham. The matrix is now supporting over 30 organisations in Nottingham and Nottinghamshire to address structures and process that contribute to the exacerbation of health inequalities experienced in minority ethnic communities.

The ICB Board has committed to implementing a number of steps to assist with the development of the tool within the ICB. These were agreed as:

- The Board will undertake a full Maturity Matrix self-assessment
- The Board will adopt Accountable Leadership following the review.
- Priority development areas will be linked to the organisation EDI objectives.
- The framework and learning from it will support the development of personal equity objectives for board members during appraisals.
- Promoting the further roll out across the ICB to support team and individual development and equity objectives.

The ICB Board has already developed equality objectives as part of their annual appraisal process, and these are disseminated through the leadership structure to ensure they are embedded at all levels of the organisation.

The ICB has supported the development of our RACE Network, that was launched in September 2024. From April 2025, each of our staff networks have a dedicated Board member to champion and support the network. The Board will be working with the RACE network to undertake the maturity matrix self-assessment to ensure that all appropriate stakeholders are involved. The RACE network will then work with the Board to implement the delivery of matrix.

12. Disability Pay Gap

In accordance with the recommendations from NHS England. The ICB will review our Disability Pay Gap, alongside our Gender and Ethnicity Pay Gaps and develop meaningful action plans to address any identified gap.

Appendices

Appendix A – Summary of the legislative framework for equality

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

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

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**Committee Highlight Reports**
Paper Reference:	ICB 25 019
Report Author:	Committee Secretariat
Report Sponsor:	ICB Committee Chairs
Presenter:	ICB Committee Chairs

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

Summary:

This report presents an overview of the work of the Board's committees since the last Board meeting in March 2025. The report aims to provide assurance that the committees are effectively discharging their delegated duties and to highlight key messages for the Board's attention. The report includes the committees' assessments of the levels of assurance they have gained from the items received and any actions instigated to address any areas where low levels of assurance have been provided.

All committees have recently approved their annual reports for 2024/25, setting out how they have discharged their responsibilities during the year. These reports are provided for the Board's information at item 21.

Recommendation(s):

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

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	The Board's committee structure has been designed to provide assurance to the Board that statutory duties and responsibilities in line with the core aims are being effectively discharged.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

A: Highlight Report from the Strategic Planning and Integration Committee
B: Highlight Report from the Quality and People Committee
C: Highlight Report from the Finance and Performance Committee
D: Highlight Report from the Audit and Risk Committee
E: Highlight Report from the Remuneration and Human Resources Committee
F: Current high-level operational risks being oversighted by the Board's committees

Board Assurance Framework:
The Board's committees scrutinise assurances in relation to the strategic risks for which they are the 'lead' committee and escalate levels of assurance to the Board.

Levels of assurance:	
Full Assurance	The report provides clear evidence that: • Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required.
Adequate Assurance	The report demonstrates that: • Desired outcomes are either being achieved or on track to be achieved; and/or • Required levels of compliance with duties will be achieved; and/or • There are minor weaknesses in control and risks identified can be managed effectively. Unlikely that the achievement of strategic objectives and system priorities will be impaired. Minor remedial and/or developmental action is required.
Partial Assurance	The report highlights that: • Achievement of some outcomes are off-track or mechanisms for monitoring achievement in some areas have yet to be established/fully embedded; and/or • Compliance with duties will only be partially achieved; and/or • There are some moderate weaknesses that present risks requiring management. Possible that the achievement of strategic objectives and system priorities will be impaired. Some moderate remedial and/or developmental action is required.
Limited Assurance	The report highlights that: • Achievement of outcomes will not be achieved or are significantly off-track for achievement; and/or • Compliance with duties will not be achieved; and/or • There are significant material weaknesses in control and/or material risks requiring management. Achievement of strategic objectives and system priorities will be impaired. Immediate and fundamental remedial and/or developmental action is required.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Appendix A: Strategic Planning and Integration Committee Highlight Report

Meeting Date(s):	**03 April and 01 May 2025**
Committee Chair:	**Jon Towler, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. Integrated Care System Research Strategy Delivery Plan	Members received the Nottingham and Nottinghamshire Integrated Care System Research Strategy 2024-29 Delivery Plan, and discussed the actions, current opportunities and risks. It was noted that the plan should be driven forward through collective system working, and whilst there was a commitment to deliver the priorities for 2025/26, capacity to support implementation had been identified as a risk. Future reports to the Committee will provide a progress update against agreed research metrics and provide details of the research activities taking place across primary care.	**Adequate**	**Adequate** (*awarded at the meeting held on 7 November 2024)*
2. Primary Medical Services Contracting Panel Assurance Report	Members received a summary of the discussions, decisions, challenges, and risks considered by the Primary Medical Services Contracting Panel since November 2024. It was noted that a representative of the Local Medical Committee had been provided a standing invitation to observe the Panel's meetings going forward, which would complement current transparency arrangements. Members discussed the arrangements for considering requests by GP practices to close their patient lists, resource to support management of the Advice and Guidance Service, and the decisions taken since November 2024, which in the main, related to transformation funding applications for a Modern General Practice Access Model.	**Adequate**	**Full** *(awarded at the meeting held on 7 November 2024)*

Item	Summary	Level of assurance	Previous level of assurance
	The overall assurance rating recognised that although the report outlined a number of challenges and risks, the mitigations were clearly articulated.		
3. Special Educational Needs or Disability (SEND) Joint Commissioning Strategy: Delivery Plans for 2024/25 and 2025/26	Members received a paper which provided a progress update on the 2024/25 SEND joint commissioning priorities and outlined the processes by which the 2025/26 priorities and plan would be developed, approved and published. Members discussed the complex nature of the SEND programme, challenges around data and data quality, the exponential rise in demand and the improved governance arrangements that would support the design and delivery of the 2025/26 priorities. The detailed SEND Joint Commissioning Strategy Delivery Plan for 2025/26 will be presented at the Committee's meeting in July 2025.	**Limited**	*Not applicable*
4. Assertive and Intensive Community Mental Health Care- Action Plan: Review and Update	Members received a progress update against the Assertive and Intensive Community Mental Health Care Action Plan, following its presentation to the Board in November 2024. There had been a continued focus on safety and quality, ensuring improved oversight of patients requiring assertive engagement. Some actions within the plan had been delayed as they required further national guidance/standards and confirmation of national investment. The next steps were noted and included the completion of an NHS England self-assessment against the latest principles for this pathway, to identify any additional areas for improvement. A further progress update will be presented to the Committee in November 2025.	**Adequate**	*Not applicable*
5. Mental Health, Learning Disability and Neurodiversity Specialist Treatment/ Funding Requests Panel	The Annual Report for the Mental Health, Learning Disability and Neurodiversity Specialist Treatment / Funding Requests Panel provided an	**Full**	**Full** *(awarded at the meeting*

Item	Summary	Level of assurance	Previous level of assurance
and Governance Process Annual Report 2024/25	overview of the activity of the Panel during the period 1 April 2024 to 31 March 2025. During this time, six cases had been reviewed and supported. Going forward, there will be an enhanced focus on the outcomes from funding requests through ensuring that providers used the nationally recommended patient reported outcome measures in their progress reports to clearly evidence the difference the treatments were making.		*held on 6 June 2024)*
6. Individual Funding Request (IFR) Panel Annual Assurance Report	The IFR Annual Assurance Report, which provided a comprehensive overview of the activity received in relation to IFR requests during the period 1 April 2024 to 31 March 2025, was received. The impact of the delegation of specialised services by NHS England on IFR activity will be monitored going forward and the importance of ensuring clarity around the responsibilities of the ICB and specialised commissioning was highlighted. Members discussed the trends, thresholds and exceptionality of IFR requests, and noted the potential requirement for a consistent policy across a larger geography in the future.	**Full**	**Full** *(awarded at the meeting held on 6 June 2024)*

Decisions made:
The Committee approved: a) Its 2024/25 Annual Report and its 2025/26 Annual Work Programme. b) The natural termination of the 'Time 2 Talk' pilot at the end of the 12-month contract. c) The rate of uplifts for care home and home care agencies in relation to a number of NHS continuing healthcare funded care packages. The Committee also endorsed the Primary Care Strategy 2025-2030 and, subject to the suggested amendments, recommended the strategy for Board approval in May 2025.

Information items and matters of interest:
a) The Committee discussed the proposed approach to the Board approved review of acute services, to ensure local services are safe, effective, and cost efficient.
b) The Committee discussed progress to date in mobilising the 2023/24 Health Inequalities and Innovation Investment Fund (HIIF) schemes and a proposal for the 2025/26 HIIF to focus on the aim of treatment to prevention, with funding targeted to primary care at either a GP practice, federation, or neighbourhood level. A further paper will be presented to the June 2025 meeting of the Committee to outline the 2025/26 HIIF proposals in more detail.
c) The Committee received and discussed the operational risks relating to the Committee's responsibilities, with a focus on the three high scoring risks. Despite incremental improvements being made across the high scoring risk areas, the risks had remained static on the Operational Risk Register for a prolonged period due to the inherent challenges within these areas. The risk scores would be challenged with risk owners to ascertain whether it would be possible for the likelihood for these risks to be reduced. The high scoring risks are provided for the Board's information at Appendix F.
d) The Committee received the Log of Investment, Disinvestment, Procurement and Contract Award Decisions (Healthcare) 2025/26 for information.

Appendix B: Quality and People Committee Highlight Report

Meeting Date(s):	**19 March and 16 April 2025**
Committee Chair:	**Marios Adamou, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. ICB Patient Safety Incident Response Framework Update	Members received a report to provide assurance that the ICB had embedded its own elements of the Patient Safety Incident Response Framework (PSIRF) internally, whilst appropriately supporting provider partners to do the same. Whilst all relevant providers within the system had met the 1 April 2024 national deadline for the implementation of PSIRF policies and plans, it was recognised nationally that the approaches and improvement infrastructure would take time to build capacity and capability and to demonstrate consistent and measurable improvements. Members were advised that a PSIRF 'one year' event would be held to mark the occasion, celebrate the work undertaken to date and focus on strengthening PSIRF arrangements for the next year. Patient engagement will form part of the planned development for year two. The overall assurance rating recognised the good work that had been done to date but that arrangements had not yet fully matured.	**Adequate**	**Adequate** *Awarded at the meeting held on 19 June 2024.*
2. Learning Disability and Autism (LDA) Programme Quality Improvements	Members received a report that provided an overview of the current quality oversight that the ICB had of its LDA community service provisions, the processes in place to reduce unnecessary admissions, reduce premature deaths, increase the uptake of annual health checks and improve autism/attention deficit hyperactivity disorder (ADHD) waiting times. Whilst	**Adequate**	**Partial** *Awarded at the meeting held on 20*

Item	Summary	Level of assurance	Previous level of assurance
	ADHD was not part of the LDA Programme, waiting time management for ADHD sat within the LDA oversight arrangements for NHS England and had therefore been included within the report. In discussion, it was confirmed that there were no quality concerns related to individuals transitioning from children and young people (CYP) LDA services to adult LDA services, as the LDA programme took a whole life approach. An overall assurance rating of 'adequate' was agreed with regard to the processes in place to reduce unnecessary admissions, reduce premature deaths and increase the uptake of annual health checks. However, members stressed that the element of the report advising of processes in place to improve autism/ADHD waiting times provided limited assurance.		*March 2024.*
3. Quality Oversight Report	Members received the Quality Oversight Report at both meetings and concluded on each occasion that the assurance provided was limited due to the inherent challenges within these areas. Demand throughout the urgent and emergency care pathways remained high and work was taking place collaboratively across the system to develop local solutions. The March 2025 report provided additional content in relation to the level of risk and mitigating actions being taken on services for children and young people with complex needs, as requested by the Board. Members discussed the work taking place to ensure children and young people received the right care in the right places and to support children and young people with the transition to adult services.	**Limited**	**Limited** *Awarded at the meeting held on 19 March 2025*
4. Management of Medicines: Medicines Optimisation	Members received a report that provided an overview of the structure of the range of medicines optimisation work being undertaken in the ICB, described the outcomes achieved by reviewing performance against the National	**Adequate**	*Not applicable*

Item	Summary	Level of assurance	Previous level of assurance
Annual Assurance Report 2024/25	Medicines Optimisation Opportunities metrics for 2024/25 and work being undertaken to ensure the safe and effective management of medicines. Members discussed the level of primary care engagement in the activities described within the report, highlighted the importance of patient engagement and questioned the actions that were being taken to improve performance against a number of benchmarking metrics and to address problematic polypharmacy. The overall assurance rating recognised that plans to address problematic polypharmacy were maturing.		
5. Primary Care Antimicrobial Stewardship	Members received an update report on primary care performance and prescribing against National Oversight Framework indicators, including the activities occurring across primary care to reduce antimicrobial resistance The ICB's performance against national benchmarks had been recognised both regionally and nationally and the ICB had been asked to support other systems by sharing recommendations.	**Full**	*Not applicable*
6. Quality Improvements in the delegated commissioning areas of Pharmacy, Optometry and Dental (POD)	Members received a report that aimed to provide assurance that the joint working arrangements across the East Midlands ICBs were delivering quality improvements in Pharmacy, Optometry and Dentistry (POD) services. Members discussed the process for managing POD incidents, the three-tier governance structure and the improved position around complaints management. Some concern was expressed around the reactive nature of the quality oversight arrangements for POD services. The ICB had utilised existing quality resource to support these services since they had been delegated and it was noted that the developing 'Model ICB' would shape the POD quality oversight arrangements going forward.	**Partial**	*Not applicable*

Item	Summary	Level of assurance	Previous level of assurance
7. Focussed Quality Oversight Report – Providers in National Oversight Framework Segment Three and National Oversight Framework Segment Four	At the March 2025 meeting, members received a focussed update on the position and next step plans for Nottingham University Hospitals NHS Trust and Nottinghamshire Healthcare NHS Foundation Trust. Both providers were in National Oversight Framework segment four. Members noted that the ICB would continue to fulfil its existing oversight responsibilities until it was instructed to do otherwise. As strategic commissioners, ICBs would be responsible for commissioning good quality services. The overall assurance rating recognised that whilst there was limited assurance around the pace of progress, the governance and oversight arrangements outlined within the report were robust.	**Partial**	*Not applicable*

Other considerations:

Decisions made:
The Committee: a) Approved its 2025/26 Work Programme. b) Endorsed the draft Integrated Care System Quality Strategy (Framework Model) 2025-2028. The final version of the Strategy will be presented to the Committee prior to consideration at the July 2025 meeting of the Board. c) Approved the ICB's corroborative statement for inclusion in the Nottingham University Hospital NHS Trust's annual Quality Account and publication in line with the ICB's responsibility for review and scrutiny of Quality Accounts. d) Approved the Equality Delivery Scheme report for publication on the ICB's Website, subject to the date error on the front page of the report being amended, and with the caveat that the improvement plan was still under development.

Information Items and Matters of interest:
The Committee also: a) Reviewed identified risks relating to its areas of responsibility. The number of risks remained high, at 44, with 12 of those risks graded as high risks. The current live risks were reflective of the discussions held throughout the meetings. The risks are provided for the Board's information at Appendix F. b) Received the Quality Integrated Performance Report for information. c) Received the People Operational Delivery Report for information.

Appendix C: Finance and Performance Committee Highlight Report

Meeting Date(s):	**26 March and 30 April 2025**
Committee Chair:	**Stephen Jackson, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. 2024/25 System and ICB Finance Report (Month 11 and 12)	The system had delivered a break-even position, with a small surplus of £0.1 million. This was a draft reported position that would be finalised following external audit scrutiny of the accounts of the ICB and the system's providers. The ICB had also delivered on its key financial duties and measures, which again, was subject to confirmation by the external audit function. Members noted that this had been a significant achievement during challenging times and congratulated the ICB teams for their persistent hard work to deliver the Financial Plan.	**Full**	**Adequate** *(awarded at the meeting held on 26 February 2024)*
2. 2025/26 System Financial Efficiency Update	The report provided an update on progress towards developing plans to meet the £279 million efficiency target, as detailed in the 2025/26 Operational Plan. This was the first of what would form a monthly assurance report to the Committee. 96 per cent of efficiency plans had been identified, plans had also been phased more evenly than in previous years to avoid back loading of delivery into quarter four, and system governance arrangements were in place to progress the development of the efficiency plans.	**Limited**	*Not applicable*

Item	Summary	Level of assurance	Previous level of assurance
	Members asked the ICB to provide greater assurance in the next report on delivery confidence levels, and on workforce reduction plans, and on plans for those service change enactments that required engagement or consultation. Although the Committee was assured of the robust governance arrangements that had been put in place, at this point in time, until the delivery confidence of plans had been fully tested, assurance was deemed limited, particularly in light of the wider challenges facing both the ICB and system partners.		
3. Operational Plan 2024/25 Delivery and Service Delivery Report	Members received reports highlighting areas of improvement and challenges. Areas of particular concern were highlighted as the GP two-week appointment target, planned care cancer targets and the urgent care four-hour performance target; and the actions and mitigations taking place to improve performance were discussed. The Committee asked for a specific focus on actions to address continued under performance of speech and language services to be brought to the May meeting. The overall assurance rating remained at partial, recognising good progress in many areas to date but acknowledging the risks and challenges that remained in achieving the operational plan.	**Partial**	**Partial** *(awarded at the meeting held on 26 February 2024)*
4. Primary Care Medical Services Performance Report	At a previous meeting the Committee had asked for assurance on the performance monitoring of Primary Medical Services (GP practices); and members were subsequently assured that robust governance arrangements were in place.	**Full**	*Not applicable*

Other considerations:

Decisions made:
The Committee: a) Endorsed the final draft of the ICS Infrastructure Strategy ahead of presentation to the Board at its May 2025 meeting. However, members did reference the challenging financial climate in which the system was operating and noted that the achievement of many of the aims within the strategy required considerable capital investment, the deliverability of which was difficult to test without understanding the financial requirement. b) Approved the Finance and Performance Committee's Annual Work Programme 2025/26

Information items and matters of interest:
The Committee: a) The Committee received a more in-depth report on dental performance and investment, as requested at a previous meeting. Although it had reported a positive increase in delivery of dental services and a more stable service provision, the Committee agreed that there was further work to be undertaken to understand variations in service provision, and whether access had improved in areas of particular need. b) An extract from the Operational Risk Register relevant to the Committee's remit was reviewed, which included 20 risks, with ten rated as high risks, which are provided for the Board's information at Appendix F.

Appendix D: Audit and Risk Committee Highlight Report

Meeting Date(s):	**27 March 2025**
Committee Chair:	**Gary Brown, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. Board Assurance Framework Target Risk Reports	Members had an in-depth discussion with the Acting Director of Delivery and Operations and the Acting Director of Strategy and System Development regarding the strategic risks 'owned' in their areas, which included assurance on the control environment and the work being undertaken to address any gaps in control or assurance. Noting that there had been no movement in the scores for the three strategic risks under discussion and all were some way off their target score, members sought to understand whether there were any significant weaknesses in the control environment. The discussion that followed noted that the control environments for all three risks continued to be strengthened and work to close any gaps in controls was substantially complete. In relation to the strategic risk relating to timely and equitable access, members noted the tension between meeting performance targets and meeting financial targets and noted the need for the Board to have a discussion regarding the risk appetite for this area at the scheduled session later in the year.	**Adequate**	*Not applicable*
2. Senior Information Risk Owner (SIRO) Annual Report	Members received the report, which provided assurance that information risks were being effectively managed within the ICB. It summarised key activities which had been undertaken during 2024/25, including work undertaken to meet the	**Adequate**	*Not applicable*

Item	Summary	Level of assurance	Previous level of assurance
	requirements of the Data Security and Protection Toolkit, and provided assurance on the management of cyber security and information risks and incidents. The Committee welcomed the comprehensive report that provided good assurance on the robustness of arrangements.		

Other considerations:

Decisions made:
The Committee: a) Approved the Internal Audit Plan for 2025/26 and the Counter Fraud Plan for 2025/26. b) Approved the ICB's Information Governance Management Framework.

Information items and matters of interest:
The Committee: a) Received and commented on an early draft of the Corporate Governance Report, which formed part of the ICB's Annual Report and Accounts 2024/25. The Committee also received the Interim Head of Internal Audit Opinion, which would form part of the draft annual report submission in April 2025. b) Received a progress report from the ICB's counter fraud function. The Committee also received an early draft of the annual Counter Fraud Functional Standard Return, which indicated that the ICB was on track to submit a compliant return by the deadline of 31 May 2025. c) Received an update on the progress of the 2024/25 Internal Audit Plan, which was noted as substantially complete. d) Received a verbal update from the ICB's External Audit function, noting good progress on the audit plan. e) A risk report on the two risks overseen by the Committee was discussed. The high scoring risks are provided for the Board's information at Appendix F.

Appendix E: Remuneration and Human Resources Committee Highlight Report

Meeting Date(s):	**07 April 2025**
Committee Chair:	**Mehrunnisa Lalani, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. ICB Workforce Report (including Sickness Absence Deep Dive)	The Committee received a report that provided a summary of the key information presented and discussed by the ICB's executive-led Human Resources Steering Group related to performance against a range of workforce metrics, and on this occasion, the report also included a deep dive on sickness absence, as requested by the Committee at its last meeting. Acknowledging the upcoming period of transition, members highlighted the importance of taking a proactive approach to reaching out to all staff and ensuring that early support interventions were in place for those who required them. Feedback from the staff listening events and staff health and wellbeing pulse surveys, alongside the actions taken by the Executive Management Team in response, would be presented to the next meeting of the Committee.	**Partial**	**Partial** *(Awarded at the meeting held on 27 January 2025)*
2. ICB Staff Survey Results 2024	The Committee received the ICB's 2024 NHS Staff Survey results, alongside an update on the work being completed to develop an associated action plan, which would be executive owned, but staff led. Members discussed the results and agreed that the ICB's zero-tolerance approach to bullying and harassment must continue. The staff survey action plan would be further developed to build in more relevant actions in response to the recent national announcements.	**Partial**	*Not given*

Other considerations:

Decisions made:
The Committee approved the extended appointments of the Acting Director of Delivery and Operations and Acting Director of Strategy and System Development, until such time as new ICB configurations/structures were agreed.

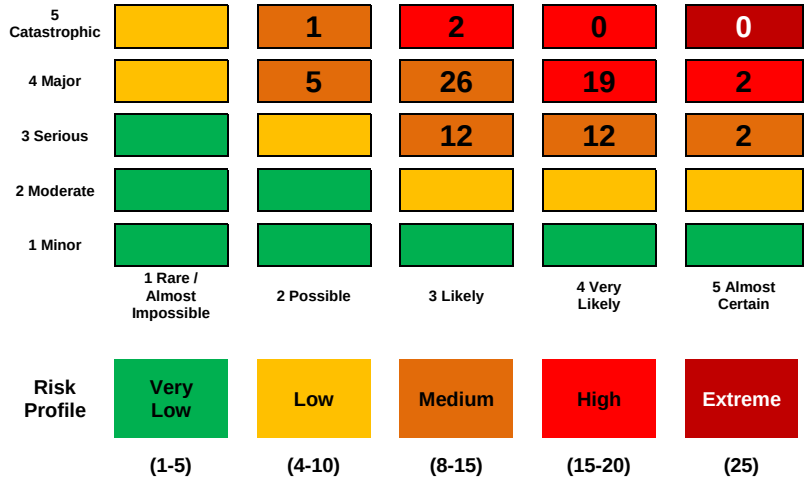
Information items and matters of interest:
The Committee: a) Discussed a proposal to appoint and remunerate an independent chair to the Nottingham and Nottinghamshire Local Maternity and Neonatal System Perinatal Scrutiny and Oversight Board. It was agreed that current chairing arrangements should continue whilst ICB recruitment was paused, and the new operating model defined. b) Received the Operational Risk Report, noting the work that would be taken forward at pace to review the existing risks and identify any required amendments to existing risks or new risks for registering following the recent national announcements. c) Members received the full 2024 NHS Staff Survey Results for information.

Appendix F: Current high-level operational risks being oversighted by the Board's committees

Risk Profile

There are 81 'live' risks within the Operational Risk Register (including both ICB and system risks). This is a decrease of three risks since the last report to the Board. Of these 81 risks; 23 risks are scored at a high-level, accounting for 28% of the total risks. This proportion is moderately lower than the last report to the Board when 40% were scored at a high-level. The risk profile is shown in figure 1 below.

Figure 1



The 23 high-level operational risks include three risks classed as confidential, due to the nature of these risks. Risk may be classed as confidential if they are commercially sensitive or at draft stage. The confidential risks are reported separately and excluded from the analysis and detail of this report.

Risk Movement

The remaining 20 high-level operational risks included in this paper are detailed in the below table. There is an overall decrease of six risks since the last report to the Board. Movement in the high-level risks is described below:

a) Two risks previously reported in the confidential report are no longer classed as confidential and, as such, have been included in this report *(risk 128 relating to children in crisis cared for in inappropriate clinical settings and risk 218 relating to relationships during financial efficiency and operational delivery challenges).*

b) One new risk has been identified since the last report to the Board (*risk 249 relating to insufficient appropriate mental health placements, inpatient and community).*

c) Four risks have decreased in score and no longer meet threshold for reporting to the Board.

d) Five risks have been archived.

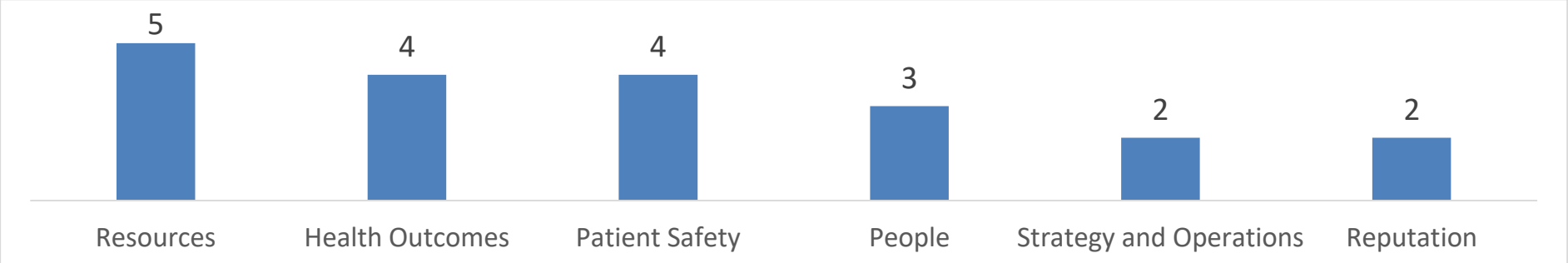
Risk Appetite

Due to being high-level, all risks reported to the Board are above the organisation's agreed risk appetite levels. Furthermore, Board members should note that 98% of all the operational risks in the ORR are above agreed risk appetite levels.

Risk Domains

As a reminder, there are nine risk domains used when classifying operational risks. Figure 2 below shows how many high-level risks sit which each domain. There are no high-level risks within the risk domains of health inequalities, legal and social and economic development.

Figure 2



Details of High-Scoring Risks

Operational risk reports continue to be routinely presented to the Board's committees, enabling the ongoing review and scrutiny of all risks, including those high-level risks. At present, 43% of the high-level risks are reported to the Quality and People Committee.

Risk Ref.	Risk Description	Score	Responsible Committee
ORR084	If organisations within the ICS are unable to access IT systems (i.e. unexpected system outage, successful cyber-attacks or issues with the availability of products and	**High** 20 (I4 x L5)	Audit and Risk Committee

Risk Ref.	Risk Description	Score	Responsible Committee
	services) they may not be able to conduct core business as usual functions. This may result in patients not receiving timely diagnosis or treatment due to necessary equipment not functioning or patient records being unavailable. It may also result in unfavourable media coverage, reputational damage, and significant cost pressures.		
ORR090	If the Nottingham and Nottinghamshire system does not have sufficient system partner 'buy in' and capacity (digital workforce and operational workforce) to engage with and deliver digital transformation schemes alongside business-as-usual delivery it may not be possible to progress the System, Primary Care and ICB digital transformation agenda. Additionally, this may lead to missed opportunities in relation to funding available for digital transformation. This risk may be further exacerbated by current financial challenges.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR195	If NHS Nottingham and Nottinghamshire ICB is unable to identify and implement sustainable recurrent financial efficiency solutions, at pace, there is a risk the ICB's underlying position (UDL) will continue to worsen with impact to the ability to deliver within the ICB's financial resources.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR196	If the Nottingham/shire NHS system, as a collective, does not meet its agreed 2024/25 year-end financial position, there is a risk to the extent to which the system will be able to create financial 'headroom' to invest in services. This may lead to reputational issues and increasing levels of intervention by NHS England.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR197	If the Nottingham/shire NHS system, as a collective is unable to identify and implement sustainable recurrent financial efficiency solutions, at pace, there is a risk the collective underlying position will continue to worsen, which may significantly impact Nottingham/shire's ability to become a financially sustainable system.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR212	As workforce planning is based on short term plans set nationally, and due to limitations with access to data, there is a risk the Nottingham/shire system may not have a clear understanding of future NHS workforce requirements. This may lead to	**High** 16 (I4 x L4)	Finance and Performance Committee

Risk Ref.	Risk Description	Score	Responsible Committee
	inability to identify and implement a sustainable workforce plan, exacerbating the risk to financial stability.		
ORR218	In pursuit of NHS financial efficiencies and operational delivery across the system, there is a risk that relationships may decline (with ICS partners and wider stakeholders). This may lead to deterioration in collaborative efforts, communication breakdowns and wider stakeholder dissatisfaction.	**High** 16 (I4 x L4)	Finance and Performance Committee
ORR210	If the management of ICB headcount reductions, driven by ICB financial 'grip and control' processes, continues amidst ongoing operational challenges and workforce pressures, there is a risk to deterioration in staff health, wellbeing and morale. This may impact on staff productivity and lead to staff feeling disconnected or disengaged with the ICB.	**High** 16 (I4 x L4)	Remuneration and HR Committee
ORR191	If Nottinghamshire Healthcare NHS Foundation Trust (NHCT) do not have the capability to make the required quality improvements identified as a result of current quality, staffing and performance concerns and exacerbated by regional and national reviews, there is a risk the quality of services provided may not meet optimal care standards. This may lead to potential risk of harm and poor health outcomes to the population of Nottingham/shire.	**High** 20 (I4 x L5)	Quality and People Committee
ORR077	If the NHS continues to implement headcount reductions as part of its financial 'grip and control' measures, while social care providers face their own financial and operational pressures, there is a risk of ongoing workforce strain across both sectors. This could result in increased sickness, exhaustion, and burnout, undermining the psychological safety of the workforce across health, social care, and primary medical services providers.	**High** 16 (I4 x L4)	Quality and People Committee
ORR128	If demand and capacity constraints continue, children in crisis or children who are emotionally dysregulated, including those medically fit after a crisis, may be placed in unsuitable clinical settings (e.g. Emergency Departments, children's wards, or S136 suites). This poses risks to the child, other children, and staff. It could also delay	**High** 16 (I4 x L4)	Quality and People Committee

Risk Ref.	Risk Description	Score	Responsible Committee
	treatment beyond NHS England targets and result in children not receiving care and treatment in a timely way. Moreover, these inappropriate placements limit access to appropriate settings for those in need.		
ORR177	If system workforce planning continues to be set nationally on a short-term basis, and local operational and financial challenges persist, there is risk medium to longer term strategic education and planning needs may not be addressed. This may lead to issues with initial workforce supply and ineffective use of workforce. This risk is exacerbated by challenges experienced in getting system data into a single place to support ICS workforce planning and projections.	**High** 16 (I4 x L4)	Quality and People Committee
ORR207	If challenges in the provision and delivery of community mental health services persist, there is risk that these services may not be accessed, or accessed promptly, and/or meet the current and future needs of the population. This may result in worsening health outcomes for adults and children across Nottingham/shire. This risk may also result in increased demand on other services as activity may be displaced to other partners within the system.	**High** 16 (I4 x L4)	Quality and People Committee
ORR221	If ongoing adverse reports in national and local media continue, there is a growing risk of declining public confidence, which may lead to citizens failing to access appropriate services in a timely manner. This could result in delayed interventions, reduced service effectiveness, and further strain on public resources.	**High** 16 (I4 x L4)	Quality and People Committee
ORR224	If Nottingham University Hospitals NHS Trust (NUH) fail to sustain improvements made to date following CQC and external recommendations, there is a risk quality of services may decline. This may lead to compromised patient safety and quality of care which could result in poor patient experience and adverse health outcomes for the population of Nottingham/shire.	**High** 16 (I4 x L4)	Quality and People Committee
ORR249 (new risk)	If challenges relating to delayed discharge and unavailability of mental health placements (both inpatient and community) continue, there is an increased risk of adults being placed out-of-area and/or in inappropriate care settings. This may cause	**High** 16 (I4 x L4)	Quality and People Committee

Risk Ref.	Risk Description	Score	Responsible Committee
	distress, potential harm, and crisis situations, straining urgent care services and the wider health system. This risk relates to adults including those in acute beds requiring ongoing mental health support once their physical health issues have resolved.		
ORR208	If the quality of maternity services does not improve, services provided may not meet optimal care standards. This may result in potential risk of harm (i.e. physical and psychological) and poor patient experience for women, birthing people, their babies, and families.	**High** 15 (I5 x L3)	Quality and People Committee
ORR155	If the transformation of urgent and emergency care services is not delivered, there is a risk that limited health and social care resources may not be used most efficiently. This may lead to an inability to meet demand: today and in the future.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee
ORR159	If General Practices, Primary Care Networks, community pharmacy and the ICB do not have appropriate capacity, capability and resources to deliver actions in relation to delivery of ICS Primary Care Strategy, Primary Care Access Recovery Plan (PCARP) and achievement of NHS England's two-week GP appointment target then expected transformation may not be delivered. This may, in turn, impact on the ability to meet the needs of our population.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee
ORR192	If resources at Nottinghamshire Healthcare NHS Foundation Trust (NHCT) are primarily focused on addressing immediate quality, staffing and performance concerns, there is risk that there may not be sufficient capacity or ‘headspace’ to deliver mental health and community service transformation. This may result in future population needs not being made and/or anticipated efficiencies not materialising.	**High** 16 (I4 x L4)	Strategic Planning and Integration Committee

NHS Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**2024/25 Senior Information Risk Owner Annual Report**
Paper Reference:	ICB 25 020
Report Author:	Dr Dave Briggs, Medical Director (Senior Information Risk Owner) Loretta Bradley, Head of Information Governance and Data Protection Officer (DPO)
Report Sponsor:	Dr Dave Briggs, Medical Director (Senior Information Risk Owner)
Presenter:	-

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

Summary:

The purpose of the Senior Information Risk Owner (SIRO) Annual Report is to provide assurance to the Board that information risks are being effectively managed within the ICB. It summarises the key activities undertaken during 2024/25, including work completed to meet the requirements of the Data Security and Protection Toolkit, and provides assurance on the management of cyber security and information risks and incidents.

Recommendation(s):

The Board is requested to **note** the 2024/25 SIRO Annual Report and Information Governance Management Framework for information.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	Robust data security supports safe, data-driven healthcare improvements.
Tackle inequalities in outcomes, experience, and access	Secure information systems help identify and reduce health disparities.
Enhance productivity and value for money	Strong cyber resilience protects data integrity, enabling efficient resource use.
Help the NHS support broader social and economic development	Secure data sharing underpins system-wide collaboration and innovation.

Appendices:

A: Information Governance Management Framework.

Board Assurance Framework:

Not applicable.

Report Previously Received By:

The SIRO Annual Report was reviewed and endorsed by the Audit and Risk Committee at its 27 March 2025 meeting.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

2024/25 Senior Information Risk Owner Annual Report

Introduction and background

1. As the Senior Information Risk Owner (SIRO) for NHS Nottingham and Nottinghamshire Integrated Care Board (ICB), I am responsible for ensuring that our organisation has a robust approach to information governance, data security, and information risk management. This is an important Board-level role, and I take overall accountability for managing information risks across the ICB.
2. The ICB has a robust control framework in place to manage information risks; this is well described within the ICB's Information Governance Management Framework (which is provided at Appendix A for information).
3. The Audit and Risk Committee is responsible for overseeing the ICB's compliance with the regulatory requirements for information governance (including data protection and cyber security). It receives information governance assurance updates on at least a twice-yearly basis.
4. The ICB has a well-established Information Governance Steering Group (IGSG) that has operational responsibility for developing, monitoring, and implementing comprehensive and effective information governance arrangements within the organisation. The IGSG drives the information governance agenda within the ICB and provides a focal point for the discussion and resolution of information governance risks and issues. I am an active member of this group, along with Rosa Waddingham, as the ICB's the Caldicott Guardian, ensuring executive-level ownership of both the information governance and cyber security agendas. The IGSG met five times during the period April 2024 to March 2025.
5. The purpose of my Annual Report is to provide assurance to the Board that information risks are being effectively managed within the ICB. It summarises key activities that have been undertaken during 2024/25, including work to meet the requirements of the Data Security and Protection Toolkit, and provides assurance on the management of cyber security and information risks and incidents.

Data Security and Protection Toolkit (DSPT)

6. The annual Data Security and Protection Toolkit (DSPT) self-assessment deadline is the 30 June. The DSPT annual self-assessment submission for 2023/24 was made on the 28 June 2024 and we submitted a 'fully met' assessment. Our self-assessment was subject to an independent internal audit review, by 360 Assurance, prior to submission.

7. 360 Assurance reviewed the ICB's self-assessment against 13 assertions across ten National Data Guardian Standards within the 2023/24 Toolkit. A 'substantial' level of assurance was provided overall, as well as for each of the ten individual Standard areas.

8. The DSPT was updated in September 2024 to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and information governance assurance. This was a commitment made in the Department of Health and Social Care's cyber security strategy to 2030.

9. The new CAF-aligned DSPT aims to:

   a) Emphasise good decision-making over compliance, focussing on better understanding and ownership of information risks at the local organisation level, where those risks can be most effectively managed.

   b) Support a culture of evaluation and improvement by encouraging processes that meet desired outcomes, focused on effective measures, rather than what ticks a compliance box.

   c) Create opportunities for better practice by ensuring processes remain current with new security measures to address emerging threats and risks.

10. The CAF-aligned DSPT consists of five objectives, 18 principles and 46 contributing outcomes (supported by 540 indicators of good practice). The five objectives are summarised in the table below:

Objective	Goal	Focus
A. **Managing Risk**	Enhance decision-making and ownership of information risks at the local level.	Encourage a proactive approach to identifying, assessing, and mitigating risks.
B. **Protecting Against Cyber Attacks**	Implement measures to safeguard against cyber threats and data breaches.	Strengthen defences to prevent unauthorised access and data loss.
C. **Detecting Cyber Security Events**	Improve the ability to detect and respond to cyber security incidents.	Develop robust monitoring and alerting systems to identify potential threats.
D. **Minimising the Impact of Incidents**	Reduce the impact of cyber security incidents on operations and data integrity.	Establish effective incident response and recovery plans.
E. **Using and Sharing Information Appropriately**	Ensure information is used and shared securely and in compliance with regulations.	Promote best practices for data handling and sharing within and between organisations

11. The CAF-aligned DSPT is not designed with an expectation that organisations will achieve all outcomes. For many outcomes, a level of ‘partially achieved’ is seen as proportionate, and in some cases ‘not achieved’ may be appropriate (for example – some CAF outcomes represent capabilities only normally held by organisations with very high cyber security maturity and resources). NHS England will set a minimum achievement level for each outcome, known as the ‘CAF profile’; this will need to be met to be graded ‘Standards Met’ on the DSPT. The CAF profiles will be made progressively more stringent over time; however, as the assessment framework will remain effectively constant, organisations will be able to forecast future expectations much further in advance, enabling better planning.
12. The scope of the CAF-aligned DSPT is centred on the organisation's ‘essential functions’, which must be locally defined and approved. Through the work of the IGSG, I have overseen the completion of an initial scoping exercise of the ICB’s essential functions (and the information, systems and networks that support the functions). This documents, as required, a risk-based justification of the scope of the CAF-aligned DSPT assessment for 2024/25. This will be maintained as an evolving document over the coming months ahead of the final submission on the 30 June 2025.
13. In response to the significant changes brought about by the new CAF-aligned DSPT, a revised programme approach has been established within the ICB. This ensures that the annual submission process is supported by a robust and continuous programme of work to address information governance and cyber risks, while ensuring that the ICB remains secure and compliant with NHS standards and regulations.
14. A baseline submission was made in December 2024 as per national requirements of the CAF-aligned DSPT. This reported the ICB’s position as ‘not achieved’ against all outcomes; however, the submission was able to confirm that a full assessment had been undertaken and that work had commenced to meet the required levels of achievement by June 2025.
15. A detailed DSPT Improvement Plan has been developed and delivery is monitored through the established programme management arrangements, overseen by the IGSG. At time of writing, there are no areas of concern regarding achievement of the plan.
16. An internal audit of the ICB’s self-assessment is scheduled for completion ahead of the final 2024/25 submission. The audit will focus on a common set of eight outcomes mandated by NHS England, along with four locally determined outcomes that have been agreed by the IGSG.

Cyber security

17. The Nottingham and Nottinghamshire ICS Cyber Security Strategy (2024-2030) was approved by the Board in November 2024. This shared strategy, across NHS partners within the ICS, supports a unified and collaborative approach to ensuring cyber security across the system.

18. Progress in relation to the Strategy, which is built around the following five 'core' pillars, will be overseen by the ICB's Audit and Risk Committee:

    a) Focus on the greatest risks and harms (risk management, asset management and vulnerability management).

    b) Defend as one (identity and access management, logging, and monitoring).

    c) People and culture (engagement and training).

    d) Build secure for the future (architecture and configuration, data security, supply chain security).

    e) Exemplary response and recovery (incident management).

19. Overall, responsibility for the ICB's cyber security sits with the Chief Digital Officer, who is accountable to me, as SIRO. However, operational cyber security and information and communication technology support is provided by Nottinghamshire Health Informatics Service (NHIS), which has an established cyber security assurance infrastructure in place. This includes a Cyber Security Assurance (CSA) Programme Board and CSA Delivery Group. The Programme Board meets bi-monthly and has representation from Sherwood Forest Hospitals NHS Foundation Trust, NHS Nottingham and Nottinghamshire ICB and Nottingham CityCare Partnership.

20. The CSA Delivery Group has a cyber workplan which consists of 59 commitments to maintain an effective and cyber-secure network and infrastructure. Progress in relation to delivery of the workplan is also overseen by the ICB's Audit and Risk Committee. Good progress is being made, and at the time of writing, 34 commitments have been completed, ten are almost complete and 15 are in progress.

21. The CAS Programme Board and Delivery Group also routinely consider information technology and cyber risks relating to local, regional, and national activities. Escalation of ICB relevant risks is via the IGSG and Audit and Risk Committee.

Information assets and personal data flows

22. The effective management of information assets is essential to ensuring the organisation can manage information risks. The ICB maintains a Register of

Information Assets, and personal data flows, as part of the requirement to keep a Register of Processing Activities (RoPA) under data protection legislation.

23. Each information asset has an assigned Information Asset Owner and an Information Asset Manager, who are responsible for their assets, which includes proving me with assurance that they are keeping their entries on the register up to date. The register is updated continuously and reviewed in its entirety at least annually. Each recorded asset has a high-level risk assessment, which IAOs must review and keep updated.

24. Following the 2023/24 annual review of the Information Asset Register, a report was presented to the IGSG, which confirmed the completion of the review process, summarised key findings and highlighted any significant outcomes. Where applicable, findings were incorporated into staff training, policy and procedure updates, and internal communications to enhance information governance practices.

25. A thorough review of the Information Asset Register is currently underway for 2024/25; scheduled to be concluded by June 2025. This will ensure that all essential functions are accurately mapped to the corresponding information assets and data flows. The review will also verify that the register remains accurate, up to date, and complete. At the time of writing, 230 information assets and 363 data flows are recorded within the register.

Information risks

26. Information and data security risks are identified through various sources, including Data Protection Impact Assessments, regular reviews of the Information Asset Register, and the identification of gaps in compliance with the requirements of the DSPT. They may also be identified following incidents, business continuity exercises, audit findings, and external assessments.

27. Risks are also identified through discussions at key governance and partnership groups (such as the Cyber Security Assurance Programme Board), as well as engagement with senior responsible officers, operational leads, and clinical colleagues.

28. All identified risks are captured and mitigated in line with the ICB’s corporate risk management arrangements. The IGSG reviews the ICB’s data protection and information security risks at every meeting, and as SIRO, I am kept fully informed of all high-scoring risks.

29. There are currently two data protection and information security risks that are at a significant enough level to be recorded on the ICB’s Operational Risk Register. Both relate to the risk of successful cyber-attacks, recognising the potential for healthcare services to be disrupted if access to records or essential equipment is impacted, and the potential for data to be extracted,

shared inappropriately or exploited. These risks are being mitigated through delivery of a system-wide cyber security strategy, focussed on enhancing digital solutions to reduce vulnerabilities and reducing risks related to emerging technologies.

Incidents and near misses

30. Information governance incidents or personal data breaches, including near misses, are reportable. Serious incidents must also be reported to the Information Commissioner's Office under the Data Protection Act 2018. Serious data breach incidents are reported through the DSPT and incidents meeting a specified threshold will trigger automatic notification to the Department of Health and Social Care and Information Commissioner's Office.

31. There have been 27 reported data breach incidents and four near misses during the period 1 April 2024 and 31 March 2025; 25 of the data breaches resulted from accidental disclosure, which is the most common cause of information governance incidents. The other two incidents were due to inappropriate access and unlawful destruction, loss, alteration, or disclosure. Three of the near misses resulted from accidental disclosure, with the remaining one being due to failure and/or loss of equipment, allowing unauthorised access or use.

32. All reported information incidents are received and reviewed by the Information Governance Team, acted upon quickly and followed up, as necessary. None of the reported incidents occurring since 1 April 2024 were classed as serious.

33. The overriding common cause of incidents is data shared in error with 'human error' being the leading contributory factor or root cause (i.e. email accidentally sent to an incorrect email address). Root causes are carefully identified as are lessons learned, which are shared appropriately and as widely as is useful, with the objective of preventing them from reoccurring. Any identified trends are incorporated into staff communications and training, and are used to inform policy and procedure updates, as relevant.

Staff awareness (training and communication)

34. In December 2024, a refreshed Staff Training, Awareness and Communications Plan was agreed, which sets out how the ICB will ensure that all staff are appropriately trained and aware of their responsibilities regarding data security and protection. The plan serves as a strategic framework for raising awareness and promoting a culture of data security throughout the ICB and sets out the specific training requirements for staff across various roles within the organisation, ensuring staff are competent and well-equipped to handle

personal and sensitive data securely, in compliance with relevant laws and guidelines.

35. The plan is supported by a comprehensive Training Needs Analysis (TNA). As part of this, all staff are mandated to complete data security awareness training on an annual basis. The target compliance rate is 95%, which was achieved for the purposes of the 2023/24 DSPT submission. At the time of writing, the ICB had achieved the required compliance rate of 95% for the 2024/25 submission.

36. The TNA also identifies staff groups that require additional, role-specific training due to the nature of their responsibilities; this includes training for information asset owners and information asset managers, as well as training for me as the ICB's SIRO and the Caldicott Guardian. A twice-yearly Freedom of Information and Records Management Training Masterclass has also been introduced.

37. Communications activities are both proactive and reactive, helping the ICB continuously improve its data security maturity while addressing issues that arise in real-time. Six 'targeted' and proactive Staff News articles have been published since July 2024 relating to cyber security and data protection. A further seven reactive communications have been released in response to incidents, publications and queries identified by staff.

38. Delivery of the plan is routinely monitored by the IGSG and overseen by the Audit and Risk Committee.

Conclusion

39. As SIRO, I am assured that we have a strong foundation for managing information risks within the ICB. We have fully met the requirements of the NHS Data Security and Protection Toolkit and received substantial assurance from our internal auditors, demonstrating our commitment to compliance. Our new Cyber Security Strategy, agreed in 2024, provides a clear direction for strengthening our resilience, supported by robust oversight and embedded governance through NHIS.

40. We continue to enhance our processes for managing information assets and personal data flows, and our risk management framework is well-embedded. A key focus this year has been strengthening staff awareness through both proactive and reactive communication and training. This approach is helping to embed a culture where information governance and security risks are recognised and addressed effectively.

41. However, cyber threats remain a significant and evolving challenge. While we have strong protections in place, continued vigilance, and a collective commitment to cyber resilience will be essential. I am confident in the progress we have made and our ability to adapt to emerging risks, ensuring that information security remains a priority for the ICB.

Appendix A

Nottingham and Nottinghamshire Integrated Care Board

Information Governance Management Framework

March 2025 - March 2028

CONTROL RECORD	
Title	Information Governance Management Framework
Reference Number	IG-001
Version	3.0
Status	Final draft
Author	Head of Information Governance
Sponsor	Director of Corporate Affairs
Team	Information Governance Team
Amendments	Reviewed to ensure accessibility requirements met.
Purpose	Ensures compliance with legal and regulatory requirements, defines roles and responsibilities, standardises policies and procedures, mitigates risks, promotes staff awareness, enables secure information sharing, and provides assurance that data is managed lawfully, securely, and effectively.
Superseded Documents	N/A
Audience	All staff within the NHS Nottingham and Nottinghamshire Integrated Care Board, including those working in a temporary capacity.
Consulted with	Information Governance Steering Group
Equality Impact Assessment	N/A
Approving Body	Audit and Risk Committee
Date approved	March 2025
Date of Issue	April 2025
Review Date	March 2028
This is a controlled document and whilst this policy may be printed, the electronic version available on the ICB's document management system is the only true copy. As a controlled document, this document should not be saved onto local or network drives.	

NHS Nottingham and Nottinghamshire Integrated Care Board (ICB's) policies can be made available on request in a range of languages, large print, Braille, audio, electronic and other accessible formats from the Engagement and Communications Team at nnicb-nn.comms@nhs.net.

Contents

1. Introduction

1.1 Information governance is a framework for handling personal information in a confidential and secure manner to appropriate ethical and quality standards in a modern health service. It provides a consistent way for employees to deal with the many different information handling requirements including:

- Information governance management.
- Clinical information assurance for safe patient care.
- Confidentiality and data protection assurance.
- Corporate information assurance.
- Information security assurance.
- Secondary use assurance.
- Respecting data subjects' rights regarding the processing of their personal data.

1.2 NHS Nottingham and Nottinghamshire ICB's Information Governance Management Framework (IGMF) provides a structured approach to managing information governance activities. It ensures compliance with relevant legislation and standards, identifies, and mitigates information risks, and outlines accountability for information governance. The framework promotes continuous improvement, includes training and awareness programs, and establishes procedures for incident management, ultimately supporting the secure and effective handling of patient data and enhancing the quality of commissioned services.

1.3 The Information Governance Management Framework (IGMF) ensures compliance with key legal requirements, including the Data Protection Act 2018, the UK General Data Protection Regulation (UK GDPR) 2016, the Common Law Duty of Confidence, the Human Rights Act 1998, and the Privacy and Electronic Communications (EC Directive) Regulations 2003.

It also aligns with the NHS Data Security and Protection Toolkit (DSPT) and the National Cyber Security Centre's Cyber Assessment Framework (CAF). By adhering to these regulations and frameworks, the IGMF ensures that the ICB manages information securely, protects patient confidentiality, and meets all statutory and regulatory obligations.

2. Purpose

2.1 To outline the strategic framework for managing and supporting the information governance agenda of the ICB. The IGMF provides a solid basis upon which information governance and all its component parts will be implemented throughout the ICB.

2.2. To describe the roles and responsibilities of those who are tasked with overseeing that information governance is appropriately supported and to describe the information governance responsibilities of all staff.

2.3. The ICB will ensure:

- Regulatory and legislative requirements will be met.
- Confidentiality of information will be assured.
- Information will be protected against unauthorised access.
- Quality and integrity of information will be maintained.
- Business continuity plans will be produced, maintained, and tested.
- Information governance training will be available to all staff.
- All information governance breaches, actual or suspected, will be reported to, and investigated by the Information Governance Team, in conjunction with the Data Protection Officer.
- The mandatory requirements of the annual CAF-aligned Data Security and Protection Toolkit are met.

2.4. To inform and support staff to protect the organisation's essential functions through effective information asset management.

2.5 To help ensure that the ICB can demonstrate personal data is:

- Held securely and confidentially.
- Processed fairly and lawfully.
- Obtained for specific purpose(s).
- Recorded accurately and reliably.
- Used effectively and ethically.
- Shared and disclosed appropriately and lawfully.

3. Scope

3.1 This Information Governance Management Framework applies to:

- All staff – This includes all individuals employed by the ICB and those working within the ICB in a temporary capacity, including agency staff; seconded staff; students and trainees; self-employed consultants or other individuals working for the ICB under contract for services individuals appointed to the Integrated Care Board and its Committees and any other individual directly involved with the business or decision-making of the ICB.

- Systems – ICB systems include, but are not limited to, discrete systems such as those holding information relating to patients, finance, risk, complaints, incidents, corporate records, human resources, and payroll; less technical systems such as excel spreadsheets held on the network, and paper-based systems such as complaints files.
- Information – All information processed (electronic and paper based) in relation to any ICB activity whether by employees or other individuals or organisations under a contractual relationship with the ICB.
- Networks – the infrastructure that provides the means to connect computers, servers, and devices to facilitate communications and the sharing of data.

4 Information Governance Policy and Strategy Framework

4.1 The ICB has a number of key policy and strategy to ensure that compliance with all relevant legal and regulatory frameworks is achieved, monitored, and maintained. These are outlined in the table below:

Document	Description
ICB Policies	
Confidentiality and Data Protection Policy (IG-002)	Sets out the roles and responsibilities for compliance with the Data Protection Act and lays down the principles that must be observed by all who work within the ICB and have access to personal or confidential business information in line with common law obligations of confidentiality and the NHS Confidentiality Code of Practice.
Information Security Policy (IG-003)	This policy is to protect, to a consistently high standard, all information assets. The policy defines security measures applied through technology and encompasses the expected behaviour of those who manage information within the organisation.
Internet and Email Policy (IG-004)	Ensures ICB staff understand their responsibilities for correctly accessing the internet and understand what the ICB deems to be acceptable use of the email system via the organisation's IT systems, while on ICB premises, working remotely and when acting in representation of the organisation.
Data Quality Policy (IG-005)	Sets out a clear policy framework for maintaining and increasing high levels of data quality within the ICB in order to ensure reliable, complete, and accurate data for analysis and decision-making and which is in line with data protection and other legislation and standards.
Records Management Policy (IG-009)	Promotes the effective management and use of information, recognising its value and importance as a resource for the delivery of corporate and service objectives.

Document	Description
Freedom of Information Policy (IG-010)	Sets out the roles and responsibilities for compliance with the Freedom of Information Act and Environmental Information Regulations.
Risk Management Policy (GOV-001)	Describes the ICB's approach to the management of strategic and operational risks specifically including information risks across the ICB. It references the SIRO's role in information risk management.
Incident Reporting and Management Policy (H&S 004)	Describes the approach to the reporting, management, and investigation of all corporate incidents (including accidents and near misses) that occur within the ICB including data security and other Information Governance incidents.
Emergency Planning and Preparedness Policy (EPRR-001)	Outlines how the ICB will have plans and arrangements in place to act in accordance with the Civil Contingencies Act 2014 (CCA), the Health and Social Care Act 2012 (H&SCA) and to comply with the requirements of the NHS England EPRR Core Standards, links into business continuity which is closely connected to information security and the protection of essential functions.
Nottinghamshire Health Informatics Services (NHIS) Policies *(required to be followed by ICB staff)*	**Network Security Policy** **Account Management and Access Policy** **Removable Media Policy** **Registration Authority Policy** **Audit Logging and Monitoring Policy**
Strategies	**Nottingham and Nottinghamshire ICS Cyber Security Strategy** **Digital, Data and Technology Strategy** Digital Notts Strategy I Digital, Data & Technology (DDaT)

5 Roles and Responsibilities

5.1 Senior level ownership and understanding of information risk management is vital and ensures a clear link to the overall risk management culture of the organisation. Senior leadership demonstrates the importance of the issue and is critical for ensuring information security remains high on the agenda of the ICB and that resource requirements needed to support this agenda are understood.

The table below provides high level descriptions of the information governance responsibilities within the ICB and more detailed descriptions for the key roles can be found at **Appendix A.**

Role	Responsibilities
Board	The Board has overall responsibility for ensuring that the ICB complies with information governance standards, including the protection of data in accordance with all relevant legislation. It is also responsible for overseeing development and implementation of a comprehensive cyber security strategy, ensuring the resilience of digital infrastructure against evolving cyber threats.
Audit and Risk Committee	The Audit and Risk Committee is responsible for overseeing the ICB's compliance with the regulatory requirements for information governance (including data protection and cyber security).
Information Governance Steering Group	The Information Governance Steering Group (IGSG) has operational responsibility for developing, monitoring, and implementing comprehensive and effective information governance arrangements within the organisation. The IGSG drives the information governance agenda within the ICB and provides a focal point for the discussion and resolution of information governance risks and issues.
Chief Executive	The Chief Executive is accountable for ensuring the ICB adheres to information governance, data protection and cybersecurity standards, driving a culture of compliance and risk management across the ICB.
Senior Information Risk Owner (SIRO)	The SIRO operates at Board level and is responsible for ensuring that organisational information risk is properly identified and managed, and that appropriate assurance mechanisms exist to support the effective management of information risk.
Caldicott Guardian	The Caldicott Guardian operates at Board level and is responsible for ensuring that personal information and patient information in particular is used legally, ethically, and appropriately, and that confidentiality is maintained.
Data Protection Officer (DPO)	The Data Protection Officer has a direct reporting line to the ICB's Board and will assist in the monitoring of internal compliance, inform, and advise on data protection obligations and risks, provide advice regarding Data Protection Impact Assessments (DPIAs) and act as a contact point for data subjects and the Information Commissioner's Office. The ICB will ensure that the Data Protection Officer has sufficient support to carry out their role independently, ensuring that they are not penalised for performing their tasks. *Article 38 of the GDPR provides that the controller and the processor shall ensure that the DPO is 'involved, properly and in a timely manner, in all issues which relate to the protection of personal data'.* *Article 39(1)(b) entrusts DPOs with the duty to monitor compliance with the GDPR. Recital 97 further specifies that the DPO 'should*

Role	Responsibilities
	assist the controller or the processor to monitor internal compliance with this Regulation.
Chief Digital Officer *supported by IT function and Nottinghamshire Health Informatics Service (NHIS)*	The Chief Digital Officer is responsible for leading the development and execution of the ICB's digital strategy, ensuring that cybersecurity is integrated into all digital initiatives and innovations. They work to align digital transformation with robust security frameworks, safeguarding systems, data, and infrastructure from emerging cyber threats.
Director of Corporate Affairs *supported by the Risk, Information and Assurance Team*	The Director of Corporate Affairs advises the Board on information governance matters, ensuring that polices related to data protection, transparency and accountability are effectively communicated and adhered to across the ICB. They also oversee compliance with legal and regulatory requirements.
Information Asset Owners (IAOs) *(Executive / Senior Leadership Level)*	Information Asset Owners (IAOs) are responsible for ensuring that information assets under their control are managed securely, in compliance with data protection and information governance policies. They oversee the use, protection, and retention of data, ensuring that risks are mitigated, and access is appropriately controlled.
Information Asset Managers (IAMs) *aka. Information Asset Administrators (IAAs)*	Information Asset Managers are responsible for the data integrity of applications, user access including auditing of access, ensuring that there are appropriate operational procedures that include backup, business continuity planning. They liaise with system suppliers, where appropriate, to ensure that the asset is maintained and 'fit for purpose'. IAMs are responsible for ensuring their asset information is up to date on the ICB's Information Asset Register (IAR).
All staff	All staff, as defined by the scope of the IGMF, must be aware of their own individual responsibilities for the maintenance of confidentiality, data protection, and information security management and information quality. This is cascaded through employment contracts, third party contracts, policy and processes and staff awareness and training.
Information Governance Team	The IG Team develops and delivers the Information Governance Annual Work Plan and supports key roles like the SIRO, Caldicott Guardian, and DPO. Their main responsibilities include: • Ensuring compliance with information governance targets, data protection, Caldicott principles, and information security. • Implementing robust security and encryption for electronic resources.

Role	Responsibilities
	• Managing records storage, archiving, and security for personal data. • Mapping personal information flows and maintaining a register of information assets. • Identifying and reporting information governance risks. • Providing advice on information governance, data protection, and related legislation. • Developing and maintaining documentation and policies. • Delivering communications and training to staff. • Supporting the Information Governance Steering Group (IGSG). • Advising on tendering and procurement processes to ensure robust information governance.
Corporate Assurance Team	The Corporate Assurance Team is responsible for ensuring compliance with NHS corporate record standards, managing corporate records, and overseeing Freedom of Information (FOI) process. They also handle policy management, ensuring that all ICB policies are up-to-date, accessible, and aligned with legal and regulatory requirements. The Corporate Assurance Team also project manages delivery of the CAF-aligned Data Security and Protection Toolkit.

6 Staff Awareness

6.1 The ICB has a robust Staff Training, Awareness and Communications Plan, which sets out how the ICB will ensure that all staff are appropriately trained and aware of their responsibilities regarding data security and protection. The plan serves as a strategic framework for raising awareness and promoting a culture of data security throughout the ICB and sets out the specific training requirements for staff across various roles within the organisation, ensuring staff are competent and well-equipped to handle personal and sensitive data securely, in compliance with relevant laws and guidelines.

6.2 The plan is supported by a comprehensive Training Needs Analysis (TNA). As part of this, all staff are mandated to complete data security awareness training on an annual basis.

6.3 Any individual who has comments regarding the content of this IGMF or has difficulty understanding how this framework relates to their role, should raise this with their line manager or contact the Information Governance team at: nnicb-nn.igteam@nhs.net

Appendix A: Key Role Descriptions

Senior Information Risk Owner (SIRO)	Caldicott Guardian
Accountability: Holding Information Asset Owners accountable for managing information assets and related risks. **Leadership:** Leading efforts to protect and use information effectively for the success of the Integrated Care Board (ICB) and its population. **Security Oversight:** Overseeing assurance of information governance and cyber security compliance among commissioned service providers. **Advisory Role:** Advising the ICB on information risk, system-wide issues, performance, and conformance with risk management requirements. **Policy Ownership:** Owning and ensuring consistent implementation of the ICB's information risk policy and risk assessment processes. **Incident Management**: Owning the ICB's information incident management framework and ensuring effective communication and execution of risk management approaches. **Governance Advice:** Providing written advice to the Chief Executive on information risk for the Annual Governance Statement. **Incident Response:** Establishing mechanisms for responding to and reporting serious information governance incidents. **Collaboration:** Working closely with the Caldicott Guardian, Head of Information Governance, and Data Protection Officer. **Training:** Undertaking Information Risk management training and maintaining knowledge of the organisation's business, goals, and essential functions.	**Championing Information Governance (IG):** Advocate for IG requirements and confidentiality issues at the Integrated Care Board level. **Organisational Conscience:** Act as the 'conscience' of the ICB, enabling appropriate information sharing while ensuring ethical practices. **Policy Integration:** Ensure confidentiality issues are reflected in ICB strategies, policies, and staff procedures. **Leadership and Guidance:** Provide leadership and informed guidance on complex matters involving confidentiality and information sharing. **Oversight of Information Sharing:** Oversee arrangements, protocols, and procedures for sharing confidential personal information with external bodies, including those responsible for social care and safeguarding. **Collaboration:** Work closely with the Senior Information Risk Owner, Head of Information Governance, and Data Protection Officer. **Data Security Standards:** Have oversight of the implementation of the National Data Guardian's 10 Data Security Standards. **Training and Knowledge:** Undertake biennial training and maintain strong knowledge of confidentiality and data protection matters. **Ethical Use of Data:** Ensure that personal confidential data is handled legally, ethically, and responsibly1. **Strategic Role:** Represent and champion information governance issues at senior management and board levels. **Compliance with Caldicott Principles**: Apply the eight Caldicott Principles wisely, ensuring high standards for handling person-identifiable information. **Support for Digital Systems**: Play a key role in the governance of information management and technology, especially in the implementation of digital and paperless systems.

Appendix A: Key Role Descriptions

Data Protection Officer (DPO)	Information Asset Owner (IAO)
Monitoring Compliance: Assist with monitoring internal compliance with GDPR and other data protection laws, as well as internal and local data protection policies. Raise awareness on relevant data protection topics, ensure adequate and appropriate training for staff, and participate in relevant audits. **Advisory Role:** Inform and advise staff and Integrated Care Board (ICB) management on data protection obligations. **DPIA Guidance**: Provide advice regarding Data Protection Impact Assessments (DPIAs). **Contact Point:** Act as a contact point for data subjects and the Information Commissioner's Office. **Risk Consideration:** Consider information risks associated with processing operations, taking into account the nature, scope, context, and purposes of processing by the organisation. **Accountability:** Help demonstrate compliance as part of an enhanced focus on accountability. **Collaboration:** Work closely with the Caldicott Guardian, Information Governance Team, and Senior Information Risk Owner. **Knowledge Maintenance:** Ensure expert knowledge is kept up to date with relevant changes to legislation, national policy, and guidance. **Incident Management:** Oversee the information incident management framework, ensuring effective communication and execution of risk management approaches.	**Leadership and Culture:** Lead and foster a culture that values, protects, and uses information for the success of the Integrated Care Board (ICB) and the benefit of its population, while maintaining individuals' data protection and confidentiality rights. **Data Flow Understanding:** Understand the nature and justification of data flows, including personal data, to and from information assets and systems. **Access Management:** Know who has logical access to the asset or system and ensure that access is monitored and compliant with relevant legislation and guidance. **Risk Identification:** Identify and understand information assets and systems, address risks, and provide assurance to the Senior Information Risk Owner (SIRO). **Collaboration:** Liaise with the Information Governance Team to update and maintain the Information Asset and Data Flow Mapping Registers, either directly or through nominated Information Asset Managers. **Incident Response**: Participate in the response to information governance incidents, ensuring that appropriate measures are taken to mitigate risks.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**2024/25 Annual Reports from the Board's Committees**
Paper Reference:	ICB 25 021
Report Author:	Committee Secretariat
Report Sponsor:	ICB Committee Chairs
Presenter:	-

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

Summary:

The Board is responsible for ensuring that appropriate arrangements are in place to exercise the ICB's functions effectively, efficiently, and economically and in accordance with the principles of good governance. The Board has established a number of committees to support it in discharging this responsibility, all of which operate under terms of reference and memberships agreed by the Board. As the Board remains accountable for all functions, appropriate reporting and assurance arrangements have been established to demonstrate how each committee is effectively discharging its delegated duties. This report supplements the in-year reporting to the Board by providing a summary of all Committee's activities during 2024/25.

The Annual Reports demonstrate that the Board's committees have effectively discharged their responsibilities throughout 2024/25 and will inform the ICB's annual Governance Statement for 2024/25; an important public accountability document in which the Chief Executive details how the ICB has met its responsibilities with regard to governance, risk, and control.

Recommendation(s):

The Board is asked to **note** the 2024/25 annual reports from the Board's committees for information.

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	The Board's committee structure has been designed to provide assurance to the Board that statutory duties and responsibilities in line with the core aims are being effectively discharged.
Tackle inequalities in outcomes, experience, and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

A: 2024/25 Annual Report from the Strategic Planning and Integration Committee

Appendices:
B: 2024/25 Annual Report from the Quality and People Committee C: 2024/25 Annual Report from the Finance and Performance Committee D: 2024/25 Annual Report from the Audit and Risk Committee E: 2024/25 Annual Report from the Remuneration and Human Resources Committee

Board Assurance Framework:
The Board's committees scrutinise assurances in relation to the strategic risks for which they are the 'lead' committee and escalate levels of assurance to the Board.

Report Previously Received By:
All Committee Annual Reports have been agreed by the relevant Committees prior to presentation to the Board.

Are there any conflicts of interest requiring management?
No

Is this item confidential?
No

Appendix A

Strategic Planning and Integration Committee – Annual Report 2024/25

Introduction

1. The Board is responsible for ensuring that appropriate arrangements are in place to exercise the ICB's functions effectively, efficiently, and economically and in accordance with the principles of good governance. The Board has established a number of committees to support it in discharging this responsibility, all of which operate under terms of reference and memberships agreed by the Board.
2. As the Board remains accountable for all functions, appropriate reporting and assurance arrangements have been established to demonstrate how each committee is effectively discharging its delegated duties. This report supplements the in-year reporting from the Strategic Planning and Integration Committee to the Board by providing a summary of the Committee's activities during 2024/25.
3. This report will also inform the ICB's annual Governance Statement for 2024/25, an important public accountability document in which the Chief Executive details how the ICB has met its responsibilities with regard to governance, risk, and control.

Role of the committee

4. The Strategic Planning and Integration Committee exists to exercise the ICB's duties and powers to commission certain health services, as set out in sections 3 and 3A of the NHS Act 2006 (as amended by the Health and Care Act 2022), other than those explicitly delegated elsewhere. In exercising these functions, the Committee makes strategic commissioning decisions in order to further the four aims of the ICS to: improve outcomes in population health and healthcare; tackle inequalities in outcomes, experience, and access; enhance productivity and value for money; and help the NHS support broader social and economic development.
5. The Committee actively promotes system development in line with the principles of subsidiarity, integration and collaboration, and compliance with the general duties of ICBs, public sector equality duties, social value duties, and the rules set out in NHS Provider Selection Regime.
6. The Committee also has responsibility for overseeing arrangements for refresh and delivery of the ICB's Joint Forward Plan, and for scrutinising arrangements for public involvement and consultation and the promotion of research.

Meetings during 2024/25

7. The Strategic Planning and Integration Committee is scheduled to meet monthly. Its membership has been reviewed and updated during the year following the 2023/24 committee effectiveness review and in light of changes to the ICB's Executive Management Team. Its membership comprises three non-Executive Directors and nine managerial members, including two members nominated from Local Authority partners.

8. During 2024/25, the Committee has met formally ten times, with an overall attendance rate of 77 per cent. Further detail of members' attendance is set out below:

Name	Membership Period	Possible	Actual
Alex Ball	1 April 2024 to 31 March 2025	10	10
Katy Ball	1 April 2024 to 31 March 2025	10	5
Dave Briggs	1 April 2024 to 31 March 2025	10	8
Gary Brown	1 March 2025 to 31 March 2025	1	1
Maxine Bunn	1 November 2024 to 31 March 2025	4	3
Diane-Kareen Charles	1 April 2024 to 31 March 2025	10	7
Lucy Dadge	1 April 2024 to 30 September 2024	5	4
Roz Howie	1 April 2024 to 31 December 2024	8	2
Stephen Jackson	1 April 2024 to 28 February 2025	9	8
Mehrunnisa Lalani	1 February 2025 to 31 March 2025	2	2
Caroline Maley	1 April 2024 to 30 September 2024	5	4
Victoria McGregor-Riley	1 October to 31 March 2025	5	5
Andrew Morton	1 April 2024 to 31 March 2025	10	8
Amanda Sullivan	1 April 2024 to 31 March 2025	10	7
Jon Towler (Chair)	1 April 2024 to 31 March 2025	10	10
Ian Trimble	1 April 2024 to 30 September 2024	5	4

9. Conflicts of interests are required to be managed in advance of committee meetings. Processes are in place within the Corporate Governance Team to ensure that these are managed, including the identification of any declared interests from the ICB's Register of Interests in advance of the meeting. At the outset of all committee meetings, the Chair prompts members to declare any interests that arise during the meeting. All conflicts identified during 2024/25 were managed in accordance with the ICB's Standards of Business Conduct Policy.

Summary of activity

10. During the year, the Strategic Planning and Integration Committee has discharged all duties stipulated in its terms of reference; as such, the Committee has:

Strategic planning, service reconfiguration and transformation

a) Oversighted the development and progress of the 2024/25 Joint Forward Plan (JFP), the approach, outcomes, and ambition to be achieved through delivery of the JFP, and the approach to the 2025/26 refresh. The 2025/26 refresh of the JFP was endorsed ahead of submission to the Board for approval.

b) Kept under review progress on key system transformation programmes, including Preventative Care and Long-Term Conditions Management and Community Services. Plans to accelerate the ICB's approach to prevention were also kept under review and the Nottinghamshire County Council's Draft Adult Social Care Prevention Framework was received for information.

c) Received assurance updates on delivery of the General Practice chapter of the ICB's Primary Care Strategy and the development of the Community Pharmacy, Optometry and Dental chapters.

d) Received an update on the progress of system development activities related to Place Based Partnerships and place-based working.

e) Maintained oversight on the mobilisation, implementation, and evaluation of the 2023/24 Health Inequalities and Innovation Fund (HIIF) schemes and development of the process for the 2025/26 HIIF.

f) Received an update on the proposed strategic approach to scale up collaborative commissioning arrangements between the ICB and Local Authority partners in social care and public health.

g) Received an update on progress with the 12 strategic commissioning reviews being carried out where approval had previously been given for contract extensions and direct contract awards to incumbent providers.

h) Endorsed the Nottinghamshire Special Educational Needs and/or Disabilities Joint Commissioning Strategy (2024-2027) and Nottinghamshire local area Special Educational Needs and/or Disabilities Strategy (2024-2027), ahead of submission to Nottinghamshire County Council for approval.

i) Approved the Three-year Mental Health Inpatient Strategic Plan for Adult Services.

j) Oversighted progress on the strategic development approach to the Tomorrow's Nottingham University Hospitals programme, the system's programme within the Government's New Hospitals Programme. Given the national announcement to delay the expected construction start date for the programme, the Committee received assurances regarding the actions being taken to deliver the clinical reconfiguration and estate improvements needed.

Commissioning policies and decisions

k) Approved several commissioning policies, including the Individual Funding Request Policy, Healthcare Contributions to Adult Care Packages Commissioning Policy, and Children and Young Peoples Continuing Care Commissioning Policy. Progress regarding the alignment of the fertility policies of the former Nottingham and Nottinghamshire and Bassetlaw Clinical Commissioning Groups has also been kept under review.

l) Approved the process for decision making in relation to National Institute for Clinical Excellence Technology Appraisals (TAs) and endorsed several recommendations regarding compliance with TAs.

m) Received bi-annual assurance updates on the discussions, decisions, challenges, and risks considered by the Primary Medical Services Contracting Panel. Updates on the proposed collective action by primary medical services providers, including key risks, potential impact, and next steps to support risk mitigation, were also received.

n) Received Annual Reports from the Individual Funding Request Panel and the Mental Health, Learning Disability and Neurodiversity Specialist Treatment/Funding Requests Panel.

o) Maintained oversight of the service review process, approved amendments to the Terms of Reference of the Commissioning Review Group, and endorsed the approach being taken to identify financial efficiencies and savings and a risk-based approach to deliver financial undertakings through an overall efficiency programme.

p) Received an update on the implementation of the NHS Provider Selection Regime and Patient Choice Accreditation process following their recent introduction.

q) Received a significant number of decision-making papers and approved proposals, ensuring compliance with the NHS Provider Selection Regime, where appropriate, relating to:

- Hospice at Home, Bereavement Support, and Day Therapy Services in South Nottinghamshire.
- The Hospice at Home Service in Mid-Nottinghamshire.
- A direct Alternative Provider Medical Services contract award.
- The provision of four enhanced supported living beds for the adult inpatient population with learning disabilities and/or autism.
- Non-weight bearing pathway funding.
- Children and Young People Neurodevelopmental Support Services (Autism and Attention Deficit Hyperactivity Disorder).

- Children and Young People's Emotional Health and Wellbeing Early Support Services.
- The commission of a system-wide service for common mental health needs across the Integrated Care System.
- Wheelchair Services.
- The Bassetlaw Urgent Care Service.
- Service development funding for Local Area Co-Ordination.
- Nottingham and Nottinghamshire Long-COVID Services.
- Mental Health Level Two Inpatient Rehabilitation Services.
- The Targeted Lung Health Check Programme.
- The Nottingham City Better Care Fund.
- The Bassetlaw Palliative and End of Life Hospice Bedded Unit and Specialist Palliative Care Community Outreach Nursing Team.
- The Children and Young People Learning Disabilities and Autism Keyworking Service.
- Urgent and non-urgent care services.
- Care Navigation Services.

r) Approved the spend associated with the 2024/25 urgent and emergency care capacity fund and the health element of the adult social care discharge fund that was associated with the Better Care Fund. A section 256 funding agreement was also approved with Nottingham City Council for the 'Changing Futures' project, which was an approved HIIF project.

s) Received a log of Investment, Disinvestment and Contract Award Decisions (Healthcare Services) as a standing item. This ensures the Committee is informed of all decisions made relating to the ICB's healthcare commissioning responsibilities and has provided assurance of the robustness of decisions being made and compliance with the financial limits set out in the ICB's Scheme of Reservation and Delegation.

Working with people and communities

t) Received assurance updates on the arrangements for working in partnership with people and communities through citizen intelligence and coproduction. This included approval of the ICB's Public Involvement and Engagement Policy, following its review.

Research

u) Endorsed the Integrated Care System Research Strategy, ahead of submission to the Board for approval, and maintained oversight of delivery progress.

Risk management

v) Discussed the risks detailed within the Operational Risk Report with particular focus on the high (red) risks and identified new risks for inclusion.

11. As a comprehensive review of committee effectiveness was undertaken in 2023/24, the Committee agreed that a proportionate approach should be taken for 2024/25. Along with all ICB committees, a mid-year stock-take of the Committee's annual work programmes was undertaken to ensure that its responsibilities were on track to be discharged throughout the year. This was complemented in-year by an independent review of committee effectiveness by the ICB's internal auditors. This included review of the Committee's terms of reference, delivery of its annual work programme, the quality of papers, minutes, and action log management, reporting to the Board, attendance by members, and observation at a committee meeting. The review provided a substantial assurance rating, which is the highest level able to be achieved.
12. The Committee's annual work programme has been used to support good governance and appropriately prioritise the Committee's workload to ensure it discharges its statutory duties. The Committee's agendas operated flexibly throughout 2024/25 to respond to ongoing system developments and to ensure timely decision-making in support of financial sustainability requirements. Some scheduled items had therefore been re-scheduled to later dates, with some carried over to the 2025/26 work programme.

Conclusion

13. This report demonstrates that the Strategic Planning and Integration Committee has effectively discharged its responsibilities throughout 2024/25, providing robust oversight of strategic commissioning plans, service transformation, and ongoing system development. The Committee received positive assurances across a range of areas, while also constructively challenging areas requiring improvement. Through its work, the Committee has supported the ICB in maintaining robust decision-making that is compliant with statutory responsibilities.

Appendix B

Quality and People Committee – Annual Report 2024/25

Introduction

1. The Board is responsible for ensuring that appropriate arrangements are in place to exercise the ICB's functions effectively, efficiently, and economically and in accordance with the principles of good governance. The Board has established a number of committees to support it in discharging this responsibility, all of which operate under terms of reference and memberships agreed by the Board.
2. As the Board remains accountable for all functions, appropriate reporting and assurance arrangements have been established to demonstrate how each committee is effectively discharging its delegated duties. This report is intended as a key part of these arrangements, providing a summary of the Committee's activities during 2024/25.
3. This report will also inform the ICB's annual Governance Statement for 2024/25, an important public accountability document in which the Chief Executive details how the ICB has met its responsibilities with regard to governance, risk, and control.

Role of the committee

4. The Quality and People Committee exists to provide the Board with assurance that the ICB is meeting its statutory requirements regarding continuous quality improvements and enabling a single understanding of, and shared commitment to, quality care across the system that is safe, effective, equitable and that provides a personalised experience and improved outcomes. The Committee also has responsibility for developing robust arrangements with partners to support 'one workforce', by leading system development and implementation of the Integrated Care System (ICS) People Plan.
5. The Committee also scrutinises the robustness of safeguarding arrangements, medicines management and compliance with equality legislation (including the Public Sector Equality Duty).
6. The remit of the Committee incorporates the relevant requirements set out within the Delegation Agreement between NHS England and the ICB (Primary Medical Services), insofar as they relate to quality.
7. In September 2024, the Committee had its remit extended by the Board to include oversight of health inequalities and early prevention of deaths.

Meetings during 2024/25

8. The Quality and People Committee is scheduled to meet monthly. Its membership has been reviewed and updated during the year and comprises three Non-Executive Directors, five managerial members and one Primary Care Partner member.

9. During 2024/25, the Committee has met formally ten times, with an overall attendance rate of 77 per cent. Further detail of members' attendance is set out below:

Name	Membership Period	Possible	Actual
Marios Adamou	1 April 2024 to 31 March 2025	10	10
Dave Briggs	1 October 2024 to 31 March 2025	5	3
Lucy Dadge	1 April 2025 to 30 September 2024	5	4
Sarah Fleming	1 October 2024 to 31 March 2025	5	4
Stephen Jackson	1 October 2024 to 31 March 2025	5	2
Mehrunnisa Lalani	1 January 2025 to 31 March 2025	3	2
Kelvin Lim	1 April 2024 to 31 March 2025	10	7
Caroline Maley	1 April 2025 to 30 September 2024	5	5
Maria Principe	1 October 2024 to 31 March 2025	5	2
Mohammad Rahman	1 April 2025 to 30 September 2024	5	4
Jonathan Rycroft	1 October 2024 to 31 March 2025	5	3
Rosa Waddingham	1 April 2024 to 31 March 2025	10	10

10. The ICB has robust arrangements in place regarding the identification and management of any conflicts of interest and processes are in place to anticipate any issues prior to meetings taking place. Members' interests are included as part of the meeting papers for visibility and the Chair prompts members to declare any interests (not already recorded) that may arise during the meeting. During 2024/25, no conflicts of interest were identified.

Summary of activity

11. During the year, the Quality and People Committee has maintained its key responsibility of providing the Board with assurance relating to its terms of reference. The Committee as received a range of reports and updates across its responsibilities, which are summarised as follows:

    Quality oversight

    a) The Committee has received the Quality Oversight Report at each of its meetings, which detailed areas under enhanced surveillance and in mandated support arrangements (in line with the National Oversight Framework). This has enabled members to scrutinise and receive assurance on key areas of quality concerns, in particular, those relating to Nottingham University Hospitals NHS Trust (NUH), Nottinghamshire

Healthcare NHS Foundation Trust (NHT) and Nottingham CityCare Partnership. The Committee has consistently agreed that assurance has been **limited**, which is attributed to the nature of the reports.

b) Complementary to the Quality Oversight report, the Committee has also received the full Quality Integrated Performance Report for information at each of its meetings.

c) The Committee has maintained close oversight of NHT this year, particularly in response to the Section 48 review. Whilst members have been kept informed of the new arrangements implemented and the actions being taken, the phased nature of the Trust's improvement programme has been noted and evidence of impact is yet to be demonstrated. As such, assurance was consistently rated by members as **limited** throughout the year.

d) Following publication of the independent homicide investigation in February 2025, the Committee was provided with a detailed report, which included the ICB's own reflections in response to the review and actions already implemented and planned. **Adequate** assurance was awarded to this item, and it was agreed that quarterly updates on progress would be scheduled during 2025/26.

e) An update was provided on the development and progress of the System Quality Framework and the work being performed with partners to define 'quality' in the Nottingham and Nottinghamshire System and ensure alignment across quality strategies. Assurance reports on the implementation and embedding of the Patient Safety Incident Response Framework (PSIRF) have also been received, which covered both the ICB and the approach being taken to support partners. Members agreed these reports provided **adequate** assurance in light of the maturing arrangements.

f) At the request of the Board, the Committee received a report on urgent and emergency care at its meeting in September. The request was following a letter from NHS England to all ICBs, asking organisations to assure themselves against a number of areas. Members were advised of the work being performed with partners and that actions would be developed and reported through the Urgent and Emergency Care (UEC) Board.

g) Members were provided with assurance that quality had been considered in the 2024/25 winter planning process. Members agreed the report provided **adequate** assurance, noting alignment to the operational workforce plan and that learning from other systems had informed the local ambition around vaccinations and immunisations.

h) Members reviewed and supported the revised process for undertaking Equality and Quality Impact Assessments (EQIAs) in support of the ICB's Financial Recovery Plan and considered changes to the EQIA Procedure which would enable a greater focus on the effective and timely review of EQIAs and accelerate the EQIA review process.

i) As part of the Committee's schedule of focussed quality reports, the following were received:

Report	Assurance level given
Learning Disabilities and Autism Programme Quality Improvements	Adequate
Maternity Services, Health Outcomes and the Local Maternity and Neonatal System	Partial
Care Homes and Home Care	Limited (Meeting in June 2024) Adequate (meeting in November 2024)
Healthcare Associated Infections	Adequate
Continuing Healthcare and Children's Continuing Care	Full
Primary Medical Services	Adequate
Medicines Management including Primary Care Antimicrobial Stewardship	Full
Safeguarding Adults	Full
Safeguarding Children	Full
Safeguarding Looked After Children	Partial
Nottingham and Nottinghamshire Special Educational Needs and Disabilities Local Area Partnerships Arrangements	Partial
UEC System Rapid Quality Review NUH	Limited
Winter Planning and Emergency Care System Quality Considerations	Adequate
Patient Experience	Adequate

j) The Committee has reviewed and approved the ICB Corroborative Statements to be inserted into Quality Accounts for: NUH, NHT, Sherwood Forest Hospitals NHS Foundation Trust (SFH), Nottingham CityCare, Primary Integrated Community Services and Woodthorpe Hospital.

k) Members received the Measles Plan following the declaration of a national incident by the UK Health Security Agency in January 2024. The local measles elimination plan encompassed a wide range of actions to prevent the spread of this most infectious respiratory disease, and members agreed it provided **adequate** assurance.

l) The Committee also approved the ICB's Modern Slavery Statement 2024/25.

Medicines optimisation

m) The Committee has received comprehensive reports providing assurance that the ICB is meeting is responsibilities with regard to the management of medicines. Specific reports received were:

Report	Assurance level given
Medicines Optimisation - Quality and Safety in Social Care	Adequate
Nottinghamshire Area Prescribing Committee	Full
Medicines Safety Officers Report	Full
High-Cost Medicines	Full
Safe Management of Controlled Drugs	Full
Medicines Optimisation Annual Assurance Report	Full

n) The Committee also reviewed and approved the publication of the ICS Medicines Optimisation Strategy 2024-29, welcoming the collaborative approach taken with system partners and local people with lived experience to develop the Strategy.

Health inequalities and avoidable mortality

o) In September 2024, the Committee assumed responsibility for providing oversight of health inequalities and early prevention of deaths, following an extension of its remit by the Board.

p) The Committee subsequently received a detailed report on the impact of smoking on health inequalities at its November meeting, noting that smoking remains the leading preventable cause of ill health and death, particularly among more deprived populations. Acknowledging that smoking rates across the system were above the national trajectory for meeting the 2035 target, members discussed variation in referral rates to tobacco dependency services and were informed of work being undertaken to address this. An assurance level of **adequate** was agreed in relation to the ICB's contribution to the work being undertaken.

q) Members received a report on early cancer diagnosis, which focussed on reducing inequalities in access and outcomes, highlighting the lower early-stage diagnosis rates in in deprived communities. Members discussed the

importance of supporting primary care capacity and tailored community engagement to address variation. An assurance level of **adequate** was awarded, which reflected the demonstration of positive impacts of early diagnosis rates.

r) The Committee also received a separate information item on wider health inequalities, which provided an update on system-level actions aligned to Core20PLUS5. Members noted the progress made in embedding health inequalities into strategic planning and the use of data to target interventions.

People and culture

s) The Committee received an ICS People and Culture Annual Report at its meeting in May 2024, which covered the activities undertaken in key areas such as workforce development and staff wellbeing efforts. Members requested that further reporting show the impact of such initiatives and whilst the report was welcomed in terms of providing a comprehensive summary of work during the previous year, **Limited** assurance was agreed due to a lack of information around the effectiveness of actions.

t) At the February and March 2025 meetings, the Committee reviewed the draft ICS People and Workforce Plan. Members welcomed the ambitious approach, whilst discussing the potential for future involvement from wider system partners and stronger alignment with health inequalities. Concerns were raised around affordability and the reliability of data, but the overall direction was supported, and the Plan was endorsed for Board approval.

u) Monthly assurance updates on delivery against the 2024/25 workforce plan have been scrutinised, covering key metrics such as sickness absence, turnover and agency usage. Members have noted positive cultural shifts, particularly with regard to reliance on agency staff; however, persistent issues remained around sickness and the ability to embed and sustain change. Overall, the Committee has agreed that the reports provided **partial** assurance, recognising the improvements made but scale of transformation still required. (*NB – oversight of the workforce plan has now transferred to the Finance and Performance Committee*).

Equality, diversity and inclusion

v) In April 2024, the Committee reviewed the Equality Delivery System (EDS) report, focussing on the ICB's performance across commissioned services, workforce, and leadership. Whilst members challenged the

evidence provided to support the scoring, areas of improvement were noted and the submission to NHS England was approved.

w) A follow-up discussion with regard to the ICBs equality objectives took place at the October meeting, which reported varying levels of progress made. Members applied an assurance level of **limited** to the report, due to delays in implementing some of the actions. A report in November outlined the approach being taken with regard to the EDS 2024/25, explaining that the equality objectives would be refreshed as part of the work being undertaken.

x) The Committee received the Annual Equality, Diversity and Inclusion (EDI) Report in May, demonstrating how the ICB had discharged its statutory duties. Members discussed the visibility of EDI at Board level and the need to ensure the active application of equality considerations in decision-making. An assurance rating of **adequate** was agreed.

Risk management

y) The Committee's Operational Risk Report has been received at every meeting; detailing risks aligned to the Committee's responsibilities. Members have welcomed the comprehensive reports and consistently challenged the high number of risks, where risk scores have appeared static and the robustness of stated mitigations. In response, 'confirm and challenge' sessions have been introduced between ICB risk leads and the Quality team, with the outputs feeding into subsequent reports.

12. As a comprehensive review of committee effectiveness was undertaken in 2023/24, it was agreed that a proportionate approach would be taken for 2024/25. To support this work, all ICB committees received a mid-year stock-take of the Committee's annual work programmes which demonstrated that responsibilities were on track to be discharged throughout the year. This internal work was complemented by an independent review of committee effectiveness by the ICB's internal auditors. This included review of the Committee's terms of reference, delivery of its annual work programme, the quality of papers, minutes, and action log management, reporting to the Board, attendance by members, and observation at a committee meeting. The review provided a substantial assurance rating, which is the highest level able to be achieved).
13. The Committee's annual work programme has been used to support good governance and appropriately prioritise the Committee's workload to ensure it discharges its statutory duties.

Conclusion

14. This report demonstrates that the Quality and People Committee has effectively discharged its responsibilities throughout 2024/25. The Committee has provided robust oversight across is range of duties, constructively challenging areas requiring improvement. Through its work, the Committee has contributed positively to the ICB’s governance and assurance framework and supported compliance with statutory requirements.

Appendix C

Finance and Performance Committee – Annual Report 2024/25

Introduction

1. The Board is responsible for ensuring that appropriate arrangements are in place to exercise the ICB's functions effectively, efficiently, and economically and in accordance with the principles of good governance. The Board has established a number of committees to support it in discharging this responsibility, all of which operate under terms of reference and memberships agreed by the Board.
2. As the Board remains accountable for all functions, appropriate reporting and assurance arrangements have been established to demonstrate how each committee is effectively discharging its delegated duties. This report supplements the in-year reporting from the Finance and Performance Committee to the Board by providing a summary of the Committee's activities during 2024/25.
3. This report will also inform the ICB's annual Governance Statement for 2024/25, an important public accountability document in which the Chief Executive details how the ICB has met its responsibilities with regard to governance, risk, and control.

Role of the committee

4. The Finance and Performance Committee exists to scrutinise arrangements for ensuring the delivery of the ICB's statutory financial duties in line with sections 223GB to 223N of the NHS Act 2006 (as amended by the Health and Care Act 2022).
5. The Committee oversees the ICB's performance management framework, including the scrutiny of actions to address shortfalls in performance against national and local health targets and performance standards.
6. In addition, the Committee is responsible for scrutinising the ICB's arrangements and delivery in relation to operational planning, estates, environmental sustainability (including statutory duties as to climate change) and data and digital, ensuring continuous improvements in performance and outcomes. The Committee also oversights non-healthcare contracts.
7. Following the 2023/24 committee effectiveness review, the Committee's terms of reference were updated; this resulted in a transfer of oversight responsibilities for health inequalities duties to the Quality and People Committee and the inclusion of a new responsibility regarding the ICS Infrastructure Strategy.

8. The remit of the Committee incorporates the relevant requirements set out within the Delegation Agreement between NHS England and the ICB (Primary Medical Services), insofar as they relate to finance, performance, and estates.

Meetings during 2024/25

9. The Finance and Performance Committee is scheduled to meet monthly, with the exception of August and December. Its membership was reviewed and updated during the year following the 2023/24 committee effectiveness review and in light of changes to the ICB's Executive Management Team. The Committee's membership now comprises three Non-Executive Directors and nine managerial members.

10. During 2024/25, the Committee has met formally ten times, with an overall attendance rate of 85%. All meetings have been well attended and quoracy achieved on all occasions. Further detail of members' attendance is set out below:

Name	Membership Period	Possible	Actual
Stephen Jackson	1 April 2024 to 31 March 2025	10	10
Jon Towler	1 April 2024 to 31 March 2025	10	10
Dave Briggs	1 April 2024 to 1 Sept 2024	5	4
Stuart Poynor	1 April 2024 to 30 June 2024	3	2
Andrew Rose-Britton	1 April 2024 to 30 April 2024	1	0
Nigel Smith	1 April 2024 to 30 April 2024	1	1
Marcus Pratt	1 July 2024 to 31 March 2025	7	7
Sarah Fleming	1 October 2024 to 31 March 2025	5	5
Nicola Jay	1 October 2024 to 31 Dec 2025	2	0
Maria Principe	1 October 2024 to 31 March 2025	5	4
Rosa Waddingham	1 October 2024 to 31 March 2025	5	4
Marios Adamou	1 January 2025 to 31 March 2025	3	2
Mohammad Rahman	1 January 2025 to 31 March 2025	3	2

11. Conflicts of interests are required to be managed in advance of committee meetings. Processes are in place within the Corporate Governance Team to ensure that these are managed, including the identification of any declared interests from the ICB's Register of Interests in advance of the meeting. At the outset of all committee meetings, the Chair prompts members to declare any interests that arise during the meeting. All conflicts identified during 2024/25 were managed in accordance with the ICB's Standards of Business Conduct Policy.

Summary of activity

12. During the year, the Finance and Performance Committee has discharged all duties stipulated in its terms of reference; as such, the Committee has:

Financial sustainability

a) Monitored progress against the 2024/25 Finance Plans for the ICB and wider NHS system. At the beginning of the year members had applied limited assurance to the delivery of plans. However, as the year progressed, further assurance was taken in the enhanced arrangements that had been put in place to ensure that the system's financial plan would be delivered, including the work by PA Consulting, to ensure that there were consistent controls across the system. Members had welcomed the increased transparency across the system, which indicated a positive shift in culture and behaviour. At the end of the year a rating of full assurance had been given in light of the robust arrangements that had been put in place.

b) Monitored the implementation of an action plan to ensure the delivery of the ICB's statutory financial duties following NHS England's enforcement undertakings (in connection with NHS England's functions under the National Health Service Act 2006, as amended), with regard to the Nottingham and Nottinghamshire NHS system's financial sustainability.

c) Received bi-annual reports on the Capital Resource Use Plan allocation and monitored progress, seeking assurance on areas subject to delay.

Operational planning and service delivery

d) Scrutinised monthly service delivery and performance reports, covering urgent care, planned care, mental health, primary and community care. The reports highlighted key improvements and challenges and set out the mitigating actions being taken to address areas of concern. Specific reports were presented to provide assurance around the governance and oversight arrangements for the following areas: diagnostics; Continuing Healthcare; and the rise in non-elective activity in mid Nottinghamshire.

e) Members consistently applied partial assurance to delivery of plans throughout 2024/25. Although enhanced performance management arrangements had been established at the beginning of the year, and there had been sustained improvement in performance metrics in several service areas throughout the year, significant and persistent performance issues remained in areas such as the GP two-week appointment target, planned care cancer targets and the urgent care four-hour performance target.

f) Received regular assurance reports on the development of a system-wide Winter Plan.

g) Received updates regarding health inequalities information, including quarterly dashboards and thematic reviews, examining clinical areas

identified by NHSE via the Core20Plus5 approach, including respiratory care; severe mental illness; and a report into avoidable deaths under the age of 75.

h) Oversaw the development of the 2025/26 NHS Operational and Financial Plan. Members reviewed the principles, assumptions, and risks that had been discussed with system partners in support of the final submission for Board approval in early March 2025. Members had tested its credibility and emphasised the importance of having detailed delivery plans in place at a much earlier stage than in previous years in order to meet the challenging targets within the plan.

Digital transformation

i) Received updates on ICB's responsibilities for leading system-wide action on digital transformation, reviewing the progress the Digital, Data and Technology Strategy and monitoring progress against digital priorities. An investment for the Notts Digital Care Record had been approved.

Infrastructure and environmental sustainability

j) Endorsed the final draft ICS Infrastructure Strategy ahead of submission to NHS England, which was presented to the Board in September 2024.

k) Received update reports on GP and ICB Corporate estates. The Committee gave approval for the expansion of Gamston Medical Centre and Sherwood Medical Practice.

l) Received progress summaries on delivery against the ICS Green Plan, which aims to achieve net zero carbon emissions by 2040.

Risk management

m) Received monthly reports on risks within the Committee's remit, discussing further potential risks at each meeting. Workforce-related risks were highlighted, reflecting the direct link between workforce and the financial position. Cash flow issues had also been raised as an on-going concern and a separate report had been requested to understand how the issue was being mitigated.

13. As a comprehensive review of committee effectiveness was undertaken in 2023/24, the Committee agreed that a proportionate approach should be taken for 2024/25. Along with all ICB committees, a mid-year stock-take of the Committee's annual work programmes was undertaken to ensure that its

responsibilities were on track to be discharged throughout the year. This was complemented in-year by an independent review of committee effectiveness by the ICB's internal auditors. This included review of the Committees' terms of reference, delivery annual work programmes, the quality of papers, minutes, and action log management, reporting to the Board, attendance by members, and observation at a committee meeting. The review provided a substantial assurance rating, which is the highest level able to be achieved.

14. The Committee's annual work programme has been used to support good governance and appropriately prioritise the Committee's workload to ensure it discharges its statutory duties. The Committee's agendas operated flexibly throughout 2024/25 to respond to ongoing system developments and to ensure timely decision-making in support of financial sustainability requirements. Some scheduled items had therefore been re-scheduled to later dates, with some carried over to the 2025/26 work programme.

Conclusion

15. This report demonstrates that the Finance and Performance Committee has effectively discharged its responsibilities throughout 2024/25, providing robust oversight of the ICB's and the NHS system's financial and operating plans. The Committee received positive assurances across a range of areas, while also constructively challenging areas requiring improvement. Through its work, the Committee has contributed positively to the ICB's governance and assurance framework and supported compliance with statutory requirements.

Appendix D

Audit and Risk Committee – Annual Report 2024/25

Introduction

1. The Board is responsible for ensuring that appropriate arrangements are in place to exercise the ICB's functions effectively, efficiently, and economically and in accordance with the principles of good governance. The Board has established its committees to support it in discharging this responsibility, all of which operate under terms of reference agreed by the Board.
2. As the Board remains accountable for all functions, appropriate reporting and assurance arrangements have been established to demonstrate how each committee is effectively discharging its delegated duties. This annual report supplements the in-year reporting from the Audit and Risk Committee to the Board by providing a summary of the Committee's activities during 2024/25.
3. This report will also inform the ICB's annual Governance Statement for 2024/25; an important public accountability document in which the Chief Executive details how the ICB has met its responsibilities with regard to governance, risk, and control.

Role of the committee

4. The Audit and Risk Committee exists to provide the Board with an independent and objective view of the ICB's financial systems, financial information and compliance with laws, regulations and directions governing the organisation, in so far as they relate to finance.
5. The Committee also has responsibility for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities. This includes reviewing the integrity of the ICB's financial statements, the adequacy and effectiveness of all risk and control related disclosure statements and ensuring that the organisation has effective anti-fraud systems in place.
6. The Committee scrutinises every instance of non-compliance with the ICB's Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions, and monitors compliance with the ICB's policies relating to standards of business conduct. The Committee is responsible for approving the ICB's annual report and accounts and also has duties relating to the regulatory requirements for information governance and monitoring progress against the ICB's overarching policy work programme.

Meetings during 2024/25

7. During 2024/25, the Committee met six times, which is in line with its terms of reference. Membership is comprised solely of Non-Executive Directors of the Board; however, meetings are supported by regular attendance of the ICB's internal auditors, external auditors, and local counter fraud specialist. ICB officers with expertise in the areas of finance and governance are also in attendance. Details of members' attendance this year is set out below:

Name	Possible	Actual
Caroline Maley (Chair of the committee until 30 September 2024, when membership ceased)	2	2
Stephen Jackson (Interim Chair of the committee from 1 October 2024 to 28 February 2025)	6	6
Gary Brown (Chair of the committee from 1 March 2025, when membership commenced)	1	1
Marios Adamou	6	5

8. Processes are in place within the Corporate Governance Team to ensure that any conflicts of interest are identified and managed according to the ICB's policy and the Chair prompts members at the start of each meeting to declare any interests that arise during the course of discussions. During 2024/25, no conflicts of interest were identified.

Summary of activity

9. The work of the Committee during the year can be summarised as follows:

Annual report and accounts

a) The Committee commenced the year by reviewing the ICB's draft annual report and accounts (ARA) for 2023/24, ensuring compliance with DHSC and NHS England reporting requirements and the accuracy of financial disclosures. The ARA was subsequently approved at the meeting in June.

b) In advance of receiving the ARA 2025/26 for approval (June 2025), the Committee reviewed and commented on an early draft of the Corporate Governance Report, which included the ICB's annual governance statement.

Integrated governance, risk management and internal control

c) The Board Assurance Framework (BAF) was reviewed at multiple points throughout the year to monitor the status of key strategic risks. These reviews were presented by the relevant executive lead to enable the appropriate 'confirm and challenge' with regard to the mitigating actions being taken and the effectiveness of established controls. During these discussions, members questioned the stagnation of some risk scores and whether the ICB's risk appetite accurately reflected current system pressures. In summary, members

were satisfied that processes underpinning the BAF were robust and noted that specific risks remained challenging due to external factors and ongoing strategic developments.

d) Reports on the ICB's strategic and operational risk management arrangements were received, which ensured the Committee's continued oversight and engagement with risk management processes. In terms of 'live' operational risks, members challenged the lack of movement in some long-standing risks and sought further assurance as to how emerging risks were being identified and captured. The number of risks exceeding the risk appetite were also noted and as such, the Committee initiated more visible reporting of these to the Board.

e) Amendments to the ICB's Risk Management Policy relating to risk appetite were also approved. In the main, the Committee has been satisfied that risk management arrangements are well-embedded and that system risk management arrangements are maturing effectively.

f) Members received assurance with regard to the ICB's Standards of Business Conduct Policy, reviewing the arrangements in place for managing conflicts of interest and ensuring compliance with national guidance and best practice. Decision-making arrangements have also been scrutinised through reviewing urgent decisions made via the Board and committees' emergency powers, which evidenced that this had only been performed in exceptional circumstances. There have been no instances of non-compliance with the ICB's Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions reported during the year.

g) Updates on progress against the 2023/24 ICB Committee Effectiveness Action Plan were received, with members advised that the majority of actions had been implemented and the completion date for the two remaining actions extended. This report also provided an opportunity to discuss and input into plans to review committee effectiveness during 2024/25 and members were supportive of a less comprehensive approach, noting the work already undertaken in this area since the ICB's establishment and the planned internal audit review of governance this year (the review was completed in January 2025, providing an assurance opinion of 'substantial').

Internal audit

h) The Internal Audit Progress (IA) Report was received at every meeting, providing regular updates on IA delivery. During these reviews, members emphasised the importance of timely reporting and requested greater visibility on progress at future meetings and assurance that any slippage would not impact on the year-end Head of Internal Audit Opinion. Only one IA report was presented for formal review, Workforce Planning, due to receiving a 'moderate'

level of assurance attributed to the clarity required around responsibilities and undefined milestones. Members were satisfied with the management response to the findings, noting it was a complex area with ongoing challenges. Other IA reports were distributed outside of meetings for members' information.

External audit

i) The External Audit Plan for 2024/25 was presented in December 2024 and members oversaw delivery of the plan via regular updates, ensuring that any delays or emerging risks were escalated in a timely manner.

Counter fraud

j) At the meeting in May, the Committee reviewed and approved the ICB's self-assessment for 2023/24 against the Government Functional Standard 013: Counter Fraud, noting that the ICB had been rated as compliant across all areas. Oversight of the Counter Fraud, Bribery and Corruption Plan enabled members to seek further assurance that lessons from fraud investigations were being captured and applied and it was agreed that such learning should form part of future reports. The Committee approved the Counter Fraud Plan for 2025/26 at its meeting in March.

Financial reporting and stewardship

k) The Committee scrutinised reports on financial stewardship, with a particular focus on agency staff expenditure, as the ICB had breached the NHS agency price cap due to a short-term need for specialist nursing staff in continuing healthcare. Members subsequently received assurance around actions being taken to address this, which included appropriate engagement with NHS England on the issue and implementing a plan to reduce reliance on agency staff to zero by 1 April 2025. Members also reviewed procurement card transactions, which confirmed appropriate usage, and received assurance that any competitive tender waivers had been undertaken in line with procurement regulations and the ICB's own financial policies.

l) As part of the Committee's responsibilities for financial oversight, the outcome of an ICB review of third party assurance reports was received. The review was noted as best practice, with the outcome report providing the Committee with further assurance as to the control environments of organisations contracted to deliver services to the ICB. In addition, an ICB report regarding the national move to the new Integrated Single Financial Environment (ISFE2) was presented for information, with members considering the organisational implications of the delayed implementation date.

m) Assurance was provided that the ICB is compliant with the NHS Provider Selection Regime (PSR), with the report advising members of the established governance and decision-making arrangements, which included the role of the ICB's Representation Panel. Members sought assurance around the management of conflicts of interest in the arrangements and were advised that these were aligned to the ICB's Standards of Business Conduct Policy.

Information governance

n) Assurance on compliance with information governance was received at various points through the year, covering the Data Security and Protection Toolkit (DSPT), cyber security and compliance with data protection legislation. At the June meeting, members reviewed progress towards the ICB's DSPT submission and sought further assurance around the policies in place to mitigate the risk of data breaches. Later in the year, the Committee discussed the new Cyber Assurance Framework aligned DSPT, noting the ICB's baseline position as 'not achieved' and seeking assurance that this was being addressed. In addition, the Committee endorsed the System's Cyber Security Strategy for onward adoption by the Board.

o) At its last meeting of the year, the Committee received the Senior Information Risk Officer (SIRO) annual report and approved the ICB's Information Governance Management Framework.

Other regulatory and mandatory requirements

p) The Committee provided oversight across a number of key corporate functions. Receipt of the annual health and safety report confirmed the ICB as a low-risk organisation and statutory and mandatory training compliance was scrutinised, with the Committee noting high training completion rates and supporting the work being done to address any non-compliance. Additionally, members received the ICB's Policy Management Framework, ensuring that corporate policies were reviewed and updated in line with governance requirements and any legislative changes. Some extensions to policy review dates were agreed as appropriate following discussion; however, greater visibility was requested to show where previous extensions had been approved.

q) Reports on emergency preparedness, resilience, and response (EPRR) were received, which covered compliance with national EPRR core standards, system resilience risks and business continuity arrangements. While partial compliance remained in some areas of the standards, members were assured that clear actions were in place to address any gaps. Members approved the updated Incident Response Plan and sought assurance on alignment with system partners and confirmation of consistent escalation procedures. The risk of cyber-attacks was noted as a key risk and despite this not forming part of the

core standards, members were assured that cyber resilience was considered an equal priority.

10. The Committee's annual work programme (AWP) has been monitored at meetings, which has supported good governance and prioritisation of the Committees workload. A mid-year 'stocktake' of the AWP demonstrated that the Committee was on track to discharge its range of responsibilities by year-end.
11. Following an assessment of the Committee against the latest addition of the HFMA Audit Committee Handbook, members were assured that the ICB continued to operate in line with requirements and best practice. As the handbook advocated audit committee oversight of legal activity, Freedom to Speak Up (FTSU) and learning from national enquiries, it was agreed that these responsibilities should be added to the Committee's terms of reference and work programme.
12. In line with ICB Board reporting requirements, the Committee has consistently agreed and applied an assurance rating to ICB assurance items it has received. A summary of the ratings is provided for information at Annex A.

Conclusion

13. This report demonstrates that the Audit and Risk Committee has effectively discharged its responsibilities throughout 2024/25, providing robust oversight of internal and external audit, financial stewardship, risk management, and assurance functions. The Committee received positive assurances across a range of areas, while also constructively challenging areas requiring improvement. Through its work, the Committee has supported the ICB in maintaining strong governance, transparency, and accountability.

Annex A - Assurance levels applied to agenda items

Paper Title	Assurance Rating applied
Meeting held on 16 May 2024	
Risk Management Arrangements	Adequate
Use of Emergency Powers for Urgent Decisions	Full
Health and Safety Assurance Report	Full
Financial Stewardship Assurance Report	Adequate
Meeting held on 19 June 2024	
EPRR Update Report	Adequate
Information Governance Assurance Report	Full
Statutory and Mandatory Training Compliance	Adequate
Meeting held on 9 October 2024	
Biannual Review of Risk Management Arrangements	Full
Provider Selection Regime Assurance Report	Adequate
Third Party Assurances Reporting – Complementary User Entity Controls	Adequate
Meeting held on 11 December 2024	
EPRR Assurance Report	Partial
Board Assurance Framework: Targeted Risk Report	Full
Statutory and Mandatory Training Compliance	Full
Financial Stewardship Assurance Report	Full
Meeting held on 12 February 2025	
Board Assurance Framework: Targeted Risk Report	Full
Standards of Business Conduct	Full
Policy Management Framework	Full
Information Governance Assurance Report	Adequate
Annual Fraud Risk Assessment	Adequate
Meeting held on 27 March 2025	
Board Assurance Framework: Targeted Risk Report	Adequate
Senior Information Risk Owner (SIRO) Annual Report	Adequate

Appendix E

Remuneration and Human Resources Committee – Annual Report 2024/25

Introduction

1. The Board is responsible for ensuring that appropriate arrangements are in place to exercise the ICB's functions effectively, efficiently, and economically and in accordance with the principles of good governance. The Board has established a number of committees to support it in discharging this responsibility, all of which operate under terms of reference and memberships agreed by the Board.
2. As the Board remains accountable for all functions, appropriate reporting and assurance arrangements have been established to demonstrate how each committee is effectively discharging its delegated duties. This report supplements the in-year reporting from the Remuneration and Human Resources Committee to the Board by providing a summary of the Committee's activities during 2024/25.
3. This report will also inform the ICB's annual Governance Statement for 2024/25, an important public accountability document in which the Chief Executive details how the ICB has met its responsibilities with regard to governance, risk, and control.

Role of the committee

4. The Remuneration and Human Resources Committee exists to exercise the ICB's functions as set out in paragraphs 18 to 20 of Schedule 1B to the NHS Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022). The remit of the Committee excludes the remuneration, fees, allowances, and other terms of appointment for the Chair of the ICB and for the non-executive members of the Board. These are set by NHS England and the NED Remuneration Panel, respectively.
5. The Committee determines the remuneration, fees, allowances, and other terms of appointment for Executive Directors and all other Very Senior Manager (VSM) appointments. In addition, the Committee determines any allowances to be paid to other Board and Committee members who are not employees (excluding Non-Executive Directors). The remuneration, fees, allowances, and other terms of appointment for any individuals engaged on a contract for service will be determined by the Remuneration Committee, as will approval of all exit payments, (seeking HM Treasury pre-approval if required).

6. The remit of the Committee also includes overseeing compliance with the requirements set out in the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, as well as overseeing human resources management arrangements for all ICB staff. During the year, the Committee's duties were expanded to include a specific role in reviewing the ICB's VSM structure.

Meetings during 2024/25

7. The Remuneration and Human Resources Committee is scheduled to meet on a quarterly basis and at other times as required. Its membership is comprised of Non-Executive Directors of the Board, which includes the Chair of the ICB. The Chair of the Audit and Risk Committee cannot be a member of the Committee.

8. During 2024/25, the Committee met on nine occasions, with an overall attendance rate of 97%. Further detail of members' attendance is set out below:

Name	Membership Period	Possible	Actual
Marios Adamou	1 April 2024 to 31 December 2024	8	8
Stephen Jackson	1 April 2024 to 31 October 2024	5	5
Mehrunnisa Lalani (Chair from 1 January 2025)	1 January 2025 to 31 March 2025	1	1
Kathy McLean	1 April 2024 to 31 March 2025	9	8
Jon Towler (Chair until 31 December 2024)	1 April 2024 to 31 March 2025	9	9

9. Conflicts of interests are required to be managed in advance of committee meetings. Processes are in place within the Corporate Governance Team to ensure that these are managed, including the identification of any declared interests from the ICB's Register of Interests in advance of the meeting. At the outset of all committee meetings, the Chair prompts members to declare any interests that arise during the meeting. All conflicts identified during 2024/25 were managed in accordance with the ICB's Standards of Business Conduct Policy.

Summary of activity

10. During 2024/25, the Remuneration and Human Resources Committee has discharged all duties stipulated in its terms of reference; as such, the Committee has:

    ICB workforce and organisational development activities:

    a) Received quarterly workforce assurance reports, which included information on staff engagement and health and wellbeing activities and

employee relations matters, alongside a range of key workforce metrics covering the ICB's funded establishment, vacancy rates, staff turnover, sickness absences, and appraisal rates.

b) Received quarterly assurance reports on delivery of the 2023 Staff Survey action plan.

c) Approved the 2024 Gender and Ethnicity Pay Gap, Workforce Race Equality Standard and Workforce Disability Equality Standard Reports, data, and action plans for publication.

d) Discussed the ICB's approach to succession planning and talent management.

e) Discussed the ICB's workforce risks detailed within the Operational Risk Register, with particular focus on high-risk areas.

f) Received the 2024/25 objectives set for the Chief Executive and Executive Directors for information.

Remuneration related activities:

g) Approved the 2024 pay awards for Very Senior Managers and medical and dental staff in line with recommendations by the national Review Body on Senior Salaries and the Doctors and Dentists Review Body.

h) Approved the recruitment process and remuneration rates for two new Executive Director roles (Director of Strategy and System Development and Director of Delivery and Operations), which replaced the former Director of Integration, and the establishment of a Joint Executive Director of Finance role with NHS Derby and Derbyshire ICB. This included approval of transitional shadow/acting up arrangements for these roles.

i) Approved the establishment of a Joint Chief Digital Officer role with NHS Derby and Derbyshire ICB.

j) Approved the appointment of, and remuneration arrangements for, an Independent Chair for the Nottingham and Nottinghamshire Adult and Children's Mental Health Partnership Board.

11. As a comprehensive review of committee effectiveness was undertaken in 2023/24, the Committee agreed that a proportionate approach should be taken for 2024/25. Along with all ICB committees, a mid-year stock-take of the Committee's annual work programmes was undertaken to ensure that its responsibilities were on track to be discharged throughout the year. This was complemented in-year by an independent review of committee effectiveness by the ICB's internal auditors; this provided a substantial assurance rating, which is the highest level able to be achieved.

12. The Committee's annual work programme has been used to support good governance and appropriately prioritise the Committee's workload to ensure it discharges its statutory duties.

Conclusion

13. This report demonstrates that the Remuneration and Human Resources Committee has effectively discharged its responsibilities throughout 2024/25, providing robust oversight of ICB workforce and organisational development matters. The Committee received positive assurances across a range of areas, while also constructively challenging areas requiring improvement. Through its work, the Committee has supported the ICB in maintaining robust decision-making that is compliant with statutory responsibilities.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	14/05/2025
Paper Title:	**2025/26 Internal Audit Plan**
Paper Reference:	ICB 25 022
Report Author:	Glynis Onley, Assistant Director, 360 Assurance
Report Sponsor:	Bill Shields, Director of Finance
Presenter:	-

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

Summary:

The 2025/26 Internal Audit Plan, approved by the ICB's Audit and Risk Committee at its 27 March 2025 meeting, was developed through discussions with the Committee's members, the ICB's Executive Management Team, and the Director of Corporate Affairs.

Recommendation(s):

The Board is asked to **note** the 2025/26 Internal Audit Plan for information.

How does this paper support	the ICB's core aims to:
Improve outcomes in population health and healthcare	Internal audit work provides assurance to the ICB on its framework of governance, risk, and control. It reflects the ICB's objectives and priorities and supports improvement.
Tackle inequalities in outcomes, experience, and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

Not applicable.

Board Assurance Framework:

This paper provides assurance in relation to the management of all ICB strategic risks.

Report Previously Received By:

Not applicable.

Are there any conflicts of interest requiring management?

No

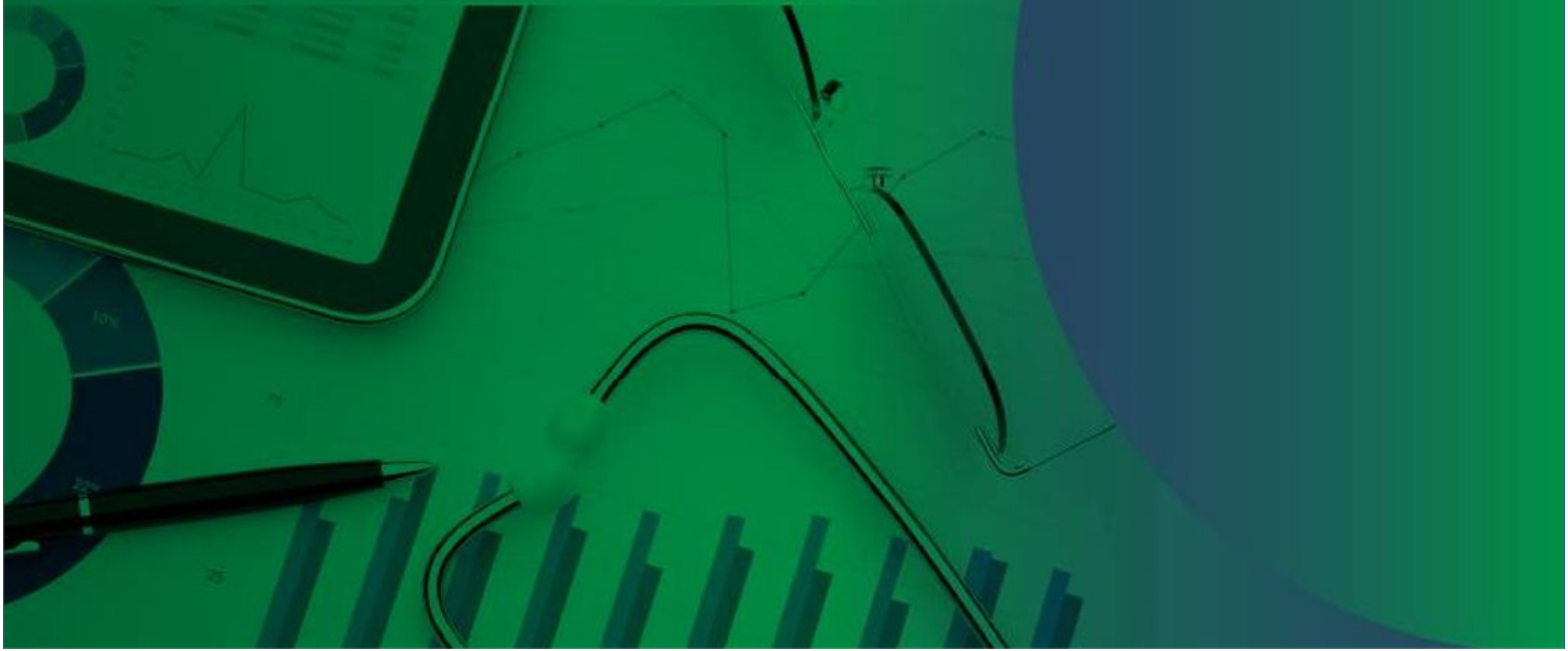
Is this item confidential?

No

NHS Nottingham and Nottinghamshire ICB

2025/26 Internal Audit Plan (approved by Audit and Risk Committee)

27 March 2025



Contents

Introduction

Your Internal Audit Plan has been developed to meet your assurance requirements, support you in meeting the requirements for an Annual Governance Statement and provide for an annual Head of Internal Audit Opinion.

We have reviewed key documents and held planning discussions with the following stakeholders:

- Director of Corporate Affairs and Operational Director of Finance on 12 February 2025
- Executive Management Team on 24 February 2025
- Audit and Risk Committee members on 3 March 2025.

Where relevant, we have considered expected third party assurances to enable coordination of services and minimise duplication. Our Plan is cross-referenced with the Counter Fraud Plan, where applicable, for joint delivery.

The Plan does not cover all identified risks from our risk assessment, reflecting prioritised allocation of internal audit resources through discussions with ICB officers. The Audit and Risk Committee should acknowledge this limitation when approving the Plan, which is based on available internal audit resources advised by the Chief Financial Officer.

2025/26 Draft Internal Audit Plan

Planning process

We undertake a risk assessment and assurance mapping to ensure your Plan is focused on your key risks and:

- considers high priority risk to delivering an opinion on governance, risk management and controls
- ensures appropriate coverage to meet the requirements of the Global Internal Audit Standards
- facilitates the Audit and Risk Committee in discharging its responsibilities
- supports achievement of strategic objectives.

The output of this risk assessment process informs the annual plan. Appendix A summarises 2025/26 annual plan. Each review will have an agreed Terms of Reference which will set out any limitations of scope and the evidence required to complete the work. The strategic internal audit plan is presented in Appendix B.

We recognise that 2025/26 will be a period of significant change for the ICB. We will continue to take a flexible approach and will keep the annual plan under review throughout the coming year. We will continue to scan your local and national risks and agree any proposed changes to the Plan through the Audit and Risk Committee. We will take into account any third party assurances received.

Statutory requirements

Head of Internal Audit Opinion

Our planning process is designed to meet the requirements of the Head of Internal Audit Opinion and to support your Annual Governance Statement, including ensuring the risk management processes in place are well designed and operating as intended.

Our year-end Head of Internal Audit Opinion will take the following into account:

- outcomes from internal audit work (including a review of the Board Assurance Framework)
- implementation of internal audit actions
- third party/other assurances.

The Head of Internal Audit Opinion levels are available on our website.

Global Internal Audit Standards in the UK Public Sector

The Plan is compliant with the Global Internal Audit Standards in the UK Public Sector which came into effect on 1 April 2025. The planning process we have undertaken has informed our understanding of your governance, risk management and control processes. This includes how you identify and assess significant risks through your risk management framework, ie the Board Assurance Framework. Our Internal Audit Charter is included at Appendix D to demonstrate how we align to your internal audit requirements.

Conclusion

The Audit and Risk Committee has been delegated responsibility by the Board to approve the Internal Audit Plan and Charter for the ICB. The Committee must be satisfied with the planned coverage and take into account other sources of independent assurance. The Plan has been developed on the basis of 200 internal audit days being delivered during the year. This is a reduction in audit days compared to 2024/25 of 50 days.

The Plan was approved by the Audit and Risk Committee on 27 March 2025. We will continue to horizon scan and liaise with executive officers to ensure the Plan remains relevant to the rapidly changing environment in which you operate.

We work in partnership with the ICB to deliver this Plan and continue to seek efficiencies in the way we work. Cooperation of ICB officers is essential to support the timely delivery of our Plan.

Appendix A1 – Your Internal Audit Plan and indicative phasing for 2025/26

Ref.	Audit and nominated lead officer	BAF reference	Phasing*	Outline scope	Assurance or Advisory
1	Head of Internal Audit Opinion (Director of Corporate Affairs)	All	Q1-4	To deliver an annual internal audit opinion that concludes on the overall adequacy and effectiveness of an organisation's framework of governance, risk management and control for the period for which it relates.	Assurance (mandated annually)
	Governance				
2	Board Assurance Framework (Director of Corporate Affairs)	All	Q3	To review how strategic risks are managed by the Board and its committees.	Assurance (mandated annually)
3	Risk Management (Director of Corporate Affairs)	All	Q2	To review if operational risk management processes and reporting and escalation arrangements are clearly defined and working effectively at all levels of the organisation. Not reviewed at the ICB previously. Required once in a three year cycle.	Assurance (high priority)
4	Fit and Proper Persons Test (Director of Corporate Affairs)	All	Q2	The Fit and Proper Persons Test Framework issued by NHSE states that, every three years, NHS organisations should have an internal audit to assess the processes, controls and compliance supporting the FPPT assessments. The internal audit should include sample testing of the FPPT assessment and associated documentation.	Assurance (high priority)

Ref.	Audit and nominated lead officer	BAF reference	Phasing*	Outline scope	Assurance or Advisory
	Finance and sustainability				
5	Efficiency programme (Director of Finance)	Risk 3	Q2	To assess the arrangements for identifying and managing delivery of efficiencies/productivity improvements.	Assurance (high priority)
	Clinical quality				
6	Quality oversight arrangements (Director of Nursing)	Risk 4	Q3	To assess whether the ICB has established clear and effective arrangements for overseeing the quality of NHS services within the system, both individually and collectively, ensuring required quality standards are met.	Assurance (high priority)
	Performance				
7	Contract management (Director of Finance)	Risk 3	Q4	To assess whether the ICB has an effectively designed contract management function that is fit for purpose and operates in line with 2025/26 contract guidance expectations.	Assurance (high priority)
8	Delivery of operational plans (Director of Finance/Director of Delivery and Operations)	Risk 9	Q3	To provide assurance regarding the ICB's arrangements for overseeing delivery of key priorities set out within the annual operational plan.	Assurance
	People				
9	No review included.				

Ref.	Audit and nominated lead officer	BAF reference	Phasing*	Outline scope	Assurance or Advisory
	Digital				
10	Data Security and Protection Toolkit (Director of Corporate Affairs)	All	Q1	To complete in Q1 to inform submission as at 30 June 2025. The overall objective is to assess the effectiveness of your Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit Assessment. The scope of the audit is determined by NHSE.	Assurance (mandated annually)
				Sub-total: Total number of audit days	**127 days**
	Other				
11	Review to be determined		TBC	Days for an additional review are included to enable flexibility in the plan and to be able to respond to changes in assurances that may be required during the year.	
12	System wide review – Transformation (Director of Strategy and System Development/Director of Delivery and Operations)	Risk 5	TBC	Scope of review to be agreed with system partners. It could: • focus on the delivery of a particular service transformation programme, including the extent to which improved outcomes are being achieved • focus on the delivery of system productivity/efficiency priorities.	Advisory
				Sub-total: Total number of other days	**23 days**
	Management, action tracking, and contingency				
13	Management	N/A	Q1-4	For management of the organisation's internal audit service, including:	Mandated

Ref.	Audit and nominated lead officer	BAF reference	Phasing*	Outline scope	Assurance or Advisory
				• production of the Strategic Internal Audit Plan and annual work programme • continual review and update of the Internal Audit Plan to ensure it meets the needs of the organisation • provision of ad hoc advice and support regarding internal control and governance issues • quality management • progress reports to the Audit and Risk Committee and Director of Finance • liaison with External Audit • attendance at Audit and Risk Committee, client progress meetings, and other meetings as required. *This section is in accordance with requirements of the GIAS.*	
14	Action tracking	N/A	Q1-4	To follow up agreed actions in all internal audit reports using the tracker, Pentana.	Mandated
15	Events and benchmarking papers	N/A	N/A	Annually we provide training and development sessions for Audit Committee members and governance leads and a series of benchmarking papers.	Mandated
16	Contingency	N/A	Q1-4	Contingency is used to cover the following: • changes to audit assignments that could not have been reasonably foreseen • facilitate additional work where required or scope increases • where we experience delays in obtaining evidence and/or receiving responses to queries	Mandated

Ref.	Audit and nominated lead officer	BAF reference	Phasing*	Outline scope	Assurance or Advisory
				• where meetings are cancelled and we prepared and/or travelled to client sites • in line with our KPIs where we do not receive agreement to Terms of Reference and agreement to draft reports in a timely manner. *This section is in accordance with requirements of the GIAS.*	
				Sub-total: Total number of management days	**50 days**
				Total number of days	**200 days**

** Quarters have been allocated where specifically requested. Other audits will be balanced across the year to align with client requirements and resource availability.*

Appendix A2 – Exclusions from the 2025/26 Internal Audit Plan

A2.1 The following audits have been recommended for review in 2025/26 but not included in the Plan

Recommended review	Reason for non-inclusion in the Plan
Safeguarding	Other third party assurances already available to the ICB.
Staff management (absence)	Not considered a priority given the relatively low number of ICB employees.

A2.2 Risks on the Board Assurance Framework not covered by reviews in the Plan

BAF Risk	Reason for non-inclusion in the Plan
Risk 1: Timely and equitable access	2024/25 system wide review of system governance will provide some assurance to address gap.
Risk 2: Primary care	BAF risk currently scored 8 and not considered a priority.
Risk 6: Workforce	2024/25 review of Delivering the People Plan provides some assurance.
Risk 7: Digital transformation	2024/25 review of Delivering Digital Transformation provides some assurance.
Risk 10: Culture and leadership.	BAF risk currently scored 8. No significant gaps in assurance and not considered a priority.

A2.3 Areas requested by Audit and Risk Committee members or ICB officers which have not been included in the Plan

Area	Reason for non-inclusion in the Plan
Development and delivery of Place plans	Consideration of place to be incorporated into system wide review.
Population health management	Not considered a priority at the current time. Included in strategic plan in 2026/27.
Capital	The Infrastructure Strategy is to be reported to March 2025 ICB Board for approval. Proposed for 2026/27 to assess progress being made.
Response to the Staff Survey	Not considered a priority at the current time given ICB staffing levels and potential changes in 2025/26. An annual 'People' review is not required for the Head of Internal Audit Opinion.

Appendix B – Strategic audit plan 2024-2027

Ref.	Audit	2024/25	2025/26	2026/27
	Governance			
1	Strategic governance	x		
2	Board Assurance Framework	x	x	x
3	Risk management		x	
4	Fit and Proper Persons Test		x	
5	Place level governance			x
	Finance and sustainability			
6	Financial systems (accounts receivable and treasury and cash management)	x		
7	Budgetary control and budget management	x		
8	Efficiency programme		x	
9	Capital			x
10	Financial ledger and reporting			x
	Clinical quality			
11	Quality management arrangements - PSIRF	x		

Ref.	Audit	2024/25	2025/26	2026/27
12	Quality oversight arrangements		x	
13	Population Health Management			x
	Performance			
14	Provider selection regime			
15	Contract management		x	
16	Delivery of operational plans		x	
17	Strategic commissioning (PODs/specialised commissioning)			x
	People			
18	Delivering the People Plan	x		
19	Framework for clinical and care professional leadership	x		
	Digital			
20	Data Security and Protection Toolkit	x	x	x
21	Delivering digital transformation	x		

Appendix C – 360 Assurance Charter 2025/26

This annual Charter sets out the purpose and mandate of internal audit in accordance with the Global Internal Audit Standards in the UK Public Sector. The Global Internal Audit Standards set forth principles, requirements, considerations, and examples for the professional practice of internal auditing globally. The Standards apply to any individual or function that provides internal audit services, whether an organisation employs internal auditors directly, contracts them through an external service provider, or both.[1]

The Charter is a formal document that includes the internal audit function's mandate, organisational position, reporting relationships, scope of work, types of services, and other specifications. It should be read in conjunction with our Service Level Agreement/Contract.

Definitions from the Global Internal Audit Standards in the UK Public Sector

Internal auditing

An independent, objective assurance and advisory service designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of governance, risk management, and control processes.

Internal audit mandate

The internal audit function's authority, role, and responsibilities, which may be granted by the board and/or laws and regulations.

Board

The highest level body charged with governance. This is the Audit and Risk Committee.

Senior Management

The highest level of executive management of an organisation that is ultimately accountable to the board for executing the organisation's strategic decisions, typically a group of persons that includes the chief executive officer or head of the organisation. This is the Executive Management Team.

Chief Audit Executive/Head of Internal Audit

The leadership role responsible for effectively managing all aspects of the internal audit function and ensuring the quality performance of internal audit services in accordance with Global Internal Audit Standards. This is the Director of 360 Assurance.

[1] globalinternalauditstandards_2024january9_editable.pdf

Purpose of internal audit

The purpose of internal audit is to provide independent, risk-based and objective assurance, advice, insight and foresight designed to add value and improve the organisation's operations.

Commitment to adhering to the Global Internal Audit Standards

360 Assurance will adhere to the mandatory elements of The Institute of Internal Auditors' International Professional Practices Framework, which are the Global Internal Audit Standards in the UK Public Sector and Topical Requirements. The Head of Internal Audit will confirm compliance with the Standards on an annual basis through the annual report to the Audit and Risk Committee.

Mandate of internal audit

Authority and oversight

The internal audit mandate is found in the Board's standing documents and Audit and Risk Committee Terms of Reference.

The ICB's standing documents state the following in relation to Internal Audit:

> 3.1.5 Internal audit will review, appraise and report upon policies, procedures and operations in place to:
>
> (a) Establish and monitor the achievement of the organisation's objectives.
>
> (b) Identify, assess and manage the risks to achieving the organisation's objectives.
>
> (c) Ensure the economical, effective and efficient use of resources.
>
> (d) Ensure compliance with established policies (including behavioural and ethical expectations), procedures, laws and regulations.
>
> (e) Safeguard the organisation's assets and interests from losses of all kinds, including those arising from fraud, irregularity or corruption.
>
> (f) Ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes.
>
> 3.1.6 The Head of Internal Audit will provide to the Audit and Risk Committee:
>
> (a) A risk-based plan of internal audit work, agreed with management and approved by the Audit and Risk Committee, which will enable the internal auditors to collect sufficient evidence to give an opinion on the adequacy and effective operation of the organisation.
>
> (b) Regular updates on the progress against plan.

(c) Reports of management's progress on the implementation of action agreed as a result of internal audit findings.

(d) An annual opinion based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). The Chief Executive uses this opinion to inform their annual Governance Statement and by NHS England as part of its performance management role.

(e) Additional reports as requested by the Audit and Risk Committee.

3.1.7 Whenever any matter arises during the course of internal audit work, which involves, or is thought to involve, irregularities in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately. If the Director of Finance is thought to be involved in an irregularity, then this should instead be reported to the Chief Executive.

3.1.8 The Head of Internal Audit will normally attend Audit and Risk Committee meetings and has a right of access to the Chair of the Audit and Risk Committee and the ICB Chair and Chief Executive.

3.1.9 The Head of Internal Audit reports to the Audit and Risk Committee and is accountable to the Director of Finance. The reporting system for internal audit will be agreed between the Director of Finance, the Audit and Risk Committee and the Head of Internal Audit and will comply with the guidance on reporting contained in the Public Sector Internal Audit Standards.

(Standing Financial Instructions, 9 January 2025)

The Audit and Risk Committee Terms of Reference state the following in relation to Internal Audit:

The Committee will approve arrangements for the provision of internal audit services. The Committee will ensure that there is an effective internal audit function established by management that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, ICB Chief Executive, ICB Chair and the Board. This will be achieved by

g) Considering the provision of the internal audit service and the costs involved; ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.

h) Reviewing and approving of the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the ICB (as identified in the Board Assurance Framework).

i) Considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.

j) Monitoring the effectiveness of internal audit and completing an annual review.

(Terms of Reference, 1 October 2024)

360 Assurance is an NHS shared service hosted by University Hospitals of Derby and Burton NHS Foundation ICB. The governance of 360 Assurance, including our strategy and budget, is approved by a Management Board of NHS representatives. Host policies and procedures are adopted in full.

The Director of 360 Assurance is ultimately responsible for the delivery of the client's audit plan in line with the service level agreement. To achieve this they are assisted by a designated client lead. The Director of 360 Assurance and client lead will be suitably qualified and experienced. Any change of client lead will be discussed with the Audit and Risk Committee and Chief Financial Officer. Other internal audit staff will be suitably qualified and/or experienced, in line with agreement regarding skill mix through the service level agreement/contracting process.

360 Assurance will have unrestricted access to communicate and interact with the accountable officer, Chair of the Board and Chair of the Audit and Risk Committee, including in private meetings without management present.

360 Assurance will work with the whole of the Executive Management Team who will support us in delivering the Internal Audit Plan and work from the Plan will be reported directly to the Audit and Risk Committee.

Authority is granted by the client for full, free and unrestricted access by 360 Assurance to any and all of its records, physical properties and personnel relevant to any function under review, for example, care records and staff information. All client employees will assist internal audit in fulfilling its function. 360 Assurance will not be responsible or liable if information material to our task is withheld and concealed from us or wrongly represented to us.

Independence, organisational position and reporting relationships

360 Assurance will seek to ensure the independence and objectivity of our personnel engaged in the provision of the services. You will be made aware of any relationships that, in our professional judgement, may reasonably be thought to impinge on our independence and the objectivity of the personnel involved in the provision of the services. This is essential in order to reach impartial and unbiased judgements in the reporting of the services.

The Head of Internal Audit will be positioned at a level in the organisation that enables internal audit services and responsibilities to be performed without interference from management, thereby establishing the independence of the internal audit function.

On an operational basis the client lead will report to the client's lead contact, normally the Chief Financial Officer.

The Head of Internal Audit will disclose to the Audit and Risk Committee any interference and related implications in determining the scope in internal auditing, performing works and/or communicating results.

Changes to the Mandate and Charter

The Mandate and Charter will be reviewed on an annual basis to reflect significant changes.

Head of Internal Audit roles and responsibilities

Ethics and professionalism

The Head of Internal Audit will ensure that internal auditors:

- conform with the Global Internal Audit Standards in the UK Public Sector, including the principles of Ethics and Professionalism: integrity, objectivity, competency, due professional care, and confidentiality
- understand, respect, meet, and contribute to the legitimate and ethical expectations of the organisation and be able to recognise conduct that is contrary to those expectations
- encourage and promote an ethics-based culture in the organisation
- report organisational behaviour that is inconsistent with the organisation's ethical expectations, as described in applicable policies and procedures.

360 Assurance's provision of internal audit to each client will follow the Seven Principles of Public Life (also known as the 'Nolan Principles') set out in the Global Sector Internal Audit Standards in the UK Public Sector. Our staff are required to follow the Principles as well as related 360 Assurance guidance and professional requirements of any professional body to which the auditor belongs.

Objectivity

The Head of Internal Audit will ensure that the internal audit function remains free from all conditions that threaten the ability of internal auditors to carry out their responsibilities in an unbiased manner, including matters of engagement selection, scope, procedures, frequency, timing, and communication. If the Head of Internal Audit determines that objectivity may be impaired in fact or appearance, the details of the impairment will be disclosed to appropriate parties.

Managing the internal audit function

Annually, the client lead will submit to senior management and the Audit and Risk Committee a Plan for the forthcoming year. The annual planning process will identify strategic risk-based and key internal control systems reviews for consideration and will be aligned to the objectives and priorities of the organisation, any reviews not prioritised will be identified. Any significant deviation from the formally approved Plan will be communicated to senior management and the Audit and Risk Committee for approval. The size of the internal audit programme will be based on the organisation's risk appetite. The Internal Audit Plan and its content are owned by the Audit and Risk Committee.

360 Assurance will work with the whole of the Executive Management Team who will support us in delivering the Plan and will report on work from the Plan directly to the Audit and Risk Committee.

Audit work is carried out for the client only unless it is agreed during the planning stage that the audit will involve third parties.

360 Assurance will ensure all Plan engagements are completed, including the establishment of objectives and scope, the assignment of suitably qualified and adequately supervised resources and the documentation of work programmes and testing results. Following the conclusion of each audit we will confirm our findings in writing which will be issued by the client lead. Management have an opportunity to formally respond to each report and detail the corrective action taken, or to be taken, in regard to the specific findings and recommendations raised; responses should include allocated responsibility and timeframes for anticipated completion of each action and an explanation for any recommendations not addressed. Approval will be sought from the relevant Executive Lead. Any disagreements will be escalated to the Executive Director of Finance and Estates or the Audit and Risk Committee Chair.

The client will be responsible for notifying 360 Assurance of any reasons for delays in planned work with sufficient notice and also ensuring that information requested is provided in a timely manner. Other than in exceptional circumstances, clients should provide requested information, evidence and responses to audit enquiries within five working days.

Follow up arrangements are in place to ensure that management implement corrective actions within specified timeframes. 360 Assurance shall be responsible for providing assurance over the appropriateness of management's monitoring of actions to address recommendations.

Individual assurance assignments provide audit opinions based upon a sound methodology and using accepted best practice. Where, in the opinion of 360 Assurance, an issue arises which requires the urgent attention of the client, the matter will be reported to the Executive Director of Finance and Estates without delay. Governance, risk and control themes are summarised for Audit and Risk Committee as relevant.

The Director of 360 Assurance will give a Head of Internal Audit Opinion which encompasses governance, risk management and control. Our risk matrix, audit review and overall Head of Internal Audit opinions are available to view in full on our website.

360 Assurance will consider whether it is possible or practical to coordinate with other assurance providers.

We will liaise with your external auditors to maximise the value of the total audit effort.

Any external auditor or other reviewer of work undertaken as part of the services will need to draw their own conclusions from the work as it will have been undertaken and concluded on by 360 Assurance for its own purposes.

Quality assurance

Performance of the service provided will be assessed in line with the agreed key performance indicators, which are included within the service level agreement/contract.

360 Assurance undertakes a programme of quality monitoring to ensure that audits are delivered in line with the Audit Manual, which reflects extant professional requirements.

360 Assurance will engage in an independent assessment in line with the Global Internal Audit Standards in the UK Public Sector and notify the client of any quality assurance and improvement programme developed as a consequence.

This will be reported to Audit and Risk Committee through our Annual Report.

Scope of internal audit activity

The scope of internal audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management, control processes and value for money. This may include all activities, assets and personnel of the ICB.

Documents and information given to internal audit during a review will be handled in the same prudent and confidential manner as by those employees normally accountable for them.

Advisory services

Internal audit services to the organisation may consist of assurance services and/or advisory services. Assurance services involve the internal auditor's objective assessment of evidence to provide an independent opinion or conclusions regarding an entity, an operation, a function, a process, system, or other subject matter. The results of Assurance reviews will be regularly reported to the Audit and Risk Committee.

Advisory services, by their nature, are generally performed at the specific request of the client. 360 Assurance will seek approval from the Audit and Risk Committee *prior* to the commencement of any significant advisory services. Work is considered significant if it exceeds 20% of the annual audit fee.

Any advisory services will, in line with the Global Internal Audit Standards in the UK Public Sector, be limited to reviews that aim to improve governance, risk management and control. When performing advisory services, the internal auditor will maintain objectivity and will not take on management responsibility. We will apply appropriate management arrangements to ensure that any conflict is avoided if we were to undertake any non-internal audit activities and these will be dealt with in an open and transparent manner.

Role of Internal Audit in fraud related work

360 Assurance will have sufficient knowledge to evaluate the risk of fraud and the manner in which it is managed by the organisation. The potential for the occurrence of fraud and how the organisation manages fraud risk will be considered. There is a protocol in place with the client's Counter Fraud provider to review internal audit requirements where a fraud has arisen or to report any potential fraud issues to Counter Fraud where such issues arise.

Nottingham and Nottinghamshire

Nottingham & Nottinghamshire Integrated Care Board

Integrated Performance Report

Reporting Month: February 2025 / March 2025

Board Month: May 2025

Integrated Performance Report May 2025 – Report Contents

1. Introduction

This report presents progress against the key performance targets, across quality, service delivery, finance and workforce, and to note key developments and actions being taken to address performance issues. Where appropriate, information is provided for total Nottingham and Nottinghamshire population, and total provider responsibilities for those providers geographically located within Nottinghamshire, Sherwood Forest Hospitals (Acute), Nottingham University Hospitals (Acute) and Nottinghamshire Healthcare NHS Trust (Mental Health). The indicators included in the Board Integrated Performance Report (IPR) are reviewed annually and are based on the system operational plan for 2023/24, compliance and commitment targets, and any additional key local and national measures.

The intention is that each ICS Oversight Group, which is led by an ICB Executive Lead, will propose a level of assurance following the discussion of the reported metrics based upon the ICS Assurance Escalation Framework (page 98) which will support the escalation of issues to the ICB Board.

The system has achieved the financial position required for month 12, reporting a £0.1m favourable variance to plan. Efficiencies are (£0.2m) adverse to the plan and ERF estimated to be slightly ahead of the plan submitted. The finance reporting includes the key performance indicators on slide 11 alongside a narrative to support the finance scorecard table. There is further detailed financial performance and efficiencies tables by the organisations within the system with supporting narratives on slides 79-80. Workforce is over the planned position at month 12, reporting bank and substantive worse than plan and agency better then plan. Month 12 reporting is subject to external audit.

The system has made some positive progress on service delivery areas, which include achieving trajectory for the cancer 62-day standard. The volume of patients waiting over 52 weeks for community therapeutic services continues to reduce along with the number of mental health patients with a placement out of area. Sustained progress has been made with supporting children and young people with Learning Difficulties and Autism in the community, rather than needing to admit to inpatient services, and ensuring that people with LD&A are having timely access to annual health checks.

However, system pressures and challenges remain in some areas. 4 and 12-hour performance remains challenging. Handover performance and ambulance category 2 performance has improved following implementation of the 45-minute handover policy in December and hospital flow improvement has been sustained. Planned care focus remains on ENT pathways to enable further progress to be made to eradicate waits of over 65 weeks. There is also focus on further reducing waits for cancer treatment and enabling additional capacity in key diagnostic modalities such as CT Cardiac and MRI. Too many adults with Learning Disability and Autism continue to remain in inpatient care settings which are being addressed through weekly cross partner discussions.

The full detail of the performance measures which the ICB is required to deliver, are provided across a series of functional score cards on pages 4 –12. These provide an overview of the areas which are and are not delivering as planned. The SPC icons provide an indication of the improvement or deterioration in the position (variation) as well as an indication of whether the current process or performance levels will achieve the required level in future (assurance). Exception reports by functional area, detailing the areas of concern, actions being taken to address the current issues, and assurance as to whether these actions will impact upon and improve the position, are provided on pages 13 – 95.

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Quality Scorecard

Quality Scorecard	Latest Period	Plan	Actual	Variance	Section
Learning Disability & Autism					
LD&A Inpatients Rate Adults – ICB	Mar-25	09	12	+3	Section 01
LD&A Inpatients Rate Adults – NHSE	Mar-25	23	29	+6	
LD&A Inpatients Rate CYP – NHSE	Mar-25	3	1	-2	
LD&A Annual Health Checks	Mar-25	5694	5,684	-10	
Maternity					
No. stillbirths per 1000 total births	Dec 24		2.2	1.02	Section 02
No. neonatal deaths per 1000 live births	Dec 24		1.10	0.41	
Infection Prevention Control Hospital Acquired Infections ICB (Feb 25)					
MRSA	Feb 25	0	1	-1	Section 10
C-Diff	Feb 25	28	32	-4	
E.coli BSI	Feb 25	96	76	+20	
Klebsiella BSI	Feb 25	30	24	+6	
Pseudomonas BSI	Feb 25	12	6	+6	

Quality Scorecard	Latest Period	Plan	Actual	Variance	Section
Vaccinations					
MMR second dose at 5 years	Sep 23	95%	83%	-12%	Section 06
COVID Vaccination Booster dose	Jan 25		43%		
Seasonal Flu Vaccination	Jan 25		53%		

Content Author: SAIU | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

3a. Service Delivery Scorecard - Urgent Care

Pre-Hospital Flow Volumes

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
EMAS Responses Activity	ICB	March 2025	13196	13205	9	✗		
Ambulance Conveyances to ED (%) ICB Population	ICB	March 2025	45.9%	44.9%	-1%	✓		
111 Calls	ICB	February 2025	31705	29667	-2038	✓		
% 111 Calls Abandoned	ICB	February 2025	3%	1%	-2%	✓		

Pre-Hospital - Alternatives to ED

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Urgent Care Response Referrals	ICB	February 2025	1225	1490	265	✓		
2 Hour Urgent Care Response %	ICB	February 2025	70%	97.1%	27.1%	✓		
No. Patients utilising Virtual Ward	ICB	March 2025	236	198	-38	✗		
% Virtual Ward capacity utilised	ICB	March 2025	80.1%	90.4%	10.3%	✓		

In-Hospital Flow

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Total A&E Attendances	Provider	March 2025	35574	33995	-1579	✓		
Total NEL admissions	Provider	February 2025	10656	12160	1504	✗		
0 Day NEL	Provider	February 2025	4065	4640	575	✓		
1+ Day NEL	Provider	February 2025	7625	7520	-105	✓		
% Bed Occupancy	Provider	March 2025	95.3%	93.6%	-1.7%	✓		

Flow out of Hospital

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Pathway 0 - Discharge home with no support needed	ICB	February 2025	7469	12627	5158	✓		
Pathway 2 - Discharge not to usual residence	ICB	February 2025	196	214	18	✓		
CTR activity	Provider	March 2025	347	266.0	-80.0	✓		
Length of Stay > 21 days	Provider	March 2025	430	378	-52	✓		
Pathway 3 - Discharge to a care home which is likely to be permanent	ICB	February 2025	109	43	-66	✗		
Pathway 1 - Discharge home with health and/or social care	ICB	February 2025	962	958	-4	✗		

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3a. Service Delivery Scorecard - Urgent Care

EMAS Compliance								
Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Ambulance (mean) response time Cat 1 (Notts)	ICB	March 2025	00:07:00	00:08:21	00:01:21	✗		
Ambulance (mean) response time Cat 2 (Notts)	ICB	March 2025	00:22:38	00:31:18	00:08:40	✗		
Ambulance (mean) response time Cat 3 (Notts)	ICB	March 2025	03:10:46	02:15:16	-00:55:30	✓		
Ambulance response time Category 4 - 90th Centile *	ICB	March 2025	03:00:00	04:59:17	01:59:17	✗		
% Cat 2 waits below 30 minutes	ICB	March 2025	48.5%	59.2%	10.8%	✓		

Acute Performance Compliance								
Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Average C2 Handover time	Provider	March 2025	00:44:10	00:26:13	-00:17:57	✓		
% Ambulance Handovers > 30 minutes	ICB	March 2025	31.2%	26.1%	-5.1%	✓		
% Ambulance Handovers > 60 minutes	ICB	March 2025	15.4%	5.5%	-9.9%	✓		
Ambulance Total Hours Lost	Provider	March 2025	1265	1915	650	✗		
A&E 4hr % Performance (All types)	Provider	March 2025	78%	63.9%	-14.1%	✗		
A&E 12 Hour Waits	Provider	March 2025	0	596	596	✗		
A&E 12 Hour Breaches as % Overall Attendances	Provider	March 2025	2%	9.9%	7.9%	✗		

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3b. Service Delivery Scorecard – Planned Care: Elective

Total Waiting list and Long Waits

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
RTT Waiting List	Provider	February 2025	104946	119837	14891	✗		
52 Week Waiters	Provider	February 2025	2435	2611	176	✗		
Incomplete> 52 weeks CYP	Provider	February 2025	239	244	5	✗		
65 Week Waiters	Provider	February 2025	0	90	90	✗		
78 Week Waiters	Provider	February 2025	0	3	3	✗		
Total Clock Stops (Adm + Non adm)	Provider	February 2025	26672	24164	-2508	✗		
Total Clock Starts	Provider	February 2025	25404	25130	-274	✗		
% Incomplete 18 wks RTT	Provider	February 2025	-	58.7%	-			

Elective Recovery - Activity

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Elective Ordinary	Provider	February 2025	2412	2130	-282	✗		
Total Day Cases	Provider	February 2025	15958	14080	-1878	✗		
Total Outpatients 1st (Spec Acute)	Provider	February 2025	30271	24245	-6026	✗		
Total Outpatients FUp (Spec Acute)	Provider	February 2025	59452	54635	-4817	✗		
Op Plan Diagnostic Activity	Provider	February 2025	34638	42782	8144	✓		

Elective Recovery - Productivity and Transformation

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Total Outpatients Virtual	Provider	February 2025	25%	16.5%	-8.5%	✗		
PIFU	Provider	January 2025	5%	6%	1%	✓		
Specialist Advice (per 100 OPFA)	Provider	December 2024	16	22	6	✓		
Missed Appointments %	Provider	February 2025	6.4%	4.4%	-2%	✓		
Outpatient procedures - ERF scope	Provider	February 2025	19702	22848	3146	✓		
Proportion of outpatient attendances with a procedure - ERF scope	Provider	February 2025	46%	42.4%	-3.6%	✗		
Outpatient first attendances without a procedure - ERF scope	Provider	February 2025	28931	30546	1615	✓		
Outpatient follow up attendances without a procedure - ERF scope	Provider	February 2025	69116	72543	3427	✓		
Percentage outpatients follow-up without a procedure	Provider	February 2025	58.7%	57.6%	-1.1%	✓		
Percentage of Lower GI Cancer referrals with an FIT result	ICB	February 2025	79.5%	86%	6.5%	✓		
Number of people referred onto a non-specific symptoms pathway	ICB	February 2025	115	108	-7	✓		

Note: Population activity actuals include delegated specialised activity, however plans submitted did not include the delegated activity

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3b. Service Delivery Scorecard - Planned Care: Diagnostic and Cancer

Diagnostic Recovery

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Op Plan Diagnostic Activity	Provider	February 2025	34638	42782	8144	✓		
Op Plan Diagnostics Waiting List	Provider	February 2025	20700	26515	5815	✗		
Op Plan Diagnostic Backlog	Provider	February 2025	3563	4422	859	✗		
Op Plan Diagnostics 6 week Performance	Provider	February 2025	82.8%	83.3%	0.5%	✓		

Cancer Recovery

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Cancer 28 Day Faster Diagnosis	Provider	February 2025	78.7%	78.6%	-0.1%	✗		
Cancer 1st Treatment <31 days	Provider	February 2025	95.4%	92.3%	-3.1%	✗		
Cancer 62 Day Standard	Provider	February 2025	63.3%	63.5%	0.2%	✓		
2ww 62 Day Backlogs	Provider	February 2025	288	402	114	✗		

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3c. Service Delivery - Mental Health Scorecard

Talking Therapies

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
NHS Talking Therapies - Completing Treatment	ICB	February 2025	1159	1400	241	✓		
NHS Talking Therapies - Reliable Recovery	ICB	February 2025	48%	47.5%	-0.5%	✗		
NHS Talking Therapies - Reliable Improvement	ICB	February 2025	67%	70.4%	3.4%	✓		
NHS Talking Therapies- WT 1st Treatment <6 Weeks	ICB	February 2025	75%	97%	22%	✓		
NHS Talking Therapies - WT 1st Treatment <18 Weeks	ICB	February 2025	95%	100%	5%	✓		
NHS Talking Therapies - >90 Days 1st & 2nd Treatment	ICB	February 2025	10%	13.5%	3.5%	✗		

Mental Health Adult Inpatients

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Rate per 100,000 Older Adult MH LOS > 90 Days	ICB	February 2025	8	10	2	✗		
Rate per 100,000 Older Adult MH LOS > 60 Days	ICB	February 2025	8	18.0	10.0	✗		
Adult MH IP receiving a follow up <72hrs of discharge	ICB	February 2025	80%	81.8%	1.8%	✓		
Number of Inappropriate OAPs	ICB	March 2025	0	3	3	✗		

Community Mental Health

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Dementia Diagnosis Rate	ICB	February 2025	70.3%	70.1%	-0.2%	✗		
SMI Health Checks %	ICB	March 2025	60%	72%	12%	✓		
Transformed Community Services +2 Contacts	ICB	February 2025	14550	15710	1160	✓		

Mental Health Access

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Perinatal Access - Volume	ICB	February 2025	1305	1245	-60	✗		
Individual Placement Support	ICB	February 2025	1126	1470	344	✓		
EIP < 2 weeks	ICB	February 2025	60%	85.7%	25.7%	✓		

Mental Health CYP

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
CYP Eating Disorders - Urgent	ICB	December 2024	-	100%*	-			
CYP Eating Disorders - Routine	ICB	February 2025	95%	82%*	-13%	✗		
CYP Access (1+ Contact)	ICB	February 2025	19980	20630	650	✓		

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3d. Service Delivery – Primary & Community Scorecard

Primary Care and Community Response								
Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Primary Care - Total Appointments	ICB	February 2025	616808	630797	13989	✓		
Primary Care - % book 2 Weeks	ICB	February 2025	90%	84.2%	-5.8%	✗		
Primary Care - % NHS App Registrations	ICB	March 2025	75%	59%	-16%	✗		
Community Waits								
Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Community Waiting over 52 weeks (18+ years)	ICB	February 2025	65	4	-61	✓		
Community Waiting over 52 weeks (0-17 years)	ICB	February 2025	118	7	-111	✓		
Community Waiting List (18+ years)	ICB	February 2025	9299	9232	-67	✓		
Community Waiting List (0-17 years)	ICB	February 2025	4063	4702	639	✗		
Dental								
Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Child patients seen in previous 12 months	ICB	September 2024	140337	141250	913	✓		
Adult patients seen in previous 24 months	ICB	September 2024	495888	386604	-109284	✗		

4 - ICB Finance Scorecard (subject to external audit)

Indicator Measure	Outturn Position £'ms		
	Plan/ Ceiling/ Envelope	Actuals	Variance
Financial Sustainability (Variance from b/e)	0.0	0.1	**0.1**
Total Pay Spend	-2,048.1	-2,076.7	**-28.6**
Substantive Spend vs Plan	-1,912.8	-1,920.9	**-8.1**
Bank Spend vs Plan	-82.9	-111.7	**-28.8**
Agency Spend vs Plan	-52.4	-44.0	**8.4**
Agency Spend Vs Ceiling	-63.5	-44.0	**19.4**
WTE (Provider) - 24/25 plan as at 31.03.25	33,369	34,820	**-1,451**
Financial Efficiency Vs Plan	257.0	256.9	**-0.2**
Recurrent Efficiencies	201.5	158.1	**-43.4**
Achievement of MHIS	223.3	223.5	**0.2**
Capital Spend Vs System Env (inc IFRS16)	92.2	92.1	**-0.1**
ERF Performance (inc system A&G)	119.6%	120.3%	**0.7%**

- The system has reported a £0.1m surplus at month 12, which is £0.1m favourable to plan. The position includes £256.9m of efficiency against the target of £257m.
- Staff costs are (£28.6m) overspent across the system at month 12 with WTEs being 1,451 WTEs higher than plan.
- Agency spend is (£44m) which is £8.4m under the plan and £19.4m under the agency ceiling.
- Bank staff spend is over plan by (£28.8m) and substantive staff over plan by (£8.1m).
- Spend to date against the system capital envelope is £92.1m against a final system envelope of £92.2m.
- ERF estimated performance at the end of March across the system is 120.3% against the 119.6% plan.

Total ICS Provider Workforce - All Metrics

Total Workforce WTE
34,479.0

Substantive WTE
32,168.4

Bank WTE
1,937.3

Agency WTE
373.4

Total Workforce WTE
Variance to Plan
878.5
Variance %
2.6%

Bank WTE
Variance to Plan
41.0
Variance %
2.2%

Sickness/Absence
Sickness/Absence %
5.6%
Sickness/Absence Target %
5.2%

Mandatory Training
Man Training %
87.4%
Monthly Trend
-0.3%

Substantive WTE
Variance to Plan
953.6
Variance %
3.1%

Agency WTE
Variance to Plan
-116.1
Variance %
-23.7%

Turnover
Turnover %
9.6%
Turnover Target %
10.7%

Staff Appraisal
Staff Appraisal %
83.0%
Monthly Trend
-0.5%

Data Source - Provider Workforce Returns and KPI returns

NHS
Nottingham and Nottinghamshire

Quality Integrated Performance Report

March 2025

National Oversight Framework (NOF)

01 - NOF 4 Nottingham University Hospital NHS Trust

02 - NOF 4 Nottinghamshire Healthcare NHS Foundation Trust

Enhanced Oversight

03 - Nottingham CityCare

04 - Learning Disability & Autism

05 - Maternity

06 - Special Educational Needs and Disabilities

07 - Looked After Children

08 - Children & Young People

09- Infection Prevention & Control

Routine Oversight

NOF 2

10 - Sherwood Forest Hospital NHS Foundation Trust

11 - Patient Safety

12 - Universal Personalised Care

13 - Co-Production

14 - Adult & Children Safeguarding

15 - Vaccinations

People Capacity/Availability

NHS
Nottingham and Nottinghamshire

Statutory duties outlined below will be included in the Quality Integrated Performance Report Quarterly;

- **Routine Oversight -** Care Homes and Home Care
- **Routine Oversight -** Medicine Optimisation
- **Routine Oversight -** Personal Health Budgets
- **Routine Oversight -** Continuing Healthcare
- **Routine Oversight -** Patient Experience

2024/25 Quarter	Presented at Quality and People Committee
Quarter 1	17 July 2024
Quarter 2	11 November 2024
Quarter 3	10 February 2025
Quarter 4	21 May 2025

NHS
Nottingham and Nottinghamshire

National Oversight Framework (NOF)

Nottingham and Nottinghamshire Trusts

- 01 - NOF 4 Nottingham University Hospital NHS Trust
- 02 - NOF 4 Nottinghamshire Healthcare NHS Foundation Trust

	Segment description		Scale and nature of support needs
	ICB	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver on the statutory and wider responsibilities of an ICB are well developed	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	On a development journey, but demonstrate many of the characteristics of an effective ICB Plans that have the support of system partners are in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. GIRFT, Right Care, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in the capability and capacity required to deliver on the statutory and wider responsibilities of an ICB	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

01. Nottingham University Hospitals Trust (NUHT)

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Nottingham University Hospitals Trust (NUHT)

National Oversight Framework 4

Rationale for oversight level: NUHT will remain in NOF 4, with exit now anticipated for consideration in Q1 2025/26 due to financial concerns and the need to assure regulators that quality improvements made can be sustained in the light of these challenges. CQC overall 'Requires Improvement' with 'inadequate' rating for 'well led' (reported September 2021) and 'requires improvement for Maternity services in June 2024.

Current Position

- Operational pressures in the Emergency Department (ED) remain persistent with patients regularly receiving care in temporary escalation spaces (TES).
- A 45-minute deadline for ambulance handovers was introduced on 12th December, and whilst this has released ambulances to the community the department remains pressured due to poor flow through the hospital.
- There were two 48-hour breaches (both mental health patients) and five 8-hour ambulance handover breaches in March.

- The NUHT Breast Screening service is currently subject to an NHSE contract performance notice. Funding for new equipment has been secured and will increase capacity once installed
- The CQC has published its report from their visit to maternity in June 2024. The service remains rated as requires improvement overall but has been rated good on the domains of effective, caring and responsive.
- NUHT will reorganise the existing divisions into four care groups on the 1st April.
- Whilst engagement is positive and improvements evident, significant support systems are still required with ICB, NHS England and CQC partners as active participants.
- IOAG continues to monitor progress against improvement plans and the NOF 4 exit criteria, it should be noted were the Trust to move into NOF 3, enhanced oversight from the ICB would continue.

Actions Being Taken & Next Steps

- ICB Quality colleagues continue to meet in person with Deputy Chief Nurse for Operations with a focus on ED pressures, handover delays and boarding on the wards.
- The ICB Quality team continue to meet regularly with ED governance leads with a focus on improvement work. Insight visits to other parts of the UEC pathway are also taking place.
- The development of the system quality dashboard will support the introduction of the quality metrics into the UEC pathway. A set of UEC metrics to support work by the UEC Board and System Quality Group has been introduced and development of this will continue.

Risks & Escalations

- **(Risk ORR024).** If Nottingham University Hospitals NHS Trust (NUH) do not have the capacity to make improvements in a timely manner (following CQC visits), the quality of services provided may not meet optimal care standards resulting in poor patient experience and adverse health outcomes for the population of Nottingham/shire.
- **(Risk ORR023)** If Nottingham University Hospitals do not have the capability to make improvements in a timely manner following CQC recommendations, the quality of maternity services provided may not meet optimal care standards resulting in poor patient experience and adverse health outcomes for the population of Nottingham/shire.

Content Author: Rebecca Gorringe | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

02. Nottinghamshire Healthcare Foundation Trust (NHCFT)

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Nottinghamshire Healthcare Foundation Trust (NHCFT)

National Oversight Framework 4 - February 2024

Rationale for oversight level: Quality, Safety and Financial concerns requiring intensive support. Regional Recovery Support team (MHSIT) supporting improvements.

Current Position

- **Care Quality Commission –**The Care Quality Commission has undertaken seven assessments of the Trusts core services during March 2025. These included Rampton High Secure Hospital, mental health services for older people wards at Blossomwood Hospital and Highbury Hospital, HMP Lowdham Grange, HMP Fosse Way, Bassetlaw and John Eastwood Hospices.
- Following early feedback from CQC assessments of MHP Nottingham and HMP Ranby, NHCFT expect a Warning Notice for regulation 17 on both sites related to Safe Staffing
- **Regulation 28 - Preventing Future Deaths Reports.** 0 new PFDs issued directly to the Trust in March. The Trust has been asked to respond to a multi-agency PFD relating to HMP Lowdham Grange.
- **Integrated Improvement Oversight Assurance Group (IOAG) –** The IOAG met in March 2025. A refreshed IIP was presented detailing the flagship projects for 2025/26. Reported against S48 Recommendations 22/34 on track, 1 off track, 9 considered complete awaiting sign off, 2 completed and signed off. SafeNow progress update was presented with a focus on the Rampton Hospital dashboard.
- **Safe Now** – Please see next slide with Safe Now Metrics at end of March 2025. Improved indicators in community Mental health - people waiting for services, patient right's being read and recorded, Risk Assessment compliance and process and compliance for Waiting Well. Updates provided for Offender Health and Medical Engagement. The Safe Now process has been expanded into Rampton Secure Hospital. A refreshed action focused wider quality, safety, experience and improvement monthly meeting has been suggested although not yet set up and ToR's (Terms of Reference) are undecided. The last operational meeting in March was stood down.
- **Crisis Line** - Nottinghamshire Health Care Trust's (NHCT) Crisis Action Line (CAL), experienced an issue whereby it was unable to receive incoming calls via the crisis line on three occasions at the end of February and March. Action was been taken to contact all the 191 callers. 24 uncontactable (harm unknown)
- **Communication issue**- NHCFT experienced an issue where were not receiving external emails over a 36-hour period. This impacted a range of services including Community Nursing and Community Therapy, AMH, MHSOP, children's EOL. As well as a number of communications including clinical referrals sent by email, test results and potentially invites to urgent safeguarding meetings. The Trust enacted plans to address the backlog of patients and identify urgent cases, although impact was undetermined.

Actions Being Taken & Next Steps

- Monthly CQC Oversight meeting in place to review progress against CQC 'Must do' actions.
- Weekly CQC enquiries oversight tracker list
- Weekly oversight of coronial cases through the Serious Incident Review Group (SIRG), with internal ICB escalation as appropriate.
- Transition criteria aligned to IIP programmes has been proposed with a focus on 7 key areas.
- Considerations of system support mobilisation following IHR and announcement of the public Inquiry.
- Liaison and collaboration with NHCT to answer concerns re: Lings Bar.
- Weekly operational safe now oversight meeting, exceptions and escalation reporting. Monthly safe now steering group. Monthly safe now safety huddle. This is being reviewed and a monthly quality oversight meeting being considered which will also incorporate oversight of actions from the IHR.

Risks & Escalations (Risk ORR191)

NNICB risk ORRR191 - Without the capability to make the required quality improvements there is a risk that the quality of services provided may not meet optimal care standards. This may lead to potential risk of harm and poor health outcomes. Last reviewed in October 2024. Risk rating remains 20. Close oversight through the 'safe now' and IOAG process continues.

02. Nottinghamshire Healthcare Foundation Trust (NHCFT)

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Nottinghamshire Healthcare Foundation Trust (NHCFT)

		Inpatient Care								
▸	1.1	Number of patients waiting for a bed	5		12	7	records	sunday snapshot	Sunday snapshot (2025-03-23)	11.9
▸	1.2	Number of Patients in a 136 Suite Step Up for over 24 Hours	0%	6	5 (83.3%)	3 (42.9%)	records	weekly	W/C 2025-03-17	62.3
▸	1.3	Number of admissions from community who waited less than 12 hours	100%	25	22 (88%)	26 (78.8%)	records	weekly	W/C 2025-03-17	84.1
▸	1.4	Number of readmissions within 28 days	0		0	2	records	weekly	W/C 2025-03-17	0.7
▸	1.5	Wards with staffing under 85%	0%	91	4 (4.4%)	3 (3.3%)		weekly	W/C 2025-03-17	5.0
▸	1.6	Wards with staffing over 125%	40%	91	48 (52.7%)	43 (47.3%)		weekly	W/C 2025-03-17	36.5
▸	1.7	NEW: Proportion of admitted patients that have an allocated nurse recorded.	100%	223	217 (97.3%)	214 (97.7%)	records	weekly	W/C 2025-03-17	94.7
▸	1.8	UNDER REVIEW: Proportion of admitted patients with a risk assessment completed within 24hours of admission.	100%	21	13 (61.9%)	22 (78.6%)	records	weekly	W/C 2025-03-17	64.0
▸	1.9	New: Patients being read their rights under Section 132 of the MHA	100%	154	145 (94.2%)	143 (92.9%)	records	weekly	W/C 2025-03-17	89.8
▸	1.10	Compliance with physical health assessment on admission process	100%	22	15 (68.2%)	23 (76.7%)		weekly	W/C 2025-03-17	69.1
▸	1.11	Compliance with NEWS2 escalation policy	100%	41	39 (95.1%)	28 (100%)		weekly	W/C 2025-03-17	93.3
▸	1.12	Number of Pressure Ulcer Injuries reported (note: week lag)	0		1	0	records	weekly	W/C 2025-03-10	0.9
▸	1.13	Number of Falls (note: week lag)			21	3	records	weekly	W/C 2025-03-10	9.7
▸	1.14	Number and proportion of NottsHC patients requiring enhanced observations (1:1 or greater)	8%	223	25 (11.2%)	28 (12.8%)		sunday snapshot	Sunday snapshot (2025-03-23)	8.0
▸	1.15	Number and proportion of observations where no issues were found.	100%	6	6 (100%)	12 (92.3%)		weekly	W/C 2025-03-17	98.3
▸	1.16	IR1s submitted on on problem CCTV	100%	0	0 (-)*	1 (100%)		weekly	W/C 2025-03-17	85.7
▸	1.17	Patient risk assessments up to date (%)	100%	223	220 (98.7%)	214 (97.7%)	records	weekly	W/C 2025-03-17	98.6
▸	1.18	Number of patients secluded (note: week lag)	4		1	0	records	weekly	W/C 2025-03-10	1.1
▸	1.19	Episodes of seclusion (note: week lag)	4		1	0	records	weekly	W/C 2025-03-10	1.2
▸	1.20	Compliance with the Trust Seclusion Policy		1	0 (0%)	0 (-)*	records	weekly	W/C 2025-03-10	25.6

Content Author: Donna Nussey | **Exec Lead: Rosa Waddingham** | **System Oversight: System Quality Group** | **ICB Committee: Quality & People Committee**

02. Nottinghamshire Healthcare Foundation Trust (NHCFT)

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Nottinghamshire Healthcare Foundation Trust (NHCFT)

▸	1.21	Number of patients prone restrained for anything other than intramuscular tranquilisation (note: week lag)	0		2	0	records	weekly	W/C 2025-03-10	1.0
▸	1.22	Number of patients prone restrained for more than 10 mins (note: week lag)	0		0	0	records	weekly	W/C 2025-03-10	0.3
▸	1.23	Episodes of rapid tranquilisation (note: week lag)	8		15	8	records	weekly	W/C 2025-03-10	6.6
▸	1.24	Compliance with Rapid Tranquilisation Code of Practice	100%	16	2 (12.5%)	2 (33.3%)	records	weekly	W/C 2025-03-10	21.9
▸	1.25	Number of incidents where patients went AWOL and come to harm (note: week lag)	0		3	5	records	rolling 4 weeks	2025-02-17 - 2025-03-16	10.3
▸	1.27	Number of total incidents of moderate harm and above (note: week lag)	0		9	8	records	rolling 4 weeks	2025-02-17 - 2025-03-16	12.5
▸	1.28	New: Of IR2s completed how many were done so within the specified amount of time (note: week lag)	100%	219	202 (92.2%)	137 (72.5%)	records	weekly	W/C 2025-03-10	74.2
▸	1.29	Number of patients clinically ready for discharge	25		49	48		sunday snapshot	Sunday snapshot (2025-03-23)	38.5
▸	1.30	Quality of Discharge	100%	16	0 (0%)	0 (0%)		weekly	W/C 2025-03-17	0.0
▸	1.30a	NEW: Proportion of Quality of Discharge criteria met	100%	144	74 (51.4%)	144 (53.3%)		weekly	W/C 2025-03-17	50.4
▸	1.31	Deaths within 30days post discharge	0		0	0		rolling 30 days	2025-02-22 - 2025-03-23	0.8
▸	1.33	Proportion of feedback containing fairly or highly critical comments (Inpatient, note: updated monthly)		15	11 (73.3%)	9 (34.6%)	records	monthly	Feb-25	36.8

02. Nottinghamshire Healthcare Foundation Trust (NHCFT)

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Nottinghamshire Healthcare Foundation Trust (NHCFT)

		Community Services Metrics (Local Mental Health Teams - LMHT, EIP & MHSOP CMHT)								
	2.1	Compliance with 72 Hour follow up standard	80%	25	20 (80%)	21 (75%)	records	weekly	W/C 2025-03-17	85.0
	2.2	Compliance with 18 weeks wait standard for assessment	95%	2086	1947 (93.3%)	1895 (93.2%)	records	weekly	W/C 2025-03-17	92.8
	2.3	Compliance with Waiting Well Policy for 1st and 2nd Appointments (MHSOP)	95%	23	19 (82.6%)	18 (58.1%)	records	weekly	W/C 2025-03-17	65.7
	2.3a	Attempted compliance with Waiting Well Policy for 1st and 2nd Appointments (MHSOP)	95%	23	20 (87%)	20 (64.5%)	records	weekly	W/C 2025-03-17	67.5
	2.4	Compliance with Waiting Well Policy for CCO Waits (NEW DEFINITION 17/03/25 - AMH)	95%	109	77 (70.6%)	67 (69.8%)	records	weekly	W/C 2025-03-17	51.1
	2.4a	Attempted compliance with Waiting Well Policy for CCO Waits (NEW DEFINITION 17/03/25 - AMH)	95%	110	88 (80%)	79 (81.4%)	records	weekly	W/C 2025-03-17	58.1
	2.5	Patients accessing Urgent & Emergency Mental Health Care whilst awaiting Assessment			9	12	records	weekly	W/C 2025-03-17	5.6
	2.6	Compliance with 18 weeks wait standard for treatment	95%	62	47 (75.8%)	45 (75%)	records	weekly	W/C 2025-03-17	80.7
	2.7	UNDER REVIEW: Number of patients awaiting CCO allocation not on the active caseload of another NHT team	90		238	241	records	weekly	W/C 2025-03-17	283.(
	2.8	Safe Community Discharge (Placeholder)								
	2.9	NEW: Patients Discharged due to Disengagement	100%	36	17 (47.2%)	14 (46.7%)	records	weekly	W/C 2025-02-24	29.8
	2.10	UNDER REVIEW: Patients declined for service and died by suicide within 6 months (categorised under most recent team)			1	1	records	Rolling 26 weeks	2024-09-16 - 2025-03-23	0.6
	2.10a	Patients declined for service and needing Urgent & Emergency Mental Health Care within 6 weeks (developmental)			10	15	records	weekly	W/C 2025-03-17	14.3
	2.10b	Patients declined for service and re-referred back to the service within 6 months (developmental).			5	3	records	weekly	W/C 2025-03-17	3.9
	2.11	Patient risk assessments up to date (Community)	95%	10817	7884 (72.9%)	7885 (72.9%)	records	weekly	W/C 2025-03-17	72.7
	2.11a	CCO Patient risk assessments up to date (Community, developmental)	95%	5558	5228 (94.1%)	5203 (94.5%)	records	weekly	W/C 2025-03-17	92.2

Content Author: Donna Nussey | **Exec Lead: Rosa Waddingham** | **System Oversight: System Quality Group** | **ICB Committee: Quality & People Committee**

02. Nottinghamshire Healthcare Foundation Trust (NHCFT)

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Nottinghamshire Healthcare Foundation Trust (NHCFT)

		AMH & MHSOP - Crisis & Home Treatment Team Metrics								
	3.1	Patient risk assessments up to date	100%	299	249 (83.3%)	214 (83.9%)	records	weekly	W/C 2025-03-17	84.2
	3.2	Patient Crisis & Safety Plans up to date	95%	299	40 (13.4%)	33 (12.9%)	records	weekly	W/C 2025-03-17	11.6
	3.3	Proportion of very urgent patients seen within 4 hours.	95%	20	18 (90%)	18 (94.7%)	records	weekly	W/C 2025-03-17	83.0
	3.4	Proportion of very urgent patients seen within 4 hours face to face	95%	20	10 (50%)	12 (63.2%)	records	weekly	W/C 2025-03-17	71.3
	3.5	Proportion of urgent patients seen within 24 hours.	80%	67	49 (73.1%)	40 (60.6%)	records	weekly	W/C 2025-03-17	63.6
	3.6	Proportion of urgent patients seen within 24 hours face to face	80%	67	42 (62.7%)	35 (53%)	records	weekly	W/C 2025-03-17	54.5
	3.7	Number of total incidents of moderate harm and above (note: week lag)			1	1	records	rolling 4 weeks	2025-02-17 - 2025-03-16	3.2
	3.8	NEW: Of IR2s completed how many were done so within the specified amount of time (note: week lag)		19	17 (89.5%)	16 (100%)	records	weekly	W/C 2025-03-10	88.1
	3.9	Proportion of feedback containing fairly or highly critical comments (Crisis, note: updated monthly)		19	6 (31.6%)	0 (0%)	records	monthly	Feb-25	15.3
	3.10	Clinical Vacancy Rate in Crisis Response Service	11%	212.28	31.43 (14.8%)	32.7 (15.4%)		monthly snapshot	Month End Snapshot (2025-02-28)	14.4

NHS
Nottingham and Nottinghamshire

Enhanced Oversight

What does this mean? What is the assessment of risks relating to delivery / quality

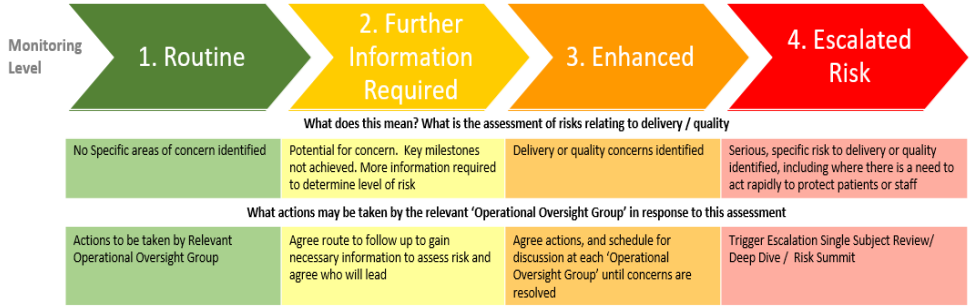
Delivery or quality concerns identified

What actions may be taken by the relevant 'Operational Oversight Group' in response to this assessment

Agree actions, and schedule for discussion at each 'Operational Oversight Group' until concerns are resolved

Quality Areas of Enhanced Oversight

- 03 - Nottingham CityCare
- 04 - Learning Disability & Autism
- 05 – Maternity
- 06 - Special Educational Needs and Disabilities
- 07 - Looked After Children
- 08 - Children & Young People



Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

03. Nottingham CityCare

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Nottingham CityCare

National Quality Board and ICB Framework - Enhanced

Rationale for oversight level: Quality and safety concerns raised with ICB Quality team through a variety of sources. In line with normal processes, triangulation of these concerns against the data and intelligence was undertaken resulting in two areas of **Escalated Risk** and six areas of **Enhanced Risk.**

Current Position

1.0 Escalated Risk:

1.1 Management of incidents - Back log of PSI remain, trajectory for recovery extended to be more achievable. NNICB are assured about level of oversight. CityCare Quality Team continue to support Community Nursing Team who have highest number of PSIs due to nature of their work, plus time to investigate is impacted by high workload.

1.2 **Quality insight** - ICB Quality Team continue to attend CityCare meetings. Process for formally sending quality reports to NNICB agreed between CityCare and NNICB Contracting Team. Quality Insight visits completed to Urgent Community Response and Virtual Ward Teams. These provided useful insights into the role of community services within the Urgent and Emergency Care pathways. Process for formally sending quality reports to NNICB agreed between CityCare and NNICB Contracting team.

2.0 Enhanced Risk:

2.1 Harm free care/Patient Safety – Challenge of high activity at UTC continues. Awaiting outcome of Learning Response for death of person with a Learning Disability. Concerns about high demand on the Paediatric Bladder and Bowel Service. Meeting planned to discuss further..

2.2 Risk Management – In meetings ICB continues to observe confirm and challenge in relation to risks.

2.3 Performance - High demand, vacancies and sickness within small teams impacting performance. Pressures remain in Podiatry (subcontracted to NHFT), MOSAIC, and Specialist Paediatric Services.

2.4 Workforce – Actions continue to reduce use of Agency across the organisation. Sickness reducing but anxiety/stress/depression/other psychological illness continues to be highest cause of sickness. Discussions at recent APF meetings focussed on supporting managers to performance manage sickness as per policy.

2.5 Culture and Leadership - Work continues to embed learning from Cultural Reviews. Results from Staff Survey under review. Commitment expressed to evaluate action plans.

2.6 Governance and Oversight - Confirm and challenge observed at APF meetings for both care groups. Further assurance required regarding how strategies to improve performance and finance positions are monitored for impact on quality. .

3.0 Caseload Capping

Joint Action Plan received but CityCare lack capacity in management team to update it further. Focussed on high impact actions but clinical teams face challenges with implementation due to high workload. CityCare are enacting daily support meetings to help manage this.

Actions Being Taken & Next Steps

- CityCare will re-present at the System Quality Group to provide further assurance of progress to support a move from a level of enhanced quality surveillance.
- ICB to finalise and send letter with feedback about CityCare's Improvement Plan, which will continue to be reviewed.
- Quality visits planned in April: PCN 7 Community Nursing Team
- Await invite to Care Group Two PSRIF Oversight meeting

Risks & Escalations (Risk ORR115)

- As a result of current quality, staffing and performance concerns at Nottingham CityCare, there is a risk that required short-term improvements may not be promptly addressed, leading to a potential risk of harm and poor health outcomes to the population of Nottingham City **(ORR189)**.

- If resources at Nottingham CityCare are primarily focused on addressing immediate quality and performance concerns, there is a risk that there may not be sufficient capacity or 'headspace' to deliver community service transformation programmes. This may result in future population needs not being met and/or anticipated efficiencies not materialising **(ORR190)**.

04. Learning Disability & Autism

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Learning Disability and Autism (LDA)

System Quality Group Oversight – Enhanced

Rationale for oversight level: Focus remains on adult inpatient performance with biannual NHS England system performance meetings in place.

Current Position

Adult Overall Performance Position: Our end of year target was to have no more than 32 adults in inpatient beds. As of yearend , our adult inpatient number is 41 which is **9** above the trajectory . We have **29** individuals within secure settings which is 6 above our trajectory and we have **12** individuals within our non-secure settings which is **3** above trajectory. As a system we continue to have high levels of patients who have passed the recommended clinical timescale (28 out of all inpatients fall within this category). Long stay patients as well as DTOC's /LOPs continues to be a focus for the local system, as well as an increase in secure discharges which will be required going forward.
Adult Admissions: The total number of new patients declared since **1st April 2024 to end March 2025 is 23.** One admission was a late notification as notified in March but admitted in January. Two admissions were out of area placements from Leeds and Derbyshire. We have had **four** late diagnoses of ASD and one late diagnosis of LD. At the **beginning of the financial year, we forecast a maximum of 7 community admissions ,** based on previous years' performance, but we had 18 community-based admissions A detailed analysis of the admissions will be undertaken by Workstream 1.
Adult Discharges: There has been 1 adult discharge (City Council LA) into the community for the month of March 2025 from ICB inpatient bed to supported living provision and the late notification secure inpatient admitted in January was also discharged this March. **In total 27 adults have been discharged** between 1st of April 2024 to 31st March 2025, one of these was a death and one patient no longer met criteria.
Lack of progression on discharges: We have 8 patients within Orion unit at this present time. We also have 1 individual on a MOJ recall who required an LD specific inpatient bed but at the time Orion unit was at full capacity therefore they were admitted to an LD locked rehab bed on an ATU pathway. There are no immediate plans to transfer them to Orion as they are doing well, and the admission is anticipated to be short – there are weekly MDT meetings to ensure discharge is progressed. The system DTOC numbers have increased again in March 2025, and patients will be escalated to senior DTOC oversight meetings to ensure progress continues and is on track. A review of the ATU service is to commence as part of the learning disability and autism model review. A focus of this work will be how we move care into the community and reduce reliance on inpatient care.
CYP Admissions and Discharges: We currently have 1 CYP within an inpatient setting. In total we have **discharged 5 CYP this financial year until end March 2025.** We have had **4 admissions since 1st of April 2024**. We have improved our performance of admissions compared to 2023-24 where we saw 14 admissions. We have reached our target of no more than 3 tier 4 CYP inpatients. As a system we continue to perform strongly in supporting CYP effectively within the community. It should however be noted that 9 of the adult inpatients are aged between 18-25 years of age and in most cases would have had identified needs whilst under 18.
Learning disability Annual Health Checks: As of 31st March 2025, there have been **5,684 heath checks completed** putting performance against this year's denominator set by NHSE against the QOF GP LD Register at **82% and 81%** against the GP LD register on E-Healthscope (14 years and over), which means **the target has been achieved. 95%** of AHCs are recorded to have a Health Action Plan (HAP) in place, with 270 people recorded to have declined a HAP which equates to a decline rate of 3.8% against the total LD register on E-Healthscope.
Adult Autism and ADHD Waiting Times: The waiting time for a first autism assessment appointment has increased from 116.39 weeks in January 2025, to 132.92 in February 2025 with the longest wait reduced from 201 weeks to 193 weeks.
The waiting time for a first ADHD assessment appointment has increased from 69.56 weeks in January 2025 to 75.91 weeks in February 2025 with the longest wait improved from 267 weeks to 205 weeks.

Risks & Escalations

- Delays with neurodevelopmental assessments continue to impact on CYP and adults not receiving support . A new model of support for adults, informed by system engagement and feedback from people using assessment services, is being developed to improve access to assessments, as well as provide pre- and post-assessment support.
- Continued failure to discharge patients that are medically fit either due to a lack of community placements or lack of clear clinical pathway is impacting on the system achieving target set by NHSE.
- Conversations are ongoing with NHT regarding the contracted beds on Orion Unit and what the admission criteria and process should be and how this fits with the local wider model.

Actions Being Taken & Next Steps

- All patients identified as lacking in progress (LOP) are being reviewed in the system wide mental health escalation meetings weekly with the system turnaround director to ensure the partnership continues to expedite discharges safely
- The partnership has developed several admission avoidance strategies including the adult and CYP Dynamic Support registers and forums, and a range of ICS wide measures to expedite discharges such as Care and Treatment Review (CTR) oversight panels and direct liaison calls with the secure provider collaborative (IMPACT)
- The Learning Disability & Autism (LDA) Board retains oversight of performance, quality and safety across the pathway.
- Quarterly performance meetings with NHS England regional colleagues continue and they have been supported with system escalation meetings.

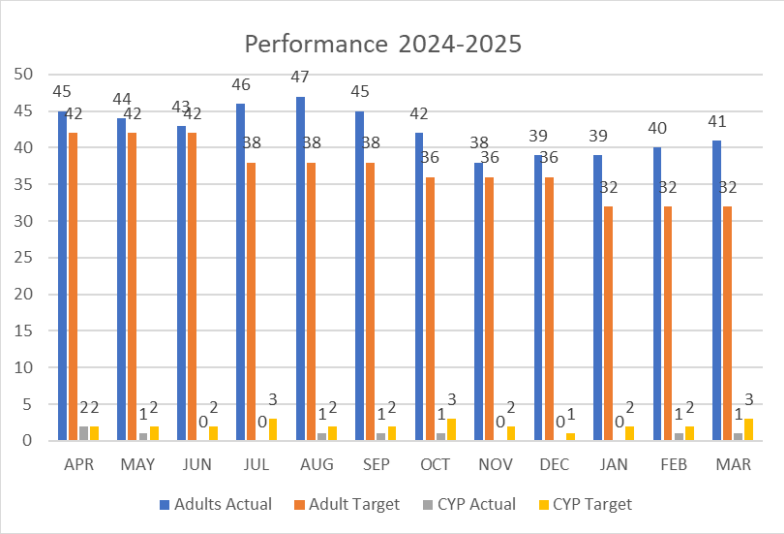
Content Author: Rhonda Christian | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

04. Learning Disability & Autism

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Learning Disability and Autism (LD&A)



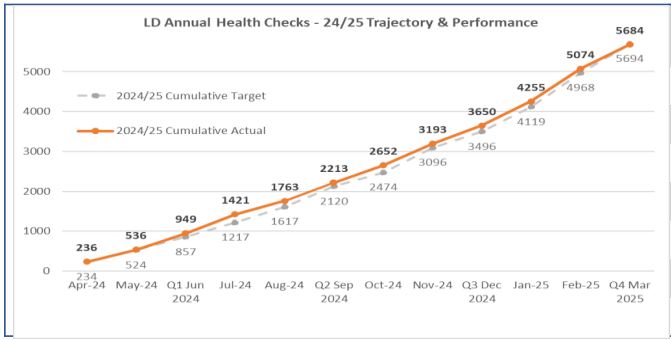
Learning Disability and Autism (LD&A) Inpatient

Data Cut-Off Date: 31/03/2025

Explanatory Note/Insight Analysis and Assurance:
Adult Inpatient Trajectories: Our current inpatient adult total number stands at 41 which is **9** above the trajectory set by NHSE. We have **29** individuals within secure settings which is 6 above our trajectory. We have **12** individuals within our non-secure settings which is **3** above trajectory

Children & Young People Inpatient Trajectories: We currently have 1 CYP within an inpatient setting. In total we have **discharged 5 CYP** as of the end of March. We have had **4 admissions since 1st of April 2024**. We have improved our performance of admissions compared to 2023-24 where we saw 14 admissions. We are on track in achieving our target of no more than 3 tier 4 CYP inpatients. As a system we continue to perform strongly in supporting CYP effectively within the community

Learning Disability Annual Health Checks



Mar-25
5684
% NHSE denom.
82%
% EHS denom.
80%
SPC Variation
-

Data Cut-off Date: 31/03/2025:

Explanatory Note/Insight Analysis and Assurance:
As of 31st March 2025, there have been 5,684 heath checks completed putting performance against this year's denominator set by NHSE at the start of the year (based on the 2022/23 all age QOF GP LD Register) at 82% and 80% against the GP LD register on E-Healthscope (14 years and over). Good news, we have met the end of year target (March 25) of 82% . 95% of AHCs are recorded to have a Health Action Plan (HAP) in place, with 270 people recorded to have declined a HAP which equates to a decline rate of 3.8% against the total LD register on E-Healthscope. A local quality audit of annual health check will seek to understand the reason that Health Actions Plans are declined, and how we can work to increase this uptake.

Whilst the performance target for LD AHCs has been officially removed for 2025/26, the expectation remains that health checks continue to be a priority, and systems are required to maintain and grow uptake of the health checks as detailed in the NHS operational plan technical guidance 2025/26. NHSE Midlands will continue to monitor systems progress against plans for 2025/26.

04. Learning Disability & Autism – Oliver McGowan Mandatory Training

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Oliver McGowan Mandatory Training for Learning Disabilities and Autism (OMMT)

System Quality Group Oversight – Enhanced

Rationale for oversight level: An evaluation and options appraisal is being developed, based on the pilot that was run in the system (ending September 2024).

Current Position

Enabling infrastructure:

- The OMMT Steering Group includes representatives from all key partner organisations, including local authorities.
- The LDA Board has provided oversight to the pilot. Formal oversight of the programme moved to the People and Culture Steering Group in October 2024, in preparation for scaling up and moving to BAU.

Developing infrastructure and sufficient trainer capacity by 2024/25:

- Approx 11% of all system staff have completed their training
- Provider organisations are focusing on OMMT e-learning completion.
- Our co-trainer numbers are growing steadily, and the next priority is to recruit facilitator trainers to further grow delivery
- OMMT Steering group is reviewing the ongoing training needs across all staff groups to understand the future needs, existing training options and how this may be delivered sustainably. The future needs are being considered based on the learnings from OMMT as well as the wider LDA services training needs.
- There has been consensus by the OMMT Steering of the benefit and opportunities of working collectively as a System and is how future models are being developed.

Actions Being Taken & Next Steps

- We have a hybrid model of delivery, with external Tier 1 and Tier 2 sessions being bought in as we continue to develop our own training infrastructure. Uptake by some providers is good but not all organisations are in a position to book staff on to the part 2 training and therefore become CQC-compliant.
- The focus is on delivering training to all health staff. During the pilot, at least 20% of sessions were made available to social care staff (as agreed with NHSE). BAU roll-out and how all staff are trained will need to be agreed through an options appraisal process.

Risks & Escalations

•In addition to the risks and escalations raised previously, there is ongoing uncertainty over future funding for this programme and no timeline for a funding decision. This will need to be captured in the options appraisal for system partners and it is likely that decision about making the programme BAU will need to be made without this information. Funding received to date is for the NHS workforce, but the ICS is adopting a system approach. Lack of social care funding and future plans places social care roll out at risk.
•The lack clarity on the funding for 2025/26 means the programme is delivering training sessions and planning the future training schedule at risk. Risk minimization is in place where possible but pausing until a decision is made cannot happen due to the disruption to the training schedule.
•KPIs were not met for 2023/24. KPIs for 2024/25 are higher than for 2023/24. The focus is on developing infrastructure and sustainable capacity for delivery of the training, as well as to make best endeavours to train >30% of eligible NHS staff (estimated at 9,840 staff) in Tier 1 and >30% of NHS staff eligible for Tier 2 (estimated at 22,960).
•NHSE have escalated the risk around Oliver McGowan Training nationally. Monthly reporting was brought in at short notice in October and is being called the Oliver McGowan Recovery Plan. While current figures are not meeting KPIs, training figures are increasing steadily. Nottingham and Nottinghamshire ICS started the programme later than other areas and our approach has been more conservative. We have safeguarded funding, and plans are in place to increase capacity further into 2025/26. It is important that all possible training spaces are utilised and this depends on appropriate staff communications and staff being released to attend training.
•NHS Trusts are at varying states of readiness to engage with the part 2 training on offer. This means that exact numbers of staff needing Tier 1 and Tier 2 training are still being determined and there is varying uptake of part 2 interactive training.
•The OMMT Code of Practice has not been published. Developing an informed ICS options appraisal will be limited while these details are not fully understood.
•There are concerns from primary care about time needed for staff to undertake the training and effects on service delivery during this time.
•Further infrastructure needs to be developed to recruit facilitator trainers. Venues for Tier 2 training will be needed on an ongoing basis to ensure training sustainability.

Content Author: Rhonda Christian | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

05. Maternity

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Local Maternity & Neonatal System (LMNS)

Saving Babies Lives Care Bundle Version Three.

Intervention Elements	Description	NUHT Element Progress Status (LMNS Validated)	NUHT % of Interventions fully implemented	SFHFT Element Progress Status (LMNS Validated)	SFHFT % of Interventions fully implemented
Element 1	Smoking in pregnancy	Partially Implemented	40%	Partially Implemented	80%
Element 2	Fetal growth restriction	Partially Implemented	90%	Fully Implemented	100%
Element 3	Reduced fetal movements	Fully Implemented	100%	Fully Implemented	100%
Element 4	Fetal monitoring in	Fully Implemented	100%	Fully Implemented	100%
Element 5	Preterm birth	Fully Implemented	100%	Partially Implemented	85%
Element 6	Diabetes	Partially Implemented	83%	Fully Implemented	100%
All elements	**TOTAL**	Partially Implemented	**87%**	Partially Implemented	**91%**

A quarterly review of evidence has been completed with both NUHT and SFHFT in March.

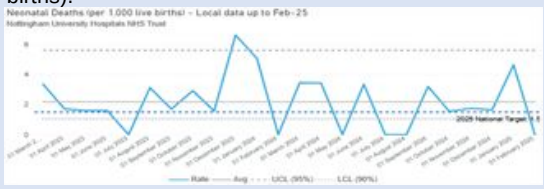
NUHT has seen a dip in compliance with Element One which is expected as they reassess past processes and strengthen the service. A meeting with the regional Senior Perinatal Quality Improvement Project Manager did not reveal any concerns, NUHT is doing everything possible to establish a sustainable stop smoking service. Overall, their compliance has improved from 84% to 87% following the latest review and they are now fully compliant in three elements compared to one following the previous review.

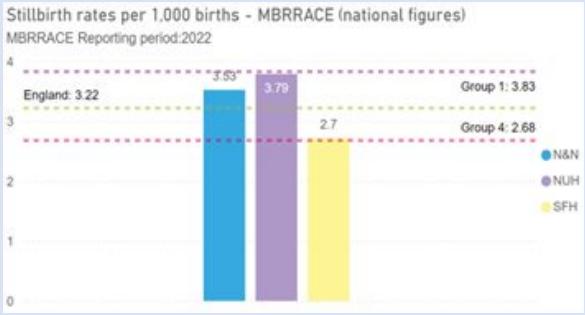
SFHFT have seen some fluctuation in compliance this review. They have maintained the same compliance level overall but are now fully compliant in four elements compared to one following the previous review.

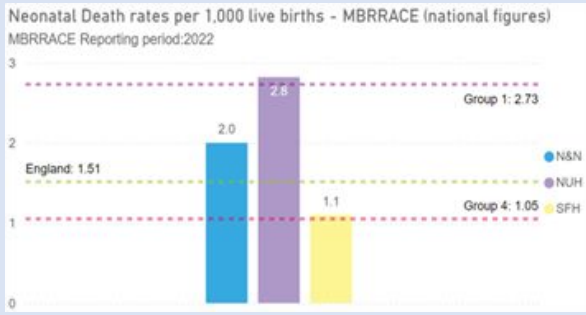
LMNS Quality & Outcomes Dashboard – March 2025 (February data).

- There were four **stillbirths** at SFHFT in February 2025. When comparing with their respective peers, SFHFT rate is 2.7 per 1000 births, compared with G4 average of 2.68.
- There were no **neonatal deaths** reported at SFHFT in February 2025. When comparing with G4 peers, SFHFT are marginally higher (1.1 vs 1.05 per 1000 live births).

- There were four **stillbirths** at NUHT in February 2025. When comparing with their respective peers, NUHT are marginally better than the G1 comparator average (3.79 vs 3.83 per 1000 live births).
- There were no **neonatal deaths** reported at NUHT in February 2025. When comparing with group 1 peers, NUHT are marginally higher (2.8 vs 2.73 per 1000 live births).







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05. Maternity

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Local Maternity & Neonatal System (LMNS)

System Quality Group Oversight – Enhanced

Rationale for oversight level: NUH maternity remains under external scrutiny with active involvement with the Maternity Safety Support Programme and the Ockenden investigation ongoing. Improvements noted in governance, engagement and some clinical outcomes although not yet consistently embedded.

Current Position

LMNS Activity

- The LMNS funded a project to provide subsidised Birth pools to women and birthing people booked with SFHFT wishing to birth at home. All 100 pools have now been hired from SFH families. SFHFT are considering how to sustain this offer and are bringing an evaluation to Transformation Board to demonstrate impact.
- A 3-month extension of the Petals Bereavement Counselling Service was agreed at LMNS Perinatal Scrutiny and Oversight board to allow time to explore sustainable funding sources for continuation of the service. An options appraisal is to be presented at LMNS extraordinary board in May.
- NHSE allocated part-year funding of £23,077 to NNICB to address recommendations in the Birth Trauma Report published May 2024. A report was presented at Commissioning Review Group and the EQIA to support was presented at EQIA panel. The LMNS board requested further information, to be re-discussed in an extraordinary meeting in May.
- Perinatal Pelvic Health Services Business as Usual by April 2025 on track. NHSE have advised recurrent funding will be added to the ICB baseline for 2024/25.
- CardMedic Pilot has now been extended to end of March 2026.
- MNVP engagement leads are to attend all PROMPT (Practical Obstetric Multi-Professional Training) sessions to provide a service user voice when simulating emergency situations.

Perinatal Quality Surveillance workstream

- Maternity Incentive Scheme year 7 is due for publication on 2 April 2025. Notification of significant updates have been received by trusts ahead of the publication.
- The stillbirth rate in Nottingham and Nottinghamshire in February is the highest it has been in the last 2 years. Four were reported at each provider. SFHFT have noticed a gradual increase in the past six months and are therefore undertaking a deep dive into stillbirths that have occurred in the last 12 months. This will be presented through LMNS PQSG to facilitate systemwide discussions and shared learning.
- As a system we continue to experience higher PPH and 3rd and 4th degree tear rates compared to our local data and compared to other ICB's in the Midlands. We have therefore reached out to ICB's who have PPH and 3rd/4th degree tear rates than us to access any shared learning.
- An informal walkaround at SFHFT took place in March.

Actions Being Taken & Next Steps

- Half day visit to SFHFT being planned for end of April. KLOE's to be agreed.
- LMNS Equity Strategy to be updated and draft to be presented at LMNS extraordinary board in May.
- Options appraisal for Petals Bereavement counselling service to be completed.
- Workplan and focus for 25/26 to be agreed in collaboration with NUHT and SFHFT Director of Midwives.

Risks & Escalations

- ORR208. If the quality of maternity services does not improve, services provided may not meet optimal care standards. This may result in potential risk of harm (i.e. physical and psychological) and poor patient experience for women, birthing people, their babies, and families.
- ORR120. Due to issues with understanding data requirements, system interoperability and data sharing there is a risk the system may not be able to tangibly measure its impact and demonstrate results, value and performance. This may adversely impact decision-making and result in resources being used ineffectively.

06. Special Educational Needs and Disabilities

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Special Educational Needs & Disabilities (SEND)

System Quality Group Oversight – Enhanced

Rationale for oversight level: As a result of various factors including capacity and demand pressures, there is a risk the needs of children and young people with Special Educational Needs and Disabilities (SEND) may not be met effectively. This may lead to unmet needs resulting in poorer educational, health and care outcomes alongside the widening of health inequalities and dissatisfaction among children and young people and their families. This may also undermine the system's ability to deliver all partners statutory SEND responsibilities.

Current Position

- Nottinghamshire SEND local area partnership have received an indication from Ofsted that the required monitoring visit is likely to take place in the summer term 2025. Preparation across the partnership is now being prioritised
- Nottingham City LA have appointed DSC. It is hoped leadership will now be strengthen to drive local area improvements and provide robust and consistent governance going forwards mitigating risk associated for the system partnership and CYP and their families
- CYP commissioning and transformation team are reviewing capacity and working to ensure portfolio areas identified can drive improvements and respond to requirements.

- **ICB Tribunals 'Extended Appeals**' raised against the ICB; 20 **OPEN - 1 STAYED**
- Nottingham City has seen a 217% increase in SENDIST tribunal appeals since 2014. Appeals represent significant financial risk to the local authority and take significant amount of staff resources.

Actions Being Taken & Next Steps

- Following the announcement around reducing further running cost for the ICB recruitment for an Associate Designated Officer has been removed from advertisement. Awaiting further advice.
- Nottingham City co-production activity continues and commissioned consultants supporting development of SEND and AP strategy
- Commissioners awaiting to receiving assurance on mitigation from NHS providers for CCYPS within NHT around recovery for challenges experienced on delivering on statutory duties relating to EHC assessments and EHCP annual reviews.
- CYP Strategic Commissioning Group received recommendations to be accountable and own improvement requirements for supporting CYP with medical conditions in education and transport settings. Still awaiting steer on decision and next steps.
- ICS Joint SEND Commissioning Strategy annual delivery plan is due for a review and key delivery actions for 2025/26 to be identified.
- Nottingham City programme manager for SEND has been working closely with DCO for ICB to review and improve existing arrangements.
- Nottinghamshire SEND local area partnership working to agree key priorities for delivery 2025/2026 as plan to review and develop annual delivery plan
- Nottinghamshire underwent a final Deep Dive on 24th of March- awaiting summary of learning report from regional advisors.
- SEND local area partnerships are preparing for local area SEND inspections, Briefing session have been arranged in Nottinghamshire local area to aid practitioners.

Risks & Escalations

- Capacity for DCO team to respond to requirements across the ICS footprint with 2 local areas preparing for inspection and supporting the improvement activity
- Oversight on current position for Nottinghamshire SEND priority area action plan PAP2 has been limited and clarity on next steps is required to assure partnership of next steps
- Whilst services providers are currently delivering to meet request for health contributors to provide statutory advice for EHC assessments and attend or provide advice for EHC annual reviews, the increase in requests and improvement activity from Nottinghamshire local area SEND priority action plan is significantly impacting on ability to deliver local offer, limiting capacity to respond to waiting lists and assess needs of CYP

07. Looked After Children

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Looked After Children (LAC)

System Quality Group Oversight – Enhanced

Rationale for oversight level: IHA and RHA statutory timeframes remain in the ICB risk register. System working continues to improve IHA pathways and compliance, as expected there has been an increase in waiting times at NUH for IHAs. NUH will recruit a locum paediatrician and are completing as updated transformation plan to improve compliance. **Quarter 4 update due in May 2025.**

Current Position

IHA summary Q3 2024-25

	DBTH	SFHT	NUH
	Q3	Q3	Q3
Total IHA referral received	19	51	123
IHA referral received from local authority within 5 days	3 (16%)	23 (45%)	26 (21%)
IHA completed and sent within 20 days of correct consent *(excluding exemptions)*	7 (37%)	12 (50%)	8 (6%)
waited times *(IHA completed) In weeks*	2 weeks	4 weeks	>10 weeks

RHA summary Quarter 3 2024-25 (Provider information only) NHCT

	City	County
	Q3	Q3
RHA referrals.	201	200
NHT sent completed RHA within timescale	16 = 8%	41 = 37%
Waiting times	16-20 weeks	16-20 weeks

Actions Being Taken & Next Steps

Review Health Assessments
- NHCT- Quality Assurance visit recommendations will be shared with senior management on 9th April.

Initial Health Assessments
- Triangulation data meetings with the local authorities in place. Tri-angulated data shows improved referral compliance from both local authorities.
- NUH – Locum Pediatrician recruitment in progress
- NUH management have developed a transformation action plan which has been reviewed via NUH internal governance processes.

Risks & Escalations

- CRG paper for increased nursing capacity to be shared April 3rd (delayed due to additional information required for EQAI)
- Transformation Action Plan in progress for NUH to be shared with commissioners and reviewed by the end of Q4 2024/25.

08. Children and Young People

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Children & Young People (CYP)

System Quality Group Oversight – Enhanced

Rationale for oversight level: Long term under investment in children's health and social care, the Covid-19 pandemic and its aftermath, and the enduring cost-of-living crisis have all combined to create a crisis that means children growing up with disadvantage are increasingly more likely to experience ill health (King's Fund 2024). N&N ICB has no clear internal routes for CYP Governance to include all areas of CYP services, which risks significant gaps, potential duplication, unclear information sharing and decision-making routes. Current funding reviews will increase the risk for CYP.

Current Position

a) Paediatric Audiology Services in DBTH continue in serious incident response, overseen by NHSE. The national NHSE targets have been amended slightly and the service is currently reporting being on track for meeting these. The number of CYP awaiting triage and priority coding, which cannot be carried out by existing team members, was reported as 1700 on 27.03.2025. The competence of the workforce has been identified as a significant risk to progress. The Trust has engaged with Sheffield Children's Hospital who, before assessment of competence, suggest a timeframe of one month for the team to be able to be practice competently. This may change, depending on the level of underlying theoretical knowledge to support the practice.

b) CYP continue to present to ED with complex behavioural, mental health and autism related needs where there is no clear route for provision or pathways for care. Raw data indicates 71 CYP have been raised in the year 2024-25 (up to 28.03.2025), with 41 of those identified as having a mental health condition/emotional dysregulation. Data is being cleansed to present the accurate picture for the year. Executive escalation pathway has been piloted across the system for 3 months but has not been implemented as issues have been managed by the multi-agency teams. The demand on capacity and joint financial agreements for placements is impacting on the ICB. Challenges continue around professional disagreement where CYP are assessed as detainable under the Mental Health Act but assessed as not requiring an inpatient bed by the Provider Collaborative Enhanced Care Referral Team. A proposal has been taken to the MHLD Funding Panel to align funding decisions for CYP and adults.

c) Sickle Cell Carrier Notification in Mid Notts and Bassetlaw has an incident management team in place, overseen by NHSE. NUH commenced the pathway for Bassetlaw and Mid-Notts from 17.03.2025 for all new notifications. There is a delay to managing the historic cases due to the recruitment processes. The individuals will have been identified and details verified by early to mid April 2025. NUH identify that recruitment will take 8 weeks. Draft comms, letters and leaflets have been prepared.

Actions Being Taken & Next Steps

a) Meetings continue two weekly for CYP and adults separately to progress actions. There are plans for education and competency achievements with Sheffield Children's hospital, which rely on the staff undertaking training on site in Sheffield. Continuing to progress the achievement of key milestones.

b) The risk register is being reviewed. Despite system working and identified escalation processes, the lack of suitable provision in the community, including the appropriate intensive, ongoing support for CYP mental health and emotional dysregulation, the risk cannot be mitigated more than it has already. Work will continue identify the health model required to support this group of CYP, across the footprint but will require considerable investment to make a difference.

c) Medical Director, AD for Health Protection and Head of Nursing for CYP are part of the Incident Management Team. Awaiting final details of individuals to be shared with NUH. There may need to be an executive escalation if there is a significant delay in historic notifications.

Risks & Escalations

- Risk ORR 128 is strategic as local actions would not resolve it due to national issues. There is high financial risk to manage care provision outside of current commissioned services to meet the high level, individual needs of specific CYP and a high risk to health and wellbeing and safeguarding for Children and Young People (CYP) who are managed in inappropriate settings.
- CYP Audiology services in DBTH is in incident response, overseen by NHSE. Harm has been identified and there is now some progress against previously assured actions.
- Sickle cell carrier status notification process is now under NHSE scrutiny as an incident raised via LFPSE and added to the ICB risk register

09. Infection Prevention & Control

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and

Infection Prevention and Control

System Quality Group Oversight – Enhanced

Rationale for oversight level: Healthcare Associated Infection (HCAI) thresholds remain challenging, the increase in HCAI nationally is reflected locally. The sustained pressure on health and social care services continues to impact on HCAI. The increase in patient acuity; aging population; limited access to primary care appointments; surgery delays; increase in antimicrobial resistance and antimicrobial prescribing; deprivation and poor self-care all increase the risk of acquiring HCAI. Monitoring of rates in addition to cases continues, cases are clinically reviewed to identify any learning and gain assurance on any key local issues. Measures taken to improve patient flow in a constantly pressurised health and social care system are considered contributory to the increased risk of acquiring HCAI.

Current Position

- There was continued improvement against gram negative BSI. Month plans met in February for E.coli/ Klebsiella /Pseudomonas BSI. Achieving year-end threshold for E.coli BSI remains challenging.
- E.coli BSI case reviews completed in line with System UTI Strategy plan
- One city community onset MRSA bloodstream infection (BSI) reported post infection review commenced.
- C.difficile infection cases stable but remain over plan, Improvement noted at NUHT as under month plan.
- System pressures continue to require patient boarding, corridor care has reduced back to exceptional circumstances.
- NUHT outbreak of Klebsiella pneumoniae closed following no further cases.
- Respiratory viruses are reducing. Norovirus continues to circulate locally at a reduced rate, with more associated admissions and outbreaks this year than in 2023-24.
- Routine mask wearing in admission areas at NUHT has stopped in line with protocol, following a reduction in respiratory admissions. This is already the case SFHFT. Other providers reviewing their plans.
- Two care homes with clusters of invasive Streptococcus pneumoniae infections reported.
- Clade 1 Mpox has been downgraded and is no longer considered to be a high consequence disease (HCID)
- SFHFT/NUHT/NHCFT need to improve current staff fit testing compliance as figures remain low in some areas.
- SFHFT need to improve water flushing in line with policies and use of associated software.
- NHCFT are to expand use of HOCL natural disinfectant across more of their secure sites following a successful trial at HMP Rampton.
- NUHT are waiting to for a decision re availability of a decant ward on both sites to support enhanced cleaning.

***Due to UKHSA data lag HCAI exception reporting is for February**

- MRSA BSI, 1 COCA case reported. This is a city case under investigation. ICB 14 cases against 0 threshold year to date.
- *C.difficile*, ICB 32/27,SFHT 8/6, NUHT 8/15. ICB remains over year-end threshold 355/308, NUHT (179/152) and SFHFT (75/65) have both exceeded year-end thresholds
- E.coli BSI , Klebsiella BSI ,Pseudomonas BSI ICB, NUHT,SFHFT all met month plan.

Actions Being Taken & Next Steps

- Previous IPC reported actions continue, providers have board assurance frameworks in place.
- System deep dive E.coli BSI reviews in line with UTI reduction strategy are highlighting poor documentation across all providers in relation to catheters. Work in place to review current software as a possible solution.
- SFHFT
- Post infection review ongoing following City MRSA BSI
- Risk logs continue to include the exceptional measures taken to improve flow. This remains an IPC area for concern as this impacts IPC and care quality. Boarding and corridor care must not become accepted practice.
- UKHSA are leading on actions following clusters of invasive Streptococcus pneumoniae in two care homes. Actions taken include IPC measures, prophylactic antibiotics and offer of vaccination to residents and eligible staff.
- SFHFT reviewing ways to improve fit testing uptake in clinics, medical staff and UEC. NUHT /NHCFT reviewing use of ESR as this can be problematic. Additional training is available.
- SFHFT are reviewing current software used to record water flushing as there are still areas of non-compliance noted. Cover during periods of annual leave also remains an element requiring improvement.
- Natural disinfection that uses electrochemically activated water and salt to form hypochlorous acid is under trial in SFHFT ED , with trial to start in CityCare UTC.
- NUHT will progress with mini deep cleans in priority areas whilst waiting for access to decant facilities.

Risks & Escalations

- IPC continued concerns re boarding of patients and use of corridor care to support flow as these measures increase the risk of HCAI acquisition.
- One MRSA BSI community case reported in City post infection review in place
- Two clusters of cases of invasive *Streptococcus pneumoniae* in care homes under UKHSA monitoring, prophylactic antibiotics and vaccination offers made.

Content Author: Sally Bird | Exec Lead: Rosa Waddingham | System Oversight: System Quality Group | ICB Committee: Quality & People Committee

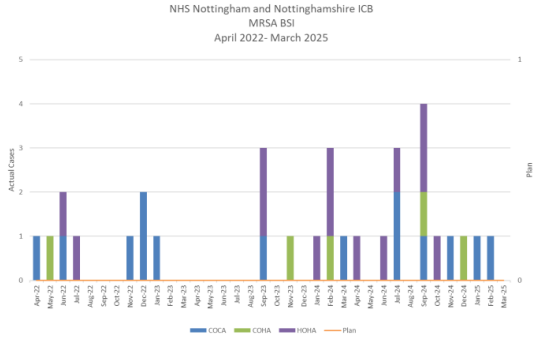
10. Infection Prevention & Control

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

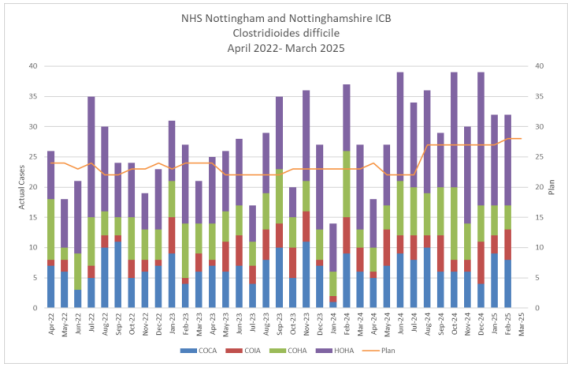
Infection Prevention and Control

HCAI Data 22-25 – MRSA Bloodstream Infections



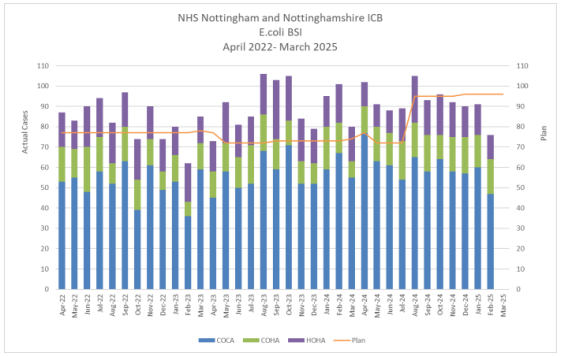
Data Cut-Off Date: 28/02/2025

HCAI Data 22-25 – C.difficile Infections



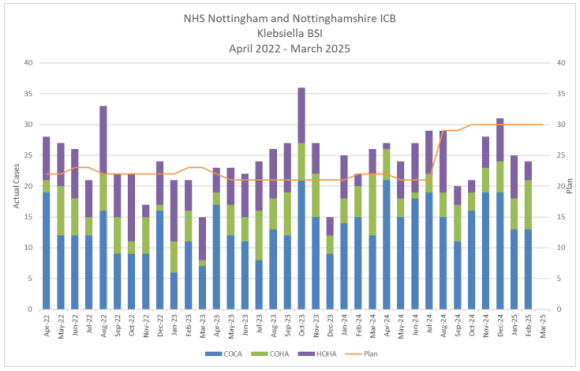
Data Cut-Off Date: 28/02/2025

HCAI Data 22-25 – E.coli Bloodstream Infections



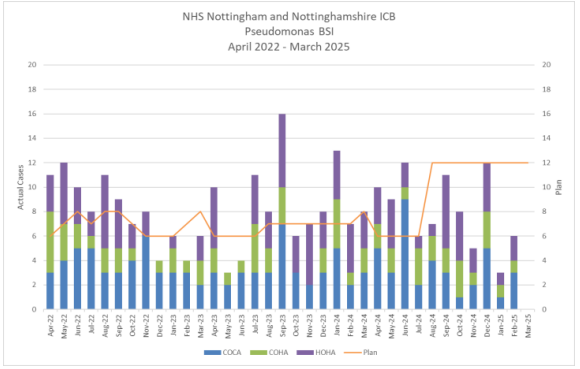
Data Cut-Off Date: 28/02/2025

HCAI Data 22-25 – Klebsiella Bloodstream Infections



Data Cut-Off Date: 28/02/2025

HCAI Data 22-25 – Pseudomonas Bloodstream Infections



Data Cut-Off Date: 28/02/2025

NHS
Nottingham and Nottinghamshire

Routine

What does this mean? What is the assessment of risks relating to delivery / quality

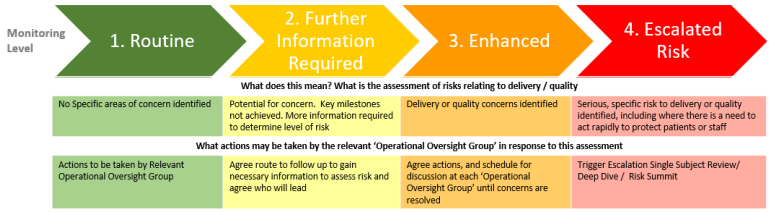
No Specific areas of concern identified

What actions may be taken by the relevant 'Operational Oversight Group' in response to this assessment

Actions to be taken by Relevant Operational Oversight Group

Quality Areas of Routine Oversight

- 09 - NOF 2 Sherwood Forest Hospital NHS Foundation Trust
- 10 - Infection Prevention & Control
- 11 - Patient Safety
- 12 - Universal Personalised Care
- 13 - Co-Production
- 14 - Adult & Children Safeguarding
- 15 – Vaccinations



Exec Lead: Rosa Waddingham **System Oversight: System Quality Group** **ICB Committee: Quality & People Committee**

10. Sherwood Forest Hospitals NHS Foundation Trust

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Sherwood Forest Hospitals NHS Foundation Trust (SFHFT)

National Oversight Framework 2 - Routine

Rationale for oversight level: Ongoing engagement and oversight of the improvement activities underway. NNICB Quality Team maintain attendance at various committees and groups where confirm and challenge is welcomed. The NNICB Quality Team continue with planned six-weekly insight visits reflecting routine oversight.

Current Position

- The Trust continues to see high demand through the UEC pathway this includes the provision of system support via EMAS diverts where possible.
- Full capacity protocol enacted as required. Three 48-hour breaches reported in March 2025 all relating to patients requiring a mental health bed..
- The ED improvement plans will continue to be divisionally led and monitored through the patient safety committee (PSC). The recent report highlighted no concerns to progress of the key workstreams. New Divisional Director has initiated quality and safety audits within the department out of hours to gain further insights.
- HSMR+ and SHMI figures are as expected NNICB Quality Team continue to engage and support as required in the learning from deaths committee at SFHFT.
- The Quality Team continue to support with insight visits and are currently developing a forward planner showing visits over the next two quarters to support joint working and review with SFHFT.
- Review of current mandatory training is ongoing to align all staff groups to mandatory and statutory training
- Multi agency action plan in place following extensive scoping and review of challenges in mortuary services following incidents. This work continues to progress with positive assurance of proportionate improvement activities.

Actions Being Taken & Next Steps

- Further quality insight visits are planned over the next month. Involvement with the Trusts 15 step peer review and the ongoing informal insight visits will continue when these are reinstated.
- NNICB Quality team continue to work with SFHFT to develop our system approach to the NHSE mandated after-action reviews where required. Outstanding returns have been received for review of themes.
- SFHFT improvement groups with a focus on the deteriorating patient and sepsis has been discussed to support insight and assurance of continued improvement in this area across the Trust. This continues to be an area of focus and challenge.
- Continued presence at key meetings to support insights and support where required.
- Awaiting National Staff Survey results publication to review triangulation and building of insights for continuous improvement.
- Delay in production of the quality dashboard will be taken to SFHFT QC for awareness.
- •Discussions continue to made at patient safety committee regarding violence and aggression reduction group. Further training, tools and support for staff planned. Closer alignment and engagement with the Admiral Nurse to support reviewing incidents involving patients with dementia and mental health needs.

Risks & Escalations

- No additional risk or escalations in this period.

11. Patient Safety

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Patient Safety

System Quality Group Oversight – Routine

Rationale for oversight level: No strategic escalations at this time.

Current Position

Patient Safety Specialists
ICB Patient Safety Specialists have completed the national Patient Safety Syllabus Levels 3 & 4 training (essential to role) have been certificated in March 2025.

PSIRF
The ICB Patient Safety Incident Response Policy (PSIRP) has been updated, and Version 2 is now published.
360 Assurance audit has been finalised for the PSIRF and covers the ICB role in supportive implementation and associated activities. The findings will be completed Q4 2024/2025.
PSIRF 1 year on event has been undertaken in March 2025 to capture, what's worked well, what will be different in year 2 and provide opportunities to showcase any significant learning from patient safety events within the previous year.

Patient Safety Partners
Two patient safety partners have been recruited to the roles and currently going through onboarding processes.

Primary Care Patient Safety Strategy
A national 'early adopters' scheme is in place for PSIRF implementation in primary care reporting updates via the Partner Quality Assurance and Improvement Group (PQAIG). The ICS implementation of the strategy will align with ongoing patient safety strategy development work across provider and primary care.

Actions Being Taken & Next Steps

- Work to align evaluation and 360 Assurance audit to support next stage in implementation work.
- Processes to establish Assurance arrangements for the ICS infrastructure for PSIRF is evolving.
- ICB Primary Care Patient Safety Strategy implementation with the system strategy is ongoing.

Risks & Escalations

- System learning from deaths arrangements not fully established.
- Coronial requests which require additional information where Patient Safety Incident Investigation (PSII) is initiated but does not answer the coronial 4 facts.
- Primary Care Patient Safety Incident Response Framework pilot and the impact of Learning from Patient Safety Events Services (LPSES) part of the GP contract.

12. Universal Personalised Care

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Universal Personalised Care

System Quality Group Oversight – Routine

Rationale for oversight level: Personalisation working through business-as-usual arrangements by embedding personalisation across the system.

Current Position

Personalised Care & Social Prescribing data:

•Limited changes within social prescribing – exit plan complete.
•Final Social Prescribing Strategic Developments Meeting focussed on Green Social Prescribing Learning; National Programme ceased 31st March 2025. Report to be circulated mid-April. Localised learning will continue until Sept 2025 – fed back via place-based partnership PBP meetings.
Transformation Leads will continue to focus on localised social prescribing activity. However, Place leads, and community transformation teams have limited influence of the PCN Social Prescribing Link Worker workforce - Clinical Directors and GP's lead on decisions to expand or reduce the ARRS workforce including how social prescribing link workers (SPLWS) are utilised. 82 FTE SPLWs currently in post.

Projects and Feedback:

- The Integrated Neighbourhood Teams are advancing supported self-management using a community-based approach, led by Health & Wellbeing coaches. Initiatives include Diabetes Peer Support, health hubs, and BAME-focused activities.
- Personalised care is embedded in the Frailty INW model, with areas being identified to pilot a care planning model in the Notts Care Record starting with the About Me.
- The Healthy Weight Management for CYP pilot concluded with 13 families benefiting from personal health budgets, achieving positive health and wellbeing outcomes. The Children with Excess Weight team continues to offer personal health budgets, improving access to community activities and overall wellbeing.
- There are 84 full time equivalent Social Prescribing Link workers employed across the 24 Primary Care Networks in Nottingham and Nottinghamshire. The Green Social Prescribing national programme ended in March 2025, with learning informing future models on referral pathways, data tracking, cost-benefit analysis, and health inequality interventions. A full review will be completed by April 2025.
- Personalised Care & Support planning guidance has been developed, and we are working in partnership with Digital Notts to develop a care planning solution in the Notts Care Record to digitalise the About Me, ReSPECT and End of Life care plans.

Actions Being Taken & Next Steps

- **Personalised Care Governance:**
- Review of all work currently being undertaken by the ICB team as structural changes will impact ongoing support
- This will be discussed by the Strategic Oversight Group to ensure ownership by system partners as well as opening the discussion about future oversight needs

Risks & Escalations

- **Data –** Developing an agreed view of data will take time, but developing iteratively will support developing more understanding
- **Digital –** Risk that system funding cannot be secured which may halt work
- **Frailty** – programme is developing objectives and deliverables without any service user engagement
- **Green Social Prescribing** – Risk National Feedback, N&NICB Commissioning teams had not been involved in the 1-year extension developments - Integrated Mental Health Commissioning team have now agreed to be involved.

13. Co-Production

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Co-Production

System Quality Group Oversight – Routine

Rationale for oversight level: Delivery continues with a focus on the development of the Coproduction Network and supporting infrastructure.

Current Position

ICB Strategy Refresh - This work is progressing. A plan is in progress to review and coproduce the content of the strategy as part of the refresh. Lived Experience members of the My Life Choices group are reviewing the content initially and a meeting is taking place on the 14 April to progress this.

Impact measure – work continues to establish a single model of measuring the impact of Coproduction, which does not currently exist. Work is starting to test and learn how models such as the Social Care Institute for Excellence and the CQC Engagement Framework can be used, what is useful and where the focus to develop further needs to be. Testing is starting with CYP Mental Health.

Strategy requirement – the development of the Coproduction Network. This is an ongoing key focus for the team for the rest of the year. The objectives of the network remain as :
•Building relationships across the system –
•Improving connectivity – connecting people who want to coproduce with coproduction activities.
•Avoiding duplication of coproduction work across the system- through better communication and awareness and by sharing best practice through case studies.
•Raising the profile of coproduction approaches and education – the Coproduction Toolkit and Coproduction Newsletter
•Scoping it taking place to evolve this offer from a database held by the coproduction team to something universally accessible and to expand the offer of promoting and connecting people to coproduction – currently this is done via the regular new coproduction newsletter.

LDA Coproduction and Experts by Experience coproduction support
Direct Support in embedding a coproduction approach with Experts by Experience continues to be provided by the team to the to the ICB Learning Disabilities and Autism team.

Raising the profile of a coproduction approach to staff and peers – the team continue to provide advice, information and guidance about coproduction approaches.

Strategy Requirement- learning resources and toolkit - Coproduction Resource – work continues on creating a resource which can be used by staff and people with lived experience to improve understanding and confidence of what coproduction is and how to carry it out. This work is co-ordinated by the ICB Coproduction Team with system membership. The resource in draft form will be tested during Coproduction Week in July 2025.

Supporting Research – The ICB is supporting PhD research from the University of Nottingham exploring the potential of deliberative democracy to address complex challenges in NHS organisations, with a specific emphasis on stakeholder engagement and public involvement, and on Nottingham and Nottinghamshire ICB. The ICB Coproduction team is working to link the Doctoral researcher into the ICB, System partners and Experts by Experience

Actions Being Taken & Next Steps

- Strategy refresh content being reviewed with lived experience members
- Updated strategy content being created with people with lived experience

Risks & Escalations

None

Content Author: Rhonda Christian | **Exec Lead: Rosa Waddingham** | **System Oversight: System Quality Group** | **ICB Committee: Quality & People Committee**

14. Adult & Children Safeguarding

Reporting Period:
01 March 25 – 31 March 25

NHS Nottingham and Nottinghamshire

Adult & Children Safeguarding

System Quality Group Oversight – Routine

Rationale for oversight level: All major statutory duties for the ICB and system partners are being met. Where concerns have been raised around specific issues, the ICS Safeguarding Public Protection and Assurance Group are monitoring and actioning these issues effectively.

Current Position

- New Nottingham & Nottinghamshire Prevent Training Strategy rolled out across the system, links with NHSE Prevent training requirements for health professionals.
- Prevent and Modern Day Slavery training provided to GP leads with very positive feedback and engagement.
- High risk identified in Mid/ North Notts potential DoLs cases not being identified and progressed in a timely way due to resource.
- Rolling programme of MCA training in place until end of March 26 – good uptake across colleagues
- Concerns around management of DHR's in County have been escalated. Agreement in principles of how DHR's should be managed by districts has now been developed and will hopefully be signed off a DA Board in April 25.
- The Safeguarding Children team continue to the multiagency cross partnership audit programme. The previous audits are currently being progressing to smart action plans and targets for updates from relevant professionals.
- The current audit focusses on Domestic Abuse which will look at children and young people as victims.
- The Children Safeguarding Practice Review subgroups of the Safeguarding Children Partnerships continue to progress two commissioned Local Safeguarding Practice reviews following the rapid review findings. The County review report was signed off in January 2025 and the recommendations are now progressing into a multi-agency action plan which has a focus on Education sector A publication date is still not confirmed The City review is delayed, the National Safeguarding Review Panel has agreed to an extension until April 2025 with the author now requesting an further extension to June 2025. A practitioner event has taken place.
- A request for a partnership review was agreed to progress as a Learning review. This is a case of chronic neglect of a 16yrold. The partnership panel are progressing the review exploring working with cases of long-term neglect. Learning will be taken into the cross-authority Neglect Steering group.
- MASH heath (County) continue to be part of the multiagency redesign. The current work is concentrating on the development of an emergency services pod. This is being discussed with how health will contribute to the development.
- Work continues with the health providers to progress the national Child Protection Information system (CPIS) project extending across service areas with information who are subject to child protection plans and children in care. The health providers are mapping the system and services in their organisations and liaison with the local authorities in progress. After a regional request by several Designated Nurse's Safeguarding Children a meeting with the National team gave some updated details to progress local plans and roll out will be working to implementation by April 2027. A regional forum has now met and supports a plan to share ideas for implementation in different settings.
- Conversation about working with education partners relating to the health of children when in school continues to progress in the City and a plan to work worth county colleagues is progressing and had been acknowledged by the Nottingham City Safeguarding Partnership Education sub-group.
- Children's Safeguarding Parentships are reviewing the key national documents on the implementation of Social Care reforms including reviewing recommendations from a recent National report Sexual Abuse in the Home Environment. The National panel report into Neglect has been delayed and no publication date has been advised on.

Actions Being Taken & Next Steps

- Learning from DHR's session booked for GP Leads in June 25
- Working on the ICB development of a Prevent Workplan to meet new Statutory Guidance.
- Task and finish group in progress for CP-IS
- Conversations relating to communications between Education and the Health of children in settings is progressing proposing to working towards a partnership event in 2025.
- Safeguarding Partnerships are working on recommendations from national reports.
- A plan to have themed meeting of the Designated Professionals in the ICB at our Chief Nurse meeting has been agreed due to changes which are legislative.

Risks & Escalations

- Capacity to meet with Mid/North Notts CHC teams to identify and progress community DoLs applications.
- Delay in agreement through governance routes in Notts County Council to bring all DHR's centrally and remove them from CSP duties. .
- Backlog and delays in Notts County DHR's.
- High number of statutory reviews across the systems currently in progress or commencing, capacity in Adults team to manage these.
- Increased push back from LA's in relation to Court of Protection applications and lead applicant

15. Vaccinations

Reporting Period:
01 September 2024 – 26 March 2025

NHS Nottingham and Nottinghamshire

Vaccinations

System Quality Group Oversight – Routine

Rationale for oversight level: Uptake for COVID vaccinations is lower than last Autumn, and uptake for flu vaccinations is slightly higher. The COVID Autumn campaign has finished, however uptake for flu vaccinations in the eligible adult population is 1-2% lower than last Autumn. Work is ongoing with system partners to improve the flu position. The reduced uptake has been seen both Regionally and Nationally.

Current Position

Flu

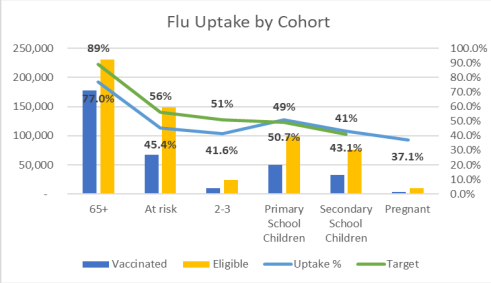
- Uptake 53% (3% higher than AW23)
- Uptake for citizens aged 65+ or at risk 1-2% lower than AW23
- Uptake for school age children is above AW23
  - Primary school children 12%
  - Secondary school children 11%
- Uptake for 2-3 year olds same as AW23

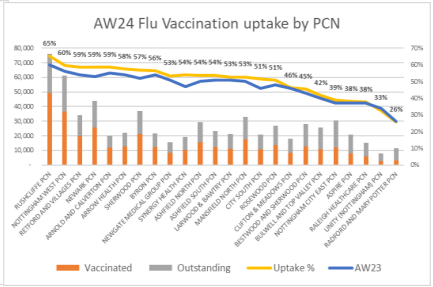
COVID Final Uptake AW24

- Uptake 43% (T2% lower than AW23)
- Uptake in population over 65 is more than 10% lower than AW23
- Uptake in at risk population whilst lower than 65+ is slightly higher than AW23

RSV

- National invite campaign commenced 10th February 2025
- Increased weekly activity (60%) seen in the following weeks





	AW24 Uptake	AW24 Vaccinations	AW23 Uptake
Healthcare worker uptake	Flu	Flu	Flu
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	43.0%	5,848	39.0%
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	37.0%	2,768	40.0%
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	48.0%	2,369	42.0%

RSV Uptake	Eligible	Vaccinated	Uptake
75-79 Catch up	50,677	31,069	61%
75-79 Routine	5,274	1,864	35%
Pregnant ladies **currently** in third trimester	2,708	926	34%

Actions Being Taken & Next Steps

- Spring COVID vaccination campaign starts on 1st April and ends on 17th June
- Eligible population:
  - Citizens over 75
  - Residents in care homes for the elderly
  - Citizens aged 6 months to 74 years that are immunosuppressed
- COVID and Flu vaccination strategy being developed for Autumn 25

Outbreaks

- Outbreaks of Invasive Pneumococcal Disease in 2 care homes, appropriate control measures put in place
- UKHSA have confirmed there are no indications of an increasing threat in relation to Streptococcus pneumoniae
- Outbreak control team to met to discuss Group A Streptococcus infractions

NHS
Nottingham and Nottinghamshire

7.0 Service Delivery Performance

ICS Aim 1: To improve outcomes in population health and healthcare

ICS Aim 2: To tackle inequalities in outcomes, experience and access

- 7.1 – Service Delivery SPC Matrix
- 7.2 - Urgent Care Pathways
- 7.3 – Elective Care Recovery
- 7.4 – Mental Health Recovery
- 7.5 – Primary and Community Care Recovery
- 7.6 – Provider Level Overview

7.1 - ICB Service Delivery Metrics Insights – Reporting Period February 2025

NHS Nottingham and Nottinghamshire

May 2025		Assurance: Pass	Assurance: Hit & Miss	Assurance: Falling Below
Variation	Special Cause - Improvement	Ambulance Conveyances to ED (Pop) % 111 Calls Abandoned (Pop) 2 Hour Urgent Care Response % (Pop) Urgent Care Response Referrals (Pop) 0 Day NEL (Prov) CTR Activity (Prov) Length of Stay >21 days (Prov) P0 - Discharges Home No Support (Pop) Op Plan Diag Activity (Prov) PIFU (Prov) Missed Appointments % (Prov) % Op FUp without Proc (Prov) Lower GI Cancer Refs with FIT result (Pop) TalkTher 1st Treat <6Weeks (Pop) TalkTher 1st Treat <18Weeks (Pop) SMI Health Checks (Pop) Tranfs Comm Serv - +2 Contacts (Pop) Individual Placement Support (Pop) CYP Access (1+ Contact) (Pop) Total Appointments (Pop) Community WL 52ww Adult (Prov) Community WL Adult (Prov)	P1 - Discharges Home with H/SC (Pop) 52 Week Waits (Prov) OP Diag +6Wks (Prov) Inappropriate OAPs (Pop) Dementia Diagnosis Rate (Pop) Dental - CYP seen in last 12mths (Pop)	No. Patients Utitlising Virtual Ward (Pop) Total Waiting List (Prov) 65 Week Waits (Prov) 78 Week Waits (Prov) Ordinary Electives (Prov) Daycases (Prov) % OP Attendances with proc (Prov) OP Diag Waiting List (Prov) OP Diag Backlog (Prov) Cancer 1st <31 days % (Prov) TalkTher > 90 days 1st & 2nd (Pop) Older Adult MH >60 day LOS (Pop) Perinatal Access Volume (Pop) CYP Eating Disorders - Routine (Pop) % Patients able to book in 2wks (Pop) % NHS App Registrations (Pop) Dental - Adult seen in last 24mths (Pop)
	Common Cause - Random	111 Calls (Pop) % Bed Occupancy (Prov) % Virtual Ward Capacity Utilised (Pop) Ambulance Response Cat 3 (Pop) % Cat 2 waits below 30 minutes (Pop) Average C2 Handover Time (Prov) % Ambulance Handovers >30 Mins (Pop) % Ambulance Handovers >60 Mins (Pop) OP Proc - ERF Scope (Prov) OP FA Without Proc - ERF Scope (Prov) Op FUp Without Proc - ERF Scope (Prov) Cancer 62 Days (Prov) TalkTher - Completing (Pop) TalkTher - Reliable Improvement (Pop) EIP <2Weeks (Pop) Community WL 52ww adult (Prov)	EMAS Response Activity (Pop) A&E Attendances (Prov) 1+ Day NEL (Prov) P2 - Discharge Not Usual Res (Pop) 52 Week Waits CYP (Prov) TalkTher - Reliable Recovery (Pop) Adult MH FUp 72hrs (Pop)	Ambulance Response Cat 1 (Pop) Ambulance Response Cat 2 (Pop) Ambulance Response Cat 4 (pop) Ambulance Total Hours Lost (Prov) A&E 4hr % (All Types) (Prov) 12 Hour Breaches Actual (Prov) Total Clock Stops (Prov) Outpatient 1st (Prov) Outpatient FUps (Prov) Cancer FDS % (Prov) Cancer 62 Day Backlog (Prov) Older Adult MH >90 day LOS (Pop)
	Special Cause - Concern	Specialist Advice (per 100 OPFA) (Prov)		NEL Admissions (Prov) P3 - Discharge Care Home (Pop) 12 Hour Breaches % Atts (Prov) Total Clock Starts (Prov) Total Outpatients - Virtual (Prov) Community WL CYP (Prov)

***Areas which continue to improve** however are still unlikely to achieve the plan set in the near future*

Items for escalation based on the indicators Falling short of the target and showing Special Cause for concern are as follows:

Non-Elective
- NEL Admissions (Prov)

Discharges
- P3 - Discharge Care Home (Pop)

ED
- 12 Hour Breaches % Atts (Prov)

Waiting List
- Total Clock Starts (Prov)

Outpatients
- Total Outpatients - Virtual (Prov)

Community
- Community WL CYP (Prov)

The Matrix supports the identification of areas of risk and concern, as well as areas of improvement, across the range of service delivery requirements.
For example, the orange bottom right box consolidates all of the areas which have deteriorating performance levels and are unlikely to achieve the required positions based on current performance levels. These, and other areas of deterioration, or areas expected to falling below requirements have been included as exception reports.

***Areas which are not significantly changing or having periods of sustained improvement** AND which continue to fail to deliver to planned levels, e.g. 4 hour ED, cancer backlogs. These areas may be deteriorating or improving, however have not had a sustained change for 6 periods to trigger a special cause 'low' or 'high' alert as yet, e.g. cancer 62 day backlog, 12 hour breaches*

7.2 Service Delivery Urgent Care Performance

7.2.1 - Streamline Urgent Care – Exception Report: Pre-Hospital Flow

NHS Nottingham and Nottinghamshire

Oversight Level	Routine

EMAS - In March 2025, there were 23,241 calls within Nottinghamshire for ambulance services, which is a decrease of 3.9% compared to the volume in March 2024 (24,166). Call volumes increased by 8.6% from February 2025 to March 2025 (21,320 to 23,241 calls). Over time, we have seen the proportion that are closed without dispatching an ambulance (Hear and Treat) increase. These formed 18.8% of the total in March 2025 compared the same 17.6% position in March 2024. 'See and Treat' (treatment carried out at patient's location) formed 28.1% of the total (Mar '24=29.8%) and 'See and Convey' (arrival at scene followed by ambulance conveyance to a healthcare facility) were 53.1% of the total (Mar '24=52.6%). The Nottinghamshire proportions are in line with the EMAS position for these three metrics.

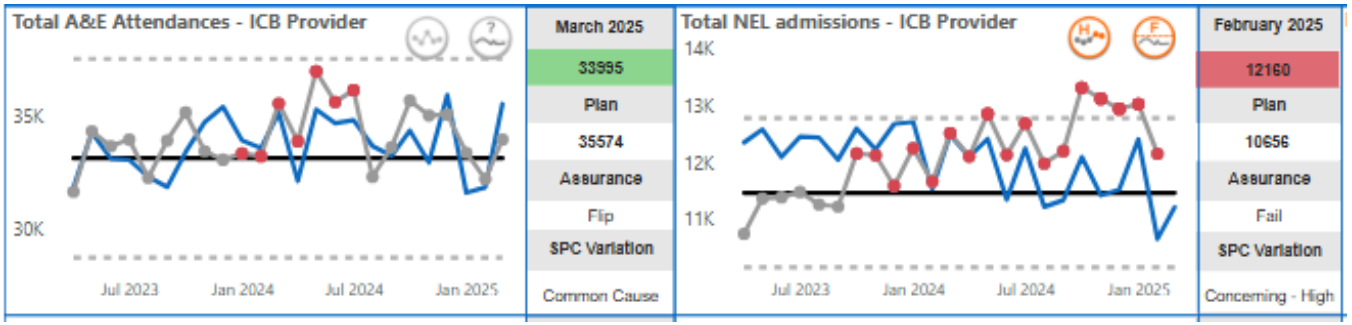
111 – There were 29,667 received for February 2025, a decrease of 1,393 from January 2025 and 2,038 lower than the same period last year (February 2024 – 31,705).

UCR - All integrated care systems must ensure urgent community response (UCR) services are available to all people within their homes or usual place of residence, including care homes, which can help to prevent avoidable hospital admissions. The ICB performance remains above the 70% standard for patients being seen within 2 hrs. In January, performance was 98.6% of 1,880 calls responded to within 2 hours. The UCR service has consistently exceeded the minimum standard of reaching 70% of two-hour crisis response demand within two hours, achieving an average of 98%. This is the highest in the Midlands and exceeding the national average of 84%. Work is being carried out on expansion of referral routes to UCR through Urgent Care Co-ordination Hub. Discussions continue around the future single UCR service offer across the ICS.

Content Author: Rob Taylor	ICB Programme Lead: Gemma Whysall	Executive Lead: Mandy Nagra	System Oversight Group: A - Delivery	ICB Committee: Finance & Performance Committee

7.2.2 - Streamline Urgent Care – Exception Report : Front Door & In-Hospital Flow

Oversight Level **Escalated Risk**



Position

A&E and Non-elective activity plans (ICB Provider) – There were 15,958 A&E attendances at NUH in March 2025, which was a decrease from the previous month of 1,068 attendances. This is below the planned level by 16.9% or 3,255 attendances. Note that these volumes exclude any patients that attend the London Road Urgent Treatment Centre. At SFH, there were 18,037 attendances in March 2025, which was an increase from the previous month of 2,835 attendances. This is above plan by 10.2% or 1,676 attendances.

ED attendances for Notts ICB patients increased by 5.6% in March 2025 in comparison to March 2024. With NUH seeing a 5.58% increase and SFH seeing a 5.64% increase, for the same period.

In February, Non-elective (NEL) admissions were 12.4% or 1,504 admissions above plan. Admissions into NUH were 1,373 admissions over plan or 16.4%, admissions to SFH were 131 or 0.03% above plan.

Actions

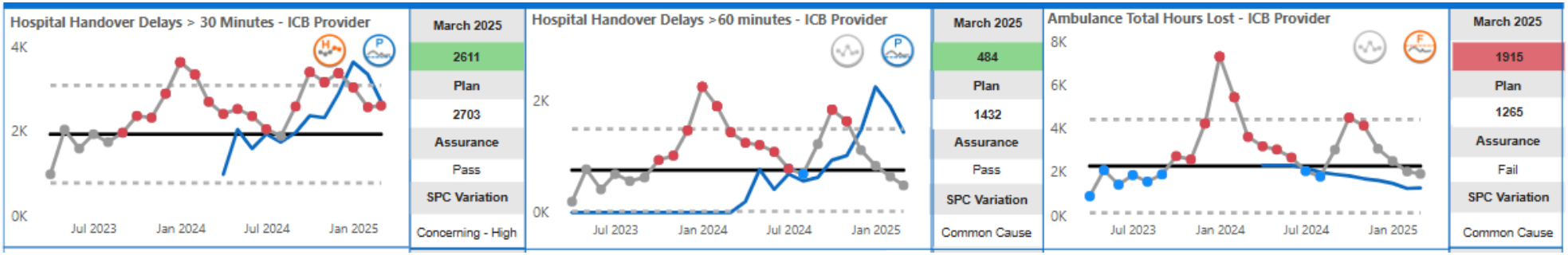
Capacity falling back in line with plan, but challenges remain around spikes in activity at certain points of the day, at both providers. 2 hourly capacity and flow calls taking place at NUH to best manage current issues.

SFH continue to face challenges recovering performance issues overnight. The high volume of breaches mean performance unable to be recovered the following day due to attendance volumes seen. Surges in minor attendance demand the afternoon has seen 4/5 people checking in per minute at points within the previous weeks and this volume overwhelms the department. However, performance heading in the right direction, with performance improving despite this challenge. CDU is working well for SFH and helps decongest minors. Attendances at Newark are consistently high which is impacting on performance and PC24 has also seen peak in attendances.

7.2.3 - Streamline Urgent Care – Ambulance Handovers

NHS Nottingham and Nottinghamshire

Oversight Level **Escalated Risk**



Position

In March 2025, there were 2,611 over 30 minutes, of which 484 were above 60 minutes. Of the 60-minute delays, 458 were at NUH and 26 were at SFH. There were 1,915 hours lost through ambulances waiting to handover patients to hospitals by providers in Nottinghamshire in March. This is time lost above the 30 minutes expected (15 mins pre and 15 mins post-handover time) and significantly limits the capacity of EMAS to respond to calls within a timely manner. The handover clock starts when the ambulance wheels stop in the patient offloading bay and the 'Red at hospital' button is pressed on the Mobile Data Terminal. Where a patient is handed over directly from the conveying crew to hospital staff, the operational handover clock stop is when clinical handover has been fully completed, and the patient has been physically transferred onto hospital apparatus. Handover times exceeding the 30 minutes are aggregated to generate the total number of lost hours from handovers.

In March 2025, QMC reported 1466 lost hours from handover delays – this is the third highest reported figure of the 27 reporting hospitals in the Midlands, and a decrease of 97 from the February position. This improvement has been driven by the implementation of the 45-minute handover protocol at NUH. The March position is 1,361 hours lower than Leicester Royal Infirmary who reported the highest position. QMC's reported lost hours account for 11.3% of the total EMAS reported lost hours for March (12,939). This is a increase on the February position where QMC lost hours made up 10% of the total. By comparison, KMH place 11th highest and Nottingham City place 18th of 27 within the region. As a County, Nottinghamshire reported 2,101 lost hours for March (191 less than the February position), this includes Doncaster & Bassetlaw Hospitals (186 lost hours), SFH (280), NUH (1,635). This was the second lowest within the region, 1,616 hours below Northamptonshire and accounting for 16.2% of total EMAS reported lost hours (14.8% in February).

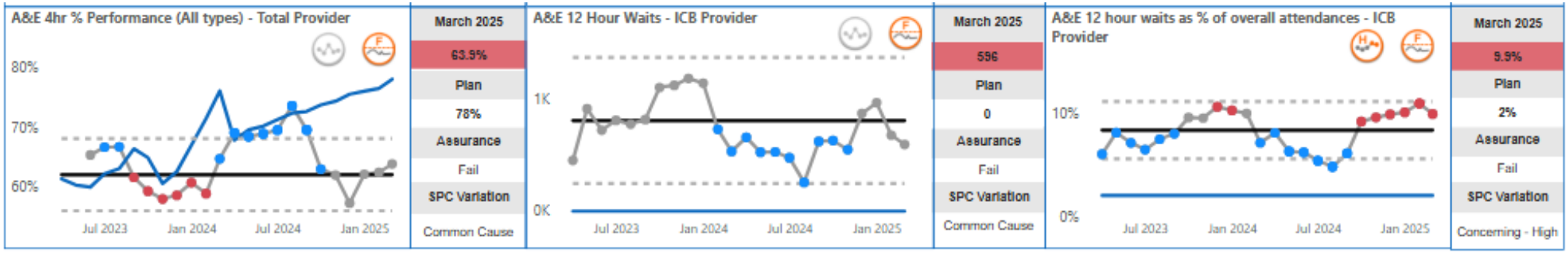
Actions

Monthly pre-handover lost hours improvement trajectories have been calculated as part of the Cat 2 Handover plan within the contract, and this provides the basis for routine improvement monitoring. EMAS continuing to work on how this can be improved. 45-minute handover protocol, which ensures no handover will exceed 45-minutes, continues to show positive signs in delivery, including improvement with number of lost hours, however this is an ongoing piece of work with continued challenges. Post handover position is going in the right direction, and work continues between EMAS and KMH around this. Combined pre-and post overall times have also seen a reduction across all sites.

7.2.4 - Streamline Urgent Care – A&E Four Hour Wait

NHS Nottingham and Nottinghamshire

Oversight Level **Escalated Risk**



Position

In March, the system achieved 63.9% performance for 4-hour waits against a plan of 78%. NUH achieved 58.2% against a plan of 78%, with SFH delivering 71.7% against a plan of 78%. As an ICB, Nottingham and Nottinghamshire were 38th of 42 nationally for 4-hour performance. With NUH 186th of 188 providers and SFH 107th.

Challenges remain on type 1 attendance performance. Note that a Type 1 department is a major emergency department that provides a consultant-led 24-hour service with full facilities for resuscitating patients, for example patients in cardiac arrest. The Type 1 majors' four-hour performance is significantly influenced by ambulatory majors and have long waits to be seen. The total provider volume of patients waiting 12 hours from arrival in March, saw an increase of 24 at NUH as well as a decrease of 107 at SFH. This was impacted by a reduction in attendances, despite both providers continuing to be above plan for attendances. The System performed at 5.9% for March against 2% target for 12-hour breaches as percentage of ED attendances, an improvement in performance since February (11%).

Actions

NUH – 2 key actions from recovery plan for April – 1. Injuries perfect week – which will include review of whether EMPs may need workforce change. 2. Extending SDEC opening hours to 1am from 21st April, which will open other pathways. May actions are preparation for single front door. Will include huddle at 7am for handover. NUH will include EMAS in the front door conversations. Doing everything possible to strengthen rotas from a type 1 perspective, validation is in place, concerned in understanding the impact of the IA and what might need to be done differently ahead of going into BH weekend. 12 hours performance is being monitored through weekly meeting where all patients breached over 12-hour are reviewed. SFH – Attendances at Newark are consistently high which is impacting on performance. PC24 performance also remains a challenge. Challenges persist around influxes of attendances at certain times, however, performance heading in the right direction. Key action being taken is escalations being put in place at key points of pathway. Combining medical rota's with KMH and Newark going forward. Focus on embedding all other areas of service change which are being actioned.

7.2.5 - Streamline Urgent Care – Exception Report : Flow Out of Hospital

NHS Nottingham and Nottinghamshire

Oversight Level Enhanced Oversight

The volume of pathway 0 (Simple) discharges remains significantly above the planned level with 12,627 discharges in February against a plan of 7,469. Pathway 1 discharges remain below planned volumes with 958 against a plan of 963 discharges in February.

Discharge levels at NUH remain high with an average of over 352 discharges per day (all pathways) in March, with SFH averaging over 145 discharges per day for the same period. Note that pathway 1 discharges are where the patient can return home with support from health and social care. Pathway 0 discharges require no input from health or social care.

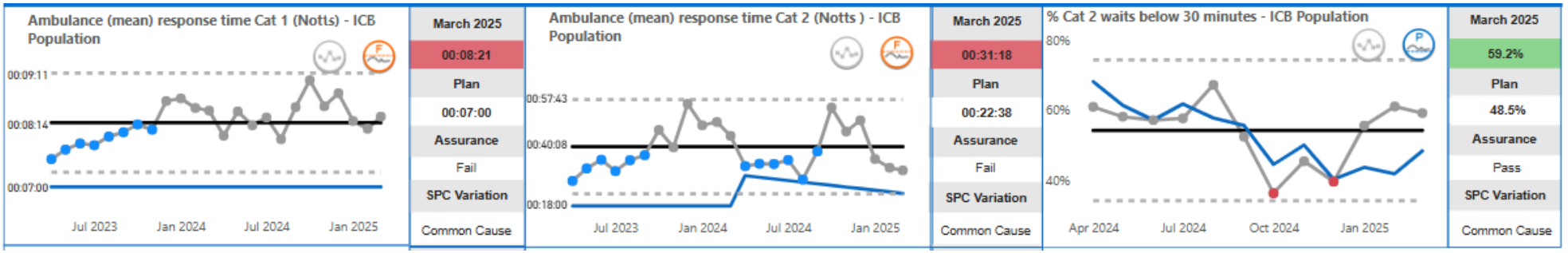
There has been a reduction in the volume of patients that have No Criteria To Reside (NCTR) within NUH and SFH. This has moved from 284 in February, down to 266 in March, and remains below the plan of 347 patients. Work continues regarding improvements to discharge readiness through discharge lounges and into pathways, as well as effective utilisation of virtual ward capacity.

For March, the ICS reported an increase in Virtual Ward bed capacity, with 198 against a plan of 236 and with an increase in occupancy, up to 90.4% (84% in February). Data issues relating to capacity and occupancy figures were identified and work around this continues, which is a factor in the recent reduction of overall capacity within the system. This reflects a more accurate position of occupancy within Virtual Wards. NHSE expectations are that wards and systems will achieve 80% utilisation of actual capacity.
Latest published data for March shows the ICB places 33rd of 42 nationally with 15.6 beds per 100,000 registered population (Aggregate England position is 20.3 per 100,000). VW utilisation benchmarking shows the ICB places 9th of 42 nationally with 90.4% occupancy (Aggregate England position is 76.2%).

7.2.5 - Streamline Urgent Care – Exception Report : Ambulance Performance

NHS
Nottingham and Nottinghamshire

Oversight Level **Escalated Risk**



Position

Ambulance Response Times: Category 1 and 2 response times remain higher than target. (Category 1: immediate response is required due to a life-threatening condition, such as cardiac or respiratory arrest. Category 2 : serious conditions, such as a stroke or chest pain which may require rapid assessment and/or urgent transport).

Category 1, Category 2 and Cat 2< 30 Mins metric have failure alerts, which signify that achievement of the standard is unlikely without a significant intervention. The average response time for category 2 calls in March was 31:18 minutes against a plan time of 22:38 mins. An improvement in performance of 00:59 minutes from February. The Category 2 performance level remains a significant challenge for the system despite improvements over recent months. Performance of this standard is linked to ambulance handover times. Extended handover waits reduce the capacity that EMAS has available to respond to calls in a timely manner.

Actions

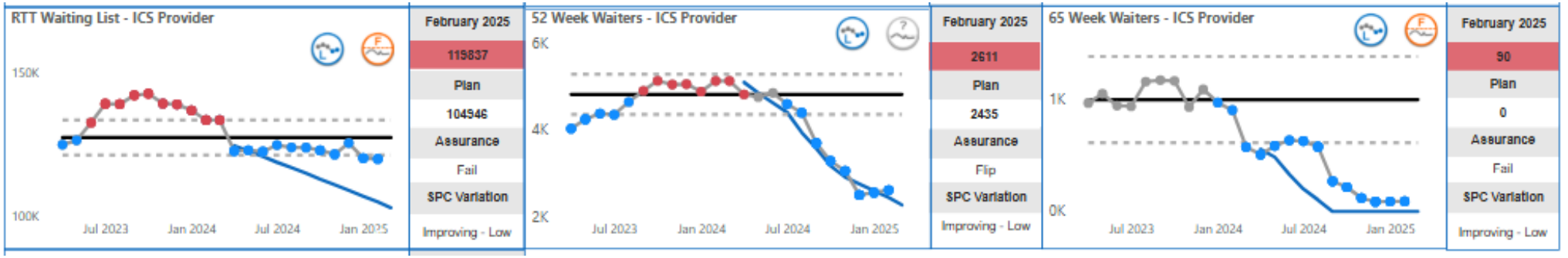
Weekly meetings between senior operational leads from EMAS, NUH and SFH continue to take place with main-focus of improving ambulance handover performance. Cat 2 performance continues to be a challenge but performance continues to improve following winter peaks, regular discussions continue to take place with EMAS. EMAS reporting conveyance rates feeling static at both sites. Fluctuations give problems at both sites and important to focus efforts on this.

7.3 Service Delivery
Elective Care Performance

7.3.1 - Planned Care – Elective Waits

Oversight Level Enhanced Oversight

NHS Nottingham and Nottinghamshire



Position

At the end of February, there were 3 patients patient waiting 78 weeks or more across the two providers. More recent data indicates that there were zero 78-week waiter within the system at the end of March.

There were 90 patients over 65 weeks at the end of February (58 at NUH, 32 at SFH) against a plan of 0. More recent unvalidated 65-week waiter data submitted to NHS England indicates that SFH did not achieve the March plan with 23 patients against a plan of 0 patients. NUH also did not achieve their March plan (61 patients against a trajectory of 0 – ENT and Corneal challenges are the main causes).

There were 2,611 patients waiting over 52 weeks at the end of February against a plan of 2,435 which is 176 patients below trajectory. More recent unvalidated data presented at SOG A indicates that NUH were behind their March plan (2,307 patients v 1,459 plan) and SFHT were also behind plan with (500 patients v 0 plan).

Actions

Electives continue to focus on reducing the long waits and planning for delivery of 18 weeks RTT (increased validation, staff training etc). The financial constraints are starting to have some impact, with alternative capacity to resolve some of the long waiting urology cases unable to proceed due to additional cost to the system. This is also a risk in relation to corneal graft capacity where NHSBA have capped the eligibility date for long waiting patients, NUH have brought in an alternative provider to support the position, however graft material is not suitable for all patients. The Trusts continue to identify areas of opportunity to support each other where possible, in particular in ENT, and review patient lists weekly to ensure longest waiting patients are prioritised equitably across the system. ENT remains a consistently challenging area locally and across the Midlands, an ENT sub-group is exploring options of a joint waiting list and the possibility to group procedures to drive efficiencies. A deep dive into ENT is scheduled for the 16th April.

Forecast

The latest forecasts for the end of April are NUH to have 38 patients of which 26 are corneal transplants and SFH to have 28 ENT patients waiting over 65 weeks.

NHS
Nottingham and Nottinghamshire

7.3.2 - Planned Care – Elective Activity

Metric Full Name	February Only				Feb-25 compared to Feb-24		April to February				Comparison to same period previous year	
	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance
Elective Ordinary - ICS Provider	2,412	2,130	-282	-11.7%	-53	-2.4%	27,968	24,615	-3,353	-12.0%	2,764	12.6%
Elective Ordinary - NUH	2,013	1,755	-258	-12.8%	-43	-2.4%	23,469	20,110	-3,359	-14.3%	2,019	11.2%
Elective Ordinary - SFHT	399	375	-24	-6.0%	-10	-2.6%	4,499	4,505	6	0.1%	745	19.8%
Total Day Cases - ICS Provider	15,958	14,080	-1878	-11.8%	533	3.9%	180,287	157,435	-22,852	-12.7%	12,415	8.6%
Total Day Cases - NUH	12,152	10,560	-1592	-13.1%	559	5.6%	137,748	116,610	-21,138	-15.3%	8,334	7.7%
Total Day Cases - SFHT	3,806	3,520	-286	-7.5%	-26	-0.7%	42,539	40,825	-1,714	-4.0%	4,081	11.1%
Op Plan Diagnostic Activity - ICS Provider	34,638	42,782	8144	23.5%	8,299	24.1%	382,389	410,661	28,272	7.4%	29,604	7.8%
Op Plan Diagnostic Activity - NUH	20,533	27,224	6691	32.6%	6,818	33.4%	229,454	242,342	12,888	5.6%	15,050	6.6%
Op Plan Diagnostic Activity - SFHT	14,105	15,558	1453	10.3%	1,481	10.5%	152,935	168,319	15,384	10.1%	14,554	9.5%
Total Outpatients 1st (Spec Acute) - ICS Provider	30,271	24,245	-6026	-19.9%	-1,420	-5.5%	346,032	279,225	-66,807	-19.3%	11,694	4.4%
Total Outpatients 1st (Spec Acute) - NUH	20,142	13,020	-7122	-35.4%	-1,721	-11.7%	227,472	149,320	-78,152	-34.4%	-12,088	-7.5%
Total Outpatients 1st (Spec Acute) - SFHT	10,129	11,225	1096	10.8%	301	2.8%	118,560	129,905	11,345	9.6%	23,782	22.4%
Total Outpatients FUp (Spec Acute) - ICS Provider	59,452	54,635	-4817	-8.1%	-7,182	-11.6%	684,444	644,395	-40,049	-5.9%	-22,801	-3.4%
Total Outpatients FUp (Spec Acute) - NUH	38,563	32,125	-6438	-16.7%	-7,984	-19.9%	443,506	392,715	-50,791	-11.5%	-43,368	-9.9%
Total Outpatients FUp (Spec Acute) - SFHT	20,889	22,510	1621	7.8%	802	3.7%	240,938	251,680	10,742	4.5%	20,567	8.9%
0 Day NEL - Provider	4,065	4,640	575	14.1%	575	14.1%	43,110	51,440	8,330	19.3%	8,330	19.3%
0 Day NEL - NUH	2,283	3,335	1052	46.1%	650	24.2%	28,319	36,895	8,576	30.3%	9,005	32.3%
0 Day NEL - SFH	1,303	1,305	2	0.2%	-75	-5.4%	14,964	14,545	-419	-2.8%	-675	-4.4%
1+ Day NEL - Provider	7,625	7,520	-105	-1.4%	-105	-1.4%	84,135	88,095	3,960	4.7%	3,960	4.7%
1+ Day NEL - NUH	4,739	5,060	321	6.8%	-70	-1.4%	58,780	59,430	650	1.1%	2,485	4.4%
1+ Day NEL - SFH	2,331	2,460	129	5.5%	-35	-1.4%	26,771	28,665	1,894	7.1%	1,475	5.4%
Total A&E Attendances - ICB Provider	35,574	33,995	-1579	-4.4%	-1,602	-4.5%	406,387	414,282	7,895	1.9%	1,024	0.6%
Total A&E Attendances - NUH	19,213	15,958	-3255	-16.9%	-2,598	-14.0%	218,492	214,496	-3,996	-1.8%	-1,794	-2.0%
Total A&E Attendances - SFH	16,361	18,037	1676	10.2%	996	5.8%	187,895	199,786	11,891	6.3%	2,818	3.5%

Metric Full Name	February Only				Feb-25 compared to Feb-24		April to February				Comparison to same period previous year	
	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance
Elective Ordinary - ICS Population	1,907	2,230	323	16.9%	38	1.7%	22,215	24,240	2,025	9.1%	1,932	8.7%
Total Day Cases - ICS Population	13,200	14,515	1315	10.0%	32	0.2%	153,786	152,920	-866	-0.6%	-807	-0.5%
Op Plan Diagnostic Activity - ICS Population	35,390	45,537	10147	28.7%	6,506	16.7%	411,796	458,057	46,261	11.2%	27,485	6.4%
Total Outpatients 1st (Spec Acute) - ICS Population	25,647	27,230	1583	6.2%	-1,623	-5.6%	298,785	311,400	12,615	4.2%	15,982	5.4%
Total Outpatients FUp (Spec Acute) - ICS Population	46,885	58,410	11525	24.6%	-7,032	-10.7%	546,217	686,350	140,133	25.7%	-12,132	-1.7%
Total A&E Attendances - ICB Population		43,743			2,038	4.9%		484,863			5,050	2.6%

* Population data now includes specialised commissioning actuals; however, plans were submitted excluding specialised as instructed

The Day Case, Elective Ordinary, Outpatient First and Follow up activity levels were below plan in February for the combined provider position (ICS Provider).

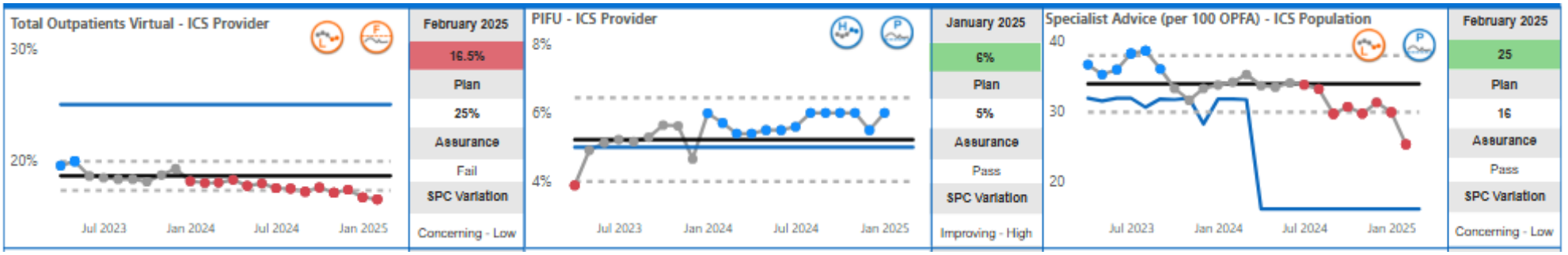
Note that the plans for 2024/25 were ambitious and that the current level of activity for Day Case exceeds that delivered in February 2024 and the year to date.

The ICB Position is influenced by the movement of specialised services transferring from NHSE to the ICB from 1st April. Planning guidance for 2024/25 stated that ICB's should plan in line with 2023/24 for consistency with prior years. This has meant that the plan is based on prior ICB activity only, however the actuals are inclusive of specialised activity, which are driving the over performance.

7.3.3 - Planned Care - Productivity and Transformation

Oversight Level Enhanced Oversight

NHS Nottingham and Nottinghamshire



Outpatient virtual appointments - The latest position for the system is 16.5%, which is below the national standard of 25%. Since April 2022, the position for the system has reduced from 24% to 16.5% reported in February. In February, NUH and SFH delivered 19% and 13.5% of outpatients virtually respectively. Ranking for February places the system in quartile 3 nationally, with NUH placed quartile 3 and SFH within the lowest quartile.

Patient initiated follow up (PIFU) - can be described as patients having the ability to initiate an appointment when they need one, based on their symptoms and individual circumstances. It can be used by patients with long or short-term conditions in a broad range of specialties. In line with the operational planning guidance, Providers are expanding the uptake of PIFU to all major outpatient specialties, the ambition was to move or discharge 5% of outpatient attendances to PIFU pathways. The performance level for the system in January 2025 was 6%. This was 5.9% at SFH and 4.9% at NUH. Overall, the system benchmarks well for PIFU utilisation and is within the highest quartile nationally for January 2025.

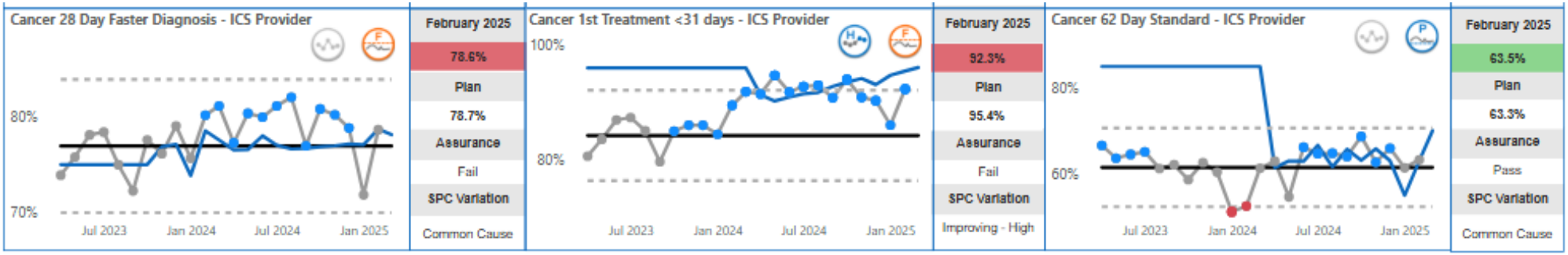
Advice and guidance - The utilisation rate in February 2025 was 25.0 against a national standard of 16 requests per 100 outpatient first attendances, which below the average. The utilisation rate has been lower in the latest four months that was seen historically. Analysis is being undertaken to explore whether this is driven by behaviour at place, practice or specialty level. Diversion rates indicate the proportion of specialist advice requests that are returned to the referrer with advice where it is expected that the advice diverted a referral. The pre-referral diversion rate was 48.4% in January and the post referral diversion rate was 14.3%, which is in line with previous months.

Proportion of outpatient attendances that attract a procedure tariff - The aim is to prioritise outpatient activities that directly address patients' needs and complete a phase of their treatment pathway ("clock-stopping" activities). Increasing the use of PIFU and remote monitoring can contribute towards reducing follow up attendances and achievement of this metric. The aim is to deliver 46% of outpatient attendances with a procedure by March 2026. The latest data highlights the system is performing at 42.4% against a plan of 46.0% for February 2025. NUH have identified opportunities to improve the accuracy and completeness of the outpatient coding undertaken within the Trust through amending outcome forms and undertaking educational sessions with teams.

7.3.4 - Planned Care – Cancer

NHS Nottingham and Nottinghamshire

Oversight Level **Escalated Risk**



Position

Performance in the 28-day Faster Diagnosis Standard (FDS) improved in February to 78.6% and achieved the 75% standard but was below the operational plan of 78.7%.
31day performance was below standard in February at 92.3% against the 96% standard and below the operational plan of 95.4%.
62-day performance achieved the operational plan in February with 63.5% against a plan of 63.3%.

NUH achieved the 62-day trajectory in February for a third consecutive month (62.3% v 61.5% plan). The key specialties of concern are the largest referring tumour sites including Urology and LGI. Other areas include Gynaecology and Head & Neck due to the number of breaches per month. At SFH, 62-day performance was 66.9% in February against a plan of 68.3%.

The 62-day backlog volume at NUH has continued at a heightened level and is at 455 patients at 04/04/25, which is above the local trajectory of 370 patients. Urology remains the largest backlog at 145 patients. SFH had a backlog of 84 patients at 04/04/2025. There continues to be a significant increase in the number of cancer referrals being received at both Trusts which is impacting on the backlog volumes.

Actions

NUH have a new CNS triage pathway in place for Gynaecology patients to improve capacity and create better patient outcomes. A decision on EMCA funding for 25/26 is expected to be announced mid-April which will help with additional surgical capacity. The cancer PTL has increased as have conversion rates, the ICB cancer lead is taking forward a piece of work to review demand and capacity into cancer across the system to ensure services are preparing for expected growth.

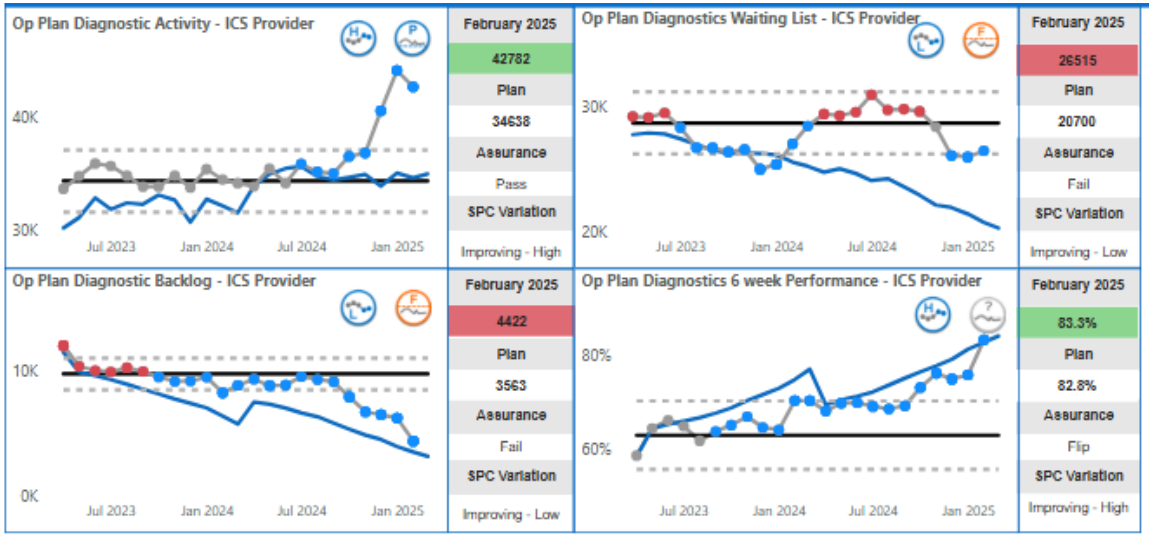
Recovery

FDS – NUH March forecasting 76.9% v 77.01% plan, SFH March forecasting 78%
31-day combined – NUH March forecasting 86.1% v 96.2% plan, but expect this to improve to above 90% with validation, SFH forecasting 95%
62-day Combined –NUH March forecasting 64.4% v 70.05% plan, SFH forecasting 54%
62 Combined backlog– NUH at 455 against 370 plan. SFH backlog has reduced to 84.

7.3.5 - Planned Care – Diagnostics

NHS Nottingham and Nottinghamshire

Oversight Level Enhanced Oversight



Position

The backlog remains above planned levels at 4,422 against a plan of 3,563 patients. MRI and Audiology are key drivers of the position due to having a high volume of patients waiting over six weeks at system level.

Activity delivery within the system decreased slightly to 42,782 tests in February, from 44,252 in January, but remains above the planned level.

In February, NUH delivered 78.3% of tests within 6 weeks against a plan of 82%. SFH delivered 94.4% within 6 weeks against a plan of 84.4%.

The largest backlog for the ICB population remain Audiology with 1,182 patients waiting over 6 weeks from a total waiting list of 2,334 patients in February (49.4% performance) This is a significantly challenging modality across the System but is beginning to show signs of recovery.

Actions

NHSE have ceased the funding of the 3 MRI accelerator vans within the system for 2025/26. Conversations continue around funding these for longer term to enable the diagnostic waiting list to be further reduced and the RTT position to be appropriately supported. In the short term NUH are only booking urgent patients through this route, which will impact on March performance. Echo performance at NUH has been impacted by locum availability and staff sickness, CDC activity commenced in April to create an additional 90 scans per week. CT has seen a significant increase in the number of 2ww referrals being received which is impacting on routine capacity.

SFHT has seen an increase in the Echo waiting list during March and are carrying out a review as to why this is. Options to improve histology (which is underpinning low performance for SFHT cancer position) continue to receive significant focus from the team – capital bids for digital scanning opportunity have been submitted which will be essential to improve diagnostic and cancer performance. SFHT are exploring options to improve Paediatric MRI GA sedations next year through potential charitable fund Kitten scanner – which is a positive sustainable move forward. NUH are continuing to improve and are progressing with their validation programme with Endoscopy and audiology having now been completed, radiology will receive focus next.

Recovery

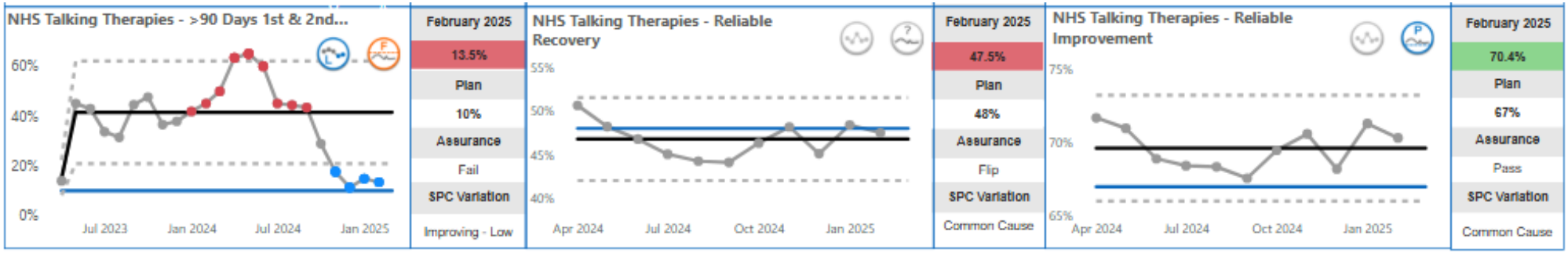
SFH delivered their end of March ambition of 86% earlier in the year. The latest position at the time of writing was 93.1%, which includes the amendment to the waiting list volume noted above. NUH are forecasting performance of 80% for the end of March against a plan of 81.1%.

7.4 Service Delivery Mental Health Performance

7.4.1 - Mental Health – Talking Therapies

NHS Nottingham and Nottinghamshire

Oversight Level Further Information Required



Position

NHS Talking Therapies (formerly IAPT) did not deliver against the improvement trajectory for 1st to 2nd wait in February (13.5% v 10% plan) but are forecasting to achieve the March plan of 10%, current local data as at 04/04/2025 is 5%. Performance has been impacted by reduced activity during the Christmas period and an increase in cancellations and DNAs.

The annual reliable recovery target for 2024/25 is 48%. Reported YTD is 47.4% based on national data, local data for February shows an increase to 48.7% in March.

The 50% recovery rate YTD position remains above target at 50.6%, local data for February shows an increase 53.7% in March.

The 67% reliable improvement target continues to be met. Local data was 70.9% for February.

Year to date performance shows an improvement an all-outcomes measures are expected to be achieved at the end of March.

Actions

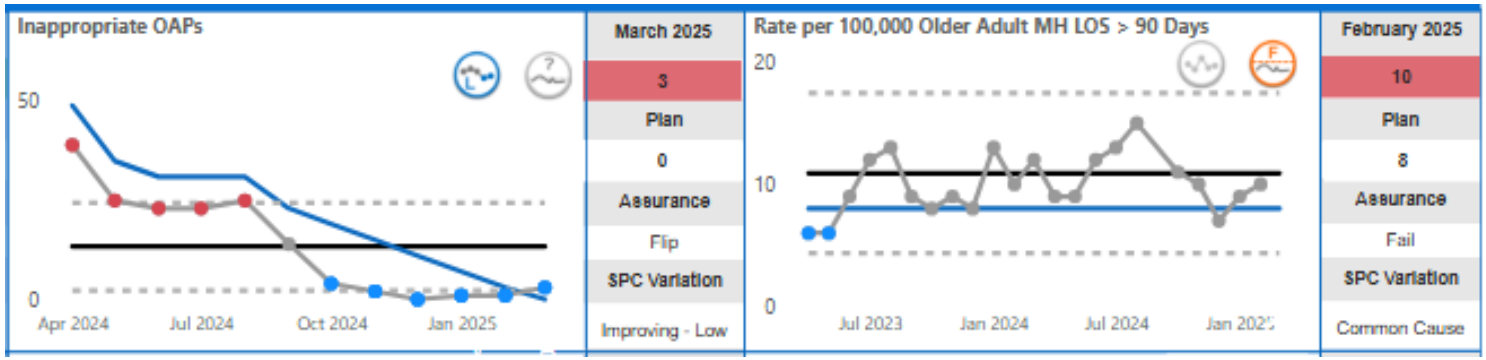
Staffing - recovery reviewed during staff supervision; support plans in place for staff not achieving the target; weekly clinical case management
Clinical leadership –steering groups that are responsible for implementing national best practice, conducting audits, developing local best practice guides
Engagement – with patients on readiness to engage with therapy; with partners e.g. Step 4 and LMHTs to ensure access to most appropriate service to meet patient needs

Recovery

Recovery plan for 1st to 2nd Waits for March 2025 is to achieve the <10% national target.

7.4.2 - Mental Health – OAPs

Oversight Level Enhanced Oversight



To Note: The operational plan for 2024/25 set a plan to improve from 49 in April to zero in March 2025.

Position
The number of inappropriate Out of Area Placement OBDs (OAPs) reported in March 2025 is 3 against a plan of 0. Local data for 8th April reported 3 patients remaining OOA. Discussions are ongoing with NHT colleagues to examine the definition of an out of area placement used by the trust to ensure that it aligns to the NHSE guidance and common practice of other similar NHS organisations. There is a risk that differences between the local and national definition of an out of area placement may lead to material increases in the reported volume, relating to local Independent Sector provision.

Actions
The Recovery Action Plan has been refreshed focusing on the optimum care pathway and flow and will be supported through the implementation of the 3-year mental health inpatient strategy programme.

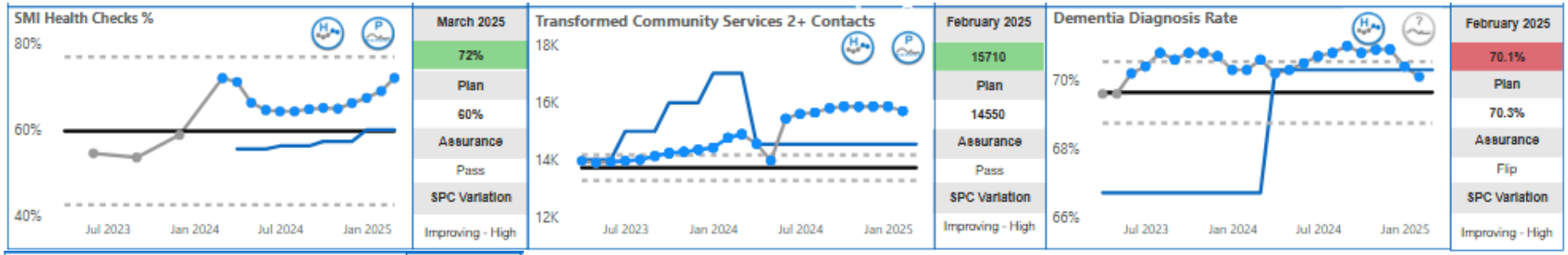
Reviews of patients who can be safely repatriated into the system are still ongoing. Increased visibility of leadership team on wards with a 'buddy' system and prompt sheets for colleagues to observe flow processes and to offer additional support. The focus is now on reducing the private bed numbers (currently at 76) to drive further improvement.

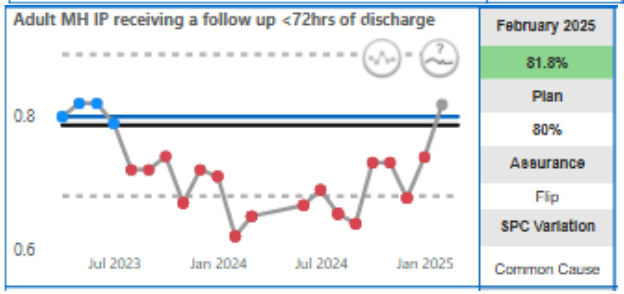
Recovery
NHT have seen continued pressure for inpatient occupancy and have increased to 76 beds, whilst discharge volumes have reduced below the mean level. The Trust are working on a finance and delivery plan for 25/26 to reduce the use of private beds.

7.4.3 - Mental Health – Adult Services

NHS Nottingham and Nottinghamshire

Oversight Level Enhanced Oversight





Position

72 Hour Follow Ups - the performance is above plan in February. At ICB level this is impacted by placements made to providers that are Out of Area, for which a data query has been lodged with the national team. Local data shows performance as higher than published national data.

SMI Physical Health Checks - In 2024/25 the ICS target is 60%, the March 2025 performance remains above target.

Dementia –The ICB continues to exceed the national dementia diagnosis rate standard (70.1%) in February 2025. Performance remains above the regional average. There is no national target for Memory Assessment Service (MAS), however, reducing waits to ensure timely assessment, diagnosis and post-diagnostic support is a key national priority within the planning guidance and a local priority

Actions

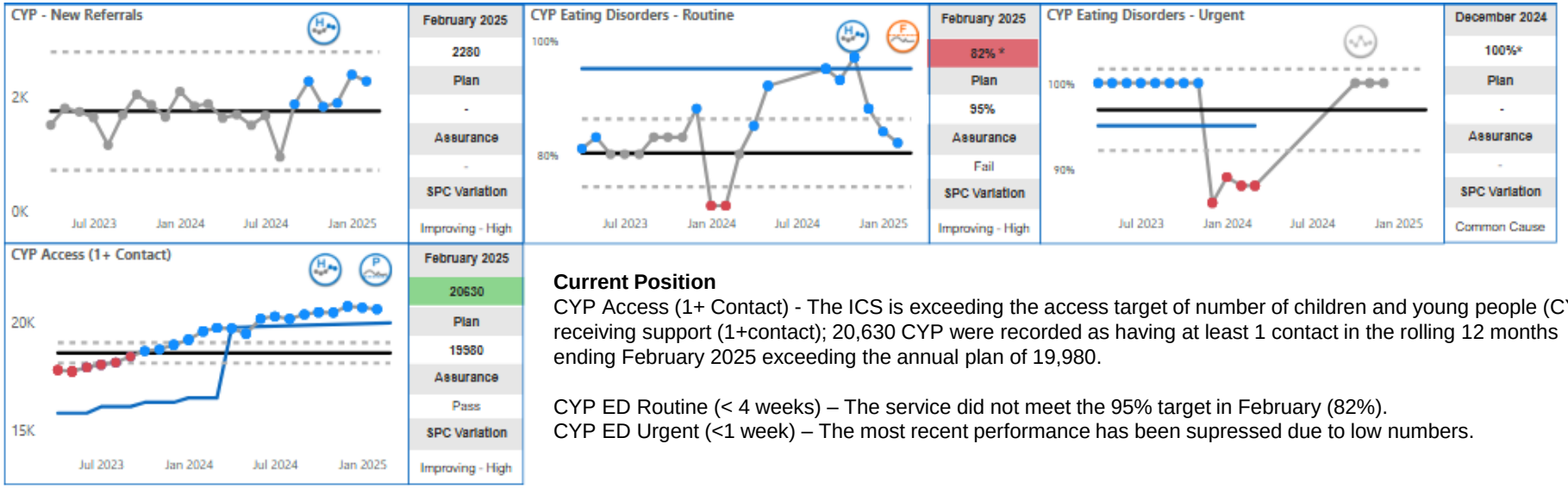
SMI Physical Health Checks - System performance is tracked through the ICB trajectory, providing updates on actions and phasing of activity. Some areas of activity are currently not included in MHSDS returns. Work continues with VCSE Providers and Primary Care to ensure the data can be flowed in the activity count against target as a system (core metric and transformed metric).

Dementia – Flexing staffing and associated clinic capacity across localities with consistently higher average waiting times, streamlining referral, assessment and diagnostic processes in line with Memory Services National Accreditation Programme (MSNAP) standards. Undertaking a redesign of the dementia pathway with NHT proposing to prioritise assessment and diagnosis (not yet agreed) and embedding of learning from the national audit of Dementia, alongside NHSE's regional MAS audit.

7.4.4 - Mental Health – Children & Young People Services

NHS Nottingham and Nottinghamshire

Oversight Level Further Information Required



Current Position

CYP Access (1+ Contact) - The ICS is exceeding the access target of number of children and young people (CYP) receiving support (1+contact); 20,630 CYP were recorded as having at least 1 contact in the rolling 12 months ending February 2025 exceeding the annual plan of 19,980.

CYP ED Routine (< 4 weeks) – The service did not meet the 95% target in February (82%).
CYP ED Urgent (<1 week) – The most recent performance has been supressed due to low numbers.

Actions

CYP Eating Disorder Service The root cause for underperformance is patient choice, the need for a Consultant Psychiatrist to attend a clinical emergency, and a lack of clarity in what a patient was referred for. A ‘deep dive’ is being undertaken to understand how to mitigate likelihood of these exceptions. Recovery trajectories are being developed for 2025/26.
The service is working on several initiatives to eliminate the risk of service-related breaches including:
Clinical space and service model - Reviewing space utilisation to expand access to clinical room availability; Continued protected time with Community CAMHs where joint assessments are required; The service is considering the possible formation of an all-age Eating Disorders Hub; The service has also completed their first round of Non-Violent Resistance (NVR) training specific to Eating Disorders
Engagement - Patient Choice; The service will complete a “deep dive” into breaches attributable to patient choice.
A piece of work is being undertaken on volumes of patients in treatment and is has been flagged by NHSE that the system has low volumes compared to other systems.

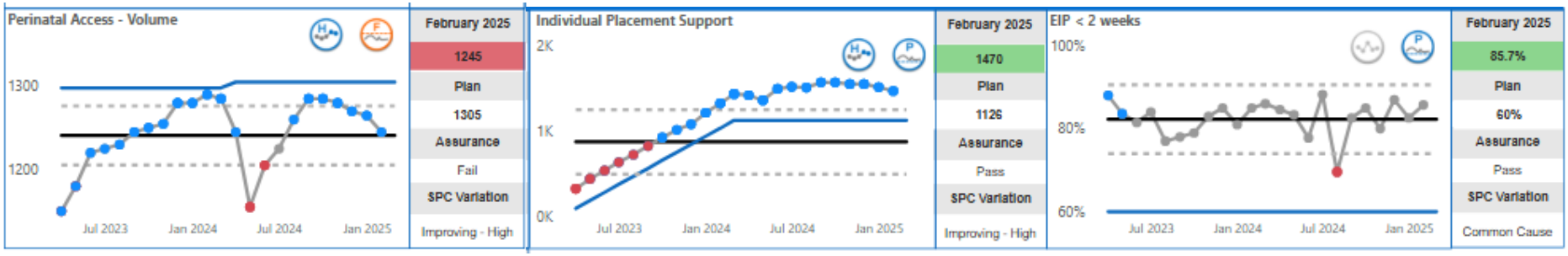
Recovery

For CYP Access (1+ contact) an ambitious trajectory for 2024/25 has been set as a stretch target based on previous performance. This exceeds the LTP target.

7.4.5 - Mental Health – Access

Oversight Level Enhanced Oversight

NHS Nottingham and Nottinghamshire



Current Position

- **Perinatal** – The rolling 12-month performance to February 2025 was 1,245 people accessing the service against a target of 1,305. Performance in Nottingham and Nottinghamshire is below the access rate of 10% (% of birthrate) and the original forecast trajectory.
- **IPS** - The number of people accessing IPS has started to dip slightly with 1,470 people accessing support in February 2025, however, remains above the planned level of 1,126.
- **EIP** - Data for February 2025 shows an improvement in performance to 85.7% of patients accessing EIP within 2 weeks and consistently remains above the target of 60%.

Actions

- **Perinatal** – Service delivery capacity has been constrained due to varying workforce pressures and leadership shortages. Re-evaluation of the assessment model is underway to better utilise service delivery capacity, and a perinatal wellbeing assessment pathway is being introduced for people who require an assessment but are less likely to need ongoing treatment. An evaluation of this pathway will be undertaken during April to assess whether waiting times and assessment capacity have been improved. Discussions are taking place at SOG A to determine whether improvements made to the Perinatal service are being hidden by the 12-month rolling average reporting of the data and if month on month reporting could be presented locally.

- **IPS** - Performance is continually monitored to ensure achievement of target continues

- **EIP** - Two-week access continues to be met. Family Intervention and Paired Outcomes remain at Level 2 and have been consistently failing despite expectance of improvement after 3-6 months.

Key actions being taken include:

- Family Intervention (FI): pool of staff allocated half a day per week to dedicate to FI, a referral process and meeting in a place to support the allocation of families, oversight at the monthly EIP performance and QOG meeting
- Outcome measures: communication from Operational manager request that each patient on a caseload is approached to have a clinical conversation involving QPR & DIALOG, each staff member has access to PROMS reporting to identify which people are out of date/never completed a PROM and supported in conversations on performance through supervision process, this is reviewed weekly and reported monthly into quality and operational governance processes.

7.5 Service Delivery Primary & Community Performance

7.5.1 – Exception Reports Primary
7.5.2 – Exception Reports Community

7.5.1 - Primary Care

Oversight Level Enhanced Oversight

Current Position
The volume of Total GP Appointments in February 2025 was 2.21% above the planned level, with 630,797 appointments against a plan of 616,808. 84.2% of appointments were offered within two weeks in February 2025, which remains below the operational plan of 90%. Discussions are taking place with a number of practices around their appointment book mappings to improve accuracy and consistency of recording.

A targeted group has been set up within the ICB to review the latest data as well as discuss and agree granular actions to improve the 14-day appointment performance. The group are focusing on addressing issues within larger GP practices with lower 14-day performance, as improvements in these areas would have a significant impact the overall ICB position.

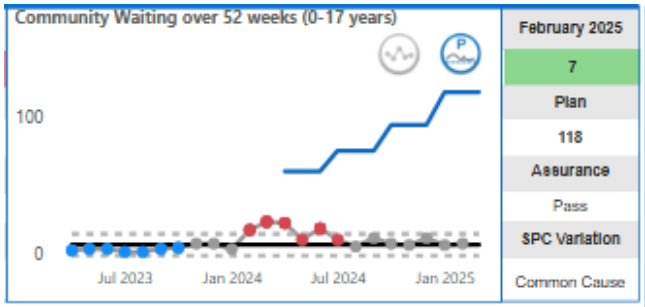
NHS App - registrations onto the NHS App have continued to increase, however the ICB remains under the target of 75% with the current position at 59% in March 2025.

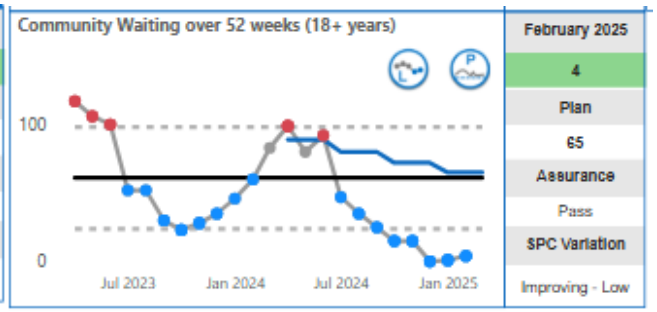
Dental - Performance for 2024/25 is improved on 2023/24 for both adults and children's provision. The number of UDAs delivered in 2024/25 (with additional March data yet to be included) were 1,513,215 compared to 1,492,988 UDAs delivered in 2023/24.There is also up to a 2-month lag in submitting claims so performance will be significantly above that seen last year, but this cannot be confirmed until final figures are received during May 2025.

7.5.2 - Community Care

Oversight Level Enhanced Oversight

NHS Nottingham and Nottinghamshire





Provider	No. 52ww in February 2025		
	Adult	CYP	Total
CityCare	0	0	0
NUH	0	0	0
NHT	4	7	11
SFH	0	0	0
Total	4	7	11

Current Position
The majority of 52ww are waiting for services at Nottinghamshire Healthcare NHS Trust. The latest published 52ww data is for February 2025, which details a static position in the total volume of 52ww to 11 patients (4 Adult, 7CYP). All patients are waiting for services delivered by NHT. NHT have confirmed that all 4 of the Adult breaches were Podiatry recording errors and have been amended.

There were 7 breaches of 52 weeks for CYP services, all of which were at NHT.

NHT Speech and Language Therapy service is routinely seeing demand that exceeds capacity. There is an average of 535 referrals per month into the service compared to capacity of 399 slots. The service has calculated that there would need to be around 10 additional therapists to meet the current demand levels. Further action is required to clear the waiting list backlog of around 900 children. Given the combined caseload of new referrals and re-referrals increases month on month, waiting times are increasing. Community waits are also now included in the SOG A weekly oversight which will ensure clarity over the waits and the progress actions which are required.

Risks
Further risks are around the demand levels for Speech and Language Therapy at NHT, which at the current level are forecasted to lead to 12 CYP 52ww by March 2026.

7.6 Provider Level Overview

7.6.1 - Provider Overview – Streamline Urgent Care and Flow

NHS Nottingham and Nottinghamshire

NUH

In-Hospital Flow

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Total NEL admissions	NUH	February 2025	7022	8395	1373	✗		
Total A&E Attendances	NUH	March 2025	19213	15958	-3255	✓		
1+ Day NEL	NUH	February 2025	4739	5060	321	✗		
0 Day NEL	NUH	February 2025	2283	3335	1052	✓		
% Bed Occupancy	NUH	March 2025	95.5%	93.6%	-1.9%	✓		

Flow out of Hospital

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
CTR activity	NUH	March 2025	236	203	-33	✓		
Length of Stay > 21 days	NUH	March 2025	320	297	-23	✓		

Pre-Hospital - Alternatives to ED

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
A&E 12 Hour Waits	NUH	March 2025	0	533	533	✗		
A&E 4hr % Performance (All types)	NUH	March 2025	78%	58.2%	-19.8%	✗		
Ambulance Total Hours Lost	NUH	March 2025	1265	1635	370	✗		
Hospital Handover Delays > 30 Minutes	NUH	March 2025	-	2244	-			
Hospital Handover Delays >60 minutes	NUH	March 2025	0	458	458	✗		

SFH

In-Hospital Flow

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Total NEL admissions	SFH	February 2025	3634	3765	131	✗		
Total A&E Attendances	SFH	March 2025	16361	18037	1676	✗		
1+ Day NEL	SFH	February 2025	2331	2460	129	✗		
0 Day NEL	SFH	February 2025	1303	1305	2	✓		
% Bed Occupancy	SFH	March 2025	94.9%	93.7%	-1.2%	✓		

Flow out of Hospital

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
CTR activity	SFH	March 2025	111	63	-48	✓		
Length of Stay > 21 days	SFH	March 2025	110	81	-29	✓		

Pre-Hospital - Alternatives to ED

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
A&E 12 Hour Waits	SFH	March 2025	0	63	63	✗		
A&E 4hr % Performance (All types)	SFH	March 2025	78%	71.7%	-6.3%	✗		
Ambulance Total Hours Lost	SFH	March 2025	0	316917	316917	✗		
Hospital Handover Delays > 30 Minutes	SFH	March 2025	0	367	367	✗		
Hospital Handover Delays >60 minutes	SFH	March 2025	0	26	26	✗		

7.6.2 - Provider Overview – Planned Care

NUH

Total Waiting list and Long Waits

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
RTT Waiting List	NUH	February 2025	73252	85399	12147	✗		
RTT Admitted Clock Stops	NUH	February 2025	3952	3292	-660	✗		
Incomplete> 52 weeks CYP	NUH	February 2025	239	184	-55	✓		
78 Week Waiters	NUH	February 2025	0	3	3	✗		
65 Week Waiters	NUH	February 2025	0	58	58	✗		
52 Week Waiters	NUH	February 2025	2340	2058	-282	✓		
% Incomplete 18 wks RTT	NUH	February 2025	-	56.8%	-			

Elective Recovery - Activity

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Elective Ordinary	NUH	February 2025	2013	1755	-258	✗		
Op Plan Diagnostic Activity	NUH	February 2025	20533	27224	6691	✓		
Op Plan Diagnostics 6 week Performance	NUH	February 2025	82%	78.3%	-3.7%	✗		
Total Day Cases	NUH	February 2025	12152	10560	-1592	✗		
Total Outpatients 1st (Spec Acute)	NUH	February 2025	20142	13020	-7122	✗		
Total Outpatients FUp (Spec Acute)	NUH	February 2025	38563	32125	-6438	✗		

Elective Recovery - Productivity & Transformation

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Total Outpatients Virtual	NUH	February 2025	25%	19%	-6%	✗		
Total Clock Stops	NUH	February 2025	19565	18209	-1356	✗		
RTT Non Admitted Clock Stops	NUH	February 2025	15613	14917	-696	✗		
RTT Admitted Clock Stops	NUH	February 2025	3952	3292	-660	✗		
PIFU	NUH	February 2025	5%	4.9%	-0.1%	✗		
Specialist Advice (per 100 OPFA)	NUH	February 2025	16	24	8	✓		
Missed Appointments %	NUH	February 2025	7%	4.7%	-2.3%	✓		
Proportion of outpatient attendances with a procedure - ERF scope	NUH	February 2025	46%	41.1%	-4.9%	✗		

SFH

Total Waiting list and Long Waits

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
RTT Waiting List	SFH	February 2025	31694	34438	2744	✗		
RTT Admitted Clock Stops	SFH	February 2025	1096	1090	-6	✗		
Incomplete> 52 weeks CYP	SFH	February 2025	0	60	60	✗		
78 Week Waiters	SFH	February 2025	0	0	0	✓		
65 Week Waiters	SFH	February 2025	0	32	32	✗		
52 Week Waiters	SFH	February 2025	95	553	458	✗		
% Incomplete 18 wks RTT	SFH	February 2025	-	63.5%	-			

Elective Recovery - Activity

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Elective Ordinary	SFH	February 2025	399	375	-24	✗		
Op Plan Diagnostic Activity	SFH	February 2025	14105	15558	1453	✓		
Op Plan Diagnostics 6 week Performance	SFH	February 2025	84.4%	94.4%	9.9%	✓		
Total Day Cases	SFH	February 2025	3806	3520	-286	✗		
Total Outpatients 1st (Spec Acute)	SFH	February 2025	10129	11225	1096	✓		
Total Outpatients FUp (Spec Acute)	SFH	February 2025	20889	22510	1621	✓		

Elective Recovery - Productivity & Transformation

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Total Outpatients Virtual	SFH	February 2025	25%	13.5%	-11.5%	✗		
Total Clock Stops	SFH	February 2025	7107	5955	-1152	✗		
RTT Non Admitted Clock Stops	SFH	February 2025	6011	4865	-1146	✗		
RTT Admitted Clock Stops	SFH	February 2025	1096	1090	-6	✗		
PIFU	SFH	January 2025	5%	5.9%	0.9%	✓		
Specialist Advice (per 100 OPFA)	SFH	February 2025	16	12	-4	✗		
Missed Appointments %	SFH	February 2025	5.2%	3.8%	-1.4%	✓		
Proportion of outpatient attendances with a procedure - ERF scope	SFH	February 2025	46%	45.4%	-0.6%	✗		

NHS Nottingham and Nottinghamshire

7.6.2 - Provider Overview – Planned Care

NUH

Diagnostic Recovery

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Op Plan Diagnostics Waiting List	NUH	February 2025	13791	18188	4397	✗		
Op Plan Diagnostics 6 week Performance	NUH	February 2025	82%	78.3%	-3.7%	✗		
Op Plan Diagnostic Backlog	NUH	February 2025	2487	3953	1466	✗		
Op Plan Diagnostic Activity	NUH	February 2025	20533	27224	6691	✓		

Cancer Recovery

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Cancer - 62 Day Backlog	NUH	February 2025	233	316	83	✗		
Cancer 1st Treatment <31 days	NUH	February 2025	95.5%	91.8%	-3.7%	✗		
Cancer 1st Treatments	NUH	February 2025	-	916	-			
Cancer 28 Day Faster Diagnosis	NUH	February 2025	77.8%	78%	0.2%	✓		
Cancer 62 Day Standard	NUH	February 2025	61.5%	62.3%	0.8%	✓		

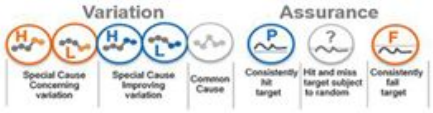
SFH

Diagnostic Recovery

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Op Plan Diagnostics Waiting List	SFH	February 2025	6909	8327	1418	✗		
Op Plan Diagnostics 6 week Performance	SFH	February 2025	84.4%	94.4%	9.9%	✓		
Op Plan Diagnostic Backlog	SFH	February 2025	1076	469	-607	✓		
Op Plan Diagnostic Activity	SFH	February 2025	14105	15558	1453	✓		

Cancer Recovery

Metric Name	Prov/ICB	Latest Period	Plan	Actual	Variance	P	V	A
Cancer 62 Day Standard	SFH	February 2025	68.3%	66.9%	-1.4%	✗		
Cancer 28 Day Faster Diagnosis	SFH	February 2025	79.9%	79.7%	-0.3%	✗		
Cancer 1st Treatments	SFH	February 2025	-	127	-			
Cancer 1st Treatment <31 days	SFH	February 2025	95%	96.1%	1.1%	✓		
Cancer - 62 Day Backlog	SFH	February 2025	55	86	31	✗		



NHS
Nottingham and Nottinghamshire

8: Finance

ICS Aim 1: To improve outcomes in population health and healthcare

ICS Aim 2: To tackle inequalities in outcomes, experience and access

- 8.1 – Month 12 Financial Position
- 8.2 – Efficiency at M12

8.1 Month 12 Financial Position (subject to external audit)

By Organisation £'m - after NR support	Plan	Actuals	Variance	In-month Plan	In- month Actuals	In month Variance
NUH	0.0	0.1	0.1	0.0	0.0	0.0
SFH	0.0	0.0	0.0	2.6	9.7	7.1
NHT	0.0	0.0	0.0	0.0	7.0	7.0
N&N ICB	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	**0.0**	**0.1**	**0.1**	**2.6**	**16.7**	**14.2**

Key Messages

- The system has a reported a (£0.1m) surplus at month 12, which is (£0.1m) favourable to plan.
- The main adverse drivers are consultant pay award pressure, shortfall on income assumptions, sub-contracted bed costs within Mental Health due to spot purchase acute and PICU beds and a shortfall of industrial action income against the industrial action impact.
- In addition, the ICB has seen pressures in continuing healthcare costs due to fast-track reviews and a continuation of GP prescribing pressures and providers seen other pressures in inflation and pay awards, urgent and emergency care demand.
- The breakeven position has been supported by a number of non-recurrent recovery actions over and above the delivery on efficiency plans and other planned spend favourable movements e.g. agency, other programme.

- The month 12 WTES are 1,451 over the March plan with substantive being 1,122 WTES over plan, bank being 413 WTES over plan and agency being 83 WTES below plan.

- The month 12 pay bill shows the actual costs are above plan at the end of March by (£28.6m) overall.
  - Substantive (and other) staff spend is over plan by £8.1m.
  - Bank staff spend is over plan by (£28.8m).
  - Agency staff spend is under plan by £8.4m.

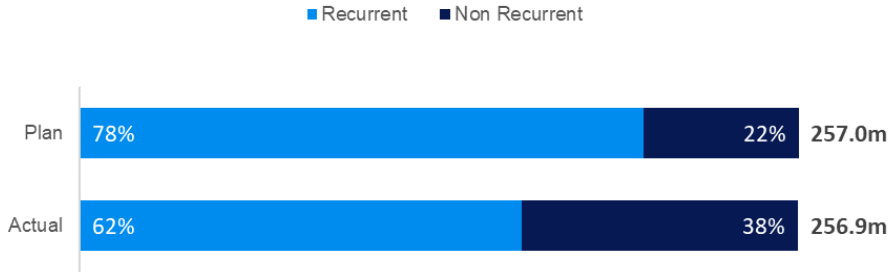
- The agency actuals at the end of March 225 is £19.4m under the agency cap & £8.4m under the plan.

- Delivery of the system's efficiency plans is £256.9m against the target of £257m with a small adverse variance of £0.16m.
- £158.1m of the efficiency delivered is recurrent & £43.4m under plan and £98.8m non-recurrent £43.2m over plan.

- At the end of March 2025, the capital envelope was £92.1m against a final capital envelope allocation of £92.2m showing a small underspend of £0.1m.

8.2 Efficiency Month 12 (subject to external audit)

- £256.9m delivered to month 12 which is £0.2m adverse to plan (month 11 £217.2m and £1.4m adverse to plan).
- £158.1m of efficiency delivered is recurrent, and £98.8m is non-recurrent.
- Outturn delivery represents just slightly under 100% of full year plan.



	RECURRENT			NON - RECURRENT			TOTAL			
CIP/Transformation Performance £'m	Rec Plan	Actuals	Rec Variance	NR plan	Actuals	NR Variance	Total Plan	Total Actuals	Total Variance	% achieved of plan
NUH	82.2	62.2	-19.9	13.5	28.9	15.4	95.7	91.2	-4.5	95%
SFH	7.3	23.8	16.5	31.1	14.7	-16.4	38.5	38.5	0.1	100%
NHT	51.5	26.8	-24.7	2.9	28.4	25.5	54.4	55.2	0.8	101%
ICB	60.5	45.2	-15.2	8.0	26.8	18.7	68.5	72.0	3.5	105%
SYSTEM TOTAL	**201.5**	**158.1**	**-43.4**	**55.6**	**98.8**	**43.2**	**257.0**	**256.9**	**-0.2**	**100%**

NHS
Nottingham and Nottinghamshire

9.0 People and Culture

ICS Aims: All 4 (Outcomes, inequalities, productivity and social and economic development)

- 9.1 – Workforce – Exception Report Provider Workforce – Operational Plan v Actual
- 9.2 – Exception Report Provider Turnover & Sickness
- 9.3 – Exception Report Provider Temporary and Agency Staffing
- 9.4 – Exception Report – General Practice – Operational Plan v Actual
- 9.5 – Social Care Employment Overview
- 9.6 – Social Care Projections
- 9.7 – Care Homes Workforce

Total ICS Provider Workforce - Actual vs Operational Plan 24/25

NUH

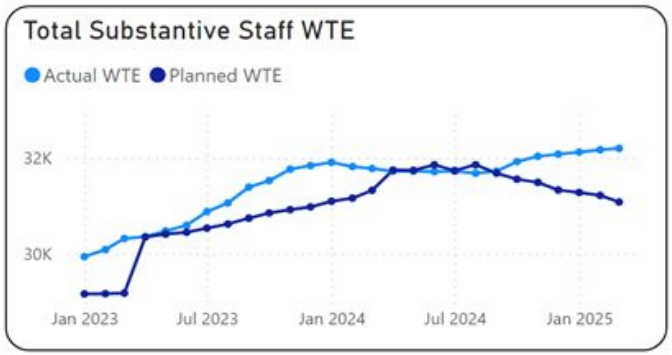
	March 2025			
	Planned WTE	Actual WTE	Variance to Plan	Variance %
Total Agency Staff	209.6	182.0	-27.7	-13.2%
Total Bank Staff	657.7	935.0	277.3	42.2%
Total Substantive Staff	17,663.7	18,302.7	639.0	3.6%
Total WTE all Staff	18,531.0	19,419.6	888.6	4.8%

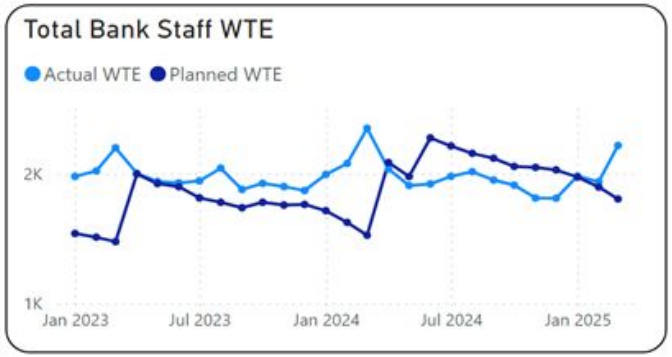
SFH

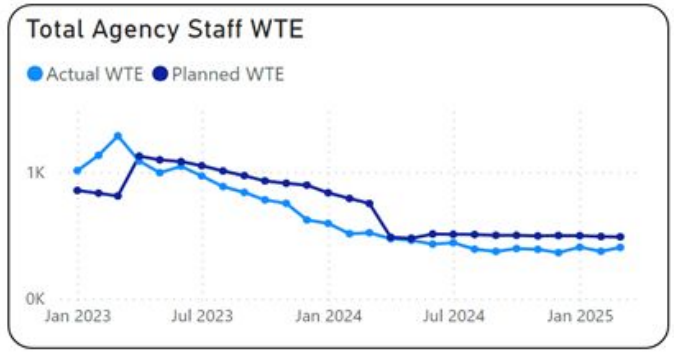
	March 2025			
	Planned WTE	Actual WTE	Variance to Plan	Variance %
Total Agency Staff	102.2	82.0	-20.2	-19.8%
Total Bank Staff	397.2	390.1	-7.1	-1.8%
Total Substantive Staff	5,324.6	5,382.2	57.6	1.1%
Total WTE all Staff	5,824.1	5,854.4	30.3	0.5%

NHCT

	March 2025			
	Planned WTE	Actual WTE	Variance to Plan	Variance %
Total Agency Staff	175.7	140.2	-35.4	-20.2%
Total Bank Staff	749.3	892.2	142.9	19.1%
Total Substantive Staff	8,088.9	8,514.0	425.1	5.3%
Total WTE all Staff	9,013.8	9,546.3	532.5	5.9%







Total Provider Current Position:

All Trusts have underperformed against their total month 12 plans being over plan by 1451.4WTE. NUH are above plan by 888.6 WTE, NHCT by 532.5WTE and SFH by 30.3WTE. All Trusts have underperformed against their substantive staffing plan by 1121.7WTE (3.6%) and overperformed against agency by 83.3WTE (17.1%). SFH have overperformed against bank staff with NUH and NHCT underperforming, as a system we are 413WTE (22.9%) above plan.

Overall, the Trusts are £13.97M adverse to their month 12 pay bill plan. NHCT under plan by £0.53M. NUH and SFH are over plan by £13.74M and £0.77M respectively All Trusts overspent on bank staff totalling £4.98M (NUH £2.88M, NHCT £1.34M, SFH £0.76M). All Trusts are underspent on agency staff totalling £0.89M (NUH £0.34M, SFH £0.04M, NHCT £0.51M)

The workforce financial efficiencies closed the year achieving a £54M saving however was £0.285M under plan delivering the largest efficiency saving. SFH overdelivered by £0.423M. NUH and NHCT underdelivered by £0.503 and £0.205M respectively. To date £46.5M workforce efficiencies have been identified for 25/26.

Workforce

Key Performance Indicators	Date	Plan	Actual	Variance	Exception Report
Total WTE Substantive Workforce	Mar-25	31,077.2	32,198.9	1121.7	Section 9
Bank Staff	Mar-25	1,804.2	2,217.2	413.0	
Agency Staff	Mar-25	487.5	404.2	-83.3	
12 Month Rolling Average Sickness Absence %	Mar-25	5.1%	5.30%	0.2%	
12 Month Rolling Average Staff Turnover %	Mar-25	10.6%	10.0%	-0.6%	
12 Month Rolling Average Staff Appraisals%	Mar-25	-	83.9%	-	
12 Month RollingAverage Mandatory Training %	Mar-25	-	87.9%	-	
Total WTE Primary Care Workforce *	Feb-25	3837	3740	-97	

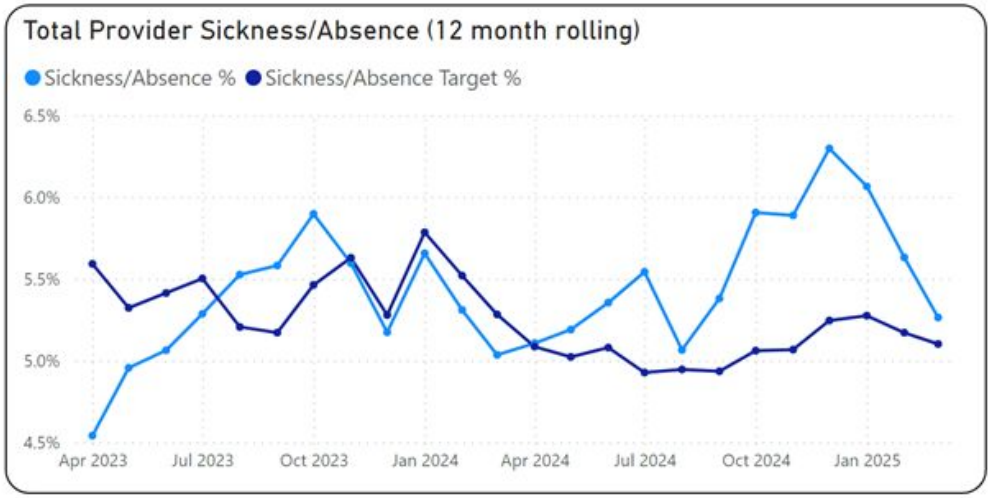
* Quarterly target figures requested in the Operational Plan Submission

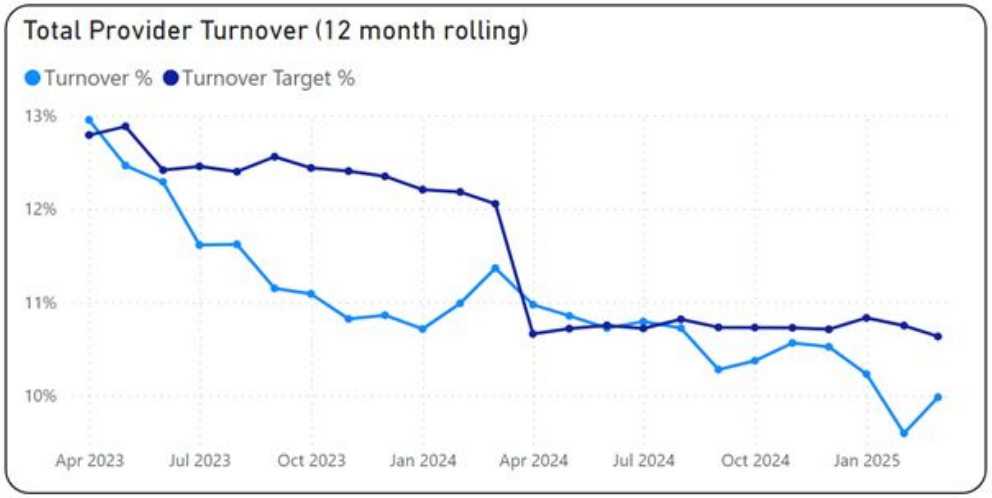
P&C Group Limited Assurance - Further Information Required:

Level of assurance is limited due to the significant variance in WTE against revised plans, the variance between WTE and pay bill, and the pay bill spend.

>3.5%
0%-3.5%
<0%

Total ICS Provider Workforce - Sickness/Absence and Turnover





Date	Sickness/Absence %	Sickness/Absence Target %
January 2025	6.1%	5.3%
February 2025	5.6%	5.2%
March 2025	5.3%	5.1%

Date	Turnover %	Turnover Target %
January 2025	10.2%	10.8%
February 2025	9.6%	10.7%
March 2025	10.0%	10.6%

Total Provider Current Position:

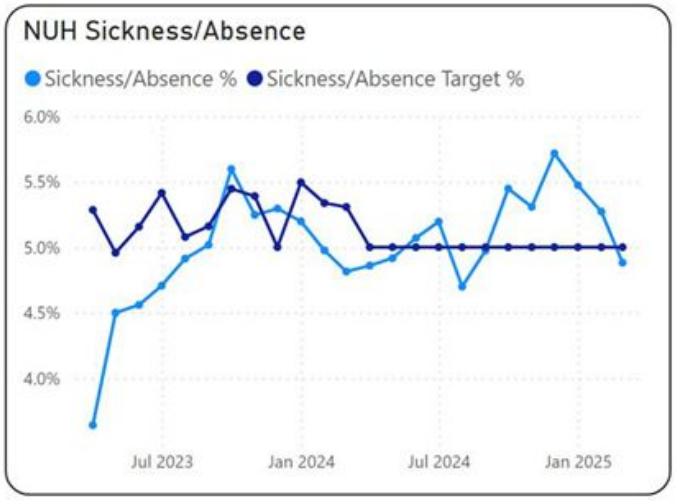
SFH and NHCT are above their sickness plan, with NUH slightly below target. Overall sickness decreased in March by 0.3% compared to month 11 and variance to plan is 0.2%. In month sickness across all staff groups reduced with Medical and Dental and Registered Qualified Scientific, Therapeutic and Technical staff remaining static. All Trusts closely monitor absence and have a number of interventions to address this including a comprehensive staff wellbeing programme which covers physical and mental health and financial wellbeing, in house Occupational Health and Staff physiotherapy.

The system is under plan for turnover this month by 0.6%. Both SFH and NUH are under their targets. NHCT has hit its turnover target for the first time with a reduction of 0.5% between months 11 and 12.

P&C Group Limited Assurance - Further Information Required:

Assurance is limited due to the above plan levels of sickness and the actions still in progress to address underperformance in organisations. Turnover is showing a continual decrease and is likely related to the reduced number of jobs available across the system due to financial efficiency programmes.

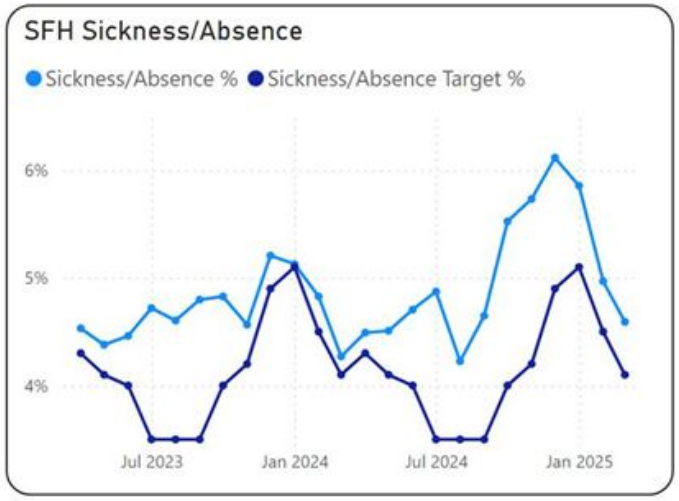
Sickness/Absence % (12 month rolling)



Sickness/Absence %	Sickness/Absence Target %
4.9%	5.0%

Provider Current Position:

NUH sickness has moved below plan in month 12. They continue to monitor this closely however, it is felt that some of the absence remains related to the reduced staffing in the organisation.



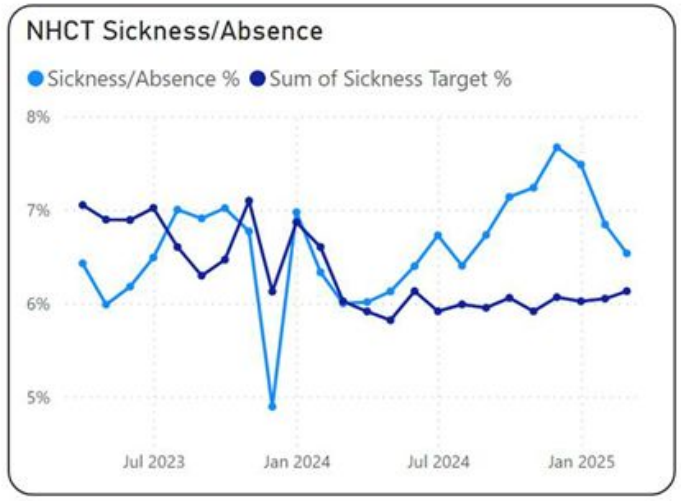
Sickness/Absence %	Sickness/Absence Target %
4.6%	4.1%

Provider Current Position:

Within the operational plan SFH vary their sickness target on a month-by-month basis. Internally the Trust work to a monthly average target of 4.2%.

Sickness has decreased from the previous month by 0.4% but remains above plan. They understand service level hot spots and continue to manage cases on an individual basis.

A deep dive into sickness has been reviewed at SFH People Committee, and an action plan has been developed for divisions that will be monitored.



Sickness/Absence %	Sickness/Absence Target %
6.5%	6.1%

Provider Current Position:

NHCT remain above sickness plan but have shown a further decrease of 0.3% compared to month 11. They believe this is being driven by the following factors;, pressure relating to Trust wide efficiency schemes; societal factors i.e cost of living.

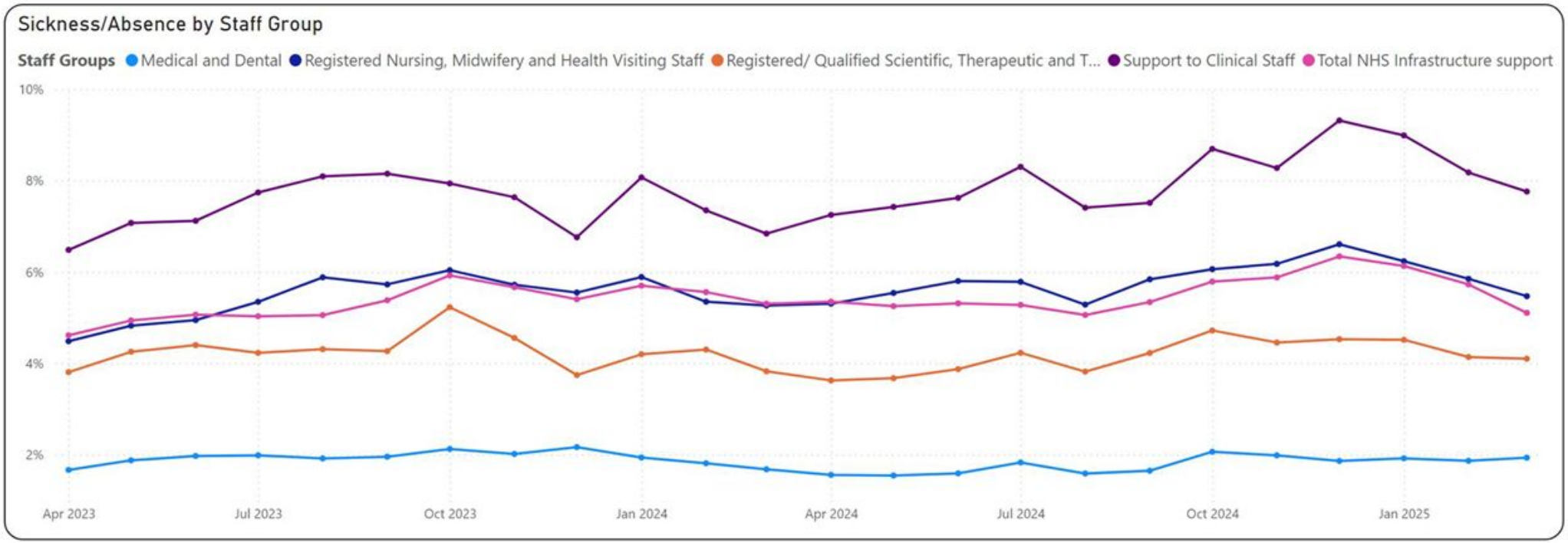
They are focusing action on short term sickness. They share a monthly sickness report and arrange deep dives in hot spots where colleagues have multiple episodes of short-term sickness or display a pattern of short-term sickness. Heads of People and Culture meet the Employee Relations team monthly to discuss more complex cases. They have refreshed the Attendance Management Policy. Where absence is particularly high within a Care Group several bespoke projects are being enacted

Staff Group Sickness/Absence % (12 month rolling)

Total Provider Current Position:

Support to Clinical staff and Registered Nursing, Midwifery and Health Visiting continue to show the highest levels of absence. Sickness across all staff groups has reduced with Registered/Qualified Scientific, Therapeutic and Technical staff and Medical and Dental remaining static.

Staff Groups	Sickness/Absence %
All Substantive Staff	5.3%
Medical and Dental	1.9%
Registered Nursing, Midwifery and Health Visiting Staff	5.5%
Registered/ Qualified Scientific, Therapeutic and Technical staff	4.1%
Support to Clinical Staff	7.8%
Total NHS Infrastructure support	5.1%



Sickness/Absence % Benchmarking

Take from NHSE data source where "NHS Nottingham and Nottinghamshire ICB" represents all NHS Organisations using ESR, therefore this collection contains data from Nottingham University Hospitals Trust, Sherwood Forest Hospitals Trust, Nottinghamshire Healthcare Trust, Nottingham CityCare Partnership CIC and Nottingham and Nottinghamshire Integrated Care Board.

12 Months Rolling Sickness Absence Rate

December 2024

	Administrative and ..	AHPs	Healthcare Scientis..	Medical and Dental	Nursing & Midwifery	Other Scientific, Th..	Support to Clinical	Total Workforce
Birmingham and Solihull	6.0%	4.5%	3.8%	1.1%	6.0%	4.4%	8.4%	5.7%
Black Country	5.2%	4.6%	3.3%	2.1%	6.1%	3.9%	7.1%	5.5%
Coventry and Warwickshire	5.4%	4.3%	4.2%	1.7%	6.0%	3.4%	8.1%	5.6%
Derby and Derbyshire	5.7%	5.7%	4.5%	2.4%	6.3%	3.9%	7.9%	6.1%
Herefordshire and Worces..	4.8%	4.0%	4.0%	2.2%	6.1%	4.2%	7.4%	5.5%
Leicester, Leicestershire a..	4.9%	3.4%	3.1%	2.2%	5.3%	3.8%	6.7%	4.9%
Lincolnshire	4.7%	4.7%	2.7%	2.4%	5.2%	4.3%	6.8%	5.1%
Northamptonshire	5.4%	3.9%	2.8%	2.5%	5.6%	4.1%	6.4%	5.2%
Nottingham and Nottingha..	5.4%	4.4%	3.4%	1.8%	5.7%	4.1%	7.7%	5.5%
Shropshire, Telford and W..	4.7%	4.2%	3.3%	2.5%	6.0%	3.9%	7.3%	5.3%
Staffordshire and Stoke-o..	5.0%	4.2%	3.8%	2.6%	5.7%	4.5%	7.0%	5.4%
Midlands	5.3%	4.5%	3.6%	2.0%	5.9%	4.1%	7.4%	5.5%

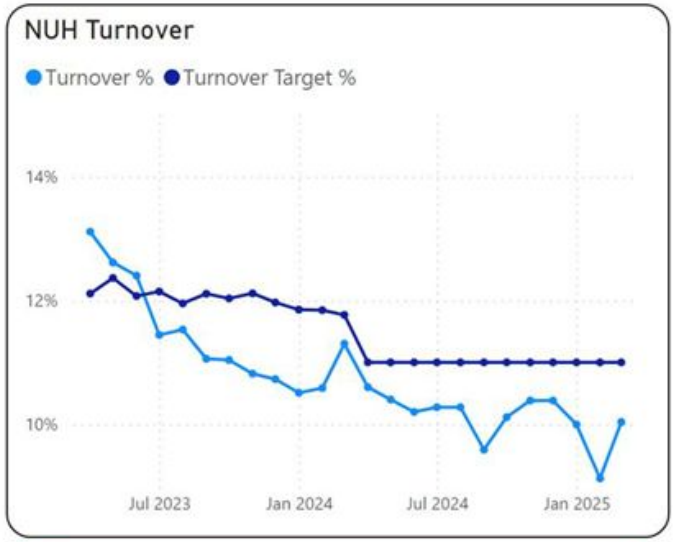
Total Provider Current Position:

The benchmarking of absence across the Midlands region demonstrates that we are not an outlier for absence when compared to other systems in the region and track on/below the Midlands average for both our plan and actuals.

When considering absence by staff group the graphs over time indicate that we have consistently performed below the benchmark in Healthcare Scientist and Nursing and Midwifery. Within Admin and Clerical staff, we are consistently above the Midlands average. For the remaining staff groups: Medical and Dental, Allied Health Professionals, Scientific, Technical and Therapeutic, and Support to Clinical Staff there has been a reducing trend over time so we now benchmark below the Midlands average in each of these areas.

At, December 24 we are in line with the Midlands benchmark, and we are below or in line with the benchmark across all staff groups except Admin and Clerical, and Support to Clinical staff where we are 0.1% and 0.3% higher. This is an increase of 0.2% for Support to Clinical Staff with Admin and Clerical remaining static.

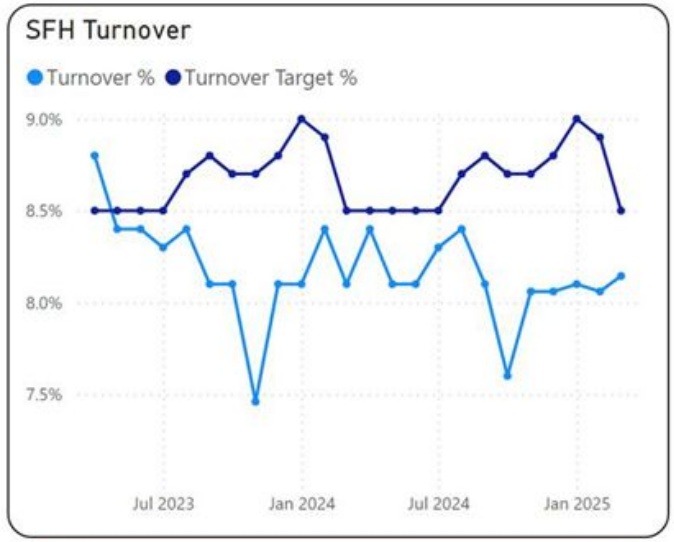
Turnover % (12 month rolling)



Turnover %	Turnover Target %
10.0%	11.0%

Provider Current Position:

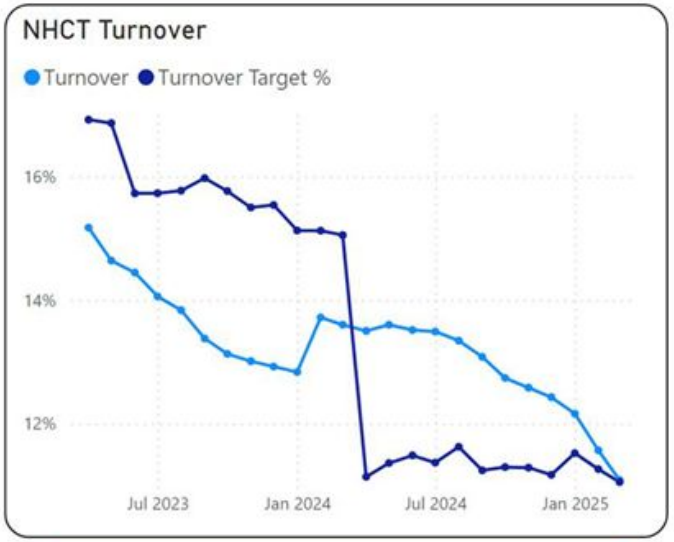
NUH turnover has remained at a consistent level for the last 12 months and remains below their target. The Trust has a retention strategy focusing on 4 main areas: strong foundations, reward and recognise staff, enable flexible working, offer training, development and wellbeing support



Turnover %	Turnover Target %
8.1%	8.5%

Provider Current Position:

SFH remains below plan. SFH became a People Promise exemplar in April 2024 and have a People Promise manager in post. They have produced an action plan and are undertaking work which is predicted to support and stabilise levels of sickness/turnover levels. The key areas of work are in the domains of; Compassionate and Inclusive, Safe and Healthy and Working Flexibly.



Turnover %	Turnover Target %
11.1%	11.1%

Provider Current Position:

NHCT turnover is reported at 11.1% hitting plan for the first time in month 12 and reducing by 0.5% compared to M11.

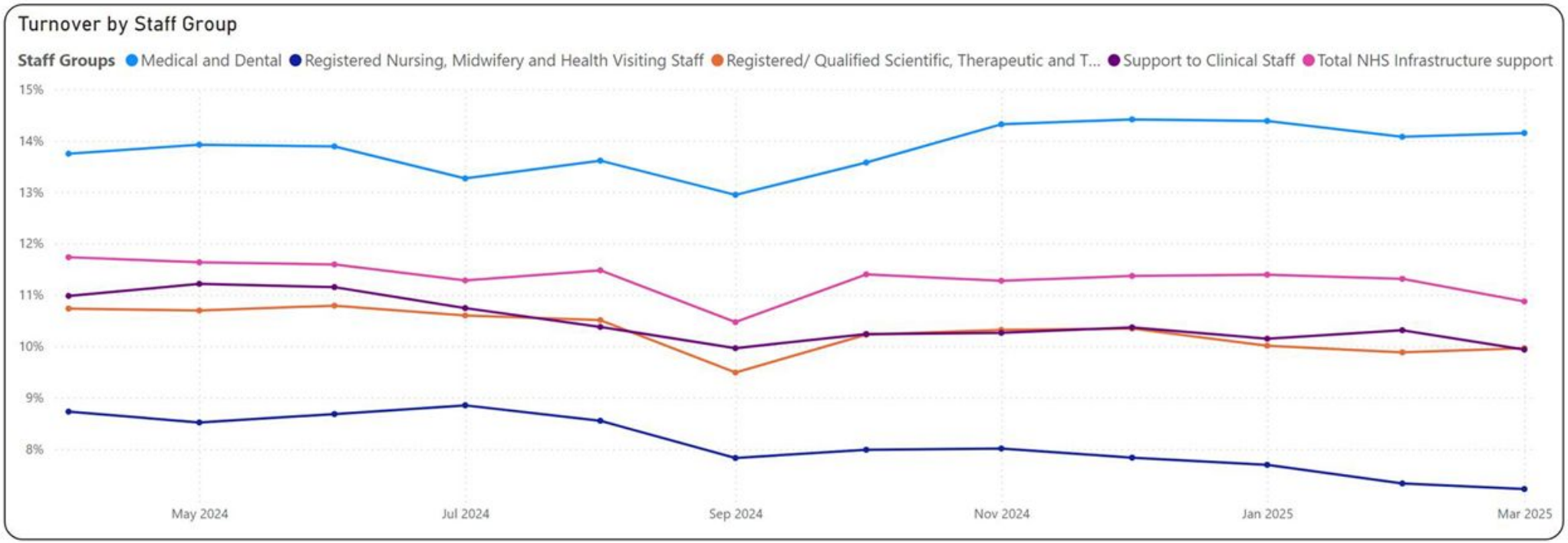
They have several actions in place to support their aspiration to be a 'great place to work'. They have an developed the exit process to improve intelligence to support retention and support focus on areas that are losing staff at a higher rate. Modelling suggests this metric will oscillate and settle within a range of 10.50% and 12.20%.

Staff Group Turnover % (12 month rolling)

Total Provider Current Position:

Overall staff turnover has increased by 0.4% compared to month 11. Last month's Medical and Dental data reporting error has been corrected creating the overall increase. In month Registered/Qualified Scientific, Therapeutic and Technical staff have increased by 0.2%, Registered Nursing, Midwifery and Health Visiting has remained static and Support to Clinical Staff and NHS Infrastructure have decreased by 0.2% and 0.3% respectively.

Staff Groups	Turnover %
All Substantive Staff	10.0%
Medical and Dental	14.1%
Registered Nursing, Midwifery and Health Visiting Staff	7.2%
Registered/ Qualified Scientific, Therapeutic and Technical staff	10.0%
Support to Clinical Staff	9.9%
Total NHS Infrastructure support	10.9%



Turnover % Benchmarking

Turnover and Leaver - 12 months rolling % rate

NHS England Midlands

Turnover/Leaver Rate: Turnover | Date: December 2024

	December 2024							
	Administrative and Clerical	AHPs	Healthcare Scientists	Medical and Dental	Nursing & Midwifery	Other Scientific, Therapeutic and Technical Staff	Support to Clinical	Total Workforce
NHS Birmingham and Solihull Integrated ..	8.9%	9.8%	7.6%	4.9%	7.2%	9.8%	11.6%	8.8%
NHS Black Country Integrated Care Board	9.8%	7.3%	7.6%	7.4%	7.8%	11.7%	9.6%	8.7%
NHS Coventry and Warwickshire Integrate..	11.7%	8.5%	9.4%	5.8%	7.8%	10.0%	12.0%	9.9%
NHS Derby and Derbyshire Integrated Car..	10.4%	7.7%	9.2%	6.0%	6.4%	10.1%	8.7%	8.3%
NHS Herefordshire and Worcestershire Int..	9.2%	9.0%	9.5%	5.2%	7.1%	9.0%	12.4%	9.1%
NHS Leicester, Leicestershire and Rutland..	9.0%	8.5%	9.3%	5.3%	5.9%	8.5%	8.9%	7.8%
NHS Lincolnshire Integrated Care Board	10.1%	8.6%	8.8%	6.2%	5.9%	5.7%	11.4%	8.8%
NHS Northamptonshire Integrated Care B..	10.2%	9.3%	10.6%	7.0%	8.1%	9.8%	9.7%	9.2%
NHS Nottingham and Nottinghamshire Int..	10.6%	8.1%	8.7%	5.1%	7.2%	9.7%	10.2%	9.0%
NHS Shropshire, Telford and Wrekin Integ..	10.1%	9.1%	9.1%	7.5%	7.0%	8.2%	10.4%	9.0%
NHS Staffordshire and Stoke-on-Trent Inte..	8.4%	7.8%	8.3%	6.2%	6.6%	8.6%	11.4%	8.6%
Midlands	8.9%	6.5%	6.9%	4.6%	5.7%	7.1%	9.4%	7.6%

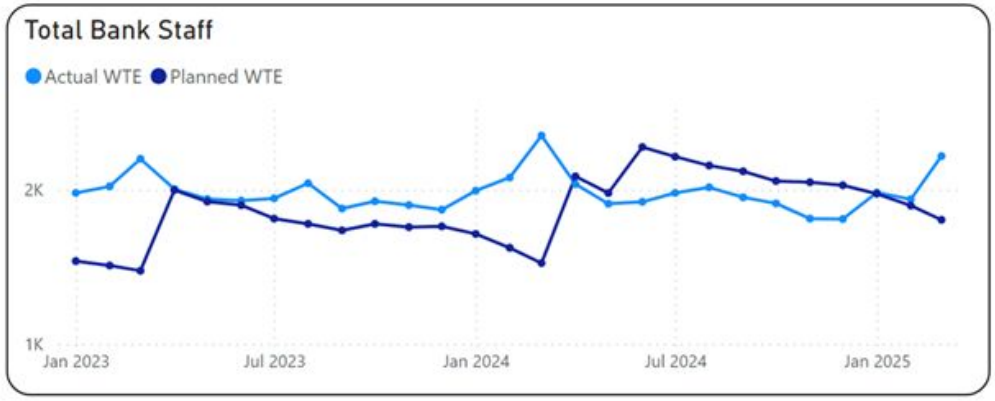
Take from NHSE data source where "NHS Nottingham and Nottinghamshire ICB" represents all NHS Organisations using ESR, therefore this collection contains data from Nottingham University Hospitals Trust, Sherwood Forest Hospitals Trust, Nottinghamshire Healthcare Trust, Nottingham CityCare Partnership CIC and Nottingham and Nottinghamshire Integrated Care Board.

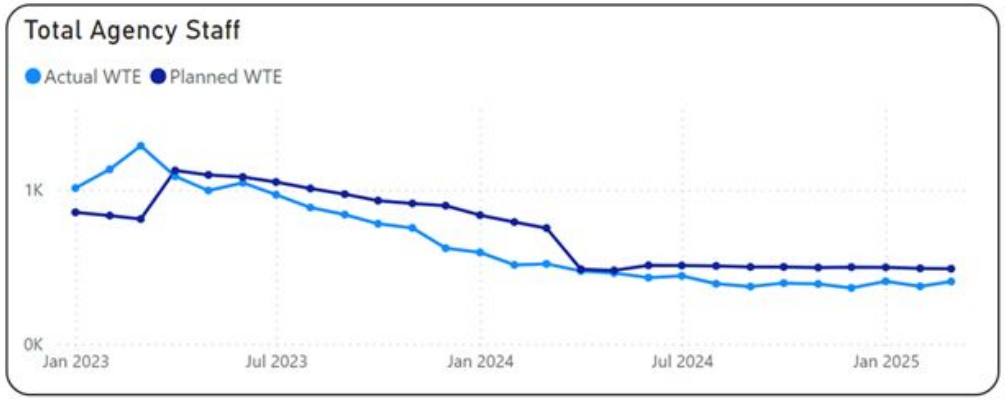
Total Provider Current Position:

Our system turnover rate shows that we benchmark higher than the Midlands average by 1.4% which is an increase of 0.2% when compared to the September data. Three systems continue to record higher turnover than us compared to 6 in September. We benchmark higher in every staff group against the Midlands average with the highest adverse variance Other Scientific, Therapeutic and Technical 2.6% and Healthcare Scientists 1.8%.

When the December benchmark data is compared to the previous September data 4 professions have seen turnover increase (Admin and Clerical 0.2%, Healthcare Scientists 0.4%, Other Scientific, Therapeutic and Technical 0.3% and Support to Clinical staff 0.3%). 3 professions have seen turnover decrease (AHP 0.1%, Medical and Dental 0.1%, Nursing and Midwifery 0.3%). Overall, the system turnover rate increased by 0.1%.

Temporary Staffing





Bank WTE vs Plan

Provider	Actual WTE	Planned WTE	Variance to Plan	Variance %
ALL	2,217.2	1,804.2	413.0	22.9%
NHCT	892.2	749.3	142.9	19.1%
NUH	935.0	657.7	277.3	42.2%
SFH	390.1	397.2	-7.1	-1.8%

Agency WTE vs Plan

Provider	Actual WTE	Planned WTE	Variance to Plan	Variance %
ALL	404.2	487.5	-83.3	-17.1%
NHCT	140.2	175.7	-35.4	-20.2%
NUH	182.0	209.6	-27.7	-13.2%
SFH	82.0	102.2	-20.2	-19.8%

Total Provider Current Position:

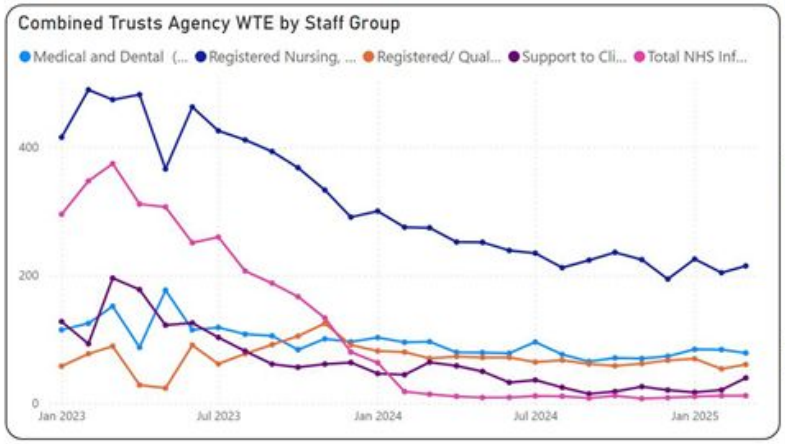
In month 12 all providers overperforming against plan for agency WTE. SFH are overperforming against plan for bank WTE with NUH and NHCT underperforming.

The total position shows them to be 431.WTE (22.9%) above plan for Bank staff and 83.3WTE (17.1%) below plan for agency staff.

Overall, the Trusts are £13.97M adverse to their month 12 pay bill plan. NHCT under plan by £0.53M. NUH and SFH are over plan by £13.74M and £0.77M respectively
NHCT have overperformed against their Agency target (£0.51M), underperformed on Bank (£1.34M) and overperformed on Substantive staff (£1.37M).
SFH have overperformed against their Agency target (£0.04M), underperformed against Bank staff (£0.76M) and underperformed on Substantive staff by (£0.05M).
NUH have overperformed against Agency (£0.34M) but underperformed against Bank (£2.88M) and Substantive staff (£11.19M).

All Trusts are again over plan for bank spend totalling £4.98M. All Trusts are underspent on agency staff totalling £0.89M.

Agency Breakdown



Total Agency WTE

Provider	November	December	January	February	March
NHCT	148.7	140.4	139.0	122.6	140.2
NUH	150.4	138.5	180.6	171.9	182.0
SFH	89.7	84.1	86.4	78.9	82.0

Off Framework Usage %

Provider	November	December	January	February	March
NHCT	0.0%	0.0%	0.1%	0.0%	0.7%
NUH	0.0%	2.4%	1.0%	0.9%	0.9%
SFH	0.0%	0.0%	0.0%	0.0%	0.0%

On Framework Above Price Cap %

Provider	November	December	January	February	March
NHCT	57.2%	55.8%	61.9%	63.1%	58.6%
NUH	64.0%	59.6%	57.2%	59.0%	62.0%
SFH	38.3%	37.7%	40.6%	40.8%	42.2%

Total Provider Current Position:

All Trusts are overperforming on their agency WTE against plan with a system overperformance of -17.1% (83.3WTE). All providers have shown a small monthly decrease in agency between Months 11 and 12.

All providers submitted a plan to remove off framework agency spend by the end of June and SFH continue to achieve this. Both NHCT and NUH have Off Framework in month 12. In NUH this remains predominately due to a requirement in Clinical Coding. These posts are on the list of nationally exempt role and NUH, despite efforts, are unable to remove this until they substantively recruit to the roles. The roles are supporting the Trust to meet income related targets, support the increase in volume of coding and therefore mitigate any potential loss of income. NHCT had a patient acuity and skill mix issue that drove the need for use of off-framework in month 12. At month 10 Nottingham and Nottinghamshire are the worst performing system in the region for off-framework usage.

NUH and SFH have an upward in month trend for the use of On Framework, over price cap (OPC) agency usage in month 12 with NHCT showing a decrease. Overall, this area of agency spend has shown no real improvement in year across the Midlands region and is predominately driven by non-compliance for Medical staffing. Trusts signed up to a regional agreement to reduce the level of agency staff that are on framework but above price cap. NHSE's ambition is to have regional price compliance for nursing by March 25 (General January 2025 and Specialised March 2025). Work on Medical compliance commenced in February with the ambition to have a rate card in place and in use by Q3. As a system Nottinghamshire is the highest in the region for OPC non-compliance. Both NHCT and NUH have high shift usage and both have a significant issue with medical staffing non-compliance.

Month 12 shows a significant decrease in agency as a percentage of pay bill from 2.04% to 1.15%. All Trusts have met the 3.2% target for agency spend as a percentage of pay bill. SFH have decreased from 3.77% to 2.07% NCHT have decreased by 1.06%, and NUH have decreased by 0.56%.

Total ICB Primary Care Workforce - Operational Plan v Actual 2023/24

Data collection at practice level shows variation due to unclear definitions on the workforce detail to be recorded. The workforce data is therefore indicative data.

Primary Care Workforce published data is always one month behind the system reporting on NHS Trust delivery of the WTE plan. ARRS reporting uses local intelligence through the claims portal.

Primary Care

Nottingham And Nottinghamshire Health And Care STP	Plan Q1 As at the end of Jun-24	Plan Q2 As at the end of Sep-24	Plan Q3 As at the end of Dec-24	Actual Q4 As of the end of Feb-24	Plan Q4 As at the end of Mar-25	Variance to Plan
Workforce (WTE)	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	WTE
Total Workforce	**3776**	**3807**	**3820**	**3740**	**3837**	**-97**
GPs (excluding GPs in Training Grade and ARRS funded roles)	591	590	591	583	588	**-5**
GPs in Training Grade	253	279	283	267	277	**-10**
Nurses (excluding ARRS funded roles)	368	372	374	340	378	**-38**
Direct Patient Care roles (ARRS funded)	651	652	652	665*	668	**-3**
Direct Patient Care roles (not ARRS funded)	290	290	290	277	291	**-14**
Other – admin and non-clinical	1622	1625	1631	1608	1635	**-27**

Total Provider Current Position:

Month 11/Month 2 of Quarter 4 has shown a small decease in vacancies from 104WTE to 97WTE compared to the previous month. All roles are under plan. The area showing the largest WTE reduction in month is GP's in training (6WTE). The Direct Patient Care Roles (ARRS funded) has an increase of 11WTE. Direct Patient Care roles are under established by 17 WTE a decrease of 16WTE compared to the previous month.

○-ARRS Retention remains a focus with NATH supporting through ambassador roles, multi-professional Support Unit added to the retention programme for GP, GPNs and non-clinical workforce, which includes wellbeing across all staff groups. There is some uneasiness amongst the ARRS roles concerning the continuation of PCN contract and if their role will continue beyond 2025. The Ambassadors are supporting the roles and communication flows are via the Ambassador lead updates. It has been confirmed that the GP ARRS role will continue into 25/26,however, the funding is yet to be confirmed. Several PCNs are forecasting overspends on their ARRS budget and are having to take corrective action. The ICB are working with PCN's to manage this.

○- GP Training numbers are below plan this month, 70% are International Medical Graduates. Limited opportunity for substantive employment exist at present given uncertainties on funding within general practice. Phoenix Programme is supporting practices with sponsorship and supporting in transition from trainee into qualified and new to practice schemes. The PCN ARRS role as it continues into 25/26 will continue to support CCTs, of which will be subject to confirmation of funding within the PCNs. The ICB is working with the PCNs who have yet to appoint to the GP ARRS role to support here necessary. Phoenix is hoping to continue to support this new ARRS role with mentorship and development support as the new GPs transition into this role subject to SDF funding continuing. The initial challenge for this new ARRs role is how the PCN will support the International Medical Graduates as a PCN cannot legally apply for sponsorship, therefore a lead practice will need to become the sponsor which will impact on the timeframes of the recruitment process. Phoenix team are supporting this process.

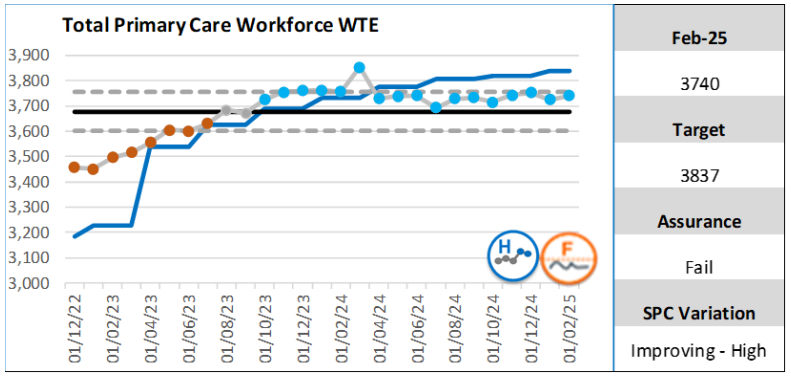
○- GPN/Nursing maintains stability this month with mid-career/improvement fellowships in progress. GPN leads in post for each place working collaboratively supporting development of transformation/pathway development and utilisation of nursing skills. The GPN Leads have developed a workforce plan that will continue to support the retention of GPNs. The development and ongoing support for GPN through CPD is managed by NATH and is reliant on SDF continuing.

○- Non-Clinical career framework established with first cohort of Practice Manager fellows and projects underway. Care navigation is also a priority. They continue to promote the virtual learning National Care Navigation offer. In previous years NATH have provided a local offer to continue to support general practice and have developed a local programme.

○Recent announcements and uncertainty within General practice, linked to funding and discontent, requires a watching brief on the impact on existing workforce and specifically trainees newly qualified is needed to be assured no negative impact seen on the current and expected workforce within the plan.

Workforce finance is a concern due to the ARRS budget issues and the increase of NI contributions which were announced as part of the Budget. An update was shared on TeamNet with the current position and the ICB have raised these concerns with national NHS leaders and are waiting for further details from NHS England about the potential mitigations for GPs and care providers. This will represent a significant amount of money at practice level and there is a risk that this may impact on staffing numbers depending on the outcome. The Pharmacy Faculty Lead post becomes vacant at the end of March 2025 and a bid has been submitted to extend funding. If this post is not filled this will have a negative impact on the ability to maintain and develop initiatives to support the retention, recruitment and development of the pharmacy workforce across Nottinghamshire

Work has been completed on operational planning for 25/26. Data produced by NHSE has been used to establish a baseline, with further work undertaken to refine this. The locally held ARRS workforce information has been validated with PCN's to ensure accuracy. Overall, the plan submission for 25/26 has remained static. The planning guidance states that SDF funding will be incorporated into baseline budgets and not ringfenced this is a concern as the funds are used to support many of the programmes of work with Phoenix Programme and Nottinghamshire Alliance Training Hub.



Feb-25
3740
Target
3837
Assurance
Fail
SPC Variation
Improving - High

P&C Group Limited Assurance - Further Information Required:

More work is needed to understand the staff experience and the movements generated through turnover as well as the loss of availability through sickness. Without these measures we can only provide an indicative position and therefore a limited assurance level.

Uncertainty within General practice, linked to funding and discontent, with potential industrial action expected adding to the limited recruitment opportunities requires a watching brief on the impact on existing workforce and specifically trainees newly qualified is needed to be assured no negative impact seen on the current and expected workforce within the plan.

Concerns regarding the finances for the ARRS budget and the increased NI contributions with both potentially impacting on staffing numbers.

Nottingham and Nottinghamshire Social Care

NHS Nottingham and Nottinghamshire

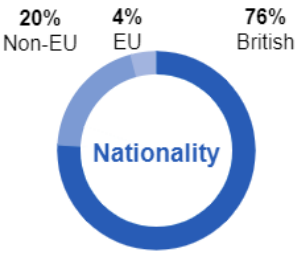
Across Local Authority, Independent sector and Direct Payment Recipients

44,000
Total posts

40,000
Filled posts

4,600
Vacant posts

Local Authority and Independent sector only:



11.5%
vacancy rate in 2023/24

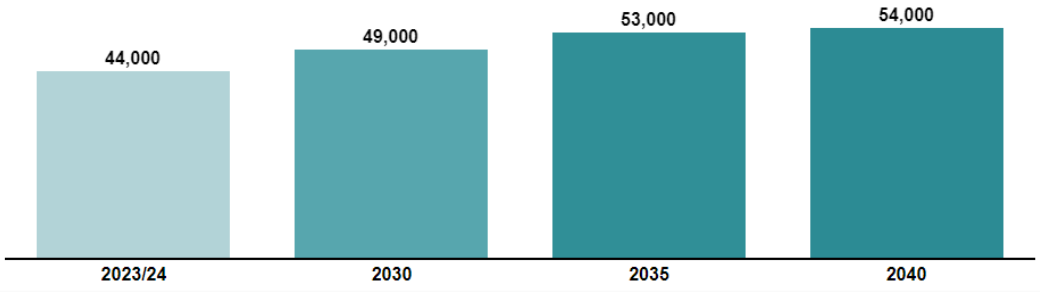
28.0%
turnover rate in 2023/24

Average hourly pay for care workers

Local authority
£11.92

Independent sector
£11.05

Projected number of total posts in adult social care required by 2040



53%
of **recruitment** is from **within adult social care**

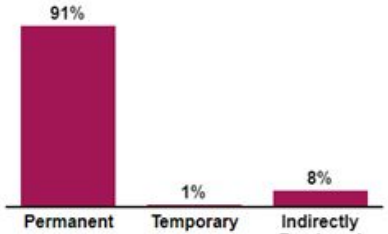
6.1
average **sickness days** taken in 2023/24

Employment overview

Full-time equivalent (FTE) filled posts

The **FTE filled posts ratio** in **Nottingham and Nottinghamshire** is **0.76**

Employment status

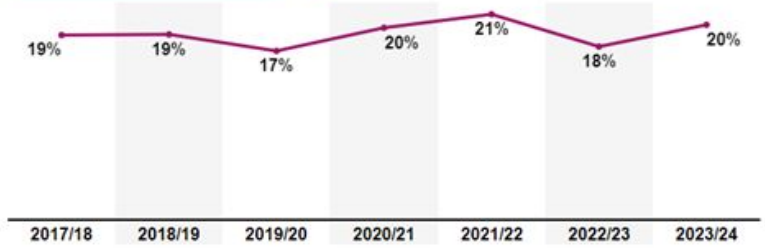


In 2023/24

20%

of filled posts were employed on a **zero-hours contract** (or 7,100 **filled posts**)

Zero-hours contract trend



Demographics

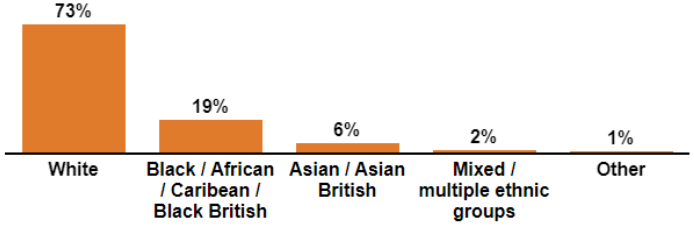
Gender

'Other' gender is collected but not yet included in analysis. See the glossary for more information.

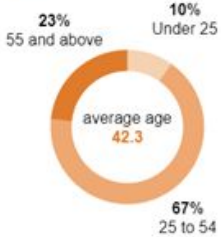
80% of the workforce were **female**

20% of the workforce were **male**

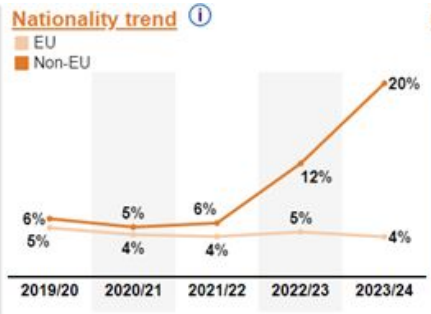
Ethnicity



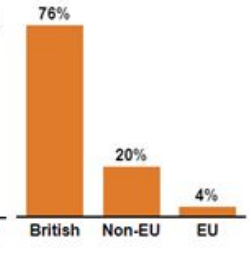
Age



Nationality trend



Nationality (2023/24)



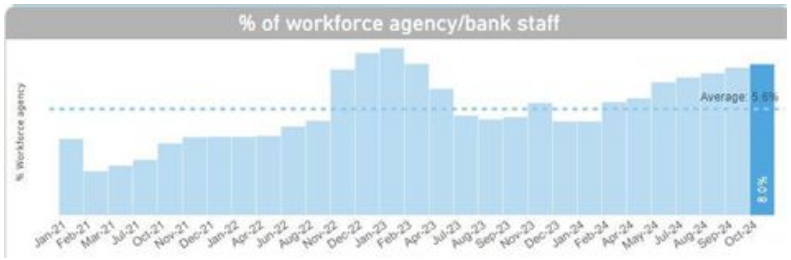
NHS
Nottingham and Nottinghamshire

Care Homes Workforce

Workforce absence and agency staff

Monthly staff trend: All staff

Aligned PBP	Employed	Absence	%	Agency	%
Bassetlaw	1,802	30	1.7%	91	4.8%
Mid Notts	4,377	111	2.5%	425	8.9%
Nottm City	2,699	29	1.1%	199	6.9%
South Notts	4,436	115	2.6%	440	9.0%
Total	**13,314**	**285**	**2.1%**	**1155**	**8.0%**



Taken from the Care Homes and Home Care System Insight Report
Data source: National Capacity Tracker

Care Home workforce absence is a currently 2.1%. Absence of CH workforce has remained around 2% since Feb 2024. Currently, nursing staff have the lowest reporting with 11 out of 619 (1.8%) staff absences. Non-Care workers have the largest absences 68 out of 2,839 (2.4%).

The Agency/Bank staff percentage of staff continues to increase each month. This data, from the National Capacity Tracker, currently reports Agency and Bank staff rates combined. Going forward it would be good to report each of these staff groups separately. This has been suggested to the National team, but no changes have been made to date.

SAIU
SYSTEM ANALYTICS INTELLIGENCE UNIT

NHS
Nottingham and Nottinghamshire

10.0 Health Inequalities

10.1 Core20Plus5 Metrics

10.2 Neighbourhood Overview

10.3 – 10.6 Spotlight on Cancer and Health Inequalities

Health Inequalities Metrics

- Table 10.1 presents the KPIs in relation to the Core20Plus5 Approach for adults across as set by NHSE.
- Table 10.2 highlights the stark differences across neighbourhoods and the population profile is supported by the Nottingham and Nottinghamshire Joint Strategic Needs Assessment (JSNA) and supporting dashboard.
- 10.3 Provides a spotlight on premature mortality from cancer
- 10.4 Provides an overview of early cancer diagnosis by cancer site.
- 10.5 Provides an overview of the disparities in early diagnosis.
- 10.6 Provides an overview of uptake of screening programmes which support earlier cancer diagnosis.

10.1 Core20Plus5 Adults: Indicators Refresh 2025-26

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Maternity: Percentage of Pre-term births	Feb 25	7%	0%			8%	6%	9%
SMI: Annual health checks for 60% of those living with SMI	Feb 25	5675	7029	F		5700	5567	5833
Respiratory: Uptake of Covid and Flu Vaccine in people with COPD	Feb 25	69%	0%			71%	63%	78%
Respiratory: Reduction of emergency admissions in people with COPD	Feb 25	5%	0%			5%	5%	5%
Cancer: Percentage of cancers diagnosed at stage 1 or 2	Feb 25	61%	0%			61%	61%	61%
Hypertension: Percentage of all people with hypertension with BP in age appropriate thresholds	Feb 25	66%	0%			68%	60%	76%
Hypertension: Optimal treatment of high risk CVD (QRISK > 20% currently on statins)	Feb 25	76%	0%			75%	70%	80%

Refreshed metrics for 2025;

1. Change to maternity indicator to reflect focus on preterm births.
2. Hypertension optimal management metrics included and removed diagnosis.

10.2 Preventing Ill Health and Reducing Health Inequalities – Neighbourhood Overview (December 2024)

Period: 202412

The stark differences between our PCN / neighbourhoods

PCN Neighbourhood	No of patients	Deprivation: IMD Quintile	Risk Factors: age-adjusted prevalence per 1,000 people: Obesity	Current Smoker	Hyper-tension	Long Term Conditions: age-adjusted prevalence per 1,000 people: Diabetes Type 2	COPD	Heart Failure	Stroke	CHD	Cancers	Serious Mental Illness	Severe Frailty	Age-adjusted rates per 100,000 people: Emergency Admissions (1+ bed days length of stay)	Avoidable deaths	Life expectancy in Years: Life expec. at birth (M)	Life expec. at birth (F)
Raleigh	29,137	1	224.0	181.3	200.0	85.1	33.5	19.0	18.2	39.9	42.7	12.9	14.7	7,784	342.1	79.2	81.0
Radford & Mary Potter	37,520	1	190.0	184.9	198.7	114.0	24.1	14.4	17.5	45.2	35.8	14.4	23.2	7,650	353.0	76.5	82.7
Aspire	39,606	1	224.5	174.8	180.2	83.4	33.6	15.9	16.7	37.2	40.9	9.0	11.8	7,826	328.9	78.0	81.3
Bulwell & Top Valley	47,407	1	242.8	195.5	181.1	71.3	33.5	15.1	17.0	35.0	45.3	10.0	7.2	7,915	331.5	78.6	80.9
Nottingham City East	68,629	1	188.1	180.7	163.7	73.5	28.7	13.7	16.8	34.4	41.7	13.6	13.4	7,318	385.9	75.5	81.7
Newgate Medical Group	30,235	2	236.2	161.5	145.3	67.0	31.0	14.1	12.6	29.4	42.2	7.9	10.0	6,092	296.5	78.6	83.7
Clifton & Meadows	35,048	2	228.7	180.0	188.0	77.4	33.6	14.3	18.8	37.5	41.4	9.7	8.0	7,348	326.5	78.5	80.1
Ashfield North	51,838	2	263.7	158.8	174.4	69.6	25.8	17.8	14.8	36.4	48.9	7.5	8.5	7,783	320.2	77.1	82.2
Rosewood	52,135	2	224.6	173.8	156.2	65.3	28.1	12.4	14.1	36.1	44.0	7.7	8.4	7,546	290.6	79.1	82.8
Bestwood & Sherwood	55,725	2	199.2	151.8	157.1	65.1	22.0	12.9	16.2	32.6	43.8	10.1	8.9	6,200	295.3	78.1	82.9
Mansfield North	59,541	2	240.8	148.0	176.7	67.5	26.1	13.7	13.6	35.8	44.3	5.8	9.5	7,579	300.5	79.3	82.0
Larwood & Bawtry	38,355	3	234.7	128.7	174.3	67.7	30.9	19.9	15.0	33.3	47.5	7.4	11.9	6,207	245.6	79.2	82.9
Byron	39,347	3	234.7	137.4	162.4	61.8	24.3	12.2	14.6	32.9	48.2	6.1	18.3	7,611	284.5	77.9	80.5
City South	39,895	3	165.9	105.3	153.1	57.3	16.9	8.8	12.6	33.0	44.2	7.1	7.2	6,179	211.6	82.2	84.0
Ashfield South	41,038	3	261.6	150.2	156.9	67.5	26.8	11.4	14.7	34.2	46.1	6.7	6.5	7,756	308.3	77.4	80.4
Retford And Villages	59,176	3	237.9	128.2	155.3	58.1	22.9	11.8	12.2	28.1	45.7	5.9	9.1	5,487	227.4	79.8	84.4
Sherwood	64,114	3	238.1	136.4	172.9	64.4	24.3	13.6	13.7	35.6	47.2	5.9	9.4	6,974	229.4	79.7	81.5
Stapleford	22,315	4	230.8	131.3	167.6	58.8	21.9	9.0	12.5	28.9	45.1	6.1	5.2	6,133	219.8	81.0	86.1
Arnold & Calverton	34,303	4	208.2	120.5	146.4	49.3	18.3	8.7	15.7	29.1	47.8	6.8	8.0	5,829	204.4	79.6	84.2
Synergy Health	36,110	4	218.4	143.7	155.1	53.8	18.1	11.7	15.3	30.2	47.9	9.4	20.2	6,396	264.2	80.5	83.1
Eastwood/Kimberley	38,086	4	227.6	118.9	156.7	56.9	20.5	14.7	14.3	32.5	48.3	5.8	7.2	6,299	232.5	80.4	85.4
Newark	79,645	4	200.2	133.3	150.3	51.0	15.4	11.3	12.3	29.7	49.8	5.5	7.1	5,678	236.7	80.5	84.3
Arrow Health	40,161	5	187.5	115.1	148.7	45.5	15.4	9.8	13.0	28.0	47.1	6.6	5.8	5,857	204.3	81.6	85.0
Rushcliffe North	42,913	5	182.9	94.5	140.6	39.5	15.0	9.0	12.3	27.4	47.5	4.1	5.6	4,978	159.2	81.3	84.2
Rushcliffe South	44,505	5	177.1	85.1	139.4	39.4	11.4	9.2	12.5	25.5	47.0	4.3	4.3	4,776	165.9	83.7	84.8
Beeston	50,286	5	182.5	105.8	152.7	51.6	16.8	11.0	14.0	28.1	47.8	7.2	11.0	5,482	221.9	79.9	82.8
Rushcliffe Central	53,346	5	137.7	64.6	138.7	42.0	10.7	9.6	12.4	26.1	48.1	5.6	5.6	4,879	182.6	79.6	86.3
Unity (Nottm)	46,768	4	114.5	64.8	152.8	40.1	10.4	9.2	8.7	20.9	44.5	3.9		3,027	118.8		86.1

Bassetlaw Place
Nottingham City Place
South Nottinghamshire Place
Mid Nottinghamshire Place

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

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

COPD = Chronic obstructive pulmonary disease
CHD = Congestive heart disease

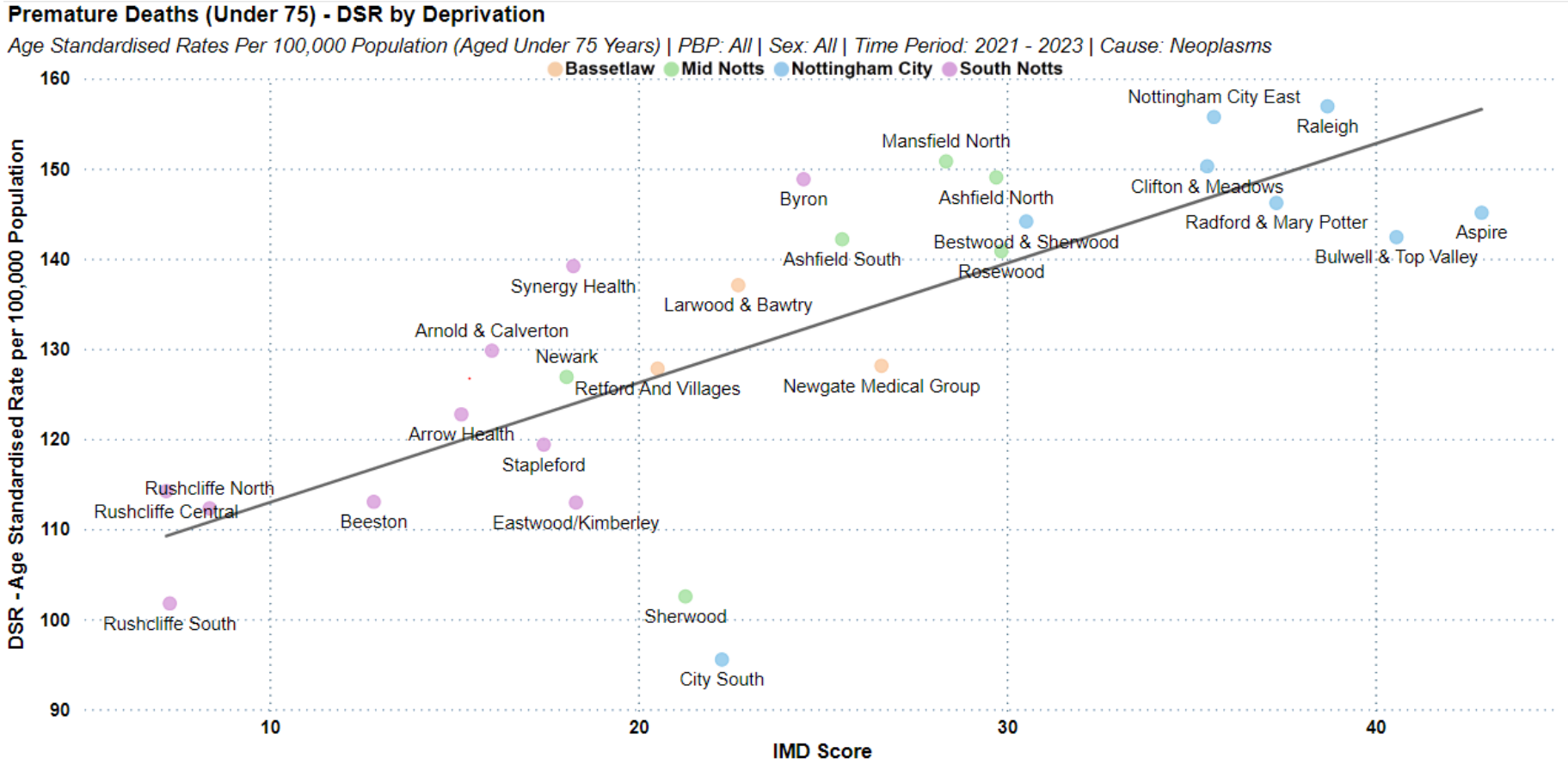
Most deprived PCN neighbourhood
Least deprived PCN neighbourhood
Low | High
*Opposite is true for Life Expectancy

Cancer
The table shows that prevalence of cancer appears lower in areas of high deprivation and high in areas of least deprivation. It is likely this trend is linked to earlier diagnosis and longer life expectancy in more affluent areas.

Over the last 12months, cancer levels in individual PCNs have fluctuated, with some seeing increases and others decreases. Incrceases could be linked to increases in case finding/screening.

10.3 Spotlight on Cancer: Premature Mortality from Cancer

Cancer is one of the leading causes of the inequality in life expectancy across Nottingham and Nottinghamshire, contributing between 18-21% of the life expectancy gap between the most and least deprived areas. The chart below shows the correlation between premature mortality from cancer and deprivation. PCNNs with higher deprivation scores also have higher premature mortality from cancer.

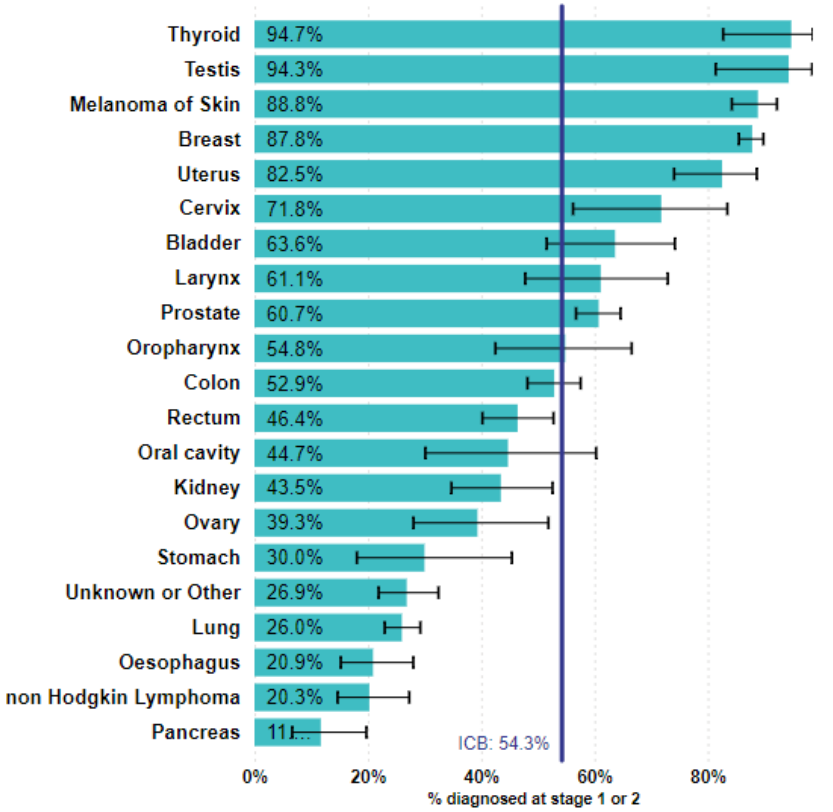


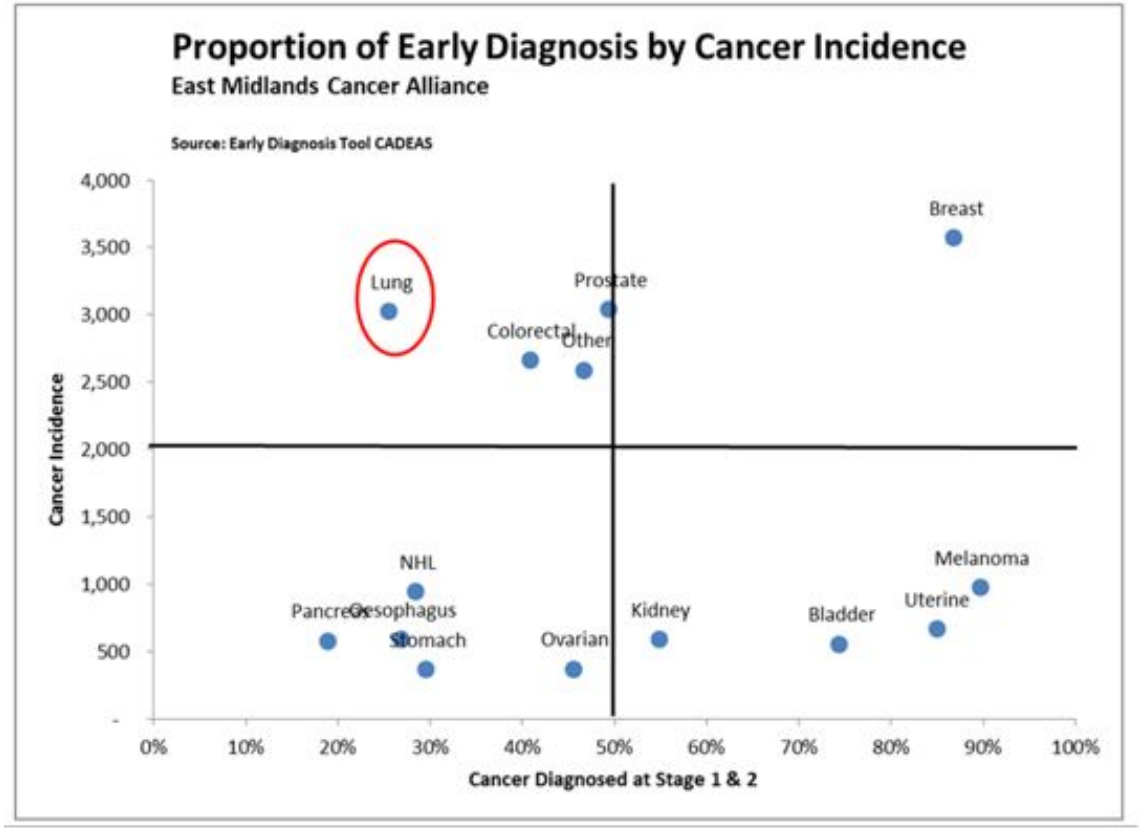
10.4 Spotlight on Cancer: Early Cancer Diagnosis by site

The cancer sites with the most diagnoses are breast, lung, prostate, and colon. In 2021, almost nine in ten breast cancers, 6 in 10 prostate cancers, and around half of colon cancers were diagnosed in the early stage. Only 26% of lung cancers were diagnosed early. This reinforces the need for programmes such as The Lung Health Check Programme, targeting ex and current smokers to detect signs of Lung Cancer earlier.

Percentage of cancers diagnosed at stage 1 or 2

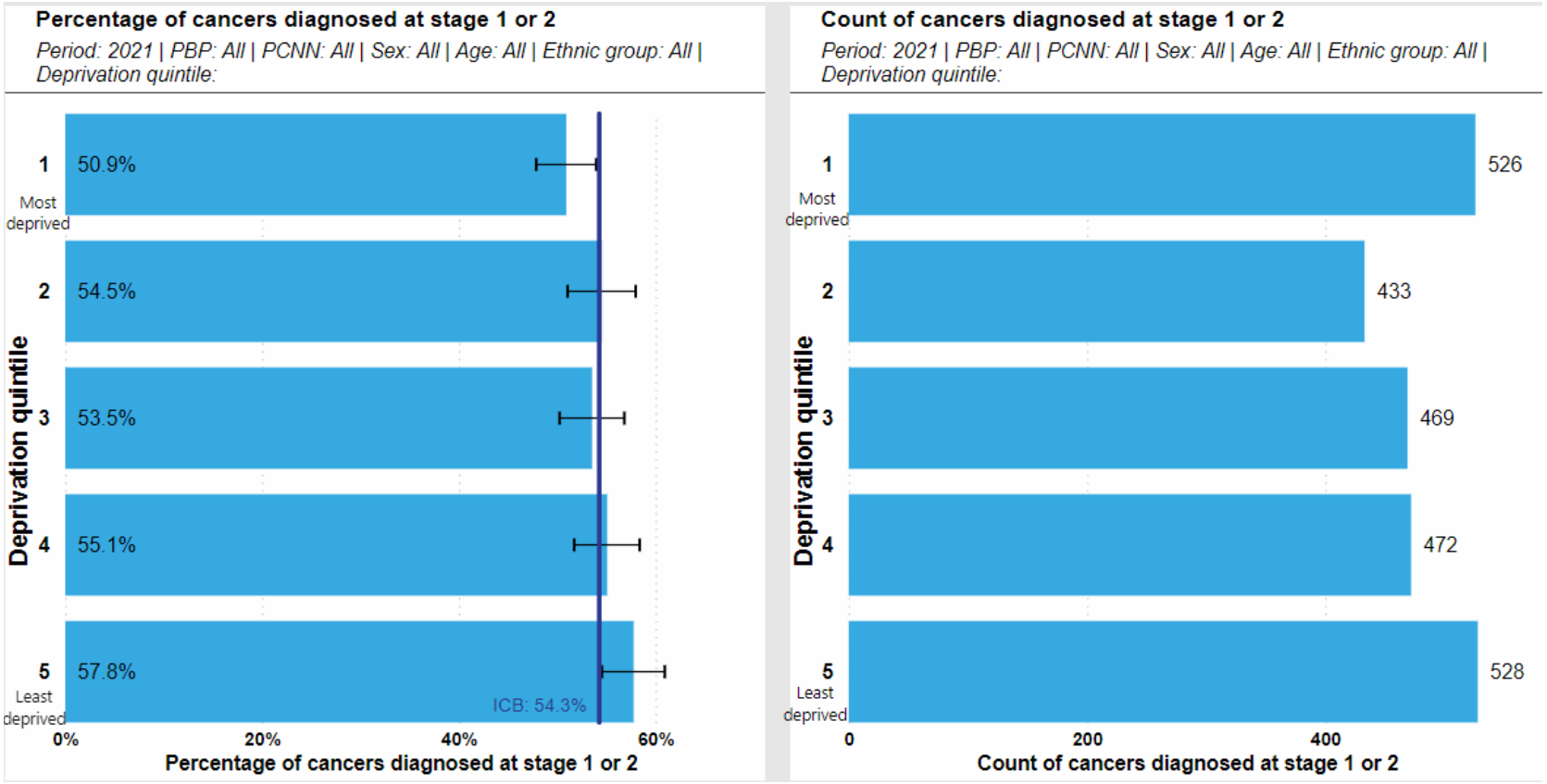
Period: 2021 | PBP: All | PCNN: All | Sex: All | Age: All | Ethnic group: All | Deprivation quintile: All | Cancer Site: All



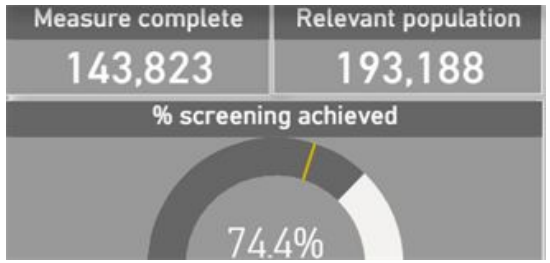


10.5 Spotlight on Cancer: Early Cancer Diagnosis by deprivation

The chart below shows the percentage of cancers diagnosed at stage 1 or 2 by deprivation. People in the most deprived areas are the least likely to have a diagnosis at stage 1 or 2. There is a 7 percentage point difference between diagnosis rates between the most and least deprived areas.
There are no statistically significant differences in early diagnosis rates between ethnic groups.

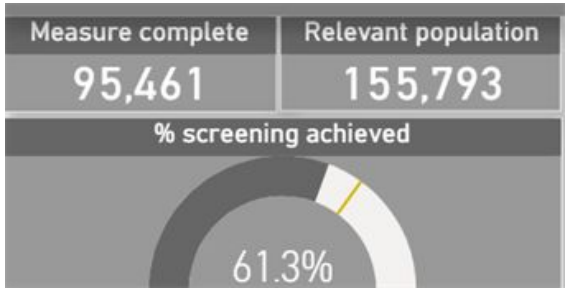


10.6 Spotlight on Cancer: Screening to support earlier cancer diagnosis



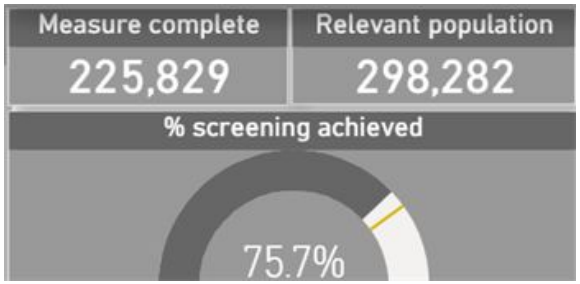
Bowel Screening:

ICS rate currently **above** national ambition of 60%.
Uptake is significantly lower in the most deprived populations, uptake is 15% lower when compared to the least deprived populations.
Uptake is lower in Asian, Black and “Other” ethnic groups.
Uptake is only 55% (lower than national ambition) in those with an ethnicity not recorded.



Breast Screening:

ICS rate currently **below** national ambition of 70%.
Uptake is significantly lower in the most deprived populations, uptake is 9% lower compared to the least deprived populations.
Uptake is lower in Mixed, Asian, Black and “Other” ethnic groups.
Uptake is only 47% in those with an ethnicity not recorded.



Cervical Screening:

ICS rate currently **below** national ambition of 80%.
Uptake is significantly lower in the most deprived populations, uptake is 9% lower compared to the least deprived populations.
Uptake is lower in Mixed, Asian, Black and “Other” ethnic groups.
Uptake is 62.5% (lower than national ambition) in those with an ethnicity not recorded.

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11.0 NHS Oversight Framework

ICS Aim 2: Tackle inequalities in outcomes, experience and access

11.1 – ICB Summary Highest and Lowest Quartile Performance Areas

Nottingham & Nottinghamshire ICB population – NOF Overview @ 13th March 2025

NHS Nottingham and Nottinghamshire

Quality of care, access and outcomes

(33 out of 38 metrics populated @13.03.2025)

Lower Quartile Areas:

- A&E - % patients managed within 4 hours (ICB) *Jan 25*
- Diag activity wait times - % patients not seen within 6 wks (DM01 - Only MRI, CT, NOU, Echo, Colon, FlexiSig, Gastro) (ICB, NNICB & BICB) *Sep 24*
- Inappropriate adult acute MH OOA bed days (ICB & NNICB) *Mar 24*
- GP apps - % regular appointments within 14 days (ICB & NNICB) *Dec 24*
- Population vaccination coverage: MMR for two doses (5 year olds) *Q2 2024-25*

Higher Quartile Areas:

- Elective Activity - value weighted elective activity growth vs. target (ICB) *Nov 24*
- Number of CYP accessing MH services - % of pop (ICB) *Mar 24*
- Dementia diagnosis rate (ICB & BICB) *May 24*
- % of 2hr UCR refs where care was provided within 2hrs (ICB) *Nov 24*
- MRSA bacteraemia infection rate (ICB) *Mar 24*
- Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care (ICB & BICB) *Jul 24*

Preventing ill-health and reducing inequalities

(7 out of 7 metrics populated @ 13.03.2025)

Lower Quartile Areas:
No indicators

Higher Quartile Areas:
No indicators

People

(14 out of 14 metrics populated @ 13.03.2025)

Lower Quartile Areas:

- Sickness absence rate (ICB) – *Sep 24*

Higher Quartile Areas:

- Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers (ICB) *2023*
- Leaver rate (ICB) *Dec 24*

Finance and Use of Resources

(0 out of 4 metrics populated @ 13.03.2025)

Finance Metrics Identified in NOF:

- MHIS – **Achieved**
- Finance Efficiency – **under plan**
- Financial Sustainability – **under plan**
- Agency Cap – **over plan**

Leadership & Capability

(0 out of 0 metric populated @ 13.03.2025)

There are no ICB Leadership & Capability metrics in the 2024/25 NHSOF

Local Strategic Priorities

(No specific metrics)

- ICB – Finance and LD&A
- NUH - Finance
- NHT – CQC, Well led, Staffing, Governance
- Financial Sustainability – Recovery
- Elective Recovery – activity v ERF Plan

60 of the metrics have been populated as at 13th March 2025.

Please note – absolute volumes are used for certain metrics including 52ww, waiting lists, IPC measures – the rankings are therefore skewed to poor performance for larger organisations such as NNCCG and NUH – this is smoothed when looking at the ICS position

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Appendices

i – ICS Assurance Escalation Framework

ii - Key to Variation and Assurance Icons (SPC) iii - Glossary of Terms

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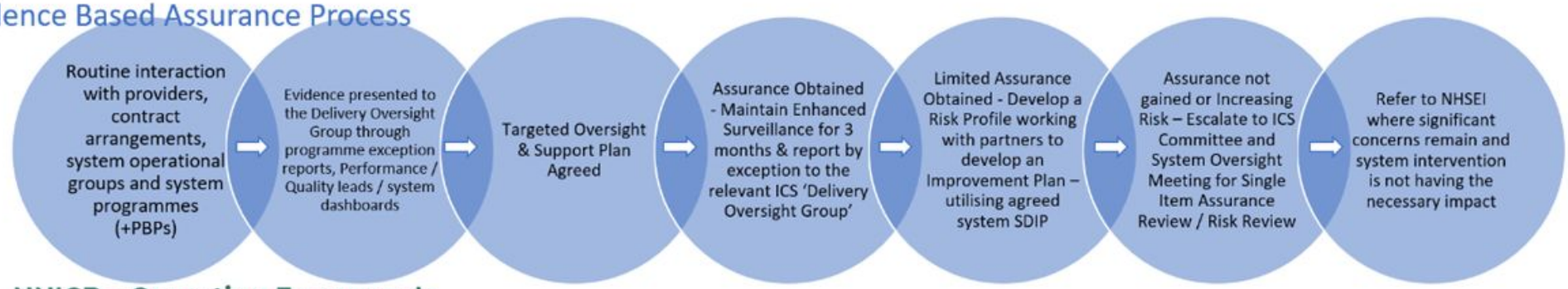
i – ICS Escalation Framework

Each key deliverable programme or oversight group will propose a level of assurance, aligned to **the escalation framework**, following discussion of reported metrics and key milestones at each group. This approach is still being developed and rolled out across the ICB. The 4 levels are as follows:

Oversight Monitoring Level	1. Routine	2. Further Information Required	3. Enhanced	4. Escalated Risk
What does this mean? What is the assessment of risks relating to delivery / quality				
	No Specific areas of concern identified	Potential for concern. Key milestones not achieved. More information required to determine level of risk	Delivery or quality concerns identified	Serious, specific risk to delivery or quality identified, including where there is a need to act rapidly to protect patients or staff
What actions may be taken by the relevant 'Delivery Oversight Group' in response to this assessment				
	Actions to be taken by Relevant Delivery Oversight Group	Agree route to follow up to gain necessary information to assess risk and agree who will lead	Agree actions, and schedule for discussion at each 'Delivery Oversight Group' until concerns are resolved	Trigger Escalation Single Subject Review/ Deep Dive / Risk Summit

Evidence Based Assurance Process



NNICB – Operating Framework

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ii – Key to Variation & Assurance Icons (SPC) and Assurance Escalation Framework

This performance report incorporates Statistical Process Control (SPC) charts, which plot data over time around a centre line (the average). They help us to understand variation which guides us to make appropriate decisions.
The Upper Control Limit (UCL) and Lower Control Limit (LCL) are derived by the variability of the data. It is expected that 99% of data points will fall within the process limits (probability) and SPC are therefore useful to identify / consider how likely it is that the target will be achieved.

The **Variation Icons** are derived from the movement of the actuals, either as an indication of run rate over 6 data points, or against the mean (higher or lower than the mean), showing whether the process is improving, deteriorating or having no significant change.

The **Assurance Icons** are derived from the position of the Lower Control Limit against the plan or standard – and the confidence level that provides as to whether the target or plan is expected to be achieved in the future. If the plan or target is higher than the lower control limit this will indicate 'inconsistent' passing or falling short. If plan or target is lower than the lower control limit this indicates that the target is being consistently passed. If the plan is higher than the higher control limit, this will indicate consistent falling short.

Essentially, the assurance icon is all about the future not the past. We don't need SPC to tell us whether we've hit our target in the past, we know if we have or not and we can report on that as is customary. However that approach doesn't give much assurance about what happens in future. Even if we've consistently missed our target for the past 10 months, what's the likelihood that we will do so again next month? Traditional reporting does not have an answer for that but SPC does. SPC charts allow us to see how the process we are monitoring is behaving. We can therefore use the mean and limits to 'predict' future performance which is what the assurance icon does.

Variation			**Assurance** (capability of meeting target)		
					
Common Cause - no significant change Up/Down arrow no special cause	**Special Cause** of *concerning* nature or *higher pressure* due to (H)igher or (L)ower values	**Special Cause** of *improving* nature or lower *pressure* due to (H)igher or (L)ower values	Variation indicates ***inconsistent*** passing or falling short of target - random	Variation indicates ***consistently (P)assing*** the target	Variation indicates ***consistently (F)alling short*** of the target

Blue lines on the charts represent the operational plan for 2022/23
Red Lines on the charts represent a required target position

Exception Reporting Rules

'Exception Reports' will be triggered if:

- An 'Orange' Variation icon or a 'Falling' short Assurance icon
- A Special Cause Variation (positive or negative)
- An area of escalation proposed via a sub-committee
- An area of escalation highlighted through the Executive Director from ICS Oversight Groups
- An area of escalation relating to sub-organisational level concerns

Further Reading / other resources
The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://improvement.nhs.uk/resources/making-data-count

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iii – Glossary of Terms

Acronym	Meaning	Acronym	Meaning	Acronym	Meaning	Acronym	Meaning
A&E	Accident & Emergency	FD	Finance Director	NEMS	Nottinghamshire Emergency Medical Services	SDMF	Strategic Decision Making Framework
A&E	Accident & Emergency Delivery Board	FOT	Forecast Out-Turn	NHP	New Hospitals Programme	SEG	System Executive Group
AMH	Anit-Mullerian Hormone	G&A	General & Acute	NHSE	NHS England	SFH	Sherwood Forest Hospitals Foundation Trust
BAU	Business as Usual	GI	Gastro-intestinal (often referred to as Upper GI or Lower GI)	NHT / NHC	Nottinghamshire Healthcare NHS Trust	SLA	Service Level Agreement
Blaw	Bassetlaw	HEE	Health Education England	NICE	National Institute for Health & Care Excellence	SMI	Severe Mental Illness
BLM	Back-log Maintenance	HFID	Hospital First Integrated Discharge	NNICB	Nottingham & Nottinghamshire ICB	SOF	System Oversight Framework
CAMHS	Child & Adolescent Mental Health Services	HLE	Healthy Life Expectancy	NRC	National Rehabilitation Centre	SOP	Standard Operating Procedure
CCG	Clinical Commissioning Group	IAPT	Improving Access to Psychological Therapies	NUH	Nottingham University Hospitals	SPC	Statistical Process Control
CDC	Community Diagnostic Centre	IBN	Information Breach Notice	OAPs	Out of Area Placements	SRO	Senior Responsible Officer
CDEL	Capital Departmental Expenditure Limits	ICATT	Intensive Community Assessment & Treatment Teams	OBD	Occupied Bed Days	TIF	Targeted Investment Fund
CDU	Clinical Decision Making Unit	ICB	Integrated Care Board	OOA	Out of Area	UEC	Urgent & Emergency Care
CHC	Continuing Health Care	ICP	Integrated Care Partnership	OP	Out Patients	UTC	Urgent Treatment Centre
CoP	Court of Protection	ICS	Integrated Care System	PBP	Place Based Partnerships	WTE	Whole Time Equivalents
CT	Computed Tomography	IPC	Infection prevention control	PCIT	Primary Care Information Technology	YOC	Year of Care
CV	Contract Variation	IR	Identification Rules	PCN	Primary Care Networks	YTD	Year to Date
CYP	Children & Younger People	IS	Independent Sector	PDC	Public Dividend Capital		
D2A	Discharge to Assess	JSNA	Joint Strategic Needs Assessment	PFDS	Public Facing Digital Services		
DC	Day Case	KMH	Kings Mill Hospital	PFI	Private Finance Initiative		
DDAT	Digital, Data, Analytics and Technology	LD	Learning Disabilities	PHM	Population Health Management		
DHSC	Department of Health and Social Care	LD&A	Learning Disabilities & Autism	PHSMI	Physical Health check for Severe Mental Ill patients		
DST	Decision Support Tool	LINAC	Linear Accelerator	PICU	Psychiatric Intensive Care Unit		
DTT	Diagnosis to Treatment Time	LoS	Length of Stay	PID	Project Initiation Document		
EBUS	Endobronchial Ultrasound	MAS	Memory Assessment Service	PIFU	Patient Initiated Follow Ups		
ED	Emergency Department	MHIS	Mental Health Investment Standard	POD	Prescription Ordering Direct		
EIP	Early Intervention Psychosis	MHST	Mental Health Support Team	PoD	Point of Delivery		
EL	Electives	MNR	Maternity & Neonatal Redesign	PTL	Patient Targeted List		
EMAS	East Midlands Ambulance Service NHS Trust	MOU	Memorandum of Understanding	QDCU	Queens Day Case Unit		
EMCA	East Midlands Cancer Alliance	MRI	Magnetic Resonance Imaging	QMC	Queens Medical Centre		
EMNNODN	East Midlands Neonatal Operational Delivery Network	MSFT	Medically Safe for Transfer	R&D	Research & Development		
EOL	End of Life	N&N	Nottingham & Nottinghamshire	R&I	Research & Innovation		
ERF	Elective Recovery Funding	NCSO	No Cheaper Stock Obtainable (prescribing)	RAG	Red, Amber & Green		
ESRF	Elective Services Recovery Funding	NEL	Non-Electives	RTT	Referral to Treatment Times		