NHS
Nottingham and Nottinghamshire

Integrated Care Board Meeting Agenda (Open Session)
Wednesday 09 July 2025 09:00-12:10
Chappell Meeting Room, Arnold Civic Centre, Nottingham, NG5 6LU

"Every person enjoying their best possible health and wellbeing"

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

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

Our core values:

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

	Item	Presenter	Type *(For Assurance, Decision, Discussion or Information)*	Enc.	Time
	Introductory items				
1.	Welcome, introductions and apologies	Kathy McLean	-	-	09:00
2.	Confirmation of quoracy	Kathy McLean	-	-	-
3.	Declaration and management of interests	Kathy McLean	Information	✓	-
4.	Minutes from the meeting held on 14 May 2025	Kathy McLean	Decision	✓	-
5.	Action log and matters arising from the meeting held on 14 May 2025	Kathy McLean	Discussion	✓	-
	Leadership and operating context				
6.	Citizen Story: Talking Therapies	Maria Principe	Discussion	✓	09:05
7.	Chair's Report	Kathy McLean	Information / Decision	✓	09:15
8.	Chief Executive's Report	Amanda Sullivan	Information / Decision	✓	09:30
	Strategy and partnerships				
9.	Joint Forward Plan Outcomes Framework	Victoria McGregor-Riley	Discussion		09:40
10.	ICS People and Workforce Plan	Rosa Waddingham	Decision		09:55
11.	ICS Quality Strategy	Rosa Waddingham	Decision		10:10
12.	Working with People and Communities Annual Report 2024/25	Alex Ball	Assurance		10:30

	Item	Presenter	Type *(For Assurance, Decision, Discussion or Information)*	Enc.	Time
	Delivery and system oversight				
13.	2024/25 Statement on Health Inequalities	Dave Briggs	Assurance	✓	10:45
14.	Population Health Management Report: Dementia Care	Maria Principe	Assurance	✓	11:00
15.	Service Delivery Performance Report	Maria Principe	Assurance	✓	11:15
16.	Quality Report	Rosa Waddingham	Assurance	✓	11:30
17.	Finance Report	Bill Shields	Assurance	✓	11:45
	Governance				
18.	Committee Highlight Reports: • Strategic Planning and Integration Committee • Quality and People Committee • Finance and Performance Committee • Audit and Risk Committee • ICB Transition Joint 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.*				
19.	2025/26 Board Work Programme	-	-	✓	-
	Closing items				
20.	Risks identified during the course of the meeting	Kathy McLean	-	-	-
21.	Questions from the public relating to items on the agenda	Kathy McLean	-	-	-
22.	Any other business	Kathy McLean	-	-	-
	Meeting close	-	-	-	12:10

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:	09/07/2025
Paper Title:	**Declaration and management of interests**
Paper Reference:	ICB 25 028
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?
Yes: members have an inherent interest in any matters being discussed relating to the ICB transition process during the course of the meeting; however, due to the nature of the transition process and the role of the Board in assuring its delivery, all members can participate in the discussions and any decisions.

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.

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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.
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.
ADAMOU, Marios	Non-Executive Director	UKAAN (training organisation currently unincorporated and in process of registering as a charity)	Director		✓			20/05/2025	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.

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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.
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	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.

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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.
LIM, Dr Kelvin	Primary Care Partner Member	Eastwood Primary Care Centre	Registered Patient			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
LIM, Dr Kelvin	Primary Care Partner Member	Primary Integrated Community Service (PICS) - provider of local health services in the Nottinghamshire area	Clinical Lead for a number of projects	✓				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 Primary Integrated Community Services.
MAJID, Ifti	Mental Health Partner Member	Nottinghamshire Healthcare NHS Foundation Trust	Chief Executive	✓				07/12/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by Nottinghamshire Healthcare NHS Trust
MAJID, Ifti	Mental Health Partner Member	NHS Confederation: BME Leaders Network	Chair		✓			07/12/2022	Present	This interest will be kept under review and specific actions determined as required.

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MAJID, Ifti	Mental Health Partner Member	NHS Confederation: Mental Health Network	Board Member and Trustee		✓			07/12/2022	Present	This interest will be kept under review and specific actions determined as required.
MAJID, Ifti	Mental Health Partner Member	Ellern Mede - provider of high intensity children and young people's eating disorder services	Spouse is Managing Director				✓	07/12/2022	Present	There is no contract in place with this organisation. To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Ellern Mede.
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.
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

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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.
MCLEAN, Kathy	ICB Chair	The Public Service Consultants Ltd (Public Sector Consultancy)	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 (including procurement activities)

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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.
MCLEAN, Kathy	ICB Chair	NHS Confederation	Trustee		✓			01/06/2025	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 arrangements) relating to
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.
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.

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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.
WADDINGHAM, Rosa	Director of Nursing	NHS Professionals (An NHS staff bank, owned by the Department of Health and Social Care)	Member of the Advisory Board		✓			01/09/2023	Present	This interest will be kept under review and specific actions determined as required.
WADDINGHAM, Rosa	Director of Nursing	Florence Nightingale Foundation (FNF) (A charity supporting Nurses and Medwives to improve patient care)	Chair of the FNF Members' Advisory Group		✓			01/09/2023	Present	This interest will be kept under review and specific actions determined as required.
WADDINGHAM, Rosa	Director of Nursing	Specsavers	Son is Dispensing Manager at Specsavers, Bingham				✓	01/02/2024	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be provided by Specsavers
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

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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.
WILLIAMS, Melanie	Local Authority Partner Member	Care Quality Commission	Board Member		✓			12/06/2025	Present	This interest will be kept under review and specific actions determined as required.
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.
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

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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
14/05/2025 09:00-12.00
Mansfield Civic Centre

Members present:

Dr Kathy McLean	Chair
Professor Marios Adamou	Non-Executive Director (from item ICB 25 008)
Dr Dave Briggs	Medical Director
Gary Brown	Non-Executive Director
Stephen Jackson	Non-Executive Director
Mehrunnisa Lalani	Non-Executive Director
Victoria McGregor-Riley	Acting Director of Strategy and System Development
Maria Principe	Acting Director of Delivery and Operations
Bill Shields	Director of Finance
Amanda Sullivan	Chief Executive
Jon Towler	Non-Executive Director
Rosa Waddingham	Director of Nursing
Melanie Williams	Local Authority Partner Member

In attendance:

Lucy Branson	Director of Corporate Affairs
Simon Castle	Deputy Director of Cancer, Diagnostics and End of Life Care (for item ICB 25 016)
Lucy Hubber	Director of Public Health, Nottingham City Council
Jack Rodber	Chief Analyst (for item ICB 25 016)
Sue Wass	Corporate Governance Officer (minutes)

Apologies:

Dr Kelvin Lim	Primary Care Partner Member
Ifti Majid	NHS Trust/Foundation Trust Partner Member
Vicky Murphy	Local Authority Partner Member

Cumulative Record of Members' Attendance (2025/26)

Name	Possible	Actual	Name	Possible	Actual
Kathy McLean	1	1	Victoria McGregor-Riley	1	1
Marios Adamou	1	1	Vicky Murphy	1	0
Dave Briggs	1	1	Maria Principe	1	1
Gary Brown	1	1	Bill Shields	1	1

Name	Possible	Actual	Name	Possible	Actual
Stephen Jackson	1	1	Amanda Sullivan	1	1
Mehrunnisa Lalani	1	1	Jon Towler	1	1
Kelvin Lim	1	0	Rosa Waddingham	1	1
Ifti Majid	1	0	Melanie Williams	1	1

Introductory items

ICB 25 001 Welcome, introductions and apologies

The Chair welcomed members to the meeting of the Board. A round of introductions was undertaken, and apologies noted as above. A particular welcome was extended to Bill Shields, who had recently joined the ICB as Director of Finance.

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

ICB 25 002 Confirmation of quoracy

The meeting was confirmed as quorate.

ICB 25 003 Declaration and management of interests

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

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

ICB 25 004 Minutes from the meeting held on: 13 March 2025

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

ICB 25 005 Action log and matters arising from the meeting held on: 13 March 2025

All actions were considered completed and no other matters were raised.

Leadership and operating context

ICB 25 006 Citizen Story: Best Years Hub

Rosa Waddingham presented the item and highlighted the following points:

a) The citizen's story focused on Debra Dulake, who had played a crucial role in the co-production of the NottAlone website, a project that provided mental health resources and support to all ages. Her

involvement had spanned from the initial stages of the project to its final implementation.

b) The report detailed the value that the co-production of the NottAlone website with citizens with lived experience had brought to the project and showcased the importance of patient and public voices in service development.

c) This was one example of how citizens shaped the services developed for Nottingham and Nottinghamshire residents and it was an approach that would continue to be replicated in future service developments.

The following points were made in discussion:

d) Board members who had accessed the website commended its user-friendly navigation.

e) Discussing the co-production approach, members noted the added value that could be brought to future service delivery developments, mindful of the future direction of the ICB as a strategic commissioner.

f) A note of caution was raised regarding the need to not rely solely on a small cohort of people with lived experience and to ensure that new volunteers were continually engaged with co-production processes to ensure a diverse range of views were heard. There was also a need to ensure that the views of service users were balanced with other sources of intelligence when designing services.

g) In response to a query regarding how the website was being promoted, it was noted that it had been promoted both internally within the ICB and the Integrated Care System Mental Health Partnership Board and more widely externally; however, a discussion would be taken forward with the ICB's Communications Team to ensure that it was promoted as widely as possible.

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

ICB 25 007 Chair's Report

Kathy McLean highlighted the following points from her report:

a) At a time of significant change, the Chair thanked everyone in the Nottingham and Nottinghamshire system for their continued hard work and co-operation in difficult times.

b) Reflecting on the past year, it had been testament to a whole system effort that the challenging financial targets had been achieved. The

same approach needed to be maintained if the ambitious targets set for the current financial year were to be achieved.

c) Much had been achieved during 2024/25 and the Integrated Care Strategy Annual Report, appended to the report, provided a helpful summary of progress on the system's four strategic aims.

d) A long-arranged meeting of the two Boards of NHS Nottingham and Nottinghamshire ICB and NHS Derby and Derbyshire ICB had taken place on 9 April 2025. The timing did naturally afford the opportunity for the two Boards to consider the content of the recent communication from NHS England, and there was agreement to closer working relationships. Transitional governance was being put in place to facilitate this.

e) Members were asked to note that the meeting with colleagues from the South Nottinghamshire Place Based Partnership, as referenced within the report, did not subsequently take place and had been re-arranged.

No further points were made in discussion and the Board **noted** the Chair's report for information.

At this point Marios Adamou joined the meeting.

ICB 25 008 Chief Executive's Report

Amanda Sullivan highlighted the following points from her report:

a) Following discussion at the last Board meeting, the Operational Plan for 2025/26 had been submitted to NHS England and was now being implemented. Robust system governance had been put in place over the previous year and work now focused on improving the delivery confidence of the identified efficiency plans to ensure that the financial targets within the plan were met.

b) Detailed plans also needed to be developed to meet the aims of the Government's NHS reform agenda to deliver the cost reductions specified. Initial plans were required to be submitted by 30 May 2025 and enacted by quarter three of 2024/25.

c) Attention was drawn to Appendix A of the report, which provided a helpful summary of progress made during quarter four of 2024/25.

d) Discussing the results of the 2024 Staff Survey, it was noted that there had been some improvement in areas such as working relationships and health and wellbeing. However, there was more to do in other areas, such as improving the quality of appraisals and

workload; and an action plan had been developed to address the areas for improvement, the progress of which would be overseen by the Remuneration and Human Resources Committee.

e) Following the discussion on the Oliver McGowan training programme at the November 2024 Board meeting, it was noted that the programme was still in its early stages of delivery and the ICB remained committed to the programme.

The following points were made in discussion:

f) Discussing the Oliver McGowan training programme, the Chair stressed the importance of Board members completing their level one training and it was agreed that a link to the required training would be re-circulated.

g) Discussing the financial challenges for 2025/26, a note of caution was raised that the challenge for 2025/26 was greater than the previous year. Although over 95 per cent of efficiency schemes had been identified, the risk adjusted position had suggested there was a circa £140 million gap. In response it was noted that the current focus of the system's Financial Recovery Group was to improve delivery confidence of the identified schemes.

h) Noting that one of the key achievements recorded in Appendix A of the report had been the modelling of local population needs over the next 20 years, members expressed an interest in accessing the detail of the modelling.

i) Congratulating Sherwood Forest Hospitals NHS Foundation Trust for their award of being the best acute trust to work for in the East Midlands for the seventh year in a row, members queried whether any analysis had been undertaken in order to share any best practice. It was noted that there had been some analysis. The Trust had a strong focus on the Staff Survey and the creation of a supportive environment. However, its culture was also noted as quite unique, due to the Trust's size, geography and workforce mix.

j) Querying the impact of the industrial action taken by healthcare support workers at Nottingham University Hospitals NHS Trust, it was noted that the Trust had worked with other trusts in a similar position and had considered that its offer was commensurate and fair. However, it was unfortunate that the Trade Unions had not recognised this.

k) As the Board had not been quorate at its meeting in March 2025, members were asked to ratify an urgent decision relating 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 Board **noted** the Chief Executive's Report for information and **ratified** the urgent decision taken at the March 2025 Board meeting using the Chair and Chief Executive's emergency powers.

Actions:

- **Rosa Waddingham to circulate the link to the Oliver McGowan training to Board members.**
- **Maria Principe to circulate details of the local population needs long term modelling to Board members.**

Strategy and partnerships

ICB 25 009 Integrated Care System Infrastructure Strategy

Bill Shields presented the item, highlighting the following points:

a) The Nottingham and Nottinghamshire Integrated Care System Infrastructure Strategy was an NHS England requirement, and had been developed to articulate a unified, long-term vision for the transformation of the health and care infrastructure estate within Nottingham and Nottinghamshire.

b) It presented a useful summary of the current infrastructure, highlighting considerable challenges, such as the £470 million backlog maintenance requirements, the 14 per cent of current estate that was unfit for purpose, and excessive energy costs.

c) The Strategy needed to be set in the context of the following item regarding the Joint Capital Resource Use Plan, and it had been developed prior to the announcement of the delay to the New Hospitals Programme. These posed significant challenges to the deliverability of the aims of the Strategy.

The following points were made in discussion:

d) Members agreed that the aims of the Strategy were laudable and that it was evident a great deal of work had gone into its development; however, they accepted that in the current climate it was difficult to take confidence that its aims could be fully realised and discussed barriers to its implementation.

e) It was noted that it had been difficult to fully engage system leaders in development of the Strategy, and it was suggested that there could

be a case for a strategic leadership role wider than Nottingham and Nottinghamshire, which would build on the proposed direction of travel for ICBs to work together over a wider footprint in a strategic role.

f) Members felt that there was a need for the delivery plan to further articulate digital opportunities and how the Strategy would support the move to integrated neighbourhood working, as well as greater use of shared estate with other public sector partners in order to provide a joint understanding of opportunities. In response it was agreed that further work was needed to evolve the delivery plan, which needed to reflect system transformation priorities and include citizen engagement.

g) The Chair thanked the team for the work invested in the Strategy to date and asked for the delivery plan, which would be overseen by the Finance and Performance Committee, to take account of the discussion.

The Board **approved** the Integrated Care System Infrastructure Strategy.

ICB 25 010 Joint Capital Resource Use Plan

Bill Shields presented the item, highlighting the following points:

a) There was a requirement for the ICB and partner NHS trusts to prepare and publish an annual plan setting out their planned capital resource use. The Joint Capital Resource Use Plan was presented for approval ahead of the deadline for submission of 30 June 2025.

b) As discussed under item ICB 25 009, the Nottinghamshire estate was 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 provider organisations were significantly higher than the funding available.

c) In recent years, the capital envelope was used mainly to address operational priorities on an annual basis, such as equipment replacement, information technology upgrades, and backlog maintenance priorities. Larger strategic priorities tended to be funded by targeted national funding as it became available.

The following points were made in discussion:

d) Members noted the potential for capital funding constraints to lead to the rationalisation of services in future years.

The Board **approved** the 2025/26 Joint Capital Resource Use Plan.

ICB 25 011 Primary Care Strategy

Victoria McGregor-Riley presented the item, highlighting the following points:

a) The paper presented the final draft of the Nottingham and Nottinghamshire Primary Care Strategy 2025-2030 for Board approval.

b) This updated strategy reflected the changes to primary care delivery, which included those following the Covid-19 pandemic. The Strategy also included the Primary Care Access Recovery Plan, new digital advancements, and reflected national pressures, such as the increase in demand and impact on access to General Practice.

c) It had been developed using insights from service users and clinical leaders and had undergone an extensive engagement exercise.

d) The paper also described how the delivery of the Strategy would be monitored. The Primary Care Transformation Delivery Group and delivery plan metrics would be incorporated into a performance dashboard and updated routinely, allowing for robust ongoing performance monitoring.

The following points were made in discussion:

e) Noting that several actions listed in the Strategy were akin to outcomes, Board members sought assurance that a delivery plan underpinned the Strategy to articulate how its aims would be met. It was noted that detailed delivery plans had been developed to ensure robust oversight of progress.

f) Members discussed risks relating to General Practice capacity and required workforce developments and stressed the importance of primary care engagement in the development of neighbourhood care models. It was noted that General Practice partners were committed to neighbourhood health; however, they would be only one element of the model. It was acknowledged that these areas could be better described within the Strategy.

g) Members also felt that the Strategy's link to the Integrated Care Strategy and NHS Joint Forward Plan could also be more clearly illustrated, in particular how the principle of equity would be addressed by the Strategy. In response it was agreed that these areas would be reviewed and strengthened where needed.

h) Noting that the Strategic Planning and Integration Committee oversighted the Strategy on behalf of the Board, the Chair requested

that the Committee review the changes to the Strategy discussed by Board members prior to its publication.

The Board **endorsed** the Primary Care Strategy 2025-2030, subject to final approval by the Strategic Planning and Integration Committee of the requested amendments.

Action: Victoria McGregor-Riley to update the Primary Care Strategy in line with Board feedback and present this to the next meeting of the Strategic Planning and Integration Committee for approval.

Delivery and system oversight

ICB 25 012 Assertive and Intensive Community Mental Health Care Action Plan: Delivery Update

Maria Principe presented the item, highlighting the following points:

a) Following the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber in 2023, one of the actions mandated by NHS England was for all ICBs to review their community services 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 challenging.

b) The outcome of the ICB's review and the associated improvement plan that was developed were presented to the Board in November 2024. The purpose of this report was to provide an update on progress since November 2024.

c) Of the 28 actions outlined in the action plan, 13 had been completed. Five actions were in progress; however, these were currently on hold pending the publication of national guidance and national funding announcements. A further ten actions were in progress but delayed due to interdependencies with other work taking place in the Trust. All actions were due to be completed by the end of September 2025.

d) The national expectation from NHS England was that systems should continue to focus on the short-term actions that had minimal resource implications.

e) Monthly Task and Finish Group meetings continued to monitor progress, which was reported to the Nottinghamshire Healthcare NHS Foundation Trust's Programme Board and the Improvement Oversight Assurance Group, which monitored the Trust's entire improvement plan.

f) New guidance on standards of care was expected to be published during summer 2025. This guidance would aim to ensure that all people with serious mental illness received a minimum level of good, personalised care and treatment, and that where care was being delivered across multiple teams or organisations, this care was well coordinated.

g) 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 would require improvement and re-design. This would be designed with stakeholders via workshop events, which were currently being planned.

The following points were made in discussion:

h) Board members found it difficult to take assurance from report without a wider overview of the Trust's broader improvement journey. While this was acknowledged, it was stressed that the plan, which focused on assertive and intensive community mental health care, had been a specific requirement of NHS England, developed in response to nationally published criteria.

i) Members went on to raise concerns that less than half of the actions had been completed and that the Trust was yet to have dedicated staffing focusing solely on this pathway.

j) In addition, it was noted that the report did not provide any indication of the outcome of the action plan in terms of improved performance or patient experience.

k) In response, it was noted that although there was still work to be done, much work had been undertaken to improve service quality and safety, and assurance was provided that the Improvement Oversight Assurance Group had an overarching view of all Trust improvement activities and outcome measures. Following discussion, it was agreed that a report updating the Board on all improvement actions being undertaken by Nottinghamshire Healthcare NHS Foundation Trust would be presented to a future meeting.

The Board **noted** the report.

Action: Lucy Branson to add an item to the Board's work programme to provide further assurance on progress across all improvement

actions being undertaken by Nottinghamshire Healthcare NHS Foundation Trust.

ICB 25 013 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 and emergency care performance remained a significant challenge, particularly with four- and 12-hour performance metrics. Despite improvements in ambulance handover times and patient flow, the system continued to face substantial pressure due to increased emergency department attendances and staffing shortages. Key actions were in place, which were validated at a recent Quarterly System Review Meeting with NHS England.

c) Whilst there had been improvements in outpatient productivity and transformation, long waiting times for elective procedures and some diagnostics tests persisted. The 65-week wait target had not been met, and cancer backlog volumes remained high. However, the expectation was that targets would be achieved during May.

d) Mental health services had demonstrated positive performance, with improvements across various service areas. However, the number of inappropriate Out of Area Placement observed bed days reported in March 2025 was three against a plan of zero. A workshop had been convened to focus on this service delivery area.

e) Primary care performance had improved compared to the previous year, particularly in dental provision. The proportion of GP appointments offered within two weeks was increasing; however, it remained just below planned levels. Targeted support to practices continued.

The following points were made in discussion:

f) Following a query relating to increased conversion rates for breast cancer, it was noted that the increase was a consequence of increased screening activity.

g) Noting the improved performance in dental services, the need to triangulate this by improved patient experience was highlighted.

h) Board members queried the mitigating actions to address the capacity issues within the speech and language service. It was noted that as the training and recruitment of additional therapists was a

medium to long-term action, work was being undertaken to replicate the ‘waiting well’ pre-treatment actions used by the Special Educational Needs and Disabilities service.

i) Noting that the focus nationally was on the 65-week waiting time target, the Chair requested that the Finance and Performance Committee receive further information on how challenges in specific specialities were being addressed.

The Board **noted** the report, having discussed its content for assurance purposes.

Action: Maria Principe to present further information to the Finance and Performance Committee on how challenges in specific specialities were being addressed to meet the 65-week waiting target.

ICB 25 014 Quality Report

Rosa Waddingham presented the item and highlighted the following points:

a) The report provided a summary of compliance against quality improvement requirements and the actions and recovery timeframes for those targets that were currently off track.

b) During March 2025, the Care Quality Commission had undertaken several assessments of Nottinghamshire Healthcare NHS Foundation Trust’s core services. Feedback had been generally positive; however, areas for improvement had been identified and as noted during item ICB 25 012, intense oversight continued to improve the quality of services.

c) After Action Reviews continued to be undertaken for people experiencing long delays in the urgent and emergency care pathway, including a focus on ensuring equity for patients presenting with mental health crisis.

d) Assurance was given that the incident management process for Sickle Cell Carrier Notifications in two areas of Nottingham and Nottinghamshire continued to be managed robustly.

The following points were made in discussion:

e) Members queried the rising still birth rates in Nottingham and Nottinghamshire. It was noted that that the data had not yet been verified; however, if a trend was evidenced, it would be discussed at the Local Maternity and Neonatal Service Perinatal Quality

Surveillance Group to facilitate system-wide discussions and shared learning. It was noted that the Nottingham and Nottinghamshire system was not an outlier in the Midlands and Public Health measures, such as the Best Start Strategy, were in place to support vulnerable families.

The Board **noted** the report, having discussed its content for assurance purposes.

ICB 25 015 Finance Report

Bill Shields presented the item and highlighted the following points:

a) At month twelve, the NHS system delivered on its break-even position, subject to completion of external audit processes.

b) There would need to be a significant improvement in the identification of recurrent efficiency savings and an intense focus on workforce costs if the financial plan for 2025/26 was to be achieved.

The following points were made in discussion:

c) Board members sought to understand the scale of the task and whether the ICB had the necessary controls in place to manage the financial position across the NHS system. It was noted the close management of workforce costs within organisations by their respective Boards would be crucial to successful delivery of the financial plan. All had individual plans in place and progress would be oversighted by the ICB using the mechanisms put in place over the previous year, which included the Investigation and Intervention processes advocated by NHS England.

d) Furthermore, it was noted that focus on bank and agency staff costs had detracted from oversight of substantive staff costs, which would need the same level of scrutiny going forward.

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

The Board **noted** the report, having discussed its content for assurance purposes.

ICB 25 016 Population Health Management Report: End of Life Care

Maria Principe presented the item, supported by Simon Castle and Jack Rodber, and highlighted the following points:

a) The report was the first of a series of reviews into areas where population health management (PHM) data and intelligence was being used to inform and drive key transformational activities.

b) Improvements had been made through working collectively with system partners on end-of-life services, informed by the data and driven by the End-of-Life Programme Board. This had included improvements to the veracity of the end-of-life register following targeted work in Nottingham City and Bassetlaw; increased coverage of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) forms across the system; and a decline in hospital deaths.

c) Whilst improvement had been evidenced, there was more to do to realise the full ambitions of the NHS Joint Forward Plan. Moving forward, there was a need to improve community capacity and access, particularly Hospice at Home and out-of-hours support; deliver a full digital integration of ReSPECT forms; a focus on areas of deprivation by reallocating resources based on population need; and strengthening care home support.

The following points were made in discussion:

d) Welcoming the report, Board members discussed the complexity of this service, taking into account cultural, economic, geographical, and clinical sensitivities.

e) In response to a query regarding how the future ambitions detailed in the report would be taken forward, it was noted that commissioning arrangements would be taken through the Strategic Planning and Integration Committee. Further to this, discussion followed regarding the need to use the data to steer resource allocation and the better use of contractual levers to drive delivery, for example, in the use of ReSPECT forms.

The Board **noted** the report, having discussed its content for assurance purposes.

Governance

ICB 25 017 Board Assurance Framework: Bi-annual Update

Lucy Branson presented the item and highlighted the following points:

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

b) Approval was sought for the continuation of the ICB's current strategic risks into 2025/26, proposing that a full review took place after the publication of the Ten-Year Health Plan and in light of the new ICB operating model. At this point the ICB's risk appetite could also be reviewed.

c) The latest position of the strategic risks was described. In year, nine of the ten risks had increased in score. However, an increased number of both external and internal assurances had been received, mitigating actions continued to be identified and all risks continued to be reviewed regularly in line with the ICB's Risk Management Policy.

The following points were made in discussion:

d) Highlighting that an opinion of 'significant assurance' in relation to the Board Assurance Framework had been provided by the ICB's Internal Auditors, the Chair commended the robust arrangements, noting that the Board and its committees' work programmes were driven by the Board Assurance Framework.

The Board **received** the year-end position of the 2024/25 Board Assurance Framework and **approved** the continuation of the current strategic risks as the opening position for 2025/26.

ICB 25 018 Meeting the Public Sector Equality Duty

Rosa Waddingham presented the item and highlighted the following points:

a) The annual assurance report described how the organisation was meeting the Public Sector Equality Duty, as described in the Equality Act 2010. It also provided an overview of work undertaken during 2024/25 regarding the ICB's equality improvement plan, which was routinely overseen by the Quality and People Committee.

b) The ICB had self-assessed itself as 'developing' against all the domains within the NHS Equality Delivery System, recognising there was more work to do to develop and improve equality, diversity and inclusion practices.

c) Actions underway to strengthen procedures and to review the ICB's equality objectives were described within the report.

The following points were made in discussion:

d) While recognising that much of the format of the report was driven by national requirements, Board members were not assured that it described the full range of activities undertaken by the ICB to address inequalities. In recognition of the need to publish the report, it was agreed that a statement should be added to the report to affirm the Board's commitment to this agenda and for future reports to cover the ICB's commissioning responsibilities in more detail.

The Board **noted** the report.

Action: Rosa Waddingham to add a statement to the 2024/25 Annual Equality and Inclusion Assurance Report affirming the Board's commitment to the equality, diversity and inclusion agenda, making clear that future reports will include more detail relating to the ICB's commissioning responsibilities.

ICB 25 019 Committee Highlight Reports

The report presented an overview of the work of the Board's committees since its last meeting in March 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 25 013, ICB 25 014 and ICB 25 015. Further updates from the Committee Chairs were invited by exception and no other points were highlighted.

The Board **noted** the reports.

Information items

ICB 25 020 2024/25 Senior Information Risk Owner Annual Report

This item was received for information.

ICB 25 021 2024/25 Annual Reports from the Board's Committees

This item was received for information.

ICB 25 022 2025/26 Internal Audit Plan

This item was received for information.

Closing items

ICB 25 023 Risks identified during the course of the meeting

No new risks were highlighted.

ICB 25 024 Questions from the public relating to items on the agenda

No questions had been received.

ICB 25 025 Any other business

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

Date and time of next Board meeting held in public: 09 July 2025 at 9:00 (Arnold Civic Centre)

NHS
Nottingham and Nottinghamshire

ACTION LOG from the Integrated Care Board meeting held on 14/05/2025

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
Closed – Action completed	14.05.2025	ICB 25 008: Chief Executive's Report	To circulate the link to the Oliver McGowan training to Board members.	Rosa Waddingham	09.07.2025	Link circulated to Board Members on 04 July 2025.
Open – On track	14.05.2025	ICB 25 008: Chief Executive's Report	To circulate details of the local population needs long term modelling to Board members.	Maria Principe	31.07.2025	To be circulated by end of July.
Closed – Action completed	14.05.2025	ICB 25 011: Primary Care Strategy	The Primary Care Strategy to be added to the work programme of the Strategic, Planning and Integration Committee.	Victoria McGregor-Riley	05.06.2025	Revised Primary Care Strategy was approved by the Strategic Planning and Integration Committee at its June 2025 meeting.
Closed – Action completed	14.05.2025	ICB 25 012: Assertive and Intensive Community Mental Health Care Action	To add an item to the Board's work programme to provide further assurance on progress across all improvement actions being undertaken by Nottinghamshire Healthcare NHS Foundation Trust.	Lucy Branson	09.07.2025	Added to the Board's work programme for November 2025.

Status	Meeting Date	Agenda Item	Action	Lead	Date to be Completed	Comment
		Plan: Delivery Update				
Closed – Action completed	14.05.2025	ICB 25 013: Service Delivery Report	To present further information to the Finance and Performance Committee on how challenges in specific specialities were being addressed to meet the 65-week waiting target	Maria Principe	28.05.2025	Requested information presented to the Finance and Performance Committee at its May 2025 meeting.
Closed – Action completed	14.05.2025	ICB 25 018: Meeting the Public Sector Equality Duty	To add a statement to the 2024/25 Annual Equality and Inclusion Assurance Report affirming the Board's commitment to the equality, diversity and inclusion agenda, making clear that future reports will include more detail relating to the ICB's commissioning responsibilities.	Rosa Waddingham	09.07.2025	Annual Equality and Inclusion Assurance Report updated and published.

Key:

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

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/072025
Paper Title:	**Citizen Story: Talking Therapies**
Paper Reference:	ICB 25 031
Report Author:	Julie Cuthbert, Head of Communications
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:

Talking Therapies is a free and confidential NHS service designed to support adults experiencing common mental health challenges such as stress, anxiety, depression, Post Traumatic Stress Disorder (PTSD), and low mood. The ICB commissions Vita Health Group to deliver the service. The service is available to anyone aged 18 or over who is registered with a GP in Nottingham or Nottinghamshire.

This paper provides a citizen's story that demonstrates how accessing Talking Therapies has benefitted a local resident who was experiencing isolation and low confidence after giving up her job due to ill health. It highlights the benefits of providing a holistic model of support, acknowledging the relationship between work and mental health and the impact that can have on wellbeing. A short video will accompany the story, with experiences of the service from other citizens.

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	Talking Therapies provide early intervention for common mental health conditions like anxiety and depression, which are among the most prevalent health issues in the region. By offering evidence-based treatments such as Cognitive Behavioural Therapy (CBT) and counselling, the service directly contributes to better mental health outcomes and overall wellbeing. Therapists are trained in working with people whose long-term conditions such as diabetes, cancer and asthma impact on their mental health
Tackle inequalities in outcomes, experience and access	The service is free, confidential, and accessible by self-referral, reducing barriers for underserved populations. Self-referral empowers individuals from diverse backgrounds to seek help without stigma or gatekeeping. Online and telephone options improve access for people in rural areas or with mobility challenges. Interpreters and resources in different languages support access for those whose first language is not English.

How does this paper support	the ICB's core aims to:
	The provider's approach to inequalities is in line with best practice guidance and focusses on the 18-25 age group, older adults and Black and Minority Ethnic (BAME) groups. Access, outcomes and patient experience is monitored for each demographic.
Enhance productivity and value for money	By addressing mental health issues early, Talking Therapies helps prevent escalation. The service supports workforce productivity by helping individuals return to, or remain in, employment through mental health recovery and has employment advisors embedded within the service alongside the therapy offer.
Help the NHS support broader social and economic development	Mental health is a key determinant of social and economic participation. By improving mental wellbeing, the service contributes to community resilience, employment retention, and reduced social isolation. The inclusion of employment support and long-term condition management further integrates health and social care goals.

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: Talking Therapies

Overview

1. Expanding access to NHS Talking Therapies is a priority within the NHS Long Term Plan. Nottingham and Nottinghamshire Talking Therapies is a free and confidential NHS service designed to support adults experiencing common mental health challenges such as stress, anxiety, depression, Post Traumatic Stress Disorder (PTSD), and low mood. The ICB commissions Vita Health Group to deliver the service and it is available to anyone aged 18 or over who is registered with a GP in Nottingham or Nottinghamshire.

Access and referral

2. Self-referral is encouraged and available via the website notts-talk.co.uk or by calling 0300 188 1060. GP referrals are accepted but not required. Referrals lead to an initial assessment, after which a tailored therapy plan is developed.

Services offered

3. The service provides a range of evidence-based therapeutic interventions, including:
    a) Cognitive Behavioural Therapy (CBT).
    b) Counselling for depression.
    c) Interpersonal Therapy (IPT).
    d) Eye Movement Desensitisation and Reprocessing (EMDR).
    e) Mindfulness-Based Programmes.
    f) Support for long-term conditions (e.g., cancer, chronic pain, diabetes).
    g) Employment support and couple's therapy.
4. Delivery formats include:
    a) Face-to-face sessions.
    b) Telephone and video consultations.
    c) Online courses and webinars.
    d) Self-help resources.
5. NHS Talking Therapies are short-term interventions, and patients will finish treatment once their symptoms are deemed clinically below threshold. The therapist will help patients plan for discharge, which will include how to keep using the skills they have learnt and how to deal with stressors or setbacks.

The patient may also be signposted to other services to support any other needs.

Employment and health

6. The relationship between work and mental health is closely intertwined. Difficulties regarding employment, such as job search, job retention, or re-entering the workforce after a career break or illness, can significantly affect overall wellbeing.

7. Embedded within NHS Talking Therapies provision are employment advisors, funded by the Department for Work and Pensions, who can offer one-on-one sessions, working alongside therapy, to address practical work-related issues. For people with severe mental illness (SMI) a similar service is available within Community Mental Health Services where Employment Specialists provide Individual Placement and Support (IPS). It is an evidence-based programme that aims to help people find and retain employment. During March 2025, 1,430 people accessed IPS against a standard of 1,126.

Key benefits of the service

8. Key benefits of the service include:

    a) Accessibility: No need for a formal diagnosis or GP referral.

    b) Flexibility: Multiple modes of delivery to suit individual preferences.

    c) Personalisation: Therapy plans are tailored following a comprehensive assessment.

    d) Community impact: Supports mental health resilience across Nottinghamshire, reducing pressure on primary care and emergency services.

Local performance data

9. In 2024/25, Nottingham and Nottinghamshire Talking Therapies received 36,705 referrals of which 18,664 patients completed treatment with the service. This reflects national rates of attrition for which approximately 25% of referrals drop out before assessment, and 60% of those starting treatment go on to complete treatment. 98% of patients started treatment within six weeks of referral and two out of three patients showed meaningful improvement in their mental health at the end of treatment. On average, patients receive eight sessions of therapy to achieve improvement or recovery but can have up to 20 if clinically appropriate, which is in line with the national NHS Talking Therapies manual.

10. Nottingham and Nottinghamshire achieved six out of seven national indicators during March 2025:
    a) 18,665 completed treatments against a target of 15,096.
    b) 48% reliable recovery against the 48% target.
    c) 70% reliable improvement against the 68% target.
    d) 97% started treatment within six weeks against the 75% target.
    e) 100% started treatment within 18 weeks against the 95% target.
    f) 7% first to second treatment waits over 90 days against the <10% target.
    g) 46% BAME reliable recovery against 48% target.
11. Nottingham and Nottinghamshire is currently the highest performing system for Talking Therapies performance in the Midlands.

Jackie's story

"I'd been on quite a journey, just before COVID, and then I became a long COVID sufferer, along with fibromyalgia and a few other health conditions. My hearing dropped quite dramatically and my eyesight and a general flare up and lots of little things.

"But I think I expected to just get back on and get things done and pick back up where I was once it had worn off and it just didn't. So, I guess that after a long period of time it just made me feel very kind of switched off.

"I'd also had to retire from my job due to ill health, as recommended by the doctor, which was very heartbreaking and a massive blow because I actually loved my job. And it was a very sociable job.

"So, in the midst of losing that and the ill health and I guess lockdown, we all became a little bit more isolated. And I know that most of the world started to get back on track and going out again, but I found it all very daunting and all very scary. So, I kind of stopped going out.

"I didn't realise that I actually needed help. And when the doctor suggested it [Talking Therapies], I actually felt a little bit irritated by it because I thought, I don't need help.

"I think I'd seen it as psychiatric treatment - that I'd be taken into this sort of darkened room and told to lie on a couch and they'd delve into my deepest, deepest, darkest secrets and try and work out what the triggers were. But it wasn't anything like that at all.

"She actually gave me three recommendations when I left. And the first interaction was with an employment coach.

"I think it's more looking at what your particular issue is and what can we do to help you get back on track and have tools to face the realities of your new situation.

“Mainly she was doing all the work, all the talking, asking questions and I was just answering them, which I think was also good for me at the time. And I think what she did for me was help build my confidence back up. She reminded me of my skill set I previously had to have had to do my job. And she was encouraging, supportive, she listened.

“And over a period of a couple of weeks, I really looked forward to the phone calls. And I felt she really helped to lift my spirits and my mood and help to see myself in a different light.

“There was an awful lot to talk about and at the end of it I was really sad when our sessions came to an end but at the end of them, I felt so much more empowered.”

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/07/2025
Paper Title:	**Chair's Report**
Paper Reference:	ICB 25 032
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 summary of the NHS Reform process, alongside 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.
- **Approve** the Joint ICB Transition Committee terms of reference.

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:

Appendix A: Joint ICB Transition Committee terms of reference.

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

NHS Reform

1. Since our last Board meeting, the national working group of which I was a member has published the ‘Model ICB Blueprint’, which sets out the framework of future functions and activities that ICBs should prioritise in order to deliver their required management cost reductions. This has been a helpful document in giving us a direction of travel for the organisation as we move forward in delivering this requirement from NHS England.
2. All ICBs were required to make a financial submission at the end of May with the headlines on how they intended to deliver the cost reduction requirement in the context of the Model ICB document.
3. Following the publication of this document and supported by a submission to NHS England by the relevant ICBs, it has now been confirmed that the three ICBs across Nottingham and Nottinghamshire, Derby and Derbyshire, and Lincolnshire will ‘cluster’ to develop shared teams and operating models, including thinking through what functions should be delivered at a local level, at a cluster level and at an East Midlands or Midlands level.
4. We have established a Joint ICB Transition Committee between the three ICBs, with the primary purpose of overseeing and scrutinising arrangements for the transition of the ICBs into their future operating model. The terms of reference for the Joint ICB Transition Committee are appended to this report for the Board’s approval.
5. The Joint Committee is supported by an executive-led transition programme architecture that has been established to deliver the transition programme. This is comprised of members from across the three ICBs and has key workstreams covering the design of the operating model, the management of change process, governance arrangements, finance, and stakeholder communications.
6. Towards the end of June all ICBs also received information about the next steps for the selection of Chairs and Chief Executive Officers for ICB clusters, which is now underway. I will be able to update the Board further on this at the meeting. Notwithstanding the pending process for confirming the Chairing arrangements for the clustered organisations, I do want to place on record that my term as Chair for this ICB has been extended to 31 March 2026.
7. On 3 July, we also saw the publication of ‘Fit for the Future: The Ten Year Health Plan for England’. The Plan sets out a bold, ambitious and necessary new course for the NHS. It seizes the opportunities provided by new technology, medicines, and innovation to deliver better care for all patients – no matter where they live or how much they earn – and better value for taxpayers.

8. The Plan fundamentally reinvents our approach to healthcare, so that we can guarantee the NHS will be there for all who need it for generations to come. Through the three shifts – from hospital to community, from analogue to digital, and from treatment to prevention – we will personalise care, give more power to patients, and ensure that the best of the NHS is available to all. The Plan is published here: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future, and has been circulated to all members of ICB staff so they can start to consider its implications and impacts on their work.

Key areas of focus

9. As previously discussed, the requirement to achieve financial balance by the end of March 2026 remains with us and we must carefully mitigate against the risk of potential disruption caused by the NHS reforms described above. The current status of the delivery of our 2025/26 financial plans will be discussed later on our agenda but I will stress, as I always do at this time of year, that we have already now consumed one quarter of the time we have available to us to deliver on our saving plans.

10. We should also note the publication of the Government's Comprehensive Spending Review in late June, which confirmed an increase of 2.8% annually in the Department for Health and Social Care budget to the end of financial year 2028/29. This settlement is higher than other Government departments and underlines the need for our system and those all over the country to transform the way we deliver services to meet the expectations of our population and of the Government in terms of access, quality and waiting lists.

11. In the last few weeks, we have seen the second anniversary of the tragic events in Nottingham in June 2023. As always, our thoughts are with the families of Barnaby Webber, Grace O'Malley-Kumar and Ian Coates who lost their lives and also with Wayne Birkett, Sharon Miller and Marcin Gawronski who were seriously injured. Following the appointment of Her Honour Deborah Taylor as Chair of the Inquiry into the attacks, the terms of reference for its work have now been published, and the ICB is committed to supporting the Inquiry it in any way requested.

12. Again, we will likely discuss this as part of the Quality Report on our agenda, but the Board should note two updates from Nottinghamshire Police regarding maternity services in our area. Firstly, regarding the temporary loss of data relating to maternity cases at Nottingham University Hospitals NHS Trust, their assessment is that this loss was likely caused "intentionally or maliciously". Secondly, the Police have confirmed that they will be pursuing a charge of Corporate Manslaughter against the Trust. Board members should also note

that the Secretary of State for Health and Social Care has announced a national investigation into maternity care at ten NHS Trusts across the country.

Developing our system

13. One of the key aspects of the Ten-Year Health Plan is the ambition to establish an Integrated Neighbourhood Health service across the country. We are delivering strongly as a system in this space, building on previous initiatives and pilots, and I was pleased that the Board held an in-depth and enlightening discussion on this topic at our most recent development session. The ICB's Executive Director of Strategy and System Development and the Medical Director led the discussion, which had excellent input from across the Board's membership.

14. At the same meeting, the Board was grateful for the attendance of two leaders from our Voluntary, Community and Social Enterprise (VCSE) sector: Jules Seblin, Chief Executive Officer of Nottingham Council for Voluntary Service and Rev. Simon Cartwright, Chief Executive Officer of Transforming Notts Together, supported by the Chair of our VCSE Alliance, Prof. Daniel King. The Board again engaged in a wide-ranging discussion about how health and the voluntary sector are already working together extensively and how this platform can be built upon going forward.

15. Over the last couple of months, I have continued to visit services and meet with teams who are delivering on our Integrated Care Strategy and NHS Joint Forward Plan. Some highlights this time include an excellent visit to Autism East Midlands where I saw the work they do to support individuals, carers and families whose lives are affected by Autism.

16. I also visited the committed team at Nottingham Women's Centre to hear about their inspiring work to support women in Nottinghamshire reach their full potential, have their voices heard, and overcome barriers to create a better future for themselves and their children. Many thanks to Louisa and her leadership team who were able to spare so much time away from their vital work to host me.

17. A common theme in conversations on many of my visits is the power of data and intelligence, this of course includes the leading work being done by the System Analytics and Intelligence Unit and also through the Research team within the ICB. On the latter I am pleased to see the launch of a new 'hub' of resources and information to support the development of research in our area. We know that research is essential to increase our knowledge and provide the evidence for new and better ways to prevent, diagnose and treat health conditions, improve population health and wellbeing, provide high quality joined up services, contribute to a net zero health and care system and to reduce health inequalities. I hope that the hub can act as a powerful one-stop shop to

drive innovation, connect colleagues working in research and inspire others to get involved for the benefit of our local population, workforce and health and care system.

18. During this most recent period I have continued my engagement with the Mayor of the East Midlands, Claire Ward and her leadership team at the East Midlands Combined County Authority (EMCCA). This has included some discussions about the proposed clustering arrangements for our ICB and also ongoing discussions about the role of health in promoting and supporting quality employment. Our teams are also working towards a joint roundtable in the autumn to explore how the wider convening powers of EMCCA can support the development of the Integrated Neighbourhood Health model.

Looking forward

19. With the clarity we now have around our clustering arrangements and the issuing of a process and timetable for the appointment of the Chair and Chief Executive Officer, I am really keen that we make rapid progress on delivering the changes needed. I know that the impact and the protracted nature of this process of change has not been positive for our staff, but I am committed to delivering more timely action.

20. It really has been a challenging period for our staff, with everyone working exceptionally hard to deliver the financial position to the end of March 2025 and then immediately entering into a period of uncertainty and ambiguity, whilst still being asked to prioritise financial recovery and also focus on transformational initiatives across our pathways. I want to recognise this hard work and resilience and say thank you again from me and the Board.

Board matters

21. Finally, as part of our annual governance processes, I can confirm that the annual ‘Fit and Proper Person Test’ assessment for each individual Board member has been completed in accordance with NHS England guidance and our local procedures. All Board members have submitted the required self-declarations confirming themselves as ‘fit and proper’, which I have reviewed alongside other available evidence to complete my assessments. I am pleased to report that no concerns were raised regarding the fitness and propriety of any Board member, including those that left during the year. Confirmation of this annual process and the outcome was submitted to NHS England by the deadline of 27 June 2025.

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Joint ICB Transition Committee – Terms of Reference

1. Introduction/ Purpose	The Joint ICB Transition Committee ("the Joint Committee") is a joint committee of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB ("the ICBs"), established in accordance with section 65Z5 of the National Health Service Act 2006 (as amended by the Health and Care Act 2022). The primary purpose of the Joint Committee is to oversee and scrutinise arrangements for the transition of the ICBs into their future operating model, in line with national guidance. Due to the nature of the Joint Committee's role, it will be time-limited in its establishment, with the Boards of the ICBs determining the appropriate timeframe for the Joint Committee to be dis-established. The Joint Committee is authorised to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from employees of the ICBs and all employees of the ICBs are directed to co-operate with any request made by the Joint Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.
2. Duties	a) Oversee the establishment of robust programme management arrangements to deliver ICB transition requirements within the prescribed timeframe. b) Oversee the development and implementation of a fit for purpose ICB operating model. This will include ensuring that the proposed new model: • Is designed to effectively deliver revised ICB functions and responsibilities, in line with the Model ICB Blueprint, based on a robust 'make, buy, share' assessment across relevant geographies. • Delivers required efficiencies and is affordable within the financial allocation for the ICBs. • Is developed taking into account the feedback from the combined workforce of the ICBs, as appropriate. c) Oversee the development and implementation of fair and transparent exit and workforce change processes for ICB

	staff, in line with national guidance and local policy requirements, working in conjunction with each ICB's Remuneration (and Human Resources) Committee, as appropriate. This will include oversight of appropriate training and development and health and wellbeing initiatives for ICB staff to ensure they are well supported throughout the transition process. d) Oversee the establishment of effective governance arrangements to support the period of transition the new ICB operating model, and to ensure its ongoing effectiveness. e) Oversee the delivery of timely, open, and transparent staff and stakeholder communications throughout the transition process. f) Oversee the identification and management of risks relating to the transition process and future ICB operating model. g) Oversee arrangements for the safe transition of any transferred functions.
3. Membership	The membership of the Joint Committee will be comprised as follows: *NHS Derby and Derbyshire ICB:* a) Two Non-Executive Members of the Board b) Chief Executive c) Executive Director Lead for Transition *NHS Lincolnshire ICB:* d) Two Non-Executive Members of the Board e) Chief Executive f) Executive Director Lead for Transition *NHS Nottingham and Nottinghamshire ICB:* g) Two Non-Executive Members of the Board h) Chief Executive i) Executive Director Lead for Transition *Attendees* The Joint Committee may invite a range of Senior Managers from each ICB to attend meetings to support the Joint Committee in discharging its responsibilities.
4. Chair and deputy	The Boards of the ICBs will appoint a Non-Executive Member to be Chair of the Joint Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Joint Committee's Non-

	Executive membership will be nominated to deputise for that meeting.
5. Quorum	The Joint Committee will be quorate with a minimum of six members, to include at least one non-executive and one executive member from each ICB. If any Joint Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
6. Decision-making arrangements	It is expected that at the Joint Committee's meetings, decisions will be reached by consensus and a vote will not be required. Any decisions taken will be record in the minutes of the meeting. If consensus cannot be reached and if timeframes allow, then the item will be re-scheduled for discussion at the next meeting of the Joint Committee. Otherwise, decisions will be taken by simple majority.
7. Meeting arrangements	The Joint Committee will initially meet on a fortnightly basis, in line with the pace of change requirements. The required frequency of meetings will be kept under review and adjusted as appropriate as the transition period progresses. Members of the Joint Committee are expected to attend meetings wherever possible. The Joint Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Joint Committee will apply, including those relating to the quorum (as set out in section 5 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Joint Committee to be open to the public. Secretariat support will be provided to the Joint Committee to ensure the day-to-day work of the Joint Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than three calendar days in advance of meetings and will be distributed by the secretary to the Committee. Agendas will be agreed with the Chair prior to the meeting.
8. Minutes of meetings	Minutes will be taken at all meetings and will be ratified by agreement of the Joint Committee at the following meeting.
9. Conflicts of interest management	In advance of any meeting of the Joint Committee, 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. At the beginning of each Joint Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Joint Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Joint Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Joint Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
10. Reporting responsibilities	The Joint Committee is accountable to the Boards of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB. The Joint Committee will provide assurance to the Boards that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, through submission of Committee Highlight Reports, summarising items discussed, decisions made and any specific areas of concern that warrant immediate Board attention. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
11. Review of terms of reference	Due to the focus of the Joint Committee's work and the nature of emerging guidance, these terms of reference will be kept under review on an ongoing basis to ensure continued fitness for purpose. Any proposed amendments to the terms of reference will be submitted to the ICBs' Boards for approval.

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/07/2025
Paper Title:	**Chief Executive's Report**
Paper Reference:	ICB 25 033
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 ICB's EPRR and Business Continuity Policies.
- **Endorse** the signing of the Nottinghamshire Suicide Prevention Charter.

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

Appendices:

A: Three-Year Integrated Mental Health Pathway Strategic Plan: Delivery Update.
B: Summary of East Midlands Joint Committee meeting held on 25 April 2025.

Board Assurance Framework:

Not applicable.

Report Previously Received By:

Not applicable.

Are there any conflicts of interest requiring management?

No.

Is this item confidential?

No.

Chief Executive's Report

Publication of the ICB's Annual Report and Accounts 2024/25

1. The ICB's Annual Report and Accounts for the period 1 April 2024 to 31 March 2025 has been published following approval by the Audit and Risk Committee.
2. The report provides key organisational details and the audited financial statements in line with the Department of Health and Social Care reporting requirements. The requirements include an assessment of performance during the reporting period, details as to how key statutory duties have been discharged, and a governance statement that describes how governance, risk management and decision-making arrangements have operated over the year. The Annual Report can be found here: https://notts.icb.nhs.uk/about-us/our-priorities/annual-reports-and-accounts/
3. The ICB will be holding its Annual Public Meeting at 2pm on 10 September 2025, at the Mansfield District Council Civic Centre, Chesterfield Road South, Mansfield, Nottinghamshire, NG19 7BH.

Annual assessments of Integrated Care Boards 2024/25

4. NHS England has released updated guidance describing the process for the annual assessments of ICBs for 2024/25; this sets out the key lines of enquiry that NHS England will use to underpin its assessments.
5. The process has been expanded from 2023/24 to include an assessment of ICB capability with extended key lines of enquiry for leadership and governance that focus on how effectively the ICB has developed strategies and plans to ensure the biggest improvement to outcomes, and how it has built strong partnerships and effective governance and decision-making arrangements to drive improvement and transformation of services. All annual assessments will be published later in the year.
6. The full guidance can be found here: https://www.england.nhs.uk/long-read/annual-assessment-of-integrated-care-boards-2024-25-supporting-guidance/.

NHS Oversight Framework 2025/26

7. The NHS Oversight Framework 2025/26 sets out how NHS England will assess NHS trusts, foundation trusts, and ICBs, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

8. The assessment will be the starting point for how NHS England works with organisations throughout the year and will help determine how they can support them to improve. The framework outlines the circumstances in which providers can obtain increased freedoms. It also describes how NHS England will determine whether a provider's performance falls below an acceptable standard and/or has governance concerns that may lead to the use of regulatory powers to secure improvement.

9. ICBs will not be segmented in 2025/26, recognising this will be a year of significant change as they transform in line with the Model ICB Blueprint. However, their performance will continue to be monitored across a range of oversight metrics including leadership capability and how well each ICB is performing its statutory duties. The full report can be found here: https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26/.

Urgent and Emergency Care Plan 2025/26

10. On 6 June 2025, NHS England published an Urgent and Emergency Care Plan, noting the imperative to enact the plan prior to the publication of the Ten-Year Health Plan, to ensure improvement in urgent and emergency care services for the coming winter period.

11. The Plan advocates a whole system approach on seven identified priorities, with every part of the system having responsibility for improving urgent and emergency care performance:

    a) Patients who are categorised as Category two – such as those with a stroke, heart attack, sepsis or major trauma – receive an ambulance within 30 minutes.

    b) Eradicating last winter's lengthy ambulance handover delays to a maximum handover time of 45 minutes.

    c) A minimum of 78% of patients who attend an accident and emergency department to be admitted, transferred or discharged within four hours.

    d) Reducing the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so that this occurs less than 10% of the time.

    e) Reducing the number of patients who remain in an emergency department for longer than 24 hours while awaiting a mental health admission. This will provide faster care for thousands of people in crisis every month.

    f) Tackling the delays in patients waiting once they are ready to be discharged – starting with reducing the 30,000 patients staying 21 days over their discharge-ready-date.

g) Seeing more children within four hours, resulting in thousands of children receiving more timely care than in 2024/25.

12. NHS England's winter planning requirements are that ICBs continue to provide system co-ordination which gathers real time situational awareness of operational pressures. ICBs are required to nominate a Winter Director with the specific accountable role of convening executives from across providers in a system to mitigate pressure between providers. This role can be delegated to a lead provider if there is someone with the local credibility and skills to coordinate across providers. The Winter Director will need to be in the role from September 2025 when NHS England will run a winter exercise to stress-test and refine their plans and will continue to oversee improvement support to the most challenged organisations in the run up to, and throughout, this winter.

13. Ahead of the exercise, NHS England has tasked system leaders to commit to developing and testing collective winter plans, which need to be signed off by every Board and Chief Executive within each system by summer 2025. As a minimum, each plan should show how, by this winter, systems will:

    a) Improve vaccination rates.

    b) Increase the number of patients receiving care in primary, community and mental health settings.

    c) Meet the maximum 45-minute ambulance handover time standard.

    d) Improve flow through hospitals with a particular focus on patients waiting over 12 hours and making progress on eliminating corridor care.

    e) Set local performance targets by pathway to improve patient discharge times and eliminate internal discharge delays of more than 48 hours in all settings.

14. To support systems, NHS England has committed to combining the various elements of improvement support that have been developed and using these resources to create a meaningful offer to systems to support them to realise their ambitions. The new NHS Performance Assessment Framework, which incorporates a range of metrics across all sectors, including primary care, hospitals, and ambulance, community and mental health trusts, will be used to drive the required focus and subsequent improvement that will support performance recovery. NHS England has also committed to publishing league tables on performance to drive improved transparency and public accountability.

15. The full plan can be found here: https://www.england.nhs.uk/long-read/urgent-and-emergency-care-plan-2025-26/.

National review of maternity services

16. Following several meetings with bereaved families, the Secretary of State for Health and Social Care has announced a national investigation into NHS maternity and neonatal services. The investigation will urgently look at the worst-performing services in the country, investigating up to ten of the most concerning maternity and neonatal units, to give affected families answers as quickly as possible. It will also undertake a system-wide review across the entire maternity system, bringing together the findings of past reviews into one clear national set of actions to improve every maternity service.

17. A National Maternity and Neonatal Taskforce will be established, chaired by the Secretary of State for Health and Social Care, and will be made up of a panel of experts and bereaved families, which will examine several issues facing maternity care in England. One key area of focus will be an anti-discrimination programme to address the inequalities that women from Black, Asian and deprived backgrounds face.

18. The review will commence this summer and report by December 2025. The full announcement can be found here: https://www.gov.uk/government/news/national-maternity-investigation-launched-to-drive-improvements.

Review of ICB Emergency Preparedness, Resilience and Response (EPRR) arrangements

19. The ICB has recently strengthened its emergency response processes to provide a more robust approach to managing EPRR incidents in its role as a Category 1 Responder under the requirements of the Civil Contingencies Act 2004. Combining its System Coordination Centre and EPRR functions enables the ICB to deliver a robust and consistent seven-day EPRR provision. This also provides considerable support to the ICB's tactical and strategic on-call manager function between the core hours of 8am to 6pm.

20. At its June 2025 meeting, the ICB's Audit and Risk Committee endorsed this development and received a mid-year progress update on compliance with NHS Core Standards following the annual assessment, which was presented to the Board in January 2025. The Committee noted good progress had been made and, following scrutiny, approved a refreshed Communications Emergency Plan; a Business Continuity Policy; and non-material changes to the existing EPRR Policy, Incident Response Plan and Business Continuity Plan.

21. The Board is asked to ratify the Business Continuity Policy and changes to the EPRR Policy, which can be found here: https://notts.icb.nhs.uk/wp-content/uploads/sites/2/2022/04/EPPR-001-EPRR-Policy-v3.0-FINAL.pdf and

https://notts.icb.nhs.uk/wp-content/uploads/sites/2/2022/04/Business-Continuity-Management-System-Policy-v1.0.pdf.

Three-Year Integrated Mental Health Pathway Strategic Plan: year one delivery update

22. Nottingham and Nottinghamshire's Three-Year Integrated Mental Health Pathway Strategic Plan, which was published on 31 July 2024, outlines an integrated mental health pathway that delivers local, inclusive, safe, personalised, and therapeutic care that meets the needs of individuals in Nottingham and Nottinghamshire.

23. Developed with experts by experience and system partners across NHS, Local Authority and the Voluntary Community and Social Enterprise sector, the plan aims to realign mental health services over a three-year period to ensure the right care is being delivered, in the right place, at the right time, and in the least restrictive environment.

24. Focus this year has been given to eight immediate priorities that set the foundations for the delivery of the programme or were time critical developments. Further detail on progress is enclosed at Appendix A, along with an overview of the whole Plan.

25. Patients have been involved in the coproduction of improvement changes and work to date has highlighted two key areas as having the biggest impact on the successful delivery of the strategic plan: prevention, and housing and accommodation. These have been agreed by partners as system priorities for year two.

26. The use of coproduction has been a key success of the strategic plan, with the Partners in Mind coproduction group being established and embedded within system governance and involved in priority areas to ensure the voice of people with lived experience has an equal voice to that of our system professionals.

27. Another key strength of the strategic plan has been the effective partnership working that has taken place across the system, with partners coming together to work on the agenda collectively and share their expertise and knowledge to make improvements.

28. As a result of this, there is a much clearer system understanding of the key challenges. The most notable result of this is the increased understanding of the impact that housing and accommodation has on people waiting to leave hospital, and the significant impact this has on pathway flow.

Nottingham and Nottinghamshire Suicide Prevention Charter

29. The ICB, Nottingham City Council and Nottinghamshire County Council have been working with people with lived experiences of suicidality and/or bereavement by suicide to develop a Suicide Prevention Charter, which outlines the key values and principles that matter to them.

30. The Charter embodies the fundamental values and principles crucial to those directly impacted by suicide. It acknowledges the profound significance of lived experiences and advocates for people with these experiences to have a central role in shaping local suicide prevention and mental health initiatives. A series of 'I' and 'We' statements articulate both personal expectations and the responsibilities of organisations and services in addressing these needs.

31. Central to its ethos is a message of hope and a reminder that recovery is possible. Embedded within the Nottingham and Nottinghamshire Self Harm and Suicide Prevention Strategy, the Charter serves as the guiding framework for Nottingham and Nottinghamshire's collective vision for suicide prevention. Organisations and stakeholders therefore have an important role in championing the Charter.

32. In signing up to the Charter the ICB will work to progress three key actions that have been co-developed with the ICB's Staff Engagement Group. These three actions are:

    a) Promote sign up to the Suicide Prevention Charter and uptake of the Zero Suicide Alliance Training across system partners.

    b) Review the opportunity to embed the Self-Harm and Suicide Prevention Strategy into the Quality Schedule for 2026/27 contracts to encourage all commissioned organisations to sign up the Suicide Prevention Charter.

    c) Promote the Zero Suicide Alliance Training to all ICB staff, and in particular with line managers, Staff Engagement Group members and Mental Health First Aiders.

33. The actions will be monitored by the Nottingham and Nottinghamshire Self-Harm and Suicide Prevention Strategic Steering Group, which reports to the Nottingham and Nottinghamshire Adult and Children's Mental Health Partnership Board.

34. Currently Nottinghamshire Police are the first organisation to sign up to the Charter and it is currently working its way through governance within Nottingham City Council, Nottinghamshire County Council, Nottinghamshire Healthcare NHS Foundation Trust, and the Harmless Community Interest Company, national centre of excellence for self-harm and suicide prevention.

35. The Charter can be found here: www.nottinghamshire.gov.uk/suicide-prevention.

Recent leadership updates

36. Councillor Helen Kalsi has been appointed as Chair of the Nottingham City Health and Wellbeing Board; and following the Nottinghamshire County local elections in May, Councillor John Doddy has been appointed as Chair of the Nottinghamshire Health and Wellbeing Board. In their roles, both sit as vice chairs of the Nottingham and Nottinghamshire Integrated Care Partnership, and we look forward to working closely with them over the coming year.

37. Melanie Williams, one of our Partner Members of the Board, and Director of Adult Social Services at Nottinghamshire County Council, has been appointed as a Non-Executive Director to the Care Quality Commission's Board.

Partnership meeting updates

38. The Nottingham City Health and Wellbeing Board last met on 28 May 2025. The meeting received a report on the Best Start Strategy, the Joint Strategic Needs Assessment Work Plan for 2025/26, a delivery report on the Joint Local Health and Wellbeing Strategy and an update from the Joint Nottingham and Nottinghamshire Health Protection Board. The papers and minutes from the meeting are published on Nottingham City Council's website here: https://committee.nottinghamcity.gov.uk/ieListMeetings.aspx?CId=185&Year=0.

39. The Nottinghamshire County Health and Wellbeing Board last met on 25 June 2025 and received a delivery report on the Joint Local Health and Wellbeing Strategy, an annual report on women's health, and the Best Start Strategy. The papers for the meeting can be found here: https://www.nottinghamshire.gov.uk/dms/Committees/tabid/62/ctl/ViewCMIS_CommitteeDetails/mid/381/id/548/Default.aspx.

40. The East Midlands Joint Commissioning Committee met on 15 April 2025 and received assurance reports on primary care finance and specialised commissioning services, and briefings on the future strategic commissioning directions for several services, including that of the National Rehabilitation Centre. A Highlight Report from the meeting can be found at Appendix B.

Appendix A: Three-Year Integrated Mental Health Pathway Strategic Plan: Delivery Update

Introduction

1. The Three-Year Integrated Mental Health Pathway Strategic Plan was published on 31 July 2024 and outlined an integrated mental health pathway that delivers local, inclusive, safe, personalised, and therapeutic care that meets the needs of individuals in Nottingham and Nottinghamshire.

2. Developed with experts by experience and system partners across NHS, Local Authority and the Voluntary Community and Social Enterprise (VCSE) sector, the strategic plan aims to localise and realign mental health services over a three-year period to ensure the right care is being delivered, in the right place, at the right time, and in the least restrictive environment.

3. Our collective commitment is to support people to live well in their local community and access the right care at the right time to prevent the need for an inpatient admission to hospital. If people do need support from inpatient services, they will receive high quality care in their local area in the least restrictive environment to meet their needs. People will only stay in hospital for the time they need to, with partners working together to identify, act upon and commission appropriate housing and support needs to enable people to go to the place they call home as soon as they are ready, and to prevent the need for readmission.

Progress to date

4. Within the strategic plan, system partners and experts by experience developed three strategic pillars and twelve key areas of focus that set the blueprint for delivery of an integrated mental health pathway. Progress, one year on from the plan’s publication, against these agreed areas of focus, is detailed in the table below.

5. Priority focus has been given to eight immediate priorities that set the foundations for the delivery of the programme or were time critical developments. Progress updates against the eight priorities are set out in paragraphs 6 to 13 below.

6. Priority One – Refreshed programme governance: The Integrated Mental Health Oversight Group membership includes all system partners and experts by experience and has been refreshed to ensure sufficient oversight, assurance and support to the delivery phase of the programme. The Group is aligned to the refreshed Nottingham and Nottinghamshire Adult and Children’s Mental Health Partnership Board and the Health and Wellbeing Boards in the City and County.

7. Priority Two – Mental Health Systems Dashboard: The mental health systems dashboard has been developed to enable strategic system oversight of performance across the whole mental health pathway to understand areas of progress and challenge and support strategic decision making within system partnership working. Led by the System Analytics and Intelligence Unit (SAIU), system partners have come together to develop metrics and enable the sharing of data to support system reporting. Phase one of the dashboard is now live for system partners, with the SAIU continuing to build the next stages of the dashboard.

8. Priority Three – Outcomes framework: The system outcomes framework aims to complement the systems dashboard and monitor the impact of care on the outcomes and experiences of the people of Nottingham and Nottinghamshire. Outcomes framework metrics have been developed by partners and experts by experience via a systems outcomes workshop held in June 2024 with 60 attendees and a working group to develop the finer detail. The framework was endorsed at Integrated Mental Health Pathway Oversight Group in September 2024. The SAIU are leading on the development of the framework as the second phase of the dashboard, and this will be live by the end of quarter two of 2025.

9. Priority Four – Inpatient Bed Modelling: Bed modelling plans are in development to ensure the right number and type of inpatient provision is in place and to reduce reliance on local independent sector and out of area beds. Work has been undertaken with NHS England region and the Commissioning Support Unit to develop a bed demand and forecasting tool, with Nottingham and Nottinghamshire ICB being one of three early implementor sites for the Midlands. A local Nottinghamshire model has been developed in partnership with the SAIU and Nottinghamshire Healthcare NHS Foundation Trust to inform future commissioning of the inpatient bed base

10. Priority Five – Housing and accommodation: The impact that housing and accommodation challenges have on delayed discharges from hospital and the impact this has on pathway flow has been recognised by system partners as one of our most significant system challenges for people with mental health needs. A workshop was undertaken in December 2024 with housing, health and social care leads to develop a shared understanding of the collective challenge, as well as the challenges that each agency faces and the key actions that can be taken to improve outcomes for people in the short, medium and long term. This has informed the development of a system housing action plan that will set the direction of priority work for the next year. As a result of this work, the Nottingham and Nottinghamshire Adult and Children's Mental Health Partnership Board agreed for housing to be one of its priorities for 2025/26, to ensure senior strategic oversight of progress to address the issues and ability to escalate support with regional and national housing colleagues.

The objective is to develop a strategy for all mental health and housing related developments to support pathway flow across the system, as well as development of an implementation plan taking account of regional and national networks and policy to support development of sufficient housing provision in Nottingham and Nottinghamshire.

11. Priority Six – Locked Rehabilitation (Level Two) Review: A system review of Level Two rehabilitation to meet guidance set out in the Commissioning Framework for Mental Health Inpatient Services (published January 2024) and the requirement to cease the use of 'locked rehabilitation' has been completed. This has resulted in agreement of a local Level Two rehabilitation model and associated funding, supporting a more personalised approach to care and support in the least restrictive environment that supports people's independence to return to live in the community.

12. Priority Seven – Integrated Commissioning opportunities: An integrated commissioning roadmap has been developed by the ICB, Nottingham City Council and Nottinghamshire County Council, focused on strengthening supported accommodation and the community support; bridging the gap from GP to crisis services/secondary care services; and exploring alternatives to inpatient admission. A pathway workshop was held in September 2024 with 60 attendees from across the system to develop and design an integrated pathway that meets peoples' needs. Endorsed by Integrated Mental Health Pathway Oversight Group in January 2025, it sets the strategic commissioning intention priorities for the next two years to support delivery of the integrated mental health pathway in line with the aspects of care required at each stage of the pathway. Key areas for development within the pathway have been identified around four key stages: self-care; getting support; getting specialist support; and support after discharge. This is focused on the objective of ensuring that the right care is available at the right time for people and enables people to manage their own health and wellbeing in the community and prevent escalating need, that the care and support offer meets local need, and that patients and professionals are clear on the full range of care and support available.

13. Priority Eight – Coproduction: The Partners in Mind expert by experience group was established in April 2024 to ensure coproduction with people with lived experience throughout development and delivery of the strategic plan. The group are involved in key aspects of work within the delivery plan, have two members on the Integrated Mental Health Pathway Oversight Group and have two members on the Nottingham and Nottinghamshire Adult and Children's Mental Health Partnership Board. To provide sufficient independent support to the group for the duration of the delivery of the three-year strategic plan, Partners in Mind coproduced a proposal for a Mental Health Coproduction Model. This commitment to embedding coproduction was agreed by the ICB

along with the funding required, and the Partners in Mind group have been receiving independent coproduction support from Improving Lives since April 2025.

Impact for people and patients

14. Patients have been involved in the coproduction of improvement changes as part of year one delivery. As a result, patients will see their ideas and suggestions reflected in local models of care giving them confidence that their views and experiences have contributed to local changes. For example, this is evidenced by the coproduction model that was developed by the Partners in Mind group, which resulted in the commitment to resource the group with independent support as well as ensure they are an active voice throughout the system mental health work. It is also evidenced through the voice of people with lived experience in the pathway workshops that directly resulted in the development of the integrated commissioning roadmap, which sets out the areas of focus that will have the largest impact for the next two years.
15. Patients will see the most immediate direct changes through the level two rehabilitation model and the ending of the use of locked rehabilitation. This means that patients will receive care in the least restrictive environment with personalised care plans that support people to move off the ward and access the community in line with individual clinical assessments. This is as a result of patient engagement and feedback through the local work.
16. Furthermore, the way in which partners have worked together as a system and identified areas of strategic focus will result in joined up pathways of care for people and will support people to be able to access the right care at the right time.

Priorities in 2025/26

17. Work to date has highlighted two key areas as having the biggest impact on delivery of the strategic plan and these have been agreed by partners as system priorities for year two: prevention and housing and accommodation.
18. Prevention will focus on secondary prevention to support those individuals who are starting to access services and prevent further escalation of need and/or de-escalation. Focus will include:
    a) Exploring opportunities for a jointly commissioned health and wellbeing hub test and learn approach to provide multi-agency support to support people to live well in their local community, to ensure accessible pathways to appropriate care when needed and facilitate successful reintegration into the community following discharge. The hub will aim to address the gap between primary care and crisis services to ensure people receive

the support they need in their local community and prevent escalation of need. Timescales are for the initial hub to be in place during quarter four for a two year test and learn period, with a full evaluation in place to inform longer term approaches.

b) Developing a ‘no wrong door’ approach across the system along with agreed processes for access points, for example by agreeing referral routes and a trusted assessor model to support timeliness of access to support.

c) Developing a trusted organisation approach to give referrers assurance to signpost and refer people to care and support offered by the VCSE sector (which is currently underutilised as professionals are unclear on the quality of the support offer).

19. All of the above will be developed and delivered through the health and wellbeing hub model in a test and learn approach, to be in place by quarter four. An initial hub model has been developed by a system working group following review and analysis of other local and national models, analysis of local data and population health needs, and feedback from partners and experts by experience at a system workshop held in May 2024. The model has been built with a strong emphasis on utilising existing assets within the community, both in terms of estates opportunities and utilising the expertise of local partners and community organisations.

20. Housing and accommodation will focus on addressing the current system challenge and the impact it has on people’s abilities to leave hospital as soon as they are ready and its associated impact on pathway flow and delayed transfers of care. Focus will include:

a) Exploring opportunities for jointly commissioned step-down pilots to support discharge flow from hospital to be in place by quarter three.

b) Agreeing community wraparound from across the system (health, social care, housing and VCSE sector) to support people to stay well in the community and maintain their housing and accommodation by quarter four.

c) Developing integrated commissioning approaches to supported accommodation informed by demand and forecasting by quarter four.

d) Developing local housing options for general needs housing with housing authorities to support timely hospital discharge and move on from supported accommodation by quarter four.

e) Developing an escalation and lobbying approach to inform national policy and decision makers by quarter four.

21. Delivery of the remaining areas of focus contained within year two of the strategic plan will be delivered by system partner leads, with the Integrated

Mental Health Pathway Oversight Group receiving updates on progress for oversight. This includes:

a) Good quality inpatient provision in place – remaining areas of action to be led by Nottinghamshire Healthcare NHS Foundation Trust, the ICB Mental Health Commissioning Team and ICB Quality Team.

b) Strengthening personalised care – personalised discharge plans and use of Personal Health Budgets to continue to be led by Nottinghamshire Healthcare NHS Foundation Trust with ICB support. This will also be a golden thread through all the work that is undertaken.

c) Addressing health inequalities and delivering equity – will not be led as separate areas of work (as outlined in the strategic plan) but rather as a golden thread through all the work that is undertaken.

d) Addressing health inequalities to meet the needs of people with autism – the planned year two work on the agreed principles for suitable environments with a focus on the needs of people with autism will be led by the ICB Learning Disability and Autism Team.

e) Workforce and culture – this area has proven challenging to develop due to there no longer being Integrated Care System workforce leads in post to lead the work. This will be discussed as a priority for the Nottingham and Nottinghamshire Adult and Children's Mental Health Partnership Board.

Successes achieved through implementing the strategic plan

22. A key strength of the strategic plan has been the effective partnership working that has taken place across the system, with partners coming together to work on the agenda collectively and share their expertise and knowledge to make improvements.

23. As a result of this, there is a much clearer system understanding of the key challenges that affect how the system can work effectively together. The most notable result of this is the increased system understanding of the impact housing and accommodation challenges have on delayed discharges, the impact this has on people waiting to leave hospital, and the significant impact this has on pathway flow.

24. The delivery and embedding of coproduction have also been a key success of the strategic plan. With the Partners in Mind coproduction group being established and embedded within system governance and involved in priority areas to ensure the voice of people with lived experience has an equal voice to that of our system professionals.

Risks to delivery

25. Significant work is still required to be undertaken to continue to deliver the priorities identified in the three-year strategic plan to improve pathway flow and make improvements that positively impact outcomes for people. Priorities require a system approach to undertake improvements to reduce out of area placements; length of stay in inpatient services; demand for crisis and emergency services; demand on social care; and developments to housing and accommodation to reduce delays in the whole pathway.

26. The delivery of the integrated mental health pathway will not be possible without active and effective partner engagement. It is noted that consistent involvement is challenging for partners who are receiving national improvement support and scrutiny, such as Nottinghamshire Healthcare NHS Foundation Trust and Nottingham City Council.

27. Priorities for 2025/26 that require a sustained focus from system partners include:

    a) Delivery and evaluation of the Health and Wellbeing Hub test and learn site to reduce escalating demand and support pathway flow.

    b) Delivery of the agreed approach to step down accommodation and associated integrated commissioning to support people to leave hospital supporting pathway flow.

    c) Development of community wraparound required from across the system (health, social care, housing and VCSE sector) to support people to stay well in the community and maintain their housing and accommodation.

    d) Ongoing commissioning and contract alignment across the system, in line with the integrated commissioning roadmap, to ensure integrated approaches across the system and ensure best value for money.

    e) Development of local housing and accommodation approaches to support timely hospital discharge and move on from supported accommodation.

28. Effective partner engagement remains under review through the Integrated Mental Health Pathway Oversight Group, with escalations in place when required.

Review against areas of year one focus

Strategic Pillar	Areas of focus	Year 1	Progress
Improving access to care and support in the right place at the right time	Clearer pathways into the full range of high quality system services and support	a) Clear mental health offer in place across the system covering high quality universal, community, targeted support and hospital admission services (including eligibility and referral criteria) delivered across the voluntary, community & social enterprise (VCSE) sector, local authorities and NHS. b) Establishment of 'no wrong door' processes. c) Embedding of personalised care approaches across pathway. d) Development of integrated pathways to reduce people being signposted repeatedly back to their GP.	a) System partners have come together to share offers in place. Utilised Nott Alone as core mental health support and signposting resource (launched October). b) Completed review of referral and access data, mapping 55 services across the area and analysing how people navigate mental health support. Findings will be tested through health and wellbeing hub test and learn approach. c) This work is being undertaken by Nottinghamshire Healthcare NHS Foundation Trust (NHT), with plans in place to widen across the system as part of work around 10 high impact discharge actions. d) Held pathway workshop with 60 stakeholders to develop integrated pathway. Commissioning roadmap developed to set future commissioning intentions and bridge the gap from GP to Crisis Services. This has identified the need for a health and wellbeing hub – which is under development and aims for launch in year 2.
	Improved information sharing, including referrals and escalation	a) Information sharing agreements established across partnership. b) Signposting materials to support no wrong door approach and shared with key partners/contact points. c) Improved public facing information to support prevention and self-management. d) Strengthened Multi Disciplinary Team (MDT) approach to support partnership working for people with most complex needs.	a) Will be developed through health and wellbeing hub test and learn approach. b) Will be developed through health and wellbeing hub test and learn approach. c) Complete - Nott Alone launched October 2024. d) Work underway at NHT.
	Bridging the gap from GP to Crisis Services	a) Clear information on the range of care and support available across the system is shared with Primary Care. b) Review of work already underway in primary care mental health practitioners and links to Local Mental Health Teams to increase impact. c) Gap analysis undertaken. d) Identification of joint commissioning opportunities across NHS, Local Authority (LA) and VCSE sector to strengthen community support offer and bridge the gap from GP to Crisis Services.	a) Mapping and review work has been undertaken with partners. Effective approaches to sharing of information with Primary Care will be developed through the health and wellbeing hub test and learn approach. b) Complete - review work undertaken with findings informing hub test and learn approach. c) Complete – Gap analysis undertaken and informed development of commissioning roadmap d) Opportunities for next two years identified through commissioning roadmap, with mental health and wellbeing hub identified to address gap between GP and Crisis Services.
How we deliver high quality care for people	Good quality inpatient provision in place	a) Review of existing service specifications and development of new specifications to ensure reflective of all national guidance (commissioning, National Institute for health & Care Excellence and Getting It Right First Time guidance) to ensure quality of care being delivered. b) Bed modelling plans agreed, and actions developed to ensure right size and type of provision in place and reduction in reliance on sub-contracted beds. c) Completion of Optimal Care Programme in Adult Mental Health inpatient services to ensure robust systems and processes in place to support flow. d) Review of Trauma Informed Care Pathway (female personality disorder) as flow priority and actions developed. e) Review of rehabilitation provision to end 'locked rehabilitation' approach and support care in least restrictive environment. f) Quality monitoring and improvement processes strengthened and in place. g) Plan to eliminate out of area placements delivered. h) Review of local Psychiatric Intensive Care Unit (PICU) provision for women to end out of area placements. i) Multi-Disciplinary Team infrastructure developed, and electronic care plan go live.	a) Rehabilitation service specifications reviewed and complete. ICB Commissioning Team undertaking planned review of all specifications in line with commissioning cycle. b) Bed modelling plans developed – ongoing discussions to agree bed model plan. c) NHT Optimal Care Programme completed and developed into new programme for 2025/26. d) NHT priority is ongoing. e) Complete – with new level 2 rehabilitation model agreed and funding in place. f) Complete – part of Quality Oversight and NHS England improvement. g) Plan led by NHT. h) To be scheduled for year 2. i) NHT electronic care plan go live scheduled for year 2.

Strategic Pillar	Areas of focus	Year 1	Progress
	Strengthening personalised care: treating the person	a) Culture change/training programme established to embed personalised care. b) Personalised discharge plans established with processes for sharing with relevant system partners.	a) To be scheduled for year 2. b) To be scheduled for year 2.
	Addressing health inequalities and delivering equity	a) Data profile development of people who are using different types of services. b) Identification of gaps and review of local provision undertaken. c) Review of current mixed sex accommodation, with actions to resolve. d) Development of system approach to cultural competency training e) Community health promotion established to reduce stigma in communities. f) NHT compliant with Patient and Carer Race Equality Framework and themes embedded across whole pathway.	a) Under development as part of Mental Health Pound work. b) Complete. c) Completed by NHT. d) Not progressed - to be scheduled for year 2. e) To be scheduled for year 2. f) NHT leading.
	Improved system integration	a) System visibility of all services and support. b) Relationships developed between partners at all levels (focus on operational level). c) Clarity on partner roles and responsibilities. d) Programme of system-wide events to strengthen partnership culture. e) Approved Mental Health Professionals (AMHPs) provision integrated as key part of the pathway.	a) Increased partner awareness of range of system services in place. b) System relationships have been developed with partners coming together on system priorities and as part of key working groups. Continued development required for life of plan. c) Partners are clearer on core roles and responsibilities, especially in relation to housing. d) Complete - System wide workshops and working groups have been undertaken throughout the year and will continue. e) Complete – included as core part of pathway. Work underway to review Section 12.
	Coproduction with people who use services as equal partners	a) System-wide coproduction and engagement approach developed. b) Experts by experience model to support programme delivery established and embedded within governance. c) Coproduction and engagement plan to actively include the diverse voices of people who use care and support services developed and delivered.	a) Complete – will be further developed by Mental Health Partnership Board Coproduction Delivery Group. b) Complete – Partners in Mind group established, and support model agreed with contract in place with VCSE provider. c) Complete – Improving Lives will increase diversity of voice through coproduction contract.
	A system-wide workforce and culture that supports safe, personalised therapeutic and trauma-informed care	a) System training offer established, maximising opportunities across organisations. b) System ethos established to enable staff to feel safe and supported to solve complex challenges together. c) System recruitment and retention plan developed. d) Trauma informed system workforce approach agreed. e) Neurodiversity awareness training and Oliver McGowan training rolled out. f) NHT completion and embedding of NHS England culture of care programme.	a) This work was paused due to their being no ICS system workforce leads in post to lead the work. This will be discussed as a priority for the Nottingham and Nottinghamshire Adult and Children's Mental Health Partnership Board. b) As above – work paused. c) As above – work paused. d) Trauma informed working group leading approach. e) Oliver McGowan training rolled out across local NHS. Neurodiversity awareness training in development. f) NHT part of Culture of Care pilot – ongoing.
Timely discharge to the place people call home	Improved system data	a) System performance online dashboard developed (including national and local indicators to measure effectiveness). b) Information sharing processes established. c) Real time patient reporting developed with system partners to support patient care and flag risk and issues.	a) Complete. b) Complete. c) Work with NHIS underway.
	Strengthening personalised care: putting people at the heart of their discharge	a) Personalised discharge plans established with processes for sharing with relevant system partners. b) Opportunities explored to maximise Personal Health Budgets (PHBs) for discharge. c) Focused work on those medically fit still in hospital and partners actions to support.	a) To be scheduled for year 2. b) Work undertaken in Personality Disorder services. c) Work underway as part of high impact discharge actions.

Strategic Pillar	Areas of focus	Year 1	Progress
	Identifying needs early at admission (housing and wider support)	a) Processes in place to support identification of housing and support needs for discharge at point of admission. b) In-reach of partner expertise to wards established. c) Information sharing and reporting processes in place to ensure all partners aware of support needs and associated actions.	a) In progress. b) Housing expertise commissioned by City and County Councils. Refugee and Asylum Seeker support established through VCSE sector. c) In progress.
	Increased housing and support to enable people to live in the place they call home	a) Gap analysis undertaken to inform service development. b) Demand forecast models for supported living and wraparound capacity completed. c) Review and modelling of required S117 aftercare support completed with associated actions identified. d) Mental Health needs reflected in local housing plans. e) Joined up approaches to accommodation-based services in the community for the most complex people established. f) Market development undertaken to grow provider market based on need.	a) Complete. b) Supported living plans in place at City and County Councils. c) In progress. d) Complete. e) In progress – priority focus identified by step down working group. f) In progress and local authorities and remains part of schedule for year 2.

Appendix B: Briefing Summary of the East Midlands Joint Committee Meeting held on Tuesday 15 April 2025

1. Purpose

1.1. This **ADVISORY** report is presented to provide a summary of the East Midlands Joint Committee meeting held on Tuesday 15 April 2025.

1.2. Confirmation of Chair Arrangements

2. Summary of Agenda Items

2.1. Confirmation of Chair

The Committee approved that Kathy McLean (Chair of NHS Derby and Derbyshire ICB and NHS Nottingham and Nottinghamshire ICB) will remain as Chair of the Committee until 31 March 2026.

2.2. Primary Care Finance and Assurance Report

The Committee received the report for **ASSURANCE.** Confirmation was received that all contracts for Intermediate Minor Oral Surgery had been extended for a further 6 months with no detrimental impact to patient care, and that following the announcement of the Governmental manifesto commitment to secure additional urgent dental care appointments the East Midlands had approached the market through an Expression of Interests exercise and are currently achieving a 75% uptake against the East Midlands target. With a view to securing the remaining 25 % a Phase 2 “Flexible Commissioning” Expression of Interest is to commence through which existing providers of General Dental Services will be able to apply to convert current underperformance into urgent care activity with subsequent stabilisation follow ups.

Work continues on the Community Pharmacy Strategy with a multi-stakeholder event planned for 10 April 2025, with the aim of completing the strategy by summer 2025.

2.3. Specialised Commissioning Services Integrated Assurance Report

The Committee received the report for **ASSURANCE.** The Committee heard the progress made at Tier 2 regarding collective action to maintain Paediatric Spinal Cord Injury, Surgical Sperm Retrieval, Environmental Controls and Specialist Prosthetics and Neonatal provision. Confirmation was received that as of month 11 delegate service were running at a surplus of £11 million across the East Midlands, with frozen reserves now released into ICB allocations and reinstated into the opening baselines for 2025/26. There were no immediate quality issues for escalation, but it was noted that the outcomes of a deep dive into Thrombectomy would be presented to an upcoming meeting.

2.4. Specialised Commissioning Strategic Brief

The Committee **RECIEVED** confirmation that all ICBs had been approved for the further delegation, all delegation agreements have now been completed and **RECEIVED** the delegated duties from each member ICB. The Committee **NOTED** the work being undertaken at Tier 2 regarding Mental Health, Learning Disability and Autism, specifically that governance proposals would be presented to the next meeting and the confirmation of the contracting model through a Lead Provider/ Collaborative Provider structure.

The Committee **NOTED** the 2025/26 Operational Plans are being presented to the April Tier 2 meetings and would flow through to the next meeting, further discussion was had regarding to developing the horizon scanning / further forward-thinking planning agenda.

2.5. National Rehabilitation Centre Briefing

The Committee **RECEIVED** an update on the National Rehabilitation Centre, notably that the build was nearing completion (scheduled for August 2025). Primary focus for discussion lay with the need for urgent consideration into how value could be achieved considering changes to funding models (Neuro) and the wider challenge across the NHS. A Task and Finish Group is to be established to facilitate consideration of the way forward and inform a wider commissioning strategy to drive value from 2026/27 and beyond. The Committee asked that a briefing note be prepared for all ICB Boards.

2.6. 111/999 Governance Arrangements

The Committee **NOTED** the progress with agreement of contracts, and the further need for all ICBs to agree to the revised governance proposals.

2.7. NHS Reforms

The formal meeting of the Committee ended with only ICB Chairs and Chief Executive Officers remaining to undertake an informal development session focused on progressing the ICBs / East Midlands response to the NHS Reforms.

3. Recommendation

3.1. This briefing summary is provided for information to be noted.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/07/2025
Paper Title:	**Joint Forward Plan Outcomes Dashboard: Annual Update**
Paper Reference:	ICB 25 034
Report Author:	Erika Wood, Advanced Data Analyst Joanna Cooper, Assistant Director of Strategy Sergio Pappalettera, Senior Analytical Lead
Executive Lead:	Victoria McGregor-Riley, Interim Director of Strategy and System Development
Presenter:	Victoria McGregor-Riley, Interim Director of Strategy and System Development

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

Summary:

This paper provides the annual progress update on population outcomes intended to demonstrate the impact that successful delivery of the Joint Forward Plan (JFP) has on the overall health and wellbeing of our population. The report recognises that the NHS contribution to the achievement of outcomes does not sit in isolation from actions taken by other system partners including public health and social care, and also the social and economic factors that are beyond the immediate influence of NHS partners.

As the ICB evolves its new role as a strategic commissioner, it is anticipated that there will need to be a renewed focus on monitoring population outcomes, setting credible ambitions based on the available evidence base, and understanding the impact of our transformation and associated contracting activities to improve outcomes for local people.

Recommendation(s):

The Board is asked to **discuss** the current performance of the system in relation to reported outcomes and consider the implications for delivery of the NHS Joint Forward Plan, and the future role of the ICB as a strategic commissioner.

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

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

Appendices:
Appendix 1: JFP outcomes

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 5: Health inequalities and outcomes – Failure to identify and/or deliver service transformation to address health inequalities and improve outcomes.

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

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Joint Forward Plan Outcomes Dashboard: Annual Update

Background

1. A light touch refresh of the NHS Joint Forward Plan (JFP) was undertaken and overseen with engagement from NHS partners and public health colleagues. The final version is published on the Integrated Care System (ICS) website.[1]
2. It was agreed that a light touch refresh would be undertaken for 2025/26 recognising that a more significant refresh was likely to be required following publication of the anticipated Ten-Year Health Plan.
3. In line with the Integrated Care Strategy priority to *bring our collective data, intelligence and insight together* a set of outcomes was developed to monitor impact of the JFP. The approach drew on the ICS Outcomes Framework agreed in 2019. Analysis has been undertaken to propose an ambitious, but achievable level of ambition for each of the outcomes, using national targets where available and applying a local methodology for all other outcomes.
4. The first outcomes report was provided to the Board and all NHS partners in July 2024. This report provides an updated report to reflect the latest information available.

Confirming the outcomes to demonstrate impact of delivery

5. In July 2024, a suite of outcomes to monitor progress on delivery of the JFP was endorsed. These cover the four core aims of the ICS.
6. Baselines have been provided for each outcome along with current performance and the direction of travel. The metrics have been updated since the last report in July 2024 with the current available data recognising that each metric has its own publication timetable.
7. The outcomes consider standardised rates, which take into account changes to the population as well as absolute numbers. This approach is effective for monitoring population outcomes but is not effective for monitoring financial impact which will only be achieved by a change in absolute numbers.
8. The System Analytics Intelligence Unit has created an outcomes dashboard to ensure a common view of Integrated Care Strategy and JFP outcomes, quality and performance across the ICS.

Impact on our population outcomes

9. A detailed report is included at Appendix 1.

[1] https://healthandcarenotts.co.uk/integrated-care-strategy/joint-forward-plan/

10. Data has been updated where this is available. Many metrics are not significantly different from the previous reporting period. Of note are the changes below:

    a) Avoidable deaths for males are higher and have increased by 7.4% between 2017-2019 and 2022-2024. These are defined as deaths from causes considered treatable or preventable given timely and effective healthcare or public health interventions in those aged under 75 years, through timely and effective healthcare or public health interventions. There is an overlap between avoidable deaths and premature deaths, which are defined as deaths that could be avoided primarily through effective public health and primary prevention interventions. Between 2014 and 2023, 67.5% of premature deaths were avoidable (excluding COVID deaths). Five groups of conditions account for over 90% of avoidable, non-COVID deaths; cancers (one in three of all avoidable deaths), circulatory disease (one in four), respiratory (one in seven), alcohol and drug related (one in 11) and injury (one in 12). Of these, the number of avoidable deaths caused by circulatory disease and alcohol/drugs have increased during and since the pandemic. The number and rate of avoidable deaths caused by injury in 2023 was the highest observed in the last ten years.

    b) Early cancer diagnosis (cancers diagnosed at stage one and two) has improved from 54.5% in 2019 to 62.2% in 2024, supporting people to access treatment earlier and having a positive impact on their prognosis.

    c) Year six prevalence of obesity has worsened from 21.6% in 2019/20 to 23.7% in 2023/24. This is in line with national trends towards increases in obesity.

    d) Average Attainment 8 scores are lower in 2022/23 than 2019/20: in Nottingham moving from 45.3% to 42.7%, and in Nottinghamshire moving from 50.8% to 46.4%.

    e) Patient experience of general practice is lower in 2024 than in 2019 (73.6% compared to 84.4%).

    f) There are more end of life patients with a ReSPECT form in 2025 compared to 2021 (rising from 42.5% to 76.1%).

    g) More people with a learning disability are receiving annual health checks: 83.2% in 2025 as compared to 68.3% in 2023. More patients with a serious mental illness are receiving physical health checks: 67.1% in 2025 compared to 37.2% 2020 (rising from 37.2% to 67.1%). These health checks are supporting vulnerable patients to better manage their own health and wellbeing.

    h) Smoking prevalence has reduced from 19.4% in Nottingham and 16% in Nottinghamshire in 2019/20 to 17.2% in Nottingham and 14.3% in

Nottinghamshire in 2022/23. Reducing smoking improves quality of life and impacts on lower incidence of conditions such as lung cancer, cardiovascular disease, chronic obstructive pulmonary disease (COPD) and stroke.

i) Age-standardised rates of emergency admissions with a length of stay of more than one day have reduced by 14.4% between 2019/20 and 2024/25.

11. Outcomes are being used to drive improvements across commissioned services. The System Analytics and Intelligence Unit (SAIU) is collaborating closely with ICB commissioners to understand and analyse population health needs and apply these insights to service and pathway planning.

Next steps

12. Governance arrangements with partners for the delivery and oversight of the JFP have been established. The Integrated Care Strategy and JFP Oversight Group meets bi-monthly to consider overall delivery of the JFP whilst not replicating the role of Programme Boards. The Group has the opportunity to report issues of escalation into the Financial Delivery and Recovery Group as required. Additionally, there is a dedicated Integrated Care Strategy Operational Outcomes Group to provide technical and analytical support to the measurement and monitoring of outcomes.

13. The SAIU is leading further work to understand the health needs of specific patient cohorts and pathways to support understanding the financial impact on the system.

14. On 3 July, the Prime Minister launched the Ten-Year Health Plan, which sets out how the government plans to deliver on the three shifts of hospital to community, treatment to prevention, and analogue to digital. As we review the JFP in light of the Ten-Year Health Plan, the Outcomes Group will provide support to articulate the link between individual transformation programmes and our agreed population outcomes. This will support the ICB cluster to undertake its strategic commissioning function.

15. There is a need to ensure the appropriate governance is in place to scrutinise population outcomes as current governance arrangements are largely focused on financial delivery and recovery.

16. Consideration is also being given to how to share outcomes reporting with the Boards of partner organisations to ensure they recognise their contribution to JFP delivery.

17. The ICB’s Board will receive an update on JFP delivery and outcomes as well as further information on how we will progress the Ten-Year Health Plan at its meeting on 10 September 2025.

Appendix 1: Joint Forward Plan (JFP) outcomes

Table showing JFP outcomes mapped to the Integrated Care Strategy strategic aims.

Aim	Indicator	Baseline Figure	Latest Figure	Change (n)	Change (%)	Direction of Change	Statistical Significance	Baseline Period	Latest Period	Indicator Description
Improve Outcomes in Population health and healthcare	ICS Life Expectancy - Female	82.8	83.2	0.4	0.5%	Better	No Difference	2019	2024	Life expectancy at birth (years)
	ICS Life Expectancy - Male	80.1	79.7	-0.4	-0.5%	Worse	No Difference	2019	2024	Life expectancy at birth (years)
	Healthy Life Expectancy – Nottingham - Females	56.2	56.8	0.6	1.0%	Better	No Difference	2017 - 2019	2021 - 2023	ONS Healthy Life expectancy at birth (years)
	Healthy Life Expectancy – Nottingham - Males	56.6	57.2	0.6	1.1%	Better	No Difference	2017 - 2019	2021 - 2023	ONS Healthy Life expectancy at birth (years)
	Healthy Life Expectancy – Nottinghamshire - Females	61.8	59.7	-2.2	-3.5%	Worse	No Difference	2017 - 2019	2021 - 2023	ONS Healthy Life expectancy at birth (years)
	Healthy Life Expectancy – Nottinghamshire - Males	62.0	60.0	-2.0	-3.2%	Worse	Lower	2017 - 2019	2021 - 2023	ONS Healthy Life expectancy at birth (years)

Aim	Indicator	Baseline Figure	Latest Figure	Change (n)	Change (%)	Direction of Change	Statistical Significance	Baseline Period	Latest Period	Indicator Description
Improve Outcomes in Population health and healthcare	ICS Multi-morbidity Free Life Expectancy - Female									Work in progress
	ICS Multi-morbidity Free Life Expectancy - Male									Work in progress
	ICS Avoidable Deaths - Female	194	191	-3	-1.8%	Better	No Difference	2017 - 2019	2022 - 2024	Age Standardised Rate per 100,000 registered population
	ICS Avoidable Deaths - Male	285	306	21	7.4%	Worse	Higher	2017 - 2019	2022 - 2024	Age Standardised Rate per 100,000 registered population
	ICS Avoidable Deaths - Total Numbers	7,245	7,837	592	7.6%	Worse	N/A	2017 - 2019	2022 - 2024	Count of Avoidable Deaths
	Infant Mortality - Nottingham	6.6	5.9	-0.7	-10.5%	Better	No Difference	2019	2024	Crude Rate per 1,000 Births

Aim	Indicator	Baseline Figure	Latest Figure	Change (n)	Change (%)	Direction of Change	Statistical Significance	Baseline Period	Latest Period	Indicator Description
Improve Outcomes in Population health and healthcare	Infant Mortality - Nottinghamshire	3.6	3.7	0.1	2.0%	Worse	No Difference	2019	2024	Crude Rate per 1,000 Births
	ICS Suicides - Rates	9.2	10.5	1.3	14.3%	Worse	No Difference	2017 - 2019	2022 - 2024	Age Standardised Rate per 100,000 registered population
	ICS Suicide - Total Numbers	292	352	60	20.5%	Worse	N/A	2017 - 2019	2022 - 2024	Count of Suicide Deaths
	ICS Early Cancer Diagnosis	54.5%	62.2%	7.7%		Better	Higher	2019	2024	% Cancers diagnosed at stage 1 & 2
Tackle inequalities in outcomes, experiences and access	ICS - Year 6 Prevalence of Obesity	21.6%	23.7%	2.1%	10.0%	Worse	Higher	2019/20	2023/24	Year 6 prevalence of obesity (including severe obesity)
	Average Attainment 8 score - Nottingham	45.3%	42.7%	-2.6%	-5.7%	Worse	Lower	2019/20	2022/23	Average Attainment 8 score

Aim	Indicator	Baseline Figure	Latest Figure	Change (n)	Change (%)	Direction of Change	Statistical Significance	Baseline Period	Latest Period	Indicator Description
Tackle inequalities in outcomes, experiences and access	Average Attainment 8 score – Nottinghamshire	50.8%	46.4%	-4.4%	-8.7%	Worse	Lower	2019/20	2022/23	Average Attainment 8 score
	School Readiness - Nottingham	60.3%	63.6%	3.3%	5.5%	Better	No Difference	2021/22	2023/24	School readiness: percentage of children achieving a good level of development at the end of Reception
	School Readiness - Nottinghamshire	66.8%	67.7%	0.9%	1.3%	Better	No Difference	2021/22	2023/24	School readiness: percentage of children achieving a good level of development at the end of Reception
	ICS - Overall patient experience of GP Practice	84.4%	73.6%	-10.8%	-12.8%	Worse	Lower	2019	2024	% Patients who had a good overall experience of GP Practice

Aim	Indicator	Baseline Figure	Latest Figure	Change (n)	Change (%)	Direction of Change	Statistical Significance	Baseline Period	Latest Period	Indicator Description
Tackle inequalities in outcomes, experiences and access	Overall Experience of Inpatient Services - DBH	8.0	8.1	0.1	1.0%	Better	No Difference	2019	2022	Total Trust Mean Score
	Overall Experience of Inpatient Services - NUH	8.1	8.0	-0.1	-1.0%	Worse	No Difference	2019	2022	Total Trust Mean Score
	Overall Experience of Inpatient Services - SFH	8.3	8.4	0.1	1.2%	Better	No Difference	2019	2022	Total Trust Mean Score
	Overall Experience of A&E - DBH	8.1	7.3	-0.9	-10.6%	Worse	No Difference	2018	2024	Total Trust Mean Score
	Overall Experience of A&E - NUH	8.0	6.9	-1.1	-13.5%	Worse	No Difference	2018	2024	Total Trust Mean Score
	Overall Experience of A&E - SFH	8.4	7.5	-0.8	-9.9%	Worse	No Difference	2018	2024	Total Trust Mean Score
	ICS - Patients on EoL with ReSPECT Form	42.5%	76.1%	33.6%	79.0%	Better	Higher	Jan-2021	Mar-2025	% Patients on GP EoL Register with a recorded ReSPECT Form
	ICS – Learning Disabled Patients with Annual Health Check	68.3%	83.2%	14.9%	21.8%	Better	Higher	Jan-2023	Mar-2025	% Patients 14+ on GP LD Register with an Annual Health Check

Aim	Indicator	Baseline Figure	Latest Figure	Change (n)	Change (%)	Direction of Change	Statistical Significance	Baseline Period	Latest Period	Indicator Description
Tackle inequalities in outcomes, experiences and access	ICS – Severe Mental Illness (SMI) Patients with 6 Physical Health Checks	37.2%	67.1%	30.0%	80.6%	Better	Higher	Mar-2020	Mar-2025	% Patients on GP SMI Register with all 6 Health Checks
	Smoking Prevalence (QOF) - Nottingham	19.4%	17.2%	-2.2%	-11.4%	Better	Lower	2019/20	2022/23	Smoking prevalence in adults (15+) - current smokers (QOF) %
	Smoking Prevalence (QOF) - Nottinghamshire	16.0%	14.3%	-1.7%	-10.5%	Better	Lower	2019/20	2022/23	Smoking prevalence in adults (15+) - current smokers (QOF) %
Productivity and value for money	ICS Emergency Admissions with 1+ Length of Stay (LOS) (Rate)	7,577	6,485	-1,092	-14.4%	Better	Lower	2019/20	2024/25	Age Standardised Rate per 100,000 registered population

Aim	Indicator	Baseline Figure	Latest Figure	Change (n)	Change (%)	Direction of Change	Statistical Significance	Baseline Period	Latest Period	Indicator Description
Productivity and value for money	ICS Emergency Admissions with 1+ LOS (Number)	87,305	87,195	-110	-0.1%	Better	N/A	2019/20	2024/25	Count of emergency spells with length of stay of 1 or more bed-days (1+ LOS)
	ICS Emergency Admissions - Bed Days (Number)	615,978	686,340	70,362	11.4%	Worse	N/A	2019/20	2024/25	Count of emergency spells bed-days
Support broader social and economic development	Workforce demographics									SAIU exploring what data are available
	% of health and care workforce under the age of 25 years	7.0%	7.4%	0.4%	5.0%	N/A	No Difference	Mar-2021	Mar-2023	% of workforce up to age 25
	Total use and appropriate utilisation of our estate									SAIU exploring what data are available
	Carbon equivalent emissions from electricity	19	20	1	5.3%	Worse	No Difference	2020/21	2023/24	kilotonnes of carbon dioxide equivalent (ktCO2e)

Aim	Indicator	Baseline Figure	Latest Figure	Change (n)	Change (%)	Direction of Change	Statistical Significance	Baseline Period	Latest Period	Indicator Description
Support broader social and economic development	Carbon equivalent emissions from gas	68	64	-4	-5.9%	Better	No Difference	2020/21	2023/24	kilotonnes of carbon dioxide equivalent (ktCO2e)

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/07/2025
Paper Title:	**ICS People and Workforce Plan**
Paper Reference:	ICB 25 036
Report Author:	Philippa Hunt, Chief People Officer
Executive Lead:	Rosa Waddingham, Director of Nursing
Presenter:	Philippa Hunt, Chief People Officer

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

Summary:

The Board approved the Integrated Care System's (ICS) Workforce and People Plan at its meeting on 13 March 2025 on the proviso that it had attached to it clear yearly targets and outcome measures, alongside robust governance arrangements similar to those used in the oversight of financial plans.

This paper provides an update on the four areas where additional work has been undertaken to add these arrangements and ensure that the ICS People and Workforce Plan can be delivered as planned.

This update includes:

- Detailed workforce transformation plans.
- Clear reference to the intent to broaden its scope to the wider social care workforce.
- Detail relating to the governance and oversight arrangements.
- Clear success measures.

It is recognised that the Plan will need a further revision to incorporate the objectives of the Government's Ten-Year Health Plan and the impact of ICB clustering.

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	This paper describes the progress in developing the ICS people and workforce plan – without the correct number of people working with the required skills it will not be possible to improve population health outcomes.
Tackle inequalities in outcomes, experience, and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:
Appendix 1: System Workforce and People Plan Appendix 2: Draft Roadmap Mansfield Workforce Plan

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. • Risk 10: Culture and leadership – Failure to orchestrate positive system culture and leadership to drive effective partnership working.

Report Previously Received By:
The Quality and People Committee has continued to oversee the development of the People and Workforce Plan.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Nottingham and Nottinghamshire ICS People and Workforce Plan

Introduction and context

1. The ICS People and Workforce Plan has two distinct parts:

   a) Part one, the People Plan section, relates to the NHS People Promise and the ten outcomes-based functions that we must deliver.

   b) Part two is transformation and financially driven, links to the pay bill and incorporates the annual operational planning process. It sets out current challenges, future ambitions and sets an ambitious workforce trajectory for the next five years, with an initial whole time equivalent workforce summary.

Plan delivery update

2. The System Workforce and People Plan has a clear programme of work, with objectives split into timed delivery slots. Between September 2024 and June 2025 there were fourteen delivery objectives covering a range of workforce initiatives from meeting national guidance, analytics, training and education, transformation, and efficiency. Table One below demonstrates the progress made against each of the fourteen objectives that have been RAG rated. Eight objectives are rated green and are either completed or on track for completion, five are rated as amber and are in progress, but require further work, and one (establishment of an education and training sub-group) is blue as it was paused pending publication of the Ten-Year Health Plan.

Table 1: Delivery of System Workforce and People Plan

Delivery plan 2025/26 (between September 2024 and June 2025)	Updates	RAG Rating
Provider Collaborative to lead ongoing extension/development of the current work.	The Provider Collaborative has been disbanded. From a workforce perspective the discussions and work has been incorporated into the Vanguard Programme.	
Establish the ICS Strategic Workforce Transformation Group.	ICS Strategic Workforce Transformation Board established.	
Confirm with NHS England the required workforce growth for delivery of the long-term workforce plan	We are awaiting the Ten-Year plan, which will include a refreshed workforce plan. The ICB's Finance and Performance Committee is monitoring the delivery of the operational workforce plan on a monthly basis.	

Delivery plan 2025/26 (between September 2024 and June 2025)	Updates	RAG Rating
Initiate process with System Analytics and Intelligence Unit for the population health data to drive demand.	Commenced and being led by the System Analytics and Intelligence Unit.	
Work across all providers and social care to map the existing and future workforce.	Utilising links into known providers and social care, we are mapping existing workforce with support from the System Analytics and Intelligence Unit.	
Implement training to raise skills and knowledge relating to workforce planning (six steps process) across programmes.	Upskilling ICS Strategic Workforce Project Manager to enable training implementation (completes July 2025). Individual support offered and templates/information created to support.	
Map workforce elements of each programme to understand timing and resource required.	Working with Transformation Programmes to understand the workforce impact in £/whole time equivalent staffing numbers, however lack of detail has delayed mapping.	
Establish education subgroup.	Not yet required.	
Establish a process to be informed of commissioning intentions (new and decommissioning) to support a Workforce Impact Assessment.	A ICB workforce team colleague attends Commissioning Review Group discussions ahead of papers going to Strategic Planning and Integration Committee. ICB colleagues have a log to track workforce impact identified.	
Active review and horizon scanning of national and regional funding.	Current horizon scanning shows that there is very limited funding available. Where there is funding, we are engaged with regional colleagues to ensure that funding opportunities are cascaded as appropriate and maximised	
Develop networks to ensure shared good practice to promote innovation and creativity.	Refresh of ICS People and Culture Insight Group to capture views and voices from wider system spaces, including equality, diversity and inclusion, clinical placements and Oliver McGowan Training.	
Ensure updates relating to the People Plan are communicated.	Communication is taking place through a variety of People Governance forums and wider system meetings. The transformation programme boards are liaising with key stakeholders and are advising where they require workforce support. However, recent national	

Delivery plan 2025/26 (between September 2024 and June 2025)	Updates	RAG Rating
	announcements regarding changes and staffing reductions have taken priority and will continue to do so as further clarity and detail is made available.	
Extension of the efficiencies work to ensure workforce growth is in-line with programme plans.	Regular monthly monitoring of achievement of plans alongside finance pay bill. Reported through ICB governance structure.	
Work with programmes to establish digital future needs.	Working with digital colleagues on the workforce ramifications of the programme. Investigating potential artificial intelligence chatbot across providers.	

Success measures

3. In addition to monitoring delivery of the objectives within the System Workforce and People Plan there are several of other key success measures that support in monitoring our overall workforce and its movements.

Operational Workforce Plan

4. Annual operational workforce planning is an important measure of both the business-as-usual operational workforce plan and the System Workforce and People Plan. It represents a fixed plan to demonstrate the changes in workforce across our NHS partners. For 2025/26 the annual plan for the system has a whole-time equivalent (WTE) total 34,178 staff with a pay bill of £1,971,547.

5. The operational workforce plan submitted in April included a net reduction of 771 (2.2%) WTE made up of 297.2 WTE (0.9%) substantive staff, 367.5 WTE (16%) bank and 107.2 WTE (26.5%) agency staff. NHS partners acknowledged that this workforce reduction was not fully aligned to the financial efficiency programme and the financial plan.

6. Partners remain committed to reducing the workforce to affordable levels, whilst also ensuring the right workforce is in the right place. To support this objective, organisations are producing revised workforce plans (WTEs) and trajectories that improve alignment to the finance and efficiency plans and delivery of 2025/26 targets. These revised workforce plans will include bridges that describe workforce growth, reduction, and efficiency impact, ensuring that the net impact is affordable. Early indications are that these will lead to approximately 1,000 further WTE reductions across NHS partners. The revised plans are due to be approved by partner Trust Boards in June/July 2025.

7. At month two, the performance against the operational workforce plan demonstrates an overall under performance of 76.4 WTE (0.2) % against plan. Sherwood Forest Hospitals NHS Foundation Trust (SFH) has over performed against its total month two plan, Nottingham University Hospitals NHS Trust (NUH) and Nottinghamshire Healthcare NHS Foundation Trust (NHT) have underperformed against their plans. Substantive and agency staffing is under plan by 28.9 WTE (0.1%) and 9.9 WTE (2.8%) respectively. Bank staffing is over plan by 115.2 WTE (6.8%) and this is predominately driven by NHT. There are several factors contributing to this regarding the case mix, including the need for increased observations.
8. When considering pay, system providers are £2.67 million adverse to their month two pay bill plan. In total substantive staffing is £1.922 million above plan, bank staff £0.464 million above plan and agency spend £0.309 million above plan. Bank staff spend forecast at month two is to be under plan by £7.5 million by the end of the year and under the NHS England bank cap by £11.5 million. Agency staff spend forecast at month two is to be under plan by £1.3 million by the end of the year but over the NHS England agency cap by (£0.1 million).

Workforce Transformation and Efficiencies

9. Alongside the fixed operational plan is a target for transformation and efficiencies of £270.466 million of which pay efficiencies total £103.556 million.
10. The £103.556 million pay related transformation and efficiencies are split into three pillars:
    a) Pillar one is £62.045 million and is aligned to the system transformation programmes (Urgent and Emergency Care, Planned Care, Digital, Estates and Facilities, Medicines Optimisation, Procurement, Corporate Optimisation, Core Services, Local Care Together, and Continuing Healthcare).
    b) Pillar two is £41.562 million and is assigned to workforce. It includes a series of high impact actions to reduce workforce costs outside of the delivery programmes, and includes actions linked to the annual operational workforce plan (i.e. to reduce reliance on temporary staffing). Some of these are assigned to provider Chief People Officers as Senior Responsible Officers (SROs) for delivery, whilst others sit with the Chief Operating Officers and other operational colleagues.
    c) Pillar three represents the true transformation over multiple years and is not yet progressing beyond initial stages.
11. The performance in month two shows that within Pillar One the programmes are £0.963 million behind plan. The largest negative variances are in Core Services (£0.924 million) and planned care (£0.314 million). Corporate Optimisation and Local Care Together are over performing by £0.131 million and £0.17 million,

respectively. Pillar Two is underperforming against target by £0.950 million. Table 2 below shows that of the 118 schemes, nine schemes are over performing, 96 are on plan or have not started, and 13 are below plan.

Table 2: Pillar two scheme performance

Scheme Performance	NUH	NHCT	SFH
Over performing	3	0	6
On Plan/Not started	67	21	8
Under performing	8	3	2

12. Whilst the efficiencies are quantified as a financial value, the detail to deliver the transformation efficiencies, both in whole time equivalent impact and process efficiencies, such as job planning and e-rostering in pillars one and two is part of a dynamic planning and review process in year.

13. Delivery of the transformation and resulting efficiencies in Pillar One requires the transformation programmes to describe and quantify the workforce impact, creating a workforce plan for the programme lead by the provider's people business partner and recorded by the provider's Programme Management Office. This work is ongoing, and Table 3 below represents a summary of the information we have to date.

Table 3: WTE impact as per Transformation Programme Project Initiation Documents

Transformation Programme	WTE Increase	WTE Decrease
Continuing Healthcare	9	-
Local Care Together	1	42.53
Core Services and Best Value Services	Unknown	Unknown
Corporate Optimisation Financial Recovery Group to agree what the priority areas are for progression	Unknown	Unknown
Digital Transformation	Unknown	Unknown
Estates and Facilities	Unknown	Unknown
Medicines Optimisation	Unknown	Unknown
Planned Care Transformation	Unknown	Unknown
Procurement	Unknown	Unknown
Urgent and Emergency Care Transformation	-	96.4

14. Across the programmes of work in Pillar One the most advanced is the planning to develop Integrated Neighbourhood Teams. The workforce planning template for Mansfield Integrated Neighbourhood Team has commenced as a pilot, working to

geographical areas producing fixed WTE numbers across both health and social care as part of their wider transformation ambitions. They have developed a roadmap (shown at Appendix 2) showing key workforce milestones as part of the plan.

a) July 2025: Current Workforce – Assess the current workforce including skills, competencies, and gaps. This involves understanding the workforce impact of transformation programs and commissioning decisions.

b) September 2025: Future Workforce Needs – Identify future workforce requirements based on organisational goals and strategic plans. This includes aligning workforce plans with local service and financial planning and scenario planning to ensure the right people are in the right place, at the right time.

c) November 2025: Recruitment and Retention – Implement strategies for effective recruitment and retention of staff including understanding future workforce needs as part of the 10-year plan.

d) December 2025: Workforce Development – Develop strategies for workforce development including training, upskilling and career progression including a supportive environment for continuous learning.

15. The System Analytics and Intelligence Unit is undertaking work to understand the population health data, activity data and the staffing to support the case for need and design.

16. The development of Integrated Neighbourhood Teams is a radical change and will shift delivery from an acute based model, where need is met in a specific location, to a community-based model delivered in a variety of settings (based on need).

17. As an example, a Geriatrician who currently works solely in a hospital may be required to work out of hospital in the community. This will require providers to think differently about resourcing models and about how, when and where people work, and may also result in new provider models emerging over time.

18. Creating as described a ‘one team’ approach as part of the ‘one workforce’ ambition will be a key part of the workforce organisational development and culture change plan. This plan for Integrated Neighbourhood Teams will include an analysis of the required behavioural and technical competence alongside education and professional regulation requirements.

19. The Local Care Together team has created case studies with patient avatars to illustrate and help communicate the future vision.

Wider social care workforce

20. The ICB now has access to greater social care workforce data through a contract with Skills4Care.

21. Working with Skills4Care the System Analytics and Intelligence Unit and the People Team are the first ICB nationally to develop a Social Care Workforce Dashboard.

22. This data shows our current workforce in detail and supports improved information on social care to support planning and transformation. The dashboard and data are being reviewed and used by Local Authority colleagues and refinements will be made based on their feedback. The provision of Social Care data is voluntary, and we are collaborating with Local Authority partners and Skills4Care to increase the number of providers submitting information.

Governance and oversight arrangements

23. The People Team has reviewed their governance arrangements and to ensure plan delivery and assurance across transformation, performance, finance, and workforce through to Board committees (as illustrated within Appendix 1). The governance includes four key workforce meetings:

    a) ICS Strategic Workforce Efficiencies and Transformation Board – Defines overarching strategic direction and workforce priorities. Oversight of the other people groups and is the senior decision-making committee. The Transformation Board will provide the relevant oversight and assurance to wider ICS groups including (but not limited to), the ICS System Transformation and Efficiencies Group, ICS Financial Recovery and Delivery Group, the ICB's Quality and People Committee, and the ICB's Finance and Performance Committee.

    b) NHS People and Culture Planning Performance and Risk Group – Receives an integrated review of workforce plans, key performance indicators, finance and financial efficiencies and the planning process. Linking with finance, activity and quality through matrix working to deliver the in-year workforce position for the system, to enable enhanced oversight, to provide data and intelligence and make recommendations for areas of escalation, opportunities for improvement and analysis of risk. This Group reports to the ICS Strategic Workforce Efficiencies and Transformation Board.

    c) ICS People and Culture Insight Group – Will focus on employee engagement, cultural insights and ensuring alignment with values via actionable recommendations. This encompasses the People Promise and elements of the Long-Term Workforce Plan.

    d) NHS People Leads Forum – Weekly working group of NHS Chief People Officers and deputies to progress all aspects of work associated with workforce.

24. This new structure is currently being evaluated alongside other governance structures in the ICB and may require further revision as the ICB develops new and revised reporting.

Next steps

25. Further objectives have been set for the delivery of the System People and Workforce Plan for June 2025 to March 2026. If we include the amber rated actions, there are ten objectives.

    a) Work across all providers and social care to map the existing and future workforce.

    b) Implement training to raise skills and knowledge relating to workforce planning (six steps process) across programmes.

    c) Map workforce elements of each programme to understand timing and resource required.

    d) Establish education subgroup.

    e) As part of the annual planning process, enhance collaboration and triangulation of demand affordability and workforce.

    f) Develop metrics for workforce supply working with NHS England and higher education institutions.

    g) With NHS England and higher education institutions, and in line with the long-term workforce plan, establish future needs and start developing Nottingham and Nottinghamshire integrated education approach.

    h) Commence work to 'right size' the workforce across transformation priorities to have clear workforce strategies - including all system partners within a programme pathway taking account of priority programmes and available funding.

    i) Scope a recruitment hub for the ICS.

    j) Create digital workforce plans for programmes ensuring cross dependencies are mapped. e.g. e-rostering, digital solutions to reduce non-clinical capacity requirements, promoting digital/IT solutions for patient monitoring and remote care, and using AI to reduce clinical time, e.g. diagnostics and reporting of diagnostic information.

26. Although in preliminary stages of development, work on these objectives has already commenced and forms part of either operational workforce planning and/or transformation and efficiencies.

Conclusion

27. Considerable progress has been made to date on delivering the System People and Workforce Plan. It is acknowledged that considerable additional work is required to deliver the transformation to our workforce across the system to meet the national priorities, demand, activity, and financial requirements.

28. The Board is asked to note the further work required, the pace of change needed within the changing environment of the system, and the associated risks, which will be managed through the workforce governance arrangements (NHS People and Culture Planning Performance and Risk Group) and within the wider ICB governance.

29. The Board is asked to take assurance from the work completed and the developing actions to take forward the remainder of this year's system workforce and people plan objectives alongside the transformation and efficiency work.

Integrated Care System
Nottingham & Nottinghamshire

ICS People and Workforce Report

ICB Board

9th July 2025

Objectives

Integrated Care System
Nottingham & Nottinghamshire

Following presentation provides assurance on the delivery of the ICS Workforce and People Plan.

In the March ICB Board we were asked to return in July 2025, with further detail on the following areas:

DELIVERY Delivery of workforce transformation plans

SOCIAL CARE Clear reference to the intent to broaden scope to the wider social care workforce

ASSURANCE Assurance of the governance and oversight arrangements

FUTURE Future plans including success measures

The next slide details the areas of delivery to the end of Q1.

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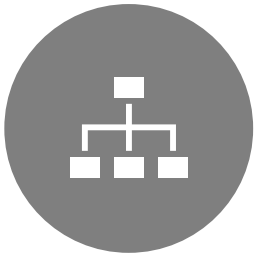
DELIVERY

SOCIAL CARE



ASSURANCE

FUTURE

How are we performing against the System Workforce and People Plan?

Delivery plan 2025/26 (between September 2024 and June 2025)	Updates	RAG Rating
Provider collaborative to lead work ongoing extension/development of the current work.	The provider collaborative has been disbanded . From a workforce perspective the discussions and work has been incorporated into the Vanguard programme.	
Establish the ICS Strategic Workforce Transformation Group.	Established the ICS Strategic Workforce Transformation Board.	
Confirm with NHS England the required workforce growth for delivery of the long-term workforce plan	We are awaiting the new 10-year plan which will include a refreshed workforce plan. We are monitoring the delivery of the operational workforce plan monthly to F&P Committee.	
Initiate process with System Analytics and Intelligence Unit for the population health data to drive demand.	Commenced and being led by the SAIU.	
Work across all providers and social care to map the existing and future workforce	Utilising links into known providers and social care, we are mapping existing workforce with support from the SAIU.	
Implement training to raise skills and knowledge relating to workforce planning (six steps process) across programmes.	Upskilling ICS Strategic Workforce Project Manager to enable training implementation (completes July 2025). Individual support offered and templates/information created to support.	
Map workforce elements of each programme to understand timing and resource required.	Working with Transformation Programmes to understand the workforce impact in £/WTE however lack of detail has delayed mapping.	
Establish education subgroup.	Not yet required.	
Establish a process to be informed of commissioning intentions (new and decommissioning) to support a Workforce Impact Assessment.	ICB Workforce colleague attendance at CRG discussions ahead of papers going to SPI Committee. ICB colleagues have a log to track workforce impact identified.	
Active review and horizon scanning of national and regional funding.	Limited as no funding available. Changes to Education Activity requests being in-year only which have previously been requested with 5 year forward view.	
Develop networks to ensure shared good practice to promote innovation and creativity.	Refresh of ICS People and Culture Insight Group to capture views and voices from wider system spaces including EDI, Clinical Placements and OMMT.	
Ensure updates relating to the People Plan are communicated.		
Ongoing and an extension of the efficiencies work to ensure workforce growth is in-line with programme plans.	Regular monthly monitoring of achievement of plans alongside finance pay bill. Reported through ICB governance structure.	
Work with programmes to establish digital future needs.	Working with digital colleagues on the workforce ramifications of the programme. Investigating potential AI chatbot across providers.	

Total ICS Provider Workforce and Finance

Total WTE
34,332 !
Planned: 34,256 (+76.4 +0.2%)

Total Spend
£170,597.9 !
Planned: £167,922.0 (-£2,675.9 -1.6%)

Substantive WTE
32,164 ✓
Planned: 32,193 (-28.9 -0.1%)

Substantive Spend
£158,488.9 !
Planned: £156,566.0 (-£1,922.9 -1.2%)

Bank WTE
1,819 !
Planned: 1,704 (+115.2 +6.8%)

Bank Spend
£8,698.2 !
Planned: £8,234.0 (-£464.2 -5.6%)

Agency WTE
349 ✓
Planned: 359 (-9.9 -2.8%)

Agency Spend
£3,140.9 !
Planned: £2,831.0 (-£309.9 -10.9%)

Provider	Staff Group		March 2025	April 2025	May 2025
NHCT	Agency Staff	WTE Variance %	-20.2%	8.3%	2.8%
		Cost Variance %	42.1%	10.9%	-5.9%
	Bank Staff	WTE Variance %	19.1%	-7.4%	25.0%
		Cost Variance %	-51.8%	-42.8%	-39.6%
	Substantive Staff	WTE Variance %	5.3%	-0.2%	-0.1%
		Cost Variance %	3.7%	-1.3%	-2.0%
	Total Staff	WTE Variance %	5.9%	-0.7%	1.7%
		Cost Variance %	0.8%	-3.6%	-4.4%
NUH	Agency Staff	WTE Variance %	-13.2%	-4.6%	-6.7%
		Cost Variance %	17.5%	-18.8%	-11.6%
	Bank Staff	WTE Variance %	42.2%	-7.3%	-0.7%
		Cost Variance %	-282.2%	-7.1%	2.6%
	Substantive Staff	WTE Variance %	3.6%	0.3%	0.3%
		Cost Variance %	-13.4%	-2.8%	0.0%
	Total Staff	WTE Variance %	4.8%	-0.0%	0.2%
		Cost Variance %	-9.0%	-3.1%	-0.0%
SFH	Agency Staff	WTE Variance %	-19.8%	-12.2%	-2.9%
		Cost Variance %	3.9%	-3.1%	-15.4%
	Bank Staff	WTE Variance %	-1.8%	-6.9%	-10.5%
		Cost Variance %	-43.2%	5.8%	20.0%
	Substantive Staff	WTE Variance %	1.1%	-1.1%	-1.4%
		Cost Variance %	-0.2%	-2.5%	-4.6%
	Total Staff	WTE Variance %	0.5%	-1.6%	-2.0%
		Cost Variance %	-1.6%	-2.0%	-2.9%

Variance Legend (WTE):
+ Positive Values: Workforce Increase
- Negative Values: Workforce Decrease

Variance Legend (Pay Bill, £):
+ Positive Values: Savings/Spend Decrease
- Negative Values: Over-Spend/Spend Increase

Agency Overview

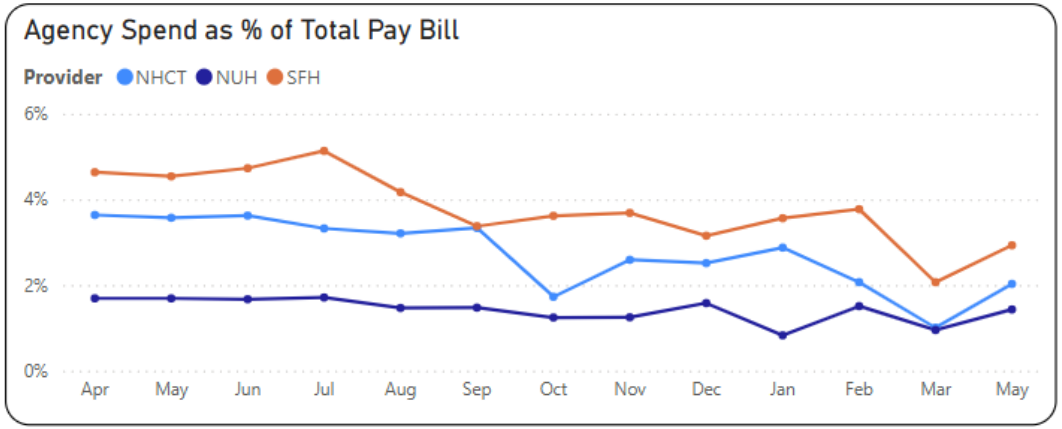
Off Framework

Provider	Shifts	Monthly Trend
NHCT	3.00	
NUH	60.00	
SFH	0.00	

On Framework Above Price Cap*

Provider	Shifts	Monthly Trend
NHCT	167.00	-1,407.00
NUH	1,191.00	-605.00
SFH	467.00	-149.00

*On Framework Above Price Cap captures any breaches 50% or above price cap as per the guidance of the NHSE Monthly Bank and Agency Report.



Agency Spend as % of Total Pay Bill in Month

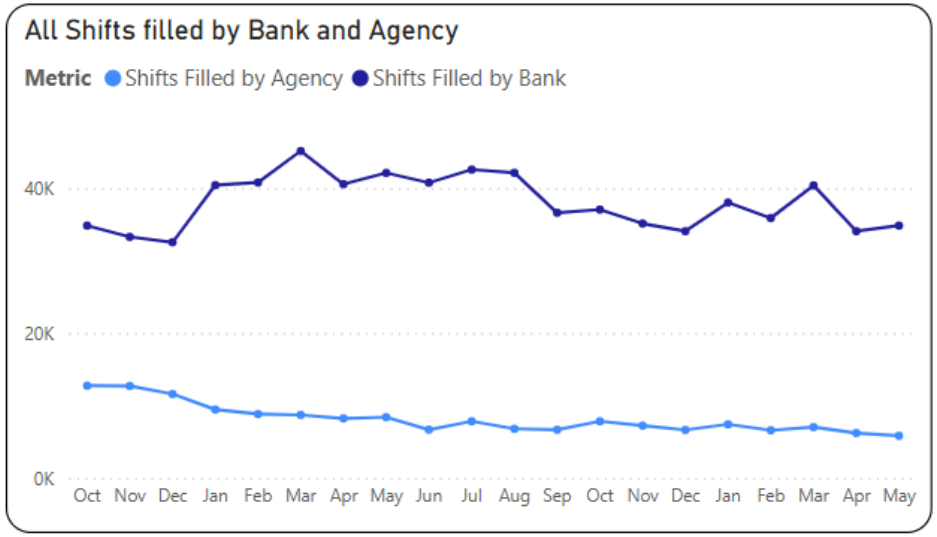
Provider	Agency Cost %
ALL	1.84%
NHCT	2.03%
NUH	1.43%
SFH	2.93%

Agency Spend Against Cap

Agency £'m	Agency Cap	Forecast	Variance	Plan	Forecast	Variance
NUH	12.01	13.95	-1.95	13.95	13.95	0.00
SFH	10.22	9.67	0.55	9.67	9.67	0.00
NHT	9.91	9.91	0.00	9.91	9.91	0.00
TOTAL	**32.13**	**33.53**	**-1.40**	**33.53**	**33.53**	**0.00**

Bank Spend Against Cap

Bank £'m	Bank Cap	Forecast	Variance	Plan	Forecast	Variance
NUH	38.51	35.16	3.34	35.16	35.16	0.00
SFH	27.79	27.31	0.47	27.31	27.31	0.00
NHT	31.36	31.12	0.24	31.12	31.12	0.00
TOTAL	**97.65**	**93.60**	**4.05**	**93.60**	**93.60**	**0.00**



NHS Transformation and Efficiency revised month 2
Total £261,746 m of which Pay efficiencies are £103,556 m

Oversight

- BAU – annual workforce plan CFO and CPO responsible for delivery, Oversight through the monthly system CFO/CPO meeting, PPRG, agency working group etc
- Pillar 1 -Provider CFO and CPO responsible for delivery. Oversight through the monthly system CFO/CPO meeting.
- Pillar 2 – CPO(s) responsible for delivery supported by appropriate leads/programmes. Oversight through STEG
- Pillar 3 – Transformation Programme Leads responsible for model development, supported by people partners. Oversight through STEG.

Principles

- System-designed, and collaboratively delivered
- Ensure services are delivered on principle of 'right people, right place, right time, but with a commitment to maximising opportunities of scale.
- Appropriate accountability for delivery and oversight which are clearly identified and then supported.
- Clear read across from finance to people plans

Plans are fixed

Plans are dynamic

Annual Plan

Total WTE 34,178
Pay Bill £1,971,547

		Other	Agency	Bank	Substantive	Total
NUH	WTE	0	172	874	18,028	19,074
NUH	Pay	£0	£13,952	£35,164	£1,090,224	£1,139,340
SFT	WTE	0	96	385	5,238	5,719
SFT	Pay	£1,380	£9,671	£27,314	£299,712	£338,077
NHFT	WTE	0	205	744	8,436	9,385
NHFT	Pay	£2,055	£9,905	£31,120	£451,050	£494,130
Total	WTE	0	473	2,003	31,702	34,178
Total	Pay	£3,435	£33,528	£93,598	£1,840,986	£1,971,547

Pillar 1

Pay cost reduction
£62,045 m

ICB	£4,900 m	WTE TBC
NUH	£19,183 m	WTE TBC
SFT	£18,520 m	WTE TBC
NHFT	£19,422 m	WTE TBC

Transformation Programme SROs Accountable Delivery

- UEC Transformation
- Planned Care Transformation
- Local Care Together
- Digital Transformation
- Estates and Facilities
- Medicines Optimisation
- Procurement
- Corporate Optimisation
- Core Services
- CHC
- Unidentified

These programs are set and overseen by system PMO. ICB CPO support intersectionality with other schemes accountability sits with specific program SROs not CPOs

Pillar 2

HIA workforce Inc. pay efficiencies cost reduction
£41,562 m

NUH	£18,497 m	WTE TBC
SFT	£11,584 m	WTE TBC
NHFT	£11,481 m	WTE TBC

Enabling and Cash releasing Approaches

Cash Releasing

- outsourcing/lead provider increasing back office and payroll alignment
- Maximise digital technologies and Workforce Systems
- AI access solutions
- System vacancy control approach

Enabling agreed agency and bank reduction

- Introduction of a Collaborative Bank
- Medical Job planning
- Nursing Headroom
- Harmonised rates of pay (Medical / Nursing)

Pillar 3

Strategic workforce transformation
Development of new workforce models and plans – providing a route to cash for Pillar 1 to deliver

Support to transformation

- Programme led and supported by provider people leads.
- Detailing models that enable a reduction in workforce (headcount and cost) driven by clinical transformation.
- Designing a system workforce driven by transformation, reflecting
  - Increase in digital solutions
  - Shift to community
  - Focus on prevention

Workforce Efficiencies

- The workforce financial efficiencies programmes has increased in value in month 2 from £34,611M to £41,562M which is attributed to NUH (£1.9M) and NHCT (£5.1M). This is 'risk adjusted' to £31,883M.

- At month 2 they are underperforming against target by £0.950M. SFH are overdelivering by £0.044M mainly due to an over delivery in non-clinical bank reduction and medical agency reduction. NUH are underdelivering by £0.703M and NHCT by £0.291M. The schemes making the largest contribution to NUH being behind plan remains non-patient facing enhanced VC and workforce resource alignment. The largest contributor to NHCT being off plan is E-rostering to reduce temporary staffing.

- The workforce financial efficiencies contains 118 schemes in total. NUH -78, NHCT – 24, SFH-16 and ICB -0. Year to date 9 schemes show a positive variance, 96 are on plan/have not started and 13 show an adverse variance.

Scheme Performance	NUH	NHCT	SFH	ICB
Positive Variance	3	0	6	0
On plan/Not started	67	21	8	0
Adverse Variance	8	3	2	0

- In addition to the workforce schemes there is a further £61,994M that are pay savings associated the other programmes. In month 2 these are £0.963 behind plan. The largest negative variances are in Core Services (£0.924M) and planned care (£0.314M). Corporate Optimisation and Local care together are over performing by £0.131M and £0.17M respectively.

- Whilst costs are included in the dashboard to date there is no information about the WTE impact of these schemes. To date the only limited source of information has been the transformation PIDS and papers discussed and Commissioning Review Group.

Workforce Transformation Plans – WTE numbers

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Table 1 – **WTE impact as per Transformation Programme PIDs**

Transformation Programme	WTE increase	WTE decrease
CHC	9	-
Local Care Together	1	42.53
Core Services and Best Value Services	Unknown	Unknown
Corporate Optimisation *FRG to agree what the priority areas are for progression*	Unknown	Unknown
Digital Transformation	TBC	-
Estates and Facilities	Unknown	Unknown
Medicines Optimisation	Unknown	Unknown
Mental Health Beds *NHFT organisational efficiencies programme*	-	-
Planned Care Transformation	Unknown	Unknown
Procurement	Unknown	Unknown
UEC Transformation	-	96.4

Table 2 – **WTE impact identified in CRG (Commissioning Review Group)**

Commissioning Review reductions	WTE increase	WTE decrease
Community Transformation inc. Frailty	90	26.59
UEC Transformation	-	11

- Table 1 shows existing Transformation Programme PIDs have varying detail regarding WTE impact of their proposed changes with only UEC and Community able to provide indicative WTE numbers.
- From attending the Commissioning Review Group (CRG), ICB workforce colleagues have captured some further WTE impacting commissioning decisions which are not detailed in the PIDs. These are detailed in table 2.

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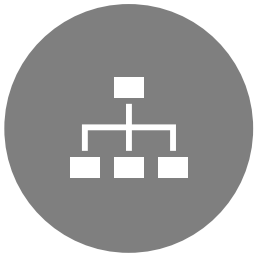
DELIVERY

SOCIAL CARE



ASSURANCE

FUTURE

Social Care Dashboard

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- Working with Skills4Care we are the first ICB nationally to produce a Social Care Workforce Dashboard. Adult Social CareWorkforce (ASC-WDS) - Home
- This data shows our current workforce in detail and supports improved information on Social Care to support planning and transformation.

Social Care Dashboard continued

- The dashboard and data is being reviewed and used by local authority colleagues and refinements will be made based on their feedback.
- The provision of Social Care data is voluntary, and we are working with Local Authority partners and Skills4Care to increase the number of providers submitting information.

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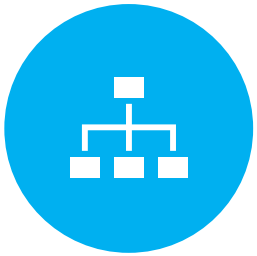
DELIVERY

SOCIAL CARE



ASSURANCE

FUTURE

Updated ICS People/Workforce Governance

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Key

- Strategic Delivery / Assurance
- Commissioning Decision Making
- Advisory
- Delivery

ICS People and Culture Insight Group (quarterly)

Focused on employee engagement, cultural insights and ensuring alignment with values via actionable recommendations.

System Staff Networks
Retention
Clinical Placements
Talent and Leadership
Health and Wellbeing
AHP Workforce
Social Care (incl. Skills for Care)

NHS People and Culture Planning, Performance and Risk Group (monthly)

Monitors planning, performance and associated risks. Outputs inform financial decision-making.

Workforce Intelligence Group

ICS Strategic Workforce Efficiencies and Transformation Board (monthly)

Defines overarching strategic direction and workforce priorities.

UEC Transformation
Planned Care Transformation
Digital Transformation
Estates and Facilities
Medicines Optimisation
Procurement
Corporate Optimisation
Core Services
CHC
Mental Health Beds
Unidentified
Major BAU

ICS Transformation and Efficiencies Oversight Group (fortnightly)

ICS Financial Delivery and Recovery Group (bi-weekly and monthly deep dive)

NHS People Leads Forum
(working group - weekly)

System Vacancy Control Process

ICB Finance and Performance Committee (monthly)

ICB Quality and People Committee (monthly)

Commissioning Review Group [need to review approval process following submission to SPI committee]

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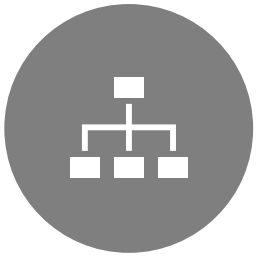
Nottingham & Nottinghamshire

DELIVERY

SOCIAL CARE



ASSURANCE

FUTURE

Are we prepared for the next phase of the System People and Workforce Plan?

Integrated Care System
Nottingham & Nottinghamshire

The System People and Workforce Plan Delivery plan 2025/26 (between June 2025 and March 2026)	Comments	RAG Rating
Work across all providers and social care to map the existing and future workforce	Work continuing with Providers and Primary Care as part of planning, Social Care dashboard is initial step to gain greater understanding of Social Care workforce.	
Implement training to raise skills and knowledge relating to workforce planning (six steps process) across programmes.	Upskilling ICS Strategic Workforce Project Manager to enable training implementation (completes July 2025). Individual support offered and templates/information created to support.	
Map workforce elements of each programme to understand timing and resource required.	Working with Providers and Programmes to understand the WTE impact and timings. We expect these at the end of Q1	
Establish education subgroup.		
As part of the annual planning, enhance collaboration and triangulation of demand affordability and workforce.	Operational planning completed for 25/26 and lessons learned underway to inform changes for 26/27.	
Develop metrics for workforce supply working with NHS England and higher education institutions.	On Hold. We are awaiting the new 10-year plan which will include a refreshed workforce plan. We are monitoring the delivery of the operational workforce plan monthly to F&P Committee.	
With NHS England and higher education institutions, and in line with the long-term workforce plan, establish future needs and start developing Nottingham and Nottinghamshire integrated education approach.	On Hold. We are awaiting the new 10-year plan which will include a refreshed workforce plan. We are monitoring the delivery of the operational workforce plan monthly to F&P Committee.	
Commence work to 'right size' the workforce across transformation priorities to have clear workforce strategies - including all system partners within a programme pathway taking account of priority programmes and available funding	Working with Transformation Programmes to understand the workforce impact in £/WTE however lack of detail has delayed mapping.	
Scope a recruitment hub for the ICS.	Discussions on areas of corporate optimisation ongoing.	
Create digital workforce plans for programmes ensuring cross dependencies are mapped. e.g. e-rostering, digital solutions to reduce non-clinical capacity requirements, promoting digital/IT solutions for patient monitoring and remote care, using AI to reduce clinical time, e.g. diagnostics and reporting of diagnostic information	Collaboration with digital colleagues in known areas of development i.e. e-Roster, AI chat bot for people services	

Mansfield Workforce Plan ROADMAP

Vision & Objectives June 25

Define the overarching goals and objectives of the workforce plan. This includes the vision for a dynamic, integrated workforce with digitally enabled solutions.

Future Workforce Needs September 2025

Identify future workforce requirements based on organisational goals and strategic plans. This includes aligning workforce plans with local service and financial planning. Gap & supply analysis etc.

Recruitment & Retention November 25

Implement strategies for effective recruitment and retention of staff subject to workforce & PHM needs. This includes understanding the future workforce needs as part of the 10-year plan.

Organisational Development January 26

Plans developed to improve the overall performance and effectiveness of the organisation through change in culture and process.

Monitoring and Evaluation March 26

Establish mechanisms for monitoring and evaluating the workforce plan. This includes tracking progress, measuring outcomes, and making necessary adjustments.

2025 • 2026

Current Workforce July 25

Assess the current workforce, including skills, competencies, and gaps. This involves understanding the workforce impact of transformation programs and commissioning decisions.

PHM Planning September 25

Scenario planning to support PHM planning, anticipate, plan and ensure that the right people are in the right place at the right time to maximise asset utilisation and delivery of care.

Workforce Development December 25

Develop strategies for workforce development, including training, upskilling, and career progression. This involves creating a supportive environment for continuous learning and development.

Digital & Technology Integration February 26

Integrate digital and technology solutions to enhance workforce efficiency and effectiveness.

Annual Review April 26

Develop programme into an annual cycle.

Version 0.1 – 05/06/25

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/07/2025
Paper Title:	**Nottingham and Nottinghamshire Integrated Care System Quality Strategy (Model Framework)**
Paper Reference:	ICB 25 036
Report Author:	Diane-Kareen Charles, Deputy Chief Nurse and Director of Quality.
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 presents the Integrated Care System's (ICS) Quality Strategy and quality priorities for approval. The Strategy also has an easy read version.

The ICB leads on arrangements for the development of an ICS Quality Strategy and revisions to system quality priorities. The Strategy was coproduced with system partners through a System Implementation Design Group across health, care and the voluntary, community and social enterprise sectors during 2023/2024.

The Quality Strategy (model framework) fully aligns with the updated NHS England National Quality Guidance for Integrated Care Systems and Boards, which was updated in May 2025. The approach taken is to ensure consistent language and understanding across health, care and voluntary sectors in delivering high quality care. It is written to consider the anticipated strategic commissioning responsibilities of ICBs in the future.

The existing ICB and system governance oversight and assurance arrangements are not affected and reporting on the quality priorities will be through system and ICB quality infrastructures.

Recommendation(s):

The Board is asked to **approve** the Integrated Care System Quality Strategy and System Quality Priorities 2025-2028, refresh.

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	The Nottingham and Nottinghamshire Integrated Care System Quality Strategy (Model Framework) 2025-2028 refresh and quality priorities will ensure there is consistent approach to quality considerations across our health and social care delivery. This will ensure visible and equitable decision making.
Tackle inequalities in outcomes, experience and access	The Nottingham and Nottinghamshire Integrated Care System Quality Strategy (Model Framework) 2025-2028 and the System Quality Priorities will enable quality, planning, building improvement and assurance pillars will

How does this paper support	the ICB's core aims to:
	enable consistent approaches focus on improved outcomes.
Enhance productivity and value for money	Consistent improvement initiatives through quality priorities across vulnerable population cohorts to improve health outcomes will have positive benefits health and care interventions.
Help the NHS support broader social and economic development	As above.

Appendices:
Appendix 1: Nottingham and Nottinghamshire Integrated Care System Quality Strategy (Model Framework) 2025-2028.

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 4: Quality improvement – Failure to systematically improve the quality of healthcare services.

Report Previously Received By:
The ICS Quality Strategy (Model Framework) 2025-2028 has been revised to consider comments and amendments made by the Quality and People Committee, when it was presented in April and June 2025.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Nottingham and Nottinghamshire Integrated Care System Quality Strategy (Model Framework)

Background and context

1. The previous System Quality Strategy 2022-2023 was developed from three distinct drivers:
    a) The lack of clarity within the newly formed system about quality arrangements.
    b) System transparency in defining ‘one version of the truth’.
    c) To enable voices to have equal opportunity to be heard and contribute.
2. That strategy also had twelve agreed system priorities, including a shared system definition of quality, supported by a shared developed system quality framework. However, this was an NHS dominated strategy and approach that did not translate well into all sectors.
3. Whilst the refresh of the strategy has taken longer than anticipated, it has been extensively co-created, mapped against extant strategies, and refined to ensure longevity in an evolving system.

Approach to developing a singular definition of quality

4. The development of the ICS Quality Strategy was undertaken by a system implementation design group led by the ICB, with representation across health, care, and voluntary sectors.
5. The ICS quality priorities were reviewed and redrafted to reflect broad aims of improvements for the population, which were felt to have universal application across all sectors equally.
6. The six quality priorities are:
    a) Actively support improvements for all partners to deliver quality within the system.
    b) Focus on improving access to, and quality of, maternity services for our population.
    c) Ensure that the system provides quality support to those who experience mental ill-health.
    d) Improve health and well-being for people with a learning disability and or autism.
    e) Ensure we are protecting the most vulnerable.

f) Ensure an integrated approach to supporting children and young people between health and local authorities, improving access to and experiences of our services.

7. The refreshed ICS Quality Strategy 2025-2028 supports the system to refocus on quality priorities, and the framework and singular approach to defining quality will also support future changes to the ICB's role as a strategic commissioner.

8. It provides common language through the framework pillars of quality planning, building improvement and assurance, and having a consistent approach adopted across health, care, and voluntary sectors; and supports the integrated cross sector engagement required in the ongoing system transformation work.

Alignment within the Nottingham and Nottinghamshire system

9. The ICS Quality Strategy 2025-2028 enclosed at Appendix 1, is in line with the Nottingham and Nottinghamshire Integrated Care Strategy[1] and the Joint Forward Plan[2].

10. The ICS Quality Strategy is based on the Healthcare Improvement Scotland's Quality Management System (2022)[3] but fully aligned with the NHS England National Quality Guidance for Integrated Care Systems and Boards, which was updated in early 2025[4].

11. A mapping exercise undertaken in 2024 reviewed system partners' strategic organisational plans and proposals and found they broadly align with the six quality priorities, which in turn, support the work of the eleven system transformation programmes.

The Implementation and governance arrangements for monitoring ICS Quality Strategy and quality priorities

12. The implementation of the ICS Quality Strategy 2025-2028 will not alter existing ICB and system governance oversight and assurance arrangements for quality monitoring. The current governance reporting arrangements can be found at page 17 within the Strategy**.**

13. The arrangements for monitoring, implementation and reporting have been strengthened by an additional requirement, which has been formalised within the contractual Quality Schedules 2025/2026.

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[1] integrated Care Strategy (updated March 2025) Integrated Care Strategy 2023-2027 - NHS Nottingham and Nottinghamshire ICS - NHS Nottingham and Nottinghamshire ICS
[2] Joint Forward Plan (updated and approved March 2025) NHS Nottingham and Nottinghamshire JFP
[3] Demonstrating Safety, Promoting Improvement: An Overview of the Quality Assurance System: 20220906-HIS-Quality-Assurance-System-v1.pdf
[4] National Quality Board *Shared Commitment to Quality* nqb-position-statement.pdf

Nottingham and Nottinghamshire Integrated Care System

Quality Strategy (Model Framework) 2025-2028

Quality Strategy (Model Framework) 2025-2028

Integrated Care System
Nottingham & Nottinghamshire

> “The aim is in establishing a shared understanding of safety, effective, personalised and equitable experiences for population needs across the system.

Rosa Waddingham
Chief Nurse

Quality Strategy (Model Framework) 2025-2028

Integrated Care System
Nottingham & Nottinghamshire

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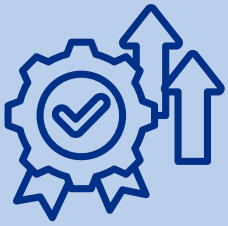


Quality Strategy (Model Framework) 2025-2028

Integrated Care System
Nottingham & Nottinghamshire

Introduction

The Nottingham and Nottinghamshire Integrated Care System (ICS) came together in July 2022. The Quality Strategy 2022-2024 identified as one of the quality priorities that all system partners sought to have a unified approach across health and care, ensuring consistency in understanding and delivering equitable and quality services.

The development of our refreshed Integrated Care System Quality Strategy (Model Framework) 2025-2028 stemmed from a collective need for a singular definition of quality. The aim is in establishing a shared understanding of safety, effective, personalised and equitable care experiences for population needs across the system.

This approach fosters a common language between health, care and voluntary sector partners that helps shape that ambition. Healthcare Improvement Scotland's model [i] influences our strategic approach:

Quality Planning *– ensuring services are designed with quality at their core.*

Building Improvement Together *– fostering collaboration to drive system-wide improvement.*

Quality Assurance *– maintaining high standards and accountability.*

By adopting these principles, in a consistent way we are laying the foundations for a developed learning system, that defines what quality means, how we will embed it, and understand the impact it will have on the people of Nottingham and Nottinghamshire.

This strategy ensures that all partners across the integrated care system work towards a shared vision of delivering high-quality, safe, fair and effective care. The strategy is written and acknowledges future changes to how the system will need to strategically commission and support collaborative working arrangements with the sole aim of delivering the right care to our population.

Rosa Waddingham, Chief Nurse
Nottingham and Nottinghamshire ICB.

Quality Strategy (Model Framework) 2025-2028

Integrated Care System
Nottingham & Nottinghamshire

Nottingham and Nottinghamshire Pledge

As partners of the Nottingham and Nottinghamshire Integrated Care System **we are committed to ensuring we develop and embed a common understanding of the Nottingham and Nottinghamshire Integrated Care System Quality Strategy (Model Framework)** and in doing so, our individual organisational quality priorities align with the Integrated Care System Quality Priorities in delivering transformation for our population.

NHS Nottingham and Nottinghamshire Integrated Care Board

Rosa Waddingham
Chief Nurse
Nottingham and Nottinghamshire Integrated Care Board.

NHS Nottingham University Hospitals NHS Trust

Tracy Pilcher
Chief Nurse
Nottingham University Hospitals NHS Trust.

NHS Sherwood Forest Hospitals NHS Foundation Trust

Phil Bolton
Chief Nurse
Sherwood Forest Hospital Foundation Trust.

NHS Nottinghamshire Healthcare NHS Foundation Trust

Diane Hull
Chief Nurse
Nottinghamshire Healthcare NHS Foundation Trust.

CityCare

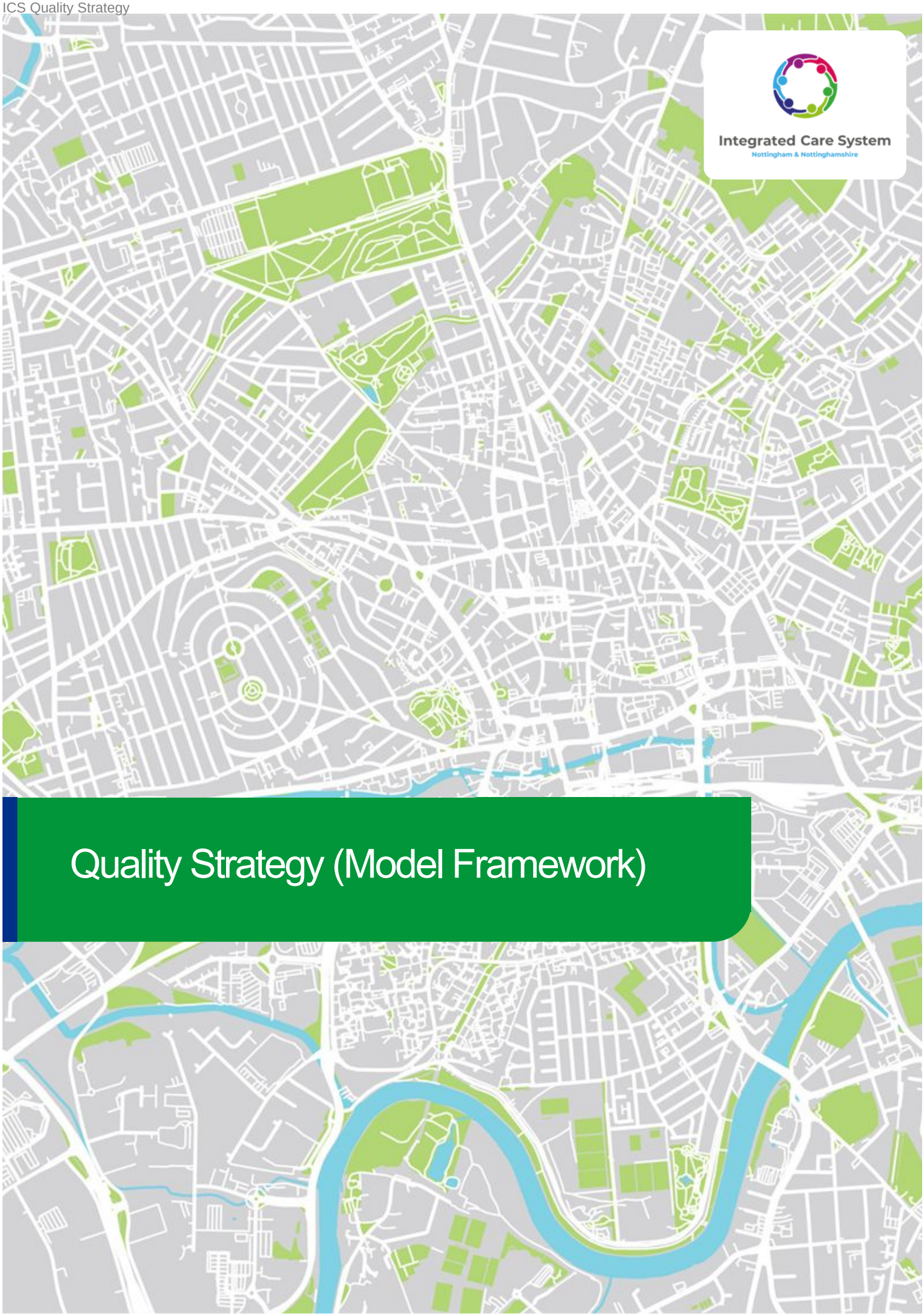
Judith Douglas
Chief Nurse
City Care Community Interest Company.

Nottingham City Council

Directors of Social Care Adults and Children

Nottinghamshire County Council

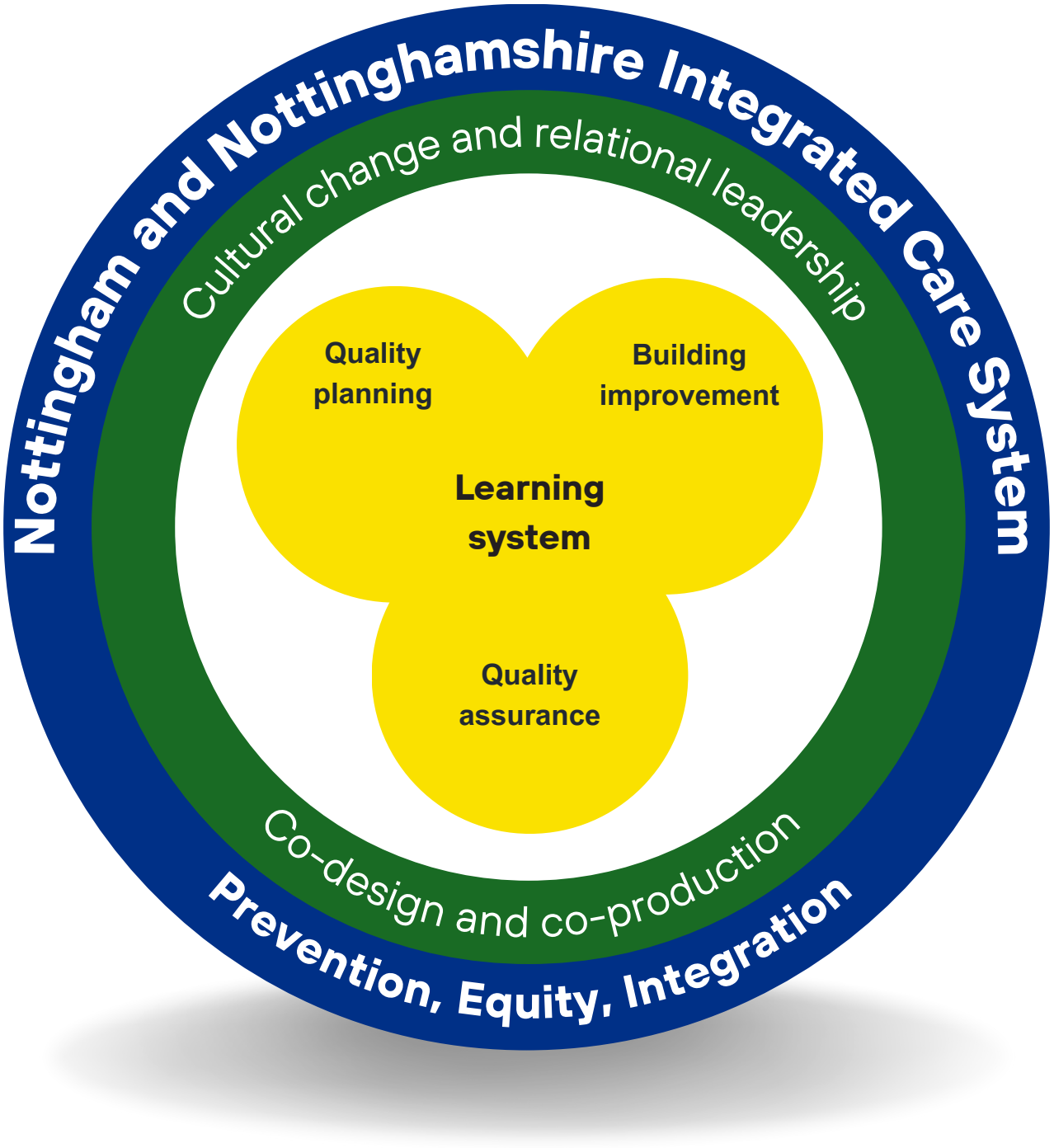
Melanie Williams
Corporate Director, Adult Social Care and Health
Directors of Social Care Adults and Children



Quality Strategy (Model Framework)

Quality Strategy (Model Framework)

Integrated Care System
Nottingham & Nottinghamshire



Defining the quality in our system

What do we mean by Quality?
In health and social care, quality refers to delivering effective, safe, and positive patient experiences, while also ensuring care is patient-centred, timely, equitable, and efficient [ii]. This definition encompasses not only clinical effectiveness but also the overall individual's care and experience that will have the most profound impact on people's lives[iii].

Quality Planning
Quality planning (quality by design) is defined as the mechanisms by which a team, service, organisation or system across health, care and voluntary sectors chooses its priorities for improvement and then designs appropriate interventions to deliver those improvements, including services that are commissioned.
A critical, and fundamental stage often overlooked, our commitment is understanding the full extent of a person's needs and assets by re/designing processes and services with our population whilst making best use of their existing resources.

Building Improvement
Quality improvement is about giving the people closest to issues in care quality, the time, permission, skills and resources they need to solve them. It involves a systematic and coordinated approach to solving a problem using specific methods and tools to bring about a measurable improvement. The NHS Impact Framework [iv] for improvement provides a unique opportunity within our system to have a common commitment to building improvements and collective learning.

Our plan is to involve partners across health, social care and voluntary sectors help shape and deliver this consistently.

Quality Assurance
Effective assurance mechanisms look more broadly at whether a team, organisation and/or system has effective approaches to managing the quality of care in the round. It involves assessing or evaluating quality; identifying problems or issues with care delivery and designing quality improvement activities to overcome them; with monitoring to make sure the activities did what they were supposed to.

Cultural Change and Relational Leadership
Embracing cultural change involves fostering a work environment that aligns with our integrated strategic objectives, and joint forward plan. These agreed foundational approaches emphasises developing, attracting, and retaining inspirational, innovative cultural leadership. This will result in a drive towards innovation. Change culture supports those development opportunities.

Relational leadership refers to a leader and relates their ability to develop positive relationships within an organisation and beyond, to enable collective efforts of people (across organisational boundaries) working together to accomplish positive social development and growth to achieve a common goal.

We know effective leadership is crucial across health, social care, and the voluntary sectors. This requires a shift towards collaborative, community-centred approaches to address complex challenges and improve patient outcomes [v]. Leaders need to foster trust, promote shared values, and empower individuals to take responsibility for their actions and contributions.

Co-Design and Co-production
Co-production happens when people who access services and their carers are valued as equal partners, can share power, and have real influence over the decisions that are made. It happens when people and carers are included from the start to the end of any work that affects them [vi].

Co-producing services with people with lived experience is beneficial to the integrated care system as a whole and patients, service users and their families. A coproduction approach using insight and information from those living with a health condition means that services we commission, accurately reflect the needs of those using them which this leads to better health outcomes, it is also a cost-effective way of making sure we spend vital system money in the right way, first time.

We will work in partnership with people who have lived experience of using health and care services, including people with personal experience of a particular health condition or need, their carers or family and the wider community, so that they can share information about living their lives with us. We can then use that information to strategically create new services or understand the impacts to improve existing services so that they can better meet the needs of people using them, doing this from the very start of services or changes being developed.

ICS planning
for the future

2025

Prevention, Equity, Integration

The Nottingham and Nottinghamshire Integrated Care Partnership (ICP) involving health, social care and voluntary providers developed an Integrated Care Strategy 2023-2027 [vii] to improve health and care outcomes and experiences for local people has now been refreshed and the quality strategy (framework) aligns to those guiding principles in delivering person centred care:

Prevention is Better Than Cure
Early detection and prevention to reduce the need for treatment and improve health outcomes.

- **Health**: Implementing preventative measures like Immunisations, lifestyle changes, and early interventions.
- **Social Care**: Supporting people to remain healthy and independent through early social care interventions.
- **Voluntary Sector**: Engaging community organisations to promote health literacy and preventative practices.

Equity in Everything
Tailoring support to meet the diverse needs of the population, ensuring fair access and outcomes.

- **Health**: Providing equitable access to healthcare services, especially for vulnerable groups.
- **Social Care**: Addressing social determinants of health to reduce disparities.
- **Voluntary Sector**: Collaborating with community groups to reach underserved populations and ensure inclusive support.

Integration by Default
Promoting collaboration among health and care services to provide seamless, person-centred care.

- **Health**: Coordinating care across different health services to care and treat the whole person.
- **Social Care**: Integrating social care with health services to provide comprehensive support.
- **Voluntary Sector**: Involving voluntary organisations in service delivery to enhance community-based care to improve experiences.

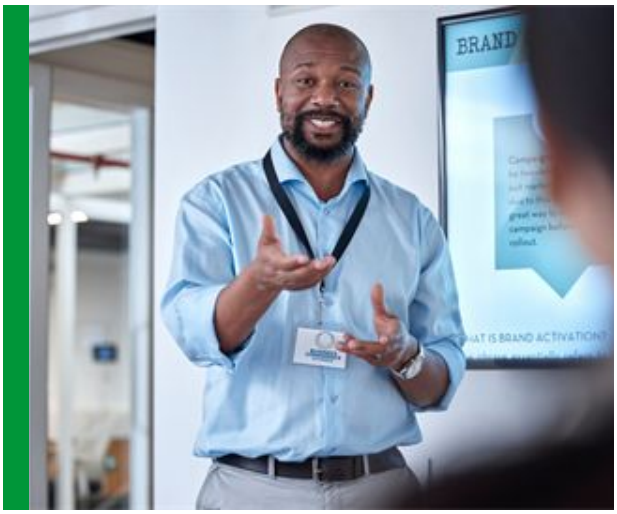
The learning system

Health and Social Care is complex and there is increasing need health and care systems which enable staff at every level to continually review how well their service is doing (quality assurance), identify their priorities for strategic improvement and design appropriate interventions (quality planning), and then test ideas to make care better (quality improvement).

Using research and the use of a broad range of metric insights to inform learning and improvements will be our way. The importance of having methods to evaluate and use evidence led knowledge within our definitions of quality aligns with the four pillars our ICS Research Strategy 2024-2029 [viii].

Doing this well in a complex system requires individuals, teams, organisations and systems to develop the infrastructures for continuous learning with co-design and co-production, and cultural change and relational leadership as key enablers.

Our strategic approach links with our system quality priorities identify areas for improvement that matter to the people of Nottingham and Nottinghamshire and priorities through the refreshed Integrated Care System Joint Forward Plan [ix].



Quality Strategy (Model Framework) 2025-2028

2025

Delivering the Integrated Care System Quality Strategy

How we deliver quality aligns with the refreshed statement from the National Quality Board Shared Commitment to Quality to provide a common definition and vision of quality for those working in health and care systems[x]. Together we will work to deliver the ambitions are set out on this page.

Setting clear direction and priorities

To deliver a new service model for the 21st century which delivers better services in response to local needs, invests in keeping people healthy and out of hospital, and is based on clear priorities, including a commitment to reducing health inequalities.

Bringing clarity to quality

Setting clear standards for what high quality care and outcomes look like, based on what matters to people and communities in Nottingham and Nottinghamshire.

Measuring and publishing

Quality measuring what matters to people using services, monitoring quality and safety consistently sharing information in a timely and transparent way using data effectively to inform improvement and decision making. Using our system analytical resources to build one accessible version of quality.

Maintaining and improving quality

Working together to maintain quality to reduce risks and drive improvement across the Nottingham and Nottinghamshire footprint.

Building capability for improvement

Providing multi professional and population partnership for quality; building learning and improvement cultures; supporting staff and people using services to engage in coproduction; supporting staff development and wellbeing. We have started to build capacity through system quality improvement initiatives and communities of practice.

Recognising and rewarding quality

Recognising, celebrating and sharing outstanding health and care, learning from others and helping others learn, recognising when things have not gone well.

Quality Strategy (Model Framework) 2025-2028

2025

Delivering the Integrated Care Quality Strategy: Plan on a Page

Direction		Implementation and delivery		Results
How clear is our vision and purpose?	**How supportive is our culture leadership?**	**How well do we engage?**	**How well do we manage and improve performance?**	**What difference have we made and what have we learned?**
1 →	2 →	3 →	4 →	6
Clear vision and purpose • Defined purpose and vision • Understanding the population profile, needs, and inequalities • Understanding context, own capabilities, and major challengers • Agreed framework and priorities • Key quality, performance, and risk indicators	**Cultural change and relational leadership** • Shared values • Person-centred planning and care • Staff empowerment and wellbeing • Diversity and inclusion • Openness and transparency • Robust governance arrangements	**Co-design and co-production** • People who experience care and carers • Workforce • Partners, governing stakeholders, and suppliers • Local community • Person-centred and safe outcomes	**Building improvement** • Pathways, procedures and policies • Financial planning • Workforce planning • Staff development and performance 5 → **Quality planning** • Plans for delivery • Performance management and reporting • Risk management and business continuity • Audit, evaluations and research • Improvements and innovation	**Quality assurance** • Delivery of key quality, risk, and performance indicators • Delivery of strategy and priorities • Lessons learned and plans to apply

Focus	Domain
Direction	1: Clear vision and purpose
	2: Cultural change and relational leadership
Implementation and delivery	3: Co-design and co-production
	4: Building improvement
	5: Quality planning
Results	6: Quality assurance

13

Quality Strategy (Model Framework) 2025-2028

2025

Integrated Care System Quality Priorities

Collaborating as an Integrated Care System through the use of the Quality framework will help health and care organisations in Nottingham and Nottinghamshire to consistently working together to tackle the complex challenges facing our population. This linked to collectively achieving our six system quality priorities reflected in our system partners own organisation delivery plans:

Actively support improvements for all partners to deliver quality with the system.

Focus on improving access to, and quality of, maternity services for our population.

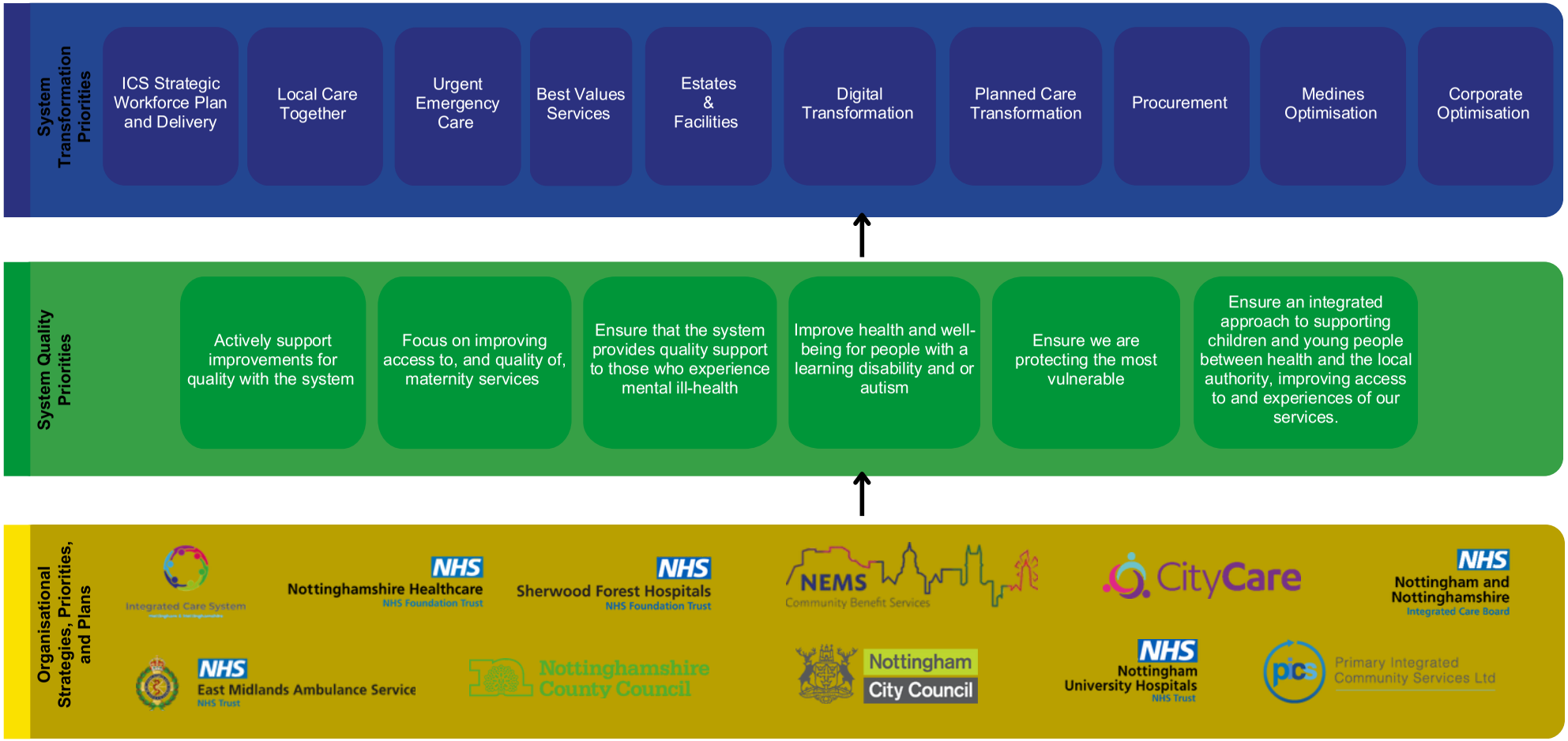
Ensure that the system provides quality support to those who experience mental ill-health.

Improve health and well-being for people with a learning disability and or autism.

Ensure we are protecting the most vulnerable.

Ensure an integrated approach to supporting children and young people between health and the local authority, improving access to and experiences of our services.

Quality Priorities with Organisational and Transformational Alignment



Delivering the Integrated Care System Quality Priorities

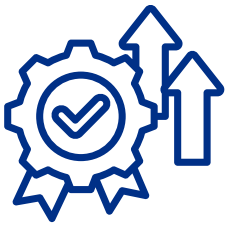
All system partners are committed to aligning their organisational priorities supported by a consistent approach to quality planning, building improvement and assurance processes.

Part of this ongoing commitment to associate individual organisational plans to the system quality priorities is to ensure consistent reporting by all partners and is reflected within the annual coproduced local quality schedules [xi]. The Nottingham and Nottinghamshire Integrated Care System commit to quarterly reporting against the system quality priorities.

Nottingham and Nottinghamshire Integrated Care system's Partner Quality Assurance and Improvement Group is a shared system improvement group where the Nottingham and Nottinghamshire Integrated Care System Quality Strategy (Framework) and Quality Priorities will be monitored.

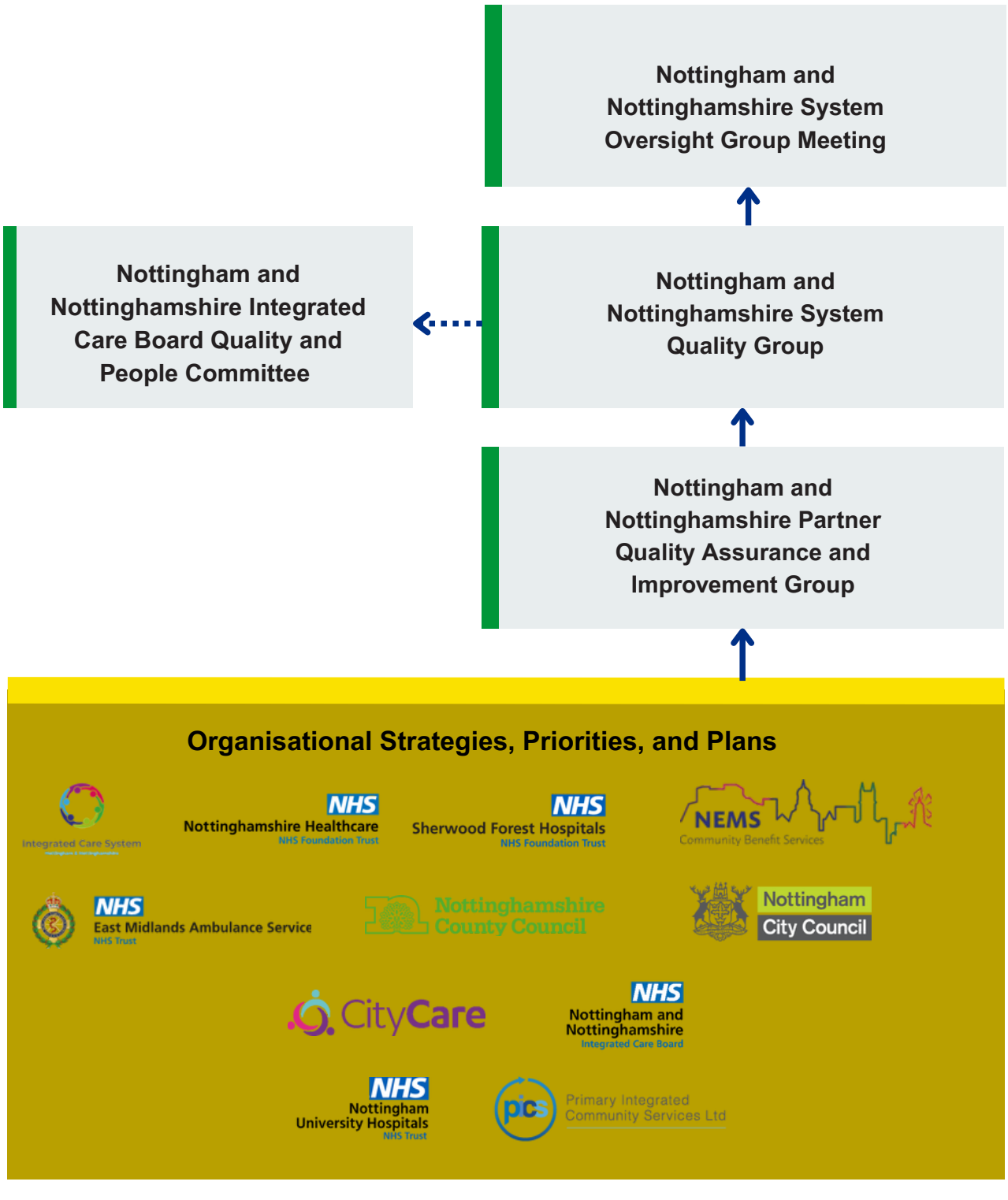
Image credit: Stavros Pourikas

The Nottingham and Nottinghamshire Integrated Care System commits to an annual refresh of the priorities which will include an annual report and stock take.



Quality Strategy (Model Framework) 2025-2028 **2025**

Quality Assurance Arrangements for Nottingham and Nottinghamshire Integrated Care System.



References

[i] Demonstrating Safety, Promoting Improvement: An Overview of the Quality Assurance System:
20220906-HIS-Quality-Assurance-System-v1.pdf
[ii] World Health Organisation- Quality of Care Quality of care
[iii] National Quality Board (April 2013) Quality in the new health system -Maintaining and improving quality
https://assets.publishing.service.gov.uk/media/5a7c5f01e5274a7ee501a849/Final-NQB-report-v4-160113.pdf
[vi] [1]NHS IMPACT: NHS England » The five components of NHS IMPACT
[v] [1] Kings Fund (2023) The practice of collaborative leadership across health and care services The Practice Of Collaborative Leadership | The King's Fund
[vi] Nottingham and Nottinghamshire Integrated Care Board Coproduction Strategy 2022-2024: Nottingham and Nottinghamshire ICB Coproduction Strategy 2022 to 2024
[vii] integrated Care Strategy (updated March 2025) Integrated Care Strategy 2023-2027 - NHS Nottingham and Nottinghamshire ICS - NHS Nottingham and Nottinghamshire ICS
[viii] ICS Research Strategy 2024-2029 ICS-Research-Strategy-2024-29-FINAL.pdf
[ix] Joint Forward Plan (updated and approved March 2025) NHS Nottingham and Nottinghamshire JFP
[x] National Quality Board Shared Commitment to Quality nqb-position-statement.pdf
[xi] Nottingham and Nottinghamshire Long Form Quality Schedules 2025/2026

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/07/2025
Paper Title:	**Working with People and Communities Annual Report 2024/25**
Paper Reference:	ICB 25 037
Report Author:	Prema Nirgude, Head of Insights and Engagement Dave Bradley, Strategic Quality and Transformation Manager
Executive Lead:	Rosa Waddingham, Director of Nursing
Presenter:	Rosa Waddingham, Director of Nursing Alex Ball, Director of Communications and Engagement

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

Summary:

Nottingham and Nottinghamshire Integrated Care Board (ICB) has a legal duty to produce an annual report on how it has discharged its functions in the previous financial year. Section 14Z58 of the NHS Act (2006) requires that the annual report must include an explanation as to how an ICB has discharged its legal duties on public involvement and consultation among other duties.

Given the wide range of requirements to include in the annual report, Nottingham and Nottinghamshire ICB has included a brief synopsis of how the legal public involvement duty has been discharged in the ICB's main annual report, and a link to the Working with People and Communities Annual Report is included.

The Nottingham and Nottinghamshire ICB Working with People and Communities Annual Report aims to provide assurance on how Nottingham and Nottinghamshire has discharged its legal duties on public involvement and consultation, setting out the ways that we have worked with people and communities from 1 April 2024 – 31 March 2025.

When presented to the Board last year, members highlighted:

- The importance of continuing to seek out the views of people and communities that the ICB was not hearing from.
- That the report could better detail the positive difference that hearing the citizen's voice had made during the period.

This has been addressed through the following sections of the report:

- Section 7.5. sets out some of actions that have been taken forward to better support people with learning disabilities.
- Section 8.3. describes how we engaged with the citizens of Nottingham and Nottinghamshire to hear their views and experience of Coproduction before working together to produce a refreshed ICB Coproduction Strategy.
- Section 9.2.2. shows the work done by the Maternity and Neonatal Voices Partnership in developing its engagement with more diverse communities. This also recognises the work done with broadening its work with father inclusivity and refugee groups.

Summary:
The publication of the Model ICB Blueprint presents a timely and strategic opportunity to strengthen our engagement with people and communities across Nottingham and Nottinghamshire. This development aligns with our ambition to deepen our understanding of citizens' needs and aspirations through inclusive, responsive, and experience-informed approaches, in line with our role as a strategic commissioner. The Blueprint introduces updated terminology and highlights areas for further development in how we work with people and communities. In response, we are considering how to ensure alignment between our strategic priorities and the Blueprint's ambitions, reinforcing our commitment to delivering services that reflect and respond to the needs of our population.

Recommendation(s):
The Board is asked to **receive** the 2024/25 Working with People and Communities Annual report for assurance.

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

Appendices:
Appendix 1: Working with People and Communities Annual Report

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 4: 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.

Report Previously Received By:
Strategic Planning and Integration Committee (3 July 2025).

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Working with People and Communities Annual Report

Background

1. Nottingham and Nottinghamshire Integrated Care Board (ICB) has a legal duty to produce an annual report on how it has discharged its functions in the previous financial year.
2. The minimum contents of the annual report are prescribed by the National Health Service Act 2006 (NHS Act 2006) as amended. Section 14Z58 requires that an annual report must include an explanation as to how an ICB has discharged its legal duties on public involvement and consultation.
3. NHS commissioning organisations have a legal duty under the NHS Act 2006 to 'make arrangements' to secure that individuals to whom services are being or may be provided and their carers/representatives are involved when commissioning services for NHS patients. For ICBs, this duty is outlined in section 14Z45 of the NHS Act 2006.
4. To fulfil the public involvement duty, the arrangements must provide for the public to be involved in:
    a) The planning of services.
    b) The development and consideration of proposals for changes which, if implemented, would have an impact on the manner or range of services.
    c) Decisions which, when implemented, would have such an impact.
5. On 14 February 2023, NHS England published guidance[1] on how ICBs should describe their work with people and communities in the context of discharging their public involvement legal duties. No updated guidance has been published since.
6. The guidance states the following content should typically be included in an ICB Working with People and Communities Annual Report:
    a) Governance and assurance information.
    b) Demonstration of how the ICB's strategy on working with people and communities is being put into practice.
    c) An illustration of how insight and data have been used by the ICB to inform its work with people and communities.
    d) Evidence that equality and inclusion principles were considered when working with diverse communities.
    e) Demonstration of how the ICB has worked with partner organisations.

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

f) Sharing learning and good practice examples.

g) Communications, social media and marketing.

h) Future planning.

7. The content of the Nottingham and Nottinghamshire ICB Working with People and Communities Annual Report is aligned with the guidance from NHS England.

8. The publication of the Model ICB Blueprint[2] presents a timely and strategic opportunity to strengthen our work with people and communities across Nottingham and Nottinghamshire.

9. The Blueprint introduces updated terminology and highlights areas for further development in how we work with people and communities, including:

   a) Using both quantitative and qualitative data and intelligence (including user feedback, partner insight, outcomes data, public health insight) to develop a deep understanding of citizens and their needs, and how these are likely to change over time.

   b) Drawing on a variety of inputs (e.g. population health analysis, user priorities, costing, feasibility) to develop strategic options for testing with partners, people and communities.

   c) Embedding feedback from people and communities, staff and partners into evaluation approaches.

   d) Adopting new engagement methods, such as deliberative dialogue, design thinking methodologies and user led design.

10. In response, we are considering how to ensure alignment between our strategic priorities and the blueprint's ambitions, reinforcing our commitment to delivering services that reflect and respond to the needs of our population.

[2] Model Integrated Care Board – Blueprint v1.0

NHS
Nottingham and Nottinghamshire

Working with People and Communities

Annual Report

April 2024 – March 2025

Nottingham and Nottinghamshire Integrated Care Board

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1 Foreword

As we look back on the past year, we are proud to present our third Working with People and Communities Annual Report as NHS Nottingham and Nottinghamshire Integrated Care Board (ICB). This report highlights the significant progress and achievements of the ICB in this crucial area. Building upon the strong foundations established in previous years, we have further strengthened our approach to hearing from our population, ensuring that health and care services are effectively tailored to meet their needs.

Lord Darzi's Independent Investigation into the NHS and the subsequent consultation on a new Ten-Year Plan for the NHS by the Government has prompted a good deal of reflection across the NHS and in health and care systems across England. This period of introspection has been instrumental in shaping our approach to working with people and communities, ensuring that their voices are at the heart of our strategic planning and service delivery.

I am also pleased that our system has been part of the Care Quality Commission's piloting of a new framework for health inequalities improvement, which was launched for wider use in February 2025. The framework, which we have tested alongside three other Integrated Care System (ICS) areas between September and November 2024, is intended to help ICSs to understand how well their engagement with people and communities is helping to tackle health inequalities.

As we move forward, the insights gained from citizens and the feedback from our communities will continue to guide our efforts. We remain steadfast in our mission to create a more inclusive, responsive, and effective health and care system that meets the diverse needs of our population.

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

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

Alex Ball

Director of Communications and Engagement

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

In our rapidly changing Health and Social Care System, coproduction must be the foundation of our work. This approach should be integral to service redesign, transformational change, and patient safety.

By listening to, respecting, and acting upon the voices of people with lived experience, service users, our population, and professionals, we can create effective, efficient, and accessible services that improve experiences for all.

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

Rosa Waddingham

Chief Nurse

2 Introduction

2.1 About us

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

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

We serve a population of just over 1.2million people, covering urban and rural areas. We have some of the country's most deprived communities, and there are significant health inequalities between our most affluent and most deprived areas.

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

2.2 Our statutory duties

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

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

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

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

The report covers our activity for the period 1 April 2024 – 31 March 2025.

3 Our commitment to working with people and communities

The ICB is committed to putting people at the heart of all that we do by consistently listening to, involving, and collectively acting on, the experience and aspirations of local people and

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

their communities. This is clearly set out in our Constitution and supported by our Public Involvement and Engagement Policy which describes the ICB's approach to ensure public involvement and engagement in the development, implementation, and review of health and care policies and services across the statutory organisation.

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

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

3.1 Overview

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

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

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

3.2 Our principles

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

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

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

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

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

3.3 Citizen Intelligence

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

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

3.4 Coproduction

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

Our coproduction approach is strengthened through building connections and relationships with our local health, local authority, voluntary sector partners and people with lived experience,

A key priority during 2024/25 was to continue to develop the infrastructure and resources necessary to embed coproduction more effectively across the ICB. This included creating with users the tools, networks, and learning opportunities that build staff engagement, confidence and capacity, alongside strengthening relationships with the wider system.

Our approach centred on enabling teams to integrate coproduction within their existing involvement methods and practices.

4 Governance and assurance

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

4.1 Nottingham and Nottinghamshire ICB arrangements

Progress on the delivery of the Working with People and Communities strategy is formally reported to the ICB Board through our SPI Committee. The Working with People and Communities Annual Report will be presented to the SPI Committee on 3 July 2025, then to the ICB Board on 9 July 2025.

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

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

4.2 Coordinating how we listen to people and communities

4.2.1 ICS Engagement Practitioners Forum

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

Since its inception, the membership of the Forum has expanded, bringing together representatives from over 70 members from various organisations across our ICS. This includes health and care colleagues, Local Authority officers, VCSE organisations, Office of

the Police Crime and Commissioner, NHS Trusts, Community Champions Leads and Healthwatch Nottingham and Nottinghamshire. The Lead Governors from Nottinghamshire Healthcare NHS Foundation Trust, Sherwood Forest Hospitals NHS Foundation Trust, and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust have also joined the forum, strengthening how we hear the needs of local people and communities.

Over the last twelve months, members have focused on sharing and triangulating citizen insight. This supported the development of a wider Citizen Insight report, which was shared with the Nottingham and Nottinghamshire Integrated Care Partnership in October 2024. Members have further supported the generation and coordination of citizen insight by facilitating discussions at the ICS Partners Assembly, contributing the NHS 10 Year Plan Engagement, the East Midlands Fertility Policy Review and the Nottingham and Nottinghamshire Insights Hub.

The Engagement Practitioners Forum has become a well-established mechanism for coordinating citizen intelligence and insights, as well as sharing best practices in working with people and communities. Our members also recognise its value, as evidenced by the following quotes from them:

“Attending the Engagement Practitioners Forum has enabled Digital Notts to share key updates on our digital inclusion programme, helping residents to feel supported and confident when using the NHS App to take control of their own health. Networking through the Engagement Practitioners Forum has ensured we can avoid duplication of effort and work together to improve the lives of citizens.”

NHS member

“I have found the Forum to be very useful and helpful. It is run in a professional manner and the fellow guests contribute well. The guest speakers are very knowledgeable and the topics very relevant. This is one of the meetings that I try my hardest not to miss. It supports my day to day work and the work of my greater team.”

VCSE member

“I have found the Engagement Practitioners Forum invaluable over the past two years. As a one person team, it is a real challenge to keep up with everything that is going on across the sector, especially as Public Health does not sit directly within Health. The meetings have provided a great opportunity to network with other engagement partners across statutory and third sector, share good practice, and challenges and avoid duplication around consultation. The administration and leadership of the forum by the ICB team is essential to its smooth running.”

Local Authority member

4.2.2 Voluntary, Community and Social Enterprise Alliance

Nottingham and Nottinghamshire's Voluntary, Community, and Social Enterprise (VCSE) sector plays a crucial role in the ICB’s approach to working with people and communities. The VCSE Alliance is now integrated into strategic decision-making processes through the independent Chair Professor Daniel King, who is a formal member of the Nottingham and Nottinghamshire Integrated Care Partnership and is an advisory member to the ICB Board.

To date, the VCSE Alliance has 107 members, representing 81 different organisations (a 17% increase on 2023/24). This includes representation from both the 'umbrella' CVS organisations, who support the small and medium sized members of the sector, and also larger regional and national organisations such as Stroke Association, The National Society for the Prevention of Cruelty to Children, Parkinson's UK, Royal Air Forces Association, Citizen's Advice and SHE UK (see Appendix 2).

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

The Alliance's activities in 2024/25 have focused on exploring strategies that would support the sector to become better integrated into our system.

On 9 May 2024, the ICB Board received a report developed collaboratively with members on the VCSE Alliance[5]. The purpose of the report was to provide an update on the establishment of the Alliance and discuss how the VCSE sector could be further embedded within the health and care system.

The report highlighted the previous focus of ensuring members understand the local health and care landscape by developing resources such as a dedicated webpage, glossary of terms, and introductory videos. It also detailed how instrumental the VCSE Alliance has been in several initiatives, including supporting the development of the Integrated Care Strategy, the establishment of the REN project, and creating an intelligence and insights framework to understand community needs better. The challenges facing the Alliance were also noted such as short-term funding and the need for a better understanding of the commissioning process. Next steps included expansion of membership to include faith groups, continued engagement with the third Sector Commissioning Group (exploring how the commissioning of services by VCSE organisations can be improved), and the establishment of the Nottingham and Nottinghamshire Insight Hub, all of which were developed in the following months.

The paper helped raise awareness of the Alliance and wider VCSE sector within the leadership of the ICB. There was an openness and willingness from the board to further embed and include the Alliance for the three Integrated Care Partnership priorities – prevention, integration by default, and equity in everything. There were also discussions about the appropriate use of the sector, how the ICS can support the voluntary sector, with its capacity and challenges and the governance and organisation within the Nottingham and Nottinghamshire system. The board wanted to explore how to create a more collaborative environment and unlock resources both ways, also thinking about how the NHS can provide assistance using its broad wealth of insights and data.

On 13 November 2024, representatives from 12 VCSE organisations within the VCSE Alliance attended a workshop guided by CoNavigator principles[6], participants identified critical themes, relationships, and ideas to address challenges.

[5] public-board-09.05.24.pdf
[6] CoNavigator hands-on interdisciplinary collaboration & problem solving tool

The workshop fostered a collaborative environment, emphasising the Alliance's potential to drive meaningful change within the ICS whilst recognising barriers. Participants also discussed strengthening the Alliance's role as a vital link between the voluntary sector and statutory bodies and defining its long-term impact.

A number of themes emerged during discussions:

a) The VCSE sector faces significant challenges in collaborating with NHS and statutory bodies due to their complexity, size, and a lack of accessible structures, often resulting in VCSE-led outreach.
b) Smaller charities struggle with limited access to the ICB and require greater investment from statutory organisations to facilitate meaningful participation.
c) Commissioning processes and restrictive key performance indicators further hinder the sector, stifling innovation and funding opportunities, particularly in preventive initiatives.
d) The VCSE Alliance holds great potential as a unifying network, capable of fostering information sharing, resilience, and long-term partnerships to advance the ICS's goals.

In terms of next steps, the themes from the workshop will be discussed with the wider VCSE Alliance members and the focus of the Alliance will be to cocreate an action plan to address key issues identified.

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

4.2.3 Coproduction Network

The ICB wide Coproduction Network which was launched in 2024 continues to serve as a hub for sharing resources, insights, and best practice with system partners and people with lived experience.

The virtual network is central to sharing experience and resources about coproduction, peer support and working to avoid duplication of both time, effort and resources for organisations.

Membership of this group has grown and diversified during 2024/25.

4.2.4 ICS Partners Assembly

The ICB coordinates on behalf of the system an annual public conference which we call the Partners Assembly. This attracts more than a hundred voluntary sector leaders, patient and citizen representatives, civic partners, and others. The Assembly has been used to explore topics and approach for the system's Integrated Care Strategy, the ICB's Joint Forward Plan and the national 10 Year Plan for health. Reports and fundings from the Assembly are shared widely, including to the Integrated Care Partnership and the ICS Reference Group. Further details about the work of the ICS Partners Assembly can be found in sections 5.2 and 6.1.

5 Putting our Working with People and Communities Strategy into practice

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

5.1 Understanding the healthcare needs of older adults and carers

We are committed to engaging with the population of Nottingham and Nottinghamshire to understand peoples' needs as they age, as well as those who support them and to build that into how we design services. Our mission is to empower older adults to lead healthier, independent and fulfilling lives.

As part of this work, we wanted to engage with older adults and carers about how they receive healthcare and what matters to them. We are committed to engaging with the population of Nottingham and Nottinghamshire to understand peoples' needs as they age, as well as those who support them and to build this knowledge into how we design services.

This work was to look at how best to try to prevent or slow deterioration of health and "frailty". Much of this is not medical, but may be about other factors, like supporting independence or avoidance of social isolation. We are also working on better identification of health issues and reducing repeated appointments and admissions to hospital. Additionally, we wanted to understand how best to help people with multiple health conditions. The final aspect focused on end of life provisions and supporting choice and control in planning for end of life and support with compassion and dignity according to a persons' wishes.

The engagement was carried out via an online survey. Paper copies of the survey were also distributed upon request. There was also an offer extended to visit the community groups and meetings and talk to communities and citizens directly.

In total 105 surveys were completed, and group visits were undertaken to Mid-Nottinghamshire Community groups and foodbank centres, Dementia Groups, and the Deaf Community Older People's Group, ran by the Nottinghamshire Sign Language Interpreting Service. Information was also shared in system partners newsletters.

We heard that patient education and information needs to be clear for carers, families, and relatives around how people can manage their health and wellbeing in later life, especially for those who have communication difficulties, including the deaf community. We also found that many people noted that they were not aware of the information available around End of Life Care, which is vital to ensure that their wishes are fulfilled. We know that digital access is a great issue for the ageing well community with many citizens not having access to the necessary technology to fully engage in the current healthcare pathways.

A final copy of the Ageing Well[7] report has been submitted to the Frailty Team for consideration in the redesign of the pathway moving forward to ensure that the conclusions and recommendations are taken on board together with a deep understanding on how this will look, feel and what this would mean for the ageing population in Nottingham and Nottinghamshire.

[7] Ageing Well report

5.2 Change NHS – Help build a health service fit for the future: Local engagement

In response to Lord Darzi's independent investigation report[8], released in September 2024, the Government is developing a Ten-Year Plan for Health. In October, a national conversation was launched called "Change NHS – Help build a health service fit for the future".

The proposed plan focused on three key "shifts":

1. Moving care from hospitals to community.
2. Making better use of technology.
3. Focusing on preventing sickness not just treating it.

The ICB Engagement Team carried out work to involve Nottingham and Nottinghamshire stakeholders and citizens in the development of the NHS Ten-Year Plan for Health. There were two stages to the work, firstly a desktop review, followed by a period of engagement.

Stage 1: Desktop review

The desktop review examined the involvement of people and communities in developing local authority strategies, including Joint Health and Wellbeing Strategies, and refreshed Joint Strategic Needs Assessments. Insights were collated from reports and additional readings sourced from the Nottingham and Nottinghamshire Public and Patient Insights Hub.

The research found consistent support for the proposed changes during the planning stages. For the Hospital to Community shift, local health and care service users appreciated the ease of access but expressed concerns about service consistency and awareness due to decentralization. Feedback on digital services was positive, with patients willing to engage digitally as long as it did not exclude those unable or unwilling to use such platforms. This was particularly valued for more convenient health monitoring and consultations.

Regarding the shift from sickness to prevention, both healthcare professionals and the public prioritised illness prevention to reduce the impact of chronic illnesses and save NHS resources.

Stage 2: Engagement

During the second phase of work, 657 individuals participated through one of the engagement events which were organised. There were specific meetings with ICS Governors and ICS Non-Executive Directors. Conversations were conducted on the 10 Year Plan the ICS Partner's Assembly, together with ICB staff events, and a bespoke online engagement event. Views were also gathered during meetings at the VCSE Alliance and Engagement Practitioners Forum.

At the ICS Partners Assembly on the 3 February 2025 delegates were asked about the three shifts, including potential challenges facing them, and examples of how the key shifts could be addressed.

[8] Independent investigation of the NHS in England - GOV.UK

Following the engagement period, NHS Nottingham and Nottinghamshire ICB submitted their response[9] to the Change NHS Forum for consideration in line with the publication of the NHS 10 Year Plan in 2025.

5.3 Understanding the experiences of unpaid carers

During February – March 2025, the ICB Engagement Team carried out an engagement exercise to understand the lived experience of unpaid carers. A discussion was prompted at the Integrated Care Partnership meeting on 28 October 2024[10] as a response to the Integrated Care Partnership insight report[11] which highlighted the impact on carers based on national data. It was suggested that carers could be an area of greater focus, aligned to the existing Carers Strategy. The Engagement Team received some funding from NHS England to conduct this engagement.

We were keen to engage with carers who we had not yet connected with, carers who have a disability, were from the LGBTQ+ community, from an ethnic community or have a support need themselves. The overarching aim was to uphold the voice of the carer recognising their often, hidden contribution to the health and care system. Local authorities and NHS commissioning teams were involved from the start and throughout the project to embed valuable insights into pathways and approaches, notably the ongoing work on the Joint Carers Strategy[12].

The aims of the exercise were to:

- Engage unpaid carers to understand which support is accessed by them and why.
- Understand what factors make the caring role challenging and suggestions for how these issues could be resolved.
- Understand what would support carers from different backgrounds.
- Gather insights around what carers feel positive about in terms of their caring role.

The engagement activities centred around visits to community groups and a bespoke listening session to hold conversations directly with carers. An online survey was also available to involve citizens panel members and for those preferring to share views online. Paper copies were available upon request.

In total, 35 individuals were engaged with. Visits to City Carers Support Group, Ladybrook Community Centre, Mapperley Carers Coffee Morning, and a bespoke listening event held at Nottingham city library engaged 23 individuals. Nine online surveys were completed, and three carers provided feedback via telephone interviews.

We heard that carers have limited time to either research or attend carers groups which provide peer support and information. There is also a lack of clarity for some carers about what they may be eligible for and how to access it.

For cared for individuals whose first language is not English, there are barriers to accessing respite care if it is not possible to be matched with a carer who speaks the same language. Similarly, an issue can arise if respite carers are not trained to support people who are

[9] 10-Year-Plan-Engagement-Report-Final-Version-Feb-25-Accessbile.pdf
[10] ICP-24.03.25.pdf
[11] Microsoft Word - Oct24_ICP insight report final submitted
[12] Joint Carers Strategy - Nottingham / Nottinghamshire Carers Hub Service

neurodivergent. Many carers expressed that they do not feel heard or listened to by professionals when addressing the needs of their cared for person.

A full report[13] has been shared with contributors and be made available on the Nottingham and Nottinghamshire Public and Patient Insights Hub[14] to enable wider sharing of system insights. Insights from the engagement activities will also support the ongoing work around the Joint Carers Strategy. This report will also be shared with the Integrated Care Partnership.

5.4 Fertility Policy Alignment

In July 2022, the ICB inherited a number of clinical commissioning policies from the former NHS Bassetlaw Clinical Commissioning Group (CCG) and NHS Nottingham and Nottinghamshire CCG. The remaining policy requiring additional work is the Fertility Policy, which requires updates to modernise and standardise the offer across the East Midlands.

Prior to any changes being made, the ICB sought the views of Nottingham and Nottinghamshire citizens and stakeholders and to gather quantitative and qualitative evidence to inform the new policy. The listening exercise launched on 11 November 2024 and ended on 10 January 2025.

To ensure meaningful engagement with patients and the public, we:

- Tailored our methods and approaches to specific audiences as required.
- Identified and used the best ways of reaching the largest amount of people and provide opportunities for underserved groups to participate.
- Provided accessible documentation suitable for the needs of our audiences.
- Offered accessible formats, including translated versions relevant to the audiences we wanted to engage with.
- Undertook equality monitoring of participants to review the representativeness of participants and adapted activity as required.
- Used different virtual/digital methods or direct and one-to-one telephone activity to reach certain communities where we become aware of any under-representation.
- Arranged our engagement activities so that they covered the local geographical areas that make up Nottingham and Nottinghamshire.

Elected member briefings

Two one-on-one briefings with MPs were carried out by ICB representatives, providing information about the proposals, methods of engagement, and requesting any support in dissemination to constituents as well as gathering initial feedback from the MPs.

In November 2024, the Nottinghamshire Health Scrutiny Committee (HSC) received a briefing on the Fertility Policy Review. Background information as well as the proposed policy was outlined. The engagement approach and methods were introduced including the targeted outreach to affected groups such as residents of Bassetlaw, single women, and LGBTQ+ individuals. The HSC was invited to review the briefing, contribute to discussions,

[13] Carers Engagement report
[14] Introducing the Nottingham and Nottinghamshire Public and Patient Insights Hub - NHS Nottingham and Nottinghamshire ICB

suggest community groups for outreach, help disseminate engagement details and determine how they wished to stay informed on the policy's development.

Public meetings

Three virtual public meetings were arranged for members of the public to give feedback about the proposals and to ask any questions they had to ICB representatives. These meetings were arranged at times suitable for the working age population given the age profile of those who typically access fertility treatments.

In each public meeting, ICB spokespeople described why there were different fertility policies in Nottingham and Nottinghamshire, the process underway to align these across the East Midlands and what criteria would be included in the proposed policy. Attendees were then given the opportunity to ask questions or provide any comments they had which were responded to live. For any questions that were not answered, a commitment was made to provide a response on our website. No such questions were raised.

Recordings of the online public meetings were made available on the ICB YouTube channel[15], and within the landing page for the fertility listening exercise on the ICB website[16] for people who were unable to join the live event.

In total, nine individuals attended either of the public meetings.

Attendance at these public meetings was lower than anticipated despite the extensive promotional activities and outreach work. This was consistent with the experience of other ICBs in the East Midlands. It is surmised that given the personal and emotional response that discussions about fertility often generate that citizens did not want to participate in public discissions and instead preferred to complete the online survey.

Community group events and meetings

Local community group events and meetings were found through online research and utilising the knowledge and experience of external colleagues and resources. This included visits to local health community hubs, where a stand with information on the listening exercise was hosted. At that event, the team spoke to 30 members of the public. Information was also shared at the local asylum seeker and refugee multi-agency forum, for information to be further distributed.

Community group meetings

Key groups and communities were identified through an extensive stakeholder mapping database undertaken by the ICB. An invitation was sent to 2000 stakeholders (including Healthwatch, local VCSE groups, LGBTQ+ groups, Women's groups, and Bassetlaw place groups), offering members of the ICB Engagement Team to attend community/groups meetings, provide presentations and obtain feedback. This offer was also shared at the public and community events attended as above. The ICB did not receive any invitations to attend group meetings.

[15] A recording of the online fertility session is available on YouTube here
[16] The recording of the online fertility session is also available for viewing on the ICB website

Leaflet Drops

Key community hubs were selected to improve the LGBTQ+ engagement. ICB colleagues attended these locations to drop off A5 leaflets describing the proposed policy change and how the public could share their voice, including a QR code linking to the survey. A total of 100 leaflets were dropped off across Nottingham and Nottinghamshire.

Survey

Citizens and stakeholders were invited to complete an online survey about the proposals. The survey was circulated electronically to individuals and groups whose details were held on our stakeholder database.

Paper surveys were also available which contained the same questions as the online survey. There were no requests for other languages or formats.

The survey comprised a number of questions, where responses could be made via rating scales or through free text. In total, 427 individuals of the 2,046 who provided a response to the survey were from Nottinghamshire, with 33 of those being from Bassetlaw specifically. It was acknowledged that not all those who completed the survey disclosed their locality, and therefore this number may be even higher.

For more information on how Nottingham and Nottinghamshire ICB has been working with other ICBs across the region for the Fertility Policy Alignment see section 8.1. A full report will be available in May 2025 together with a local report for Nottingham and Nottinghamshire. The feedback from this listening exercise will be considered and fed into the final policy, which will be presented to the SPI Committee for approval.

6 How we have used insight and data

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

6.1 Refreshing the NHS Joint Forward Plan and Integrated Care Strategy

The Nottingham and Nottinghamshire Integrated Care Partnership (ICP) has developed an Integrated Care Strategy[17] to improve health and care outcomes and experiences for local people (2023 – 2027). The Strategy has been developed for the whole population using the best available evidence and data, covering health and social care, and addressing the wider determinants of health and wellbeing. In addition to developing the Strategy, the ICP is also responsible of overseeing the implementation of the Strategy and its refreshing. To support the annual refresh of the Strategy and to ensure ongoing consideration of the needs of people and communities, the ICP:

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

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

Each NHS organisation in the country is required to produce an NHS Joint Forward Plan which outlines the organisations contribution to the delivery of the Integrated Care Strategy. The Joint Forward Plan was therefore refreshed in 2024/25.

6.1.1 Involving partners

One approach for the ICP to engage with the wider assembly partners is via the ICS Partners Assembly. The ICS Partners Assembly is a bi-annual gathering of organisations and individuals who have an influence and interest in the health and care of the region's population. The third ICS Partners Assembly was held in April 2024 and attended by over 200 system stakeholders, including representatives from the VCSE sector, NHS organisations, Local Authority, citizens, patient leaders, and people with lived experience.

This Assembly aimed at involving citizens in the development of the NHS Joint Forward Plan for Nottingham and Nottinghamshire and help with refreshing the Strategy.

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

1. System-wide collaboration for Integrated Care Strategy.
2. Timely and consistent communication.
3. Strengthening service-patient relationships.
4. Advancing digital technology and system integration.
5. Building and maintaining partner confidence.
6. Community-based care.
7. Proactive community support.
8. Workforce development and training.
9. Engagement with grassroots and VCSE organisations to better understand local need.

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

"I like the ethos of the Integrated Care Strategy. Also investing in in-person engagement like this with senior people in the room is definitely the right thing to do."

6.1.2 Development of the Citizen Insight Report

The ICB Engagement Team produced the second Citizen Insight Report[18], which was presented to the ICP on 28 October 2024. The report included:

1. An overview of what matters to citizens, including perceptions of the NHS and social care and the civil unrest which took plan during August 2024.
2. A summary of all recent activity involving working with people and communities across our system.
3. Deep dive on key topics including:
   - Timely access and early diagnosis of cancer.
   - The needs of children, young people, and families
4. Several discussion points for the ICP to consider.

The ICP agreed that continuing to listen to the citizen voice was critical to ensuring the success of the Integrated Care Strategy, and there was an emphasis placed on the

[18] Microsoft Word - Oct24 ICP insight report final submitted

importance of not just using citizen insights when designing services, but to evidence their use.

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

6.2 Supporting the mental health needs of citizens

The ICB Engagement Team produced a citizen insight presentation for discussion at the ICB Board Development Session which considered the current mental health needs of our population and future mental health services. Participants considered citizen insights alongside the current quality concerns and improvement requirements within mental health services. An action arising from this session was to better understand what the patient voice is saying across the system.

In response to this, the ICB Engagement Team produced a detailed Mental Health Insight Report, an overview of which was included in the ICB Board papers at their meeting on 9 January 2025 and was discussed at the Board’s Development Session on this topic. The insights informed the Joint Forward Plan refresh process.

7 Equality and inclusion when working with our diverse communities

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

7.1 Equality and inclusion principles

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

7.2 Lung Cancer Screening Programme

The Lung Cancer Screening programme (formerly known as the Targeted Lung Health Check Programme) aims to find lung cancer at an early stage (stages one and two), often before symptoms develop. Early diagnosis increases lung cancer survival rates as there are more curative treatment options available.

As of March 2025, over 5,500 people across England have been diagnosed with lung cancer through the programme and 75% were found at an early stage. This compares to less than 30% outside of screening.

The programme is being rolled out across Nottingham and Nottinghamshire in a targeted approach with the highest risk areas prioritised. The first area was Mansfield and Ashfield in 2021 and since then invites have been expanded into Nottingham City and South Nottinghamshire. Eligible people from Mansfield and Ashfield are also being re-invited for follow up scans and check-ups.

As part of the screening, those aged 55-74, who are current or past smokers are invited for an initial telephone lung health assessment. Following the assessment, a patient may be invited for a low dose CT scan at one of the mobile units that are equipped with a CT scanner. To make the screening accessible to as many people and communities as possible, the mobile units are sited in community locations, such as supermarket car parks and leisure centres. These locations have good transport links to ensure transport is not a barrier to attending appointments and a private transport service is also available to patients should they need it.

As of March 2025, across Nottingham and Nottinghamshire, over 81,000 people have been invited and over 29,000 scans performed. 65% of people invited have taken up the screening offer and 312 cancers have been diagnosed. 64% of these cancers have been diagnosed at an early stage and 70% have a curative treatment plan.

Due to the innovative approach of delivering screening in the community, the programme team won the ICS Health and Care Award for Health Inequalities at the System's inaugural awards ceremony in October 2023 and came runner up in 2024. The team was also selected to present on addressing Health Inequalities in lung cancer screening at the British Thoracic Oncology Conference in Dublin in March 2025.

Further work has taken place to improve access for some of the most vulnerable people in Nottingham City as the team adapted the service provision to make it easier for people experiencing severe and multiple disadvantage (SMD) to attend. This initiative saw the mobile unit set up in the city centre with the offer of drop in and longer appointments and specialist support provided. This is a great example of services working together to deliver patient-centred care. Many people attended with the support from key workers and partners. The feedback received on the day was extremely positive with high service ratings and several people attended who do not usually engage with healthcare settings. A kind donation of sandwiches was also provided by local food manufacturer; Samworth Brothers.

The local NHS worked with Nottingham City Council to access the city centre location and local charities and outreach workers supported in sharing the message to the eligible cohort in the city centre, many of whom have been sleeping rough. Feedback from patients described the service as "nice and welcoming" and "very straightforward". The team are continuing to work closely with SMD groups in Nottinghamshire with plans to deliver more drop in clinic days in Mansfield and Ashfield.

To increase awareness of the screening programme, the team also attend events in the local community such as, local befriending groups, over 65s groups, community groups and Notts Pride. These events provide opportunity to share information, answer questions, and gather feedback on programme materials.

The programme is also widely promoted on local radio stations, public transport (bus and trams) and social media channels. The team also links with GP practices, councils, charities,

and faith centres to gain valuable local insight to shape the communication and engagement strategy and reduce barriers to participating.

Case studies are a valuable promotional asset which provide real life examples which people can relate too. The team are always keen to hear from patients who are willing to share their lung cancer screening experience. Jacqui, a Nottingham City resident has kindly shared her journey with the team which is being widely shared on the dedicated lung cancer screening website, Integrated Care Board website, social media and through an animation. Jacqui's story has also been presented to the East Midlands Cancer Alliance.

Stakeholder mapping continues to take place, together with establishing new relationships with community groups and networks. This has allowed communication to be delivered to our diverse and ethnic communities.

Working with the District Council, discussions have also started to recognise and understand the culture of the Gypsy Roma Traveller community. Face to face engagement is planned to best reach these families and learn what information and adaptations would be helpful to overcome any potential barriers to attend a lung cancer screening appointment.

7.3 Developing a Research Engagement Network for Nottingham and Nottinghamshire

The overall aim of the Integrated Care System (ICS) Research Engagement Network (REN) Programme is to ensure that all communities are actively involved in health and care research and that research is more representative of our diverse and underserved populations, so that everyone can benefit from research. The REN brings together communities, voluntary and community organisations, NHS partners, Local Authorities, and researchers.

A key priority is to undertake research with communities and in geographical areas where health and social care needs are greatest. Nationally and locally, there is less research happening in the areas where there are higher levels of poor health. Health conditions which are more common among disadvantaged communities are more likely to be studied in healthier, more affluent, and less diverse populations. This is important because the research findings may not be relevant to those who face far greater challenges to their health and wellbeing.

This year we focused on developing research engagement through existing community health and wellbeing champion networks, community champions and CVS organisations, with an agreed approach to work with people who are 'trusted voices' in their communities and ensuring that what we do benefits communities not just researchers or the 'system'.

In parallel, we have continued to develop links with research communities to create accessible pathways into research for underserved groups. We have built connections with researchers aligned with the REN's engagement approach including the Co(l)laboratory, a joint initiative between Nottingham Trent University and the University of Nottingham.

We have also worked with the VCSE Data and Insights Observatory at Nottingham Trent University to develop a prototype interactive dashboard that works to connect researchers with communities. The dashboard allows VCSE organisations to express research priorities, set boundaries for engagement, and connect with aligned researchers. For researchers, it

offers a way to discover and collaborate with relevant, trusted community partners. The objective is to remove barriers to engagement in research for underserved communities and enable more equitable, balanced, and inclusive research relationships that are mutually beneficial.

7.4 Understanding the needs of young people

The Golden Thread project empowers young people to pursue further education and employment by connecting them with local volunteering opportunities. Participants receive tailored training and are matched with organisations aligned to their interests. This not only helps reduce social isolation and build confidence, but also enhances their access to education and supports the development of new skills and self-esteem.

Importantly, the programme also provides valuable insights into the needs of younger people. For instance, it recently highlighted a significant gap in access to sexual health services in the Sherwood area - particularly around emergency contraception. In response, a survey has been distributed to local partner agencies to gather their perspectives and identify opportunities for outreach. Meanwhile, awareness of existing services is being raised among those involved in the initiative.

7.5 Amplifying the voice of people with learning disabilities

The Broxtowe Learning Disability Collaborative is a local initiative focused on improving the health and wellbeing of people with learning disabilities in the Broxtowe area. The collaborative's work is part of a broader effort within the Nottingham and Nottinghamshire ICS.

Broxtowe Learning Disability Collaborative designed and implemented a series of Learning Disability Health and Wellbeing Roadshows aimed at improving the outcomes and experiences of people with learning disabilities.

The roadshows provided a safe space for people with learning disabilities to have their voices heard and to share their experiences about what matters to them. They also encouraged uptake of the annual learning disability review, raised awareness of the wider determinants of health and promoted a holistic approach to health and wellbeing.

As a result, a number of actions have been implemented including training experience for every PCN trainee nursing associate, Oliver McGowan training with leisure staff, setting up sensory flu clinics for people with learning disabilities and creation of a learning disability advise and information repository.

7.6 Coproduction and the Learning Disabilities and Autism (LDA) Programme

The LDA Programme is set up to support making health and care services better so that more people with a learning disability, autism or both can live in the community, with the right support, and close to home.

During 2024/25 the programme has been a coproduction priority by employing a dedicated role to support the development of their Virtual Expert by Experience Group.

This group has two members actively contributing at a strategic level through their roles on key programme boards. Their involvement has ensured that lived experience insight is embedded in decision-making and service development, influencing both the direction and delivery of the LDA programme priorities.

An example of their work has been the “Minds of All Kinds” initiative, which is co-producing a neurodevelopmental support website. Feedback from a series of parent carer workshops conducted with the University of Nottingham’s Neurodevelopmental Network are directly informing service improvements, to improve the accessibility of communication and pathway information, with easy read and visual infographics now in use based on family feedback.

7.7 Partners in Mind – Mental Health Coproduction

Launched in April 2024, Partners in Mind is a monthly health and social care sector coproduction group focused on the integrated mental health pathway programme. Membership of the group includes people with lived experience of using mental health services and coproduction 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 during the year focused on 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 including with transition into adult services.

The group has also been involved in further development of a system wide coproduction resource delivered to support the transformation and commissioning of local mental health and well-being services. The resource is widely accessible and available to support future transformation work.

8 Demonstration of how the ICB has worked with partner organisations

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

8.1 Fertility Policy Alignment

The Fertility Policy engagement exercise detailed in section 5.4 of this report is an example of how NHS Nottingham and Nottinghamshire ICB has been working with other ICBs in the East Midlands in 2024/25. Since July 2022, extensive work has been undertaken to align policies from the former NHS Bassetlaw Clinical Commissioning Group (CCG) and NHS Nottingham and Nottinghamshire CCG across the ICB’s geographical footprint, and as appropriate, across the East Midlands ICBs. The remaining policy requiring additional work is the Fertility Policy, which requires updates to modernise and standardise the offer across the East Midlands.

Nottingham and Nottinghamshire ICB has been working with other ICBs across the region (Derby and Derbyshire; Leicester, Leicestershire and Rutland; Northamptonshire; and Lincolnshire) to develop a new fertility policy which is consistent across the whole geographic area and is also up to date with modern expectations in society.

Throughout the engagement period, we worked closed with our other ICBs meeting on a regular basis, sharing information and also frequently asked questions which could adapted. Information was also shared online providing details of online engagement sessions together with the case for change.

In November 2024 – January 2025, the ICB Engagement Team undertook a listening exercise to seek the views of citizens and stakeholders and gather quantitative and qualitative evidence to inform the new policy.

Across the East Midlands a total of 2046 surveys were completed. In Nottingham and Nottinghamshire 427 citizens/stakeholders completed the survey with 33 responses specifically for Bassetlaw. A full report will be available in May 2025 together with a local report for Nottingham and Nottinghamshire.

8.2 Developing an engagement and health inequalities improvement framework

In August 2024, the draft Care Quality Commission (CQC) Engagement Framework to address Health Inequalities was launched[19]. Nottingham and Nottinghamshire were one of four initial pilot sites to test the framework. The pilot ran from 2 September - 1 November 2024.

Working with Coproduction colleagues, the four domains tested were:

a) Check: Identify relevant existing assets and knowledge (and gaps).
b) Challenge: Consider power dynamics, leadership culture and commitment to engagement.
c) Prove: Define, measure and evidence impact.
d) Improve: Implement necessary changes and spread learning.

The two programmes that were retrospectively reviewed were Speech, Communication and Language Services for Children and Young People and NottsAlone Website.

Feedback was provided by the ICB Engagement and Coproduction Teams on suggested adaptations and potential application of the framework when it was launched in February 2025.

As part of the launch members from the Engagement and Coproduction team participated in a series of videos to talk about the work, which were shared at the event.

Tracey Halladay, Delivery Unit Manager – Regulatory Leadership, Regulatory Pioneer Fund ICS Health Inequalities Improvement Project kindly thanked Nottingham and Nottinghamshire ICB for their support:

On behalf of all of the project team, CQC, National Voices and the Point of Care Foundation I wanted to thank you all for the huge contribution you made to the development of the self-assessment and improvement framework for integrated care systems. Your willingness and commitment throughout has been great to see, particularly we appreciate the time taken by

[19] Developing an engagement and health inequalities improvement framework for integrated care systems: progress update - Care Quality Commission

you to participate in the testing phase which we know has made a big impact on the final version of the framework. We could not have got to the place we are without you.

The ICB Engagement and Coproductions Teams will now consider how, as an organisation, the framework is embedded into our current engagement toolkits and commissioned work.

8.3 Refreshing the Coproduction Strategy

To ensure that our refreshed strategy was built on the foundation of engaging honestly and openly with the citizens of Nottingham and Nottinghamshire we hosted a series of in-person and online listening events during the past year, where anyone with experience or an interest in coproduction could attend and share their views directly with us.

These events allowed all system partners and service users to reflect on their experiences and perspectives, the progress made across our system, define priorities, and co-create future approaches.

Key themes emerged around the need for a shared definition of coproduction, avoiding duplication, working with existing groups, and ensuring coproduction is inclusive, planned, and supported by accessible training and peer support for both professionals and Lived Experience members.

The refreshed strategy will retain relevant elements of the previous version which were felt by Lived experienced members to be vital to continue with, while incorporating feedback from the Listening Events and is being coproduced with My Life Choices coproduction group and the Our Voice, Local Authority coproduction group.

It includes updated values, principles, and a visual of coproduction to align with national guidance and feedback from people with lived experience.

The refreshed Strategy is being finalised and will be published during Q2 2025.

8.4 Coproduction with Children and Young People – MH2K

Since 2017, the ICB has commissioned MH:2K – Leaders Unlocked[20] - a coproduction programme that empowers young people to shape mental health services through the Citizen Researcher model. MH2K has played a central role in informing local service transformation, with young people directly contributing to data collection, analysis, and recommendations.

During 2024/25, MH2K's insights have driven the development of the coproduced *NottAlone* mental health website, improved awareness and confidentiality in Mental Health Support Teams in Schools, and shaped transition support for 18–25-year-olds. Their work with local authority education teams has also informed strategies to re-engage young people not in school.

MH2K has supported the development of service specifications and contributed to the Children and Young People's (CYP) Mental Health Local Transformation Plan. Several young people have progressed into CAMHS roles or further education as a result of their involvement. One secured a paid involvement role within the Children and Adolescent Mental Health Services (CAMHS) in Nottinghamshire, another is actively supporting the

[20] MH:2K – Leaders Unlocked

Youth Impact Board, and a third has gone on to study for a degree in psychology, building on their lived experience.

A recent commissioning review found MH2K provided more consistent and meaningful engagement than individual provider-led efforts, helping decision-makers access a stronger evidence base. However, the review also highlighted gaps in engagement with under-14s, parents, and vulnerable CYP, which are currently being incorporated into future commissioning options. These findings will guide future coproduction priorities as the current contract approaches renewal in March 2025.

Further details about the development of the NottAlone website can be found in section 10.2.

9 Sharing learning and good practice examples

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

9.1 Supporting the ICS to work effectively with people and communities

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

9.1.1 Nottingham and Nottinghamshire Public and Patient Insights Hub

The Nottingham and Nottinghamshire Public and Patient Insights Hub[21] is a central database of citizen, patient and service user insights collected from across Nottingham and Nottinghamshire, as well as nationally. It exists to be the first port-of-call when health, local authority, and VCSE colleagues across the system are asking the question, “what do we know about the population and their use of this service or experience of this condition?”. It is one of the ways that we, as a system, coordinate and understand citizen intelligence, and aims to reduce duplication and avoid engagement fatigue from the population. Since its launch in April 2024, the Insights Hub has grown significantly in terms of users, information, and functionality.

Currently the Insights Hub database holds over 210 entries, 134 of which focus on the Nottinghamshire system locally, with others coming from national studies and charity reports. The documents have been gathered through a combination of local VCSE partners submitting their reports to be held in the Hub and research by the ICB Engagement Team. The reports are tagged with relevant themes and service types to ensure they are easy to navigate. More than 190 people are signed up to the Insights Hub and the platform is used by between 30 and 70 individuals per month.

As well as providing a database, we have also designed the hub to act as a catch all for other helpful information. Currently this includes a database for local newsletters, a “more resources” section, which holds census data and other interactive resources, and the System Partner Forums.

We worked with our system VCSE Alliance and Engagement Practitioners Forum to develop the more resources section of the hub. Members of these groups told us that they would value an area which would signpost users to helpful tools which could support them with

[21] https://future.nhs.uk/nottsinsighthub

citizen intelligence work. The area hosts over 35 links through to resources, including ONS insights, the NHS Patient Survey resource, health and care related podcast series, engagement toolkits for specific groups, as well as interactive resources like population maps.

The System Partner Forums is an area where bespoke workspaces can be created for individual groups to use. Once they are set up, those who requested the Forum's creation can control who has access to it. The area can host a private calendar, discussion forum, and hold documents, essentially forming a hub within the Hub. There are currently two System Partners Forums in operation, one used by the VCSE Alliance, which holds meeting dates and papers, and another being used by the Research Engagement Network (REN). The REN have found the forum incredibly helpful as it has provided a quick way for the members from different organisations to store documents in a common area, which was not possible before.

To mark six months since its launch, an evaluation was carried out on the Nottingham and Nottinghamshire Public and Patients Insights Hub. It was sent out via email to all members at the time (164 members) and included on the internal Nottingham and Nottinghamshire ICB Staff News Bulletin, gaining a total of 24 responses.

Most respondents (86%) who had revisited the Insights Hub since signing up had accessed the report database, a quarter of the respondents had used the Hub to guide projects by searching for existing insights.

We learned how the platform was helping separate organisations better work together:

"System Partner Forum as a way of keeping all programme documents in one place that system partners can access. We tried using a [Microsoft] Teams channel, but the VCSE partners had technical issues accessing it."

Respondents commented that they found the reports easy to access, that there was a wide number of reports available, and that it is a rich source of information. However, we heard that some people found it difficult to search or navigate.

As part of the evaluation, we asked if respondents would be interested in any follow up session to demonstrate how to use the hub. The majority of selected the option to have video recordings uploaded to the hub.

In response to the evaluation, the ICB Engagement Team carried out some tasks and created a You Said We Did document (See below). Actions included updating the Nottingham & Nottinghamshire ICB website and added a new ICS website page explaining how the hub can be used and FAQs, and organising a live drop-in session, which was recorded highlighting how to use the different areas of the Hub, and then uploaded to the relevant section.

During the ICB's January all staff briefing, a short presentation was held on the Insights Hub. The presentation answered three questions which arose during the 6-month evaluation: "What is the Insights Hub?", "How do you use it?", and "How can it help my work?". The staff briefing was attended by 240 people within the organisation.

As part of the actions resulting from the evaluation, an online tutorial session was held to answer the above questions that people had during the evaluation and demonstrate the main features of the Hub. 14 people attended the session, including colleagues from within the ICB, local authority, and the VCSE sector. Feedback was gathered at the start and end of the session which showed an improvement in the attendees understanding of the platform, a member from the team was also invited to give a similar presentation to DigitalNotts at one of their team meetings.

9.1.2 Citizens' Panel

The Citizens' Panel aims to be a demographically representative, consultative body of local residents, utilising a 'person-centred' approach to shape and inform the delivery of health and care services. Panels enable a rolling programme of engagement, tapping into a pool of involved people which can elicit higher levels of engagement, compared to one-off surveys. The Citizens' Panel adds to our existing methods of engaging local people and is another way that is enabling us to listen the views of our citizens.

The Panel adds value by identifying local priorities and consulting on specific issues that affect our communities. Benefits include the ability to track trends in opinion, targeted work with communities, and the ability to focus on specific ICS priorities at various points in the year.

Nottingham and Nottinghamshire's Citizens' Panel was initially launched in Nottingham City on 28 September 2022, expanded to Mid-Nottinghamshire on 2 September 2024 and Bassetlaw and South-Nottinghamshire on 28 February 2025 and has 223 members, an increase of 112% since 2023/24. The ICB Engagement Team continue to work in partnership with System partners, Voluntary, Community and Social Enterprise Alliance, Engagement Practitioners Forum, and Place representatives to grow the Panel membership.

The Panel has been sent one survey per quarter since launch in 2022, forming part of the 2024/25 data gathered for engagement exercises detailed within this report such as the East Midlands Fertility Policy Review, Care Homes Review, NHS Joint Forward Plan, Ageing Well and insights on Carers' experiences.

Regular, meaningful engagement with Citizens' Panel members will ensure there is clarity and consistent feedback about how their views have shaped the provision of services and how it has contributed to improvements and change therefore demonstrating how we have turned this data into action.

9.1.3 Engagement Toolkit

The Engagement Toolkit[22] is a practical guide to support Primary Care Networks, staff, and members of the public wanting to carry out meaningful engagement activity. In 2024 the Engagement Team finalised a refresh of the Toolkit.

My Life Choices, Primary Care Network staff and teams in the Integrated Neighbourhood Working Programme, shared feedback which shaped the refresh. In response to this, the following pages were added to the Toolkit:

- Introduction and contents page.
- A diagram demonstrating the steps to; informing, engagement, consultation, co-designing and co-producing.

[22] PCN-Toolkit-FINAL-VERSION-21-October-24-compressed.pdf

- The importance of why we need to talk to people and how we will do it.
- A checklist for planning engagement (incorporating 6W's slides).
- Our commitment to engagement.
- A diagram of the Integrated Carer System and the local picture.
- Kings Fund Video explaining how the NHS is changing to work in a more joined up way.

The Toolkit is now embedded in the Integrated Neighbourhood Working programme. It has been uploaded to their NHS Futures page and shared at Local Design Team meetings.

"The Engagement Toolkit has been pivotal for all of the five early adopter sites in the programme for introducing an approach and considerations when engaging with our communities. Each of the early adopter sites have taken the 6 W's to create a bespoke approach for their specific neighbourhood."

The refreshed Engagement Toolkit has proven to be an invaluable resource, enabling a more structured and effective approach to how we listen to citizen. Its integration into the Integrated Neighbourhood Working programme and widespread dissemination through NHS Futures and Local Design Team meetings underscore its significance. The positive impact on the five early adopter sites highlights the Toolkit's role in shaping bespoke engagement strategies, ultimately enhancing the quality of interactions and outcomes within our people and communities.

9.1.4 Coproduction training, toolkits and learning resources

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

The developed and delivered a range of learning materials and sessions, including case studies, skills workshops on facilitation and accessibility, and introductory coproduction training.

Innovative sessions on using digital graphic design tools further broadened the accessibility of coproduction. These materials were made available system-wide and nationally, with positive uptake and feedback from staff and people with lived experience.

Experiential evidence captured by the ICB Coproduction Team from the listening events and Resource Group (Which is System wide peer group made up of professionals from all parts of the Integrated Care System who are actively engaged in Coproduction as part of their role) captured that users felt the resources provided clear and effective support to empower and enable coproduction to take place. There was some feedback that the support was focused primarily on staff, and more work was needed to identify the specific support and resource to support Lived Experienced members.

The limited data available from NHS Futures also shows that the number of users accessing the NHS Futures site has also increased during the year Whilst the data shows an increase it does not currently provide a richer picture of user interactions.

Conducting a broader user survey has been rescheduled until Q2 2025 as there was a substantial amount of review and feedback captured through the listening events during 2024. As part of the survey, we will consider how we gain insightful feedback of what is

useful, its impact in supporting effective coproduction as well as areas where further tools, training or resources are needed.

9.1.5 Coproduction Week 2024

Coproduction week is a national celebration of coproduction created by the Social Care Institute for Excellence (SCIE).

The ICB delivered a programme of events and workshops as part of National Coproduction week which supported the theme of “What’s Missing, focusing on increasing equity and diversity in coproduction. Events included “Lunch and Learn” sessions on engaging children, young people, refugees, and asylum seekers, and a webinar in partnership with Small Steps Big Changes - Getting Started with Meaningful Coproduction.

A data collection exercise was also undertaken called The Big Coproduction Conversation, to capture people’s feelings about coproduction which is being used to shape the design and delivery of further resources for delivering Coproduction.

Key themes included:

- A strong commitment to collaborative, inclusive, and meaningful engagement in service design and transformation across the system.
- That coproduction could be strengthened by meaningful collaboration to strengthen co-production efforts.
- Coproduction faces several challenges across the system, including difficulties in recruiting diverse service users, the time it takes to coproduced being reflected in transformation planning, and a need for genuine commitment, adequate resourcing, and inclusive stakeholder engagement.
- Ensure working with diverse communities and representative communities.
- There needs to be an investment in time and resources to coproduce.
- A move to learning collaboratively from the insight gained from coproducing as a system.
- There are concerns about tokenism, unclear planning, and unrealistic expectations, which can hinder meaningful collaboration.

9.2 Sharing successful programmes

This section outlines programmes that have been undertaken, which have had significant positive outcomes and can serve as models for future initiatives.

9.2.1 Small Steps, Big Changes (SSBC)

Over the last ten years, SSBC has commissioned over 40 services supporting babies, children, and families to have ‘a better start’ in life in some of the most deprived areas of Nottingham.

They have coproduced all the projects and services, as well as being an integral member and supporter of the ICBs approach to Coproduction. They have also supported the Systems strategic approach to Coproduction through part funding roles with the ICB.

SSBCs National Lottery came to an end during 2024/25, but the positive impact of their work is still being felt.

Key areas that SSBC implemented include:

Father inclusive practise

Several projects have been delivered across the partnership to facilitate the strategic aims, including;

- Funded projects focused on supporting local dads – Ideas Fund activities such as Shifting Your Mindset, Recliner Chairs, Fathers Reading Every Day (FRED).
- Developing resources for dads and the local workforce to facilitate positive change – Dad's pack, Think Dads Training, Think Dads Conference and webinars, and Father Friendly Checklists and Service Standards.
- Advocating for father inclusion across the partnership in developing new services or projects and nationally through written evidence to the Health and Social Care Committee on Men's Health in 2023.
- Embedding father inclusion in SSBC, such as in workforce planning, and delivery of flagship projects such as the Family Mentor Service.

Feed Your Way
SSBC's work supporting breastfeeding extended to two key projects: Feed Your Way and a breastfeeding incentive scheme.

Feed Your Way was a behaviour change public health breastfeeding campaign addressing community and societal attitudes to breastfeeding.

The campaign is aimed at new parents and parents-to-be in Nottingham who are making decisions around infant feeding. The campaign also recognises the importance of support networks, allies, influencers, professionals, and the wider community, all who have a role to play in infant feeding decisions.

Breastfeeding Incentive Scheme

The aims of the breastfeeding incentive scheme were to:
- Increase the number of children receiving any breast milk.
- Increase the duration that children receive breast milk.
- Provide evidence for whether breastfeeding incentives are an effective way to increase breastfeeding rates.

Healthy Little Minds

Healthy Little Minds helps to nurture the relationship between parent/carer and child. They provide support and the tools needed to understand the baby's needs. They do this by helping parents/carers to deal with difficulties, focus on the emotional health needs of the baby, and build parenting strengths.

HLM offers various targeted interventions including one-to-one support and home visits, psychotherapy, video feedback, and parenting groups such as Mellow Babies and group massage sessions. The programme supports families with a range of needs, including those experiencing mental health issues and difficulties bonding with their infants.

The team have both supported parents and children with specific interventions, and workforce with training advice, consultation, and supervision. They have also developed a range of innovative tools and resources for parents and professionals.

The team consisted of
- 1 project administrator
- 5 Maternity and Family Support Workers
- 4 Specialist Practitioners
- 1 Senior Specialist Practitioner

- 1 Team Manager
- 1 Service Lead

They supported families across the whole of Nottingham City.

All SSBCs projects were coproduced from their outset, with a key principle of their coproduction approach being that all local people who participate in coproduction activities can see the benefit from their contribution.

Six Parent Champions secured paid employment as part of the Parent Champion Family hub project, and it resulted in the parents they worked with reporting increased confidence, skills, and experience.

All SBBC resources including their final report can be found on the Learning Hub - SSBC[23].

9.2.2 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 2024/25, the Nottingham and Nottinghamshire MNVP made significant strides in advancing coproduction by playing a key role in shaping responses to the 2024 CQC Maternity Reports, working closely with providers to coproduce 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 coproduction 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.

[23] Learning Hub - SSBC

Volunteer infrastructure has also been enhanced to support sustained involvement. A refreshed set of welcome and onboarding materials for coproduction volunteers has been aligned with the ICB's broader approach to Experts by Experience. Volunteers took part in two in-person coproduction events at Kings Mill Hospital, contributing to service improvements in triage and transitional care.

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 coproduction in maternity and neonatal services has matured over the past year becoming more embedded, inclusive, and impactful across the system.

10 Communications, social media, and marketing

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

10.1 Overview

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

- Producing regular newsletters and podcasts for system partners, so that they are aware of the work that is being done in this area.
- Producing a monthly stakeholder update.
- Providing health and wellbeing information and advice to our population through our website, social media, WhatsApp channel and campaign work.
- Sharing final reports with those who were involved in generating citizen intelligence as part of bespoke programmes of work, including direct distribution and publication on our website.
- Proactively briefing and updating (both verbally and in written form) Members of Parliament and councillors.
- Informally meeting with the Chairs of Nottingham Adult Health and Social Care Committee and Nottinghamshire Health Scrutiny Committee monthly.
- Engagement with the East Midlands Combined County Authority.
- Providing regular verbal and written updates to Healthwatch.
- Holding our Annual Public Meeting, which offers the opportunity for the public to ask questions.

10.2 Developing the NottAlone website

The launch of the new all-age NottAlone website[24] which offers mental health advice and signposting to anyone with mental health concerns was one real highlight of the past 12 months. Originally launched in 2021, as a website for children and young people, the site now offers mental health support to anyone of any age in Nottingham and Nottinghamshire.

NottAlone – which a is joint project between Nottingham and Nottinghamshire ICB, Nottinghamshire County Council and Nottingham City Council – also gives users the

[24] Mental Health Support Services For People In Nottinghamshire | NottAlone

opportunity to seek support for themselves, for someone they care about, or to look for information in a professional capacity.

Children and young people were very much at the heart of the project and were given opportunity to give their feedback into colours, user pathways, graphics and more. They also provided feedback on our social media plans and launch event ideas. Extensive engagement was also carried out with our adult audience. We revived the County Council's Citizen's Panel and worked with the ICB's Engagement team to ensure we sought input and feedback from as many people from as many different backgrounds as possible.

Service signposting has also been a key focus of communications activity over the past year within mental health. A fold-out pocket-size signposting leaflet was designed in-house and has been printed and shared with GP surgeries and other clinical staff. This fold-out, credit-card leaflet lists all the service that are there to help depending on a patient's individual circumstances. A downloadable version is also available[25].

A traffic light signposting graphic has also been created to provide an easy-to-understand overview of the different mental health services available. Those in red are here to help those are in crisis, yellow is for those services that support people in need of help and support with their mental health, and green for general mental health advice and wellbeing.

The traffic light along with NottAlone messaging, has been used extensively on social media. Digital advertising on Facebook saw the traffic light reach in excess of 100,000 people and has been shared more than 1,200 times.

Additionally, a video version of the traffic light was created to use on TikTok to test a different social media channel and reach different demographics based on feedback. We specifically and successfully reached a younger, male audience.

An in-depth digital guide to dementia booklet was created using Microsoft Sway. The document gives a very thorough insight into all aspects of living with and caring for someone with Dementia – from diagnosis to end of life care. It was created with significant input from Nottinghamshire GPs and those with first-hand experience of caring for someone with Dementia.

We have also reached out to people through several newspaper articles in the Worksop Guardian, Mansfield Chad and Hucknall and Bulwell Dispatch. These articles have been published at key times when people may be particularly struggling with their mental health for example around the Christmas period.

11 Future planning

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

11.1 Citizen intelligence

During the 2024/25 period, we have made significant strides in embedding the voice of our citizens into every aspect of our service delivery. Our ambition has been to ensure that the starting point for all considerations on how we deliver services begins with insights from our population. This includes understanding what services they value, how they prefer to access

[25] Mental Health Services

them, and the most effective ways to deliver these services. However, there is more to do and during 2025/26, we will:

- Recruit a total of 1,000 individuals across the whole of Nottingham and Nottinghamshire to our Citizens Panel.
    - Over Q1 and Q2 2025/2026, recruitment to the Panel will be promoted further. The planning phase involves mapping Nottingham and Nottinghamshire's population demographics using recent census data and the engagement team's established stakeholder database to ensure representative recruitment. Insights from local membership data and SAIU information will help identify those we do not often hear from.
    - Discussions at key meetings such as the Engagement Practitioners Forum, VCSE Alliance and PBP meetings will ensure that feedback is incorporated and actioned and help promote the panel.
- Continue to develop the Insights Hub to serve as the primary resource for the System to understand citizen insights.
    - We will continue to expand the number of reports held in the database and increase regular user numbers.
    - We will increase the number of groups using the System Partner Forums as a base for their teams to work, as well as looking to create new functions in response to user feedback.
    - We are already working with the ICS System Analytics and Intelligence Unit to migrate the Insights Hub to allow it to be used in tandem with the SAIU Dashboard. This work will unlock the capability of doing a search of both the quantitative data and qualitative insights which are available and combining them to reach a better understanding of the system's understanding of citizen needs as a whole.
    - In the future, Artificial Intelligence may be used to generate a report combining all this information to provide engagement professionals a fast and complete view of what we already know about a subject they are starting projects on.
- Consider how best to incorporate elements of the CQC Engagement and Health Inequalities Improvement Framework into the existing ICB Engagement Toolkit to enhance awareness among commissioners and system partners regarding its practical use and how it can be effectively utilised in programmes of work.
- Continue to deliver insight reports on citizen and service user intelligence and insight to the Integrated Care Partnership.
- Deliver reports on citizen and service user intelligence and insight to the SPI Committee and ICB Board on specific issues, linked to the work programme.
- Deliver formal public consultations for major service change programmes as required.

11.2 Coproduction

In 2025/26, the Nottingham and Nottinghamshire ICB will advance its coproduction strategy by working to further embed a more dynamic, inclusive, and measurable approach across the system.

We will do this by building on the foundations of the 2022–2024 strategy and publishing our refreshed strategy during Q2 2025. The refreshed strategy and the key intelligence gained (co-produced with Experts by Experience) ensures lived experience directly shapes our priorities and delivery.

The strategy recognises feature a stronger emphasis on planning of activity, reducing duplication of work, shared power, and system-wide alignment, with a need for senior leaders to actively championing coproduction at all levels.

We will work with strategic commissioners and system partners to ensure that Coproduction is a planned activity incorporated into all their work. We will also work with partners to understand the barriers within existing reporting and how we can enhance how we report and update on our corporation work within existing reporting structure.

We will continue to evolve the Coproduction Toolkit, updating it using the insights from our listening events, will support staff and communities with practical resources, while new success measures will identify in activity track impact and accountability. Through regular reviews, feedback, surveys, and engagement we will continually seek to understand what it useful, enhance the areas were our system needs greater support and look to the future areas of development.

A key area of focus will be coproducing the tools and support for Lived experience members. By the end of 2025/26 we will have a toolkit that is broader, more representative of the people who coproduce and has been developed by the experts who use them. We will do this by developing a task & finish approach using existing Lived Experience groups to conduct this work.

We will undertake a ICB review of the wrap around support needed to enable lived experiences members to engage actively, easily, and effectively with all parts of our coproduction work. We will be do this during Q2.

This will then inform the ICB of the requirements that should consider having in place. This will include a focus on the training (both formal and peer group) and support to engage, onboard and confidentiality work with professionals and other members. The review will look at the barriers to engaging and highlight weaknesses or barriers.

This marks an evolution from awareness-raising to embedding co-production as a core operating principle, with a focus on holistic measurable outcomes, inclusive design, and sustained cultural change.

Planning for how Nottingham and Nottinghamshire ICB will celebrate and use the opportunity of the 2025 National Coproduction week (30 June – 4th July) has started based on the 2025 theme of #Innovation through Coproduction. Coproduction week will include both locally delivered sessions and National webinars to aid learning, discussion, and practical sessions.

12 Working with People and Communities: How to get involved

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

Please visit our website[26] to find out how people and communities can get involved in the work of Nottingham and Nottinghamshire ICB or call or text 07385 360071.

[26] NHS Nottingham and Nottinghamshire ICB - Get involved

13 Appendices

13.1 Appendix 1: Engagement Practitioners Forum: organisations represented

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

Organisation
Talking Therapies Service
The Health Shop
Thriving Nottingham
University of Nottingham

13.2 Appendix 2: VCSE Alliance: organisations represented

Organisation	Organisation category
Active Health Coach	Sports/Fitness
Active Partners Trust	Sports/Fitness
Age UK Nottingham and Nottinghamshire	Older people
Al-Hurraya	BAMER communities
Alzheimer's Society	Health condition
Angolan Women Voice Association UK	Women's community group
Arthritis Action	Health condition
Ashfield Voluntary Action	Community infrastructure organisation
Autism East Midlands	Autism
Autistic Nottingham	Autism
Base51	Young people
Bassetlaw Action Centre	Community, Older people, disabilities
Bassetlaw Citizens Advice	Advice on debt, housing, jobs, legal
Bassetlaw CVS	Community infrastructure organisation
British Liver Trust	Health condition
Broxtowe Womens Project	Women
Canal & River Trust	Charity to improve waterways
Children’s Bereavement Centre	CYP, bereavement, mental health
Citizens Advice Nottingham and District	Advice on debt, housing, jobs, legal
City Arts	Community art organisation
Dementia UK and Admiral Nursing	Health condition
Disability Nottinghamshire	Disabilities
Diversify Education and Communities	Primary Education
Double Impact Services and Cafe Sobar	Addiction rehabilitation centre
Enable	Education and skills
Endometriosis UK Nottingham Support Group	Health condition
Framework	Homelessness
Health Alliance Group (BHAG) CIC	BAME
Healthwatch Nottingham and Nottinghamshire	Health and social care
Himmah	Refugees and asylum seekers
Homestart Nottingham	Children and Young people
Improving Lives	Mental Health Care
Ladybrook Enterprise	Community
Mansfield Citizens Advice	Advice on debt, housing, jobs, legal
Mansfield CVS	Community infrastructure organisation
My Sight	Supporting Blind people
Newark and Sherwood CVS	Community infrastructure organisation
Nottingham and Nottinghamshire Refugee Forum	Refugees and asylum seekers

Organisation	Organisation category
Nottingham City Council	Local authority
Nottingham Citycare Partnership	Healthcare provider
Nottingham CVS	Community infrastructure organisation
Nottingham Counselling Service	Counselling
Nottingham Focus on Wellbeing	Mental Health
Nottingham Mencap	Disabilities
Nottingham Muslim Womans Network	Women's community group
Nottingham Recovery Network	Addiction
Nottingham Trent University	University
Nottingham Womens Centre	Women
Nottinghamshire Community Dental Services CiC	Dental care for disadvantaged groups
Nottinghamshire Deaf Society	Health condition
Nottinghamshire Disabled People's Movement	Disabilities
Nottinghamshire Hospice	End of life
Nottinghamshire Mind	Mental Health
Notts SVSS	Sexual abuse, exploitation, and violence
NSPCC	Children and Young people
Opus music	Music for people in health or social care
P3	Community Services
Parkinson's UK	Disabilities
Place2Be	Children and Young people
POhWER	Advocacy for vulnerable people
Railway Children	Children and Young people
Rainbow Parents Carer Forum	Parents and carers of CYP with SEND
Royal Air Forces Association	Military
Royal Voluntary Service	Volunteering
Rural Community Action Nottinghamshire	Community
Rushcliffe CVS	Community infrastructure organisation
Self Help UK	Self help
SHE UK	Sexual abuse, exploitation, and violence
Sherwood and Newark Citizen Advice Bureau	Advice on debt, housing, jobs, legal
SSBC (Small Steps Big Changes)	Children and Young people
Stroke Association	Health condition
Sustrans (sustainable transport)	Sustainable transport
Tackling Loneliness Collaborative	Loneliness
The Centre Place - LGBT+ Service Nottinghamshire	LGBT+
The Helpful Bureau	Older people, disabilities
The Place (Change Grow Live)	Addiction, housing, domestic abuse, and mental and physical wellbeing
The Pythian Club	Children and Young people
The Robin Cancer Trust	CYP Cancer

Organisation	Organisation category
The Toy Library	Education centre
Transforming Notts Together	Religious connection
Trussell Trust	Food banks

NHS Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/07/2025
Paper Title:	**2024/25 Statement on Health Inequalities**
Paper Reference:	ICB 25 038
Report Author:	Hazel Buchanan, Associate Director of Health Inequalities and Clinical Strategic Programmes
Executive Lead:	Dave Briggs, Medical Director
Presenter:	Dave Briggs, Medical Director

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

Summary:

To drive forward the NHS focus on health inequalities, NHS England published a Statement on Information on Health Inequalities in November 2023. The Statement set out a description of the powers available to relevant NHS bodies to collect, analyse and publish information and as part of this, specific indicators for publication. NHS England has specified the indicators to be included within the Statement and these provide a breadth of intelligence in relation to national priorities for health inequalities including the Core 20+5.

2024/25 is the second year that the ICB has published a Statement with the full complement of indicators (see Appendix 1). The corresponding report outlines changes to the data from 2023/24 to 2024/25 and additional detail on commissioning decisions and impact. Appendix 2 of the report includes an overview of the components of the Nottingham and Nottinghamshire health inequalities plan and alignment with the indicators in the Statement.

Recommendation(s):

The Board is asked to **receive** the Health Inequalities Statement in preparation for publication alongside the ICB's 2024/25 Annual Report.

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	The report on the Health Inequalities plan outlines the programme and impact on statement indicators. Nottingham and Nottinghamshire Integrated Care Board (ICB) and Integrated Care System (ICS) recognise that good quality, robust data enables the NHS and wider system partners to understand more about the populations we service. The ICB and ICS are supported by a Strategic Analytics Intelligence Unit (SAIU) that has the skills and expertise to allow for effective reporting and analysis to identify groups that are at risk of poor access to healthcare, have poor experiences or outcomes from care and as a result take targeted action to reduce health inequalities.
Tackle inequalities in outcomes, experience and access	As above.

How does this paper support	the ICB's core aims to:
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:
Appendix 1 – 2024/25 Health Inequalities Statement Appendix 2 – Overview of Health Inequalities Approach

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 5: Health inequalities and outcomes – Failure to identify and/or deliver service transformation to address health inequalities and improve outcomes.

Report Previously Received By:
The Statement was presented to the May 2025 meeting of the Quality and People Committee.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

2024/25 Statement on Health Inequalities

Introduction

1. To drive forward the NHS focus on health inequalities, NHS England published a Statement on Information on Health Inequalities in November 2023 and therefore, 2024/25 is the second year the Nottingham and Nottinghamshire ICB has incorporated this into the Annual Report. The Statement sets out a description of the powers of the ICB to collect, analyse and publish information in relation to health inequalities.
2. NHS England has provided a list of key metrics that are the focus of the Statement. The metrics align with the five national strategic health inequality priorities alongside the clinical areas of the Core20+5. The metrics have been built into the Nottingham and Nottinghamshire health inequalities dashboard and provide a high-level indication of the priorities for the Nottingham and Nottinghamshire health inequalities approach, which incorporates a broad range of initiatives, including enablers and commissioning decisions.
3. The report highlights any changes since the publication of the 2023/24 report. The report also provides an overview of commissioning and other activities relevant to the impact on long term conditions, as outlined in the Statement.
4. Appendix 2 includes an overview of the elements of the health inequalities plan as they relate to the Statement, including enablers and commissioning decisions.

Changes in the indicators from 2023/24 to 2024/25

5. The indicators within the Statement have been prescribed by NHS England on the basis of data being available nationally and that the indicators relate to the national approach to health inequalities.
6. Appendix 2 provides an overview of the Nottingham and Nottinghamshire approach to health inequalities, incorporating local plans, national frameworks and guidance and how the different elements relate to the Statement.
7. Within this context, the information below highlights any changes in the indicators since the Statement was first published in 2023/24 and are elements of a whole, informing relative impact on disparities in access, experience and outcomes.
8. The changes inform the essential requirement to target resources to population need in order to have the greatest impact on disparities and to narrow the gap in health inequalities across cohorts.

Emergency admissions and Emergency Department (ED) attendances

9. The age-standardised rate of both emergency admissions and ED attendances increased for all deprivation and ethnic groups between 2023 and 2024 (calendar years):

    a) The age-standardised rate of emergency admissions per 100,000 population increased by 9% from 2023 to 2024 for the most deprived population (deprivation quintile 1). The age-standardised rate of admissions increased for all groups over this period, as such the gap has not changed substantially.

    b) The age-standardised rate of ED attendances per 100,000 population increased by 5% from 2023 to 2024 for the most deprived. ED attendances increased by a similar proportion for all deprivation quintiles.

Elective activity

10. Elective activity, including admissions and outpatients, is increasing, and any improvement in waiting times has happened at a similar rate across deprivation quintiles and ethnic groups.

    a) The age-standardised rate of outpatient first attendances per 100,000 population increased by 14% from 2023 to 2024. This is in line with the increase for the ICB overall and shows that outpatient recovery is not leaving behind the most deprived.

    b) The first outpatient appointment Do Not Attend (DNA) rate fell slightly, by 0.2 percentage points for the most deprived quintile between 2022/23 and 2023/24. Over this period, the DNA rate for those in the least deprived quintile reduced by 0.3 percentage points, meaning the gap has widened slightly. The disparity in DNA rates between the most deprived and the least deprived remains the largest inequality covered by the statement indicators.

    c) The age-standardised rate of elective admissions per 100,000 population increased by 10% from 2023 to 2024. This was slightly higher than the increase for the least deprived and, again, shows that elective recovery is not leaving behind the most deprived.

Prevention and long-term conditions

11. Some indicators focussing on the prevention and management of long-term conditions in primary care, particularly around diabetes, have improved. Generally, these have improved for all deprivation quintiles and ethnic groups, although there are some exceptions where the gap has grown narrower or wider.

a) The percentage of Diabetes Type 2 patients living in the most deprived quintile who had all eight care processes competed in the previous year increased by three percentage points from 43% to 46% between March 2024 and March 2025. While this is still below the figure for quintile 5, the increase has larger for quintile 1, so the gap has narrowed.

b) The percentage of prediabetic patients offered a place on a diabetes prevention programme in the last 12 months increased by five percentage points from 53% to 58% March 2024 between March 2025. However, this indicator improved faster for the least deprived, which means the gap between the most deprived and least deprived has widened.

Commissioning activities and impact on indicators

12. Reducing the incidence of premature mortality and morbidity is a fundamental outcome to addressing health inequalities. Consequently, a central focus of the Statement is on long-term conditions, encompassing prevention, case-finding, and effective management. The following information provides an indication of impact and an overview of commissioning activities.

Tobacco harm and smoking cessation

13. Smoking prevalence has fallen from 20% to 15% over the last ten years.

14. Through the Nottingham and Nottinghamshire Tobacco Alliance there is a robust partnership allowing for a comprehensive approach to smoking cessation. The majority of the funding and services are commissioned by the Local Authority and the ICB commissions the NHS in-patient, mental health and maternity smoking cessation services. In addition, actions taken within community pharmacies and by Primary Care Networks (PCN) and GP Practices contribute to the opportunities within the NHS to impact on smoking cessation. The strategic approach will continue to be driven through the prevention priorities and plans.

Respiratory

15. Local clinical transformation indicators show improvement over the last year for some chronic obstructive pulmonary disease (COPD) indicators:

a) The percentage of COPD patients with an MRC Dyspnoea (breathlessness) Scale >3 referred to pulmonary rehab increased by 36.5 percentage points from 52% to 88%.

b) The percentage of COPD patients with a self-management care plan increased by 17 percentage points from 33% to 50%.

c) The coverage of COPD patients with an annual review increased by three percentage points in the last six months from 74% to 77%.

16. The ICB implemented a pulmonary rehabilitation five year plan, which includes active case finding in order to target those groups who are not engaging and to adapt the service offer to improve on equity of access. The focus on case finding is in addition to promotional activity to increase pulmonary rehabilitation referrals, and in turn, increasing completion rates (improves on the quality outcomes for those affected and eligible for pulmonary rehab). Actions are progressing for enabling digital COPD care plans via Patient Knows Best, to further empower individuals with managing their condition and recognising early warning signs and what intervention to take. Ongoing case finding support has been implemented to target towards areas of deprivation and offering additional access to appointments outside of usual primary care hours. The strategic approach will continue to be driven through the Community Transformation Programme supported by prevention priorities and plans (i.e. seasonal and pneumonia vaccinations).

Cardiovascular Disease (CVD)

17. There have been improvements in several primary care CVD management indicators from June 2022 to December 2024, based on CVD Prevent data:

    a) The percentage of patients with GP recorded hypertension, with a record of a blood pressure reading in the preceding 12 months has increased by nine percentage points since June 2022, from 81% to 90%.

    b) The percentage of patients with a blood pressure reading is within the appropriate treatment threshold increased by six percentage points since June 2022, from 61% to 67%.

    c) The percentage of patients with no GP recorded CVD and a GP recorded QRISK score of 10% or more, who are currently treated with lipid lowering therapy increased by eight percentage points since June 2022, from 47% to 55%.

    d) The percentage of patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy increased by five percentage points since June 2022, from 57% to 62%.

18. For all these measures, there was improvement at a similar rate for all deprivation quintiles.

19. Place Based Partnerships have focused on CVD in relation to hypertension case-finding and this has been supported by robust community engagement and increasing awareness by working in partnership with the voluntary sector. Also, proactive case finding has been a priority for local PCNs and

demonstrates the benefits of focusing on a neighbourhood level. This includes piloting schemes at a PCN level and adopting more widely where they have been successful (i.e. a CVD Nurse in Mid Notts). Through primary care pharmacists there has been a focus on medicines optimisation treatments as outlined below. The strategic focus will continue to be driven through the Community Transformation Programme and prevention priorities.

Diabetes

20. The National Diabetes Audit shows year-on-year improvements in type 2 diabetes eight care processes (8CP) coverage. 8CP coverage improved by 12 percentage points, from 47% to 59% from 2021/2022 to 2023/2024.

21. More recent local data shows the overall coverage of the 8CP for type 2 diabetes continues to improve (by 3.5 percentage points since January 2024). Coverage increased faster in the most deprived quintile, meaning the inequality gap narrowed.

22. The ICB has maintained its focus on diabetes and the eight care processes through the commissioning of the Diabetes Local Enhanced Service with GP Practices. This is combined with the commissioning of education programmes for diabetes for clinical staff across the ICS, as well as patient education programmes. Furthermore, prevention programmes are essential including the Type 2 Diabetes remission programme.

Cancer

23. Preliminary registration data for 2024 shows overall the percentage of cancers diagnosed in the early stage has increased to 60%, and Nottingham and Nottinghamshire ICB now has the best performance for this indicator in the East Midlands.

24. Screening programmes are commissioned by NHS England on a regional basis and the ICB, along with Local Authority partners, has carried out a variety of programmes to engage with local communities and encourage uptake for screening programmes. Programmes are often funded through the East Midlands Cancer Alliance, which provides non-recurrent funding to target specific cohorts. The Targeted Lung Health Check programme is separate to this, and through the efforts of the ICB, has had considerable success at targeting those most at risk and increasing diagnoses at an earlier stage. Furthermore, if cancer is suspected, primary care services can refer a patient through the urgent referral pathway. In October 2023, NHS England introduced the Faster Diagnosis Standard to help reduce the time between referral and diagnosis, supporting earlier cancer diagnosis. Through the delegation of

screening to ICBs there will be the opportunity for a fully integrated approach from community engagement through to access and experience of services.

Conclusion

25. The Statement is a robust document that meets the requirements of the ICB to collect, analyse and publish information in relation to health inequalities. The metrics have been prescribed by NHS England and are used to provide an overview of our understanding of health inequalities in Nottingham and Nottinghamshire.

26. The activities within the Nottingham and Nottinghamshire approach to health inequalities can be aligned to the Statement and impact is through a combination of activities, underpinned by robust partnership and system working.

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

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Introduction

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

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

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

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

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

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

Nottingham and Nottinghamshire Population Profile

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

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

Based on the 2021 Census, 80% of the Nottingham and Nottinghamshire population are from a White British ethnicity. People from an Asian heritage are the second largest ethnicity group in Nottingham and Nottinghamshire, making up around 6% of the overall population. 6% of the ICS population are from a White Other group, 4% are from Black African/Caribbean heritage, 3% are from a mixed heritage and 1% are from other ethnic groups.

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

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

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

People in the most deprived areas of Nottingham and Nottinghamshire are more likely to develop long term conditions at a younger age and live in poor health for longer. The life expectancy difference is around 8 years less for those in the most deprived areas of the ICS compared the least deprived areas. The average life expectancy of the ICS is also lower than the England average by up to 3 years for males and 2 years for females, life expectancy is consistently worse across the ICS for males. Nottingham City ranks in the lowest 25% of districts in England for life expectancy for both men and women.

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

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

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

Condition Prevalence Across the ICS

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

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Table 1

The stark differences between our PCN / neighbourhoods

Period: 202503

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 = best days length of stay)	Avoidable deaths	Life expectancy in Years: Life expec. at birth (M)	Life expec. at birth (F)
Arrow Health	40,348	5	188.8	113.3	150.5	45.5	15.4	10.0	13.1	27.8	47.3	6.6	5.5	5,857	221.4	79.8	83.7
Rushcliffe North	43,052	5	184.8	92.7	142.5	39.7	14.7	9.4	12.4	27.4	48.4	4.4	6.0	4,978	162.5	82.8	84.6
Rushcliffe South	44,616	5	179.3	84.0	142.7	40.3	11.4	9.2	12.7	25.4	46.8	4.2	4.6	4,776	166.3	81.5	85.5
Beeston	50,298	5	184.4	104.6	154.6	51.7	16.8	11.1	13.9	27.5	48.0	7.3	10.8	5,482	206.0	79.7	83.6
Rushcliffe Central	53,487	5	138.7	64.8	139.7	42.1	10.6	9.6	12.3	25.9	48.5	5.6	5.7	4,879	162.0	83.7	85.4
Stapleford	22,246	4	231.4	130.6	168.7	59.9	21.8	9.2	12.6	28.2	44.3	6.3	5.5	6,133	203.1	81.9	86.8
Arnold & Calverton	34,437	4	210.7	120.1	148.8	49.5	18.8	9.3	15.6	28.7	48.3	6.7	8.1	5,829	195.1	80.9	84.2
Synergy Health	36,016	4	219.5	143.2	155.9	53.9	18.6	12.1	15.6	30.3	47.5	8.8	18.9	6,396	252.5	78.0	83.6
Eastwood/Kimberley	38,077	4	231.2	117.1	158.5	57.2	20.6	14.7	14.3	32.1	48.2	5.7	7.2	6,299	215.0	80.3	82.8
Newark	79,743	4	203.8	132.0	152.6	51.3	15.6	11.7	12.5	29.6	50.1	5.6	7.2	5,678	222.2	80.8	84.3
Larwood & Bawtry	38,338	3	235.6	128.1	179.7	68.5	30.7	20.0	14.9	33.0	47.2	7.5	11.2	6,207	241.8	79.8	83.8
Byron	39,419	3	236.1	134.1	164.7	62.0	24.2	12.5	14.4	32.9	49.1	6.2	18.6	7,611	264.2	78.2	81.4
City South	39,798	3	166.5	105.1	153.4	57.4	17.3	8.7	13.1	32.5	44.5	6.9	6.9	6,179	212.7	81.9	84.5
Ashfield South	41,099	3	264.3	149.1	159.1	68.6	27.4	12.0	14.7	34.3	47.0	6.7	6.1	7,756	306.1	77.6	81.4
Retford And Villages	59,413	3	241.4	126.6	158.2	59.0	23.0	11.9	12.3	27.8	46.2	5.8	9.8	5,487	238.3	79.7	83.4
Sherwood	64,205	3	239.8	133.2	175.8	64.7	24.7	13.5	13.7	35.3	47.7	5.9	9.7	6,974	226.0	80.8	84.4
Newgate Medical Group	30,234	2	237.6	160.4	154.5	67.4	30.7	14.8	12.8	29.1	42.3	7.7	10.2	6,092	277.4	80.6	80.5
Clifton & Meadows	34,989	2	230.5	177.7	189.6	77.3	33.9	14.1	19.0	37.2	41.5	9.5	8.5	7,348	301.0	77.9	80.3
Ashfield North	51,844	2	266.0	157.6	175.3	69.8	25.8	17.9	15.0	36.0	49.5	7.4	8.5	7,783	292.3	76.9	83.1
Rosewood	52,174	2	226.6	172.6	157.8	65.5	28.3	12.8	14.1	35.7	44.3	7.7	8.4	7,546	297.2	77.9	82.1
Bestwood & Sherwood	55,715	2	200.9	149.7	158.9	64.9	22.1	12.7	16.1	32.2	43.9	10.1	9.6	6,200	271.9	79.5	83.2
Mansfield North	59,572	2	244.5	145.9	178.2	67.9	26.8	13.8	13.4	35.3	45.3	5.7	9.2	7,579	272.5	78.9	82.6
Raleigh	29,337	1	224.8	179.5	203.1	85.9	33.4	19.0	18.2	39.7	43.4	12.8	14.5	7,784	328.8	78.1	80.5
Radford & Mary Potter	37,517	1	188.8	182.4	197.5	113.9	24.9	13.1	17.1	44.9	35.8	14.5	21.0	7,650	381.8	76.3	82.9
Aspire	39,426	1	226.0	173.3	182.8	83.3	33.6	15.8	16.8	37.5	40.7	8.9	11.5	7,826	323.7	78.7	79.5
Bulwell & Top Valley	47,409	1	243.7	193.8	182.5	72.0	33.8	15.3	17.3	35.0	45.1	10.4	7.3	7,915	334.5	76.6	80.2
Nottingham City East	68,807	1	190.5	180.4	164.1	73.6	28.6	13.5	16.7	33.6	41.6	13.8	14.5	7,318	362.9	78.6	83.3
Unity (Nottm)	46,775	4	112.6	63.9	152.6	39.0	10.9	9.4	8.7	20.1	45.1	3.8		3,027	75.3		

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

Impacting on Health Inequalities

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

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

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

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

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

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

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Utilising data from the indicators included in this statement can help the system to identify disparities in access to services and patient's outcomes, highlighting where change is needed. Equitable approaches focussed on improving outcomes will allow a focus on those population groups where need and risk is higher, ensuring resources are distributed in the most effective way.

How do we Measure Deprivation?

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

Integrated Care System

Summary of 2024/25 Position: Position as of 1st April 2025

The tables below are taken from the summary page of the Nottingham and Nottinghamshire Health Inequalities Dashboard. This dashboard was developed to monitor the statement indicators, with some additional metrics added based on local priorities.

The health inequalities summary compares indicators for each demographic group to the Nottingham and Nottinghamshire ICB population overall. Values are coloured based on whether they are statistically significantly different to the ICB overall.

For some indicators, data quality is not robust enough to present accurate statistical comparisons. This is a particular issue for comparisons by ethnic group for indicators which use a primary care-based denominator and a secondary care-based numerator such as age-standardised rates of admissions. For these, values are still presented for information but should be interpreted cautiously. 'Other' ethnic group values have been omitted because they are particularly affected by this issue. Ethnicity-specific values for patients with 'Unknown' ethnicity are not presented here but are included in the total values. In some instances, this may lead to the overall value being higher than any given ethnicity-specific values.

Elective Care

Indicator	Period	ICB	Sex		Ethnic group					Deprivation quintile				
			Male	Female	Asian	Black	Mixed	Other	White	1 Most deprived	2	3	4	5 Least deprived
Age-standardised rate of emergency attendances per 100,000 pop.	202401 - 202412	36,700	36,863	37,669	24,023	32,216	22,449		34,129	43,579	38,635	35,496	33,126	28,846
Age-standardised rate of emergency admissions per 100,000 pop.	202401 - 202412	11,319	10,718	12,068	7,775	10,133	6,616		10,488	14,206	12,204	10,777	9,503	8,031
Crude rate of emergency admissions in 0-17s per 100,000 pop.	2023/2024	6,455	6,620	6,291	4,904	4,336	5,359		6,501	8,647	6,874	6,714	5,863	5,433
Age-standardised rate of elective admissions per 100,000 pop.	202401 - 202412	17,101	16,915	17,526	8,389	11,203	7,855		14,372	17,067	17,199	17,354	17,084	16,459
Waiting list: waits >18 weeks (cumulative)	29/12/2024	41.9%	41.9%	41.9%	43.8%	45.0%	43.5%	44.9%	41.6%	42.5%	41.5%	41.4%	40.9%	42.8%
Waiting list: waits >52 weeks (cumulative)	29/12/2024	2.4%	2.5%	2.4%	2.4%	2.1%	2.3%	2.6%	2.2%	2.4%	2.5%	2.6%	2.4%	2.3%
Waiting list: waits >65 weeks (cumulative)	29/12/2024	0.1%	0.1%	0.1%	0.1%	0.1%	0.3%	0.1%	0.1%	0.1%	0.2%	0.2%	0.1%	0.1%
Age-standardised rate of outpatient appointments per 100,000 pop.	202401 - 202412	43,641	38,140	49,659	25,007	30,132	25,930		37,655	43,824	44,221	44,543	44,554	40,966
First outpatient appointments attended virtually	2023/2024	11.2%	11.6%	10.9%	9.9%	10.9%	9.0%	9.4%	11.0%	11.2%	11.3%	11.2%	11.1%	10.9%
First outpatient appointments not attended by patient (DNA)	2023/2024	6.8%	7.8%	6.2%	8.5%	10.5%	10.3%	8.0%	6.0%	9.8%	7.5%	5.9%	4.8%	4.1%

Cardiovascular Disease (CVD)

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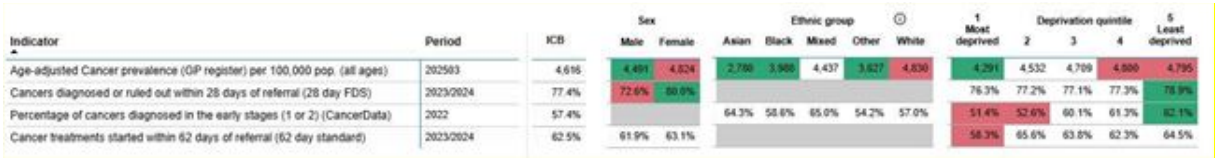
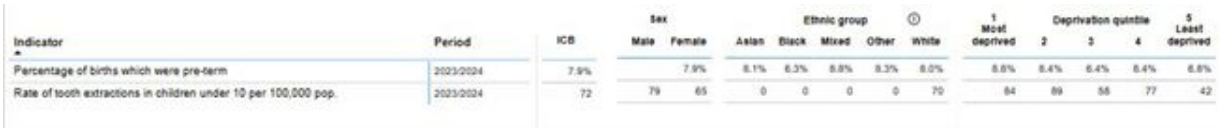
Indicator	Period	ICB	Sex		Ethnic group					Deprivation quintile				
			Male	Female	Asian	Black	Mixed	Other	White	1 Most deprived	2	3	4	5 Least deprived
Age-adjusted Hypertension prevalence per 100,000 pop. (all ages)	202412	15,982	16,633	15,291	17,920	21,809	17,378	14,554	14,029	17,849	16,603	16,007	15,167	14,089
Hypertension crude prevalence	202503	15.3%	15.2%	15.4%	7.3%	11.4%	8.3%	8.8%	17.7%	13.4%	14.8%	16.0%	17.1%	16.4%
Hypertension pts. prescribed antihypertensive medicine, with review (L15M)	202503	74.0%	73.6%	74.4%	67.7%	60.5%	65.5%	67.0%	75.2%	70.4%	72.1%	74.3%	77.1%	77.0%
CVDP007HYP: Hypertension pts. with BP reading below treatment threshhold	202503	68.6%	66.4%	70.8%	64.7%	58.7%	58.4%	59.4%	68.8%	65.9%	67.7%	68.5%	70.8%	71.0%
CVDP002AF: AF pts. with CHA2DS2-VASc of >=2, prescribed anticoagulant	202503	95.3%	95.5%	95.1%	95.1%	91.0%	90.0%	93.0%	95.4%	94.9%	94.9%	95.1%	95.6%	96.0%
CVDP003CHOL: Pts. with no CVD & QRISK score of >=20%, on lipid lowering	202503	60.7%	61.6%	59.4%	65.6%	57.8%	59.3%	58.0%	60.7%	65.1%	61.9%	60.0%	59.0%	57.4%
Age-standardised rate of emergency Myocardial Infarction adm. per 100,000 ...	202401 - 202412	116	183	70	139	59			91	147	135	95	104	90
Age-standardised rate of emergency Stroke admissions per 100,000 pop.	202401 - 202412	164	185	143	134	217	109		143	213	178	158	136	134

Cancer



Indicator	Period	ICB	Sex		Ethnic group					Deprivation quintile				
			Male	Female	Asian	Black	Mixed	Other	White	1 Most deprived	2	3	4	5 Least deprived
Age-adjusted Cancer prevalence (GP register) per 100,000 pop. (all ages)	202503	4,616	4,491	4,824	2,788	3,988	4,437	3,627	4,830	4,291	4,532	4,709	4,888	4,795
Cancers diagnosed or ruled out within 28 days of referral (28 day FDS)	2023/2024	77.4%	72.6%	80.0%						76.3%	77.2%	77.1%	77.3%	78.9%
Percentage of cancers diagnosed in the early stages (1 or 2) (CancerData)	2022	57.4%			64.3%	58.6%	65.0%	54.2%	57.0%	51.4%	52.6%	60.1%	61.3%	62.1%
Cancer treatments started within 62 days of referral (62 day standard)	2023/2024	62.5%	61.9%	63.1%						58.3%	65.6%	63.8%	62.3%	64.5%

Maternity and Child Health



Indicator	Period	ICB	Sex		Ethnic group					Deprivation quintile				
			Male	Female	Asian	Black	Mixed	Other	White	1 Most deprived	2	3	4	5 Least deprived
Percentage of births which were pre-term	2023/2024	7.9%		7.9%	8.1%	6.3%	8.8%	8.3%	8.0%	8.8%	8.4%	6.4%	8.4%	6.8%
Rate of tooth extractions in children under 10 per 100,000 pop.	2023/2024	72	79	65	0	0	0	0	70	84	89	58	77	42

Diabetes

Indicator	Period	ICB	Sex		Ethnic group					Deprivation quintile				
			Male	Female	Asian	Black	Mixed	Other	White	1 Most deprived	2	3	4	5 Least deprived
Prediabetic pts. referred to National Diabetes Prevention Programme (L12M)	202503	62.3%	62.3%	62.3%	64.5%	64.9%	59.0%	61.0%	62.1%	58.4%	61.2%	63.0%	64.8%	66.2%
Diabetes Type 1 pts.: all 8 diabetes care processes completed (L12M)	202503	34.2%	34.8%	33.5%	31.7%	37.2%	23.9%	31.1%	34.5%	31.8%	33.5%	35.4%	36.9%	35.2%
Diabetes Type 2 pts.: all 8 diabetes care processes completed (L12M)	202503	51.7%	53.2%	49.9%	44.3%	46.9%	46.8%	47.0%	53.2%	45.6%	52.0%	52.3%	56.7%	56.1%
Diabetes Type 1 pts. prescribed continuous glucose monitoring (L3M)	202503	58.7%	60.3%	56.5%	52.4%	45.2%	47.3%	50.0%	60.0%	56.7%	56.6%	56.8%	58.2%	62.4%
Diabetes Type 2 pts. prescribed continuous glucose monitoring (L3M)	202503	5.2%	5.0%	5.5%	4.5%	5.4%	6.9%	4.4%	5.3%	5.3%	4.9%	5.3%	5.2%	5.5%
Diabetes Type 2 pts.: all 3 diabetes treatment targets met (NDA def.) (L12M)	202503	27.4%	27.5%	27.2%	23.6%	17.0%	18.7%	21.2%	28.7%	24.5%	27.1%	27.8%	30.2%	30.0%

Learning Disabilities and Autism

Indicator	Period	ICB	Sex		Ethnic group					Deprivation quintile				
			Male	Female	Asian	Black	Mixed	Other	White	1 Most deprived	2	3	4	5 Least deprived
Learning Disability Health Checks Completed (L12M)	202503	83.2%	82.8%	83.9%	86.0%	80.4%	82.8%	75.8%	83.4%	81.5%	83.3%	80.1%	89.4%	86.3%

Mental Health

Indicator	Period	ICB	Sex		Ethnic group					Deprivation quintile				
			Male	Female	Asian	Black	Mixed	Other	White	1 Most deprived	2	3	4	5 Least deprived
Talking therapies recovery rate	2023/2024	50.4%	52.9%	49.6%	42.5%	46.7%	43.8%	46.2%	51.4%	44.1%	47.8%	50.2%	57.2%	58.0%
Serious Mental Illness Health Checks: All 6 Complete (L12M)	202503	67.1%	64.0%	70.8%	63.5%	62.5%	57.1%	65.7%	68.6%	64.5%	65.4%	67.8%	71.3%	75.0%
Percentage of CYP with at least 1 NHS Mental Health Contact in period	2023/2024	7.4%	8.0%	6.7%	2.2%	4.0%	7.1%	11.3%	7.4%	8.7%	8.0%	7.1%	6.3%	5.5%

Respiratory

Indicator	Period	ICB	Sex		Ethnic group					Deprivation quintile				
			Male	Female	Asian	Black	Mixed	Other	White	1 Most deprived	2	3	4	5 Least deprived
Age-adjusted COPD prevalence per 100,000 pop. (all ages)	202412	2,222	2,434	2,048	731	964	1,202	1,333	2,396	3,813	2,783	2,041	1,535	1,022
COPD patients with medication review (L12M)	202503	66.4%	66.0%	66.9%	65.2%	53.0%	58.8%	58.7%	66.8%	62.5%	65.1%	68.7%	71.9%	71.7%
Age-standardised rate of emergency COPD admissions per 100,000 pop.	202401 - 202412	221	211	232	73	83	55		218	432	286	191	121	80

Vaccinations and Immunisations

Indicator	Period	ICB	Sex		Ethnic group					Deprivation quintile				
			Male	Female	Asian	Black	Mixed	Other	White	1 Most deprived	2	3	4	5 Least deprived
MMR dose 1 uptake in patients age 0-24	202503	81.7%	82.3%	81.1%	58.1%	65.2%	80.8%	56.4%	89.7%	79.6%	77.6%	79.6%	85.1%	89.6%
MMR dose 2 uptake in patients age 0-24	202503	69.5%	69.8%	69.1%	47.7%	51.5%	65.3%	42.3%	77.5%	66.4%	65.4%	68.1%	73.6%	78.0%
Influenza vaccination uptake age 18-64 (current/recent season) (IIF VI02)	202503	63.7%	61.7%	65.4%	59.9%	62.1%	60.6%	49.5%	65.3%	57.8%	62.2%	64.0%	68.5%	71.5%
Influenza vaccination uptake age 65+ (current/recent season) (IIF VI01)	202503	88.9%	88.9%	88.9%	76.5%	66.8%	77.1%	74.4%	90.2%	83.0%	86.9%	89.4%	91.0%	92.7%
COVID vaccination dose 1	202503	75.3%	72.8%	78.0%	51.3%	46.0%	61.1%	46.7%	82.4%	64.0%	72.1%	77.4%	83.0%	86.1%
COVID vaccination dose 2	202503	72.0%	69.1%	74.9%	48.0%	41.4%	48.4%	43.0%	79.2%	59.7%	66.8%	74.4%	80.6%	83.1%
COVID vaccination booster	202503	57.8%	54.5%	61.2%	32.6%	23.8%	28.7%	27.5%	65.5%	42.9%	53.8%	60.2%	68.0%	72.2%

Elective Care

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

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

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

Changes in the overall size of the waiting list over time can be viewed in figure 1 which shows the reduction in size over 2024. It should be noted that there was a step change in April 2024 because of Sherwood Forest Hospitals (SFH) changing how they reported patients who are overdue for a review, reducing their overall waiting list numbers by around 12,000. The change brought SFH in line with national guidance. Even without this change, the ICB's overall number of waits lasting more than 18 weeks would have fallen in the last year.

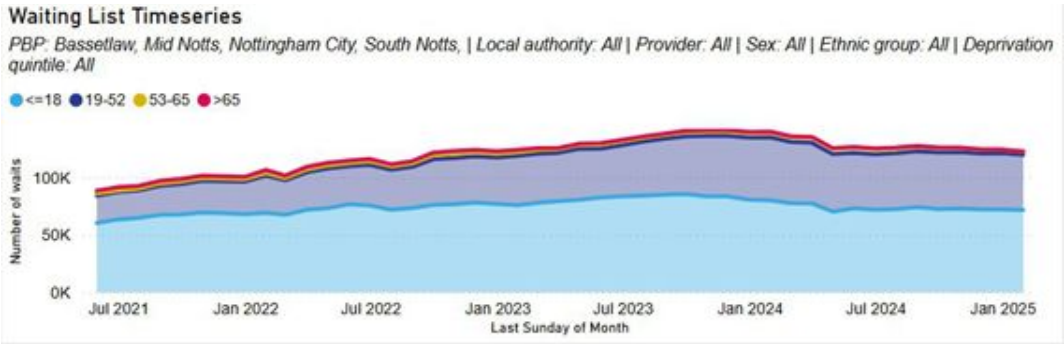


Figure 1: Waiting list time series as of January 2025

Locally there are no statistically significant differences in the proportion of waits which are more than 52 weeks by deprivation quintile for the overall waiting list. Nor are there statistically significant differences in the proportion of waits which are more

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than 52 weeks by ethnic group. The tables below detail the breakdown of the waiting list by deprivation and ethnicity.

Figure 2: Waiting list by deprivation as of January 2025

Waiting List Breakdown at 26 January 2025

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

Weeks waiting	<=18		19-52		53-65		>65		Total	
Deprivation quintile	Waits	%	Waits	%	Waits	%	Waits	%	Waits	%
1	18,510	57.6%	12,790	39.8%	748	2.3%	66	0.2%	**32,114**	**100.0%**
2	13,503	58.9%	8,856	38.7%	509	2.2%	39	0.2%	**22,907**	**100.0%**
3	14,194	59.1%	9,255	38.6%	506	2.1%	47	0.2%	**24,002**	**100.0%**
4	12,083	59.4%	7,768	38.2%	455	2.2%	33	0.2%	**20,339**	**100.0%**
5	13,364	57.7%	9,251	40.0%	507	2.2%	31	0.1%	**23,153**	**100.0%**
Total	**71,654**	**58.5%**	**47,920**	**39.1%**	**2,725**	**2.2%**	**216**	**0.2%**	**122,515**	**100.0%**

Figure 3: Waiting list by ethnicity as of January 2025

Waiting List Breakdown at 26 January 2025

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

Weeks waiting	<=18		19-52		53-65		>65		Total	
Ethnic group	Waits	%	Waits	%	Waits	%	Waits	%	Waits	%
Asian	2,432	55.9%	1,818	41.8%	101	2.3%			**4,353**	**100.0%**
Black	1,506	55.9%	1,135	42.1%	51	1.9%			**2,695**	**100.0%**
Mixed	1,046	57.5%	730	40.1%	42	2.3%			**1,820**	**100.0%**
Other	1,339	56.4%	978	41.2%	54	2.3%			**2,376**	**100.0%**
Unknown	17,359	59.1%	11,217	38.2%	713	2.4%	61	0.2%	**29,350**	**100.0%**
White	47,972	58.6%	32,042	39.1%	1,764	2.2%	143	0.2%	**81,921**	**100.0%**
Total	**71,654**	**58.5%**	**47,920**	**39.1%**	**2,725**	**2.2%**	**216**	**0.2%**	**122,515**	**100.0%**

For those living in the most deprived quintile, the proportion of waits which are more than 18, 52, or 65 weeks has decreased since the last statement period. The gap between the most deprived and the least deprived quintiles has also decreased for all long waits except those lasting more than 65 weeks. However, those waiting > 65 weeks accounts for a very small number of waits, and the difference is not statistically significant.

Figure 4: Changes to the waiting list for the most deprived quintile, January 2024 - January2025

				Change over time			Inequalities vs reference value		
Indicator	Period	Deprivation Quintile	Value	Direction compared to baseline	Baseline Period	Baseline value	Reference Value: Least Deprived (Quintile 5)	Statistical Significance Compared to Reference Value	Gap Direction
Waiting <= 18 Weeks	31/01/2025	1	57.7%	▲	31/01/2024	56.4%	58.0%	Not Statistically Significantly Different	Narrowing
Waiting >18 Weeks (cumulative)	31/01/2025	1	42.3%	▼	31/01/2024	43.6%	42.0%	Not Statistically Significantly Different	Narrowing
Waiting >52 Weeks (cumulative)	31/01/2025	1	2.5%	▼	31/01/2024	3.7%	2.3%	Not Statistically Significantly Different	Narrowing
Waiting >65 Weeks (cumulative)	31/01/2025	1	0.2%	▼	31/01/2024	0.7%	0.1%	Not Statistically Significantly Different	Widening

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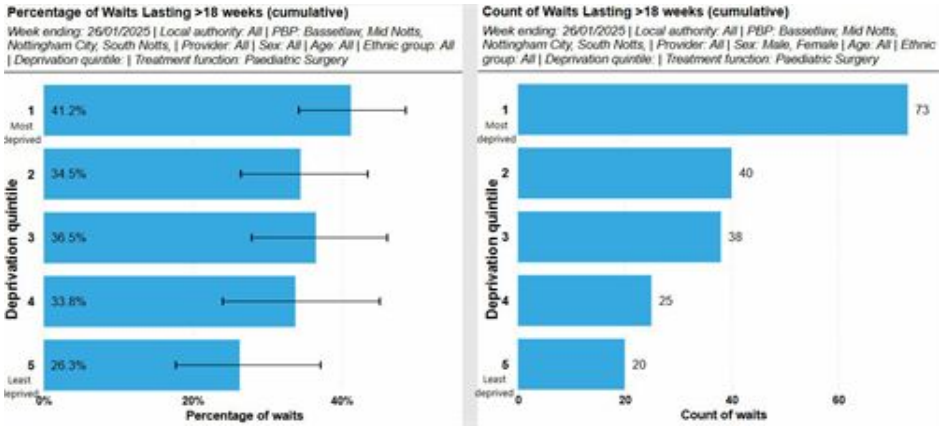
Inequalities by Specialty

An analysis was undertaken in February 2025 to understand whether there were waiting list inequalities by deprivation for each specialty. While there were some percentage point gaps for those waiting more than 18 weeks between the most and least deprived for specialties, these reflected only small absolute numbers, and the gaps were not statistically significant. The table below summarises the largest percentage point gaps by specialty, and the charts further below provide an example of the waiting list analysis available through the SAIU Health Inequalities dashboard. The paediatric surgery example shows the gap in the percentage waiting more than 18 weeks between the most deprived and least is not statistically significant.

Table 1: Specialties with the largest percentage point difference in the percentage of patients waiting more than 18 weeks in the most and least deprived quintiles at 26 January 2025. Only specialties with over 100 total waits over 18 weeks are included.

Specialty/ Treatment Function	Total Waiting List	Total Waiting List >18 weeks	Percentage of patients living in deprivation quintile 1 waiting for >18 weeks	Percentage of patients living in deprivation quintile 5 waiting for >18 weeks	Gap between percentage of waits more than 18 weeks between the most and least deprived
Specialities with a pp gap in favour of least deprived					
Paediatric Surgery	547	196	41.2%	26.3%	14.9pp
Orthodontics	414	247	62.9%	50.0%	12.9pp
Paediatric Trauma & Orthopaedics	597	196	36.5%	24.1%	12.3pp
Endocrine Surgery	376	161	48.4%	36.4%	12.0pp
Dermatology	7472	3049	45.3%	39.8%	5.5pp
Specialities with a pp gap in favour of most deprived					
Oral and Maxillofacial Surgery	2461	1604	62.0%	66.8%	4.8pp
Audiology	824	281	33.1%	41.1%	8.0pp
Spinal Surgery Service	1540	564	32.6%	41.1%	8.5pp
Geriatric Medicine	784	324	35.4%	45.0%	9.6pp
Pain Management Service	400	182	38.8%	52.4%	13.5pp

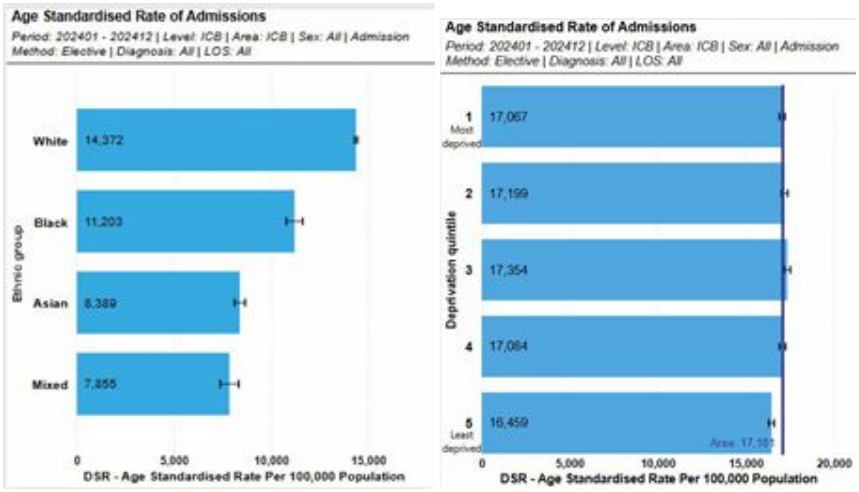
Figure 5: Waits for paediatric surgery lasting more than 18 weeks by deprivation quintile, January 2025



Age-standardised rates of elective admissions

Data for 2024 shows there has been an increase in the number of age standardised elective care admissions for those in the most deprived areas. These figures now show the elective admission rate for those in IMD Quintile 1 are now in line with the ICB overall, suggesting an improvement in equity of access to elective care. Elective admission rates remain below the ICB overall for those in IMD Quintile 5. Elective rates of admission by deprivation and ethnicity are shown in figure 4. Emergency rates of admission and emergency attendance are provided within the Urgent Care Section.

Figure 6: Age standardised rates of Elective Admissions by deprivation and ethnicity Jan 2024 – Dec 2024.

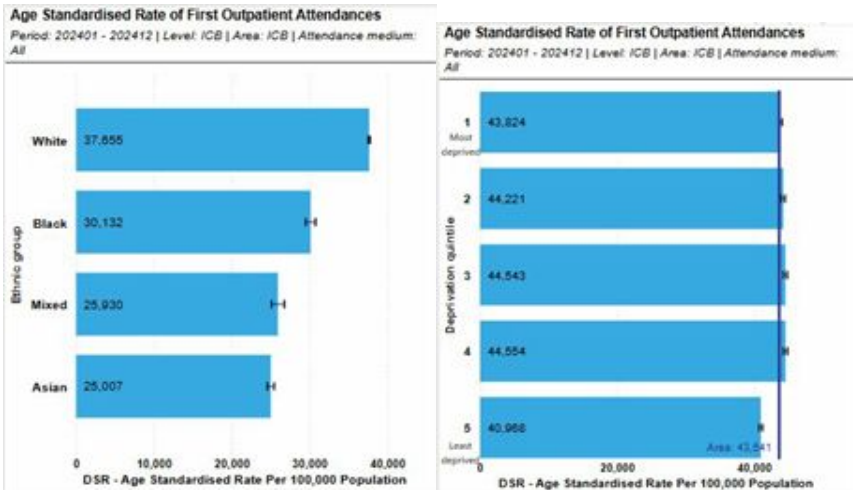


Age-standardised rates of outpatient appointments

The charts below show the age-standardised rate of first outpatient appointments completed in the most deprived populations is in line with the ICB overall. Figures in 2023 showed this was slightly higher than the ICB overall. Numbers of first appointments have increased across all population groups over 2024.

Outpatient appointment rates, where ethnicity is known, are significantly higher in the White population than other ethnic groups. Rates in the White population were around 1.3 times higher than for the Black population and 1.6 times higher than for the Asian population. However, it should be noted that the same issues with ethnicity coding which affect the calculation of rates for admissions also affect outpatient appointments.

Figure 7: Age standardised rates of First Outpatient Appointments by deprivation and ethnicity January 2024 to December 2024.

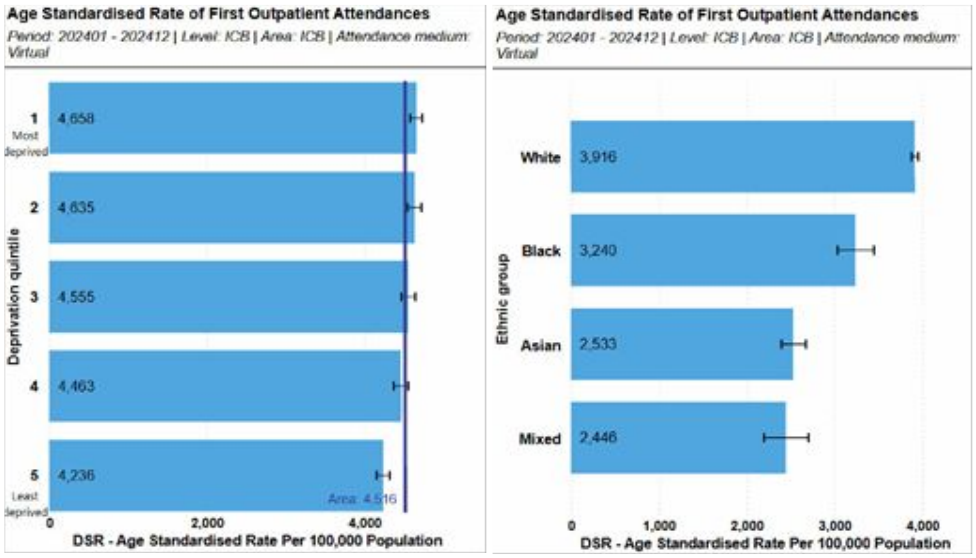


Age-standardised rates of virtual outpatient appointments

In 2024 a total of 56,331 first outpatient appointments were attended virtually by the Nottingham and Nottinghamshire ICB population. This equates to an age standardised rate of 4,516 appointments per 100,000 population. This is an increase of around 3,000 appointments in total and 200 per 100,00 population in comparison to 2023.

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

Figure 6: Age standardised rates of Virtual Outpatient Appointments by deprivation and ethnicity 2023/24.

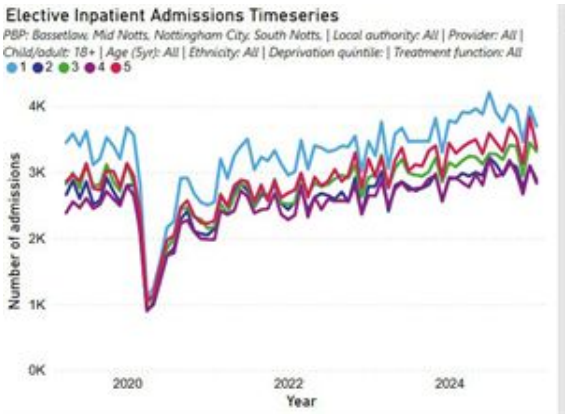


Elective activity vs pre-pandemic levels for under 18s and over 18s

Across both age groups, the number of elective admissions increased from April-December 2019 to April-December 2024. For under 18s, the overall increase was 9.5%, and for adults the increase was 14.7%. For both age groups, this also represents a year-on-year increase against the period covered by the previous statement, April-December 2023.

By deprivation quintile, the percentage increases against baseline were broadly similar for adults. The largest percentage increases were for those living in the least deprived areas (18.3% for quintile 5, 16.4% for quintile 4), and those living in the most deprived quintile (14.7%).

Figure 7 Adult (18+) Elective admissions time series by deprivation Apr 2019 – May 2024



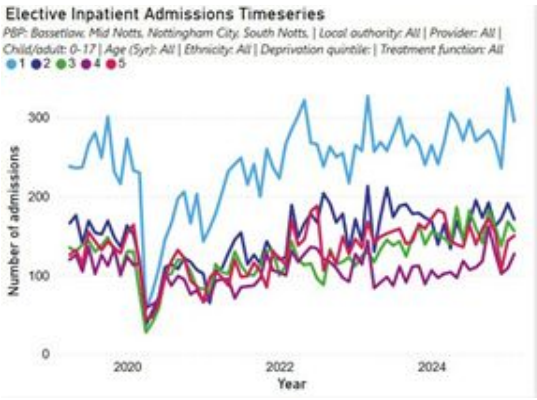
Change in elective admissions vs 2019 (April-December period)

Period	2019 Apr-Dec	2023 Apr-Dec			2024 Apr-Dec		
Adult/Child...	Admissions	Admissions	Dif.	% Dif.	Admissions	Dif.	% Dif.
18+	129,558	135,816	6,258	4.8%	148,598	19,040	14.7%
1	30,485	31,280	795	2.6%	35,006	4,521	14.8%
2	24,235	24,663	428	1.8%	27,146	2,911	12.0%
3	25,969	26,974	1,005	3.9%	29,079	3,110	12.0%
4	22,753	24,721	1,968	8.6%	26,476	3,723	16.4%
5	26,116	28,178	2,062	7.9%	30,891	4,775	18.3%
Total	129,558	135,816	6,258	4.8%	148,598	19,040	14.7%

For children, the overall number of elective admissions is much smaller, and there is more variation in the percentage changes by deprivation quintile. Deprivation quintile three saw an almost 20% increase in elective activity for under 18s. Elective activity

increased by 11% for deprivation quintile 1. There were slightly fewer elective admissions for children in quintile 4 compared to the baseline.

Figure 8 0-17 Elective admissions time series by deprivation quintile April 2019 – May 2024

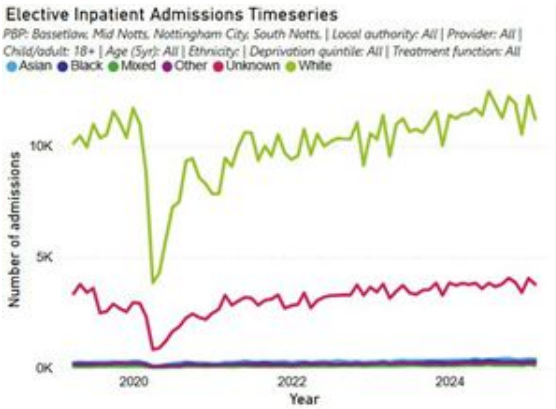


Change in elective admissions vs 2019 (April-December period)

Period Adult/Child...	2019 Apr-Dec Admissions	2023 Apr-Dec Admissions	Dif.	% Dif.	2024 Apr-Dec Admissions	Dif.	% Dif.
0-17	7,133	7,497	364	5.1%	7,810	677	9.5%
1	2,255	2,410	155	6.9%	2,503	248	11.0%
2	1,410	1,597	187	13.3%	1,511	101	7.2%
3	1,199	1,251	52	4.3%	1,435	236	19.7%
4	1,061	874	-187	-17.6%	1,047	-14	-1.3%
5	1,208	1,365	157	13.0%	1,314	106	8.8%
Total	7,133	7,497	364	5.1%	7,810	677	9.5%

By ethnic group, elective admissions increased for all ethnicities across both age groups except for children with an 'Unknown' ethnicity. Elective admissions increased by a smaller percentage for both White children and adults compared to other, smaller, ethnic groups. The largest percentage increases were for Asian and Black children (76.7% and 74.4%), and adults of Mixed ethnicity (68.8%). It is likely that changes in the ethnic profile of Nottingham and Nottinghamshire partially explain the large relative increases in elective admissions for ethnic minority groups. Improvements in ethnicity recording may also have contributed to higher recorded activity for these groups.

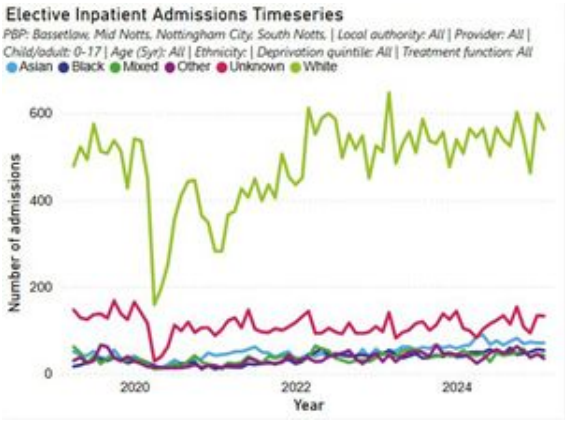
Figure 9 Adult (18+) Elective admissions time series by ethnicity April 2019 – May 2024



Change in elective admissions vs 2019 (April-December period)

Period Adult/Child...	2019 Apr-Dec Admissions	2023 Apr-Dec Admissions	Dif.	% Dif.	2024 Apr-Dec Admissions	Dif.	% Dif.
18+	129,558	135,816	6,258	4.8%	148,598	19,040	14.7%
Asian	2,521	3,138	617	24.5%	3,694	1,173	46.5%
Black	1,876	2,199	323	17.2%	2,809	933	49.7%
Mixed	730	1,024	294	40.3%	1,232	502	68.8%
Other	1,730	1,844	114	6.6%	2,217	487	28.2%
Unknown	27,308	31,240	3,932	14.4%	33,816	6,508	23.8%
White	95,393	96,371	978	1.0%	104,830	9,437	9.9%
Total	129,558	135,816	6,258	4.8%	148,598	19,040	14.7%

Figure 10 0-17 Elective admissions time series by ethnicity April 2019 – May 2024



Change in elective admissions vs 2019 (April-December period)

Period Adult/Child...	2019 Apr-Dec Admissions	2023 Apr-Dec Admissions	Dif.	% Dif.	2024 Apr-Dec Admissions	Dif.	% Dif.
0-17	7,133	7,497	364	5.1%	7,810	677	9.5%
Asian	386	540	154	39.9%	682	296	76.7%
Black	258	368	110	42.6%	450	192	74.4%
Mixed	335	418	83	24.8%	393	58	17.3%
Other	356	420	64	18.0%	413	57	16.0%
Unknown	1,234	989	-245	-19.9%	1,028	-206	-16.7%
White	4,564	4,762	198	4.3%	4,844	280	6.1%
Total	7,133	7,497	364	5.1%	7,810	677	9.5%

Urgent and Emergency Care

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

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

Age standardised activity rates with 95% confidence intervals for emergency admissions

The rate of emergency admissions is significantly higher for those in IMD quintile 1 than the ICB overall and those in IMD quintile 5. In comparison to 2023, age standardised rates of emergency admissions for the ICB overall have increased by 10%. Rates in IMD quintile 1 have increased by 9%, and rates in IMD quintile 5 increased by 11%.

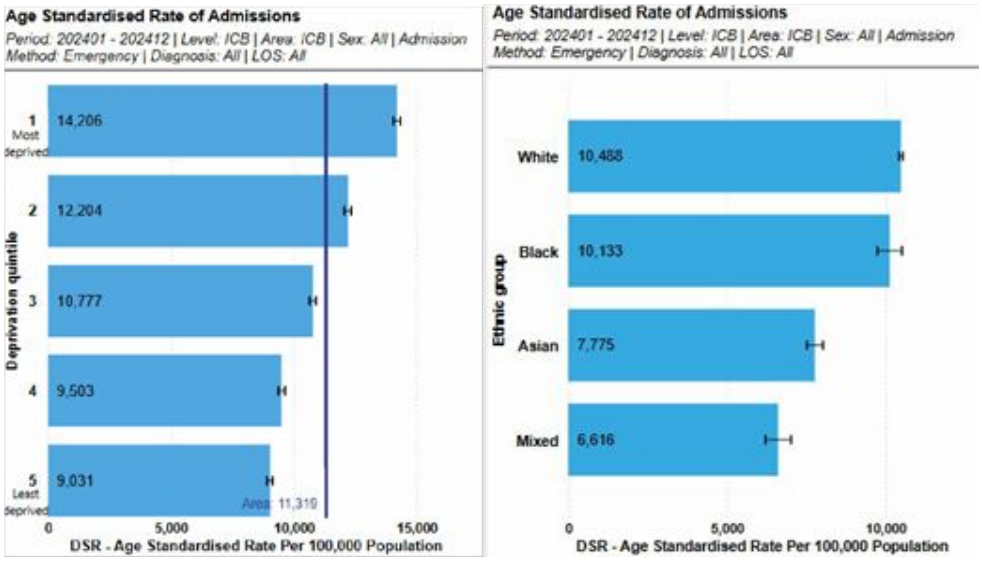
Rates of emergency admissions are statistically significantly higher in the White and Black populations than other ethnic groups. Rates for these populations were around 1.3 times higher than for the Asian population. Compared to 2023, age-standardised rates for minority ethnic groups have increased faster than for the White population.

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

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

This may indicate an improvement in ethnicity coding as the number of emergency admissions with an Unknown ethnicity increased at a slower rate than emergency admissions overall.

Figure 11: Age standardised rates of Emergency Admissions by Deprivation and ethnicity, 2024



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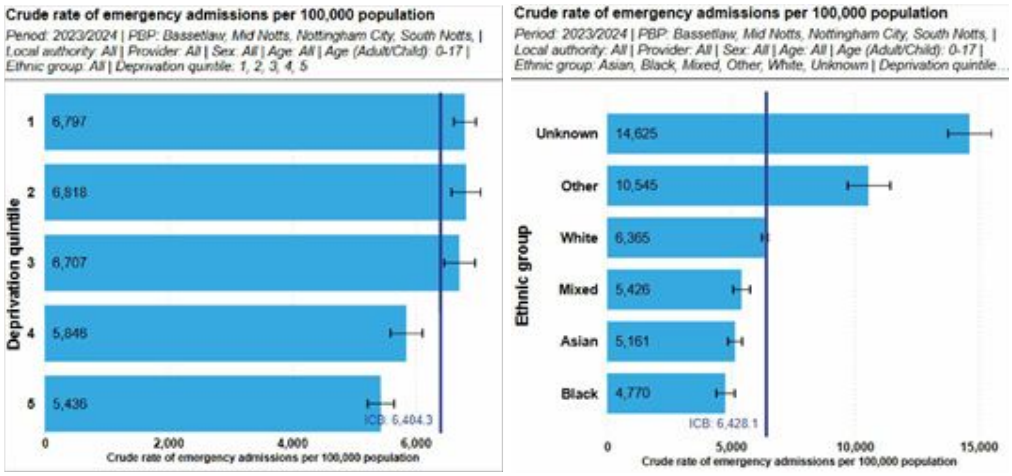
Emergency Admissions for Under 18s

The chart below shows the crude rate of emergency admissions for under 18s over financial year 2023/24. This is an update to the data included in the previous statement which provided data over the 2022/23 period. Emergency admissions for under 18s remain higher in the two most deprived IMD quintiles, and there has been in increase in the rate of emergency admissions for quintile 3.

Figure 12 also presents emergency admissions by ethnicity. Rates are highest in those from other and unknown ethnic groups, with a 7 percentage point increase in figures when compared to the previous year. In comparison, the ICB overall over the year increased by 0.9%. This potentially highlights continued issues in ethnicity recording and data quality. The Data Quality section of this Statement refers to the accuracy and completeness of patient demographics recorded in Secondary Care.

Figure 12: Crude rate of Emergency Admissions by deprivation and ethnicity in 0-17s, 2023-2024

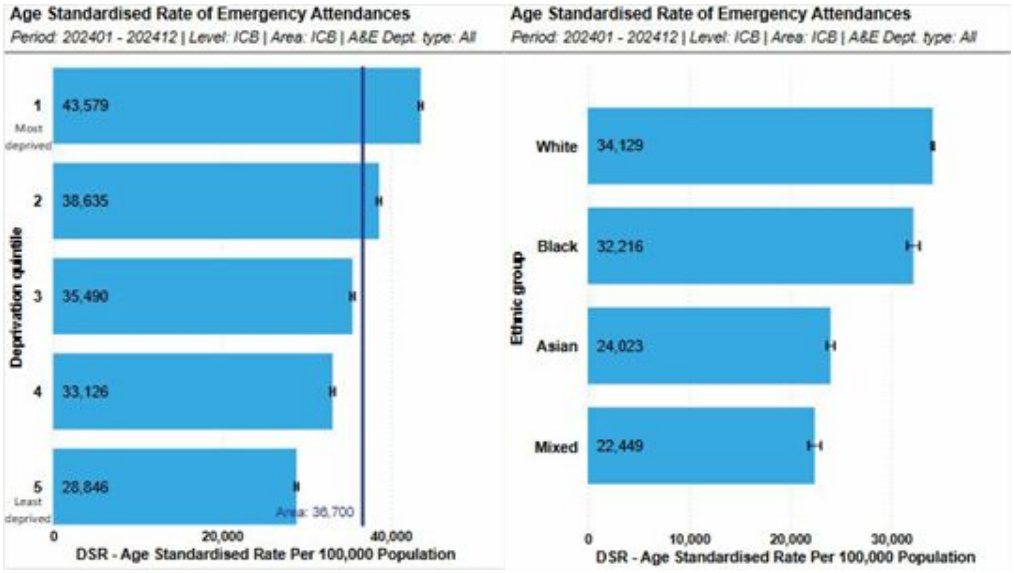


Age standardised rate of emergency attendances at emergency departments

For the calendar year 2024, the ICB overall for attendances at emergency departments increased by around 5% over 2023. Increases to the most and least deprived populations were in line with this rise. The rate of attendances at emergency departments is significantly higher in the most deprived quintile compared to all other quintiles. Rates of emergency attendances are 1.5 times higher in the most deprived quintile compared to the least deprived quintile.

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

Figure 13: Age standardised rate of emergency attendances by deprivation and ethnicity, January to December 2024



Respiratory

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

Uptake of covid and flu vaccinations by age and demographic

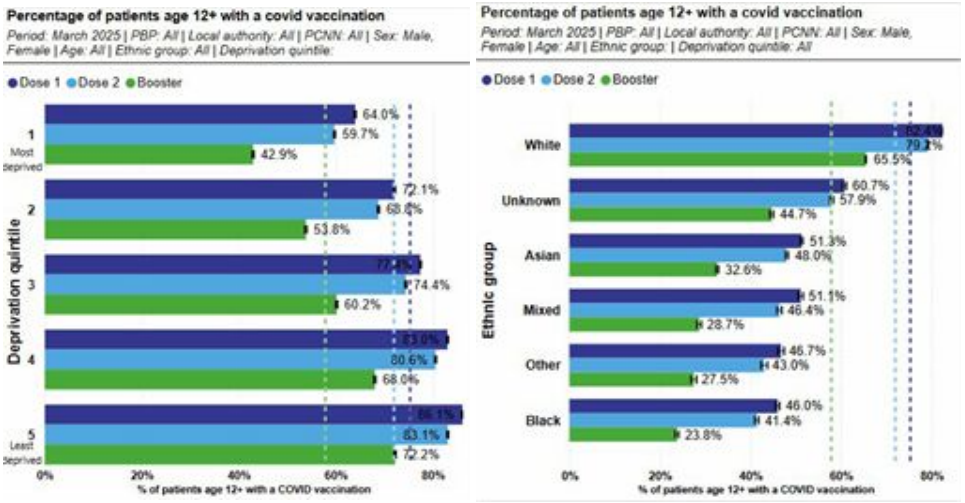
Vaccination rates for both covid and flu are lowest across younger age ranges, Black, Mixed, Asian and Other ethnic groups and for those in the most deprived IMD quintiles. Rates increase for all ethnic groups in the least deprived quintiles, although coverage remains lower than for the White ethnic group. This data is shown below in figures 14, 15, 16 and 17. These trends have remained the same throughout the 2023/24 and 2024/25 vaccination seasons.

Figure 14 The proportion of all eligible patients with a flu vaccination by age, as of March 2025

Figure 15 The proportion of all eligible patients with a flu vaccination by deprivation decile, March 2025

Figure 16 The proportion of patients aged 18+ with a flu vaccination by ethnicity, March 2025

Figure 17 The proportion of patients aged 12+ with a Covid vaccination by deprivation and ethnicity, March 2024



Mental Health

Mental health problems can affect anyone and have a significant effect on the lives of individuals, their families, communities and wider society. Research in 2018 found that over the course of a week, 1 in 6 adults had experienced a common mental health disorder, such as anxiety[4].

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

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

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

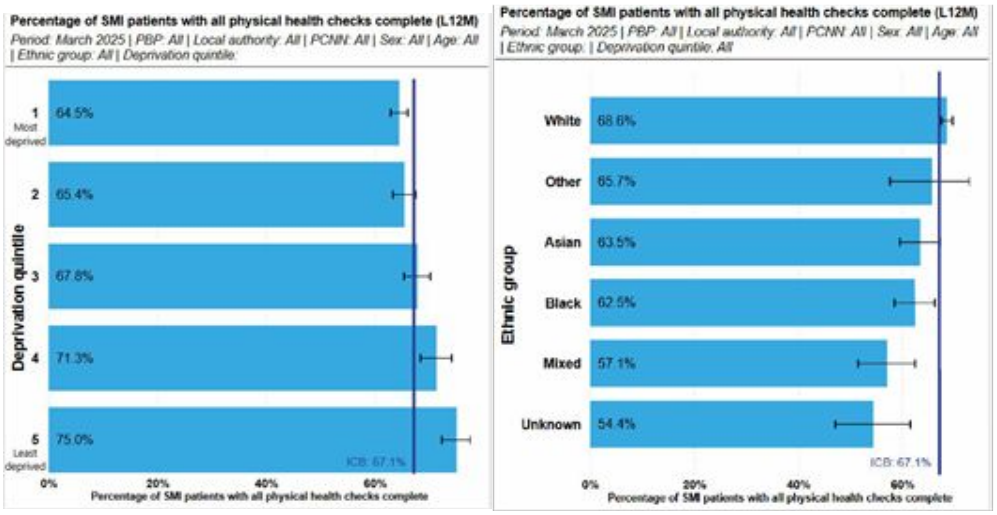
It is estimated that for people with SMI, 2 in 3 deaths are from physical illnesses that could be prevented. Major causes of death in people with SMI include chronic physical medical conditions such as cardiovascular disease, respiratory disease, diabetes and hypertension. Physical health checks provide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

In March 2025, 67% of people with SMI received a health check, exceeding the target figure of 60%. Figure 18 shows the breakdown of completed SMI checks by deprivation and by ethnicity. A lower proportion of checks were completed in people from IMD quintile 1, with a 10 percentage point gap in uptake of checks between the most and least deprived populations. By ethnicity, those from Asian, Black, Mixed, and unknown ethnic groups are less likely to have a completed check than those from White ethnic groups. Uptake across all ethnic groups has remained similar to 23/24 levels.

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

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

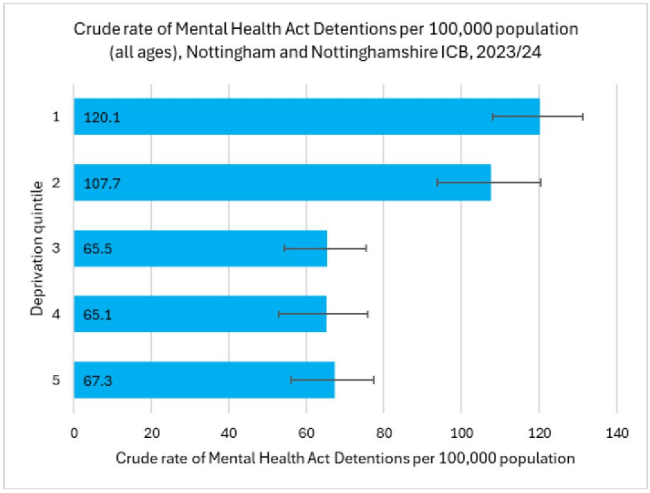
Figure 18 The rate of patients with an SMI Health check by deprivation and ethnicity



Rates of total Mental Health Act detentions

The chart below shows the crude rate of detentions under the mental health act by deprivation quintile, taken from the national data set Mental Health Act Statistics, Annual Figures 2023-2024[6]. The rate uses the GP-registered population for the denominator. Those living in the most deprived areas are significantly more likely to have been detained under the Mental Health Act.

Figure 19 The count of detentions under the Mental Health Act by deprivation 2023/2024.

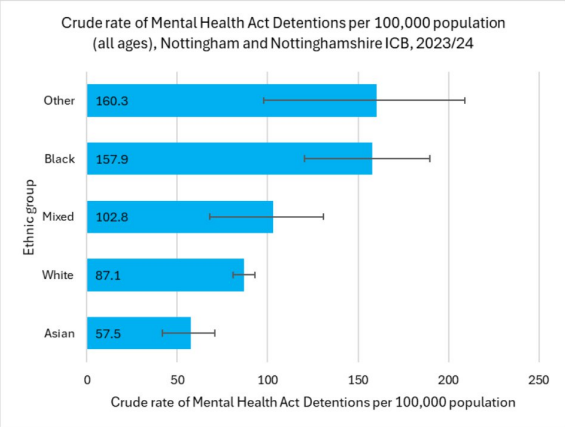


The chart below shows the crude rate of Mental Health Act detentions by ethnicity, again using the GP-registered population for the denominator. The chart shows there is a higher rate of detentions of those from Other and Black ethnic groups in comparison to those from a White or Asian ethnic group. However, this data should be interpreted with caution as crude rates can provide only a basic understanding of

[6] Mental Health Act Statistics Annual figures 2023-24 Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital

whether there is under or over representation between population groups. In addition, there are further complexities surrounding interpretation of this data; age, severity and the point of contact with the system can be contributing factors impacting on restrictions used and are not reflected in this data set. It is the longer-term aim of the ICB to continue working with Trusts to help interpret and understand this data in a standardised way which will help to identify any disparities more clearly. This will also allow us to identify any additional factors contributing to these disparities, such as point of access to the system, which could highlight further inequalities regarding access and experience.

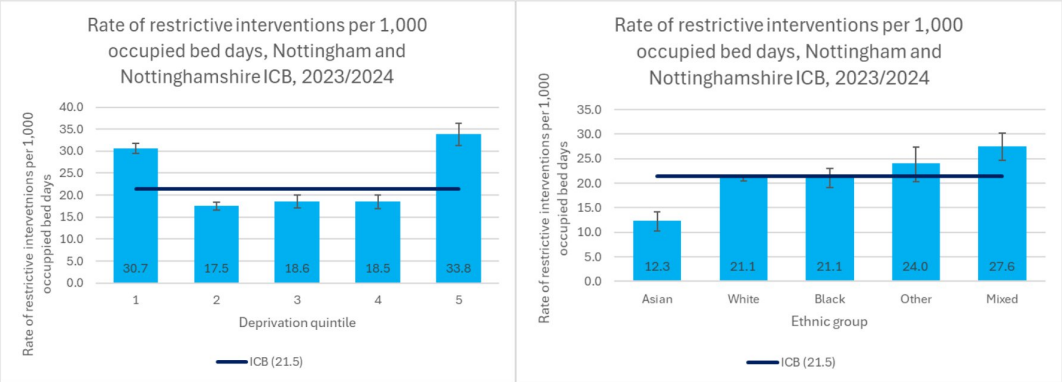
Figure 20 The crude rate of detentions under the Mental Health Act by ethnicity, 2023/2024



Rates of restrictive interventions

The charts below show the rate of restrictive interventions in NHS funded secondary mental health, learning disabilities and autism services per 1,000 bed days, broken down by the deprivation quintile and ethnicity of the patient.[7] By using bed days as the denominator, this measure allows us to understand inequalities in the frequency of mental healthcare staff deciding to use a restrictive intervention for a specific group rather than just providing a proxy for the rate of mental health inpatients for the population overall. Restrictive interventions are more frequently used for those living in the most and the least deprived areas. By ethnicity, restrictive interventions are used less frequently for Asian mental health inpatients, and more frequently for mental health inpatients of mixed ethnicity.

Figure 21: The crude rate of detentions under the Mental Health Act by ethnicity, 2023/2024



[7] NHS England, Mental Health Bulletin, 2023-24 Annual report, Chapters 4 and 7 data tables

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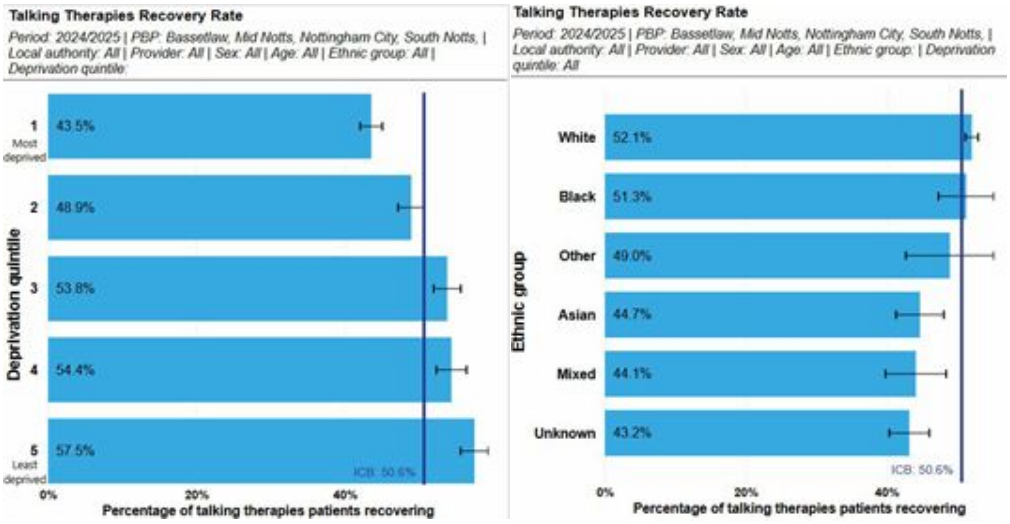
NHS Talking Therapies recovery rate

Talking therapies are psychological treatments for mental and emotional problems like stress, anxiety and depression. The Talking Therapy recovery rate for the ICS is currently 50.4%, which is similar to the 2022/2023 figures of 51.2% included in the previous statement. This is within the range of the national target figure of 50%. The charts below show there is a 14 percentage point gap in the recovery rates between the most and least deprived areas. The recovery rate amongst all ethnic minority groups except Black and Other is also lower than White ethnic groups.

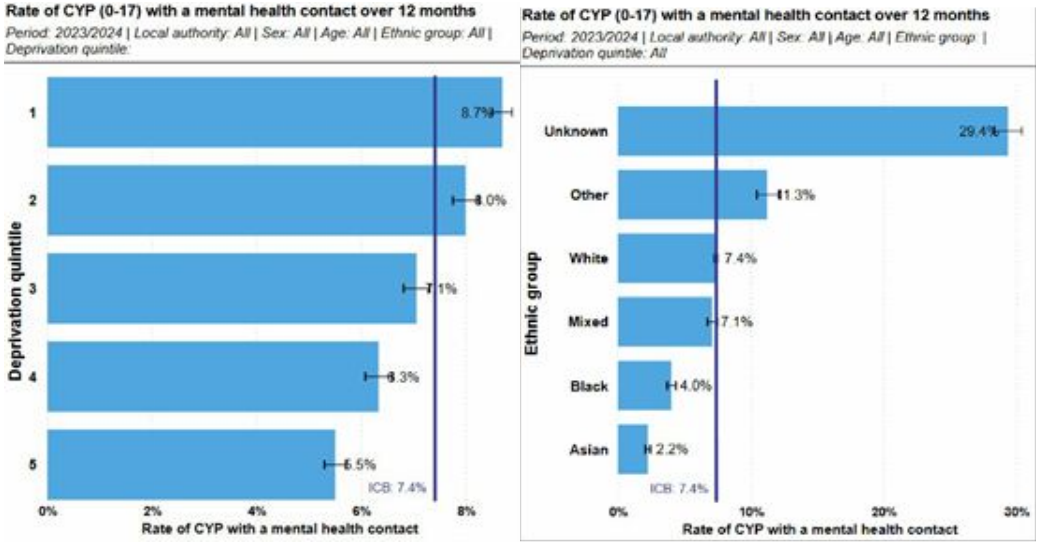
Figure 21 The rate of talking therapies recovery by deprivation and ethnicity.



Children and Young People's (CYP) Mental Health Access

The charts below show the rate of children and young people age 0-17 who had contact with a mental health service in 2023/2024 by deprivation and ethnicity. This shows rates are higher than the ICB overall in the most deprived IMD quintile and lower than the ICB in the least deprived quintiles. The high numbers of contacts with 'Unknown' or 'Other' ethnicity make comparisons by ethnic group difficult. However, where ethnicity is known, Black and Asian CYP appear to have a significantly lower rate of contact with mental health services.

Figure 22 Rate of CYP with a mental health first contact in the last 12 months, by deprivation and ethnicity



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. Breast, prostate, lung and bowel cancers are the most common cancers in the UK, however around a fifth of all cancer deaths are from lung cancer. Around 38% of cancers are estimated to be preventable, with many cases attributed to lifestyle factors such as smoking, obesity, alcohol consumption, and poor diet[8]. There may also be occupational risks which could increase the risk of cancer.

Populations with higher deprivation often have higher prevalence of cancer risk factors. These populations may also be less aware of symptoms of cancer and report more barriers to seeking help, participation in screening programmes is lower

[8]Cancer statistics UK Cancer Statistics for the UK (master-7rqtwti-hreqyzlibi4ac.uk-1.platformsh.site)

and there are higher proportions of cancer diagnosed through routes with worse survival outcomes[9].

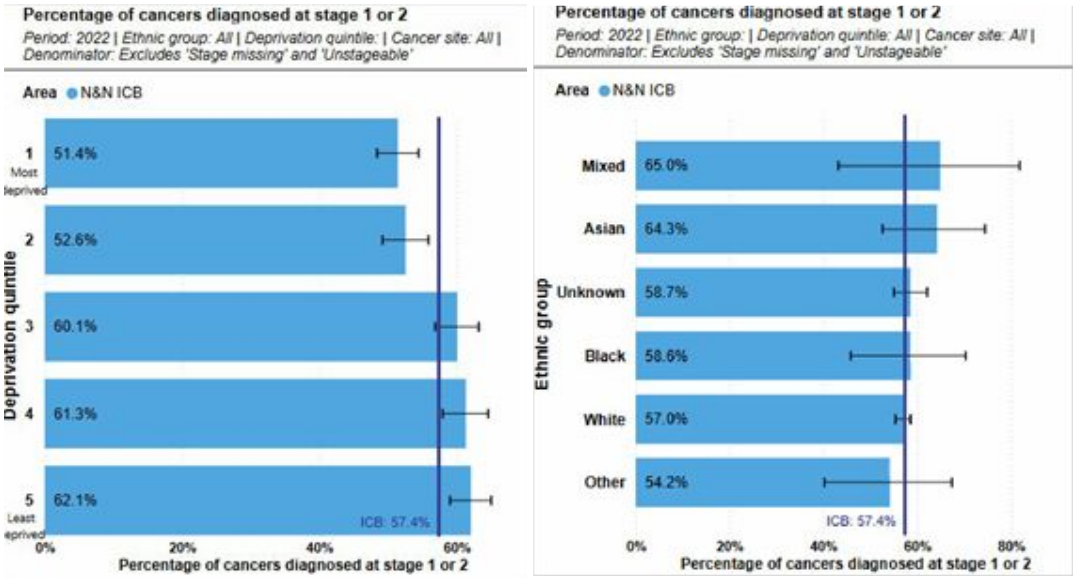
Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex

Data on cancer diagnosis is available through the East Midlands Cancer Alliance as well as nationally published data through the National Disease Registration Service. The previously published statement contained data on cancers diagnosed at stage 1 or 2 between 2018 and 2020. The ICB has now moved to reporting cancer staging data by year for health inequalities.

Between 2021 and 2022, the overall percentage of cancers diagnosed in the early stages increased by two percentage points from 55% to 57%. Rapid registrations statistics from the East Midlands Cancer Alliance up to March 2024 indicate this figure may have improved further with potentially 61% of cases being diagnosed at stage 1 or 2, however these figures are awaiting formal verification and publication. These figures are, however, still below the national target of 75% of cancers diagnosed in stage 1 or 2.

The most recently available verified data shows there is a significant gap between those living in the most and least deprived quintiles, with 51% of cancers diagnosed early for IMD quintile 1, and 62% of cancers diagnosed early for IMD quintile 5. There are no statistically significant differences between ethnic groups where the ethnicity is known.

Figure 23 Proportion of stageable cancers diagnosed at stage 1 or 2 by deprivation quintile and ethnicity as of 2022



[9] Cancer in the UK 2020: Socio-economic deprivation Cancer in the UK 2020: socio-economic deprivation (cancerresearchuk.org)

Cardiovascular Disease (CVD)

CVD is an umbrella term for conditions which affect the heart and circulatory system. CVD is one of the leading causes of the gap in life expectancy between the least and most deprived across Nottingham and Nottinghamshire.

Ashfield has overtaken Nottingham City as area with the highest premature mortality from CVD in the ICS, with a rate of 124.6 per 100,000 deaths from CVD under age 75 this is the 5th highest rate in England and an increase of 37.5 since 2021 and 2022 data.[10] Nottingham City rates are 113 per 100,000, which has decreased since 2021 data reported in the previous statement of 131 per 100,000. This figure remains double the rate of Rushcliffe, the least deprived area of the ICS at 52 per 100,000. Ethnicity can also increase the risk of developing some cardiovascular conditions; Black African/Caribbean or South Asian ethnic groups are two ethnic groups which may have an increased risk of development.

Hypertension is the leading preventable risk factor for CVD development and mortality. The risk of hypertension development is higher in areas of deprivation. People from Black African/Caribbean ethnic groups are also more likely to develop hypertension[11] and are also disproportionally more likely to live in areas of high deprivation in the ICS[12].

[10] OHID, Fingertips, Under 75 mortality rate from cardiovascular disease (Persons, 1 year range)
[11] Public Health England 2017, Health matters: combating high blood pressure https://www.gov.uk/government/publications/health-matters-combating-high-blood-pressure/health-matters-combating-high-blood-pressure

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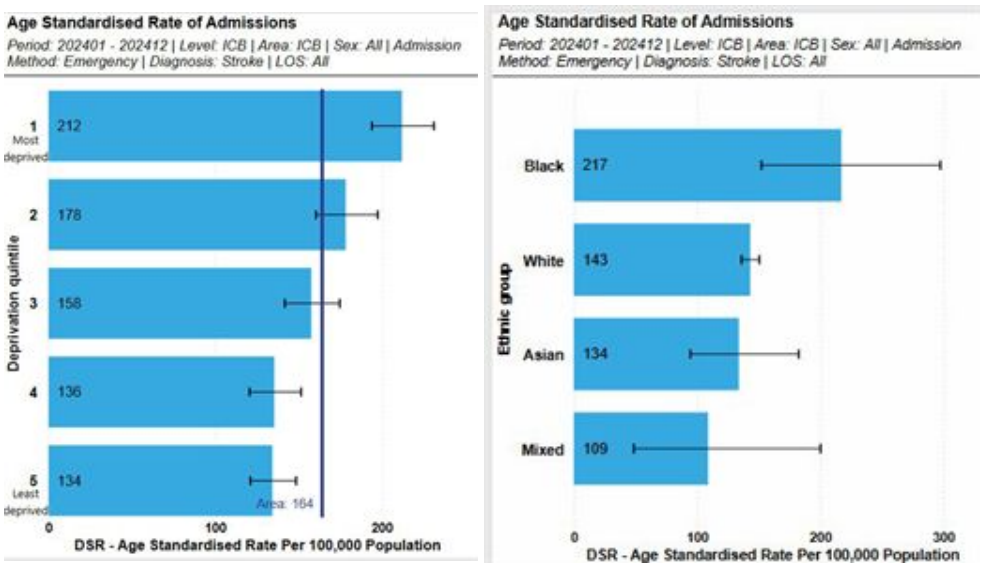
Stroke - rate of non-elective admissions (per 100,000 age, sex standardised)

Stroke is a form of CVD. The charts below show the age standardised admissions for Stroke across the ICB by deprivation and ethnicity. Rates of admission are higher in the most deprived populations and are lowest in the least deprived populations.

Data for 2024 shows there was a slight reduction in the age standardised rates of stroke admissions for those in the most deprived areas, however larger reductions were seen in the least deprived areas, meaning the gap has widened. Where ethnicity is known, emergency admission rates for Stroke are similar across ethnic groups.

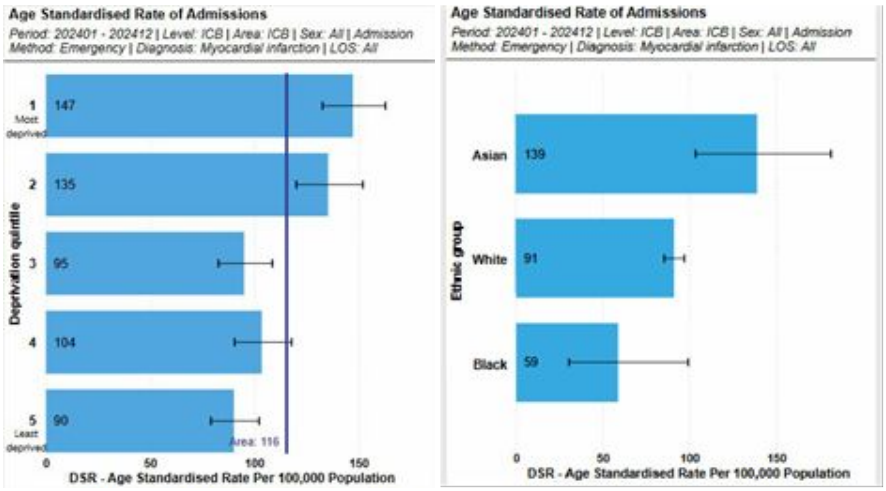
Figure 24 Age standardised rates for non-elective stroke admission by deprivation and ethnicity 2024



Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)

Myocardial infarction is also a form of CVD. The overall rate of admissions for myocardial infarction reduced from 2023 to 2024. However, rates remain significantly higher in people for the most deprived populations and lower for those in the least deprived populations. Numbers are too small and ethnicity coding too unreliable to draw reliable conclusions about the differences in myocardial infarction for admissions by ethnicity.

Figure 25 Age standardised rates for non-elective myocardial infarction admission by deprivation and ethnicity Jan 2024 – Dec 2024

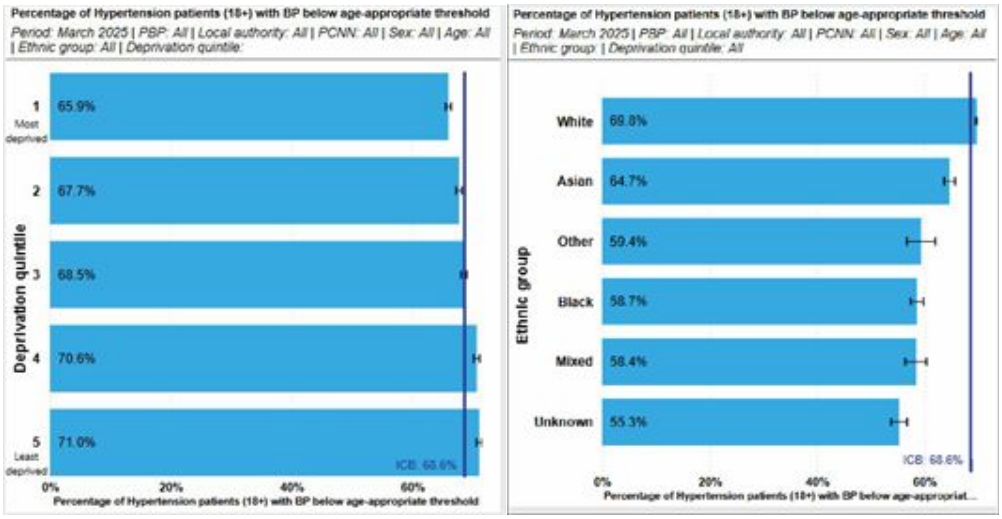


Percentage of patients aged 18 or over with GP recorded hypertension, in whom the last blood pressure reading in the preceding 12 months is below age-appropriate treatment thresholds (indicator of optimal condition management)

Hypertension (high blood pressure) is the leading modifiable risk factor for CVD development. A blood pressure reading within age-appropriate thresholds for people diagnosed with hypertension is an indicator of optimal management of the condition. In the long term, optimal management will improve patient outcomes, reducing the risk of heart attacks, strokes and other complications resulting from high blood pressure.

Across the ICS, older adults and females are more likely to be within these thresholds, indicating better management within these groups. However, those from the most deprived areas are less likely to be within these thresholds as highlighted in the chart below. This could lead to an increased risk of serious illness from the effects of having high blood pressure in these cohorts. People from White ethnic groups are more likely, and those from all other ethnic groups less likely, to meet these targets. Figures have remained similar in the last year when comparing March 2025 data to 2024 data.

Figure 26 Percentage of hypertensive patients with their latest blood pressure reading within age-appropriate thresholds by deprivation and ethnicity, March 2025

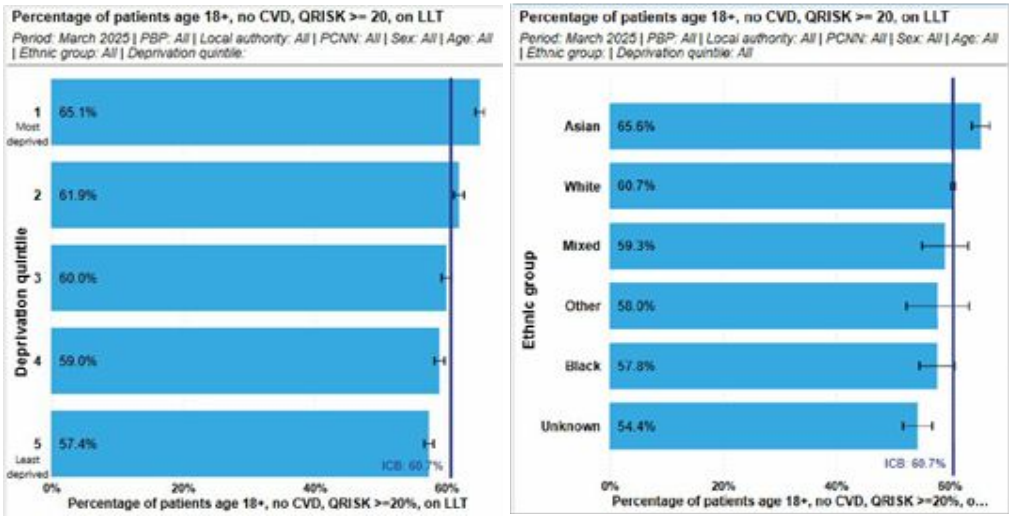


Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy

Over the last 12 months, the overall percentage of eligible patients on lipid lowering therapy has remained at a similar level to March 2024. Those living in the most deprived areas are more likely than those living in the least deprived areas to be treated with lipid lowering therapy, reversing the usual link between deprivation and poorer treatment uptake. This pattern is also true for England overall. The gap between the most and least deprived has narrowed slightly in the last year as lipid uptake has increased in the least deprived areas.

Figure 27 also shows Asian patients are the most likely within this cohort to be on lipid lowering therapy. Between the other main ethnic groups there are no statistically significant differences.

Figure 27 Proportion of patients aged 18+, no CVD and a QRISK score above 20% on lipid lowering therapy by deprivation and ethnicity, March 25.



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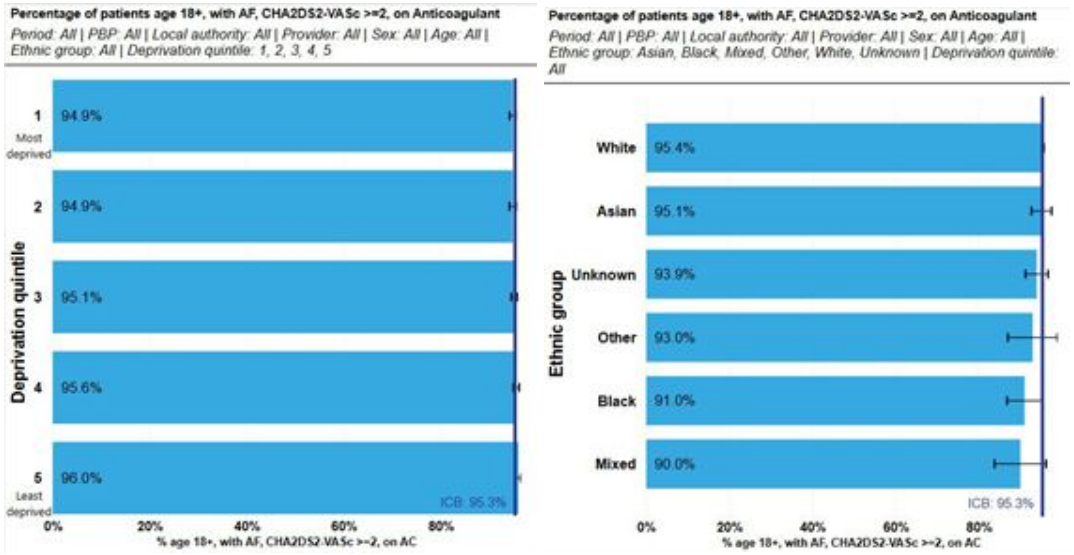
Percentage of patients aged 18 or over with GP recoded atrial fibrillation and a record of CHA2DS2-VASc Score of 2 or more who are currently treated with anti-coagulation drug therapy

There are no statistically significant differences by ethnic group or deprivation quintile for this indicator. The overall performance for this indicator has remained similar over the last 12 months.

Figure 28 Percentage of patients aged 18+ with Atrial Fibrillation and a record of CHA2DS2-VASc score 2 or more treated with anti-coagulation drug therapy by deprivation and ethnicity, March 2025



Diabetes

Type 1 Diabetes is an autoimmune condition where the body cannot produce insulin and cannot be prevented. Differently, with Type 2 Diabetes the body can still produce insulin, however it is unable to produce enough insulin or the insulin produced by the body is not working well enough for optimal health.[13] Type 2 diabetes can be prevented through lifestyle factors, with obesity being the main driver in development of the condition. The risk of development also increases with age, family history and ethnicity (South Asian and Black African/Caribbean ethnic groups have a higher risk). Type 2 diabetes is often more prevalent in areas of higher deprivation where people may be more likely to experience lifestyle risk factors associated with its development. Across the ICS, 30.5% of the Type 2 diabetic population are from IMD quintile 1, the most deprived quintile.

Diabetes can weaken the body's immune system which can increase the risk of poorer outcomes from ill health. The consequences of uncontrolled diabetes are also severe and can be life changing, for example developing chronic kidney disease or requiring limb amputation.

[13] Differences between type 1 and type 2 diabetes Differences between type 1 and type 2 diabetes | Diabetes UK

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Variation between percentage of people with Type 1 and Type 2 Diabetes receiving all 8 care processes.

The 8 care processes are key health markers identified by NICE Guidance for the treatment of diabetes and are an importance factor in ensuring positive patient outcomes and preventing complications associated with the condition. The 8 care processes should be checked annually. For patients with type 1 diabetes this is usually within a hospital setting, for patients with type 2, this is often managed within primary care.

The charts below show the variation in completed 8 care processes for type 1 and type 2 diabetics by deprivation. There is a clear correlation between deprivation and achieving all 8 care processes for Type 2 diabetes with those in the least deprived quintile 1.3 times more likely to achieve all eight than those in the most deprived quintile.

By ethnicity, for type 1 diabetes, those of mixed heritage are less likely to have all care processes completed. For type 2 diabetes, white patients are more likely than all other ethnicities to have all care processes completed.

Figure 29 Percentage of people with all 8 care processes complete for Type 1 vs Type 2 Diabetes by deprivation quintile (March 2024 - March 2025)

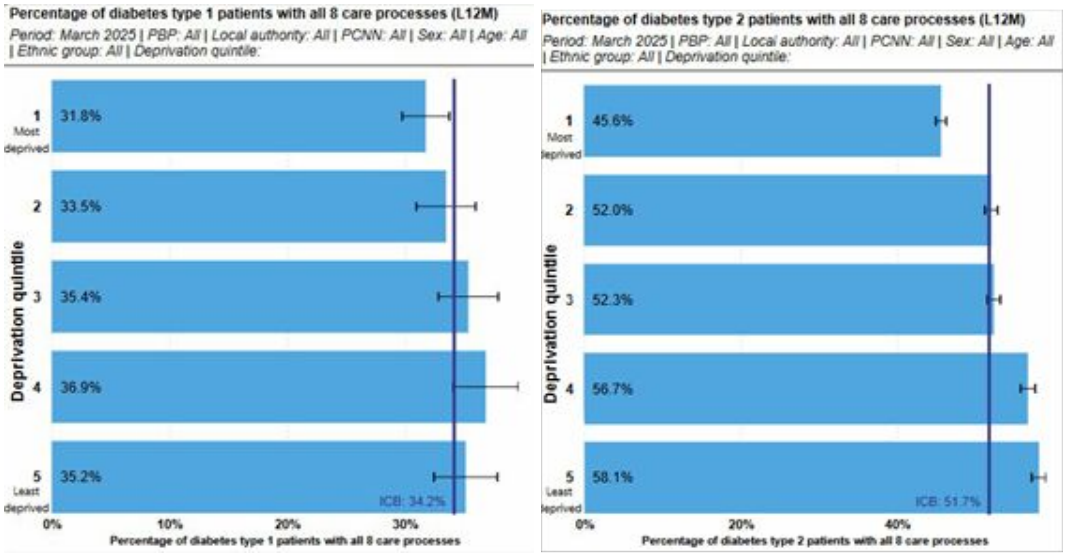
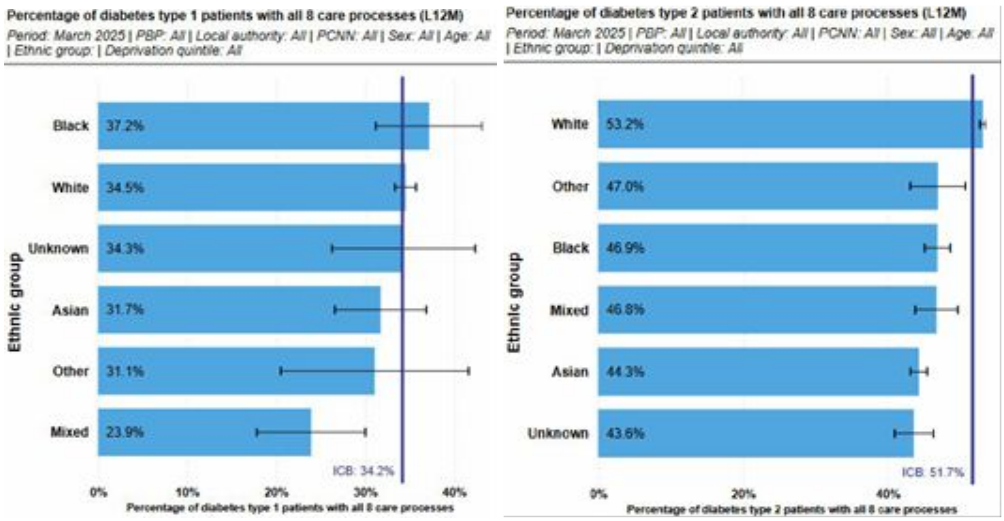


Figure 30 Percentage of people with all 8 care processes complete for Type 1 vs Type 2 Diabetes by ethnicity (last 12 months)

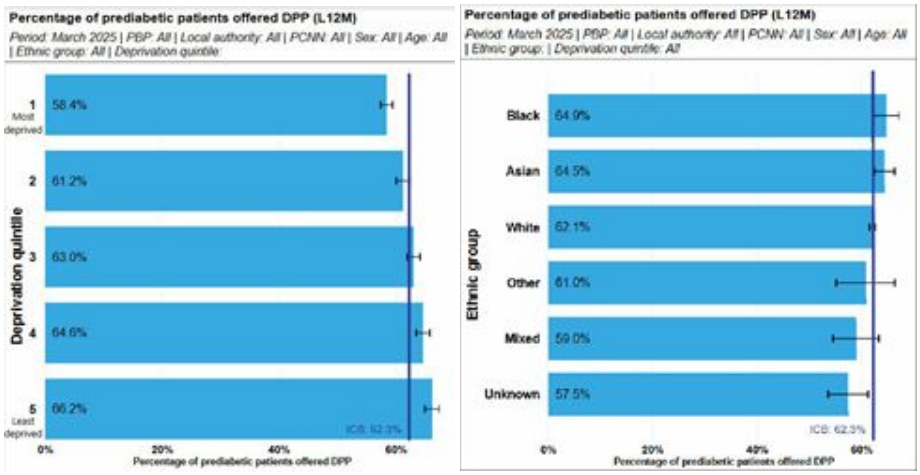


Variation between percentage of referrals to the National Diabetes Prevention Programme from the most deprived quintile and percentage of Type 2 Diabetes from the most deprived quintile

The National Diabetes Prevention Programme (NDPP) identfies people at risk of Type 2 diabetes and offers the opportunity to take part in a 9 month lifestyle programme with the aim to prevent the condition developing.

Referals to the NDPP have increased by 7% in the last 12 months. Despite this uptake is still lower in the most deprived areas and the difference in uptake between the most and least deprived areas has widened from 5 to 8 percentage points. There are not statistically significant diffferences by ethnicity where ethnic group is known

Figure 31 Percentage of people at risk of Type 2 Diabetes referred to the NDPP by deprivation and ethnicity, March 2025



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Smoking Cessation

Smoking is the leading cause of health inequalities and accounts for half of the difference in life expectancy between the most and least affluent communities in England[14]. An estimated 12% of the Nottingham and Nottinghamshire population aged 18+ are current smokers.[15] This is a 4% decrease on the data included in the previous statement and is now similar to the England average, previously the ICS average was worse.

Despite reductions in the overall figures, there are still disparities with higher smoking rates often within areas of high deprivation. Nottingham City has the highest smoking rates at around 18%, followed by Broxtowe at 14%. In 2021, Mansfield had the highest smoking rates at 25%, however 2023 data shows a significant decrease to 13%. Ashfield is one of the most deprived districts in the ICS but has seen reductions in smoking rates since 2011, when rates were as high as 28%. As of 2023, figures were at 7% which is now significantly better than the England average.

NHS partners are members of the Nottingham and Nottinghamshire Smoking and Tobacco Alliance, led by Public Health. The Alliance brings together partner organisations including Nottingham City Council and Nottinghamshire County Council, to work towards eliminating smoking and tobacco-related harm, creating a smoke-free generation for Nottingham and Nottinghamshire by 2040.

The Alliance has published the Nottingham and Nottinghamshire Smoking and Tobacco Long Term Vision which confirms a clear and shared ambition to see smoking amongst adults reduced to 5% or lower by 2035 as well as ensuring those born in 2022 remain smoke free by their 18th birthday to help create a smoke-free generation. There are four key delivery themes of the vision:

a) Helping vulnerable people quit smoking: A particular focus on more deprived communities, those in social housing, working in manual and routine jobs, those with poor mental health and those with multiple needs such as homelessness.
b) Effective regulation of tobacco products
c) Reducing exposure to second hand smoke
d) Prevention and engagement with children and young people

Key actions within each of the four areas and can be viewed within the vision Statement here: 43.114-Smoking-and-Tobacco-Control-Vision.pdf (mynottinghamnews.co.uk)

Proportion of adult acute inpatient settings offering smoking cessation services

100% of adult acute inpatient settings offer smoking cessation services across Nottingham and Nottinghamshire.

[14] Smoking and Health Inequalities 2019 ASH-Briefing_Health-Inequalities.pdf
[15] OHID, Fingertips, Smoking prevalence in adults (aged 18 and over) – current smokers (APS) 2023

Smoking tobacco is linked to just over 500,000 hospital admissions each year, with smokers being 36% more likely to be admitted to hospital than non-smokers. Smoking tobacco is linked to over 100 different conditions. Stopping smoking results in an improved response to cancer treatments, faster recovery after surgery, fewer exacerbations of cardiovascular disease, slower decline in lung function, lower pharmacotherapy costs and a beneficial impact on long-term levels of depression and anxiety. Increasing access to tobacco treatment services whilst in hospital can help improve quit rates, continued support in the community following discharge is also an important part of the pathway to ensure continued positive outcomes for patients.

Proportion of maternity inpatient settings offering smoking cessation services

100% of maternity inpatient settings offer smoking cessation services across Nottingham and Nottinghamshire.

Smoking is also the single greatest modifiable risk factor for poor outcomes in pregnancy. The harms associated with smoking relate not only to the mother but also to the unborn child, where we see a doubling of the likelihood of stillbirth and tripling of the likelihood of sudden infant death[16]. Smoking rates are higher amongst those in the most deprived areas. The service offer aims to help pregnant people who smoke set quit dates to reduce risks during pregnancy.

[16] Tobacco Dependency Programme 2019 NHS England » Tobacco dependency programme

Oral Health

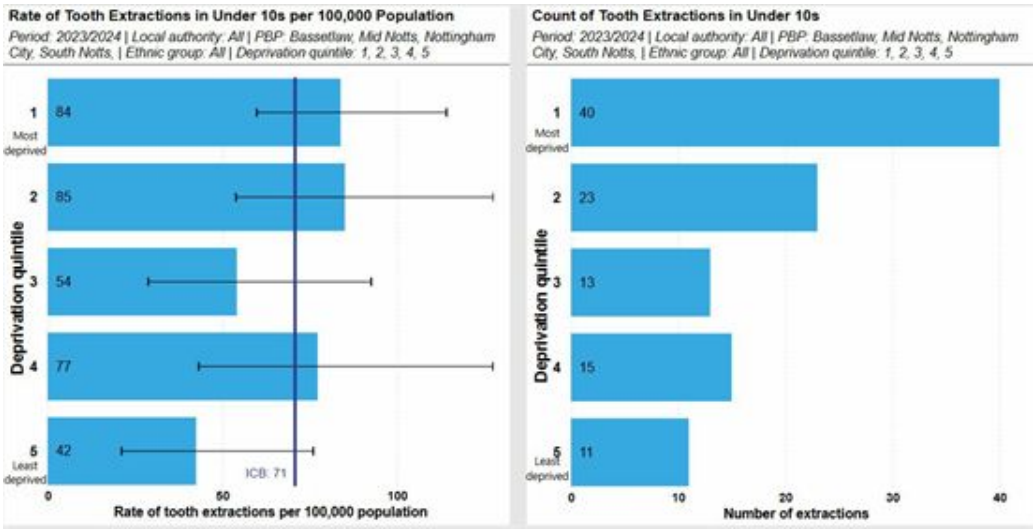
Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable. Almost 9 out of 10 hospital tooth extractions among children aged 0 to 5 years are due to preventable tooth decay and tooth extraction is still the most common hospital procedure in 6 to 10 year olds, according to data up to 2019[17]. Data also shows that children in the most deprived populations have more than twice the level of tooth decay than those in the least deprived areas.

Tooth extractions due to decay for children admitted to hospital aged 10 and under (number of admissions)

The overall number of children admitted as inpatients to hospital tooth extractions in Nottingham and Nottinghamshire is relatively small, with between 100 and 150 extractions each year. In 2023/24 there were 93 extractions in under 10s.

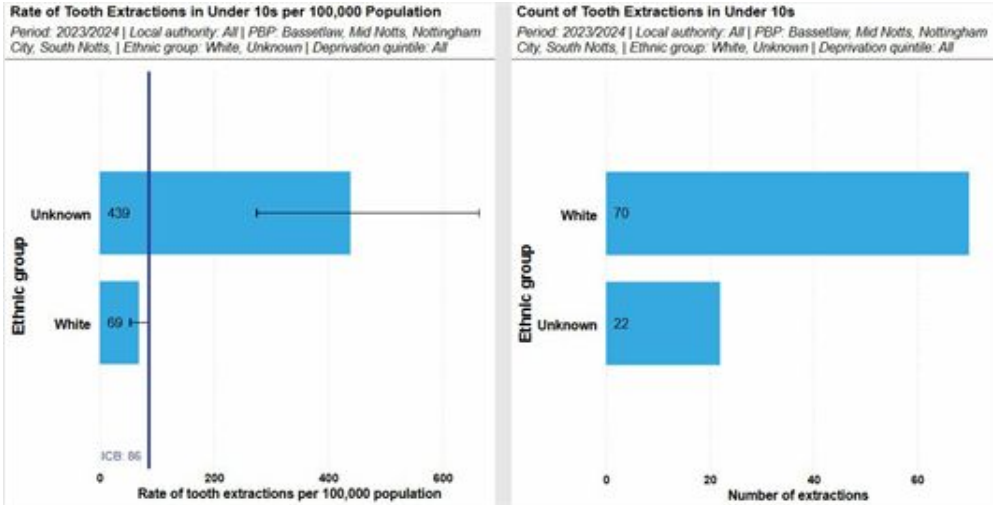
In 2023/24, Bassetlaw remains the highest locality for tooth extractions in under 10s. As numbers are so low, there is no statistically significant variation by deprivation or ethnicity.

Figure 32 Rate and count of tooth extraction admissions in under 10s by deprivation quintile, 2023/24



[17] Child oral health: applying All Our Health 2022 Child oral health: applying All Our Health - GOV.UK (www.gov.uk)

Figure 33 Rate and count of tooth extraction admissions in under 10s by ethnicity, 2023/24



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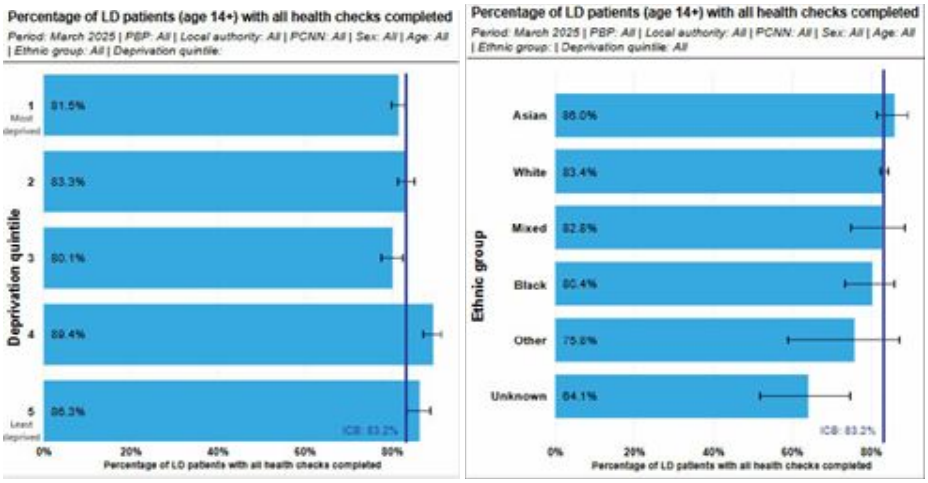
People with Learning Disabilities and Autistic People

Health Inequalities are evident in people with Learning Disabilities, with the average life expectancy around 20 years less in this population group. Further data indicates that 49% of deaths in this group were from avoidable causes[18]. Annual health checks enable contact with a health professional to spot early signs of illness and prevent conditions worsening.

Learning disability annual health checks

As of March 2025, 83% of people with a learning disability (age 14+) had an annual health check completed in the previous year. The rate of checks is lower in IMD quintiles 1 and 3. While the percentage of checks completed is also below the ICS average for several ethnicity categories, these differences are not statistically significant. Those in younger age categories (below age 33) also have a lower rate of checks than older age categories. Figures have remained similar to those from March 2024.

Figure 34 Rate of completed learning disability health checks by deprivation and ethnicity, March 2025.

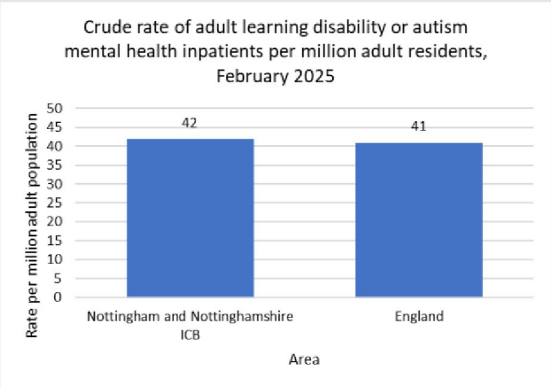


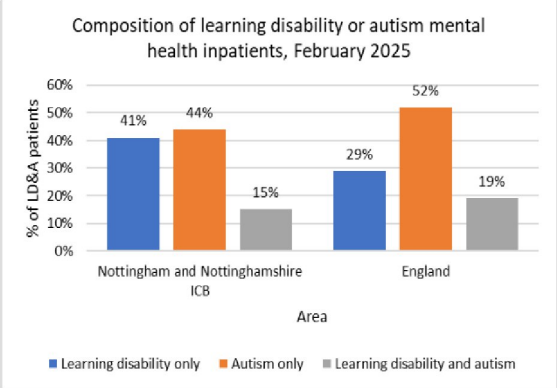
Adult mental health inpatient rates for people with a learning disability and autistic people

Based on the Learning Disability: Assuring Transformation Dataset[19], there were 40 mental health inpatients who were registered with a Nottingham and Nottinghamshire GP and had a learning disability or autism at the end of February 2025. This equates to 42 per million adult population, which is similar to England overall. Around 41% of this group had learning disabilities only, 44% had autism only, and the remainder had both learning disabilities and autism. This is a broadly similar composition to England considering the small number of patients involved.

[18] Learning disability - applying All Our Health (2023) Learning disability - applying All Our Health - GOV.UK (www.gov.uk)
[19] NHS England, Learning Disability Services Monthly Statistics, AT: February 2025

Data broken down by deprivation and ethnicity is not available for this indicator.





Maternity and Neonatal

Pre-term births under 37 weeks

Complications from premature birth remains one of the three main causes for infant mortality in the UK. The Marmot Review 2010 stated that one quarter of all deaths under the age of one would potentially be avoided if all births had the same level of risk as those to women with the lowest level of deprivation.

As shown by the charts below, those in the most deprived IMD Quintile have the highest count of pre-term births and are 1.3 times as likely to have a preterm birth than those in the least deprived quintile. Pre-term births by ethnic group are also presented, however numbers of pre-term births where the ethnicity of the mother is known are too small to show statistically significant differences.

Figure 35 Rate and count of preterm births by deprivation, 2023/24

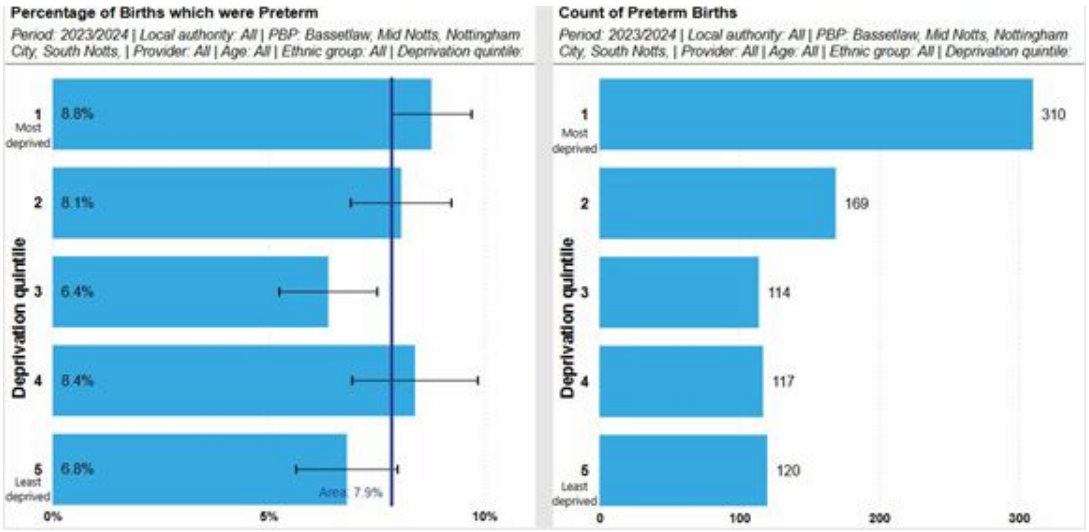
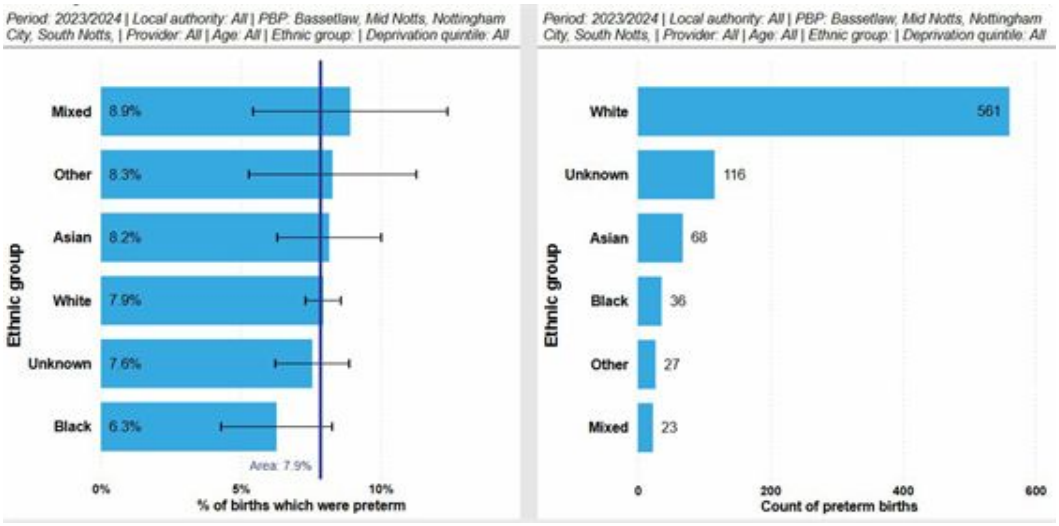


Figure 36 Rate and count of preterm births by ethnicity, 2023/24



Data Quality

The data used in this statement has been take from the suggested NHS England data sources as well as local primary and secondary care data where available.

Efforts have been taken to ensure data sources are complete and valid. Data Quality is part of Contract and/or Information review meetings led by Contracting Teams. Data quality issues are raised and discussed as part of these meetings, usually when problems are identified.

However, it should be noted that within ethnicity coding, “Not Stated” is considered a valid code, in addition the category “other” may also be used incorrectly for example in instance’s when ethnicity is not stated or unconfirmed. This may result in a distorted view of differences by ethnicity for some indicators.

Impact of ethnicity coding quality on the calculation of rates from secondary care data

The population denominators used for indicators presented here are based on the Nottingham and Nottinghamshire ICB GP-registered population. Ethnicity coding in the GP-registered population is generally near-complete, with only 5% of patients having an unknown ethnicity, either because they have declined to share their ethnicity, or it has not been recorded.

Secondary care data sources, such as SUS and the Waiting List Minimum Dataset, tend to have a significantly higher proportion of 'Unknowns', often between 10 and 25%. Additionally, the number of patients in secondary care data sources with an 'Other' ethnicity is substantially higher than would be expected for the GP-registered population.

When crude or age-standardised rates are calculated with a secondary care data source as the numerator and the GP-registered population as the denominator this produces a distorting effect when viewed by ethnicity due to the mismatch between the numerator and denominator: Rates for the 'Unknown' and 'Other' populations appear to be excessively high, and rates in smaller ethnic groups (Asian, Black,

Mixed), for which missing a small number in the numerator has a greater effect, are likely depressed.

Crude and age-standardised rates based on secondary care data should be interpreted with caution when broken down by ethnic group. For age-standardised rates, 'Unknown' and 'Other' ethnic groups have been omitted.

For further information, please see the below tables which detail the Nottingham and Nottinghamshire GP Population breakdown by ethnicity and the validity of ethnicity coded within secondary provider trusts.

Nottingham and Nottinghamshire ICB GP-registered population by ethnicity, March 2025

Ethnic Group	% of population	Count of population
White	75.8%	969,328
Asian	9.5%	121,494
Unknown	4.7%	60,336
Black	4.6%	53,563
Mixed	3.5%	45,211
Other	1.8%	23,459

Ethnicity coding validity for Nottingham and Nottinghamshire Secondary Care providers

The table below details the percentage of patients with a valid ethnicity code for Secondary Care Providers in comparison with the national average based on the Data Quality Maturity Index for ethnicity fields. The DQMI accepts ethnicity codes which are not null or 99 (Not known) as valid. Z (Not Stated) is considered a valid code. Nottingham and Nottinghamshire Secondary Care providers generally perform better than the national average for ethnicity coding validity.

In September 2024, Nottingham University Hospitals, the ICS' largest secondary care provider performed slightly worse than the national average for the Admitted Patient Care Dataset, and Nottingham Citycare Partnership performed worse than the national average for the Emergency Care Dataset.

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Table xx Valid ethnicity coding, Data Quality Maturity Index, September 2024

Data Provider Name	Dataset	Org Type	% Valid Ethnicity Coding	National Data Item Average
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	APC	NHS TRUST	93.9	87.7
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	APC	NHS TRUST	97.6	87.7
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	APC	NHS TRUST	95.7	87.7
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	APC	NHS TRUST	84.8	87.7
NOTTINGHAM CITYCARE PARTNERSHIP	CSDS	INDEPENDENT	89.6	71.7
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	CSDS	NHS TRUST	83.8	71.7
NOTTINGHAM CITYCARE PARTNERSHIP	ECDS	INDEPENDENT	72.3	85.9
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	ECDS	NHS TRUST	95.1	85.9
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	ECDS	NHS TRUST	95.9	85.9
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	ECDS	NHS TRUST	87.3	85.9
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	MHSDS	NHS TRUST	95	67.8
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	MHSDS	NHS TRUST	97	67.8
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	MHSDS	NHS TRUST	94.1	67.8
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	OP	NHS TRUST	97.5	80
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	OP	NHS TRUST	96.6	80
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	OP	NHS TRUST	95.7	80
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	OP	NHS TRUST	84.7	80

Because the DQMI treats 'Not Stated' as a valid entry, it does not provide a complete view of how many records have a usable ethnicity, and therefore how useful a dataset is for analysis by this dimension.

The Midlands Ethnicity Reporting Dashboard includes records with null, 99 (Not known), and Z (Not Stated) in the percentage of with no ethnicity recorded. Among local NHS providers, Nottingham University Hospitals has a higher percentage of records without an ethnicity recorded compared to other trusts and England. Other providers and local GPs perform better than England on this metric.

Table xx Known ethnicity coding, Future NHS Midland Region Ethnicity Reporting, October 2024

Provider name	Dataset	% Records with no ethnicity recorded October 2024	National
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	APC	6.9	12.1
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	APC	22.2	12.1
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	APC	4.4	12.1
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	ECDS	19.9	13.9
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	ECDS	5.5	13.9
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	OPA	10	17.6
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	OPA	22.1	17.6
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	OPA	5	17.6
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	MHSDS	5	12
N&N ICB 52R (Nottinghamshire Sub-ICB)	GPES	6.6	9
N&N ICB 02Q (Bassetlaw Sub-ICB)	GPES	5.6	9

Appendix 2

Overview of the strategic and planning components of the Nottingham and Nottinghamshire approach to health inequalities: Alignment with the Health Inequalities Statement

Introduction

1. The ICB approach to health inequalities is informed by national frameworks, including Core20+5, national and local priorities, Public Health and Health and Wellbeing Strategies.
2. In 2022, Nottingham and Nottinghamshire ICS approved a comprehensive health inequalities plan that has been progressed through to the ICS Strategy and Joint Forward Plan. The plan confirms the ICS approach to national frameworks, fundamentally Core20+5, national priorities, local priorities and Health and Wellbeing Strategies. The plan highlighted the need to focus on barriers to access and in experiences that then impact on positive and optimal outcomes. The plan informed the ICS Strategy and the three ICS principles of prevention, equity and integration.
3. The report provides an overview of the different elements within the plan and approach and alignment with the Statement indicators. Through the work of the SAIU, public health frameworks, Joint Strategic Needs Assessments and the structure of the dashboards, including the outcomes framework, the ICB work from a broader range of indicators to inform population health management, impacting on health inequalities.

Prevention, Equity and Integration and Impact on Health Inequalities

Prevention

4. Prevention is directly linked to reducing health inequalities by addressing the root causes of avoidable ill health and ensuring equitable access to resources and services. By focusing on preventative measures, particularly for those most at risk, health inequalities can be narrowed and improved health outcomes achieved for all. Figure 1 is from the ICS Strategy and provides an overview of a preventative approach across the different tiers. More detail on the ICB approach to prevention is detailed further down in the report, under secondary prevention and the Health Inequalities Innovation and Investment Fund (HIIF).

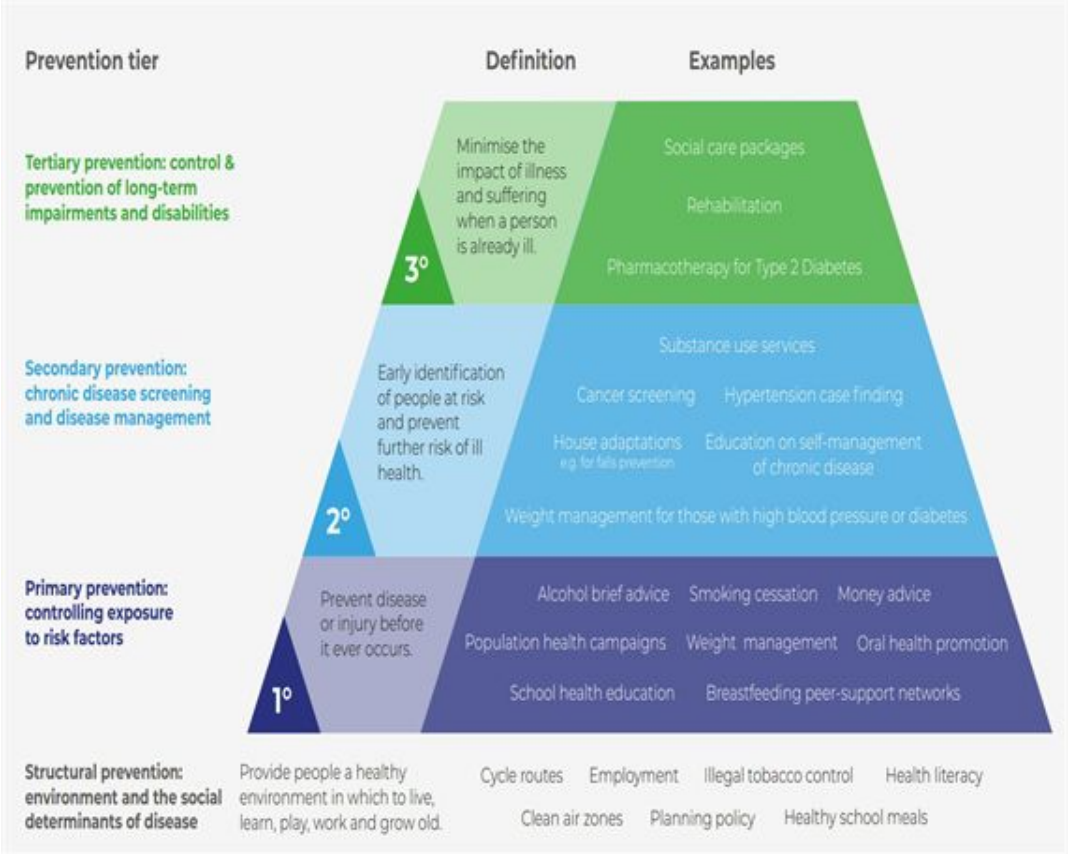


Figure 1 – Prevention Tiers

Equity

5. Equality is about sameness; equity is about fairness. This means that sometimes, to give people equal health outcomes, we have to do something more or different for some people, to make it fair. If we want to change life expectancy, we need to understand why what affects people's health and what might make it difficult for some people to lead healthier lives. Health and care services need to use this information to think differently about how they inform people about their health, provide services and link in with other partners to tackle the wider determinants of health.

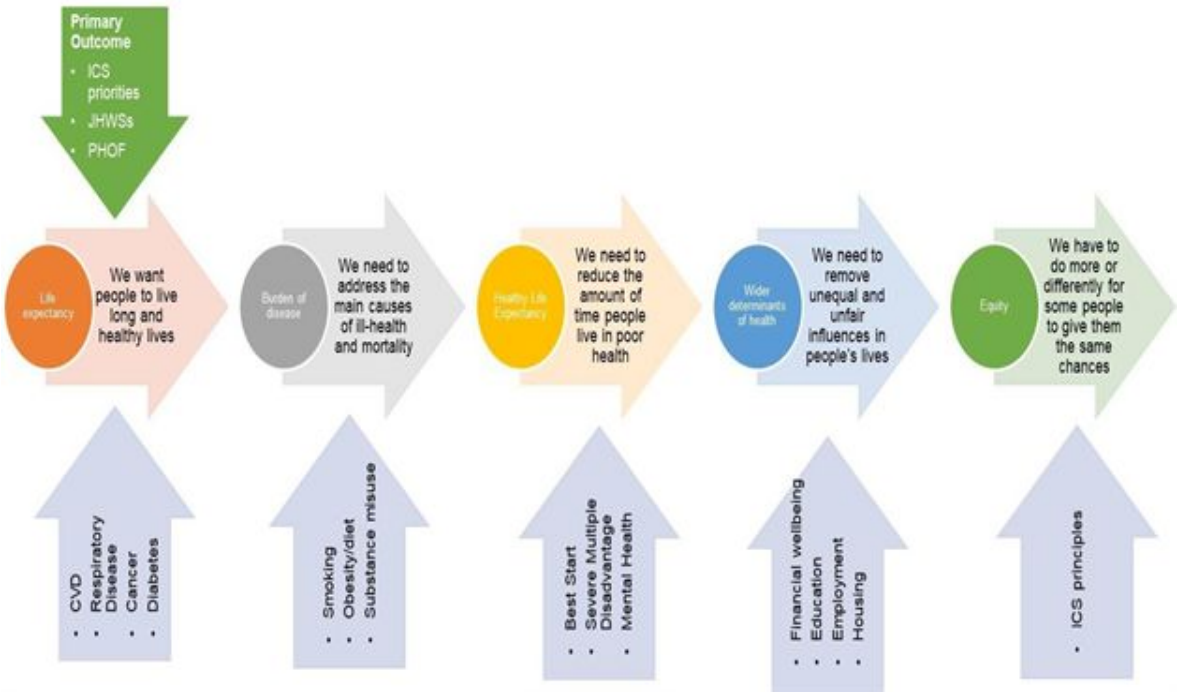


Figure 2 – Understanding Equity

Integration

6. As a healthcare provider the NHS can influence between 15 and 43% of the variation in health outcomes. Though the fundamental social drivers of health inequalities lie outside the healthcare system, the NHS can make a central contribution to narrowing inequalities by integration and tackling disparities – in access to services, patient experience and healthcare outcomes as a healthcare provider through service delivery.
7. In order to impact on health inequalities our ICS partnerships are essential and integration and co-production by working with our communities is crucial. Integration allows for a focus on population need as opposed to a reactive approach responding to supply and demand.

Risk Factors Impacting on Health Inequalities

8. The Nottingham and Nottinghamshire statement (page 5) on health inequalities includes a stark profile of the risk factors, long term conditions and life expectancy by PCN. This is further understood through the analysis by the Global Burden of Disease and the conditions that create the greatest gap in life expectancy.

Global Burden of Disease[i]

9. The Global Burden of disease shows us that the leading risk factors for ill health in Nottingham and Nottinghamshire are smoking, high BMI and harmful alcohol use. These are all modifiable factors, are socioeconomically patterned and contribute significantly to widening health inequalities. If we can reduce smoking and obesity rates across the ICS, it would have a positive impact on the health of the population.

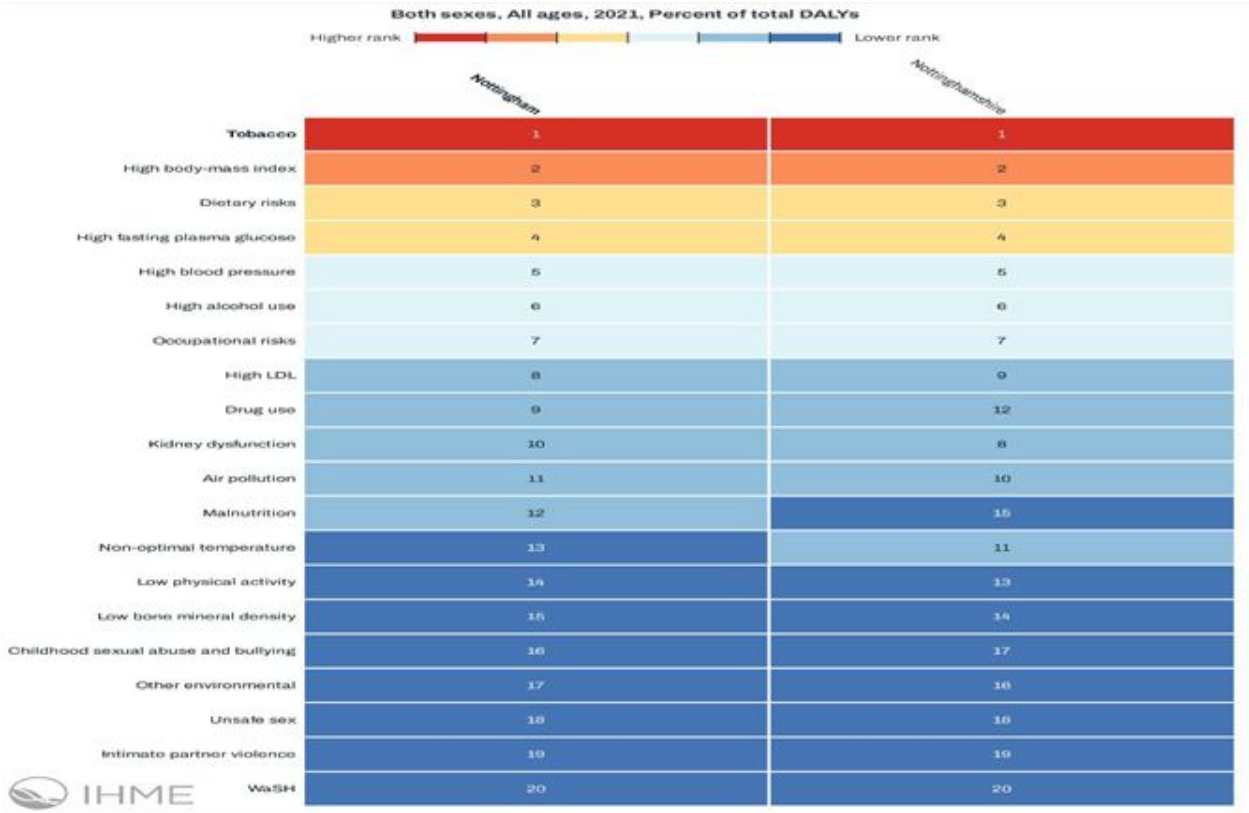


Figure 3 – Global Burden of Disease Leading Risk Factors for Ill Health

Life Expectancy and Healthy Life Expectancy

10. Health inequalities, particularly socio-economic differences in health, significantly impact life expectancy, meaning that people in more deprived areas tend to live shorter lives. This disparity is further pronounced when considering "healthy life expectancy," which measures the time spent in good health, highlighting a significant gap between the most and least deprived areas. Figure 4 highlights the differences in life expectancy in Nottingham and Nottinghamshire. Disparities in life expectancy are even starker for certain population cohorts i.e. people with severe mental illness have a significantly shorter life expectancy compared to the general population, typically 15 to 20 years less. Healthy life expectancy for

females is 55.6 in the City (2nd lowest in England) and 61.6 in the County. For males in Nottingham City is 56.4 (3rd lowest in England) and 63.4 in Nottinghamshire County.

11. Figure 5 clearly indicates the level of contribution certain conditions contribute to the gap in life expectancy between the least and most deprived, emphasising the importance of focusing on cancer, diabetes, cardiovascular disease (CVD) and respiratory programmes in relation to prevention (primary and secondary), case finding and compliance to treatment.

12. Since 2020 there has been an increase in avoidable deaths, partly due to COVID-19, but also due to an increase of deaths from CVD, and alcohol or drug related problems and injuries. The increase observed in 2022 and 2023 has occurred mainly in the 50-64 and 65-74 age groups. Avoidable deaths are strongly linked with deprivation: the highest age-adjusted mortality rates are observed in the most deprived areas of the ICS. Nottingham City Place Based Partnership (PBP) has the highest rates, whilst South Notts PBP has the lowest rates.

13. Avoidable deaths account for 40.1% of all deaths in the most deprived areas of England compared with 17.8% in the least deprived areas. The following charts provide an understanding of the life expectancy gap and conditions that contribute most to the disparity between the most and least deprived. [1]The criteria impacting on the life expectancy gap, combined with our understanding of avoidable mortality, provides valuable insight into the areas and conditions impacting most on health inequalities.

Information on inequalities between the most and least deprived quintile of NHS Nottingham and Nottinghamshire, 2014 to 2016 to 2020 to 2021

Male	2014-16	2017-19	2020-21
Life expectancy most deprived quintile	74.6	74.8	73.5
Life expectancy least deprived quintile	82.7	82.5	81.8
Gap	8.1	7.7	8.3

Female	2014-16	2017-19	2020-21
Life expectancy most deprived quintile	78.9	78.8	78.4
Life expectancy least deprived quintile	86.0	85.0	85.0
Gap	7.1	6.2	6.6

Figure 4 – Life Expectancy Gap

[1] Office for Health Improvement and Disparities. Segment Tool. Segment Tool

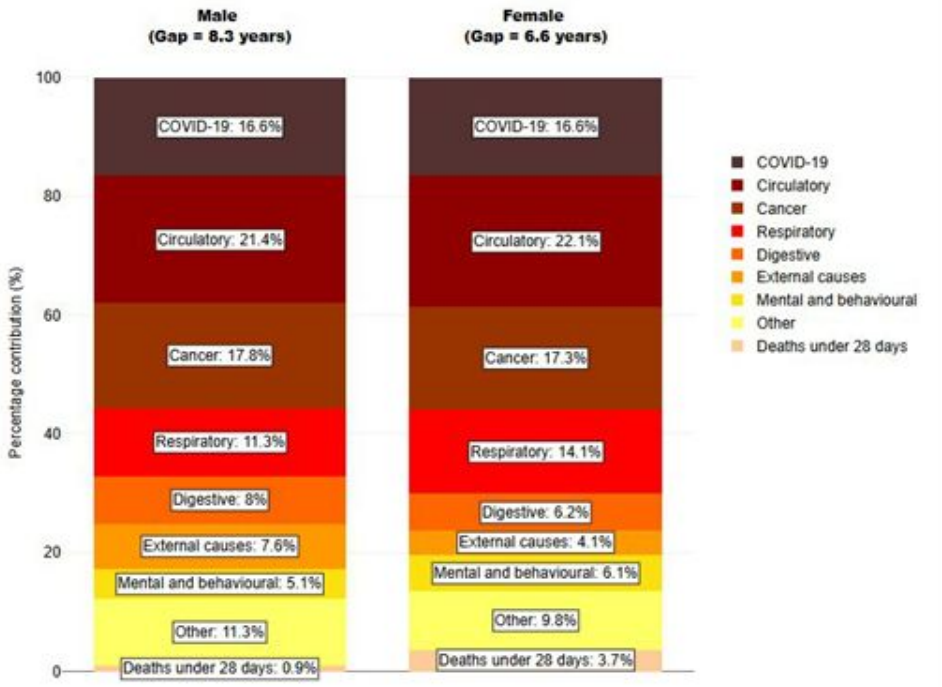


Figure 5 – Breakdown of the life expectancy gap between the most and least deprived quintiles of NHS Nottingham and Nottinghamshire by cause of death, 2020 to 2021[2]

Impacting on Health Inequalities

A. Enablers

Related Health Inequality Statement Indicators

- Elective Care
- Urgent and Emergency Care
- Data Quality

14. Table 1 provides an overview of key enablers being progressed as part of the strategic approach to health inequalities. The enablers align with the NHSE national health inequality priority areas and opportunities outlined in the Health Inequalities Statement.

[2] Office for Health Improvement and Disparities based on ONS death registration data and 2020 mid-year population estimates, and Department for Levelling Up, Housing and Communities Index of Multiple Deprivation, 2019

Leadership, Place Based Partnerships and Neighbourhoods	Data	Digital Exclusion	Inclusive Services	Demonstrating Value
• Integrated Neighbourhood Teams • Prioritising Long Term Conditions • ICS Health Inequalities Oversight Group • Provider Frameworks	• Ethnicity Coding • Disability Coding • SAIU Dashboards including Health Inequalities Dashboard • SAIU Analysis • Joint Strategic Needs Assessments • Health Equity Impact Assessments • National Dashboards	• Digital Transformation Programme and focus on Digital Inclusion • Implementation of national Digital Inclusion Framework • Nottingham and Notts Population Profile of Digital Inclusion	• Developed Local Inclusion Health Tool – launched in May • NHS Nottingham and Notts focus on Severe Multiple Disadvantaged • Place Based Partnerships • Elective Care • High Intensity Users	• Funding including Health Inequalities Innovation and Investment Fund • Demonstrating Return on investment

Table 1 – Enablers

15. Areas specifically referenced in the Health Inequalities Statement in relation to the enablers includes elective care and data quality.

16. Elective Care – the Statement provides analysis on the waiting lists shows that the proportion of waits for the most deprived has decreased and the gap is narrowing for waiting times. The Health Inequalities Plan and approach as a system includes initiatives relevant to:

    - Referral Optimisation – optimising access through effective communication and engagement with individuals. Through the data, identifying gaps by specialty and implementing targeted actions.
    - Waiting Well – targeted schemes to reduce the number of cancellations or delays due to individuals not being fit for surgery (linked to diabetes management as a prevention priority)
    - Outpatients – Focus on Did not attends, digital inclusion and individual choice.

17. In terms of data quality, through the System Analytics and Intelligence Unit there is a dedicated focus on working with secondary care providers to increase ethnicity recording. System Analytics and Intelligence Unit analysis on ethnicity is supported by robust data in GP practice systems and data warehouses.

B. Core20+5

Related Health Inequality Statement Indicators

- Urgent and emergency care
- Respiratory

- Mental Health
- Cancer
- Oral Health
- Maternity and Neonatal

18. Core20+5 is a national framework introduced to support systems to focus on clinical priorities where the NHS can address the social gradient in the most common causes of death, and stark inequalities faced by other groups. Core20+5 has been central to defining and driving forward the Nottingham and Nottinghamshire health inequalities plan with targeted programmes of work across all clinical areas for adults and children. Figures 6 and 7 provide the areas of focus as part of the Core20+5.
19. The indicators within the Health Inequalities Statement directly align to Core20+5 and relevant actions are central to the Health Inequalities Plan i.e. vaccination uptake for those with a respiratory condition and increasing cancer diagnoses at an earlier stage.
20. The Core20+5 for children and young people focuses on inequalities in disease areas where the NHS can make a specific contribution that will complement the work of wider partners. In terms of the Statement, actions being taken in response to the clinical areas for children and young people will impact on emergency admissions for under 18s and mental health access. In terms of mental health access, considerable work has been undertaken to establish a co-produced and peer support offer for children and young people. Through Core20+5 oral health is included in plans, with opportunities being led by Public Health.
21. Through the Core20+5, in Nottingham and Nottinghamshire we have also supported Core20+5 Ambassadors and Core20+5 Community Connectors.

Figure 6 – Core20+5 Adults

Figure 7 – Core 20+5 Children and Young People

C. Health Inequalities Innovation and Investment Fund
Relevant Health Inequalities Statement Indicators

- Cardiovascular Disease
- Diabetes
- Smoking Cessation
- Urgent and Emergency Care

22. In recognising the commitment of the Integrated Care System (ICS) in tackling health inequalities across access, experience and outcomes, the Nottingham and Nottinghamshire financial planning process for 2023-25 included a proposal for a Health Inequalities and Innovation Investment Fund (HIIF) with an initial value of £4.5 million recurrently for schemes identified in 2023/24. Spending against the Fund has also been approved for 2025/26.

2023/24 Fund

23. For 2023/24, nine schemes listed in figure 8, relating to system priorities for Best Start in Life, Severe Multiple Disadvantage (SMD) and Integrated Neighbourhood Working, were approved for recurrent or fixed term funding via an expression of interest and business case process. The schemes were mobilised across 2024 and will continue recurrently. The learnings from Integrated Community Working will be translated into a health inequalities focus for integrated neighbourhood teams.

A. Best Start in Life	B. Integrated Community Working	C. SMD and Alcohol Dependency
Family Mentor Programme	Integrated Neighbourhood Teams – Bassetlaw	SMD Infrastructure and Delivery Model
Childhood Vaccinations and Immunisations in Nottingham City	Integrated Neighbourhood Teams – Mid Nottinghamshire	County Integrated SMD Clinical Team
Obesity in Children and Young People	Integrated Neighbourhood Working – South Nottinghamshire	

Figure 8 – 2023/24 HIIF Schemes

2025/26 Fund

24. The 25/26 fund will be supporting the strategic focus on Treatment to Prevention through a robust approach to secondary prevention. Ensuring a strong, evidence-based offer for the priority areas identified for secondary prevention provides a strategic focus on risk factors driving health inequalities and premature mortality and morbidity. This includes impacting on modifiable factors that contribute to infant mortality and prevention in children i.e. obesity.

25. Secondary prevention priority areas and the HIIF allows for an integrated approach across primary, secondary and tertiary prevention which then means that can do more of and/or do differently for areas of highest need in line with ICS Strategy principle for equity. This includes a focus on priority cohorts, including mental health and frailty, and inclusion health groups.

26. Making Every Contact Count (MECC) **-** Essential component for impacting on the building blocks of health/wider determinants within integrated neighbourhood teams and for providers.

27. Secondary prevention priority areas have been agreed as follows:
    - CVD – continue with case finding and management through PBPs and Integrated Neighbourhood Team and across the intervention decay model. The intervention decay model provides a framework for prioritising and describing how we can work systematically to drive forward prevention, understanding the barriers and risks for local populations from the point of being at risk through to compliance with treatment plan.

- Diabetes – focus on pre-diabetes and management of type 2 diabetes and young people with diabetes (including risk of type 2 diabetes in children).
- Smoking – continue to fund and maximise offer for smoking cessation services in the NHS (in-patient, mental health, maternity) along with integration with Local Authority services, PBP targeting and opportunities through Integrated Neighbourhood Teams.
- Weight Management (adults and children) – access to weight management services along with promotion of physical activity and introduction of injectables.
- Alcohol – reduction in alcohol harm through brief advice and access to effective treatment building on existing commissioned services including integration with Local Authority.
- Vaccination Uptake – increasing uptake across all vaccinations through new delivery models.
- Screening – increasing uptake for routine screening and alignment from screening to symptomatic pathways.
- Exercise/Moving Well/Physical Activity – promotion of moving well by embedding across pathways. Integrating with Local Authority programmes, including Sport England initiatives. This aligns with an NHS E published statement in March on return on investment for physical activity and embedding in healthcare.

Conclusion

28. The Health Inequalities Plan incorporates the national priorities as well as local initiatives. The Health Inequalities statement includes indicators that monitor the national priorities, and these have been used to build the foundations for the Nottingham and Nottinghamshire health inequalities dashboard. Through the national and local priorities progress is being made against all indicators in the statement.

NHS Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/07/2025
Paper Title:	**Population Health Management Report: Dementia**
Paper Reference:	ICB 25 039
Report Author:	Sergio Pappalettera, Senior Analytical Lead Matt Curtis, Population Health Management and Health Inequalities Advanced Analyst Alex Julian, Senior Mental Health Commissioning Manager
Executive Lead:	Maria Principe, Acting Director of Delivery and Operations
Presenter:	Maria Principe, Acting Director of Deliver and Operations

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

Summary:

Drawing on the outputs of the recent Clinical Design Authority Senate on dementia, this report highlights system-wide recommendations to transform dementia care, alongside placing a spotlight on the key challenges in meeting the needs of a significant increase projected in dementia prevalence over the coming years.

Local benchmarking reveals high levels of emergency admissions and prolonged hospital stays for people with dementia, alongside variation in diagnosis, care planning, and prescribing practices. At the same time, opportunities exist to address modifiable risk factors, expand early intervention and diagnosis, ensure equity in care delivery, prepare for new technologies in diagnosis and treatment and improve support for carers.

The recommendations proposed align with the NHS Dementia Well Pathway and support integrated, preventative, and outcomes-driven care, ensuring dementia remains a priority within system transformation and within the development of the integrated neighbourhood health model, supporting the strategic shift from hospital to community.

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 living with Dementia.
Tackle inequalities in outcomes, experience and access	The paper highlights unwarranted variation in outcomes for people living with Dementia and proposed actions to address this unwarranted variation.
Enhance productivity and value for money	The paper highlights the cost of Dementia care, the risks associated with increasing prevalence and need to improve productivity.
Help the NHS support broader social and economic development	The paper outlines the wider societal costs of Dementia.

Appendices:
Appendix A: Clinical Design Authority Senate - Dementia Deep Dive Appendix B: NHS Commissioned Dementia Services

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 5: Health inequalities and outcomes – Failure to identify and/or deliver service transformation 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: Dementia

Executive summary

1. This paper provides an example of how we are utilising population health management (PHM) data and intelligence to inform and drive key transformational activities within dementia services.
2. The analysis undertaken has been clinically led, grounded in data and population health intelligence, and triangulated with expert insight to generate system-wide recommendations for dementia services, which aim to support transparent, evidence-based improvements in how we care for those living with dementia from prevention to end of life.

Introduction

3. Dementia is an umbrella term for a range of progressive conditions that affect the brain, leading to a decline in cognitive abilities, including memory, thinking and reasoning. These impairments can significantly impact a person's daily life and ability to perform normal activities.
4. For family members and caregivers, dementia can be challenging to manage, both emotionally and practically. Providing care for a loved one with dementia can be time-consuming, stressful, and costly, and may lead to caregiver burnout and other negative outcomes.
5. 10,820 people have a diagnosis of dementia in Nottingham and Nottinghamshire, representing 0.84% of the population and 4.7% of the population aged 65 and over. A further 4,300 people are expected to be living with dementia without a diagnosis.
6. Dementia prevalence is expected to increase by 50% in the next two decades, increasing at a faster rate than any other long-term condition.
7. Based on analysis by the Strategic Analytical Intelligence Unit on local, NHS indicative commissioning costs, the annual, per person cost for dementia is £10,000. When including social care costs this increases to £17,000. In 2025, this totals £108 million, in 2045, it is expected to rise to £162 million. Including social care costs this increases to £184 million in 2025, increasing to £275 million in 2045.
8. A report by Alzheimer's Society and Carnall Farrar in 2024 included the contribution of unpaid carers in estimates of the current cost of dementia care in the UK, totalling £42 billion in 2024, rising to £90 billion in 2040. Approximately 63% of this cost is borne by patients and their families. The annual per person cost for mild dementia is estimated at £28,700 compared to

£80,500 for severe dementia, driven by increasing need for more complex health, social and unpaid care.

9. Nottingham and Nottinghamshire has a well-established Dementia Steering Group with members from all key sectors. The Steering Group oversees improvements in dementia care, alongside monitoring performance against three key performance indicators aligned to the Well Pathway for Dementia, a strategic framework based on NICE guidance:

   a) Dementia diagnosis rate (>66.7%)

      - Consistently delivered target.
      - Current achievement 70.1% (April 2025).
      - Second best in East Midlands region.

   b) Memory assessment waiting times

      - Not achieving average 12-week referral to assessment target.
      - Not achieved since August 2024.
      - Current average 17 weeks referral to assessment (April 2025).
      - Performance Improvement Plan is in place with oversight from Mental Health Performance and Assurance Programme Board.

   c) Access to post-diagnostic support

      - Over 2,000 people living with dementia accessing the Dementia Wellbeing Service.
      - Above regional average for medication reviews.
      - Above regional average for annual care plans.
      - Below regional average for anti-psychotic prescribing.

Clinical Design Authority Senate

10. In April 2025, a Clinical Senate was convened, bringing together over 70 clinical experts and professionals from across the local health and social care system aiming to examine barriers, share local innovation, and co-produce recommendations for the dementia pathway. The Senate was supported by a comprehensive deep dive completed by the System Analytical Intelligence Unit, which incorporated local intelligence and national datasets to understand gaps, variation and population need now and in the future.

11. Key insights from the deep dive include:

    a) Dementia prevalence is expected to increase by 50% in the next two decades, increasing at a faster rate than any other long-term condition.

b) The estimated cost of meeting this increase in prevalence in 20 years is an increase of £62 million per annum for the ICB and £91 million per annum across the ICB and social care.

c) The ICB has significantly high rates of non-elective admissions for Dementia (ranked sixth highest nationally).

d) Patients aged 65 and over with dementia stay in hospital a week longer on average than those without dementia.

e) 45% of dementia cases are preventable through lifestyle changes or timely intervention.

f) 38% (3,940) of patients with dementia aged 65 and over live in a care home, and 60% of the total care home population aged 65 and over has a dementia diagnosis.

g) The projected increase in patients with dementia will require an additional 1,000 care home beds by 2033.

12. To aid in the development of recommendations the Senate included presentations on local innovations in dementia care:

    a) Social prescribing delivery of the dementia care plan review.

    b) Diagnosing Advanced Dementia Mandate (DiADeM) pilot, led by Nottingham West and Rushcliffe Primary Care Networks to enable diagnosis within care homes.

    c) Admiral Nurse role embedded in Ashfield North Primary Care Network.

    d) Dementia Wellbeing Service delivery of Cognitive Stimulation Therapy and Community Development roles.

13. In addition, three workshops were determined by the Clinical Design Authority planning group:

    a) Preventing and delaying onset of dementia.

    b) Diagnosing dementia early and accurately.

    c) Reducing avoidable hospital admissions for those living with dementia.

14. Following a process of review by the Clinical Design Authority planning group and attendees, the recommendations were finalised in May 2025 and have been summarised below in line with the ‘Well Pathway for Dementia’. An accompanying action plan has been developed alongside the recommendations, which will initiate a programme of transformation across the dementia pathway.

Dementia recommendations

15. Preventing well:

a) Implement community development roles within the new Dementia Wellbeing Service to tackle stigma and reduce inequalities in dementia diagnosis.

b) Co-produce a dementia prevention campaign in high-risk communities, with focussed messaging on the modifiable risk factors.

c) Develop support offer for those diagnosed with Mild Cognitive Impairment.

16. Diagnosing well:

a) Redesign the diagnosis pathway to ensure the service is fit for the future, maintaining Dementia Diagnosis Rate ≥66.7% and reducing waiting times to 12 weeks from referral to assessment.

b) Share and embed the DiADeM tool across primary care to support diagnosis within care home settings.

c) Conduct a dementia health equity audit and Joint Strategic Needs Assessment.

d) Embed dementia services within the Integrated Neighbourhood Health Model.

17. Supporting well:

a) Promote post-diagnosis referral and self-referral routes.

b) Increase the proportion of staff with Level 1 dementia awareness training across the health and social care workforce.

c) Increase the uptake and quality of medication reviews and care plan reviews.

18. Living well:

a) Increase the number of Dementia Friendly Activities in the community.

b) Increase the support available for unpaid carers working with Local Authority partners.

c) Explore opportunities to increase and embed Admiral Nurses into dementia pathways.

d) Ensure equity of dementia support to those living in a care home.

19. Dying well:

a) Reduce the number of avoidable admissions for people with dementia and reduce average length of stay.

b) Increase the uptake and sharing of advance care plans (i.e. ReSPECT forms).

c) Increase the number of people with dementia dying in their preferred place of care.

20. The System Analytics and Intelligence Unit Portal provides various dashboards and reports to monitor key dementia metrics.

Conclusion

21. With an established Steering Group, population health data and a strategic framework for improvement, Nottingham and Nottinghamshire are well positioned to transform dementia pathways to meet existing need. However, meeting the needs of a significantly increasing prevalence over the next two decades will require a step change in how we commission and deliver dementia care. Moving forward the system should prioritise:

    a) Tackling avoidable hospital admissions through prioritisation of evidence-based interventions to targeted cohorts ensuring those living with dementia, live well in their place of residence.

    b) Proportionate investment to align to the increasing prevalence, which poses significant risk to the sustainability of the health and social care system and to the quality of life of those living with dementia.

    c) Modernisation of the dementia pathway, harnessing the shift from analogue to digital across the pathway from pre-diagnosis to end of life including potential implementation of blood biomarkers in diagnosis, disease modifying treatments and virtual assessments.

    d) Scoping opportunities for dementia services to be embedded in the integrated neighbourhood health model, embedding preventative approaches and integrating within pathways such as end of life and frailty, delivering on the shift from hospital to community.

    e) Focussing on delivery of equitable outcomes across the dementia pathway, by tackling unwarranted variation, including working with communities where dementia is seen as a natural part of ageing and those residing in a care homes.

    f) Development of a Dementia Joint Strategic Needs Assessment, building upon the dementia deep dive. A proposal is planned into the Nottingham City workplan for publication in quarter three of 2025/26. Nottinghamshire County is yet to finalise its Dementia Joint Strategic Needs Assessment prioritisation process.

    g) Agreeing governance and oversight arrangements with the Mental Health Partnership Board to monitor delivery of system recommendations progressed by the Dementia Steering Group. A proposal will be shared with the Partnership Board in quarter three of 2025/26, which will include the development of system wide Dementia Strategy in quarter four of 2025/26.

Appendix A – Clinical Senate Deep Dive Data

Figure 1: Modifiable Dementia risk factors and the potential reduction in cases if the risk factor is eliminated.

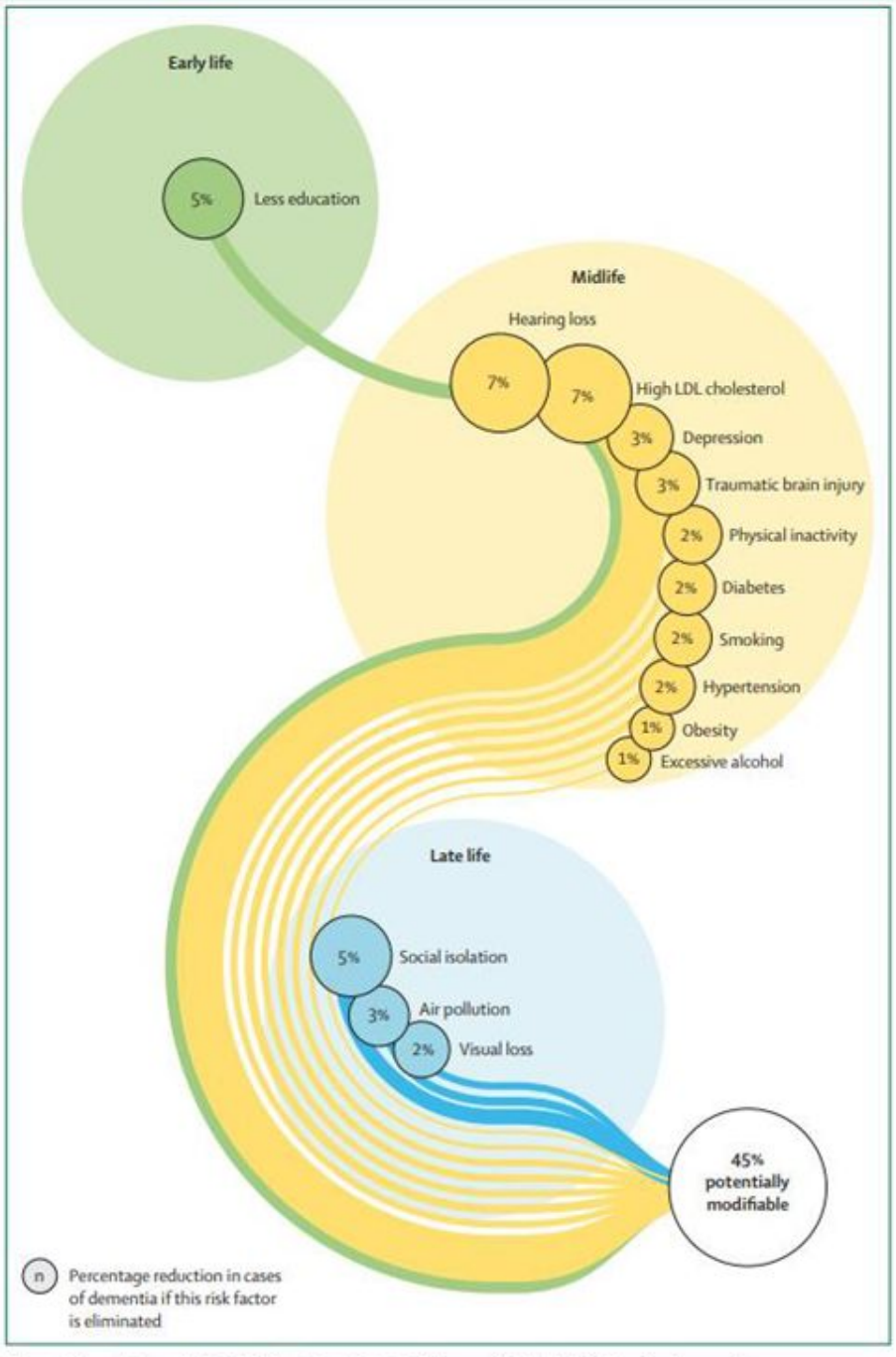


Figure 9: **Population attributable fraction of potentially modifiable risk factors for dementia**

From *The Lancet*, Dementia prevention, intervention, and care: 2024 report of the Lancet Standing Commission

Figure 2: Number of Dementia patients by Place Based Partnership and Primary Care Network neighbourhood

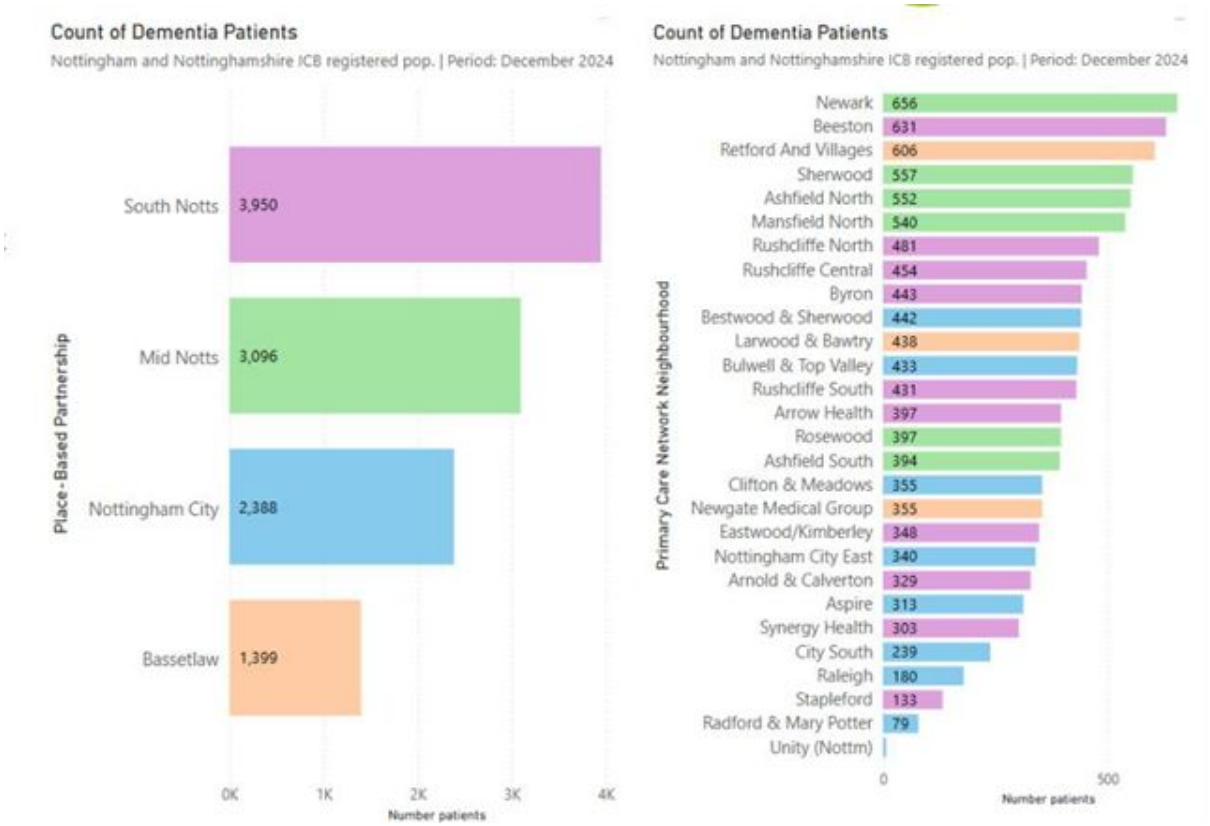
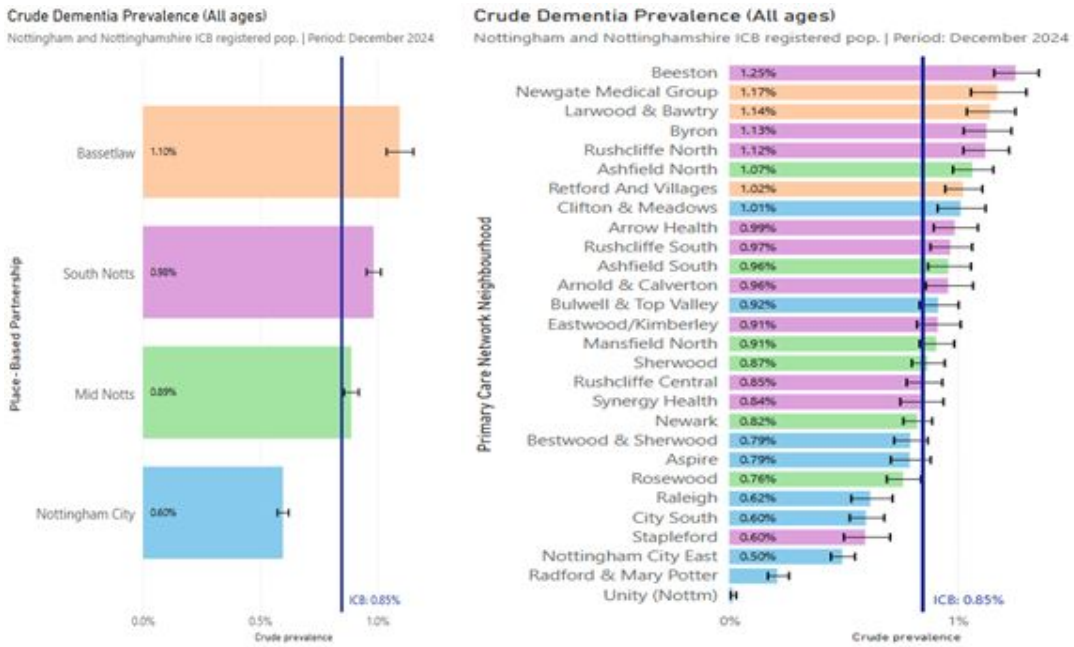
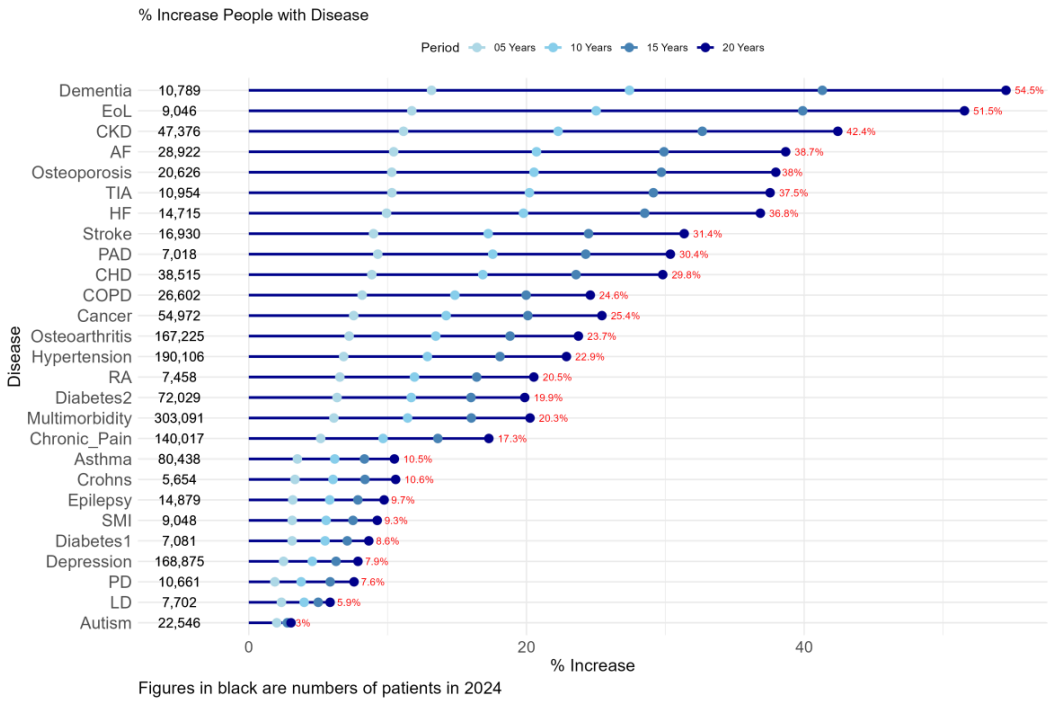


Figure 3: Crude Dementia prevalence (all ages) by Place Based Partnership and Primary Care Network neighbourhood



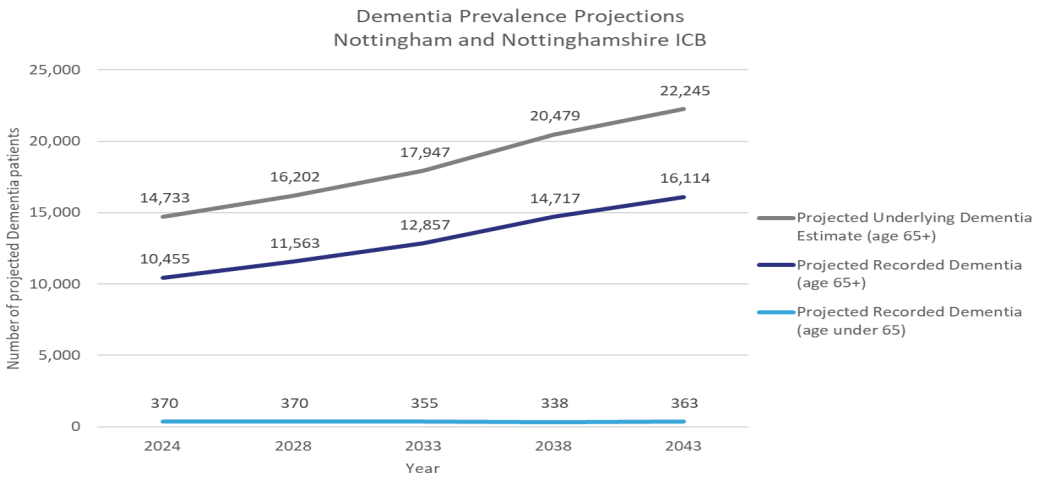
As percentage of the overall population, Bassetlaw and South Nottinghamshire have the highest Dementia prevalence. It should be noted that as a crude prevalence, these figures do not adjust for age, and the prevalence in some Primary Care Networks is likely to affected by the presence of care homes.

Figure 4: Projected percentage increase in the number of patients with various long-term conditions in Nottingham and Nottinghamshire ICB patients.



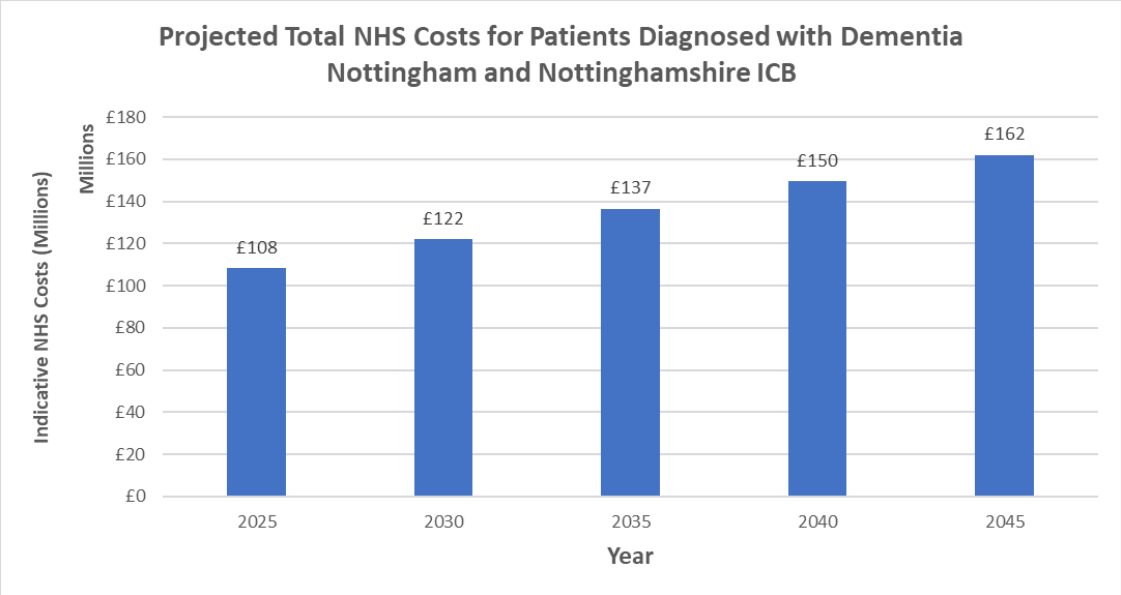
Dementia is predicted to be the fastest growing condition over the next 20 years. Based on Office for National Statistics population projections Dementia Deep Dive.

Figure 5: Projections of the number of people with Dementia, estimated, diagnosed, and aged under 65.



The chart uses Office for National Statistics population projections to estimate the increase in the number of patients in each category up to 2043. Dementia Deep Dive.

Figure 6: Projected total NHS costs for patients diagnosed with Dementia.



Indicative commissioning costs covering most of GP, Medications, Hospital, Community, Mental Health, Ambulance and Continuing Healthcare services.

Figure 7: Projected total NHS and Social Care costs for patients diagnosed with Dementia.

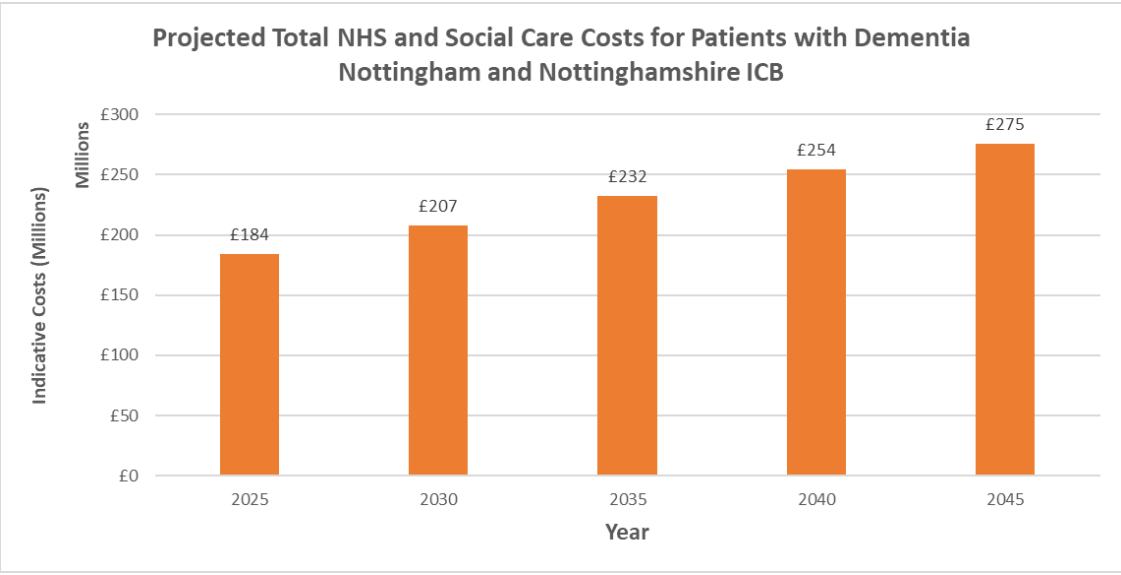
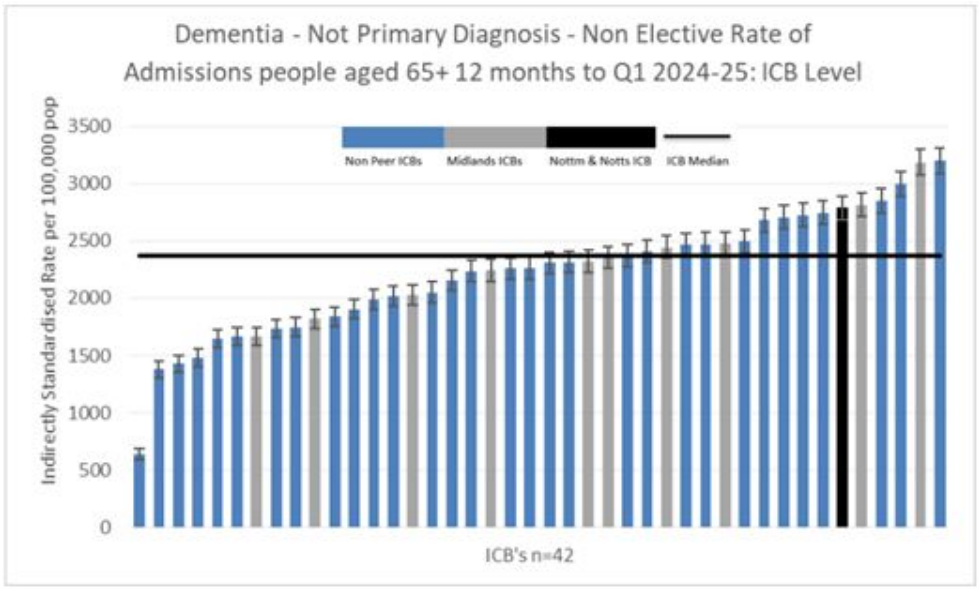
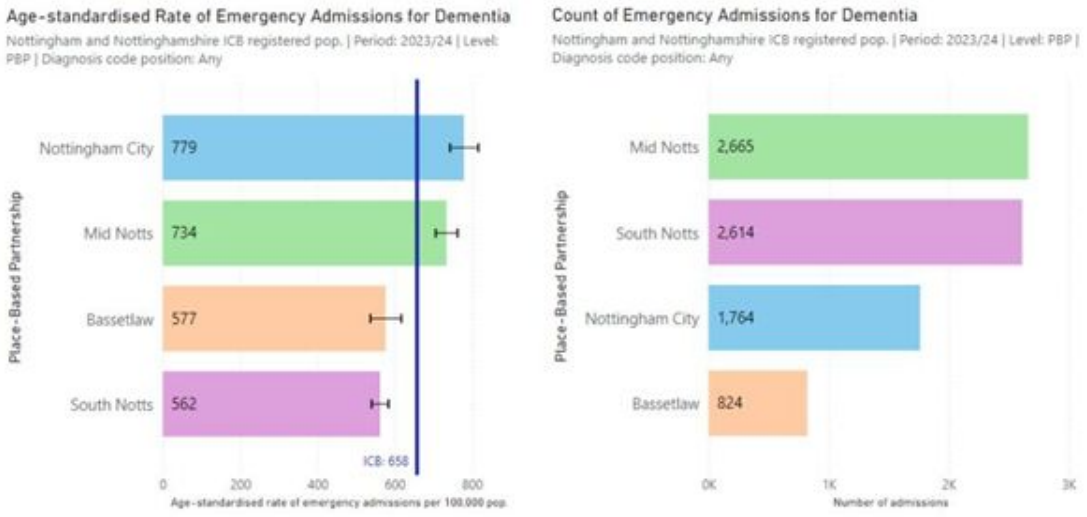


Figure 8: Indirectly-standardised rate of non-elective admissions with Dementia not in the primary diagnosis position by Integrated Care Board, Q1 2024/25



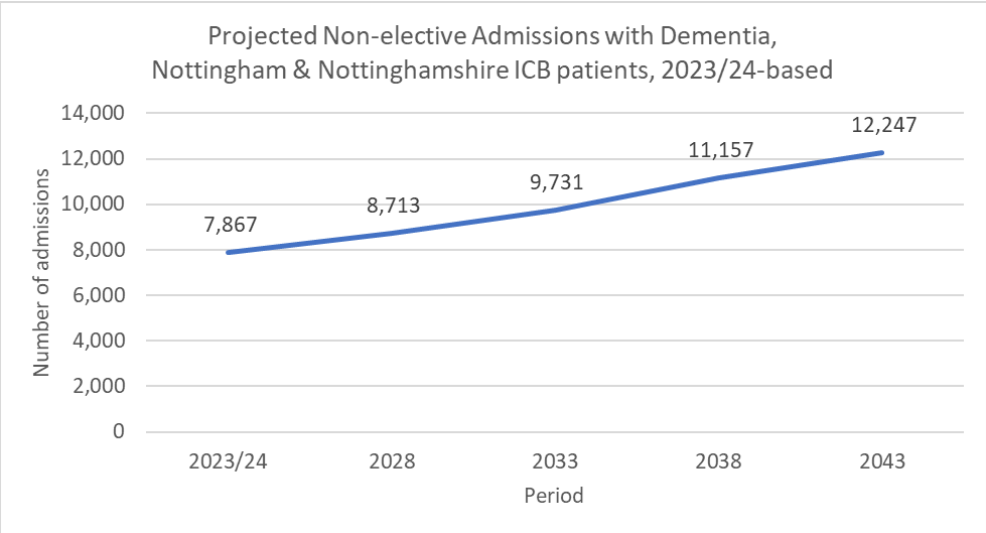
Nottingham and Nottinghamshire's rate of 2,788 per 100,000 population is statistically significantly higher than the England ICB median at 2,367 per 100,000 population. The ICB has the 6th highest rate out of 42 ICBs in England. Dementia Deep Dive.

Figure 9: Age-standardised rates and counts of non-elective admissions with Dementia in any diagnosis position by Place-based Partnership.



Mid and South Nottinghamshire have higher absolute numbers of admissions with Dementia owing to their size and demographic structure. Nottingham City and Mid Nottinghamshire have higher age-standardised rates. Dementia Deep Dive.

Figure 10: Projected numbers of non-elective admissions with Dementia from 2023/24 to 2043.



This chart uses Office for National Statistics population projections, which predict substantial growth in the population aged over 65 in the next two decades, as the basis for the increase in admissions.

Figure 11: Table showing the current and projected number of care home beds required for Dementia patients for the ICB overall and by place-based partnership.

PBP	Number of Older People's Care Home Beds (Nursing and Residential)	Total Number of Dementia Patients age 65+	Number of Dementia Patients Age 65+ in Care Homes	Estimated Proportion of Care Homes Beds Occupied by Dementia Patients	Projected number of total Dementia patients in 2028	Projected number of total Dementia patients in 2033	Projected increase in the number of care home beds required	Projected increase in the number of care home beds required
ICB	8,257	10,350	3,940	48%	11,449	12,732	525	1,136
South Notts	3,278	3,805	1,515	46%	4,225	4,668	194	399
Mid Notts	2,235	2,955	1,100	49%	3,287	3,695	163	364
Nottingham City	1,692	2,225	795	47%	2,393	2,623	79	187
Bassetlaw	1,052	1,365	530	50%	1,544	1,745	90	192

Dementia Deep Dive.

Appendix B – Dementia Services

Figure 12: Table showing NHS commissioned Dementia services outside of acute hospital provision.

Service	Service Summary	Provider	Commissioner
Dementia Wellbeing Service	Provides 1:1 and group support to help those living with Dementia and their carers live well. The service comprises of Carer Training, Cognitive Stimulation Therapy and personalised care and support planning, including advance care planning.	Alzheimer's Society	NHS Nottingham & Nottinghamshire ICB Nottingham City Council Nottinghamshire County Council
Carer's Hub Service	Provides a support service for unpaid carers, offering access to carer support groups, support with carer assessments and respite alongside connecting carers to other specialist services.	Carer's Federation	NHS Nottingham & Nottinghamshire ICB Nottingham City Council Nottinghamshire County Council
Memory Assessment Service	Provides memory assessment, diagnosis, care planning and treatment for people experiencing memory problems and Dementia over 65.	NHS Nottinghamshire Healthcare Community Foundation Trust	NHS Nottingham & Nottinghamshire ICB
Young Onset Dementia Service	Provides memory assessment, diagnosis, care planning and treatment for people experiencing memory problems and Dementia under 65.	NHS Nottinghamshire Healthcare Community Foundation Trust	NHS Nottingham & Nottinghamshire ICB
Therapeutic Intervention Service	Provides group interventions for individuals with a recent diagnosis of Dementia of all ages and their carers / family members.	NHS Nottinghamshire Healthcare Community Foundation Trust	NHS Nottingham & Nottinghamshire ICB
Dementia Outreach Service / Dementia Outreach Team	Provides specialist support to care homes aiming to improve the quality of Dementia care and reduce avoidable hospital admissions by providing assessment, treatment, support with care planning, medication reviews and training and support to care home staff.	NHS Nottinghamshire Healthcare Community Foundation Trust (County) CityCare (City)	NHS Nottingham & Nottinghamshire ICB
Intensive Home Treatment Team	Provides specialist support for those living with Dementia at home who are at risk of a hospital admission. The service provides 8 weeks of intensive support to the person living with Dementia and their carer to help them live well at home.	NHS Nottinghamshire Healthcare Community Foundation Trust	NHS Nottingham & Nottinghamshire ICB
Community Mental Health Team (Older People)	Provides specialist support for those living with Dementia and / or those over 65 and living Severe Mental Illness. The service provides specialist interventions including care management, emotional support and a range of therapies to help recovery.	NHS Nottinghamshire Healthcare Community Foundation Trust	NHS Nottingham & Nottinghamshire ICB
Rapid Response Liaison Psychiatry (Older People)	Provides specialist Dementia and / or mental health support for people in emergency departments or admitted to hospital, liaising with hospital teams to improve care for this cohort of people.	NHS Nottinghamshire Healthcare Community Foundation Trust	NHS Nottingham & Nottinghamshire ICB

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/07/2025
Paper Title:	**ICB Service Delivery Performance Report**
Paper Reference:	ICB 25 040
Report Author:	Sarah Bray, Associate Director of Performance and Assurance Rob Taylor, Deputy Director of Performance and Assurance
Executive Lead:	Maria Principe, Executive Director of Delivery and Operations
Presenter:	Maria Principe, Executive 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 2025/26. 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 continues to encounter significant challenges, particularly in meeting the 4- and 12-hour performance targets; although some progress has been observed and the system expects to deliver to the June planned target for 4-hour wating times. Whilst ambulance handover times and hospital patient flow have improved, the system remains under strain due to rising emergency department attendances and ongoing staffing shortages, which drives significant volatility in handover performance. Length of stay has increased at both acute hospitals.

Long waiting times for elective procedures and some diagnostics tests persist. Efforts are ongoing to reduce waiting times, with improvement trajectories by specialty and test modality being monitored weekly. The system is focusing on eradicating 65-week waiting times by the end of July, with the Chief Executive of Nottingham University Hospitals NHS Trust (NUH) leading efforts to improve the position through collaboration and increased utilisation of the independent sector. There has been improved delivery against cancer standards, but late tertiary referral demand continues to be challenging.

The Mental Health programme is performing well across most national standards, including Individual Placement Support and NHS Talking Therapies. Performance related to Dementia diagnosis has shown a gradual decrease since January 2025. Ongoing monitoring will continue, and the matter will be discussed at the Performance Oversight Group if the trend persists. The use of independent sector beds continues to be high, reflective of the demand for mental health inpatient services.

Primary care dental provision delivered activity above the level seen in the previous year. In April 2025, 83% of GP appointments were offered within two weeks, below the NHS England expectation of 85%. A focus on practices with low levels of performance is ongoing, including practice visits supported by the Nottinghamshire Health Informatics Service.

Summary:
There has been an increase in patients waiting over 52 weeks for community services in April, with significant growth seen at CityCare Community Interest Company and NUH. However, additional focus on data quality is required to ensure that reported waits are accurate and valid. Regarding Learning Disability and Autism services, there are ongoing challenges with long-stay patients and delayed transfers of care. There are long waits for Attention Deficit Hyperactivity Disorder and Autism assessment and diagnosis within children and adult services.

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 System Oversight Group.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No

Key Performance Metric Summary

The table below provides a summary of the key performance indicators for urgent care, planned care, mental health, primary care and community services. The table includes the latest monthly position against the plan as well as the plan for March 2026. The plan for March 2026 is included to enable current performance to be viewed alongside the year end ambition. ICB Ranking is provided to enable a view of comparable performance across the 42 ICBs (1/42 = top performing). Ambulance ranking is based on the five systems that utilise EMAS services.

Programme Area	Key Metric	Metric Basis	Latest data Period	Plan	Actual	Variance	Plan Mar-26	SPC Variation	ICB Ranking	IPR Page No.
Urgent Care	A&E 4hr % Performance (All Types)	Provider	Jun-25	66%	69.7%	3.7%	75%	Common Cause	30/42	52
Urgent Care	12hr waits as % of overall attendances	Provider	May-25	8%	5%	-3%	7%	Common Cause		52
Urgent Care	Ambulance Cat 2 Pre-Handover Times	Population	May-25	00:26:39	00:26:47	00:00:08	00:26:47	Common Cause		51
Urgent Care	Ambulance Cat 2 Mean Response Time	Population	May-25	00:27:38	00:30:13	00:02:35	00:27:29	Common Cause	2/5	51
Urgent Care	7+ day LOS (as % of GA beds occupied)	Provider	May-25	47.0%	50.7%	3.7%	47.0%	Concerning - High		
Urgent Care	% patients discharged on Disch Ready Day	Population	Apr-25	80.6%	82.8%	2.2%	81.8%	Common Cause		53
Planned Care	Total Incomplete Waiting list	Provider	Apr-25	120866	118413	-2453	111754	Improving - Low	29/42	
Planned Care	RTT waits <18wks % overall WL	Provider	Apr-25	59.1%	59.4%	0.3%	63.6%	Improving - High	10/42	56
Planned Care	RTT waits to first appt <18wks % of WL	Provider	Apr-25	68.7%	66.9%	-1.8%	73.5%	Improving - High	6/42	56
Planned Care	52ww as % of overall waiting list	Provider	Apr-25	1.8%	2%	0.2%	1%	Improving - Low	7/42	56
Planned Care	No. Patients waiting over 65 weeks	Provider	Apr-25	0	89	89	0	Improving - Low	16/42	56
Planned Care	Diagnostic Waits <6 week %	Population	Apr-25	83.8%	79.7%	-4.1%	95%	Improving - High	21/42	60
Planned Care	No. Diagnostic Waits >13 week	Population	Apr-25	0	737	737	0	Improving - Low	9/42	60
Planned Care	Cancer 28 Day Faster Diagnosis %	Provider	Apr-25	76.4%	77.6%	1.1%	80.2%	Common Cause	25/42	59
Planned Care	Cancer patients seen within 62 days %	Provider	Apr-25	63.9%	66%	2.1%	75.1%	Common Cause	29/42	59
Mental Health	No. Inappropriate OAPs	Population	May-25	1	7	6	0	Improving - Low	33/42	63
Mental Health	Inpatient Mean LOS adult acute beds	Population	Apr-25	60	52	-8	53	Common Cause	12/42	
Mental Health	Comm MH Adult waits >104wks 1st contact	Population	Apr-25	0	65	65	0	Concerning - High		
Mental Health	Comm MH CYP waits >104wks 2nd contact	Population	Apr-25	0	1640	1640	0	Common Cause		
Mental Health	NHS TT Reliable Improvement %	Population	Apr-25	68%	71%	3%	68%	Common Cause	16/42	62
Mental Health	NHS TT Reliable Recovery rate (%)	Population	Apr-25	50%	49%	-1%	50%	Common Cause	18/42	62
LD&A	Inpatients - adults with a LD	Population	Apr-25	21	19	-2	18	Common Cause		
LD&A	Inpatients - Autistic Adults	Population	Apr-25	17	16	-1	14	Improving - Low		
LD&A	Inpatients - CYP with LD and/or autism	Population	Apr-25	3	1	-2	0	Common Cause		
LD&A	Learning Disability Annual Health Checks	Population	May-25	850	500	-350	2196	Concerning - Low		
Community	Therapeutic Comm Waits >52wks-Adult	Population	Apr-25	0	15	15	0	Improving - Low		69
Community	Therapeutic Comm Waits >52wks-CYP	Population	Apr-25	10	45	35	13	Concerning - High		69
Community	Urgent Care Response %	Population	Apr-25	70%	97.2%	27.2%	70%	Common Cause		49
Community	Virtual Wards %	Population	Apr-25	80.2%	67.7%	-12.5%	80.2%	Common Cause	13/42	53

Programme Area	Key Metric	Metric Basis	Latest data Period	Plan	Actual	Variance	Plan Mar-26	SPC Variation	ICB Ranking	IPR Page No.
Primary Care	No. GP Appointments	Population	Apr-25	637653	618206	-19447	660148	Common Cause		68
Primary Care	No. Advice & Guidance Requests	Population	Apr-25	4122	4219	97	5433	Common Cause		
Primary Care	NHS App Registrations	Population	Apr-25	75%	59%	-16%	75%	Improving - High		68
Primary Care	Dental UDAs Delivered	Population	2024/25	1847123	1513215	-333908	156535	Common Cause		
Primary Care	Dental Urgent Delivered	Population	Apr-25	5311	4843	-468	7621	-		
Primary Care	Pharmacy First Consultations	Population	May-25	10169	8848	-1321	10169	Improving - High		

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. Sherwood Forest Hospitals NHS Foundation Trust (SFH) is demonstrating strong four-hour wait performance and Newark Urgent Treatment Centre continues to perform well, exceeding trajectory at around 95%. However, attendances remain high with analytical work taking place with input from primary care colleagues to understand the drivers of demand.
2. Due to improved four-hour wait performance, NHS England will meet with Nottingham University Hospitals NHS trust (NUH) on a monthly basis within Tier 2 oversight arrangements, rather than fortnightly and continue to review four-hour performance closely.
3. NUH implemented a single assessment process during May to improve handover times. Secondary assessment process improvements are being discussed to improve patient flow. Single day Emergency Care continues to have increased patient volume, with two new pathways opening in June. The 12-hour wait position in the Emergency Department is improving, despite infection, prevention and control issues, but remains challenging.
4. CityCare Community Interest Company has a recovery plan in place to improve patient throughput and reduce waiting times at London Road Urgent Treatment Centre. There have been improvements in recruitment, with additional Advanced Clinical Practitioners joining the organisation, which has led the vacancies position to fall from 7.19 whole time equivalent (WTE) to 4.48 WTE. There are also plans to increase the number of medical prescribers, with ten staff currently prescribing and additional staff in training. Same day return slots for walk-in centre and Urgent Treatment Centre patients began during May, which assist in balancing demand with capacity.
5. The 45-minute ambulance handover policy introduced at NUH in December 2024, continues to deliver measurable operational improvements. Notably, this has enhanced Category 2 ambulance response performance across Nottinghamshire and significantly reduced lost hours at the Queens Medical Centre. However, In May, the percentage of ambulance handovers exceeding 60 minutes increased slightly from the April position. An increase in lost hours was also seen at Queens Medical Centre. For 2025/26, penalties will be introduced for sites failing to achieve planned performance for lost hours. A 3% tolerance will be applied above and below with no reconciliation applied for hospitals within this tolerance. This highlights that despite previous improvements in lost hours, further work is required.
6. Discharge levels at NUH remain high with an average of over 351 discharges per day (all pathways) in May, with SFH averaging over 135 discharges per day

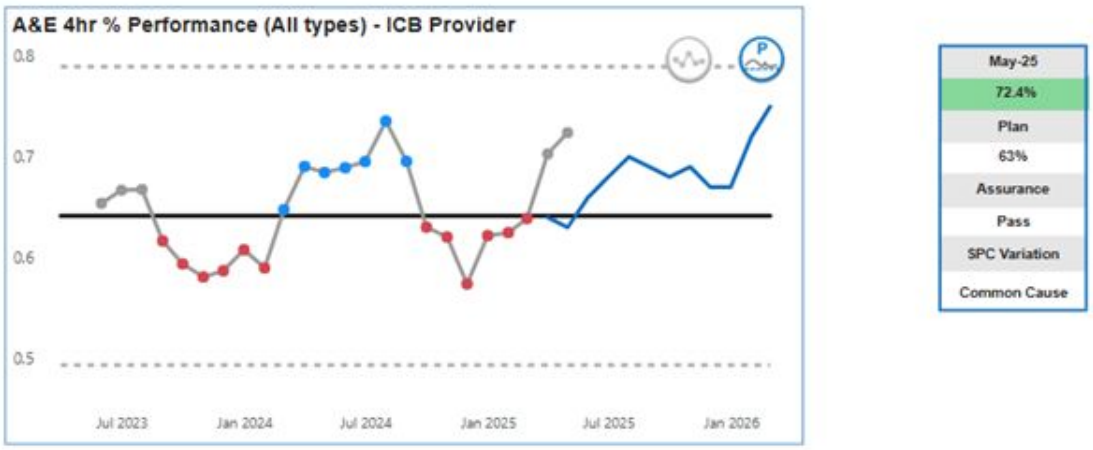
for the same period. There has been an increase in the percentage of patients whose date of discharge is the same as their discharge ready date, achieving 82.8% for April against plan of 80.6%. NUH achieved 83.1% against plan of 80.9%, with SFH at 82.1% against plan of 80%.

7. At SFH, discharge performance was impacted by delays with medications to take out and transport. Delays in Pathway One care packages represent a considerable concern, with 15 to 20 Pathway One cases typically pending each day and experiencing wait times of up to three days. Efforts are being made to address these delays, including discussions with social care.

8. Four and 12-hour Emergency Department performance continues to be a challenge, particularly at NUH. However, improvements have been seen recently with the system achieving plan for April and May 2025.

9. In May, the system achieved 72.4% performance for four-hour waits against a plan of 63.0%. NUH achieved 67.9% against a plan of 65.6%, with SFH delivering 79% against a plan of 70.2%. As an ICB, Nottingham and Nottinghamshire were 30th of 42 nationally for four-hour performance.

10. 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 April and May 2025 has been above the historical mean level of 64%. The position for May was 72.4% against a plan of 63.0%.



11. Actions being taken by NUH and next steps:

    a) Extended opening hours for Same Day Emergency Care.

    b) Eye casualty focussing on redesigning the triage process and development of a Same Day Emergency Care area and standardisation of practice.

    c) Bookable appointments went live in June for NEMS.

d) NEMS is preparing to take injury patients from July to support Urgent Treatment Centre designation.

e) Band 5 prescribing support and dedicated theatre nurse are being provided to mitigate staffing gaps in the injuries area.

f) Paediatric development of single assessment for the Emergency Department.

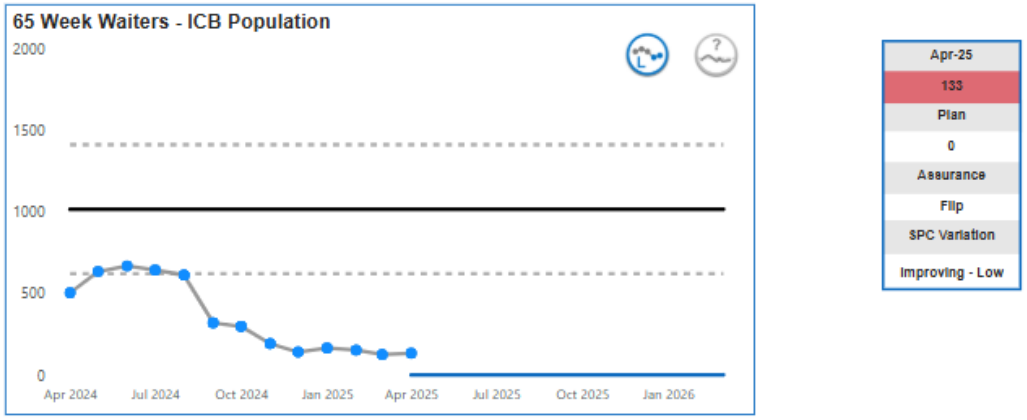
g) Secondary assessment process improvements are being discussed to speed up patient flow.

Planned care

12. Provisional data for the end of May shows that nine patients registered with Nottingham and Nottinghamshire ICB were waiting more than 78 weeks for treatment. Four of these patients were waiting at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust; two were waiting at University Hospitals of Derby and Burton; two patients at The Park; and one patient at NUH (Urology). No patients were waiting over 78 weeks at SFH at the end of May.

13. The 65 weeks wait position for the ICB Population at the end of May was 151, this is based on unvalidated provision data. 92 of these patients were waiting within the Nottinghamshire system at either NUH, SFH, The Park or Woodthorpe. Of the remaining 59 patients, 54 were waiting for treatment at Doncaster and Bassetlaw Hospitals (48), Sheffield Teaching Hospitals (three), University Hospitals of Derby and Burton (three). The other five patients were at various hospitals across the country.

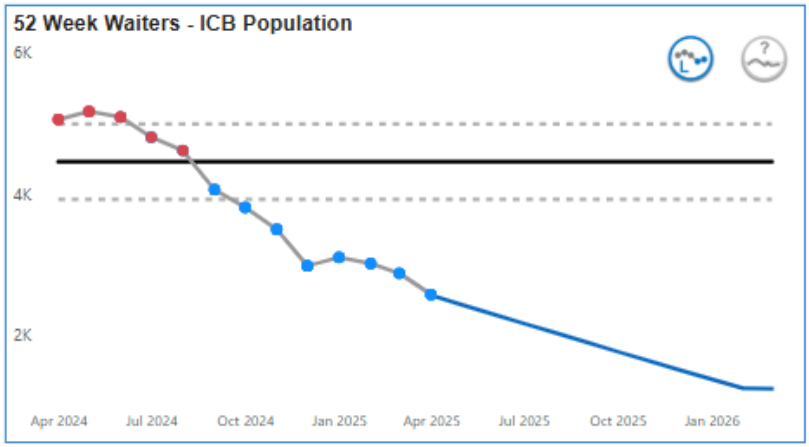
14. The chart below displays the volume of registered patients of the constituent GP practices of the ICB waiting 65 weeks or more for treatment at any provider nationally between April 2022 to April 2025. The chart illustrates the reduction from 504 patients in April 2024 to 133 patients in April 2025. It is based on validated data, which has been published by NHS England.



15. Provisional data shows that there were 84 patients at NUH and 36 patients at SFH waiting over 65 weeks at the end of May.

16. At the end of May 2025 unvalidated data shows that there were 2,642 Nottingham and Nottinghamshire ICB registered patients waiting more than 52 weeks at various providers around the country, which failed to achieve the plan of 2,432 patients waiting. The providers with the most patients waiting were NUH (1,643), Doncaster and Bassetlaw Hospitals (379) and at SFH (349). The providers with the next largest number of patients waiting over 52 weeks, were PICS (79), University Hospitals of Derby and Burton (49) and Sheffield Teaching Hospitals (34).

17. The chart below shows the reduction in the number of Nottingham and Nottinghamshire ICB patients waiting over 52 weeks from 4,456 in April 2024 to 2,573 in April 2025.



18. At the end of May 2025, the number of patients waiting over 52 weeks at NUH was 2,012 against a plan of 1,500. For the same period 433 patients were waiting over 52 weeks at SFH, this achieved the plan of 442 patients.

19. In May, the percentage of patients waiting below 18 weeks route to treatment standard is expected to achieve plan at around 61.0% against a plan of 59.5% based on indicative weekly data.

20. The system is continuing to focus on eradicating 65-week waits. As such NUH's Chief Executive is leading system work to explore whether the position can be improved further through a more collaborative approach, as well as increased utilisation of the independent sector and out of area NHS providers. The latest position for the end of June was a reduction to 39 patients waiting over 65 weeks at NUH and SFH, which is a material reduction from 89 patients at the end of April. System level reviews are scheduled on a weekly basis to identify further improvements and a route to eliminate waits above 65 weeks.

21. The system's Planned Care Board is co-ordinating a formal review of Ear, Nose and Throat services and will provide recommendations for the service across

the system. The Board is also developing a forward plan for reviewing specific specialties based on system sustainability and performance improvement recommendations, which will be presented to the system Performance Oversight Group in July.

Cancer

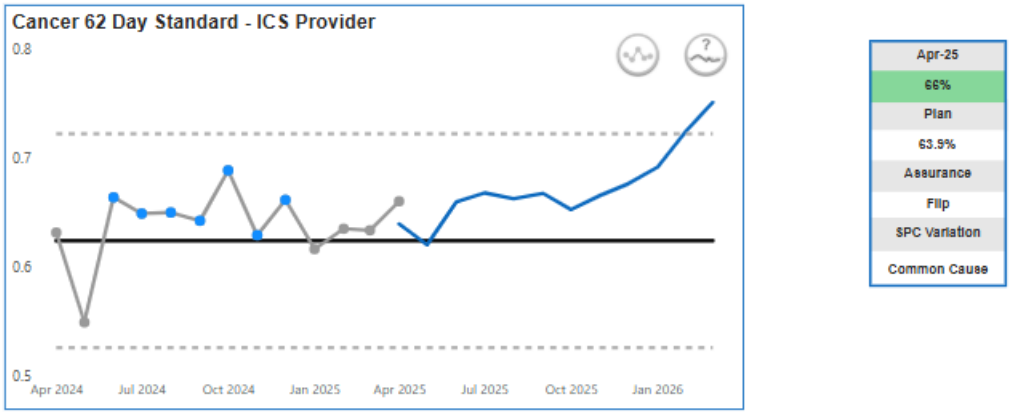
22. NUH delivered the Faster Diagnosis Standard 31-day and 62-day standards for April 2025. SFH delivered Faster Diagnosis Standard and 62-day plans but were below plan for the 31-day standard.

23. SFH is delivering improvements in Histopathology delays and is now focusing on head and neck cancers, aiming to expedite patient transfers to NUH earlier in the pathway. The Cancer Board will review joint head and neck options, whilst considering the complexity of tertiary service users at NUH.

24. Backlogs at NUH have increased to 547 against a plan of 370. SFH has 92 patients on the cancer backlog against a plan of 76 patients. An increase in the volume of late tertiary referrals received has been seen at NUH in the lung tumour site, which can be received post 62 days in the pathway. A weekly Patient Tracking List meeting has been established to identify and address any avoidable delays. A chief operating officer level conversation will take place to address the issues between providers around late tertiary referrals.

25. NUH has developed tumour site improvement plans, which will be routinely tracked and discussed as part of the weekly Performance Oversight Group meetings.

26. 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 2024 to March 2025. The latest position is 66% against a plan of 73.9%. Despite performance being above the planned level, delivery remains a complex and significant challenge for the system. Cancer Patient Tracking List growth is an area of concern for both trusts, as they are reporting increased conversion rates for breast cancers.



27. Analysis has been undertaken within the ICB to examine the growth in cancer demand and treatments over the last three financial years and compare this to the level of growth in treatment plans for 2025/26. This work highlighted that providers have built in growth into the treatment volume plans for 2025/26, however providing capacity above that level to respond to in year fluctuations in demand will continue to be a challenge.
28. A deep dive into Urology cancers is being undertaken, which includes focus on demand, capacity, diagnostics, treatments and performance improvements.
29. The Cancer Board will determine priority areas for collaboration between NUH and SFH and report proposals to the weekly Performance Oversight Group in future.

Diagnostics

30. Weekly data indicates that the system did not deliver against the six-week wait performance target, being 79.5% against a plan of 85.7%; however, improvements are forecast for June.
31. SFH has taken action to raise the level of capacity for Echocardiography, which has begun to deliver increased performance for the modality, as well as improve the aggregate position for the Trust. However, the latest performance remains below their ambitious plan, with 88.4% of patients seen within six weeks against a plan of 92.4% for the nine key modalities within the Operational Plan. The Trust has three modalities above plan, which are MRI, Non-Obstetric Ultrasound and Audiology.
32. NUH performance for the nine modalities within the Operational Plan remains below the planned level, with 74.3% of patients seen within six weeks against a plan of 82.7%. NUH have DEXA (bone density scan) above plan.
33. Diagnostic performance has not yet fully returned to previous levels following the dip in performance due to capacity withdrawal in April. However, gradual improvements are being seen.
34. Both providers are unable to fully eliminate waits of over 13 weeks. The latest position is that NUH have 501 patients and SFH have 55 patients over 13 weeks. However, whilst the SFH position remains relatively stable, the NUH position has increased over recent weeks. Further work is required to eliminate the longest waits for diagnostic tests, and there are particular difficulties with paediatric MRI requiring general anaesthetic. There is a joint review of MRI Paediatric between NUH and SFH, including the use of best practice from elsewhere, the capacity needed to tackle the 13 week waits and the development of a system view of 13 week wait clearance.
35. Referrals for Audiology at Doncaster and Bassetlaw Teaching Hospitals have significantly reduced. Activity levels are stable and below historic levels, with

minimal outsourcing/mutual aid for adults. There is a small improvement in waiting times seen, with recovery forecast to take place gradually during 2025/26.

36. NUH is developing a diagnostic action plan to improve performance, which will be presented to the Performance Oversight Group in July.

37. Work is taking place to investigate the high proportion of Lincolnshire ICB sleep studies activity flowing to SFH.

Mental health

38. As a programme, mental health performs well, with improvements being made across many service areas.

39. The Out of Area patient reported position remains at a low level. Local data for June reported four out of area patients. For any patients admitted to an out of area bed (inappropriate or appropriate) there is an out of area case manager who works to repatriate the patients. Nationally there are limited beds available. Repatriation options continue to be reviewed. Discussions have taken place with NHT colleagues to examine the definition of an out of area placement used by the trust to ensure that it aligns to the NHS England guidance for continuity of care and common practice of other similar NHS organisations; this is of concern given the continued high use of local Independent Sector provision.

40. The Mental Health programme is performing very well across most national standards, including Individual Placement Support and Physical Health checks for people with Severe Mental Illness, which is very positive.

41. NHS Talking Therapies continues to deliver against the local improvement trajectory for first to second wait in April, local data for May is forecasting that the service is maintaining performance below the 10% plan.

42. Independent sector beds utilisation continues to increase with demand remaining high. The local data available for June 2025 is showing 80 beds in use. NHT is reviewing the level of risk around decisions to admit patients to ensure it is appropriate and consistent. A trajectory of recovery is being developed at NHT and will be shared at the Performance Oversight Group once it has received internal approval.

43. Performance against Dementia diagnosis has shown a gradual decline since January 2025. It will be monitored and discussed at the Performance Oversight Group if performance continues to deteriorate.

Primary Care

44. Dental performance for 2024/25 had improved on 2023/24 for both adults and children's provision. The number of units of dental activity delivered in 2024/25 was 1,513,215 compared to 1,492,988 in 2023/24.

45. The volume of Total GP Appointments in April 2025 was 3.1% below the planned level, with 618,206 appointments against a plan of 637,653. 83% of appointments were offered within two weeks in April 2025, which is below the NHS England expectation of 85%.

46. An action plan is in place and actions being taken are making improvements in performance. Work taking place to understand if the mappings used by practices to record appointment data is accurate, with discussions taking place with several practices to improve accuracy and consistency of recording.

47. 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 is 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.

48. Nottinghamshire Health Informatics Service is providing support to practices that are willing to undertake the appointment book changes which could lead to improved categorisation of appointments.

Community care

49. There has been an increase in the volume of patients waiting over 52 weeks for community services, from 22 patients in March to 60 in April 2025. The growth has been seen at CityCare from zero to 15 breaches and at NUH from 16 to 31 breaches between March and April.

50. Of the 60 patients, 15 were adult and 45 were children and young people. The patients waiting at NUH (31) are waiting for the Community Paediatric Service, the CityCare patients (15) are waiting for Podiatry services, and the NHT patients (14) are awaiting Speech and Language Therapy.

51. Subsequent investigation by CityCare has shown that their submission contained errors, and all patients were found not to have breached the 52 week waiting period. The provider confirmed that their longest wait is less than 40 weeks at present. Similar investigations are taking place at NUH around their data submission.

52. Improvements have been made in the completeness of the Community Situation Report submission made by NHT, which now fully includes the Musculoskeletal position. NHT continues to focus on data quality with their staff to ensure that reports on waiting list breaches are accurate and valid. However,

further work is required by other providers to ensure that data is reliable and accurately reflects the positions of their services.

53. NHT's 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 ten 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-referral 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 to 12 by March 2026.

54. During 2024/25 Nottinghamshire Healthcare Trust received some non-recurrent investment to pilot transformational changes in their delivery models for meeting the speech, language and communication needs of children and young people. These initiatives included drop-in sessions with a view to earlier identification, signposting and advice and an advice line to support families and professionals whilst they are waiting for specialist services. The funding ends in July 2025 and commissioners are working alongside NHT to collate the learning from the pilots to understand the most impactful elements in relation to waiting times and children and young people's experience. This learning will inform the development of a delivery model that is sustainable, responsive and ensures young people are able to access the service most relevant for their needs first time.

Learning disability and autism

55. 500 Annual Health Checks were recorded as completed 2024/25, with 88% of Annual Health Checks recorded as having a Health Action Plan in place.

56. April data indicates that adult inpatients with learning disabilities are two below plan, those with autism are one below plan, and children and young people inpatient numbers are two below plan.

57. As a system there continues to be a high level of patients who have passed the recommended clinical timescale. Long stay patients, as well as delayed transfers of care/lack of progress continues to be a focus for the local system.

58. Lack of respite options are increasing pressure on carers.

59. There continues to be long waits for attention deficit hyperactivity disorder (ADHD) and Autism assessment and diagnosis within children and adult services. Delays in assessment and diagnosis mean that there are delays to children and adults accessing the support they need.

60. There are some data quality issues and limitations, which impact on the accuracy of information being verified. Next steps are listed as:

    a) Commissioners and providers are working together to review processes and the service model to increase capacity and streamline the referral and assessment process. There is continued work with primary care to ensure that referrals are appropriate.

    b) Childrens services are providing early pre-diagnostic support, whilst individuals are waiting a confirmed diagnosis.

    c) A full review of the children and young people's neurodevelopmental pathway is scheduled to take place during Quarter Two 2025/26 with children and young people and families with lived experience and system partners to develop and implement an improved and sustainable model by April 2026.

    d) Discussions with NHT about the contracted beds on Orion Unit and what the admission criteria and process should be.

    e) Finance and process for contracting include a Senior Intervenor; however, this has not progressed until a pending agreement regarding priority patients is finalised.

    f) The Learning Disability and Autism Board retains oversight of performance, quality and safety across the pathway.

NHS Oversight Framework

61. For 2025/26, the NHS Performance and Assurance Framework will replace the NHS Oversight Framework, where the ICB and providers will receive separate assessments. As this process is finalised and concluded, further information and reporting on the position for the ICB will be included in future reports. This is expected to be published by NHS England during quarter two of 2025/26.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/07/2025
Paper Title:	**Quality Report**
Paper Reference:	ICB 25 041
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 Committee is asked to **receive** this report for assurance.

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	Provides an overview of quality and performance within the system which supports the view of outcomes relating to population and healthcare.
Tackle inequalities in outcomes, experience and access	Quality oversight provided by the paper is central to understanding the impact on outcomes, experiences and access.
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 ICB's 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 three inspections of core services during April and May 2025: Lings Bar Hospital, Arnold Lodge and Wathwood, and HMP Lincoln. During this time, it has also published five reports for the following areas:
    a) Community health services for children and young people – following assessment of the quality statement for Safe and Caring in February 2025, were given a rating of “outstanding”.
    b) Acute wards for adults of working age and psychiatric intensive care units – following assessment of the quality statement for Safe and Well-Led in January 2025, were given a rating of “requires improvement”.
    c) Community End of Life Care services – following an unannounced assessment of the quality statements for Safe and Caring in March 2025, were given a rating of “Good”.
    d) High Secure Hospitals – following an unannounced assessment of the quality statements for Caring and Well Led in February 2025, were given a rating of “Requires Improvement”.
    e) Wards for older people with mental health problems – following assessment of the quality statements for Safe in March 2025, were given a rating of “Requires Improvement”.

Monthly exceptions

2. BBC media published a story on 23 May 2025 relating to stabbing attacks involving two separate patients under NHT care in 2023.

New risks

3. No new risks have been identified for this reporting month.

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

Reflections on previous month:

4. The Quality Team continues to maintain key relationships with planning for periodic visits to the urgent and emergency care pathway.

5. A new Single Door Assessment Area and Secondary Assessment processes were introduced to NUH's Emergency Department on 13 May 2025, as part of a commitment to ensuring that no patients receive care on a corridor. 'Corridor Care' more formally called patient care in 'Temporary Escalation Spaces' has been an issue for a number of months. The Single Door Assessment Area undertakes primary assessment for patients arriving via ambulance to ensure all patients arriving to Emergency Department despite mode of arrival, will receive the same primary assessment.
6. 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. Phased installation of new equipment has commenced and additional administrative support is in place.

Monthly exceptions

7. There are no new exceptions to report for this reporting month.

New risks

8. No new risks have been identified for this reporting month.

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

Reflections on previous month:

9. 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.
10. Work continues to address issues highlighted by sepsis audits. Weekly sepsis meetings will commence in the coming weeks, which the ICB Quality Team will engage with.
11. A stroke audit presented in the SFH Patient Safety Committee highlighted areas of non-compliance. An action plan is to be developed and presented to the Quality and People Committee in the next couple of months.

Monthly exceptions

12. A forward planner has been developed showing intended quality insight visits over the next two quarters. This has been shared with SFH to support joint working and allow the ICB's Quality Team to continue to support the Trust with a 15 step peer review.
13. End of life care planning and discharge planning for patients with a learning disability has been identified as an area of improvement from Learning from Lives and Deaths (LeDeR) reviews.

New risks

14. No new risks have been identified for this reporting month.

Nottingham CityCare (Community Interest Company) – Enhanced Oversight

Reflections on previous month:

15. To manage peaks of demand at its Urgent Treatment Centre, Nottingham CityCare has instigated an appointment-based model in addition to the walk-in model. They have described robust triage and safety netting processes; however, the ICB's Quality Team has requested that an Equality and Quality Impact Assessment (EQIA) is completed.
16. Discussions with Nottingham CityCare have taken place regarding the challenges to update and progress the Joint Plan for the Community Nursing Service. An updated version has now been shared and a meeting is planned to assess the level of progress.
17. The Children and Young People Commissioning and Quality Teams continue to support exploration of options to manage the high demand experienced by the Paediatric Bladder and Bowel Service.

Monthly exceptions

18. Nottingham CityCare presented to the System Quality Group progress made since the organisation was placed in Enhanced Quality Surveillance status for quality concerns.

New risks

19. No new risks have been identified for this reporting month.

Urgent and Emergency Care – Enhanced Oversight

Reflections on previous month:

20. Operational pressures within urgent and emergency care have remained persistent, with patients regularly receiving care in Temporary Escalation Spaces.
21. Following the implementation of 45-minute handovers 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.
22. The process remains in place to support NHS England's request for After Action Reviews for individuals experiencing prolonged delays in the urgent and emergency care pathway, including eight-hour ambulance delays and 48- and

72-hour Emergency Department journeys. Thematic reporting continues through the System and Regional Quality Group.

Monthly exceptions

23. There are no new exceptions to report for this reporting month.

New risks

24. No new risks have been identified for this reporting month.

Maternity – Enhanced Oversight

Reflections on previous month:

25. Confirmation has been received that both SFH and NUH have achieved full compliance with all ten safety actions outlined in Year Six of the NHS Resolution Maternity Incentive Scheme.
26. The CQC conducted unannounced visits to both NUH maternity units in May 2025. Feedback is currently awaited.
27. The independent maternity review stopped accepting new families on 31 May 2025. The ICB remains fully committed to driving continuous improvement in maternity services at NUH and will continue to engage closely with Trust and system partners, maintaining strong oversight and governance through current established mechanisms.
28. A system-wide working group has been established to update the ICB's Perinatal Equity Strategy, an update was presented at Perinatal Scrutiny and Oversight Board in June 2025.

Monthly exceptions

29. There are no new exceptions to report for this reporting month.

New risks

30. No new risks have been identified for this reporting month.

Special Educational Needs and Disabilities (SEND) – Enhanced Oversight

Reflections on previous month:

31. Challenges within the Nottingham City SEND Local Area Partnership continue regarding leadership, oversight, and accountability for SEND improvement activity. Assurance has been received from the Local Authority that there are plans in place to support the Local Area Partnership moving forward.
32. The Nottinghamshire SEND Local Area Partnership has received notification from Ofsted indicating that, now the SEND Local Area Monitoring Visit Framework is published, they should anticipate an immediate inspection to

assess progress on identified priority areas. The partnership has prepared accordingly and is ready to engage with the inspectorates upon notification.

33. Work has continued refreshing the ICS Quality Assurance Framework for Education, Health and Care Plans. The revised framework aims to embed a whole-system approach across all agencies, promoting an end-to-end delivery model.

34. The Children and Young People Strategic Commissioning Group has revisited and agreed to progress recommendations to improve support for children and young people with complex health needs in education settings.

Monthly exceptions

35. There are no new exceptions to report for this reporting month.

New risks

36. No new risks have been identified for this reporting month.

Looked After Children – Enhanced Oversight

Reflections on previous month:

37. ICB Commissioners and the Designated Nurse have updated the Initial Health Assessment service specification, which will now be standardised across the three providers. Initial Health Assessment benchmarking data is awaited to inform planned activity.

38. Quarter 4 2024/25 key performance indicator data demonstrates improved waiting times and compliance at NUH, and it is expected that waiting times and compliance will improve in NHT in quarter one of 2025/26.

Monthly exceptions

39. The National Advisor for Care Leavers has undertaken a visit to review care leavers services in Nottingham City in June.

New risks

40. Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust quarter four data indicates that statutory Initial Health Assessment compliance is reduced, with waiting times at three weeks. The Trust is working with ICB commissioners to review current clinic and administrative capacity to improve compliance.

Children and Young People – Enhanced Oversight

Reflections on previous month:

41. There continues to be some extremely complex young people in inappropriate settings and significantly challenging issues for children and young people from other areas and work is continuing around this area.

42. Doncaster and Bassetlaw Teaching Hospital's Paediatric Audiology Services confidential incident continues to be overseen by NHS England. Progress remains slow and clinical competence remains a significant concern.

Monthly exceptions

43. There are no new exceptions to report for this reporting month.

New risks

44. No new risks have been identified for this reporting month.

Infection Prevention Control – Enhanced Oversight

Reflections on previous month:

45. The Infection Prevention Control Team at NUH needed to request no further ward boarding to reduce further infection transmission whilst they managed an increased incidence of COVID-19 on an admission ward. Bays already had additional patients, adding to ward pressures.

46. Norovirus has also been contributory to the increased number of infection outbreaks at NUH over both sites. The lack of isolation facilities remains a factor, as is the ability to safely isolate cases. The continued use of mask wearing by staff has positively reduced the number of staff being affected.

47. An ICB insight visit to NHT Lings Bar Hospital identified improvement required on one ward area, related to personal protective equipment use and soiled equipment, leadership and poor communication. Areas of old estate remain outstanding areas of action previously raised through the Trust Wide Infection Prevention and Control Group; these are to be re-escalated. Positive assurance was gained from other areas viewed during the visit.

48. A draft system Infection Prevention Control Strategy has been shared with members of the Healthcare System Infection Prevention Control Assurance Group for contribution and comment. This will have shared ownership and aims to drive infection prevention control quality improvement work across all system partners.

Monthly exceptions

49. The new Healthcare-Associated Infection thresholds have been released for 2025/26. These apply from April 2025 and local plans are being developed to support delivery of the revised targets.

50. Two ward related C.difficile outbreaks were reported, one at NUH and one at SFH and quality improvement work and monitoring measures have been instigated in response.

New risks

51. No new risks have been identified for this reporting month.

Appendix 1. Escalation Framework

The ICS developed an Escalation Framework, to provide structure and consistency across all areas of oversight for escalation of concern through the governance routes of the system, and which then feed into the formal governance of the ICB. The framework has been created based upon work undertaken through the quality route building upon previous National Quality Board (NQB) guidance.

Monitoring level	Routine	Further Information Required	Enhanced	Escalated Risk
What does this mean?	No specific areas of concern identified	Potential for concern. Key milestones not achieved. More information required to determine level of risk	Delivery or quality concerns identified.	Serious specific risk to delivery or quality identified, including where there is a need to act rapidly to protect patients or staff.
What action should be taken?	Actions to be taken by relevant operational oversight group	Agree route to follow up to gain necessary information to assess risk and agree who will lead.	Agree actions and schedule for discussion at each Operational oversight Group until concerns resolved.	Trigger escalation single subject review /deep dive / risk summit.

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/07/2025
Paper Title:	**Finance Report**
Paper Reference:	ICB 25 042
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:

NHS system: The NHS system is reporting a £6.7 million deficit at month two, which is £5.1 million adverse to plan. Despite this, the system forecasts breakeven for the full year, supported by £70 million non-recurrent deficit funding.

The adverse variance is seen in Nottinghamshire Healthcare NHS Foundation Trust and is due to mental health bed costs, temporary staffing, and efficiency shortfalls, although these are partially offset by underspends elsewhere.

Efficiency delivery is £12.6 million behind plan, with £24.4 million delivered to date. The full-year target remains £279 million.

Gross financial risks total £155 million, with mitigations identified to fully offset these risks. Key concerns include non-pay inflation, continuing healthcare cost growth, and the NHS Agenda for Change pay award.

Capital allocation is reduced by £2.9 million due to deficit support; 7% of the capital envelope has been spent to date.

ICB: The ICB is on plan and breakeven for both year-to-date and full-year forecast. Delivery of the £76.3 million efficiency plan is critical to maintaining this position. Gross risks of £47.0 million have been identified, primarily linked to efficiency delivery and contract performance. These are fully mitigated through reserves and non-recurrent solutions.

Efficiency delivery is £2.2 million behind plan. 90% of the target has been identified, with £7.95 million still to be found. Governance has been strengthened via the Financial Recovery and Delivery Group (FRDG), chaired by the ICB's Chief Executive.

Recommendation(s):

The Board is asked to **receive** the report for assurance.

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

Appendices:
None.

Board Assurance Framework:
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Risk 3: Financial sustainability – Failure to achieve financial sustainability across the system.

Report Previously Received By:
The Finance and Performance Committee has previously considered the report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Finance Report

Nottingham and Nottinghamshire NHS System Position

Indicator Measure	Year to date Plan	Year to date Actuals	Year to date Variance	Plan/ Ceiling/ Envelope	Forecast outturn	Variance	RAG Year to date	RAG Forecast outturn
Financial Sustainability (break-even)	-1.6	-6.7	**-5.1**	0.0	0.0	**0.0**	Red	Green
Total Pay Spend	336.6	344.4	**-7.8**	1,971.5	1,973.8	**-2.3**	Red	Red
Substantive Spend vs Plan	314.3	320.0	**-5.7**	1,841.0	1,852.1	**-11.1**	Red	Red
Other Spend vs Plan	0.6	0.5	**0.0**	3.4	3.4	**0.0**	Green	Green
Bank Spend vs Plan	16.1	17.8	**-1.7**	93.6	86.1	**7.5**	Red	Green
Bank Spend vs Ceiling				97.7	86.1	**11.5**		Green
Agency Spend vs Plan	5.6	6.1	**-0.5**	33.5	32.2	**1.3**	Red	Green
Agency Spend Vs Ceiling				32.1	32.2	**-0.1**		Red
Whole time equivalent (Provider) - 25/26 plan	34,256	34,332	**-76**				Red	
Financial Efficiency Vs Plan	37.0	24.4	**-12.6**	279.0	279.0	**0.0**	Red	Green
Recurrent Efficiencies	29.6	18.7	**-11.0**	230.0	191.2	**-38.8**	Red	Red
Achievement of Mental Health Investment Standard	0.0	40.5	**0.0**	250.3	253.2	**2.9**		Green
Capital Spend Vs System Envelope	8.4	6.3	**-2.0**	86.7	86.7	**0.0**	Green	Green

1. The NHS system has a reported a £6.7 million deficit at month two, which is £5.1 million adverse to plan.
2. The system has received £70 million of non-recurrent deficit support to achieve a break-even plan, and the year-to-date element is included in month two position.
3. The system forecast at month two is in line with the planned break-even position.
4. The year-to-date position is off plan mainly due to sub-contracted bed costs within mental health due to spot purchase acute and psychiatric intensive care unit beds, flexible temporary staffing, and efficiency shortfalls, which are being offset by other plan underspends.
5. A potential implication of the month two off-plan position is the withdrawal of deficit support funding across the system for quarter two.

By Organisation £'000	Year to date Plan	Year to date Actuals	Year to date Variance	In-month Plan	In-month Actuals	In month Variance	Total Full Year Plan	Forecast outturn	Variance
Nottingham University Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Sherwood Forest Hospitals	-1.6	-1.6	0.0	-0.7	-0.7	0.0	0.0	0.0	0.0
Nottinghamshire Healthcare	0.0	-5.1	-5.1	0.0	-5.1	-5.1	0.0	0.0	0.0
Nottingham and Nottinghamshire ICB	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	**-1.6**	**-6.7**	**-5.1**	**-0.7**	**-5.8**	**-5.1**	**0.0**	**0.0**	**0.0**

6. **Workforce**: Staff costs are £7.8 million overspent across the NHS system at month two, with whole time equivalents (WTEs) being 76 WTEs higher than plan. Agency spend is £6.1 million, which is £0.5 million over the year-to-date plan. Agency forecasts are £1.3 million under the plan and £0.1 million above the agency cap. Bank spend is £17.8 million, which is £1.7 million over the year-to-date plan. Bank forecasts are £7.5 million under the plan and £11.5 million under the bank cap.
7. **Efficiencies**: The year-to-date position includes £24.4 million of efficiency. All organisations within the NHS system continue to develop financial recovery plans, as the risk on the delivery of the efficiency plan target of £279 million remains high.
8. **Cashflow Position**: The system is facing increasing pressures associated with the management of its cashflow position and is taking actions to mitigate those pressures.
9. **Financial Risk**: In addition to efficiency delivery, there are also risks associated with finalising contracts, prescribing pressures and growth and price increases relating to Continuing Healthcare. There are also risks around non-pay inflation and risks around pay awards/uplifts.
10. **Governance and Oversight**: The system has enhanced its efficiency governance and oversight arrangements. All organisations have financial sustainability boards/groups with senior ICB attendance. This feeds into a system financial sustainability group which scrutinises and oversees the efficiency and finance position weekly. The system continues to mature schemes week on week and is aiming for 80% risk-adjusted delivery by the end of quarter one.
11. **Capital Envelope**: The system submitted a capital envelope plan of £86.65 million, which included a deduction of £2.92 million from the initial capital envelope allocation of £89.57 million. The reduction in capital available being one of the implications of the system having a non-recurrent deficit support. £6.3 million of the capital envelope has been spent to date, which is £2 million under the year-to-date plan. The forecast remains to spend the total system capital envelope in full. The system also submitted plans to support several national programmes (totalling £80.1 million) including

estates safety, return to constitutional standards and front-line digitalisation, of which £5.7 million has been spent to date.

12. The Joint Capital Resource Use Plan 2025/26, as approved by the Board at its meeting in May, has now been published on the ICB's website and can be found here :Our Spend - NHS Nottingham and Nottinghamshire ICB.

ICB Position

13. The ICB's overall financial position is on plan and breakeven from an income and expenditure point of view for both year to date and forecast outturn.

14. The forecast outturn assumes that the efficiency plan of £76.3 million delivers in full. All efficiency targets have been allocated to programme areas.

15. There are other risks, e.g. activity and price pressures, as well as the efficiency risk noted above associated with delivering the balanced plan and these are described in full in the risk section of the report below.

16. The capital allocation for the ICB's business as usual capital stands at £2.5 million for the financial year. This will be invested, in full, across GP IT, ICB IT and GP premises schemes.

Financial Position – Month Two

17. The table below shows the key financial performance indicators. At this stage of the year both year to date and forecast outturn are showing achieved for all indicators, apart from year-to-date efficiency (see Savings Plan section below).

Key Financial Performance Indicator	Target	Year to Date	Forecast
Deliver planned surplus/deficit	Breakeven	Breakeven	Breakeven
Deliver income and expenditure breakeven	Breakeven	Breakeven	Breakeven
Achieved mental health investment standard	Spend in full	On target	On target
Deliver better payment practice code targets	>95% all four categories	On target	On target
Do not exceed capital allocation	Spend <£2.5 million	On target	On target
Do not exceed running cost allowance	Spend <18.5 million	On target	On target
Delivery efficiency target	Deliver £76.3 million	£2.2 million shortfall	On target

Savings Plan

27. The overall efficiency plan is for £76.3 million, and delivery of this target is key to remaining on a breakeven forecast outturn position.

28. The year-to-date plan is £11.4 million and delivery of this is £9.2 million, leading to a shortfall of £2.2 million against the targeted submitted plan to NHS England. The key

schemes that are not yet delivering to plan are Community schemes including Ruddington Manor (£2.7 million), which is a timing issue subject to contractual agreement.

29. £24.9 million worth of the £76.3 million target has been identified as a risk to delivery using NHS England risk criteria. The focus is on reducing this risk and ensuing delivery.

Risks

30. In addition to the efficiency risk noted above, a further £22.2 million of financial risk has been identified, giving gross risks of £47.0 million. This includes risks around contract resolution and/or subsequent over performance in acute NHS and independent sector contracts, risks of increased activity and/or price pressure on continuing healthcare and section 117 packages and similarly activity and/or price pressures on prescribing.

31. Total mitigations of £47.0 million have been identified leading to a balanced risk position. These include the efficiency programme delivering in full, plus holding back of reserves and identifying further nonrecurrent finance solutions. A full risk schedule is presented below.

Risks (full year) from reported breakeven	**£000**
Programme efficiency forecast outturn risk	£24,866
Acute NHS contract resolution/overperformance	£4,000
Acute Independent Sector contract resolution/overperformance	£500
Estates prior year resolution/in year inflation	£1,000
Pharmacy overspends	£3,000
Ophthalmic overspend	£1,400
Continuing Healthcare package activity/price	£2,300
Section 117 package activity/price	£1,000
Prescribing activity/price pressures	£9,000
Total risks	**£47,066**

Mitigations	**£000**
Efficiency programme delivery	£24,866
Health Inequalities Investment Fund reserve slippage	£2,000
Pharmacy pressure Inter Authority Transfer	£3,000
Mental Health Investment Standard use for section 117/other mental health risk	£2,000
Mental Health Investment Standard reserve	£2,000
Other finance solutions	£6,700
Dental resource reallocation	£6,500
Total mitigations	**£47,066**

Net Risk / (Mitigation)	**£0**

Detailed financial performance

32. The Operating Cost Statement for the period is presented to the Finance and Performance Committee in full: a summary is as follows:

2025/26 Programme Area	Year to Date				Forecast Outturn		
	Budget £'000	Actual £'000	Variance £'000		Budget £'000	Actual £'000	Variance £'000
Acute	259,462	260,110	(648)		1,510,290	1,509,335	955
Specialised services	55,160	55,160	0		356,098	356,098	0
Community	46,957	50,618	(3,661)		277,098	277,097	1
Mental health	49,890	49,930	(40)		310,642	310,862	(220)
Continuing healthcare	27,624	27,664	(40)		172,688	172,357	331
Delegated primary care	41,956	41,998	(42)		261,628	259,078	2,500
Delegated pharmacy, ophthalmic, dental	17,949	18,221	(272)		117,517	117,517	0
Prescribing	34,365	34,365	0		208,777	208,777	0
Other primary care	6,913	6,906	7		23,588	23,063	6
Programme corporate costs	6,614	6,396	218		33,886	33,063	823
Efficiency reserve	0	0	0		0		0
General reserve	(599)	0	(599)		2,470	12,304	(9,834)
Contingency reserve	4,971	0	4,971		4,971	0	4,971
Total programme costs	**551,262**	**551,368**	**(106)**		**3,279,653**	**3,280,070**	**(417)**
Running costs	3,028	2,922	106		18,372	17,955	417
Toal prior to planned surplus / (deficit)	**554,290**	**554,290**	**0**		**3,298,025**	**3,298,025**	**0**
Planned surplus/deficit	0	0	0		0	0	0
Total reported position	**554,290**	**554,290**	**0**		**3,98,025**	**3,298,025**	**0**

33. *Operating Cost Statement*

a) The overall revenue resource limit for month two is £3,298.0 million, reflecting:

- Opening budgets: £3,221.859 million
- Less Q2–Q4 deficit support: -£41.426 million
- Plus, indicative allocations: £66.913 million
- Plus, Specialised Commissioning Inter Authority Transfer: £50.679 million

34. *Acute Services*

a) Covers contracts with Nottingham University NHS Hospitals NHS Trust (NUH), Sherwood Forest Hospitals NHS Foundation Trust, and other NHS/independent providers.

b) Key risks: pass-through drug/device costs and elective recovery funding caps.

c) £0.6 million over plan year to date, mainly due to £0.7 million undelivered efficiency.

d) £1.0 million under plan forecast outturn, driven by underspends in independent sector contracts.

e) NHS contracts are not yet finalised, so shown as on plan.

35. *Specialised Commissioning*

a) Delegated to the ICB in 2024/25, covering high-cost, low-volume acute and mental health services (mainly with NUH).

b) Charged on a cost and volume basis.

c) A regional risk share is in place to manage volatility.

d) Assumed on plan for both year to date and forecast outturn.

36. *Community Services*

a) Primarily delivered by Nottinghamshire Healthcare NHS Trust (NHT), Nottingham CityCare, and includes Better Care Fund payments.

b) Mostly block contracts, reducing volatility.

c) £3.7 million over plan year to date, entirely due to efficiency non-delivery.

d) Forecast breakeven, assuming catch-up delivery by year-end.

37. *Mental Health Services*

a) Includes block contract with NHT and cost/volume contracts for locked rehabilitation, Talking Therapies, and Section 117 placements.

b) Subject to Mental Health Investment Standard.

c) £0.04 million overspend year to date, £0.22 million overspend forecast outturn, both due to Section 117 pressures.

d) All other areas assumed on plan due to limited data.

38. *Continuing Healthcare*

a) Cost and volume contracts with nursing/care homes; some jointly funded with local authorities.

b) High growth area, under close scrutiny.

c) £0.04 million overspend year to date, £0.33 million underspend forecast outturn, assuming full efficiency delivery.

39. *Primary Care Delegated – GP Providers*

a) Covers General Medical Services contracts, Local Enhanced Services, Additional Roles Reimbursement Scheme, and premises costs.

b) Allocation continues to match expenditure.

c) £0.042 million overspend year to date, £2.55 million underspend forecast outturn due to reserve usage and accrual differences.

40. *Primary Care Delegated – POD (Pharmacy, Optometry, Dental)*

a) Delegated in 2023/24.

b) Historic pressures on pharmacy allocations mitigated by non-recurrent NHS England funding.

c) £0.5 million overspend year to date (pharmacy/optometry), offset by £0.23 million dental underspend.

d) Forecast breakeven, subject to risks and mitigations.

41. *Prescribing*

a) Covers GP-prescribed pharmaceutical items.

b) High volatility due to pricing and new drug approvals.

c) Assumed on plan for both year to date and forecast outturn due to data lag (two months).

42. *Corporate Programme and Running Costs*

a) Split between programme (healthcare) and running (admin) costs.

b) New limit: £18.76 per head, covering both running and Commissioning Support Unit programme costs.

c) £0.33 million underspend year to date, £1.2 million underspend forecast outturn, mainly from vacancies in medicines management.

d) Forecast remains within annual allowance.

43. *ICB Reserves*

a) General reserves held for unallocated purposes (e.g., Health Inequalities Investment Fund).

b) Forecast includes assumed expenditure to balance forecast outturn and net risk.

c) £4.97 million contingency reserve from uncommitted Service Development Funding fully phased into Month two.

44. *Underlying Financial Position*

a) Forecast underlying financial position at plan stage: £10.2 million deficit.

b) Dependent on delivery of £66.6 million recurrent savings.

c) No updated underlying financial position forecast at month two due to data limitations.

45. *Balance Sheet Items*

a) Cash: £0.24 million held at 31 May against £3.19 million target.

b) Better Payment Practice Code: All targets met (95%+ invoices paid within 30 days).

c) Debtors: £304k over 90 days (mainly Nottingham City Council recharges), actively pursued.

46. *Capital*

a) Business as usual capital plan: £2.5 million, fully allocated to GP IT, ICB IT, and estate development.

b) Additional £1.4 million in project initiation documents submitted to the Utilisation and Modernisation fund, with £0.6 million more in pipeline.

NN ICB Aged Debtors Profile	0 - 30 Days	31 - 60 Days	61 - 90 Days	> 90 Days	Total
Amount Due £'000	**197.59**	**811.35**	**111.81**	**307.74**	**1,428.49**

NHS
Nottingham and Nottinghamshire

Meeting Title:	Integrated Care Board (Open Session)
Meeting Date:	09/07/2025
Paper Title:	**Committee Highlight Reports**
Paper Reference:	ICB 25 044
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 May 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.

For the first time, a Highlight Report from the Joint ICB Transition Committee is also included.

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 Joint ICB Transition 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):	**05 June and 03 July 2025**
Committee Chair:	**Jon Towler, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. Activating Integrated Neighbourhood Teams	Members received a paper that described the implementation of Integrated Neighbourhood Teams (INTs) across the ICB area with the aim of improving the coordination of health and care for the most vulnerable populations identified from proactive case finding. The importance of utilising existing resources to support delivery and maximise efficiency, understanding the co-location requirements of INTs and clearly articulating the expectations of health and care professionals were highlighted through discussion. Although it would be challenging, the aim was to implement INTs across the whole of Nottingham and Nottinghamshire by the end of the financial year. The overall assurance rating of adequate recognised that whilst there was a clear direction of travel, implementation was still in the early stages. It was agreed that a progress update would be presented to the Committee in six months' time, with any delivery issues raised by exception in the interim.	**Adequate**	*Not applicable*
2. Working with People and Communities Annual Report	Members received a report which aimed to provide assurance on how the ICB had discharged its legal duties on public involvement and consultation, setting out the ways in which the ICB had worked with people and communities during the period 1 April 2024 to 31 March 2025. In response to feedback from the Committee and the Board, the report included sections that demonstrated how the ICB had sought the views of	**Full**	**Full** *Awarded at the meeting*

Item	Summary	Level of assurance	Previous level of assurance
	people and communities that the ICB was not hearing from, the positive difference that hearing the citizen's voice had made during the reporting period, details of the engagement work being undertaken to support the prevention agenda and examples of services changes that had resulted from co-production activities. Recognising the evolving role of ICBs, members discussed the future skills and capabilities needed to support engagement and requested that future annual reports demonstrated the year-on-year impact of the ICB's work with people and communities.		*held in June 2024*
3. Joint Forward Plan Outcomes Dashboard: Annual Update	Members received a report which outlined the annual progress update on the population outcomes that would be achieved by successful delivery of the NHS Joint Forward Plan. Whilst many metrics had not changed significantly, the report highlighted areas of notable improvement and decline. Noting that the strategic outcomes should inform long-term planning and could take some time to evolve, members requested that future reports be aligned with delivery updates to describe the actions that were being taken to drive forward improvements. The overall assurance rating of adequate reflected confidence in the outcomes data and the intention to better integrate reporting on population outcomes with delivery progress.	**Adequate**	*Not applicable*
4. Three-Year Integrated Mental Health Pathway Strategic Plan: Delivery Update	Members received a report that set out the progress achieved in year one of the Three-Year Integrated Mental Health Pathway Strategic Plan, along with priorities identified for year two.	**Adequate**	*Not applicable*

Item	Summary	Level of assurance	Previous level of assurance
	Members discussed the risks to delivery, including the need for a system-wide approach to housing and accommodation developments, and the challenge of securing active partner engagement from organisations under national improvement support and scrutiny in delivering the integrated mental health pathway. The NHS England (Midlands region) requirement for the review to be published on ICB websites by 31July 2025 was noted. To meet this deadline, the progress review would be incorporated within the Chief Executive's report to the Board on 9 July 2025. Members applied an assurance rating of adequate, noting that the inclusion of metrics would enhance future update reports.		
5. Transformation Programme Delivery: Continuing Healthcare and Health Packages of Care	Members received a report that provided a progress update on the creation of a new Continuing Healthcare (CHC) operating model, the delivery of sustainable transformation and efficiencies in CHC and the management and oversight of the process for decision making. Considering the national requirements for ICBs to transition to a new operating model, work to redesign the CHC service had been paused. Members discussed the application of the Inter-Agency NHS CHC Dispute Resolution Protocol and noted improvements in supporting joint decision-making with system partners. The overall assurance rating of adequate acknowledged the solid progress made during 2024/25 whilst recognising the challenges ahead in delivering transformation and efficiencies in 2025/26.	**Adequate**	*Not applicable*

Other considerations:

Decisions made:
The Committee approved: a) The Primary Care Strategy 2025-2030, following initial consideration by the Board in May 2025. b) An extension to the Section 117 After Care Policy's review date to July 2026. c) The Inter-Agency NHS Continuing Healthcare Dispute Resolution Protocol. d) The Committee received a number of decision-making papers and approved proposals relating to: i. The recommissioning of Integrated Urgent Care and non-urgent care services ii. Newly published or revised NICE Technology Appraisals iii. The 2025/26 Health Inequalities and Innovation Fund iv. The Enhanced Service Delivery Scheme v. The Diabetes Local Enhanced Service vi. Enhanced Residential Care Provider for people with Learning Disabilities and Autistic People vii. Better Care Fund Discharge Spend 2025/26 viii. The Discharge to Assess Service ix. The Bassetlaw Children and Young People's Learning Disabilities Nursing Service x. Care Navigation Services xi. Non-Emergency Patient Transport Services xii. Services provided by the Voluntary, Community and Social Enterprise Sector The Committee also: e) Endorsed the strategic commissioning framework for secondary prevention. f) Supported the newly developed Primary Medical Services (PMS) – Service Decision Framework.

Information items and matters of interest:
a) The Committee discussed the East Midlands Fertility Policy Review Case for Change for Nottingham and Nottinghamshire and potential key policy changes, and agreed to progress the policy review, with the aim being to implement a consistent policy across the ICB cluster footprint, at a minimum, by April 2026.
b) The Committee received and discussed the operational risks relating to the Committee's responsibilities. Following a 'confirm and challenge' session with the Executive Management Team, there had been a shift in the narrative and focus of some of the risks, which had led to the identification of six new risks and the archiving of six others. There were currently 15 risks relating to the Committee's responsibilities, two of which were categorised as high scoring risks. Details of these high scoring risks are provided for the Board's information at Appendix F.
c) The Committee received the Log of Investment, Disinvestment, Procurement and Contract Award Decisions (Healthcare) 2025/26 for information, which provided details of all such decisions made outside of the Committee's meetings.

Appendix B: Quality and People Committee Highlight Report

Meeting Date(s):	**21 May and 18 June 2025**
Committee Chair:	**Marios Adamou, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. Delivering Quality Functions in Integrated Care Systems	The ICB Quality Directorate had undertaken a review of its quality functions to assess the ICB's compliance against its statutory duties and members received a report that outlined the review process and findings. The review was carried out prior to publication of the Model ICB Blueprint and members discussed the ICB's capacity to maintain compliance with its statutory duties throughout the period of transition. The review methodology used and the triangulation of the findings with outcomes and risks was also discussed. Members noted that the Committee's Annual Work Plan routinely provided more detailed assurance around the discharge of duties and agreed that the report provided additional assurance that the ICB had the appropriate capacity and oversight arrangements in place to support this.	**Adequate**	*Not applicable*
2. 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. Members focussed on areas of concern that were confidential in nature and sought assurance on the ongoing actions. With regard to organisations in National Oversight Framework (NOF) segment four, it was noted that a focussed assurance report was scheduled for the July meeting.	**Limited**	**Limited** *Awarded at the meeting held on 21 May 2025*

Item	Summary	Level of assurance	Previous level of assurance
3. Nottingham and Nottinghamshire ICB Health Inequalities Statement and Plan	Members received the ICB Health Inequalities Statement 2024/25, which would be published alongside the organisation's annual report and accounts. The report outlined the key components of the ICB Health Inequalities Plan and programmes of work, and an indication of which elements of the plan impacted on the relevant statement indicators. Members noted the areas of focus related to waiting list times, which included supporting patients to wait well through signposting and prehabilitation. It was also noted that further work would be carried out, linked to the outcomes framework, to better demonstrate the return on investment and long-term impact of the work to date on health inequalities at all levels across the system.	**Adequate**	**Full** *Awarded at the Finance and Performance Committee meeting held on 24 April 2024*
4. Patient Experience Assurance Report 2024/25	Members received the Patient Experience Assurance Report 2024/25 that outlined the number of complaints received and managed by the ICB from 1 April 2024 to 31 March 2025 and aimed to provide assurance that the ICB was meeting its statutory requirements and that systematic learning from complaints was in place. There had been a significant increase in the number of complaints received by the ICB related to the funding of continuing healthcare (CHC) packages. Through investigation, it had been determined that the ICB had made CHC funding decisions in a fair and equitable way aligned to the approved decision-making processes. Members requested that future Patient Experience Team assurance reports include demographic data and further detail on how learning from complaints had been implemented and whether it had led to improved outcomes.	**Full**	**Adequate** *Awarded at the meeting held on 17 April 2024*

Item	Summary	Level of assurance	Previous level of assurance
	The overall assurance rating of full recognised that plans were in place to improve the service that citizens received.		
5. Quality and Safety in Social Care Annual Report 2024/25	Members received a report that outlined the work undertaken by the ICB Medicines Optimisation (MO) Team during 2024/25 to enable and support social care establishments within the ICB footprint and to provide the governance, oversight and assurance that was jointly required by local authorities, health and regulatory bodies. Members noted that although all issues identified through quality assurance visits were acted upon and appropriate interventions were put in place, the exact number of interventions was not recorded. The overall assurance rating of adequate recognised that the ICB was fulfilling its duty as commissioners of placements in social care settings, to ensure the quality and safety of medicines in this sector.	**Adequate**	**Adequate** *Awarded at the meeting held on 19 June 2024*
6. Medicines Optimisation Assurance Report – Nottingham Area Prescribing Committee Annual Report 2024/25	Members received a report that provided an overview of the Area Prescribing Committee's (APC) work in reviewing medicines, developing prescribing guidelines, supporting antimicrobial stewardship, and contributing to the financial sustainability of the local healthcare system during 2024/25. It was noted that the APC was working to reduce the pressure on community pharmacy and other avenues had been explored to address the challenge around recruiting members.	**Full**	**Full** *Awarded at the meeting held on 18 September 2024*
7. Integrated Care System (ICS) People and Workforce Plan Update	A progress update on delivery of the ICS People and Workforce Plan was presented to the Committee in advance of an update being submitted to the Board in July 2025.	**Limited**	*Not applicable*

Item	Summary	Level of assurance	Previous level of assurance
	Members noted that the update to the Board would be focussed on delivery of the plan. Whilst there was some uncertainty around where the responsibility for strategic workforce planning would sit in the future, the strategy that had been developed still needed to be delivered. The overall assurance rating of limited recognised that delivery of the strategy was still in the early stages and a delivery plan was still to be developed.		

Other considerations:

Decisions made:
a) Approved the NHS Nottingham and Nottinghamshire ICB Modern Day Slavery Statement for 2025/26. b) Approved the following ICB corroborative statements for inclusion in the respective annual Provider Quality Accounts and for publication in line with the ICB's responsibility for review and scrutiny of Quality Accounts, subject to the amendments put forward throughout the discussion being made: • Vita Health Group • The Woodthorpe Hospital • Sherwood Forest Hospitals NHS Foundation Trust • Nottinghamshire Healthcare NHS Foundation Trust • Nottingham CityCare Partnership • Primary Integrated Care Services c) Endorsed the draft Integrated Care System Quality Strategy (Framework Model) 2025-2028 for approval at the Board in July 2025, subject to the amendments put forward throughout the discussion being made.

Information Items and Matters of interest:
The Committee also: a) Reviewed identified risks relating to its areas of responsibility. Following 'confirm-and-challenge' sessions with the Director of Nursing and her team, and a separate review of live operational risks by the ICB's Executive Management Team, the number of risks within the Committee's remit had reduced to 36. 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 following Provider Quality Accounts for information. • Vita Health Group • The Woodthorpe Hospital • Sherwood Forest Hospitals NHS Foundation Trust • Nottinghamshire Healthcare NHS Foundation Trust • Nottingham CityCare Partnership • Primary Integrated Care Services d) Received the Committee's 2025/26 Annual Work Programme for information.

Appendix C: Finance and Performance Committee Highlight Report

Meeting Date(s):	**28 May and 25 June 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 and Workforce Report (Months 1 and 2)	At the end of month two the system was reporting a £6.7 million deficit and the ICB was reporting a £2.2 million deficit. Both the system and the ICB were forecasting a year-end break-even position; however, there was significant risk to achieving the Financial Plan. The Committee discussed the current drivers of the deficit, which were, in the main, pay-related overspend, a shortfall in efficiency savings and the spot purchase of acute and psychiatric intensive care unit beds. Assurance was taken that the ICB was taking proactive action to address shortfalls at an early stage in the financial year, nevertheless the significant challenges to the achievement of the Financial Plan could not be underestimated.	**Limited**	**Full** *(awarded at the meeting held on 30 April 2024)*
2. 2025/26 System Financial and Workforce 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. Although 99% per cent of efficiency plans had been identified, delivery confidence levels had not reached the 80% requirement by the end of June 2025. There was now an urgent requirement to improve delivery confidence, and the risk adjusted value of plans. Although the Committee continued to be assured of the robust governance arrangements that had been put in place, at this point in time, until the delivery	**Limited**	**Limited** *(awarded at the meeting held on 30 April 2024)*

Item	Summary	Level of assurance	Previous level of assurance
	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 2025/26 Delivery and Service Delivery report	Members received reports highlighting areas of improvement and challenges, noting that increased grip and control by programme boards and the Performance Oversight Group was resulting in improvements to several performance metrics. However, there were areas where performance remained stubbornly static and the Committee asked for more information on activity in areas such as GP 14-day appointment waits, diagnostic waits and long waiting times for some cancer specialities to be brought to the next meeting. Members acknowledged that there had been a positive move towards working as a system to resolve long-standing operational issues, and the robust oversight and governance arrangements had been put in place; however, there was an increasing potential conflict between the competing priorities of financial efficiencies and performance improvement, therefore the overall assurance rating remained at partial, recognising the significant risks and challenges to achieving the operational plan.	**Partial**	**Partial** *(awarded at the meeting held on 30 April 2024)*
4. Thematic Service Review: Urgent and Emergency Care	The Committee received a detailed report of the steps taken to address performance issues in relation to urgent and emergency care kay metrics, noting how the establishment of the System Co-ordination Centre was providing daily oversight, and a weekly system oversight group had led to improved performance. Closer working relationships with all providers had resulted in the implementation of additional pathways and improved resilience within teams.	**Partial**	*Not applicable*

Item	Summary	Level of assurance	Previous level of assurance
	Welcoming the improved metrics, albeit the Committee highlighted the resource intensive nature of the work of the Team and queried whether it could be sustained in the longer term. Other issues impacting performance were also discussed. As the new way of working was not yet fully embedded, an assurance rating of partial was awarded.		
5. General Practice Estates Plan	A progress report on the development of the General Practice Estates Plan was provided. Although this had been a challenging process for several reasons outside of the ICB's control, capital funding had been utilised to support improvements to GP estate over the last three years. The key issue going forward and over the longer term was a lack of significant capital resource to provide primary care capacity in areas of significant population growth or where replacement estate was required. Funding was approved to conclude an exercise to provide an independent list of priority pipeline projects This would then allow for the creation of a joint estates strategy to be developed in conjunction with Derbyshire and Lincolnshire. Members noted the need going forward for any plan to also be cognisant of the development of Integrated Neighbourhood Teams.	**Adequate**	*Not applicable*

Other considerations:

Decisions made:
a) The Committee approved a refreshed Primary Care Digital Strategy, requesting an update on progress at the end of year one. b) £15,847 was approved to fund the development of a list of priority pipeline primary care estate projects.

Information items and matters of interest:

a) The Committee received a report on the Corporate Services Optimisation Programme, which aimed to respond to the national requirement to reduce corporate costs at pace and scale. Further detail will be examined at the next meeting.

b) The Committee received the Log of Investment, Disinvestment, Procurement and Contract Award Decisions (Non-Healthcare) 2025/26 for information, which provided details of all such decisions made outside of the Committee's meetings, in line with the Scheme of Reservation and Delegation (SORD).

c) An extract from the Operational Risk Register relevant to the Committee's remit was reviewed, which included 19 risks, with seven 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):	**20 May 2025 and 18 June 2025**
Committee Chair:	**Gary Brown, Non-Executive Director (20 May)** **Stephen Jackson, Non-Executive Director (18 June)**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. Bi-annual Risk Management Arrangements Update	The report provided an update on the work being undertaken to embed strategic and operational risk management arrangements within the ICB. Recent Audit and Risk Committee discussions had highlighted questions about whether current risk tolerance levels were too cautious, given the current NHS operating context. A review of the ICB's risk appetite, with the Board is planned for quarter two. Acknowledging that there existed a robust mechanism for the reporting and monitoring of risk, Board members went on to discuss the effectiveness of actions to mitigate the risks, noting that 73 of the 84 risks on the operational risk Register had not changed in score since the last update. The Committee asked that the ICB continued to challenge teams around their mitigating actions to the risks and requested that a 'Red, Amber, Green' (RAG) rating of action progress be added to future reports to monitor changes.	**Adequate**	**Full** *(Awarded at the meeting held on 09 October 2024)*
2. Legal Activity Report	This was a first report to the Committee describing the internal controls established to ensure legal activity across the organisation was appropriately managed, monitored, and subject to effective oversight. It also provided an overview of legal activity and expenditure during 2024/25, categorised into	**Adequate**	*Not applicable*

Item	Summary	Level of assurance	Previous level of assurance
	proactive or reactive advice. Future years' reports would build on this framework and provide learning around emerging trends. Members had welcomed the report.		
3. Health and Safety Annual Report	An annual report on the embedment of arrangements across the ICB to meet health and safety requirements was received by the Committee. As the ICB is classified as a 'low risk' organisation, with staff being predominantly office or home based, focus in this area related to the health, safety, and welfare of its workforce. Members considered the governance in this area to be proportionate to the level of risk and asked for further detail in the next report on processes for monitoring home worker health and safety.	**Adequate**	**Full** *(Awarded at the meeting held on 16 May 2024)*
4. Use of Emergency Powers for Urgent Decisions	The Committee reviewed the six urgent decisions that had been undertaken since the last report in May 2024 using the emergency powers permitted via the ICB's Standing Orders and the committees' terms of reference. Members were satisfied with the rationale for using the powers.	**Adequate**	**Full** *(Awarded at the meeting held on 16 May 2024)*
5. Financial Stewardship Assurance Report	The report provided an update on the ICB's key financial arrangements. The Committee noted that procurement card usage and agency spend continued to be proactively managed. The Committee was also provided with details of the four instances where competitive tendering requirements had been waived during the financial year 2024/25 and considered the decisions to be appropriate.	**Adequate**	**Full** *(Awarded at the meeting held on 11 December 2024)*
6. Provider Selection Regime Assurance Report	The report had provided a year-end update to the Committee regarding its responsibilities for overseeing compliance with the Provider Selection Regime (PSR), noting that the ICB had received only one representation from a provider since January 2024. The Representation Panel had reviewed the case and was	**Adequate**	**Adequate** *(Awarded at the meeting held on 09*

Item	Summary	Level of assurance	Previous level of assurance
	satisfied that the ICB had applied the regime correctly, which had subsequently been accepted by the provider. An assurance rating of adequate was provided, pending the review of PSR compliance by the Internal Audit function, as part of this year's Internal Audit Plan.		*October 2024)*
7. Information Governance Assurance Report:	Members were assured of the arrangements established within the ICB to ensure compliance with the requirements of the Cyber Assurance Framework (CAF) aligned Data Security and Protection Toolkit (DSPT) ahead of the year-end (2024/25) submission by 30 June 2025. An Internal Audit check on the ICB's self-assessment had concluded, with an overall 'substantial' opinion rating. The report had also provided assurance to the Committee in relation to its wider responsibility for scrutinising compliance with legislative and regulatory requirements relating to cyber security, information governance incidents, and the ICB's management of subject access requests and freedom of information requests.	**Adequate**	**Adequate** *(Awarded at the meeting held on 25 May 2025)*
8. Emergency Preparedness, Resilience and Response (EPRR) Report	The report provided an update of work towards achieving full compliance against NHS England' EPRR core standards. The ICB had been rated as partially compliant by NHS England at the beginning of the year. The Committee was assured that work to improve compliance rates was being undertaken, with full compliance expected by the end of the reporting period in August 2025.	**Adequate**	**Partial** *(Awarded at the meeting held on 11 December 2024)*
9. Statutory and Mandatory Training Compliance	The Committee reviewed ICB's current statutory and mandatory training compliance figures and the processes in place to monitor and improve compliance rates. Overall, compliance rates remained high.	**Full**	**Full** *(Awarded at the meeting held on 11 Dec 2024)*

Other considerations:

Decisions made:
a) The Committee approved the Annual Report and Accounts for the ICB for the period 1 April 2024 to 31 March 2025 for onward submission to NHS England ahead of the deadline of 27 June 2025. The Committee also endorsed the signing of the letter of representation, which stated compliance with accounting and auditing standards. These approvals followed scrutiny of the External Audit report of the accounts; third party assurance reports; and the Head of Internal Audit Opinion report, which had provided an overall rating of 'significant assurance'. The External Audit opinion was 'unqualified'.
b) The Committee approved the ICB's Business Continuity Policy and Communications Emergency Plan and approved non-material changes to the EPRR Policy, the Incident Response Plan and the Business Continuity Plan.
c) A proposal to amend the Committee's terms of reference was endorsed to incorporate the responsibilities of the Mandatory Learning Oversight Group. This is part of a national programme, led by NHS England to provide greater local governance and assurance regarding statutory and mandatory training and adherence to the Core Skills Training Framework.
d) The Committee's work programme for 2025/26 was approved.

Information items and matters of interest:
a) Members received an update on the progress of the 2025/26 Internal Audit Plan. The one remaining advisory report had been received, which had concluded the 2024/25 Plan.
b) 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: Joint ICB Transition Committee Highlight Report

Meeting Date(s):	**12 and 25 May 2025** – Joint Committee meeting between NHS Nottingham and Nottinghamshire ICB and NHS Derby and Derbyshire ICB **27 June 2025** – Joint Committee meeting between NHS Nottingham and Nottinghamshire ICB, NHS Derby and Derbyshire ICB, and NHS Lincolnshire ICB
Committee Chair:	**Jon Towler, Non-Executive Director**

Item	Summary
1. Terms of Reference	The Joint Committee reviewed and endorsed its terms of reference for onward presentation to the three ICB's Boards for approval in July 2025. Members noted that the Joint Committee's primary role was to oversee the transition to a new ICB cluster operating model, seeking assurance on development and delivery of the transition programme plan and the management of transition risks. It was agreed that fortnightly Joint Committee meetings would continue for three months to maintain momentum, to be reviewed again in September 2025.
2. Transition Planning and Financial Modelling	The Joint Committee oversaw the development of the ICBs' planning submissions to NHS England by 30 May 2025, ahead of approval by each ICB's Board. The submissions responded to the mandate to reduce ICB management costs to £18.76 per head of population (subsequently uplifted to £19.00 per head). Members discussed the need to balance national guidance, strategic commissioning needs and talent retention/development, and the importance of establishing robust governance arrangements for the ICB cluster was also emphasised during discussions. A three-phase transition programme was agreed: • Phase 1: Operating model design and management of change. • Phase 2: Function transfer aligned with the Model ICB Blueprint. • Phase 3: Establishment of the future strategic commissioning form.

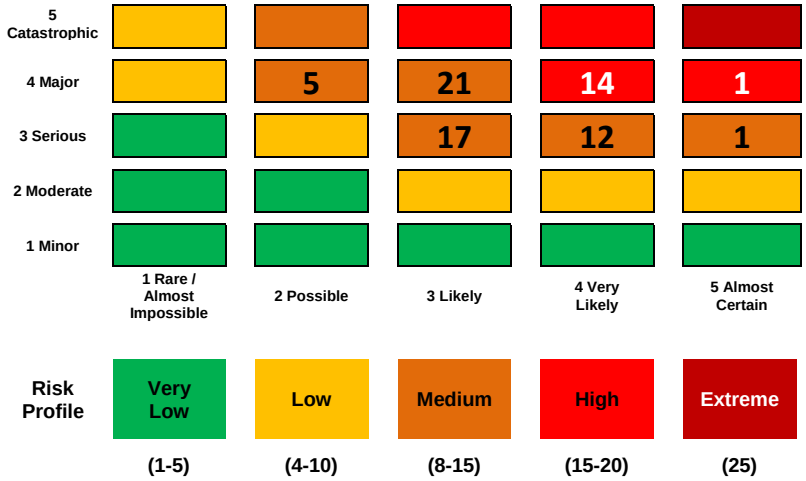
Item	Summary
3. Transition Programme Architecture	Members reviewed and approved the programme management arrangements for the transition programme. This included the establishment of an ICB Transition Programme Group that would oversee the work of five operational workstreams: operating model design; management of change; governance; finance; and stakeholder communications. Members noted the importance of having a single, fair and transparent management of change process and a clear vision across all ICBs to underpin the process. Members also discussed concerns relating to short delivery timelines that were dependent on national guidance and processes and the capacity of staff to manage both transition requirements and their day-to-day duties. Members were assured that a detailed programme plan with milestones and interdependencies was in development, which would be finalised ahead of the next meeting. This would form the basis of future assurance reporting to the Joint Committee.
4. Transition Risk Log	The Joint Committee considered an initial set of transition risks and noted that a consolidated risk log for the ICB cluster was in development, which would be finalised ahead of the next meeting.

Appendix F: Current high-level operational risks being oversighted by the Board's committees

Risk Profile

There are 71 'live' risks within the Operational Risk Register (including both ICB and system risks). This is a decrease of ten risks since the last report to the Board. Of these 71 risks; 15 risks are scored at a high-level, accounting for 21% of the total risks. This proportion is moderately lower than the last report to the Board when 28% were scored at a high-level. The risk profile is shown in figure 1 below.

Figure 1



The 15 high-level operational risks include five 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 ten high-level operational risks included in this paper are detailed in the below table. There is an overall decrease of ten risks since the last report to the Board. Movement in the high-level risks is described below:

a) Three new risks have been identified since the last report to the Board (risk 257 relating to mental health bed flow and capacity issues, risk 267 relating to ongoing negative media and risk 274 inadequate capacity and capability may hinder delivery of ICS Primary Care Strategy).
b) Two risks have decreased in score and no longer meet threshold for reporting to the Board.
c) Eleven further risks have been archived as they are no longer applicable or have been mitigated to a risk score which does not meet the threshold for reporting on the ORR. It is important to note while certain risks may be archived following mitigation or resolution, risk landscapes are dynamic and archived risks may re-emerge in new forms, either by focusing on a specific element of the original risk or by reflecting updated circumstances. This ensures our risk register stays current and relevant.

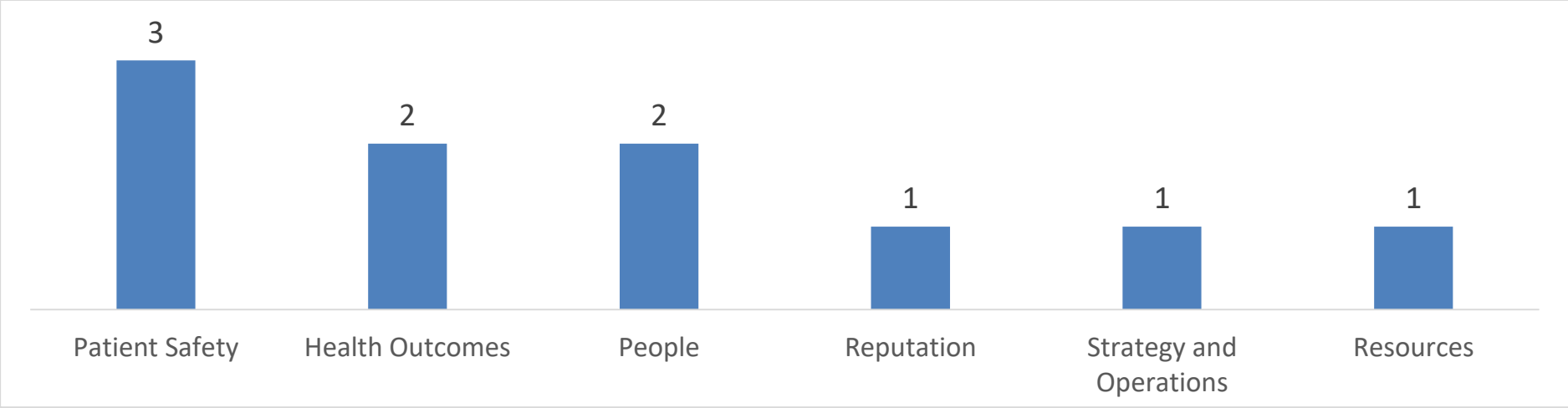
Risk Appetite

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 96% 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 the risk domains where the high-level risks sit. 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, 60% of the high-level risks are reported to the Quality and People Committee.

Risk Ref.	Risk Description	Score	Responsible 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, 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 headcount reductions, alongside social care providers facing financial and operational pressures, workforce strain may increase, leading to sickness, exhaustion, burnout, and undermining psychological safety across health, social care, and primary medical services providers.	**High** 16 (I4 x L4)	Quality and People Committee
ORR207	If challenges in the provision and delivery of community mental health services persist, these services may not be accessed, or accessed promptly, which may worsen health outcomes for adults and children across Nottingham/shire. This could also increase demand on other services, as activity shifts to other ICS partners. This risk is exacerbated by the rise in the complexity and volume of people requiring mental health services.	**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
ORR257	If mental health bed flow issues and capacity constraints persist amid rising demand, then individuals (children and adults) experiencing mental health crises, including those	**High** 16 (I4 x L4)	Quality and People Committee

Risk Ref.	Risk Description	Score	Responsible Committee
(new risk)	detained under the Mental Health Act or medically fit for discharge, may be placed in inappropriate or out-of-area settings (Emergency Departments, children's wards, or Section 136 suites). This may result in increased distress and risk of harm, delayed access to appropriate care, and heightened pressure on urgent care services and system partners.		
ORR267 (new risk)	If adverse media coverage relating to key health services (e.g. maternity, mental health, primary care) persists, public confidence in the local health and care system may continue to decline. This may lead to reduced trust, and impact on public confidence in local NHS services. This risk is exacerbated by current coverage of the proposed workforce reductions across ICS NHS partners.	**High** 16 (I4 x L4)	Quality and People Committee
ORR210	If ICB headcount reductions continue amid ongoing operational challenges and workforce pressures, staff health, wellbeing, and morale may deteriorate. This could impact productivity and lead to staff feeling disconnected or disengaged with the ICB.	**High** 16 (I4 x L4)	Remuneration and HR 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
ORR274 (new risk)	If General Practices, Primary Care Networks, community pharmacy, and the ICB lack sufficient capacity, capability, and resources to deliver the ICS Primary Care Strategy and implement modern general practice access models, then the transformation of primary care and improvements in access may not be achieved.	**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 may not be sufficient capacity or 'headspace' to deliver mental health and community service transformation. This could result in unmet population needs and 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:	09/07/2025
Paper Title:	**Board Annual Work Programme 2025/26**
Paper Reference:	ICB 25 044
Report Author:	Lucy Branson, Director of Corporate Affairs
Executive Lead:	Rosa Waddingham, Director of Nursing
Presenter:	-

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

Summary:

The purpose of this item is to provide the Board's Annual Work Programme 2025/26 for Member's information at each meeting.

Recommendation(s):

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

How does this paper support	**the ICB's core aims to:**
Improve outcomes in population health and healthcare	The ICB's governance arrangements ensure appropriate oversight and decision-making with regard to achievement of the core aims.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help the NHS support broader social and economic development	As above.

Appendices:

Appendix A – Annual Work Programme 2025/26
Appendix B – Purpose and content of agenda items

Board Assurance Framework:

Not applicable.

Report Previously Received By:

Not applicable.

Are there any conflicts of interest requiring management?

No

Is this item confidential?

No

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. At the request of the Board, the November update will to provide further assurance on progress across all improvement actions being undertaken by Nottinghamshire Healthcare NHS Foundation Trust. *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

No.	Agenda item	Purpose
		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: • 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