

Shared Agenda for the meetings in common of:
NHS Derby and Derbyshire ICB Board
NHS Lincolnshire ICB Board
NHS Nottingham and Nottinghamshire ICB Board

Thursday 16 July 2026 10:00-13:00

Post Mill Centre, South Normanton, Derbyshire, DE55 2EJ

Ref	Item	Presenter	Type	DD	L	NN	Enc	Time
Introductory items								
1.	Welcome, introductions and apologies	Kathy McLean	-	✓	✓	✓	-	10:00
2.	Confirmation of quoracy	Kathy McLean	-	✓	✓	✓	-	-
3.	Declarations and management of interests	Kathy McLean	Information	✓	✓	✓	✓	-
4.	Minutes of the meetings in common, held on 21 May 2026	Kathy McLean	Decision	✓	✓	✓	✓	-
5.	Action log and matters arising from the meetings in common, held on 21 May 2026	Kathy McLean	Discussion	✓	✓	✓	-	-
Leadership and operating context								
6.	Citizen Story: Embedding Storytelling to Improve Quality – Team Up, Swadlincote	Clair Raybould	Discussion	✓	-	-	✓	10:05
7.	Chair's Report	Kathy McLean	Information	✓	✓	✓	✓	10:20
8.	Chief Executive's Report	Amanda Sullivan	Information/ Decision	✓	✓	✓	✓	10:30
Population health and commissioning priorities								
9.	Population Health Strategy Progress Report: Frailty and End of Life	Clair Raybould, Maria Principe, Dr Dave Briggs	Assurance	✓	✓	✓	✓	10:50

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Oversight and delivery of commissioning outcomes								
10.	Approach to Quality	Rosa Waddingham	Discussion	✓	✓	✓	✓	11:15
11.	Quality Oversight Report	Rosa Waddingham	Assurance	✓	✓	✓	✓	11:25
12.	Commissioning Oversight Report	Maria Principe, Dr Dave Briggs	Assurance	✓	✓	✓	✓	11:35
13.	Finance Report	Bill Shields	Assurance	✓	✓	✓	✓	11:50
Governance								
14.	Annual Reports on Working in Partnership with People and Communities	Clair Raybould	Assurance	✓	✓	✓	✓	12:05
15.	Annual Statements on Health Inequalities	Dr Dave Briggs	Assurance	✓	✓	✓	✓	12:20
16.	Risk Management Policy	Lucy Branson	Decision	✓	✓	✓	✓	12:35
17.	Committee Highlight Reports	Committee Chairs	Assurance	✓	✓	✓	✓	12:45
Closing items								
18.	Risks identified during the course of the meeting	Kathy McLean	Discussion	✓	✓	✓	-	12:55
19.	Questions from members of the public	Kathy McLean	-	✓	✓	✓	-	-
20.	Any other business	Kathy McLean	-	✓	✓	✓	-	-
Meeting close								13:00

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)

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	16/07/2026
Paper title:	Declaration and management of interests
Paper reference:	ICB CIC 26 025
Paper author:	Committee Secretariat
Paper sponsor:	Kathy McLean, Chair
Presenter:	Kathy McLean

Paper type:

For assurance ☐	For decision ☐	For discussion ☐	For information ☒
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Report 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 ICBs' arrangements for the management of conflicts of interests are set out in the organisations' 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 ICBs' agreed arrangements for managing these are provided for reference at Appendix B.

Recommendation(s):

The Boards are asked to **note** this paper for information.

Appendices

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

Board Assurance Framework

Not applicable.

Relevant statutory duties:

☐ Quality improvement	☐ Public involvement and consultation
☐ Reducing inequalities	☐ Equality and diversity
☐ Financial limits/ breakeven	☐ Effectiveness, efficiency and economy
☐ Integration of services	☐ Wider effect of decisions (triple aim)
☐ Promoting innovation	☐ Promoting research
☐ Patient choice	☐ Obtaining appropriate advice

Relevant statutory duties:

☐ Promoting education/training

☐ Climate change

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

NHS Derby and Derbyshire ICB
NHS Lincolnshire ICB
NHS Nottingham and Nottinghamshire ICB
Board Meetings in Common Register of Interests 2026/27

Shaded entries indicate interests that have expired and will be removed from the register six months after the date of expiry.

Surname	Forename	Position	Member of			Declared interest (name of organisation and nature of business)	Nature of interest	Type of Interest				Date of Interest		Action taken to mitigate risk
			NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB			Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Briggs	Dave	Director of Outcomes (Medical)	✓	✓	✓	Member of the British Medical Association	Professional association membership.		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
Dunderdale	Karen	NHS Trust/Foundation Trust Partner Member	–	✓	–	Group Chief Executive of Lincolnshire Community and Hospitals NHS Group	Role within an NHS, local authority or provider organisation.	✓				01/07/2024	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Lincolnshire Community and Hospitals NHS Group.
Dunstan	John	Non-Executive Member	✓	✓	✓	Director and Owner of John Dunstan Limited, a private unlisted company that provides strategic and financial services	Ownership and/or directorship of a private company	✓				01/04/2025	Present	This interest will be kept under review and specific actions determined as required.
Dunstan	John	Non-Executive Member	✓	✓	✓	Contracted via John Dunstan Limited as Chief Finance Officer for KnowCarbon, a Carbon Footprint consulting company in Ireland	External role or association (non-NHS), declared for transparency.	✓				01/04/2025	Present	This interest will be kept under review and specific actions determined as required.
Dunstan	John	Non-Executive Member	✓	✓	✓	Registered patient at Lombard Medical Practice, Newark.	Use of NHS services commissioned by the ICB (registered patient).			✓		01/04/2025	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.
Gildea	Margaret	Non-Executive Member	✓	✓	✓	Chair of the Melbourne Assembly Rooms, a voluntary not for profit organisation that runs the former council controlled leisure centre	Trustee or leadership role in a voluntary, charitable or community organisation		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
Gildea	Margaret	Non-Executive Member	✓	✓	✓	Trustee of Foundations Independent Living Trust Limited, which supports local authorities and home improvement agencies across England to deliver better home adaptations	Trustee or leadership role in a voluntary, charitable or community organisation		✓			01/11/2025	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Foundations Independent Living Trust Limited.
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Chair of the Nottingham Business Improvement District (BID), a business-led, not for profit organisation helping to champion Nottingham.	Trustee or leadership role in a voluntary, charitable or community organisation		✓			01/07/2022	Present	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 Member	✓	✓	✓	Governor at Nottingham High School	Governance role in an education provider (non-NHS).		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Governor at Portland College	Governance role in an education provider (non-NHS).		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Joint Owner and Chief Executive Officer of Imperial Business Consulting Ltd - a management consultancy business, based in Leicestershire.	Ownership and/or directorship of a private company	✓				01/07/2022	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Imperial Business Consulting Ltd
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Registered patient at Ravenshead Surgery (Abbey Medical Group)	Use of NHS services commissioned by the ICB (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 Member	✓	✓	✓	Spouse is a non-executive Director at Nottingham City Transport	Non-executive director role in a private or non-NHS company.				✓	01/11/2023	Present	This interest will be kept under review and specific actions determined as required.
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Spouse is a non-executive director at Nottingham Ice Centre	Non-executive director role in a private or non-NHS company.				✓	01/11/2023	Present	This interest will be kept under review and specific actions determined as required.
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Non-executive director at Birmingham Women's and Children NHS Foundation Trust	Role within an NHS, local authority or provider organisation.	✓				01/10/2024	Present	This interest will be kept under review and specific actions determined as required.
Jackson	Stephen	Non-Executive Member	✓	✓	✓	Non-executive director at Futures Housing Group	Non-executive director role in a private or non-NHS company.	✓				01/02/2025	Present	This interest will be kept under review and specific actions determined as required.

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Lalani	Mehrunnisa	Non-Executive Member	✓	✓	✓	Fitness to Practice Panel Member at the British Association for Counselling and Psychotherapy	External role or association (non-NHS), declared for transparency.	✓				01/01/2025	Present	This interest will be kept under review and specific actions determined as required.
Lalani	Mehrunnisa	Non-Executive Member	✓	✓	✓	Equity, Diversity and Inclusion Strategic Lead at Coventry University Group	External role or association (non-NHS), declared for transparency.	✓				01/01/2025	Present	This interest will be kept under review and specific actions determined as required.
Lalani	Mehrunnisa	Non-Executive Member	✓	✓	✓	Member of the Post Office Scandal Research Advisory Group	External role or association (non-NHS), declared for transparency.		✓			01/01/2025	Present	This interest will be kept under review and specific actions determined as required.
Lalani	Mehrunnisa	Non-Executive Member	✓	✓	✓	Director of Sara (Leicester) LTD, consultancy and advisory services	Ownership and/or directorship of a private company	✓				01/01/2025	Present	This interest will be kept under review and specific actions determined as required.
Lalani	Mehrunnisa	Non-Executive Member	✓	✓	✓	Brother is employed by IBC Healthcare, which provides specialist support and bespoke accomodation to adults with complex care needs	Role within an NHS, local authority or provider organisation.				✓	01/01/2025	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by IBC Healthcare LTD.
Lim	Kelvin	Primary Medical Services Partner Member	–	–	✓	Registered patient at Eastwood Primary Care Centre	Use of NHS services commissioned by the ICB (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	Kelvin	Primary Medical Services Partner Member	–	–	✓	Clinical lead for various projects at Primary Integrated Community Service (PICS), a provider of local health services in the Nottinghamshire area	Role within an NHS, local authority or provider organisation.	✓				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.
McLean	Kathy	Chair	✓	✓	✓	Director of Kathy McLean Limited, a private limited company offering health related advice	Ownership and/or directorship of a private company	✓				01/07/2022	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Kathy McLean Limited.
McLean	Kathy	Chair	✓	✓	✓	Member of the Workforce Policy Board at NHS Employers, an organisation which supports workforce leaders and represents employers in the NHS	Role within an NHS, local authority or provider organisation.		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
McLean	Kathy	Chair	✓	✓	✓	Chair of National Negotiation Committee for staff and associate specialists on behalf of NHS Employers, an organisation which supports workforce leaders and represents employers in the NHS	Role within an NHS, local authority or provider organisation.		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
McLean	Kathy	Chair	✓	✓	✓	Occasional Advisor to the Care Quality Commission, the Independent regulator of health and social care services in England	External role or association (non-NHS), declared for transparency.	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
McLean	Kathy	Chair	✓	✓	✓	Chair of The Public Service Consultants Ltd, a public sector consultancy business	External role or association (non-NHS), declared for transparency.	✓				01/07/2022	Present	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	Chair	✓	✓	✓	Advisor at Lio (formerly Oxehealth) Ltd, a health-tech company that develops digital monitoring and operational platforms focussed on inpatient mental health care.	External role or association (non-NHS), declared for transparency.	✓				01/11/2024	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Lio Ltd.
McLean	Kathy	Chair	✓	✓	✓	Chair of the ICS Network Board at NHS Confederation, a membership organisation for the whole healthcare system in England, Wales and Northern Ireland.	Role within an NHS, local authority or provider organisation.	✓				01/04/2024	Present	This interest will be kept under review and specific actions determined as required.
McLean	Kathy	Chair	✓	✓	✓	Trustee of the NHS Confederation, a membership organisation for the whole healthcare system in England, Wales and Northern Ireland.	Trustee or leadership role in a voluntary, charitable or community organisation		✓			01/06/2025	Present	This interest will be kept under review and specific actions determined as required.
Melbourne	Jon	NHS Trust/Foundation Trust Partner Member	–	–	✓	Chief Executive of Sherwood Forest Hospitals NHS Foundation Trust	Role within an NHS, local authority or provider organisation.	✓				TBC	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 Sherwood Forest Hospitals NHS Foundation Trust
Melbourne	Jon	NHS Trust/Foundation Trust Partner Member	–	–	✓	Director and Shareholder of Ten Five Four Homes Limited	Ownership and/or directorship of a private company	✓				01/08/2022	Present	This interest will be kept under review and specific actions determined as required.

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Mott	Andrew	Primary Medical Services Partner Member	✓	–	–	Managing GP partner at Jessop Medical Practice	Role within an NHS, local authority or provider organisation.	✓				01/07/2022	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Jessop Medical Practice.
Mott	Andrew	Primary Medical Services Partner Member	✓	–	–	Shareholder (via Jessop Medical Practice) of Amber Valley Health Limited, provider of services to Amber Valley Primary Care Network	Role within an NHS, local authority or provider organisation.	✓				01/07/2022	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Amber Valley Health Limited.
Mott	Andrew	Primary Medical Services Partner Member	✓	–	–	Medical Director of Derbyshire GP Provider Board, which develops the future of general practice provision within the Derbyshire health and care system	Role within an NHS, local authority or provider organisation.	✓				01/07/2022	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Derbyshire GP Provider Board.
Mott	Andrew	Primary Medical Services Partner Member	✓	–	–	Spouse is a Consultant Paediatrician at University Hospitals of Derby and Burton NHS Foundation Trust	Role within an NHS, local authority or provider organisation.				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
Posey	Stephen	NHS Trust/Foundation Trust Partner Member	✓	–	–	Chief Executive Officer at University Hospitals of Derby and Burton NHS Foundation Trust	Role within an NHS, local authority or provider organisation.	✓				01/08/2023	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that currently, or could be provided by University Hospitals of Derby and Burton NHS Foundation Trust.
Posey	Stephen	NHS Trust/Foundation Trust Partner Member	✓	–	–	Partner is Chief Executive Officer at the Royal College of Obstetricians and Gynaecologists	Role within an NHS, local authority or provider organisation.				✓	01/08/2023	Present	This interest will be kept under review and specific actions determined as required.
Posey	Stephen	NHS Trust/Foundation Trust Partner Member	✓	–	–	Partner is a non-executive director at Health Innovation Kent Surrey Sussex Ltd, a health innovation network	Non-executive director role in a private or non-NHS company.				✓	01/08/2023	Present	This interest will be kept under review and specific actions determined as required.
Posey	Stephen	NHS Trust/Foundation Trust Partner Member	✓	–	–	Chair of Stakeholder Group at the National Institute for Health and Care Research East Midlands Regional Research Delivery Network	External role or association (non-NHS), declared for transparency.		✓			01/04/2025	Present	This interest will be kept under review and specific actions determined as required.
Posey	Stephen	NHS Trust/Foundation Trust Partner Member	✓			Care Quality Commission Executive Well-Led Reviewer	External role or association (non-NHS), declared for transparency.	✓				19/02/2025	Present	This interest will be kept under review and specific actions determined as required.
Powell	Mark	Ordinary Member - Mental Health	✓	✓	✓	Chief Executive at Derbyshire Healthcare NHS Foundation Trust, provider of mental health services	Role within an NHS, local authority or provider organisation.	✓				01/04/2023	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that currently, or could be provided by Derbyshire Healthcare NHS Foundation Trust.
Powell	Mark	Ordinary Member - Mental Health	✓	✓	✓	Treasurer at Derby Athletic Club	External role or association (non-NHS), declared for transparency.		✓			01/03/2022	Present	This interest will be kept under review and specific actions determined as required.
Principe	Maria	Director of Commissioning	✓	✓	✓	Director of Boho Beauty - Aesthetics and Beauty	Ownership and/or directorship of a private company	✓				01/10/2024	Present	This interest will be kept under review and specific actions determined as required.
Principe	Maria	Director of Commissioning	✓	✓	✓	Registered patient at Bilsthorpe Surgery	Use of NHS services commissioned by the ICB (registered patient).				✓	05/01/2026	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.
Principe	Maria	Director of Commissioning	✓	✓	✓	Son is employed as a helpdesk technician at Sherwood Forest Hospitals NHS Foundation Trust	Role within an NHS, local authority or provider organisation.				✓	05/01/2026	Present	This interest will be kept under review and specific actions determined as required.
Raybould	Clair	Director of Strategy & Citizen Experience	✓	✓	✓	Registered patient at Tasburgh Lodge Practice	Use of NHS services commissioned by the ICB (registered patient).				✓	01/11/2025	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.
Robson	Sharon	Non-Executive Member	✓	✓	✓	Niece employed by NHS England as a Quality Lead. Whilst based in Leeds, covers Maternity and Neonatal Services across the East Midlands Regional Team.	Role within an NHS, local authority or provider organisation.				✓	01/01/2026	Present	This interest will be kept under review and specific actions determined as required.

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Samuels	Martin	Local Authority Partner Member	–	✓	–	Executive Director of Adult Care and Community Wellbeing at Lincolnshire County Council	Role within an NHS, local authority or provider organisation.	✓				01/11/2023	Present	This interest will be kept under review and specific actions determined as required.
Samuels	Martin	Local Authority Partner Member	–	✓	–	Association of Directors of Adult Social Services	External role or association (non-NHS), declared for transparency.		✓			01/04/2023	Present	This interest will be kept under review and specific actions determined as required.
Shields	Bill	Director of Finance	✓	✓	✓	Chair of Financial Recovery Group at the Healthcare Financial Management Association	External role or association (non-NHS), declared for transparency.		✓			01/04/2025	Present	This interest will be kept under review and specific actions determined as required.
Shields	Bill	Director of Finance	✓	✓	✓	Vice Chair of ICB Chief Finance Officers' Forum at the Healthcare Financial Management Association	External role or association (non-NHS), declared for transparency.		✓			01/04/2025	Present	This interest will be kept under review and specific actions determined as required.
Shields	Bill	Director of Finance	✓	✓	✓	Chair of the 360 Assurance Management Board	Role within an NHS, local authority or provider organisation.		✓			01/12/2025	Present	This interest will be kept under review and specific actions determined as required.
Shields	Bill	Director of Finance	✓	✓	✓	Member of Advisory Committee on Resource Allocation	External role or association (non-NHS), declared for transparency.		✓			01/04/2026	Present	This interest will be kept under review and specific actions determined as required.
Shields	Bill	Director of Finance	✓	✓	✓	Chair of CFO AI Network	External role or association (non-NHS), declared for transparency.		✓			01/04/2026	Present	This interest will be kept under review and specific actions determined as required.
Smith	Adrian	Local Authority Partner Member	–	–	✓	Chief Executive of Nottinghamshire County Council	Role within an NHS, local authority or provider organisation.	✓				01/11/2025	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
Sullivan	Amanda	Chief Executive Officer	✓	✓	✓	Registered patient at Hillview Surgery	Use of NHS services commissioned by the ICB (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.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	GP partner at Market Rasen Practice	Role within an NHS, local authority or provider organisation.	✓				01/08/2023	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.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Company Director of RCWT Property Ltd	Ownership and/or directorship of a private company	✓				01/11/2020	Present	This interest will be kept under review and specific actions determined as required.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Clinical Director of East Lindsey Primary Care Network	Role within an NHS, local authority or provider organisation.	✓				01/03/2022	Present	This interest will be kept under review and specific actions determined as required.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Workforce lead at the Lincolnshire Training Hub, which assists with workforce transformation in primary care	Role within an NHS, local authority or provider organisation.	✓				01/04/2021	Present	This interest will be kept under review and specific actions determined as required.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Deputy Chair of the Lincolnshire Primary Care Network Alliance	Role within an NHS, local authority or provider organisation.		✓			01/04/2022	Present	This interest will be kept under review and specific actions determined as required.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Director of East Lincolnshire Primary Care Limited	Role within an NHS, local authority or provider organisation.	✓				01/03/2022	Present	This interest will be kept under review and specific actions determined as required.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Spouse is a salaried GP at Lincolnshire Practice and an employee of United Lincolnshire Hospitals NHS Trust	Role within an NHS, local authority or provider organisation.				✓	01/08/2018	Present	This interest will be kept under review and specific actions determined as required.
Towler	Jon	Non-Executive Member	✓	✓	✓	Registered patient at Sherwood Medical Practice	Use of NHS services commissioned by the ICB (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 Member	✓	✓	✓	Family members are registered patients at Major Oak Medical Practice, Edwinstowe	Use of NHS services commissioned by the ICB (registered patient).				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

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			NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB			Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Towler	Jon	Non-Executive Member	✓	✓	✓	Chair (Trustee and Director) of The Conservation Volunteers: a national charity bringing together people to create, improve and care for green spaces.	Trustee or leadership role in a voluntary, charitable or community organisation	✓				01/12/2022	Present	This interest will be kept under review and specific actions determined as required.
Waddingham	Rosa	Director of Quality (Nursing)	✓	✓	✓	Member of the Advisory Board at NHS Professionals, an NHS staff bank, owned by the Department of Health and Social Care.	Role within an NHS, local authority or provider organisation.		✓			01/09/2023	Present	This interest will be kept under review and specific actions determined as required.
Waddingham	Rosa	Director of Quality (Nursing)	✓	✓	✓	Son is employed as a dispensing manager at Specsavers (Bingham)	Role within an NHS, local authority or provider organisation.				✓	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 Quality (Nursing)	✓	✓	✓	Honorary Professor at Nottingham Trent University	External role or association (non-NHS), declared for transparency.		✓			11/11/2024	Present	This interest will be kept under review and specific actions determined as required.
Waddingham	Rosa	Director of Quality (Nursing)	✓	✓	✓	Division Commissioner for Grantham and the villages / Charity Trustee of GirlGuiding Lincolnshire South	Trustee or leadership role in a voluntary, charitable or community organisation			✓		01/08/2025	Present	This interest will be kept under review and specific actions determined as required.
The following individual will be in attendance at the meeting but is not part of the Committee's membership:														
Branson	Lucy	Director of Corporate Governance and Assurance	✓	✓	✓	Registered patient at St George's Medical Practice	Use of NHS services commissioned by the ICB (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.
Dillstone	Helen	Director of Transition	✓	✓	✓	No relevant interests declared	No interests declared.					—	—	Not applicable
Houlston	Ellie	Public Health Representative	✓			No relevant interests declared	No interests declared.					—	—	Not applicable
Smith	Andy	Local Authority Representative	✓			Strategic Director for People Services	Role within an NHS, local authority or provider organisation.	✓				01/01/2016	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 Derby City Council

Appendix B

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.

Minutes of the meetings in common of:

NHS Derby and Derbyshire ICB Board

NHS Lincolnshire ICB Board

NHS Nottingham and Nottinghamshire ICB Board

21 May 2026, 10:00-13:00

Boardroom, Bridge House, The Point, Lions Way, Sleaford, NG34 8GG

		NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB
Members present:				
Dr Kathy McLean	Chair	✓	✓	✓
Dr Dave Briggs	Executive Director of Outcomes (Medical)	✓	✓	✓
Karen Dunderdale	NHS Trust/ Foundation Trust Partner Member	-	✓	-
John Dunstan	Non-Executive Director	✓	✓	✓
Stephen Jackson	Non-Executive Director	✓	✓	✓
Mehrunnisa Lalani	Non-Executive Director	✓	✓	✓
Dr Kelvin Lim	Primary Care Partner Member	-	-	✓
Jon Melbourne	NHS Trust/ Foundation Trust Partner Member	-	-	✓
Dr Andrew Mott	Primary Care Partner Member	✓	-	-
Stephen Posey	NHS Trust/ Foundation Trust Partner Member	✓	-	-
Mark Powell	Ordinary Member – Mental Health	✓	✓	✓
Maria Principe	Executive Director of Commissioning	✓	✓	✓
Clair Raybould	Executive Director of Strategy and Citizen Experience	✓	✓	✓
Sharon Robson	Non-Executive Director	✓	✓	✓
Martin Samuels	Local Authority Partner Member	-	✓	-
Bill Shields	Executive Director of Finance	✓	✓	✓
Adrian Smith	Local Authority Partner Member	-	-	✓
Amanda Sullivan	Chief Executive	✓	✓	✓
Dr Kevin Thomas	Primary Care Partner Member	-	✓	-
Jon Towler	Non-Executive Director	✓	✓	✓
Rosa Waddingham	Executive Director of Quality (Nursing)	✓	✓	✓
In attendance:				
Lucy Branson	Director of Corporate Governance and Assurance	✓	✓	✓
Diana Camies	Fighting Fit attendee, Mablethorpe Group (for item ICB CIC 26 006)	-	-	-
Trudi Grant	Director of Public Health, Lincolnshire County Council	-	✓	-
Paul Gutherson	Chair, Voluntary and Community Sector Alliance	-	✓	-
Liezi Nagel	Lifestyle Consultant / Exercise Referral Specialist, Magna Vitae Trust for Leisure and Culture Group (for item ICB CIC 26 006)	-	-	-

		NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB
Gurmail Nizzer	Director of Commissioning and Delivery, Derby City Council	✓	-	-
Laura Spurr	Health and Wellbeing Lead, Lincoln City Foundation Group (for item ICB CIC 26 006)	-	-	-
Sue Wass	Corporate Governance Officer, NHS Nottingham and Nottinghamshire ICB (Minutes)	✓	✓	✓
Apologies:				
Margaret Gildea	Non-Executive Director	✓	✓	✓

Cumulative record of members' attendance (from commencement of 'in common' meetings):

Name	Possible	Actual	Name	Possible	Actual
Dr Kathy McLean	1	1	Mark Powell	1	1
Dr Dave Briggs	1	1	Maria Principe	1	1
Karen Dunderdale	1	1	Clair Raybould	1	1
John Dunstan	1	1	Sharon Robson	1	1
Margaret Gildea	1	0	Martin Samuels	1	1
Stephen Jackson	1	1	Bill Shields	1	1
Mehrunnisa Lalani	1	1	Adrian Smith	1	1
Dr Kelvin Lim	1	1	Amanda Sullivan	1	1
John Melbourne	1	1	Jon Towler	1	1
Dr Andrew Mott	1	1	Dr Kevin Thomas	1	1
Stephen Posey	1	1	Rosa Waddingham	1	1

Introductory items

ICB CIC Welcome, introductions and apologies

26 001

The Chair welcomed members and attendees to the meetings in common of the Boards of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB (hereafter referred to collectively as "the Boards" unless the item being discussed pertains to an individual ICB).

A round of introductions was then undertaken, and apologies noted as above.

Welcome was extended to Gurmail Nizzer, who was in attendance pending the appointment of a substantive Chief Executive at Derby City Council; and as the Boards were meeting in Lincolnshire, a welcome was also extended to Trudi Grant and Paul Gutherson.

ICB CIC Confirmation of quoracy

26 002

The meetings were confirmed as quorate.

ICB CIC Declarations and management of interests

26 003

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 CIC Minutes of the meeting held on 19 March 2026

26 004 The minutes were agreed as an accurate record of the discussions held.

ICB CIC Matters arising from the meeting held on 19 March 2026

26 005 No actions were recorded from the last meeting and no other matters were raised.

Leadership and operating context

ICB CIC Citizen Story: Fighting Fit

26 006 The Chair invited Clair Raybould to introduce the item, and the following points were highlighted:

- a) Fighting Fit was a Lincolnshire-based initiative focused on improving health, wellbeing and physical activity levels across local communities, with a specialist focus on supporting people living with and beyond cancer. It was a good example of how several organisations were working together for the benefit of communities and to improve the quality of life for individuals whose lives had been impacted by cancer.
- b) It was run by Lincoln City Foundation, supported through a grant from the Tackling Inequalities Fund (now Together Fund) distributed through Active Lincolnshire. Eligible patients received ten free sessions and paid a small contribution towards any further sessions should they wish to continue, which many did.
- c) Laura Spurr and Liezi Nagel provided an overview of the support that the service offered, noting that its offer aligned closely with Commitment Four of the National Cancer Plan, providing accessible, community-based intervention to improve physical, psychological and social wellbeing.
- d) Diana Camies explained to members how the service had supported her to regain confidence and fitness following two rounds of treatment for cancer, noting that it was a much-valued resource.

The following points were made in discussion:

- e) Responding to a question regarding whether the service felt joined up for the people running the service, it was noted that the offer was not consistent across different geographies within Lincolnshire, which was an aspiration going forward.
- f) Following on from this discussion, there was a question as to whether there were similar services within Derbyshire and Nottinghamshire, and it was reported that all geographies had the involvement of professional football clubs'

charitable foundations, which was considered an invaluable resource for the initiatives.

- g) Discussing how the success of the initiative was evaluated, it was noted that there was much qualitative data; although, with the exception of the one pre-rehabilitation service, which ran in Lincoln, quantitative data was not collected at this time. However, going forward there could be a method of capturing more quantitative data using an 'e-gym' application.
- h) Members highlighted the need to ensure that these services were being offered on a consistent basis to everyone eligible to access it; and it was agreed that Dr Dave Briggs would take forward work within the Outcomes Directorate to maximise the impact of the service.
- i) The Chair thanked Laura, Liezi and Diana for their motivating presentation.

The Boards **noted** the Citizen Story.

At this point Laura Spurr, Liezi Nagel and Diana Camies left the meeting.

ICB CIC Chair's Report

26 007 Kathy McLean introduced the item, highlighting the following points:

- a) Noting the recent appointment of the Rt Hon James Murray MP as the new Secretary of State for Health and Social Care, Kathy asked members to note that there was no indication of a change of policy direction at this time; and the recently published Health Bill was due to receive its second reading in Parliament at the beginning of June.
- b) Although the Bill contained some significant changes in health architecture, there were some areas that lacked clarity and a session had been included on the Boards' forward work programme to examine the implications of the changes in some detail later in the year, when the Bill had progressed further through the Parliamentary process. It would also be an opportunity to examine local government reorganisation, as Government announcements on local authority reform were expected before the summer recess.
- c) The ICBs' management of change process to enact the nationally mandated cost reductions continued; and thanks were given both to those ICB colleagues who were leaving the organisation, having taken voluntary redundancy, and to colleagues who continued to work hard under challenging circumstances.
- d) With reference to the forthcoming publication of the Ockenden Review into Maternity Services at Nottingham University Hospitals NHS Trust and the continuing Public Inquiry into the Nottingham attacks, Kathy noted the need for the ICBs to be well prepared to take forward any agreed recommendations or actions stemming from the reviews.
- e) Noting that that annual appraisals for non-executive directors had now been completed, the annual Fit and Proper Person Test (FPPT) review process for

all Board members would commence, which formed part of the ICBs' ongoing arrangements to support compliance with the NHS England FPPT Framework.

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

ICB CIC Chief Executive's Report

26 008

Amanda Sullivan introduced the item, highlighting the following points:

- a) Asking the Boards to note the letter from NHS England Chief Executive, Sir James McKay, regarding collective priorities for 2026/27, productive conversations with system partners continued to align the medium-term actions required to transform services.
- b) The process for the annual assessment of ICBs by NHS England was underway. Recognising the significant organisational changes taking place, this would be a proportionate exercise to minimise impact on ICBs.
- c) The ICBs would be shortly undertaking a baseline self-assessment against NHS England's Strategic Commissioning Framework, which would inform the organisational structure of the ICBs and their development programmes. The output of the exercise would be presented to the Boards when available.
- d) The publication of recent guidance on the development of Neighbourhood Health Centres was welcomed. The ICBs were co-ordinating the development of a pipeline of centres and proposals would be refined over the summer.
- e) Asking members to note changes in the delivery of Freedom To Speak Up activities, the ICBs were currently reviewing and aligning their arrangements, which would include the involvement of Mehrunnisa Lalani, as Non-Executive Lead for Freedom to Speak Up, with oversight by the Audit Committees.
- f) The publication of the ICBs' updated Modern Slavery and Human Trafficking Statements was highlighted.
- g) Asking the Boards to note the approval of a revised Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Policy by the ICBs' Audit Committees, attention was drawn to the recent work undertaken to strengthen emergency response processes to provide a more robust and consistent approach to managing EPRR incidents. The Policy set out how the ICBs would meet their statutory and regulatory duties to prepare for, respond to, and recover from emergencies and business continuity incidents. It established a single framework for governance, accountability, risk management, training, exercising, assurance and continuous improvement across the three ICBs, aligned to the Civil Contingencies Act, NHS EPRR Framework, NHS EPRR Core Standards, and ISO 22301 principles. The policy clarified roles and requirements as well as EPRR resourcing across the ICBs to ensure effective delivery of the EPRR programme. In effect, it provided the overarching organisational and system-wide approach to maintaining resilient services and protecting patient safety, whilst making clear that incident-specific response plans must be used during an actual event. This policy was noted as

particularly pertinent, as the UK's national terrorism threat level had been raised from 'substantial' to 'severe', indicating that an attack was considered highly likely. EPRR Teams were also working with the UK Health Security Agency to monitor the Hantavirus situation closely, although there was no evidence at present of sustained community transmission within the UK.

- h) Reference was made to other recent national announcements and publications, including plans to address corridor care and the publication of the Women's Health Strategy.

The following points were made in discussion:

- i) There was a query regarding the ICBs' response to the Women's Health Strategy. It was noted that its contents would be discussed at the Women and Children's and Young People's Programme Board, which was due to meet for the first time in June 2026 and assurance on progress would be provided to the Joint Strategic Commissioning Committee.
- j) Discussing changes to Freedom to Speak Up arrangements and noting that it had historically been difficult to have a consistent arrangement for GP practices, Dr Andrew Mott noted that Derbyshire had operated a centralised approach. It was agreed that this could be an area for alignment across the ICBs and work would be taken forward to that effect.
- k) Regarding the ICBs' refreshed EPRR and Business Continuity Policy, Trudi Grant asked whether the role of the Directors of Public Health in collaborating with ICBs regarding EPRR arrangements could be further drawn out within the Policy to provide greater assurance of partnership arrangements; and it was agreed that the Policy should be amended to reflect this ahead of its publication.
- l) Welcoming the implementation of a more consistent approach to managing EPRR arrangements within the ICBs, the Chair hoped that this would translate into full compliance with NHS Core Standards for each ICB following the self-assessment later in the year.

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

Actions:

- **Lucy Branson to add a report on how actions from the Women's Health Strategy were being taken forward to the work programme of the Joint Strategic Commissioning Committee.**
- **Lucy Branson to progress alignment of Freedom to Speak Up arrangements between the ICBs.**
- **Maria Principe to amend the EPRR and Business Continuity Policy to add further detail on the role of the Directors of Public Health in collaborating with ICBs.**

Strategy and partnerships

ICB CIC Neighbourhood Health Development

26 009

Clair Raybould and Maria Principe introduced the item, highlighting the following points:

- a) The report provided an overview of the recently published national Neighbourhood Health Framework and its implications for ICBs as strategic commissioners.
- b) Whilst statutory accountability for NHS commissioning remained with ICBs, the framework was explicit that neighbourhood health plans should be developed jointly through Health and Wellbeing Board-led partnership arrangements, involving local authorities, providers, primary care, voluntary, community and social enterprise organisations, and wider partners.
- c) It placed increasing expectations around neighbourhood-based commissioning and integrated provider delivery arrangements and called for a progressive shift of activity and resource into community settings where clinically appropriate.
- d) Acknowledging the complexity of delivering the ambitions, a pragmatic phased approach was proposed for 2026/27 to focus initially on the nationally mandated minimum requirements, building on existing place and neighbourhood arrangements, avoiding any unnecessary structural disruption in-year, and ensuring alignment with Health and Wellbeing Board partnership arrangements.

The following points were made in discussion:

- e) Noting that neighbourhood health was an aspiration that had been discussed over many years, but had not been able to be fully realised, members queried what mechanisms were now in place to achieve the ambitions in the Framework. It was noted that there were incentives within the Framework for partners to work together in a much more systematic joined-up manner. Nevertheless, the complexity of the task should not be underestimated. There were outstanding questions in areas such as the flow of finance; and digital and governance considerations, which all required resolution at pace. It was noted that without a financial framework to support change, it would be difficult to achieve the ambitions.
- f) Regarding potential financial frameworks, Bill Shields asked members to note that there needed to be an alignment of incentives, with the use of contractual levers following the ending of block contract arrangements. Although it had been disappointing that the majority of the proposed Transformation Fund monies set aside for 2026/27 had needed to be utilised by several acute trusts for non-recurrent purposes, over the following two years, it was expected that the Fund would yield circa £99 million for neighbourhood health transformation.

- g) It was further noted that commissioning would need to be on an outcomes-basis, with lead provider arrangements that could bring in wider delivery partners, such as those from the voluntary, community and social enterprise sectors. The importance of maintaining focus on the priority of meeting constitutional standards was highlighted.
- h) It was noted that the pragmatic approach also related to building on the progress already started by, for example, Primary Care Networks, which may not result in a consistent approach in the short term, but it was important not to lose valuable work and best practice.
- i) Members discussed the culture shift, both within organisations and within the wider public, that would be required to ensure success. It was noted that close commissioner-provider relationships would be key. The need for a wider vision, or long-term statement of intent, setting out how the model of public services would be different in order to ensure buy-in was also raised.
- j) Mark Powell asked for mental health services to be more explicit in the plans and this was agreed.
- k) Querying oversight arrangements, members noted that oversight within the ICB would be undertaken by the Joint Strategic Commissioning Committee. A wider partnership grouping would also be required, which would incorporate Health and Wellbeing Board representatives; however, this was a medium-term focus.
- l) Acknowledging the complexity of the task for the NHS element of implementation, the Boards endorsed the pragmatic approach to be taken during 2026/27. However, members asked the ICBs to ensure strong connections and communications with all partners, with updates on progress, as the long-term vision was for fully integrated services as part of the Government's public service reform.

The Boards **noted** the report and **endorsed** the proposed approach to implementation during 2026/27.

ICB CIC Joint Capital Resource Use Plans 2026/27

26 010

Bill Shields introduced the item, highlighting the following points:

- a) There was a requirement for the ICBs and their partner NHS trusts to prepare and publish annual plans setting out their planned capital resource use.
- b) Endorsed by the ICBs' Joint Finance and Performance Committee at its May 2026 meeting, the Joint Capital Resource Use Plans demonstrated how resources would be prioritised in line with national guidance and local priorities; and were presented for approval ahead of submission to NHS England by the stated deadline.
- c) In recent years, the capital envelope had been 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.

- d) Members were asked to note that the Plans would be subject to change as arrangements were firmed up around neighbourhood health centres and as the ICBs responded to local actions arising from, for example, the recent policy announcement regarding the NHS Property Services portfolio.
- e) Progress of the Plans would be subject to oversight by the Joint Finance and Performance Committee on a quarterly basis.

The following points were made in discussion:

- f) Discussing backlog maintenance within large NHS trusts, it was acknowledged that the current funding envelope would not be sufficient to address this in full and Trusts would need to explore other mitigating actions, such as service reconfiguration.
- g) In response to a query on whether more emphasis and resource could be put towards frontline digitalisation, it was noted that the ICBs had recently submitted a bid for national funds to take forward a different approach to digitalisation. It was noted that the Joint Strategic Commissioning Committee would oversee progress, ahead of a scheduled Board update later in the year.

The Boards **approved** the 2026/27 Joint Capital Resource Use Plans for NHS Derby and Derbyshire, NHS Lincolnshire and NHS Nottingham and Nottinghamshire ICBs.

Delivery assurance

ICB CIC Finance Report

26 011 Bill Shields introduced the item, highlighting the following points:

- a) The combined financial position of the ICBs and NHS providers at the end of the 2025/26 financial year was noted as an overall position of £201.8 million adverse to plan. Nottingham and Nottinghamshire providers remained the key driver of the position at £163.3 million adverse to plan, mainly due to staffing cost pressures and shortfalls in efficiency delivery. Derby and Derbyshire providers ended the year £40.6 million adverse to plan, whilst Lincolnshire providers were £8.2 million above plan.
- b) NHS Nottingham and Nottinghamshire ICB had ended the year with a deficit position of £6.2 million, entirely due to the non-receipt of Deficit Support Funding, as discussed at previous meetings. NHS Derby and Derbyshire ICB posted a small £0.1 million favourable variance and NHS Lincolnshire ICB delivered to plan. All other key financial duties for the ICBs had been delivered, with capital spending remaining within allocation, Mental Health Investment Standard spend targets achieved, cash balances delivered under maximum allowed, running costs delivered within target, and all Better Payment Practice Code targets met.

The following points were made in discussion:

- c) In response to a query regarding arrangements for oversight of NHS providers' financial plans, it was clarified that going forward, NHS England had resumed responsibility for oversight. The same rigorous management of ICB plans would continue to ensure that the ICBs met their statutory duties within 2026/27. There was currently a reasonable level of efficiency savings still to be identified, but progress on the development of efficiency plans was ahead of previous years. Irrespective of changed oversight arrangements, the Chair noted the importance of the ICBs and NHS providers continuing to work together as systems to ensure financial plans continued to meet the expectations in the operational plan.
- d) In response to a query as to the ramification of NHS Nottingham and Nottinghamshire ICB not meeting its financial plan target, it was noted that the ICB's External Auditor would be required to write formally to the Secretary of State on the matter. However, the breach was a technical issue, which had been discussed in detail with NHS England over the past months.

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

ICB CIC Commissioning Oversight Report

26 012 Maria Principe introduced the item, highlighting the following points:

- a) The report provided an overview of the national priority service delivery metrics against the operational plans submitted for 2025/26 for NHS Derby and Derbyshire, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire ICBs, as well as an update on the developing arrangements for commissioning leadership and oversight across the ICBs' areas, and the transitioning arrangements for provider oversight and delivery.
- b) Overall, detail within the report reflected a pressured system; however, there were clear areas of progress and a strengthened commissioning approach to support recovery and delivery.
- c) A revised commissioning oversight approach was being implemented across the ICBs to strengthen commissioner-led oversight of performance, finance, quality, contracting and operational delivery. This represented a significant cultural shift towards a more proactive and co-ordinated commissioning model focused on delivery, escalation and system accountability.
- d) The full roll out of programme oversight arrangements would take place during June, with Programme Boards established over all areas of ICB-commissioned services.

The following points were made in discussion:

- e) Members sought assurance that the revised arrangements would have a positive impact on areas of sustained under performance. It was noted that the

dismantling of block contract arrangements and the establishment of programme boards would enable a far more rigorous oversight of performance and enable prompt action to be taken in areas where performance was off trajectory.

- f) The Chair asked that the revised format of the report included plans, trajectories and current performance in priority areas, such as outpatient performance. The Chair also asked that the report contained sufficient data to enable the Boards to focus on where outcomes differed across the ICB geographies.

The Boards **noted** the report.

Action: Maria Principe to reflect on the discussion on the future format of the Commissioning Oversight Report and present a revised report at the next meeting.

ICB CIC Quality Report

26 013

Rosa Waddingham introduced the item, highlighting the following points:

- a) The report provided a summary of the quality issues affecting commissioned services across the three ICB areas. The status and progress of improvement plans for those providers within the highest level of NHS England's National Oversight Framework was also provided within the report.
- b) The report also reflected the transition to a single cluster-wide System Quality Group, which from May 2026, would provide a consolidated forum for system-level quality oversight, intelligence sharing and escalation. It would highlight key risks, areas of focus, and the mitigating actions in place to address quality concerns and confirmed how assurance was obtained through established governance arrangements.
- c) Quality priorities were detailed within the report and the ICBs' role was to maintain effective system oversight and escalation arrangements, identifying areas of deteriorating performance and safety risks and supporting improvement by strengthening system learning and assurance processes.
- d) Members were asked to note that, as quality concerns were interlinked with performance concerns, going forward the metrics associated with quality oversight would be incorporated into the Commissioning Oversight Report.

The following points were made in discussion:

- e) Chair of the Joint Quality and Service Improvement Committee, Sharon Robson, asked the Boards to note that the Committee was supportive of the revised approach to reporting arrangements and the Committee was able to interrogate a more in-depth report going forward.

The Boards **noted** the report.

ICB CIC Annual Equality Assurance Report

26 014

Rosa Waddingham introduced the item, highlighting the following points:

- a) The annual assurance report described how the ICBs were meeting the Public Sector Equality Duty, as required by the Equality Act 2010. The report set out how a systematic approach to 'due regard' had been applied, including the routine use of equality impact assessments, targeted engagement with underserved groups, data-driven commissioning, and robust governance oversight. Equality considerations had also been integral to organisational change, supported by structured and transparent processes.
- b) The ICBs had self-assessed themselves against domain one of the NHS Equality Delivery System, regarding commissioned services; and further detail was provided within the report. Formal assessments against domains two and three had not been completed for 2025/26, due to the ongoing organisational change programme.
- c) It was acknowledged that, due to the management of change process currently being undertaken within the ICBs, this was somewhat of a retrospective report; however, key areas for further development in 2026/27 included developing joint equality objectives, improving the quality and consistency of impact assessments, strengthening the use of equality data, and the full implementation of the NHS Equality Delivery System.

The following points were made in discussion:

- d) In discussion, members highlighted the importance of the Boards leading the promotion of an inclusive culture throughout the ICBs in order to set an inclusive environment within the ICBs and welcomed the enhancing of mandatory training requirements to provide this.
- e) Further to this point, members were asked to note that the ICBs' Joint Remuneration and Human Resource Committee had raised concern regarding a lack of diversity amongst the ICBs' senior leadership team and had tasked the Executive Team to focus on this issue moving forward.
- f) There was a wider discussion regarding measures to capture patient experience and it was noted that going forward, reports such as the Ockenden review of maternity services would help to challenge the ICBs' future actions with regard to ensuring equality, diversity and inclusion were embedded across commissioned services.

The Boards received the item for **assurance** that the ICBs were meeting their statutory equality duties.

ICB CIC Senior Information Risk Owner Annual Report

26 015

Dr Dave Briggs introduced the item, highlighting the following points:

- a) The report provided assurance that information risks were being managed effectively within the ICBs. It summarised the work undertaken in-year, including management of information and cyber security risks and incidents and the progress made towards meeting the requirements of the NHS Data Security and Protection Toolkit.
- b) It also summarised the key activities undertaken during 2025/26, including work completed to meet the requirements of the Data Security and Protection Toolkit, and provided assurance on the management of cyber security and information risks and incidents.
- c) The ICBs' Audit Committees had reviewed and endorsed the report at their May 2026 meetings in common.

The following points were made in discussion:

- d) Highlighting that one of the key risks was the potential for a cyber security breach to lead to the use of manual systems, members noted that a cyber incident exercise was due to take place over the summer.
- e) It was further noted that one of the weakest areas with regard to cyber security was within small service providers with less sophisticated anti-virus software and work was being undertaken at a national level on this issue.

The Boards **received** the item for assurance that information risks were being managed appropriately and that the ICBs are complying with statutory, regulatory, and legal obligations.

ICB CIC Committee Highlight Reports

26 016

The report presented an overview of the work of the committees since the Boards' last meeting in March 2026; 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.

Updates from the Committee Chairs were invited by exception and the following points were highlighted:

- a) Chair of the Joint Finance and Performance Committee, Stephen Jackson, asked members to note that the Committee continued to oversee progress of several key estate-related programmes.
- b) Chair of the Joint Quality and Service Improvement Committee, Sharon Robson, informed the Boards that the Committee had taken full assurance that the Patient Safety Incident Response Framework had been embedded across all three ICBs.
- c) Chair of the Joint Transition Committee, Jon Towler, asked members to note the good progress being made to implement the transition programme.

- d) Chair of the Audit Committees, John Dunstan, asked the Boards to take assurance that the Committees had reviewed the ICBs' unaudited draft annual reports and accounts for 2025/26, with no concerns raised ahead of approval at the June 2026 meeting.
- e) Discussing the ICBs' high-level risks appended to the report, it was noted that work continued to strengthen reporting arrangements and a further discussion would take place at the Boards' June 2026 development session, which would examine the organisations' joint risk appetite.

The item was **noted** by the Boards.

Closing items

ICB CIC Risks identified during the course of the meeting

26 017 No new risks were identified.

ICB CIC Questions from the public relating to items on the agenda

26 018 No questions had been received.

ICB CIC Any other business

26 019 No other business was raised, and the meeting was closed.

Action Log from Board meetings in common, held on 21 May 2026

Meeting date	Agenda item	Action	Lead	Due date	Updates	Status
21.05.2026	ICB CIC 26 008	To add a report on how actions from the Women's Health Strategy were being taken forward to the work programme of the Joint Strategic Commissioning Committee.	Lucy Branson	16.07.2026	Added to the Committee's work programme, with a report scheduled in October 2026.	Closed – action completed
21.05.2026	ICB CIC 26 008	To progress alignment of Freedom to Speak Up arrangements between the ICBs.	Lucy Branson	17.09.2026	Not yet due – aligned interim arrangements have been established across the ICBs, with new Guardian roles to be recruited to as part of the management of change process. Further discussions to be held in relation to arrangements for primary care.	Open – on track
21.05.2026	ICB CIC 26 008	To amend the EPRR and Business Continuity Policy to add further detail on the role of the Directors of Public Health in collaborating with	Maria Principe	16.07.2026	Policy amended to include further detail on the role of the Directors	Closed – action

Meeting date	Agenda item	Action	Lead	Due date	Updates	Status
		ICBs.			of Public Health.	completed
21.05.2026	ICB CIC 26 012	To reflect on the discussion on the future format of the Commissioning Oversight Report and present a revised report at the next meeting.	Maria Principe	16.07.2026	See agenda item 12.	Closed – action completed

Key:

Closed – Action completed or no longer required

Open – Off-track (may not be completed by expected date of completion)

Open – On-track (to be completed by expected date of completion)

Open – Off-track (has not been completed by expected completion date)

Meeting title	Integrated Care Boards: Open Session (meeting in common)
Meeting date	16/07/2026
Paper title	Citizen Story
Paper reference	ICB CIC 26 028
Paper author	Abi Cuffling, Communications Officer, NHS Lincolnshire ICB
Paper sponsor	Clair Raybould, Executive Director for Strategy and Citizen Experience
Presenter	Clair Raybould

Paper type
For assurance ☐ For decision ☐ For discussion ☒ For information ☐

Report summary

Derby and Derbyshire Team Up, a collaborative partnership between the NHS Derby and Derbyshire ICB, Derbyshire County Council, and Derby City Council, is a person-centred, neighbourhood-based model of integrated care that brings together multidisciplinary teams around Primary Care Networks and local communities to deliver coordinated care across health, social care and community services.

By enabling professionals to work collaboratively and respond rapidly to changing needs, the model supports people to receive the right care, at the right time, in the right place. Whilst performance data demonstrates the effectiveness of this approach, patient stories provide valuable insight into the difference integrated neighbourhood working makes to individuals and their families.

Recommendation(s)

The Boards are asked to **discuss** the citizen story.

Appendices

None.

Board Assurance Framework

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

- Failure to deliver a coordinated transformation of commissioned services, including prevention, community care models, and digital enablement

Relevant statutory duties

☒ Quality improvement	☐ Public involvement and consultation
☒ Reducing inequalities	☐ Equality and diversity
☐ Financial limits/ breakeven	☒ Effectiveness, efficiency and economy
☒ Integration of services	☐ Wider effect of decisions (triple aim)

Relevant statutory duties☐ Promoting innovation☐ Promoting research☒ Patient choice☐ Obtaining appropriate advice☐ Promoting education/training☐ Climate change**Are there any conflicts of interest requiring management?**

No.

Is this paper confidential?

No.

Citizen Story

1. The Derby and Derbyshire Team Up Team are sharing the story of Barbara, aged 87, who was living with dementia and had moved in with her daughter, Lucy, two years earlier. Barbara's story tells of the challenges and omissions in Barbara's care support, as well as the obstacles faced by her daughter Lucy and the impact of those.
2. Barbara's story outlines how, after a referral to the South Derbyshire Local Navigation Hub, they were able to convene a rapid multidisciplinary team, bringing together the community GP, Advanced Clinical Practitioner, Emergency Care Practitioner, care coordinator, district nursing and adult social care.
3. A visit to Barbara by these specialists identified that Barbara had not eaten or drunk for over a week and had no equipment, continence support, advance care planning or anticipatory medications in place. Working together, the multidisciplinary team made timely decisions to coordinate care that enabled Barbara to remain at home, in line with her wishes. Within hours, a comprehensive package of support was implemented, including a fast-track care package with four daily care visits, delivery of a hospital bed and pressure-relieving equipment, overnight support, nutritional supplements, continence support, dementia palliative care input, completion of a RESPECT form and anticipatory care planning. Regular contact from the Advanced Clinical Practitioner and wider team also provided Lucy with practical guidance and emotional support, helping her understand what to expect as Barbara approached the end of her life.
4. Barbara died peacefully at home less than two weeks later, surrounded by her family. Lucy reflected that the coordinated support enabled her to spend her mother's final days as a daughter rather than solely as a carer, and that Barbara was able to die with dignity in the place she wanted to be.
5. This case demonstrates the value of integrated, person-centred care delivered through rapid multidisciplinary collaboration. Early intervention, trusted relationships and coordinated decision-making enabled services to respond quickly, avoid an unnecessary hospital admission, and provide compassionate end-of-life care that reflected Barbara's wishes while supporting Lucy through an exceptionally difficult time. It also highlights the importance of building trust with patients and carers, recognising the value of home visits in fully understanding need, and creating the conditions that enable multidisciplinary teams to make timely, confident decisions.
6. Barbara's story reflects the wider impact of the Team Up model across Derby and Derbyshire. Between April 2024 and February 2025, Team Up released

more than **3,000 hours of GP capacity**, avoided **429 attendances at Accident and Emergency** for people with severe frailty, prevented **262 hospital admissions**, and saved **2,253 hospital bed days**. In addition, enhanced falls responses supported **226 people in their own homes**, resulting in **188 fewer ambulance dispatches**, **79 fewer hospital conveyances**, and a further **690 hospital bed days saved**.

7. Whilst these figures demonstrate improved system efficiency and capacity, Barbara's experience illustrates the human impact of integrated neighbourhood working—delivering coordinated, compassionate care that improves outcomes for patients, supports carers, and enables people to receive care in the place they choose.

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	16/07/2026
Paper title:	Chair's Report
Paper reference:	ICB CIC 26 029
Paper author:	Dr Kathy McLean, Chair
Paper sponsor:	Dr Kathy McLean
Presenter:	Dr Kathy McLean

Paper type:

For assurance ☐ For decision ☐ For discussion ☐ For information ☒

Report summary:

This report outlines my activities and actions in my role as Chair of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB, and provides an update on the NHS Reform process, alongside a synopsis of some of the meetings I have attended on behalf of the ICBs.

Recommendation(s):

The Boards are asked to **note** this paper for information.

Board Assurance Framework

Not applicable.

Relevant statutory duties:	
☒ Quality improvement	☒ Public involvement and consultation
☐ Reducing inequalities	☐ Equality and diversity
☒ Integration of services	☐ Wider effect of decisions (triple aim)
☒ Promoting innovation	☐ Promoting research
☐ Patient choice	☐ Obtaining appropriate advice
☐ Promoting education/training	☐ Climate change

Appendices

None.

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Chair's Report

Introduction

1. The publication of Donna Ockenden's independent review into maternity services at Nottingham University Hospitals NHS Trust, alongside Baroness Amos' national investigation into maternity and neonatal services, has rightly prompted significant reflection across the NHS. The experiences described by families are deeply distressing and our thoughts remain with all those affected. Their courage in sharing their experiences must lead to lasting change.
2. These reports reinforce the importance of placing women, babies and families at the centre of service improvement, listening carefully when concerns are raised, and fostering cultures where staff are empowered to speak up about safety. As Chairs, we have an important role in ensuring that organisations are held to account for delivering sustainable improvements and that appropriate oversight arrangements remain in place.
3. As ICBs, we remain committed to supporting improvement in maternity and neonatal services and seeking assurance that learning from both reviews is translated into meaningful and measurable change for local communities.
4. The Nottingham Inquiry, which began in February, concluded its evidence hearings on 5 June, having heard from 164 witnesses to build a clear understanding of the events, acts and omissions that led to the attacks in Nottingham on 13 June 2023. Our thoughts remain with the families of Ian, Grace and Barnaby who were killed and also with Wayne, Sharon and Marcion who were injured. Amanda Sullivan attended to provide evidence from NHS Nottingham and Nottinghamshire ICB's perspective during the final week of the Inquiry's evidence phase.
5. Judge Deborah Taylor is chairing the Inquiry and we anticipate her report being published next spring. In the meantime, extensive governance arrangements, including oversight from the ICB and regional and national NHS England teams, are in place to monitor quality and regulatory concerns at Nottinghamshire Healthcare NHS Foundation Trust. Senior ICB leaders are part of this process, including the Chief Executive and Executive Director of Quality (Nursing).
6. These arrangements provide scrutiny for operational and quality risks and provide wider stakeholders, including specialised commissioning teams within NHS England and the Care Quality Commission, with a single forum to support and challenge the progress of improvements at the Trust. We are committed to safe and high-quality services for our communities and we will continue to provide support and challenge to the Trust to ensure sustained improvements in the delivery of safe services.

National matters

7. I welcome the resolution of the resident doctors' dispute following acceptance of the Government's revised offer and would like to thank NHS colleagues across our organisations who worked hard to maintain patient services during a prolonged period of industrial action.
8. Whilst the possibility of further industrial action remains following the recent consultant ballot, I am confident that partners across our systems will continue to work effectively together to prioritise patient safety and minimise disruption to services.

Local matters

9. The ICBs continue to make significant progress in delivering the nationally required reduction in operating costs and in developing future organisational arrangements across the cluster. This has been a challenging period for colleagues and I would like to recognise the professionalism, resilience and commitment that staff have demonstrated throughout the programme.
10. My priority during this period has been to ensure that change is undertaken in a transparent and supportive manner, with appropriate engagement of staff and recognised trade unions, while maintaining organisational stability and continuing delivery of our statutory responsibilities and strategic priorities.
11. I would also like to formally thank those colleagues who have now left the organisations through the voluntary redundancy process. Their contributions have played an important role in supporting the health and wellbeing of our communities and I am grateful for their service.
12. I have continued discussions with partners, local authorities, elected representatives and NHS organisations regarding the future development of the NHS operating model and proposals relating to ICB mergers. My focus has been on ensuring that the views of local stakeholders are reflected in discussions with NHS England and that strong local relationships and place-based leadership arrangements are maintained through any future organisational changes.
13. I also met with the East Midlands Mayor and representatives of the East Midlands Combined County Authority to discuss the implications of health reform, neighbourhood health and opportunities to strengthen partnership working across health, care and wider public services. These conversations demonstrate the increasing importance of collaboration across organisational boundaries in improving health outcomes for local communities.
14. We have commenced discussions with local partners to plan Neighbourhood Health Centres (NHCs) across the three ICB areas, focusing on location, accessibility, integration, funding, and delivery models. This has included

engagement with our key local stakeholders including elected members and other partners. NHCs will be a key enabler of the delivery of the Neighbourhood Health Service and so it is really important that we are developing our plans in partnership with organisations that share our whole-population approach and who might be able to pull levers like housing, transport, employment, which all have a direct impact on health and wellbeing. These conversations will continue through the next few months to reach consensus and realise these opportunities.

15. Work on our Five-Year Population Health Strategy continues, and the July Board meeting is receiving a specific paper on that. Our Board agendas have been set to ensure focus on our identified priority areas, and in July we will hear more detail about our work on frailty and end of life care.
16. I have continued my visits to local services, which have proved invaluable in understanding in greater depth the services we fund for local residents, the fabulous work of teams in our communities, as well as helping to identify where we may have common issues that can help our Boards in their roles. During June, I visited the End of Life Referral Hub serving Mid and North Nottinghamshire. The visit provided an excellent opportunity to see first-hand how partners are working together to improve people's experiences at the end of life and help more individuals receive care in the place of their choice. I was particularly encouraged by the strong focus on partnership working and coordinated care, which aligns closely with the ambitions of our Population Health Strategy and demonstrates the benefits that can be achieved through integrated approaches to service delivery.
17. Earlier this month I also attended, the opening of an impressive state of the art endoscopy unit at the Queen's Medical Centre. This is a great example of a development that will benefit patients across our entire cluster, not only by delivering high quality complex care, but by training clinicians to work across the East Midlands.
18. I also continue with my series of podcasts with health and care leaders from across the system. I am hosting the next of these on the Shared Care Record, which assists clinicians from across our health services in accessing vital patient information to support joined up care. I will be joined by clinical and digital colleagues from across the cluster, and the output will be published in July.

Board matters

19. As part of our annual governance processes, I can confirm that the annual 'Fit and Proper Person Test' assessment for each individual Board member of the three ICBs 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 30 June 2026.

Looking forward

20. It is clear from this report, and also the other items on today's agenda, that a huge volume of activity is taking place across the ICBs' footprints to deliver our Population Health Strategy, develop our role as strategic commissioners, work alongside NHS England to identify and improve quality of care where necessary, and live within our budget allocation, alongside the internal re-organisation. As ever, we must track progress in all of these areas but use our commissioning role to deliver our core aim of population health improvement, and finding stability following the period of significant change, and the organisational development that will support that, will be an important focus for the next few months.
21. Once again, I want to underline my empathy for colleagues undergoing a considerable period of change and thank them for their fortitude and resilience as we move forward.

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	16/07/2026
Paper title:	Chief Executive's Report
Paper reference:	ICB CIC 26 030
Paper author:	Amanda Sullivan, Chief Executive
Paper sponsor:	Amanda Sullivan
Presenter:	Amanda Sullivan

Paper type:
For assurance ☐ For decision ☒ For discussion ☐ For information ☒

Report 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 Boards are asked to: • Note this paper for information. • Adopt the Government's working definition of anti-Muslim hostility. • Confirm their commitment to completing the new anti-racism training when it becomes available.

Board Assurance Framework
Not applicable.

Relevant statutory duties:	
☒ Quality improvement	☒ Public involvement and consultation
☒ Reducing inequalities	☒ Equality and diversity
☒ Financial limits/ breakeven	☒ Effectiveness, efficiency and economy
☒ Integration of services	☐ Wider effect of decisions (triple aim)
☒ Promoting innovation	☐ Promoting research
☒ Patient choice	☐ Obtaining appropriate advice
☐ Promoting education/training	☐ Climate change

Appendices
Appendix A: Out of Area Placements Update.

Are there any conflicts of interest requiring management?
No.

Is this paper confidential?
No.

Chief Executive's Report

Letter from the Rt Hon James Murray MP, Secretary of State for Health and Social Care

1. On 27 May 2026, the Secretary of State for Health and Social Care issued a letter to all NHS and social care colleagues setting out the Government's priorities for the health and care system. For the NHS, these priorities include reducing waiting times, embracing innovation and delivering the ambitions of the Ten-Year Health Plan for England.
2. The Secretary of State's letter reaffirmed that the direction of travel remains consistent with the Health Bill, introduced in the House of Commons on 14 May 2026. The Department has subsequently published a series of supporting fact sheets, including one focused on the future role of Integrated Care Boards (ICBs). The Bill proposes a range of reforms intended to strengthen the role of ICBs as strategic commissioners, including expanded commissioning responsibilities, streamlined planning arrangements, changes to Board membership requirements, and revisions to system financial controls.
3. Under the proposed arrangements, over 90% of NHS commissioning budgets would be delegated to ICBs, enabling greater flexibility to design services that meet local population needs. The Bill would also establish neighbourhood health plans as a key mechanism for local planning between ICBs and local authorities, strengthen alignment with mayoral strategic authorities, remove requirements for certain provider representatives on ICB Boards, and place greater emphasis on the strategic planning and commissioning role of ICBs.
4. The ICBs continue to assess the operational, governance and partnership implications of these proposals and will work with NHS England and system partners to support implementation as legislative changes progress.
5. Further information can be found here:
<https://www.gov.uk/government/publications/health-bill-icbs-as-strategic-commissioners-fact-sheet/health-bill-icbs-as-strategic-commissioners-fact-sheet>.

Publication of the Ockenden Review of Maternity Services at Nottingham University Hospitals NHS Trust and the Independent Investigation into Maternity and Neonatal Services in England

6. Following the publication of Donna Ockenden's review into maternity services at Nottingham University Hospitals last month, the national maternity and neonatal investigation led by Baroness Valerie Amos also published its interim findings. Both reports were very difficult reading for many of us, as the experiences described are deeply upsetting. We recognise the great strength

and courage that affected families have shown, in order for the failings to be fully exposed. Whilst both reports contain very difficult messages, they reinforce the importance of listening to women and families, fostering cultures of openness and learning, and continuing our collective efforts to improve safety, quality and equity in maternity care. As system leaders, we all have a role to play in supporting that improvement and ensuring lessons are translated into meaningful change.

7. Our thoughts are with the families affected and their voices will be central to ensuring that services improve and lessons are learned. We remain absolutely committed to maintaining a relentless focus on improvement in maternity services and will use the learning from both reviews to do this across the ICBs' areas. That means not only delivering change, but ensuring those improvements are sustained over time. Our priority is clear: to work with families, providers and partners so that every family receives care that is consistently safe, high-quality and compassionate. We all have a part to play in supporting that ambition and in creating the conditions for openness, learning and continuous improvement.
8. The ICBs' Joint Quality and Service Improvement Committee received a report on the detailed findings of both reports and, noting that the ICBs will be key partners in delivering the improvements required in maternity and neo-natal services, the Committee supported the development of a full assessment of the actions from both reports and from NHS England's Ten-Point Maternity Urgent Plan, which will be presented to the next Committee meeting. The assessment will incorporate additional oversight of post death care and a focus on specific actions relating to Nottingham University Hospitals NHS Trust.
9. A full report will be brought to the next meeting of the Boards and key areas of focus for the ICBs will be:
 - a) Maintaining strong oversight of maternity and neonatal safety, especially in relation to the improvements required at Nottingham University Hospitals NHS Trust, working with partners to align rather than duplicate oversight, and continuing to seek assurance that organisational learning translates into demonstrable improvement.
 - b) Identifying, monitoring, and addressing inequalities in maternity outcomes across the ICBs' populations.
 - c) Ensuring effective implementation of the Patient Safety Incident Response Framework and high-quality investigations.
 - d) Triangulating intelligence from incidents, complaints, claims, staff feedback, and patient experience, developing data dashboards and reporting to support this.
 - e) Promoting cultures of openness, psychological safety and speaking up.

- f) Ensuring the roll out of Martha's Rule across all maternity services.
 - g) Ensuring women, families and carers are actively involved in service oversight, design and improvement, both through our Maternity and Neonatal Voices Partnership and broader engagement.
 - h) Addressing inequalities, racism and discrimination, making inequality a patient safety priority.
 - i) Building a quality management system as outlined in the ICBs' approach to quality that triangulates and responds to intelligence appropriately. Further information on this approach can be found at item 10 on this agenda.
10. Further information on the findings of the reports and of the Government's national response can be found here:
- <https://www.gov.uk/government/publications/ockenden-review-into-maternity-services-at-nottingham-university-hospitals-nhs-trust-final-report>.
- <https://www.matneoinv.org.uk/final-reports/>.
- <https://www.gov.uk/government/news/uks-first-maternity-and-neonatal-commissioner-to-be-appointed>.

Nottingham maternity review findings on post-death care and key actions required

- 11. Further to the publication of the two reports described above, NHS England wrote to all NHS Trusts and ICBs focusing on mortuary oversight and post-death care. It responds to findings from the Nottingham maternity review and the Fuller Inquiry, highlighting the need for improved dignity, security, and compassionate care for the deceased in NHS settings.
- 12. As an immediate action, the Human Tissue Authority is requiring mortuaries to audit reportable incident records from 2015 to 2026, ensuring all incidents are logged and reported. A regulatory update will be issued in July, with findings reported to the Secretary of State in October 2026.
- 13. NHS Trust Boards and senior leaders must regularly review mortuary departments, assess the culture and values of their services, and ensure robust oversight of mortuaries and related areas and provide a Board Assurance Statement to NHS England by 31 July 2026, confirming compliance and plans for improvement.
- 14. The full letter can be found here: <https://www.england.nhs.uk/long-read/nottingham-maternity-review-findings-on-post-death-care-and-key-actions-required-following-the-fuller-inquiry/>.

Publication of the Mann Review

15. On 4 June 2026, Lord Mann published his review into tackling racism and antisemitism within the NHS, with recommendations to support our shared goal of making services safe for all patients, communities and colleagues. The review demonstrates that the NHS is not achieving that consistently and as effectively as it should be, and the recommendations will help drive change. The report sets out clear expectations for all organisations to strengthen leadership accountability, improve reporting and investigation processes, and embed a consistently anti-racist culture across all services. This is about more than compliance, it is about ensuring that every colleague and every patient feels safe, respected and treated with dignity.
16. NHS England has issued a set of immediate actions for all organisations to take:
 - a) To join NHS England in signing up to the NHS Race and Health Observatory Seven Anti-Racism Principles.
 - b) To ensure implementation of the Violence Prevention and Reduction Standard, including data capture and use to target improvement with affected groups, which will be monitored via the NHS Oversight Framework.
 - c) To prepare to implement the forthcoming NHS Staff Standards.
 - d) To adopt the new government definition of anti-Muslim hostility.
 - e) To ensure all staff have completed the NHS Core Skills Framework module on Equality, Diversity and Human Rights (EDHR), which includes content on antisemitism and Islamophobia.
 - f) To ensure all staff complete the new bitesize module co-created with faith leaders in the NHS when it becomes available (with the exception of those who have completed EDHR mandatory training in the last six months).
 - g) To ensure Board agreement to undertake new anti-racism training when it becomes available.
 - h) To ensure colleagues, staff representatives, patients and communities are aware of the organisation's actions through internal and external communications channels, with appropriate engagement in further developments to address antisemitism and all forms of racism locally.
 - i) To ensure the Board and its relevant committees fully understand staff survey data on the experience of racism in the organisation and are taking appropriate action on key problem areas related to this issue and monitoring progress.

17. NHS England has requested confirmation of the ICBs' adoption of the International Holocaust Remembrance Alliance's definition of antisemitism and the Government definition of anti-Muslim hostility by 31 July 2026.
18. The Boards formally adopted the International Holocaust Remembrance Alliance working definition of antisemitism at their meeting on 20 November 2025. The Government's definition of anti-Muslim hostility is set out below, and the Boards are asked to adopt this:

Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts – including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.

It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals.

It is engaging in unlawful discrimination where the relevant conduct – including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life.

19. The Boards are also asked to confirm their commitment to completing the new anti-racism training when it becomes available.
20. All recommendations from the review are currently being considered to ensure that the ICBs' approach to inclusion, staff experience and organisational culture is both robust and visible in day-to day practice. An action plan is being developed, with progress to be overseen by the ICBs' Joint Remuneration and Human Resource Committee.

Board and Executive Assurance: Cyber Security Risk

21. In June 2026, NHS England wrote to all NHS trust and ICB Chairs and Chief Executives to emphasise the increasing cyber security risks arising from geopolitical events and technology developments, and to reinforce the responsibility of Boards and executive teams to assure themselves that cyber security risks are being effectively identified, managed and mitigated. The letter requires NHS organisations to strengthen Board-level assurance and executive accountability for cyber security, maintain compliance with the Data Security and Protection Toolkit (DSPT), and evidence resilient and continuously improving cyber controls. The full letter can be accessed here:

<https://www.england.nhs.uk/long-read/board-and-executive-assurance-cyber-security-risk/>.

22. Cyber security is recognised by the ICBs as a significant organisational risk and is managed through a combination of cyber security, information governance, data protection, emergency preparedness, resilience and response, and business continuity arrangements. The ICBs' approach reflects NHS England's emphasis on organisation-wide resilience, effective governance and continual improvement through the DSPT, which is aligned to the Cyber Assessment Framework (CAF).
23. Executive accountability is in place through Dr Dave Briggs, Executive Director of Outcomes (Medical), who is the jointly appointed Senior Information Risk Owner for the ICBs. In this role, Dr Dave Briggs is the named executive accountable for information risk, including cyber security risks.
24. Board oversight is provided through the Board Assurance Framework, which includes a strategic cyber risk. The opening position of the ICBs' Board Assurance Framework was presented to the Boards at their March 2026 meeting in common, with the next update scheduled for September 2026. This is supported by the SIRO Annual Report, which was received in May 2026, and by the formal role of the Audit Committees in overseeing the adequacy and effectiveness of information governance, data protection and cyber security arrangements.
25. The Audit Committees receive regular reports on DSPT compliance, cyber risk, improvement activity and emerging national requirements from the Information Governance, Data Protection and Cyber Steering Group. This enables the Committees to provide assurance to the Boards and to escalate significant risks, control issues or matters requiring further attention. A dedicated Board session on cyber security, using National Cyber Security Centre assured training, is scheduled for December 2026 to further support Board-level understanding, oversight and challenge.
26. All three ICBs submitted their 2025/26 DSPT returns by the national deadline of 30 June 2026. Internal audit assessments were completed to support the submissions and provide assurance on the robustness of the evidence presented. NHS Derby and Derbyshire ICB and NHS Nottingham and Nottinghamshire ICB achieved an overall position of 'Standards Met'. However, NHS Lincolnshire ICB submitted an overall position of 'Approaching Standards', due to limitations in the assurance evidence available to the ICB in relation to elements of its outsourced IT support arrangements, rather than evidence of a significant or immediate cyber security control failure.
27. An improvement plan has been submitted alongside the NHS Lincolnshire ICB DSPT return and will be overseen through established information governance and cyber security governance arrangements. Delivery will focus on

strengthening assurance mechanisms, clarifying responsibilities between organisations, improving documentation and evidence processes, and ensuring the ICB can demonstrate compliance with national requirements. Progress will be monitored regularly and reported to the Audit Committees, with updates provided to the Boards through committee reporting arrangements.

28. The CAF-aligned DSPT requires organisations to evidence effective controls across key domains, including asset management, supply chain risk, access controls, vulnerability management, backup protection and testing, security monitoring, and incident response planning. Ongoing alignment and improvement of the ICBs' control environment is overseen by the Information Governance, Data Protection and Cyber Steering Group, with routine compliance monitoring in place. Priority actions for 2026/27 include reviewing and aligning Information Asset Registers and associated ownership arrangements across the ICBs, recognising the importance of robust information asset management as a foundation for cyber resilience and risk management.
29. Preparedness and resilience arrangements are also in place through the ICBs' joint EPRR and Business Continuity Policy, which is aligned to ISO 22301, the NHS England Business Continuity Management Toolkit, the Civil Contingencies Act 2004, and NHS EPRR requirements. As Category 1 Responders, the ICBs maintain arrangements to ensure critical functions can continue or recover following disruption, including disruption resulting from cyber incidents. These arrangements include business impact analysis, business continuity planning, exercising, audit, lessons identified, and continuous improvement processes.
30. The ICBs continue to test resilience arrangements through a structured programme of business continuity and cyber resilience exercises. In May 2025, NHS Nottingham and Nottinghamshire ICB's System Coordination Centre and EPRR Team undertook Exercise Troy, a tabletop exercise testing the response to a significant loss of IT services following a simulated cyber-attack, including loss of access to email, SharePoint, operational databases and internet connectivity. NHS Derby and Derbyshire ICB undertook a similar exercise in July 2025 (Exercise CIRE), which assessed incident response and cyber resilience arrangements across partner organisations. Both exercises demonstrated effective escalation arrangements, strong partnership working and the ability to implement alternative ways of working during disruption, with associated actions either having been completed or incorporated into ongoing work programmes. Further assurance has been provided through Exercise Black Cormorant, undertaken in Lincolnshire on 8 July 2026, which tested business continuity and cyber response arrangements using a phishing email scenario. In addition, Exercise Sentinel Strike will soon be delivered as the annual cyber resilience tabletop exercise for NHS Derby and Derbyshire ICB and NHS Nottingham and Nottinghamshire ICB, in line with NHS EPRR Core

Standards requirements, to test cyber incident identification and escalation, business continuity arrangements for critical digital dependencies, mutual aid arrangements and the coordination of a system-wide response to large-scale digital disruption.

31. Future national cyber requirements will form part of the 2026/27 DSPT requirements. The Information Governance, Data Protection and Cyber Steering Group will oversee development of a 2026/27 DSPT action plan, which will be updated once the strengthened national requirements are published. This will ensure that the ICBs continue to maintain Board and committee oversight of cyber risk, respond to national expectations, and strengthen the evidence base for cyber security assurance across the three ICBs.
32. Overall, the Boards can take assurance that cyber security risks are subject to active management through established governance, assurance and resilience arrangements, supported by regular exercising and continuous improvement. NHS Lincolnshire ICB continues to mature elements of its control environment following the recent transition of IT services, with a clear programme of work in place to strengthen assurance and embed Cyber Assessment Framework-aligned cyber security arrangements across all three ICBs.

Publication of the ICB's Annual Reports and Accounts 2025/26

33. The ICBs' Annual Reports and Accounts for the period 1 April 2025 to 31 March 2026 have been published following approval by the ICBs' Audit Committees.
34. The reports provide 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.
 - a) NHS Derby and Derbyshire ICB reported achievement of their statutory financial duties and received a Head of Internal Audit Opinion providing significant assurance and had no significant control issues to report.
 - b) NHS Lincolnshire ICB reported achievement of their statutory financial duties and received Head of Internal Audit Opinion providing reasonable assurance and had no significant control issues to report.
 - c) NHS Nottingham and Nottinghamshire ICB reported achievement of all statutory financial duties except financial breakeven for the year. This deficit was due entirely to the non-receipt of the ICB component of NHS England Deficit Support Funding for the second half of the year, which was withheld due to the financial performance of Nottinghamshire NHS

system partners being lower than planned. However, financial sustainability remains a key priority for the ICB. The ICB received a Head of Internal Audit Opinion providing significant assurance and had no significant control issues to report.

35. The Annual Reports can be found here:

<https://joinedupcarederbyshire.co.uk/publications/annual-reports/>

[https://lincolnshire.icb.nhs.uk/wp-](https://lincolnshire.icb.nhs.uk/wp-content/uploads/2026/07/QJM_ICB_Annual_Report_2025-26_FINAL.pdf)

[content/uploads/2026/07/QJM_ICB_Annual_Report_2025-26_FINAL.pdf](https://lincolnshire.icb.nhs.uk/wp-content/uploads/2026/07/QJM_ICB_Annual_Report_2025-26_FINAL.pdf)

<https://notts.icb.nhs.uk/wp-content/uploads/sites/2/2025/08/NNICB-Annual-Report-and-Accounts-2025-26-Audited.pdf>

36. The ICBs will be holding their Annual Public Meetings in common at 4pm on Thursday 3 September 2026. Due to the practicalities of holding in person events across the ICBs' footprints, the event will be held virtually.

Mental health inpatient plans

37. As part of plans to strengthen oversight arrangements, NHS England has recently requested that ICBs provide a regular monthly stocktake of individuals in mental health inpatient settings where placements do not align with the ICBs' three-year mental health inpatient plans.
38. NHS England has also requested that ICB Boards receive an update to provide:
- a) Assurance that the ICBs have full visibility of where all patients placed out of area are currently receiving care.
 - b) Confirmation of the ICBs' plan to eliminate all adult out of area placements by March 2028.
39. The report at Appendix A was presented to the ICBs' Joint Strategic Commissioning Committee during June and sets out the current position across NHS Derby and Derbyshire, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire ICBs in relation to adult mental health inpatient out of area placements. It describes the governance and oversight arrangements in place to ensure full visibility of all patients receiving care outside their local ICB area, and outlines the actions being taken to reduce reliance on such placements. In addition, the paper provides assurance in relation to the coordinated transformation of commissioned services, including the key risks to delivery and the mitigations in place.
40. In receiving the paper, the Committee applied an assurance rating of 'adequate', concluding that whilst the ICBs had full visibility of all out of area placements and clear plans in place to eliminate their use by March 2028, structural and clinical constraints presented risks to achieving this ambition.

The Committee also asked that future updates provided greater detail on the quality of care delivered.

Critical incidents

41. The severe hot weather during June triggered the declaration of critical incidents within two trusts in the ICBs' area. East Midlands Ambulance Services NHS Trust declared an incident due to a significant increase in demand caused by the extreme heat, and Nottingham University Hospitals NHS Trust declared a critical incident due to severe and sustained pressure on all services. Both incidents were stood down within three days following the implementation of system wide emergency preparedness, resilience and response protocols co-ordinated by the ICBs with the support of partners.

Industrial action

42. Emergency preparedness, resilience and response protocols continued to be used to manage the latest round of industrial action, which took place between 15 and 19 June. However, positive news was received at the end of the month that the British Medical Association had voted to accept the Government's latest offer, ending the year-long dispute. The deal will set resident doctor pay at 35.2% higher on average compared to four years ago. They will also benefit from pay structure reform, leading to more frequent wage rises as they progress and gain new skills.
43. Consultants have since voted in favour of industrial action over pay and pensions issues. The British Medical Association now has a mandate to take action over the next twelve months. Consultants will continue to work in emergency and urgent care, but potentially large numbers of appointments and operations requiring senior doctors may not take place.

NHS Oversight Framework 2026/27

44. The NHS Oversight Framework 2026/27 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.
45. NHS England has highlighted that this update for 2026/27 is intentionally evolutionary, retaining the core architecture and oversight approach from the 2025/26 Oversight Framework, updated to reflect the maturing operating model, introducing delivery segmentation for ICBs, and clarifying the role of NHS England's regional teams in overseeing performance.

46. Each part of the system has been given a clear role. NHS England's national team and the Department of Health and Social Care set national outcomes and build shared platforms. NHS England's regional teams provide leadership with a single line of sight across performance and support, with ICBs being strategic commissioners, shifting resource into prevention and community capacity.
47. ICBs and providers will be assessed and assigned a segment between one and four based on data and a high-level view of the breadth of challenges they face. Organisations in segment one will likely have a narrow range of issues, while those in segment four have the broadest. Organisations in higher segments and with lower capability are likely to receive the most intensive oversight and support or intervention. By contrast, organisations in lower segments with higher capability are likely to benefit from lighter-touch oversight arrangements and be potential candidates for greater freedoms and incentives.
48. For 2025/26, the statutory annual assessment of each ICB's performance will be conducted in line with the ICB annual assessment guidance for 2025/26. During 2026/27, NHS England will work with ICBs to develop an approach to assess capability, reflecting the ICBs' central role as strategic commissioners and system leaders, including for primary care services, and aligned with the strategy for neighbourhood health. From 2027/28, it is anticipated that formal ICB capability assessments will be incorporated into the annual assessments, alongside a delivery score derived from the ICB's average segment in the preceding year.
49. Further detail on the assessments and domains to be assessed can be found here: <https://www.england.nhs.uk/long-read/nhs-oversight-framework-2026-27/>.

NHS Leadership and Management Framework

50. NHS England has written to all ICB Chairs and Chief Executives to launch its revised Leadership and Management Framework, which will apply across all clinical and non-clinical leadership and management roles. It defines the principles, behaviours and skills the NHS expects from its leaders and managers.
51. For the first time, the NHS will have a single national framework describing what excellent leadership and management looks like across every setting, profession and level of responsibility. It will support stronger management capability, competent, compassionate and inclusive leaders, better staff experiences and, ultimately, improved care for patients.
52. The Framework, which has been developed in response to a number of reviews into leadership within the NHS, including the Messenger and Kark Reviews, sets standards, or essential competencies for leadership and management at every level, and provides a self-assessment tool to enable evaluation against

the expected standards of managers to support a clearer understanding of individuals' strengths and development areas when undertaking appraisals.

53. NHS England has asked organisations to begin embedding the Framework into local people strategies, policies, training, appraisal and recruitment, by aligning existing leadership and management development offers to the new standards within their development, appraisal, recruitment and talent processes, and by supporting managers to use the self-assessment as part of their normal appraisal and development conversations during 2026/27.
54. NHS England stipulates that by the end of quarter four, every manager and leader should self-assess against the framework stage that is relevant to their level, discuss the outcomes with their line manager, and agree a focused development plan; and that all senior managers should also use the 360-degree feedback tool to inform that conversation.
55. The ICBs' Joint Remuneration and Human Resources Committee will receive a briefing on the Framework and oversee its implementation within the ICBs. Rosa Waddingham will be the ICBs' lead Executive Director for this work.
56. Further information can be found here:
<https://www.england.nhs.uk/publication/nhs-college-of-leadership-and-management/>.

Strategic commissioning of hospice services and update on the Modern Service Framework for Palliative Care and End-of-Life Care

57. NHS England had written to all ICBs to provide an interim update on the Modern Service Framework for palliative care and end-of-life care ahead of full publication in the autumn. The letter asks that ICBs prioritise two actions to ensure progress is made towards strategic commissioning of palliative care and end-of-life care services.
58. This Modern Service Framework, one of six, announced by the Government in November 2025 to address their top priorities, will improve palliative and end-of-life care by address rising demand; late identification of need; inequitable variation in access, experience and outcomes; and the wider pressures facing the health and care system. A review of the evidence and engagement undertaken to date has identified five goals, and actions will be now developed around these goals for organisations commissioning and delivering services.
59. Ahead of the finalisation of the Framework, the immediate actions for ICBs are to produce an integrated needs assessment and understand service provision and utilisation; and to move to sustainable contracting of hospice services.
60. Palliative and end-of-life care remains a priority within the ICBs' Five-Year Population Health Strategy. Work is underway to respond to the emerging Modern Service Framework requirements, including development of integrated

needs assessments and sustainable commissioning arrangements, and a further update is provided elsewhere on this agenda.

61. Further information can be found here: <https://www.england.nhs.uk/long-read/strategic-commissioning-hospice-services-update-modern-service-framework-palliative-care-end-of-life-care/>.

Minimum standards for NHS staff working in secondary care

62. The Ten-Year Plan committed to developing a new set of staff standards to outline minimum standards for employment across a range of areas, aimed at improving staff experience. To address this, the Department of Health and Social Care has worked with NHS England and the Social Partnership Forum to develop the new NHS staff standards. These standards set clear minimum expectations for employers, focusing on: line management; health and wellbeing; violence prevention and reduction; tackling racism; championing sexual safety; and promoting flexible working.
63. The standards will apply to all secondary care organisations and will be measured through the NHS Oversight Framework and wider assurance processes. Further information can be found here: <https://www.england.nhs.uk/publication/nhs-staff-standards/>.

Standards for planned care

64. As part of a drive to improve individuals' experiences of NHS care, NHS England has issued minimum standards for what patients should expect when being referred to non-urgent NHS care. The standards have been developed with patients, unpaid carers and patient representatives, clinicians and other NHS teams, and set clear expectations for all providers of NHS planned care to deliver, ensuring that every patient's experience of planned care becomes smoother, clearer and more supportive.
65. All providers of NHS care are responsible for making sure patients receive clear, consistent and supportive communications throughout their planned care experience. They should explain what is happening, what to expect next, and who to contact if patients have questions or concerns. Hospitals should use these standards to shape their delivery of planned care, including how appointments are planned, how cancellations are handled, and how waiting lists are kept accurate.
66. All NHS trusts will need to review performance against the standards, reporting progress annually to their Boards, and publishing a summary of progress each year, so that patients, carers and the public can see the improvements being made.

67. The standards relate to when and how a patient is referred, what to expect whilst on a waiting list, and planning and understanding appointments. Further information can be found here: <https://www.england.nhs.uk/long-read/minimum-standards-planned-patient-care/>.

NHS England Net Zero Supplier Roadmap – April 2027 milestone requirements

68. As part of the NHS's continued work with suppliers and industry to reach net zero by 2045, NHS England has issued guidance to ensure suppliers and buyers have clarity on what is required to prepare for compliance with, and support the delivery of, the NHS England Net Zero April 2027 milestone targets.
69. From April 2027, the NHS will implement new proportionate requirements for suppliers to publicly report targets and emissions, and to publish a carbon reduction plan for all of their relevant global scope 1, 2 and 3 emissions (as defined in the guidance).
70. The requirements apply to the commissioning and purchasing of goods, services and works (including pharmaceuticals and healthcare services) by all NHS organisations that commission or procure such goods, services or works, including where they have appointed a third party to act on their behalf.
71. The ICBs' Joint Finance and Performance Committee includes responsibilities for this area, and reports on progress are scheduled during the year as part of its work programme.
72. Further information can be found here: <https://www.england.nhs.uk/long-read/2027-nhs-carbon-reduction-plan-requirements-for-the-procurement-of-nhs-goods-services-and-works/>.

Framework for maintaining the oral health of an ageing population

73. NHS England has published a new framework to help improve and maintain the oral health of England's ageing population. The framework highlights the growing number of older people retaining their natural teeth for longer and the increasing challenges this can create as people develop frailty, dementia or other long-term conditions. It calls for a stronger focus on prevention, earlier intervention and better integration of oral health into wider health and care services, recognising the close relationship between oral health, nutrition, wellbeing and overall health.
74. The Framework argues that to date the focus in dental service design for older people has been dental care provision for those living in care homes, which overlooks the carer training, dental access and prevention needs of those continuing to live in their own homes. Service design needs to consider early intervention for all older adults regardless of setting.

75. It asks systems to better understand the local oral health needs for the older people residing in their area and how well these are being met by public health approaches and access to dental care. As older adults are treated across dental care settings, planning should be considered in partnership with local dental committees, local dental networks, oral health promotion services, workforce training and other experts.
76. The full framework can be found here: <https://www.england.nhs.uk/long-read/framework-for-maintaining-the-oral-health-of-our-ageing-population/#who-is-this-framework-for>.

Planning, assuring and delivering service change for patients

77. Updated statutory guidance has been issued by NHS England to support colleagues involved in designing and delivering substantial service change. It reflects powers for the Secretary of State to 'call in' NHS reconfigurations, and the duty for NHS commissioning bodies to notify the Secretary of State about new substantial reconfigurations.
78. ICBs will also need to follow the statutory guidance when working to involve and consult the public and more generally when undertaking any service change. The guidance contains the processes that should be followed, criteria for business cases and best practice checks.
79. The full guidance can be found here: <https://www.england.nhs.uk/long-read/planning-assuring-and-delivering-service-change-for-patients-2/>.

NHS Work Well Programme

80. The NHS Work Well Programme is a free, voluntary service designed to help individuals stay in work or return to employment if they are struggling due to a physical or mental health condition. It connects the NHS, local councils, and employment services to provide tailored, one-to-one coaching. I am pleased that the ICBs have agreed to receive grant funding from Department of Work and Pensions (DWP) to enable the delivery of the Work Well Programme within our geographies. Services may include vocational support, health interventions and practical advice. Individuals can self-refer or be referred by their employer or healthcare professional.

Health and Wellbeing Board updates

81. The Derbyshire Health and Wellbeing Board met on 9 July 2026. The agenda focussed on plans for the Better Care Fund 2026/27; and the Neighbourhood Health Plan and Neighbourhood Health Framework requirements. Papers for

the meeting can be found here: [Browse meetings - Health and Wellbeing Board - Derbyshire County Council](#).

82. The Nottingham City Health and Wellbeing Board met on 27 May 2026. The agenda focussed on the Joint Strategic Health Needs Assessment Workplan for 2026/27, a delivery update on the Joint Health and Wellbeing Strategy, and the Strategic Neighbourhood Health Plan. Papers for the meeting can be found here:
<https://committee.nottinghamcity.gov.uk/ieListDocuments.aspx?CId=185&MId=11558&Ver=4>.
83. The Nottinghamshire Health and Wellbeing Board met on 17 June 2026. The agenda focussed on progress of the Integrated Neighbourhood Plan, the Better Care Fund for 2026/27, and progress on the delivery of the Joint Health and Wellbeing Strategy. Papers for the meeting can be found here:
<https://www.nottinghamshire.gov.uk/care/health-and-wellbeing/health-and-wellbeing-board>.
84. The Lincolnshire and Derby City Health and Wellbeing Boards have not met since the last update

Appendix A

Out of Area Placements Update

Section A: Introduction

1. **National planning context:** The NHS 2023/24 planning guidance required systems to co-produce strategic plans to localise and realign mental health inpatient services over a three-year period, in line with the national Commissioning Framework. The Medium-Term Planning Framework builds on these plans, with a continued focus on localising care, reducing out-of-area placements (OAPs), and ending the commissioning of locked rehabilitation inpatient services.
2. **Strengthening oversight:** Following discussion at the Regional Mental Health Oversight Group, NHS England and ICBs have recognised that oversight of these placements should be strengthened. To support this, the NHS England Executive has asked ICBs to provide a regular monthly stocktake of people in hospital settings that do not align with the ICB's three-year plan. This includes:
 - a) People in adult acute services, including Psychiatric Intensive Care Units (PICU), and rehabilitation OAPs, whether classified as appropriate or inappropriate.
 - b) People receiving care in locked rehabilitation settings.
3. **Board reporting requirements:** NHS England has also asked that ICB Boards receive updates that provide:
 - a) Assurance that the ICBs have full visibility of where all patients placed out of area are currently receiving care.
 - b) Confirmation of the ICBs' plans to end all adult OAPs by March 2028.
4. This paper provides an update on the actions being taken to deliver the requirement to commission services in line with the national [Inpatient Commissioning Framework](#) from 2027/28, with the aim of ending all adult OAPs by March 2028.
5. The paper gives full assurance that NHS Derby and Derbyshire, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire ICBs know where all patients placed out of area are currently receiving care.
6. The paper outlines the plans in place across Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire to commission services in line with the Inpatient Commissioning Framework, with an aim to end all out of area placements by March 2028.

Section B: Strategic Context

7. Transforming mental health services across the ICBs is a core strategic priority, essential to improving quality and access, supporting system sustainability and meeting NHS England expectations over the next five years. The ICBs' Five-Year Strategic Commissioning Plan outlines the following ambitions:
 - a) Deliver inpatient quality transformation to ensure continuity, valued therapeutic relationships, safety and quality improvements in line with high performing peer ICB communities.
 - b) Be a national exemplar in developing cross-agency commitment to reduce reliance on inpatient care for people with learning disability and autistic people, strengthening community alternatives and discharge pathways.
8. A key deliverable within the Commissioning Plan is to reduce reliance on out-of-area placements, with a specific focus on reducing inappropriate out-of-area placements.
9. In May 2026, NHS England provided ICBs with a three-year plan review tool to support assessment of progress against published plans to localise and realign inpatient care. The tool is intended to support structured system-wide discussion by enabling ICBs to identify where significant progress has been made and where further targeted support or intervention may be required. The outputs will inform ongoing governance arrangements and support delivery of the requirement to commission services in line with the national Inpatient Commissioning Framework from 2027/28.

Section C: ICBs' Performance

10. Figure 1: The chart below outlines current inappropriate OAP performance across the ICBs' footprint.



Section D: Lincolnshire

People receiving care out of area

11. NHS Lincolnshire ICB (LICB) has robust oversight arrangements in place to ensure full visibility of all individuals placed out of area. The Learning Disability and Autism Host Commissioner guidance¹ is fully implemented by LICB and, as part of an NHS England Midlands pilot, LICB has also implemented the Host and Home ICB guidance, which provides a strengthened framework for joint oversight. This ensures clear accountability between the Home ICB for individual patient care and the Host ICB for provider quality, supported by shared data, intelligence, and escalation processes. These arrangements enable early identification of risks and ensure coordinated action to safeguard patient safety and experience.
12. LICB maintains a comprehensive and OAPs for rehabilitation inpatients, and Lincolnshire Partnership NHS Foundation Trust (LPFT) maintains a comprehensive and up-to-date record of all OAPs for acute and PICU inpatients, which is reported regularly to LICB. This is underpinned by close collaboration with providers and partner organisations; and is complemented by routine clinical oversight at individual patient level, ensuring all placements are appropriate, regularly reviewed, and actively managed. Collectively, these processes provide assurance to the Board that LICB knows who its out-of-area patients are, where they are placed, and that their care is being proactively monitored.

Reducing Inappropriate Out of Area Placements

13. LICB's Mental Health, Dementia, Learning Disability and Autism (MHD LDA) [Inpatient Strategy](#) (published July 2024) sets out a three-year vision to realign and localise inpatient services. The strategy is structured around six strategic pillars: workforce, environment, patient pathway optimisation, procurement and contracting, system interface improvement, and data quality - underpinned by the development of new models of care. Delivery is led through the Inpatient Quality Transformation Programme in partnership with LPFT, with governance through the Lincolnshire MHD LDA Alliance. Progress is published annually, with year two reporting due in July 2026, following a programme-wide prioritisation exercise.
14. A structured review using the three-year plan review tool is underway, involving LICB, LPFT and people with lived experience, to identify gaps and inform priorities beyond the current programme period (to March 2027). This will support continued alignment with the national Inpatient Commissioning Framework and ensure a sustained focus on reducing reliance on out-of-area provision.

¹ [NHS England » Learning disability and autism – host commissioner guidance](#)

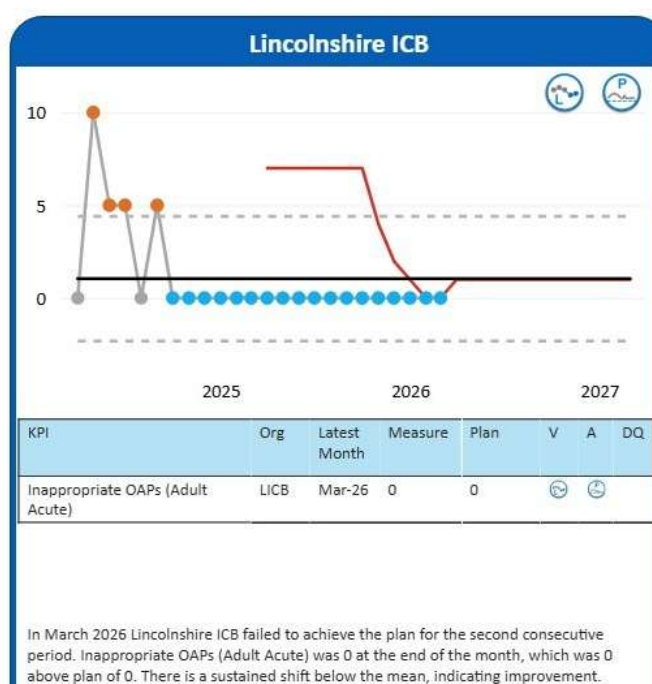
15. A range of actions are in place to improve flow and reduce reliance on out-of-area placements, including:
 - a) Piloting a recovery-focused stepdown pathway to support timely discharge from acute wards;
 - b) Implementing the 10 high impact actions for discharges², including Implementation of Multi-Agency Discharge Events (MADE) to unblock complex discharges and drive system learning;
 - c) A system-wide quality improvement project focused on discharge planning;
 - d) Monthly LICB/LPFT out of area and inappropriate placement reduction group to monitor and reduce OAPs;
 - e) Dedicated flow and out-of-area coordination functions within LPFT, supported by virtual ward oversight and investment in additional flow leadership roles across inpatient and community services;
 - f) Development of a Mental Health and Housing strategic plan to improve the focus on housing as a wider determinant of health and take action to reduce housing related delays in the pathway;
 - g) Demand and capacity modelling to inform a sustainable long-term inpatient bed model.

Current Performance

16. Figure 2: A Statistical Process Control (SPC) chart to show the current LICB performance in reducing inappropriate out of area mental health placements.

Risks and mitigations

17. A key risk relates to the relaunch of an LPFT ward as a dedicated level two rehabilitation service. Previously, the ward managed a mixed cohort, including individuals with complex emotional needs, which is now recognised as clinically suboptimal.
18. The revised model is expected to improve pathway clarity and patient flow. However, the parallel development of a community-based complex emotional



² [NHS England » Discharge challenge for mental health and community services providers](#)

needs pathway - aligned to national guidance that advises against inpatient admission - will take time to design, agree, and resource. In the interim, there is a risk of increased out-of-area placements for this cohort, as there is currently no suitable local inpatient provision. Additionally, people with complex emotional needs are remaining in PICU or acute services longer than is expected by the commissioning framework. This risks a significant cost pressure for LICB. However, this risk may be partially mitigated by the improved patient flow and reduced length of stay in such settings that is anticipated by the relaunch of this level two rehabilitation ward.

19. Lincolnshire does not currently have a female PICU, resulting in an ongoing requirement for out-of-area placements for this cohort. While this represents a structural dependency, different opportunities are being explored to mitigate this including a community-based complex emotional needs pathway to try to avoid admission in future; a business case for a new build in Lincolnshire; and potential system collaboration, such as access to PICU capacity within the cluster.
20. At present, there is no national guidance defining how ICB clustering arrangements may impact the classification of OAP. However, the definition of an inappropriate OAP is based on whether a placement sits within a routinely commissioned service offer, rather than strictly on ICB geography. There is potential for placements commissioned through a formal cluster arrangement to be considered part of the ICB's usual network of care, where supported by clear system-level planning, agreed commissioning frameworks, and routine access pathways. Until national guidance is established, this remains an emerging position.

Section E: Nottingham and Nottinghamshire

People receiving care out of area

21. NHS Nottingham and Nottinghamshire ICB has robust quality oversight in place to maintain a comprehensive view on OAPs for rehabilitation inpatients, and Nottinghamshire Healthcare NHS Foundation Trust (NHT) maintains a comprehensive and up-to-date record of all OAPs for acute and PICU inpatients which is reported to the ICB via several means including through data flows such as the patient level data set, daily system mental health bed management and flow meetings where NHT update on plans to repatriate patients and system quality oversight arrangements.

Reducing Inappropriate Out of Area Placements

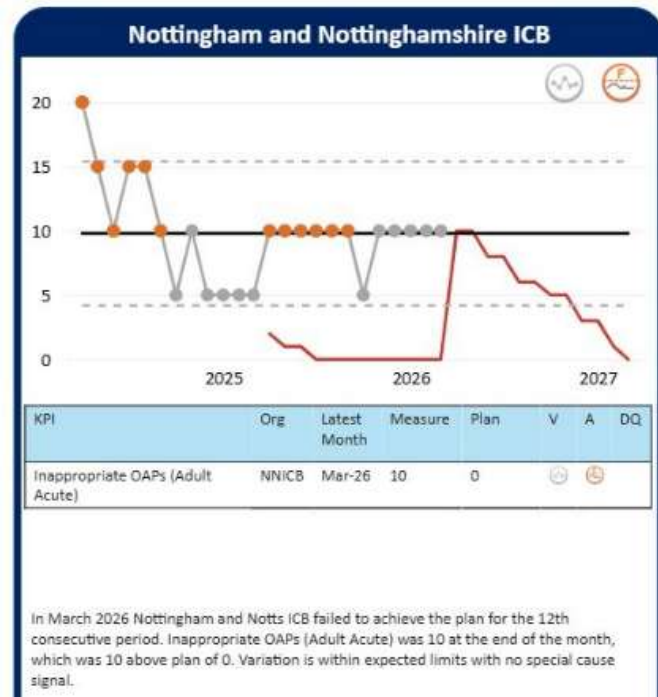
22. The co-produced [Nottingham & Nottinghamshire three-year integrated mental health pathway strategic plan](#) was published on 31 July 2024 and outlined an integrated mental health pathway that delivers local, inclusive, safe, personalised, and therapeutic care that meets the needs of individuals in

Nottingham and Nottinghamshire. The strategic plan covers the financial years of 2024/25 – 2026/27.

23. The plan is centred on three strategic pillars, improving access to care and support in the right place at the right time, how we deliver high quality care for people and timely discharge to the place people call home. Projects and programmes delivered through these pillars are expected to deliver the associated system trajectories of zero OAP's, reduced Length of Stay, reduction in Learning Disabilities and Autism patients within an inpatient setting, ending the use of 'locked rehab' and ensuring a sustainable bed base. The delivery of the plan is monitored via the Mental Health Partnership Board.
24. A range of actions from the strategic plan include:
 - a) A system workshop on the High Impact Changes for improving Mental Health Discharge, including MADE events and an ongoing Task and Finish Group responsible for delivery.
 - b) Mental Health inpatient demand and capacity modelling developed in partnership with the Commissioning Support Unit and the ICB's System Analytical and Intelligence Unit.
 - c) Process mapping workshops across adult and older adult mental health inpatient pathways aiming to benchmark against best practice guidance.
 - d) ICB approval of an adult mental health step down unit and wellbeing hub at Alex House, Mansfield. This is now expected to progress as the system's first Neighbourhood Mental Health Centre.
 - e) Two Mental Health and Housing workshops focussed on system self-assessment of challenges and opportunities and developing system-wide improvements in hospital to housing discharge pathways and processes.
 - f) The commissioning of Partners in Mind, a co-production partner supported by Voluntary, Community and Social Enterprise provider, Improving Lives. The aim of Partners in Mind is to ensure lived experience representation and participation is embedded in all mental health transformation and governance processes, accessible to all system partners.

Current Performance

25. Figure 3: An SPC chart to show the current NHS Nottingham and Nottinghamshire ICB performance in reducing inappropriate out of area mental health placements.



Risks and Mitigations

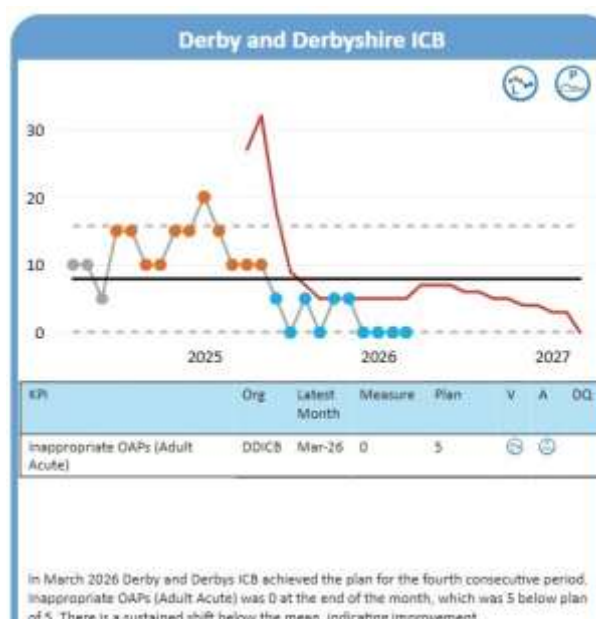
26. Significant system work is still required to be undertaken to continue to deliver the priorities identified in the final year of the three-year strategic plan to improve pathway flow and make improvements that positively impact outcomes for people. Priorities require a system approach to undertake 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.
27. A range of capital submissions including a 12 bedded female PICU, four Neighbourhood Mental Health Centres and a Mental Health in Emergency Department unit located at Queen's Medical Centre will all contribute to improvements in mental health urgent and emergency care pathway and provide opportunity to redesign services.
28. Year two progress has been impacted by the changes within the ICB, with the Project Manager leaving in June 2025 and the Programme Manager leaving in March 2026. Partners will therefore need to work effectively together in Year three to continue working at the scale and pace undertaken to date. Partners have developed good foundations for this work, but it is likely that pace will reduce due to capacity challenges within providers.
29. As the ICB cluster arrangements take effect, governance arrangements and ICB and provider responsibilities will change. Currently, the Mental Health Partnership Board provides oversight for this work and the extent to which this will continue is not yet known. However, governance arrangements are being finalised for a cluster-wide Mental Health, Learning Disability and Autism Programme Board.

Section F: Derby and Derbyshire plans

30. The [Derby-Derbyshire-MH-IP-Strategy-July-2024.pdf](#) 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 Derby and Derbyshire. The strategic plan covers the financial years of 2024/25 – 2026/27.
31. NHS Derby and Derbyshire ICB has robust quality oversight in place to maintain a comprehensive view on OAPs for rehabilitation inpatients, female PICU patients (there is no female PICU facility in NHS Derby and Derbyshire ICB) and Learning Disabilities and Autism cohort; and Derbyshire Healthcare NHS Foundation Trust (DHcFT) maintains a comprehensive and up-to-date record of all OAPs for Acute, PICU and Assuring Transformation inpatients which is reported to the ICB via several means including through data flows such as the patient level data set, daily system mental health bed management meetings, bi-weekly MADE and flow meetings where DHcFT update on plans to both discharge and repatriate patients and record actions for system quality oversight arrangements.
32. NHS Derby and Derbyshire ICB has co-produced a robust delivery trajectory to eliminate OAP aligned to DHcFT ambitions and considering the significant investment in new build Derbyshire based male PICU accommodation and the refurbishment of an existing unit to provide Female Enhanced Care opportunities within the geographic footprint. Reviews and transformational plans were agreed with NHS England to ensure that all parties are working towards a zero OAP position by March 2028, following continuity of care principle and adhering to the ambitions within the Operational Plan.
33. The plan is centred on strategic outcome measures, improving access to community care and support in the right place at the right time, aligning to the aspirations of neighbourhood transformation, delivery of high-quality care for people and timely discharge to the place people call home. Projects and programmes delivered, are expected to deliver the associated system trajectories of zero OAP's, reduced Length of Stay, reduction in Learning Disabilities and Autism patients within inpatient settings, ending the use of 'locked rehab' and ensuring a sustainable bed base. The delivery of the plan was monitored via the Mental Health System Delivery Board and will now report to the newly formed Cluster Mental Health and Learning Disabilities and Autism Programme Board.

Current Performance

34. Figure 4: An SPC chart to show the current NHS Derby and Derbyshire ICB performance in reducing inappropriate out of area mental health placements.



Section G: Summary

35. The ICBs remains fully committed to the national ambition of eliminating inappropriate adult OAPs and has established a clear programme of work in each ICB to eliminate their use by March 2028, where possible.
36. The work programmes include investment in community alternatives, pathway redesign through capital bids including Neighbourhood Mental Health Centres and Mental Health Units co-located in Emergency Departments, and strengthening local capacity and flow. However, it is important to recognise that there are structural and clinical constraints that mean there are risks to achieving a zero-OAP position.
37. These include the current absence of certain specialist services within individual ICB footprints, the lead time and cost implications associated with developing additional inpatient and community capacity, and the inherent variability in demand, where periods of surge may temporarily exceed local provision.
38. As such, we are working towards minimising OAPs to the greatest extent possible and ensuring any placements are appropriate, short-term, and actively managed. In order to eliminate all OAPS, adult inpatient services need to remain a priority for the ICBs.
39. We will continue to provide robust oversight, transparent reporting, and a clear trajectory of reduction to give the Boards confidence in our progress and risk management.

Meeting title	Integrated Care Boards: Open Session (meeting in common)
Meeting date	16/07/2026
Paper title	End of Life and Frailty Priorities of the ICBs' Five-Year Population Health Strategy
Paper reference	ICB CIC 26 031
Paper author	Tom Diamond, Director of Population Health Strategy Feargus Mack, NHS Lincolnshire ICB Strategy
Paper sponsor	Clair Raybould, Executive Director for Strategy and Citizen Experience Maria Principe, Executive Director of Commissioning Dr Dave Briggs, Executive Director of Outcomes (Medical)
Presenter	Clair Raybould

Paper type			
For assurance ☒	For decision ☐	For discussion ☐	For information ☐

Report summary

The NHS Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire ICBs' Five-Year Population Health Strategy was received by the Boards at their meeting in March 2026. Following its completion, a schedule of reports was agreed to give the Boards a collective view of the progress being made in relation to each of the priorities within the strategy. This is the first report on progress and covers priorities related to end of life services and frailty services.

For both priorities this report:

- Sets out why they are strategically important.
- Provides an initial baseline assessment for strategic key performance indicators that will be used to show progress against delivery.
- Provides an overview of the current and planned strategic commissioning actions that will support and drive improvements in the strategic key performance indicators.

The paper concludes with key risks, implications and actions relating to the two priorities.

Recommendation(s)

The Boards are asked to **receive** the paper for assurance in relation to establishing strategic key performance indicator baselines and mobilising strategic commissioning actions relating to the End of Life and Frailty population cohort priorities in the ICB's Population Health Strategy.

Appendices

- 1 – Additional information relating to the End of Life priority strategic key performance indicator baselines
- 2 – Additional information relating to the Frailty priority strategic key performance indicator baselines

Board Assurance Framework

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

- Failure to develop and maintain a comprehensive, evidence-based understanding of local population health needs
- Failure to deliver a coordinated transformation of commissioned services, including prevention, community care models, and digital enablement
- Failure to systematically improve the quality of healthcare services

Relevant statutory duties

☒ Quality improvement	☐ Public involvement and consultation
☒ Reducing inequalities	☐ Equality and diversity
☐ Financial limits/ breakeven	☐ Effectiveness, efficiency and economy
☒ Integration of services	☐ Wider effect of decisions (triple aim)
☐ Promoting innovation	☐ Promoting research
☐ Patient choice	☐ Obtaining appropriate advice
☐ Promoting education/training	☐ Climate change

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

End of Life and Frailty Priorities of the ICBs' Five-Year Population Health Strategy

End of Life

Why people who need end of life care are a priority

1. Care quality and experience are highly variable. Nationally and locally, there is wide variation in place of death, which is a practical proxy for whether people are being supported to die in their preferred place with appropriate community capacity.
2. It is a nationally defined improvement agenda with a clear 'what good looks like'. The 'Ambitions for Palliative and End of Life Care, 2021-2026', provides an accepted national framework for local action across health, social care and the voluntary, community and social enterprise/hospice sector.
3. It is one of the most avoidable pressure points in urgent care and bed capacity. A material proportion of late-stage deterioration and hospital utilisation can be mitigated through earlier identification, anticipatory care planning, community response and reliable care-home/hospice/community pathways (particularly in last 90 days of life).
4. End of life care is typically one of the most resource-intensive periods of care, particularly when pathways default to repeated crisis attendance, ambulance conveyance and inpatient stays rather than planned, coordinated community support.
5. Better Palliative and End of Life Care reduces carer breakdown, improves bereavement outcomes and stabilises demand across community services, ambulance conveyances and acute admissions.
6. Public and lived-experience feedback from across the DLN ICBs' footprints highlights:
 - a) Provision is shaped by personal circumstances, with unmet need and uneven access.
 - b) Services feel disconnected, with families forced to act as coordinators.
 - c) Informal carers provide most care but feel unsupported and excluded from decisions.
 - d) There is inconsistent information, with limited advance care planning.
 - e) Patient experience varies by setting, consistently praised in specialist settings but more acute and out of hours provision is more variable.

7. The table below provides estimates¹ of the proportion of the ICBs' population that are end of life, the size of this cohort in each of the three ICBs and the disproportionate system impact of this priority segment.

Segment size		Total Cost	Ambulance Calls	Non elective admissions	Non elective occupied bed days
2% of Total Population	Derby and Derbyshire ICB: 23.0k	16%	25%	25%	34%
	Lincolnshire ICB: 21.4k				
	Nottingham and Nottinghamshire ICB: 29.8k				
	Total: 74.2k				

8. The ICBs' Five-Year Commissioning Plan identifies a 5% reduction in emergency attendance, 5% reduction in non-elective care admissions and a 2% reduction in occupied by days by the end of 2026/27. Given End of Life is a priority cohort, it will need to be a key contributor to delivering these reductions.

Initial baseline assessment of strategic key performance indicators (KPIs)

9. As part of developing the ICBs' Population Health Strategy a set of strategic key performance indicators (KPIs) were identified for each priority to support reporting. Given each of the three ICBs had a different method and maturity to their Population Health Management data at the point of working together; and a significant amount of work is currently underway to establish a single methodology, a pragmatic approach has been taken to establish baselines for an initial set of indicators to track progress (see Appendix 1 for more detail).
10. The table below provides an overview of the 2025/26 baseline position for the ICBs, figures in brackets show the change from the previous year.

Stage of Pathway	Strategic KPI	Derby and Derbyshire	Lincolnshire	Nottingham and Nottinghamshire
1. Identifying People in Last Year of Life	Palliative care Quality Outcome Framework register	0.83% (▲ 0.04%)	0.90% (▲ 0.10%)	0.86% (▲ 0.04%)
2. Delivering Proactive Care	End of Life Register with ReSPECT form	-	63.0% (▲ 2.3%)	79.2% (▲ 3.1%)
3. Coordination and Support		-	-	-
4. Reduce Hospital Utilisation	% of deaths with 3+non elective admissions in the last 90 days of life	6.8% (▼ 0.4%)	5.9% (▼ 0.5%)	7.0% (▲ 0.2%)

¹ Estimated using Nottingham and Nottinghamshire Population Health Management data

Stage of Pathway	Strategic KPI	Derby and Derbyshire	Lincolnshire	Nottingham and Nottinghamshire
	% days spent in hospital in last 90 days of life	18.1% (▲ 0.4%)	17.9% (▼ 0.6%)	19.2% (▲ 0.4%)
	Number of unplanned bed days in the last 90 days of life	93.0k (▲ 930 / 1%)	77.8k (▼ 8.9k / 10%)	118.3k (flat)
5. Dying in Preferred Place of Death	% of deaths occurring in hospital	41.0% (▼ 1.7%)	36.3% (▼ 2.8%)	42.3% (▼ 1.4%)

11. The initial data set suggests positive progress in identifying people approaching the end of life and strengthening advance care planning, with emerging evidence that effective neighbourhood models can reduce avoidable hospital utilisation.
12. However, variation in hospital admissions, bed days and place of death indicates implementation remains inconsistent. The key strategic challenge is to move from improved identification and planning to consistently delivering coordinated neighbourhood care that enables more people to remain at home, avoid unnecessary hospitalisation and receive care aligned to their preferences.

Strategic commissioning action

13. Within the ICBs' Population Health Strategy, a set of five evidence-based interventions were defined to drive improvements in the care and outcomes, including the headline strategic KPIs, for people who need end of life care. The table below provides an overview of the 2026/27 Neighbourhood Health strategic commissioning actions that will support and drive these improvements.
14. The interventions will respond to the Government's Modern Service Framework for palliative care. An interim update has recently been published ahead of the full publication in the autumn. The interim update asks the ICBs to undertake two immediate actions: to produce an integrated needs assessment and understand service provision and utilisation; and to move to sustainable contracting of hospice services.
15. The ICBs are in the final stages of developing a Palliative and End of Life Care Strategic Framework that satisfies this national requirement. There is very close alignment between national guidance and our strategic intent. However, once the finalised Modern Service Framework is released, the ICBs will undertake a further full review to ensure that the ICBs' direction of travel continues to meet the national requirements.

Interventions	2026/27 Strategic Commissioning Actions	
	Completed (C) / In progress (IP)	Planned
1. Identify the last year of life cohort and actively manage the Palliative and End of Life Care register	• Develop Integrated Neighbourhood Team specification (C) • Align services / existing provider contracts into Integrated Neighbourhood Team specifications (IP) • 18-month Integrated Neighbourhood Team delivery plan (IP) • 2 year Primary Care Network and Emergency Department Support Pilot in Derby and Derbyshire (IP)	• Confirm provider governance arrangements for delivering Integrated Neighbourhood Team specifications • Develop Integrated Neighbourhood Team delivery plan metrics and trajectories (incl. strategic KPIs)
2. Last days of life clinical reliability (including medicines and equipment)	• INVOLVE programme - Palliative and End of Life Care for those with severe multiple disabilities and homelessness in Nottingham and Nottinghamshire (IP) • Palliative Care Drug Stockist Scheme – Service Review and Options Appraisal (IP) – linked with broader Palliative and End of Life Care Strategic Framework and Commissioning Plan	• Mobilisation of End of Life Hubs in North Notts • Digitisation of ReSPECT forms across Nottingham and Nottinghamshire • Expand user access of Shared Care Records to hospices
3. Coordinated personalised care with a shared coordination record	• Working with system-partners on development of Neighbourhood Plans (IP) • Neighbourhood-based care coordination model for priority cohorts (Palliative and End of Life Care & Severe Frailty) with social finance (IP) • Roll-out of Digital ReSPECT forms across Derby and Derbyshire (C)	
4. 24/7 advice plus rapid community response and specialist care where more complex need	• Hospice Roaming services and Palliative Care Urgent Response Service in Derby and Derbyshire (C)	• Align same-day care and urgent response pathways – identify service gaps • Develop Same Day Care (extended neighbourhood services) specification
5. Enhanced care: self-care and self-management	• Working with system-partners on development of Neighbourhood Plans (IP)	
<i>Cross cutting</i>	• <i>Palliative and End of Life Care programme with two elements:</i> - <i>Strategic Framework to shape the future commissioning of Palliative and End of Life Care services</i>	• <i>Health Economic analysis to support resource 'shift' from acute to Neighbourhood.</i>

Interventions	2026/27 Strategic Commissioning Actions	
	Completed (C) / In progress (IP)	Planned
	- <i>Commissioning Plan, which details specific commissioning and contracting plans for Derbyshire, Lincolnshire and Nottinghamshire.</i> • <i>Alignment of Population Health Management data architecture across ICBs (IP)</i>	• <i>Ongoing stakeholder engagement of strategic KPIs to further develop insights and identify 'good practice'</i>

Frailty

Why people with frailty are a priority

16. Frailty is a major and growing driver of demand across the ICBs, with disproportionate impact on outcomes and resource utilisation.
17. Frailty is closely linked to avoidable emergency admissions and bed days. Frailty-related deterioration (falls, delirium, deconditioning and medication harm) is a major driver of unplanned care.
18. It is also a leading cause of delayed discharge and 'stranded' beds. A significant proportion of the acute hospital bed base is classified as 'discharge ready', many of these beds are occupied by frail patients.
19. Dementia also carries a very high cost and carer burden. Improving diagnosis, post-diagnostic support and crisis prevention provides both positive outcomes for people and sustainability for health and care services.
20. Public and lived-experience feedback from across the ICBs highlights:
 - a) Frailty is often recognised too late.
 - b) Access to care and support can vary substantially.
 - c) Pathways feel fragmented and hard to navigate.
 - d) Home-based care is preferred when safe and reliable.
 - e) Prevention and maintaining independence are clear opportunities.
21. There is a clear, evidence-based response. Proactive, neighbourhood-based models (risk stratification, Integrated Neighbourhood Team working, personalised care and anticipatory support) can deliver measurable improvements within 12–18 months, reducing admissions and length of stay while improving experience and outcomes for people.

22. The table below provides estimates² of the proportion of the ICBs' population that are frail (moderate/severe), the size of this cohort in each of the three ICBs and the disproportionate system impact of this priority segment.

Segment size		Total Cost	Ambulance Calls	Non elective admissions	Non elective occupied bed days
1% of Total Population	Derby and Derbyshire ICB: 11.5k	7%	13%	11%	17%
	Lincolnshire ICB: 10.7k				
	Nottingham and Nottinghamshire ICB: 14.9k				
	Total: 37.1k				

23. The ICBs' Five-Year Commissioning Plan identifies a 5% reduction in emergency department attendance, 5% reduction in non-elective admissions and a 2% reduction in occupied by days by the end of 2026/27. Given Frailty is a priority segment, it will need to be a key contributor to delivering these reductions.

Initial baseline assessment of strategic key performance indicators (KPIs)

24. As part of developing the ICBs' Population Health Strategy a set of strategic KPIs were identified for each priority to support reporting. Given each of the three ICBs had a different method and maturity to their Population Health Management data at the point of working together and a significant amount of work is currently underway to establish a single methodology, a pragmatic approach has been taken to establish baselines for an initial set of indicators to track progress (see Appendix 2 for more detail).
25. The table below provides an overview of the 2025/26 baseline position for the ICBs, figures in brackets show the change from the previous year.

Stage of Pathway	Strategic KPI	Derby and Derbyshire	Lincolnshire	Nottingham and Nottinghamshire
1. Identifying Frailty	% Clinical Frailty Scale value recorded for those aged 65+ (last 12 months)	-	-	27.7% (▲ 14%)
2. Delivering Proactive Care	% Moderate/Severe frailty with Structured Medication Review last 12 months	-	32.3% (▲ 4%)	
	Aged 65+ with Clinical Frailty Scale >= 6 recorded last 12 months and Structured	-	-	39.8% (▲ 3%)

² Estimated using Nottingham and Nottingham shire Population Health Management data

Stage of Pathway	Strategic KPI	Derby and Derbyshire	Lincolnshire	Nottingham and Nottinghamshire
	Medication Review recorded last 12 months			
	Aged 65+ with Clinical Frailty Scale ≥ 6 recorded last 12 months and Personalised Care Plan completed last 12 months	-	-	33.6% (flat)
3. Reducing Deterioration	Falls non-elective hospital admissions for people aged 65+ any length of stay	4.6k (▲ 200 / 5%)	3.6k (▲ 139 / 4%)	-
4. Reducing Crisis	Type 1&3 A&E attendances people aged 65+	121.6k (▲ 7.9k / 7%)	115.7k (▲ 6.9k / 6%)	110.2k (▲ 7.6k / 7%)
	Emergency admissions people aged 65+ with 1+Length of Stay	44.8k (▲ 234 / 0.5%)	33.5k (▲ 455 / 1.4%)	46.3k (flat)
5. Reducing Hospital Utilisation	All emergency admissions people aged 65+ with 1+ Length of Stay total occupied bed days	419.4k (▲ 13.1k / 3%)	327.5k (▲ 5.9k / 2%)	484.4k (▲ 16.5k / 4%)

26. Whilst proactive care indicators show some improvement, albeit with variation at a Primary Care Network level, all three systems are experiencing continued growth in urgent care utilisation, which demonstrates that the ICBs' systems remain predominantly reactive and acute based.

27. Accelerating the transition from identification of frailty to effective neighbourhood-based intervention represents the greatest opportunity to improve outcomes, reduce avoidable hospital use and deliver the shifts from hospital to community and treatment to prevention set out in the NHS Ten Year Plan.

Strategic commissioning action

28. Within the ICBs' Population Health Strategy, a set of five evidence-based interventions were defined to drive improvements in the care and outcomes, including the headline strategic KPIs, for people living with frailty. The table below provides an overview of the 2026/27 Neighbourhood Health strategic commissioning actions that will support and drive these improvements.

Interventions	2026/27 Strategic Commissioning Actions	
	Completed (C) / In progress (IP)	Planned
1. Frailty identification and actively managed register	- Develop Integrated Neighbourhood Team (INT) specification (C) - Align services / existing provider contracts into INT spec (IP)	- Confirm provider governance arrangements for delivering INT spec - Develop INT delivery plan metrics and trajectories (incl. strategic KPIs)
2. Proactive frailty bundle for moderate/severe frailty	18-month INT delivery plan (IP) - Develop GP clinical leadership model (IP)	Embed consistent coding of Clinical Frailty Scale
3. Falls and functional decline prevention pathway	Working with system-partners on development of Neighbourhood Plans (IP)	
4. Crisis avoidance and functional recovery pathway	Frailty emergency department review (Lincolnshire) (C)	- Align same-day care and urgent response pathways – identify service gaps - Develop Same Day Care (extended neighbourhood services) specification
5. Lifestyle risk reduction with practical support	Working with system-partners on development of Neighbourhood Plans (IP)	
<i>Cross cutting</i>	<i>Local quality schedules in contracts contain relevant Patient safety indicators (C)</i> <i>Alignment of Population Health Management data architecture across ICBs (IP)</i>	<i>Health Economic analysis to support resource 'shift' from acute to Neighbourhood.</i> <i>Ongoing stakeholder engagement of strategic KPIs to further develop insights and identify 'good practice'</i>

Collective risk and mitigation

Key risks and priority actions

29. The key risks and implication to achieving the ICBs' Strategy End of Life and Frailty priorities are outlined in the table below, together with a set of mitigations. These have been aggregated, given the synergy between the population cohorts and requisite commissioning actions.

Risk	Implication	Mitigation
Rising demand not yet offset at scale:	Risk to delivery of planned reductions in emergency	Accelerate implementation of Integrated Neighbourhood

Risk	Implication	Mitigation
- Increasing Accident and Emergency Department demand - Continued pressure on hospital admissions - Growing acute hospital bed use	department activity, admissions and bed days Benefits likely delayed without pace increase	Team (INT) and Same Day Care specifications Establish and assure associated delivery plans (through ICB Neighbourhood Boards)
Significant variation limiting aggregate improvement: - Wide variation across Primary Care Networks - Improvement often offset by deterioration elsewhere	Unequal outcomes and reduced overall system impact unless variation is actively managed	Standardise delivery via INT and Same Day Care specifications and wider neighbourhood plans Scale best practice and target deteriorating 'hotspots' Strengthen clinical leadership and contractual levers
Data immaturity constraining grip and assurance	Reduced ability to evidence progress and target interventions effectively	Standardise Population Health Management data-set methodology Ongoing stakeholder engagement of strategic KPIs to further develop insights

30. The Board are asked to support the following priority actions:

- a) Acceleration of Integrated Neighbourhood Team delivery and Same Day Care as the primary mechanisms for improving end of life and frailty care.
- b) Shift the pattern of health spending so the share of expenditure on hospital care falls with a proportionally greater investment in out of hospital care.
- c) Target intervention in known high-variation and/or substantially deteriorating areas.

Appendix 1

Approach to ICBs' End of Life Headline Strategic KPIs and baselines

As part of developing the ICBs' Population Health Strategy a set of strategic key performance indicators were identified for each priority to support reporting.

At the point of 'coming together, each of the three ICBs had a different method and maturity to their Population Health Management data (a significant amount of work is currently underway to establish one methodology).

Therefore, to ensure a view of progress against the End of Life priority is available, a pragmatic approach has been taken to establish baselines for an initial set of indicators. This approach is based on establishing:

- A 'core' set of indicators that are based on national data and available across all three ICBs.
- 'Local' indicators that are currently readily available from an individual ICBs Population Health Management dataset.

Stage of Pathway	Strategic KPI	Core / Local	DLN Pop Health Strategy
1. Identifying People in Last Year of Life	Palliative care Quality Outcome Framework register	Core	
	End of Life Register: excludes palliative care patients not at end of life	Local (N&N)	
2. Delivering Proactive Care	End of Life Register with ReSPECT form	Local (N&N and Lincs)	✓
3. Coordination and Support	-	-	
4. Reduce Hospital Utilisation	% of deaths with 3+non elective admissions in the last 90 days of life	Core	✓
	% days spent in hospital in last 90 days of life	Core	
	Number of unplanned bed days in the last 90 days of life*†	Core	✓
5. Dying in Preferred Place of Death	% of deaths occurring in hospital	Core	✓

These metrics, their initial baselines and the insights they create are subject to ongoing engagement and refinement with stakeholders.

Summary of Derby and Derbyshire ICB End of Life Strategic KPI baselines

Derby and Derbyshire ICB Headline Strategic Key Performance Indicator Overview

- Identification is improving marginally, though there is significant PCN variation – as with all metrics
- While multiple admissions are reducing, the overall amount time spent in hospital in last 90 days of life is increasing
- Some areas suggest improvement, which provide an opportunity to scale best practice

1. Identifying people in the last year of life

PEOL register
0.83% (▲0.04%)

PCN variation: 0.27% ⇒ 1.74%

Overall: improvement at system level

IMD: No consistent IMD trend; higher coverage in rural/market-town PCNs and lower coverage in some urban Derby City PCNs

2. Plan & deliver proactive care

No indicator currently available

3. Coordinate & Support

No indicator currently available

4A. Reducing hospital utilisation

3+ admission in last 90 days of life

6.8% (▼0.4%)

PCN variation: 4.6% ⇒ 8.7%

Overall: improvement at system level

IMD: No IMD variation; several urban core PCNs have higher rates of multiple NEL admissions

4B. Reducing hospital utilisation

Unplanned bed days in the last 90 days of life

93k (▲930 / 1%)

PCN variation: -1,109 ⇒ +789 bed days

IMD: No IMD variation; urban PCNs have generally improved markedly, while a number of rural and market-town PCNs have deteriorated

5. Increasing proportion of people dying in preferred place of death

% dying in hospital

41.0% (▼1.7%)

PCN variation – 25/26 figures:
32.6% ⇒ 47.0%

PCN variation – y-o-y change:
-7.58% ⇒ +3.61%

IMD: more deprived urban PCNs showing higher hospital death rates; rural and market-town PCNs have lower rates

1. Identifying People in Last Year of Life Are people with palliative care needs being identified?	0.78% to 0.83% (0.04%) ▲ Overall improvement at system level	Largest system impact (coverage & pop size) • Chesterfield & Dronfield (1.24% cov.) • Erewash (0.86% cov.) • Alfreton Ripley Crich & Heanor (0.91% cov.)	Low coverage/deteriorating areas • NE Derbyshire (-0.12%) • Belper (-0.08%) • Oakdale Park (-0.06%)	Improving areas • Chesterfield & Dronfield (+0.37%) • North Derbyshire (+0.28%) • Derbyshire Dales (+0.21%)
	There is no consistent IMD trend, but there is a notable pattern of higher coverage in rural/market-town PCNs and lower coverage in some urban Derby City PCNs			
2. Delivering Proactive Care Are patients receiving proactive and personalised care?	Data not available			
3. Coordination & Support Are patients & their carers receiving coordinated care & support?	Data not available			
4A. Reduce Hospital Utilisation Are people being admitted to hospital multiple times in their last few months of life?	7.2% to 6.8% (0.4%) ▼ Overall improvement at system level	Best overall performers • Chesterfield & Dronfield • Erewash • Belper	High current rate, large pop & limited improvement: • Greater Derby • Derby City South • Derby City North Most deteriorated: • H Peak & Buxt (+3.2%) • Swadlincote (+1.6%) • PCCO (+1.5%)	Most improved: • Oakdale Park (-2.7%) • Chesterfield & Dronfield (-2.2%) • South Hardwick (-2.1%)
	Variation appears to be more strongly associated with urban vs rural/market-town settings than with IMD quintile alone, with several urban core PCNs having higher rates of multiple NEL admissions			
4B. Reduce Hospital Utilisation How much of people's last few months of life are spent in hospital?	17.7% to 18.1% (0.4%) ▲ Overall deterioration at system level	Best overall performers • South Hardwick • Chesterfield & Dronfield • North East Derbyshire	Highest proportion of days • PCCO • Swadlincote • Belper Most deteriorated: • North East Derbyshire • South Hardwick • PCCO (+1.5%)	Most improved • Belper (-1.8%) • Derby City North (-1.6%) • Oakdale Park (-1.0%)

	Little evidence of a deprivation gradient. Re. community type, rural and market-town PCNs have fewer hospital days near end of life than urban-core PCNs, though several rural PCNs have deteriorated in 25/26			
4C. Reduce Hospital Utilisation How much of people's last few months of life are spent in hospital on an unplanned basis?	92,087 to 93,017 (930 / 1%) ▲ Overall deterioration at system level	Best overall performers re scale • PCCO • Chesterfield & Dronfield • South Hardwick	Largest current burden • Erewash • Greater Derby • Swadlincote Most deteriorated • N Derbyshire (+14%) • Swadlincote (+13%) • NE Derbyshire (+12%)	Most improved • Derby City N (-22%) • PCCO (-11%) • South Hardwick (-9%)
	IMD appears to be a weaker explanatory factor than community type; urban PCNs have generally improved markedly, while a number of rural and market-town PCNs have deteriorated			
5. Dying in Preferred Place of Death Is the model supporting more people's wishes?	42.7% to 41.0% (-1.7%) ▼ Overall improvement at system level	Best overall performance considering 25/26 hospital death rate & pop size • Belper • North East Derbyshire • High Peak & Buxton	Greatest concern given system impact re pop size: • North Derbyshire • Derby City North • PCCO Most deteriorated • Swadlincote (+3.6%) • Derby City S (+3.2%) • No Derbyshire (1.9%)	Most improved • Belper (-7.6%) • PCCO (-7.2%) • Derby City N (-6.8%) Belper has both the lowest hospital death rate (32.6%) and largest improvement
	While there is a moderate deprivation gradient, with more deprived urban PCNs showing higher hospital death rates, community type has a stronger pattern, with rural and market-town PCNs having lower rates			

Summary of Lincolnshire ICB End of Life Strategic KPI baselines

Lincolnshire ICB Headline Strategic Key Performance Indicator Overview

- All headline strategic KPIs improving year on year at a county level
- There is extensive variation by PCN, with a broad theme of urban PCNs performing better/improving quicker than rural and coastal PCNs
- Overall improvement at system level (10%) in reducing bed days

1. Identifying people in the last year of life

PEOL register

0.9% (▲0.1%)

PCN variation: 0.43% ⇒ 2.16%

Overall: improvement at system level

IMD: No clear IMD or community type pattern

2. Plan & deliver proactive care

PEOL register with ReSPECT

63.0% (▲2.3%)

PCN variation – 25/26 figures:
40.5% ⇒ 82.9%

PCN variation – y-o-y change:
–5.1% ⇒ +16.8%

IMD: No consistent relationship between deprivation and ReSPECT coverage

3. Coordinate & Support

No indicator currently available

4A. Reducing hospital utilisation

3+ admission in last 90 days of life

5.9% (▼-0.5%)

PCN variation: 4.0% ⇒ 8.1%

Overall: improvement at system level

IMD: Only a weak IMD effect; Coastal and some market-town/rural PCNs have higher rates of repeated emergency admissions,

4B. Reducing hospital utilisation

Unplanned bed days in the last 90 days of life

77.8k (▼8.9k / 10%)

PCN variation: -2,366 ⇒ +488 bed days

IMD: No IMD variation; urban PCNs have generally improved markedly, while rural and market-town PCNs have deteriorated

5. Increasing proportion of people dying in preferred place of death

% dying in hospital

36.3% (▼-2.8%)

PCN variation – 25/26 figures:
25.3% ⇒ 45.0%

PCN variation – y-o-y change:
–8.9% ⇒ +2.1%

IMD: No clear IMD gradient. Urban PCNs - lower hospital death rates; some rural & coastal PCNs - higher hospital death rates

1. Identifying People in Last Year of Life Are people with palliative care needs being identified?	0.8% to 0.9% (0.1%) ▲ Overall improvement at system level	Largest system impact (coverage & pop size) • East Lindsey • Lincoln Heath Partnership • First Coastal	Low coverage/deteriorating areas • S Lincs Rural (0.56% cov) • Boston (0.65% cov) • Meridian only declining PCN (-0.04%)	Improving areas • Trent Care (+0.69%) • East Lindsey (+0.30%) • Grantham & Rural (+0.22%)
	No clear IMD pattern			
2. Delivering Proactive Care Are patients receiving proactive and personalised care?	60.7% to 63.0% (2.3%) ▲ Overall improvement at system level	Largest positive system impact re coverage & pop size • Lincoln Health Partnership • Four Counties • Apex	Low coverage/deteriorating areas • S Lincs Rural • K2 Sleaford • Imp Most deteriorated • South Lincs (-11.2%) • Spalding PCN (-5.1%) • Four Counties (-2.7%)	Improving areas • Trent Care (+16.8%) • East Lindsey (+12.0%) • K2 Sleaford (+4.6%)
	No consistent relationship between deprivation and ReSPECT coverage			
3. Coordination & Support Are patients & their carers receiving coordinated care & support?	Data not available			
4A. Reduce Hospital Utilisation Are people being admitted to hospital multiple times in their last few months of life?	6.4% to 5.9% (-0.5%) ▼ Overall improvement at system level	Greatest positive system impact considering rate, pop size & improvement • Boston • Lincoln Health Partnership • Grantham & Rural	Deteriorating areas • Trent Care (+1.6%) • First Coastal (+1.2%) • East Lindsey (no improvement) Trent Care increased from 5.4% to 7.0%	Improving areas: • Apex (-1.8%) • Boston (-1.4%) • S Lincs Rural (-1.1%) Boston has the strongest improvement given pop size and reduction
	Only a weak IMD effect; The more noticeable pattern is that coastal and some market-town/rural PCNs (particularly First Coastal and Trent Care) have higher rates of repeated emergency admissions,			
4B. Reduce Hospital Utilisation How much of people's last few months of life are spent in hospital?	18.5% to 17.9% (-0.6%) ▼ Overall improvement at system level	Biggest impact re performance and population served • Imp • Lincoln Health • Grantham & Rural	Deteriorating areas: • Lincoln Health (+2.7%) • Trent Care (+2.0%) • S Lincs Rural (+1.0%) Lincoln Health is one of the strongest performers overall	Improving areas • Meridian (-3.0%) • South Lincs (-2.4%) • Boston (-2.1%)

			but has largest y-on-y deterioration	
	Little evidence of an IMD effect. Re. community type, urban and mixed urban/rural PCNs showing lower hospital utilisation in the last 90 days of life, while several rural and market-town PCNs have higher levels			
4C. Reduce Hospital Utilisation How much of people's last few months of life are spent in hospital on an unplanned basis?	86,764 to 77,826 (8.9k / 10%) ▼ Overall improvement at system level. This improvement equates to ~27 beds	Lowest bed days relative. to pop served & overall impact: • Lincoln Health • Trent Care • Four Counties	Deteriorating areas: • Apex (+6.4%) • Trent Care (+0.5%)	11 of 13 PCNs improving Biggest improvements are: • Lincoln Health (-28.5%) • First Coastal (-26.2%) • Four Counties (-22.5%)
	With 11 of 13 PCNs improving, no obvious IMD trend and no clear urban-rural divide			
5. Dying in Preferred Place of Death Is the model supporting more people's wishes?	39.1% to 36.3% (-2.8%) ▼ Overall improvement at system level	Biggest system & patient impact based on pop size and rate: • Lincoln Health • Grantham & Rural • Imp	Deteriorating areas: • South Lincs (+2.1%) • Lincoln Health (+1.8%) • K2 Sleaford (+0.8%) Lincoln Health remains best performer but has worsened.	Improving areas • Apex (-5.5%) • Boston (-5.8%) • East Lindsey (-5.5%) Boston has the strongest improvement given pop size and reduction
	No clear IMD gradient. Re. community type, several urban PCNs are achieving lower hospital death rates, while some rural and coastal PCNs have substantially higher death rates in hospital			

Summary of Nottingham and Nottinghamshire ICB End of Life Strategic KPI baselines

Nottingham & Nottinghamshire ICB Headline Strategic Key Performance Indicator Overview

- Identification and proactive care planning metrics are improving
- Hospital utilisation figures for the last 90 days of life are slightly deteriorating in terms of multiple admissions and overall bed days – however a smaller proportion of people are dying in hospital
- A number of PCN areas potentially provide an opportunity to scale good practice

1. Identifying people in the last year of life

PEOL register

0.86% (▲0.04%)

PCN variation: 0.31% ⇒ 1.48%

Overall: improvement at system level

IMD: No IMD link; Market-town, rural & suburban PCNs - higher

PEOL register prevalence;
several urban-core Nottingham PCNs - lower coverage

2. Plan & deliver proactive care

PEOL register with ReSPECT

79.2% (▲3.1%)

PCN variation – 25/26 figures:
57.4% ⇒ 92.5%

PCN variation – y-o-y change:
–2.3% ⇒ +19.6%

IMD: No relationship between deprivation and ReSPECT coverage

3. Coordinate & Support

No indicator currently available

4A. Reducing hospital utilisation

3+ admission in last 90 days of life

7.0% (▲0.2%)

PCN variation: 4.0% ⇒ 8.5%

Overall: deterioration at system level

IMD: Deprived PCNs - highest rates; deterioration across all IMD groups - particularly noticeable in several more affluent PCNs.

4B. Reducing hospital utilisation

Unplanned bed days in the last 90 days of life

118.3k
(flat)

PCN variation: -1,035 ⇒ +1,127 bed days

IMD: Strongest improvements are concentrated in several IMD 1–2 PCNs

5. Increasing proportion of people dying in preferred place of death

% dying in hospital

42.3% (▼1.4%)

PCN variation – 25/26 figures:
35.3% ⇒ 52.0%

PCN variation – y-o-y change:
–13.26% ⇒ +5.55%

IMD: Deprived PCNs - higher proportion of hospital deaths; deterioration in some more affluent suburban and rural PCNs

1. Identifying People in Last Year of Life Are people with palliative care needs being identified?	0.82% to 0.86% (0.04%) ▲ Overall improvement at system level	Largest system impact (coverage & pop size) • Newark • Ashfield North • Mansfield North	Low coverage/deteriorating areas • Radford & Mary Potter (-0.12% to 0.31% coverage) • City South (improving but 0.32% coverage) • Aspire (-0.12%) (Unity disregarded as primarily uni students)	Improving areas • Retford & Villages (+0.31%) • Beeston (+0.14%) • Eastwood & K; Stapleford (both +0.13%)
	Strongest pattern is not deprivation but community type. Market-town, rural and suburban PCNs generally have higher PEOL register prevalence, while several urban-core Nottingham PCNs have lower coverage.			
2. Delivering Proactive Care Are patients receiving proactive and personalised care?	76.1% to 79.2% (3.1%) ▲ Overall improvement at system level	Largest system impact (pop. size, preference & ReSPECT coverage) • Ashfield North • Sherwood • Newark	Low coverage/deteriorating areas • Mansfield North (57.4% coverage) • Arrow Health (-2.3%) • Newgate (-0.6%)	Improving areas • Radford & Mary Potter (+19.6%) • City South (+8.7%) • Stapleford (+7.6%)
	No relationship between deprivation and ReSPECT coverage			
3. Coordination & Support Are patients & their carers receiving coordinated care & support?	<i>Data not available</i>			
4A. Reduce Hospital Utilisation Are people being admitted to hospital multiple times in their last few months of life?	6.8% to 7.0% (0.2%) ▲ Overall improvement at system level	Greatest positive system impact considering rate, pop size & improvement • Radford & Mary Potter, • Bulwell & Top Valley • Newark	Deteriorating areas • Sherwood (+2.5%) • Rushcliffe North (+2.0%) • Nottingham City East (+1.3%)	Improving areas • Radford & Mary Potter (-9.7%) • Bulwell & Top Valley (-1%) • Ashfield South (-0.9%)
	Deprived PCNs (IMD 1–2) generally have the highest rates, though deterioration is occurring across all deprivation groups and is particularly noticeable in several more affluent Rushcliffe/Sherwood PCNs.			
4B. Reduce Hospital Utilisation How much of people's last few months of life are spent in hospital?	18.86% to 19.22% (0.36%) ▲ Overall deterioration at system level	Greatest positive system impact considering rate, pop size & improvement • Arnold & Calverton • Aspire • Ashfield North	Deteriorating areas • Newgate (+2.8%) • Synergy (+2.5%) • Stapleford (+2.3%)	Improving areas • Arnold & Calverton (-3.8%) • Aspire (-2.2%) • Ashfield North (-1.5%)
	No clear deprivation gradient			
4C. Reduce Hospital Utilisation How much of people's last few months of life are spent in hospital on an unplanned basis?	118,279 to 118,347 (flat) Slight overall deterioration at system level	Greatest positive system impact considering reduction and pop. size • Ashfield South • Eastwood & Kimberley • Sherwood	Deteriorating areas • Stapleford (+28%) • Rushcliffe North (+27%) • Synergy (+17%)	Improving areas • Radford & Mary Potter (-20%) • Ashfield South (-20%) • City South (-15%) • Raleigh (-20%)
	Strongest improvements are concentrated in several IMD 1–2 PCNs			
5. Dying in Preferred Place of Death Is the model supporting more people's wishes?	43.7% to 42.3% (-1.4%) ▼ Overall improvement at system level	Greatest positive system and patient experience impact • Mansfield North • Eastwood/Kimberley • Ashfield South	Deteriorating areas • Stapleford (+5.5%) • Ashfield North (+5.2%) • Aspire (+5.06%)	Improving areas • Radford & Mary Potter (-13.3%) • Beeston (-9.1%) • City South (-4.8%)
	Deprived PCNs (IMD 1–2) generally have higher proportion of hospital deaths, though deterioration is occurring across the deprivation spectrum, particularly in some more affluent suburban and rural PCNs.			

Appendix 2

Approach to ICBs' Frailty Headline Strategic KPIs and baselines

As part of developing the ICBs' Population Health Strategy a set of strategic key performance indicators were identified for each priority to support Board reporting.

At the point of working together each of the three ICBs had a different method and maturity to their Population Health Management data (a significant amount of work is currently underway to establish one methodology).

Therefore, to ensure a view of progress against the frailty priority is available, a pragmatic approach has been taken to establish baselines for an initial set of indicators. This approach is based on establishing:

- A 'core' set of indicators that are based on national data and available across all three ICBs.
- 'Local' indicators that are currently readily available from an individual ICBs Population Health Management dataset.

Stage of Pathway	Strategic KPI	Core / Local	DLN Pop Health Strategy
1. Identifying Frailty	% Clinical Frailty Scale value recorded for those aged 65+ (last 12 months)	Local (N&N)	✓
2. Delivering Proactive Care	% Moderate/Severe frailty with Structured Medication Review last 12 months	Local (L)	✓
	Aged 65+ with Clinical Frailty Scale ≥ 6 recorded last 12 months and Structured Medication Review recorded last 12 months	Local (N&N)	✓
	Aged 65+ with Clinical Frailty Scale ≥ 6 recorded last 12 months and Personalised Care Plan completed last 12 months	Local (N&N)	✓
3. Reducing Deterioration	Falls non-elective hospital admissions for people aged 65+ any Length of Stay	Core	
4. Reducing Crisis	Type 1&3 accident and emergency attendances people aged 65	Core	
	Emergency admissions people aged 65+ with 1+ Length of Stay	Core	
5. Reducing Hospital Utilisation	All emergency admissions people aged 65+ with 1+ Length of Stay total occupied bed days	Core	✓

These metrics, their initial baselines and the insights they create are subject to ongoing engagement and refinement with stakeholders

Summary of Derby and Derbyshire ICB Frailty Strategic KPI baselines

Derby and Derbyshire ICB Headline Strategic Key Performance Indicator Overview

- 'Upstream' demand is rising: falls admissions (5%) and A&E attendance (7%)
- Small increase in admissions to hospital (0.5%) however larger increase in hospital bed use (3%)
- A comparatively smaller number of larger PCNs drive substantial pressure and growth
- Some areas suggest improvement, which provide an opportunity to scale best practice

1. Identifying frailty

No indicator currently available

2. Delivering Proactive Care

No indicator currently available

3. Reducing Deterioration

Falls-related NEL admissions age 65+ (any length of stay):

4,592 (▲200 / 5%)

19.1 per 1k pop.

PCN variation: 14.6 ⇒ 22.9

Overall: Deterioration not being reduced at system level

IMD: No obvious consistent deprivation relationship. However largest ↑ is in an IMD1 PCN

4A. Reducing Crisis

Type 1 & 3 A&E attendances age 65+:

121.6k (▲7.9k / 7%)

511.5 per 1k pop.

PCN variation: 414.2 ⇒ 637.7

Overall: Crisis demand increasing substantially

IMD: Strong growth across most IMD groups, however IMD 1 shows strong upward pressure

1 of 17 PCNs saw a 5% or more reduction in last 12 months

4B. Reducing Crisis

NEL admissions age 65+ (1+ length of stay):

44.8k (▲234 / 0.5%)

188.7 per 1k pop.

PCN variation: 123.9 ⇒ 236.9

Overall: Modest improvement at system level

IMD: Upward pressure across most PCNs, lower IMD groups tend to show a higher rate

No PCN saw a 5% or more reduction in last 12 months

5. Reducing Bed Use

Occupied Bed Days: age 65+:

419.4k (▲13.1k / 3%)

Increase equivalent to c.35 beds

PCN variation: 10.6k ⇒ 40.7k

Overall: Hospital utilisation increasing at system level

IMD: No clear deprivation gradient. IMD 1 shows both deterioration and 'stability'

2 of 17 PCNs saw a 2% or more reduction in last 12 months

1. Identifying Frailty Are older people living with frailty consistently identified	No indicator currently available			
2. Delivering Proactive Care Are people with frailty receiving proactive care	No indicator currently available			
3. Reducing Deterioration Are proactive interventions reducing drivers of crisis?	Falls-related NEL admissions (65+): 4,321 ⇒ 4,529 (5%) ▲ 18.5 ⇒ 19.1 per 1k Overall: deterioration not being reduced at system level	Largest System Impact (high volume + high rate) • Chest & Dron (21.6) • Greater Derby (20.5) • Derby City S. (20.3)	Deteriorating Hotspots (driving system increase) • Derby City N. (+27%) • Swadlincote (+33%) • N. Derbyshire (+26%)	Substantial Improvement • NE Derbyshire (-23%) • N Hard & Bol (-6%)
No obvious consistent deprivation relationship. Variation within IMD groups > between groups. IMD shows both significant deterioration (Derby City North) and improvement (PCCO)				
4A. Reducing Crisis Are fewer people presenting in crisis?	A&E attendances (65+): 113.6k ⇒ 121.6k (7%) ▲ 485.5 ⇒ 511.5 per 1k Overall: crisis demand increasing	Largest System Impact (high volume + high rate) • ARCH (570.3) • Chest & Dron (513.9) • Erewash (496.7)	Deteriorating Hotspots (driving system increase) • Derby City N. (+16%) • Erewash (+20%) • High P. & Bux (+19%)	Some Improving Areas • Glossop (-2%) • N Hard & Bol (-3%) • Derby Dales (-1%)
Strong Growth across most IMD groups, however IMD 1 shows strong upward pressure (Derby City North and PCCO)				
4B. Reducing Crisis Are fewer people being admitted to hospital?	NEL admissions (65+): 44.6k ⇒ 44.8k (0.5%) ▲ 191.0 ⇒ 188.7 per 1k Overall: increase in absolute numbers at system level	Key Contributors To Improvement • N Hard & Bol (-5%) • N E Derbyshire (-4%)	Limited Impact (high volume but flat) • ARCH (+1%) • Derby City S (+2%) • Erewash (+1%)	Growth Hotspots (offsetting gains) • High P. & Bux (+11%) • Swadlincote (+7%)
No clear deprivation gradient. IMD. Variation within IMD groups is more significant. IMD 1 shows both significant deterioration (Derby City North) and stable (PCCO)				
5. Reducing Hospital Utilisation Are fewer hospital beds being used?	Occupied Bed Days (65+): 407.8k ⇒ 419.4k (3%) ▲ Overall: hospital bed utilisation increasing	Largest System Impact (high volume + growth) • Swadlincote (+11%) • High P. & Bux (+10%) • Erewash (+9%)	Growth Hotspots (driving increase) • Oakdale. (+16%) • PCCO (+13%)	Some Improving Areas • Glossop (-5%) • N Hard & Bol (-5%)
No obvious consistent deprivation relationship. IMD 3 is dominate driver of bed day growth. IMD shows both significant deterioration (Derby City North) and 'stabilisation' (PCCO)				

Summary of Lincolnshire ICB Frailty Strategic KPI baselines

Lincolnshire ICB Headline Strategic Key Performance Indicator Overview

- Improvement in proactive care (proxy) at system level – high coverage in large PCNs
- 'Upstream' demand is rising: falls admissions (4%) and A&E attendance (6%)
- Increase in admissions to hospital (3%) however increased hospital bed use (2%)
- Some areas suggest improvement – these provide an opportunity to scale best practice

1. Identifying frailty

No indicator currently available

2. Delivering Proactive Care

% Moderate/Severe Frailty with Structured Medication Review in last 12 months:

32.3% (▲4.1%)

PCN variation: 1.1% ⇒ 63.3%

Overall: Improvement in recording /proactive care proxy – high coverage in large PCNs

IMD: Strong variation within IMD groups. IMD 1 shows decline, IMD 3 shows improvement

3. Reducing Deterioration

Falls-related NEL admissions age 65+ (any length of stay):

3,683 (▲139 / 4%)

18.9 per 1k pop.

PCN variation: 17.1 ⇒ 24.9

Overall: Deterioration not being reduced at system level

IMD: Deterioration present across IMD1-4, no clear deprivation gradient

4A. Reducing Crisis

Type 1 & 3 A&E attendances age 65+:

115.7k (▲6.9k / 6%)

593.9 per 1k pop.

PCN variation: 446.8 ⇒ 777.1

Overall: Crisis demand increasing significantly

IMD: Deterioration present across IMD1-4, however strongest in IMD1.

No PCN saw a 5% or more reduction in last 12 months

4B. Reducing Crisis

NEL admissions age 65+ (1+ length of stay):

33.5k (▲455 / 1.4%)

167.3 per 1k pop.

PCN variation: 134.0 ⇒ 192.6

Overall: Admissions increasing at system level

IMD: Upward pressure across most PCNs, lower IMD groups tend to show a higher rate

2 of 14 PCNs saw a 5% or more reduction in last 12 months

5. Reducing Bed Use

Occupied Bed Days: age 65+:

327.5k (▲5.9k / 2%)

Increase equivalent to c.15 beds

PCN variation: 6.0k ⇒ 49.2k

Overall: Hospital utilisation increasing at system level

IMD: Growth concentrated in IMD3 (largest population group)

3 of 14 PCNs saw a 2% or more reduction in last 12 months

1. Identifying Frailty Are older people living with frailty consistently identified	No indicator currently available			
2. Delivering Proactive Care Are people with frailty receiving proactive care	Structured Medication Review coverage (moderate/severe frailty) 28.2% ⇒ 32.3% (4%) ▲ Overall: improvement in recording / proactive care proxy at system level	Largest System Impact (coverage + pop size) • Boston (62%) • Meridian (63%) • Gran & Rur (57%)	Low Coverage / Deteriorating Areas • First Coastal (1.1%) • S Lincs & R (21%) • Trent Care (-4.7%)	Improving Areas • Meridian (+30%) • Four counties (+20%)
IMD 1 shows low coverage/decline. IMD 3 shows significant improvement				
3. Reducing Deterioration Are proactive interventions reducing drivers of crisis?	Falls-related NEL admissions (65+): 3,544 ⇒ 3,683 (4%) ▲ 17.9 ⇒ 18.9 per 1k Overall: deterioration not being reduced at system level	Largest System Impact (high volume + high rate) • First Coastal (19.8) • Boston (19.7) • S Lincs & R (17.7)	Deteriorating Areas (driving system increase) • Meridian (+16%) • S Lincs & R (+12%) • Trent Care (+13%)	Substantial Improvement Areas • South Lincoln (-13%) • Spalding (-13%) • Apex(-11%)
No consistent deprivation gradient; variation within IMD groups				
4A. Reducing Crisis Are fewer people presenting in crisis?	A&E attendances (65+): 108.8k ⇒ 115.7k (6%) ▲ 548.0 ⇒ 593.9 per 1k Overall: crisis demand increasing significantly	Largest System Impact (high volume + high rate) • First Coastal (691.5) • Boston (622.4) • S Lincs & R (585.8)	Deteriorating Hotspots (driving system increase) • K2 Sleaford (+13%) • Boston (+10%) • S Lincs & R (+7%)	Some Improving Areas
Strong Growth across all IMD groups, however strongest in IMD 1				
4B. Reducing Crisis Are fewer people being admitted to hospital?	NEL admissions (65+): 33.0k ⇒ 33.5k (1.4%) ▲ 161.8 ⇒ 167.3 per 1k Overall: Admissions increasing	Key Contributors To Improvement • South Lincoln (-12%) • Four Counties (-7%)	Limited Impact (high volume but flat) • Grantham and Rural (-0.5%)	Growth Hotspots (offsetting gains) • K2 Sleaford (+7.3%) • Apex (+4.3%) • First Coastal (+3.8%) • Meridian (+1.1%)
Upward pressure across most PCNs				
5. Reducing Hospital Utilisation Are fewer hospital beds being used?	Occupied Bed Days (65+): 321.7k ⇒ 327.5k (2%) ▲ Overall: hospital bed utilisation increasing	Largest System Impact (high volume + growth) • S Lincs & R (+5%) • Gran & Rur (+6%) • Imp (+8%)	Growth Hotspots (driving increase) • Apex (+13%) • Imp (+8%) • Meridian (+5%)	Some Improving Areas • South Lincoln (-15%) • Boston (-7%)
Growth concentrated in IMD3 (largest population group)				

Summary of Nottingham and Nottinghamshire ICB Frailty Strategic KPI baselines

Nottingham & Nottinghamshire ICB Headline Strategic Key Performance Indicator Overview

- Improving identification (14%) and some improvements in delivering proactive care (3%)
- 'Upstream' demand shows mixed performance: A&E attendance (7%)
- Admissions to hospital stable (0.2%) however increased hospital bed use (4%)
- A number of areas potentially provide an opportunity to scale 'good practice'

1. Identifying frailty

% Clinical Frailty Scale value recorded for those aged 65+ (last 12 months):

27.7% (▲ 14%)

PCN variation: 8.2% ⇒ 63.9%

Overall: Identification improved overall, but remains uneven

IMD: IMD 3-5 stronger improvement; IMD 1 & 2 more mixed performance

2. Delivering Proactive Care

Aged 65+ with Clinical Frailty Scale ≥6 and Structured Medication Review in last 12 months:

39.8% (▲ 3%)

PCN variation: 10.0% ⇒ 62.6%

Overall: 'Unstable': gains in PCNs offset by declines in others

IMD: Variation within IMD groups greater than between groups

Aged 65+ with Clinical Frailty Scale ≥6 and Personalised Care Plan completed in last 12 months:

33.6% (flat)

3. Reducing Deterioration

Falls-related NEL admissions age 65+ (any length of stay):

Not reported as under-reported due to NUH coding issues

4A. Reducing Crisis

Type 1 & 3 A&E attendances age 65+:

110.2k (▲ 7.6k / 7%)

472.5 per 1k pop.

PCN variation: 290.8 ⇒ 655.3

Overall: Crisis demand increasing at system level

IMD: Deterioration present across IMD1-4

1 of 28

PCNs/Neighbourhoods saw a 5% or more reduction in last 12 months

4B. Reducing Crisis

NEL admissions age 65+ (1+ length of stay):

46.3k (flat)

198.4 per 1k pop.

PCN variation: 131.0 ⇒ 267.1

Overall: Slight improvement at system level

IMD: Improvement across IMD groups, rates in IMD1 group tend to be higher

6 of 28

PCNs/Neighbourhoods saw a 5% or more reduction in last 12 months

5. Reducing Bed Use

Occupied Bed Days: age 65+:

484.4k (▲ 16.5k / 4%)

Increase equivalent to c.45 beds

PCN variation: 3.7k ⇒ 32.7k

Overall: Hospital utilisation increasing at system level

IMD: Growth seen across all IMD groups

7 of 28 PCNs saw a 2% or more reduction in last 12 months

1. Identifying Frailty Are older people living with frailty consistently identified	Clinical Frailty Scale value recorded (those aged 65+) 14.1% ⇒ 27.7% (14%) ▲ Overall: Identification improved, but remains uneven – particularly in urban PCNs	Largest System Impact (coverage + pop size) • Beeston (64%) • E'twood & Kim (62%) • Rushcliffe PCNs	Low Coverage & Low Growth Areas • Arrow (+1.2) • Beest & Sher (+2.2%) • Raleigh (+2.9%)	Improving Areas (largest gains) • E'twood & Kim (+46%) • Newgate (+45%) • Rushcliffe N (+35%)
	IMD 3-5 stronger improvement; IMD 1 & 2 more mixed performance			
2. Delivering Proactive Care Are people with frailty receiving proactive care	Structured Medication Review coverage (moderate/severe frailty) 37.1% ⇒ 39.8% (3%) ▲ Overall: improvement in recording at system level	Largest System Impact (coverage + pop size) • Rushcliffe N (51.6%) • Beeston (50%) • Ret & Vill (57%)	Deteriorating Areas • Lar & Baw (-36%) • Aspire (-26%) • Newgate (-13%)	Improving Areas • E'twood & Kim (+46%) • Ashfield South (+20%) • Sherwood (+17%)
	Variation within IMD groups greater than between groups			
	Personalised Care Plan completion (moderate/severe frailty) 33.4% ⇒ 33.6% (flat) Overall: No overall improvement, declines in some PCNs	Largest System Impact (coverage + pop size) • Beeston (64%) • E'wood & Kim (62%)	Low Coverage & Deteriorating Areas • Aspire (-12%) • City & South (-4.5%) • N City East (-3%)	Improving Areas • Ashfield South (+28%) • Newark (+14%)
	Wide variation within IMD groups; IMD 1 generally lowest			
3. Reducing Deterioration Are proactive interventions reducing drivers of crisis?	Not reported as under-reported due to NUH coding issues			
4A. Reducing Crisis Are fewer people presenting in crisis?	A&E attendances (65+): 102.5k ⇒ 110.2k (7%) ▲ 449.3.0 ⇒ 472.5 per 1k Overall: crisis demand increasing	Largest System Impact (high volume + high rate) • Newgate (655) • Newark (631.4) • Lar & Baw (623.0)	Deteriorating Hotspots (driving system increase) • Stapleford (+28%) • N C East (+16%) • E'wood & Kim (+15%)	Some Improving Areas • Rosewood (-5%)
	Deterioration present across IMD1-4			
4B. Reducing Crisis Are fewer people being admitted to hospital?	NEL admissions (65+): 46.2k ⇒ 46.3k (+0.3%) ▲ 202.4 ⇒ 198.4 per 1k Overall: Slight improvement in rates but slight increase in absolute numbers	Key Contributors To Improvement • Synergy (-8%) • City South (-8%) • Beest & Sher (-6%) • Beeston (-6%)	Limited Impact (high volume but flat) • Ashfield North (+3%) • Sherwood (+2%)	Growth Hotspots (offsetting gains) • Rushcliffe N (+9%) • Clif & Mead (+8%)
	Improvement across IMD groups, rates in IMD1 group tend to be higher			
5. Reducing Hospital Utilisation Are fewer hospital beds being used?	Occupied Bed Days (65+): 467.8k ⇒ 484.4k (4%) ▲ Overall: hospital bed utilisation increasing	Largest System Impact (high volume + growth) • Mansfield N (+9%) • Bull & Top V (+7%) • Newark (+4%)	Growth Hotspots (driving increase) • Byron (+16%) • Rushcliffe N (+13%) • Cliff & Mead (+12%)	Some Improving Areas • Ashfield N (-2%) • City & South (-3%) • Arnold & Calv (-3%)
	Growth seen across all IMD groups			

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	16/07/2026
Paper title:	Approach to Quality for 2026/27
Paper reference:	ICB CIC 26 032
Paper author:	Rebecca Neno, Director of Quality, Safety and Improvement
Paper sponsor:	Rosa Waddingham, Executive Director of Quality (Nursing)
Presenter:	Rosa Waddingham

Paper type:			
For assurance ☒	For decision ☐	For discussion ☐	For information ☐

Report summary:

The report provides an update on the quality approach being developed across NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB (DLN) during 2026/27.

The approach builds upon the ICBs' existing quality strategies, as well as the emergent National Quality Board guidance and awaited new national quality strategy. The approach was developed and refined following discussions at the Joint Quality and Service Improvement Committee during December 2025 and January 2026 and a Committee development session in March 2026.

The report outlines a key set of quality priorities for 2026/27 and through the recently launched System Quality Group these have been tested with providers and partners for synergy and difference and aligned with the ICBs' Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan.

The quality governance approach for escalation and oversight of commissioned services is outlined, alongside next steps once the awaited National Quality Board guidance and national quality strategy is published.

Recommendation(s):

The Boards are asked to **receive** the DLN Approach to Quality 2026/27 report.

Appendices

Appendix A: DLN Approach to Quality
 Appendix B: Quality Governance.
 Appendix C: Quality Oversight Risk Escalation Process.

Board Assurance Framework

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

- Failure to systematically improve the quality of healthcare services

Relevant statutory duties:

☒ Quality improvement	☐ Public involvement and consultation
☒ Reducing inequalities	☐ Equality and diversity
☐ Integration of services	☐ Wider effect of decisions (triple aim)

Relevant statutory duties:☐ Promoting innovation☐ Promoting research☐ Patient choice☐ Obtaining appropriate advice☐ Promoting education/training☐ Climate change**Are there any conflicts of interest requiring management?**

No.

Is this paper confidential?

No.

Approach to Quality for 2026/27

Introduction

1. NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB have developed an approach to quality for 2026/27, which ensures due consideration of both the restorative and transformational aspects of quality. This will ensure a focus on the delivery of safe quality services at a foundational level – restorative and quality improvements, alongside a transformational focus on quality that aligns to the ICBs' emergent approach to outcomes. The approach builds upon the ICBs' existing quality strategies, as well as the emergent National Quality Board guidance and awaited new national quality strategy.
2. The Approach to Quality was developed and refined through consideration by the Joint Quality and Service Improvement Committee between December 2025 and March 2026 and is attached for information at Appendix A. It provides a transitional framework for quality across the three ICBs as they move towards their future role as strategic commissioners and sets out how the principles of a Quality Management System will be embedded within the strategic commissioning cycle, alongside the ICBs' continuing statutory quality duties and functions. The approach also establishes the shared quality priorities for 2026/27 and a series of development objectives to guide the further development and implementation of quality arrangements across the three ICBs.
3. The purpose of this report is to provide the Board with an overview of the Approach to Quality and an update on progress in developing the governance and oversight arrangements that will support its implementation during 2026/27. This includes the establishment of the cluster-wide System Quality Group, development of standardised quality oversight and risk escalation arrangements, and establishment of the ICB Quality Oversight and Assurance Group.

Development of the quality approach

4. The Approach to Quality identifies five development objectives for 2026/27, which set out the key areas of work required to further develop and implement consistent quality arrangements across the three ICBs. These objectives focus on embedding a Quality Management System; establishing a consistent approach to quality oversight of commissioned services; developing quality governance arrangements; aligning the work programme and reporting arrangements of the Joint Quality and Service Improvement Committee to the

emerging quality strategy and risk profile; and standardising Equality and Quality Impact Assessment arrangements.

5. The objectives will guide the further development of the ICBs' approach to quality during 2026/27 and provide the foundations for the development of the ICBs' Quality Strategy during quarter four. The Quality Strategy will acknowledge the complexity of the challenges faced, as detailed within the Ten-Year Health Plan, and will articulate the role of quality both within the strategic commissioning function and in assuring outcomes and patient safety.
6. Alongside these development objectives, the Approach to Quality identifies a set of shared quality priorities for 2026/27. While the development objectives set out the work required to strengthen and embed the ICBs' quality arrangements, the shared quality priorities identify the areas of focus for quality planning, improvement, control and assurance across the three ICBs. Together, the objectives and priorities provide the framework for developing the ICBs' quality arrangements and ensuring that quality intelligence, oversight and improvement inform the ICBs' wider strategic commissioning approach.
7. The ICBs' shared quality priorities for 2026/27 were agreed by the Joint Quality and Service Improvement Committee in February 2026. These are:
 - a) Access and capacity: Ensuring timely, equitable access to services.
 - b) Patient safety and experience: Reducing harm, learning from incidents, and improving user experience. With a particular focus on maternity and mental health.
 - c) Reducing health inequalities: Targeted interventions for underserved groups, using population health management.
 - d) Workforce: Acknowledging the impact workforce has on quality ensuring a focus on this in quality including training, sickness, retention, and staff wellbeing.
 - e) Clinical effectiveness: Ensuring evidence-based care, pathway optimisation, and outcome measurement.
 - f) Digital maturity: Leveraging technology for safer, more effective care. With an internal focus on continuing healthcare transformation.
 - g) Safeguarding and health protection: Robust frameworks for vulnerable groups and infection prevention. With a particular focus on children and young people with mental health and/or learning disabilities and autism.
8. The Joint Quality and Service Improvement Committee will consider delivery of the priorities through its work programme, with thematic reviews scheduled throughout the year to enable more detailed scrutiny of progress, risks, challenges and opportunities for improvement and to inform the assurances provided by the Committee to the ICB Boards.

System Quality Group

9. Implementation of the ICBs' Approach to Quality is supported by local intelligence and information gained through the contractual oversight of commissioned services and wider system intelligence sharing through the System Quality Group, which is focused on enabling quality improvement across the system. The emerging overarching quality governance arrangements for the ICBs are detailed at Appendix B.
10. In May 2026, the ICBs hosted the first System Quality Group across the cluster footprint chaired by the ICBs' Executive Director of Quality (Nursing) and in line with the emerging National Quality Board guidance. This provided an opportunity to test the ICBs' shared quality priorities for 2026/7 across the system for synergy and difference. Each provider presented their top three quality priorities and top three quality risks for their respective organisations. There was very little difference in priorities and risks that could not be attributable to organisational focus and speciality but there was considerable synergy in priorities, which closely mapped to those outlined in the ICBs' approach to quality.
11. The top five quality priorities and risks outlined by providers across the ICBs' footprint at the System Quality Group have been used to confirm and challenge our current approach and all have an agreed response, which is mapped into wider ICB strategies for development and oversight:
 - a) Improve access and reduce waiting times.
 - i) Aligned to ICBs' shared quality priorities for 2026/27.
 - ii) Aligned to ICBs' Five-Year Strategic Commissioning Plan.
 - b) Strengthen workforce sustainability and safe staffing.
 - i) Aligned to ICBs' shared quality priorities for 2026/27.
 - c) Develop integrated neighbourhood health models.
 - i) Aligned to ICBs' Five-Year Population Health Strategy.
 - ii) Aligned to ICBs' Five-Year Strategic Commissioning Plan.
 - iii) Aligned to ICBs' Strategic Commissioning Plan Transformational Programme.
 - d) Enhance patient, family and community involvement in service design.
 - i) Aligned to ICBs' shared quality priorities for 2026/27.
 - ii) Aligned to ICBs' Five-Year Population Health Strategy.
 - iii) Aligned to ICBs' Five-Year Strategic Commissioning Plan.
 - e) Strengthen quality governance, safety learning and continuous improvement.

- i) Aligned to ICBs' shared quality priorities for 2026/27.
- 12. There is good strategic alignment across provider and ICB priorities mapped across ICB strategies, providing a foundational structure to build upon as the ICBs' approach to quality and associated governance matures and evolves.

Quality governance

- 13. Steady progress is being made to move to standardised quality oversight approaches across the ICBs. Whilst the ICBs' wave three management of change reorganisation completes, an interim quality oversight structure has been confirmed, with a senior quality lead identified for large, commissioned services.
- 14. A risk escalation process has been introduced, as detailed at Appendix C, to standardise escalation across the ICBs. This is also currently being aligned to the Commissioning Delivery Escalation Ladder to ensure consistent oversight and response.
- 15. A new ICB Quality Oversight and Assurance Group has been established to provide operational oversight and support the triangulation of quality intelligence relating to commissioned services across the three ICBs. The outputs of the Group will inform the assurances provided to the Joint Quality and Service Improvement Committee. The first meeting is scheduled for July 2026.
- 16. Quality governance arrangements will also align with the commissioning programme boards to support the integration of quality throughout the commissioning cycle and reflect the principles of the emerging Quality Management System and the ICBs' Approach to Quality for 2026/27. Further work will take place during 2026/27 to develop and embed the Quality Management System and progress the wider development objectives set out within the Approach to Quality.

Conclusion

- 17. Good progress has been made in the development of our strategic approach to quality across both restorative and transformational elements. It is expected that the National Quality Board will publish the national quality strategy during quarter two of 2026/27, and at this point, a further review will take place in readiness for the development of the ICBs' Quality Strategy 2027-2030.

Appendix A

Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire

Approach to Quality 2026 - 2027

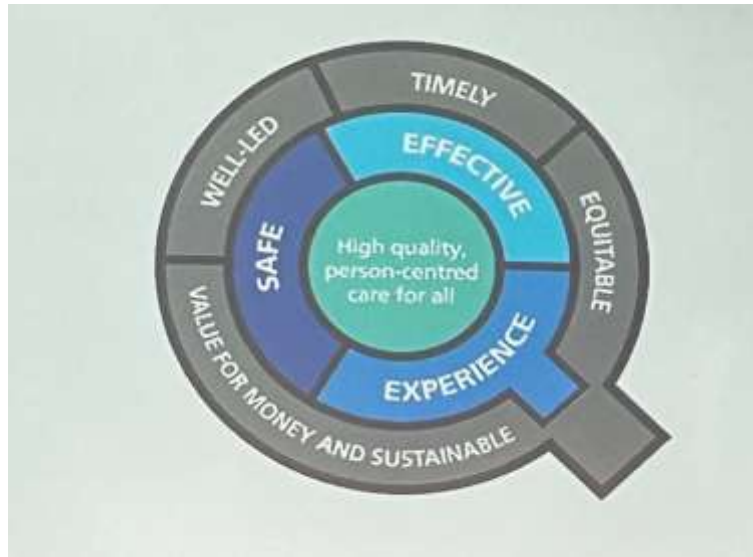


Introduction

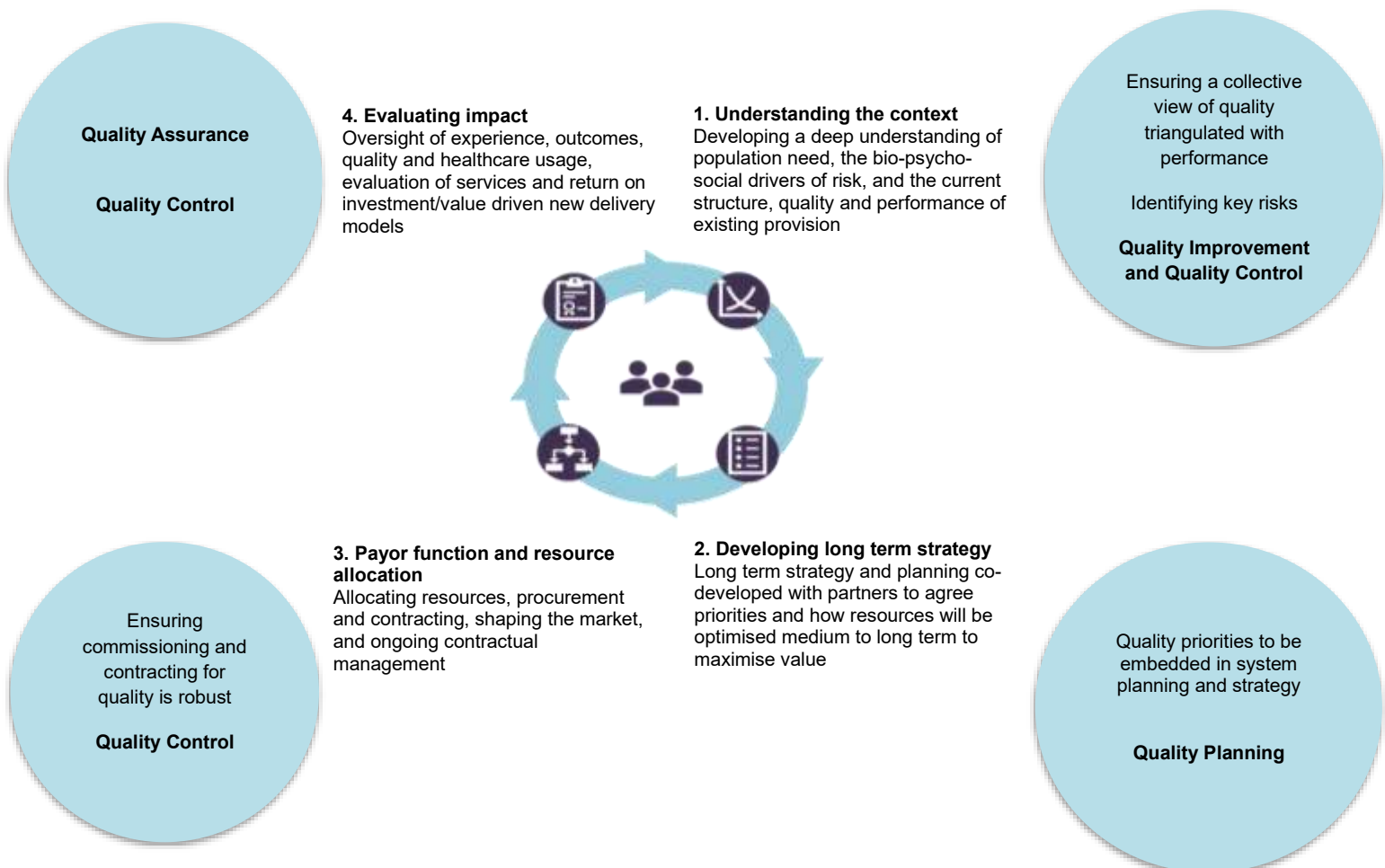
1. The purpose of this document is to provide an outline of the quality approach to be taken across the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire (DLN) Integrated Care Boards (ICBs) Cluster during 2026/2027. At its core is the requirement for ICBs to move from the role of system convenor to strategic commissioner and the transitional arrangements required for this to be enacted.
2. The approach will build upon each ICB's existing quality strategies, as well as the emergent National Quality Board (NQB) guidance and awaited new national quality strategy. The approach has been developed and refined following discussions at the joint Quality and Service Improvement Committees during December 2025 and January 2026 and a Committee development session in March 2026.
3. In addition, the approach supports the aspirations of the DLN Population Health Strategy and acknowledge that this should be the north star' for guidance and as such would ensure that all foundational and statutory considerations are addressed consistently.
4. The ICB remains accountable with providers and regulators for the quality of the care our population receives. The ICB is committed to ensuring commissioning for quality-working together to proactively share intelligence, drive improvement and mitigate and escalate quality risks. This approach to quality seeks to align internal process to national quality and strategic commissioning strategies to ensure that we work collectively to deliver care of the best value and highest possible quality.

Background

5. In April 2021, as Integrated Care Systems were being established, the National Quality Board published a set of operational requirements to be adopted to support the delivery of quality in the new operating model. The requirements were:
 - Designated executive clinical leadership for quality, embedded at all levels
 - Clear strategy and credible strategy to deliver quality improvement in the ICS
 - Defined governance and escalation process in place for quality oversight
 - Agreed way to measure quality, including key quality metrics triangulated with intelligence and professional insight
 - Dedicated forum to share intelligence through a System Quality Group.
6. Under the new NHS Operating Model and Strategic Commissioning Framework these operational requirements still remain. Use of the National Quality Board Risk Response and Escalation Guidance will continue under the new NHS Operating Model. ICBs will be responsible for contractual oversight of quality, whilst regions will take on a stronger oversight role and be responsible for calibrating improvement support and coordinating the deployment of targeted NHSE improvement resource where appropriate.
7. Within the NHS Ten Year Plan (2025) there is a clear focus on quality: *"Our objective will be twofold: to universalise high-quality care and, in support of that, to make the NHS the most transparent healthcare system in the world"*.
8. The emerging NHS England definition of high quality acknowledges the significant demands facing both commissioners and providers and for the first time acknowledges that care must be safe and effective but experience may not always meet expectations of the public: *'Care that is safe and effective; experience that is as positive as possible'*.
9. There is also clear acknowledgment of the importance of equity, timeliness, leadership, sustainability and value when considering quality as detailed within the graphic below.



10. Aligned with the National Quality Board approach, providers, commissioners and regions are expected to implement a Quality Management System (QMS) approach incorporating, Quality Planning – *what do we need?*, Quality Control – *what is our performance?*, Quality Improvement – *what could be better and how do we get there?* and Quality Assurance – *are we meeting standards?*.
11. This approach is informed by the NHS Strategic Commissioning Framework, which positions quality as a central component of strategic commissioning, integral to understanding population health needs, shaping service delivery, allocating resources, and evaluating outcomes. The diagram below overlays the quality management system approach to the steps within the strategic commissioning cycle and the table on the following page details the quality activities to be undertaken within each stage of the quality management system.



Quality Planning	Quality Improvement	Quality Control	Quality Assurance
Set strategic plans to deliver high-quality, cost-effective care and reduce inequalities for local communities, in collaboration with local authorities Commission high-quality care, co-designed with people using services, unpaid carers, staff and local communities, including neighbourhood health services.	Use contractual levers to drive quality improvement and address variation, including NHS Standard Contract Support providers to implement national standards (e.g. NHS Standard Contract, CQC requirements) Proactively manage and escalate risks in accordance with the National Quality Board guidance Use System Quality Groups to share intelligence to inform improvement and risk management Delivery of statutory quality functions.	Monitor quality in contract management, including: Quality schedules and Service Development and Improvement Plans (SDIPs) Quality metrics, including PROMs/PREMs Minimum practice standards and guidelines Service user, unpaid carer, staff and learner feedback Patient Safety Strategy. Maintain quality oversight of neighbourhood health services Use data/ intelligence to understand and improve the quality of services strategically commissioned. Triangulate metrics with wider intelligence and identify key themes and areas for improvement across services/ pathways. Commission Patient Safety Investigations and Independent Investigations, ensuring actions and learning are implemented	Effective and insightful governance to ensure visibility of quality, including: Clinical leadership Use of data and insight, including feedback from users and staff Equality and Quality Impact Assessments and assessments of cost-effectiveness Incident management, audits and risk reporting. Specify and assess quality in procurement activities, under the Provider Selection Regime. Compliance with oversight and regulatory frameworks (including NHS Oversight Framework and ICB Annual Assessment).

12. In addition, the ICB has a set of core statutory duties and function as outlined below and these will remain until any national change to the relevant acts.

Statutory Duties

NHSE / DHSC HQ

NHSE / DHSC Regions

ICBs

Service Providers

Core across all geographies:

- Triple Aim Duty, which includes duty, when making decisions, to have regard to the quality of services provided to individuals
- Duty to advance equality and reduce inequalities
- Duty to involve the public in the commissioning, design and delivery of services

NHSE:

- Duty to establish and operate systems to collect and analyse information about the safety of services
- Duty to license providers, with quality conditions
- Duty to monitor NHS trusts and power to direct an Integrated Care Board where it has failed to comply with duty for quality improvement

ICBs:

- Duty to secure continuous improvements in the quality of services
- Duty to receive NHS Quality Accounts
- Specific duties in relation to children, including Special Education Needs and Disabilities (SEND), safeguarding and promoting welfare (including the SEND Code of Practice 2015, Children Acts 1989 and 2004, and the Children and Families Act 2014), all age CHC, Primary Care & Dental Optom

Providers:

- Duty to enter contractual arrangements with commissioners to provide services, which includes quality
- The NHS Standard Contract contains terms and conditions and imposes contractual obligations on providers in relation to quality
- Duty to prepare NHS Quality Accounts

Statutory Functions

- Complaints
- Patient Safety Strategy (including incident reporting, national alerts, and patient safety specialists and experts)
- Safeguarding
- CHC All age
- Digital Clinical Safety strategy
- Clinical Audit and NICE Quality Standards and Guidelines
- Infection Prevention and Control
- Freedom to Speak Up
- Professional Standards
- Independent Investigations and wider reviews
- Coroners Regulation 28 Reports
- NHS Quality Accounts
- Special Education Needs and Disabilities (SEND)

Shared ICB Quality Priorities 2026/7

13. The following Quality Priorities were agreed at the Joint Quality and Service Improvement Committee in February 2026:

- **Access and capacity:** Ensuring timely, equitable access to services.
- **Patient safety and experience:** Reducing harm, learning from incidents, and improving user experience. *With a particular focus on maternity and mental health.*
- **Reducing health inequalities:** Targeted interventions for underserved groups, using population health management.
- **Workforce:** Acknowledging the impact workforce has on quality ensuring a focus on this in quality including training, sickness, retention, and staff wellbeing.
- **Clinical effectiveness:** Ensuring evidence-based care, pathway optimisation, and outcome measurement.
- **Digital maturity:** Leveraging technology for safer, more effective care. *With an internal focus on CHC transformation.*
- **Safeguarding and health protection:** Robust frameworks for vulnerable groups and infection prevention. *With a particular focus on Children and people with mental health and/or learning disabilities and autism*

14. Whilst each ICB has local nuances, a common set of expectations around quality will support cluster working and ensure commissioners, providers, and system leaders are working towards the same goals. These quality priorities will be used as the focus and foundation for quality planning, control, assurance and improvement and the further development of the Quality Management System during 2026/7. An action plan identifying delivery activity, anticipated benefits and anticipated outcomes for these priorities will be developed in line with this approach.

15. We will work across the ICB as the structure and working arrangements develop to ensure that we have aligned and collegiate arrangements across the directorates and teams which enable information sharing, robust escalation of quality and performance concerns and triangulation of intelligence and information.

Further Developing the Approach to Quality during 26/27 and Beyond

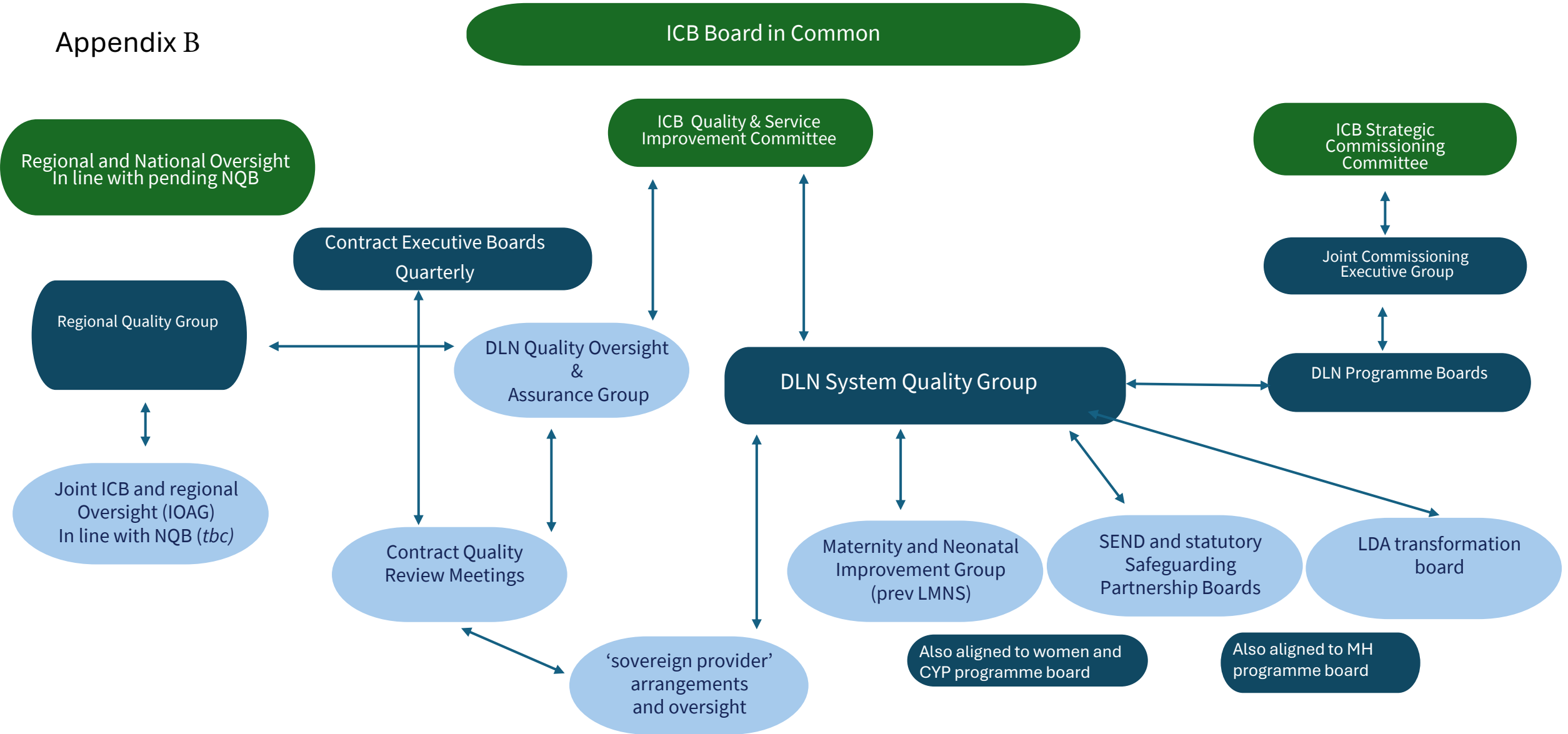
16. During 2026/27 the following objectives will guide the further development of our approach to Quality across the DLN Cluster footprint resulting in the publication of a DLN Quality Strategy during quarter 4. Our DLN Quality Strategy will acknowledge the complexity of the challenges faced as detailed within the NHS 10-year plan and described earlier in this document and will clearly articulate the role of quality both within the strategic commissioning function and in assuring outcomes and patient safety.

- a. Embed consistently a Quality Management System across the DLN Cluster ICBs which staff understand and have confidence in to shape and manage the work of the quality directorate.
- b. Consistently apply a foundational, contract driven, partnership-based approach to quality oversight of commissioned services across the DLN Cluster with a focus on aspirational improvement so insights are systematically embedded into commissioning, outcomes and service improvement to add value. Ensuring that the relationship between performance and quality is understood across the ICBs.

- c. Review the quality governance across the directorate to ensure it is fit for purpose and based upon the Quality Management System including the introduction of a cluster wide System Quality Group to support thematic oversight and drive consistent behaviours and improvement across the footprint.
 - d. Align the annual work programme of the Joint Quality and Service improvement Committee to the emerging strategy and risk profile, to ensure comprehensive coverage of key risks. A clear quality report along with an escalation framework to support proportionate and effective committee reporting will be developed as part of the quality strategy. During 2026/7 the Committee will receive standard quality control and assurance reporting, with deep-dives into specific issues to demonstrate learning and improvements. The focus will be on the highest-rated risks (including NOF 5 providers) with a quality report on these areas presented at each meeting. Thematic updates on providers at NOF 4 (or equivalent) will be received at alternate meetings, with reporting on providers at NOF 3 or below provided quarterly.
 - e. Review and embed a standardised Equality and Quality Impact Assessment (EQIA) across the Cluster ICBs. From May 2025 the Derby and Derbyshire ICB EQIA process will be adopted cluster wide but this will be further refined and developed during 2026/7.
17. A review of the DLN approach to quality for 26/7 will be undertaken prior to the development of a DLN Quality Strategy in quarter 4 of 26/7 and will form an iterative approach to quality as the role of ICBs as strategic commissioners matures and embeds.

Quality Oversight DRAFT for discussion and pending NQB guidance

Appendix B



Appendix C

Quality Oversight Risk Escalation Process

Using a stepped oversight and intelligence model



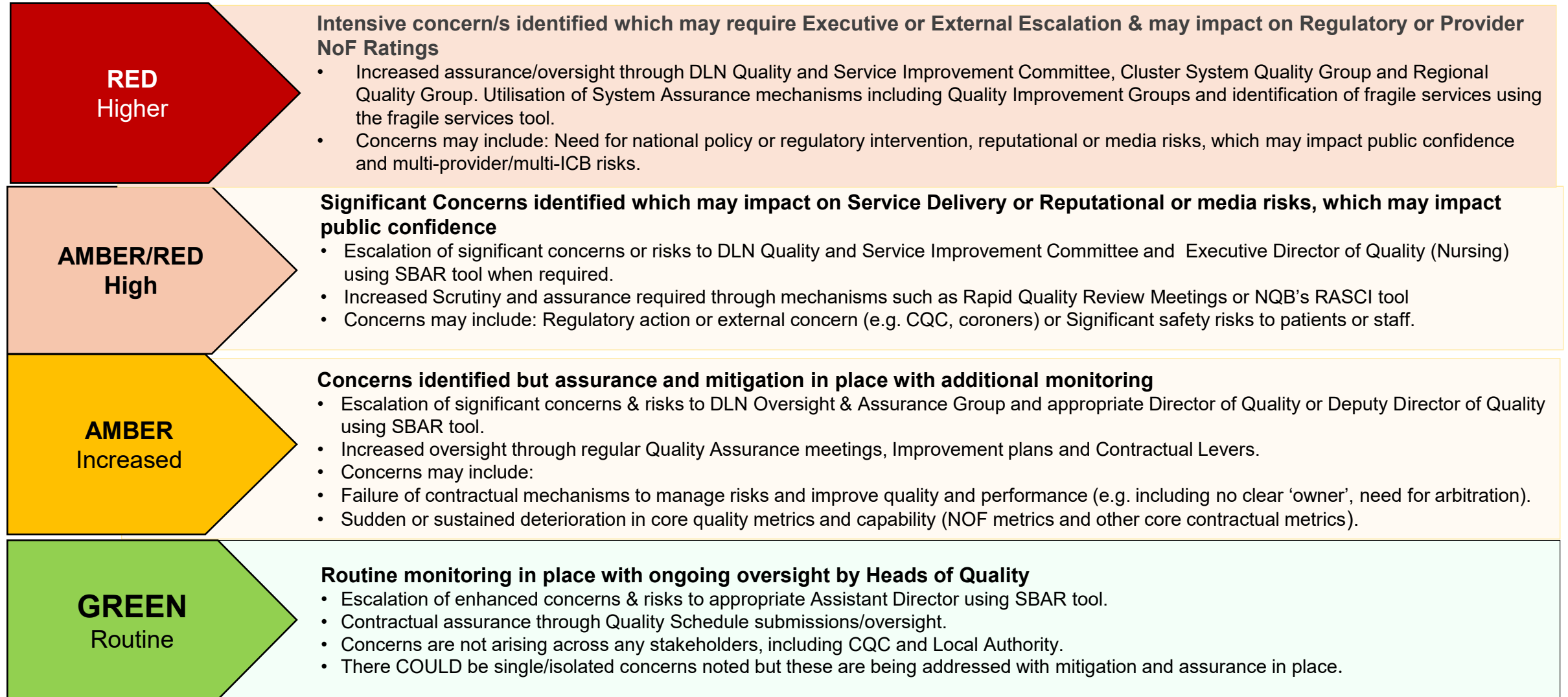
Derby and Derbyshire
Integrated Care Board



Lincolnshire
Integrated Care Board



Nottingham and
Nottinghamshire
Integrated Care Board



Meeting title	Integrated Care Boards: Open Session (meeting in common)
Meeting date	16/07/2026
Paper title	Quality Oversight Report
Paper reference	ICB CIC 033
Paper author	Rebecca Neno, Director of Quality, Safety and Improvement Rachel Jeffery, Quality Intelligence Manager, NHS Nottingham and Nottinghamshire ICB Philip Sugden, Assistant Director of Quality NHS Derby and Derbyshire ICB
Paper sponsor	Rosa Waddingham, Executive Director of Quality (Nursing)
Presenter	Rosa Waddingham

Paper type
For assurance ☒ For decision ☐ For discussion ☐ For information ☐

Report summary
This report provides the Boards with assurance on the quality and safety of services across the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire Integrated Care Systems. It sets out the current position in relation to providers' and system pathways subject to enhanced or escalated oversight, in line with the NHS Oversight Framework and National Quality Board guidance. It highlights key risks, areas of focus, and the mitigating actions in place to address quality concerns and confirms how assurance is obtained through established governance arrangements. Overall, the quality position across the ICBs' footprint remains stable, with robust oversight arrangements in place for organisations and services subject to escalated or enhanced monitoring. No new system-wide risks have emerged that cannot be managed through existing governance arrangements; however, sustained pressures in urgent and emergency care, workforce capacity, infection prevention, and maternity services continue to require close oversight. The establishment of the ICBs' Quality and Oversight Assurance Group, as the operational coordination group for quality oversight of commissioned services, provides an opportunity to further strengthen coordinated quality governance across the ICBs' footprints.

Recommendation(s)
The Boards are asked to receive the report for assurance on the quality and safety position across the ICB systems, including areas of enhanced or escalated oversight.

Appendices
1: Quality Performance Report

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

Board Assurance Framework

- Failure to develop and maintain a comprehensive, evidence-based understanding of local population health needs
- Failure to allocate resources effectively and shape provider markets to deliver value, productivity and system priorities
- Failure to systematically improve the quality of healthcare services
- Failure to ensure timely and equitable access to healthcare services in line with national and local performance standards
- Failure to develop and deploy an effective ICB cluster operating model with the necessary workforce skills and capabilities for strategic commissioning

Relevant statutory duties

- | | |
|---|---|
| ☒ Quality improvement | ☐ Public involvement and consultation |
| ☐ Reducing inequalities | ☐ Equality and diversity |
| ☐ Financial limits/ breakeven | ☐ Effectiveness, efficiency and economy |
| ☐ Integration of services | ☐ Wider effect of decisions (triple aim) |
| ☐ Promoting innovation | ☐ Promoting research |
| ☐ Patient choice | ☐ Obtaining appropriate advice |
| ☐ Promoting education/training | ☐ Climate change |

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Quality Oversight Report

Introduction

1. This report provides assurance on quality oversight across the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs' footprints for the period 28 May to 30 June 2026. It summarises intelligence from the System Quality Group, highlights organisations and programmes subject to escalated or enhanced oversight and identifies key quality risks and mitigating actions requiring the Boards' awareness.
2. The ICBs' approach to quality remains aligned to the National Quality Board's single shared view of quality and its recent guidance reinforcing the importance of maintaining a focus on quality, safety and leadership during a period of system change and operational pressure.
3. The ICBs continue to discharge their statutory duty through clear provider accountability, system oversight, and proportionate escalation arrangements in line with the NHS Oversight Framework.

System Quality Group

4. As outlined within the Approach to Quality report, discussed at agenda item 10, the first cluster-wide System Quality Group was held in May 2026, providing an opportunity to share quality intelligence across providers and partners and test the ICBs' Shared Quality Priorities against those identified across the wider system.
5. The priorities and risks identified through the System Quality Group demonstrated broad alignment with the ICBs' Shared Quality Priorities and wider strategic plans. Intelligence arising from the Group will continue to inform the triangulation of quality information, identification and escalation of emerging risks, and opportunities for quality improvement across the three ICBs.

Areas of escalated oversight

Provider	Status	Key Issue	Current Assurance
Chesterfield Royal Hospital NHS Foundation Trust	New	Rapid Quality Review planned for July 2026	Review scheduled with NHS England
United Hospitals of Derby and Burton	Ongoing	Maternity oversight	Improvement programme Regional oversight

NHS Foundation Trust			
Northern Lincolnshire and Goole NHS Foundation Trust	Ongoing	Elective recovery, workforce and flow	Improvement programme Regional oversight
Nottinghamshire Healthcare NHS Foundation Trust	Ongoing	Mental health delivery	Improvement programme Regional oversight
Nottingham University Hospitals NHS Trust	Ongoing	Mortuary, urgent and emergency care and corridor care	Improvement plan Regional Oversight

Areas of enhanced oversight

Theme	Current Position	Key Assurance
Learning Disability and Autism	Performance variable across the ICBs' footprints	Improvement work underway
Children and Young People	Special Educational Needs and Disabilities reform progressing	Continued oversight required
Infection Prevention and Control	Health Care Associated Infection performance mixed	System improvement actions in place
Maternity	Ongoing improvement	National oversight continues

Quality Performance Report

Patient Safety

8. Quarter four reporting is broadly stable, timely and highly variable by provider. The next step is to triangulate outliers with Patient Safety Incident Investigation themes, denominator changes and provider coding practice before drawing performance conclusions.
9. During 2025/26 there were 18 'Regulation 28' reports identified for Preventing Future Deaths. Nottingham and Nottinghamshire ICB has the highest volume (13), Derby and Derbyshire ICB has five, and Lincolnshire ICB has none recorded. The main themes were clinical procedures and medical

management, emergency services, mental health / suicide, medicines safety and care home health.

Urgent and Emergency Care

10. The corridor care national publication daily averages (May returns) creates visibility of patients cared for in non-designated areas of care, where privacy and safe, dignified care can be compromised. Data shows Emergency Departments are 70% of the selected daily average, with the worst performing provider United Hospitals Derby and Burton Foundation Trust (UHDB) 55.23/day and highest ICB, Derby and Derbyshire at 85.55/day. NHS England marks this as an experimental, new metric collection and as such should be treated as immature whilst completeness and validation improve.

Maternity

11. Maternity is a key area of national focus and the impact of service failure and gaps on safety, experience and outcomes is clear. National and local maternity reviews continue to provide key areas of learning and local focus on equity and outcomes for black and brown women, as well as key clinical tasks, remain a focus.
12. The Nottingham and Nottinghamshire ICB continues to provide ongoing support for the families included in the Ockenden Independent Maternity Review following publication.

Infection, Prevention and Control

13. The ICBs' quality directorate has developed an interim model for Infection, Prevention and Control work at cluster level with a single combined resource. Plans are now being developed to create a new approach to Infection, Prevention and Control assurance, oversight and support to ensure provider organisations maintain their focus on Healthcare Associated Infections (HCAI) reduction programmes. The ICBs' Infection, Prevention and Control team has met with the Infection, Prevention and Control Regional Lead within NHS England to develop a shared understanding of the priorities of work that will form the work plan for the cluster going forward.

Learning Disabilities and Autism

14. The monitoring and reporting of inpatients with a Learning Disability and/or Autism continues. Derby and Derbyshire ICB remains the real outlier in the cluster, not achieving any of the National Key Performance Indicators. Work is underway to support providers with best practice and developing a much firmer grip on the monitoring processes. Moving forward, the monitoring and reporting processes for the ICBs and NHS England (Midlands) will be streamlined across the cluster.

Continuing Healthcare (CHC) 28-day clock: >28-day incomplete referrals

15. Quarter four 2025/26 shows 21 incomplete referrals over 28 days across the three ICBs; none are over 12 weeks. Nottingham and Nottinghamshire accounts for 16 and will remain the focus, whilst Lincolnshire is at zero.

Care Quality Commission (CQC)

16. Across the ICBs' footprint 83% registered providers are rated as 'Good' or 'Outstanding'. There are 147 Providers rated as 'Requires Improvement' or 'Inadequate' and the majority of these are Care Homes or GP Practices. Nottinghamshire Healthcare NHS Foundation Trust is excluded from these figures as CQC ratings are currently suspended.



SAIU

**STRATEGIC
ANALYTICS
INTELLIGENCE
UNIT**

Quality Performance Report

June 2026

Version: v1

Date: 15th June 2026

Prepared By: Rachel Jeffery

Reviewed By: Simon Frampton



Derby and Derbyshire
Integrated Care Board



Lincolnshire
Integrated Care Board



**Nottingham and
Nottinghamshire**
Integrated Care Board

Patient Safety



Patient Safety Incident Reporting

Q4 2025/26 — ICB view, national peer comparison and assurance implications

Headline: The assurance issue is uneven reporting behaviour by ICB and provider — not incident volume alone.

Peer index: 100 = same-trust-type national median.

Derby and Derbyshire ICB

Q4 position: 13.6k incidents; median lag 0.5 days. **Signal:** 2 of 4 providers below peer median.

Provider peer index

Chesterfield Royal Hospital NHS Foundation Trust **(100)**

Derbyshire Community Health Services NHS Foundation Trust **(82)**

Derbyshire Healthcare NHS Foundation Trust **(100)**

University Hospitals of Derby and Burton NHS Foundation Trust **(89)**

Reflection: Validate whether lower indices reflect reporting completeness, coding practice or denominator mix.

Lincolnshire ICB

Q4 position: 9.9k incidents; median lag 0 days. **Signal:** Lincolnshire Partnership is an outlier.

Provider peer index

Lincolnshire Community Health Services NHS Trust **(116)**

Lincolnshire Partnership NHS Foundation Trust **(315)**

United Lincolnshire Teaching Hospitals NHS Trust **(76)**

Reflection: Triangulate LPFT’s high reporting with PSII themes before inferring pressure or culture.

Nottingham and Nottinghamshire ICB

Q4 position: 14.8k incidents; median lag 0 days. **Signal:** all providers below peer median.

Provider peer index

Nottingham University Hospitals NHS Trust **(83)**

Nottinghamshire Healthcare NHS Foundation Trust **(93)**

Sherwood Forest Hospitals NHS Foundation Trust **(66)**

Reflection: Test reporting completeness before treating lower peer-index rates as safety improvement.

Source: <https://www.england.nhs.uk/statistics/statistical-work-areas/patient-safety-data/2025-26/>



Patient Safety Incident Reporting

Q4 2025/26 — trends and national comparators

Headline: Q4 reporting is broadly stable, timely and highly variable by provider — the assurance question is reporting consistency, not incident volume alone.

38.2k

Q4 incidents across the 10 providers

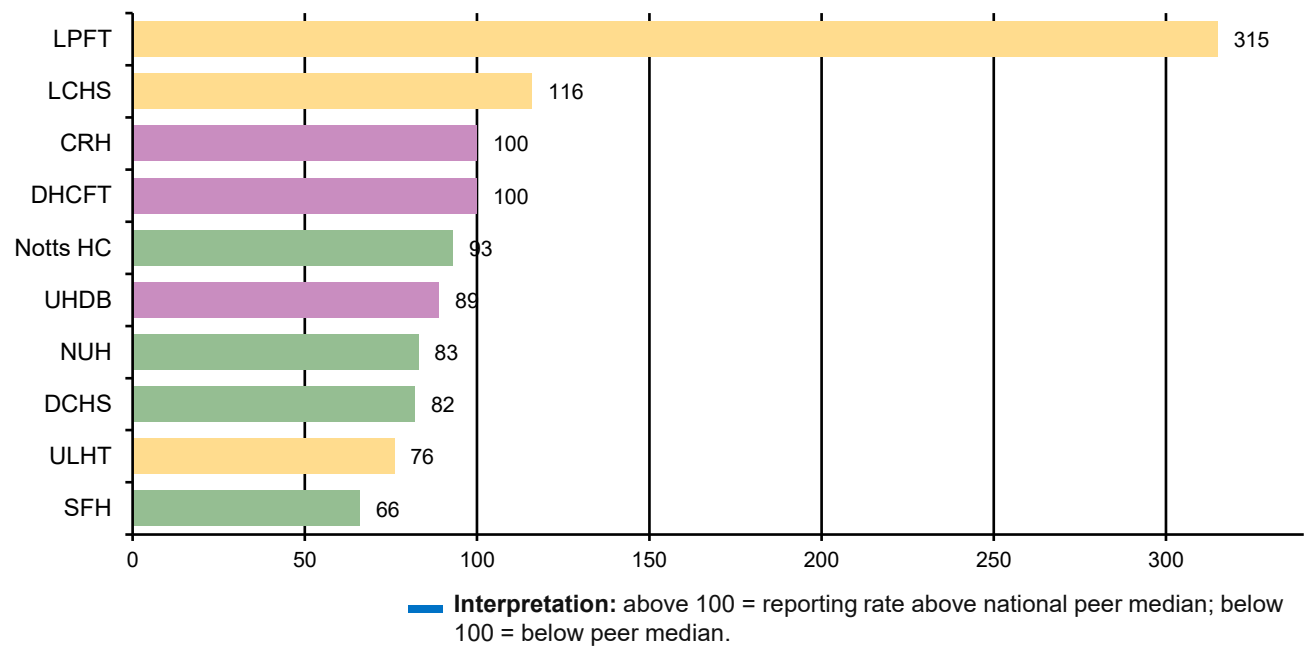
0 days

Median Q4 reporting lag; 10/10 providers at 0–1 day

6/10

Providers below their national peer median rate

Q4 provider recording rate vs national peer median (index: 100 = median)



Source: <https://www.england.nhs.uk/statistics/statistical-work-areas/patient-safety-data/2025-26/>

Reflection

Not a system-wide surge. Total local incidents moved 39.4k → 37.8k → 38.2k, Q4 is broadly stable rather than a step-change.

Variation is the risk signal. LPFT reports at 273.2 per 1,000 bed days — 2.6× the national mental health average — while most acute providers sit below the acute peer median. This could be as a result of positive reporting culture.

Assurance focus. Test data quality and reporting culture where the movements are largest: NUH rose +29.2 points vs the prior release, while Notts Healthcare fell -52.2.

Themes, denominator changes and provider coding practice should be triangulated before drawing performance conclusions.



Patient Safety: Never Events

2025/26

Headline: Higher proportion of never events at United Hospitals of Derby and Burton NHS Foundation Trust (UHDB) in comparison to other providers. Oversight and assurance is ongoing.

Derby and Derbyshire ICB

7	Total Never Events	
	3 of 4 providers	
Provider count		
Chesterfield Royal		1
Derbyshire Community		1
Derbyshire Healthcare		0
UHDB		5

Lincolnshire ICB

1	Total Never Events	
	1 of 3 providers	
Provider count		
Lincs Community		0
Lincs Partnership		0
United Lincs Teaching		1

Nottingham and Nottinghamshire ICB

2	Total Never Events	
	2 of 3 providers	
Provider count		
Nottingham University		1
Notts Healthcare		0
Sherwood Forest		1

Actions and recovery received

A focused improvement plan has been completed by UHDB in relation to the never events.



Preventing Future Deaths – summary of report themes and areas for system oversight

Overall position: 18 Regulation 28 reports identified; NNICB has the highest volume (13), DDICB has 5, and LICB has none recorded.

Main themes:

Clinical procedures and medical management, emergency services, mental health / suicide, medicines safety and care home health.

Note: includes Regulation 28s directed to the ICB and/or commissioned organisations for full system oversight.

LICB Summary (0)

Reports: 0 total.

Position: No Regulation 28 reports recorded in this dataset.

Focus: Continue monitoring for emerging themes and maintain system oversight.

DDICB Summary (5)

Reports: 5 total.

Themes: Alcohol, drugs and medication; suicide; care home health; community and emergency services.

Focus: Medicines safety, mental health risk, community pathways and cross-service learning.

NNICB Summary (13)

Reports: 13 total — highest volume across the cluster.

Themes: Hospital death / clinical procedures, emergency services, care home health, police and mental health links.

Focus: Clinical governance, emergency / mental health interfaces and care home oversight.



Q4 2025/26 Patient Safety Incident Investigations (PSII) – summary of activity and learning themes

Overall position: 74 PSII's were commissioned across the three ICBs; DDICB has the highest volume (50), followed by NNICB (22) and LICB (2).

Main themes:

Ambulance delays, acute care processes, clinical risk recognition, mental health, urgent care escalation / handover and documentation controls.

PSII: Patient Safety Incident Investigation — used here to identify where learning should be tracked through ICB systems.

LICB Summary (2)

Investigations: 2 PSII's commissioned.

Themes: Mental health cases highlight escalation, physical health monitoring and handover quality.

Assurance: Acute and community providers share learning through a regular forum.

Focus: Earlier deterioration recognition and continuity of care.

DDICB Summary (50)

Investigations: 50 PSII's — 35 ambulance, 8 acute care, 4 out-of-hours and 3 adult mental health.

Themes: Treatment delay, documentation and checklists not followed or updated.

Focus: Ambulance pathway performance and theatre safety documentation.

NNICB Summary (22)

Investigations: 22 PSII's — 9 ambulance, 8 acute care, 4 community services and 1 adult mental health.

Themes: Clinical processes and risk recognition were most prominent, especially timely diagnosis and treatment.

Focus: Diagnostic decision-making, risk escalation and follow-up across pathways.



Patient Safety - Summary Hospital-level Mortality Indicator

February 2025 – January 2026 Summary Hospital-level Mortality Indicator (SHMI)
At a glance: 1 higher than expected, 3 as expected and 1 lower than expected SHMI position. Local aggregate SHMI 1.034 vs England baseline 1.000.

England baseline SHMI 1.000	Trust median / mean 0.999 / 1.009	National banding 12 higher · 98 expected · 8 lower	Local aggregate 1.034
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Local provider view with national baseline comparison

Provider	Position	Provider spells	Obs. deaths	Exp. deaths	SHMI value	vs baseline	Obs. vs exp.
Nottingham University Hospitals*	Higher than exp.	162,995	4,355	3,680	1.1830	+0.183	+675
Sherwood Forest Hospitals	As expected	65,155	2,205	2,115	1.0439	+0.044	+90
United Lincolnshire Teaching Hospitals	As expected	90,380	3,525	3,425	1.0280	+0.028	+100
Chesterfield Royal Hospital	As expected	52,445	1,930	1,885	1.0222	+0.022	+45
UH Derby & Burton	Lower than expected	141,275	4,565	4,930	0.9265	-0.074	-365

Note: Nottingham University Hospitals NHS Trust has a high percentage of invalid diagnosis codes; values should be interpreted with caution.

Source: NHS England SHMI trust-level dataset <https://digital.nhs.uk/data-and-information/publications/statistical/shmi/2026-06/shmi-data> National calculations based on 118 trusts in the provided file.



Urgent and Emergency Care



Corridor care: daily averages (May returns)

Daily average = supplied May totals ÷ 31 days | provider detail grouped by ICB

Why this matters

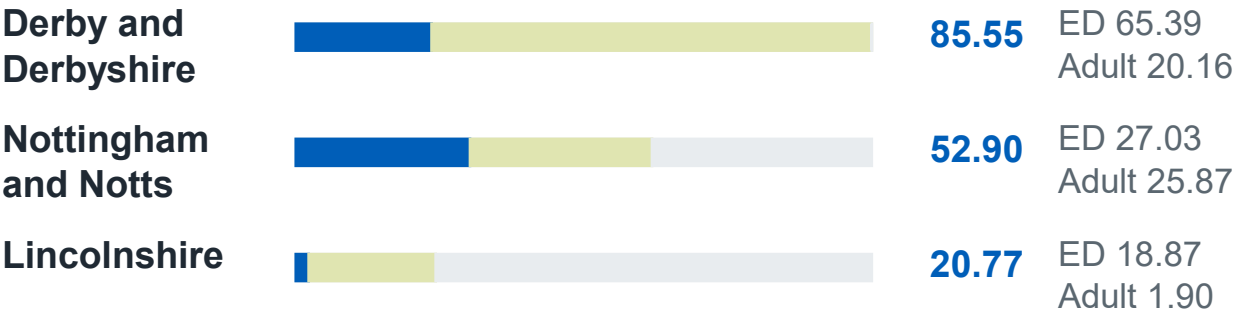
National publication creates visibility of patients cared for in **non-designated areas**, where privacy and safe, dignified care can be compromised.

Use cautiously: NHS England marks this as an experimental, new metric collection. It should be treated as immature while completeness and validation improve.



Daily average by ICB and subject

Stacked bars show Adult + ED daily average; paed = zero.



Legend: Adult ED Paeds

Provider daily averages

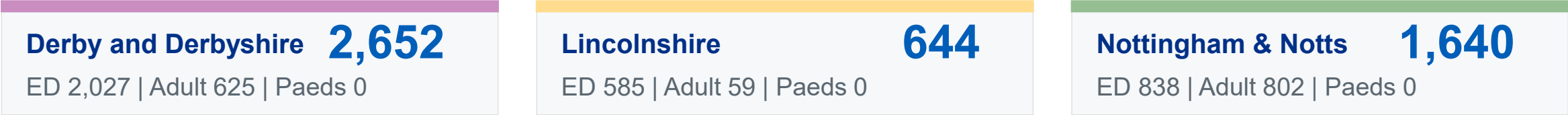
Provider-level detail

Provider	Adult	ED	Total
UHDB	20.16	35.06	55.23
NUH	25.87	27.03	52.90
Chesterfield	0.00	30.32	30.32
ULHT	1.90	18.87	20.77
Sherwood	0.00	0.00	0.00

Key readout: Emergency Department (ED) is 70% of the selected daily average (111.29 of 159.23). Highest provider: UHDB 55.23/day; highest ICB: Derby and Derbyshire 85.55/day.

Corridor care by provider and subject

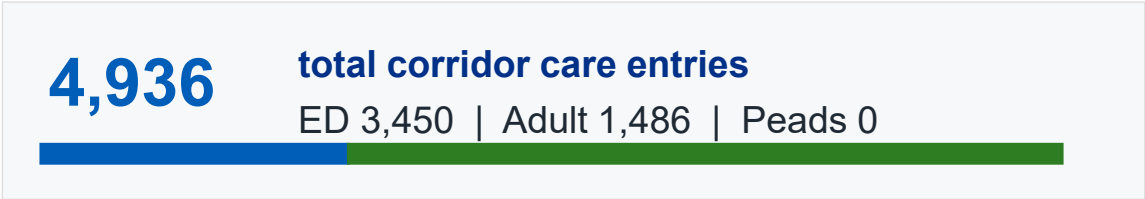
May 2026 experimental data



Provider matrix — Adult, Peads and ED

ICB	Provider	Adult	Peads	ED	Total	Subject mix
D&D	Chesterfield Royal	0	0	940	940	
D&D	UH Derby and Burton	625	0	1,087	1,712	
Lincs	United Lincolnshire	59	0	585	644	
N&N	Nottingham UH	802	0	838	1,640	
N&N	Sherwood Forest	0	0	0	0	

All selected providers



Key readouts

ED is the largest subject: 3,450 of 4,936 entries (70%). Peads is zero across all five providers. Adult activity is concentrated in NUH and UHDB.





Derby and Derbyshire
Integrated Care Board



Lincolnshire
Integrated Care Board



**Nottingham and
Nottinghamshire**
Integrated Care Board

Maternity



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DLN Cluster view

Indicative RAG
Green Amber Red

Provider	Narrative description	10-week booking	NND	Stillbirths	Tears	PPH
Nottingham University Hospitals	Low booking and highest stillbirth; prioritise access and safety review.	60% R	1.99 A	3.42 R	46.0 A	34.0 A
Sherwood Forest Hospitals	Strong booking, stillbirth and Postpartum Haemorrhage (PPH); neonatal deaths and tears need review.	71% G	2.87 R	1.01 G	51.0 R	20.0 G
United Lincolnshire Teaching Hospitals	Balanced profile; strong neonatal, tears and PPH, with stillbirths to monitor.	69% A	1.03 G	2.94 A	27.0 G	23.0 G
Chesterfield Royal Hospital	Mixed profile: low neonatal deaths but booking and PPH require focused improvement.	63% R	1.18 G	2.84 A	40.0 A	44.0 R
Derby & Burton University Hospitals	Good booking and neonatal profile; watch PPH, stillbirth and tears.	72% G	0.91 G	2.89 A	39.0 A	39.0 A

RAG ratings based on peer-relative performance.

RAG note: higher is better for booking; lower is better for mortality, tears and PPH.



Maternity

Nottingham University Hospitals NHS Trust

NUH's neonatal mortality (1.99 per 1,000 live births) and stillbirth rate (3.42 per 1,000 births) remain below Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) group averages, demonstrating continued improvement in key mortality outcomes. However, performance remains challenging in relation to early booking (60%), 3rd/4th degree tears (46.0 per 1,000 births) and severe postpartum haemorrhage (34.0 per 1,000 births), all of which exceed national and peer group benchmarks.

An NUH deep dive has shown that 20% of women are self-referring into the service after 8 weeks making it difficult to arrange a booking appointment before 10 weeks. They will now work to support earlier engagement with maternity services.

NUH has demonstrated a small improvement in rates PPH over the last 12 months compared to the previous 12 months. Rates of 3rd/4th degree perineal tears have increased slightly; however, the Trust is not currently identified as a national outlier. Improvement activity has included engagement with regional partners and higher-performing organisations to share best practice, alongside the relaunch of the Obstetric Anal Sphincter Injury (OASI) Care Bundle and continued embedding of the Perinatal Pelvic Health Service to support improved maternal outcomes.

Bookings at 10 weeks

% of total bookings
April 2026

60%

Neonatal Deaths

Per 1,000 live births
2024

1.99

Stillbirths

Per 1,000 births
2024

3.42

3rd/4th Degree Tears

Per 1,000 births
April 2026

46.0

PPH >= 1,500 ml

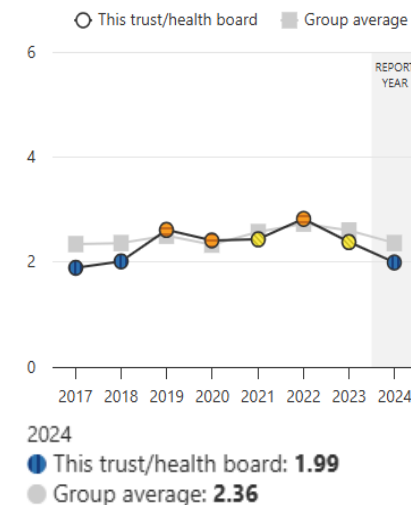
Per 1,000 births
April 2026

34.0

Neonatal Deaths

Mortality rates, by year

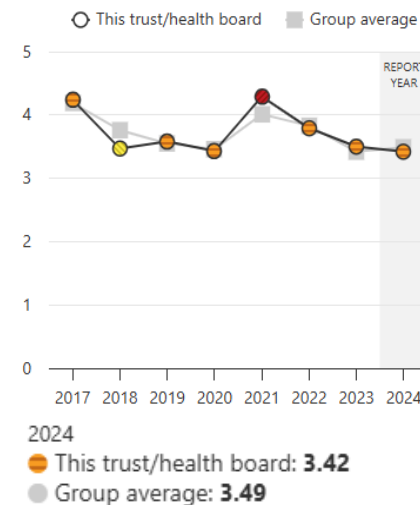
Stabilised & adjusted neonatal mortality rate per 1,000 live births



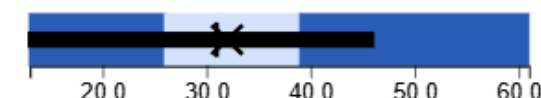
Stillbirths

Mortality rates, by year

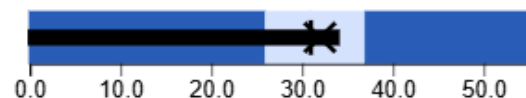
Stabilised & adjusted stillbirth rate per 1,000 total births



Women who had a 3rd or 4th degree tear at delivery (Rate per 1,000)



Women who had a PPH of 1,500ml or more (Rate per 1,000)



Maternity

Sherwood Forest Hospitals NHS Foundation Trust

SFHFT continues to demonstrate positive performance across several key maternity outcomes. The stillbirth rate of 2.87 per 1,000 births is broadly in line with comparable organisations, while the neonatal mortality rate of 1.01 per 1,000 live births remains below the MBRRACE group average. Early access to maternity care remains a focus, with 71% of women booked by 10 weeks gestation, below the National Maternity and Perinatal Audit (NMPA) ambition of 80%.

The Trust has demonstrated strong performance in relation to PPH, with rates lower than both national and peer group benchmarks. However, rates of 3rd/4th degree perineal tears remain above national and MBRRACE averages, and improvement activity continues through implementation of the OASI Care Bundle and the Perinatal Pelvic Health Service.

Bookings at 10 weeks

% of total bookings
March 2026

71%

Neonatal Deaths

Per 1,000 live births
2024

2.87

Stillbirths

Per 1,000 births
2024

1.01

3rd/4th Degree Tears

Per 1,000 births
March 2026

51.0

PPH $\geq$ 1,500 ml

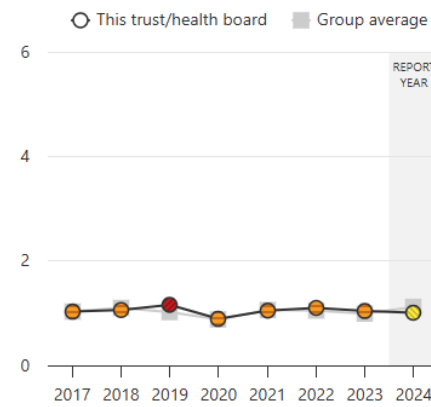
Per 1,000 births
March 2026

20.0

Neonatal Deaths

Mortality rates, by year

Stabilised & adjusted neonatal mortality rate per 1,000 live births

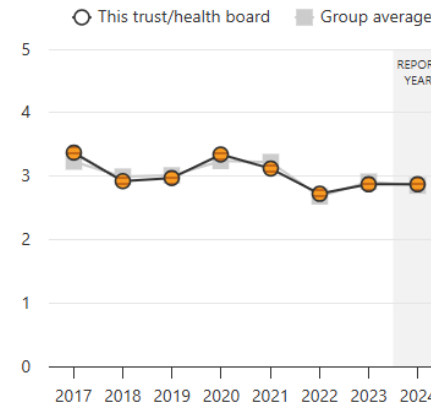


2024
 This trust/health board: **1.01**
 Group average: **1.12**

Stillbirths

Mortality rates, by year

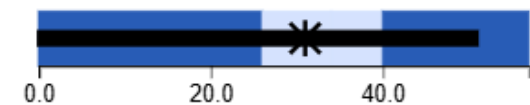
Stabilised & adjusted stillbirth rate per 1,000 total births



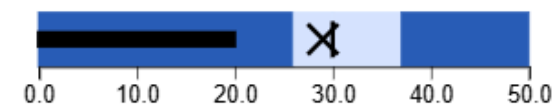
2024
 This trust/health board: **2.87**
 Group average: **2.85**



Women who had a 3rd or 4th degree tear at delivery (Rate per 1,000)



Women who had a PPH of 1,500ml or more (Rate per 1,000)



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Maternity

United Lincolnshire Teaching Hospitals NHS Trust

ULHT stillbirth rate (4.14 per 1,000 births) increase in stillbirth rates has been identified and is currently above national threshold. All cases are undergoing detailed review via the Perinatal Mortality Review Tool (PMRT), supported by thematic analysis at trust and system level.

Booking by 10 weeks is 67.23% (Target of 69%) Deep dive required to determine if late patient referral or delay in response to referrals into maternity services.

3rd and 4th degree rates 2.46% below the national average .PPH Rates over 1500mls 3.48% and PPH rates over 2000mls 1.45% thematic analysis involving human factors, themes and trends rather than looking at individual cases now in place

Bookings at 10 weeks

% of total bookings
April 2026

69%

Neonatal Deaths

Per 1,000 live births
2024

1.03

Stillbirths

Per 1,000 births
2024

2.94

3rd/4th Degree Tears

Per 1,000 births
April 2026

27.0

PPH >= 1,500 ml

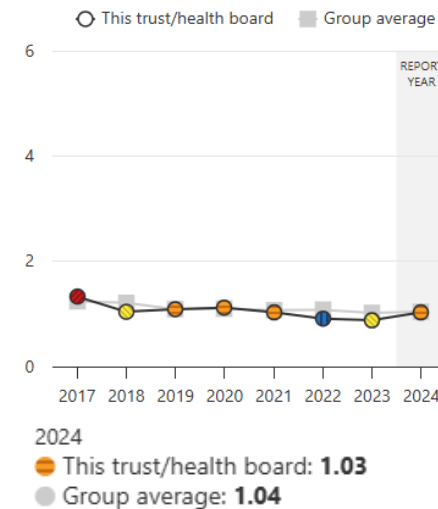
Per 1,000 births
April 2026

23.0

Neonatal Deaths

Mortality rates, by year

Stabilised & adjusted neonatal mortality rate per 1,000 live births



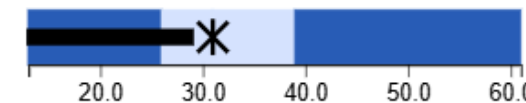
Stillbirths

Mortality rates, by year

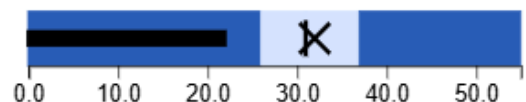
Stabilised & adjusted stillbirth rate per 1,000 total births



Women who had a 3rd or 4th degree tear at delivery (Rate per 1,000)



Women who had a PPH of 1,500ml or more (Rate per 1,000)



Trust value 29.0

National value 31.0

MBRRACE group value 31.0

Trust value 22.0

National value 31.0

MBRRACE group value 32.0



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Maternity

Chesterfield Royal Hospital NHS Foundation Trust

- Perinatal mortality rates remain below national average.
- PPH >1500mls remains raised and is under trust review. Guideline reviewed to recognise early identification, risk assessment and early escalation. Obstetric Bleeding Study UK (OBSUK) has led to more accurate measurement and a decrease in blood product use and ICU admission. Assurance required of embedded actions
- 3rd/4th degree tears reducing following improved staff education and support for new staff at CRH but remains under review. Assurance required of embedded actions
- NHS Midlands perinatal team supporting the trust to review theatre capacity for caesarean sections
- Coroner's inquest April – Neonatal death -no actions requested. A further case of neonatal death pending inquest date
- An increase in maternity leave is affecting midwifery workforce. Trust support for recruitment of newly qualified midwives. Birthrate plus report pending.
- Bookings under 10 weeks under review as screening data suggests compliance of 83%. Investigation into data entry, access to booking appointments and notification through My Pregnancy Notes.

Bookings at 10 weeks

% of total bookings
April 2026

63%

Neonatal Deaths

Per 1,000 live births
2024

1.18

Stillbirths

Per 1,000 births
2024

2.84

3rd/4th Degree Tears

Per 1,000 births
April 2026

40.0

PPH >= 1,500 ml

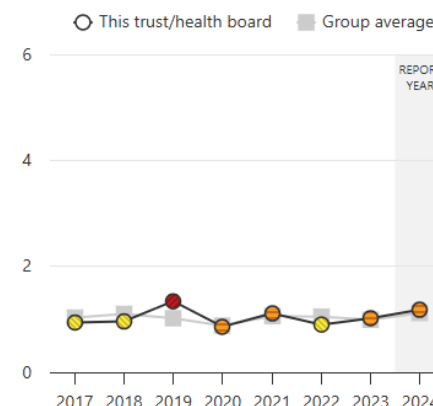
Per 1,000 births
April 2026

44.0

Neonatal Deaths

Mortality rates, by year

Stabilised & adjusted neonatal mortality rate per 1,000 live births



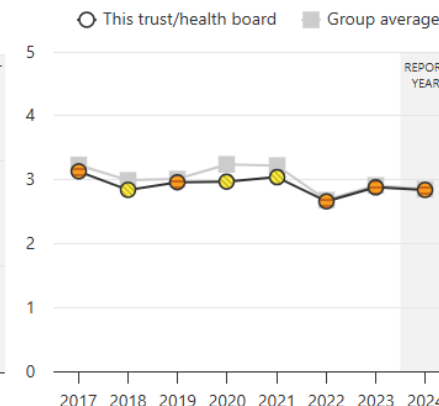
2024

● This trust/health board: **1.18**
● Group average: **1.12**

Stillbirths

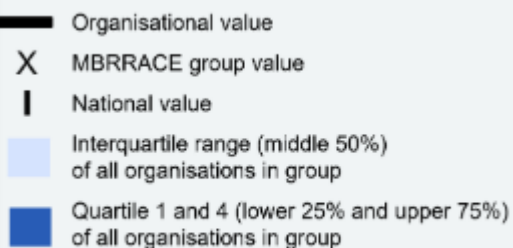
Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births

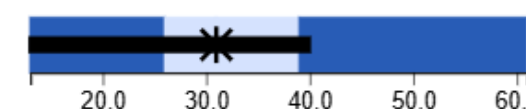


2024

● This trust/health board: **2.84**
● Group average: **2.85**



Women who had a 3rd or 4th degree tear at delivery (Rate per 1,000)

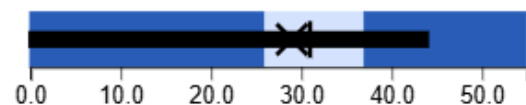


Trust value 40.0

National value 31.0

MBRRACE group value 31.0

Women who had a PPH of 1,500ml or more (Rate per 1,000)



Trust value 44.0

National value 31.0

MBRRACE group value 29.0



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Maternity

University Hospitals of Derby and Burton NHS Foundation Trust

- NHSE Maternity and Neonatal Improvement Support Team providing targeted support until July 2026
- CQC inspection June 24th-26th 2026 for maternity services
- Perinatal mortality rates remain below national average
- A Coroner's case for neonatal death awaiting a date for the inquest
- 25wte Band 5 vacancies to be offered to newly qualified midwives
- NHS Midlands working with ICB to support implementation of Perinatal Pelvic Health Service by September 2026. Behind national trajectory but progress being made. Assurance required that the service will meet trajectory.
- Community transformation project underway to review service offer including continuity of carer and homebirth service to improve service user experience and staff satisfaction.

Bookings at 10 weeks

% of total bookings
April 2026

72%

Neonatal Deaths

Per 1,000 live births
2024

0.91

Stillbirths

Per 1,000 births
2024

2.89

3rd/4th Degree Tears

Per 1,000 births
April 2026

39.0

PPH $\geq$ 1,500 ml

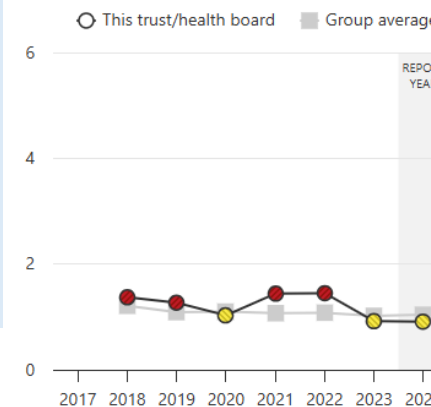
Per 1,000 births
April 2026

39.0

Neonatal Deaths

Mortality rates, by year

Stabilised & adjusted neonatal mortality rate per 1,000 live births



2024

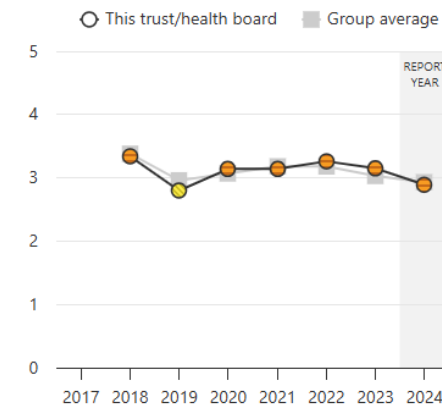
● This trust/health board: **0.91**

■ Group average: **1.04**

Stillbirths

Mortality rates, by year

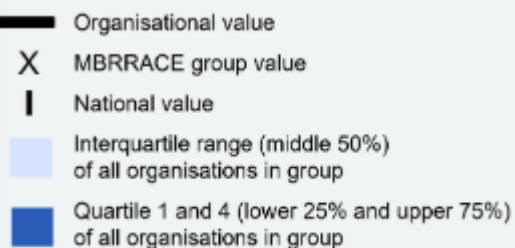
Stabilised & adjusted stillbirth rate per 1,000 total births



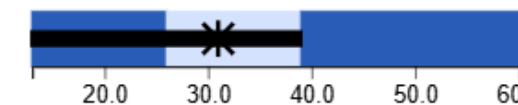
2024

● This trust/health board: **2.89**

■ Group average: **2.93**



Women who had a 3rd or 4th degree tear at delivery (Rate per 1,000)

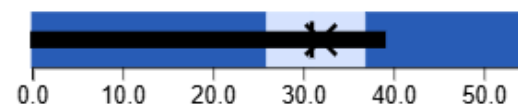


Trust value 39.0

National value 31.0

MBRRACE group value 31.0

Women who had a PPH of 1,500ml or more (Rate per 1,000)



Trust value 39.0

National value 31.0

MBRRACE group value 32.0



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Infection, Prevention and Control



Priority Cluster-level IP&C assurance model and shared HCAI reduction work plan.

The DLN Cluster quality directorate has developed an interim model for IP&C work at cluster level with a single combined resource. Plans are now being developed to create a new approach to IP&C assurance, oversight and support are being developed to ensure provider organisations maintain their focus on Healthcare Associated Infections (HCAI) reduction programmes. The ICB Cluster IP&C team has met with the IP&C Regional Lead within NHSE to develop a shared understanding of the priorities of work that will form the work plan for the cluster going forward.

Trust / ICB	C.Difficile							MRSA			MSSA		
	Month			YTD			12m rate	Month Actual	YTD Actual	12m rate	Month Actual	YTD Actual	12m rate
	Actual	Plan	Var	Actual	Plan	Var							
DDICB Chesterfield Royal Hospital NHS Foundation Trust	7	4	+3	49	50	-1	26.48 ↑	0	1	0.54 ▬	1	27	14.59 ↓
NNICB Nottingham University Hospitals NHS Trust	13	12	+1	197	152	+45	34.99 ↓	1	10	1.78 ↓	8	125	22.20 ↓
NNICB Sherwood Forest Hospitals NHS Trust	4	5	-1	94	65	+29	38.48 ↓	0	3	1.23 ▬	2	35	14.33 ↓
LICB United Lincolnshire Teaching Hospitals NHS Trust	5	8	-3	113	90	+23	33.87 ↓	2	5	1.50 ↓	4	52	15.58 ↑
DDICB University Hospitals of Derby and Burton NHS Foundation Trust	8	14	-6	182	169	+13	35.30 ↓	0	4	0.78 ▬	5	62	12.02 ↑

Learning Disabilities and Autism



Programme	Metric	Category	OP Plan Ref	% / Value	Period	DQ ⓘ	NHS Derby and Derbyshire ICB					NHS Lincolnshire ICB					NHS Nottingham and Nottinghamshire ICB				
							Plan	Value	Variance	V	A	Plan	Value	Variance	V	A	Plan	Value	Variance	V	A
LD&A	LD/Autism Adult Inpatients	Ops Plan		Value	Apr-26		32	38	6	✗	☹️	34	35	1	✗	☹️	36	40	4	✗	☹️
	LD Adult MH Inpatients	Ops Plan	E.H.32	Value	Apr-26		15	19	4	✗	☹️	12	12	0	✓	😊	20	26	6	✗	☹️
	Autistic Adult MH Inpatients	Ops Plan	E.H.33	Value	Apr-26		17	19	2	✗	☹️	22	23	1	✗	☹️	16	14	-2	✓	😊
	LD/Autism CYP Inpatients	Ops Plan	E.K.1c	Value	Apr-26		3	4	1	✗	☹️	2	1	-1	✓	😊	3	2	-1	✓	😊
	Learning Disability Annual Health Checks	Ops Plan	E.K.6	Value	Apr-26		251	195	-56	✗	☹️	188	142	-46	✗	☹️	285	286	1	✓	😊
	Learning Disability Annual Health Checks (Quarterly)	Ops Plan	E.K.6	Value	Mar-26		1,983	1,997	14	✓	😊	1,346	1,377	31	✓	😊	2,196	2,029	-167	✗	☹️
	LD/Autism Long MH Stays	Ops Plan	E.K.4	Value	Apr-26		19	15	-4	✓	😊	15	20	5	✗	☹️	24	25	1	✗	☹️
	MH Admission Rate – LD/Autism Adults	Ops Plan	E.K.5a	Value	Apr-26	⚠️	23.0	34.0	11.0	✗	☹️	37.0	46.0	9.0	✗	☹️	16.0	16.0	0.0	✓	😊
	MH Admission Rate – LD/Autism CYP	Ops Plan	E.K.5b	Value	Apr-26	⚠️	47.0	52.0	5.0	✗	☹️						10.0	39.0	29.0	✗	☹️

Headlines

The monitoring and reporting of inpatients with a Learning Disability and/or Autism continues. Derby and Derbyshire ICB remain the real outlier in the Cluster, not achieving any of the National Key Performance Indicators. Work is underway to support the Provider with best practice and developing a much firmer grip on the monitoring processes. Moving forwards the monitoring and reporting processes for ICB and NHSE (Midlands) will be streamlined across the Cluster.

Continuing Healthcare (CHC)



CHC 28-day clock: >28-day incomplete referrals

2025/26 quarterly position | standard NHS CHC (non-Fast Track)

What the 28-day clock means

Start: earliest notification that full assessment is required.

Process: Multi Disciplinary Team/Decision Support Tool recommendation, then ICB decision.

End: eligibility decision or referral discounted.

Do not pause for consent forms or missing Checklist information.

21

Q4 total
incomplete >28d

0

Over 12 weeks
Q4 across ICBs

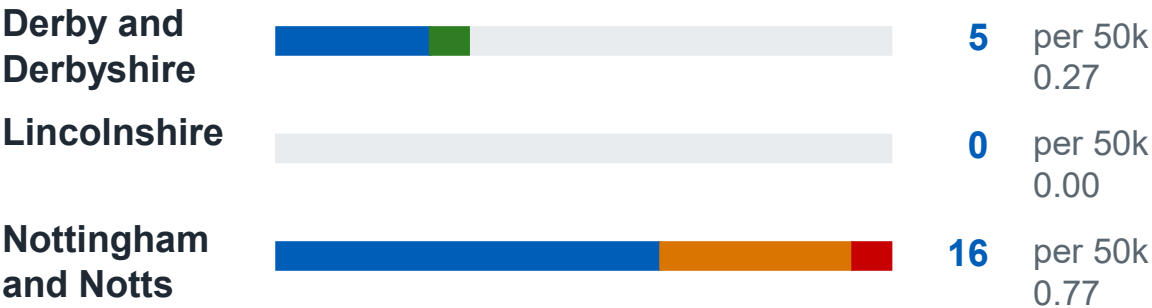
16

Notts Q4
highest ICB

-48%

Notts change
from Q2 peak 31

Latest quarter: where the >28-day backlog sits



≤2w 2–4w 4–12w 12–26w >26w

Quarterly trend by ICB

Nottingham and Nottinghamshire remains highest; down from Q2 peak.

ICB	Q1	Q2	Q3	Q4	
DD ICB		0	1	1	5
LICB		4	0	2	0
NNICB		12	31	22	16

Executive Summary: Q4 shows 21 incomplete referrals over 28 days across the three ICBs; none are over 12 weeks. Nottingham & Nottinghamshire accounts for 16 and will remain the focus, while Lincolnshire is at zero.



Care Homes



Lincolnshire ICB

Lincolnshire's care home comprises approximately 282 registered care homes distributed across a large and predominantly rural county, covering the districts of Lincoln, Boston, East Lindsey, South Holland, South Kesteven, West Lindsey and North Kesteven, with additional provision in the neighbouring unitary authorities of North Lincolnshire and North East Lincolnshire with continued monitoring and support provided through the ICB Quality Team to maintain safe, effective care and minimise impacts on placement availability. Approximately 282 care homes across Lincolnshire, providing residential, nursing, dementia and specialist care services. Currently 2 care homes are suspended to new admissions and 3 care homes currently operating with admission restrictions.

Derby and Derbyshire ICB

Currently one home has restrictions in place for admissions, one home under a voluntary suspension and one home formally suspended. All have actions plans in place and regular monitoring.

Nottingham and Nottinghamshire ICB

Oversight levels remain stable, with a small reduction in high-risk (enhanced oversight) homes in the County and no high-risk homes in the City.

County services show growing operational pressures, particularly in contract suspensions, safeguarding alerts, complaints, and patient safety incidents.

City services demonstrate comparatively stable and improving performance, with low escalation levels and reductions in safety incidents.

There are currently 2 nursing homes with formal contract suspensions and 1 nursing home with a voluntary pause on admissions.



Care Quality Commission (CQC)



CQC Provider Ratings

DLN at a glance

1,009

provider locations in view

83%

rated Good or
Outstanding

147

Require improvement /
Inadequate

Organisation type	Total number of providers	Outstanding 	Good 	Requires improvement 	Inadequate 	Not rated
Care Homes	703	53	502	125	3	20
Acute	5	-	3	2	-	-
Community	2	2	-	-	-	-
Mental Health	2	-	2	-	-	-
GP Practices	297	35	245	17	-	-

Notes

- 1 New CQC rules mean some multi-service locations no longer receive location-level ratings. ¹
- 2 Nottinghamshire Healthcare NHS Foundation Trust is excluded from these figures as CQC ratings are currently suspended. ²

¹ <https://www.cqc.org.uk/about-us/improving-how-we-work>

² <https://www.cqc.org.uk/provider/RHA>



CQC Provider Ratings

Nottingham and Nottinghamshire

Organisation	Report Published	Safe	Effective	Caring	Responsive	Well-led	Overall
Nottingham University Hospitals NHS Trust	13 September 2023	Requires improvement	Requires improvement	Outstanding ★	Requires improvement	Requires improvement	Requires improvement
Sherwood Forest Hospitals NHS Foundation Trust	14 May 2020	Good	Good	Outstanding ★	Good	Good	Good
Nottinghamshire Healthcare NHS Foundation Trust	During the 2023/24 period, the CQC conducted 9 assessments of various services within the Trust. One of these inspections was carried out under Section 48 of the NHS Act 2008, commissioned by the Secretary of State for Health and Social Care. This review looked at patient safety and quality of care in the services provided by the Trust. While the review is underway, the CQC ratings for the Trust have currently been suspended.						

Organisation type	Total number of providers	Outstanding ★	Good	Requires improvement	Inadequate	Not rated
Care Homes	346	33	240	53	0	20
GP Practices	113	17	93	3	0	0

There are currently 2 nursing homes with formal contract suspensions and 1 nursing home with a voluntary pause on admissions.



CQC Provider Ratings

Derby and Derbyshire

Organisation	Report Published	Safe	Effective	Caring	Responsive	Well-led	Overall
Chesterfield Royal Hospital NHS Foundation Trust	29 May 2020	Good	Good	Good	Good	Good	Good
Derbyshire Community Health Services NHS Foundation Trust	12 September 2019	Good	Good	Outstanding ★	Good	Outstanding ★	Outstanding ★
University Hospitals of Derby and Burton NHS foundation Trust	6 June 2019	Good	Good	Good	Good	Good	Good
Derbyshire Healthcare NHS Foundation Trust	6 March 2020	Requires improvement	Good	Good	Good	Good	Good

Organisation type	Total number of providers	Outstanding ★	Good	Requires improvement	Inadequate	Not rated
Care Homes	98	4	78	16	0	0
GP Practices	107	16	86	5	0	0

Currently one home has restrictions in place for admissions, one home under a voluntary suspension and one home formally suspended. All have actions plans in place and regular monitoring.



CQC Provider Ratings

Lincolnshire

Organisation	Report Published	Safe	Effective	Caring	Responsive	Well-led	Overall
United Lincolnshire Teaching Hospitals NHS Trust	8 February 2022	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Lincolnshire Partnership NHS Foundation Trust	22 June 2019	Good	Good	Good	Good	Outstanding ☆	Good
Lincolnshire Community Health Services NHS Trust	22 June 2019	Good	Good	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆

Organisation type	Total number of providers	Outstanding ☆	Good	Requires improvement	Inadequate	Not rated
Care Homes	259	16	184	56	3	0
GP Practices	77	2	66	9	0	0

Currently 2 care homes are suspended to new admissions and 3 care homes currently operating with admission restrictions.



Meeting title	Integrated Care Boards: Open Session (meeting in common)
Meeting date	16/07/2026
Paper title	Commissioning Delivery Oversight Report
Paper reference	ICB CIC 26 034
Paper author	Sarah Bray, Associate Director of System Performance and Assurance, NHS Nottingham and Nottinghamshire ICB
Paper sponsor	Maria Principe, Executive Director of Commissioning
Presenter	Maria Principe

Paper type			
For assurance ☒	For decision ☐	For discussion ☐	For information ☐

Report summary

This report provides an overview of delivery across the ICBs against 2026/27 operational plan requirements and outlines implementation of the ICBs' Commissioning Oversight Framework, including strengthened programme governance, provider oversight and assurance arrangements. The report highlights current performance, delivery risks, recovery actions and transformation priorities across the major commissioning programmes.

Planned Care remains a key delivery priority. Whilst all three systems continue to maintain the 18-week Referral to Treatment standard, activity delivery has fallen below plan and progress in reducing waiting lists and long waits has slowed. Commissioners continue to strengthen oversight, improve activity delivery and accelerate pathway transformation and left-shift initiatives to support sustainable recovery.

Diagnostics and Cancer performance remains below operational plan trajectories. Diagnostics continues to represent a significant constraint across both elective and cancer pathways, whilst cancer recovery remains dependent on improvements in diagnostic capacity, treatment capacity and pathway performance. Commissioners are implementing enhanced oversight, recovery actions and targeted interventions across the most challenged pathways and providers.

Urgent and Emergency Care performance remains mixed across the ICBs' footprint. Derbyshire and Lincolnshire continue to perform above plan for four-hour performance, whilst discharge delays, patient flow, bed occupancy and ambulance handovers continue to present challenges. Recovery actions remain focused on admission avoidance, discharge improvement, transfer of care arrangements and wider flow initiatives.

Neighbourhoods and Community Services continue to demonstrate positive delivery, including the elimination of adult waits over 52 weeks. However, workforce and capacity pressures continue to affect Children and Young People's community services, particularly neurodevelopmental, speech and language therapy and occupational therapy pathways. Recovery plans and pathway redesign activities remain in place.

Primary Care performance remains broadly positive, with urgent same-day access delivering above plan and Pharmacy First continuing to support demand management. Dental access

Report summary

remains a commissioning priority, with recovery initiatives progressing across all three systems.

Mental Health services continue to demonstrate strengths across Talking Therapies, Individual Placement Support and Children and Young People's mental health access. However, inpatient flow, older adult length of stay, inappropriate out-of-area placements, Children and Young People's eating disorder access and Learning Disability and Autism inpatient trajectories remain areas requiring ongoing commissioner focus and targeted recovery action.

Children and Young People services continue to experience demand, capacity and waiting time pressures across a number of pathways. A strengthened commissioning approach is being implemented through the Children and Young People Programme Board to improve oversight, accountability and recovery planning. Women's Health remains focused on establishing governance arrangements, strategic commissioning priorities and neighbourhood-based models to support future transformation and improved outcomes.

Alongside programme delivery, Appendix 1 provides updates on the implementation of the Provider Performance Framework, NHS Oversight Framework findings and the ICBs' Data Quality Framework. Together these arrangements strengthen commissioner oversight, accountability, escalation and assurance in support of operational recovery and delivery during 2026/27.

Recommendation(s)

The Board is asked to **receive** the paper for assurance in relation to service delivery against the operational plans submitted for 2026/27.

Appendices

1: Commissioning Delivery Oversight Report

Board Assurance Framework

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

- Failure to systematically improve the quality of healthcare services
- Failure to ensure timely and equitable access to healthcare services in line with national and local performance standards

Relevant statutory duties

☒ Quality improvement	☐ Public involvement and consultation
☒ Reducing inequalities	☐ Equality and diversity
☐ Financial limits/ breakeven	☐ Effectiveness, efficiency and economy
☒ Integration of services	☐ Wider effect of decisions (triple aim)
☐ Promoting innovation	☐ Promoting research
☐ Patient choice	☐ Obtaining appropriate advice
☐ Promoting education/training	☐ Climate change

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Commissioning Delivery Oversight Report

Overview

1. Performance across the Derbyshire, Lincolnshire and Nottinghamshire footprint remains mixed, with continued strengths in primary care access, community delivery, prevention programmes and neighbourhood development, offset by significant challenges across elective recovery, diagnostics, cancer performance, urgent and emergency care flow, and Learning Disability and Autism (LD&A) services. Commissioners have used the first quarter of 2026/27 to establish and begin operating a strengthened oversight framework designed to provide greater grip, more proactive intervention and stronger accountability for operational delivery across providers and programme areas.
2. The ICBs continue to demonstrate strong delivery against a number of operational plan ambitions. Referral to Treatment performance under 18 weeks is being maintained across all three systems, GP appointment delivery remains above plan, Pharmacy First activity continues to grow significantly, and adult community waits that exceed 52 weeks have largely been eliminated. There have also been sustained improvements in proactive care, frailty identification, diabetes management, Talking Therapies outcomes and neighbourhood-based service development, providing a strong foundation for longer-term transformation, prevention and demand management.
3. Alongside operational recovery, commissioners continue to progress a significant programme of pathway redesign, left shift, prevention and neighbourhood-based transformation. Early evidence of benefit is emerging within selected specialties and services, supporting delivery closer to home, reducing avoidable demand on acute services and strengthening the longer-term sustainability of operational recovery across the ICBs. In Nottingham and Nottinghamshire, for example, community dermatology pathways have redirected a significant proportion of referrals away from acute services, demonstrating the potential for left-shift initiatives to improve access, reduce demand and release capacity for patients requiring specialist care.
4. Following discussion through the Commissioning Oversight Group and associated Programme Boards, commissioners have agreed a series of actions in relation to transformational programmes focused on translating programme and provider oversight into clear delivery plans, measurable milestones, recovery actions and evidence-based escalation. Programme boards are expected to demonstrate how pathway redesign, prevention, left shift, neighbourhood models, service improvement and commissioning intentions will

improve operational, financial and quality outcomes, supported by consistent metrics, trend reporting, provider-level analysis and strengthened data quality.

5. Alongside this, Commissioning Oversight Group provider focus is using triangulated performance, activity, finance, contracting and quality intelligence to identify where delivery is below plan or recovery trajectories, where contracted activity may be insufficient, and where activity may need to be commissioned differently or elsewhere. Priority commissioning actions include recovery planning for diagnostics, elective, cancer, urgent care and children and young people / community waits; review of neurodevelopmental assessment and primary care transformation arrangements; alignment of Better Care Fund trajectories with acute plans; deconstruction of the block as a structured project; review of Nottinghamshire Healthcare NHS Foundation Trust rebasing, East Midlands Ambulance Service recovery and independent sector utilisation; and strengthening the Activity Finance and Performance Group's Terms of Reference, in terms of seniority and commissioner input so that technical issues convert into clear actions, recommendations and escalation through Commissioning Oversight Group where required.

Planned Care, Diagnostics and Cancer

6. Whilst all three systems continue to achieve the 18-week referral to treatment standard, elective recovery remains the most significant delivery risk across the ICBs. Waiting lists have increased since March and activity delivery in April was below plan across elements of the elective pathway. Reduced clock stops are beginning to constrain the pace of waiting list reduction and long-wait recovery, creating a risk that performance deteriorates as the benefit of year-end recovery activity and validation exercises reduces. There were 118 patients waiting longer than 65 weeks across the ICBs at the end of April, concentrated within University Hospitals of Derby and Burton NHS Foundation Trust, Chesterfield Royal Hospital NHS Foundation Trust, United Lincolnshire Teaching Hospitals NHS Trust, Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust, reflecting ongoing capacity and pathway pressures across gynaecology, ear, nose and throat, ophthalmology, dermatology, diagnostics and endoscopy services.
7. Cancer performance remains below operational plan trajectories across all three ICB areas. Delivery against the Faster Diagnosis Standard, 31-Day Treatment Standard and 62-Day Referral to Treatment Standard continues to be affected by diagnostic constraints, treatment capacity pressures, workforce challenges and pathway complexity. Whilst recovery plans are in place and there are signs of improvement in selected tumour pathways, sustained improvement remains dependent on successful recovery within diagnostics and increased treatment capacity. Diagnostics therefore continues to represent one

of the most significant dependencies across both elective and cancer pathways.

Urgent and Emergency Care

8. Urgent and Emergency Care performance remains under sustained pressure. Derby and Derbyshire and Lincolnshire are currently performing above plan for four-hour performance, whilst Nottingham and Nottinghamshire continue to experience significant flow-related challenges. Performance across the ICBs continues to be affected by discharge constraints, high bed occupancy, ambulance handover delays, increasing length of stay and limitations in community capacity. Although coordinated recovery actions are being implemented through Transfer of Care development, discharge pathway redesign, Same Day Emergency Care expansion and neighbourhood delivery models, these improvements will take time to translate into sustained operational performance gains.

Mental Health and Learning Disabilities and Autism

9. Mental Health services continue to demonstrate strengths across Talking Therapies, Individual Placement Support and children and young people mental health access. Inpatient flow, older adult length of stay, inappropriate Out of Area Placements, children and young people eating disorder access and Learning Disability and Autism inpatient trajectories remain areas requiring ongoing commissioner oversight and targeted recovery action. Similarly, although adult community waiting lists remain positive, children and young people services continue to experience workforce and capacity pressures, particularly within neurodevelopmental pathways, Speech and Language Therapy and Occupational Therapy services.

Commissioning Oversight Framework

10. In response to these challenges, the ICBs have implemented a strengthened Commissioning Oversight Framework through the establishment of the Commissioning Oversight Group and a series of cross-ICB Programme Boards covering Planned Care (including Cancer and Diagnostics), Urgent and Emergency Care, Neighbourhoods, Primary Care, Mental Health, Children and Young People and Women's Health. This represents a significant shift towards a more proactive and commissioner-led model of oversight, moving beyond retrospective performance monitoring towards structured accountability, escalation, recovery planning and contractual assurance.

11. All programme boards will maintain formal delivery plans containing clear milestones, trajectories, metrics, risks, mitigating actions and expected benefits. Oversight arrangements place greater emphasis on recovery action, escalation routes and sustained deterioration, ensuring that programme reporting provides assurance not only on performance but also on the effectiveness of actions being taken to recover delivery. Commissioners are also strengthening the integration of finance, contracting and performance management functions within programme governance arrangements to improve oversight and support more effective intervention where performance risks emerge.
12. The metric exception review for July, which is shown on slide 10 of Appendix 1 demonstrates both the scale of opportunity and challenge across the ICBs. Forty-one headline metric instances are currently assessed using the Making Data Count principles of Statistical Process Control as failing against required targets or plans. Of these, nine are of greatest concern due to either sustained low performance or clear deterioration, whilst a further nine remain off plan but show evidence of improvement. Twenty-three metrics continue to demonstrate common-cause variation, indicating that further step-change improvement is required to achieve planning assumptions and operational standards.
13. To support recovery, a formal Provider Performance Framework has been agreed through the Commissioning Oversight Group and will be implemented during July 2026. The framework introduces a consistent and objective assessment of provider delivery against key operational metrics, combining delivery against plan, recent performance trends and statistical process control analysis to determine escalation levels and commissioner intervention. This will strengthen commissioner grip, improve consistency of provider challenge, support timely recovery planning and provide clearer assurance to executive teams and committees.

NHS Oversight Framework

14. The latest ICB NHS Oversight Framework assessment provides an additional source of assurance regarding areas of relative strength and challenge across the ICBs. Although the assessment reflects a broader range of measures than those reported within this briefing and relates to Quarter 4 2025/26, common themes emerge around access, patient flow, productivity, workforce experience and health inequalities, reinforcing the importance of the recovery actions and oversight arrangements described throughout this report.

Data Quality Framework

15. Alongside operational delivery, an ICB-wide Data Quality Framework has now been established to strengthen assurance and support improved confidence in

reporting, commissioning and contractual decision-making. More than twenty active data quality issues are currently being managed through formal governance arrangements, with the greatest concentration affecting mental health, urgent care and planned care pathways. Whilst many issues relate to national reporting and submission processes, the framework is improving visibility, escalation and resolution and will remain a key enabler of effective commissioning oversight during 2026/27.

Conclusion

16. Overall, the ICBs have established a stronger foundation for commissioner-led recovery through enhanced governance, programme oversight, provider escalation and data quality assurance. There remains significant delivery risks across planned care, diagnostics, cancer and urgent care; however, there is now greater visibility of risk, stronger recovery arrangements and a clearer framework for intervention. Successful implementation of the Commissioning Oversight Framework will be critical to improving operational performance, strengthening accountability, reducing unwarranted variation and delivering sustainable improvements in patient outcomes across Derbyshire, Lincolnshire and Nottinghamshire during 2026/27.



SAIU

**STRATEGIC
ANALYTICS
INTELLIGENCE
UNIT**

Appendix 1



Derby and Derbyshire
Integrated Care Board



Lincolnshire
Integrated Care Board



**Nottingham and
Nottinghamshire**
Integrated Care Board

Commissioning Delivery Oversight Report

Derby and Derbyshire ICB; Lincolnshire ICB and Nottingham and Nottinghamshire ICB

ICB Board - July 2026

Date: 16th July 2026

Prepared By: SAIU Performance Team

Supported By: SAIU Team



DLN Commissioning Oversight Delivery Report - Contents

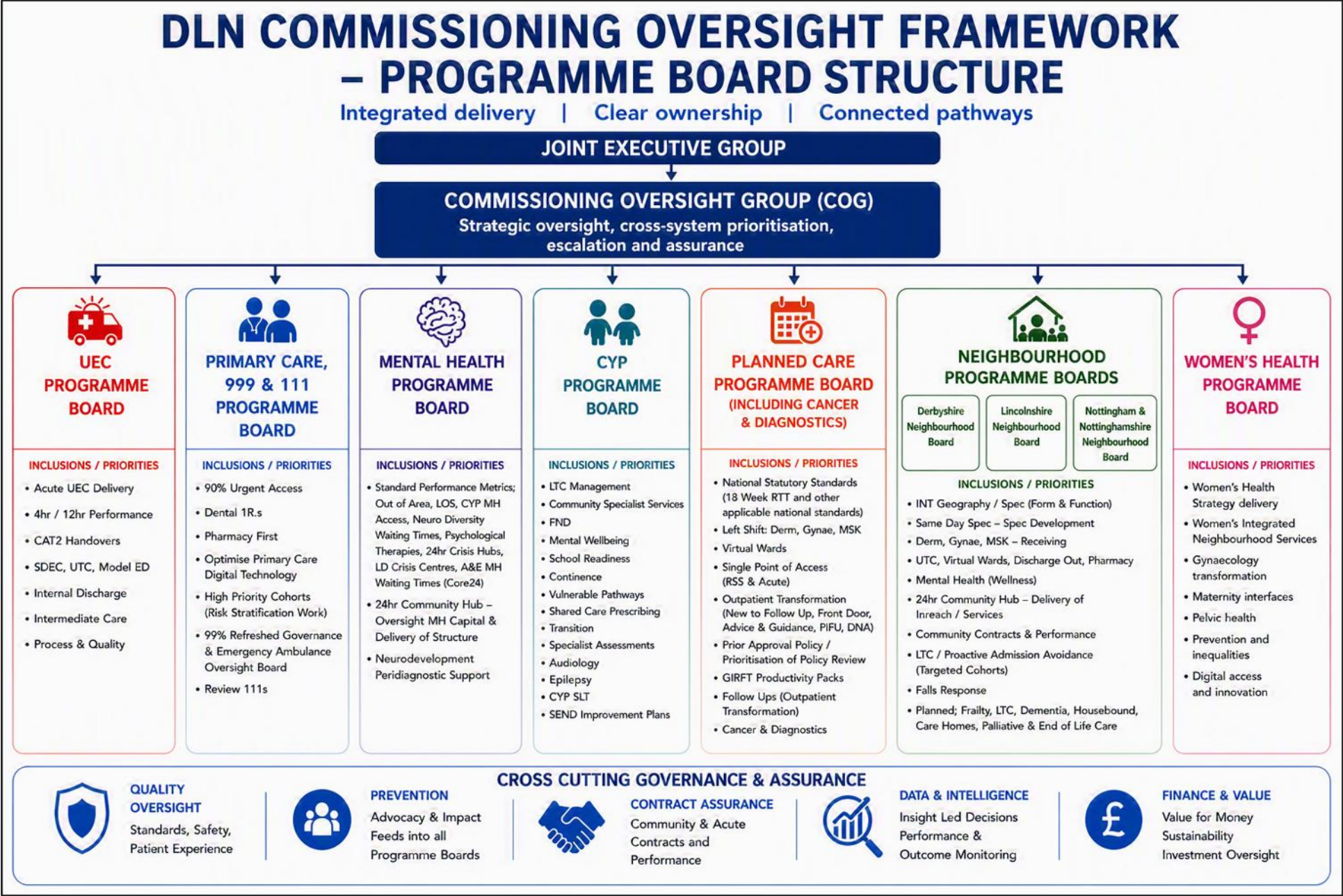
Item	Contents	Page Number
1.0	Executive Summary	3-5
2.1	Operational Plan Overview	6-9
2.1 i-1v	Operational Plan Delivery Exceptions	10-14
	Programme Overviews:	
3.1	Elective	15
3.2	Diagnostics	16
3.3	Cancer	17
3.4	Urgent Care	18
3.5	Community	19
3.6	Primary Care	20
3.7	Mental Health & LD & A	21
3.8	CYP and Womens	22-23
4.0	Provider Oversight	24
5.0	Data Quality Framework and Assurance	25

1.0 DLN Commissioning Oversight Delivery Report – Executive Summary (1)

1. The latest Commissioning Oversight position demonstrates a mixed but improving start to 2026/27 across the DLN cluster. Whilst April delivery shows early variation against plan, there is clear evidence of strengthened system grip, improved oversight and more proactive commissioning intervention, providing a stronger foundation for sustained recovery.
2. Planned care performance at year end was strong, with all three ICBs achieving the RTT 18-week standard and delivering PTL positions better than plan in March 2026, providing a solid baseline for 2026/27 delivery. The April position continues to reflect this strong year-end position, with performance partially supported by the benefits of March backlog clearance and validation activity. It is important that providers transition from year-end recovery into sustained in-year delivery and have a focus on embedding recurrent improvement and maintaining performance as the effect of March interventions reduces.
3. The April volume of activity shows delivery below plan across elements of the elective pathway, which is beginning to impact the pace of waiting list reduction. Reduced clock stops in April present a key emerging risk, as lower throughput limits the system's ability to sustain RTT performance and reduce long-wait cohorts once the benefit of the year-end position unwinds. However, this position is now being actively addressed through strengthened commissioning oversight, improved trajectory management and tighter alignment between plans and delivered activity, with a clear focus on increasing clock stops, restoring activity levels and supporting sustained RTT delivery over the coming months.
4. A major strategic focus across the DLN cluster remains the acceleration of left shift and pathway transformation, supporting delivery in lower-acuity settings and reducing reliance on constrained acute capacity. This is already delivering measurable benefit, particularly in dermatology, where 47% of 704 referrals have been redirected and demand reduced by ~15%, demonstrating the opportunity to improve access and release capacity. However, delivery remains variable across the cluster and requires further scaling to deliver consistent system-wide impact.
5. Diagnostics continues to represent a key system constraint, with performance below plan across all systems in April and sustained pressure across core modalities. While recovery actions are in place, performance remains materially below trajectory and continues to limit delivery across both elective and cancer pathways.
6. In response to these pressures, systems have strengthened commissioner grip, governance and delivery oversight. These arrangements are improving visibility of delivery risk and enabling earlier intervention, although the impact of these changes will need to be demonstrated through sustained improvement in delivery over the coming months.
7. Cancer performance remains below trajectory in April; however, recovery plans are in place and there are early signs of progress in some pathways. Notwithstanding this, performance remains below plan across key standards and is dependent on recovery in diagnostics and treatment capacity.

1.0 DLN Commissioning Oversight Delivery Report – Executive Summary (2)

8. Urgent and Emergency Care performance remains variable but demonstrates positive delivery in Derbyshire and Lincolnshire, with 4-hour performance of 75.5% and 82.8% respectively, both above plan. Nottingham and Nottinghamshire remains under pressure, reflecting the complexity of system flow challenges. Continued focus on discharge, flow and front-door models is expected to support gradual and sustained improvement.
9. The primary constraint across UEC remains system flow and discharge, with high bed occupancy and extended length of stay limiting overall resilience. However, there is now a more coordinated, system-wide response, including Transfer of Care development, strengthened discharge pathways and improved alignment with community services, which provides a stronger platform for recovery over time.
10. Community services continue to demonstrate a stable and positive position for adults, with all ICBs delivering the 52-week standard in April. CYP services remain under pressure, particularly in Lincolnshire and Nottinghamshire; however, there is now a clearer and more structured recovery approach in place. Given the scale of demand and workforce constraints, delivery risk remains material in the short term
11. Primary care delivery remains mixed, with some early delivery gaps in GP activity and dental provision. However, Pharmacy First and wider access initiatives continue to perform strongly and support demand management. Recovery will depend on sustained delivery across general practice and improved dental access across all systems
12. Mental health delivery remains comparatively strong, with access standards being met across multiple services and health checks delivered ahead of plan. However, inpatient flow, length of stay and out-of-area placements remain areas of focus, with continued reliance on improvements in community capacity and discharge pathways to sustain performance.
13. Overall, the April position reflects a system with a strong underlying foundation and improving commissioning grip, with clear actions in place to address early variation. Systems are well positioned to improve performance during 2026/27; however, delivery will depend on restoring activity levels, improving system flow and sustaining commissioner grip across all programmes
14. A Provider Performance Framework has been agreed through the Commissioning Oversight Group which applied an objective numerical assessment of delivery of key metrics, following which escalation levels for engagement with the providers on recovery plans will be undertaken. This will be rolled out through July 2026 and will be managed through Commissioning Oversight Group.
15. The NHS Oversight Framework assessment has been received for the ICBs and Providers for Quarter 4 2025-26, the provider positions have worsened and the ICB positions are variable with DDICB has the strongest relative profile, LICB is mixed, and NNICB is the most challenged overall. There were positive positions for the cluster around waiting lists, cancer diagnosis, CHC referrals, prescribing and staff survey indicators. Focus areas for improvement included access, discharge flow, productivity, workforce experience and health inequalities.
16. There are a number of data quality concerns included within the latest performance data, which are being discussed with the providers for resolution, these include mental health data submissions, weekly information flows, ED type 3 consolidation errors at a national level with the Trust footprints. These are being managed through the DLN Data Quality Oversight Group.



2.1 Operational Plan: Delivery Risk Key Headlines 2026/27

DDICB

LICB

NNICB

Programme Performance Headlines

1. Elective Care & Waiting Times			
			• 18-Week RTT: All three ICBs achieved plan in April 2026
			• Long Waits (52+ Weeks): NNICB are off plan for reducing long waits. DDICB and LICB are achieving the % of patients under 52 weeks. All ICBs are working to eradicate 65-week waits. NNICB risk due to PICS gynae patient transfers
			• PTL (Patient Tracking List): DDICB are better than plan in April 2026, LICB and NNICB are worse than plan. Waiting lists in local NHS Providers remain challenging, validation sprints and productivity programs are in progress.
2. Cancer Pathways			
			• 28-Day Faster Diagnosis: Performance is below the plan target for all three ICBs. There is variation across the Cluster tumour sites, some increased capacity in key specialties.
			• 62-Day Treatment: Performance is below trajectory for all ICBs.
3. Diagnostics			
			• 6-Week Waits (DM01): Performance is off plan in all three ICBs. Audiology, ECHO, MRI, NOUS, and endoscopy are particularly challenging. Improvement plans include increasing capacity and insourcing.
4. Urgent and Emergency Care			
			• 4-Hour ED Waits: System performance is below national plans for NNICB, with acute trusts facing challenges, for ED performance, DDICB and LICB are achieving the plan. The 12-hour target was missed at all three ICBs.
5. Primary, Community, and Mental Health Services			
			• Primary Care: GP appointments are achieving the plan in April at all three ICBs. Dental UDA plans have not been met in April at any of the three ICBs. Pharmacy first appointments are performing well in all three ICBs.
			• Community Services: All ICBs are achieving plan for 52ww Adults. LICB and NNICB are achieving the 52ww CYP plan.
			• Mental Health & LD&A: Access performance is positive across several areas, including IPS, Talking Therapies improvement and CYP mental health access. Key pressures remain in older adult inpatient length of stay, Lincolnshire EIP, CYP eating disorder routine access in Lincolnshire and Nottinghamshire, and LD&A adult inpatient trajectories across all three ICBs.
6. Vaccinations			
			• Vaccinations: COVID spring campaign – commenced on 13th April 2026 and ends on 30th June 2026.
7. NHS Oversight Framework Q3			
			• Q4 assessments have led to NHT, NUH, ULH, CRH, and UHDB being rated NOF 4.

Forecast
Delivery
RAG

1.1 SCP -
Summary Report

1.2 Operational
Plan - Executive
Summary

1.3 Contract
Delivery –
Executive
Summary (tdb)

2.1 Operational
Plan - Overview

2.2 Contract
Delivery –
Overview (tdb)

3.1 Programme
Overview –
Electives

3.2 Programme
Overview –
Diagnostics

3.3 Programme
Overview - Cancer

3.4 Programme
Overview – UEC

3.5 Programme
Overview –
Community

3.6 Programme
Overview – Primary
Care

3.7 Programme
Overview – Mental
Health & LDA

3.8 Programme
Overview – CYP &
Women’s

4. NHS Oversight
Framework
Benchmarking

2.1 Operational Plan - Latest Delivery Position

Programme	Metric	Category	OP Plan Ref	% / Value	Period	DQ	NHS Derby and Derbyshire ICB					NHS Lincolnshire ICB					NHS Nottingham and Nottinghamshire ICB				
							Plan	Actual	Variance	V	A	Plan	Actual	Variance	V	A	Plan	Actual	Variance	V	A
Electives	First OP <18 Weeks (%)	Ops Plan	E.M.42	%	Mar-26		71.2%	67.0%	-4.2%	✗	👍👎👎	67.2%	62.8%	-4.4%	✗	👍👎👎	73.8%	66.9%	-6.9%	✗	👍👎👎
	RTT <18 Weeks (%)	Ops Plan	E.B.40	%	Apr-26		62.9%	63.3%	0.4%	✓	👍👎👎	60.6%	60.8%	0.2%	✓	👍👎👎	63.1%	63.8%	0.7%	✓	👍👎👎
	RTT >52 Weeks (%)	Ops Plan	E.B.18	%	Apr-26		1.7%	1.6%	-0.1%	✓	👍👎👎	1.0%	1.0%	0.0%	✓	👍👎👎	1.0%	1.9%	0.9%	✗	👍👎👎
	RTT >65 Weeks (No.)	Nat Std		Value	Apr-26		0	51	51	✗	👍👎👎	0	18	18	✗	👍👎👎	0	49	49	✗	👍👎👎
	RTT Waiting List Size	Ops Plan	E.B.3a	Value	Apr-26		113,864	112,857	-1,007	✓	👍👎👎	108,435	109,034	599	✗	👍👎👎	122,717	124,861	2,144	✗	👍👎👎
Cancer	Cancer Faster Diagnosis <28 Days (%)	Ops Plan	E.B.27	%	Apr-26		80.0%	73.1%	-6.9%	✗	👍👎👎	80.0%	64.2%	-15.8%	✗	👍👎👎	80.0%	73.2%	-6.8%	✗	👍👎👎
	Cancer Treatment <31 Days (%)	Ops Plan	E.B.38	%	Apr-26		94.1%	91.0%	-3.1%	✗	👍👎👎	92.7%	85.0%	-7.7%	✗	👍👎👎	94.0%	93.9%	-0.1%	✗	👍👎👎
	Cancer Referral-to-Treatment <62 Days (%)	Ops Plan	E.B.35	%	Apr-26		75.6%	66.6%	-9.0%	✗	👍👎👎	72.6%	60.7%	-11.9%	✗	👍👎👎	75.3%	67.3%	-8.0%	✗	👍👎👎
Diagnostics	Diagnostics >6 Weeks (%)	Ops Plan	E.B.28x	%	Apr-26	⚠️	17.6%	29.5%	11.9%	✗	👍👎👎	37.0%	50.4%	13.4%	✗	👍👎👎	24.9%	33.5%	8.6%	✗	👍👎👎
Urgent Care	A&E <4 Hours (%)	Ops Plan	E.M.13	%	May-26	⚠️	73.5%	75.5%	2.0%	✓	👍👎👎	76.7%	82.8%	6.1%	✓	👍👎👎	75.4%	65.4%	-10.0%	✗	👍👎👎
	A&E >12 Hours (%)	Ops Plan	E.M.13g	%	May-26	⚠️	4.4%	10.7%	6.3%	✗	👍👎👎	9.3%	11.6%	2.3%	✗	👍👎👎	7.9%	13.6%	5.7%	✗	👍👎👎
	Ambulance Cat 2 Mean Response (mins)	Ops Plan	E.B.23c	Value	May-26		00:25:00	00:32:59	00:07:59	✗	👍👎👎	00:25:00	00:39:43	00:14:43	✗	👍👎👎	00:25:00	00:31:48	00:06:48	✗	👍👎👎
	Average Handover Time	Ops Plan	E.B.42	Value	May-26		00:30:51	00:25:24	-00:05:30	✓	👍👎👎	00:29:31	00:35:18	00:05:48	✗	👍👎👎	00:25:25	00:31:32	00:06:08	✗	👍👎👎
Primary Care	GP Appointments Delivered	Ops Plan	E.D.19	Value	Apr-26		600,846	603,676	2,830	✓	👍👎👎	474,080	489,613	15,533	✓	👍👎👎	675,562	705,249	29,687	✓	👍👎👎
	Same Day Urgent GP Appointments (%)	Ops Plan	E.D.27	%	Apr-26		70.0%	73.0%	3.0%	✓	👍👎👎	68.7%	71.0%	2.3%	✓	👍👎👎	75.0%	77.9%	2.9%	✓	👍👎👎
	Dental UDAs Delivered	Ops Plan	E.D.24	Value	Apr-26		124,614	116,304	-8,310	✗	👍👎👎	88,579	72,529	-16,050	✗	👍👎👎	156,451	137,543	-18,908	✗	👍👎👎
	Pharmacy First Consultations	Ops Plan	E.D.26	Value	Mar-26		7,891	13,912	6,021	✓	👍👎👎	5,309	8,571	3,262	✓	👍👎👎	10,169	16,415	6,246	✓	👍👎👎
Community	Adult Community Waits >52 Weeks	Ops Plan	E.T.9b	Value	Apr-26		112	0	-112	✓	👍👎👎	0	0	0	✓	👍👎👎	0	0	0	✓	👍👎👎
	CYP Community Waits >52 Weeks	Ops Plan	E.T.9a	Value	Apr-26		76	818	742	✗	👍👎👎	1,255	1,153	-102	✓	👍👎👎	200	199	-1	✓	👍👎👎
Mental Health	Inappropriate OAPs (Adult Acute)	Ops Plan	E.A.5	Value	Apr-26	⚠️	7	*				1	*				10	10	0	✓	👍👎👎
	MH Inpatient Mean LOS Adult and PICU	Ops Plan	E.H.38	Value	Apr-26		55.5	50.0	-6	✓	👍👎👎	21.3	26.0	5	✗	👍👎👎	48.6	46.0	-3	✓	👍👎👎
	MH Inpatient Mean LOS Older Adult	Ops Plan	E.H.39	Value	Apr-26		82.2	91.0	9	✗	👍👎👎	55.9	138.0	82	✗	👍👎👎	77.2	88.0	11	✗	👍👎👎
	IPS Access (Rolling 12-month)	Ops Plan	E.H.34	Value	Apr-26		789	895	106	✓	👍👎👎	670	735	65	✓	👍👎👎	1,375	1,550	175	✓	👍👎👎
	EIP <2 Weeks (%)	Nat Std		%	Apr-26		60.0%	67.0%	7.0%	✓	👍👎👎	60.0%	49.0%	-11.0%	✗	👍👎👎	60.0%	77.0%	17.0%	✓	👍👎👎
	Talking Therapies Reliable Recovery (%)	Ops Plan	E.A.4a	%	Apr-26		47.1%	53.0%	5.9%	✓	👍👎👎	50.3%	45.6%	-4.7%	✗	👍👎👎	50.1%	51.8%	1.7%	✓	👍👎👎
	Talking Therapies Reliable Improvement (%)	Ops Plan	E.A.4b	%	Apr-26		68.6%	73.1%	4.5%	✓	👍👎👎	70.2%	71.8%	1.6%	✓	👍👎👎	68.1%	73.6%	5.5%	✓	👍👎👎
	CYP MH Access	Ops Plan	E.H.9	Value	Apr-26		14,620	14,795	175	✓	👍👎👎	12,346	12,515	169	✓	👍👎👎	21,820	22,600	780	✓	👍👎👎
	CYP ED Routine <4 Weeks (%)	Nat Std		%	Apr-26		95.0%	100.0%	5.0%	✓	👍👎👎	95.0%	62.0%	-33.0%	✗	👍👎👎	95.0%	79.0%	-16.0%	✗	👍👎👎
LD&A	LD/Autism Adult Inpatients	Ops Plan		Value	Apr-26		32	38	6	✗	👍👎👎	34	35	1	✗	👍👎👎	36	40	4	✗	👍👎👎
	LD/Autism CYP Inpatients	Ops Plan	E.K.1c	Value	Apr-26		3	4	1	✗	👍👎👎	2	1	-1	✓	👍👎👎	3	2	-1	✓	👍👎👎
	LD Annual Health Checks (Qtr)	Ops Plan	E.K.3	Value	Mar-26	⚠️	1,983	1,997	14	✓	👍👎👎	1,346	1,377	31	✓	👍👎👎	2,196	2,029	-167	✗	👍👎👎

Data Quality Notes: 1) From April 2026, Diagnostics waiting times include all 15 modalities captured in the DM01. 2) There are data quality issues affecting the accuracy of 4 hour wait performance in Derbyshire, which include duplicated data, a range of data capture issues and incorrect assignment of attendance types. The ICB is working with providers to address these issues.

1.1 SCP - Summary Report

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2.1 Operational Plan - Overview

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3.1 Programme Overview – Electives

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4. NHS Oversight Framework Benchmarking

2.1 Operational Plan - Latest Delivery Position – National Benchmarking

			DDICB			LICB		NNICB		
			DDICB	UHDB	CRH	LICB	ULH	NNICB	NUH	SFHT
Programme	Metric	Period	Rank	Rank	Rank	Rank	Rank	Rank	Rank	Rank
Planned Care	RTT <18 Weeks (%)	Apr-26	27/36	121/148	115/148	34/36	126/148	25/36	98/148	88/148
	RTT <52 Weeks (%)	Apr-26	25/36	96/131	114/131	11/36	55/131	32/36	109/131	64/131
	RTT <65 Weeks	Apr-26	17/36	79/92	48/92	6/36	16/92	15/36	19/92	-
Cancer	Cancer Faster Diagnosis <28 Days (%)	Apr-26	28/36	101/133	93/133	36/36	127/133	27/36	109/133	61/133
	Cancer Referral-to-Treatment <62 Days (%)	Apr-26	28/36	119/134	49/134	34/36	124/134	22/36	83/134	118/134
Diagnostics	Diagnostics >6 Weeks (%)	Apr-26	25/36	108/134	57/134	36/36	133/134	28/36	122/134	64/134
Urgent Care	A&E <4 Hours (%)	May-26	18/36	70/118	31/118	1/36	8/118	35/36	106/118	110/118

The table above shows the national ranking for each ICB and Provider in the Cluster against key metrics in the Operational Plan. Ranking is from best (1) to worst.

The different numbers of organisations reflects the data submission count for the month.

SFHT does not have a ranking for RTT <65 Weeks as there were no 65 week wait patients in April.

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4. NHS Oversight Framework Benchmarking

2.1 Operational Plan - Latest Activity Position

Latest Month Only	Derby and Derbyshire ICB Population						Lincolnshire ICB Population						Nottingham and Nottinghamshire ICB Population					
	April 2026 Only				Apr 26 v Apr 25		April 2026 Only				Apr 26 v Apr 25		April 2026 Only				Apr 26 v Apr 25	
	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance
First OP Attendances (Consultant Led)	33,283	32,411	-872	-2.6%	46	0.1%	23,835	21,425	-2,410	-10.1%	-1,855	-8.0%	30,909	28,672	-2,237	-7.2%	475	1.7%
Follow Up OP Attendances (Consultant Led)	75,599	73,306	-2,293	-3.0%	-1,249	-1.7%	38,433	38,489	56	0.1%	-4,103	-9.6%	63,139	62,545	-594	-0.9%	-1,277	-2.0%
Elective Day Case Spells	14,055	13,452	-603	-4.3%	-1,017	-7.0%	8,538	9,248	710	8.3%	-633	-6.4%	15,290	14,340	-950	-6.2%	-517	-3.5%
Elective Ordinary Admissions	2,098	2,084	-14	-0.7%	68	3.4%	1,297	1,352	55	4.2%	-17	-1.2%	2,371	2,280	-91	-3.8%	127	5.9%
Diagnostic Tests Performed	44,444	42,224	-2,220	-5.0%	1,271	3.1%	38,774	35,987	-2,787	-7.2%	-409	-1.1%	47,985	47,408	-577	-1.2%	500	1.1%
A&E Attendances (total)	50,563	55,650	5,087	10.1%	-992	-1.8%	28,866	31,564	2,698	9.3%	2,540	8.8%	40,968	40,947	-21	-0.1%	1,096	2.8%

Year to Date	Derby and Derbyshire ICB Population						Lincolnshire ICB Population						Nottingham and Nottinghamshire ICB Population					
	April 2026				YTD 26/27 v YTD 25/26		April 2026				YTD 26/27 v YTD 25/26		April 2026				YTD 26/27 v YTD 25/26	
	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance
First OP Attendances (Consultant Led)	33,283	32,411	-872	-2.6%	46	0.1%	23,835	21,425	-2,410	-10.1%	-1,855	-8.0%	30,909	28,672	-2,237	-7.2%	475	1.7%
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Diagnostic Tests Performed	44,444	42,224	-2,220	-5.0%	1,271	3.1%	38,774	35,987	-2,787	-7.2%	-409	-1.1%	47,985	47,408	-577	-1.2%	500	1.1%
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3.2 Programme Overview – Diagnostics

3.3 Programme Overview - Cancer

3.4 Programme Overview – UEC

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4. NHS Oversight Framework Benchmarking

2.1 Operational Plan – Exception Reporting

Concerning Variation

Go back >>

9

Metric	Org	Period	V	A	Actual
Cancer Faster Diagnosis <28 Days (%)	LICB	Apr-26			64.2%
Cancer Faster Diagnosis <28 Days (%)	NNICB	Apr-26			73.2%
Diagnostics >6 Weeks (%)	LICB	Apr-26			50.4%
Diagnostics >6 Weeks (%)	NNICB	Apr-26			33.5%
A&E >12 Hours (%)	NNICB	May-26			13.6%
Community Waits >52 Weeks (Total)	LICB	Apr-26			1,153
Community Waits >52 Weeks (Total)	NNICB	Apr-26			199
Inappropriate OAPs (Adult Acute)	NNICB	Apr-26			10
CYP ED Routine <4 Weeks (%)	NNICB	Apr-26			79.0%

Overall, there are **41 metric** instances which are ‘Failing’ in the assurance of delivery to the targets and plans required, from the key headline metrics.

9 are failing and are of concerning variation for continued low performance or a deteriorating position. These areas have been outlined on the table to the left, and exception reports have been provided.

9 are improving indicating that although they remain unlikely to achieve plan on current assessments, they are reporting areas of improvement, these include long elective waits, cancer treatments, CYP mental health access and LD/ Autism inpatients.

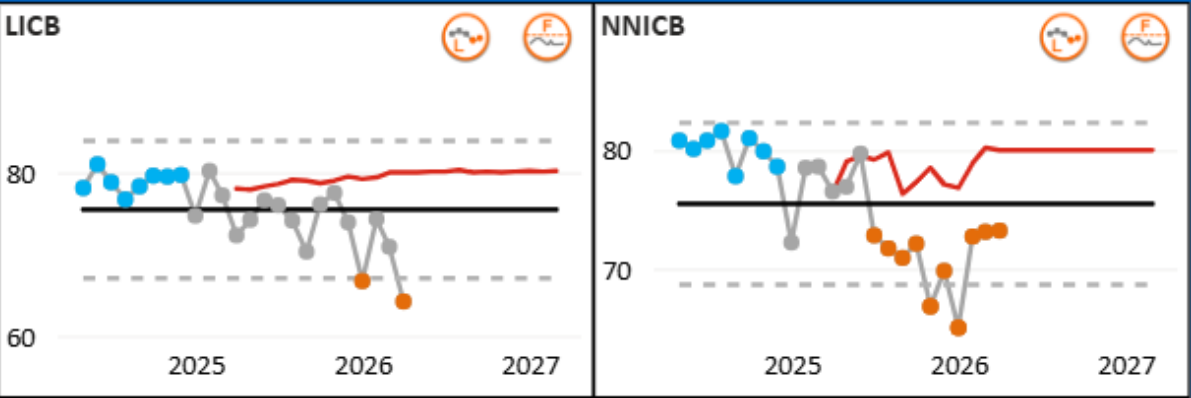
23 are common cause meaning that there is no discernible change in their performance when a stepped improvement is required.

5. There are 6 main theme areas across DLN which are of highest concern;
- i. Cancer Faster Diagnosis – exception report provided – LICB and NNICB
 - ii. Diagnostics – exception report provided – LICB and NNICB
 - iii. A&E 12 Hour – exception report provided - NNICB
 - iv. Community Waits – exception report provided – LICB and NNICB
6. Nottingham and Nottinghamshire ICB:
- v. Mental Health OAPs have remained at a constant '10' for a number of months. There is significant use of independent sector inpatient and PICU beds. Plans have been developed to repatriate all patients back within the Nottinghamshire geographical boundary. Quality and strategic commissioning colleagues are working with Nottinghamshire Health Care on a series of inpatient flow improvement workshops.
 - vi. CYP ED Routine low performance primarily relates to patient choice waiting for appointments after the four-week period, often due to holidays and exams. An improvement plan is in place to recover to target by September 2026.
7. Performance Framework – Triggers and Escalations
- The ICB has developed a methodology for identifying areas of concern and escalation in relation to provider performance, which has been agreed through the Commissioning Oversight Group. The initial approach is targeted towards acute services, with development planned to expand to mental health and community services. The framework is based on three areas; 1. the latest four weeks unvalidated weekly data; 2. assessment of delivery against planned levels for the previous 2 months; and 3. the latest view of the SPC analytical tool. The combination of these determines the level of escalation required, following which engagement will be undertaken with providers.

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4. NHS Oversight Framework Benchmarking

2.1 Operational Plan – Exception Reporting

i. Cancer 28 Day Faster Diagnosis



Metric Overview: The objective is to increase the percentage of patients who are receiving a cancer diagnosis within the required 28 days up to a required target of 80%.

KPI	Org	Latest Month	Actual	Plan	V	A	DQ
Cancer Faster Diagnosis <28 Days (%)	DDICB	Apr-26	73.1%	80.0%			
Cancer Faster Diagnosis <28 Days (%)	UHDB	Apr-26	72.6%	74.5%			
Cancer Faster Diagnosis <28 Days (%)	CRH	Apr-26	75.2%	75.2%			
Cancer Faster Diagnosis <28 Days (%)	LICB	Apr-26	64.2%	80.0%			
Cancer Faster Diagnosis <28 Days (%)	ULTH	Apr-26	61.7%	80.0%			
Cancer Faster Diagnosis <28 Days (%)	NNICB	Apr-26	73.2%	80.0%			
Cancer Faster Diagnosis <28 Days (%)	SFH	Apr-26	78.6%	79.6%			
Cancer Faster Diagnosis <28 Days (%)	NUH	Apr-26	71.0%	74.6%			

Benchmarks:

- LICB is the lowest ranking nationally; 36/36 ICBs
- NNICB ranks 27/36
- DDICB ranks 28/36

Commissioner and Provider Actions:

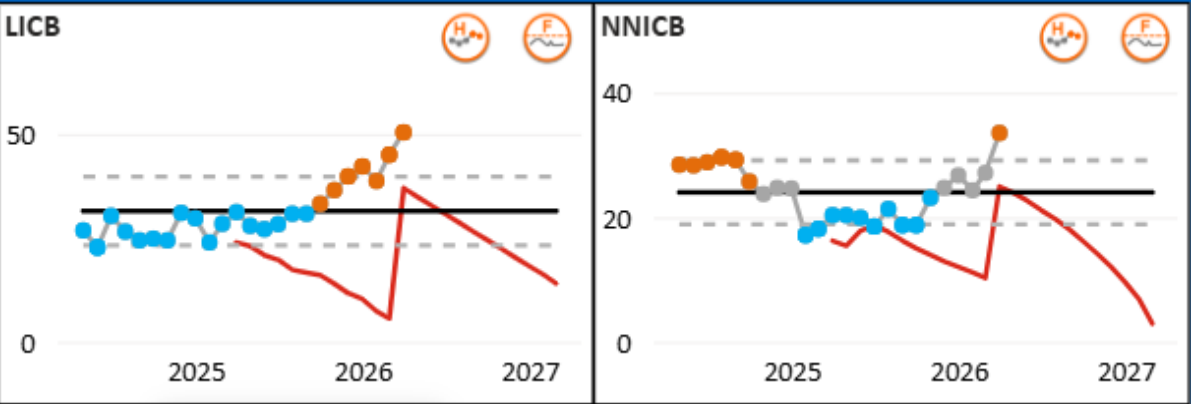
1. **LICB:** United Lincolnshire Hospitals is under Tier 2 with NHS England, for which fortnightly review meetings are being held and ICB Commissioners attend. Breast is showing some recovery with reductions in backlogs and return to plan is expected by September and **overall FDS to have returned to plan by November**. Enhanced contract oversight arrangements have been implemented. The ICB continues to work in close partnership with the trust to support recovery, strengthen delivery and ensure robust improvement plans are in place.
2. **NICB:** Nottingham University Hospitals is under Tier 1 with NHS England for which fortnightly review meetings are being held and ICB Commissioners attend. Breast had been an area of concern however improvements are being made with June expecting to report c89% which is a significant improvement and will support overall FDS delivery. This will be further supported by additional breast radiologists in July and August. Gynaecology pathway continues to be of concern with deterioration being reported. **Overall FDS is expected to return to plan in May for NUH**, which will support ICB overall delivery against plan.
3. Both systems have submitted bids to EMCA for additional funding to support challenged areas, the outcome of which is currently being awaited.

Quality and Clinical Actions:

1. Quality improvement is the cornerstone of the additional EMCA funding .
2. Oversight of clinical harm review process through quality schedules requirements and reporting.

2.1 Operational Plan – Exception Reporting

ii. Diagnostics 6 week waits



Metric Overview: The objective is to reduce the percentage of patients who waiting longer than 6 weeks for a diagnostic test, to an individually notified ICB target (LICB 14%; NNICB 2.9%).

KPI	Org	Latest Month	Actual	Plan	V	A	DQ
Diagnostics >6 Weeks (%)	DDICB	Apr-26	29.5%	17.6%			
Diagnostics >6 Weeks (%)	UHDB	Apr-26	33.4%	29.7%			
Diagnostics >6 Weeks (%)	CRH	Apr-26	16.0%	17.7%			
Diagnostics >6 Weeks (%)	LICB	Apr-26	50.4%	37.0%			
Diagnostics >6 Weeks (%)	ULTH	Apr-26	54.2%	25.0%			
Diagnostics >6 Weeks (%)	NNICB	Apr-26	33.5%	24.9%			
Diagnostics >6 Weeks (%)	SFH	Apr-26	17.7%	8.8%			
Diagnostics >6 Weeks (%)	NUH	Apr-26	42.7%	32.1%			

Benchmarks:

- LICB lowest ranking 36/36
- NNICB ranks 28/36
- DDICB ranks 25/36

Commissioner and Provider Actions:

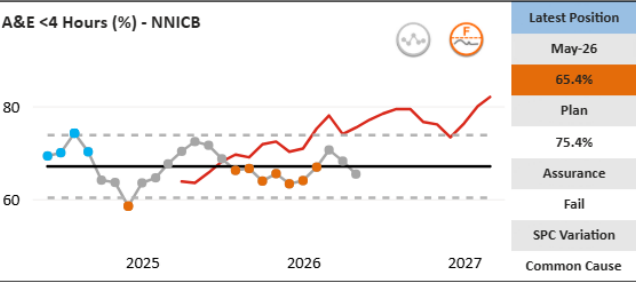
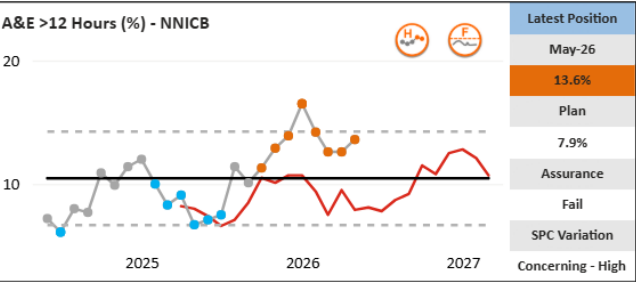
1. **LICB:** United Lincolnshire Hospitals has had a Contract Performance notice issued by the LICB for a formal recovery plan request due to low and deteriorating performance. Review meetings are held every fortnight. Main areas of concern include audiology assessments, cystoscopy, MRI and NOUS. There are a significant number of waits over 13 weeks across NOUS as well as other areas, and a volume of audiology patients waiting over 104 weeks. Audiology, MRI and NOUS will be subject to a diagnostic deep dive by NHSE at the end of June.
2. Lincolnshire three CDCs continue to perform well, with the fourth anticipating completion in March 2027. The Nurse-led remote rapid angina pathway at Skegness CDC has been shortlisted for the HSJ ‘Nursing-Led Patient Safety Innovation of the Year’ award.
3. **NICB:** Nottingham University Hospitals is under Tier 2 with NHS England for which fortnightly review meetings are being held and ICB Commissioners attend. Significant deterioration in performance across CT, US, DEXA, ECHO and Endoscopy. MRI had a low plan level set with slow improvement through quarter 4. The funding for the additional mobile MRI van is due to end in August; this is a risk to the MRI position deteriorating further. The Trust are also needing to address increasing 13-week backlogs, significant increases in CT and NOUS. Discussions are being held to secure additional US capacity with a third-party provider as the performance reduction was attributable to workforce shortages, and the trust are to undertake a review of booking and pathway processes. Modality level recovery plans have been requested.

Quality and Clinical Actions:

Oversight of clinical harm review process through quality schedules requirements and reporting.

2.1 Operational Plan – Exception Reporting

iii. A&E 12-Hour and 4-Hour Performance



KPI	Org	Latest Month	Actual	Plan	V	A	DQ
A&E >12 Hours (%)	DDICB	May-26	10.7%	4.4%			
A&E >12 Hours (%)	UHDB	May-26	11.7%	8.8%			
A&E >12 Hours (%)	CRH	May-26	7.9%	8.9%			
A&E >12 Hours (%)	LICB	May-26	11.6%	9.3%			
A&E >12 Hours (%)	ULTH	May-26	11.6%	9.3%			
A&E >12 Hours (%)	NNICB	May-26	13.6%	7.9%			
A&E >12 Hours (%)	SFH	May-26	9.7%	3.0%			
A&E >12 Hours (%)	NUH	May-26	15.8%	11.5%			

KPI	Org	Latest Month	Actual	Plan	V	A	DQ
A&E <4 Hours (%)	DDICB	May-26	75.5%	73.5%			
A&E <4 Hours (%)	UHDB	May-26	69.4%	73.2%			
A&E <4 Hours (%)	CRH	May-26	71.8%	74.3%			
A&E <4 Hours (%)	LICB	May-26	82.8%	76.7%			
A&E <4 Hours (%)	ULTH	May-26	76.1%	63.0%			
A&E <4 Hours (%)	NNICB	May-26	65.4%	75.4%			
A&E <4 Hours (%)	SFH	May-26	64.1%	77.3%			
A&E <4 Hours (%)	NUH	May-26	66.3%	74.1%			

12 Hour Metric Overview: The objective is to reduce the percentage of patients who waiting longer than 12 hours in A&E, from last years position.

Benchmarks:

- Not currently provided
- DDICB ranks 25/36

Metric Overview: The objective is to increase the percentage of patients who waiting less than 4 hours in ED, towards 82% target.

Benchmarks:

- LICB highest ranking 1/36
- NNICB ranks 35/36
- DDICB ranks 18/36

Data Quality- there are data quality reporting issues currently across all 3 ICBs which are being worked through with providers.

Commissioner and Provider Actions:

1. **NICB:** Nottingham University Hospitals remains under Tier 2 with NHS England for which fortnightly review meetings are being held and ICB Commissioners attend. Significant demand through quarter one with additional capacity being opened to facilitate flow. A GIRFT LLOS rapid improvement framework has been launched. Sherwood Forest Hospitals performance has also deteriorated which is attributed to reporting issues since moving to NerveCentre ED which has impacted upon the reported achievement of ED performance. There has been some improvement recently, back towards previous levels, as some of the data and operational issues are being resolved.
2. The UEC Commissioning team are focussing on commissioning and developing pathways that support admission avoidance and facilitate discharge.
- Expansion of co-located UTC at QMC to take up to 180 patients a day from ED
 - KMH pilot for the 'interceptor' role that has been successful at QMC
 - NEMS as the provider of our urgent care coordination hub have also piloted some new pathways to support EMAS and alternatives to ED.
 - Pathway One (supported discharge at home) re-commissioning continues with one provider now mobilising and the other due to mobilise in July 2026.
 - Single transfer of care hub has been approved as a concept; expressions of interest are being sought. An outcomes-based service specification is being drafted that will further support flow and timely discharge.

Quality and Clinical Actions:

3. DLN-Wide adult SDEC Utilisation Review commenced in February 2026 – initial findings show significant variation in SDEC models and maturity, referral routes, access to diagnostics, estate constraints, opening hours, and the extent to which they are protected as non-bedded admission avoidance pathways. Emerging themes for opportunity include earlier senior clinical decision-making at the front door of ED to fully utilise SDEC. Full support and engagement by providers is required to fully identify opportunities available.
4. A high-level review of virtual wards across the cluster has commenced with the aim of agreeing future strategic alignment due to persistently low occupancy and variation in delivery across providers, and the requirement to determine future technology-enabled model. A commissioning paper is being prepared for consideration.
5. Oversight of Provider Principles of Providing Care in corridors and associated action plans
6. Oversight of clinical harm review process through quality schedules requirements and reporting.

1.1 SCP -
Summary Report

1.2 Operational
Plan - Executive
Summary

1.3 Contract
Delivery –
Executive
Summary (tbd)

2.1 Operational
Plan - Overview

2.2 Contract
Delivery –
Overview (tbd)

3.1 Programme
Overview –
Electives

3.2 Programme
Overview –
Diagnostics

3.3 Programme
Overview - Cancer

3.4 Programme
Overview – UEC

3.5 Programme
Overview –
Community

3.6 Programme
Overview – Primary
Care

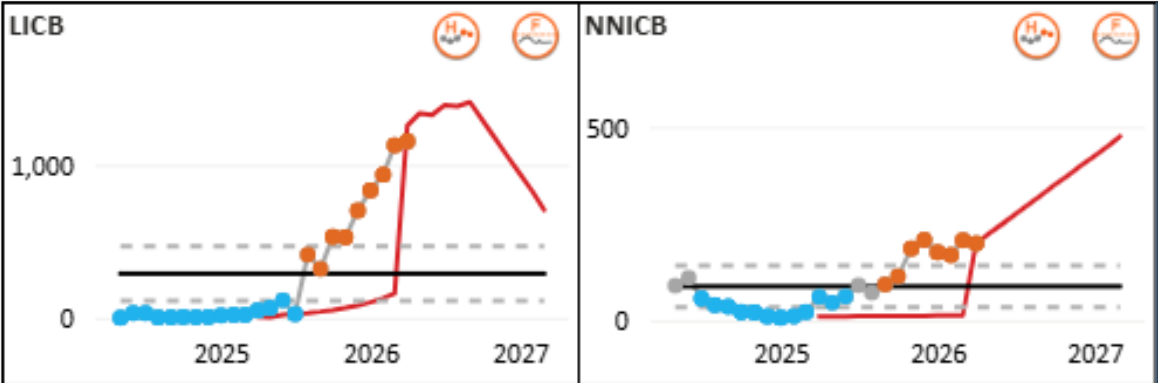
3.7 Programme
Overview – Mental
Health & LDA

3.8 Programme
Overview – CYP &
Women's

4. NHS Oversight
Framework
Benchmarking

2.1 Operational Plan – Exception Reporting

iv. Community 52 week waits



Commissioner and Provider Actions:

- 1. LICB:** All long waits relate to CYP. There are no adult waits over 52 weeks. The transition of the service under the group model from United Lincolnshire hospitals to Lincolnshire Community Health Services has impacted on development and deliver of the paediatrics community service. A sustained surge in demand in far exceeding the capacity available. No clear recovery plan is currently confirmed.
- 2. NICB:** All long waits relate to CYP. There are no adult waits over 52 weeks. The CYP waits relate to Speech and Language therapy (SLT) and Occupational Therapy. The ICB is maintaining oversight through contract and performance management arrangements. Recovery plans have just been revised which have extended recovery periods due to ongoing demand and capacity imbalance. In addition, a system wide pathway review is ongoing through the SEND programme working with Nottinghamshire Healthcare NHS Trust and system partners to redesign SLT pathways in line with national direction and Expert at Hand model, which includes improving access to advice to reduce the demand into the service. Providers have been requested to revise recovery plans with clear and credible trajectories to reduce the over 52 week waits.

Metric Overview: The objective is to eradicate waits over 52 weeks for therapeutic community services.

KPI	Org	Latest Month	Actual	Plan	V	A	DQ
Community Waits >52 Weeks (Total)	DDICB	Apr-26	818	817			
Community Waits >52 Weeks (Total)	CRH	Apr-26	0	0			
Community Waits >52 Weeks (Total)	DHCFT	Apr-26	818	817			
Community Waits >52 Weeks (Total)	DCHS	Apr-26	0	0			
Community Waits >52 Weeks (Total)	LICB	Apr-26	1,153	1,255			
Community Waits >52 Weeks (Total)	ULTH	Apr-26	1,153	1,255			
Community Waits >52 Weeks (Total)	LCHS	Apr-26	0	0			
Community Waits >52 Weeks (Total)	NNICB	Apr-26	199	200			
Community Waits >52 Weeks (Total)	SFH	Apr-26	0	0			
Community Waits >52 Weeks (Total)	NUH	Apr-26	5	0			
Community Waits >52 Weeks (Total)	NHT	Apr-26	194	250			
Community Waits >52 Weeks (Total)	CityCare	Apr-26	0	0			

Quality and Clinical Actions:

- 3. Community Stroke Rehab services are being reviewed across DLN as they are at varying stages of development in relation to the Integrated Community Stroke Service national guidance. This reflects historic commissioning decisions and differing levels of provider engagement. Pathway improvement plans for 2026/27 have been agreed across the DLN with providers. Work is underway to establish a DLN Stroke Clinical Network to provide end-to-end clinical governance and assurance across the stroke pathway. Subject to ICB resource arrangements, a Stroke Rehabilitation Task and Finish Group will also be established to support the development and delivery of a Strategic Commissioning Framework.
- 4. Oversight of clinical harm review process for those waiting in excess of 52 weeks through quality schedules requirements and reporting.
- 5. Oversight of the Minimum Standards for Planned Patient Care launched on 06/07/26.

1.1 SCP - Summary Report

1.2 Operational Plan - Executive Summary

1.3 Contract Delivery – Executive Summary (tbd)

2.1 Operational Plan - Overview

2.2 Contract Delivery – Overview (tbd)

3.1 Programme Overview – Electives

3.2 Programme Overview – Diagnostics

3.3 Programme Overview - Cancer

3.4 Programme Overview – UEC

3.5 Programme Overview – Community

3.6 Programme Overview – Primary Care

3.7 Programme Overview – Mental Health & LDA

3.8 Programme Overview – CYP & Women’s

4. NHS Oversight Framework Benchmarking

3.1 Programme Overview: Electives – Operational Plan Delivery Risk and Mitigations

1. Delivery Summary:

2. 18-week RTT: Systems entered 2026/27 from a strong baseline, having achieved plan at year end and delivered PTL positions better than plan in March. The April 18 weeks RTT position is also above the plan across the cluster, with continued delivery dependent on increased activity delivery.

3. 52-week waits: Nottingham and Nottinghamshire remain off plan, with continued backlog pressure. Lincolnshire and Derbyshire are within plan, resulting in a mixed cluster position. Progress in reducing long waits has slowed in April, reflecting reduced throughput.

4. 65-week waits: Elimination of 65ww continues be challenging for the cluster with Derbyshire, Lincolnshire and Nottinghamshire having 51, 18 and 49 breaches at the month end respectively.

5. Activity delivery: The April position shows activity below plan across elective pathways, resulting in insufficient clock stops. This is directly constraining RTT delivery and contributing to stagnation in long-wait reduction.

6. Demand management and left shift: Nottingham and Nottinghamshire continues to demonstrate measurable impact, with 47% of 704 dermatology referrals redirected to community settings, contributing to a 15% reduction in acute demand at NUH.

7. Key Programme Delivery Risks:

8. Delivery remains dependent on non-recurrent activity and validation, with insufficient embedded productivity to sustain RTT improvement

9. Activity under-delivery in April presents a material risk to trajectory, limiting clock stops and waiting list reduction

10. Continued diagnostic constraints (MRI, endoscopy, ultrasound) are restricting elective throughput

11. Risk that 52-week and 65-week cohorts increase if activity does not recover at pace Transformation and left shift benefits not yet fully realised at scale, limiting system-wide impact

12. Commissioner Response and Mitigating Actions:

13. Commissioners are progressing a significant programme of left shift and pathway redesign, including community dermatology, MSK, ophthalmology and gynaecology models, supported by Advice and Guidance, triage redesign and single points of access to reduce avoidable acute demand and improve pathway control.

14. The ICBs are strengthening commissioner grip on elective delivery through enhanced weekly oversight of PTL, long waits and trajectory delivery, enabling earlier identification of risk and faster escalation through contract and governance routes.

15. A more directive commissioning approach is being implemented, including development of in-year elective opportunity pipelines and targeted intervention in the highest-risk specialties, with a clear focus on recovery in 18-week RTT, 52-week waits and the current 65-week cohort.

16. There is already measurable impact emerging in Nottingham and Nottinghamshire, where 47% of 704 dermatology referrals have been redirected to community settings and acute demand at NUH has reduced by 15%, supporting confidence that pathway redesign can deliver meaningful improvement when fully mobilised.

17. Commissioners are strengthening alignment between activity, contracts and financial flows so that elective recovery actions translate not only into improved waiting time performance, but also into better value and clearer delivery against planning assumptions.

18. Formal contractual levers are being used where appropriate, including performance notices and strengthened monitoring of provider delivery, supported by oversight through contract forums and wider commissioning governance.

19. Delivery monitored through Planned Care Programme Board with escalation through the Commissioning Oversight Group

1.1 SCP - Summary Report
1.2 Operational Plan - Executive Summary
1.3 Contract Delivery – Executive Summary (tbd)
2.1 Operational Plan - Overview
2.2 Contract Delivery – Overview (tbd)
3.1 Programme Overview – Electives
3.2 Programme Overview – Diagnostics
3.3 Programme Overview - Cancer
3.4 Programme Overview – UEC
3.5 Programme Overview – Community
3.6 Programme Overview – Primary Care
3.7 Programme Overview – Mental Health & LDA
3.8 Programme Overview – CYP & Women’s
4. NHS Oversight Framework Benchmarking

3.2 Programme Overview: Diagnostics– Operational Plan Delivery Risk and Mitigations

1. Delivery Summary:

2. DM01 / 6-week waits: Derbyshire remains over plan and diagnostics continues to act as a material constraint to elective and cancer recovery. Lincolnshire’s position continues to worsen, with 50.5% of patients waiting more than 6 weeks for a diagnostic test against a plan of 37.0%. Nottingham and Nottinghamshire has performance of 33.5% against a plan of 24.9%

3. Modality-level performance: Derbyshire continues to report diagnostic pressure affecting downstream pathways, including endoscopy. Lincolnshire identifies audiology, MRI and non-obstetric ultrasound as the principal areas of concern. Nottingham and Nottinghamshire has issues with long waits in MRI, CT and endoscopy.

4. Capacity gap: Derbyshire continues to report pressure in core diagnostic capacity. Lincolnshire’s deterioration reflects a worsening mismatch between activity and waiting list growth. Nottingham and Nottinghamshire has clear CT and MRI capacity challenges at NUH.
5. Key Programme Delivery Risks:

6. Sustained demand–capacity mismatch across key modalities (MRI, endoscopy, NOUS, audiology)

7. Continued reliance on temporary capacity (insourcing, mobile units), creating fragility in delivery

8. Workforce, booking and reporting constraints limiting recovery pace and productivity

9. Risk that DM01 underperformance continues to destabilise elective and cancer pathways

10. Increasing demand linked to early diagnosis and recovery plans further widening the capacity gap
11. Commissioner Response and Mitigating Actions:

12. Commissioners are applying strengthened contractual and performance management grip, including Contract Performance Notices, fortnightly recovery meetings and escalation through established governance arrangements.

13. A coordinated programme is in place to increase diagnostic capacity, including optimisation of CDC utilisation, use of mobile MRI, insourcing and additional sessions, with a clear focus on aligning capacity to the areas of greatest operational risk.

14. Commissioners are also driving improvement through NHS England-supported diagnostic deep dives focused on the worst-performing modalities and using this process to identify targeted service and pathway improvements.

15. In Lincolnshire, the fourth CDC in Boston continues to progress positively, remaining within budget and approximately six weeks ahead of schedule, with completion expected in March 2027, providing a stronger long-term basis for recovery.

16. In Nottingham and Nottinghamshire, action includes temporary workforce and premium sessions, diagnostic stewardship to reduce unnecessary demand, and modality-level recovery plans, including clearer backlog trajectories and a stronger focus on value for money and productivity in MRI provision.

17. Across the cluster, diagnostics recovery is being aligned more explicitly to elective and cancer priorities so that available capacity is targeted where it can have the greatest system impact.

18. Delivery monitored through Planned Care Programme Board with escalation through the Commissioning Oversight Group

1.1 SCP -
Summary Report

1.2 Operational
Plan - Executive
Summary

1.3 Contract
Delivery –
Executive
Summary (tbd)

2.1 Operational
Plan - Overview

2.2 Contract
Delivery –
Overview (tbd)

3.1 Programme
Overview –
Electives

3.2 Programme
Overview –
Diagnostics

3.3 Programme
Overview - Cancer

3.4 Programme
Overview – UEC

3.5 Programme
Overview –
Community

3.6 Programme
Overview – Primary
Care

3.7 Programme
Overview – Mental
Health & LDA

3.8 Programme
Overview – CYP &
Women’s

4. NHS Oversight
Framework
Benchmarking

3.3 Programme Overview: Cancer– Operational Plan Delivery Risk and Mitigations

1. Delivery Summary:

2. Faster Diagnosis Standard: Derbyshire remains below trajectory in April, with cancer performance continuing to operate below plan across the principal standards. Lincolnshire also remains below trajectory, although there are early signs of improvement and a stronger focus on the tumour sites under greatest pressure. Nottingham and Nottinghamshire remains off track for Faster Diagnosis in April, with NUH specifically not achieving plan.

3. 31-day standard: Derbyshire remains below trajectory overall. Lincolnshire is also below planned delivery. In Nottingham and Nottinghamshire, the ICB-level position remains off track, although at provider level NUH achieved plan in April and SFH also delivered plan for 31-day performance.

4. 62-day standard: Derbyshire remains below trajectory in April. Lincolnshire also remains below trajectory, although recovery is expected to improve from June as pathway interventions mature. Nottingham and Nottinghamshire remains below trajectory at system level, with both NUH and SFH below plan on 62-day in April.

5. 62-day Recovery trajectory: Derbyshire’s position remains below pace, with improvement dependent on timely mobilisation of recovery actions and funding. Lincolnshire is expected to improve further through May and June, with fuller recovery not anticipated until September 2026. Nottingham and Nottinghamshire continues to show early pathway-level improvements, but the overall cancer recovery position remains off track.
6. Key Programme Delivery Risks:

7. Continued gap between demand and diagnostic/treatment capacity impacting FDS and 62-day performance

8. Strong dependency on diagnostics recovery to enable pathway improvement

9. Workforce fragility and complexity in high-pressure tumour sites (e.g. breast, gynae, GI)

10. Risk of continued underperformance against national standards, with potential regulatory escalation

11. Limited pace of improvement in April increases risk to trajectory delivery across 2026/27
12. Commissioner Response and Mitigating Actions:

13. Commissioners are strengthening tumour-site accountability and oversight, ensuring clearer ownership of delivery and stronger escalation of underperformance through programme and contract routes.

14. Additional recovery funding is being aligned to delivery priorities, including EMCA Wave 2 bids submitted in June 2026, with investment targeted to the most challenged pathways and providers.

15. A more focused programme of recovery action is being progressed, including Best Practice Timed Pathways, strengthened early diagnosis initiatives, targeted support to high-risk tumour sites and closer alignment between diagnostics and cancer recovery.

16. Workforce capacity is being actively reinforced, including the planned arrival of two substantive breast radiologists in July and August, alongside wider work to improve resilience and delivery pace through the summer period.

17. In Nottingham and Nottinghamshire, the commissioner response includes forecasting tools, increased oncology clinic capacity, NHS England-supported work on the gynaecology pathway and skin analytics going live on 29 June, all intended to improve flow and recovery performance over the coming months.

18. In Lincolnshire, current planning assumptions indicating improvement through the summer and fuller recovery expected by September 2026.

19. Delivery monitored through Planned Care Programme Board with escalation through the Commissioning Oversight Group

1.1 SCP - Summary Report
1.2 Operational Plan - Executive Summary
1.3 Contract Delivery – Executive Summary (tbd)
2.1 Operational Plan - Overview
2.2 Contract Delivery – Overview (tbd)
3.1 Programme Overview – Electives
3.2 Programme Overview – Diagnostics
3.3 Programme Overview - Cancer
3.4 Programme Overview – UEC
3.5 Programme Overview – Community
3.6 Programme Overview – Primary Care
3.7 Programme Overview – Mental Health & LDA
3.8 Programme Overview – CYP & Women’s
4. NHS Oversight Framework Benchmarking

3.4 Programme Overview: UEC – Operational Plan Delivery Risk and Mitigations

Delivery Summary:

- 1. 4-hour A&E performance: Derbyshire is above plan at 75.5% against 73.5%, a positive variance of 2.0 percentage points, although this headline masks wider pathway fragility. Lincolnshire is also above plan at 82.8% against 76.7%, a positive variance of 6.1 percentage points, despite very high activity. Nottingham and Nottinghamshire remains under pressure, with current focus on reducing emergency department attendance and improving flow.
- 2. 12-hour waits: Derbyshire continues to report 12-hour waits significantly above plan. Lincolnshire reports 12-hour performance at 11.6% against a plan of 9.3%, a negative variance of 2.3 percentage points against the target direction. Nottingham and Nottinghamshire continues to identify system flow and discharge as key pressures, with 13.6% against a plan of 7.9%, which is a variance of 5.7%.
- 3. Ambulance handover delays remain a system-wide pressure driven by flow constraints, with Derbyshire experiencing sustained delays linked to 12-hour performance, Lincolnshire reporting 11.3% vs 9.3% (+2.0pp), and Nottingham and Nottinghamshire remaining the most challenged with prolonged queueing, reducing ambulance availability across the cluster.
- 4. Ambulance response times remain below trajectory across all systems, with Derbyshire at almost 8 minutes over plan, Lincolnshire Category 2 at almost 6 minutes over plan, and Nottingham and Nottinghamshire underperforming at just under 7 minutes over plan, reflecting the ongoing impact of handover delays and high demand.
- 5. Key Programme Delivery Risks:
- 6. Persistent flow and discharge constraints limiting system resilience and recovery
- 7. High demand and bed occupancy sustaining pressure across front door, wards and ambulance services
- 8. Continued failure of the 12-hour standard in multiple systems
- 9. Dependency on community, social care and discharge capacity to support improvement
- 10. Risk of deterioration in performance if demand increases or flow improvements are not sustained
- 11. Commissioner Response and Mitigating Actions:
- 12. Commissioners are strengthening system-wide flow and discharge management through Transfer of Care Hub development, greater oversight of discharge pathways and closer system partnership working with local authority and provider colleagues.
- 13. A coordinated programme is under way to reduce avoidable emergency department demand, including expanded use of urgent treatment centres, same day emergency care, urgent community response, navigation hubs and alternatives to admission.
- 14. In Nottingham and Nottinghamshire, the co-located urgent treatment centre at QMC has been expanded to manage up to 180 patients per day diverted from emergency department, and a pilot is under way at KMH to test whether the successful interceptor model can be replicated locally.
- 15. Commissioners are also progressing recommissioning of supported discharge pathways, with one provider already mobilised and a further provider expected to mobilise in July 2026, supported by wider work to develop a single Transfer of Care Hub and an outcomes-based service specification.
- 16. In Lincolnshire, commissioner action continues through implementation of the one front door and life-and-limb model, including standardised initial assessment and better use of MEAU capacity to improve front-door flow.
- 17. A strategic review of virtual wards across the cluster is also under way, supporting a more coherent neighbourhood-based approach to demand management and flow over time.
- 18. Delivery monitored through UEC Programme Board with escalation through the Commissioning Oversight Group

1.1 SCP -
Summary Report

1.2 Operational
Plan - Executive
Summary

1.3 Contract
Delivery –
Executive
Summary (tbd)

2.1 Operational
Plan - Overview

2.2 Contract
Delivery –
Overview (tbd)

3.1 Programme
Overview –
Electives

3.2 Programme
Overview –
Diagnostics

3.3 Programme
Overview - Cancer

3.4 Programme
Overview – UEC

3.5 Programme
Overview –
Community

3.6 Programme
Overview – Primary
Care

3.7 Programme
Overview – Mental
Health & LDA

3.8 Programme
Overview – CYP &
Women’s

4. NHS Oversight
Framework
Benchmarking

3.5 Programme Overview: Community – Operational Plan Delivery Risk and Mitigations

Delivery Summary:

- 1. Adult 52-week waits: Derbyshire, Lincolnshire and Nottinghamshire are reporting zero adult waits at 52 weeks in April.
- 2. CYP 52-week waits: In Derbyshire, CYP waits underling causes have been identified, and improvement planning is in place. Lincolnshire’s CYP waits remain under significant pressure, with waits over 52 weeks linked to demand materially outstripping capacity. Nottingham and Nottinghamshire has 199 CYP waiting over 52 weeks against a plan of 200, effectively 1 below plan and therefore nominally on trajectory, although underlying pressure remains significant in speech and language therapy and occupational therapy.
- 3. Key Programme Delivery Risks:
 - 4. Sustained growth in CYP demand exceeding workforce and service capacity
 - 5. Backlog pressure across community paediatrics, speech and language therapy and occupational therapy
 - 6. Risk of further growth in long waits in the absence of additional capacity or pathway redesign
 - 7. Interdependency with UEC, discharge and neighbourhood services diverting focus from planned recovery
 - 8. Variation in provider capacity and trajectory maturity across systems
- 9. Commissioner Response and Mitigating Actions:
 - 10. Commissioners are progressing focused action to improve CYP waiting times, beginning with validation and assurance of waiting list positions and a clearer understanding of pathway-level drivers.
 - 11. In Derbyshire, a plan is under way to improve CYP waits, particularly in assessment pathways, beginning with validation and followed by procurement through a framework route to improve capacity.
 - 12. In Lincolnshire, commissioners are working to define a whole-pathway response to the current backlog and are continuing discussions to agree a revised model and more credible trajectory, recognising that the current position remains highly challenged.
 - 13. In Nottingham and Nottinghamshire, actions underway include strengthened oversight through contract, quality and CRM processes, system-wide SEND pathway transformation, detailed demand and capacity modelling for occupational therapy, and a requirement for providers to produce revised and credible recovery plans.
 - 14. Across the cluster, commissioners are increasingly aligning community recovery to broader governance and transformation programmes, supporting a more strategic and sustainable approach to reducing long waits.
 - 15. Delivery monitored through INT Boards with escalation through the Commissioning Oversight Group

1.1 SCP - Summary Report
1.2 Operational Plan - Executive Summary
1.3 Contract Delivery – Executive Summary (tbd)
2.1 Operational Plan - Overview
2.2 Contract Delivery – Overview (tbd)
3.1 Programme Overview – Electives
3.2 Programme Overview – Diagnostics
3.3 Programme Overview - Cancer
3.4 Programme Overview – UEC
3.5 Programme Overview – Community
3.6 Programme Overview – Primary Care
3.7 Programme Overview – Mental Health & LDA
3.8 Programme Overview – CYP & Women’s
4. NHS Oversight Framework Benchmarking

3.6 Programme Overview: Primary Care – Operational Plan Delivery Risk and Mitigations

Delivery Summary:

- 1. Same-day urgent GP appointments: Derbyshire is above plan at 73.0% against 70%, a positive variance of 3.0 percentage points. Lincolnshire is above plan at 71.0% against 69%, a positive variance of 2.0 percentage points. Nottingham and Nottinghamshire is above plan at 77.9% against 75%, a positive variance of 2.9 percentage points. Across all three systems, urgent same-day access is therefore ahead of submitted April trajectories.
- 2. Dental: Derbyshire is progressing a structured Quarter 1 recovery approach through the 110% delivery scheme and UDA recommissioning. Lincolnshire is taking a similar action-led approach to improve access and utilisation. Nottingham and Nottinghamshire also continues to treat dental capacity and access as an active commissioning priority.
- 3. Pharmacy First: Derbyshire, Lincolnshire and Nottingham and Nottinghamshire all ended the year above plan for Pharmacy First consultations, supporting wider urgent care demand management and access transformation, although system-specific actual and plan figures are not quoted in the written source.

4. Key Programme Delivery Risks:

- 5. Workforce constraints across general practice, dentistry and pharmacy limiting delivery and resilience
- 6. Risk of dental access issues increasing demand on urgent and emergency care pathways
- 7. Variation in practice-level delivery, digital maturity and access models
- 8. Reliance on Pharmacy First uptake and alternative pathways to support demand management

9. Commissioner Response and Mitigating Actions:

- 10. Commissioners are maintaining strong oversight of same-day urgent access delivery and actively supporting practices to deliver against the national ambition that at least 90% of clinically urgent appointments should be seen on the same day by March 2027.
- 11. Practice engagement is continuing across the cluster to improve coding, support adoption of the metric and reinforce best practice in delivery against access standards.
- 12. Dental access remains a key commissioning priority, with Quarter 1 action focused on implementing a 110% delivery scheme across the cluster and recommissioning UDAs released through rebasing to maximise capacity and improve access.
- 13. Commissioner oversight includes active review of uptake and impact from the 110% scheme, targeted provider engagement and ongoing work to reduce variation and improve utilisation in identified areas of need.
- 14. Pharmacy First and digital access continue to be supported as part of a wider programme of primary care transformation and demand management linked to neighbourhood and urgent care priorities.
- 15. Delivery monitored through Primary Care Programme Board with escalation through the Commissioning Oversight Group

1.1 SCP -
Summary Report

1.2 Operational
Plan - Executive
Summary

1.3 Contract
Delivery –
Executive
Summary (tbd)

2.1 Operational
Plan - Overview

2.2 Contract
Delivery –
Overview (tbd)

3.1 Programme
Overview –
Electives

3.2 Programme
Overview –
Diagnostics

3.3 Programme
Overview - Cancer

3.4 Programme
Overview – UEC

3.5 Programme
Overview –
Community

3.6 Programme
Overview –
Primary Care

3.7 Programme
Overview – Mental
Health & LDA

3.8 Programme
Overview – CYP &
Women’s

4. NHS Oversight
Framework
Benchmarking

3.7 Programme Overview: Mental Health & LDA – Operational Plan Delivery Risk and Mitigations

Delivery Summary:

1. Out-of-area placements: Derbyshire is meeting the out-of-area placement target and remains committed to the trajectory to zero by March 2028. Lincolnshire reports zero inappropriate out-of-area placements, indicating delivery in line with plan. Nottingham and Nottinghamshire is on plan, with 10 inappropriate out-of-area placements against a plan of 10.
2. Mean length of stay: Derbyshire reports mean length of stay for adults and PICU at 50.0 days against a target of 55.5 days, a positive variance of 6 days. Older adults is 91 days against a plan of 82.2 days. Lincolnshire average length of stay for adult and PICU at 26 days against a plan of 21.3 days. Older adult is 138 days against plan of 55.9 days. Nottingham and Nottinghamshire reports mean length of stay for adult and PICU of 46.0 days against a plan of 48.6, a positive variance of 3 days. Older adults is 88.0 days against a plan of 77.2 days.
3. Individual Placement and Support: Derbyshire is meeting the IPS target. Lincolnshire is above plan, supported by full recruitment. Nottingham and Nottinghamshire is also meeting the IPS access target.
4. Early Intervention in Psychosis: Derbyshire is meeting the EIP standard. Lincolnshire deteriorated and is at a negative variance of 11% against plan. Nottingham and Nottinghamshire is meeting the EIP <2 weeks target.
5. Talking Therapies reliable recovery and improvement: Derbyshire and Nottingham and Nottinghamshire are all delivering Talking Therapies recovery and improvement in line with targets. Lincolnshire is below plan for recovery but achieving plan for improvement.
6. Key Programme Delivery Risks:
7. Inpatient flow and discharge remain the primary constraint, with sustained variance in length of stay and out-of-area placements across systems.
8. Long-stay inpatient cohorts, particularly in Nottingham and Nottinghamshire, continue to limit trajectory delivery and reduce system flexibility.
9. Workforce and capacity constraints within community and specialist pathways are impacting access standards and recovery pace.
10. CYP pathway pressures, particularly in eating disorders and neurodevelopmental services, continue to affect access and waiting time delivery.
11. System dependency on community provision and housing capacity remains a key risk, with delays in these areas directly impacting discharge performance.
12. Commissioner Response and Mitigating Actions:
13. Commissioners are maintaining strong oversight of inpatient flow and discharge, supported by regular MADE sessions, delayed transfer reviews and closer joint working with provider and local authority partners.
14. In Derbyshire, twice-weekly MADE sessions are targeting clinically ready for discharge patients, with the ten high-impact changes for mental health inpatients being used to improve flow and reduce mean length of stay.
15. In Lincolnshire, remedial actions have addressed earlier issues linked to data flow and sickness absence, and the expectation is that the remaining off-track measures will continue to improve.
16. In Nottingham and Nottinghamshire, an extensive recovery programme is in place, including weekly Bed Management Team reviews, inpatient improvement workshops, pathway redesign linked to neighbourhood models and a formal performance improvement plan in CYP eating disorders, with recovery to target planned by September 2026.
17. Commissioners are also continuing to align mental health delivery to wider programme priorities, including community alternatives, flow, housing support and capital opportunities that can support more sustainable improvement over time.
18. Commissioners are actively managing LD&A inpatient flow through regular discharge reviews, provider collaboration and targeted community-based alternatives. Actions include identifying earlier discharge opportunities, developing additional accommodation options, progressing supported living schemes, strengthening delayed transfer and long-stay reviews, and improving admission avoidance to reduce future reliance on inpatient care.
19. Delivery monitored through Mental Health Programme Board with escalation through the Commissioning Oversight Group

1.1 SCP -
Summary Report

1.2 Operational
Plan - Executive
Summary

1.3 Contract
Delivery –
Executive
Summary (tbd)

2.1 Operational
Plan - Overview

2.2 Contract
Delivery –
Overview (tbd)

3.1 Programme
Overview –
Electives

3.2 Programme
Overview –
Diagnostics

3.3 Programme
Overview - Cancer

3.4 Programme
Overview – UEC

3.5 Programme
Overview –
Community

3.6 Programme
Overview – Primary
Care

3.7 Programme
Overview –
Mental Health &
LDA

3.8 Programme
Overview – CYP &
Women’s

4. NHS Oversight
Framework
Benchmarking

3.8 Programme Overview: CYP – Operational Plan Delivery Risk and Mitigations

1. Delivery Summary:

2. The CYP Programme provides a coordinated, matrix-based approach across the DLN Cluster to strengthen oversight and delivery of services impacting children and young people. Performance remains under pressure across several CYP access and waiting time standards, with the most significant risks concentrated in community and neurodevelopmental pathways.

3. CYP mental health access continues to perform positively across the cluster and is currently above plan in all three systems. Demand remains high and continues to increase, requiring continued focus on sustainable capacity and future trajectory delivery.

4. Pathway pressure (neurodevelopmental and therapies): Across all three ICBs, April performance continues to show sustained pressure in neurodevelopmental pathways, speech and language therapy and occupational therapy, with Derbyshire maintaining trajectory and Lincolnshire and Nottingham and Nottinghamshire experiencing demand exceeding capacity, limiting progress in reducing waits.

5. Key Programme Delivery Risks:

6. Significant backlog of >52-week waits, particularly in Lincolnshire and Nottinghamshire

7. Sustained demand growth in CYP mental health and neurodevelopmental pathways

8. Insufficient workforce capacity to meet assessment and treatment demand

9. Immaturity of recovery plans across pathways limiting delivery confidence

10. Data quality and pathway visibility issues, particularly within neurodevelopmental services, reducing assurance

11. Strong interdependency with SEND, community and social care systems impacting delivery

12. Commissioner Response and Mitigating Actions:

13. Commissioners are using the CYP Programme Board to establish a clearer oversight and delivery framework, including provider membership, explicit deliverables and a more structured approach to recovery action.

14. The development of a dedicated CYP dashboard will provide stronger visibility of performance and recovery and support improved commissioner challenge and assurance over time.

15. This is an important step in moving the programme toward a more mature commissioning model for CYP oversight, with clearer ownership of delivery and stronger linkage to wider community and SEND priorities.

16. Maintain strong cluster-level oversight through the CYP matrix governance model, with escalation through contract, SEND and programme governance where delivery risk persists

17. Use shared DLN commissioning arrangements to prioritise intervention in community paediatrics, SLT, OT and neurodevelopmental pathways, supported by clear trajectories, milestones and assurance arrangements

18. Align commissioning decisions across CYP services to support pathway-based recovery, including coordination of workforce, capacity, SEND and transformation actions rather than isolated provider responses

19. Work with system partners to improve transparency, reduce inequalities of access and support elimination of the longest waits, including continued recovery planning for 104-week neurodevelopmental waits and sustained community support for vulnerable cohorts.

20. Delivery monitored through CYP Programme Board with escalation through the Commissioning Oversight Group

1.1 SCP - Summary Report
1.2 Operational Plan - Executive Summary
1.3 Contract Delivery – Executive Summary (tbd)
2.1 Operational Plan - Overview
2.2 Contract Delivery – Overview (tbd)
3.1 Programme Overview – Electives
3.2 Programme Overview – Diagnostics
3.3 Programme Overview - Cancer
3.4 Programme Overview – UEC
3.5 Programme Overview – Community
3.6 Programme Overview – Primary Care
3.7 Programme Overview – Mental Health & LDA
3.8 Programme Overview – CYP & Women’s
4. NHS Oversight Framework Benchmarking

3.8 Programme Overview: Women's Health – Operational Plan Delivery Risk and Mitigations

- 1. Delivery Summary:
- 2. Programme development and governance: Derbyshire, Lincolnshire and Nottingham and Nottinghamshire are all represented within a shared cluster-wide Women’s Health programme approach, but the programme is not yet reported through numerical actual, plan and variance metrics at ICB level. The current position is best described through the shared strategic aims of integrated life-course services, neighbourhood and community delivery, prevention and early intervention, and reduction in inequalities.
- 3. Maturity and implementation position: Across all three ICBs, the programme remains at an earlier stage of development, with current activity focused on establishing governance architecture, using the renewed NHS England Women’s Health Strategy and regional data packs to identify priorities, and undertaking an initial review of implementation of commissioning guidance for abortion services. A metric-based delivery view is not yet available for this programme.
- 4. Key Programme Delivery Risks:
- 5. Variation in commissioning models and service provision across ICBs creates risk to consistent delivery and equitable access across the cluster
- 6. Limited dedicated programme capacity and resource is constraining the pace of implementation and reducing the ability to progress transformation at scale
- 7. Financial pressures and uncertainty in non-recurrent funding streams may limit the ability to deliver key improvements, particularly where service redesign requires upfront investment
- 8. Dependency on wider system programmes, particularly elective care (gynaecology), primary care and community services, creates risk where pathway redesign and capacity alignment are not coordinated
- 9. Lack of mature data, KPI frameworks and reporting infrastructure limits the ability to track delivery, identify risk early and demonstrate impact
- 10. Commissioner Response and Mitigating Actions:
- 11. Commissioners have established a cluster-wide Women’s Health Programme Board to provide clearer governance, challenge and assurance, with formal links into Commissioning Oversight and wider system boards.
- 12. The programme is progressing a strategic commissioning approach focused on integrated life-course services, prevention, reduction in inequalities and greater use of neighbourhood and community-based models for higher-volume, lower-complexity pathways.
- 13. Commissioning and pathway redesign options are being explored to develop Women’s Integrated Neighbourhood Services, with a particular focus on gynaecology pathways and improved digital access models.
- 14. A dedicated performance management approach is also being developed through delivery trackers, KPIs and RAG-rated oversight aligned to regional and national metrics, strengthening commissioner visibility and enabling earlier identification of delivery risk.
- 15. Delivery monitored through Women’s Health Programme Board with escalation through the Commissioning Oversight Group

1.1 SCP - Summary Report
1.2 Operational Plan - Executive Summary
1.3 Contract Delivery – Executive Summary (tbd)
2.1 Operational Plan - Overview
2.2 Contract Delivery – Overview (tbd)
3.1 Programme Overview – Electives
3.2 Programme Overview – Diagnostics
3.3 Programme Overview - Cancer
3.4 Programme Overview – UEC
3.5 Programme Overview – Community
3.6 Programme Overview – Primary Care
3.7 Programme Overview – Mental Health & LDA
3.8 Programme Overview – CYP & Women's
4. NHS Oversight Framework Benchmarking

4.0 NHS Oversight Framework: ICB Delivery Overview

- 1. Overall position:** DDICB has the strongest relative profile, LICB is mixed, and NNICB is the most challenged overall.
- 2. Main themes:** There were positive positions for the cluster around waiting lists, cancer diagnosis, CHC referrals, prescribing and staff survey indicators. Focus areas include access, discharge flow, productivity, workforce experience and health inequalities.
- 3. DDICB Position:** Above average or better in access, experience, safety and workforce; finance is the key lowest-quartile risk. **Positive themes include** improved waiting list position, cancer diagnosis, CHC referrals, mental health OAPS, GP appointments and staff survey scores. **Areas of focus include** GP booking satisfaction, discharge delays, antibiotic prescribing, implied productivity and healthy-years inequality.
- 4. LICB Position:** Strongest in safety, finance and population health, but below average for access, experience and workforce. **Positive themes include** CHC referrals, NICE hypertension and cardiovascular treatment, cancer staging, stroke admission gap and financial plan performance. **Areas of focus include** Cancer diagnosis stage, discharge delays, GP appointment access, neonatal still-births, breast screening and workforce leaver rate.
- 5. NNICB Position:** Access, experience and finance sit in the lowest quartile; workforce and population health are below average. **Positive themes include** CHC referral waits, CYP antibiotic prescribing and some prevention activity around smoking, weight management and diabetes. **Areas of focus include** GP booking satisfaction, discharge delays, diabetes care processes, productivity, staff survey concerns and cancer staging.
- 6. Q1 2026/27** will be the first quarter assessed against the new framework, with segmentation expected to be published around August 2026. Whilst the NOF reflects a broader measure set than the operational plan, the themes are largely consistent with the risks and opportunities identified elsewhere in this report.

2025/26 Q4 ICB Assessments

NOF Domains	DDICB	LICB	NNICB
Access	Above Average	Below Average	Lowest scoring quartile
Experience	Highest scoring quartile	Below Average	Lowest scoring quartile
Safety	Above Average	Highest scoring quartile	Above Average
Finance	Lowest scoring quartile	Highest scoring quartile	Lowest scoring quartile
Workforce	Above Average	Below Average	Below Average
Population Health	Below Average	Highest scoring quartile	Below Average

1.1 SCP - Summary Report

1.2 Operational Plan - Executive Summary

1.3 Contract Delivery – Executive Summary (tbd)

2.1 Operational Plan - Overview

2.2 Contract Delivery – Overview (tbd)

3.1 Programme Overview – Electives

3.2 Programme Overview – Diagnostics

3.3 Programme Overview - Cancer

3.4 Programme Overview – UEC

3.5 Programme Overview – Community

3.6 Programme Overview – Primary Care

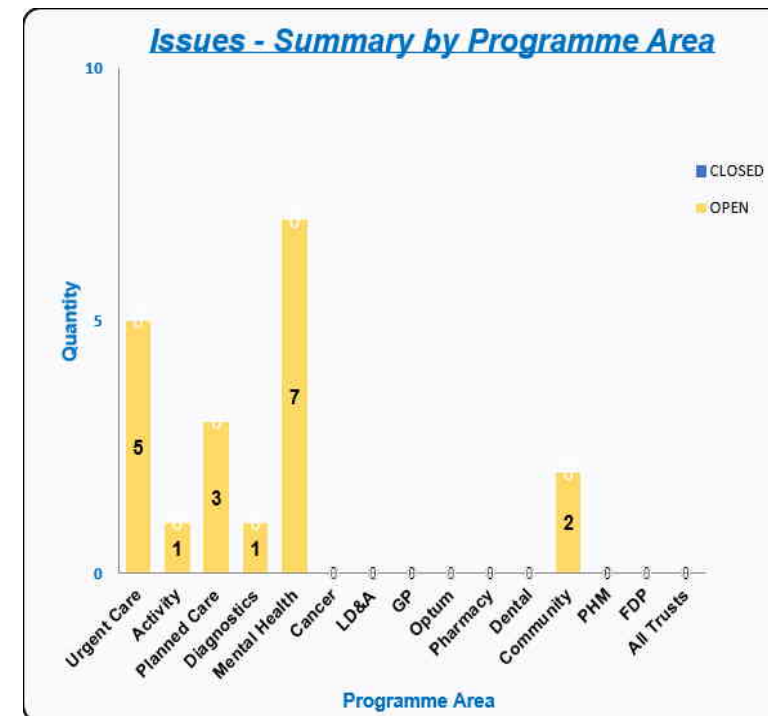
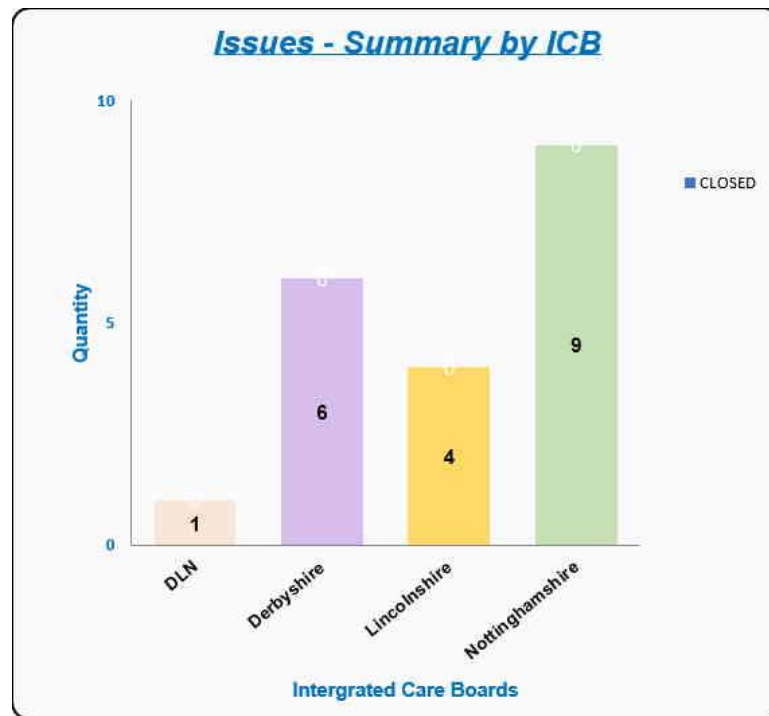
3.7 Programme Overview – Mental Health & LDA

3.8 Programme Overview – CYP & Women’s

4. NHS Oversight Framework Benchmarking

5.0 Data Quality Position

1. A DLN-wide Data Quality Framework has been established to strengthen the consistency, reliability and assurance of data used across performance reporting, commissioning and contract management. The framework introduces clear governance, roles and accountabilities, linking operational data processes to system-level oversight through DQOG, AF&P and COG, ensuring data quality is managed as a core delivery enabler rather than a technical function.
2. The framework standardises data quality processes across the cluster, embedding both preventative controls (e.g. validation, coding accuracy) and detective controls (e.g. system-level scrutiny and audit). Assurance is delivered through a combination of local ownership and central SAIU oversight, supported by formal reporting routes and structured governance.
3. A consistent risk management approach is now in place, with data quality risks assessed using a standardised methodology, tracked through a DQOG-managed risk register, and escalated through AF&P and COG as required. Current data shows: 20+ active data quality issues across the cluster, with the highest concentration in Nottinghamshire (9 issues) and Derbyshire (6 issues)Issues primarily impacting mental health (7), urgent care (5) and planned care (3)This demonstrates both the scale of current challenge and improved visibility of risk through the framework
4. The framework establishes clear escalation thresholds and reporting mechanisms, ensuring issues are identified early, acted on consistently and explicitly linked to performance and delivery risk. This is strengthening confidence in system reporting and improving alignment between activity, performance and financial management, which is critical to effective commissioning oversight.
5. The charts below summarise the volume and type of issues logged on the data quality register at the end of June 2026, most issues relate to inaccurate or data submission issues through national routes. There are issues relating to ED reporting which affect all 3 systems, which are being progressed by the SAIU with the providers concerned, the majority relate to type 3 reporting duplication issues. The framework is providing commissioners with increased confidence in performance reporting and strengthening the quality of operational, contractual and financial decision-making



Meeting title	Integrated Care Boards: Open Session (meeting in common)
Meeting date	16/07/2026
Paper title	Finance Report
Paper reference	ICB CIC 26 036
Paper author	Emma Rhodes, Director of Finance – Reporting and Control
Paper sponsor	Bill Shields, Executive Director of Finance
Presenter	Bill Shields

Paper type
For assurance ☒ For decision ☐ For discussion ☐ For information ☐

Report summary

This report outlines the financial position of the three ICB systems, including both ICB and provider positions, for the two-month period April to May 2026.

All three ICBs are delivering in line with plan year-to-date. The full-year forecast across all organisations is also aligned to plan, reflecting a stable position at this early stage of the financial year.

Efficiency delivery across the ICBs is £2.1 million behind the year-to-date target. This is primarily driven by Nottinghamshire providers (£1.8 million adverse) and Derbyshire providers (£1.1 million adverse), partially offset by Lincolnshire providers (£0.8 million favourable). Despite the early shortfall, all systems are currently forecasting delivery of efficiency plans in full by year end.

The risk position for the three ICB systems is £51.9 million, with identified mitigations offsetting these risks in full, resulting in a net nil risk position. Risks and mitigations remain aligned to plan and continue to be actively managed across all systems.

Common pressure areas across the three ICBs remain in line with plan assumptions, particularly within continuing healthcare and mental health services. Maintaining grip on efficiency delivery and actively managing demand pressures will be key to ensuring delivery of the financial position over the remainder of the year.

Recommendation(s)

The Boards are asked to **receive** the paper for assurance in relation to the financial position of the ICBs.

Appendices

None

Board Assurance Framework

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

- Failure to allocate resources effectively and shape provider markets to deliver value, productivity and system priorities
- Failure to commission services through effective procurement and contract management arrangements, compromising financial sustainability

Relevant statutory duties

☐ Quality improvement	☐ Public involvement and consultation
☐ Reducing inequalities	☐ Equality and diversity
☒ Financial limits/ breakeven	☒ Effectiveness, efficiency and economy
☐ Integration of services	☐ Wider effect of decisions (triple aim)
☐ Promoting innovation	☐ Promoting research
☐ Patient choice	☐ Obtaining appropriate advice
☐ Promoting education/training	☐ Climate change

Are there any conflicts of interest requiring management?

No

Is this paper confidential?

No

Finance Report May 2026 (Month 2)

Contents

System Overview – slides 1

ICB Financial Position – slides 2-4

Provider Financial Position – slides 5-7

Appendix –System Summary Income and Expenditure– slide 8

Systems Overview

Key Finance Metrics by System at Month 2

Organisation	Income and Expenditure Position Including Deficit Support Funding		
	Year to Date Plan £'m	Year to Date Actual £'m	Year to Date Variance £'m
Derby & Derbyshire ICS	(11.5)	(11.3)	0.2
Lincolnshire ICS	(11.2)	(11.1)	0.1
Nottingham & Nottinghamshire ICS	(29.3)	(38.7)	(9.4)
Grand Total	(52.0)	(61.1)	(9.2)

Overview of the Derbyshire, Lincolnshire, Nottinghamshire (DLN) NHS Integrated Care Systems (ICS)

At Month 2, the ICBs’ systems are reporting **a deficit of £61.1m against a planned deficit of £52.0m, representing an adverse variance of £9.2m**. Derbyshire and Lincolnshire are marginally ahead of plan at this stage of the year, with the adverse position driven by Nottinghamshire, which is reporting a £9.4m variance against plan.

The primary drivers of the variance within Nottinghamshire are, Nottingham University Hospitals NHS Trust (£6.1m adverse), reflecting pay cost pressures and under-delivery of efficiencies, and Nottinghamshire Healthcare NHS Foundation Trust (£2.8m adverse), driven by both pay and non-pay pressures.

All organisations are, however, forecasting delivery of their full-year financial plans.

Efficiencies

At Month 2, **efficiency delivery is £5.6m behind the planned £66.8m**. All systems are reporting behind plan, with Derbyshire £2.7m adverse (primarily driven by University Hospitals Derby and Burton NHS Foundation Trust at £2.0m), Lincolnshire £0.2m adverse (mainly linked to Lincolnshire Community Health Services NHS Trust), and Nottinghamshire £2.7m adverse, driven by Nottingham University Hospitals NHS Trust (£0.8m) and Sherwood Forest Hospitals NHS Foundation Trust (£2.2m).

The variance across all systems is largely attributable to delays in schemes moving into the delivery phase and the phasing of planned savings.

All organisations are, however, forecasting delivery of their full-year efficiency plans.

Integrated Care Boards (1 of 3)

Key Financial Metrics for Integrated Care Boards (ICBs) at Month 2 (31 May 2026)

ICB Key Metrics	Variance to Plan - Surplus / (Deficit)															
	Year to Date								Full Year							
	DDICB £m		LICB £m		NNICB £m		DLN Total £m		DDICB £m		LICB £m		NNICB £m		DLN Total £m	
Financial Performance	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G
Efficiency	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G
Spend of Capital Allocation	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G
Spend of Running Cost Allocation	0.0	G	0.5	G	0.0	G	0.5	G	0.2	G	0.1	G	0.0	G	0.3	G
Mental Health Investment Standard	N/A	-	N/A	-	N/A	-	N/A	-	0.0	G	0.0	G	0.6	G	0.6	G
Risk Position (Net)	N/A	-	N/A	-	N/A	-	N/A	-	0.0	G	0.0	G	0.0	G	0.0	G
Underlying Position	N/A	-	N/A	-	N/A	-	N/A	-	24.0	G	(16.9)	R	(4.4)	R	2.7	G
Better Payment Practice Code	>95%	G	>95%	G	>95%	G	>95%	G	>95%	G	>95%	G	>95%	G	>95%	G

The ICBs remain on plan against all key financial metrics and is forecasting delivery of its breakeven financial plan.

A favourable underlying position of £2.7m is forecast, with NHS Derby and Derbyshire ICB offsetting underlying deficits within NHS Lincolnshire ICB and Nottingham and Nottinghamshire ICB.

The position remains reliant on non-recurrent measures and therefore continues to present a longer-term sustainability risk.

ICBs (2 of 2)

The ICBs remain on track to deliver their 2026/27 financial plan and all statutory financial duties. Whilst financial pressures continue across Mental Health, Continuing Healthcare, Acute Commissioning and Primary Care, these remain manageable within the overall forecast position. Continued focus is required to strengthen recurrent efficiency delivery, manage demand-led pressures and improve long-term financial sustainability.

Financial pressures

The most significant financial pressures continue to arise from **Mental Health and Learning Disabilities services**, where demand for out-of-area placements, complex care packages and Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder pathways is driving a forecast £3.8m adverse position.

Continuing Healthcare is forecasting a £1.9m pressure, reflecting growth in fully funded and fast track packages and risks associated with delivery of the efficiency programme.

Activity across **Acute Commissioning** remains above planned levels within both NHS and Independent Sector providers, while **Primary Care and Prescribing** budgets continue to face cost and demand pressures, with prescribing forecasts remaining sensitive to national pricing adjustments.

Efficiency

The ICBs are forecast to achieve its £163.1m efficiency target, with Month 2 delivery broadly in line with plan and all ICBs forecasting full-year delivery.

However, delivery remains increasingly dependent upon non-recurrent measures. Forecast recurrent efficiencies are currently below plan and are being offset by one-off benefits, creating a longer-term sustainability challenge and increasing future recurrent efficiency requirements.

Key actions: Accelerate delivery of existing schemes, identify additional recurrent opportunities and maintain robust oversight through established Financial Recovery governance arrangements.

ICBs (3 of 3)

Risks and Financial Sustainability

The ICBs have identified £51.9m of gross financial risks, all of which are currently mitigated within forecast plans. The largest risks relate to efficiency delivery, prescribing and Continuing Healthcare costs and wider operational pressures.

All three ICBs remain on track to deliver their planned breakeven positions. The ICBs also report a favourable underlying position of £2.7m, although this reflects favourable performance within NHS Derby and Derbyshire ICB offsetting underlying deficits within NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB. The position remains supported by non-recurrent measures and therefore represents an ongoing sustainability risk.

Other Areas to Note

Cash performance remains consistent with planning assumptions and all ICBs continue to operate within available resource limits. Performance against the Better Payment Practice Code remains strong, with all organisations achieving the required payment targets.

Key Actions

- Continued focus on demand management, package reviews, activity monitoring, contract and referral management and repatriation of out-of-area mental health placements.
- Accelerate delivery of existing efficiency schemes, identify additional recurrent opportunities and maintain robust oversight through established Financial Recovery governance arrangements.
- Ongoing review of risks and mitigations, continued scrutiny of efficiency delivery and development of sustainable recurrent solutions to improve the underlying position.

Appendix 1 –System Income and Expenditure

	Net Expenditure									
	Year to Date					Full Year				
	Plan £m	Actual £m	Variance			Plan £m	Actual £m	Variance		
			£m	%				£m	%	
Revenue Resource Limit	(1,449.7)					(8,859.3)				
Acute Services	668.6	668.8	(0.2)	(0.0%)	R	3,999.2	3,999.2	(0.1)	(0.0%)	R
Acute services - NHS	634.6	634.8	(0.2)	(0.0%)	R	3,809.9	3,810.2	(0.3)	(0.0%)	R
Acute services - Independent/commercial sector	28.2	27.8	0.4	1.4%	G	150.6	149.8	0.8	0.5%	G
Acute services - Other non-NHS	2.8	3.1	(0.2)	(8.2%)	R	17.0	17.3	(0.2)	(1.4%)	R
Acute Services - Other Net Expenditure	2.9	3.1	(0.1)	(4.5%)	R	21.6	21.9	(0.3)	(1.5%)	R
Community Health Services	113.7	113.7	0.0	0.0%	G	671.4	671.3	0.0	0.0%	G
Mental Health Services	153.6	153.6	0.0	0.0%	G	924.8	928.5	(3.8)	(0.4%)	R
MH Services - NHS	95.9	96.0	(0.1)	(0.1%)	R	575.9	576.2	(0.4)	(0.1%)	R
MH Services - Independent / Commercial Sector	33.7	32.0	1.7	5.0%	G	197.1	180.0	17.2	8.7%	G
MH Services - Other non-NHS	23.3	25.3	(1.9)	(8.3%)	R	140.5	159.5	(19.0)	(13.5%)	R
MH Services - Other net expenditure	0.6	0.3	0.4	56.0%	G	11.3	12.8	(1.6)	(13.8%)	R
Continuing Care Services	64.0	65.2	(1.2)	(1.8%)	R	377.1	379.0	(1.9)	(0.5%)	R
Prescribing	94.1	94.2	(0.1)	(0.1%)	R	567.2	565.4	1.8	0.3%	G
Delegated Primary Medical Services	117.5	117.6	(0.1)	(0.1%)	R	702.2	700.9	1.3	0.2%	G
Delegated Dental, Ophthalmic and Pharmacy	47.4	47.9	(0.5)	(1.0%)	R	328.2	328.2	0.0	0.0%	G
Dental Services	27.9	28.4	(0.5)	(1.7%)	R	208.7	208.7	0.0	0.0%	G
Ophthalmic Services	5.5	5.5	0.0	-	G	33.9	33.9	(0.0)	(0.0%)	R
Pharmacy Services	14.0	14.0	(0.0)	(0.0%)	R	85.7	85.7	(0.0)	(0.0%)	R
Other Primary Care Services	18.4	18.7	(0.3)	(1.8%)	R	93.9	98.1	(4.2)	(4.5%)	R
Delegated Specialised Commissioning	140.0	138.3	1.6	1.1%	G	883.3	873.6	9.6	1.1%	G
Other Programme Services	13.6	13.5	0.1	0.4%	G	79.4	80.9	(1.4)	(1.8%)	R
Reserves/Contingencies	12.8	12.6	0.2	1.4%	G	183.1	184.5	(1.4)	(0.8%)	R
Total Programme	1,443.6	1,444.1	(0.5)	(0.0%)	R	8,809.7	8,809.7	(0.0)	(0.0%)	R
Running Costs	8.3	7.8	0.5	5.6%	G	49.6	49.6	0.0	0.1%	G
Grand Total	1,451.9	1,451.9	(0.0)	(0.0%)	R	8,859.3	8,859.3	(0.0)	(0.0%)	R
Surplus/(Deficit)	(2.1)	(2.1)	0.0	0%	G	0.0	0.0	0.0	100%	G

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	16/07/2026
Paper title:	Working with People and Communities Annual Reports
Paper reference:	ICB CIC 26 036
Paper author:	Dave Bradley, Strategic Quality and Transformation Manager, NHS Nottingham and Nottinghamshire ICB Stephanie King, Engagement Lead, NHS Lincolnshire ICB Karen Lloyd, Head of Engagement and Insight, NHS Derby and Derbyshire ICB Prema Nirgude, Head of Insights and Engagement, NHS Nottingham and Nottinghamshire ICB
Paper sponsor:	Clair Raybould, Executive Director of Strategy and Citizen Experience
Presenter:	Clair Raybould

Paper type:	For assurance ☒ For decision ☐ For discussion ☐ For information ☐
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Report summary:
The NHS Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs ('the ICBs') each have a legal duty to produce an Annual Report. Section 14Z58 requires that each Annual Report must include an explanation as to how an ICB has discharged its legal duties on public involvement and consultation. Given the wide range of requirements to include in each Annual Report, the ICBs' approach is to manage content volume and clarity of information by including a summary of this Section 14Z58 in the ICBs' main annual reports, alongside a link to the corresponding ICB's Working with People and Communities Annual Report. This approach has proved successful in previous years in managing the discharge of duty. The Working with People and Communities Annual Reports have been produced by each of the three ICBs. For 2025/26, report production and governance remain on an individual, statutory basis, reflecting the position throughout that period. Therefore, it is necessary to produce three reports, each providing assurance on how that individual ICB has discharged its legal duties regarding public involvement and consultation, setting out the ways that people and communities have been involved from 1 April 2025 to 31 March 2026. These reports will be published separately, representing the individual ICB as is appropriate for the time period to which they correspond. For this reason, the reports remain aligned to individual ICB approaches stylistically, with the expectation that next year's reports will be unified in accordance with national guidance on merging. The ICBs' Joint Strategic Commissioning Committee received the reports at its meeting on 28 May 2026 and applied an assurance rating of adequate, acknowledging the intention that greater emphasis will be given to citizen experience and case studies, particularly in relation to service redesign. The Committee requested that that future reports should also more clearly demonstrate the impact of actions taken.

Recommendation(s):

The Boards are asked to **receive** the paper for assurance of the ICBs' compliance regarding their legal duties on public involvement and consultation.

Appendices

Appendix 1 – NHS Derby and Derbyshire ICB: Engaging with people and communities in commissioning

Appendix 2 – NHS Lincolnshire ICB: People and Communities Involvement Report

Appendix 3 – NHS Nottingham and Nottinghamshire ICB: 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):

- Failure to involve people and communities meaningfully in commissioning and service design

Relevant statutory duties:

☐ Quality improvement	☒ Public involvement and consultation
☐ Reducing inequalities	☒ Equality and diversity
☐ Financial limits/ breakeven	☐ Effectiveness, efficiency and economy
☐ Integration of services	☐ Wider effect of decisions (triple aim)
☐ Promoting innovation	☐ Promoting research
☐ Patient choice	☐ Obtaining appropriate advice
☐ Promoting education/training	☐ Climate change

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Working with People and Communities Annual Reports

Introduction

1. The NHS Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs ('the ICBs') each have a statutory duty to produce an annual report setting out how they have discharged their functions during the previous financial year.
2. The minimum content of the annual report is prescribed by the National Health Service Act 2006 (as amended). Under section 14Z58, the annual report must include an explanation of how each 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 guidance¹ outlining how ICBs should describe their work with people and communities when discharging these statutory duties. No updated guidance has been issued since. The guidance sets out the areas that would typically be included within a Working with People and Communities Annual Report, covering governance and assurance, the application of strategy, the use of insight and data, equality and inclusion, partnership working, learning and good practice, communications activity, and future planning.
6. Given the breadth of statutory requirements placed on ICB annual reports, each of the three ICBs will include a brief synopsis of how its public involvement duties have been discharged within its main annual report, supported by a link to a dedicated Working with People and Communities Annual Report.
7. Each ICB had produced its own Working with People and Communities Annual Report (see Appendices 1 to 3). These reports provide assurance on how the individual ICBs have discharged their legal duties on public involvement and

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

consultation, setting out the ways in which people and communities have been involved during the period 1 April 2025 to 31 March 2026. While each report reflects local context and delivery, they are informed by shared principles and cluster-wide approaches.

8. Looking ahead, this reporting sits within a context of increasing collaboration across the ICBs' footprint, as ICBs move towards more clustered ways of working. Alongside meeting statutory requirements, there is a shared focus on strengthening how insight from people and communities is gathered, used and shared, improving consistency where appropriate while respecting local nuance across rural, coastal and urban communities. This includes ongoing learning across systems, greater alignment of relevant strategies and policies, and close working with Voluntary, Community and Social Enterprise partners and Alliances to support effective engagement and co-production as the system continues to evolve.

Summary of ICB Engagement and Involvement Reports (2025/26)

9. The three documents outline how the ICBs have worked with people and communities to shape health and care services during 2025/26. Across all three reports, there is a strong emphasis on co-production, reducing health inequalities, involving underserved communities, and ensuring that lived experience directly influences commissioning and service improvement. There is a strong focus on commissioning decisions being shaped by 'community-led insight' and on translating engagement into measurable service change.
10. Together, the documents show a shared direction of travel across the three ICBs, moving from engagement as a compliance exercise toward ongoing partnership with communities.
11. All three reports:
 - a) Emphasise the legal duty to involve patients and the public in healthcare commissioning and service change.
 - b) Promote co production and partnership working rather than traditional consultation.
 - c) Prioritise reducing health inequalities and reaching underserved groups.
 - d) Use lived experience and community insight to influence decisions.
 - e) Highlight collaboration with Voluntary, Community and Social Enterprise (VCSE) organisations, Healthwatch, local authorities and community leaders.
 - f) Demonstrate how engagement activities led to changes in services, pathways or governance.

- g) Stress the importance of feedback loops so communities can see how their input influenced outcomes.
- h) Reflect wider NHS priorities around integrated care, neighbourhood working and prevention.

NHS Derby and Derbyshire ICB – Engaging with People and Communities in Commissioning

- 12. Focuses on how public engagement and community insight are embedded into commissioning decisions and service redesign.
- 13. Key themes:
 - a) Embedding people and communities into commissioning and quality improvement.
 - b) Moving beyond one off consultation towards long term relationships and trust building.
 - c) Co-production and community-led approaches to reduce health inequalities.
 - d) Governance and assurance structures supporting public involvement.
 - e) Practical examples of engagement influencing services.
- 14. Examples highlighted:
 - a) Barrow Hill Health Hub – community-led development of accessible health and wellbeing spaces.
 - b) Sickie Cell Community Health Alliance – rebuilding trust and improving communication following a newborn screening incident.
 - c) Maternity and neonatal inequalities work – engaging Black, Asian, Mixed ethnic and deprived communities to shape maternity care.
 - d) Women’s Health Hub engagement – involving over 1,700 women to inform service improvements and action planning.

NHS Lincolnshire ICB – People and Communities Involvement Report

- 15. Provides a broad annual overview of how involvement and engagement activities influenced healthcare planning, redesign and improvement across Lincolnshire outlining comprehensive use of quantitative engagement data and metrics, including surveys, website traffic, community visits and social media reach.
- 16. Key themes:
 - a) Meeting statutory duties for involvement under the Health and Care Act.

- b) Governance, partnership working, and shared insight across the system.
- c) Reaching underserved and disadvantaged groups.
- d) Use of data, engagement metrics, surveys, and community outreach.
- e) Demonstrating impact through detailed case studies.

17. Examples highlighted:

- a) Continuing Healthcare – feedback on confusing processes led to plans for more person-centred approaches and co production groups.
- b) Children and Young People neighbourhood initiative – engagement informed new integrated support models.
- c) Dementia engagement – identified gaps in diagnosis, support and coordination, helping shape future dementia priorities.
- d) Dermatology services review – patient feedback highlighted waiting times, travel barriers and access concerns.

NHS Nottingham and Nottinghamshire ICB – Working with People and Communities Annual Report

18. Explains the ICB's wider strategic approach to 'Citizen Intelligence' and co production across the Integrated Care System, with emphasis on governance, infrastructure, partnerships and long term transformation.

19. Key themes:

- a) Citizen Intelligence as a systematic way of gathering insight.
- b) Co production as a routine and accountable method of service design.
- c) Strong collaboration with VCSE organisations.
- d) Governance and assurance during major organisational and financial change.
- e) Embedding engagement into neighbourhood working and system transformation.

20. Examples highlighted:

- a) Development of system-wide engagement and co production frameworks.
- b) Expansion of the Engagement Practitioners Forum to coordinate insight and reduce duplication.
- c) Strengthening the VCSE Alliance as a strategic partner in decision-making.
- d) Focus on ensuring public voice remains central during the ICBs' transition arrangements.

Appendix 1

Derby and Derbyshire Integrated Care Board (DDICB)

Engaging with people and communities in commissioning: Assurance Summary 2025/26

1. Ambition and approach: involving people and communities in commissioning

The ICB has a legal duty to involve people who use NHS services, and their carers/representatives, in commissioning decisions - especially where decisions affect how services are planned and delivered. These duties are set out in the National Health Service Act 2006 (as amended by the Health and Care Act 2022).

We use NHS England's statutory guidance on working in partnership with people and communities to inform our approach and assure our practice.

Beyond statutory requirements, we know that commissioning decisions are stronger when they are shaped by lived experience. Our ambition is to ensure that insight from patients, carers, communities and staff meaningfully influences priorities, service specifications, options appraisal, quality improvement and evaluation. How we do this:

- Embed people and communities in commissioning: proactively seek out and use diverse insight to shape priorities, service models and quality improvement - so decisions are better and outcomes improve.
- Build trust through planned, ongoing engagement: invest time and resource in authentic relationships (not one-off consultations), and improve how we feedback what changed as a result.
- Share power and reduce inequalities: involve communities early, remove barriers to participation, and support community-led approaches so that those most affected by decisions can influence them.

Listening well matters because it helps us commission services that work for real lives. We gather feedback from across Derby and Derbyshire about people's experiences of care, what they think needs to change, and the wider things that affect health and wellbeing. Doing this consistently and reaching people who are often missed helps us improve access, tackle health inequalities, and make better use of public money.

In 2025/26 we continued to focus on building relationships, connections and trust rather than only doing one-off engagement. We've supported people to have more say in what matters to them, while also making sure their insight helps shape plans, priorities and day-to-day improvements in services.

To be effective, engagement must go beyond 'transactional' activity where professionals run engagement and communities are asked to react. We focus on partnership, where people help shape the agenda, options and decisions supporting stronger commissioning and more sustainable change.

Our engagement culture aims to create more equal and honest relationships with people and communities, so they feel respected and able to influence decisions. This widens the conversation from individual experiences of services to what matters in everyday life and what would improve outcomes. We continue to use our locally developed [Insight Framework and 'development and support tool'](#) (co-produced with stakeholders in 2023/24) to plan, deliver and reflect on engagement activity.

There are five areas of the tool, and within each of the five areas, there are three levels. Users of the tool are invited to consider each of the five areas, and reflect on their starting point, to build good practice in all interactions with local communities.

Understanding power	Achieve meaningful relationships with the community.
	Build trust.
	Develop and share the importance of an accurate and deep understanding of community experiences, needs, ideas and ambitions.
Enable social action	So that change can be led by the community.
	To explore what people want to talk about, change and influence.
	To understand how people want to do this.
Building a picture of community experiences, needs, ideas and ambitions	So that accurate and deep community led insights can be understood and shared.
Connecting community and JUCD	So that community led insights can shape solutions and services.
Making a difference together	To address health inequalities.
	To improve services and health outcomes.
	By translating community-led insight into action.

2. Evidence: examples of insight influencing commissioning and service improvement

2.1 Barrow Hill Community Memorial Hall Health Hub

What this was about: Barrow Hill (near Chesterfield) is an ex-mining village with high levels of deprivation and long-standing inequality in access to services. Partners are supporting the Community Trust to develop a Health Hub in the Memorial Hall (phase 1 is due to open in spring).

Who we spoke to: the Barrow Hill Community Trust, local residents, and health and social care partners working together through the Integrated Neighbourhood Team.

How we listened: we used local interviews and 'deep dive' conversations and kept the conversation going through fortnightly neighbourhood working so plans stayed led by local insight.

What people told us: people want services that are easy to access, in a space that feels welcoming and non-judgemental. They value informal connection and support, want the Hub to stay community-led, and want a mix of private consultation rooms and open community space.

What we changed: the Hub plans are being shaped around what local people said mattered right down to the balance of spaces and the 'feel' of how services show up (for example, trauma-informed and health-literacy aware). Partners are also planning events so residents can explore the building and meet providers early, not after decisions are made.

How this influenced commissioning: the insight is helping shape decisions about the mix of clinical and community space, what we expect from providers using the Hub, and how we align capacity at the community service interface so neighbourhood working stays community-led and sustainable.

How we know: documented themes from interviews and deep dives, regular neighbourhood meetings, and agreed engagement principles for the Hub with local partners.

What's next: we will continue work with partners, keep neighbourhood working going, and be clear in capturing the specific decisions made as a direct result of what we heard.

2.2 Community Health Alliance: sickle cell newborn screening incident response and co-production

What this was about: after an NHS England Midlands review, we learned that some families may not have been told about carrier status following newborn bloodspot screening. This was linked to the loss of a specialist role and unclear responsibility for communication. Even when the clinical issue was addressed, the impact on trust was significant, and it needed both immediate response and longer-term improvement work.

Who we spoke to: parents/carers and affected communities (including Black African and Caribbean communities), community leaders, and NHS partners including University Hospitals of Derby and Burton (UHDB) and system communications/engagement colleagues.

How we listened: community events in Derby city and Chesterfield (originally set up to explain the new service) became honest listening sessions. We then stayed with the work running further sessions over around 10 months and held co-production sessions with community leaders to agree aims, principles and governance.

What people told us: there was real frustration about not being involved and not being communicated with clearly. People wanted to help shape the new advice and guidance service, wanted improvements to sickle cell services more broadly, and wanted a long-term way to influence and co-produce services with the NHS (not just a one-off conversation).

What we changed: we set up an ongoing programme of engagement and co-production, including the Community Health Alliance (community leaders, members of the public and the NHS) and support to establish a sickle cell patient group. We also shared themes and recommendations with the Trust, and improvements are being taken forward.

How this influenced commissioning: this work created clearer routes for community insight to influence how the service is communicated and experienced and put governance in place so lived experience can continue to shape provider and commissioning decisions over time.

How we know: a themes and recommendations report, an online video explaining the service and safeguards, co-produced aims, principles and governance for the Alliance, and the establishment of a patient group.

What's next: we will support further community-led engagement to agree priorities for the Alliance, with clear routes into commissioning and provider governance, and we will track actions and report back on progress.

More information about the Community Health Alliance can be found on our [Involvement Platform](#).

Information about the sickle cell newborn screening incident can be found on our [website](#) including full reports regarding the activities, process and outcomes to date.

2.3 Local Navigation Hubs: using patient and carer stories to evidence value and improve pathways

What this was about: Home Visiting Teams help people to live well at home for longer. Teams told us that it can be hard to explain (and evidence) the value of integrated working in a way that lands in system decision-making.

Who we spoke to: teams in South Derbyshire and High Peak, patients and carers (through quotes and stories), and system partners in the forums where decisions and priorities are discussed.

How we listened: we created safe spaces for structured storytelling, using reflection and learning approaches (Gibbs' Reflective Model and Kolb's Experiential Learning Cycle) and public narrative principles to help teams draw out what changed for people and what could be measured.

What people told us: there was a real appetite for clearer, more human evidence of what integrated neighbourhood working achieves for patients, carers and system capacity, alongside the 'hard' data.

What we changed: teams reworked their stories, so they clearly showed value, backed up with patient and carer quotes. We then took those stories into system spaces, for example, steering groups, neighbourhood teams and Quest sessions, which helped partners spot pathway gaps and improvement opportunities.

How this influenced commissioning: the stories have been used in decision-making spaces to highlight pathway gaps, for example, getting information to carers earlier, to prompt service improvement actions, and to strengthen the case for sustaining local integrated care models.

How we know: written stories that include patient/carers quotes, use of stories in system forums, and the improvement actions identified from them, including earlier information for carers and families.

What's next: we will run a county-wide learning event to share the storytelling approach and make it easier to capture value and track improvement actions in a consistent way.

2.4 Community partnership to address maternity and neonatal health inequalities

What this was about: maternity and neonatal outcomes are not experienced equally across Derby and Derbyshire. Evidence shows poorer outcomes and more negative care experiences for women and babies from Black, Asian and Mixed ethnic backgrounds, and for those living in the most deprived communities. Existing feedback routes have not consistently captured these experiences or enabled them to shape decisions.

Who we spoke to: women from Black, Asian and Mixed ethnic communities and women living in the most deprived areas, alongside partners including Derby Health Inequalities Partnership, Derby City Council and Family Hubs, UHDB, Voluntary, Community and Social Enterprise (VCSE) organisations, community leaders and connectors, and Derbyshire Maternity and Neonatal Voices (DMNV).

How we listened: engagement was community-led and took place in trusted, familiar spaces, using flexible approaches shaped by each community. Community leads were offered training and ethical guidance, with support in place for sensitive conversations and appropriate signposting when needed. This enabled honest discussion and reduced barriers to participation.

What people told us: women shared what mattered most to them across pregnancy, birth and postnatal care, including barriers to accessing services and information, communication needs (language, culture and trust), and experiences of Family Hubs, antenatal settings and maternity spaces. As a partnership we understood that engagement needs to be long term and trusted, and visibly influence decisions, not sit alongside them.

What we changed: we supported the development of a Maternity and Neonatal Health Inequalities Forum – a co-produced partnership bringing communities, commissioners, providers and local authorities together as equal partners. Community insight from this engagement will directly inform the Forum's purpose, priorities and emerging work programme.

How this influenced commissioning: the Forum provides a clear, formal route for lived experience of inequality to inform commissioning, service development and improvement work, aligned with system and national priorities. It strengthens accountability by ensuring communities most affected by inequality are supported to be meaningfully involved and that insight shapes decisions, rather than being only advisory. Commissioners and providers are jointly responsible for responding to what is heard.

How we know: impact is evidenced through community-led engagement activity, the design and function of the Forum, and early learning about what supports effectiveness – including consistent relationships, clarity about what can be influenced, shared ownership, and visible action with feedback to communities.

What's next: we will agree measures for reach, involvement and representativeness, track actions through the Forum and governance structures, and ensure communities can see clear progress and the changes being made as a result of their involvement.

Supporting information for the engagement can be found on our [website](#) including the full case for change information and Insight Report.

2.5 Women's Health Hub engagement: turning women's voices into system change

What this was about: we wanted women's voices to shape improvements to women's health services across Derby and Derbyshire.

Who we spoke to: women across Derby and Derbyshire, supported by a Patient and Public Partner who helped co-design the work from the outset. We spoke to around 1700 women, 744 from a local survey and just under 1000 from community engagement events from 39 community groups who ran workshops. The final report was developed into an action plan by the Inclusivity Group, spanning commissioning, public health, patient and public partners, and primary care.

How we listened: a mix of survey and community-led workshops in trusted settings. We funded, trained and supported community groups to lead sessions so we could reduce barriers and reach a wide range of women (including South Asian, Black, Eastern European and refugee communities, LGBTQ+ women, disabled and neurodivergent women, younger women, and women experiencing deprivation).

How we know (reach): we reached 1,730+ women in total (744 survey responses and 986 women taking part in community-led workshops).

What people told us: key themes included access to services, experiences of care, health literacy, barriers to screening and vaccination, and culturally specific needs. A strong message was the importance of primary care reflecting how often women's experiences start (and sometimes stall) in GP and community services.

What we changed: we held feedback events so women and community groups could see what we heard, and we reflected on the findings with community leads and the Patient and Public Partner. The Inclusivity Group then co-produced an action plan and practical outputs to support implementation and improvement.

A Patient Representative who was involved throughout the project said: "This was some of the best community engagement I've ever seen. It wasn't superficial or extractive, it was rooted in connection, respect, listening, and action. The richness and diversity of voices ensured the findings were grounded in truth, rather than assumption. The contributions of lived experience and community partners had a direct and visible impact on project outcomes. My hope is that this project sets the standard for how engagement should be done – with integrity, humility, and a deep commitment to inclusion."

How this influenced commissioning: the insight shaped the overall development approach for Women's Health improvements across the system, such as staff training, and also turned into practical commissioning outputs to support implementation, including a Primary Care Focus Report, a Primary Care Inclusivity Checklist, and an Inclusivity Resource Pack. Work is also underway on a "Talking Heads" video, which will share the experiences of women as a training tool for professionals based on what women have told us.

How we reported back: we used community feedback events and an impact report to show how women's contributions influenced and shaped decisions, actions and changes. One participant said: "For the first time, it feels like what we're saying might actually change something. Not just for me, but for other women too."

What's next: we will keep supporting implementation using the co-produced outputs, track delivery of the action plan and keep the feedback loop going so women can see what is changing.

You can read all about the engagement and view the reports on our [website](#).

2.6 Carers Insight

Case study: Building a carers insight framework to support system working

At a glance: The ICB brought together national and local evidence and lived experience to create a shared, system-wide picture of what unpaid carers need now, and to provide a consistent evidence base to inform commissioning, service improvement and integrated care planning.

The challenge: Unpaid carers are essential to the sustainability of health and social care, yet many carers remain under-identified, struggle to navigate fragmented pathways, and experience avoidable inequalities (including employment and financial strain, poorer mental and physical health, and barriers linked to language and culture). Locally, evidence also showed inconsistent carer recognition and variable access to carer assessments and support.

Why the ICB did the work:

- To treat caring as a key driver of population health and health inequalities, and to ensure carers are visible within local population health management approaches.
- To create a single, trusted evidence base that could be used consistently across NHS, local authority and VCSE partners.
- To respond to clear signals from carers and local insight that recognition, communication, respite/planning and navigation of systems remained persistent issues (and, in some areas, were worsening).
- To support delivery of statutory duties and good practice expectations (including proactively identifying carers, involving carers in decisions, and enabling access to assessment and support).

What the ICB did:

- Used the 2019 *What Carers Want* summary as a practical framework and “sense-check” against more recent evidence and lived experience.
- Triangulated national research, local population data and local lived-experience insight (listening events, consultations and survey findings) to identify what has stayed the same and what has changed.
- Brought through specific “pressure points” where system processes directly affect carers (for example, early identification, access to information, care planning and discharge, assessment pathways, and contingency planning).
- Made the insight usable for decision-making by grouping it into clear themes and highlighting implications for commissioning and service improvement.

Why this was important: The work strengthened the case for early, proactive support for carers as both a health inequalities issue and a system sustainability issue. Nationally, carers are providing care worth around £184 billion per year, equivalent to the scale of a second NHS, while many experience worsening health and reduced ability to stay in work. Locally, the insight showed that carers can be positive about the care their loved one receives but still miss out on carer identification and support, particularly those providing higher hours of care.

What it highlighted: Core needs have remained consistent since 2019 (recognition, involvement, clear information and support to navigate the system), but the context has become more urgent due to economic pressures and rising care intensity.

- Carer identification is a recurring system weakness – many people do not use the word “carer”, and this can be a barrier to accessing help.
- Carers’ mental health and wellbeing need to be treated as a core offer, not an add-on, especially for carers providing higher hours of care.
- Employment and finances are major drivers of inequality for carers, with clear links to stress, reduced income and future insecurity.
- Carers from ethnic minority communities can face additional barriers (including language, mistrust and cultural expectations), reinforcing the need for culturally competent approaches and community-based engagement.
- Carers experience the system most sharply at transition points (diagnosis, hospital discharge, crisis, and moving from children’s to adult services), where consistent communication and contingency planning are essential.

How the insight is intended to be used (decision-making):

- To underpin the new System Carers Strategy.
- To prioritise system actions that improve early identification (including language and prompts that reflect how people describe caring).
- To inform commissioning and service development (for example, access routes, respite and breaks, peer support, culturally appropriate offers, and improved signposting).

- To strengthen integrated working expectations (information sharing, “no wrong door” approaches, and consistent practice across organisations).
- To provide a baseline for tracking change over time (including future surveys and insight refreshes) and to support ‘You said, we did’ feedback loops with carers.

In addition to the evidence presented above to demonstrate how insight has influenced commissioning and service improvement, we also have further insight that can be viewed on our Insight Library.

The [Patient and Public Insight Library](#) is a hub for collating and storing reports from across the Derbyshire health, care, statutory and voluntary organisations, as well as some national reports, which provide invaluable patient and public insight. The library is open to a wide variety of professionals from across the system who access these reports and use the insight to help shape services to the needs of the people of Derby and Derbyshire.

New reports are being uploaded to the library on a regular basis. We feature regular updates about the content on the library in our JUCD Newsletter, which is published monthly and is sent directly to 4000+ subscribers, including members of the public and stakeholder organisations across Derby and Derbyshire.

Our template for the library has been adopted and used by Integrated Care Boards (ICBs) across England.

The library is held on the Futures NHS Platform, so if you are already a member you can [access the library](#).

3. Governance and assurance routes

The ICB's commitment to embed the voice of people and communities in commissioning and service change is reflected in our governance. These structures provide routes for engagement insight to be considered alongside clinical, quality, finance and equality information when options are developed and decisions are made.

Below are 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 Derby and Derbyshire system. Progress on the delivery of the [Working with People and Communities strategy](#) is formally reported to the ICB Board through the Joint Strategic Commissioning Committee (JSCC). Prior to the establishment of the ICB cluster, progress was reported to the NHS Derby and Derbyshire Strategic Commissioning Committee.

1 April 2025 to 30 September 2025

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 Commissioning Committee	The Strategic Commissioning Committee is responsible for assuring the ICB Board in regard to its statutory duties for patient and public involvement. This is explicit within its Terms of Reference.
Chief People Officer	The Chief People Officer has executive responsibility for sponsoring the ongoing development and implementation of the Working with People and Communities Strategy. They also oversee the teams that support the organisation in its duties and ambitions to work with and hear from people and communities.

1 October 2025 to 31 March 2026

Governance arrangements and board sub-committees were adjusted in year to reflect the move towards cluster working for NHS Derby and Derbyshire ICB, alongside NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB.

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.
Joint Strategic Commissioning Committee	The Joint Strategic Commissioning Committee is responsible for assuring the ICB Board in regard to its statutory duties for patient and public involvement.
Executive Director of Strategy and Citizen Experience	The Executive Directors of Strategy and Citizen Experience, and Quality (Nursing) 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.
Executive Director of Quality (Nursing)	

Throughout this period of transition, the [Working With People and Communities Strategy](#) continued to be governed and applied through use of established frameworks, which ensured appropriate levels of patient and public involvement in commissioning activity. These frameworks are:

[Governance Framework](#)
[Engagement Framework](#)
[Insight Framework](#)
[Co-Production Framework](#)
[Evaluation Framework](#)

Patient and Public Involvement Assessment Process

During 2025, 49 potential service changes were assessed through our involvement assessment process. This helps determine the likely impact on patients and the public, the level and type of involvement required, and the appropriate assurance route (including where formal consultation may be needed).

All assessments are logged and shared with local Health Overview and Scrutiny Committees (HOSCs), who can ask questions or request further information about changes of interest or concern.

Our suite of guidance

We have been developing this guidance for a number of years. This comprehensive set of guidance is available to all our commissioner and provider colleagues working within JUCD to help people to navigate the common legal and policy issues from the very start of a service change programme through to the final decision-making. Links through to all our guidance can be found below and outline the systematic way in which we ensure patient and public involvement is factored into all decisions that might have an impact. This year we have added NHSE Assurance Guidance, Clinical Senate Guidance, and Notifying and Requesting a Call-In by the Secretary of State Guidance to highlight the new requirement to notify the Secretary of State of significant changes to health services.

- [Guide to working with people and communities / Engagement Model](#)
- [PPI Guidance](#)
- [PPI Form](#)
- [HOSC Guidance](#)
- [Case for Change Guidance](#)

- [Inform Guidance](#)
- [Primary Care PPI Guidance](#)
- [Temporary Service Change Guidance](#)
- [Notifying and Requesting a Call-In by the of Secretary State](#)
- [NHSE Assurance Guidance](#)
- [Clinical Senate Guidance](#)

3.1 Evidence: example of implementing our guidance

Case study: demonstrating how the ICB has engaged and listened on same day urgent care in Derbyshire

Case study aim: to show how NHS Derby and Derbyshire Integrated Care Board (DDICB) has engaged and listened to people and partners during the early discovery phase of the Community Same Day Urgent Care (CSDUC) programme, and how what was heard is shaping the programme's direction.

Context: the CSDUC programme sits within a wider urgent and same-day care review across Derby and Derbyshire, focused on how urgent treatment centres, primary care, out-of-hours services, community urgent response and navigation pathways work together and how they are experienced by patients. The programme has been designed as a phased, longer-term piece of work, with early phases focused on listening, understanding local context, reviewing data and building shared understanding before any formal proposals are developed.

What we did to engage and listen: we used a mix of public-facing and partner engagement to test the emerging case for change, understand what matters to people, and surface access and inclusion issues.

- **Publishing the CSDUC Case for Change** and a public-facing summary to provide a clear narrative and accessible information to support early dialogue.
- **Holding an online Public Information Session (May 2025)** positioned explicitly as an early information-sharing and listening event.
- **Ongoing system and stakeholder engagement** through existing structures with primary care, community, acute and voluntary sector partners.
- **Early place and neighbourhood-level discovery conversations** in South Derbyshire, North East Derbyshire and Bolsover, and Amber Valley to explore local context, feasibility, workforce and estates considerations, and the shape of future engagement.

Who we heard from: the May 2025 Public Information Session was attended by around 70 people, including members of the public, healthcare professionals and community representatives from across Derby and Derbyshire, with the highest representation from Amber Valley, South Derbyshire and Derby city, and contributions from rural and border areas. In parallel, programme teams have engaged through existing system structures with primary care, community, acute and voluntary sector partners, and through Primary Care Network (PCN), Neighbourhood Alliance and Place-level conversations in priority areas.

What people told us (what we heard): across engagement to date, people consistently highlighted:

- **Confusion about where to go** for urgent care and concerns about being directed to the wrong service.
- **Access and waiting times** including difficulty accessing GP appointments, limited weekend/out-of-hours options, and long waits in some urgent care settings.
- **Transport and travel barriers** including poor public transport, parking issues and long journeys, particularly affecting older people, disabled residents and those in rural/border areas.
- **Digital exclusion and communication needs** including barriers for people who are digitally excluded, deaf or hard of hearing, or who face language barriers, and a need for clearer public information.

- **Workforce and capacity concerns** about staffing levels and whether services can meet rising demand.
- **Service integration and navigation** including clearer referral pathways, better coordination between services (including VCSE support) and clarity on what different parts of the system provide.
- **Equity and inclusion** including concern that pockets of deprivation, people with complex needs and communities near county borders risk being overlooked.

Equality, access and inclusion: engagement has reinforced that future work must actively consider digital exclusion, transport barriers and the needs of people whose voices are often under-represented, including people with disabilities, mental health needs, learning disabilities, carers and those facing language barriers. This will shape the design of future engagement plans, including the use of face-to-face approaches where appropriate and close working with VCSE partners and local participation groups.

Current position and next steps: the programme remains in early engagement and discovery – no formal service change proposals are currently being engaged on.

You can [view the case for change](#) on our website.

4. Involvement infrastructure

The ICB has a range of methods and tools to support the involvement of people and communities in work to improve, change and transform the delivery of our health and care provision. These include:

- **Patient and Public Partners (PPPs)** – our [JUCD webpage](#) details how patients and public partners can get involved and includes a [full suite of guidance](#), co-produced with current patient and public partners within the ICB, via the Peer Support Network for patient and public partner recruitment.

In addition, we have developed a range of [learning and development resources](#) to support both PPPs and the staff who work with them. For PPPs, these resources aim to build confidence, understanding, and practical skills to support them in their role. For staff, they are designed to support meaningful partnership working and good practice in involving people and communities throughout programmes and service change.

- **[JUCD Involvement](#)** – our online engagement platform, designed to facilitate two-way dialogue with residents, and support participation and updates.
- **[Readers' Panel](#)** – volunteers made up of members of the public and healthcare professionals have been instrumental in ensuring the information we share with the public, on projects such as Winter Vaccines and Specialist Advice, is easy to read and understand, and contains all the information patients may need.
- **[Patient Participation Group network](#)** – this was created to represent the patient population of General Practices in Derby and Derbyshire. The PPG Network meets bi-monthly. You can find out more about PPGs by visiting the [JUCD website](#) or by contacting your practice.

In addition, we have created an [online shared space for members of the Derbyshire PPG Network](#). This space will host agendas, resources and updates from network meetings, as well as a discussion board where members can connect, share learning, and suggest ideas for future sessions. It also includes templates and resources developed or shared by PPG members and the ICB Engagement Team, supporting ongoing learning, collaboration and consistency across PPGs.

- **Derbyshire Dialogue** – a conversation between the residents of Derby and Derbyshire, and those commissioning and providing services. Derbyshire Dialogue is delivered by senior clinicians, or officers in their field, and allows participants to ask questions during the session. Recent subjects have been diverse and have included Improving Women's Health and Building a Carer-Friendly Derby and Derbyshire, and are recorded and uploaded to our [Engagement Platform](#) and to our [YouTube channel](#).
- **Mental Health Together** – 35 volunteer Experts by Experience who bring insights from lived experience of mental health services. The group provides ongoing input into service improvement and has supported system work, including reviewing and challenging service design proposals where lived experience indicates potential unintended impacts. Experts sit in Derbyshire ICB mental health governance groups where they provide the vital patient lens and educate the professionals about minority community concerns. Over this past year, Mental Health Together has grown significantly in numbers of Experts and has collaborated with several professional leads across the system. Amongst their achievements have been:
 - Coproduced with Consultant Psychiatrists a new out-patient leaflet which is supported by the Department of Psychiatry at Oxford University. The aim of this is to empower much more open, honest and effective conversations between patient and psychiatrist.
 - Codesigned the Suicide Prevention Framework for Derbyshire 2026–30.
 - Helped shape an urgent and emergency mental health review carried out by NHSE Improvement team.
 - Coproduced the mandatory risk assessment staff training for Derbyshire Healthcare Foundation Trust.
 - Produced a '[Pearls of Wisdom](#)' brochure, highlighting the value of the voice of lived experience for World Mental Health Day.

Read a [review of Mental Health Together's last 12 months](#).

Case study: Experts by Experience in Action – NHS 111 (mental health option)

Background: NHS 111 includes a mental health route (“option 2”), available 24/7 for all ages. People can use it for urgent mental health concerns for themselves or someone they know. Calls are transferred to a dedicated member of a local mental health team.

Challenge / issue raised: Mental Health Together (MHT) Experts by Experience raised two issues via the Urgent Mental Health Care Delivery Group, which were agreed for escalation to the NHSE Midlands 111 option 2 Forum.

Insight from lived experience (parity and access): Experts by Experience highlighted that the recorded message (“...if your call is about your physical health press 1, if you are in mental health crisis press 2...”) can be interpreted as discouraging people who need mental health information or advice but do not identify as being “in crisis” (for example, self-care advice, support for carers, or condition-related information). This creates a perceived lack of parity between access to mental health advice and physical health advice and may lead people to misrepresent their needs in order to reach support.

Why it matters: access to timely health information and improved health literacy can help people manage their health, support self-care, and potentially prevent deterioration. A message that appears to restrict access to broader mental health advice may represent an inequality and a missed opportunity for early support and crisis avoidance. The current wording is likely to be experienced as an additional barrier by many people especially people who are autistic and people from minority backgrounds where there is still a very strong stigma attached to mental health.

Proposed change: replace the wording with “...if your call is about your physical health press 1, if your call is about your mental health press 2...”, so people can access mental health information and support as well as crisis response – without the message being interpreted as filtering out non-crisis mental health calls.

Implementation considerations (process design): any change to the recorded message would require review of the end-to-end call handling process flow. Prior to launch, the NHSE Midlands 111 option 2 Forum completed extensive process design for regional call handling and transfer to local call centres; this would need to be revisited.

Implementation considerations (demand and variation): a broader message could change call volumes and the mix of call types. ICBs vary in how they respond to callers seeking information who are not in a self-defined crisis. The NHSE Midlands 111 option 2 Forum is running a snapshot survey of these variations and estimated call rates. However, the Forum also noted national intent to implement Natural Language Processing for call handling, which may have similar implications regardless of interim wording changes.

Additional insight (call waiting music)

Experts by Experience reported that some call waiting music can be stressful for callers with a propensity to hear voices, where sounds may be interpreted as human voices (sometimes discussed as Musical Ear Syndrome or pareidolia). The recommendation is to review the library of music used for NHS 111 waiting, involving people with lived experience in the selection to minimise potential distress and demonstrate genuine co-authorship of the service experience.

Next steps

The NHSE Midlands 111 option 2 Forum will share the issues and recommended modifications with the NHSE national team to inform ongoing review and improvement of NHS 111 call handling, including future implementation of Natural Language Processing. The Forum has also requested attendance of national NHSE colleagues at a Midlands Forum meeting.

Working together with Experts should be part of everything we do. Their input helps us stay focussed on what local people really need. I'm very thankful for their support and excited to keep working with the.

A big thank you also to Mental Health Together for helping our Experts to make a real difference across Derby and Derbyshire. Having experts in the room has been the best thing that ever happened to these strategic groups.

Jenny Appleby Head of Adult Mental Health Commissioning (DDICB)

Conclusion

Our approach to working with people and communities, our governance arrangements and our involvement infrastructure will continue to provide consistent and authentic routes for the involvement of people in the coming year, supporting a range of people to contribute, in a range of different ways. Providing assurance and accountability that we will keep listening, learning and reporting on what we hear and how it has influenced decisions, so that involvement remains meaningful and results in better experiences, better outcomes and improved wellbeing for the population of Derby and Derbyshire.

People and Communities Involvement Report 2025/26 April 2026



Lincolnshire
Integrated Care Board



Foreword

Welcome to the **2025/26 Annual People and Communities Involvement Report** for the Lincolnshire Integrated Care Board (ICB).

This report brings together the wide range of ways we have listened to, learned from, and worked alongside people and communities across Lincolnshire over the past year. It highlights the real impact that lived experience, insight and feedback have had on shaping how health and care services are designed and delivered.

At the heart of our approach is a simple but powerful belief: **services work best when they are shaped by the people who use them**. By actively involving patients, carers, voluntary and community organisations, and the wider public, we can design services that are more responsive, inclusive and better aligned with local needs.

Throughout this report, we showcase the depth and breadth of our involvement activity and, importantly, the difference it has made. From influencing service redesign to improving access, experience and outcomes, the voices of people and communities have played a vital role in informing decisions and driving improvement.

We invite you to explore the report and see how feedback has shaped projects, challenged established ways of working, and helped us move closer to a health and care system that genuinely values partnership, compassion and collaboration.

Thank you to everyone who gave their time, shared their experiences and helped shape our work.

NHS Lincolnshire ICB Engagement Team

Introduction

This report shows how engagement has influenced decisions and improvements and how we - the NHS Lincolnshire Integrated Care Board (ICB) - has met our statutory duties for involvement and how we are delivering our [Lincolnshire People and Communities Strategy](#)

The NHS Constitution is clear that patients and the public should be at the heart of everything the NHS does. This annual People and Communities Involvement report explains how we have fulfilled our duty to involve the public and outlines how we work with people and communities to involve them in our decision making.

When we refer to 'Our People and Communities in Lincolnshire', we mean:

- residents
- people who access care and support (and those who do not)
- unpaid carers
- families
- staff
- stakeholders
- partner organisations
- community champions and leaders

About this document

Throughout this report, you will find examples of the engagement and involvement activities carried out during 2025/26.

The report explains why the ICB engages with people and communities and highlights the positive impact this involvement has had on services and local communities across Lincolnshire. By sharing these activities, we aim to show the real differences engagement has made, informed by lived experience and local insight.

The focus of the report is our involvement activity and the impact it has had. But before that, we also provide further information about the NHS Lincolnshire ICB, how we work collaboratively across the system, and how we meet our statutory duty to involve people and communities.

Contents	
Foreword and introduction	
About this document	
Why we involve people and communities	
Our governance	
Working with others	
Using insight and data; reaching diverse groups	
How the ICB listens and involves our people and communities	
Showcasing our involvement activities: Examples of activity and best practice	
• Wider population projects and activities	
• Involving people within Primary Care	
• Involving Health Inclusion Groups	
• Community Development	
• Current involvement projects	
Conclusion	

Why we involve people and communities

The ICB is dedicated to making sure patients, the public, partners, and key stakeholders are fully involved in shaping our services. Their experiences and insights sit at the heart of everything we do.

We believe that strong partnerships are essential to giving people greater choice and control over their health. Working together helps us better understand the needs of our population, what our communities need to live well and improve health outcomes.

We are committed to building stronger relationships with residents, communities, and representative groups, ensuring they have a powerful voice and the confidence to shape decisions. We will continue to strengthen our approach to engagement, making it easier for people to share their views and ensuring our work reflects and responds to the diverse needs of our communities.

- The NHS Lincolnshire ICB Constitution sets out the legal duties and principles we will adhere to when developing and maintaining arrangements for public involvement
- Our People and Communities Strategy demonstrates how we will deliver our duties to understand and empower our communities
- Listening to the patient and members of public that use our services help us understand the needs of the communities that we serve
- By giving local people and partners a voice, we can make sure that the services meets the needs of the local community
- The Integrated Care Board has a legal duty to involve patients and the public in decision making and service development.
- There are clear standards for public engagement to shape decisions, monitor quality and to set priorities

Involvement can be in different ways:



Our legal duty to involve

Under section 14Z45 of the Health and Care Act 2022, the Integrated Care Board (ICB) has a legal duty to involve the public in:

- the planning of commissioned services
- the development and consideration of proposals for changes to commissioning arrangements that may affect service delivery
- decisions that impact how services are provided

The ICB has met these responsibilities by making sure local people are genuinely involved in shaping the services we plan and any changes that may affect how those services are delivered.

By listening closely to our communities and working alongside the groups and individuals who represent them, we make better, more grounded decisions that reflect the real needs of people living in Lincolnshire.

We are committed to continually strengthening how we involve our communities. Every piece of feedback matters to us, and we want people to feel confident that their voices make a difference. It is important that residents can clearly see how their ideas, concerns, and lived experiences help shape local services and influence the choices we make together.

Our approach is rooted in the values set out in our constitution and guided by the principles in our People and Communities Strategy. These values shape how we work with individuals, neighbourhoods, partner organisations, and patient representatives, helping us build stronger relationships and create more meaningful opportunities for people to get involved. Through this shared effort, we aim to keep improving how we listen, respond, and work in partnership with the communities we serve.



To see our other legal duties and responsibilities:

[Click here to see Lincolnshire ICB constitution](#)



[Click here to see public sector equality duty](#)



[Click here to see Health and Care Act 2022](#)



[Click here to see Health Act 2006 **](#)



**** Health Act 2006 covers:**

- Duties as to reducing health inequalities – s.14Z34 NHS Act 2006
- Annual reporting – s.14Z58 NHS Act 2006
- Duty to promote involvement of each patient – s.14Z36 NHS Act 2006

Governance and assurance

Timely, meaningful involvement is a key priority for us, and we want our communities to feel genuinely connected to the decisions that shape local services. A clear framework helps us do this well, but at the heart of it is our commitment to making sure people's voices guide our work.

Insights from our engagement work, including what we hear from different equality and health inequality groups, are shared with project and programme leads. This helps shape their work and ensures that those designing and improving services are hearing directly from the people affected. **See diagram opposite.**

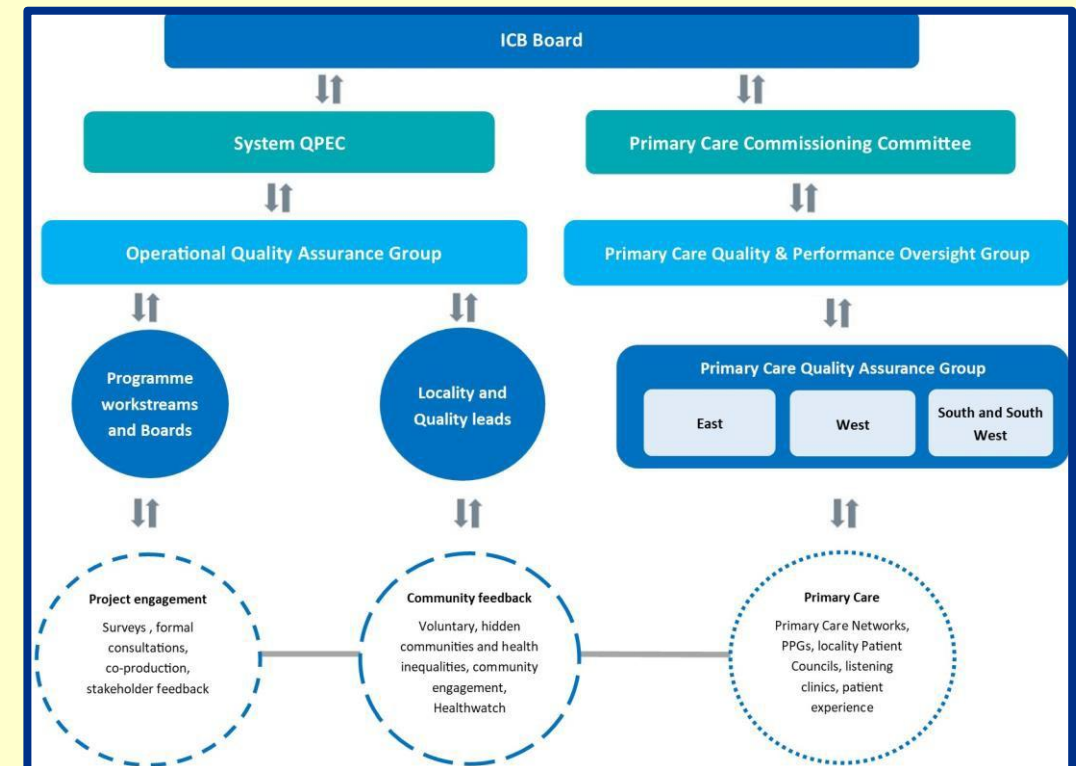
Updates on our involvement activity and the impact of this are taken to the ICB Operational Quality Assurance Group, with escalation prior to clustering to the System Quality and Patient Experience Committee or the Primary Care Commissioning Committee if it is regarding a primary care service.

Feedback from engagement and consultation activity is shared with our Board so that community voices directly inform decisions on major projects.

During December 2025, an audit of the ICB engagement and Involvement function was undertaken with assurance provided in all aspects including governance and reporting. The only improvements required were updates to terms of reference dates for meetings where engagement was represented.

In 2024/25 we developed the Lincolnshire Voices report, presented to the System Quality and Patient Experience Committee. This continues to strengthen and brings together feedback and insight from across the ICB, provider trusts, Healthwatch, and partner organisations. It provides a triangulated, consistent view of what people are telling us and highlights key areas for the system to focus on. This continues to evolve and now includes details of complaints and patient experience feedback to give a rounded picture of what we are hearing across Lincolnshire.

How we report and listen to the feedback we've heard:



Working with partner organisations

Lincolnshire has a long tradition of working together across the Local Authority, the NHS, and many community partners. These relationships have been built over years of shared effort, all with one purpose in mind: helping people across Lincolnshire live healthier, happier lives.

The ICB values the trusted connections our partners already hold with local people, and we see collaboration as the most powerful way to reach communities, listen to their experiences, and involve them in shaping services that truly reflect their needs.

Working together means we can connect with a wider range of people, in ways that feel familiar and comfortable to them, often through individuals and organisations they already know and trust.



Our strong partnerships with voluntary, community, and social enterprise organisations also mean we can commission them to lead conversations on our behalf, using their deep local knowledge to reach communities we might not otherwise reach.

At a local level, we continue to strengthen our relationships with community groups and support organisations.

We work with warm spaces, foodbanks, and local venues, as well as with trusted individuals such as Islamic leaders, social prescribers, and community connectors.

These partners help us reach people whose voices might otherwise go unheard, offering insight and connections that are invaluable to our work.

These partners bring valuable experience and established relationships, helping us to reach people and communities we might not otherwise be able to engage with.

Our partners in ICB governance

Healthwatch are key partners and play a vital role as an independent view of the voice for patients and the public. They act as a critical friend and are active members of the ICB Board, the ICP Board, and several committees.

We work closely with the **Health Overview Committee** when service changes are being considered, enabling agreement of substantial and significant service changes requiring formal consultation. This helps ensure that any proposals reflect the needs and aspirations of local communities and that people have fair and equal access to services.



Public Health and Local Authority colleagues sit alongside us at every formal ICB Board meeting, strengthening our shared understanding of local needs.

The **Voluntary and Community Sector** is represented at Board level too, ensuring community perspectives are embedded in our decision-making.

Our **provider and primary care** partners are part of our extended team and central to shaping and delivering our shared priorities, bringing frontline insight into every discussion.

Joined up working across Lincolnshire

We have established a **Lincolnshire Engagement Leads Steering Group** with representatives from our District and County Councils, LVET (Lincolnshire Voluntary Engagement Team), Healthwatch, University of Lincolnshire, Research Hub, Personalisation and Health Inequalities Teams.

This group meets monthly to scope joint working opportunities, reduce duplication, share best practice, support each other's engagement and involvement projects and identify opportunities for collaboration such as development of a master stakeholder analysis tool and process flowchart.

The Lincolnshire Co-production Conversation Group (LCCG)



This group brings together colleagues from across the ICS (NHS, LCC, VCFSE) and people with lived experience with a shared passion for co-production. Work continues in this group to develop a co – production guiding framework and set of principles which is accessible and meaningful to all.

Healthwatch Lincolnshire Liaison meetings

Regular meetings have been established to plan and agree future work programmes across the Lincolnshire system. This will support alignment of engagement activities and reduce duplication, enabling targeted Healthwatch support for key programmes of work.

Insight and data

People access services differently, have varied health needs, and prefer different ways of sharing their views. Because of this, we base all our commissioning and involvement work on a deep understanding of our population, their lived experiences, and the people and organisations who support them.

We support our programme teams to ensure that **Equality Impact Assessments, Quality Impact Assessments, and Health Inequality Impact Assessments (HEAT)** are carried out. These assessments help us understand who may be affected by changes and ensure that the voices of people who experience the greatest inequalities are heard and acted upon. Their insights are essential in helping us tackle the challenges faced by our health and care system.

Population Health Management (PHM) uses historical and current data about people's health and how they are using health and care services to design new proactive models of care which will improve health and wellbeing today as well as in 20 years' time.

Our **Insight Database** brings together what we hear from involvement activities across the NHS and our partner organisations. This shared directory of feedback gives us a strong foundation for planning, decision-making, and shaping future involvement. We are continuing to explore how to make the most of this rich insight and are working closely with partners towards a shared platform where feedback and insight can be brought together in one place, strengthening our collective understanding of what matters most to people in Lincolnshire.

Healthwatch Lincolnshire provides the ICB a monthly report of the information and insight that has gathered by Healthwatch through engaging with individuals and communities. This information is widely circulated within the ICB and shared with colleagues in primary care.

Feedback is used to monitor quality of services and helps address any issues with the quality of primary care medical services. The ICB has carried out listening clinics and discussed with practices.

[Click here to visit the LHIH website](#)



Reaching diverse, potentially excluded and disadvantaged groups

We recognise that Lincolnshire is made up of many different communities, each with its own diverse needs, challenges, and ways of engaging.

People access services differently, have varied health needs, and prefer different ways of sharing their views. Because of this, we base all our commissioning and involvement work on a deep understanding of our population, their lived experiences, and the people and organisations who support them.

Our Involvement Team includes a dedicated lead focused on engaging those experiencing health inequalities and making sure people and communities across Lincolnshire feel confident, supported, and able to take part in every aspect of our work.

This people-centred approach is being woven through all our priorities and programmes so that tackling health inequalities always starts with listening to those most affected. We have also refreshed our equality and health inequality survey questions so we can better understand who is engaging with us and, just as importantly, who we still need to reach.



To strengthen our digital engagement, we are expanding our database of over 10,000 individuals, groups, and communities. This helps us connect directly with people from all backgrounds and invite them to get involved in our work, including those less likely to get involved, such as people with caring responsibilities, those in full-time employment, residents of rural areas, and individuals experiencing health inequalities or living in specific geographic regions.

We also recognise that not everyone wants to or is able to engage digitally. That is why we make a conscious effort to meet people where they are—at local events, fun days, fresher fairs, and community gatherings. These settings help us reach a wide range of people, including communities who may not usually come forward.

We also hold targeted events in areas experiencing inequalities and offer small incentives to encourage participation, maximising involvement. At all these events, we share information about how people can get involved with the ICB or our partners, and we provide translated materials when needed to make sure language is never a barrier.

How the ICB listens and involves people and communities



On the following pages, we share examples that demonstrate how the ICB is putting the involvement principles of our People's and Communities Strategy into practice:

This report shows:

- How we have met our involvement duties
- How we are delivering the People and Communities strategy
- How we have proactively reached out into the community
- How we have worked with many partners across the sectors to support inclusive involvement
- How we have involved people and communities who experience health inequalities
- How working with diverse communities makes a difference



Our commitment to involving people and communities

Lincolnshire ICB has adopted the **ten principles of engagement** set out by NHS England in the ICS design framework – these have been developed from work with systems across the country and, when embedded effectively, will create a golden thread running throughout the ICS, whether involvement takes place within neighbourhoods, in places or across the whole of Lincolnshire.

Delivering the following principles demonstrates and evidences our commitment to involving our people and communities.



1. Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS



2. Start engagement early when developing plans and feed back to people and communities how their involvement has influenced activities and decisions.



3. Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect



4. Build relationships with excluded groups, especially those affected by inequalities



5. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners



6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust



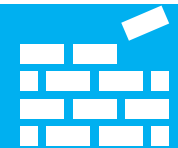
7. Use community development approaches that empower people and communities, making connection to social action



8. Use co-production, insight and engagement to achieve accountable health and care services.



9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.



10. Learn from what works and building on the assets of all ICS partners – networks, relationships, activity in local places.

Our impact in numbers

The figures shown opposite highlight our engagement activity over the year. We carried out 71 community visits, which is an increase compared with last year.

Survey participation was strong with over 6,000 individual responses received from members of the public and staff.

Our social media posts were seen over 2 million times, with 2,053,630 views in people's feeds. Around 3 in every 100 people who saw our posts interacted with them, and the ICB gained 2,051 new followers across its social media channels.

In addition, bulletin sign-ups increased by 387 over the year, reflecting our ongoing commitment to encouraging people to get involved and stay engaged on a continuous basis.

These figures underscore the successful efforts in enhancing community involvement and outreach.



33 surveys
published



36 interviews



163K visitors to website
731K page views



6180 survey
responses received

conducted over the
phone



71
community
visits



Spoke to

1001

people in
the community



Attended **18**
events



4 projects
were co-produced



3 Patient Council
meetings held &
9 Locality PPG
meetings



Social media posts reached
2,000,000+.
Gained **2,051**
new followers



9,883
contacts on
newsletter
distribution list



11,195 on
stakeholder
database



387 signed up
to receive the
bulletin



ICB ENGAGEMENT

Showcasing our engagement and involvement: demonstrating best practice and the difference it makes.

This section highlights the range of engagement and involvement activities the ICB has carried out to work effectively with people and communities across Lincolnshire.

The examples shared demonstrate our commitment to good practice and show the positive impact of the work led by the ICB's involvement team and supported by a wide range of projects and partners.

Through this activity, we ensure that the voices of patients and the public are heard, valued and acted upon, helping to build a culture of inclusion, learning and continuous improvement.

This is especially true for projects where we recognise improvements are needed, and we welcome the range of positive and negative feedback, both of which is essential to shape improvements.

Further detail on these activities is provided on the following pages.



Click on the tiles to go to more examples of involvement within specific projects and programmes

Colorectal –
teachable
moment

Dementia

Experience
of
Care

Gluten Free
Prescriptions

Pain
Management

Prostate
Cancer

Helping
People to Age
Well

Continuing
Healthcare

DMC
Dermatology

Fertility
Review

Intermediate
Care

Palliative and
End of Life
Care

Sensory loss

Our shared
agreement

Maternity &
Neonatal

CYP -
neighbourhood
initiative

ECHO, MRI
and NOUS
relocation

Functional
Neurological
Disorder

Ovarian
Cancer

PEOL co-
production

Vaccinations
Campaign

Special
Educational Needs
& Disabilities



Click this symbol to
return to this page



Public & Patient Participation

Colorectal – teachable moment

Early diagnosis and timely support following bowel cancer screening are critical to improving outcomes and supporting people to make positive changes to their health. NHS Lincolnshire Integrated Care Board (ICB) and system partners undertook this work to understand how patients experience information and support following a clear diagnosis of cancer on the Rapid Access Colorectal Pathway (RACP).

As part of this programme, educational materials (leaflet and video) were co-designed to support people at a key “teachable moment” following diagnosis, helping them understand their condition and consider lifestyle changes that may reduce future risk.

The aim of the engagement was to understand how well newly developed patient information resources were received and whether they supported understanding, decision making and lifestyle change.

Our approach

- A leaflet and an animated film were co designed and shared with patients following diagnosis by specialist nurses. Feedback was then gathered through a follow up survey to understand:
 - How accessible and useful the materials were
 - Whether they helped patients understand their condition and next steps
 - Whether they influenced decisions about managing health and lifestyle
- The insight gathered was used to inform future patient communications and educational materials within colorectal pathways.

Engaging our communities

- Over 500 patients diagnosed through the Rapid Access Colorectal Pathway were directly invited to take part in the survey. Received 7 responses.
- Invitations were sent following patients' follow up appointments, when materials had been shared by specialist nurses.
- Engagement focused on people aged 50 and over, reflecting the screened population.
- The animated film was made available online, while the leaflet was distributed directly to patients via post or at appointments.
- Video: [Understanding your cancer screening journey | what's next and reducing your risk](#)

What we heard

- The leaflet was the preferred format, with most respondents finding it easier to access, read and understand than the film.
- Many respondents valued having clear, written information they could read at their own pace, particularly older patients.
- Both the leaflet and film helped people better understand their condition, though the leaflet had more influence overall.
- The leaflet was more likely to influence decisions about managing symptoms and lifestyle, including diet and hydration.
- Information was often shared with family members, extending its wider impact.

The difference it made

- Engagement confirmed that simple, clear written information is most effective for this patient group.
- Feedback supported continued use and refinement of the leaflet as a key patient resource.
- Learning from this work is informing how future educational materials are developed and shared, ensuring they are accessible, meaningful and aligned to patient preference.
- The insight gathered will support future projects across colorectal pathways and wider cancer services.
- People felt informed and supported. Wider family members were also informed and able to support.



Public & Patient Participation

Continuing Healthcare - CHC

We gathered feedback from members of the public who receive Continuing Healthcare (CHC) funding, or who care for someone who does. This included people with a Personal Health Budget and those receiving Funded Nursing Care in a registered care home.

We also spoke with staff from across the system who support the CHC process. Separate reports were produced to reflect public and staff experiences.

This engagement formed part of a wider programme of work involving Continuing Healthcare, Adult Social Care and partner organisations across Lincolnshire. The purpose was to take a closer look at the CHC journey from start to finish.

The aim was not only to understand how CHC processes work, but to better understand people's lived experiences. What we heard will help shape a system that feels more personal, compassionate and connected for those who rely on CHC support.

Our approach

- Produced surveys for both staff and the public
- Co-produced the surveys with personalisation team, Adult Social Care and Continuing Health Care.
- Produced materials complete with QR codes and survey links – distributed to connected groups, venues and professionals
- Survey was promoted to staff and public through social media, newsletters and websites.

Engaging our communities

- Survey open between 23rd October 2025 – 12th January 2026.
- Received 62 responses to public survey with 42 responses from the staff.

What we heard

- Many people were unclear about what CHC is and what they are entitled to, particularly Personal Health Budgets. Those who did have a PHB described it as very positive.
- Information before assessments was often poor or missing, with many people only learning about CHC during a hospital stay, which caused confusion and anxiety.
- Experiences of the CHC checklist assessment were mixed; people valued being treated with dignity but wanted clearer explanations, more time, and greater opportunity to share what mattered to them.
- The Decision Support Tool (DST) process caused the most dissatisfaction, with people feeling meetings were long, stressful, and that their views were not always fully heard or understood.
- Communication about decisions and next steps was unclear, with many people unsure about outcomes, available choices, or what would happen next.
- Most people were not meaningfully involved in care and support planning, and many felt their personal priorities were not reflected in plans.
- Awareness of how to make a complaint was low, and while some found the process easy, delays in responses caused frustration.
- Positive experiences were linked to good communication and compassionate staff, particularly GPs and multidisciplinary teams who listened and worked collaboratively.

The difference it made

- Feedback has informed ongoing CHC process review, with findings shared with the CHC Process Mapping Group.
- It reinforced the need for more person-centred, compassionate care, prompting reflection and a move away from process-driven approaches.
- Clear opportunities for improvement were identified, including better communication, clearer information and earlier involvement of people and families.
- Feedback has shaped practical improvement activity, such as pilots, training, simplified processes and improved communication materials.
- It laid the foundations for future co-production, with plans to involve people with lived experience through a CHC Co-Production Group from 2026/27



Public & Patient Participation

CYP – neighbourhood initiative

We set out to understand how children, young people and their families experience health and care support locally, and how this could be improved for those who need it most.

We gathered feedback from children and young people in Lincoln—aged 0–19, or up to 25 for those with special educational needs or disabilities—and their families registered with Brayford Medical Practice or Heart of Lincoln Medical Group.

The engagement explored a new local way of working, bringing together GPs, hospital paediatricians and community paediatric services more closely.

The intention was to improve access to care, support families to attend and manage appointments, and reduce avoidable use of Accident and Emergency and other urgent services.

This work was part of a wider NHS England programme requiring Integrated Care Boards to establish at least one Children and Young People (CYP) Neighbourhood Health Team by 31 March 2026. In Lincolnshire, local data and evidence informed the decision to pilot the model in Lincoln.

Our approach

- Produced surveys for both staff and the public
- Produced a toolkit for capturing feedback from community visits
- Working with the Children and Young People Transformation Board
- Produced materials complete with QR codes and survey links – distributed to associated groups, venues and professionals
- Engagement plan focussed on 3 areas – gaps in provision; challenges for CYP and suggested improvements

Engaging our communities

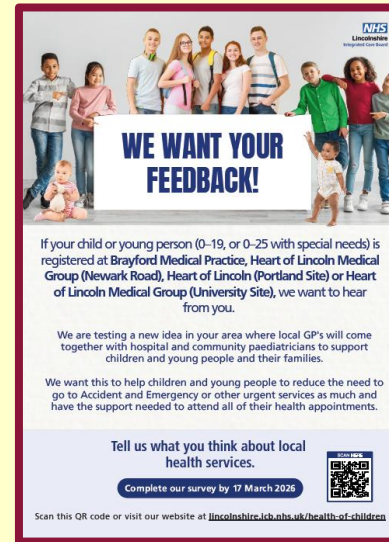
- Between 17 February and 17 March 2025 surveys were open.
- Visited 3 community groups and spoke to 13 parents / grandparents and 7 staff
- Promoted the surveys to public and staff
- Received 15 responses to staff survey and 1 public response

What we heard

- Getting mental health help is hard, especially for CAMHS, support outside normal hours and having the same support over time.
- Children who have additional needs (such as autism, ADHD or long-term health conditions) often struggle to get the right help quickly or consistently.
- Specialist services are difficult to access, including speech and language therapy, occupational therapy, wheelchair services and paediatric care.
- Moving from children to adult services is challenging - support drops away during this change.
- Not enough local, preventative support, so families turn to A&E - earlier help could have avoided this.
- Services can be hard to access and understand - long waits, language barriers, limited information, and poor coordination between services

The difference it made

- What families told us has helped shape the Children and Young People Neighbourhood Health pilot in Lincoln, influencing how future services will be delivered.
- The findings were shared with and considered by the Children and Young People Transformation Board to inform decision-making.
- Local partners and stakeholders are now clearer about the challenges children and young people face, and where improvements are most needed.
- We will share learning from the pilot and use it to support plans to roll this approach out to other areas of Lincolnshire in the future.



Public & Patient Participation

Dementia

Dementia is a progressive condition that affects memory, thinking, behaviour and the ability to carry out everyday activities, and it impacts not only the person living with the condition but also their families and carers.

NHS Lincolnshire ICB sought feedback to understand what is working well and what could be improved for people living with dementia and their carers across Lincolnshire.

The engagement explored people's experiences of dementia care in Lincolnshire, from diagnosis and ongoing support to prevention, community resources and overall wellbeing. The feedback received is helping to inform improvements to services and support for people living with dementia and those who care for them.



Our approach

- The engagement team worked with the project lead to understand the best approach within the allocated timeframe
- Created an online survey
- Created a comprehensive distribution plan
- Produced materials complete with QR codes and survey link to encourage participation

Engaging our communities

The survey was open between 22 December and 9 February and received 136 responses. The engagement was promoted through a multi-channel approach, including:

- Seven Facebook posts, reaching 10,052 people
- 169 visits to the dedicated engagement webpage (Dementia Carer and lived experience survey)
- Promoted via three ICB engagement bulletins and two primary care bulletins
- Four posts on the Nextdoor platform, reaching local communities across the county
- Circulated through provider member databases and staff networks

This approach helped ensure feedback reflected experiences from a broad range of individuals and communities across the county.

What we heard

- Diagnosis was often difficult and slow, with many people experiencing long waits and poor coordination between services.
- Communication at diagnosis was inconsistent, with some people receiving little or no information about next steps, support, or entitlements.
- Post-diagnosis support was limited, with many reporting a lack of follow-up, no single point of contact, and insufficient professional support.
- Most people did not feel supported overall in Lincolnshire, identifying needs for clearer signposting, regular contact, respite and more face-to-face help.
- Community support was variable, with dementia cafés and groups valued but gaps reported in professional input and meaningful activities.
- Prevention and risk-reduction information was lacking, with many people saying opportunities to access this locally were rare or unavailable.

The difference it made

- Feedback was reported into the Dementia Programme Board (held quarterly) and helped inform the Dementia 100 survey.
- The engagement helped identify gaps and variations in provision at both locally (place-based) and system wide levels.
- Insight supported alignment with the five-year dementia plan helping to shape future priorities.

Public & Patient Participation

DMC Dermatology - relocation

NHS Lincolnshire Integrated Care Board (ICB) undertook engagement to understand patient experiences of dermatology services and gather views on proposed changes to how services are accessed across Lincolnshire.

At the time of engagement, dermatology referrals operated through two different pathways: patients in East Lincolnshire accessed Community Dermatology Clinics at Skegness Hospital or Parkside Medical Centre, Boston, while patients in other areas were triaged via the Elective Activity Coordination Hub (EACH). This variation created inconsistencies in access and complexity for both patients and clinicians.

The proposed change was to move towards a lead provider model, with United Lincolnshire Hospitals NHS Trust (ULHT) taking responsibility for dermatology services across Lincolnshire and all referrals being directed through EACH.

Our approach

Our approach aimed to:

- understand patient experiences of current dermatology services
- gather views on the proposed changes
- explore potential impacts on access, satisfaction and equity
- ensure patient feedback informed decision-making and service design

We created an online survey and distributed through extensive channels and networks to encourage participation.

Engaging our communities

- The online survey ran between 26th June and 19th September 2025.
- Participation was encouraged through a multi-channel communication and distribution approach – enabling us to reach a wide and diverse audience.
- Promotion included ICB engagement and primary care bulletins; Nextdoor posts (reaching 110,000) and circulation through provider databases and staff networks.
- A targeted Facebook campaign with six post reached over 10,600 people
- The dedicated engagement webpage received 166 visits.
- In total, 108 survey responses were received from across the county.

What we heard

- Overall experiences were mixed, with many patients valuing professional and respectful care, clear communication, and effective treatment when services worked well.
- Long waiting times were a major concern, with some patients reporting very long delays..
- Communication problems were highlighted, including missed referrals and lack of updates.
- Travel and accessibility challenges, particularly for patients in rural and coastal areas, older people, and those with mobility or transport challenges.
- Views on the proposed service changes were mixed, balancing improved consistency with concerns about loss of local access and capacity at hospital sites.
- What mattered most to patients was fair access across Lincolnshire, shorter waits, clear community and clinics that meet individual needs.
- Patient feedback highlighted key strengths and gaps in dermatology services, particularly around access, waiting times, communication and travel.
- Engagement raised equity concerns, especially for rural, coastal, older and disabled patients, informing consideration of potential impacts.

The difference it made

- Insights informed internal discussions on service design, including referral consistency, capacity and patient choice. Feedback also reinforced priorities for fair access, clearer communication and reduced waiting times as changes progress.



Public & Patient Participation

ECHO, MRI & NOUS

The NHS Lincolnshire Integrated Care Board (ICB) reviewed echocardiology (ECHO) services across Lincolnshire to address challenges relating to access, capacity and efficiency. At the time, most services were provided by United Lincolnshire Teaching Hospitals NHS Trust (ULHT), with additional support from NHS trusts and an independent provider - InHealth – who deliver community-based services.

The ICB proposed two service changes to improve access to diagnostic services and make better use of available facilities:

- Patients attending Marisco Medical Practice in Mablethorpe for ECHO would have the option to attend Skegness Community Diagnostic Centre (CDC), or another preferred location.
- Patients using Johnson Community Hospital in Spalding for ECHO, MRI or non-obstetric ultrasound (NOUS) would have the option to attend Pilgrim Hospital in Boston, or another suitable site.

This engagement aimed to understand patient experiences of current services and explore how the proposed changes might affect them.



Our approach

- The ICB planned and coordinated activities across ULTH and community provider
- Produced materials to support promotion of the engagement and survey
- Used existing networks and channels to promote the survey and the proposed changes
- Shared in NHS bulletins – including primary care
- Used social media to promote the proposed changes.

Engaging our communities

- Survey ran from 19th June to 20th August 2025
- Distributed through provider networks and staff databases for targeted outreach
- Promoted on Facebook with 4 posts, reaching 10,698 people and 203 engagements
- Reached 110,000 people across 471 neighbourhoods via Nextdoor
- Received 123 responses to the survey
- Attracted 636 visits to the dedicated engagement webpage

What we heard

- Most patients are happy with current echocardiology services, with high satisfaction at Johnson Community Hospital and Marisco Practice.
- Patients value fast appointments, easy access and friendly staff as key strengths of existing services.
- Views on the proposed service changes were mixed, with similar levels of support, opposition and uncertainty.
- Travel distance and accessibility were main concerns, especially for older or less mobile patients.
- Negative views of Pilgrim Hospital affected support for moving services from Johnson Hospital.
- Most people travel by car to attend appointments, with limited use of public or volunteer transport.
- What matters most to patients is keeping services local, reliable transport, high-quality care, and fair choice across Lincolnshire.

The difference it made

- The ICB considered concerns raised around access, travel and service quality.
- Nearly half of patients supported relocating ECHO services from Marisco Practice to Skegness CDC improving access to a wider range of tests in one location. Early feedback has been positive.
- Improved access to local diagnostics, reducing long journeys.
- Concerns about Pilgrim Hospital were heard, informing plans of new CDC in Boston, rather than relocating all services there.
- NOUS services will continue at Johnson Community Hospital, alongside improved communication to GP practices and patients about available options.
- Patient feedback will continue to be collected, including Friends and Family Test responses at CDC and hospital sites.



Experience of care

The *Experiences of Care* survey was launched in June 2022. It was originally developed through the Equality Forum and is now overseen by the ICB Engagement Team as an established, ongoing source of system-wide feedback.

The survey was designed to help us understand – on a continuous basis – what is working well and what could be improved for individuals and communities when accessing NHS services across Lincolnshire.

It has provided an ongoing route for people to share feedback on any aspect of their healthcare experience. During 2025/26, it continued to be a valuable tool used by the ICB's engagement team when engaging people in the community, helping to ensure that people's experiences and stories are captured and not lost.

Our approach

- The Experience of Care survey was live throughout 2025/26
- Always open – ensuring a meaningful way of capturing people's experiences
- Analysis and reported on a monthly basis

Engaging our communities

- Promoted online via the ICB website, social media and the Involvement Bulletin (The Contributor) and at face-to-face engagement events.
- Open to all members of the public
- Received 142 responses during 2025/26

What we heard

Feedback covered a broad range of services and topics, including:

- Primary care & secondary care
- Ambulance services & NHS111
- Community Diagnostic Centres
- Mental health services & Autism services
- Palliative and end of life care
- Dentistry
- Screening services
- Carers and care homes
- Pain management

This breadth of feedback provided valuable insight into people's experiences across multiple pathways and settings.

The difference it made

- Findings were shared through the Lincolnshire Voice Report and presented quarterly to the Lincolnshire ICB System Quality and Patient Experience Committee.
- Feedback was considered alongside other quality, safety and patient experience data, acting as an early indicator of emerging themes and concerns.
- Insights also informed wider programmes of work, including identifying primary care issues and reports were added to the ICB's insight database for further reference.
- The Experiences of Care survey will remain live and continue to be promoted throughout 2026/27



Public & patient participation

Functional Neurological Disorder

Functional Neurological Disorder (FND) is a condition where people experience real neurological symptoms, but without structural damage to the nervous system

FND Lincs, NHS Lincolnshire ICB and system partners are working together to develop a Functional Neurological Disorder (FND) strategy for Lincolnshire.

We wanted to hear directly from people living with FND in Lincolnshire. Many told us it's hard to get the right support after diagnosis, so this survey was designed to help us to understand real experiences of how they were diagnosed with FND and the way they engaged with services.

Our approach

- Engagement aimed to capture lived experience to inform service improvement and pathway development.
- A county-wide survey and community discussions were used to understand experiences of diagnosis and engagement with services

Engaging our communities

- A county-wide survey was launched in October 2025, receiving 127 responses from people with lived experience of FND.
- Survey questions were co-produced with FND Lincs, NHS Lincolnshire ICB and system partners.
- Engagement was promoted through:
 - Digital posters with QR codes shared with NHS providers, community groups, PPGs, carers services, ASC and neighbourhood leads
 - FND Lincs newsletters and the ICB Engagement Team bulletin (*The Contributor*)
 - Awareness-raising at the *Fit for the Future* event in Spalding
- The ICB Engagement Team attended an FND Lincs support group to gather further feedback.
- A patient shared personal lived experience at the ICB Cluster Board.

What we heard

- Many of the respondents found it difficult or very difficult to obtain an FND diagnosis.
- Nearly two-thirds were dissatisfied with the speed of diagnosis.
- Three-quarters did not receive information about FND or symptom management at diagnosis.
- Many people reported repeated GP visits, emergency attendances and unnecessary appointments before diagnosis.
- Over half travelled outside Lincolnshire for diagnosis or treatment, at significant personal cost.

The difference it made

- Feedback was shared with NHS Lincolnshire ICB and system partners to inform a review of the current FND pathway and contributing to development of a local FND strategy shaped by lived experience.
- Findings shaped the next phase of engagement, focusing on service design and improvement.
- £5,000 in charitable funding was secured by Lincs FND to co-create patient information, educational materials and FAQs – designed with people who have lived experience of FND.
- A phase 2 survey – will gather views on a proposed FND service model for Lincolnshire.
- Learning and best practice will be shared through participation at the annual FND Awareness Conference including presenting the draft Lincolnshire FND Strategy.



Public & Patient Participation

Gluten Free Prescription

NHS Lincolnshire Integrated Care Board (ICB) launched a public consultation to gather views on proposed changes to the prescribing of gluten-free bread and flour. The aim was to ensure that any future policy decisions were informed by the experiences and needs of those affected, particularly people with coeliac disease or dermatitis herpetiformis.

The consultation aimed to:

- Raise awareness of the proposed changes to gluten-free prescribing.
- Involve patients, the public and key stakeholders in shaping future prescribing arrangements.
- Meet the ICB's statutory involvement duties under the Health and Social Care Act 2022.
- Identify equality impacts and consider potential actions to address concerns raised.

Our approach

- Between 18 March and 13 May 2025, we ran a county-wide consultation, reaching thousands of people through a multi-channel communications and engagement campaign.
- Produced and delivered consultation plan – detailed plan of the engagement activities to encourage participation.
- We worked with community groups, healthcare professionals, voluntary organisations, and condition-specific charities like Coeliac UK to ensure wide and inclusive participation

Engaging our communities

- 10,000+ stakeholders received the consultation via our Engagement Bulletin.
- 6 Facebook posts reached nearly 30,000 people, generating 211 clicks to the survey.
- A dedicated webpage attracted 2,254 visitors, with traffic driven by social media, direct searches, and partner referrals.
- We received 428 responses, including 378 individuals (mostly local residents); 33 healthcare professionals; 17 organisations and community groups and one written response from Coeliac UK

What we heard

- Strong opposition to stopping all prescribing, with 73% of respondents disagreeing - mostly patients and members of the public while majority of professionals supported stopping prescriptions.
- Widespread concerns about affordability - for people on low incomes, benefits / pensions.
- Health risks were a major theme, potentially leading to poor adherence to a gluten-free diet.
- Access and equity issues were raised, including access to gluten-free products in rural areas
- Limiting prescriptions was opposed by most respondents, due to concerns about discrimination and rising health inequalities, although patients favoured this over removal altogether.
- Respondents suggested alternatives, including voucher schemes, refined eligibility criteria, improved supermarket availability, and better access to dietary advice and specialist support.
- The Coeliac Society opposed both proposals, citing legal, clinical and equality concerns, and encouraged exploration of alternative support models

The difference it made

- The findings directly informed the final decision made by NHS Lincolnshire Integrated Care Board (ICB), ensuring that any changes were evidence-based, equitable and clinically informed.
- As a result, the prescribing of gluten-free food for people diagnosed with coeliac disease or dermatitis herpetiformis changed. From 1 August 2025, gluten-free food will no longer be available on prescription in Lincolnshire.



Public & Patient Participation

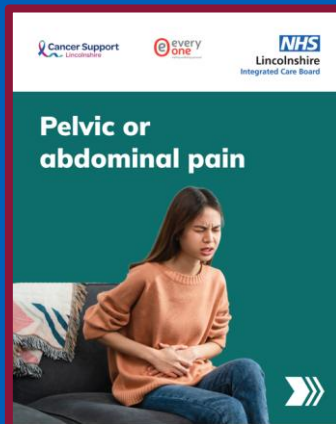
Ovarian Cancer

Ovarian cancer can be difficult to identify in its early stages, as symptoms are often vague and can be mistaken for other conditions. Evidence shows that earlier recognition and timely help-seeking can lead to better outcomes, making public awareness a key factor in early diagnosis.

To support this, NHS Lincolnshire Integrated Care Board (ICB) carried out engagement to understand current levels of awareness of ovarian cancer among people living in Lincolnshire, including knowledge of symptoms, attitudes to seeking help, and potential barriers to early diagnosis.



Examples of the campaign materials.



Campaign featured on Lincolnshire's buses

Our approach

The engagement aimed to:

- identify gaps in awareness and understanding of symptoms
- understand attitudes towards help-seeking and diagnosis
- explore barriers that may delay people seeking advice or care
- identify how and where awareness campaigns could have the greatest impact

Engaging our communities

- The survey ran between 23 October and 27 November 2025 and received 378 responses.
- To maximise reach and ensure accessibility, the survey was promoted via:
 - Featured in 3 NHS Lincolnshire ICB engagement bulletins and 2 Primary Care bulletins
 - 4 posts on the Nextdoor platform, reaching communities across 471 neighbourhoods
 - Shared through provider member databases, staff networks and partner organisations
 - Promoted on the NHS Lincolnshire ICB website and partner websites
 - 4 Facebook posts, reaching 10,316 people; 75 people visited the campaign webpage
- The survey was also available in alternative formats on request

What we heard

- Awareness was high but knowledge was limited, with many unsure about symptoms beyond bloating, pain and fatigue.
- Confidence in early detection was low, with symptoms often normalised and concerns about misdiagnosis or delayed referral.
- Delay in seeking help was common, driven by embarrassment, life pressures, poor access to GP appointments and fear of not being taken seriously.
- Around a third would be unlikely to contact their GP, even if symptoms were persistent.
- People wanted clear, simple and reassuring campaign messages, using symptom checklists, lived experiences and short videos, delivered through social media, TV and familiar settings such as GP practices and workplaces

The difference it made

- Feedback provided a clear understanding of awareness gaps and barriers to recognising symptoms and seeking help.
- Insight shaped the campaign messages, tone and delivery, ensuring they are clear, reassuring and avoid fear-mongering while emphasising urgency.
- Findings informed the delivery of a targeted ovarian cancer campaign; helping to support the channels, formats and materials, focusing on clarity, reassurance and empowerment.
- The campaign focuses on improving symptom recognition, addressing misconceptions, encouraging timely help-seeking and building confidence in accessing healthcare services

Public & Patient Participation

Fertility review

Access to NHS funded fertility treatment currently varies across the East Midlands due to historical differences in local policies inherited from former Clinical Commissioning Groups. These variations have resulted in inequitable access depending on where people live, including differences in eligibility criteria, age limits, BMI thresholds and the number of funded cycles.

To address this, the five East Midlands Integrated Care Boards (ICBs), including NHS Lincolnshire ICB, are working together to develop a modernised, consistent and evidence based regional Fertility Policy. Engagement with residents, patients and stakeholders has been a central part of this work, ensuring that lived experience and public values inform the policy as it develops.

The Fertility Review is being taken forward through a phased and transparent approach, combining clinical evidence, national guidance, financial considerations and public engagement.

Further information can be found: [East Midlands Fertility Policy Review](#)

Our approach

- A Case for Change was developed in 2024, setting out the need for greater equity and consistency.
- Carried out a regional listening exercise, designed to test early proposals and understand the impact they may have on individuals and families.
- Feedback is being used alongside emerging NICE Fertility Guidelines to shape policy options.
- The ICBs have been clear that no final decisions will be taken until national guidance is finalised and further engagement has taken place, recognising the sensitivity and complexity of this review.

Engaging our communities

Engagement on the Fertility Review has taken place at both regional and local levels:

- A regional listening exercise ran between November 2024 and January 2025, with 235 responses from Lincolnshire residents, overall 2,000+ responses
- Engagement methods included surveys, focus groups and targeted engagement with people directly affected by fertility policies
- Feedback has been shared with ICBs across the region and continues to inform policy development
- This work built on earlier discussions with scrutiny committees, patient groups and stakeholders, and ensured that voices from across the East Midlands were heard, including people who have experienced fertility treatment, infertility, or barriers to care.

What we heard

The regional listening exercise highlighted strong and often mixed views on the early proposals:

- There was broad support for greater equity and consistency across the East Midlands
- Concerns were raised about proposals to limit NHS funded IVF cycles - one cycle; the non-clinical eligibility criteria, e.g. partners have existing children and gamete and embryo storage
- Respondents emphasised the importance of personalised assessment, compassionate support and clear communication
- The feedback reflected the emotional, financial and personal impact of fertility treatment and highlighted the need for policy decisions to be both fair and clearly explained.

The difference it made

- Engagement feedback has directly informed emerging policy options, alongside clinical evidence and affordability considerations.
- Issues raised led to clearer separation between fertility treatment and cryopreservation policies, addressing concerns related to cancer and medical fertility preservation.
- Feedback has been used to sense-check alignment with draft NICE guidance.
- Findings reinforced the need for further engagement once final NICE guidelines are published, supporting trust and transparency.
- NICE Fertility Guidelines (March 2026) will inform the next phase of policy development.
- The single East Midlands Fertility Policy will only proceed following further engagement, formal approval and clear communication.



Public & Patient Participation

Pain Management

Living with persistent pain has a significant impact on people's physical health, emotional wellbeing and quality of life. NHS Lincolnshire Integrated Care Board (ICB) carried out a review of pain management services – overseen by Lincolnshire's Academy Centre of Excellence (LACE), to support the planned re-procurement of the service in 2026/27.

The engagement team worked closely with the project team and LACE to ensure the patient, carer and staff voices were central throughout the review, helping to build a clear understanding of experiences of pain management services across Lincolnshire and to identify opportunities for improvement.

This work aimed to inform the development of accessible, compassionate, evidence-based pain management services, tailored to individual needs, particularly for people living with long-term and complex pain.

Our approach

- A comprehensive programme of engagement was delivered to capture experiences of pain management services from a wide range of perspectives. The approach combined:
 - a public survey to understand experiences of current and future services
 - a staff and stakeholder survey to explore operational challenges and opportunities
 - in depth patient interviews to capture lived experience and personal journeys
- The aim was to understand what works well, where gaps exist, and how services could be redesigned to better meet the needs of people living with pain.

Engaging our communities

Between 13 May & 29 July 2025, the engagement reached a wide and diverse audience in Lincolnshire:

- 397 public survey responses and 24 staff survey responses were received
 - 18 in depth patient interviews were conducted; 5 patient reps attended the Expert Reference Groups
 - More than 54,000 people were reached through social media
 - Engagement was also promoted via bulletins, Nextdoor, provider & provider networks,
 - Rural communities, older adults, people with disabilities & complex conditions were well represented
- This approach ensured both breadth and depth of insight, with space for people to share detailed experiences as well as system level feedback.

What we heard

- Overall satisfaction with pain management services was low, particularly around physical pain management, exercise support and medication management.
- People valued kind, knowledgeable staff and clear communication, but experiences were inconsistent.
- Many described long waiting times, limited follow up and lack of face-to-face appointments.
- Respondents felt services were often “one size fits all”, lacking personalised, holistic care.
- Geographical barriers and travel distances affected access, particularly for rural communities.
- The emotional impact of living with pain was clear, with people feeling unheard or dismissed and both patients and staff calling for better coordination, clearer referral pathways and improved service awareness.

The difference it made

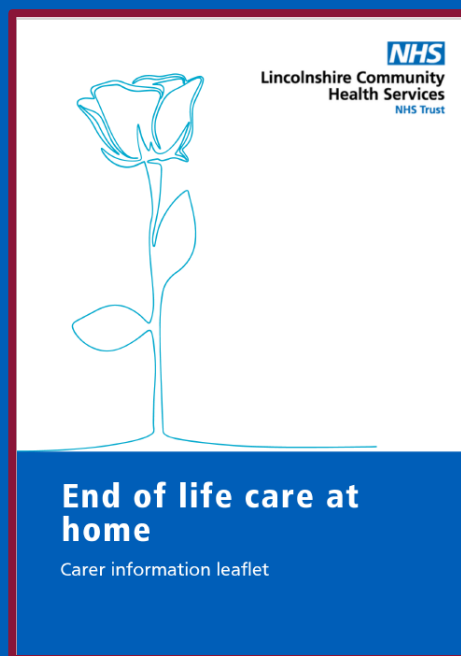
- Feedback provided a detailed understanding of patient and staff experiences, highlighting critical gaps in access, communication and service design.
- Insight is being used to inform the redesign and commissioning of pain management services, ensuring lived experience shapes future models of care.
- Findings have been shared with the Pain Management Project Board and Expert Reference Groups, supporting evidence-based decision making.
- Engagement reinforced the importance of empathetic communication, holistic care, local access and continuity, shaping priorities for future service development.

Public & patient participation

Palliative End of Life (PEOL)

Palliative and end of life care plays a vital role in supporting people, families and carers at some of the most challenging times in their lives. Understanding people's experiences of these services is essential to ensuring care is compassionate, personal and responsive.

To support this, the NHS in Lincolnshire carried out its third annual palliative and end of life care survey, providing an opportunity to listen to those who have used these services and to learn from their experiences over time.



Our approach

By repeating the survey for a third year, we aimed to:

- compare experiences year on year and track progress
- understand what is working well across the palliative and end of life care pathway
- identify areas where improvements are needed
- use lived experience to inform service development and quality improvement

This approach helped ensure that feedback continues to shape and improve palliative and end of life care services across Lincolnshire.

Engaging our communities

- Between 10 April - 30 September 2025, a public survey was launched, receiving 222 responses.
- Survey questions were co-produced with the Palliative and End of Life Care Co-Production Group.
- An A5 flier with the survey link and QR code was distributed to a wide range of stakeholders, including voluntary and community organisations, hospices, wellbeing centres, Macmillan teams, community nursing teams, bereavement services, patient groups, primary care, local authority services and funeral directors across Lincolnshire.
- The survey was actively promoted through social media, newsletters and dedicated websites

What we heard

- Most people spent their final months at home, with families playing a key role, but support was often felt to be insufficient.
- Joined-up working gaps were common, particularly around out-of-hours care, GP support, communication and home visits.
- Hospices, community nurses and specialist services received the most positive feedback, while hospitals and GP services were more mixed, especially around communication and continuity.
- Nearly half died at home and many felt some choice was offered, but bereavement support was limited, with families wanting clearer communication and more consistent aftercare.

The difference it made

- This work will continue into 2026/27, with feedback continuing to inform improvements across the palliative and end of life care pathway.
- Insights were shared with the Palliative and End of Life Care Co-Production Group & Quality Group.
- A co-produced action plan was developed to address key priorities.
- Tiered palliative and end of life care training was rolled out across the system.
- Engagement increased, with 28 additional people expressing interest in further involvement



Public & Patient Participation

PEOL – co-production group

The Palliative and End of Life Care Co-Production Group is facilitated by NHS Lincolnshire Integrated Care Board (ICB).

Co-production brings together people with lived experience of using services and professionals who plan, deliver and commission them.

By working side-by-side as equal partners, the group helps shape improvements, design new ways of working and ensure that palliative and end of life care services reflect what matters most to individuals, carers and families.

Our approach

- The Palliative and End of Life Care Co-Production Group meets on a bi-monthly basis and met on 4 occasions throughout the year.
- The group is chaired by the ICB's Engagement Manager and is supported by a Macmillan Nurse (PSPA lead) from Lincolnshire Community and Hospitals group.
- The group is supported well by people with lived experience with an average attendance of six individuals, ensuring that lived experience remains central to discussions and decision making.

Engaging our communities

- We listened directly to people with lived experience of palliative and end of life care in Lincolnshire, including patients, families, carers and loved ones, as well as staff involved in delivering palliative and end of life care services.
- This involvement provided a safe and meaningful space for people to share experiences, concerns and reflections, helping us to understand what matters most at the end of life and where care and support can be strengthened. The work aimed to ensure that services are shaped by compassion, dignity and real experience, and that learning is used to improve care for others.

What we heard

- People shared honest and deeply personal experiences of palliative and end of life care, highlighting both positive aspects of care and areas where support could be improved. Feedback focused on communication, coordination of care, consistency, emotional support, and the experiences of families and carers alongside patients.
- These insights provided a clearer understanding of what good palliative and end of life care looks like and where change is needed across the pathway.

The difference it made

- Co-produced survey questions for the VOICES Palliative and End of Life Care survey.
- Provided insight and recommendations on the language and definitions used in palliative and end of life care, ensuring these are more sensitive and understandable.
- Shared and reflected on lived-experience stories, highlighting what is working well, areas of concern, and opportunities for improvement across the care pathway.
- Contributed feedback on experiences of the ReSPECT process, supporting better understanding and communication around care planning.
- Reviewed and informed updates to key information resources, including *Care After Death*, *Last Weeks/Days of Life*, and *Palliative Care in Lincolnshire* leaflets.
- Developed a co-produced action plan based on the VOICES survey finding and will continue to inform service improvement, training and information resources aligned to the Palliative and End of Life Strategy 2023–2028 and associated work programmes.



Public & Patient Participation

Prostate Cancer

Prostate cancer is one of the most common cancers affecting men. Lincolnshire has an older male population, and the risk of prostate cancer increases with age, meaning local health services regularly support men with diagnosis, treatment and ongoing care.

We wanted to hear directly from people affected by prostate cancer in Lincolnshire including patients, carers, families, to understand what is working well, where challenges exist and how we can make things better. Engagement activity began in 2024/25 and continued into 2025/26, with a comprehensive engagement report produced to capture learning and inform future work.

This review was part of our commitment to improving cancer care through the Living with Cancer Strategy 2023–28, focusing on real experiences to shape future services.



Our approach

- In 2024/26 the engagement team lead and facilitated the involvement activities for this project
- Engagement plan developed and executed
- Co-produced the survey with the Macmillan Living with Cancer co-production group
- Promotional materials were produced to enhance the promotion of the survey.

Engaging our communities

A county-wide survey was launched between 13 January and 28 February 2025. The response was significant, with 868 survey responses. The engagement activity included:

- Co-production of survey questions with the Macmillan Cancer Co-Production Group.
- 4,733 mailshots sent to patients referred for prostate cancer inviting them to take part.
- Posters with QR codes and survey links shared with Patient Participation Groups (PPGs), GP practices, pharmacies and community venues.
- A targeted social media campaign aimed at men aged 60 and over. Targeted outreach to specific groups, including veterans, men's groups, carers and older people's groups.
- The co-production group reviewed the survey findings - focusing on key themes, insights & stories.
- Patient representatives attended the Urology Stakeholder Group to share first-hand experiences with clinicians, programme managers and GPs.

What we heard

- Symptoms varied, with many experiencing increased urination, while some had no symptoms.
- Information on physical side effects was often provided, but people wanted more support with emotional wellbeing, family and carer support, diet and lifestyle, and financial advice.
- Support and communication were mixed, with some feeling well-supported and others wanting clearer information and more emotional support, particularly after treatment.
- Most felt informed about side effects, support to manage long-term impacts was inconsistent, with issues such as incontinence and erectile dysfunction causing ongoing concern.
- Most respondents were confident in their treatment decisions, though wanted to discuss alternatives.
- Living beyond cancer was positive for some, while others faced difficulties with supplies, managing side effects and navigating follow-up care.

The difference it made

- The engagement provided rich insight through people's lived experiences, informing meaningful service improvement.
- Findings were shared with the Lincolnshire Cancer Board & Urology Stakeholder Group.
- A working group and action plan were established to address priorities including communication, care planning and patient support.
- New patient resources are being developed, including a co-produced support pack, enhanced discharge information, and planned improvements to the ULTH patient information website.

Public & Patient Participation

Intermediate Care

Intermediate Care plays a key role in supporting people to recover, regain independence and avoid unnecessary hospital admissions or long-term care. NHS Lincolnshire Integrated Care Board (ICB), working in partnership with Lincolnshire County Council (LCC), Lincolnshire Community Health Services (LCHS) and system partners, undertook engagement to understand experiences of Intermediate Care services across Lincolnshire.

This engagement formed part of the development of a future Intermediate Care strategy, ensuring that the views of people who use services, carers, frontline staff and partners informed how services are shaped and delivered.

Engagement aimed to capture both breadth and depth of insight across the Intermediate Care pathway, including Reablement, Discharge to Assess, Urgent Community Response, Hospital Avoidance Response Team, Active Recovery Beds, Transitional Care Beds and Community Hospital Beds.

The engagement took place between 18 March and 29 April 2025 and focused on understanding:

- what is working well within current Intermediate Care services
- where improvements are needed
- what matters most to people using services, carers and staff
- priorities for the future Intermediate Care model

Feedback was analysed across demographic, equality and health inequality groups, with differences highlighted where numbers allowed.

Engaging our communities

The engagement took place between 18 March and 29 April 2025 and was delivered through a combination of surveys and targeted, supported activity:

- 108 staff survey responses were received from across health and social care
- 193 responses from members of the public, including people who had used Intermediate Care services
- 13 care homes were visited by the LCHS Engagement Lead, supporting 31 people to complete the survey in person
- The survey was promoted through ICB engagement bulletins, partner networks, local authority channels and provider staff networks
- Engagement activity was constrained by the pre-election period, but targeted work ensured key voices were still included
- In addition, 22 staff and 55 members of the public expressed an interest in continuing involvement to support the development of the strategy.

What we heard

Across the engagement, strong and consistent themes emerged:

- Intermediate Care services were highly valued for supporting recovery, promoting independence and helping people remain at home, with person-centred care and coordinated multidisciplinary working seen as key strengths
- Capacity, staffing and availability were recurring challenges across all services
- Staff and public feedback highlighted the need for simpler referrals, clearer criteria, better coordination and communication, with staying safely at home and avoiding unnecessary hospital admissions seen as key outcomes
- There was strong alignment between staff and public views on the three strategic aims: timely and simple support, enabling people to remain at home, and maximising independence.

The difference it made

- Intermediate Care services were highly valued for supporting recovery, promoting independence and helping people remain at home.
- Person-centred care, compassionate staff and coordinated multidisciplinary working were seen as key strengths across services.
- Services such as Reablement, Community Hospital Beds, Transitional Care Beds and Urgent Community Response were widely viewed as effective and beneficial.
- Capacity, staffing, referrals and communication were recurring challenges, with calls for simpler pathways and better co-ordination.
- There was strong alignment between staff and public views on priorities: timely and simple access, staying safely at home, and maximising independence while reducing reliance on long-term care.



Public & Patient Participation

Sensory loss

Sensory loss affects people of all ages across Lincolnshire and can significantly impact independence, wellbeing and access to health and care services when systems are not accessible or inclusive.

Previous local and national evidence, alongside earlier engagement activity, has consistently highlighted barriers for people living with sight loss, hearing loss, Deafness and dual sensory loss.

In response, NHS Lincolnshire Integrated Care Board (ICB), Lincolnshire County Council (LCC) and HWLincs worked collaboratively to build a shared understanding of lived experience. The engagement explored everyday experiences of accessing health and care services, focusing on access, communication, navigation and system design.

Engagement was led by the ICB, supported by LCC and HWLincs, and used digital, social media, bulletin, partnership and face-to-face routes enabling wide participation from people with sensory loss, as well as carers and advocates.

Our approach

- A nine-week programme of engagement took place between 16 January and 24 March 2026, combining an accessible online survey with in-depth community conversations.
- Feedback was gathered from people with lived experience of sensory loss, carers, family members and professionals. Feedback was analysed across demographic, equality and health inequality groups, with differences highlighted where they emerged.

Engaging our communities

Engagement used a range of formats to support inclusion and reach under-represented groups:

- 322 survey responses, including completed and partial submissions
- 4 telephone interviews and additional written feedback
- Community conversations with around 150 people living with sensory loss
- Visits to 11 community and voluntary sector locations across rural, coastal and urban areas
- Collaboration with specialist organisations including Lincolnshire Sensory Service, blind societies, Deaf groups and voluntary organisations

What we heard

- People valued the care they received once accessed but described significant barriers at the front door of services, particularly booking GP and hospital appointments.
- Phone-based and digital-only systems often excluded people, creating avoidable barriers.
- Communication needs were not consistently recognised or acted upon, requiring people to repeatedly explain their needs and increasing reliance on carers.
- Health and care environments were often difficult to navigate, with poor signage, verbal-only systems and inaccessible layouts, compounded by rurality, transport and distance.
- Sensory and voluntary sector services were highly valued where accessed, but awareness was low.
- Some experiences raised patient safety and safeguarding concerns, including understanding medication, inappropriate reliance on family members to interpret, and missed or delayed care.

The difference it made

- Engagement provided a system-wide picture of lived experience, bringing together insight from surveys, community conversations and partner organisations
- Findings were reported to NHS Lincolnshire ICB and Lincolnshire County Council to inform service improvement and policy discussions
- Insight will directly inform the future direction and procurement of Lincolnshire Sensory Services
- The work strengthened understanding of where the Accessible Information Standard is not being implemented consistently and highlighted opportunities to improve primary care access, communication recording, navigation of services and cross-system coordination.



Public & Patient Participation

Vaccinations engagement

The engagement formed part of a wider programme of work to support the development of effective vaccination communications, helping families and carers understand the importance of vaccinations and encouraging informed, confident uptake.

We wanted to hear directly from families and carers to gather feedback on proposed vaccination campaign materials, ensuring they were clear, accessible and effective.

The engagement focused on testing and discussing:

- People's views on the draft vaccination posters and materials
- Whether the images and wording were clear, understandable and meaningful
- Whether the materials would encourage vaccination uptake
- What could be improved if the materials did not resonate
- What people liked about the campaign content
- Whether the information encouraged people to seek further information, for example by speaking to a practice nurse or attending for vaccination

This work supported wider efforts to promote the importance of vaccinations and ensure communications help protect individuals, families and communities in the safest and most effective way.

Our approach

- Based on local data, engagement was targeted and focused on families with children aged 0–5 and 5–11 years, where vaccination uptake was known to be lower. It included specific focus on Eastern European and Nigerian communities, and families living in areas of higher deprivation.
- A tailored engagement approach was developed to ensure activity was culturally appropriate, accessible and relevant, and to support meaningful conversations with families about vaccination information and campaign materials.

Engaging our communities

- Engagement took place through a multilingual group at Boston Children's Centre.
- Additional face-to-face engagement was delivered at a community health event at Bridge Central, Lincoln.
- We spoke directly with eight families, including those from Lithuanian, Polish, Latvian, Romanian and English-speaking communities.

What we heard

- Reasons for not vaccinating included children being perceived as fit, healthy and having good immunity, alongside parents feeling well-informed and confident about booking if they chose to.
- Reasons for vaccinating focused on protecting children's health, with information typically received through letters, school communications or GP correspondence.
- Posters were unlikely to influence hesitant families. Participants preferring strong visuals and minimal text and finding longer or more technical wording harder to understand. Posters were felt to work best when people have time to read, such as GP practices or children's centres, not shops. Adding website links / QR codes and avoid images of needles.
- Trusted settings such as GP surgeries, health visitors and children's centres were preferred sources for vaccination information, either online or through leaflets.
- Booking by text message at GP practices was viewed positively as convenient and easier than telephoning. Some families felt translated materials were not always necessary, depending on confidence using English.

The difference it made

- Feedback informed improvements to vaccination campaign materials.
- Links were added alongside QR codes to make it easier to access further information.
- Individual posters were developed for each childhood vaccine to improve clarity and relevance.
- Posters and leaflets were distributed to children's centres, supporting delivery via trusted settings.
- Prevention and vaccination remains a key programme of work for the ICB, with learning from this engagement continuing to inform future communications and outreach.





Health Inequalities

Helping people to age well

To help people live well for longer, the Lincolnshire Integrated Care System teamed up with health and wellbeing organisations across the county to promote healthy ageing and reduce the risk of frailty.

This partnership focused on encouraging older adults to stay active, keep doing what they love, and stay socially connected — all key factors in supporting independence and wellbeing.

It was identified that people needed better access to useful information and services, so a campaign was developed to make it easier for people to find the right information and support when they need it.

Our approach

- Lincolnshire Integrated Care System worked with health, wellbeing and community partners to promote healthy ageing and reduce the risk of frailty.
- The campaign focused on helping people live well for longer by staying active, socially connected and independent.
- The campaign was developed to improve access to clear, timely information and support.

Engaging our communities

- The campaign was co-produced with older people, ensuring it reflected real experiences and priorities.
- A frailty co-production group was established by the ICB Engagement Team.
- 180 people aged 60+ expressed interest in being involved, with 14 joining the co-production group to shape the campaign.
- Members of the co-production group worked alongside system partners to design campaign messages and materials.

What we heard

- Clear accessible information is essential to support healthy ageing
- People wanted better signposting to local wellbeing hubs and activities
- Encouragement and reassurance help people to stay motivated to look after their health
- Staying connected and continuing to do the things people love is the key to wellbeing as you get older
- Greater awareness of what carers, family, friends, and neighbours can do to help ageing.

The difference it made

- A co-produced “Let’s Age Well, Lincolnshire” campaign was created to inspire and support healthy ageing.
- A suite of accessible materials was developed, including videos, social media content, leaflets and a signposting booklet.
- The work received county-wide recognition, with the ICB Engagement Team shortlisted as finalists for the *Co-producing Together Award* at the Lincolnshire Care Awards.
- Co-produced by people of Lincolnshire - videos: [Let's Age Well!: Let's Age Well - Walking Football](#); [Let's Age Well – Alison](#)



Our Shared Agreement

Community Listeners

The Our Shared Agreement (OSA) Community Listening programme was developed to strengthen relationships between people and the health and care system in Lincolnshire by putting listening, lived experience and human connection at the heart of change. The approach recognises that meaningful improvement happens through everyday conversations in which people feel heard, respected and valued, rather than through formal consultation alone.

The programme was co-produced throughout, supported by the OSA Steering Group and a dedicated Community Listeners co-production group, ensuring people with lived experience and professionals jointly shaped the approach, materials and priorities.

Listeners were supported through briefing sessions, guidance and practical resources, building confidence and capability while maintaining a non-formal, human approach to listening.



Our approach

- The role of involvement was to embed community-based, relational listening as a core practice across the system.
- A network of Community Listeners was established to have informal, respectful conversations with residents about their experiences of health, care and wellbeing in places where people already live, meet and connect.

Engaging our communities

The Community Listening model enabled engagement in real-life settings, including community groups, events, workplaces and pop-in sessions, rather than only organisational or NHS venues.

Key activity included:

- 15 open Listener Briefing sessions
 - Recruitment and support of 35 Community Listeners
 - Delivery of 4 Listener Pop-In sessions
 - Listening in community spaces and everyday settings across Lincolnshire
- To date, Community Listeners have gathered 47 individual stories and 5 group-based stories.

What we heard

Early thematic analysis of listener stories highlights that what matters most to people includes:

- Being treated as a whole person and feeling genuinely listened to
- Compassion, kindness and trust in relationships with services
- Timely access to diagnostics and care
- Feeling supported as carers and family members
- Better coordination and communication between services
- Strong community and social support
- Support for prevention, self-care and emotional wellbeing
- The emotional impact of navigating health and care systems.

The difference it made

- Informal, relationship-based listening builds trust and enables people to share experiences often missed by structured engagement.
- Listener stories provide deeper insight into the emotional and everyday realities of using health and care services.
- Community listening is reinforced as a core practice for cultural and behavioural change, not just an engagement activity.
- Ongoing co-production and recruitment, including inviting organisations to become Listening Partners
- The work highlights the importance of clear feedback loops, so listeners can see how stories are used and the difference they make.
- Aligning activity with wider It's All About People and OSA priorities.

Our Shared Agreement



Public & Patient Participation

Special Educational Needs & Disabilities (SEND)

The Integrated Care Board (ICB) remains committed to placing children and young people with SEND at the heart of decision-making, ensuring they feel supported, included and safe.

In 2025/26, SEND focused on strengthening key SEND pathways across Lincolnshire, including EHCP quality, neurodevelopmental services, and pre-school speech and language provision.

Children and young people, families, schools, health partners and practitioners played a vital role in shaping priorities and informing improvement activity.

Our objectives were to:

- Improve the quality, consistency and impact of Education, Health and Care Plans (EHCPs).
- Reduce waiting times and improve clarity across autism and ADHD pathways.
- Increase early access to Speech and Language Therapy, support prevention & manage demand.



Engaging our communities

- Engagement took place through audits, clinical panels, digital tools, school forums, co production groups and CYP participation sessions, ensuring lived experience and professional insight shaped improvement.
- EHCP quality was strengthened through multi-agency audits, refreshed quality frameworks, co-produced guidance and exemplar plans, school-based audits, and development work with Lincolnshire Young Voices and partners including Educational Psychology.
- Neurodevelopmental pathways were improved through engagement with providers, redesign of triage and referral processes, significant improvement in referral conversion rates, and targeted investment to increase assessment capacity.
- Speech and Language Therapy access was enhanced through same-day drop-in sessions via Family Hubs, digital triage to reduce unnecessary waits, and early co-production of outcome-based commissioning aligned to the Balanced System Framework.

What we heard

- Families wanted more consistent, higher-quality EHCPs, with clearer outcomes and stronger reflection of children and young people's aspirations.
- Children and young people emphasised the importance of having a visible and meaningful voice in their plans.
- Parents reported that neurodevelopmental pathways were difficult to navigate, particularly due to historic waiting times and inconsistent communication.
- Families valued quick access, local support and practical advice, especially within the pre-school Speech and Language Therapy model.
- Communities in areas such as Spalding and Boston highlighted geographical inequity, with travel and access being key barriers.
- Across all pathways, families wanted timely, transparent communication and clearer expectations about next steps.

The difference it made

- EHCP quality improved, with greater consistency, stronger multi agency assurance and clearer representation of children and young people's voices through refreshed templates and guidance.
- Neurodevelopmental pathways showed significant improvement with higher referral to appointment conversion, increased assessment capacity and clearer foundations for future redesign.
- Speech and Language Therapy access improved, with earlier same-day support, shorter waiting times, increased parent confidence and more effective use of digital triage to prevent escalation.
- Continue strengthening EHCP quality assurance, multi agency training and co production with children, young people and families.
- Maintain ongoing involvement through audits, feedback, digital engagement, CYP participation and co production, ensuring continuous learning and improvement.



Lincolnshire Maternity & Neonatal

Black and Asian Maternal Health Group

Evidence shows that Black and Asian women are at a significantly higher risk of poorer maternity outcomes compared to the wider population. Addressing these inequalities requires services to be shaped by the lived experiences of those most affected.

To support improved maternity outcomes for Black and Asian women in Lincolnshire, involvement has played a central role in understanding barriers to care, highlighting what matters most to families, and identifying opportunities for more culturally responsive support. Listening directly to Black and Asian women and families has been essential to ensuring that maternity services are inclusive, equitable and reflective of local communities.

As a founding member of the Black and Asian Maternal Health Group, NHS Lincolnshire works as part of a multidisciplinary partnership representing the Lincolnshire Maternity and Neonatal System.

The group brings together NHS providers, commissioners, public health, voluntary sector partners and communities to collaboratively develop a programme of work focused on reducing inequalities and improving maternal outcomes.

Our approach

- Lead and supported engagement activity with Black and Asian women and families, ensuring their voices are heard, valued and meaningfully reflected in both service delivery and strategic decision-making.
- The engagement activity was designed to explore lived experience, identify barriers to accessing care, and understand how services can better meet the cultural and needs of families.

Engaging our communities

- Monthly meetings where patient feedback and insight are considered from the engagement events and activities.
- Patient reps are invited to the group to share lived experience.

What we heard

- Cultural, dietary and religious needs are not consistently understood or supported within maternity care. Access to familiar, culturally appropriate food during maternity stays was seen as essential for comfort, wellbeing and breastfeeding.
- Clinical pathways need to better reflect the needs of babies of colour, including appropriate use of tests rather than visual assessment alone.
- Antenatal education and infant feeding support need to be more inclusive and culturally responsive.
- Access to Perinatal Mental Health Services may not be equitable, highlighting the need for better data and understanding of lived experience.
- Face-to-face community engagement creates trusted, safe spaces for families to share experiences openly.
- Men in Black and Asian communities want more information and support, particularly around pregnancy, birth and early parenthood.

The difference it made

- NHS Lincolnshire Community and Hospital NHS Group Collaboration Award at the 2025 Staff Awards
- Insight informed targeted quality improvement projects, helping reduce inequalities and improve maternity experiences for Black and Asian women.
- Clearer, culturally sensitive guidance on medications, improved understanding of dietary and religious needs, and action to improve access to culturally appropriate food on maternity wards.
- Strengthened clinical pathways including routine Transcutaneous Bilirubin (TCB) testing
- Informed more inclusive antenatal education, improved understanding of Perinatal Mental Health access through better data and coding, and work to strengthen cultural awareness in breastfeeding support.
- Ongoing community engagement, including coffee mornings and mosque-based listening events, has created trusted spaces for future conversations, including support for men and partners.

Lincoln Mosque – listening event

Black and Asian women experience poorer maternity outcomes nationally, and local engagement has highlighted the importance of listening directly to families in trusted, culturally appropriate settings.

The maternity and neonatal team ran a listening event aimed to better understand the lived experiences of Black and Asian women using maternity services in Lincolnshire, to help improve support, accessibility and outcomes.

Our approach

- The aim of the engagement was to provide a safe, culturally sensitive space where women could openly share their maternity experiences.
- The event focused on listening, building trust and understanding what works well, what feels challenging, and how services could better meet cultural, religious and practical needs.

Engaging our communities

A female-only, face-to-face listening event was held at Lincoln Mosque in line with religious and cultural expectations. The session was supported by professionals from Lincolnshire maternity services and the County Council Infant Feeding Team.

- Eight women attended the event
- Discussed maternity care, breastfeeding, mental health, antenatal education and family support
- The mosque created a comfortable, trusted space for open discussion.

What we heard

- Barriers to engagement, including cultural shyness, language needs, limited family support and discomfort discussing health matters with men
- A strong need for privacy, modesty and culturally appropriate breastfeeding support
- Low attendance at antenatal education due to language barriers and lack of women-only sessions
- Desire for greater involvement of fathers, with requests for parallel sessions for men
- Perinatal mental health remains taboo, with women describing isolation and a need for basic, destigmatising awareness in community settings
- Participants found the event as supportive and valuable and asked for more sessions.

The difference it made

- Insights from the event have strengthened cultural awareness among frontline staff, with learning applied directly to practice.
- An Infant Feeding Support Worker recognised cultural communication cues during a home visit, helping a mother share previously undisclosed pain and breastfeeding difficulties.
- Findings were shared with the Black and Asian Maternal Health Group and are informing the Black and Asian Maternal Health Improvement Plan.
- Engagement has directly informed live quality improvement work, including: improving antenatal education to better reflect cultural needs and exploring use of fridges and microwaves on maternity wards to support culturally familiar food and breastfeeding
- A male-only maternity awareness session is being planned at Lincoln Mosque.
- Plans to deliver a similar listening event at Boston Mosque, building on the success of the Lincoln event.



Lincolnshire Maternity & Neonatal

Breastfeeding – expressing with support

Breastfeeding rates in Lincolnshire remain below the national average. Feedback from families has highlighted that returning to work can be a significant barrier to continuing breastfeeding, particularly where support, rights and practical arrangements are unclear.

This work aimed to understand mothers' experiences of breastfeeding when returning to work and identify what information and support would help them continue breastfeeding if they wished to do so.

Our approach

- The role of involvement was to listen directly to mothers about the challenges they face when combining breastfeeding and employment.
- Engagement focused on understanding experiences, identifying gaps in awareness, and shaping practical resources that would support both employees and employers.

Engaging our communities

- Engagement took place through:
 - Breastfeeding support groups
 - Roadshows and community events
 - One-to-one conversations and interviews with families
- This approach enabled open conversations with breastfeeding mothers at different stages of their journey, capturing a broad range of experiences.

What we heard

- Many women felt pressured to stop breastfeeding earlier than they wanted when returning to work.
- A lack of awareness about legal rights and available workplace support was a significant barrier.
- Some women felt unsure how to raise the issue with their employer or did not know what reasonable support they could expect.

The difference it made

- In response to what families told us, the Lincolnshire Maternity and Neonatal Programme developed an information pack for employers and employees.
- The pack clearly sets out legal obligations, practical support options, and the benefits of supporting breastfeeding and expressing at work.
- Insight directly shaped the content and focus of the materials, ensuring they reflect real experiences and concerns.
- A county-wide campaign has been developed to promote the information packs.
- Resources will be shared with local businesses and employees as part of wider breastfeeding promotion work.
- Ongoing engagement will support increased awareness of rights, practical support, and the benefits of breastfeeding-friendly workplaces.

Community events

Community events play a vital role in ensuring a wide range of voices are heard, particularly from families who may not engage with formal feedback processes.

This work focuses on meeting people where they are, using trusted local settings to listen, learn and improve maternity and neonatal services across Lincolnshire.

Our approach

- The role of involvement was to create accessible, informal opportunities for families to share their experiences, views and priorities.
- Engagement focused on listening rather than consultation, recognising that meaningful insight is often gained through everyday conversations in familiar settings.

Engaging our communities

- The engagement team attended a wide range of roadshows, community events and group sessions across the county, including:
 - Family Hub groups and networks
 - Community and faith-based organisations
 - Cultural and migrant community groups
 - Parent and carer forums
 - University and international student events
- This approach helped reach families with diverse backgrounds and experiences, including those less likely to take part in surveys or structured engagement.

What we heard

Across community events, families shared that:

- Language barriers can make it difficult to access services, with some women preferring female interpreters where possible.
- Returning to work can be a barrier to breastfeeding, with more employer support needed.
- Many women reported positive maternity experiences, alongside areas where support could be improved.
- Families strongly valued face-to-face communication over other contact methods.

The difference it made

- Feedback contributed to the development of information packs for employers and employees, supporting breastfeeding and expressing at work.
- Insight is informing ongoing work to improve communication, including exploring tools to reduce language barriers where interpreters are unavailable.
- Feedback is routinely shared with the Lincolnshire Maternity and Neonatal System Board and sub-groups, ensuring community insight informs service improvement and strategic decisions.
- Some families were supported to share their experiences further through the Maternity and Neonatal Voices Partnership, helping shape future service direction.
- Community-based engagement will continue, guided by gap analysis and ongoing insight from families and partners.
- Learning from community events will continue to inform maternity, neonatal and children's service development, ensuring every family has the opportunity to be heard.



Primary Care

Engagement support

The ICB is supported by a dedicated Primary Care Communications and Involvement Team, ensuring protected capacity to effectively involve patients, carers and communities in the development of primary care services.

Throughout the 2025/26, the team has supported a range of service changes and initiatives across primary care, helping to ensure that meaningful engagement and consultation takes place. This has enabled patient voices to be heard and considered in decision making processes.

Key examples:

- Supported patient involvement in service change, ensuring patient views informed consultations, decision-making and ICB responses during periods of change.
- Delivered targeted engagement on community pharmacy services, GP interpretation and translation, and specific care pathways to understand patient experience and inform service improvement.
- Strengthened the patient voice through ongoing support to Patient Participation Groups (PPGs) and Patient Councils, encouraging wider participation and shared learning.
- Used insight from Healthwatch reports, patient surveys and community events to inform quality, access and improvement work across primary care.
- Provided support to digital co-production group to complete their work on the new digital service model. Further digital engagement will be continued through PPG meetings.

Click on the tiles to go to more examples of involvement within specific projects and programmes

Community
Pharmacy

GP Interpretation
& translation
services

Portland Street

Stoma, Bowel,
Transanal &
Catheter

Spilsby
Practice

Cliff Villages

Patient
Participant
Groups

Patient Council
& Locality
Meetings



Click this symbol to return
to this page

Primary Care

Community Pharmacy

NHS Lincolnshire Integrated Care Board (ICB) carried out engagement to better understand awareness, use and experiences of community pharmacy services across Lincolnshire.

This work followed discussion of the Public Health and Health Inequalities chapter of the Lincolnshire Community Pharmacy Strategy and aimed to gather insight from patients, NHS staff and community pharmacy teams.

The engagement sought to:

- understand public awareness and experiences of community pharmacy services
- explore how NHS staff and system partners refer and signpost people to community pharmacies
- gather community pharmacy staff perspectives on service delivery and health inequalities
- identify opportunities to improve awareness, referral pathways, partnership working and future service development

The findings will help inform future work to strengthen preventative care, improve access to services, and maximise the role of community pharmacy within the wider health and care system in Lincolnshire.

Our approach

- We used three targeted surveys to gather insight from patients, NHS staff and community pharmacy teams, focusing on awareness, use and experiences of community pharmacy services.
- A communications and distribution plan was used to promote the surveys widely, including sharing through NHS and partner networks, community pharmacy channels, newsletters and digital platforms to maximise reach and participation

Engaging our communities

Promoted Engagement took place between 17 October and 30 November 2025 and used three complementary surveys to capture views from key groups across Lincolnshire:

- Public and Patient Survey on Community Pharmacy – *(277 responses)*
- NHS Staff and Stakeholder Survey – aimed at NHS staff and system partners *(42 responses)*
- Community Pharmacy Staff Survey – staff working in community pharmacies *(12 responses)*

The surveys were widely promoted through ICB & Primary Care channels, partner networks and community pharmacies supported by digital posters including QR codes.

What we heard

- People generally had positive experiences of community pharmacies, which were mainly used for non-urgent advice - awareness of some services was limited and clearer information could encourage greater use.
- NHS staff reported good awareness of community pharmacy services and routinely signposted patients to pharmacies to reduce pressure on GP services.
- Community pharmacy teams highlighted their role in supporting people affected by health inequalities and reported high confidence in providing advice, signposting and support

The difference it made

- Improved understanding and awareness of community pharmacy services, informing future communications and resources.
- Strengthened referral / signposting and collaboration between NHS and community pharmacies.
- Contributed to delivery of the Lincolnshire Community Pharmacy Strategy, supporting prevention, improved access and better integration of community pharmacy within the health and care system.
- Informed training and information needs to support appropriate use of pharmacy services and address health inequalities.



Primary Care

GP Interpretation and translation services

Access to effective interpretation and translation services in primary care is essential to ensure people can communicate safely, confidently and meaningfully with their GP and wider practice teams. For Deaf people and those whose first language is not English, communication barriers can affect understanding, decision-making and access to care, particularly as primary care is often the first point of contact.

Therefore, we wanted to hear directly from people who experience communication barriers when accessing GP services, with a specific focus on interpretation and translation. This included engagement with members of the Deaf community and with community leaders supporting people for whom English is not a first language.

The aim was to understand what is working well, where barriers exist, and how interpretation and translation services could be improved to support safe, inclusive and accessible primary care. This work was considered alongside wider Sensory Services engagement to inform improvements to GP interpretation and translation services across Lincolnshire.

Our approach

- The work began in December 2025 and will continue into summer 2026. To date, the ICB has engaged with a range of community groups representing Deaf people and people for whom English is not a first language, both directly and through trusted partner organisations.

Engaging our communities

- Gathered insight from approx. 60 people
- Lincolnshire Sensory Services (LSS): The ICB met with members of the Deaf community (2) and BSL interpreting staff (2) to gather in-depth feedback, with additional written (4) insight provided
- People for whom English is not a first language: Feedback gathered via community leaders and support organisations, including displaced Ukrainian residents (10), asylum seekers (13) in Skegness, Polish individuals (3) supported by domestic abuse services, and Afghan resettlement families registered across multiple GP practices.
- Local faith and community groups: Lincoln Mosque community leader supported this work by gathering feedback through the questionnaire (17).

What we heard

- High-quality, reliable interpretation was described as essential for confidence and independence when accessing GP services, concerns raised about availability, quality, suitability & consistency.
- There was a strong preference for face-to-face interpretation, particularly for Deaf people and for sensitive or complex appointments.
- Continuity and trust were important, with frequent changes of interpreter described as stressful.
- Digital and text-based options were helpful when accessible and easy to use, but inconsistent practice between GP surgeries created additional barriers.

The difference it made

- Feedback has provided a clearer understanding of how GP interpretation and translation services are experienced in practice. Feedback is being used to inform the procurement and design of GP interpretation and translation services, ensuring future provision is accessible, inclusive and shaped by lived experience.
- Detailed insight was shared with Primary Care, Contracts teams and the service provider to inform collective understanding.
- Engagement findings are informing service improvement discussions and future procurement and mobilisation of GP interpretation and translation services.
- The work reinforced the importance of meeting the Accessible Information Standard, improving consistency across practices, and ensuring services meet a range of communication needs.



Primary Care

Portland Street

Patients registered with Heart of Lincoln Medical Group (HLMG) were invited to share their views on a proposal to close the Portland Branch Site, located on the first floor of Newland Health Centre, 34 Newland, Lincoln LN1 1XP.

This engagement formed part of a public consultation following the practice's application to NHS Lincolnshire Integrated Care Board (ICB) to close the branch site. The proposal was based on several factors, including service sustainability, equity of access and patient usage patterns.

Key reasons for the proposed change included:

- The limited range of services available at the Portland Branch Site, resulting in inequalities compared to other practices.
- The availability of nearby sites with a wider range of services, improved facilities and better accessibility.
- Evidence that most HLMG patients already attend alternative sites for appointments.
- Rising service and utility costs, making the site financially unsustainable.

Our approach

- To understand the impact of the proposed closure of the Portland Branch Site, the practice invited feedback from patients registered at the site to take part in the consultation to inform the ICB's decision-making.
- The practice was supported by the ICB Primary Care Engagement Team, who led the engagement activities, including the communications plan, survey and analysis, to explore impacts on access, quality and patient experience.

Engaging our communities

- Public consultation ran between 11 March and 5 May 2025 to gather feedback from patients registered at Heart of Lincoln Medical Group (HLMG).
- Engagement included:
 - An online and paper survey – 48 responses
 - Three patient engagement events – supported by ICB, practice staff and PPG – despite direct communication attendance was low, only two patients attended the first event.
 - Direct communication with affected patients, including letters and two SMS reminders.

What we heard

- Use of the branch site - most respondents (75%) already used other HLMG sites, with limited recent use of the Portland Branch Site.
- Travel - most patients attended appointments on foot (44%) or by car (38%).
- Impact of closure - views were mixed; some raised concerns about access and transport, while others felt it would have little impact as they already used other sites.
- Future plans - most said they would continue using another HLMG site, with a smaller number considering registering elsewhere or unsure.

The difference it made

- The ICB approved the practice's proposal to close the Portland Branch Site on 24 June 2025 following the public consultation.
- A new triage platform was introduced, improving access to services, reducing call volumes during peak times, and enabling most patient requests to be resolved on the same day.
- Improved signposting to appropriate services, including Pharmacy First, helped increase appointment availability across the practice.
- Accessibility concerns were addressed by offering affected patients the option to register at Brayford Medical Practice, located on the ground floor of the same building.



Primary Care

Stoma, Bowel, Trans-anal & Catheter

Stoma care, trans-anal irrigation (TAI) and catheter services provide essential, ongoing support for people living with long-term and often life-changing health needs.

These services play a key role in helping individuals manage their condition safely, comfortably and with dignity, while supporting independence and quality of life.

The aim of the survey was to understand lived experiences of stoma, trans-anal irrigation and catheter care services across Lincolnshire.

In particular, the survey explored experiences relating to:

- access to reviews and specialist support
- ordering and supply of equipment
- dignity, respect and communication
- gaps in care pathways and ongoing support needs

The survey also sought to identify what was working well and where improvements could be made, drawing on feedback from patients, carers, family members and professionals to help inform future service development and improvement.

Have your say

Help us to improve stoma care, bowel care and Transanal Irrigation (TAI) services, and catheter products

NHS Lincolnshire Integrated Care Board (ICB) is inviting people with a stoma, those using Transanal Irrigation (TAI) or catheter products, and their carers, to share their views on stoma, bowel, and catheter care products and services across Lincolnshire.

How to take part

Patients, carers, and anyone who uses these services are encouraged to complete the survey, available online at: www.lincolnshire.icb.nhs.uk/stoma-tai-catheter-care-survey

Those who would prefer to speak to someone, need assistance completing the survey, require it in an alternative format or language, or need an interpreter can contact the Engagement Team.

• Email: icb.involveus@nhs.net
• Phone: 07814 939396

Scan here

Our approach

- Produced online survey to capture lived experience
- Produced materials complete with QR codes and survey links – distributed to groups, communities and professionals
- Engagement plan focussed on – seeking views and lived experience on the gaps in provision and suggested improvements.

Engaging our communities

Between December 2025 and February 2026, NHS Lincolnshire ICB ran a countywide survey to capture lived experience of stoma, trans-anal irrigation (TAI) and catheter care services.

- A total of 176 responses from patients, carers, family members and a small number of health and care professionals, with feedback representing all Lincolnshire districts and a broad age range.
- Most responses related to stoma care (90) and catheter care (60), with only 9 focused on TAI.
- The survey was promoted widely through ICB communications, GP practices, hospital clinics, voluntary and community sector partners, social media and newsletters.
- The survey was available online and paper format, ensuring accessibility.

What we heard

- Overall satisfaction was generally high across stoma, catheter and TAI care, particularly where people felt treated with dignity and respect and had access to knowledgeable specialist support.
- Regular reviews were a key gap, with many people reporting they had never received a review.
- Home delivery services were widely used for equipment supply and viewed as working well.
- TAI feedback, while from a small number of respondents, reflected largely positive experiences where specialist input was available, alongside a need for clearer pathways and reviews.
- People said care worked best when support was reliable, easy to access, & enabled independence.
- Common areas for improvement included clearer care pathways, knowing who to contact for advice, and quicker access to support when problems arose, particularly following surgery for stoma care.

The difference it made

- Feedback highlighted where services work well and where improvements are needed, particularly around access to reviews, specialist support and post-discharge care.
- Findings were shared with the Medicines Optimisation team to inform service improvement discussions and help strengthen care pathways and patient experience.
- Insight from the survey will continue to inform future service improvement work, with a focus on clearer pathways, improved access to reviews and specialist support.
- Updates will be shared as this work progresses and improvements are taken forward.

Primary Care

Spilsby Practice



NHS Lincolnshire Integrated Care Board (ICB) undertook engagement with patients from Spilsby Surgery following the temporary closure of the practice due to the removal of Care Quality Commission (CQC) registration.

The closure, which took effect on 30th September, was required to ensure compliance with regulatory requirements and patient safety, while alternative arrangements were put in place to maintain access to primary care services.

The removal of the CQC registration caused significant uncertainty and anxiety for patients, particularly in relation to accessing GP services and prescribed medication. Engagement was prioritised to ensure patient voices were heard while services were stabilised and future arrangements were considered.

Learning from this engagement helped to shape how the ICB approaches involvement during periods of service change, including subsequent work in other areas such as the Cliff Villages. The insight reinforced the importance of early, clear and accessible communication, visible face-to-face engagement, and close working with GP practices, pharmacies and local partners to identify risks and support safe access to care for vulnerable groups when unexpected disruption occurs.

Our approach

- Understand patients' experiences, concerns and priorities following the temporary closure.
- Provide reassurance and practical support – e.g. access to medication, ongoing care was at risk.
- Listen to what mattered most to patients / carers to shape safe and patient-centred decisions.
- Keep patients informed during a period of frequent change, ensuring clear, timely and consistent communication. See [FAQs](#)
- Work closely with local leaders, including MPs and councillors, to support information sharing, respond to concerns and help maintain confidence within the community.

Engaging our communities

- Provided in-person engagement support at Lincolnshire Co-op Pharmacy over four days during the temporary closure of Spilsby Surgery.
- Spoke directly with patients collecting urgent medication, offering reassurance and information.
- Help manage demand safely, supporting with practical measures alongside pharmacy staff.
- Worked closely with ICB, pharmacy and GP teams to resolve prescribing issues.
- Organised a public engagement event at Franklin Hall, providing face-to-face updates, addressing questions and offering reassurance. The event was attended by approx. 50 people.

What we heard

- Patients told us that the sudden closure of the practice caused significant anxiety and distress, particularly around access to urgent medication.
- Fear of running out of essential medication for heart conditions, pain relief, and end-of-life care etc.
- Confusion about emergency prescribing / NHS111 advice - was felt to be inconsistent and unclear.
- Poor communication, many patients unaware of the closure until arriving at the surgery or pharmacy.
- Increased anxiety among older patients / those without transport – getting to other services.
- Concerns about queues, waiting times and safety at the pharmacy during a period of high demand.
- Many patients said that direct contact with ICB staff, at the pharmacy or the public engagement event, helped them feel reassured, heard and better informed.

The difference it made

- Face-to-face, on-the-ground engagement allowed ICB staff to provide reassurance, practical support and a listening ear to patients - during a period of high anxiety and uncertainty.
- Patient feedback gave the ICB clear insight into both the practical and emotional impact of sudden practice changes.
- Engagement helped identify groups most at risk, including older people, disabled patients and those without transport, shaping the ICB's response and communications.
- Learning from this work strengthened internal assurance processes and reinforced the importance of visible, in-person engagement during service disruption.

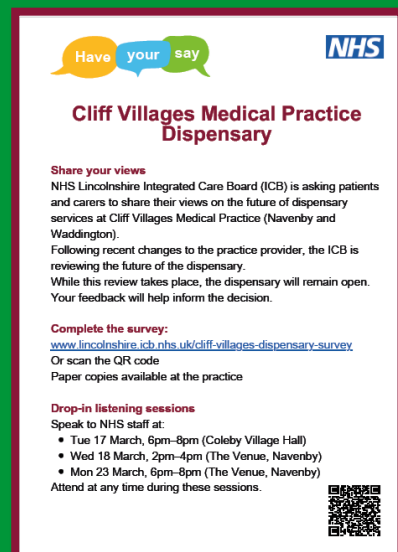
Primary Care

Cliff Villages

On 19 February, NHS Lincolnshire Integrated Care Board (ICB) undertook engagement with patients in the Cliff Villages following the temporary closure of GP services due to the removal of Care Quality Commission (CQC) registration.

The closure was required to ensure regulatory compliance and patient safety, while alternative arrangements were put in place to maintain access to primary care services. Learning from earlier engagement at Spilsby Surgery shaped how this work was approached, with a strong emphasis on early communication, visible face-to-face support, and close working with GP practices, pharmacies and local partners.

Applying this learning helped the ICB respond quickly to patient concerns, support access to urgent care and medication, and ensure that patient voices were heard during a period of uncertainty and change.



The poster is titled 'Have your say' and 'Cliff Villages Medical Practice Dispensary'. It is from NHS Lincolnshire. The text asks patients and carers to share their views on the future of dispensary services. It mentions recent changes to the practice provider and a review of the future of the dispensary. It provides a link to the survey: www.lincolnshire.icb.nhs.uk/cliff-villages-dispensary-survey and a QR code. It also lists drop-in listening sessions: Tue 17 March, 6pm-8pm (Coleby Village Hall), Wed 18 March, 2pm-4pm (The Venue, Navenby), and Mon 23 March, 6pm-8pm (The Venue, Navenby). It states that paper copies are available at the practice.

Our approach & engagement

Building on learning from earlier engagement at Spilsby, the ICB delivered targeted, face-to-face engagement and practical support in the Cliff Villages during a period of uncertainty. Engagement activity included:

- In-person engagement support at Pharmacy in Waddington, where ICB staff spoke directly with patients waiting for urgent medication, offering reassurance and information.
- ICB staff attendance at the practice to support both staff and patients during the transition period.
- A public survey running from 9–24 March 2026, which received 334 responses, including 31 responses on paper version - ensuring accessibility for people unable to respond digitally.
- Three listening events (one at Coleby Village Hall and two at The Venue in Navenby), attended by approximately 60 residents, focused on hearing views about the future of dispensary services.
- Use of multiple communication routes, including practice communications, community networks, local stakeholders, social media and ICB channels. See [webpage](#).
- Information-sharing on alternative prescription options, alongside listening to concerns about accessibility, capacity and continuity of care.
- Across the Cliff Villages, engagement focused on listening, reassurance and clear communication, informed by learning from Spilsby to provide visible, on-the-ground support during this time.

What we heard

Patients shared their views through listening events and the public survey. Key themes included:

- Strong appreciation for the dispensary as a personalised and trusted service.
- Convenience and accessibility were highly valued by patients.
- Concerns about parking and mobility at local pharmacies, particularly for older people and those with limited mobility.
- Worries about pharmacy capacity to manage increased demand.
- Frustration about communication, including uncertainty about changes and what they meant for future services.

The difference it made

- Face-to-face, on-the-ground engagement allowed ICB staff to provide reassurance, practical support and a listening ear to patients - during a period of high anxiety and uncertainty.
- Patient feedback gave the ICB clear insight into both the practical and emotional impact of sudden practice changes.
- Engagement helped identify groups most at risk, including older people, disabled patients and those without transport, shaping the ICB's response and communications.
- Learning from this work strengthened internal assurance processes and reinforced the importance of visible, in-person engagement during service disruption.



Patient Participation Groups (PPGs) continue to play a key role in amplifying the patient voice across Lincolnshire, supporting local engagement and strengthening relationships between GP practices and their communities.

During 2025/26, the ICB continued to support GP practices in meeting their contractual requirement to have an active PPG, with a focus on sustaining involvement, broadening representation and sharing good practice.

Our approach

- Practices and PPGs were supported to recruit and retain members, including exploring ways to engage a broader and more representative range of patients.
- The ICB Primary Care Engagement Manager provided ongoing advice, guidance and support through regular PPG support meetings and one-to-one discussions.
- Some PPGs successfully recruited new and younger members, including sixth-form students, helping broaden perspectives within groups.
- The ICB continued to promote and share the PPG Toolkit, offering practical resources, templates and guidance to support effective engagement, governance and development.

The difference it made

This support helped strengthen and sustain PPG engagement across Lincolnshire by providing practical support, shared learning and clearer routes for patient involvement.

As a result:

- Practice engagement was strengthened, with PPGs better supported to influence local discussion and feedback.
- Inclusive participation improved, with some groups broadening membership and representation.
- Shared learning and confidence were enhanced through locality and countywide Patient Councils, supporting PPGs to raise patient issues effectively.
- Reach of involvement activity increased, with PPGs promoting ICB surveys and engagement opportunities within their local communities.

Primary Care

Patient Participation Groups

Patient Participation Groups (PPGs) across Lincolnshire continued to show strong commitment, creativity and leadership in strengthening patient involvement and supporting links between GP practices and their local communities.

Through their voluntary contribution, PPGs played an important role in amplifying the patient voice, supporting communication, and helping practices respond to local priorities and needs.

Here are some of their achievements throughout 2025/26.

Community engagement and health and wellbeing

Many PPGs organised or supported local health and wellbeing activities, including meet-and-greet sessions, coffee mornings, walking groups, and support focused on dementia and carers. Some groups also supported community transport and car schemes, helping patients access services more easily.

Supporting practice activity and assurance

PPGs supported practices in a range of practical ways, including assisting at COVID-19 and flu vaccination clinics, supporting patient communications, and contributing to Care Quality Commission (CQC) inspections where appropriate. Some groups also led or supported medication amnesty initiatives to promote safe disposal of unused medicines and reduce waste.

Communication and information sharing

Groups strengthened communication by establishing or maintaining Facebook pages, newsletters and practice information boards. PPGs helped promote ICB surveys and NHS campaigns and shared timely updates through local and community networks, improving the reach and visibility of patient information.

Digital support and inclusion

PPGs played an active role in supporting digital inclusion, including helping patients use online consultation tools, the NHS App and self-check-in systems. Some groups organised digital drop-in sessions or informal training to build confidence and improve access to digital services.

Gathering and representing patient feedback

PPGs gathered patient views through feedback sessions, attendance at community groups and informal engagement. This feedback was shared with practices, and through locality and countywide Patient Councils, to inform understanding of patient experience, access and communication.

Reducing missed appointments (DNAs)

Several PPGs worked with practices to support initiatives aimed at reducing missed appointments, including awareness-raising, patient messaging and practical actions to improve attendance and make better use of available appointments.

Raising awareness of patient involvement

Through local promotion and participation in wider engagement activity, PPGs helped increase awareness of patient involvement opportunities, encouraged new members to get involved, and reinforced confidence among patients that their views are listened to and valued.



Primary Care

PPG Patient Council

During 2025/26, the voices of Patient Participation Groups (PPGs) and the patients they represent continued to be heard through the ICB's established programme of bi-monthly Patient Council meetings.

Meetings were held on a rotating basis every two months, alternating between Locality Patient Council meetings and a County-wide Patient Council meeting. This model ensured that both local issues and system-wide priorities were discussed and understood.

Locality Patient Council meetings provided an opportunity for PPGs to share feedback on NHS services within their local area. These meetings were held both online and face-to-face and were attended by PPG representatives from each locality, the Primary Care Engagement Manager, and ICB Quality Leads.

County-wide Patient Council meetings enabled the ICB to share updates on current programmes of work, campaigns and opportunities for involvement, while creating space for PPGs to raise issues and contribute to shaping services at a system level. These meetings were held online and attended by PPG representatives from across Lincolnshire, the Primary Care Engagement Manager, the Associate Director of Nursing and Quality, and other relevant staff.

Our approach

- Patient Council meetings were held on a bi-monthly basis, with a total of three countywide Patient Council meetings and ten Locality Patient Council meetings taking place over a 12-month period.
- From February 2026, an additional evening Locality Patient Council meeting was introduced to improve accessibility and participation for people unable to attend daytime meetings.
- To support two-way communication, Patient Participation Groups (PPGs) continued to use the Locality Patient Council Feedback Form, enabling representatives to capture patient feedback between meetings and record key discussion points. Feedback from PPGs indicated that the form helped provide focus, supported structured discussion, and strengthened the feedback loop.

Working with our PPGs

- Countywide Patient Council meetings enabled ICB teams and partners to share updates and receive patient insight on key areas including dental services, GP access, primary care estates, Pharmacy First, neighbourhood development and emerging national priorities such as the NHS Ten-Year Plan.
- PPG feedback improved understanding of access pressures, workforce and capacity challenges, variation in patient experience, and the impact of estates planning, housing growth and digital systems on access to services.
- PPG Awareness Week was delivered in partnership with PPGs, raising awareness of patient involvement, celebrating contributions and encouraging new representatives to get involved.
- Locality Patient Council meetings across East, West, and South & South-West provided space for PPGs to raise local issues relating to GP access, waiting times, community pharmacy services, diagnostics, digital inclusion and service configuration.
- Locality-specific themes reflected geographical differences, including rural and coastal access challenges in the East, digital triage and continuity of care in the West, and population growth, estates pressure and diagnostic pathways in the South and South-West. Community pharmacy discussions, including
- Pharmacy First, explored how pharmacies could better support patient access through improved awareness and clearer signposting, with feedback shared with communications teams.
- All feedback raised through Patient Council meetings was formally recorded and fed into the ICB, supporting quality assurance processes, service improvement work and decision-making at both locality and system level.

The difference it made

- Feedback and issues raised through Patient Council meetings were reported into ICB Operational Quality Assurance Groups and Primary Care Quality Assurance and Oversight meetings, with any significant concerns escalated to the System Quality and Patient Experience Committee and the Lincolnshire ICB Board.



Health Inequalities

Engagement activities

What are health inequalities?

Health inequalities are **avoidable and unfair differences** in health between different groups of people. They are not random and are largely shaped by circumstances beyond an individual's control.

Health inequalities can include differences in:

- Health outcomes such as life expectancy and long-term conditions
- Access to care including availability and timeliness of services
- Quality and experience of care such as patient experience and satisfaction
- Behavioural / lifestyle factors including smoking, alcohol use, diet, and physical activity
- Wider factors affecting health, such as employment, housing, education, and access to welfare services

Differences in health and wellbeing are often experienced across four main factors:

- Socio-economic factors e.g., income, employment and financial security
- Geography e.g., urban, rural or coastal communities
- Personal characteristics e.g., age, sex, ethnicity, disability
- Socially exclusion, affecting groups such as people experiencing homelessness

In Lincolnshire, health outcomes vary significantly, with considerable gaps between different areas and population groups. Addressing health inequalities is essential to improving fairness, access and outcomes across the county.

What are we doing in Lincolnshire?

NHS Lincolnshire Integrated Care Board has a dedicated health inequalities team working alongside health and social care providers to reduce avoidable health inequalities across Lincolnshire. The team use the NHS England approach [Core20PLUS5 for adults](#) and for [Core20PLUS5 children and young people](#).

Focusing on those most at risk of poor health outcomes. This work is delivered in close partnership with Public Health (Lincolnshire County Council) with a shared aim of reducing the gap between the healthiest and the least healthy communities in the county.

The ICB is committed to listening to and involving communities and individuals who experience health inequalities. Dedicated engagement resources support his work ensuring that lived experience and community insight are central to the design and delivery of programmes aimed at improving access, experience and outcomes.

For more information: [Reducing health inequalities - Lincolnshire ICB](#)



Missed
Children's
appointments

Inclusion
Health

Weight
Management
Services

CYP Urgent
Care



Digital
Inclusion
Strategy

SMI - Physical
Health Checks

Click on the tiles to go to these examples of involvement within the health inequalities programme of work

Click this symbol to return to this page



Health Inequalities

CYP – Missed children's appointments

Lincolnshire has some of the highest rates in the country for children and young people missing planned hospital appointments.

We wanted to hear directly from families to understand the barriers that make attending these appointments difficult.

The feedback will help us to work together with Lincolnshire's hospitals to design practical solutions to make hospital visits easier, reduce missed appointments, and improve the experience for everyone.

Our approach

- Produced public survey aimed at parents, carers and young people
- Produced materials complete with QR codes and survey links to promote the engagement activities
- Engagement focussed on engagement with members of the public plus staff – clinical and non-clinical at 2 hospitals; plus staff in education.

Engaging our communities

- Survey open between September and October 2025
- Shared survey online and in community settings
- Posters and leaflets were distributed through schools, GP practices, children's centres, community venues and family hubs.
- We spoke to 14 staff in education and clinical settings & visited hospitals and local community spaces to talk to 10 people / families face-to-face.
- We provided materials in Bulgarian, Lithuanian & Romanian to ensure inclusivity
- Received 196 responses to survey.

What we heard

- Work and school commitments make it hard for parents to attend appointments during the day.
- Poor or unclear communication, including late letters, confusing text messages and language barriers, leads to missed appointments.
- Travel, transport and parking difficulties can make getting to appointments stressful or unaffordable.
- Appointments are often inflexible, with limited options to change times or locations.
- Families are keen to support their child's health, and said attendance would improve with more flexible options such as local clinics, virtual appointments, clearer reminders and accessible information. between services.

The difference it made

- Feedback has been shared with key decision-making groups, including the NHS Lincolnshire ICB Health Inequalities Board and the Children and Young People Was Not Brought (WNB) project group.
- It has directly informed an agreed action plan, focusing on the main issues families told us affect attendance at appointments.
- A dedicated working group is in place, using this feedback to guide and prioritise improvement work.
- The work continues to develop, with regular meetings to monitor progress and support the implementation of changes.



Health Inequalities

Inclusion Health

We aimed to understand the experiences, barriers and priorities of people from Inclusion Health groups across Lincolnshire, to inform the development and future direction of Inclusion Health work.

Our goal was to ensure that the voices of people who often experience the greatest health inequalities were heard. This included people experiencing homelessness, people who use drug or alcohol services, refugees and asylum seekers, Gypsy, Roma and Traveller communities, and people involved in the criminal justice system.

This involvement work sought to:

- gather insight into how well current health and care services meet people's needs
- identify barriers that prevent people from accessing care
- understand what good and poor experiences look like
- highlight what needs to change to improve access, experience, outcomes and equity
- ensure lived experience directly informs future Inclusion Health priorities and actions



Our approach

- Created a comprehensive engagement plan
- Used different methods to meet the needs of different communities
- Produced materials complete with QR codes and survey link to encourage participation
- Created an online survey and planned community visits.

Engaging our communities

- Between September and October 2025, we carried out a variety of engagement activities.
- Received 73 response to online survey; Respondents included people experiencing homelessness, those using substance support services, ex-offenders, refugees and asylum seekers, Gypsy, Roma and Traveller communities, and people not identifying with an Inclusion Health group - some respondents identified with multiple groups
- Visited 3 organisations who run projects across the county (Lincoln, Boston and Skegness) and spoke to 18 people including those experiencing homelessness, been in prison / currently serving a sentence and people who are refugees, asylum seekers or vulnerable migrants.
- We met with people face-to-face in settings where they already feel supported. Across these settings, we gathered rich, narrative insight into lived experience, challenges and local issues.
- We spoke to staff who provide support to people from Inclusion Health groups.

What we heard

- Access to services varied, but GP, dental and mental health services were consistently the hardest to access. Long waiting times were a common challenge across all groups.
- Many people delayed or avoided seeking help due to previous negative experiences or fear of judgement.
- Barriers included mental health challenges, digital exclusion, transport, cost and language barriers, fear of stigma or discrimination, and difficulty navigating fragmented services
- Poor experiences included feeling rushed or judged, long waits in GP and A&E settings that worsened health, and poor communication, fragmented care, digital-only pathways and lack of interpretation.
- What worked best was kind, patient staff who listened, alongside consistent, face-to-face care and outreach or support workers helping people access and attend appointments.

The difference it made

- Feedback has shaped our Inclusion Health approach & continues to inform work across the system.
- Insights were presented to the Inclusion Health Oversight Group to help shape priorities and strategic direction.
- Findings were shared with health and care partners to improve awareness and understanding.
- This work is ongoing, with feedback continuing to drive improvement.



Health Inequalities

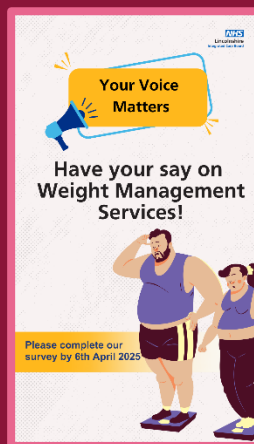
Weight Management Services

Lincolnshire has a higher rate of overweight and obesity (67.6%) than the national average (63.5%) making improved support for weight management a priority for 2025/26.

NHS Lincolnshire Integrated Care Board (ICB) is developing a Tier 3 Specialist Weight Management Service, alongside strengthening existing support offers.

Tier 3 services provide specialist support for people who need more intensive help, bringing together doctors, dietitians and lifestyle specialists to support safe and sustainable weight loss when other approaches have not been effective.

Engagement was undertaken to ensure that the voices of local people were central to the design of future services. Our aim was to understand people's experiences, needs and expectations, so that weight management services in Lincolnshire are shaped around what matters most to those who use them.



Our approach

- Created a comprehensive engagement plan
- Used different methods to meet the needs of different communities
- Produced materials complete with QR codes and survey link to encourage participation
- Created an online survey and invited people to join patient engagement group which met once and will continue into 2025/26.

Engaging our communities

- The survey ran Between March and April 2025 to gather views on the proposed Tier 3 Specialist Weight Management Service, with over 200 responses received.
- People were invited to join a patient engagement group, offering ongoing involvement in shaping the service and supporting co-production in Phase 2.
- Engagement was promoted through the ICB Engagement Bulletin, reaching 10,000+ stakeholders.
- Facebook posts reached 13,323 people, generating 177 clicks to the survey.
- A dedicated engagement webpage directed people to key information and the online survey.
- Community groups, healthcare professionals and voluntary organisations supported wider promotion of the survey.

What we heard

- Awareness was low, with many people unaware of Tier 3 Specialist Weight Management Services or having never accessed them.
- Distance and cost were the biggest barriers to accessing support.
- People felt that psychological support and access to medication would make the greatest difference to achieving and sustaining weight loss.
- Improved health and personal wellbeing were the main motivators for seeking support.
- Many respondents said they would welcome support, with a significant proportion open to weight-loss medication or injections.

The difference it made

- Feedback from this engagement helped to inform the development of Lincolnshire's Tier 3 Specialist Weight Management Service.
- Insight has helped clarify what people value most, where current barriers exist, and what support is most likely to make a meaningful difference, ensuring lived experience is embedded in service design.
- The co-production group continues to meet to support and will help shape Phase 2 of this work.
- The feedback has shaped the local design and will continue to inform the implementation of a community-based Tier 3 Weight Management Service, ensuring it reflects local need and improves access to appropriate support.



Health Inequalities

Urgent Care - Children

We sought to better understand how children and young people, and their parents and carers, experience accessing Accident & Emergency (A&E) and Urgent Treatment Centres (UTCs) across Lincolnshire.

This engagement supported the Urgent and Emergency Care (UEC) Programme, with a particular focus on health inequalities. The work centred on families living in the 20% most deprived areas and those with children aged 0–5 years, where local data shows higher use of urgent and emergency services.

By hearing directly from parents and carers, we aimed to understand:

- Why families choose to attend A&E or UTCs
- What factors influence those decisions
- Whether alternative support could help manage children's health closer to home.



Our approach

- Created a comprehensive engagement plan
- Used existing partner's networks to enhance the distribution
- Produced materials complete with QR codes and survey link to encourage participation
- Created an online survey and invited people to join patient engagement group.

Engaging our communities

- An online survey was delivered between November 2025 and January 2026, targeting parents and carers whose children had attended A&E or an Urgent Treatment Centre in the previous 12 months.
- 92 survey responses were received, with 98% from parents or carers. Most respondents had children aged over five.
- The survey was promoted through a wide range of channels, including community and stakeholder networks, ULTH internal communications (posters and TV screens), ICB and ULTH websites and social media, The Contributor bulletin, Patient Participation Groups (PPGs), primary care bulletins, GP practice networks, Lincolnshire Resilience Forum partners, and the Nextdoor app.
- To support accessibility, the survey was made available through online links, QR codes on posters and leaflets, and included contact details for support or alternative formats.

What we heard

- Most families had attended A&E or a UTC in the past 12 months, usually for a single issue rather than multiple concerns.
- Attendance was most often triggered by symptoms feeling urgent or severe, or from NHS111 advice.
- Most respondents achieved their desired outcome without needing further treatment.
- Many parents contacted NHS111, but few accessed GP support before attending urgent care.
- Many parents felt their visit was unavoidable but said better GP and out-of-hours access, clearer advice on where to go when a child becomes unwell, could help reduce future attendance.

The difference it made

- Provided clear insight into why families attend A&E and UTCs and where changes could help reduce avoidable attendance.
- Findings were shared with the Urgent and Emergency Care (UEC) Programme to inform planning.
- Feedback will shape future discussions on GP and out-of-hours access, decision-making support for families, and addressing inequalities for more deprived communities.
- Learning from this activity has informed the next phase of engagement which will include increased face-to-face activity and community outreach. Findings will continue to support the UEC Programme.



Health Inequalities

Digital inclusion strategy

Digital access plays an increasingly important role in how people access health and care services. However, not everyone is able to use or wants to use digital tools such as websites, apps or online booking systems. For some people, digital access can create new barriers rather than improving access.

To help address this, NHS Lincolnshire ICB worked with partners across the Integrated Care System to develop a Lincolnshire Health and Care Digital Inclusion Strategy (2024–2027).

Engagement focused on understanding the experiences of people most at risk of digital exclusion, ensuring their needs shape how services are designed and delivered.

Engagement aimed to:

- understand how people currently access services
- identify barriers linked to access, confidence, skills, trust and safety
- understand where people want digital support, and where non-digital options must remain
- shape a strategy that improves access without excluding people who cannot or do not want to engage digitally.

Our approach

- Our approach was to engage with people directly who are digitally excluded or at risk of exclusion, and to understand the real-life challenges they face when trying to access health and care services.
- A mix of survey activity and face-to-face community outreach was used to ensure participation from people who may not usually engage online.

Engaging our communities

- Engagement took place between 21 April and 9 May 2025, and 66 completed the survey.
- We spoke with people most at risk of digital exclusion, including older adults, people on low incomes, people experiencing homelessness, rural and coastal communities, people with long-term conditions or sensory loss, and migrant and refugee groups.
- Activity included community visits, coffee mornings and group sessions, working with voluntary, faith and community organisations, targeted workplace outreach, and an accessible survey with translated versions.
- This approach ensured we reached people often missed by digital-only consultation methods.

What we heard

- Digital access is not just about devices. Many people lacked confidence, skills or trust.
- Some people actively choose not to use digital services and value phone or face-to-face contact.
- Connectivity, affordability and usability were significant barriers, particularly in rural / coastal areas.
- People with sensory loss, dementia or low literacy found digital systems hard to navigate.
- Concerns about trust and digital safety were common, particularly scams, passwords & data security.
- Many people valued digital services for simple tasks (such as prescriptions) but still wanted non-digital options for appointments and communication.
- Support was most welcome when provided locally, face-to-face and through trusted community settings, rather than formal training courses.

The difference it made

- Engagement insight directly informed the development of the Lincolnshire Health and Care Digital Inclusion Strategy 2024–2027.
- Findings strengthened the strategy's focus on choice, ensuring digital access improves services without replacing non-digital routes.
- Feedback reinforced the need for community-based digital support.
- Insight informed priorities around access to devices, data, connectivity, skills, trust and accessibility, rather than a one-size-fits-all approach.
- Learning was shared across system partners to support more inclusive service design and communication.



Health Inequalities

Physical Health Checks - SMI

People living with Severe Mental Illness (SMI) experience significantly poorer physical health outcomes and reduced life expectancy. These risks are further compounded for people who also experience homelessness, alcohol or substance use, and social exclusion.

NHS Lincolnshire ICB undertook targeted engagement to better understand the barriers preventing some of the most marginalised groups from accessing annual SMI physical health checks, with the aim of improving equity, access and health outcomes.

Engagement focused on:

- understanding why eligible individuals are not accessing SMI health checks
- identifying practical, cultural, and system barriers to access
- co producing recommendations for reasonable adjustments and alternative models of delivery, rather than expecting people to fit existing systems.

Our approach

- Listened directly to people with lived experience and frontline staff, particularly those supporting people who are often excluded from traditional healthcare pathways.
- The work took place between February and May 2025, using flexible and supportive ways of listening that were shaped around what people needed and felt comfortable with.

Engaging our communities

Engagement was delivered through trusted community settings and services that already support people with complex needs, including people experiencing homelessness and those affected by substance use.

- Direct engagement with 9 people with lived experience, alongside support staff
- Engagement with frontline workers across housing, health, recovery and outreach services
- Visits to services such as Project Compass, Lincolnshire Recovery Partnership, Medlock House, Recovery College, and councils' homelessness and rough sleeper teams
- Conversations with GPs and NHS teams already delivering outreach health support

This approach enabled honest conversations with people who do not routinely use GP services.

What we heard

- Low awareness of right to SMI physical health checks among individuals and some professionals
- Significant access barriers, including digital exclusion, lack of phones / charging, difficulty with early morning appointments, transport issues, and lack of hygiene facilities
- Fear, mistrust and stigma were widespread, including fear of being sectioned, judged, or dismissed
- Many people prioritised crisis care (e.g. A&E) over preventative GP based care
- Individuals felt more comfortable engaging in trusted, familiar environments, often with a single known professional
- Physical health checks were already occurring in some services, but data was not routinely shared, leading to duplication and missed prevention opportunities
- There is a hidden cohort of people with suspected SMI who remain undiagnosed, despite being open to support if delivered differently.

The difference it made

- Engagement highlighted the need to move beyond a GP-only model for SMI health checks, with checks delivered in trusted community settings using existing support relationships.
- Learning demonstrated the value of the Holistic Health for the Homeless (HHH) model, with potential for wider adoption.
- Recommendations focused on better data sharing, expanded roles for trusted professionals, and reducing duplication of assessments.
- Findings were reported into the SMI Physical Health Programme, informing future service design.
- Further work will explore alternative delivery models, including expanded outreach roles and improved data sharing with GP systems.



Community Development

Listening to communities

People and communities are at the heart of everything the ICB does. Working with people and communities is crucial to creating a health and care services that are personalised, responsive and work for everyone. The ICB aims to involve people from a wide range of backgrounds, including different places, cultures, nationalities, ages, and genders.

By being visible and accessible across all parts of the county, the ICB enables people to share their concerns, ideas, and feedback directly. This face-to-face engagement helps build trust and strengthens relationships with local communities.

Maintaining existing relationships is as important as forming new ones, helping communities feel supported over time and allowing the ICB to build on previous learning and address ongoing needs effectively.

The engagement team also prioritises building connections with underrepresented communities including schools, young people and communities who may not routinely engage with health services. Reaching these groups ensures a wider range of voices are heard and reflected in decision-making, supporting a more inclusive and equitable health and care system.

Making connections

Stay connected

See the difference

Digital Outreach
for Community
Connection

Armed Forces

International
Student Day

Primary Care
Outreach



ICB
Involvement
bulletin

Community
Reporting

A day in the life of
an ICB
involvement
manager

Campus for
Future Living

*Click on the tiles to go to more examples of
involvement within specific projects and programmes*



Click this symbol to
return to this page

Community Development

Armed Forces

As part of this work, NHS Lincolnshire ICB co-hosted the second Armed Forces & NHS Lincolnshire Symposium on 3 June 2025, held at RAF College Cranwell. The event brought together around 60 NHS staff, Armed Forces representatives and voluntary sector partners, building on the success of the inaugural symposium in 2024.

The symposium showcased joint work between the NHS, Defence Medical Services, primary care and voluntary organisations, highlighting what is working well locally and where further improvement is needed.

Particular focus was given to:

- improving access for Armed Forces families
- strengthening links between Defence Medical Services and local GP practices
- supporting people transitioning from military to civilian healthcare

Keynote speakers welcomed the progress made in Lincolnshire while emphasising the need for clearer information and better navigation for those leaving the Armed Forces. The event reinforced the importance of regular dialogue, shared learning and trusted relationships.

Feedback from the symposium was shared within the ICB, system partners and primary care, informing ongoing community development work and helping shape practical next steps. The event demonstrated Lincolnshire's distinctive and mature partnership with the Armed Forces and reinforced a shared commitment to improving care and support for serving personnel, veterans and their families.

"I was delighted we were able to follow-up last year's inaugural event with another to showcase the work the NHS and the Armed Forces are doing together in Lincolnshire for the benefit of both serving and former personnel. I am very grateful to Gp Captain Elaine Rutland for co-sponsoring this event and for the Commandant for hosting us so generously in the magnificent surrounds of RAF College, RAF Cranwell," comments John Turner, Chief Executive, NHS Lincolnshire Integrated Care Board

"I get the sense that what we are doing in Lincolnshire is quite unique, I don't think anyone else has the same kind of relationship we have with our local Armed Forces colleagues, and this is backed up by what I heard at the symposium around the partnership between the NHS and the Armed Forces making positive strides in Lincolnshire. I am convinced our joint work will continue to make significant steps forward."



"I was delighted we were able to host the Armed Forces & NHS Lincolnshire Symposium again this year. Lincolnshire has a significant history with the Armed Forces going back many years and with that a substantial number of both serving and former personnel living and working in the county, so the work we are doing together is imperative."

"It was fantastic to see so many relevant people and organisations represented at the symposium, all there with a joint desire to do everything possible to improve health and health outcomes for all of our people, whether serving now or who have previously served. I think we have laid some strong foundations with the work done to-date and I look forward to our partnership with the NHS continuing." Comments from Gp Captain Rutland.

Community Development

Campus for future living

Members of the ICB attended the Campus for Future Living Open Day in Mablethorpe in June, celebrating the official launch of a landmark development for the area.

The event welcomed over 400 local residents, partners and stakeholders, showcasing a vibrant new space designed to support health, wellbeing, skills and innovation across the region.

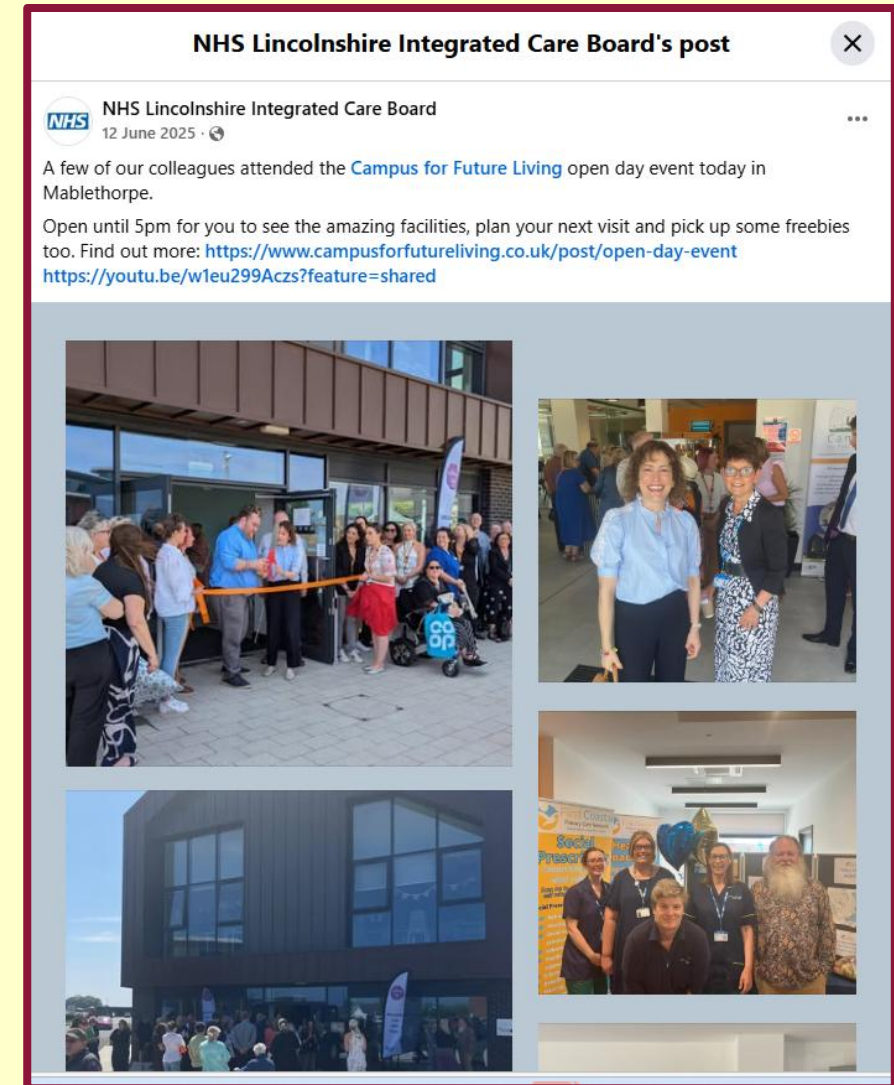
The Campus is a major multi million-pound investment owned by East Lindsey District Council and operated by Acis Group. It was delivered with support from a range of partners, including health and care system partners such as the ICB.

Funded through £8.6m Towns Fund investment, the facility provides modern flexible spaces including training rooms, consultation areas and a community café designed to support collaboration and community use.

The launch event had a strong sense of celebration and community pride, with a wide range of partner stalls and interactive activities. Residents were able to explore local services, take part in health and wellbeing activities and engage directly with organisations supporting the community.

The Campus was formally opened by local MP Victoria Atkins alongside local representatives, marking an important milestone for Mablethorpe and the wider coastal community.

Attendance provided an opportunity to celebrate a successful partnership led development and to see first hand the strong community engagement and positive impact of the Campus in action.



Community Development

Primary Care Outreach

The Primary Care Communication and Engagement team attended a range of events throughout the year to represent the ICB and support engagement across primary care networks.

Through information stands at community and partnership events, the team promoted primary care services, wider NHS-funded services, the engagement bulletin, and live ICB and partner surveys.

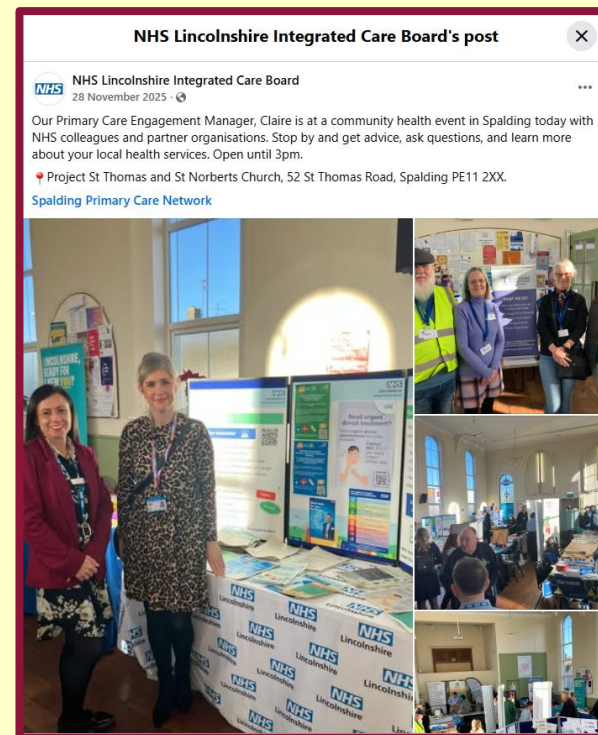
Engagement took place across Louth, Coningsby, Navenby, Minting, Spalding and Boston with conversation held with people from local communities.

These events provided valuable opportunities to engage directly with residents, partners and stakeholders, raise awareness of local services and support involvement in shaping health provision. They also enabled meaningful networking with community organisations, health and care providers, voluntary sector partners and local authority colleagues.

Across all events, the team encouraged conversation and feedback through live surveys and promoted ongoing engagement opportunities across the system.

A key focus across all events was supporting people to access the right services at the right time and make informed use of NHS services. This included raising awareness of urgent dental appointments, enhanced GP access, community pharmacy services (including Pharmacy First and blood pressure checks), contraception and emergency contraception, and digital tools such as the NHS App and the WaitLess app.

Information was also provided in multiple languages to support accessibility and inclusion.



Pictures of the ICB Primary Care Engagement Manager, out in the community.



Community Development

International Student Welcome Event

The Engagement Team attended the International Student Welcome Event on 29 January at the University of Lincoln, providing a targeted opportunity to engage directly with international students who may be less familiar with the NHS and how to access services.

The session supported wider system priorities around reducing inequalities in access to healthcare and encouraging early GP registration.

Through direct engagement with around 50 international students, the team shared practical information about accessing local health services and appropriate use of NHS services.

Outcomes of the day



- A key focus was GP registration. Students were asked whether they were registered with a GP and, where not, were supported and signposted to an on-site registration area. A significant number of students registered with a GP during the event, demonstrating the value of providing immediate, practical support to reduce access barriers.
- Students were also invited to sign up to the NHS Lincolnshire ICB engagement bulletin, helping increase awareness of future involvement opportunities and how they can shape local services.
- Information packs and goodie bags supported conversations and reinforced key messages for students to take away.
- The event also enabled engagement with healthcare providers and community partners, strengthening relationships and supporting a more joined-up approach to working with international student communities.
- Overall, the activity improved awareness of local health services, supported timely GP registration, and contributed to more equitable access to NHS care.



Community Development

International Student Wellbeing Event

Following initial engagement with LEAN (Lincoln Embracing All Nations) at the University of Lincoln International Student Wellbeing event, the Health Inequalities Engagement Manager worked in partnership to deliver on-site health checks for people attending LEAN English language sessions, which are typically attended by 40–50 people.

Many attendees were non-English speakers attending English language sessions, with translators available to support communication.

The session was attended by NHS Lincolnshire ICB engagement colleagues, Neighbourhood Team Care Coordinators and practice nurses from Portland Medical Practice.



Outcomes of the day



- All attendees were offered blood pressure and weight checks, with results recorded directly on clinical systems for those registered at the practice.
- Several high blood pressure readings were identified and appropriate follow-up arranged. Insight was also gathered on vaccinations, including myths and concerns, helping inform future engagement and health promotion activity.
- The session was highly successful, and plans are in place to develop this into a monthly provision, strengthening partnership working and improving access to preventative healthcare within the community.



Health Inequalities

Community listening

The Our Shared Agreement (OSA) Community Listening programme was developed to strengthen relationships between people and the health and care system in Lincolnshire by putting listening, lived experience and human connection at the heart of change.

The approach recognises that meaningful improvement happens through everyday conversations in which people feel heard, respected and valued, rather than through formal consultation alone.

The programme was co-produced throughout, supported by the OSA Steering Group and a dedicated Community Listeners co-production group, ensuring people with lived experience and professionals jointly shaped the approach, materials and priorities.

Listeners were supported through briefing sessions, guidance and practical resources, building confidence and capability while maintaining a non-formal, human approach to listening.

Our approach

- The role of involvement was to embed community-based, relational listening as a core practice across the system.
- A network of Community Listeners was established to have informal, respectful conversations with residents about their experiences of health, care and wellbeing.

Engaging our communities

The Community Listening model enabled engagement in real-life settings, including community groups, events, workplaces and pop-in sessions, rather than only organisational or NHS venues.

Key activity included:

- 15 open Listener Briefing sessions
- Recruitment and support of 35 Community Listeners
- Delivery of 4 Listener Pop-In sessions
- Listening in community spaces and everyday settings across Lincolnshire

To date, Community Listeners have gathered 47 individual stories and 5 group-based stories, capturing rich insight into people's lived experiences.

What we heard

Early thematic analysis of listener stories highlights that what matters most to people includes:

- Being treated as a whole person and feeling genuinely listened to
- Compassion, kindness and trust in relationships with services
- Timely access to diagnostics and care
- Feeling supported as carers and family members
- Better coordination and communication between services
- Strong community and social support
- Support for prevention, self-care and emotional wellbeing
- The emotional impact of navigating health and care systems

These insights are continuing to be analysed through People's Stories Panels and other mixed-methods approaches.

The difference it made

- Informal, relationship-based listening builds trust, enabling people to share experiences often missed by surveys or structured engagement.
- Listener stories provide insight into the emotional and everyday realities of using health and care services.
- Community listening is reinforced as a core practice for cultural and behavioural change.
- The work highlights the importance of clear feedback loops, so listeners can see how stories are used and the difference they make.
- Continue co-production and recruitment, including inviting organisations to become Listening Partners. Raise awareness of listener stories and their impact





A week in the life of The ICB involvement team

A WEEK IN THE LIFE OF OUR HEALTH INEQUALITIES ENGAGEMENT MANAGER This week was about being out there — listening, learning and making sure that the Inclusion Health Strategy is shaped by real people, not just words on a page.

Monday

It began on the road, heading to Boston North Sea Camp, and I found myself thinking about the responsibility that comes with listening to experiences that are so often unheard. Arriving on site was a reminder of the different worlds people live in. Security checks, no smart devices, waiting to be escorted — all necessary, but grounding. In the family centre, conversations were heavy with experience. People spoke openly about their lives, their families and their interactions with health and care services. I left feeling reflective, carrying those voices with me, knowing they must shape what we do next.

Tuesday

The next day took me to Lincoln, working with the Probation EPOP group. People spoke honestly — sometimes painfully — about their experiences. That openness felt like a privilege. During that session, one person agreed to share their story more widely. We spent time together preparing for that — sitting side by side at a computer, working through nerves, deciding how they wanted to tell their story. Later, they stood in front of around 40 Health Inequalities Champions and shared it. The room was silent. People were listening, reflecting, clearly moved. I felt proud — not just of that individual, but of what can happen when someone is supported to find their voice and speak in a space where change is possible. It was a strong reminder that this work isn't just about gathering insight; it's about creating opportunities for lived experience to influence decisions.

Mid-week

Between visits, there were quieter moments — driving, writing up notes, pulling together themes. Those moments matter. It's where stories begin to connect, patterns emerge and I can make sure nothing shared is rushed past or lost. Listening doesn't end when the conversation does; it continues in how we honour what people have trusted us with.

Thursday

Later in the week, I travelled to Skegness to spend time with people seeking asylum. I wasn't sure what to expect, but the warmth in the room was immediate. Language differences didn't stop connection. We shared lunch, which became one of the most important parts of the day. Sitting together broke down barriers in ways no formal session ever could.

People spoke about uncertainty, but also resilience and hope. I left feeling a mix of empathy and admiration. It reminded me how much small, human moments matter when people feel safe, welcome and heard.

Friday

By the end of the week, one thing was clear: people want to be listened to, valued and involved. Across every setting — prisons, probation, community spaces — that message stayed the same.

I finished the week tired, but grounded and motivated. This work isn't always easy, and it doesn't always come with quick answers. But it matters. It's about building trust, amplifying voices and ensuring services are shaped by the people they exist to serve.

Community Development

Digital engagement

The ICB supports the use of social media as a positive communication channel to provide members of the public, partners, and other stakeholders with information about what we do and the services we commission.

We use social media to offer opportunities for genuine, open, honest, and transparent engagement with stakeholders, giving them a chance to participate and influence decision-making. Through social media, we can listen and have conversations with a wide and diverse range of people, especially within communities.

It not only allows us to make announcements such as health news, service information, and upcoming events, but it also enables people to respond to our posts, encouraging two-way conversation and feedback. This helps improve the ongoing development of our services and informs, engages, educates, and inspires our local communities.

One of our key communication tools, often a first port of call for the public, is the ICB website. We continuously review and develop our online presence to ensure that people can easily access information about the ICB, our system partners and programmes, latest news, events, engagement opportunities, and the services available.

Between the 1st April 2025 and 31st March 2026 we had **163K active users/visitors** and **731K page views** on our website. The most popular entrance to our site was via our **homepage** and our most popular pages were our **pharmacies page** and page about **weight loss medicine**.

The **ICB social media channels** saw an **increase in reach, engagement, and new followers in this period**. Our posts reached **over 2M people**, with an **engagements rate of 3.28%**. The ICB gained **2,051 new followers** across our social platforms.



Community Development

Digital engagement

In 2025/26 we have continued to use the social media platform Nextdoor, to share information and engage with local communities across Lincolnshire.

The platform was used to:

- Publish live surveys and questionnaires
- Share urgent health messages
- Promote health campaigns
- Publicise GP listening clinics and consultations
- Share information about flu and COVID vaccinations
- Highlight bank holiday pharmacy opening times
- Promote public health messages and events

During the year, we promoted **34 engagement activities** reaching **135,839 members across 98 posts with a total of 342,771 impressions**. Our most viewed post was the GP Strategy engagement, which achieved **9,769 impressions**.

Nextdoor allows us to reach people more directly than traditional channels by targeting specific areas and neighbourhoods, making it particularly effective for promoting consultations and local events and supporting timely, place-based engagement.



Community Development

ICB Engagement Bulletin

The Contributor is a fortnightly newsletter that is produced and distributed by the Integrated Care Board (ICB) to over 11,000 contacts.

The primary purpose of **The Contributor** is to advertise involvement opportunities within the NHS, such as surveys, latest news and community events.

It is shared in collaboration with Lincolnshire Partnership NHS Foundation Trust (LPFT), Lincolnshire Community Health Services (LCHS), and United Lincolnshire Teaching Hospital (ULTH) to broaden its reach across their networks.

It features engagement activity from partners other organisations such as Healthwatch, Lincolnshire County Council, and voluntary and community organisations, helping to encourage wider participation across the system.

This newsletter support community engagement by encouraging people to get involved in projects and opportunities that contribute to improving health and social care services.

15 JANUARY 2026

NHS
Lincolnshire
Integrated Care Board

The Contributor

Discover the latest opportunities to share your views and get involved with your local NHS

Do you have sight or hearing loss? Or know someone that does?

We want to hear from you!

The NHS Integrated Care Board (ICB), Lincolnshire County Council and HW Lincs are working together to understand what life is like for people with sight or hearing loss when using health and care services.

We want to know what works well and what doesn't. Your feedback will help us make services better and remove barriers for people who are D/deaf, hard of hearing, sight impaired or deafblind.

If this is you, or you care for someone with sight or hearing loss, please share your experiences. Tell us your story, what helps, and what could be improved.

Take part your way:

- [Fill in the survey](#)
- Phone or text: 07814 939396 between 9am and 4pm
- Email: licb.involveus@nhs.net (you can send a voice note if you prefer)
- Prefer British Sign Language, large print, audio, Easy Read, or Braille? Tell us and we'll send it.

We can also visit your community group—invite us at licb.involveus@nhs.net. Or have a conversation in person.

Have your say! Our current surveys

If you would like any of the below surveys in an alternative format, or would like help in completing the forms, please email the Engagement Team at licb.involveus@nhs.net. To find out about other ways to get involved in local healthcare please visit our [website](#).

NEW NHS Lincolnshire ICB Survey: Stoma, Transanal Irrigation (TAX) and Catheter Care

The survey aims to gather feedback on what works well, what could be improved, and how services can better meet local needs. (Please complete by mid-February 2026)

CLOSING 4TH JANUARY - Parents and carers - we want your views!

If you've taken your child to A&E or an Urgent Treatment Centre (UTC), please take a few minutes to share your experience.

Your feedback will help improve urgent care for families across Lincolnshire.

Have your say

Our priority in Lincolnshire is to provide the very best quality of care for people in our county. If you, or someone you care for, has reviewed, or currently received CHC funding, whether that's holding a Personal Health Budget, or receiving Funded Nursing Care in a registered care home, we would really like to hear from you.

Sharing your experiences with us can help us make a big difference to how we do things and make it better for everyone. [Consider the survey](#)

How your say on NHS continuing healthcare in Lincolnshire

Our priority in Lincolnshire is to provide the very best quality of care for people in our county. If you, or someone you care for, has reviewed, or currently received CHC funding, whether that's holding a Personal Health Budget, or receiving Funded Nursing Care in a registered care home, we would really like to hear from you.

Sharing your experiences with us can help us make a big difference to how we do things and make it better for everyone. [Consider the survey](#)

Partner activities and events

How are you, Lincolnshire?

The H.A.Y. (How Are You?) Lincolnshire Team is hitting the road this summer, bringing wellbeing, connection, and community spirit directly to your doorstep!

Join them as they tour towns across Lincolnshire, offering a unique opportunity to explore the H.A.Y. Lincolnshire website—you go to hub or local support, or simply discover what's happening in your area. The H.A.Y. Roadshow is here to help.

Meet Your Local Community Connector!

Their Friendly Community Connectors will be on hand to chat, answer questions, and guide you through the many ways H.A.Y. Lincolnshire can support your wellbeing journey.

Upcoming Roadshow Dates:

- Skegness – Thursday 4th September, Hildreds Shopping Centre, 10 AM – 3 PM
- Fosse, Lincoln – Friday 26th September, Wagley Road, Lincoln, 10 AM – 3 PM
- Lincoln City Centre – Friday 10th October, Waterside Shopping Centre, 10 AM – 3 PM

What to Expect:

- Live demonstrations of the H.A.Y. website
- Discover activities and support groups in your area
- Find wellbeing information and self-help resources
- Meet your local Community Connector
- Information about your local Wellbeing Hub and Nightlife Cafe
- Friendly faces and a warm welcome!

Don't miss out—come say hello when H.A.Y. visit your town!

For more information and full tour details, visit: <http://www.haylincolnshire.co.uk/>

GET INVOLVED

CURRENT ENGAGEMENT ACTIVITY

Current engagement projects

This section of the report highlights the ongoing engagement projects initiated in 2025/26.

Whilst some of the projects have made substantial progress and others only just starting, the full impact of these engagement activities will not be realised until later in 2026/27.

This section provides an overview of the projects, their objectives, and the anticipated outcomes, reflecting our commitment to continuous improvement and active community involvement.

Primary care –
advice &
guidance

ADHD strategy

CHC –
transitioning from
CYP to adults

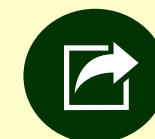
Psycho-
oncology

CYP
continence
services

Wheelchair
services



*Click on the tiles to go to more
examples of involvement within specific
projects and programmes*



Click this symbol to
return to this page

Primary Care

Advice and guidance

We launched two Advice and Guidance (A&G) surveys as part of ongoing engagement to support improvements across primary care: one for primary care staff and one for patients. The staff survey focuses on understanding experience of using A&G in practice, while the patient survey captures views on patient experience and understanding of the A&G process. Both surveys are anonymous to support open and honest feedback.

GP practices, Patient Participation Groups and our key partners and stakeholder have supported promotion of the patient survey through waiting areas, practice websites and local communication channels. Feedback from both surveys will be used to improve understanding of what is working well and where improvements can be made to strengthen the effectiveness of A&G services, with learning informing further work into 2026/27.

Public & Patient participation

ADHD strategy

There is a strong national focus on improving how Attention Deficit Hyperactivity Disorder (ADHD) is recognised, understood and supported. In Lincolnshire, NHS Lincolnshire Integrated Care Board (ICB) aims to align with this ambition while developing an approach that is shaped by the experiences, needs and priorities of local communities.

To support the development of a Lincolnshire ADHD strategy, the ICB is seeking feedback from people with ADHD, those waiting for assessment, families and carers, professionals working across local services, and wider staff and stakeholders with an interest in ADHD support.

This engagement will help us understand how national priorities can be applied locally, what matters most to people, families and professionals, where gaps or barriers exist, and what opportunities could shape ADHD support in Lincolnshire over the next five years. It will also support stronger partnership working across organisations, helping improve how ADHD services and pathways are planned and delivered.

Public & Patient Participation

CYP continence service

NHS Lincolnshire Integrated Care Board (ICB) has begun planning and scoping engagement to gather views on the future delivery of children and young people's specialist continence services in Lincolnshire.

This work is taking place in the context of planned service changes, following the decision that Lincolnshire County Council will continue to provide Tier 1 continence support (advice, guidance and signposting for daytime and night-time wetting and bowel concerns), but will no longer deliver Tier 2 specialist continence services from 1 January 2026.

Tier 2 services currently include specialist bladder and bowel assessments, scans, advice and interventions. Interim arrangements will remain in place for selected elements of the service while future provision is developed.

The planned engagement will support the re-procurement of a new provider to deliver Tier 2 specialist continence services, with the intention that a new service model is in place by July 2026.

As part of the preparation phase, we plan to seek views on what is working well, where improvements are needed, and what families, children and young people feel a future service should look like.

Feedback gathered through this engagement will be used to help shape the future model of care, ensuring services are responsive, accessible and meet the needs of children, young people and their families.

Public & Patient participation

Wheelchair services



The ICB Quality Team asked the engagement team to gather feedback on experiences of wheelchair services across Lincolnshire. Wheelchair services in Lincolnshire are currently provided by Millbrook Healthcare, who have been the appointed NHS wheelchair service provider for six months, supporting residents who are registered with a GP practice within the NHS Lincolnshire ICB area. The service includes clinical assessments, specialist seating, delivery, repairs, maintenance and the collection of equipment when no longer required.

Our approach - the engagement aimed to ensure that the views of people using wheelchair services, alongside carers and staff, informed quality oversight and ongoing service improvement.

Engagement activity launched on 16 February 2026 and is due to close on 20 April 2026. A survey was developed to gather feedback, alongside opportunities for people to attend relevant community groups or speak directly with the Engagement Team to share their experiences in person.

The objectives of the engagement are to:

- understand what is working well within the current wheelchair service
- identify where improvements are needed
- explore what an ideal wheelchair service should look like
- understand whether additional information, training or education would benefit users and carers

Findings from the engagement will be:

- presented to the ICB Quality Team
- included within the Lincolnshire Voices Report
- escalated through relevant contract and quality assurance meetings

This feedback will support ongoing monitoring of the service and inform actions to improve the quality, effectiveness and user experience of wheelchair services across Lincolnshire.

Public & Patient Participation

Psycho-Oncology

NHS Lincolnshire Integrated Care Board (ICB) was asked by LACE (Lincolnshire's Academy Centre of Excellence) to support and ensure effective public and patient involvement in the review of psycho-oncology services across Lincolnshire.

The review focuses on ensuring services meet the emotional and psychological needs of people affected by cancer, and that support is evidence-based, equitable, accessible and appropriate. Insight has been gathered from people with lived experience of cancer, carers and families, staff across the pathway, and key system partners.

Our objectives are to capture lived-experience insight, understand what is working well and what needs improving, identify gaps and opportunities for earlier intervention, and encourage meaningful involvement through sharing experiences and patient stories.

Engagement began in February and included reviewing existing insight, running public and staff surveys, holding community conversations with cancer support groups, and undertaking one-to-one interviews. Activity has been supported through newsletters, social media and partner networks.

Findings are being embedded into the commissioning process and are informing Expert Reference Group workshops – run by LACE - and service recommendations. The engagement team continues to support delivery and action planning, with updates published on the ICB website to maintain transparency and continually feedback.

Public & Patient participation

Transitioning from children and younger people to adult care (CHC)

During 2026/27, the ICB will be undertaking engagement with children and young people receiving Continuing Healthcare, and their parents, families and carers, to explore experiences of the transition from children's services to adult services.

Planning and scoping for this engagement has already commenced, with early work focused on identifying key stakeholders, approach and priorities for involvement.

The aim is to understand what works well, where challenges exist, and how transition planning and support can be improved to better meet the needs of young people and families.

Feedback gathered through this work will be shared with the Continuing Healthcare Team and used to inform improvements to transition pathways, communication and support, helping shape future service delivery.



A big thank you!

2025/26 has been a year of listening, learning and working together with people and communities across Lincolnshire.

The engagement and involvement activities featured in this report reflect the strength of those partnerships and the difference that meaningful involvement can make. By taking the time to share experiences, ideas and feedback, people have helped shape services that are more responsive, inclusive and grounded in real lives.

As we move forward, we remain committed to building on this work — strengthening relationships, learning from what we hear, and continuing to involve people and communities as equal partners in shaping health and care services.

We would like to sincerely thank everyone who contributed their time, insight and voice to support the NHS over the past year.

NHS Lincolnshire ICB Involvement Team

April 2025 – March 2026



THANK YOU!

Working with People and Communities

Annual Report

April 2025 – March 2026

**Nottingham and Nottinghamshire Integrated
Care Board**

Table of Contents

Table of Contents

1	Foreword.....	3
2	Introduction.....	4
2.1	About us	4
2.2	Our statutory duties.....	4
3	Our commitment to working with people and communities	5
3.1	Overview.....	5
3.2	Our principles.....	5
3.3	Citizen Intelligence.....	6
3.4	Co-production	6
4	Governance and assurance	7
4.1	Nottingham and Nottinghamshire ICB arrangements	7
4.2	Coordinating how we listen to people and communities	7
5	Putting our Working with People and Communities Strategy into practice.....	10
5.1	Engagement with children, young people and families.....	10
5.2	Bassetlaw VCSE Community Grants	12
6	How we've used insight and data.....	13
6.1	Refreshing the Co-production Strategy	13
6.2	Lung cancer screening.....	14
7	Equality and inclusion when working with our diverse communities	15
7.1	Equality and inclusion principles	15
7.2	Embedding co-production to reduce health inequalities	15
8	Demonstration of how the ICB has worked with partner organisations	17
8.1	Developing a Research Engagement Network for Nottingham and Nottinghamshire 17	
8.2	Strengthening relationships with elected members	18
9	Sharing learning and good practice examples.....	19
9.1	Supporting the ICS to work effectively with people and communities	19
9.2	Sharing successful programmes.....	22
10	Communications, social media and marketing	27
10.1	Overview.....	27
10.2	Co-producing patient-facing communications for Integrated Neighbourhood Teams 27	
11	Future planning	28
12	Working with People and Communities: How to get involved	29

13	Appendices	30
13.1	Appendix 1: Engagement Practitioners Forum: organisations represented	30
13.2	Appendix 2: VCSE Alliance: organisations represented	32

1 Foreword

The Working with People and Communities Annual Report sets out how Nottingham and Nottinghamshire Integrated Care Board (ICB) has continued to work with people and communities during a year of significant change for our ICB and staff, the NHS and the wider health and care system.

Throughout 2025/26, the system has operated within a challenging context of financial constraint, organisational change and emerging cluster arrangements. In this environment, the strength of relationships with people, communities and partners has mattered more than ever. Nottingham and Nottinghamshire's approach to working with people and communities, through Citizen Intelligence and Co-production, has remained central to how insight is gathered, decisions are shaped and services are improved.

We are proud of the progress reflected in this report. It highlights how insight from citizens and communities has informed commissioning, service design and system decision-making, and how co-production has continued to grow as a meaningful way of working alongside people with lived experience. The examples in this report show a more confident and mature approach, with greater emphasis on learning, impact and closing the loop by demonstrating how what people tell us leads to change.

This work would not be possible without the generosity, time and openness of local people. We are deeply grateful to the many citizens, patients, VCSE partners, staff networks and colleagues who have shared their experiences, challenged thinking and contributed their expertise over the past year. Their voices have strengthened the system and helped ensure that change remains grounded in what matters most to the people who use services.

As the system continues to evolve, listening carefully, learning together and acting on what people share will remain fundamental. Feedback on this report, and on how Citizen Intelligence and Co-production can be strengthened further, is warmly welcomed.

Engagement and Co-production Teams
NHS Nottingham and Nottinghamshire Integrated Care Board

2 Introduction

2.1 About us

NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) is responsible for commissioning (planning and arranging) NHS healthcare services that meet the needs of local people. To do this well, we 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 deliver the greatest benefit.

The ICB plays a key leadership and convening role within the Nottingham and Nottinghamshire Integrated Care System (ICS), supporting collaborative working across partners including Local Authorities, the Voluntary, Community and Social Enterprise (VCSE) sector, and other anchor institutions. As a result, whilst much of the work described in this report relates to the ICB, it also has relevance to and an impact on the wider ICS.

We serve a population of just over 1.2 million people across urban and rural areas. Some of our communities experience high levels of deprivation, and there are significant health inequalities between our most affluent and most deprived areas.

During 2025/26, Integrated Care Boards continued to operate within a context of significant national and regional change. NHS England confirmed that all ICBs are required to reduce management costs by approximately 50%, covering both running costs and programme expenditure. These reductions are being applied through a standardised reference cost per head of population of £19.40, resulting in an estimated 45% reduction in combined running and programme costs across existing ICBs.

In response to this requirement, NHS England approved the formation of a cluster comprising Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire (DLN) ICBs. The move to a clustered operating model reflects the need for ICBs to function at a significantly larger scale in order to remain sustainable within the reduced management cost envelope.

Within this context of financial constraint, organisational change and emerging cluster arrangements, the ICB's statutory duties relating to involvement, equality and transparency provide a critical foundation for how decisions are made and implemented. They help ensure that system transformation remains grounded in the needs and experiences of local people, supports accountability, and maintains public trust.

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 guidance¹.

The report covers our activity for the period 1 April 2025 - 31 March 2026.

3 Our commitment to working with people and communities

The ICB is committed to putting people at the centre of all that we do by consistently listening to, involving, and collectively acting on, the experience and aspirations of local people and 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 co-production forms our collective system approach to working with people and communities. The Executive Directors of Strategy and Citizen Experience, and Quality (Nursing) 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 holds responsibility for overseeing and scrutinising arrangements for public involvement and consultation in line with the ICB's statutory duties. This responsibility sat with the Strategic Planning and Integration (SPI) Committee between April - October 2025 and transferred to the Joint Strategic Commissioning Committee (SCC) from November 2025.

The Committee oversees the development and delivery of the ICB's Working with People and Communities Strategy, ensuring that the needs and perspectives of the diverse population are appropriately considered, particularly those experiencing the greatest health inequalities. It also reviews how people's voices and experiences are gathered, coordinated and heard across providers and system partners.

3.1 Overview

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

- Citizen Intelligence². 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.
- Co-production³. 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 Policy⁴.

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 [NHS England » Guidance on working with people and communities](#)

² [Working with people and communities strategy \(healthandcarenotts.co.uk\)](https://healthandcarenotts.co.uk/working-with-people-and-communities-strategy)

³ [Nottingham and Nottinghamshire ICB Co-production 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>

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.
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, 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've done on the Integrated Care Strategy and with care home residents, their families and carers.
- We meet regularly with our Health Scrutiny Chairs, 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 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 Co-production

During 2025–26, the ICB continued to strengthen the ways in which people and communities influence decisions about health and care. Co-production remained central to our approach

to commissioning, service redesign and improvement, with an increasing emphasis not just on involvement, but on demonstrating tangible change and impact.

This year marked a shift from establishing co-production activity towards embedding it as a routine, planned and accountable way of working. By strengthening the enabling infrastructure, clarifying expectations and improving how learning is captured and fed back, we have increased confidence that lived-experience insight is shaping decisions in meaningful and visible ways.

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 now is formally reported to the ICB Board through the Joint Strategic Commissioning Committee (JSCC). The Working with People and Communities Annual Report will be presented to the JSCC on 28 May 2026, then to the ICB Board on 16 July 2026.

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.
Joint Strategic Commissioning Committee	The Joint Strategic Commissioning Committee is responsible for assuring the ICB Board in regard to its statutory duties for patient and public involvement.
Executive Director of Strategy and Citizen Experience	The Executive Directors of Strategy and Citizen Experience, and Quality (Nursing) 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.
Executive Director of Quality (Nursing)	

4.2 Coordinating how we listen to people and communities

4.2.1 ICS Engagement Practitioners Forum

The ICS Engagement Practitioners Forum provides a system-wide platform for partners working with people and communities to collaborate, share resources, knowledge and expertise, and make better use of existing citizen insight. The Forum brings together over 65 engagement professionals from across Nottingham and Nottinghamshire, although overall membership has reduced slightly this year due to changes in roles and organisations.

Established in July 2022, the Forum includes representatives from across health and care organisations, charities, universities, NHS Foundation Trust Governors, VCSE organisations (including Healthwatch Nottingham and Nottinghamshire) and NHS Trusts. Over the past year, membership has continued to broaden, strengthening system coverage through the

inclusion of Nottinghamshire and Nottingham City Council Co-production teams, Women's Aid and Borough Councils (see Appendix 1 for a list of Engagement Practitioner Forum members).

The Forum is now a mature and well-embedded structure for coordinating citizen intelligence and insight at system level. It plays a key role in reducing duplication, strengthening consistency of approach, and providing assurance that engagement activity is aligned to shared priorities and statutory duties to involve. By enabling partners to align activity and share evidence, the Forum supports more informed commissioning, service design and improvement decisions.

The Forum provides a clear and practical route for partners to share engagement opportunities with local communities, including articulated asks to cascade opportunities through trusted organisational and community networks. This approach supports inclusive involvement by extending reach into communities where statutory organisations may not already have trusted relationships, helping to mitigate inequalities in participation and strengthening confidence in the breadth and representativeness of feedback gathered.

The ICB Engagement Team coordinates the Forum, providing administration, agenda setting, and onboarding of new members, and enabling the sharing of system-wide requests and ad hoc work between meetings. This coordination function supports accountability, continuity and responsiveness, and ensures that learning and insight generated through the Forum can be captured and used effectively.

During the last twelve months, Forum members have shared citizen insight and intelligence from their engagement activity, contributed to the testing and development of system resources (including the ICB co-production resource), and shared learning from local initiatives such as the Your Notts Community Directory. The Forum has also provided structured opportunities for partners to present work and learning, strengthening collective understanding of what is working well and where improvements are needed. Members have played an active role in contributing insight and intelligence to the Nottingham and Nottinghamshire Insights Hub, supporting system-wide visibility and use of evidence.

Governance and shared ownership are built into the Forum's operation. Chairing responsibilities rotate across the membership, supported and administered by the ICB Engagement Team, reinforcing collective accountability and system leadership. Members consistently report the value of the Forum in providing a trusted space to share challenges, good practice and lessons learned, particularly in relation to engaging underserved communities and translating insight into change:

"Being member of the Engagement Practitioners Forum enables us as a service to retain vital links with community and public partners across the sector, whilst providing the opportunity to maintain knowledge of services and what each other are doing. Therein lies its value, the consistent coming together of professionals committed to improving the lives of people in Nottingham and Nottinghamshire."

VCSE member of the Engagement Practitioners Forum

4.2.2 Voluntary, Community and Social Enterprise (VCSE) 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 continues to support strategic decision-making processes through the independent Chair Professor Daniel King, who is a formal member of the Nottingham and Nottinghamshire ICP and is an advisory member to the ICB Board.

To date, the VCSE Alliance has 117 members, representing 83 different organisations (a 9% increase on 2024/25), demonstrating increased engagement and reach. 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 Alzheimer’s Society, SSAFA and Trussell Trust (see Appendix 2).

The VCSE Alliance has continued to strengthen its position as the primary mechanism for communication and collaboration between the NHS and the voluntary, community, and social enterprise sector. It is increasingly becoming a recognised and valuable part of how the system works, serving as a trusted sounding board, amplifying the voices of marginalised communities, and generating fresh ideas and initiatives.

The Alliance's activities in 2025/26 have focussed on system governance, commissioning development, prevention and neighbourhood working, sector resilience, and the generation and use of citizen insight, particularly from underserved and marginalised communities.

National and local health and care changes of relevance to the Nottingham and Nottinghamshire VCSE Alliance

- Publication of the Review of Patient Safety Across the Health and Care Landscape⁵ by Dr Penny Dash in response to concerns about the fragmented landscape of oversight bodies which states: “CQC should assess whether every ICB and provider is listening to patients and users effectively.”
- Publication of the NHS 10 Year Health Plan⁶, which sets out three transformative shifts in the delivery of health and care services, with key implications for the VCSE sector including establishing a Neighbourhood Health Service and integrated teams and a focus to prevention, health creation, and tackling inequalities. In addition, a new expectation is set out to, “... make patient voice and experience core to how we define what high quality care looks like” and that NHS bodies will, “... look to the public, not to the centre, to decide their plans and derive their accountability. We will strengthen the role of patient voice and choice in accountability.”
- The Model ICB Blueprint⁷ sets out a central role for the voice of citizens, service users, patients and communities in the future strategic commissioning work of the ICB. This is clearly indicated in the opening section which states, “The NHS needs strong commissioners who can better understand the health and care needs of their local populations, who can work with users and wider communities to develop strategies to improve health and tackle inequalities and who can contract with providers to ensure consistently high-quality and efficient care, in line with best practice”.
- Approval has been received from NHS England to proceed with the agreed cluster comprising Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs. It is acknowledged that the organisation and operation of VCSE Alliances currently vary across the three Integrated Care Boards.

On 11 June 2025, the Chair of the VCSE Alliance was invited to present at an ICB Board Development session, contributing to a broader discussion on Integrated Neighbourhood Working. Supported by members of the VCSE Alliance, the presentation offered a concise overview of the VCSE sector, the role of the Alliance and showcased two case studies: one illustrating collaborative approaches to supporting individuals facing severe and multiple disadvantage through cross-organisational partnerships involving both statutory and VCSE organisations; the second highlighting the Places of Welcome programme led by Transforming Notts Together. The discussion also emphasised the importance of local voice

⁵ [Review of patient safety across the health and care landscape - GOV.UK](#)

⁶ [Fit for the future: 10 Year Health Plan for England](#)

⁷ [Model Integrated Care Board – Blueprint v1.0](#)

and representation within the system, and the VCSE sector's unique position to advocate for people and communities, particularly in the context of neighbourhood working.

On 10 September 2025 the ICB Board received a report developed collaboratively with members of the VCSE Alliance⁸. The purpose of the report was to provide an update on the work of the Alliance and highlight the sector's ongoing contributions in response to the evolving health and care landscape.

The report highlighted the VCSE sector's role as a strategic partner to the system, including its contribution to embedding lived experience within decision-making, supporting prevention-focused and neighbourhood-based approaches to care, and navigating the changing governance landscape across DLN cluster. This included work to shape VCSE representation at joint ICB Board meetings, build understanding of shared executive arrangements, and prepare the sector for future commissioning and planning processes spanning multiple ICBs.

Taken together, this activity demonstrates the VCSE Alliance's growing maturity and importance within the Nottingham and Nottinghamshire system. At a time of significant structural and policy change, the Alliance has provided continuity, insight and challenge, ensuring that the voices and experiences of people and communities, particularly those most at risk of exclusion, remain central to system decision-making. By strengthening relationships with system leaders, supporting neighbourhood-based working, and articulating the unique contribution of the VCSE sector, the Alliance continues to play a critical role in shaping a more responsive, preventative and community-centred health and care system.

4.2.3 Co-production Network

A scoping exercise was undertaken to test system partners' appetite for establishing the Coproduction Community of Practice at system level. While several local authorities already host local or organisational coproduction communities, engagement through early conversations suggested there remained a gap for a shared, cross system space focused on learning, problem solving and consistency of approach. Initial interest was expressed by colleagues across health and social care, providing an early indication of potential value.

This work took place during a year of significant organisational and cluster change, which inevitably shaped the pace and scope of development. Given the evolving ICB operating model and cluster arrangements, this activity was intentionally exploratory, focusing on understanding interest and feasibility rather than establishing a formal group. The learning from this scoping will inform further development as part of the cluster ICB.

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 Engagement with children, young people and families

During 2025/26, engagement activity with children, young people and families took place through partnership working at two large community events. These settings enabled conversations to happen in informal, accessible environments, using a mix of interactive approaches to gather feedback on health and care services from a broad range of voices.

At the Shadow Event (11 October 2025), organised by Nottinghamshire County Council Youth Service and Notts Outdoors, engagement was embedded within an outdoor, activity-based programme at Sherwood Forest. Children and young people took part in orientated challenges around the forest, creating opportunities for relaxed, activity-led

⁸ [NNICB-Board-10.09.2025.pdf](#)

conversations. Feedback boards and facilitated discussions were used to explore views on health and wellbeing, use of online support, and preferred times and ways of accessing services.

At the Nottinghamshire County Show (10 May 2025), child-friendly activities supported engagement with younger attendees, while direct conversations with parents and carers explored what families value in health and care services, the barriers they experience, and what good future services should look like. The setting enabled engagement with a wide cross-section of families who may not engage in other ways.

Together, these events provided practical and timely insight to inform future engagement approaches, service planning and improvement work.

Key themes emerging from the engagement included:

- Health and wellbeing are understood in a broad and holistic way, encompassing physical health, emotional wellbeing, supportive relationships, enjoyable activities and opportunities to stay active.
- Children and young people demonstrated good awareness of where to seek help in emergency and non-emergency situations, including the role of pharmacies, NHS services and mental health support.
- Clear, trusted and easy-to-understand information is important, particularly for online services, where reassurance about safety, legitimacy and anonymity is valued.
- Access to services remains a key concern for families, particularly access to GP appointments, urgent care, dental services and shorter waiting times across the system.
- Services that are timely, straightforward to navigate and available at the point of need are highly valued, including evening and weekend availability.
- Early support and prevention continue to be seen as important, including regular health checks, postnatal support, mental health provision and joined-up care.

Learning and recommendations from this activity include:

- Strengthening communications to help people understand how and when to access different services, including urgent care, general practice, pharmacy, mental health support and digital offers.
- Improving signposting to trusted online resources and addressing concerns about safety, legitimacy and anonymity that may deter access.
- Using insight from families to inform service improvement discussions around appointment availability, waiting times, onward referrals and transitions between services.
- Considering service availability and communication outside standard working hours, reflecting when families are most likely to need support.
- Maintaining a strong focus on prevention and early intervention.
- Continuing targeted engagement with children, young people and families in community settings to ensure insight reflects a wide range of experiences.

Engaging with children, young people and families in community settings has strengthened understanding of what matters most to them and how services are experienced in everyday

life. This work has helped shape future engagement activity and provides a practical evidence base to inform service improvement and planning, supporting more responsive, accessible and family-centred care.

5.2 Bassetlaw VCSE Community Grants

The Bassetlaw Voluntary, Community and Social Enterprise (VCSE) Community Grants programme provides an example of how feedback has been gathered and used to inform fair, transparent and locally responsive funding decisions.

Between 5 - 28 May 2025, a listening exercise was carried out to gather the views of citizens, VCSE organisations, professionals and stakeholders on the Bassetlaw VCSE Community Grants. The exercise was undertaken as part of a review of long-standing funding arrangements that differed from those in other parts of Nottingham and Nottinghamshire, reflecting historic commissioning approaches that pre-dated the merger of Clinical Commissioning Groups into NHS Nottingham and Nottinghamshire ICB in July 2022.

The review sought to understand how limited NHS funding could be used most effectively to meet local health and wellbeing needs, address inconsistencies across geographical areas, and reduce duplication while maintaining valued community provision. Ten VCSE organisations were in scope of the review, delivering a wide range of support to local communities, including advice services, wellbeing support, bereavement services, social prescribing, mental health support and practical assistance for vulnerable groups.

To ensure a broad and inclusive range of perspectives, multiple engagement approaches were used. In total, 425 individuals contributed through online and paper surveys, public meetings, stakeholder discussions, briefings with elected members, and visits to community groups and organisations. This approach ensured that feedback was captured from people who use services, VCSE providers, professionals and decision-makers, providing a robust evidence base for the review.

Adjustment to our approach during the listening exercise

During the engagement period, the approach was adjusted in response to feedback from local representatives. At the request of Bassetlaw District Councillors, paper copies of the survey were distributed directly to all ten VCSE organisations, with additional copies printed and hand-delivered following further requests raised at public meetings. All responses gathered through these channels were included in the analysis to ensure that no voices were excluded.

The listening exercise found that the majority of VCSE organisations received strong positive feedback from both the public and professionals. Across all services, respondents largely agreed that the support provided was high quality, beneficial to community health and wellbeing, and something they would recommend to others. Services were widely regarded as trusted and valued, often supporting people at times of vulnerability and complementing statutory provision.

Feedback highlighted specific strengths across organisations, including transport and wellbeing support, social prescribing, holistic family and bereavement care, men's mental health peer support, therapeutic activity and practical advice. While some issues were

identified (such as reliance on volunteers, affordability, capacity pressures, or overlap between services), these were generally framed as opportunities for service improvement or better coordination rather than dissatisfaction. Importantly, where respondents were not currently referring or accessing services, this was most often due to lack of need rather than a lack of confidence in the service.

Following analysis of the engagement findings, a report was produced setting out detailed insights and a series of evidence-based recommendations⁹. Engagement with organisations and community groups continued beyond the formal closing date to ensure experiences were fully understood and reflected. The final report was published on the ICB website and submitted to the Strategic Planning and Integration Committee for consideration.

As a direct result of this engagement and review process, an agreement was reached to continue funding all ten VCSE organisations for a further year. This decision recognised the strong contribution these organisations make to supporting vulnerable communities across Bassetlaw, while allowing time for further collaborative work to strengthen alignment, reduce duplication and maximise impact. The process demonstrated how inclusive engagement can support transparent decision-making, provide assurance that funding reflects community need.

6 How we've used insight and data

This section describes some examples of how we've used different sources of insight to understand people's needs and inform decision making.

6.1 Refreshing the Co-production Strategy

The refresh of the ICB's Co-production Strategy provides a clear example of how lived experience insight has been used to understand people's needs. Rather than relying solely on established approaches or assumptions, the ICB deliberately sought direct feedback on where co-production had (and had not) made a meaningful difference for people and communities.

Insight gathered through Listening Events in Beeston, Mansfield and online enabled people with lived experience, VCSE partners and system stakeholders to share candid reflections on what supports effective co-production and what acts as a barrier. This qualitative insight highlighted key challenges, including inconsistency in approach, lack of shared language and governance, limited visibility of co-production activity, and the need for stronger connections across system partners. Participants also emphasised that co-production is most impactful when it is adequately supported, creative, inclusive and responsive to the needs of those involved.

This insight was analysed, themed and fed back through a What We Heard event to ensure accuracy and shared understanding. The learning directly informed decision-making about the content and focus of the refreshed strategy, leading to clearer commitments around governance, consistency, learning and recognition, and the development of more practical support resources. The process also highlighted the importance of diversity, representation and real-world examples in strengthening co-production practice across the system.

People with lived experience then worked alongside the ICB to co-create the refreshed definition of co-production, agree shared Co-production Values, and select a visual framework that clearly communicates levels of involvement. The My Life Choices

⁹ [Bassetlaw Voluntary, Community and Social Enterprise Services Listening Exercise - NHS Nottingham and Nottinghamshire ICB](#)

Co-production Group played a central role in translating lived experience insight into practical and accessible strategic content, while joint work with Nottinghamshire County Council's Our Voice group strengthened alignment across organisations.

As a result, the refreshed Co-production Strategy¹⁰, published in 2025/26, reflects a more informed, realistic and experience-led understanding of how co-production should operate in practice. It sets out a three-year action plan shaped by citizen insight and establishes a stronger foundation for consistent, visible and impactful co-production across Nottingham and Nottinghamshire.

6.2 Lung Cancer Screening

The Nottingham and Nottinghamshire Lung Cancer Screening (LCS) Programme was established in 2021 to address historically poor lung cancer outcomes driven by late diagnosis and health inequalities. Aligned with the NHS Long Term Plan, the programme shifts care from reactive, hospital-based treatment to a proactive, preventative model by targeting asymptomatic adults aged 55–74 who have ever smoked.

As of April 2026, over 5,500 people across England have been diagnosed with lung cancer through screening, with 75% identified at an early stage, compared to fewer than 30% outside of screening. Locally, the programme has reached over 80% rollout, prioritising areas of highest risk. Delivery began in Mansfield and Ashfield in 2021 and has since expanded across Nottingham City and South Nottinghamshire, with recall invitations supporting ongoing surveillance.

Nottingham was among the first systems to adopt an opt-out invitation model, helping to normalise screening and achieve one of the highest uptake rates nationally. Over 100,000 invitations have been issued, with average uptake at 67%, rising to 75% in some areas, significantly above the national average of 51%.

Delivery is designed around accessibility and inclusion. Mobile CT scanners operate seven days a week in community settings, reducing barriers associated with travel, employment, caring responsibilities and hospital anxiety. Over 55,000 assessments have resulted in 40,000 CT scans, detecting 500 lung cancers, with 70% diagnosed at an early stage compared to 25% prior to the programme. This shift enables more patients to access curative treatment and is helping to challenge fatalistic perceptions of lung cancer.

Addressing health inequalities is central to the programme. Targeted interventions have been implemented beyond the national specification to reach people experiencing severe and multiple disadvantage (SMD), who are often underrepresented in GP-based invitation systems. In partnership with homelessness charities, flexible drop-in clinics were delivered in accessible community venues, removing the need for fixed appointments. All 22 attendees were eligible for screening, demonstrating both elevated risk and the value of targeted outreach. In line with Making Every Contact Count, wider needs were also addressed, including NHS Health Checks, wound care and GP registration.

Further tailored approaches include collaboration with learning disability nurses to develop accessible information and patient-led videos to improve understanding and reduce anxiety. Stop smoking support is offered at the point of screening, using this “teachable moment” to maximise engagement. Immediate access to support, including home delivery of quit aids, has improved both patient experience and outcomes.

A key strength of the programme is its locally driven engagement strategy. Participation is maximised through culturally inclusive, multi-channel communications, including targeted

¹⁰ <https://notts.icb.nhs.uk/wp-content/uploads/sites/2/2025/08/ICB-Coproducton-Strategy-2025-2028.docx>

digital campaigns, community networks, GP engagement and local champions. Partnerships with faith centres and community leaders have extended reach through trusted networks and community events. Materials are available in the nine most spoken local languages, supported by a fully translatable website and multilingual radio campaigns.

Bespoke pathways have also been developed for underserved groups, including prison populations, with on-site assessments and peer-led engagement to encourage uptake. The programme will continue to refine its flexible delivery model to reach groups such as Gypsy, Roma and Traveller communities and individuals in higher-category prisons, adapting services to population need rather than expecting communities to fit traditional models.

The community-based model provides a familiar, non-clinical environment, reducing anxiety and encouraging engagement. This is supported by extended clinic hours, accessible resources and patient-led content that improves understanding of the screening process.

Robust feedback mechanisms underpin continuous improvement, including patient surveys, follow-up on lower-rated responses and direct contact for concerns or complaints. Satisfaction is consistently high, with most responses rated 4 or 5. Feedback is actively used to inform service improvements.

The programme is also successfully reaching individuals with additional needs: 127 of 432 survey respondents reported an impairment, health condition or learning difference that significantly impacts daily activities, demonstrating accessibility and inclusivity in practice.

Learning from the programme is influencing national and international best practice, with visiting teams from Europe engaging with Nottingham to share insight. As rollout progresses towards full coverage, the programme will continue to evaluate, adapt and share learning. The approach is also informing other cancer initiatives, including the COMPASS pilot for Barrett's Oesophagus and Oesophageal Cancer.

Together, this work positions Nottingham and Nottinghamshire as a system leader in equitable, preventative lung cancer screening, ensuring more people benefit from earlier diagnosis, improved outcomes and a more inclusive approach to care.

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 Embedding co-production to reduce health inequalities

During 2025/26, co-production continued to play a central role across several priority programmes, including learning disability, autism, mental health, maternity and neonatal services. These programmes use lived experience not as a one-off form of engagement, but as an ongoing source of insight that informs service design, delivery and improvement.

7.2.1 All-Age Autism Strategy

Work began in February 2026 to co-produce a new All-Age Autism Strategy, bringing together people with lived and learned experience alongside commissioners and delivery partners. Early sessions focused on relationship-building, sharing experiences and developing a shared understanding of the local and national context. The work is guided by a joint Steering Group of staff and lived experience partners and will continue into 2026/27, ensuring that the strategy reflects the needs and priorities of autistic people and their families.

7.2.2 Partners in Mind: Mental health lived experience

Partners in Mind (PiM) is an established, system-wide co-production function that embeds lived experience across Nottinghamshire's mental health system. PiM integrates experts by experience into strategic governance and decision-making, with members contributing to the Mental Health Partnership Board, Trust oversight and delivery groups, provider forums and senior recruitment panels.

This approach has delivered tangible improvements. In the last year, lived experience insight directly informed enhancements to crisis care, including improvements to the Clinical (Crisis) Access Line through increased staffing capacity. These changes improved responsiveness, reduced service pressure and enabled more timely access to support. A clinician-only line was also introduced, strengthening triage and crisis response.

PiM has further influenced improvements in accessible communications, discharge processes and adult mental health pathways. It co-chairs the Co-production Delivery Group and contributes to measuring the impact of co-production, supporting service redesign, quality improvement and staff development. Training, NHFT "Story Shop" events and accessibility guidance have helped embed inclusive practice across the workforce.

Over the year, PiM has strengthened its infrastructure through clearer referral routes, improved communication tools, digital resources and expanded membership, including greater representation from younger people and neurodivergent communities. Strong partnership working and senior leadership engagement have supported greater accountability and sustained impact.

7.2.3 Voices of Experience: Learning Disability and Autism

The Voices of Experience: Learning Disabilities and Autism (LDA) Group champions lived experience involvement in system-wide service transformation. During the year, members contributed directly to the Learning Disability Joint Strategic Needs Assessment (JSNA), sharing insight on how to strengthen the participation of people with lived experience within strategic needs assessment processes.

The group also provided sustained oversight of the Adult Pathway Review, examining health-commissioned services for people with a learning disability and autistic people. Building on this insight, the group proposed and developed a Small Grants Approach, approved by the Learning Disability and Autism Executive Board. £50,000 of the co-production budget was allocated to this fund, enabling five community-led projects to proceed, including Diversify Education and Communities CIC's and their "You Good? Men's Mental Health Conference" in November 2025.

7.2.4 Maternity and Neonatal Voices Partnership (MNVP)

During 2025/26, the Maternity and Neonatal Voices Partnership (MNVP) continued to strengthen its role in amplifying the voices of women, families and babies. Supported by the Co-production Team, the MNVP established core infrastructure, expanded volunteer involvement and built strong relationships with providers.

Volunteers contributed lived experience insight to service improvement projects at Nottingham University Hospitals and Sherwood Forest Hospitals, influencing co-produced changes within neonatal and triage services. These included clearer recognition of families with babies in neonatal care, more accessible information, and improvements to medication administration processes for parents spending prolonged periods on neonatal units.

The MNVP survey received 255 responses, with high overall satisfaction, particularly in relation to neonatal care. Feedback reinforced the importance of continuity, trusted relationships with staff and clear communication. As the pilot period concludes in May 2026, work is underway to transition to a more strategic model, with a renewed focus on reaching voices that are not routinely heard, including bereaved families.

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 Developing a Research Engagement Network for Nottingham and Nottinghamshire

The Nottingham and Nottinghamshire Integrated Care System (ICS) Research Engagement Network (REN) Programme continued to develop during the year, with a focus on supporting more inclusive and representative health and care research. Through community engagement, the REN aims to ensure that research reflects the diversity of local populations, particularly underserved groups, and that communities are involved both in shaping research and in participating in studies. Where research does not adequately involve or reflect populations experiencing the greatest health inequalities, there is a risk that findings used to inform services are not relevant to those with the highest needs, potentially widening existing inequalities.

During the year, activity focused on working alongside people and organisations that are trusted voices within diverse communities. An active network was strengthened across VCSE organisations, community leaders and champions, primary care, and research institutions, with an emphasis on relationships based on respect, reciprocity and shared learning. Engagement took place with a wide range of community groups supporting under-served populations, including neurodivergent adults, ethnic minority communities, people on low incomes, and people living with physical and mental health conditions.

A programme of activity supported conversations about health and care research and the importance of diversity and inclusion. This included four community workshops and the awarding of community grants to nine organisations representing underserved groups. These grants supported health and wellbeing activities that incorporated research engagement elements, helping to raise awareness, build understanding and strengthen trust in research. At a celebration event, community leaders shared the range of approaches used, including workshops bringing communities and researchers together, creative arts activity, video development, resources and a health research role-play game. These activities supported communities to explore both their interests and concerns about research, helping to demystify research and build confidence.

A community immersion project was co-developed with the University of Nottingham and four community organisations. Researchers volunteered time within community settings, offering practical support while listening, learning and building relationships, creating space

for more equal and meaningful dialogue. In parallel, two ICS strategic workshops were held with VCSE organisations, community champions, universities, the National Institute for Health and Care Research (NIHR), the NHS and local authorities to strengthen relationships and develop a shared approach to community research engagement. Work also took place with the Nottinghamshire Deep End Network, supporting GP practices serving the most deprived populations to undertake research engagement activity with their patients and increase awareness of, and participation in, NIHR research studies.

The REN digital platform, developed by the VCSE National Observatory at Nottingham Trent University, is now ready for launch. The platform provides a practical mechanism to share research opportunities, connect VCSE organisations with researchers, and coordinate engagement in ways that support more equitable, balanced and mutually beneficial research relationships.

The REN Programme has increased the visibility and relevance of health and care research for VCSE and community organisations, while creating space for communities to articulate what meaningful research engagement looks like from their perspective. The work has strengthened relationships between communities, VCSE partners and researchers, enabling more open conversations about trust, power and priorities. Communities consistently highlighted the need for research relationships to be less extractive, more respectful and built over time. There was strong agreement that research should be shaped by issues that matter to people, with a partnership approach embedded throughout design and delivery. This learning will continue to inform REN activity during 2026/27.

8.2 Strengthening relationships with elected members

Regular and proactive engagement with elected representatives continues to be an important mechanism for understanding the needs, concerns and priorities of people and communities. Members of Parliament are briefed routinely (both verbally and in writing) on system-wide issues, supporting shared understanding of priorities, pressures and change.

Alongside this, the formal process for involvement with Health Scrutiny Committees (HSCs) has been consistently led, complemented by ongoing informal dialogue with Committee Chair. These established two-way channels have enabled issues and concerns raised by constituents to be heard and explored in a structured and transparent way, while supporting early and constructive discussion of emerging challenges.

The May 2025 local elections resulted in significant changes to the membership of the Nottinghamshire Health Scrutiny Committee. To support new Committee members in their scrutiny role, an informal briefing session was delivered in June 2025 by representatives from Nottingham and Nottinghamshire ICB. The session introduced the Integrated Care System and the ICB's role and remit, ensuring members were well informed ahead of scrutiny activity commencing from July 2025.

This approach was positively reflected by the Chair of the Nottinghamshire HSC:

“The relationship between Nottinghamshire County Council’s Health Scrutiny Committee and the ICB continues to become more proactive. What is most valuable is the ability to have open, honest conversations with transparency about the challenges and changes. There is an understanding that County Councillors want to know the reality rather than a sanitised

picture. Mutual trust has grown over the past year, and we continue to build on this as we look forward.”

Sustained, open engagement with Health Scrutiny Committees and elected representatives has strengthened mutual trust, supported more informed and constructive scrutiny, and enabled earlier, more meaningful dialogue on complex system challenges. This contributes to greater transparency, shared understanding and accountability in decision making.

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've 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

Since its launch in April 2024, the Nottingham and Nottinghamshire Public and Patient Insights Hub has continued to grow as a core system resource, strengthening how organisations across health, local government and the VCSE sector engage with people and communities.

The Insights Hub acts as a central, shared repository of citizen, patient and service user insight gathered locally across Nottingham and Nottinghamshire, alongside relevant national research and charity reports. It is designed to be the first point of access for colleagues seeking to understand what insight already exists about local communities, people's experiences of services, or the needs associated with specific conditions. By bringing this intelligence together in one place, the Hub supports a more coordinated, evidence-led approach to engagement and decision-making, while reducing duplication of activity and minimising engagement fatigue for local communities.

Over the past year, the Hub has continued to expand in both content and reach. It now holds 232 reports, an increase of 22 compared with 2024/25. Of these, 155 reports relate specifically to Nottingham and Nottinghamshire, with the remainder drawing on national studies and charity insight to support local learning. Membership has also grown, with 191 registered users, representing an increase of 27 members since December 2024. This growth reflects increasing system-wide awareness and use of shared citizen insight.

In December 2025, the Insights Hub migrated to a new online platform hosted by the System Analytics and Intelligence Unit (SAIU). This integration enables users to access the qualitative insight held within the Reports Repository alongside the system's quantitative data, all within a single portal. Bringing these data sources together supports a more rounded understanding of population needs and experiences and strengthens the system's ability to use mixed-methods insight to inform strategic commissioning and service improvement.

To support effective use of the Hub, the SAIU developed a short training video¹¹ to help users navigate the platform and access reports and insight confidently. This resource is

¹¹ [The Nottingham and Nottinghamshire Public and Patient Insights Hub - NHS Nottingham and Nottinghamshire ICB](#)

designed to build system capability, ensuring staff and partners are equipped to use existing intelligence routinely and effectively as part of their engagement and decision-making processes.

The Insights Hub is increasingly supporting more informed engagement and decision-making across the system. By making existing citizen, patient and service user insight easier to find and use alongside quantitative data, it is helping colleagues to better understand people's needs, target engagement activity more effectively, and ground strategic commissioning decisions in a richer, more holistic evidence base—while reducing duplication of engagement and unnecessary burden on local communities.

9.1.2 Citizens' Panel

The Nottingham and Nottinghamshire Citizens' Panel is a key system resource that supports ongoing, inclusive engagement with local residents, using a person-centred and consultative approach to inform the planning and delivery of health and care services. Unlike one-off surveys, the Panel enables a rolling programme of engagement with a standing group of residents, supporting deeper involvement and more consistent insight over time.

The Citizens' Panel complements existing engagement approaches and provides another route through which we listen to the views and experiences of people living in Nottingham and Nottinghamshire. Open to residents aged 16 and over, panel members are invited throughout the year to contribute to surveys, polls and questionnaires on a range of health and care topics.

Originally launched in Nottingham City in September 2022, the Citizens' Panel was expanded to cover the whole of Nottingham and Nottinghamshire. In October 2025, the Panel was relaunched following analysis of member data, which identified pockets of low participation across several districts and boroughs, including parts of Nottingham City, Broxtowe, Gedling, Rushcliffe, Mansfield, Bassetlaw, and Newark and Sherwood. This insight was used to target promotional activity more effectively and improve geographic representation.

Targeted promotion was delivered by the Communications Team through a combination of internal and external channels, including the staff intranet, Teamnet (to reach primary care colleagues), ICB social media platforms, local newsletters, and regional press. A refreshed press release was also shared with Place-Based Partnerships, health inequalities groups, local authorities and district councils to help raise awareness and encourage participation.

This focused approach led to the recruitment of an additional 106 members, increasing total Citizens' Panel membership to 267, with increases seen across all districts and boroughs. Notably strong uptake was seen in Rushcliffe, particularly West Bridgford, followed by increased participation in Bassetlaw, including Worksop and Retford.

Throughout the year, Citizens' Panel members contributed insight to surveys on urgent care services, the experiences of children and young people who identify as LGBTQ+, and communication preferences with GP practices. This feedback has helped strengthen understanding of people's needs and experiences and has informed service improvement conversations across the system.

Case study: Understanding patient preference for GP communications

A total of 133 Citizens' Panel members responded to a survey exploring preferences for communication with GP practices. The survey aimed to identify which communication methods patients find most effective and to share this insight with practices to support more patient-centred approaches.

Text messaging emerged as the preferred method of communication, with 56% of respondents selecting SMS as their first choice. This was followed by email (17%) and the NHS App (13%). While 83% of respondents reported using the NHS App, its average ease-of-use rating was 3.72 out of 5, suggesting opportunities to improve confidence and usability. Respondents also expressed interest in additional communication methods, including regular GP practice newsletters to share updates and changes, as well as the use of video consultations where appropriate.

The feedback provided valuable insight into both preferred communication channels and the types of information people want to receive through each method. Newsletters were favoured for general updates and practice information, while SMS was preferred for time-sensitive communication such as appointments and aspects of patient care.

Impact:

The findings have been shared with GP practices across Nottingham and Nottinghamshire to support a more tailored, patient-centred approach to communication. This insight is helping practices align communication methods with patient preferences, improving accessibility, clarity and engagement, and strengthening the relationship between patients and primary care services.

The Citizens' Panel is strengthening the system's ability to hear from local people in a consistent and inclusive way. By combining targeted recruitment with regular engagement activity, it is improving the diversity and reach of insight used to inform decision-making, supporting more responsive, people-centred services while reducing reliance on repeated, one-off engagement approaches.

9.1.3 Working with People and Communities Innovation session

On 16 July 2025, the Engagement and Co-production teams contributed to an ICB-led Innovation Session, delivering a joint presentation focused on strengthening understanding of how and why citizens should be involved in commissioning activity. The session aimed to build staff confidence and capability by highlighting the importance of involving people and communities in service design, commissioning and decommissioning, alongside clarifying statutory and legal duties related to public involvement.

The session was attended by over 30 participants and generated active discussion, questions and feedback throughout. It provided an opportunity to raise awareness of the practical support, resources and expertise available across the system to help teams embed engagement and co-production into their work.

Feedback collected following the session indicated a strong positive response, with respondents rating the session 5 out of 5. Participants particularly valued the practical focus and the opportunity to hear directly from both engagement and co-production leads. One attendee commented:

“Having a general overview of approaches and strategies, a worked example, hearing from both engagement and co-production leads, and being signposted to different resources and offers of support really helps to bring engagement and co-production to life.”

This session contributed to improved awareness and understanding of statutory involvement duties and practical approaches to engagement and co-production, supporting a more informed and confident workforce. By positioning engagement and co-production as core to good commissioning practice, it strengthened the system’s ability to involve people and communities effectively and consistently in decision-making.

9.1.4 Building capacity for effective co-production

A shared, system-wide Co-production Training Resource Group was established following the identification of skills and knowledge gaps across the system, both in understanding what co-production is and how to deliver it effectively in practice. The group has worked collaboratively to co-produce an accessible training package designed to build confidence and capability in planning, delivering and sustaining high-quality co-production activity.

The training resource has been co-created by staff and people with lived experience from health and social care providers, ensuring that it reflects both professional and experiential perspectives. It focuses on the practical skills needed to run successful co-production projects and is intended to support more consistent, meaningful involvement as the system moves into new cluster arrangements following the ICB restructure.

Alongside this, a series of co-production case studies was developed during the year, with a particular focus on “closing the loop”. These case studies revisit earlier examples of involvement to explore how work has progressed over time, what has changed as a result of co-production, and what learning has emerged (see section 9.2.3. for an example).

Each case study presents a shared narrative of how staff and people with lived experience worked together, the impact of that collaboration, and the insights gained along the way. This approach helps demonstrate what co-production looks like in practice, rather than in principle alone, and reinforces the importance of evidencing impact in both the short and longer term.

The series includes case studies such as Minds of All Kinds Nottinghamshire¹², a co-produced website providing accessible mental health information and resources for children, young people, families and professionals.

Together, the training resources and case study programme are strengthening system-wide understanding of co-production, supporting more consistent practice, and reinforcing the expectation that involvement leads to demonstrable change. They provide practical tools and real-world learning to support a more confident, skilled and outcomes-focused approach to co-production across Nottingham and Nottinghamshire.

9.2 Sharing successful programmes

This section highlights programmes that demonstrate best practice in engagement, delivered through close and trusted partnership working with community organisations and a clear focus on amplifying the voices of LGBTQ+ communities who are often under-represented in health services.

¹² [Home | Minds of All Kinds - Notts](#)

9.2.1 Developing a safe prescribing model for transgender patients

Adults aged 17 and over in England who experience gender incongruence can access specialist assessment through NHS England-commissioned Gender Identity Clinics (GICs). While GICs make clinical recommendations regarding hormone treatments, responsibility for prescribing and monitoring medication typically sits with the individual's GP practice. This arrangement can result in variation in access, experience and continuity of care.

To better understand people's experiences of accessing prescriptions and monitoring through GP practices and to inform the commissioning of an alternative local service where GP prescribing is not available, a listening exercise was undertaken. The aim was to understand current experiences, identify barriers to safe and consistent care, and establish what people would want to see in a new interim service for adult transgender patients in Nottingham and Nottinghamshire.

The listening exercise ran from 28 July to 12 September 2025 and was designed in close partnership with the local transgender community. Views were sought from individuals with lived experience, organisations representing transgender communities, and local transgender health services.

A range of engagement methods was used to support inclusion and accessibility, including an online survey, online and in-person focus groups, online interviews and visits to community groups

A close collaboration was established with Notts Trans Hub, enabling its members to actively participate and helping ensure the engagement was delivered in a way that felt safe, respectful and relevant. Ahead of the focus groups, the Engagement Team met with the Chair of Notts Trans Hub, who provided advice on effective engagement approaches and supported access to venues and online platforms.

In total, 114 individuals contributed to the listening exercise.

The engagement highlighted significant challenges and variation in people's experiences of accessing gender-affirming care through GP practices:

- Two-thirds of respondents (67%) reported difficulties accessing hormone prescribing and blood test monitoring through GP practices.
- Some GPs were described as open about limited specialist knowledge, while others declined shared-care arrangements, creating barriers to consistent and safe care.
- Extended waiting times for Gender Identity Clinics were reported as contributing to distress and, in some cases, self-medication despite known risks.
- Delays linked to prescriptions, blood results and appointment availability were commonly reported and affected continuity of care.
- Almost half of respondents (48%) would prefer prescribing and monitoring to take place within GP practices, provided appropriate specialist support is in place.
- Specialist clinical expertise, peer support within healthcare settings, and clear, accessible information were identified as essential features of any new service.

The findings from the listening exercise¹³ are informing the development of a new interim prescribing and monitoring service, expected to launch in 2026/27.

Following the listening exercise, a post-engagement action plan was developed to identify further actions to support the transgender community beyond service commissioning. This included a review of communication and campaign activity. Frequently used social media posts and public messaging were reviewed by a clinician from the Nottingham Centre for Transgender Health, ensuring content is inclusive, accurate and responsive to community needs.

Opportunities to extend LGBT+ allyship training into GP practices were also explored in collaboration with the Nottingham and Nottinghamshire ICB LGBTQ+ Staff Network. While individual access to the allyship programme is already in place, current capacity limitations mean a coordinated rollout to all GP practices is not yet feasible.

In addition, Engagement and Commissioning colleagues met with Spectra Trans Health Advisory Service (London). Spectra confirmed that the findings strongly reflected the experiences of transgender communities nationally and expressed interest in both the insights and the engagement methodology used.

This programme demonstrates best practice in engagement through close partnership with trans-led community organisations, inclusive methods and a clear focus on amplifying lived experience. The insight gathered is directly shaping commissioning decisions, improving understanding of risk and inequity, and supporting the development of safer, more accessible gender-affirming care for transgender people in Nottingham and Nottinghamshire.

9.2.2 Understanding the experiences of LGBTQ+ Children and Young People

In October 2025, a review was undertaken of ICB-commissioned Emotional Health and Wellbeing services for children and young people across Nottingham and Nottinghamshire, including early intervention, counselling, school-based mental health support and targeted specialist provision. The review considered services delivered across community, school and digital settings.

A key recommendation from this review was the need for services to prioritise inclusion cohorts, beginning with LGBTQ+ children and young people as a focus from 2026. Planned activity includes upskilling staff working within core EHW services to ensure practitioners have the skills and confidence required to deliver culturally competent, inclusive and responsive care. This approach supports improved access to evidence-based treatment and aligns with national priorities and statutory equality duties.

To inform future service development, feedback was sought from children and young people aged 11-25 who identify as LGBTQ+, focusing on access to services, experiences of care environments, and both positive and negative interactions with services. The listening exercise ran from 5 January to 2 February 2026 and used a range of engagement methods to maximise accessibility and participation. These included an online survey, online focus groups, telephone feedback and a visit to a community group. The ICB's LGBTQ+ Staff Network supported the development of engagement materials to ensure language and questions were relevant and appropriate. Children and young people also tested the survey prior to launch. In total, 41 individuals contributed to the engagement.

¹³ [Prescribing hormones and blockers for transgender patients: Engagement Report - NHS Nottingham and Nottinghamshire ICB](#)

Adjustment to our approach during the listening exercise

Early feedback from professionals working with LGBTQ+ young people identified hesitancy among some participants to engage. In response, the engagement approach was adapted, with additional outreach to youth workers and community groups and offers to engage young people within familiar and trusted settings.

Negative comments on Facebook were also noted at the outset of the engagement. On the advice of the ICB Staff LGBTQ+ Network, this content was removed and subsequent promotion took place via the Bluesky platform to ensure a safer and more supportive environment.

Key findings included:

- A strong preference for free-text options when describing sexual orientation (52%) and gender identity (68%), and for the inclusion of pronouns rather than titles on forms.
- Consistent feedback that many healthcare professionals lack sufficient understanding of LGBTQ+ identities and experiences.
- Reports that negative or invalidating experiences, including misgendering, contributed to deterioration in mental health, with some respondents linking this to feelings of hopelessness and suicidal ideation.
- Positive feedback for LGBTQ+ Services Nottinghamshire, with participants valuing one-to-one support and safe spaces.
- Clear signals that inclusive environments matter, with priorities including staff training in LGBTQ+ awareness, gender-neutral facilities, visible allyship (e.g. badges and lanyards), use of preferred pronouns, and access to peer support.

The findings from the listening exercise are being used to support the embedding of more inclusive and responsive care within Emotional Health and Wellbeing services across Nottingham and Nottinghamshire. LGBTQ+ Services Nottinghamshire will work closely with EHW providers to deliver training and ongoing support.

To ensure the learning was accessible to children and young people, a one-page summary was produced alongside the full engagement report¹⁴. This format was designed specifically for younger audiences, recognising that a detailed report may not be accessible or appropriate for all. The one-page summary was shared with local LGBTQ+ services to support wider dissemination and understanding.

This work demonstrates best practice in engagement through responsive and adaptive methods, close partnership with community and staff networks, and a clear commitment to ensuring LGBTQ+ children and young people feel safe, heard and represented.

9.2.3 Minds of All Kinds: Making services more accessible for children and families

An important stage in a co-production approach is completing the work by sharing relevant updates and thanking people for their participation. This is often referred to as “closing the loop”, which can lead to people who take part feeling valued as they can see the output from their efforts. It also enables potential for future involvement with the same group and over time builds trust and reputation.

¹⁴ [LGBTQ+ children and young people: Experiences of local health and wellbeing services - NHS Nottingham and Nottinghamshire ICB](#)

The Minds of All Kinds website¹⁵ was co-produced to provide a single, trusted online resource offering support, pathway guidance and practical information for neurodivergent children, young people and adults, their families and carers, and professionals. The website brings together local and national information in one accessible place, supporting individuals who are considering an assessment, awaiting results, or seeking ongoing support. A key strength of this programme was the co-production approach, which maintained relationships with participants throughout the project, including during periods when activity was paused, and ensured that learning and contributions were reflected in the final outcome.

Feedback from families highlighted the need for a single, accessible website providing reliable, jargon-free information about autism, ADHD and other neurodivergent differences, as well as clearer guidance on pathways and support while waiting for assessments or outcomes. The aim was for the website to combine clear explanations with practical support and signposting, while also functioning as a local directory for Nottingham and Nottinghamshire alongside relevant national resources.

A Steering Group was established to co-produce the website's content and design, working alongside a web developer. Membership was formed through community networks and partner organisations and included parents and carers, young people with lived experience, and professionals from education, health and social care. The group contributed to shaping content, beta-testing early versions of the site, overseeing launch communications and shortlisting potential website names for public selection. Two task-and-finish groups were later established to focus on detailed content and design, with members contributing flexibly between meetings to maintain momentum. A public survey was used to select the final website name, and regular email communication ensured transparency and kept contributors informed of progress and decisions, including those unable to attend meetings.

Technical issues during development led to delays and required a change of web developer, with activity paused to avoid unnecessary duplication. A new developer was commissioned who agreed to work with the existing co-produced content and design, ensuring that participants' contributions were retained. A smaller Steering Group was reconvened to support final development, oversee user testing and prepare the site for launch. Throughout, the co-production approach ensured that the website remained grounded in lived experience, accessible to a wide audience, and reflective of the interconnected education, health and social care systems navigated by neurodivergent individuals and families.

Before launch, the website was tested by parents, carers, children, young people and professionals. Feedback was thematically analysed and used to inform final refinements, improving clarity, navigation and usability. The website was then launched through a coordinated multi-media campaign, raising awareness across Nottingham and Nottinghamshire via channels including Notts TV, social media, newsletters, press releases and school communication platforms.

Closing the loop with contributors was an integral part of the approach. Participants were thanked directly by email and provided with a link to the live website they had helped create. Vouchers were issued as a token of appreciation, and public acknowledgement was

¹⁵ [Home | Minds of All Kinds - Notts](#)

included on the website and via Notts TV, with a message of thanks from the ICB Chief Nurse.

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 and Nottinghamshire Health Scrutiny Committees.
- Engagement with the East Midlands Combined County Authority.
- Providing verbal and written updates to Healthwatch Nottingham and Nottinghamshire.
- Holding our Annual Public Meeting, which offers the opportunity for the public to ask questions.

10.2 Co-producing patient-facing communications for Integrated Neighbourhood Teams

During 2025/26, work commenced to co-produce a suite of patient-facing communications to support the implementation of Integrated Neighbourhood Teams (INTs). This activity reflects a commitment to designing communications in partnership with people and communities, ensuring that information is clear, accessible and relevant to those using services.

A co-production group was established comprising volunteers, VCSE staff and ICB colleagues. The group is developing a leaflet aimed at people currently supported by INTs, initially focused on frailty cohorts, as well as their wider support networks, including family members and carers. The leaflet is intended to explain what Integrated Neighbourhood Teams are, what support people can expect, and how INTs link with other health and care services.

Draft versions of the leaflet were shared with members of the Citizens Reference Group in Nottingham West, whose feedback directly influenced the content and format. Suggestions included increasing font size to improve readability, clarifying language, and adding information about what to do in urgent or emergency situations. This feedback has helped ensure the leaflet reflects real-world needs and supports confidence in accessing care. To support flexibility and local relevance, the leaflet has been designed so it can be adapted by Place-Based Partnerships, Primary Care Networks and other local teams to reflect the specific characteristics and needs of their communities. This approach enables consistent core messaging while allowing for local tailoring.

The leaflet will also form the basis for additional communication assets, including a short video and digital content for use on screens in GP practices and community pharmacies. Together, these materials aim to improve awareness and understanding of Integrated Neighbourhood Teams and support more joined-up, person-centred communication across neighbourhoods.

By co-producing communications and testing them with local citizens, this work is improving the clarity, accessibility and relevance of information provided to people supported by Integrated Neighbourhood Teams. It supports informed participation in care, strengthens trust, and provides a scalable communications approach that can be adapted as neighbourhood models continue to develop.

11 Future planning

Looking ahead to 2026/27, the move towards clustered ways of working across the DLN footprint represents a significant shift in how services are planned, delivered and overseen. While this transition creates opportunities to strengthen collaboration, share learning and operate at greater scale, it also requires careful attention to ensure that effective local practice is understood, valued and built upon as new operating arrangements develop.

A key priority for the coming year will be developing a clearer, shared understanding of how insight from people and communities is gathered, used and applied across different parts of the cluster. This will include identifying where practice is already mature, exploring areas of variation, and considering where greater alignment would support quality, consistency and assurance. At the same time, it will be important to recognise and respect the different contexts in which services operate across the cluster, including rural, coastal and urban communities, and the ways in which these differences shape people's experiences, access to services and engagement needs. The emphasis will be on learning from existing strengths and experience, rather than adopting a single uniform approach.

Alongside this, there will be a focus on reviewing and aligning relevant strategies, policies and frameworks that underpin engagement and co-production activity across the DLN cluster. This will help establish greater consistency in expectations and practice, support clearer assurance, and reduce duplication, while allowing flexibility for place-based and neighbourhood-level approaches that reflect local population needs.

Particular attention will be given to understanding the different ways in which VCSE Alliances operate across the cluster, including their roles, governance arrangements and ways of working. This will support shared learning and help identify opportunities for greater collaboration or alignment where this adds value, while recognising the importance of local nuance and the distinct strengths and relationships embedded within each area. Maintaining strong relationships with VCSE partners will remain essential throughout this period of change.

There will also be a continued focus on embedding co-production as a planned and deliberate element of commissioning and transformation activity, rather than something applied retrospectively or inconsistently. Work will continue with commissioners and system partners to ensure that engagement and co-production are considered from the outset of programmes of work and aligned with emerging cluster arrangements, while retaining flexibility for place-based and neighbourhood-level delivery.

Alongside this, further work is planned to explore how existing insight from engagement, lived experience and community activity is captured, shared and accessed across the cluster. This includes scoping opportunities to strengthen or better align current insight-sharing approaches, including consideration of whether a shared or interconnected Insights Hub could support improved access to qualitative insight alongside quantitative data, reduce duplication, and enable more effective use of existing intelligence by commissioners and partners.

As delivery arrangements evolve, attention will also be given to how engagement and co-production activity is reported, assured and shared within existing governance structures. Reporting approaches will need to support learning, transparency and accountability across organisations, without creating unnecessary burden.

Throughout this period of organisational change, maintaining meaningful engagement with communities, VCSE partners and lived-experience contributors will remain essential. Ensuring that insight from people and communities, and co-production activity, continue to play a visible and meaningful role in shaping decisions will be critical to supporting effective transformation and maintaining public trust across the cluster.

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're doing well and where we could do better.

Please visit our website¹⁶ to find out how people and communities can get involved in the work of Nottingham and Nottinghamshire ICB or call or text 07385 360071.

¹⁶ [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
Bluebird Care
British Liver Trust
Citizens Advice – Central Nottinghamshire
Digital Notts
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Health Innovation East Midlands
East Midlands Ambulance Service
Framework
Gedling Borough Council
Healthwatch Nottingham and Nottinghamshire
Juno Women's Aid
Mansfield Community and Voluntary Service
Mid Nottinghamshire Place-Based Partnership
Newark and Sherwood Community and Voluntary Service (Your Voice)
NHS Nottingham and Nottinghamshire Integrated Care Board. Representatives from the following teams are in attendance: • Engagement • Coproduction • Research
Governors on behalf of: • Nottinghamshire Healthcare NHS Foundation Trust • Sherwood Forest Hospitals NHS Foundation Trust
Nottinghamshire Carers Association
Nottingham City Council
Nottingham CityCare
Nottingham Community and Voluntary Service
Nottingham University Hospitals Trust (including Research Team)
Nottinghamshire County Council
Nottinghamshire Healthcare Trust
Nottinghamshire Sexual Violence Support Services
POhWER
Police and Crime Commissioners Office
Relate Nottingham and Nottinghamshire
Sherwood Forest Hospitals NHS Foundation Trust
Talking Therapies Service
The Health Shop
Thriving Nottingham

13.2 Appendix 2: VCSE Alliance: organisations represented

Organisation	Organisation category
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
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
Dove Cottage Day Hospital	Healthcare
Endometriosis UK Nottingham Support Group	Health condition
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
Muddy Fork	Community
My Sight	Supporting Blind people
Newark and Sherwood CVS	Community infrastructure organisation
Nottingham and Nottinghamshire Refugee Forum	Refugees and asylum seekers
Nottingham City Council	Local authority
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
Primary Wellbeing CIC	Children
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
Royal National Institute of Blind People (RNIB)	
Rural Community Action Nottinghamshire	Community
SSAFA, the Armed Forces charity	Veterans
Self Help UK	Self help
SHE UK	Sexual abuse, exploitation and violence
Sherwood and Newark Citizen Advice Bureau	Advice on debt, housing, jobs, legal
Small Steps Big Changes	Children
Stronger Roots	Addiction
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

The Toy Library	Education centre
Trussell Trust	Food banks
YMCA	
Your CVS	Community infrastructure organisation

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	16/07/2026
Paper title:	Statements on Information on Health Inequalities
Paper reference:	ICB CIC 26 037
Paper author:	Emma Townend, Interim Health Inequalities and Prevention Programme Lead, NHS Lincolnshire ICB
Paper sponsor:	Dave Briggs, Executive Director of Outcomes (Medical)
Presenter:	Dave Briggs

Paper type:				
For assurance ☒	For decision ☐	For discussion ☐	For information ☐	

Report summary:

This report provides assurance with regards to the delivery of statutory duties to take account of health inequalities issues in the exercise of the functions of an ICB.

It provides assurance that NHS Derby and Derbyshire, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire ICBs have responded to the NHS England Statement on Information on Health Inequalities, which sets out the requirement for ICBs to collect, analyse and publish information relating to health inequalities.

The report outlines the limitations of the health inequalities analysis conducted and highlights issues and future actions to support addressing health inequalities.

The Statements were scrutinised by the ICBs' Joint Strategic Commissioning Committee at its meeting on 25 June 2026, receiving an assurance rating of 'full'.

Recommendation(s):

The Boards are asked to **receive** the report for assurance.

Appendices

Appendix 1: Statement on Information on Health Inequalities - NHS Derby and Derbyshire ICB

Appendix 2: Case Studies - NHS Derby and Derbyshire ICB

Appendix 3: Statement on Information on Health Inequalities - NHS Lincolnshire ICB

Appendix 4: Case Studies - NHS Lincolnshire ICB

Appendix 5: Statement on Information on Health Inequalities - NHS Nottingham and Nottinghamshire ICB

Appendix 6: Case Studies - NHS Nottingham and Nottinghamshire ICB

Appendix 7: Opportunities for Improvement at Place

Appendix 8: Opportunities for Improvement at Programme

Appendix 9: Ethnicity Recording - Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire Provider Overview

Board Assurance Framework

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

Board Assurance Framework

- Failure to develop and maintain a comprehensive, evidence-based understanding of local population health needs
- Failure to involve people and communities meaningfully in commissioning and service design
- Failure to systematically improve the quality of healthcare services
- Failure to ensure timely and equitable access to healthcare services in line with national and local performance standards

Relevant statutory duties:

- | | |
|---|---|
| ☐ Quality improvement | ☐ Public involvement and consultation |
| ☒ Reducing inequalities | ☐ Equality and diversity |
| ☐ Financial limits/ breakeven | ☐ Effectiveness, efficiency and economy |
| ☐ Integration of services | ☐ Wider effect of decisions (triple aim) |
| ☐ Promoting innovation | ☐ Promoting research |
| ☐ Patient choice | ☐ Obtaining appropriate advice |
| ☐ Promoting education/training | ☐ Climate change |

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Statements on Information on Health Inequalities

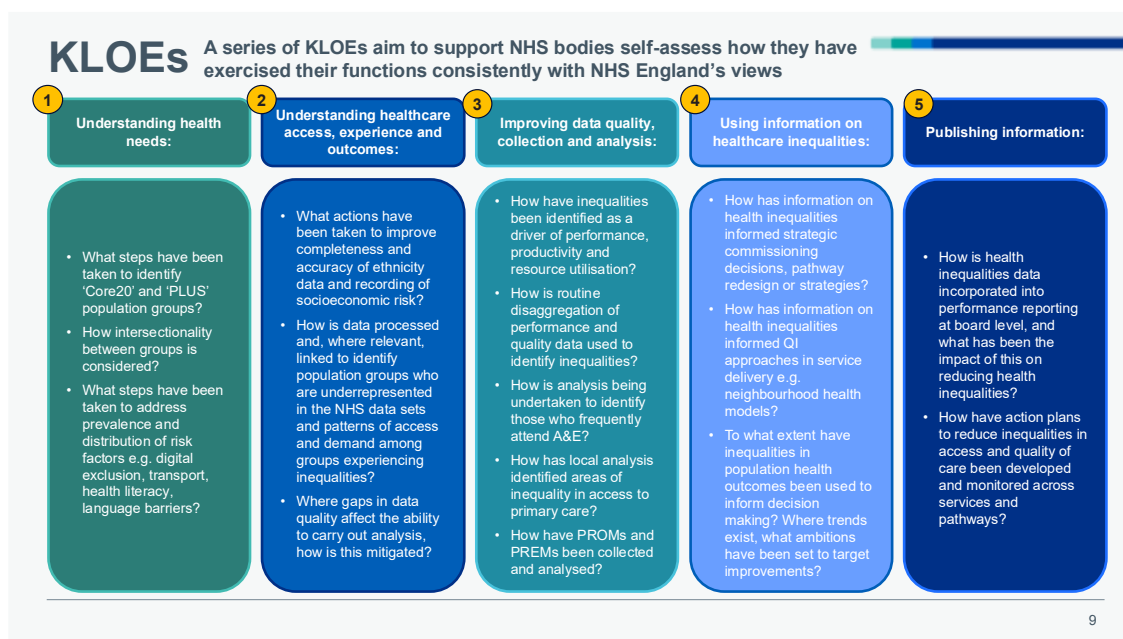
Introduction

1. This report is presented to the Boards to provide assurance with regards to the delivery of statutory duties to take account of health inequalities issues in the exercise of the ICBs' functions.
2. Under duty s.13SA of the National Health Service (NHS) Act 2006, NHS England (NHSE) published (November 2023 and subsequently updated in November 2025) its first Statement on Information on Health Inequalities, which sets out requirements for ICBs (and trusts) to collect, analyse and publish information relating to health inequalities. This report provides assurance that NHS Derby and Derbyshire, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire ICBs ('the ICBs') have met the requirements set out by NHSE for reporting on health inequalities.
3. A Statement on Information on Health Inequalities has been compiled for 2025/26 for each of the three ICBs individually (see Appendices 1, 3 and 5).
4. Health inequality conclusions for each ICB are constrained by poor ethnicity coding, and results for the same metrics are not directly comparable across ICBs due to several reasons, including variations in data warehouse structures, provider recording practices, and data completeness.

Main assurance sections

5. In the November 2025 update of the Statement on Information on Health Inequalities, NHSE listed core metrics for monitoring health inequalities that align with the national five strategic health inequality priorities and Core20Plus5 framework. These are listed here: [NHS England » NHS England's statement on information on health inequalities](#). The core metrics have been reported against by each ICB disaggregated by deprivation, ethnicity, age and sex where possible, where the data is available.
6. In the updated 2025 Statement on Information on Health Inequalities, NHSE set out a series of Key Lines of Enquiry (KLOE), Figure 1, for ICBs to use to support a self-assessment of how they have exercised their functions. The main headings are: Understanding population health needs; improving data quality, collection and analysis; understanding healthcare access, experience and outcomes; using information to take action on health inequalities; and understanding healthcare access, experience and outcomes. The Statements on Information on Health Inequalities by each of the ICBs answer all the KLOEs, supporting their responses with case studies (see Appendices 2, 4 and 6).

Figure 1



- The Statements on Information on Health Inequalities and supporting case studies by each ICB demonstrate that they have fulfilled their legal duties and taken an evidence-led improvement approach to tackling health inequalities.

Issues

- Although each core indicator has been analysed by ethnicity, health inequality conclusions have been difficult to obtain due to ethnicity coding. Ethnicity data quality is a well-documented local and national issue which influenced the development of the [NHSE Ethnicity Recording Improvement Plan](#). Ethnicity data collection and reporting vary for several reasons, including a significant proportion of records where ethnicity has not been asked of the patient, inaccurately captured, or the patient has declined to declare their ethnicity. This makes it difficult to infer with certainty whether observed differences represent genuine inequalities attributable to ethnicity, or whether they are instead influenced by missing, inconsistent, or unreliable data.
- Each ICB report has been developed using the core metrics outlined in the 2025 update to the NHSE Statement on Information on Health Inequalities measurement framework and have used broadly aligned methodologies and, where possible, the same data sources (where available). However, differences in local data warehouse structures, provider data recording, and data completeness (amongst other reasons) mean results for the same metrics should not be considered as directly comparable. Readers should read the results as indicative of patterns across the ICBs. Until a shared data environment and standardised data processing approach are in place, any-read

across between the results presented in each ICB's response to the statement should be done with caution. Furthermore, not each ICB has been able to provide a result for each indicator due to differences in local, regional, and national data availability, and data maturity. Not all data sources (local and national) are able to disaggregate by sex, age group, deprivation decile/quintile, or ethnicity, which limits the extent to which we can compare analyses across different population groups or sub-groups.

Future action

10. Best practice identified in the individual ICB responses to the KLOE and supporting case studies will be shared across teams to support improvement.
11. All future commissioning should take into account the healthcare inequalities identified within the individual ICB Statements on Information on Health Inequalities, with particular attention to the opportunities for improvement at both Place and Programme (see Appendices 7 and 8).
12. A requirement to improve ethnicity coding will be in the Data Quality Improvement Plan, which is to be issued to all Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire providers for 2026/27. It will also be detailed as part of the Schedule 2N in provider contracts across the ICBs. The [NHSE Ethnicity Recording Improvement Plan](#) will be advised as a practical tool to improve ethnicity recording and reporting for Providers. Appendix 9 shows the ethnicity data quality percentage for February 2026 by the main providers across Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire and how this compares to the national average.
13. The ICBs will undertake audits and/or routine monitoring of all key datasets to identify where metrics cannot currently be stratified by health inequality characteristics and put appropriate plans in place to ensure future health inequality analyses can be conducted when the ICBs' centralised data warehouse is operational.
14. As directed by the Joint Commissioning Executive Group in December 2025, work continues to migrate the ICBs' data into a centralised data warehouse, establishing the infrastructure necessary to support the development of health inequalities reporting within the ICBs. Ongoing collaboration with the Outcomes Directorate will continue to develop, refine, and embed health inequalities outcomes and associated measures.
15. Selected core health inequality metrics in the Statement on Information on Health Inequalities will be part of the ICBs' performance framework for 2026/27.
16. For 2026/27 there will be one Statement on Information on Health Inequalities that is produced for the ICBs.

Conclusion

17. Each ICB has met its statutory duty regarding health inequalities and responded to the NHS England Statement on Information on Health Inequalities by evidencing that it has collected and analysed information relating to health inequalities and responded to all of the KLOE by producing a Statement on Information on Health Inequalities with supporting case studies to evidence how they have exercised their functions.



Statement on Information on Health Inequalities

**Derby and Derbyshire
Integrated Care Board**

Derby and Derbyshire Integrated Care Board Response: NHS England Statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)

Introduction	4
Derby & Derbyshire Population Profile.....	4
Impacting on Health Inequalities	5
How do we Measure Deprivation?	5
Using Data to Understand Health Inequalities	6
Understanding Health needs	6
Understanding healthcare access, experiences, and outcomes	7
Improving data quality	8
Using information on healthcare inequalities	8
Publishing information.....	9
Operational priorities.....	11
Elective Care.....	11
Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks, 65 weeks	11
Inequalities in annual change in size of waiting list.....	14
Age-standardised rates of elective admissions.....	16
Age-standardised rates of outpatient appointments	17
Age-standardised rates of virtual outpatient appointments	18
Community.....	19
Inequalities in percentage of people waiting over 18 weeks, over 52 weeks, over 104 weeks for community services.....	19
Urgent and Emergency Care	20
Age standardised activity rates with 95% confidence intervals for emergency admissions	20
Age standardised activity rates with 95% confidence intervals for emergency attendances	21
Inequalities in mean time in emergency department	22
Urgent and Emergency Care – CYP	25
Emergency attendances for under 18s	25
Emergency admissions for under 18s	27
CORE20PLUS5 – Adults	29
Respiratory.....	29
Inequalities in non-elective bed days occupied by asthma, COPD and CAP.....	29
Inequalities in pulmonary rehab completion rates.....	29
Smoking Cessation	30
Inequalities in inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	30

Inequalities in inpatients who successfully quit smoking as measured at 28 days after commencing a supported quit attempt.....	30
Inequalities in percentage of pregnant women identified as smokers at antenatal booking who are identified as non-smokers at 36 weeks gestation	31
Mental Health	32
Overall number of severe mental illness (SMI) physical health checks and action plan	32
Rates of total Mental Health Act detentions	32
Rates of restrictive interventions.....	34
Inequalities in people achieving access for NHS Talking Therapies.....	36
NHS Talking Therapies recovery rate	37
Cancer	39
Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex	39
Cancer screening coverage	40
Cardiovascular Disease (CVD)	40
CVD case finding.....	40
Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised).....	41
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).....	42
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	44
Percentage of patients aged 18 or over with GP recorded atrial fibrillation and a record of CHA2DS2-VASc Score of 2 or more who are currently treated with anti-coagulation drug therapy	46
Diabetes	48
Variation between percentage of people with Type 1 and Type 2 Diabetes receiving all 8 care processes.....	48
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	50
Learning Disabilities and Autism	52
Number of people in a mental health inpatient setting who have a learning disability or are autistic	52
Percentage of patients aged 14+ on GP learning disability registers who have had an annual health check	52
Percentage of people with suspected autism waiting more than 13 weeks for contact	52
Maternity and Neonatal.....	53
Pre-term births under 37 weeks	53
Gestational age at booking	54
Vaccinations.....	55
Uptake of flu vaccinations by age and demographic	55
Uptake of covid vaccinations by age and demographic.....	56
CORE20PLUS5 – CYP.....	57
Oral Health	57
Tooth extractions due to decay for children admitted to hospital aged 10 and under (number of admissions) ..	57

Diabetes – CYP	58
Inequalities in percentage of CYP with type 1 and 2 diabetes receiving all the recommended NICE care processes	58
Mental Health – CYP	59
Children and Young People’s (CYP) Mental Health Access	59
Respiratory – CYP	60
Inequalities in emergency department admissions for asthma (CYP)	60
Inequalities in dispensing of reliever only inhalers	61
Data Quality	62
Percentage of patients with a valid, non-residual ethnicity code in data sets	62

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.

Derby & Derbyshire 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. Analysts across ICB and ICS (including colleagues from the North of England Commissioning Support Unit (NECS) have 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. 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.

Derby & Derbyshire Population Profile

Derby & Derbyshire 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. In April 2026, there were 1,143,518 patients registered with one of the 109 GP practices in Derbyshire. 21.1% (241,120/1,143,518) of the GP registered population are over the age of 65.

21.6% (247,150/1,143,518) of the GP registered population live in a CORE20 area. There are large areas of deprivation in Derbyshire, mainly around inner-city Derby and in the North East of the county around towns like Chesterfield and Bolsover.

Based on the 2021 Census, 87.4% of the Derbyshire resident population are from a White British/Irish ethnic background. 5.0% are from an Asian background.

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.

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 experience are some ways in which overall outcomes could be improved.

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.

Using Data to Understand Health Inequalities

Understanding Health needs

We have taken a range of steps to understand the health needs and inequalities experienced by local Core20 and PLUS population groups. This includes undertaking a comprehensive, benchmarked yearlong data analysis in 2025 of Children and Young People (CYP) across Derby and Derbyshire to inform 2026/27 planning, which examined physical long-term conditions (such as asthma, epilepsy, diabetes and obesity), geographical variation, educational outcomes and emergency department attendance.

We have strengthened this insight through detailed data collection and analysis within CYP mental health, drawing on the national dataset, alongside a Children in Care needs assessment, ensuring that the needs of particularly vulnerable groups are understood. We have also analysed how CYP, adults and professionals access information online, with specific consideration of barriers faced by ethnic minority groups, highlighting issues relating to digital exclusion, language and accessibility. Population level insight is further supplemented by school nursing surveys conducted annually with all children in Reception and Year 6, and analysis of the national child measurement programme, with the ability to drill down into Core20 populations to identify early risk factors such as obesity and wider determinants of health.

In addition, we use contract management processes and key performance indicators across services such as mental health, eating disorders and learning disability and autism to understand whether services are meeting the needs of specific groups, including those with protected characteristics or additional needs. Qualitative insight is also gathered through parent and carer forums, particularly representing neurodiverse children and those with SEND, ensuring lived experience informs our understanding of barriers and need. Core20 baseline and activity data is routinely reported through governance structures such as the DDICB Children's Board, including focus on CYP with long-term conditions and transition, providing ongoing oversight of inequalities.

We have explored intersectionality by systematically analysing how multiple characteristics combine to influence outcomes across our population, with children and young people (CYP) providing a clear example of how this approach is applied in practice across the ICB. For CYP, we have undertaken comparative analysis of those living in Core20 and IMD 1 (most deprived) areas compared to those in less deprived quintiles, further segmented by ethnicity and age, to understand how deprivation interacts with other factors to shape outcomes such as emergency department attendances and admissions.

We have also applied this approach to vulnerable groups, including CYP with a recognised learning disability, triangulating primary care prevalence, admissions and ED data and exploring co-morbidities such as epilepsy and obesity. This has enabled us to identify how disability, long term conditions and deprivation intersect, highlighting those at greater risk of poorer outcomes or unmet need. In addition, our mental health strategic assessment has incorporated a wide range of intersecting characteristics, including care experience, socio-economic status, ethnicity, education, long term conditions, neurodiversity, sexual orientation and gender identity, recognising that these combined factors can create additional barriers to access and poorer outcomes.

Importantly, we have translated these insights into action through commissioning and service design, including aligning services with LeDeR recommendations, embedding expectations on equitable access and inclusive engagement within service specifications, and working with primary care and providers where patterns are identified.

We have taken steps to understand and address key risk factors driving healthcare inequalities, using the development of plans to expand NHS Talking Therapies delivered in British Sign Language (BSL), this is one example of how this is applied in practice. Through engagement, data analysis and insight, we have recognised that Deaf people experience multiple and intersecting barriers to accessing timely mental health support, including communication barriers, limited availability of BSL trained therapists, and wider issues such as reduced health literacy due to inaccessible information, as well as digital exclusion where services rely on written or spoken formats.

We have also considered geographical access challenges, particularly in more rural parts of our footprint, where specialist provision is limited and transport can further restrict access to face-to-face care.

This understanding of need and distribution has informed our targeted planning and commissioning, with a focus on increasing the availability of therapies that are delivered directly in BSL rather than through interpreters, recognising the importance of culturally and linguistically appropriate care. It has also led to a broader review of how services are advertised and accessed, ensuring that information is available in accessible formats and that referral pathways do not rely solely on digital or written communication.

Understanding healthcare access, experiences, and outcomes

Health inequalities are increasingly identified as a contributing factor to variation in performance, service utilisation and outcomes across the system. Population health intelligence, including analysis of deprivation, ethnicity and avoidable mortality, is routinely used to highlight unwarranted variation in access, experience and outcomes across different population groups and clinical areas. This analysis has demonstrated that communities experiencing higher levels of deprivation and disadvantage often have greater demand for urgent and emergency care, lower uptake of preventative services and poorer health outcomes, contributing to variation in system performance and resource utilisation. These insights are reflected in routine Board reporting and have informed the identification of system priorities. The ICB uses a range of data sources, including Joint Strategic Needs Assessments, population health management analysis and system intelligence from the Strategic Analytics and Intelligence Unit, to develop a shared understanding of how inequalities influence patterns of demand and outcomes. This supports more targeted planning and the prioritisation of resources towards groups experiencing the greatest barriers to access and poorest outcomes.

Examples of this approach include targeted work aligned to Core20PLUS5, improvements in access for people living in the most deprived (e.g. British Sign Language provision in Talking Therapies), and community led programmes addressing conditions such as hypertension and sickle cell disease. These initiatives demonstrate how inequalities insight can inform service delivery and resource targeting.

Within the CVD Programme, formal PROMs and PREMs have not yet been systematically embedded within this programme, however, a range of structured and semi-structured qualitative approaches are used to capture patient experience and insight, particularly in relation to barriers to access and variation in care.

Qualitative intelligence is gathered through the CVD Community of Practice, where clinicians share direct feedback on patient experiences, challenges in accessing services, and observed inequalities in outcomes. This is complemented by the CVD Champion Network, which provides insight from general practice and local populations, highlighting variation in engagement, treatment and outcomes across different communities. In addition, targeted engagement sessions with practices are used to explore service gaps, operational challenges and population-specific barriers, including those related to deprivation, health literacy and access.

While these approaches are not formal PROMs/PREMs, they provide valuable real insights into patient experience, particularly for groups who may live in areas of deprivation. This qualitative information is triangulated with quantitative data sources such as CVD Prevent and Eclipse Live to identify patterns of variation in care, including differences in diagnosis, treatment and outcomes across population groups. This combined insight is then used to prioritise areas for improvement and to better understand the drivers of health inequalities within the CVD pathway.

Qualitative information is collected through a range of mechanisms, including patient safety incidents, complaints, the Friends and Family Test, and the annual CQC maternity survey, all of which include demographic data to support analysis of inequalities. Feedback is reviewed for themes and trends, with a focus on identifying groups who may be overrepresented in poorer experiences (see case study 4). Additional insight is captured through inclusive approaches such as “Three Words Matter,” enabling feedback from those less likely to engage in formal processes. This information is analysed alongside demographic data to identify inequalities and inform targeted care pathways and improvement actions, which are then monitored and reported quarterly through the ICB Maternity and Neonatal governance structures.

Improving data quality

We have recognised that improving the completeness, accuracy and use of data is critical to identifying and addressing health inequalities. Steps are being taken to strengthen coding and recording practices, particularly for key demographic fields such as ethnicity, protected characteristics and deprivation. This includes working with providers to improve the consistency of data recording, promoting the use of standardised coding, and increasing awareness of the importance of capturing demographic data to support inequalities analysis. While this is still developing, there is a clear focus on improving data quality as a foundation for more robust insight.

Data is processed and increasingly brought together through population health and performance functions to identify variation in access, outcomes and service use across different groups. Current analysis uses available datasets to highlight differences across pathways and services; however, this is not yet consistently linked or segmented across all protected characteristics. In some cases, proxy measures such as service or provider variation are used where direct demographic data is limited. There is recognition that linking datasets across primary care, secondary care and community services is essential to better understand patient pathways, identify underserved groups, and assess patterns of demand and access, and this is an area of ongoing development.

Where gaps in data quality impact the ability to carry out detailed inequalities analysis, these are identified through reporting and governance processes, including Board-level discussions and performance reporting. There is clear acknowledgement that current limitations—such as incomplete demographic data, variable recording practices, and reduced data granularity following ICB clustering—affect the ability to systematically track inequalities. In response, there is an organisational focus on strengthening analytical capacity, improving data completeness, and embedding inequalities metrics more consistently within reporting frameworks. This includes a commitment to move from reliance on proxy indicators towards more direct and measurable assessment of inequalities over time.

Overall, while progress has been made in recognising and using inequalities data, further work is required to embed consistent data quality, linkage and analysis across the system. This represents a key area of development to ensure that decision-making is increasingly informed by robust, population-level insight into inequalities.

Using information on healthcare inequalities

Health inequalities information has started to inform strategic commissioning decisions and elements of pathway redesign. We have used data and insight on variation in access, outcomes and levels of need to shape commissioning approaches and improve equity within available resources.

For example, a wheelchair service review used evidence of inequalities in access and differing levels of clinical need to redesign the pathway and introduce a prioritisation model based on clinical need. This has supported a more equitable allocation of resources and improved equity of access. Also, community models such as TeamUp have been developed using insight into barriers faced by underserved populations, enabling services to be delivered in more accessible, locally tailored ways within neighbourhood settings.

In addition, vaccination and screening programmes have used data on uptake by deprivation and ethnicity, alongside community engagement, to inform targeted delivery approaches, ensuring services are better aligned to the needs of populations who traditionally experience lower access (see case study 5).

We have used inequality insights, including population data and community engagement, to identify barriers to access and variation in outcomes, and to adapt services accordingly.

Through TeamUp, services have been redesigned to better meet the needs of underserved populations by addressing practical and social barriers to access, demonstrating how local insight can inform tailored delivery at neighbourhood level. In addition, vaccination and screening programmes have used data on ethnicity, deprivation and uptake alongside engagement with communities to target delivery approaches, such as outreach and location-based provision, improving access for minority and underserved groups.

Inequalities in population health outcomes are routinely identified through system data and are discussed at Board level, providing visibility of variation in access, experience and outcomes across different population groups.

Where trends have been identified, there is evidence of emerging ambition to address these gaps, however, this is not yet translated into a consistent set of clear, measurable system wide objectives. There is an opportunity to strengthen this approach by setting explicit ambitions to reduce inequalities in outcomes and access, supported by defined metrics and trajectories for improvement. In addition, embedding inequalities considerations within performance management, commissioning processes and decision-making frameworks would ensure that reducing inequalities becomes a core and routine driver of planning and resource allocation, rather than an adjunct consideration.

Publishing information

One example where an action plan has been developed and monitored across services and pathways is in the CVD Programme, where action plans to reduce inequalities in access and quality of care are developed at practice and Primary Care Network (PCN) level using data driven approaches to identify gaps and unwarranted variation. This includes analysis of key clinical areas such as hypertension and lipid management, where differences in diagnosis, treatment and control rates highlight underlying inequalities across population groups and geographical areas.

Practices are supported to interpret this data through tailored data packs, clinical system searches and facilitated engagement sessions, enabling them to identify priority areas and agree targeted actions based on their local population needs. This ensures that improvement plans are grounded in both data and local insight and are responsive to the specific challenges faced by different communities.

A consistent and co-ordinated approach is supported through the CVD Champion Network, which provides clinical leadership and supports local implementation, alongside clear system wide priorities focused on improving outcomes in key areas. There is also an explicit focus on reducing variation between practices and population groups, ensuring that improvement efforts address inequalities in a targeted and meaningful way.

Progress is monitored through a combination of benchmarking and real-time data, including CVD Prevent and Eclipse Live/VISTA at practice level. This enables ongoing tracking of performance, identification of emerging gaps, and comparison across practices and populations. Findings are reviewed through established programme governance structures and shared learning forums, allowing for continuous refinement of action plans, dissemination of good practice, and improved consistency of delivery across the system.

Action plans to reduce inequalities are developed using the Equality and Equity Action Plan, alongside feedback from PROMs, PREMs, patient safety data and engagement. This helps identify which groups are experiencing poorer access or outcomes and shape targeted actions in response.

Examples include continuity of carer in deprived areas, better use of translation tools, more accessible information (including translated and Easy Read materials), community peer support, and staff training on personalised care and anti-racism. Ongoing engagement with communities also supports co-production of services.

Progress is monitored through Quality and Safety meetings, where data is reviewed by demographic group to see if outcomes and experiences are improving. If there is little or no improvement, pathways and actions are adapted.

Action plans to address inequalities in access and quality of care have been developed through existing governance arrangements, including the Prevention and Inequalities Board, with input from system partners. These forums have enabled collaborative discussions, shared learning, and alignment of priorities across the system.

Approaches to monitoring have evolved across different services and pathways, reflecting local priorities and ways of working. As structures continue to develop, there is an opportunity to enhance this approach, including clearly defined governance routes, shared metrics, and regular reporting cycles. This will help to further strengthen oversight and support the ongoing delivery and impact of health inequalities work across the system.

Health inequalities data has been considered through established governance forums, including the Prevention and Inequalities Board, chaired by the former Chief Medical Officer and attended by Directors of Public Health. This has provided opportunities to bring together insights, support discussion and inform escalation to executive level. Wider system oversight has also been supported through Health and Wellbeing Boards and the Integrated Care Partnership Board.

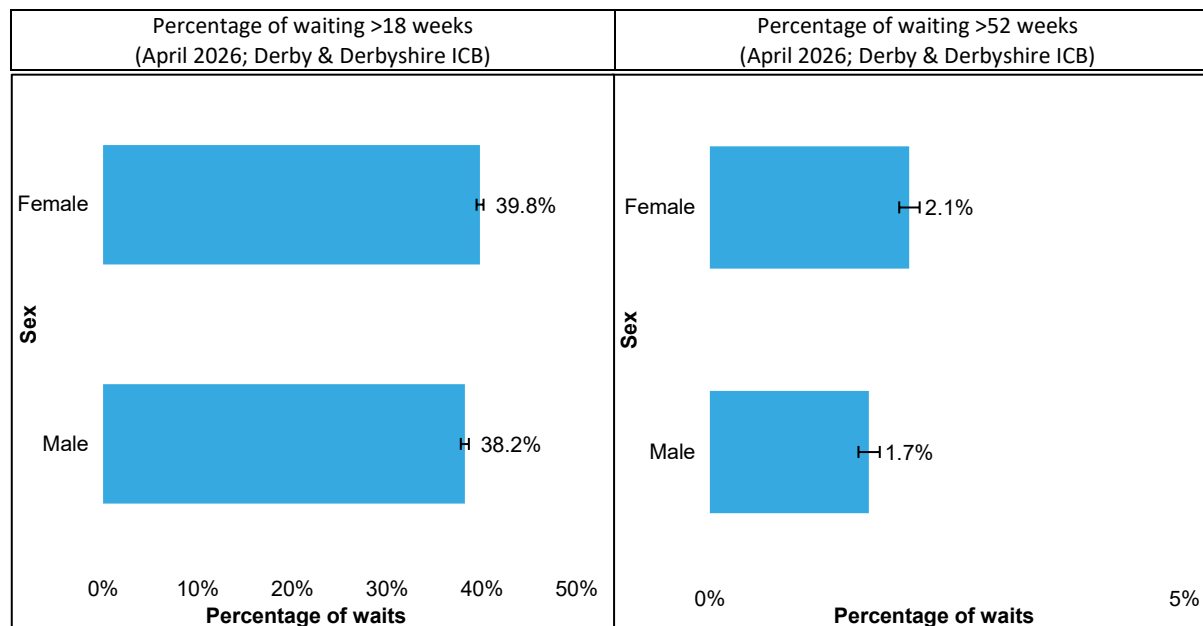
There have also been opportunities to strengthen how data and insights are drawn together within routine reporting cycles, particularly in relation to statutory duty indicators. As the system moves forward within new structures, there is a positive opportunity to build on these foundations and further enhance the consistency and visibility of health inequalities reporting.

Operational priorities

Elective Care

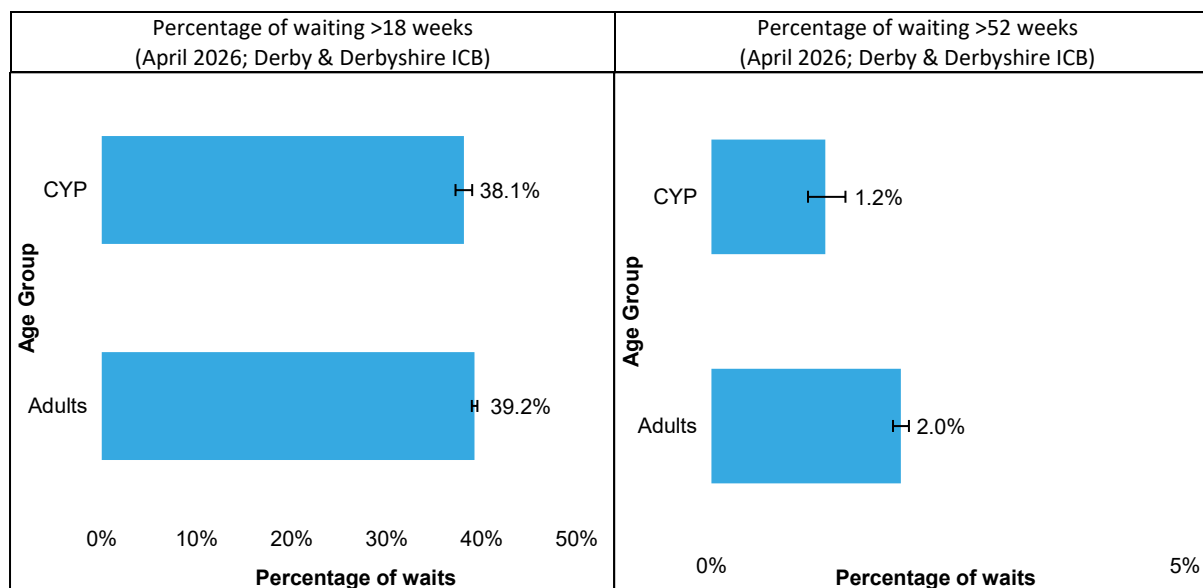
Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks, 65 weeks

Sex



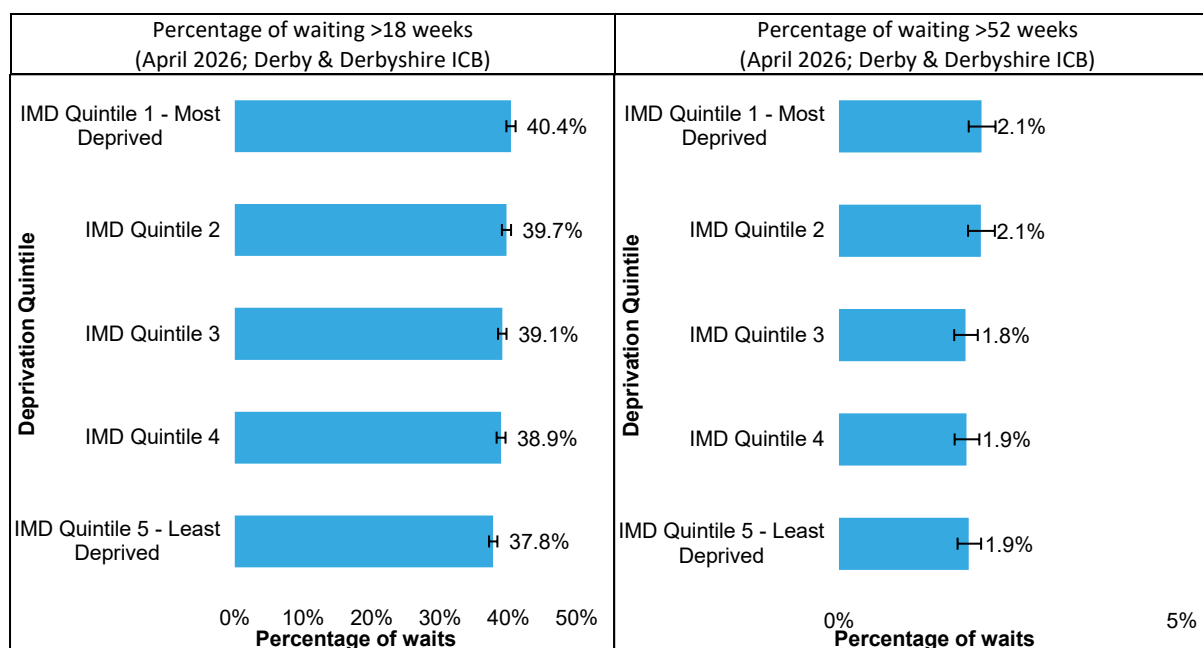
Source: Waiting List Minimum Data Set (WLMDs)

Age



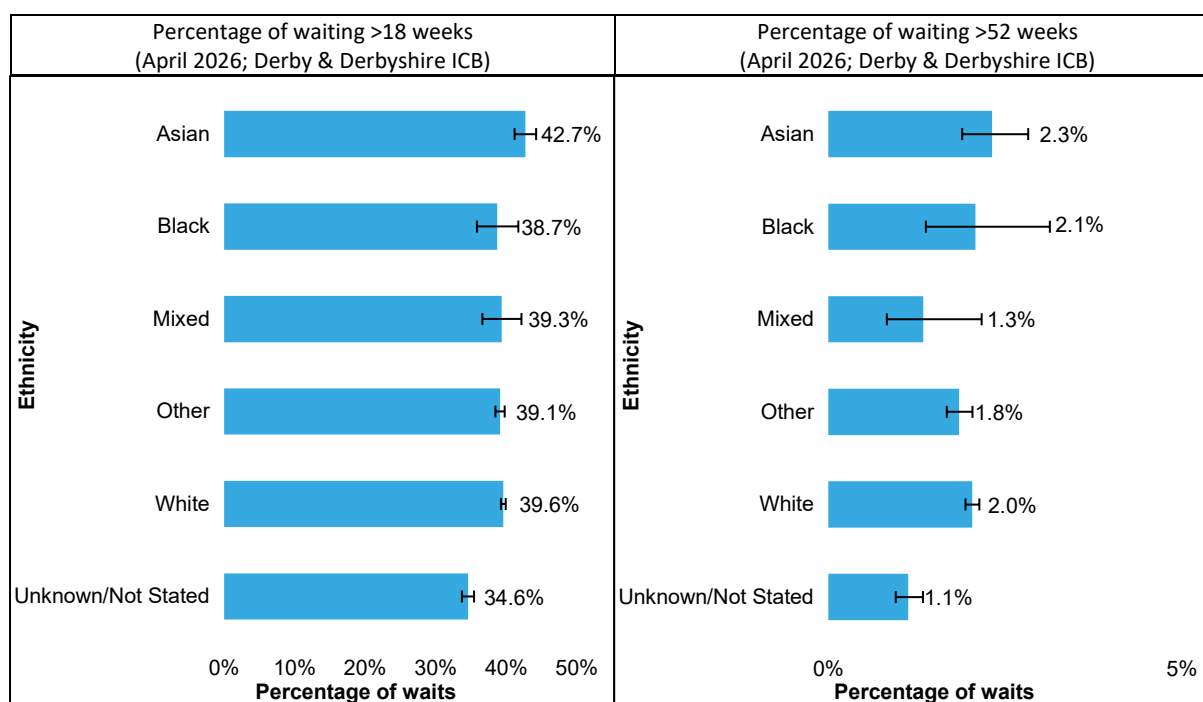
Source: Waiting List Minimum Data Set (WLMDs)

Deprivation



Source: Waiting List Minimum Data Set (WLMDs)

Ethnicity



Source: Waiting List Minimum Data Set (WLMDs)

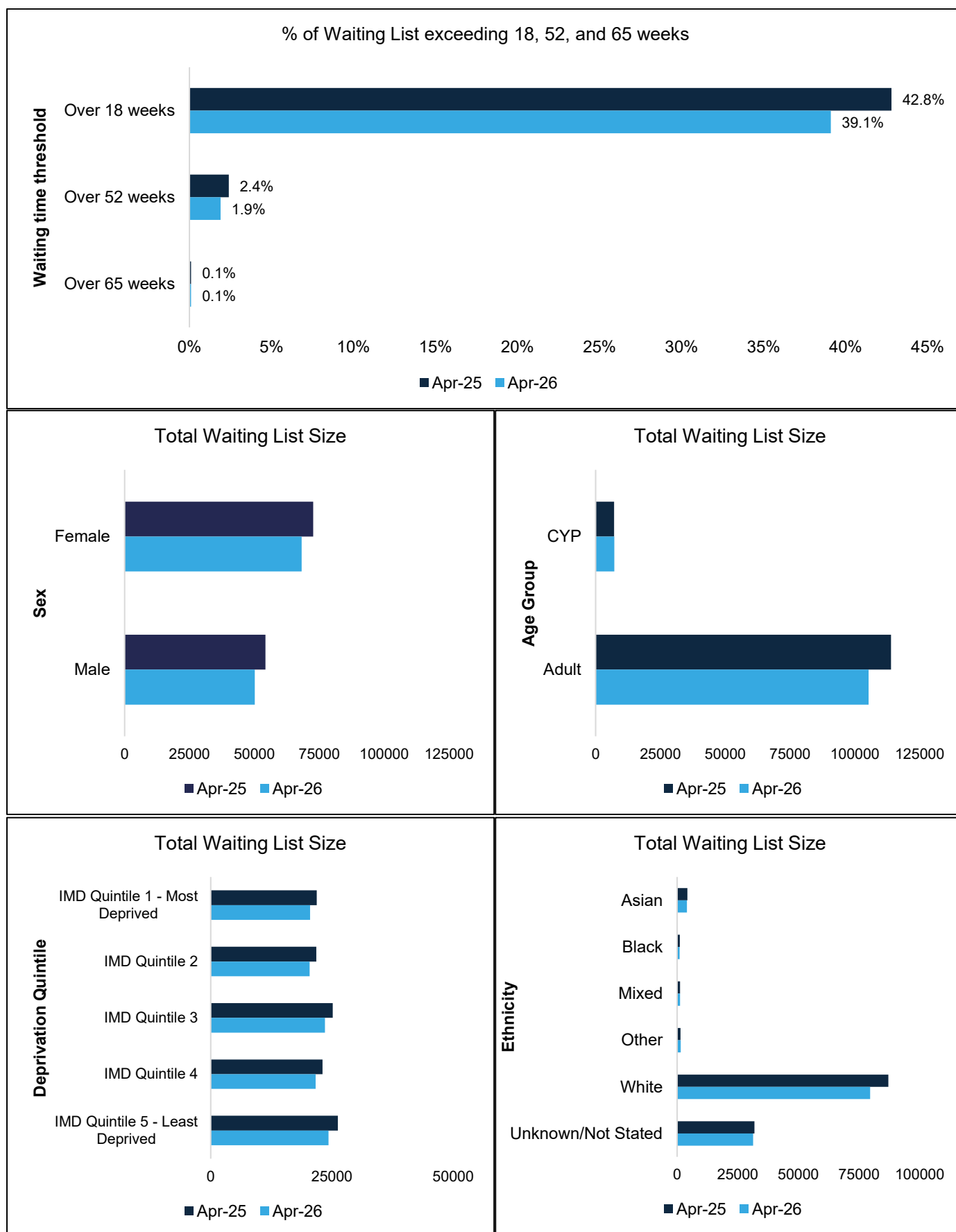
Observations for >18 week waits: Differences in patients waiting over 18 weeks are most clearly seen across the key health inequalities splits of age, ethnicity, deprivation and gender. Adults account for the vast majority of waits, while children represent a much smaller proportion, indicating that longer waits continue to be concentrated in the adult population. By ethnicity, the largest volumes are seen in the White group and in those recorded as Not Known, with much smaller numbers across other ethnic groups; this suggests that interpretation should take account of both underlying population size and the completeness of ethnicity recording. Across IMD deciles, waits over 18 weeks are present in all deprivation groups, but without a clear and consistent social gradient, indicating that inequality

patterns are not straightforward and that some deciles may be improving faster than others. By gender, both males and females are affected, with females making up a slightly larger share of long waits. Overall, although waits over 18 weeks have reduced year on year, the HI splits show that longer waits are not experienced evenly across population groups, reinforcing the importance of continued monitoring to track whether recovery is being achieved equitably.

Observations for >52 week waits: Patients waiting over 52 weeks are overwhelmingly adults, with numbers far exceeding those for children, and while there has been a clear reduction between April 2025 and April 2026, very long waits persist. By ethnicity, the over 52 week waiting list is dominated by the White group, alongside a notable “Not Known” category, both showing year on year reductions; other ethnic groups contribute relatively small numbers, indicating that patterns largely reflect population size and data completeness rather than relative risk. By deprivation, most IMD deciles show reductions since April 2025, but volumes remain higher in several more deprived and mid deprivation deciles, suggesting that progress in reducing very long waits has not been uniform. By gender, both males and females have seen reductions, with females accounting for slightly higher numbers than males. Overall, although improvement is evident, the persistence of waits over 52 weeks among adults and certain deprivation groups highlights the need for continued focus to ensure equitable backlog recovery.

Observations for >65 week waits: Patients waiting over 65 weeks are predominantly adults, with numbers markedly higher than for children, and although there is a reduction between April 2025 and April 2026, very long waits persist. By ethnicity, the over-65-week waiting list is dominated by the White group, alongside a substantial “Not Known” category, indicating that absolute volumes largely reflect population size but are also affected by data completeness, while other ethnic groups contribute relatively small numbers. By deprivation, waits over 65 weeks are concentrated in the more deprived IMD deciles and several mid-deciles, with notable reductions year-on-year but no uniform pattern of improvement, suggesting ongoing pockets of inequality. By gender, both males and females show reductions since April 2025, with females accounting for slightly higher numbers than males. Overall, while progress has been made in reducing extremely long waits, the persistence of over-65-week waits among adults, deprived populations and groups with incomplete demographic data highlights areas requiring continued focus to ensure equitable recovery.

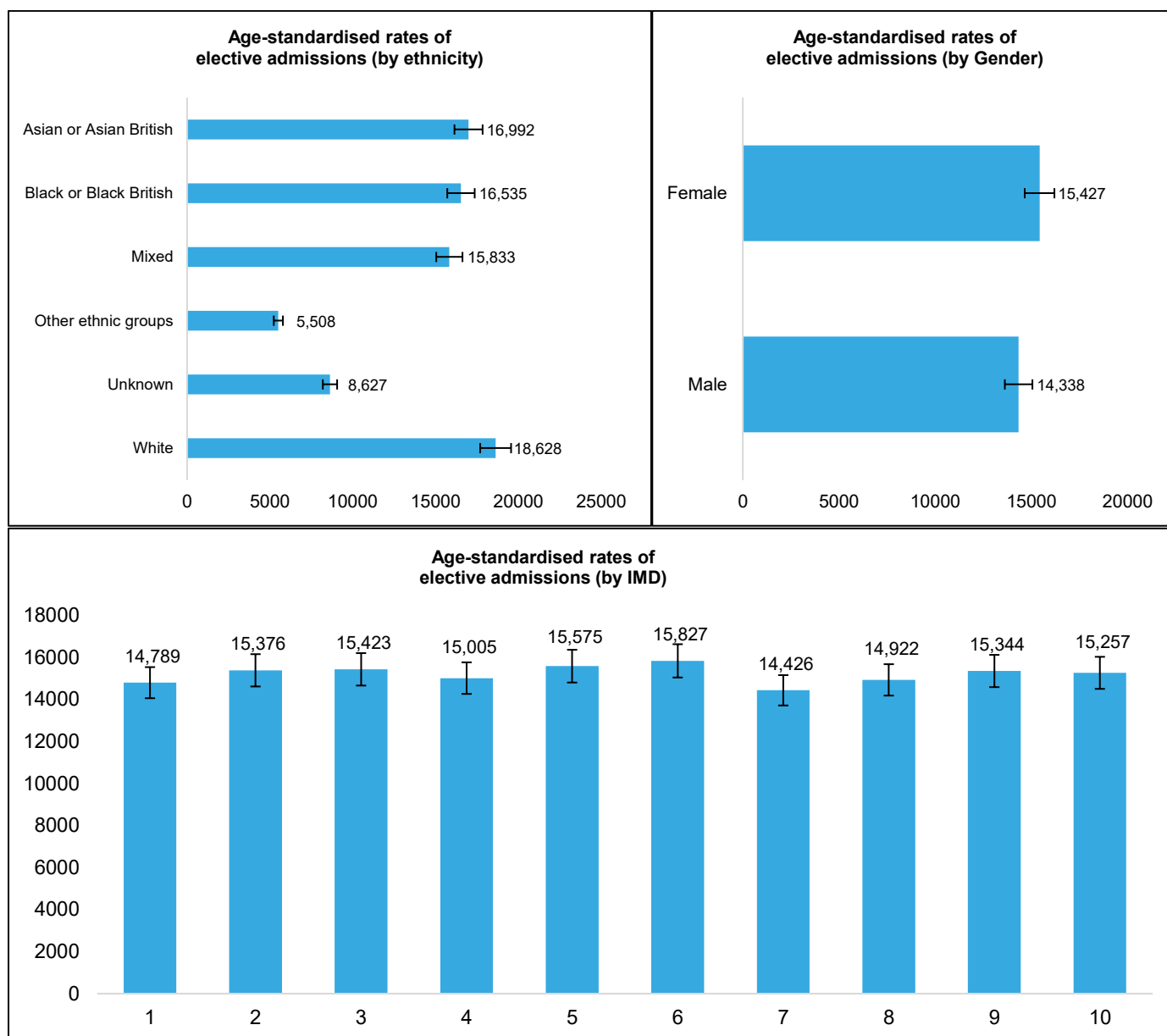
Inequalities in annual change in size of waiting list



Source: Waiting List Minimum Data Set (WLMDS)

Observations: The overall waiting list has reduced between April 2025 and April 2026, but the scale of improvement varies across population groups. Largest absolute reductions are seen among adults, females, and the White ethnic group, reflecting their dominance in total waiting list volumes, while reductions for children and some ethnic minority groups are smaller in absolute terms. By deprivation, most IMD deciles show year-on-year decreases, but the size of reduction is uneven, with some mid and more deprived deciles seeing slower improvement than others. This indicates that, although overall progress has been made, reductions have not been evenly distributed, and continued monitoring is needed to ensure that recovery of waiting lists is equitable across deprivation and demographic characteristics, rather than driven primarily by improvements in larger population groups.

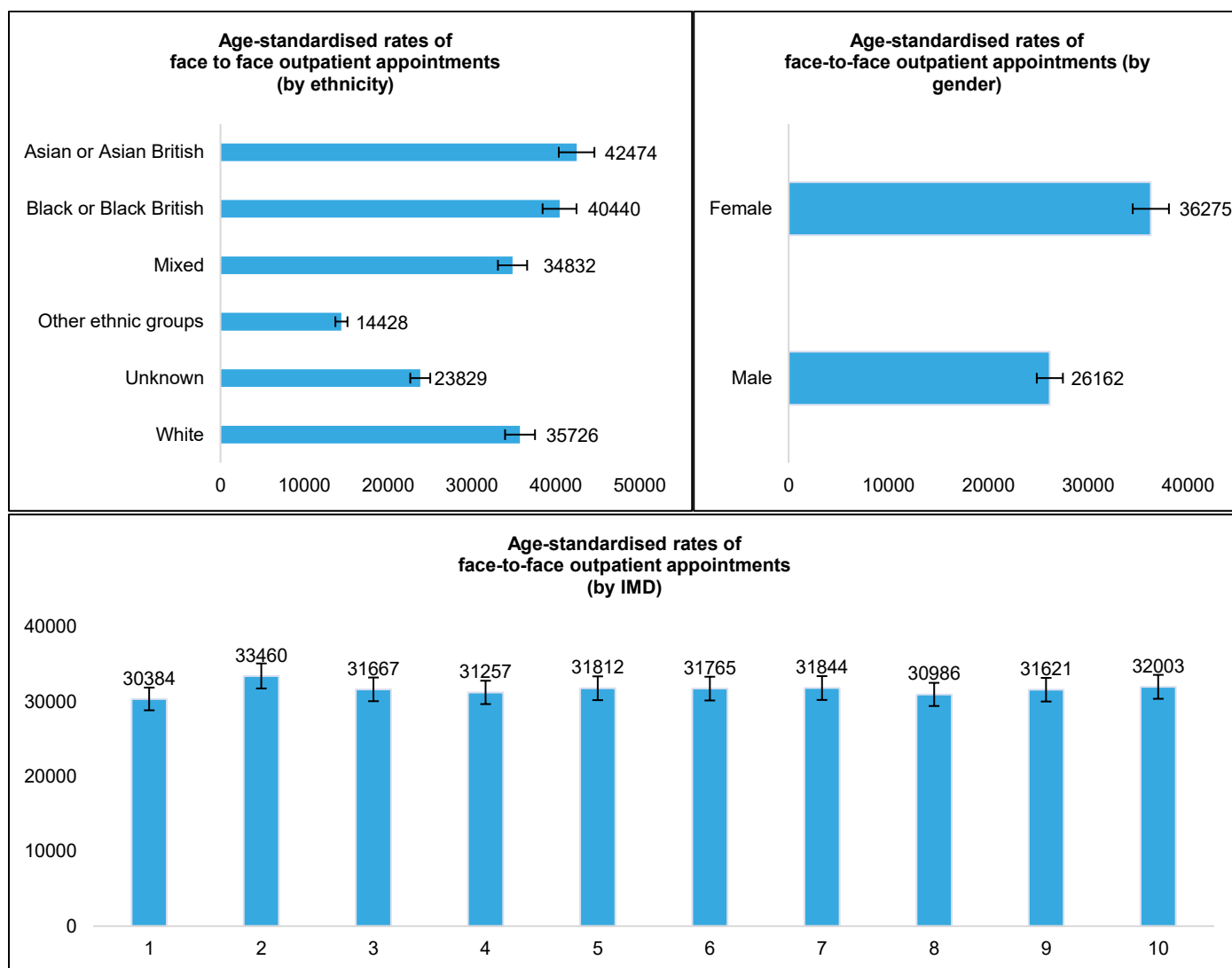
Age-standardised rates of elective admissions



Source: SUS Inpatient dataset

Observations: Age standardised elective admission rates vary by ethnicity and gender, with more limited variation by deprivation. By ethnicity, rates are highest among the White group, followed by Asian or Asian British, Black or Black British and Mixed groups, while the lowest rates are observed for Other ethnic groups; the Unknown category also records relatively high rates, which may reflect data quality or population denominator effects rather than true differences in utilisation. By gender, females have higher age standardised elective admission rates than males, indicating greater use of elective care among women. Across IMD deciles, rates are broadly similar and cluster within a relatively narrow range, with no clear deprivation gradient, suggesting that elective admission rates are not strongly patterned by deprivation once age is accounted for. Overall, variations in elective admissions appear more pronounced by ethnicity and gender than by socioeconomic deprivation.

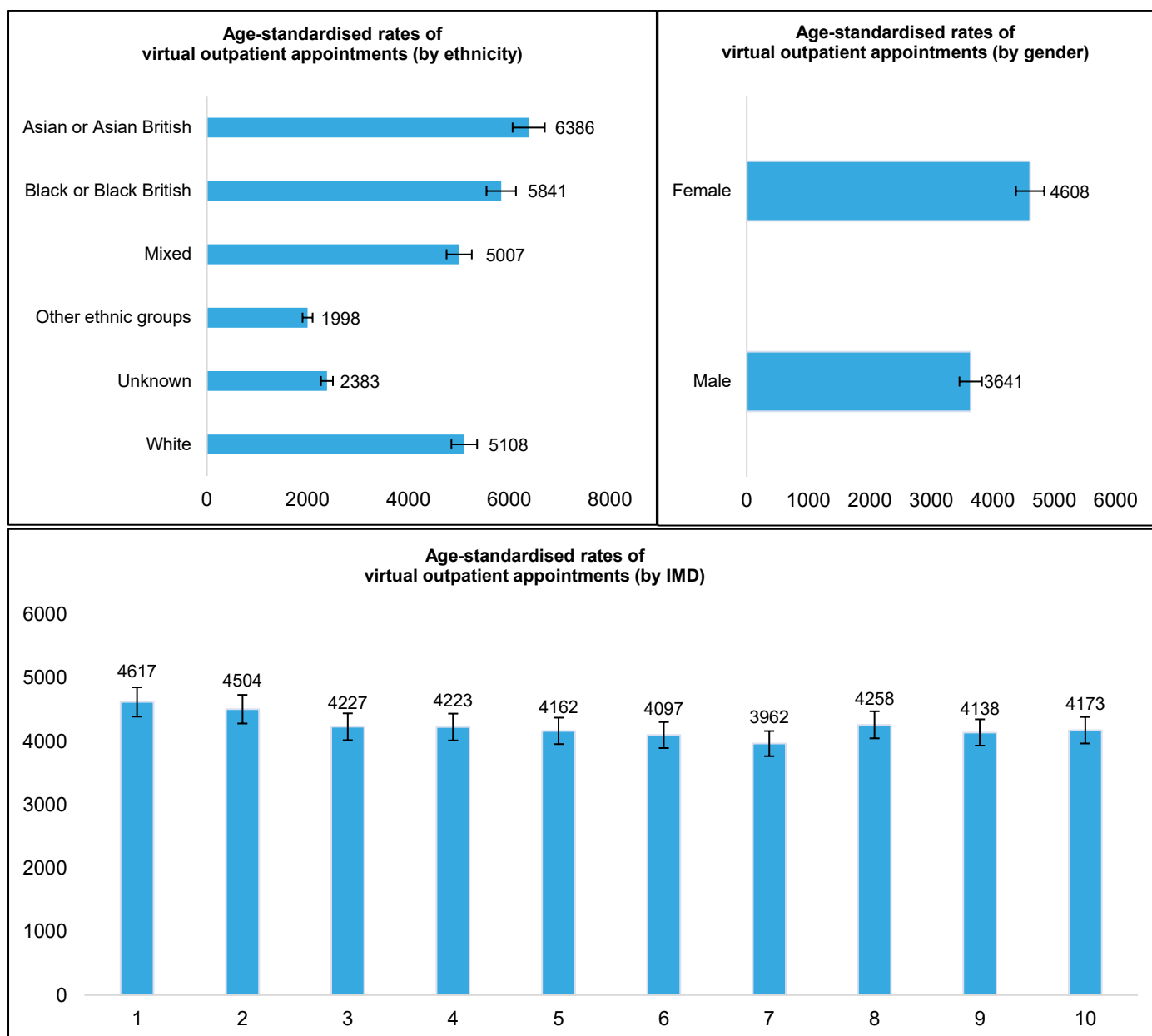
Age-standardised rates of outpatient appointments



Source: SUS Outpatient dataset

Observations: Age-standardised rates of face-to-face outpatient appointments vary more clearly by ethnicity than by deprivation. Asian or Asian British and Black or Black British groups record the highest appointment rates, noticeably above the White population, while the “Other ethnic groups” category shows the lowest rates. In contrast, variation across IMD deciles is relatively modest, with broadly similar rates across the deprivation spectrum and no clear, consistent gradient, although decile 2 appears slightly higher than others. Overall, this suggests that ethnic differences in outpatient activity are more pronounced than deprivation-based differences, and may reflect differences in clinical need, referral patterns, or service use that warrant further investigation.

Age-standardised rates of virtual outpatient appointments

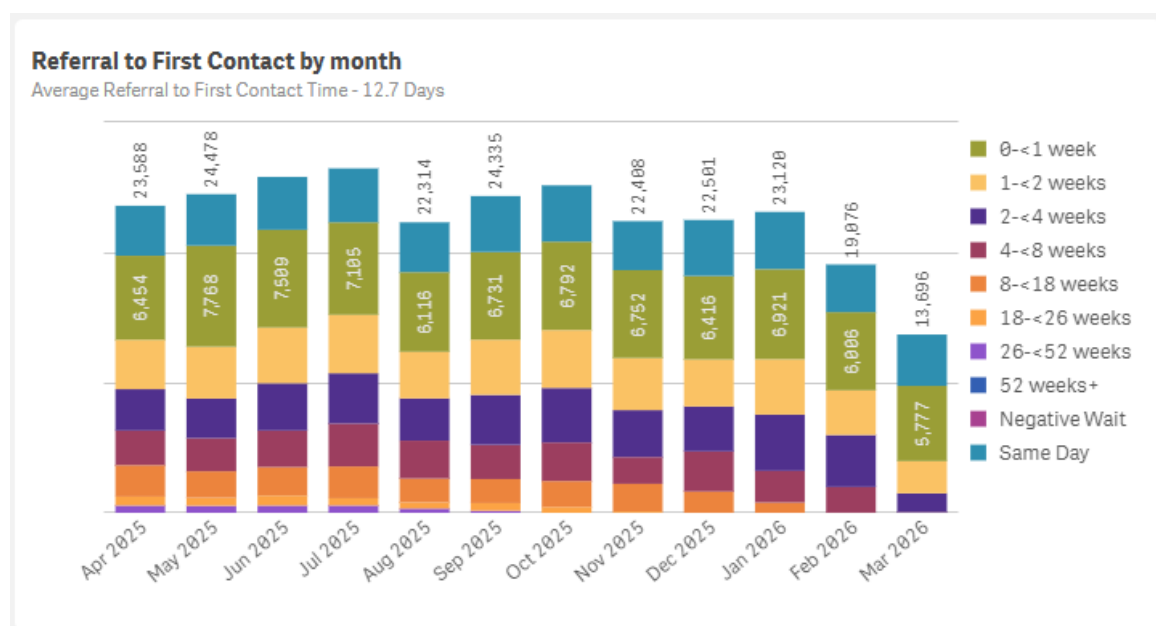


Source: SUS Outpatient dataset

Observations: Age-standardised rates of virtual outpatient appointments are substantially higher among Asian or Asian British and Black or Black British groups compared with the White population, while rates are lowest for the “Other ethnic groups” and “Unknown” categories; in contrast, variation by deprivation is relatively limited, with broadly similar rates across IMD deciles and no clear deprivation gradient, suggesting that differences in virtual outpatient use are more strongly associated with ethnicity than area-level deprivation.

Community

Inequalities in percentage of people waiting over 18 weeks, over 52 weeks, over 104 weeks for community services

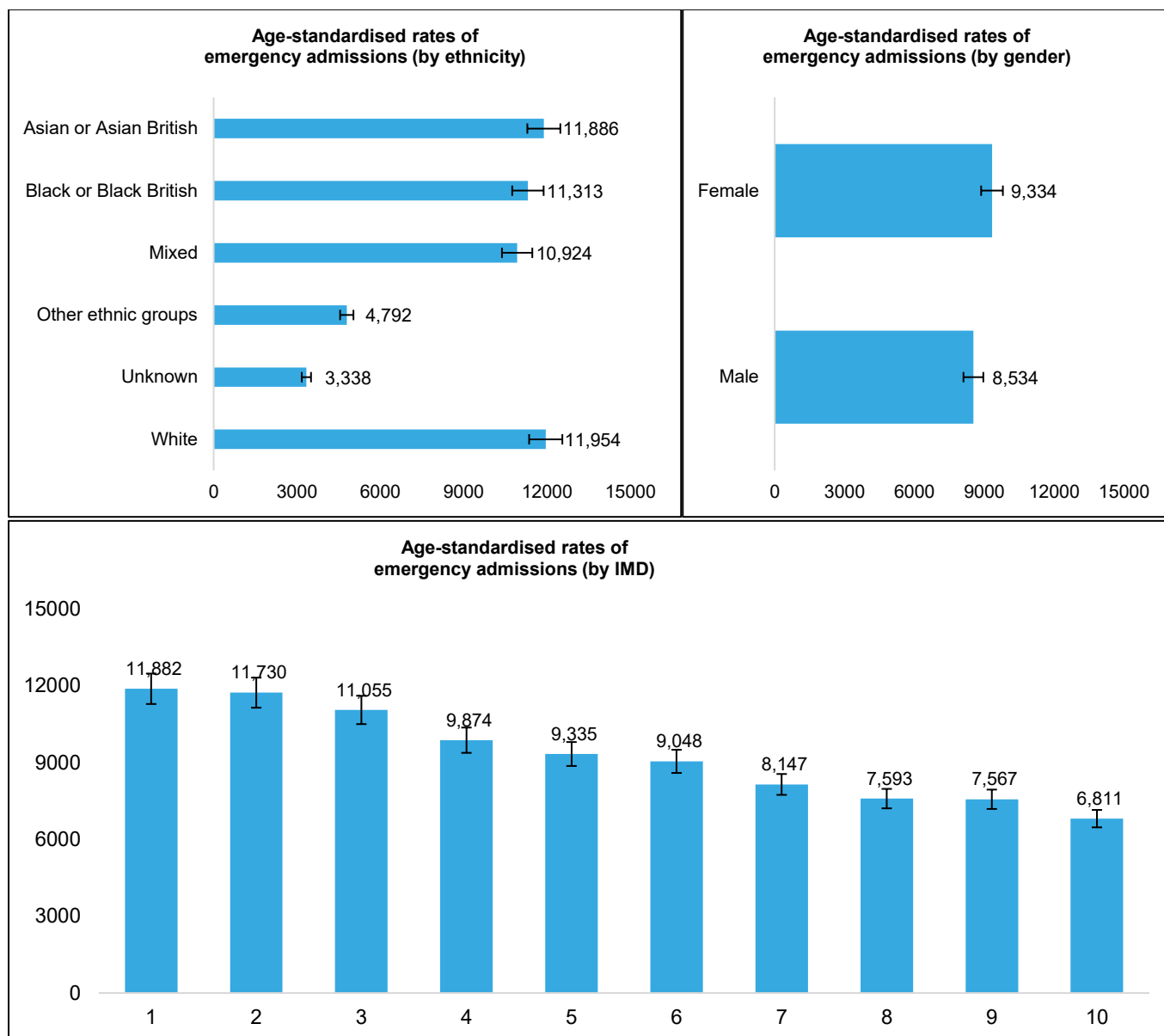


Source: [RAIDR Patient Activity - Derby and Derbyshire - Community](#)

Observations: Monthly referral volumes to community services show a broadly stable pattern between April 2025 and March 2026, with totals typically ranging from approximately 19,000 to 24,000. The majority of contacts occur within 0–1 week, though a persistent tail of waits extending to 52 weeks or more is visible across all months. The proportion waiting longer timeframes does not show a clear improving trend over the period.

Urgent and Emergency Care

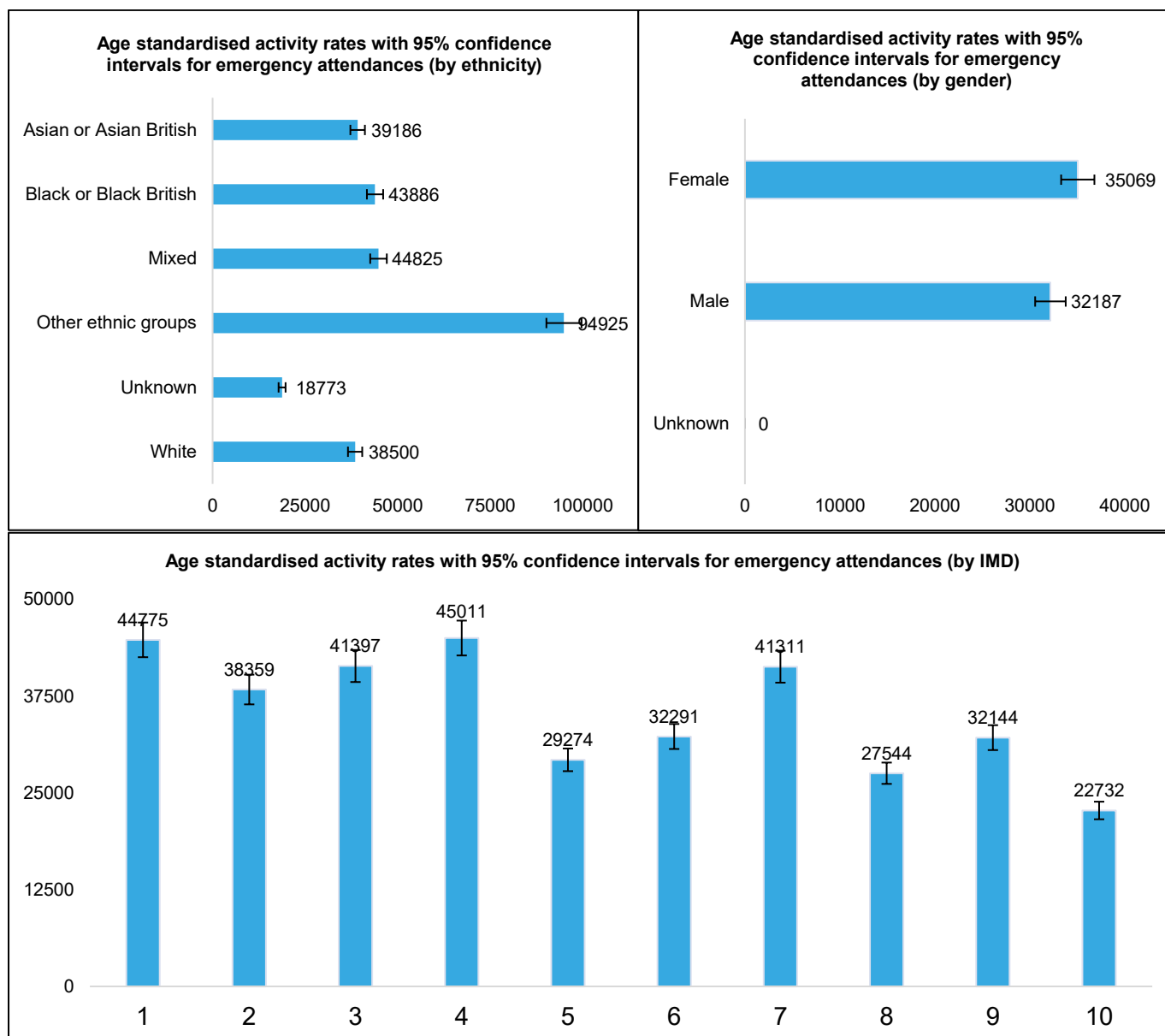
Age standardised activity rates with 95% confidence intervals for emergency admissions



Source: SUS Inpatient dataset

Observations: Age-standardised emergency admission rates show clear and consistent inequalities by deprivation, ethnicity and gender. Admission rates are highest in the most deprived areas and steadily decrease towards the least deprived deciles, indicating a clear socioeconomic gradient in emergency care use. By ethnicity, rates are highest among Asian or Asian British and White groups, with lower rates seen in Mixed, Other ethnic groups and the lowest in the Unknown category, highlighting substantial variation between ethnic groups. By gender, females have a higher age-standardised emergency admission rate than males. Overall, the charts indicate that emergency admissions are socially patterned, with higher use associated with greater deprivation and notable differences across ethnic groups and between genders.

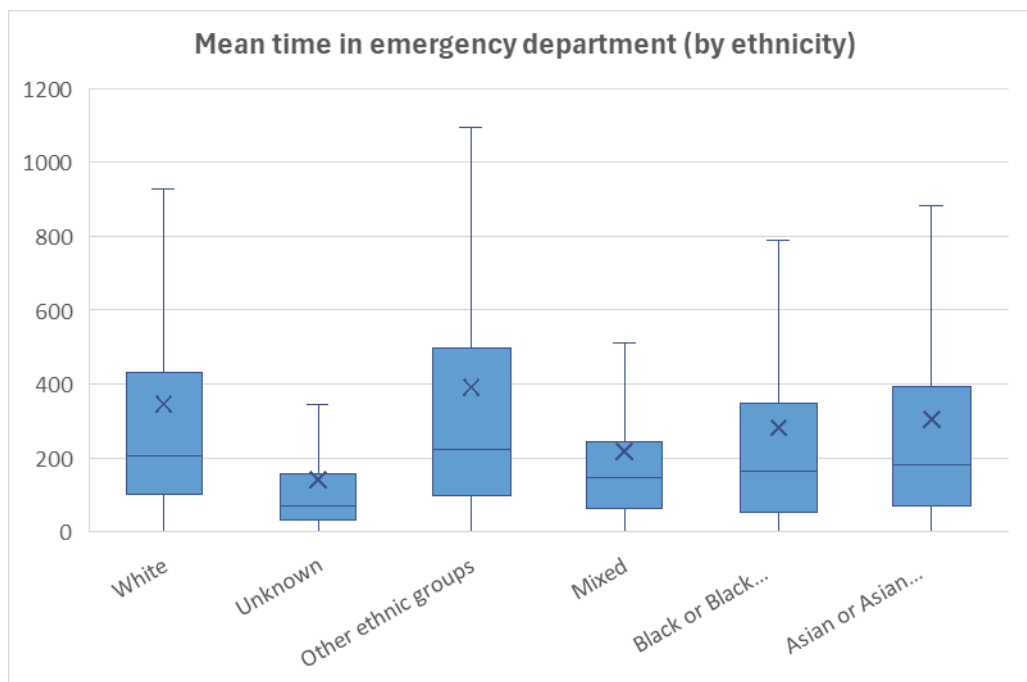
Age standardised activity rates with 95% confidence intervals for emergency attendances



Source: ECDS dataset

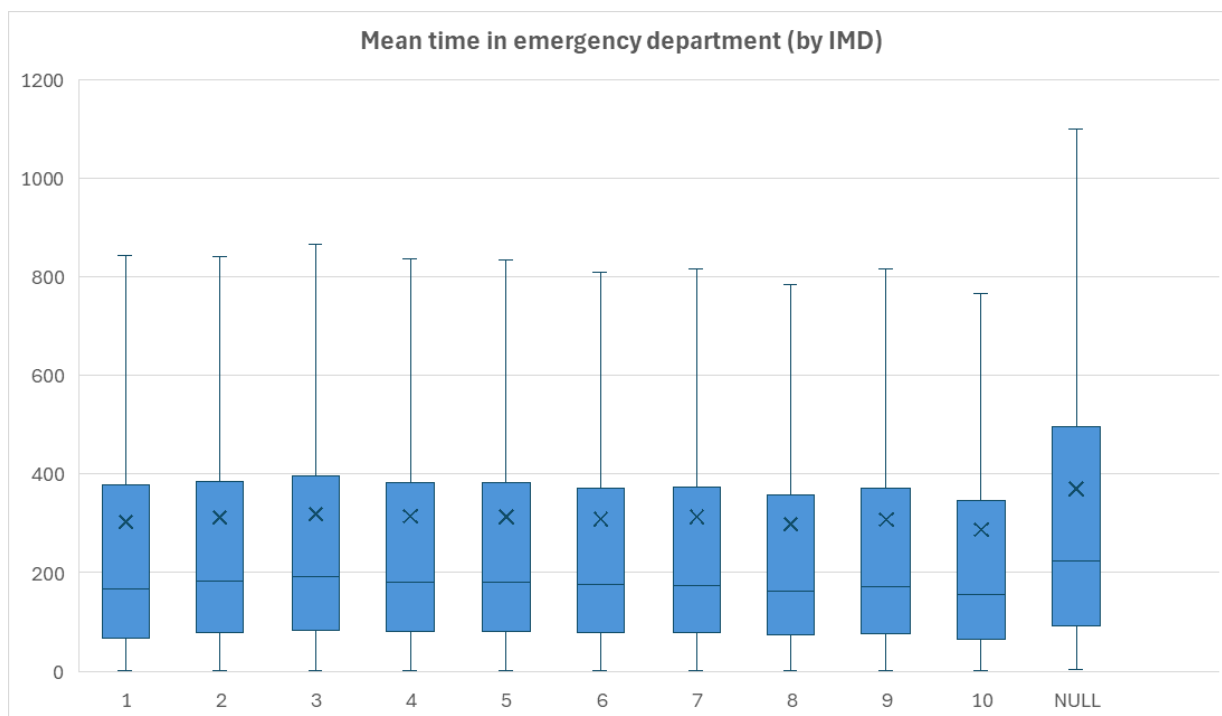
Observations: Age standardised emergency attendance rates vary substantially by deprivation, ethnicity and gender, with a strong socioeconomic pattern evident: attendance rates are highest in the most deprived IMD deciles and fall progressively towards the least deprived, indicating a clear deprivation gradient. By ethnicity, the “Other ethnic groups” category shows markedly higher attendance rates than all other groups, while Asian or Asian British, Black or Black British, Mixed and White groups have broadly similar mid-range rates and the lowest rates are seen in the Unknown category, suggesting potential data or population effects. By gender, females have higher emergency attendance rates than males, reinforcing evidence of systematic differences in emergency care use across population groups.

Inequalities in mean time in emergency department



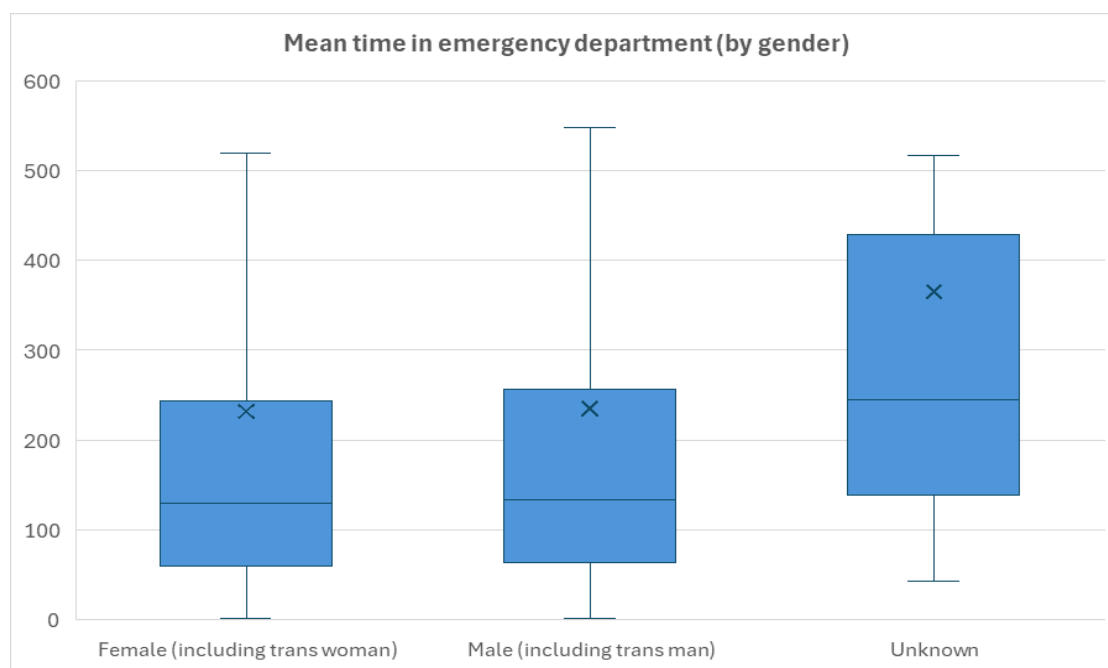
Source: ECDS dataset

Observations: Mean time in the emergency department varies by ethnicity group, with clear differences in the typical (median) time and the spread of stays. The Unknown ethnicity group shows the shortest typical times and a comparatively narrower spread, whereas White and Other ethnic groups show higher typical times alongside much wider variation and long upper tails, indicating a subset of very long stays. Asian or Asian British and Black or Black British groups also show broad distributions, with upper whiskers extending to high values, suggesting occasional prolonged attendances. Overall, the chart indicates substantial within-group variation (long right tails across most groups), so differences between groups should be interpreted as differences in both “typical time” and the frequency of very long ED stays, not just the average.



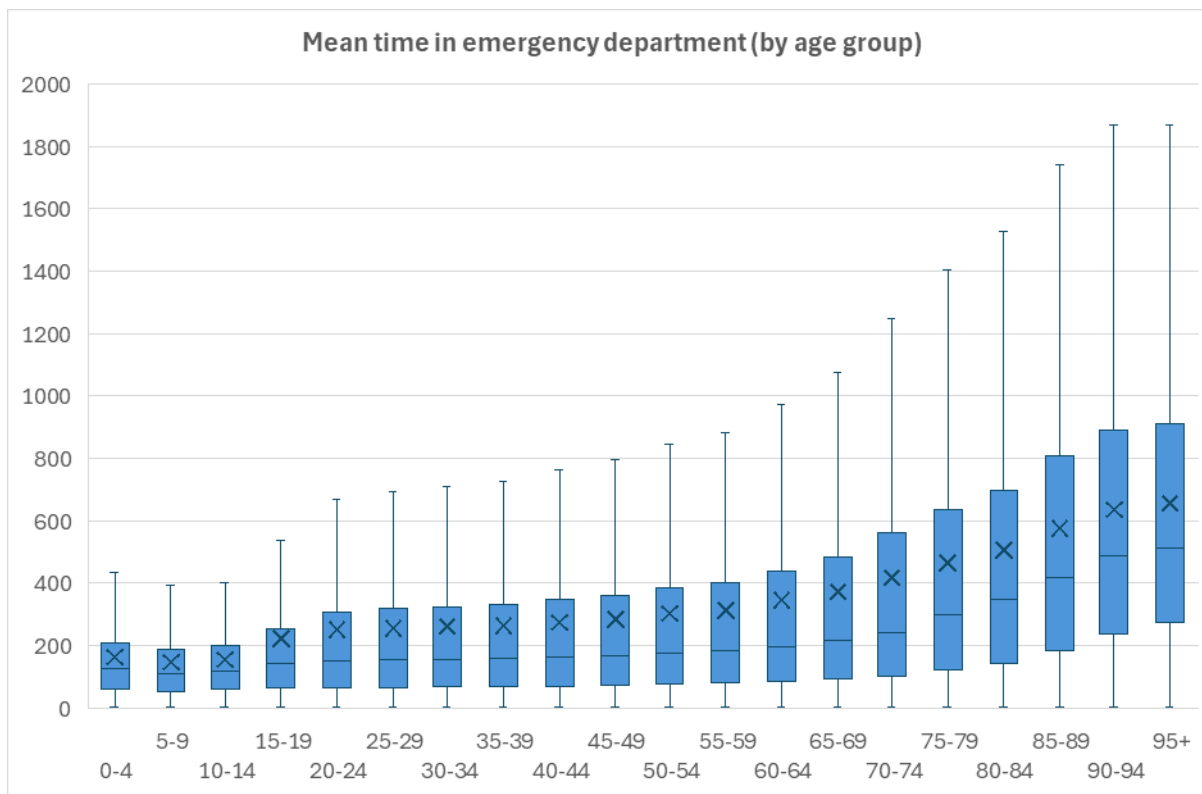
Source: ECDS dataset

Observations: Across IMD deciles (1–10), the distributions appear fairly similar, with only modest differences in median and mean times between most deciles and broadly comparable spread. Each decile shows a long right-hand tail, indicating that while typical ED times cluster in a similar range, a minority of attendances experience very long durations in every deprivation group. The most notable contrast is the NULL category, which has a higher average/typical time and wider spread, plus the highest upper range, suggesting that records without an IMD assignment may be associated with longer stays and/or more variability. Overall, the pattern suggests no strong gradient across IMD deciles in typical ED time, but a consistent presence of prolonged stays across all deprivation groups, with missing IMD (NULL) standing out as different.



Source: ECDS dataset

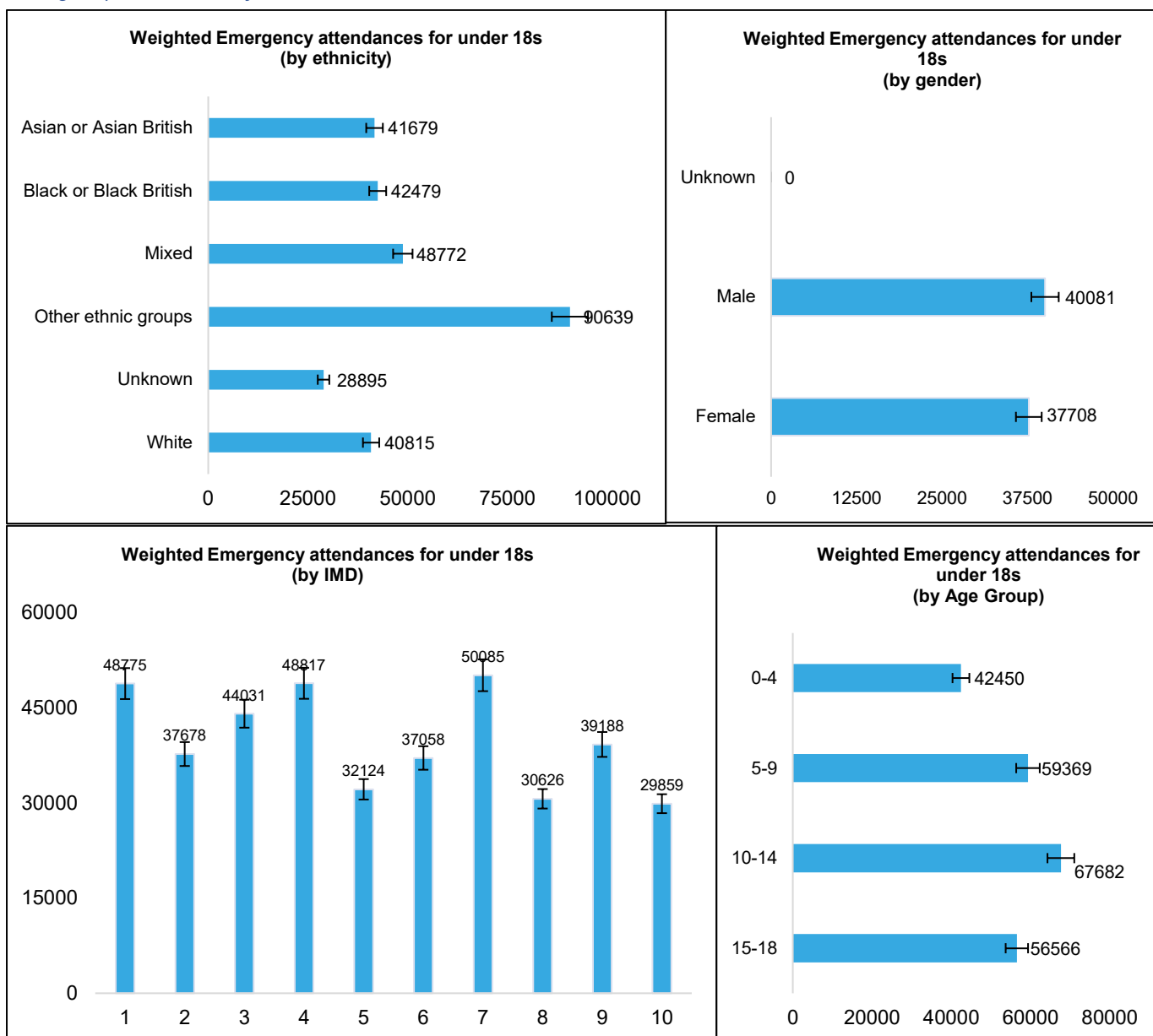
Observations: Mean time in the emergency department is similar for Female and Male categories in terms of typical (median) time and overall distribution, with both showing wide variability and upper tails extending to prolonged durations. In contrast, the Unknown category shows a higher typical time and higher mean, with a broader upper range, indicating that attendances with sex recorded as Unknown are more likely to be associated with longer ED durations. As with the other charts, all categories show right skewed distributions, meaning a relatively small number of very long stays can influence the mean, particularly where category sizes may be smaller.



Source: ECDS dataset

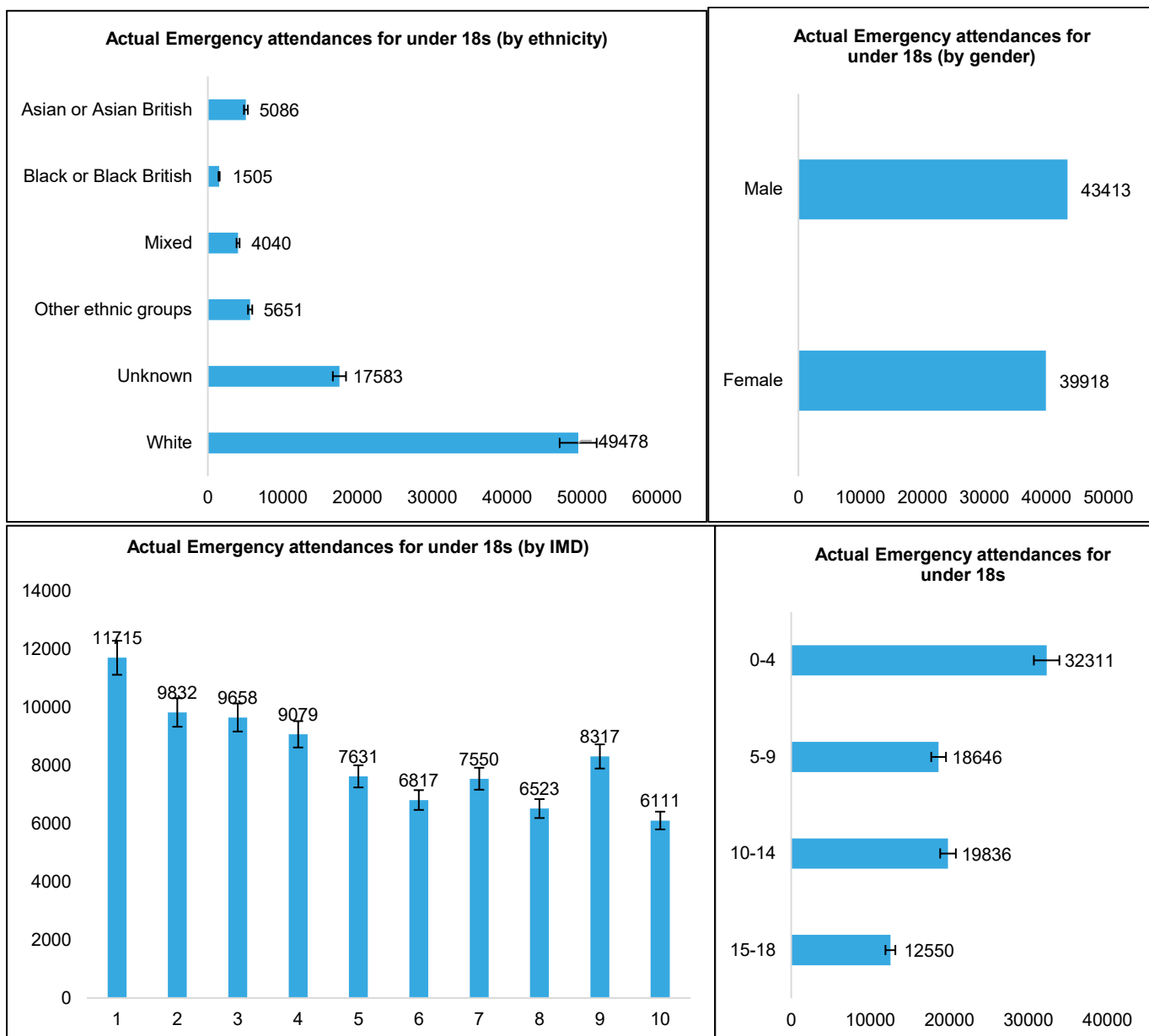
Observations: Mean and typical (median) time spent in the emergency department increases progressively with age, with a clear step-up from around late-60s/70s onwards; older age groups also show much wider distributions and longer upper tails (especially 80+ and 90+), indicating greater variability and a higher likelihood of very long ED stays. Across all age groups the distributions remain right-skewed, so a relatively small number of very long stays can pull the mean above the median—most notably in the oldest age bands where the whiskers extend furthest.

Caveat: Boxplots show substantial within-group variation and long right-tails; differences in mean values may be influenced by a relatively small number of prolonged stays, particularly for Unknown/NULL categories where data completeness may differ.



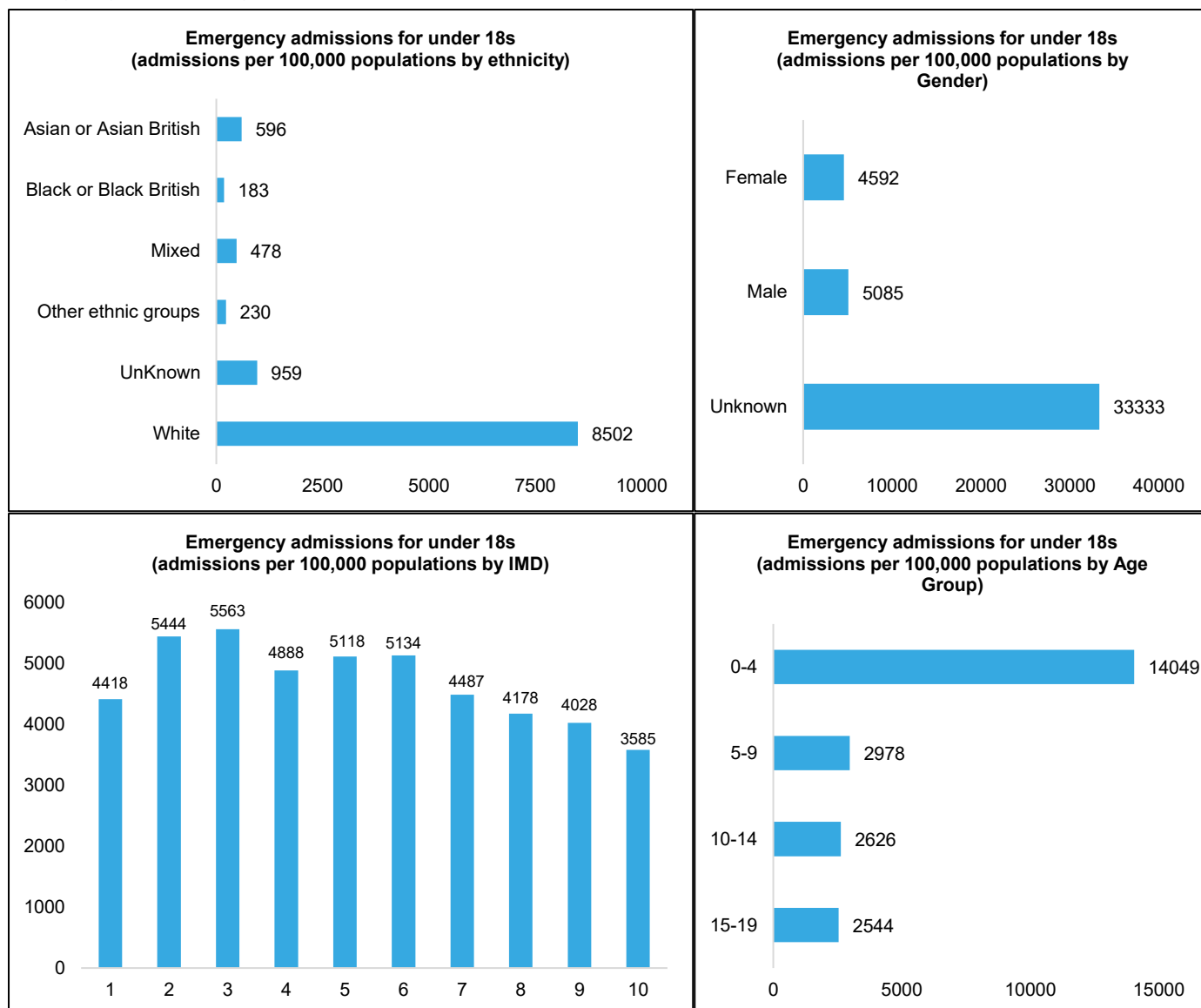
Source: ECDS dataset

Observations: Population-weighted emergency attendance rates for under-18s vary across ethnicity and deprivation, with only modest differences by gender. By ethnicity, the pattern suggests comparatively higher utilisation in the “Other ethnic groups” and “Mixed” categories, while White and Black or Black British appear lower; the relatively high rate in the Unknown category may reflect data quality and/or small denominators rather than a true utilisation difference. By deprivation decile, rates fluctuate rather than follow a strong linear gradient, with some more deprived and mid-range deciles appearing relatively higher but differences being moderate, so small variations should be interpreted cautiously. By gender, rates are slightly higher for males than females, but values are broadly similar, indicating only a limited sex difference once population size is accounted for.



Source: ECDS dataset

Observations: In absolute terms, emergency attendances are highest in the White ethnic group, with a sizeable “Unknown” ethnicity component, indicating that overall volumes largely reflect the underlying population profile but are also influenced by incomplete ethnicity recording; other ethnic groups (Asian, Black, Mixed, Other) contribute much smaller counts, so raw numbers alone are not a fair basis for comparing relative utilisation without population adjustment. Emergency attendances are also concentrated in the more deprived IMD deciles, gradually reducing towards less deprived groups, suggesting higher demand in deprived areas; considered alongside the population-weighted rates, this implies that higher volumes are only partly explained by population size, with some underlying variation in attendance behaviour by deprivation. By gender, males account for slightly more attendances than females, and this aligns with the weighted rate pattern, indicating the difference is not solely due to population size; the lack of visible activity in the “Unknown” gender category suggests negligible counts or missing/uncaptured values in that field.



Source: SUS Inpatient dataset

Observations: Emergency admission rates for children and young people show clear variation by age, deprivation, ethnicity and gender, with age and deprivation showing the strongest patterns.

Rates are highest in the youngest age group (0–4 years), at around 14,000 admissions per 100,000 population, and then fall sharply with age through 5–9, 10–14 and 15–19 years. This indicates that emergency admissions among under-18s are heavily concentrated in early childhood, with substantially lower use of emergency care among older children and adolescents.

By deprivation, emergency admission rates are generally higher in more deprived areas, peaking around IMD deciles 2–6, and then declining steadily towards the least deprived deciles. The lowest rates are seen in decile 10, suggesting a clear deprivation-related inequality in emergency admissions for under-18s, even though the gradient is not perfectly linear.

By ethnicity, recorded rates vary widely, with the White group showing by far the highest rate of emergency admissions. All other recorded ethnic groups show substantially lower rates, while the Unknown category is also relatively high, indicating that patterns are strongly influenced by population size and recording completeness. As a result, differences between ethnic groups should be interpreted with caution, particularly where denominator populations may be small.

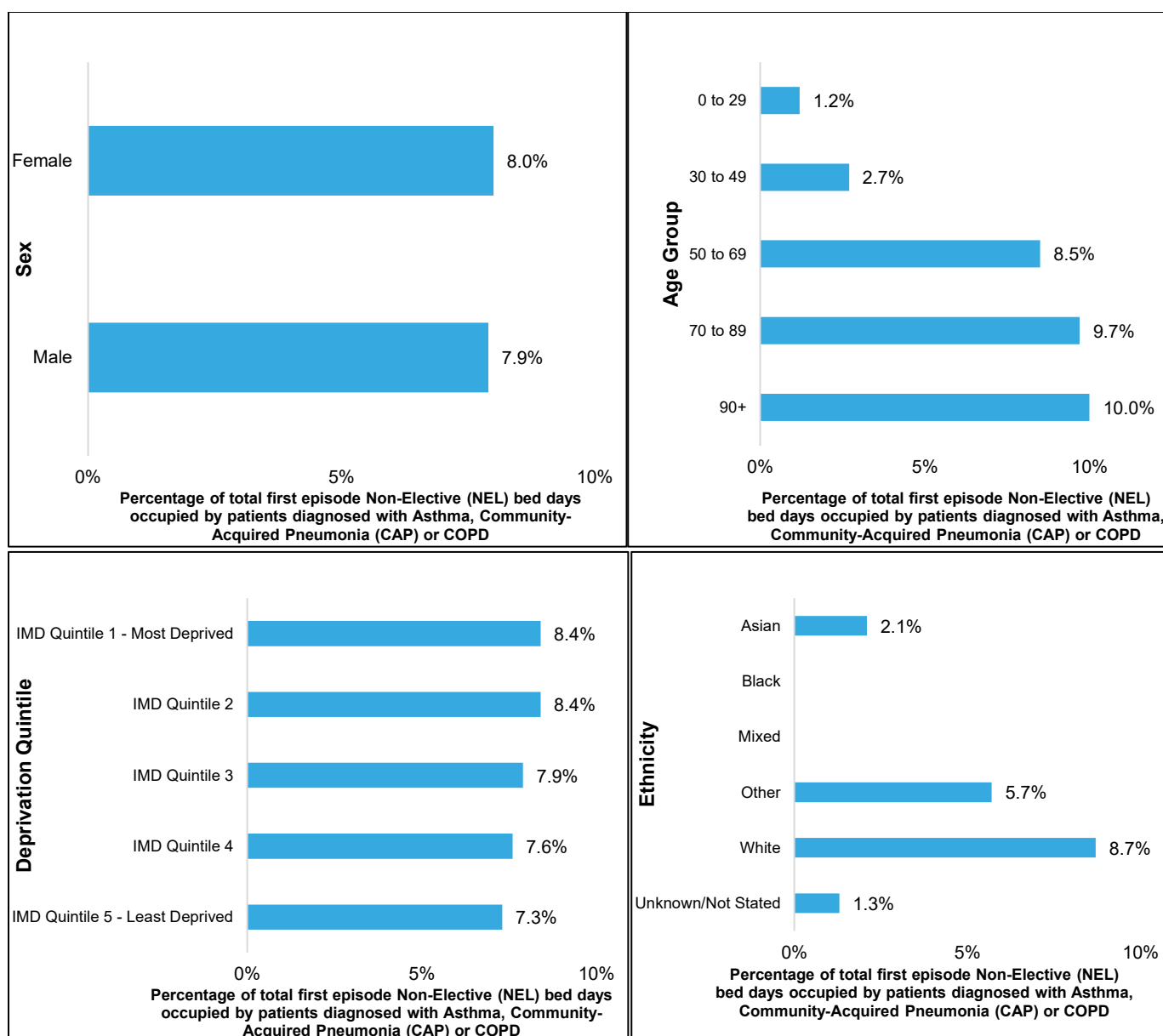
By gender, the highest rate is recorded in the Unknown category, far exceeding those seen for Female and Male. Among known genders, male and female rates are broadly similar, with males slightly higher. The prominence of the Unknown category suggests data completeness issues, limiting the reliability of direct gender comparisons.

Overall, emergency admissions for under 18s are strongly age related and socially patterned by deprivation, with younger children and those living in more deprived areas experiencing higher admission rates.

CORE20PLUS5 – Adults

Respiratory

Inequalities in non-elective bed days occupied by asthma, COPD and CAP



Source: [NHSE Respiratory Programme Dashboard](#)

Observations: In 24/25, females had a slightly higher proportion of non-elective bed days due to asthma, COPD, and CAP. Age was a significant predictor, with those over the age of 50 having a much higher rate of non-elective bed days compared to those under 50. This is unsurprising as these respiratory conditions are much more common as age increases. Those living in the most deprived parts of the county had a higher rate of non-elective bed days caused by asthma, COPD and CAP. Due to low counts/data suppression, it is difficult to determine if there are any significant health inequalities.

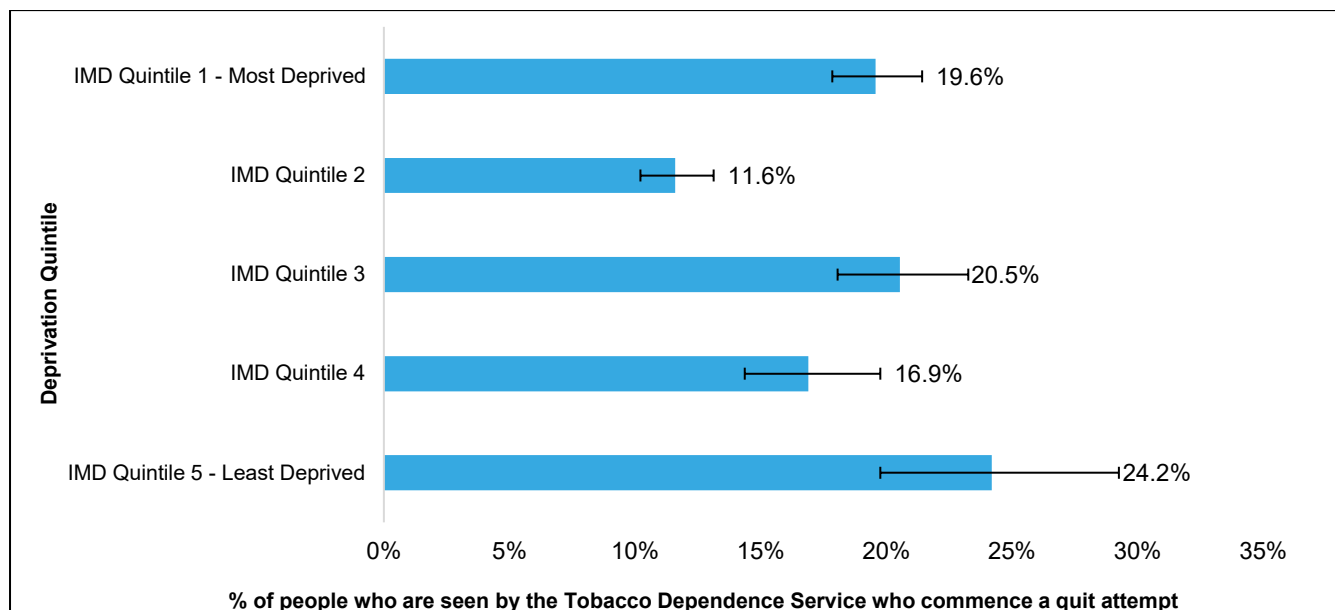
Inequalities in pulmonary rehab completion rates

Data is not currently available at the level of detail required to robustly assess inequalities in pulmonary rehabilitation completion rates across population groups. Work is ongoing to improve data completeness and linkage to enable future reporting by deprivation, ethnicity, and other protected characteristics.

Smoking Cessation

Inequalities in inpatients making a supported quit attempt with an in-house tobacco dependence treatment service

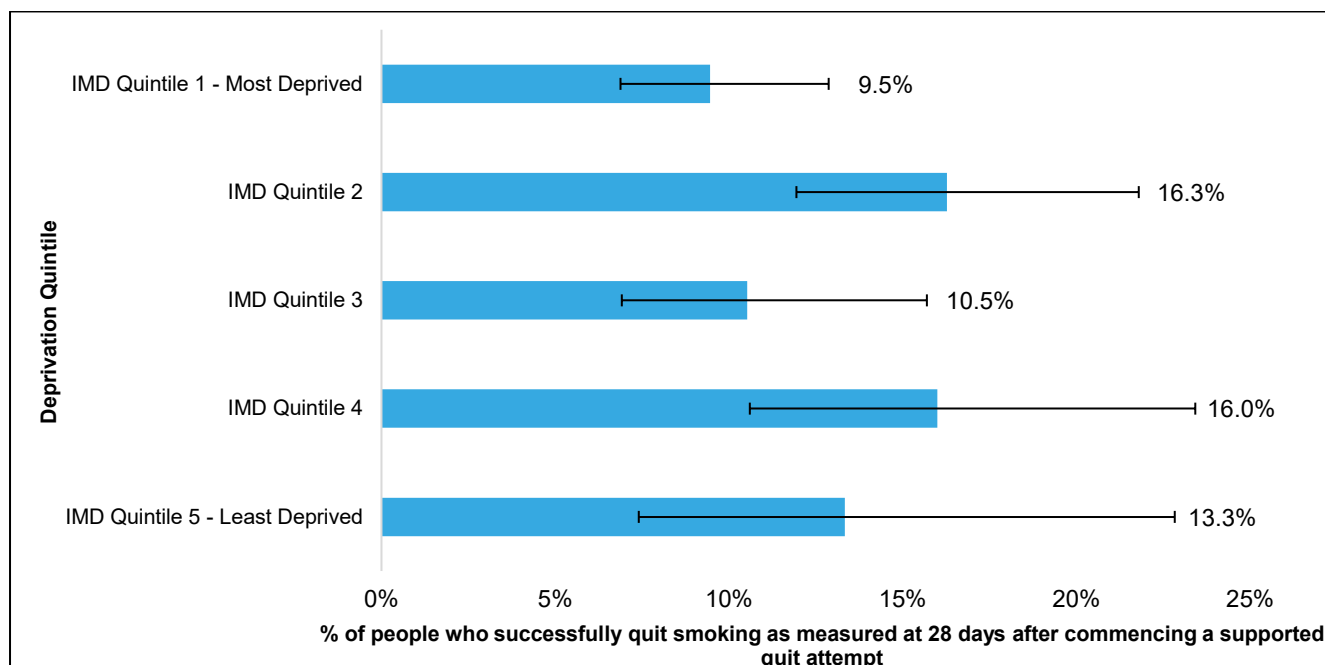
Period: February 2025 to January 2026



Source: [Tobacco Dependence Service Dashboard](#)

Inequalities in inpatients who successfully quit smoking as measured at 28 days after commencing a supported quit attempt

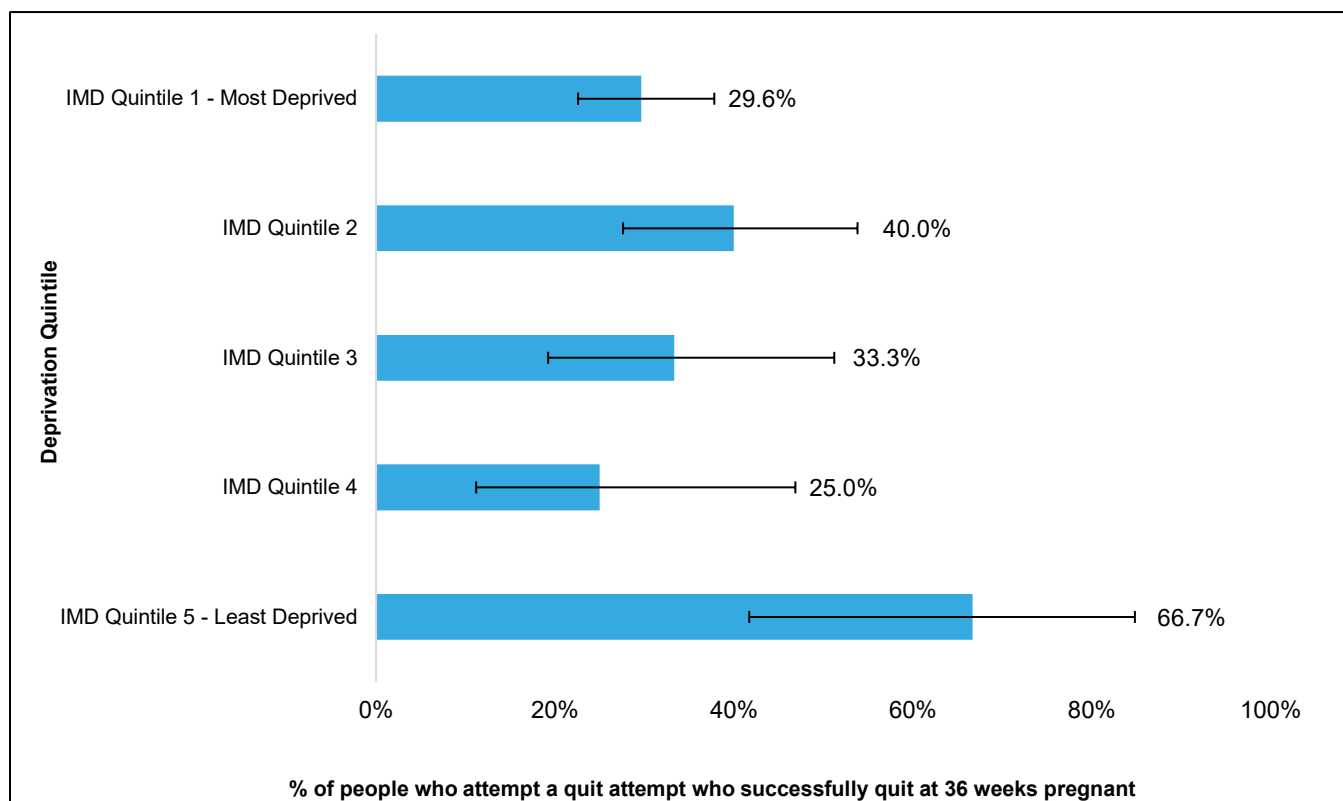
Period: February 2025 to January 2026



Source: [Tobacco Dependence Service Dashboard](#)

Inequalities in percentage of pregnant women identified as smokers at antenatal booking who are identified as non-smokers at 36 weeks gestation

Period: August 2025 to July 2025

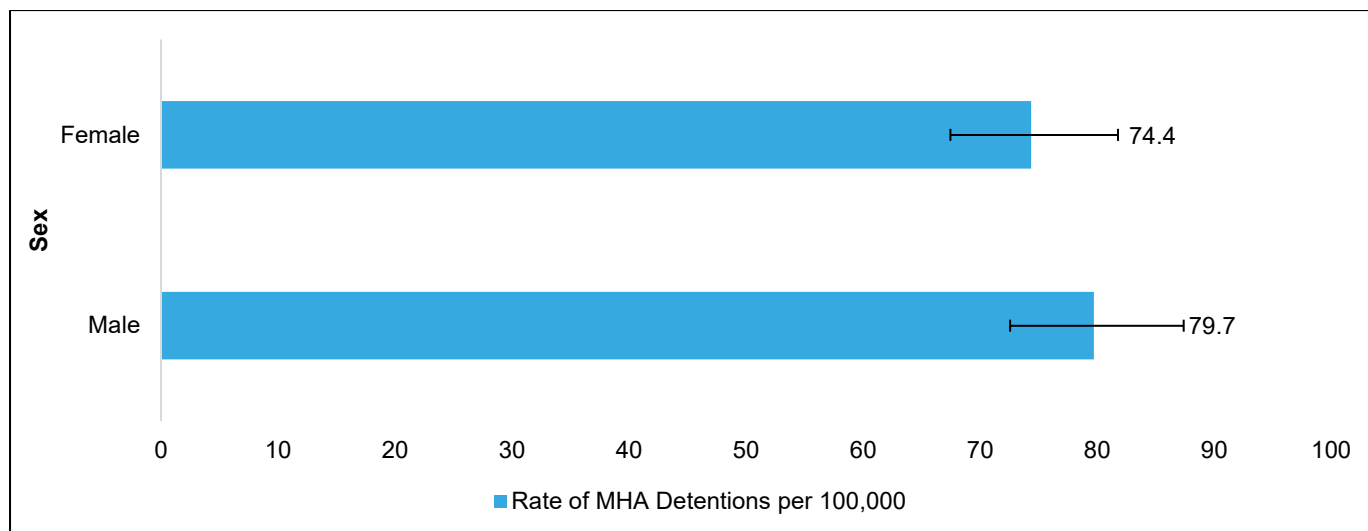


Mental Health

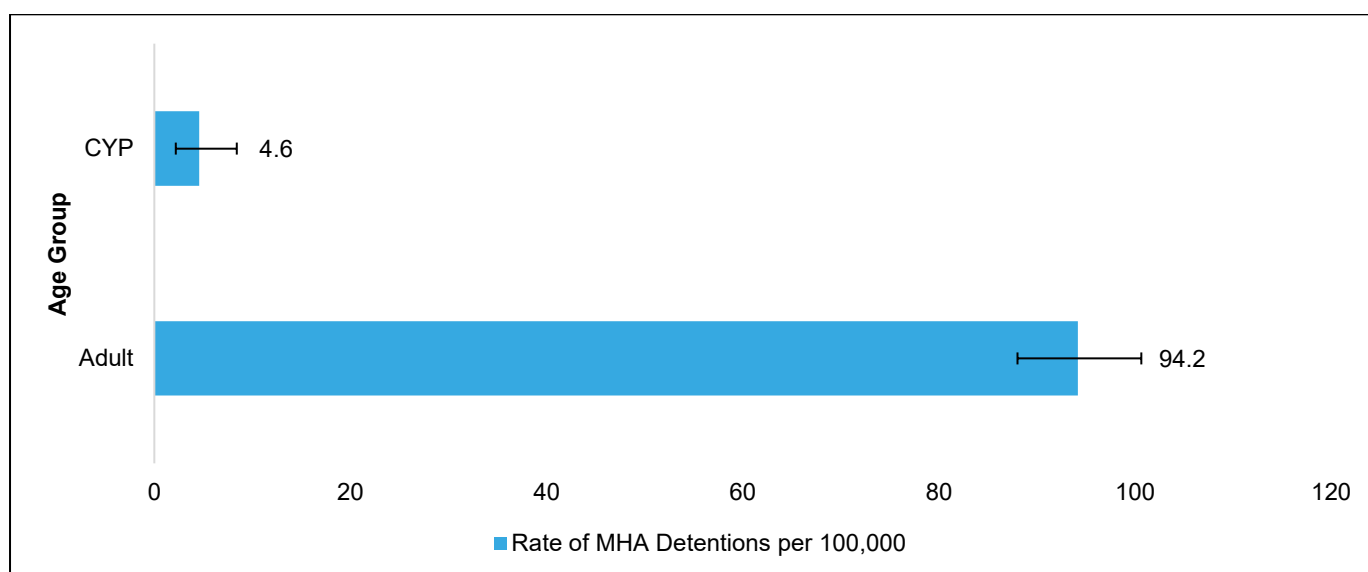
Overall number of severe mental illness (SMI) physical health checks and action plan

While activity data is available at an aggregate level, it is not currently possible to robustly assess inequalities in SMI physical health checks and associated care planning due to limitations in data completeness and segmentation. Further work is planned to improve reporting by population group.

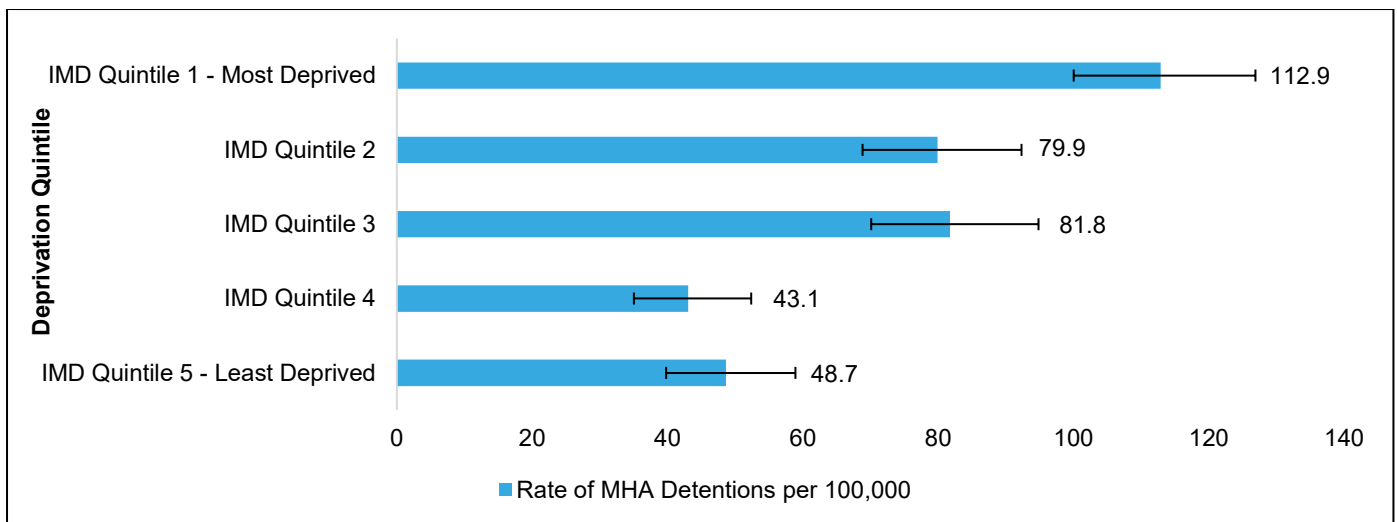
Rates of total Mental Health Act detentions



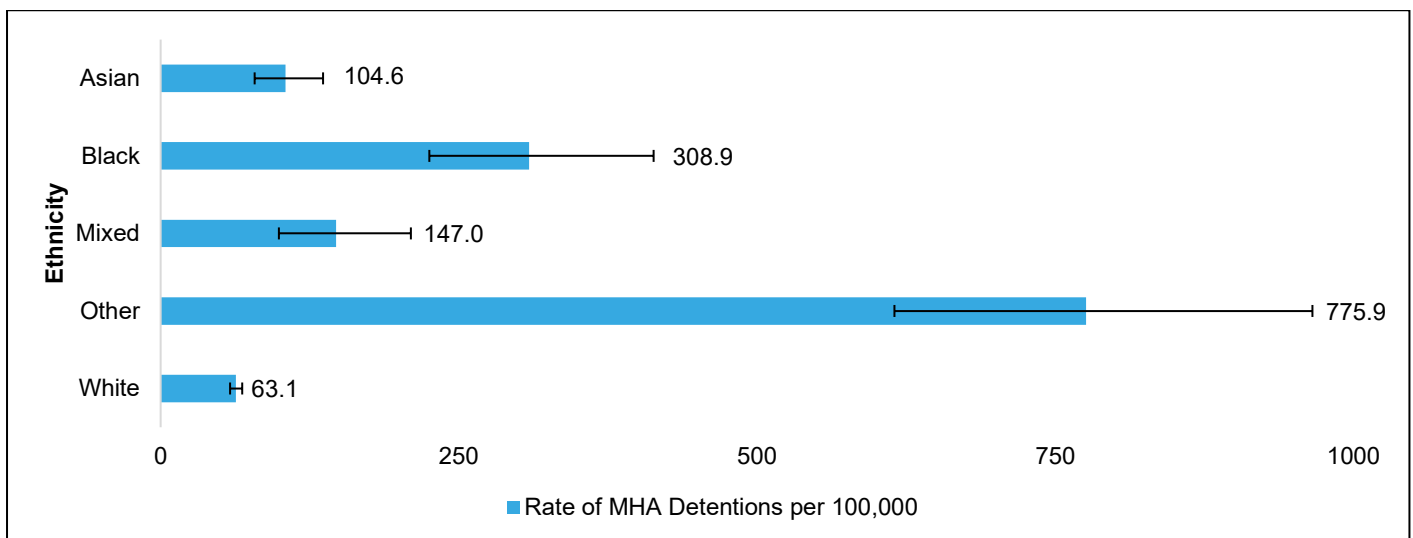
Source: [Mental Health Act Detentions 2024/25](#); [Patients registered at a GP Practice, April 2025](#)



Source: [Mental Health Act Detentions 2024/25](#); [Patients registered at a GP Practice, April 2025](#)

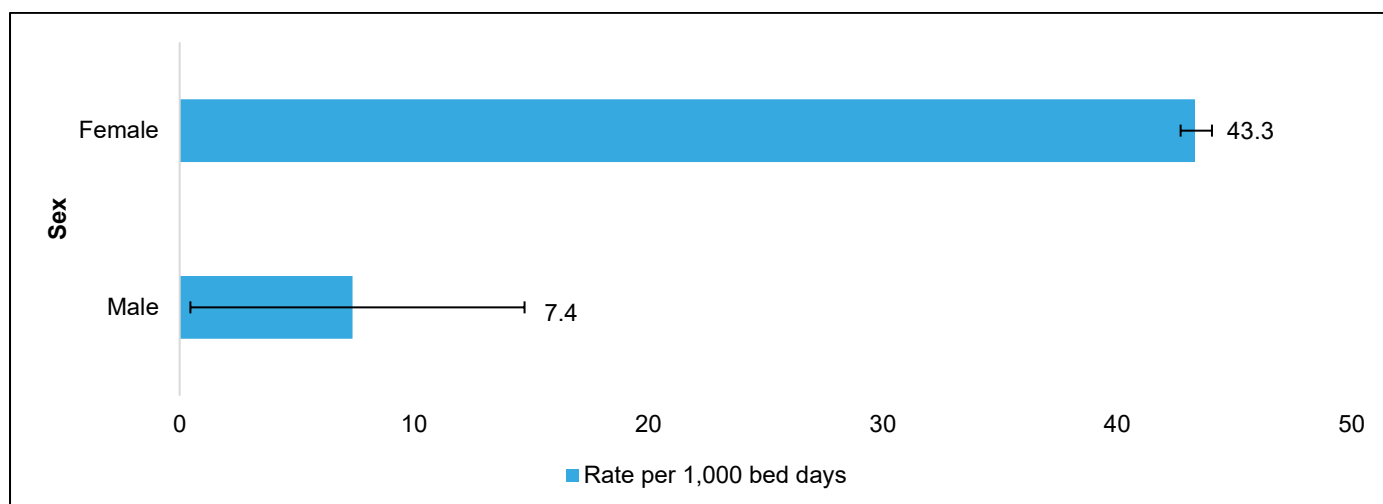


Source: [Mental Health Act Detentions 2024/25; Patients registered at a GP Practice, April 2025](#)

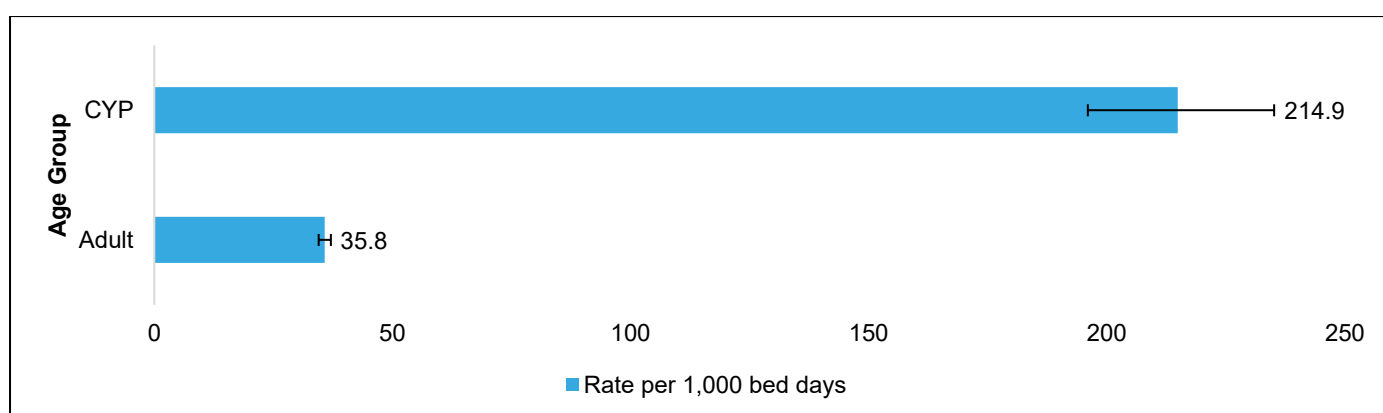


Observations: Males had a slightly higher crude rate of detentions under the Mental Health Act in 24/25, but the difference was not significantly different. Mental Health Act detentions are overwhelmingly concentrated among adults aged 18 and over, who account for around 99% of all recorded detentions, with children and young people representing only a very small share; however, these figures reflect the distribution of total activity rather than population-based risk. By deprivation, there is a clear social gradient, with a greater share of detentions occurring in the most deprived quintile, gradually reducing towards the least deprived areas, suggesting that mental health detentions are more commonly associated with deprivation, albeit based on crude rates. By ethnicity, those from an 'Other' ethnic group have the highest crude rate of MHA detentions, while those from a 'White' ethnic background have the smallest crude rate. Readers should interpret the ethnicity result with caution, as low counts in the ethnic minority groups may produce a misleading picture.

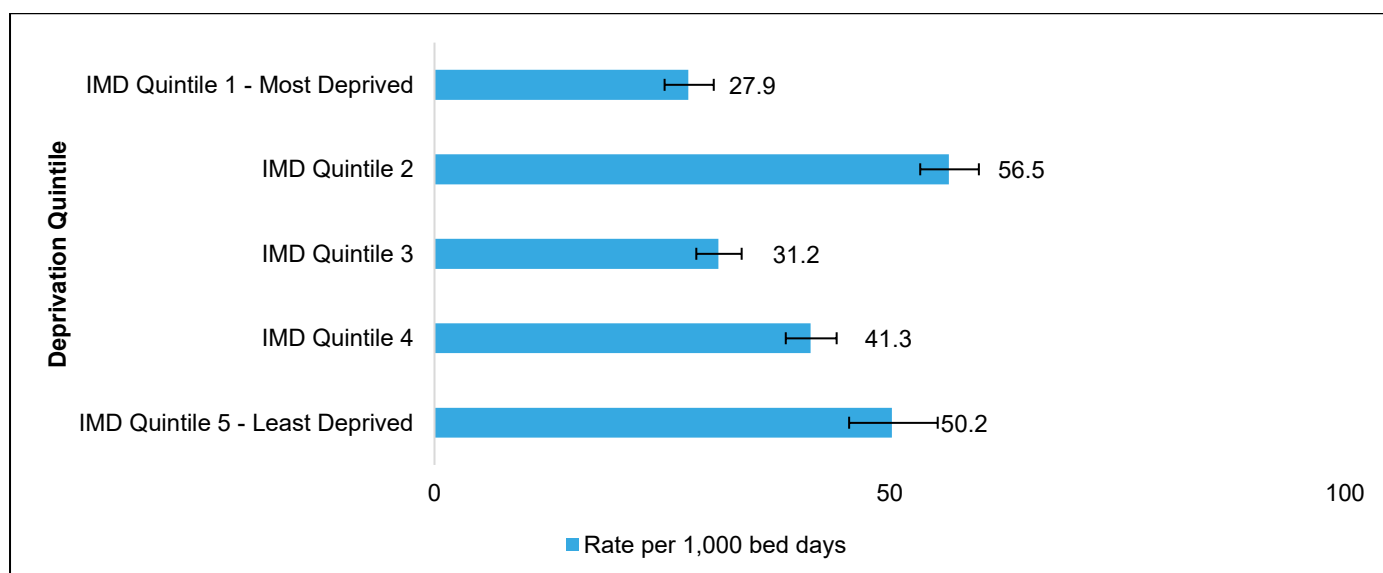
Rates of restrictive interventions



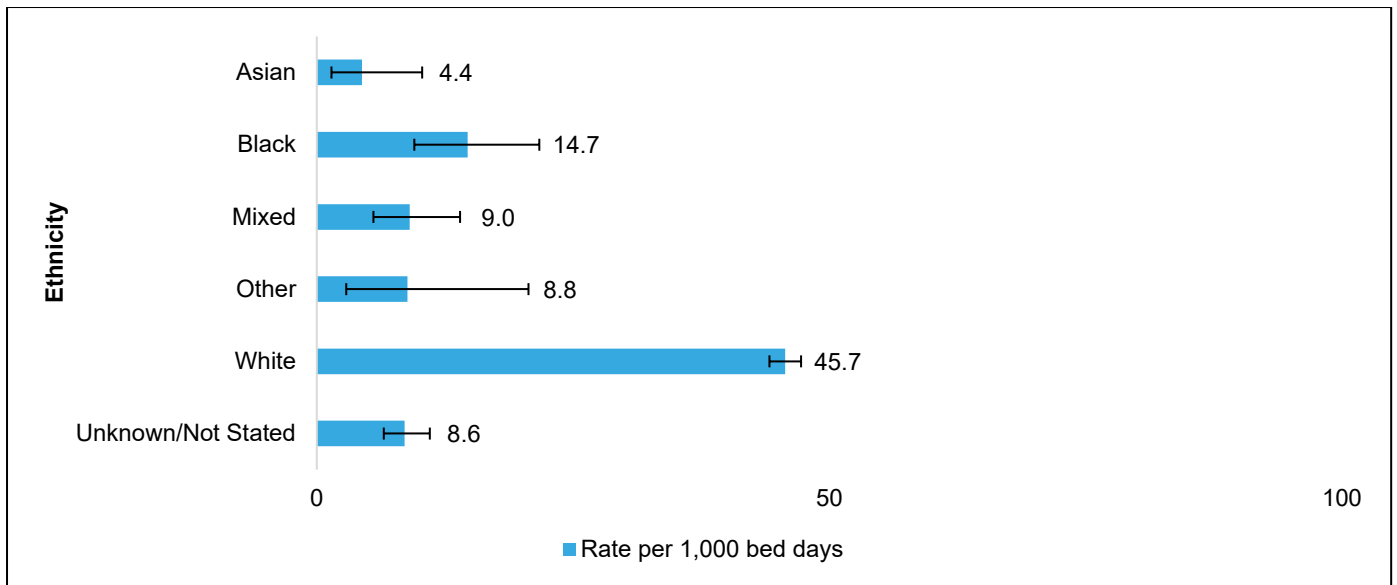
Source: [Mental Health Bulletin, 24/25](#)



Source: [Mental Health Bulletin, 24/25](#)



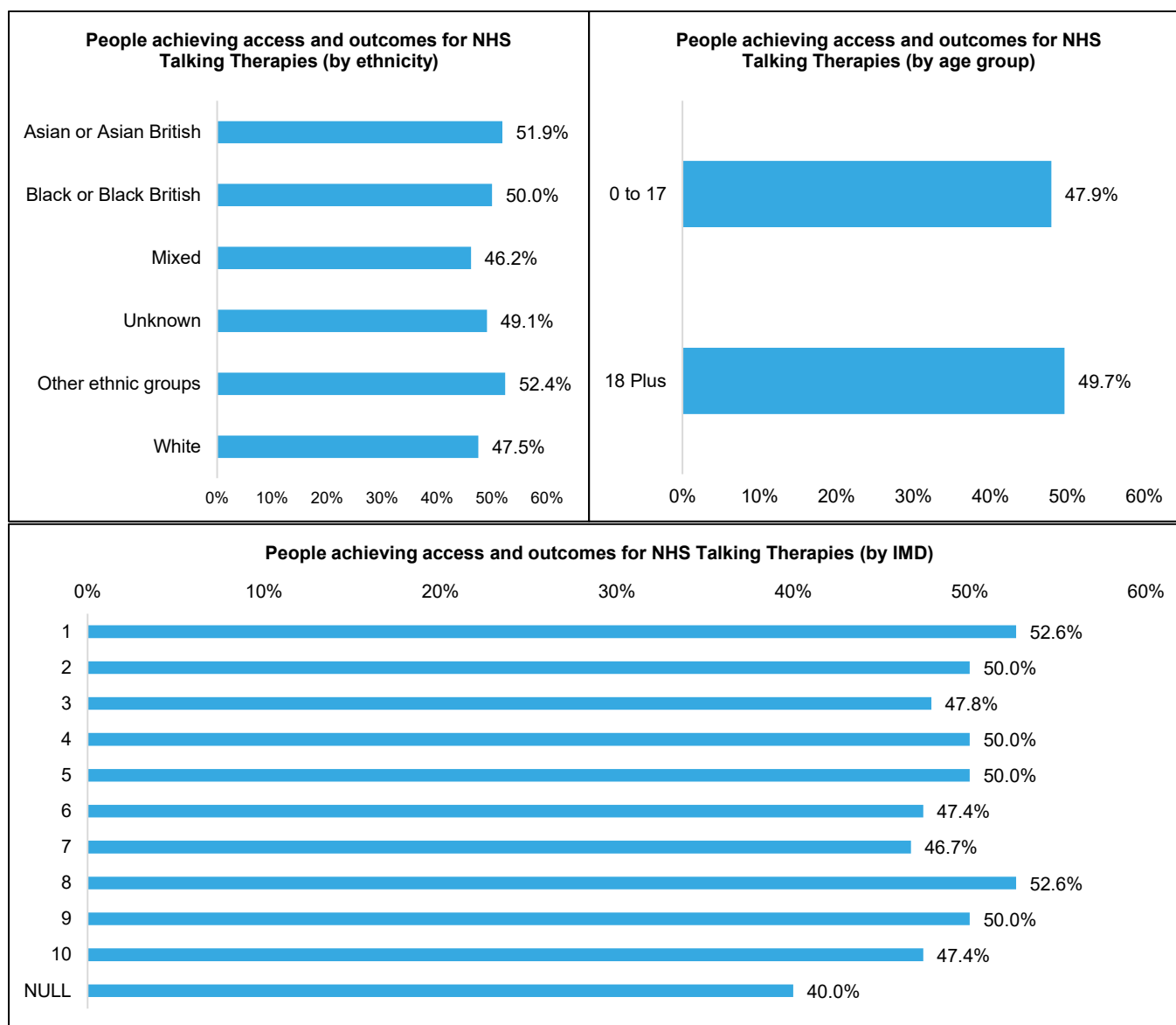
Source: [Mental Health Bulletin, 24/25](#)



Source: [Mental Health Bulletin, 24/25](#)

Observations: In 24/25, there were 3,825 restrictive interventions in an NHS funded secondary mental health, learning disabilities and autism services for Derby & Derbyshire ICB residents. There were 176,100 bed days in mental health settings; this equates to 21.72 restrictive interventions per 1,000 bed days. Females experienced a significantly higher rate of restrictive interventions per 1,000 bed days. Children under the age of 18 also experienced a significantly higher rate of restrictive interventions compared to adults. Those who live in the second most deprived quintile had the highest rate of restrictive interventions per 1,000 bed days, closely followed by those who live in the least deprived quintile. Those from a White population had the highest rate compared to all other ethnic groups. It should be noted that relatively small numbers of patients can have a distorting impact on rates of interventions, especially if the number of patients from that group or bed days is relatively low.

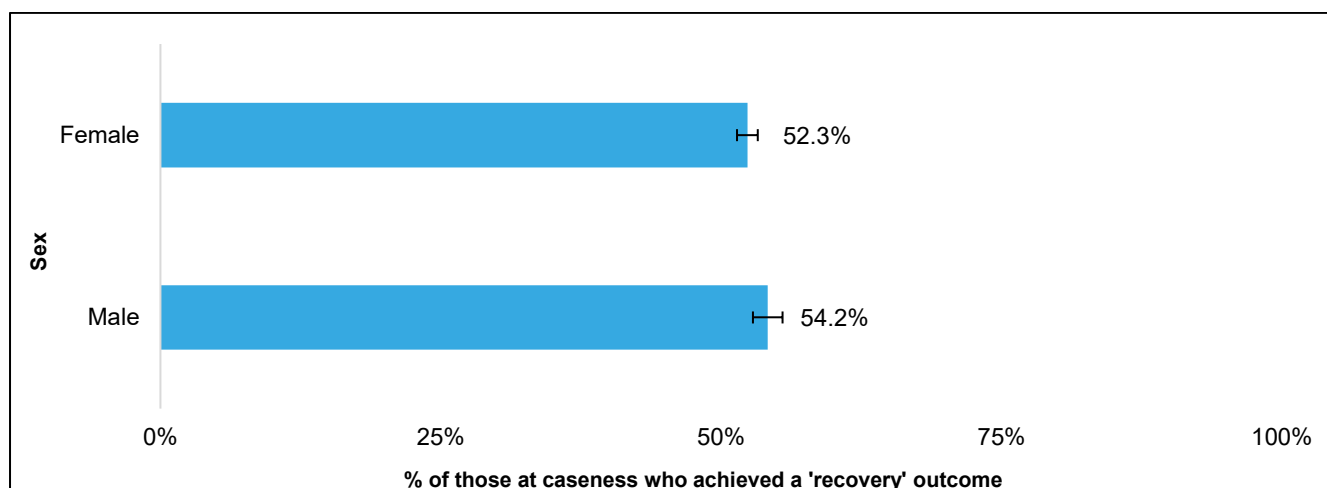
Inequalities in people achieving access for NHS Talking Therapies



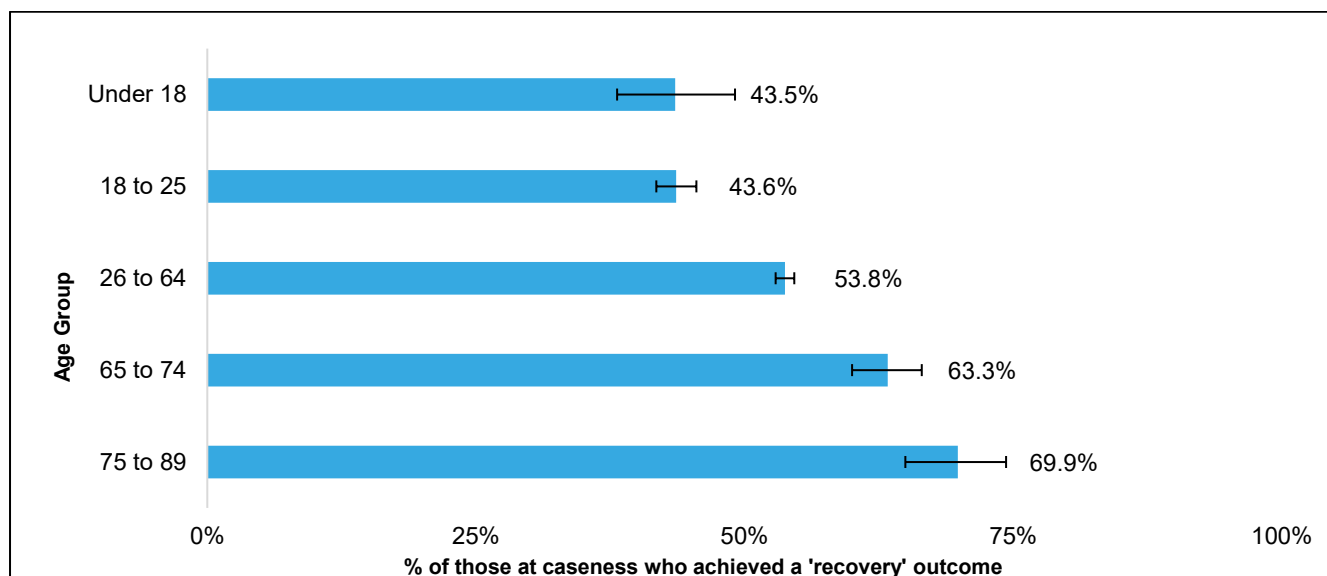
Source: NECS

Observations: Achievement of access and outcomes is broadly consistent across age, ethnicity and deprivation groups, with no large disparities evident at this level of analysis. Outcomes are similar for adults and children and young people, with adults performing marginally better, though the difference is small and both groups achieve outcomes just below 50%. By ethnicity, there is modest variation, with Other ethnic groups and Asian or Asian British showing slightly higher outcome achievement, while White and Mixed groups have comparatively lower rates; however, differences are relatively narrow and may reflect population mix or service engagement rather than substantial inequality. Across deprivation deciles, outcomes remain tightly clustered with no clear social gradient, indicating broadly equitable performance by deprivation, although the notably lower results in the NULL category suggest potential data completeness or classification issues. Overall, the pattern suggests generally comparable outcomes across groups, with only minor variation that warrants monitoring rather than indicating clear structural inequality.

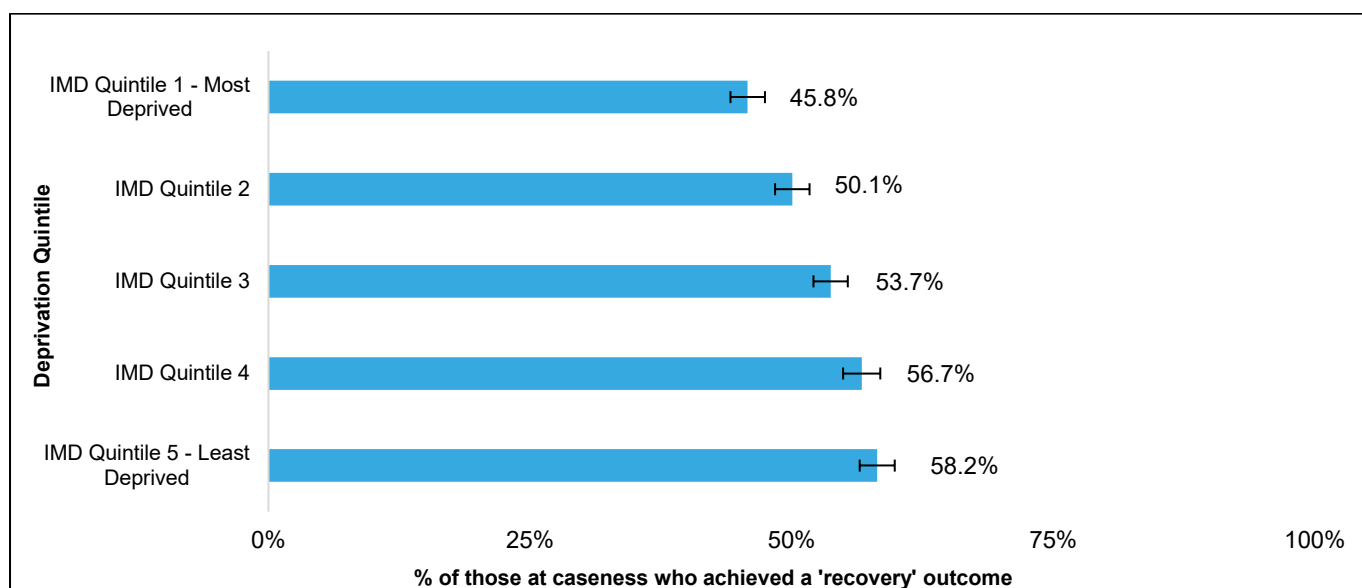
NHS Talking Therapies recovery rate



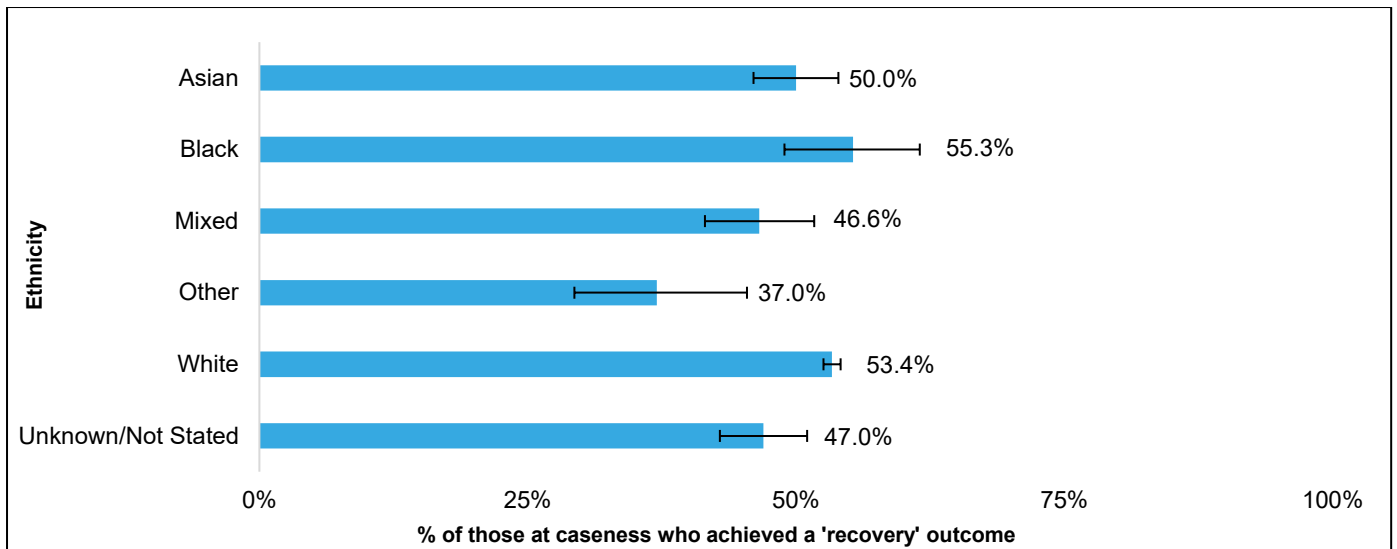
Source: [NHS Talking Therapies, for anxiety and depression, Annual reports, 2024-25](#)



Source: [NHS Talking Therapies, for anxiety and depression, Annual reports, 2024-25](#)



Source: [NHS Talking Therapies, for anxiety and depression, Annual reports, 2024-25](#)



Source: [NHS Talking Therapies, for anxiety and depression, Annual reports, 2024-25](#)

Observations: In 24/25, 53% of the population in Derby & Derbyshire ICB who accessed NHS talking therapies had an outcome of 'recovery' - meaning a person who is deemed to be a clinical case at the start of their treatment ('at caseness') and not as a clinical case at the end of their treatment, measured by scores from questionnaires tailored to their specific condition. This is a slight increase from 23/24, where 54% of the population achieved a recovery outcome.

Males experienced a higher proportion achieving a recovery outcome, although this difference was not significant. There was a slight narrowing in the gap between females and males who achieved a recovery outcome from the 23/24 period, where there was a 2.5 percentage point gap between females and males. The gap in 24/25 was 1.9 percentage points.

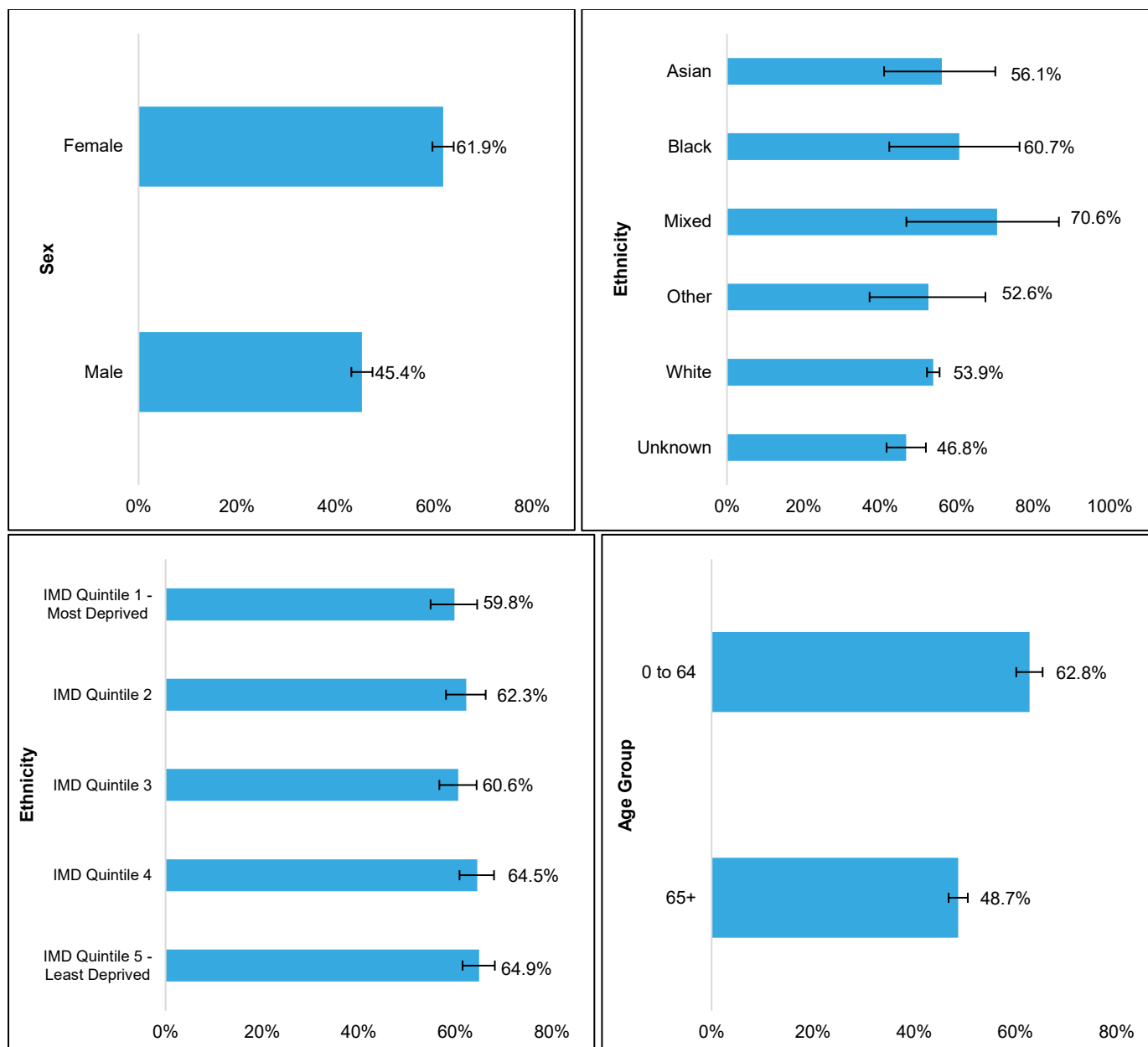
Generally, the younger populations had a lower proportion achieving a recovery outcome compared to older patients.

Those from the most deprived quintile experienced a significantly lower proportion who achieved a reliable recovery than those from the least deprived quintile. There was a slight narrowing in the gap between those from the most deprived and least deprived who achieved a recovery outcome from 23/24 to 24/25, from a 14.0 percentage point difference in 23/24 to a 12.4 percentage point difference in 24/25.

Due to low counts in ethnic minority groups, and a relatively high count of patients whose ethnicity was not known or not stated, it is difficult to infer whether there are any health inequalities due to ethnicity when it comes to achieving a recovery outcome.

Cancer

Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex



Source: National Disease Registration Service – Rapid Registration dataset

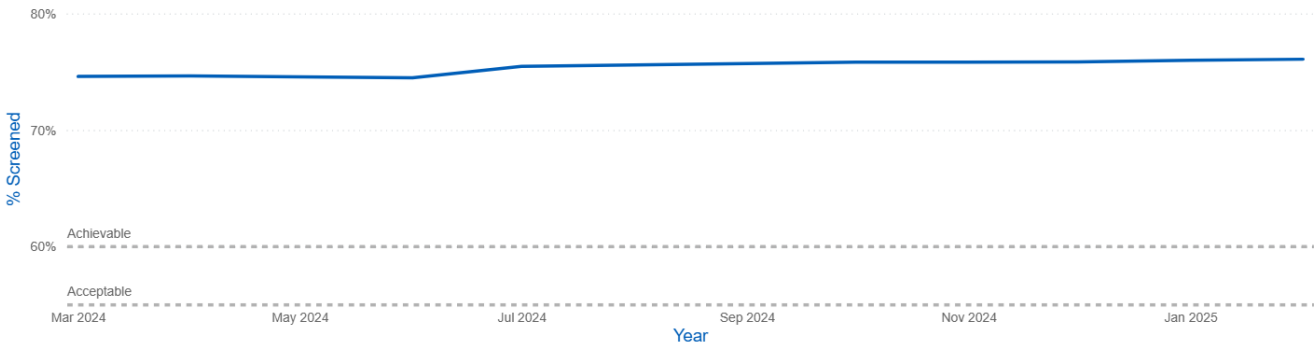
Observations: There are clear inequalities in stage at diagnosis across population groups. Females have a significantly higher proportion of early-stage diagnoses compared to males, indicating better early detection among females. Those from the most deprived groups have a lower proportion of early-stage diagnosis compared to the least deprived population, although the difference is not significantly different. A significantly higher proportion of those under the age of 64 have their cancer diagnosed at an early stage, compared to those over the age of 65. It is difficult to infer whether there are any health inequalities related to ethnicity due to low counts and a high number of people whose ethnicity is not known or not stated.

Cancer screening coverage

Definition: Number of patients screened out of the number eligible as at the report date.

Year	2024											2025
MetricKey	March	April	May	June	July	August	September	October	November	December	January	February
Tests	665,835	666,845	653,220	652,795	247,200	247,715	248,435	249,095	249,325	249,735	250,510	251,020
Eligible Population	892,610	893,455	876,005	876,410	327,555	327,720	328,165	328,550	328,775	329,260	329,670	329,960
% Tested	74.6%	74.6%	74.6%	74.5%	75.5%	75.6%	75.7%	75.8%	75.8%	75.8%	76.0%	76.1%

% Screened by Year and Month

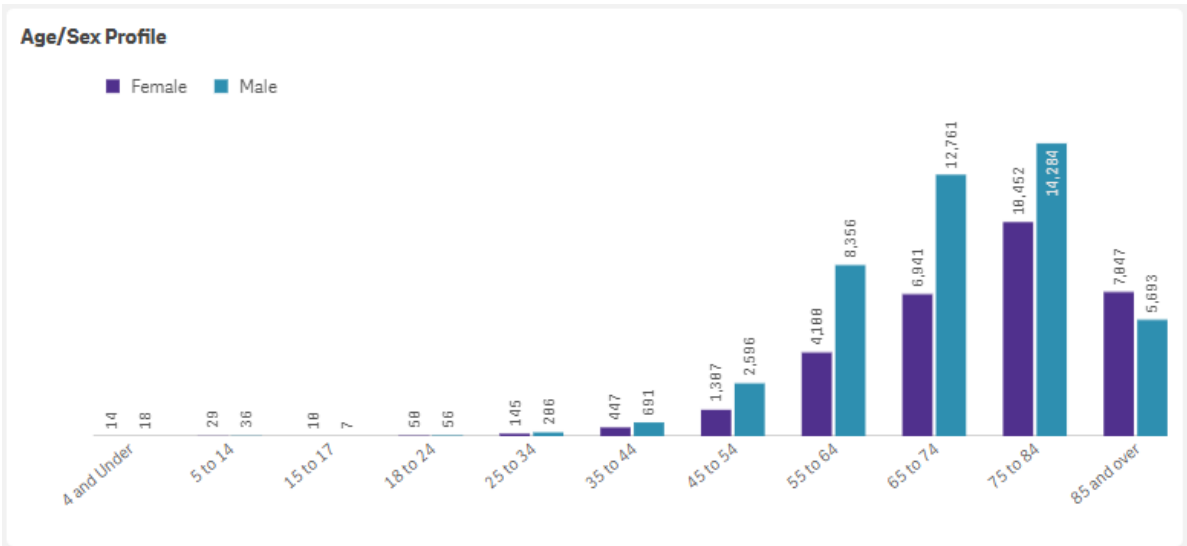


Source: [Coverage - Cancer Screening Dashboard - Power BI](#)

Observations: Cancer screening coverage has remained consistently high and stable over time, with only a slight upward trend. Coverage increased marginally from around 74.5% in March 2024 to 76.1% in February 2025, indicating steady performance rather than rapid improvement. Monthly variation is minimal, suggesting a stable screening programme, and performance remains well above the “achievable” threshold shown in the chart. However, the relatively flat trend indicates limited recent gains, suggesting further targeted efforts may be needed to increase uptake beyond the current plateau.

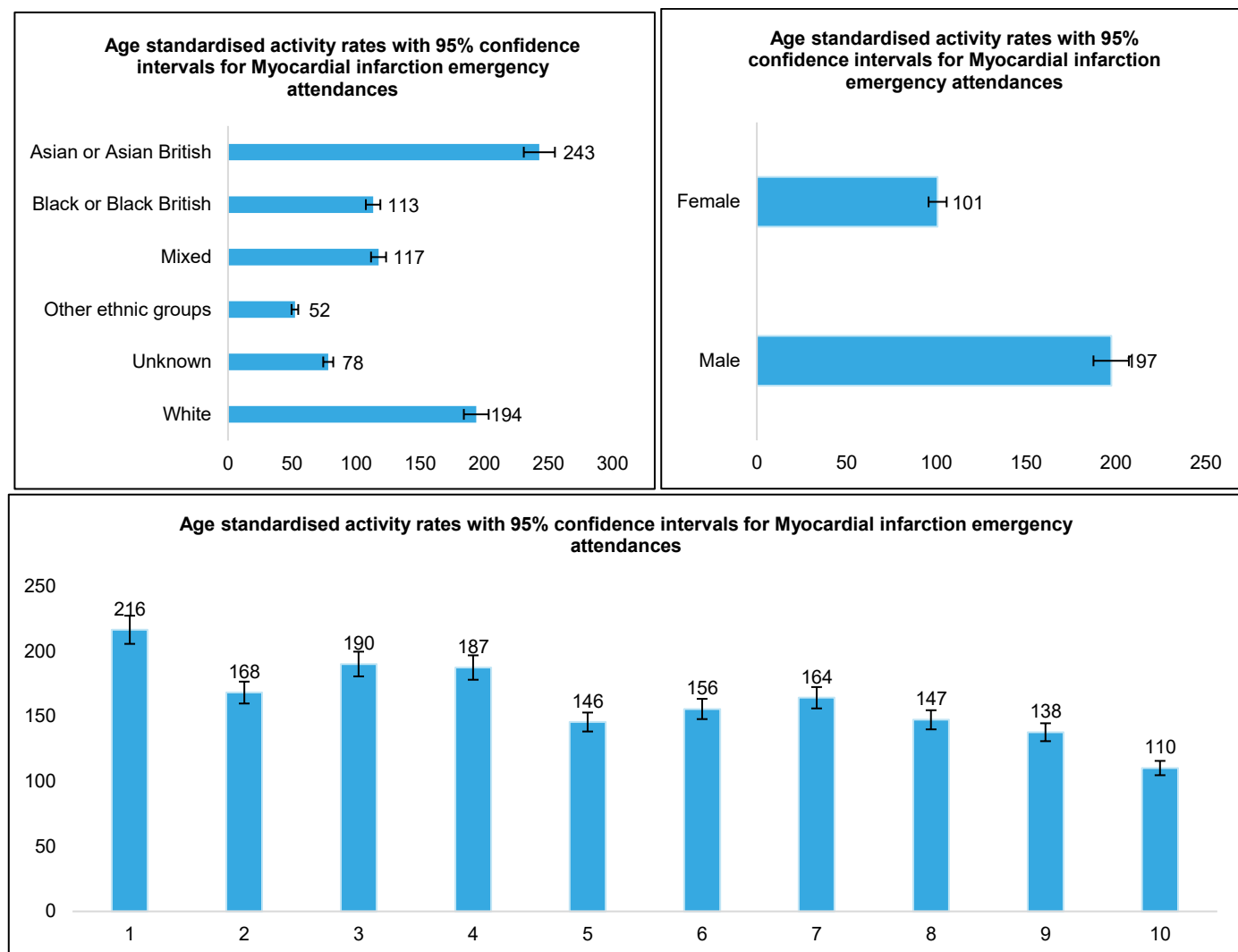
Cardiovascular Disease (CVD)

CVD case finding



Observations: The CVD population of 75,246 shows a pronounced age gradient, with the majority of cases concentrated in those aged 55 and over. Male prevalence is higher than female in the 55–84 age range, while female counts are similar or slightly higher in the 85 and over group. Very few cases are recorded in those under 35, consistent with the known epidemiology of cardiovascular disease.

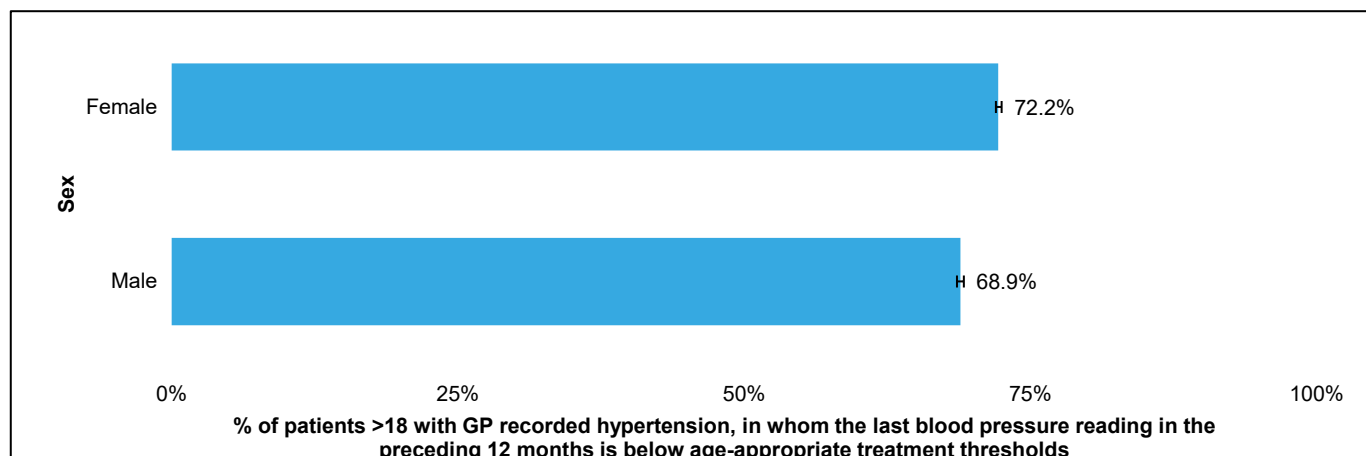
Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)



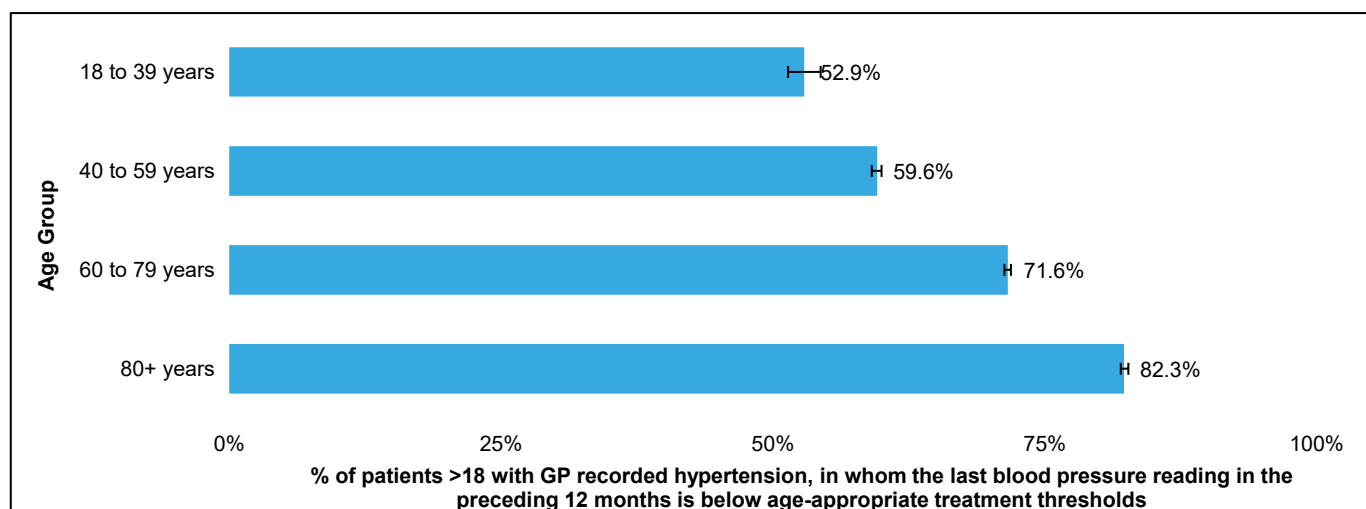
Source: SUS Inpatient dataset

Observations: Non-elective emergency admissions for myocardial infarction are predominantly recorded among older adults, with the majority of admissions occurring in patients aged 65 and over, and comparatively smaller proportions in younger age groups; however, these figures describe the distribution of recorded admissions rather than age-specific risk. By ethnicity, most admissions are recorded for the White group, followed by a notable Unknown category and smaller proportions across Asian or Asian British, Black or Black British, Mixed, and Other ethnic groups. This distribution is influenced by both the underlying population profile and completeness of ethnicity recording, and therefore does not in itself indicate disproportionality in outcomes or access. By deprivation, admissions are more frequently observed among patients living in more deprived deciles, suggesting a gradient consistent with known socioeconomic inequalities in cardiovascular disease; however, variation across deciles and the presence of a NULL category indicate that data completeness may affect interpretation. Overall, the patterns observed reflect recorded service activity and underlying population structure, and differences between groups should be interpreted cautiously, as they are not population-based rates and may be constrained by missing or unassigned data.

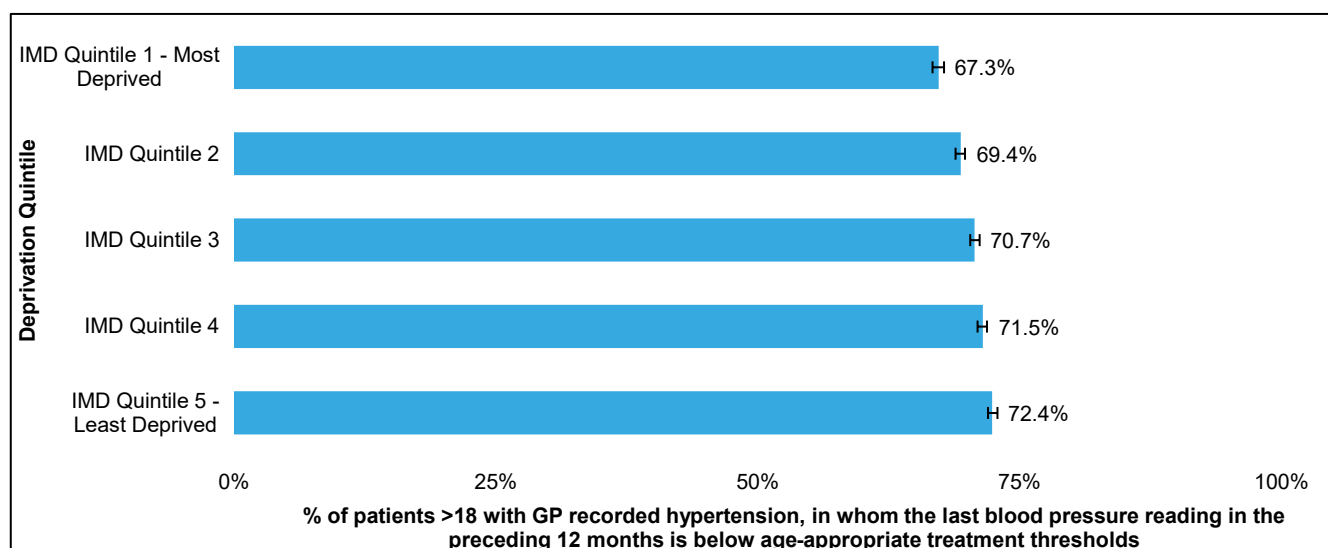
Percentage of patients aged 18 or over with GP recorded hypertension, in whom the last blood pressure reading in the preceding 12 months is below age-appropriate treatment thresholds (indicator of optimal condition management)

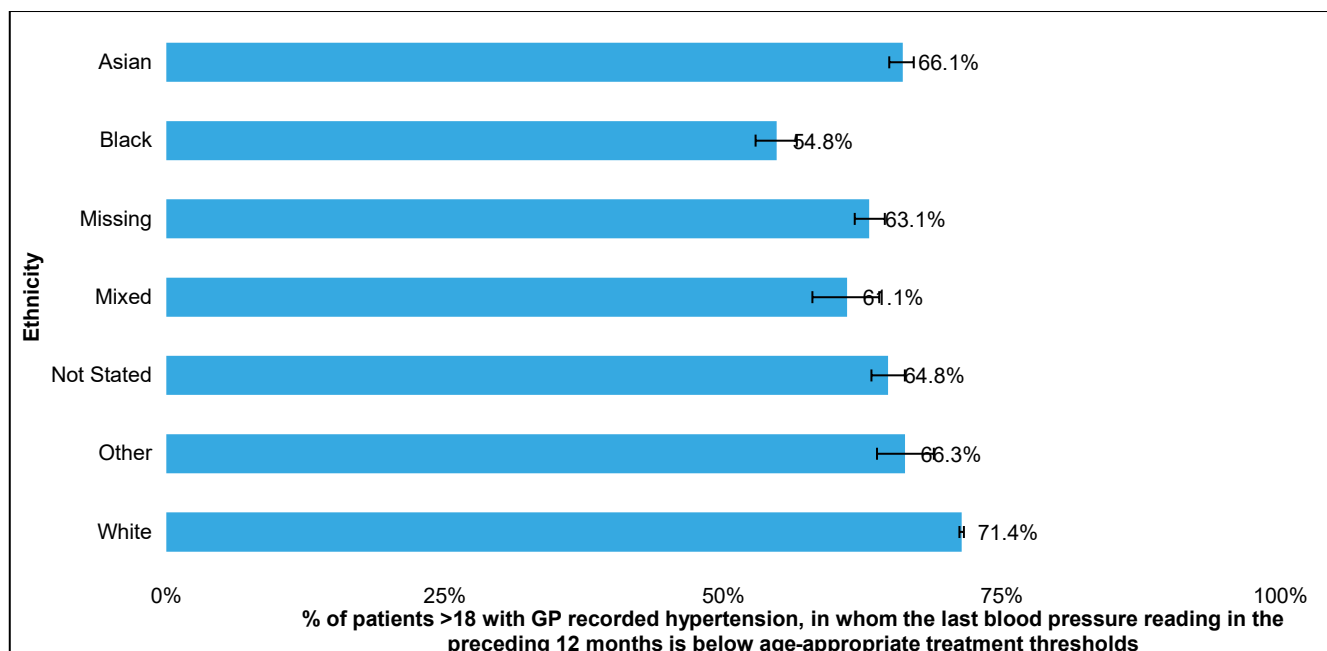


Source: [CVD Prevent](#)



Source: [CVD Prevent](#)





Source: [CVD Prevent](#)

Observations: In 2025, 70.6% of those with GP recorded hypertension had their latest blood pressure reading below the appropriate treatment threshold. This is an increase of 1.3 percentage points from 2024.

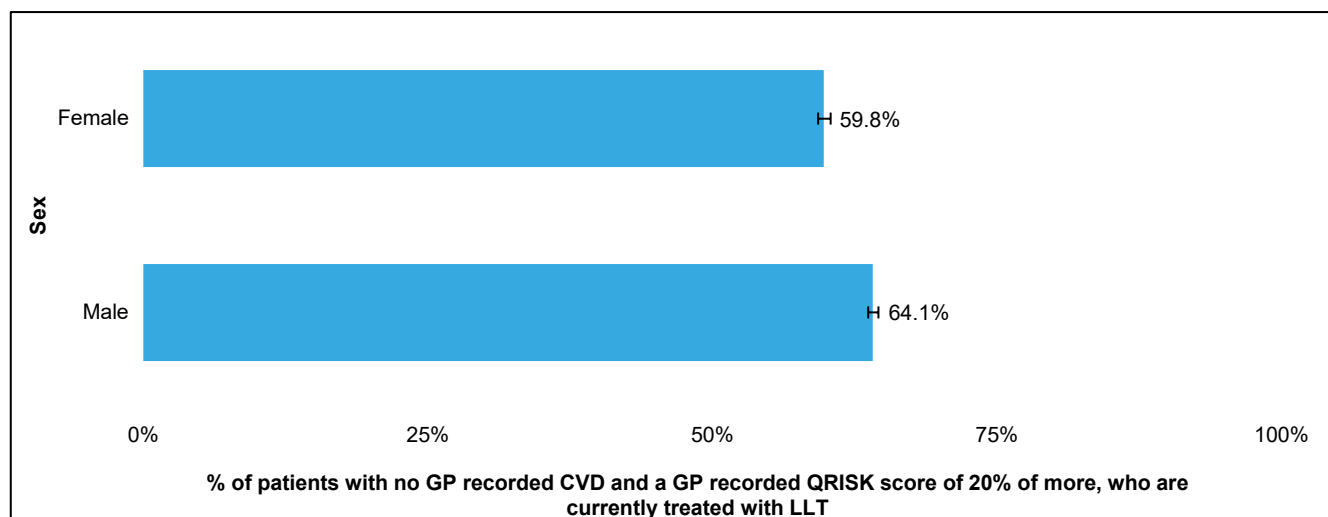
Females experienced a significantly higher proportion of optimal hypertension management than males. The gap between females and males having optimal blood pressure management did not really change between 2024 and 2025.

Those with GP recorded hypertension under the age of 60 had a significantly lower proportion who had their hypertension optimally managed. The gap between those aged under 60 and over 60 who have their hypertension optimally managed slightly narrowed from 16.3 percentage points in 2024 to 15.6 percentage points in 2025.

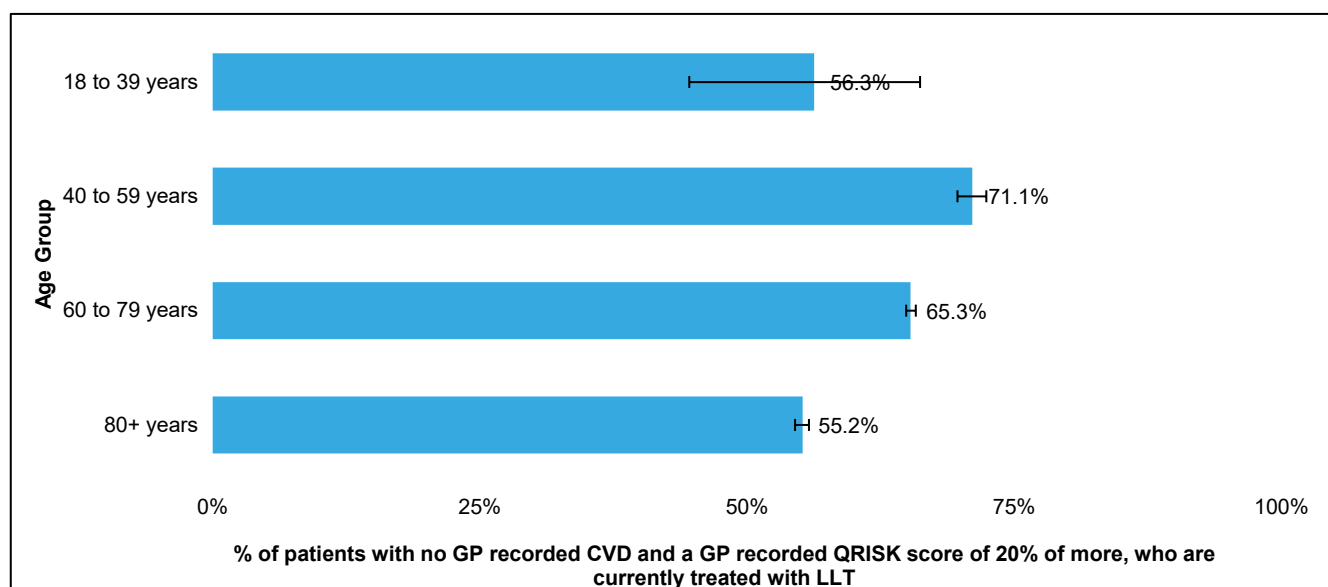
Those with GP recorded hypertension living in the most deprived quintile had a significantly lower proportion who had their hypertension optimally managed than those living in the least deprived quintile. The gap between the most deprived and least deprived populations slightly narrowed from 2024 to 2025, from a 6.0 percentage point difference to a 5.1 percentage point difference.

Given the relatively low counts of those from different ethnic minority backgrounds compared to the White population, it is difficult to state with certainty whether there is a genuine inequality in hypertension management based on ethnicity and whether there has been an improving or worsening picture compared to 2024.

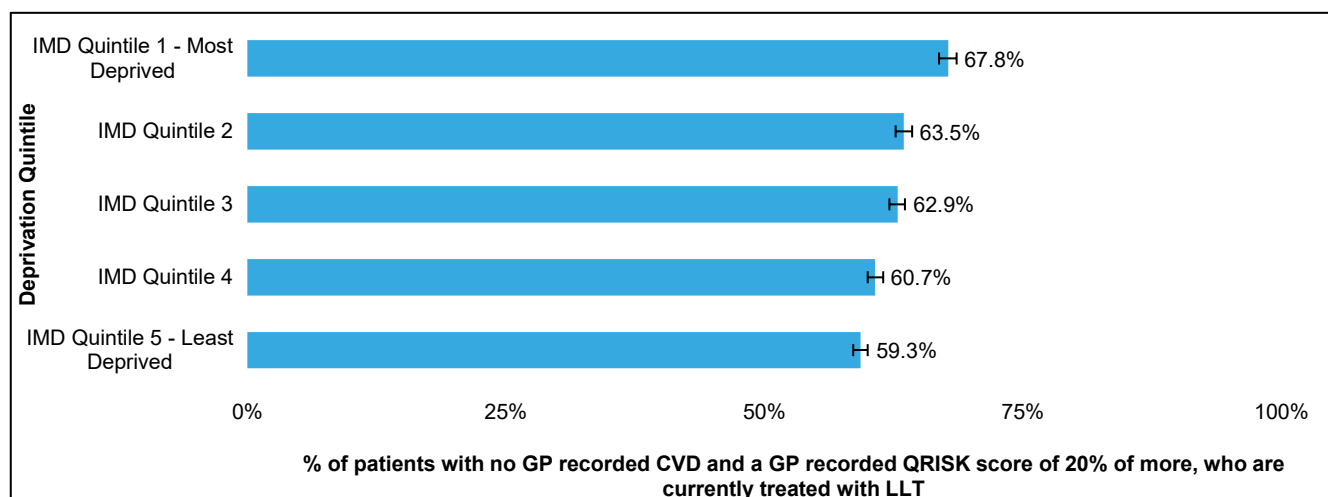
Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy



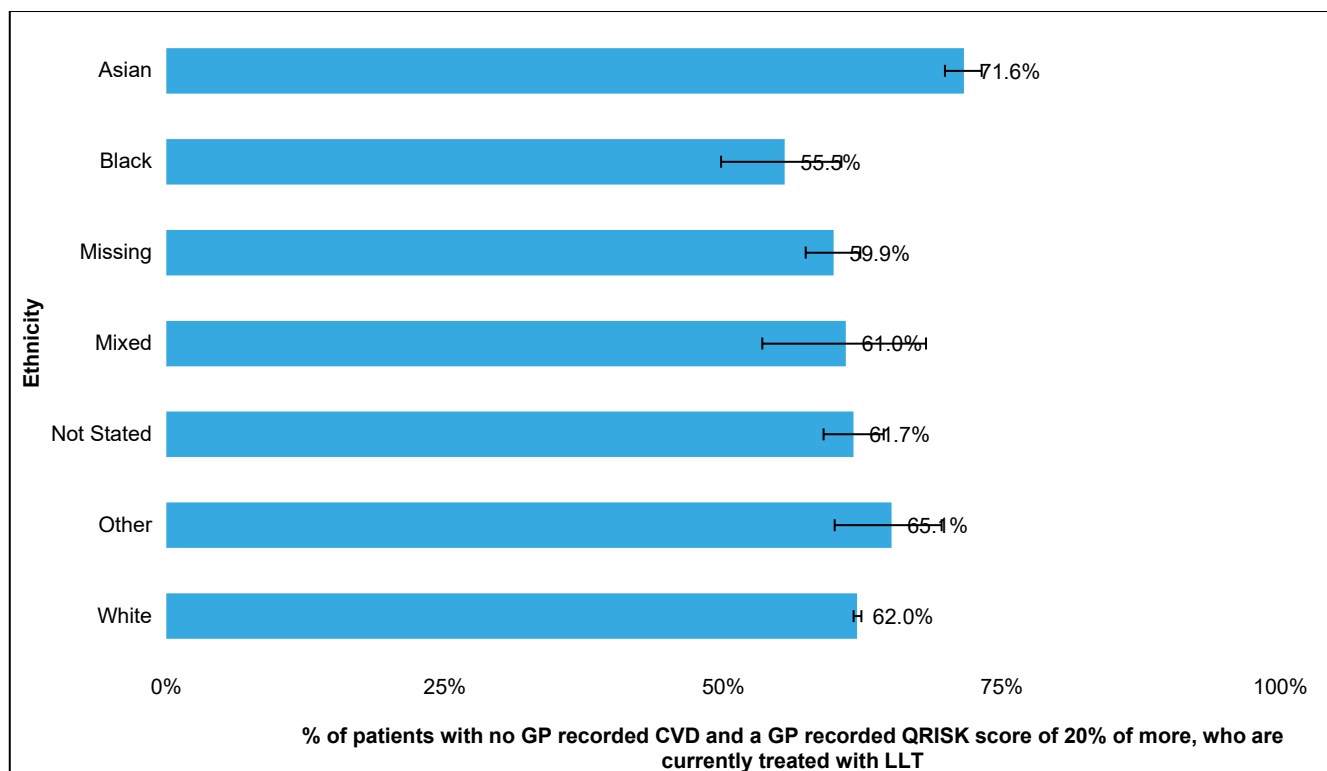
Source: [CVD Prevent Data Explorer](#)



Source: [CVD Prevent Data Explorer](#)



Source: [CVD Prevent Data Explorer](#)



Source: [CVD Prevent Data Explorer](#)

Observations: In 2025, 62.4% of patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, were being treated with lipid lowering therapy. This is an increase from 2024, where 60.5% of patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, were being treated with lipid lowering therapy.

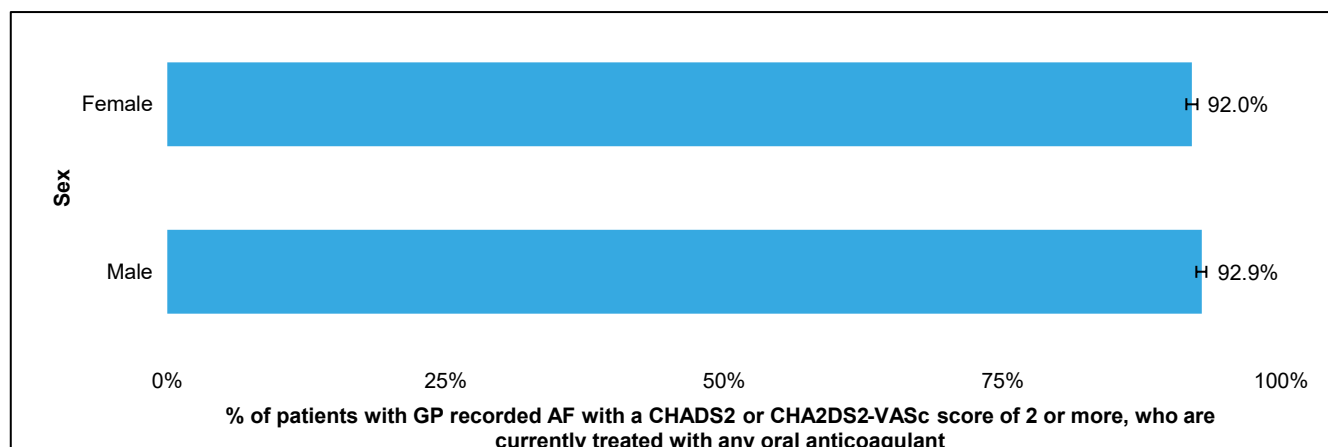
A significantly higher proportion of male patients were on LLT compared to females. There was very little change in the proportion between females and males on LLT from 2024 to 2025 (4.1 percentage point difference in 2024 vs. 4.3 percentage point difference in 2025).

Those under the age of 60 with no GP recorded CVD and a GP recorded QRISK score of 20% or more had a higher proportion of LLT compared to adults over the age of 60. The gap between under 60s and over 60s who received LLT slightly widened quite a lot between 2024 and 2025. In 2024, the gap between under 60s and over 60s who received LLT was 8.5 percentage points, compared to 9.2 percentage points in 2025.

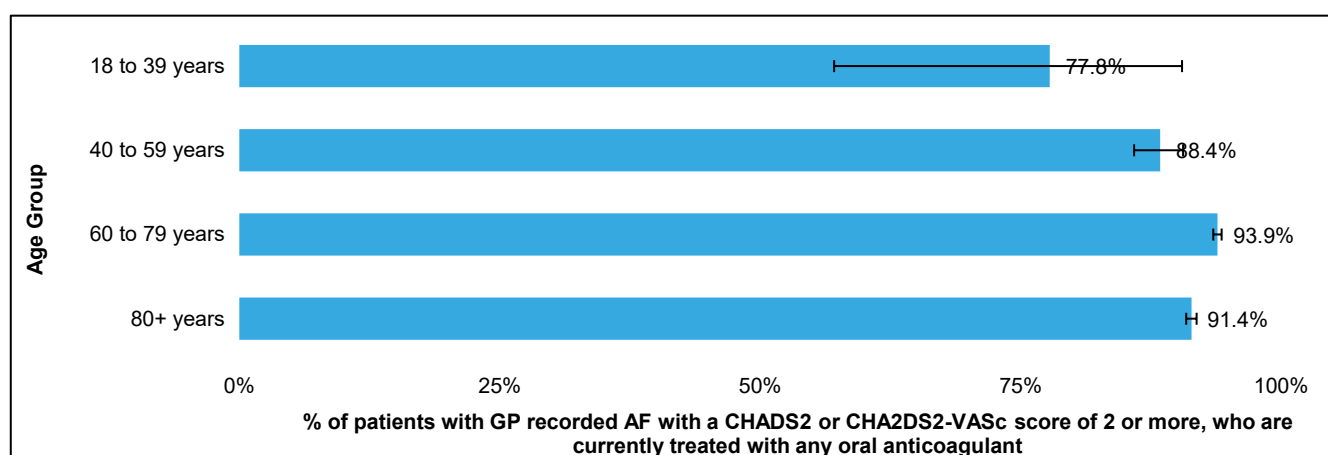
Those living in the most deprived areas are more likely than those living in the least deprived areas to be treated with lipid lowering therapy. There was a slight widening in the gap of patients from the most and least deprived quintiles being treated with LLT from 2024 to 2025. In 2024, the gap was 8.0 percentage points, and in 2025 this gap was 8.5 percentage points (with those living in the most deprived quintile having the higher uptake of LLT).

Given the relatively low counts of those from different ethnic minority backgrounds compared to the White population, it is difficult to state with certainty whether there is a genuine inequality in treatment with LLT based on ethnicity.

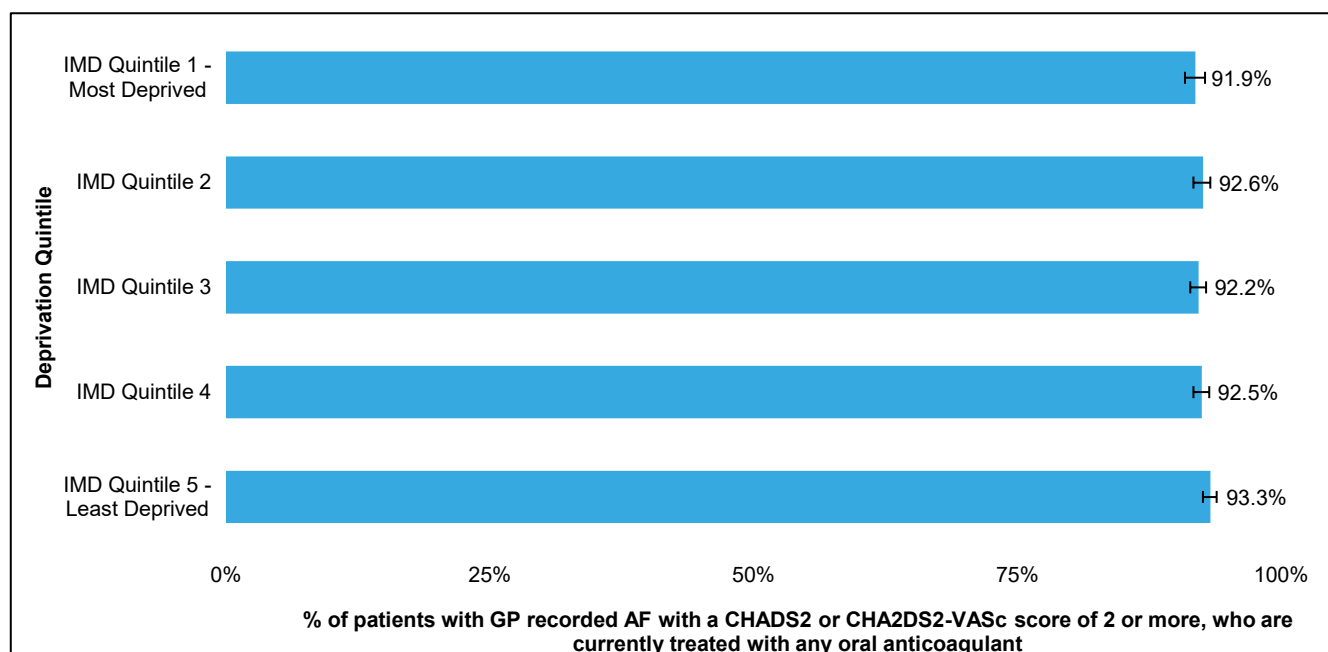
Percentage of patients aged 18 or over with GP recorded atrial fibrillation and a record of CHA2DS2-VASc Score of 2 or more who are currently treated with anti-coagulation drug therapy



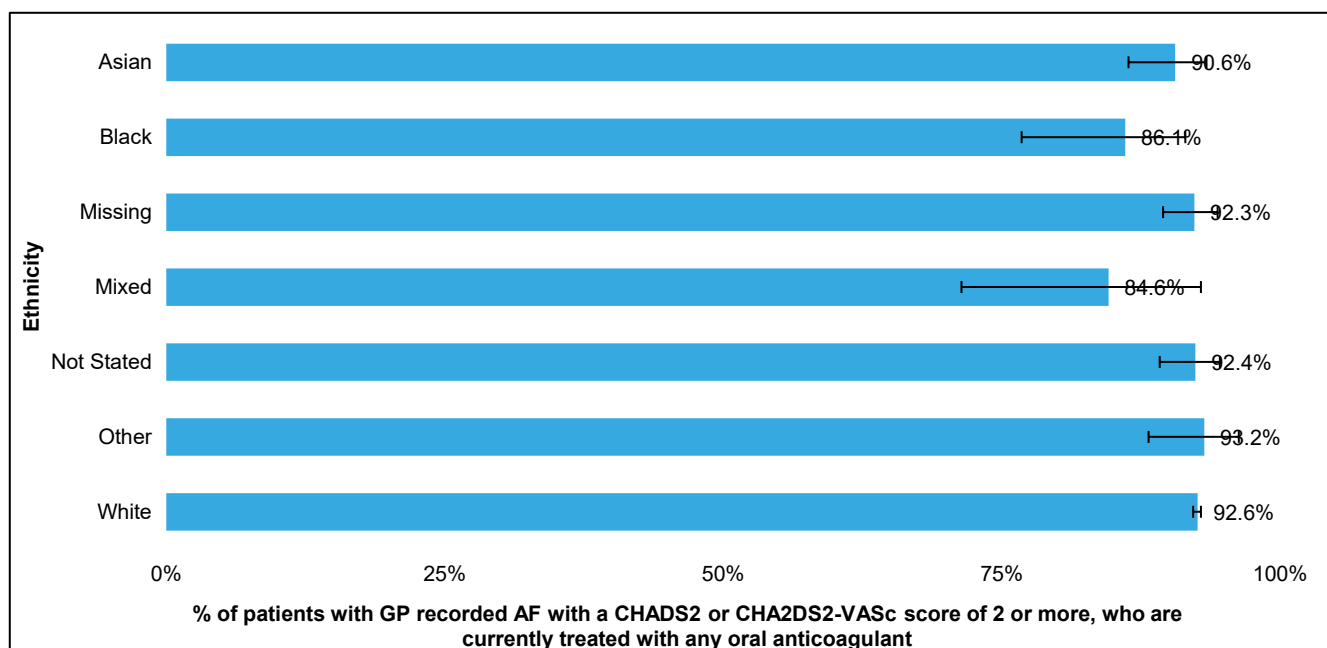
Source: [CVD Prevent](#)



Source: [CVD Prevent](#)



Source: [CVD Prevent](#)



Source: [CVD Prevent](#)

Observations: In 2025, 92.5% of patients with GP recorded atrial fibrillation and with a CHADS2 or CHA2DS2-VASc score of 2 or more are currently being treated with oral anti-coagulants. This is similar to 2024 (92.1%).

There is no significant difference between females and males, and there was no change in the gap between females and males from 2024 to 2025.

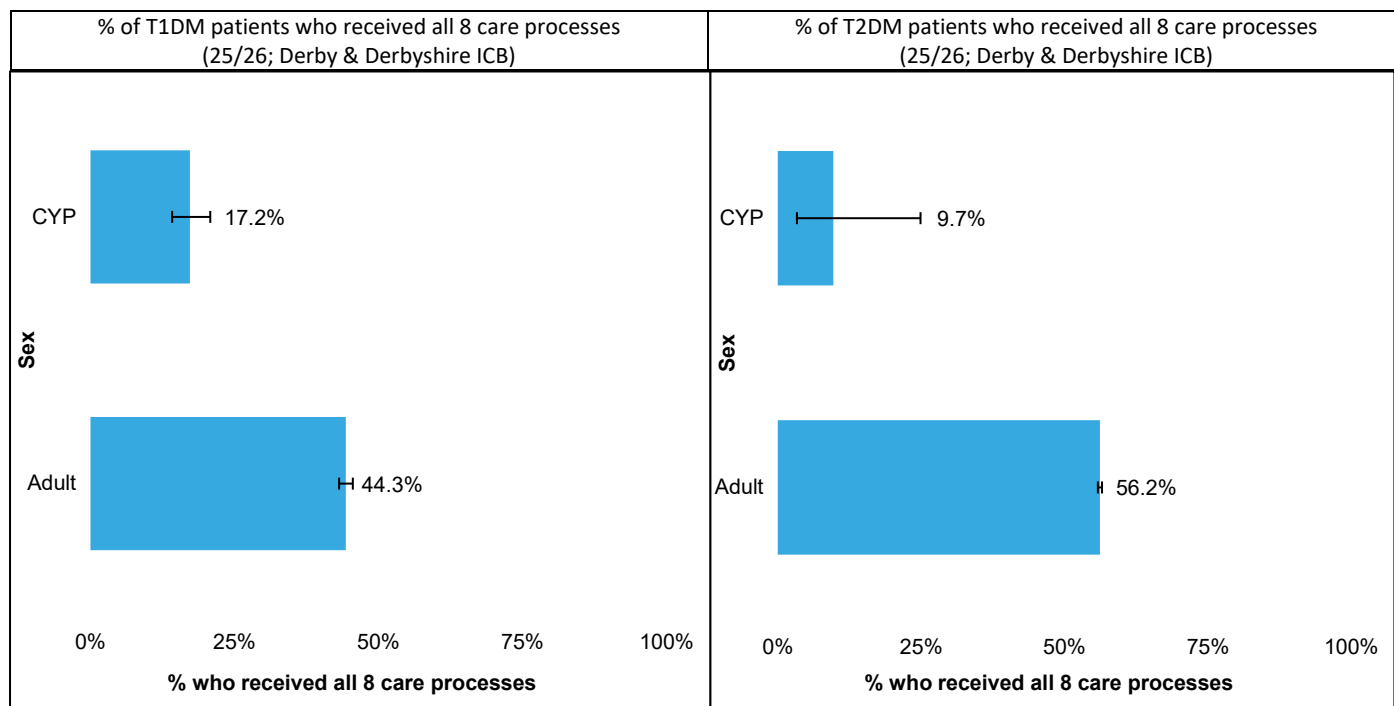
Patients over the age of 60 have a significantly higher uptake compared to under 60s, and there was a slight narrowing in the gap between under 60s and over 60s from 2024 (6.1 percentage point gap) to 2025 (4.7 percentage point gap).

There is no significant difference between patients from the most deprived and least deprived quintiles, and there was no change in the gap between the most and least deprived quintiles from 2024 to 2025.

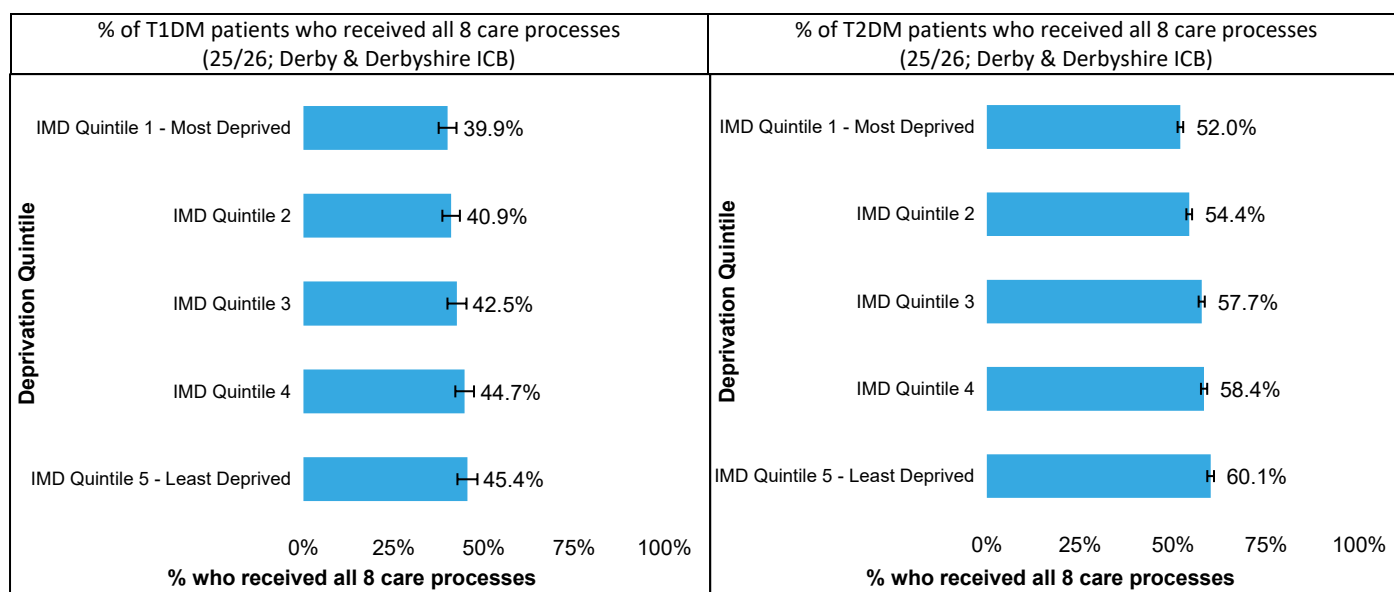
Given the relatively low counts of those from different ethnic minority backgrounds compared to the White population, it is difficult to state with certainty whether there is a genuine inequality in treatment with oral anticoagulants based on ethnicity.

Diabetes

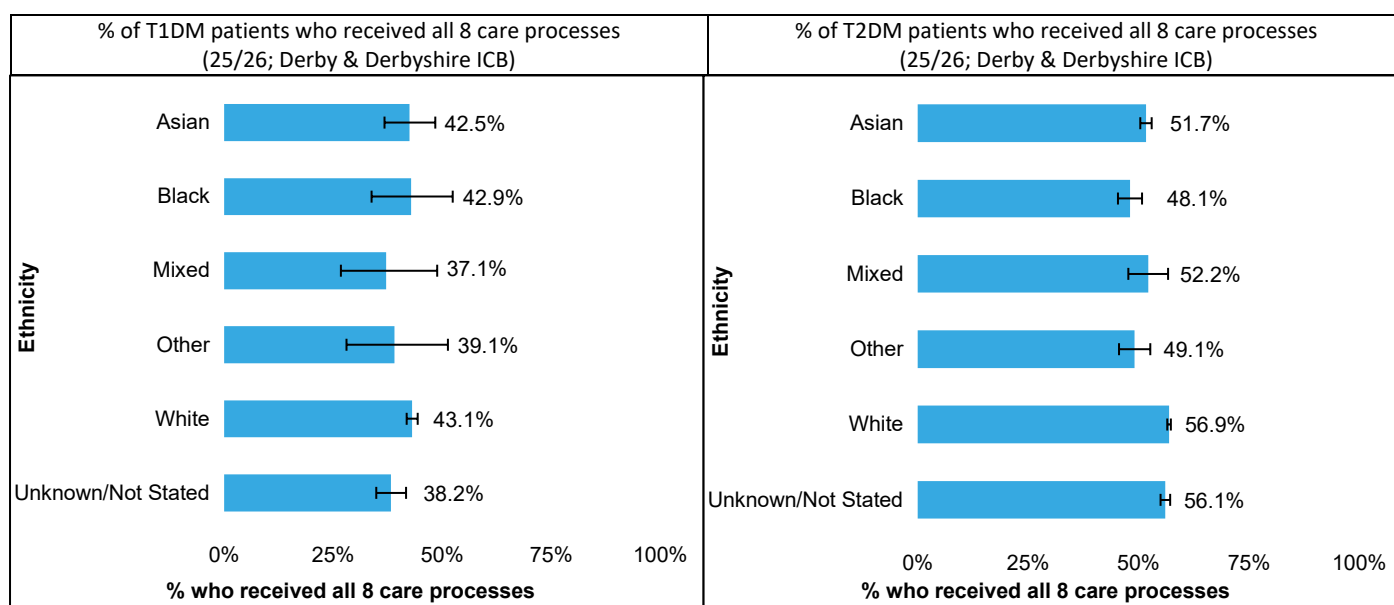
Variation between percentage of people with Type 1 and Type 2 Diabetes receiving all 8 care processes



Source: NECS



Source: NECS

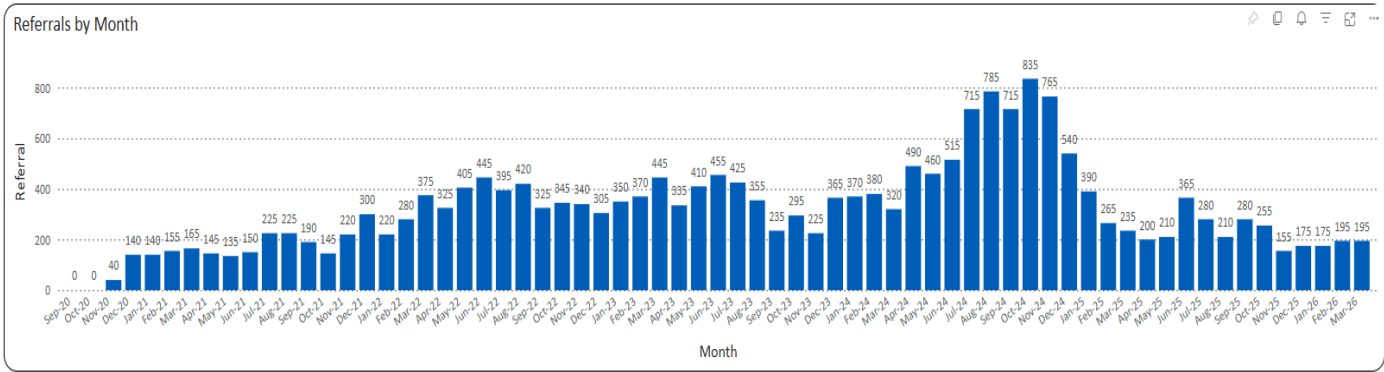


Source: NECS

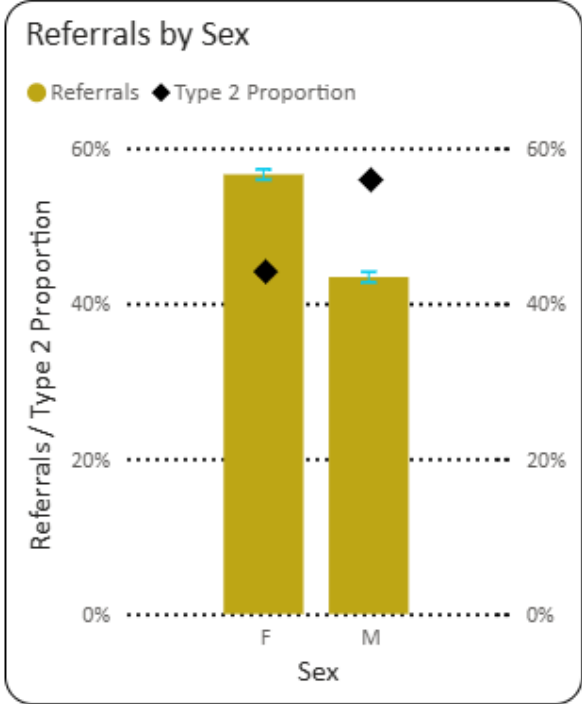
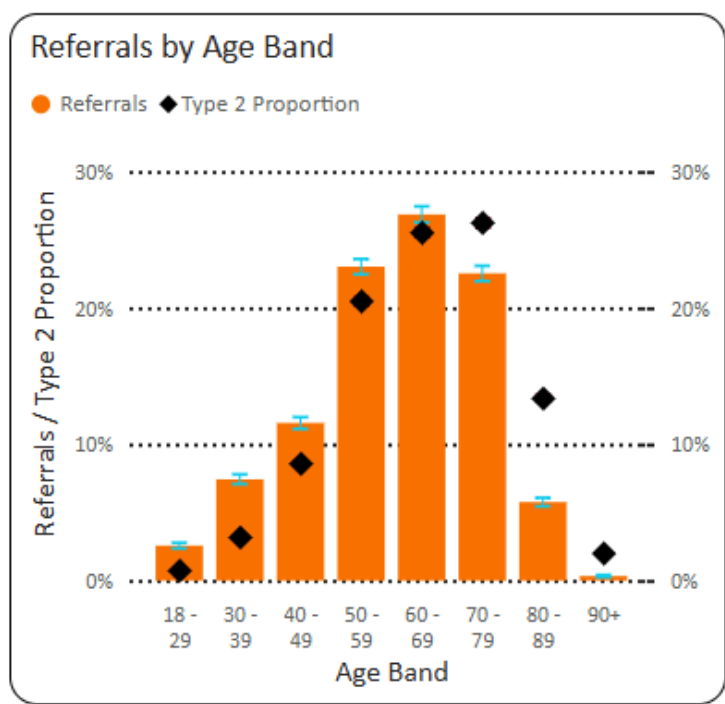
Observations: Achievement of all eight care processes shows substantial variation by age, with consistently higher completion among adults (18+) compared with children and young people (0–17) for both Type 1 and Type 2 diabetes. Adult performance is highest for Type 2 diabetes, reaching the mid-50% range, while children and young people show markedly lower completion, particularly for Type 2 diabetes where achievement is around 10%, highlighting a significant inequality in care process delivery between adults and younger patients. By ethnicity, Type 2 diabetes consistently achieves higher completion rates than Type 1 across all groups, with White and Unknown ethnic groups at the higher end and Black or Black British and Other ethnic groups slightly lower; for Type 1 diabetes, overall completion is lower and variation between ethnic groups is more modest, with interpretation limited by population size and data completeness. Across deprivation deciles, achievement varies but shows no clear or consistent social gradient for either diabetes type, with Type 2 rates generally higher and Type 1 lower across most deciles and the NULL category showing relatively high Type 2 completion, likely reflecting data quality or allocation effects. Overall, the findings indicate that age-related inequalities are most pronounced, with more moderate variation by ethnicity and deprivation and no strong deprivation-driven pattern evident.

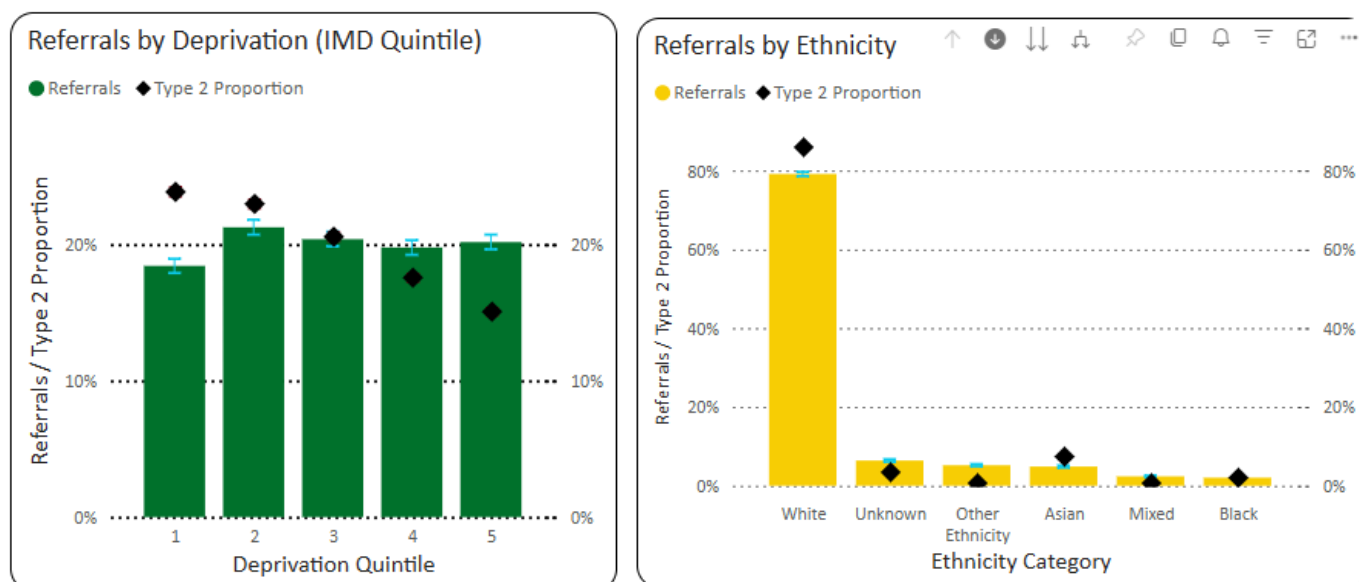
Caveat: These figures represent the proportion of patients recorded as receiving all 8 care processes, and may be influenced by data completeness, recording practices, and cohort size, particularly in smaller subgroups or where “Unknown/NULL” categories are present.

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



Observations: Monthly referral volumes show a gradual increase from 2021 through to late 2024, peaking at around 800+ referrals in autumn 2024, followed by a sharp decline into early 2025 and a more stable, lower level throughout 2025–early 2026 (generally around 150–300 per month). The trend suggests a period of rising demand and/or improved recording before a subsequent reduction, which may reflect changes in service pathways, data flows, or demand. Overall, the pattern indicates significant temporal variation, with a notable peak followed by a sustained period of lower activity.





Source: NHS Diabetes Prevention Programme (NDPP) Dashboard

Observations: Approximately 43% of the people in Derby & Derbyshire who have been diagnosed with T2DM are females. However, in 25/26, females account for about 58% of referrals to the NDPP. Approximately 57% of the people in Derby & Derbyshire who have been diagnosed with T2DM are males. However, in 25/26, males account for about 42% of referrals to the NDPP.

There is variation in referrals between the different age groups. For example, 21% of the Derby & Derbyshire population who have been diagnosed with T2DM are between 50-59 years of age. 50-59-year-olds account for 24% of referrals to the NDPP – roughly what we would expect. Whereas 14% of the Derby & Derbyshire population who have been diagnosed with T2DM are between 80-89 years of age. However, 80-89-year-olds account for 6% of referrals to the NDPP. This suggests there is an inequity in referrals to the NDPP by age groups. Proportionately, there are more people in the 30-39, 40-49, 50-59, and 60-69 age groups being referred to the NDPP than those in the 18-29, 80-89, and 90+ age groups.

There is variation in referrals between the different deprivation quintiles. For example, 25% of the people in Derby & Derbyshire who have been diagnosed with T2DM live in the most deprived quintile. However, those living in the most deprived quintile account for about 18% of referrals to the NDPP. Whereas about 15% of Derby & Derbyshire who have been diagnosed with T2DM live in the least deprived quintile. However, those living in the least deprived quintile account for 20% of referrals to the NDPP. This suggests there is an inequity in referrals to the NDPP by deprivation quintile.

Caveat: These figures represent referral proportions rather than population-adjusted rates, and therefore largely reflect underlying population structure and service demand. Differences between demographic groups should be interpreted alongside population profiles and potential variation in data completeness (e.g. Unknown categories).

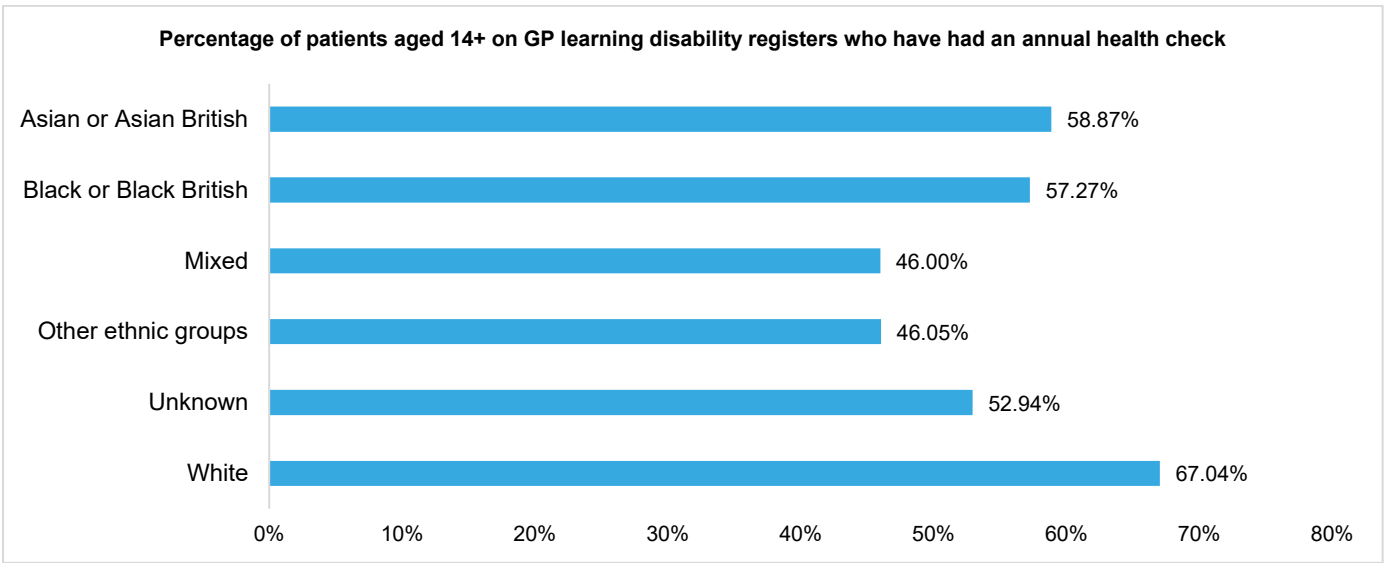
Learning Disabilities and Autism

Number of people in a mental health inpatient setting who have a learning disability or are autistic

Based on the Learning Disability: Assuring Transformation Dataset, there were 48 mental health inpatients in Derby & Derbyshire ICB and had a learning disability and/or autism at the end of March 2026. This equates to a crude rate of 44 per million of the adult population, which is slightly higher than the England average of 43 per million. 31% of this group had learning disabilities only, 55% 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.

Source: [Statistics on people with a learning disability and autistic people in mental health hospitals, AT: April 2026, MHSDS: March 2026](#)

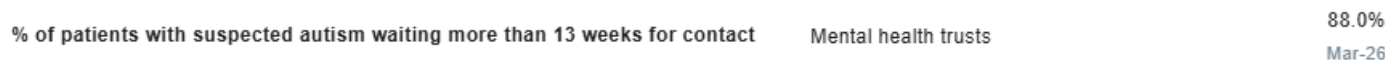
Percentage of patients aged 14+ on GP learning disability registers who have had an annual health check



Source: NECS

Observations: Annual health check completion rates vary by ethnicity. Asian or Asian British patients show the highest recorded proportion, followed closely by Mixed and White groups. 'Other ethnic groups' and 'Unknown' categories show notably lower rates, which may reflect data recording gaps or genuine access differentials. This variation warrants monitoring to ensure equitable delivery across all communities.

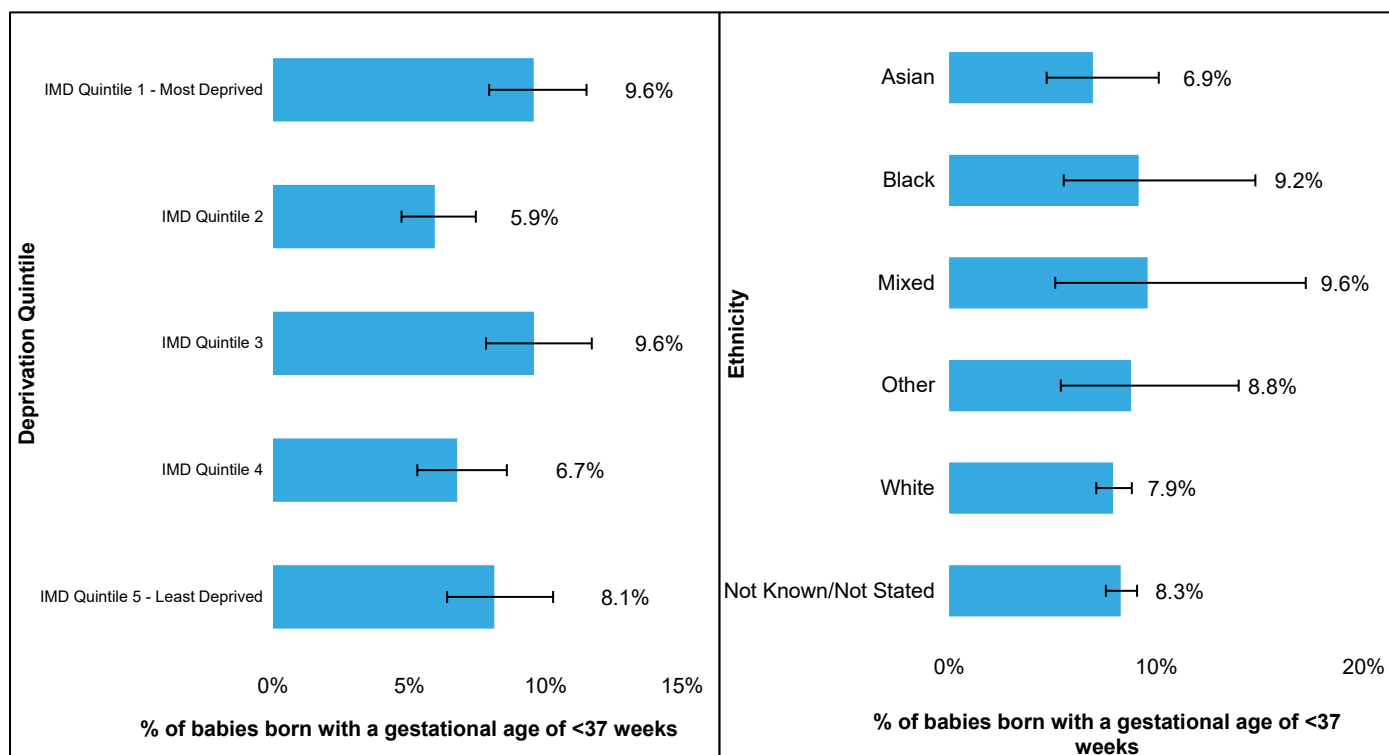
Percentage of people with suspected autism waiting more than 13 weeks for contact



Source: Performance Overview Dashboard

Maternity and Neonatal

Pre-term births under 37 weeks



Source: MAT MSDS dataset

Observations:

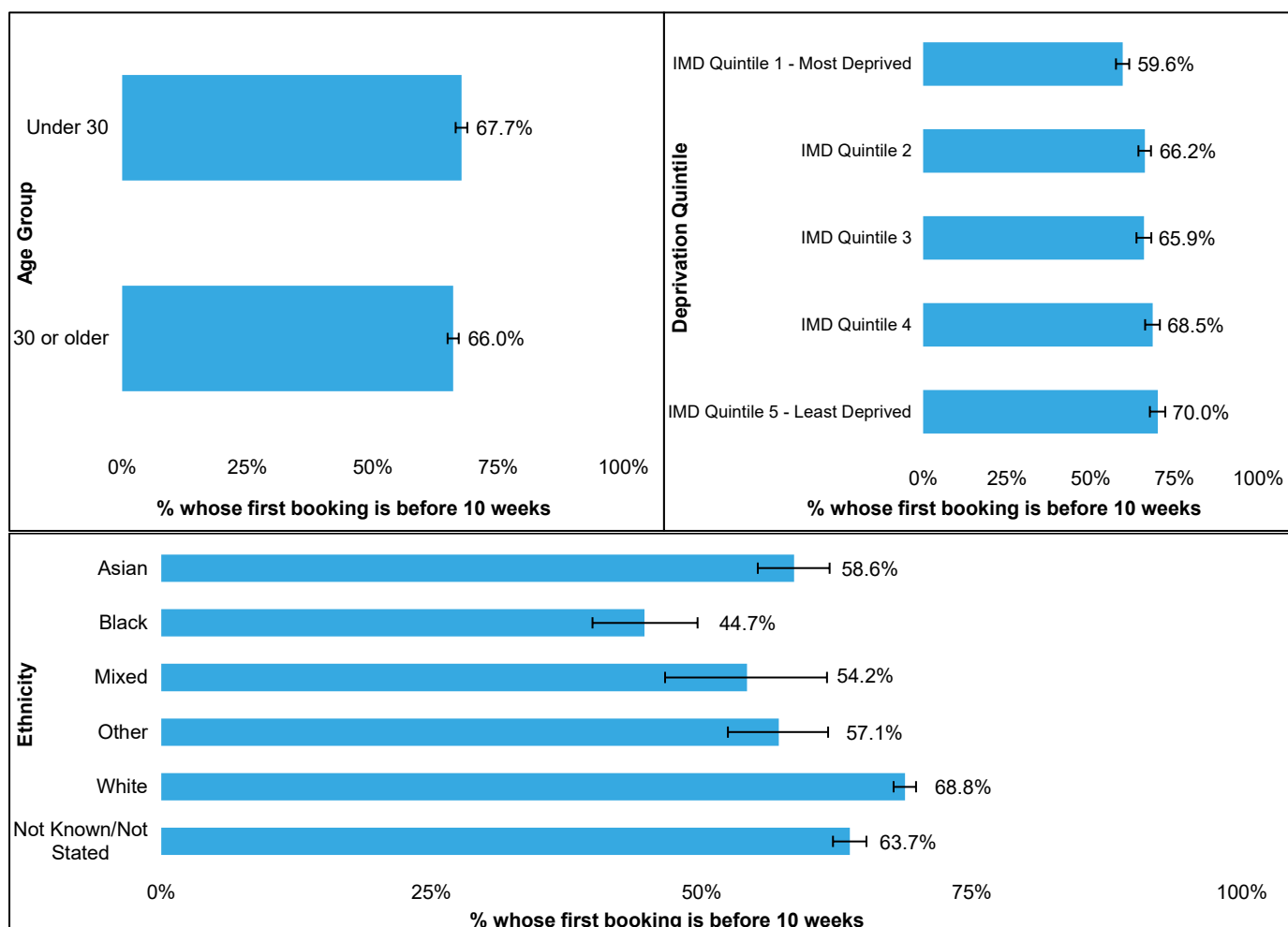
The charts show the percentage of live births recorded as pre-term, defined as babies born before 37 weeks' gestation, by deprivation quintile and by ethnicity.

There is no clear socioeconomic gradient. The highest recorded rates are seen in the most deprived quintile, and IMD Quintile 3, while the lowest rate is in IMD Quintile 2 at 5.9%. The least deprived quintile records a rate of 8.1%.

The highest recorded rates are among babies recorded as being from Mixed ethnic groups at 9.6%, followed by Black ethnic groups at 9.2% and Other ethnic groups at 8.8%. The recorded rate for White ethnic groups is 7.9%, while Asian ethnic groups have the lowest recorded rate at 6.9%. The Not Known / Not Stated category is also relatively high at 8.3%, which is important given the level of missing ethnicity information.

Overall, the charts suggest some variation in pre-term birth rates both deprivation and ethnicity. However, the differences should be interpreted carefully due to the high count of records where a deprivation quintile, or ethnicity, is not available. Approximately half of live births are missing a recorded ethnicity or deprivation decile, meaning the analysed population may not be representative of all births.

Gestational age at booking



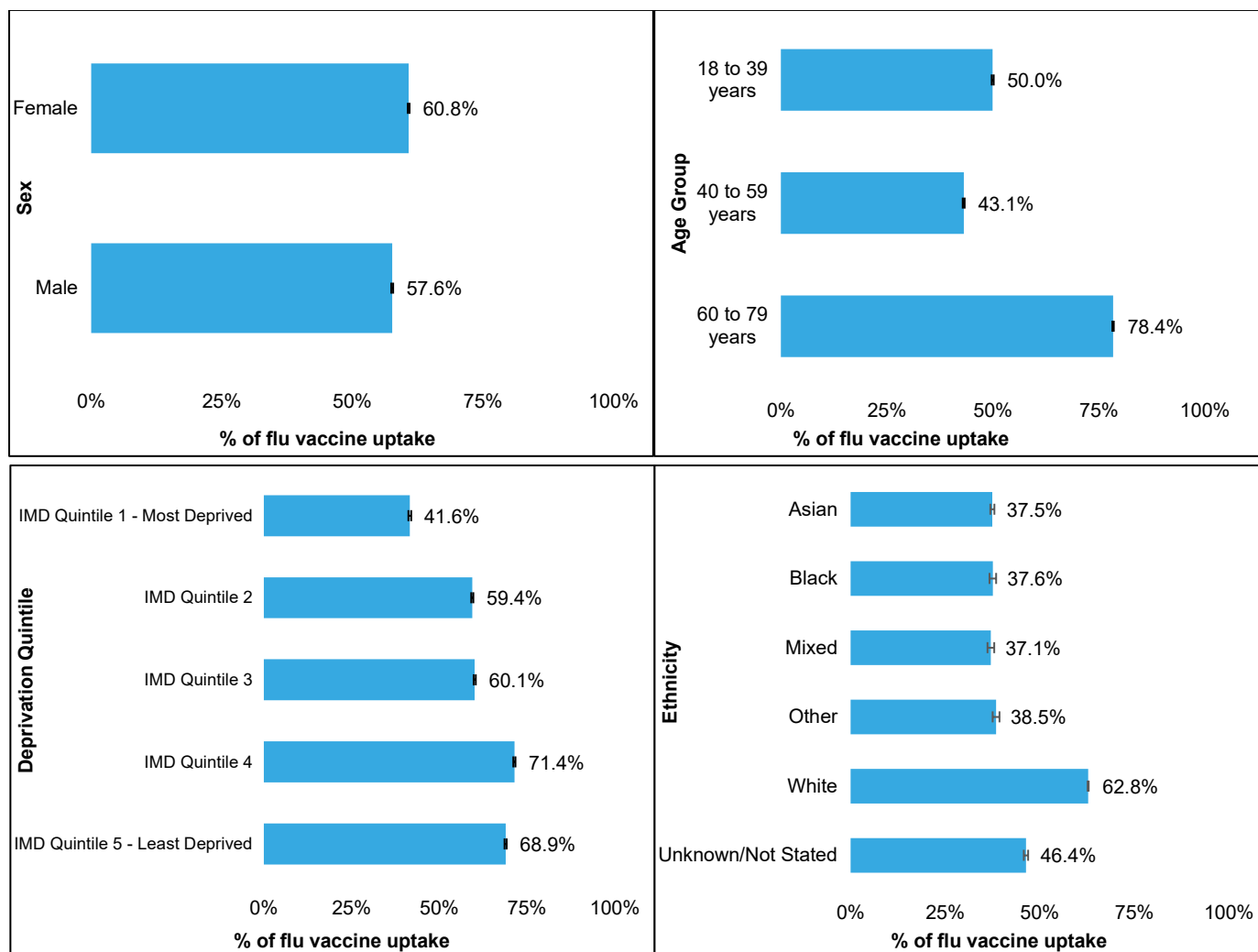
Source: MAT MSDS dataset

Observations: Across ethnicity, age and deprivation, approximately two-thirds of women are booked at or before 10 weeks, but there are clear inequalities in later booking and missing data. Early booking is most common among the White ethnic group, while mothers from an Asian, Black, Mixed and Other ethnic groups show significantly lower proportions of having their first booking at 10 weeks or earlier. Readers should not the high count of records where ethnicity or deprivation decile/quintile is not recorded, suggesting potential barriers to timely access and data completeness issues.

When stratifying the data by age (women under 30 vs. woman 30 or older), there is no significant difference in the proportion of women whose first booking appointment is 10 weeks or earlier. By deprivation, earlier booking is least common in more deprived deciles, with increasing proportions of later booking and a large “Not known” category, particularly in deprived groups, indicating a persistent social gradient and highlighting both access inequalities and limitations in data quality.

Vaccinations

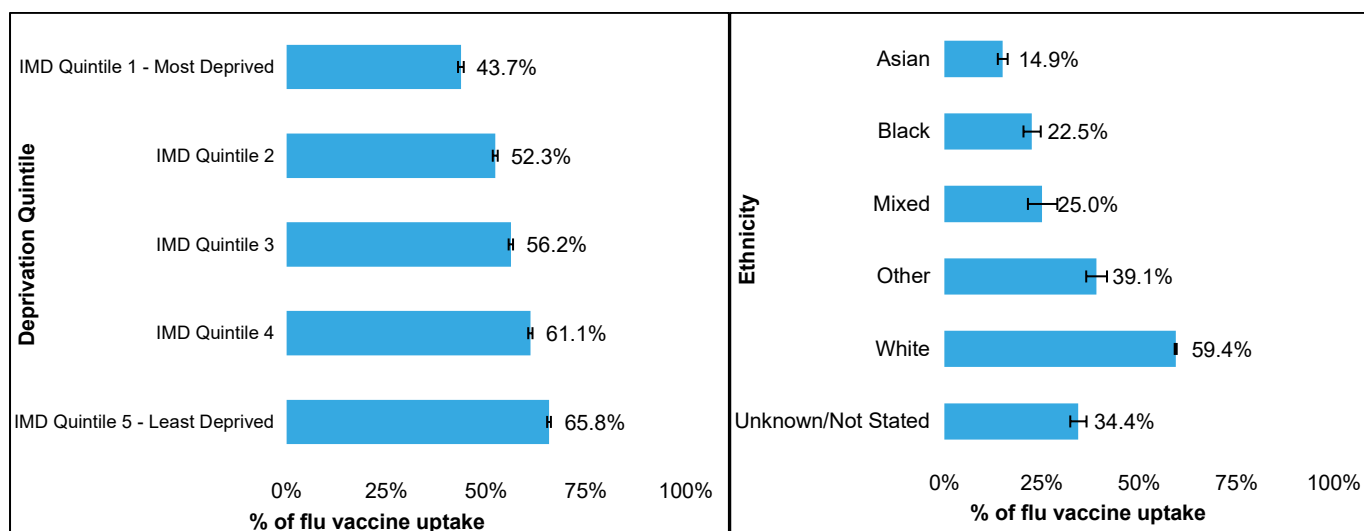
Uptake of flu vaccinations by age and demographic



Source: FDP

Observations: Flu vaccination uptake shows clear and consistent inequalities across population groups. Uptake is highest among the White ethnic group (around 60%), while all other named ethnic groups record substantially lower coverage (around 40% or below), with Asian or Asian British patients showing the lowest uptake, indicating a significant and potentially modifiable ethnic inequality in vaccination coverage. There is also a strong deprivation gradient, with uptake lowest in the most deprived quintile (around 42%) and rising steadily to around 67–70% in the least deprived quintiles, reinforcing well established socioeconomic inequalities in preventive care. By age, uptake is markedly higher in the 65+ population (around 78%), compared with 50% in children and young people and just over 40% in working age adults (18–64), suggesting that eligibility criteria and targeted programmes are effective for older people but that engagement among working age adults remains a key gap. By gender, females have slightly higher uptake than males, while the Unknown category shows substantially lower coverage, highlighting the potential influence of data completeness and engagement differences. Overall, the patterns indicate that flu vaccination uptake is lowest among younger adults, more deprived populations and most non-White ethnic groups, underlining the need for targeted, equity focused interventions.

Uptake of covid vaccinations by age and demographic



Source: FDP

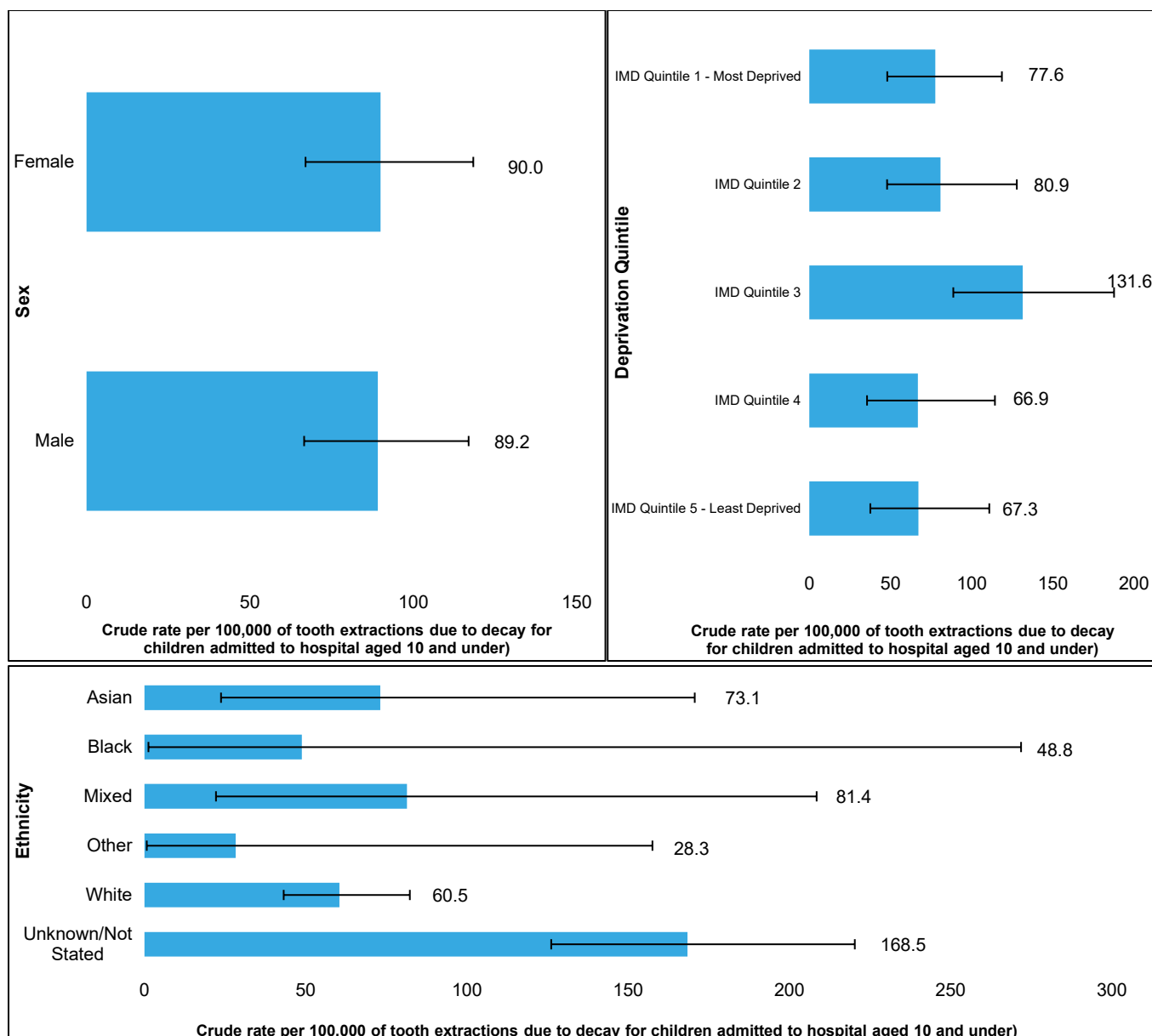
Observations: COVID vaccination uptake shows marked ethnic disparities. The White group records the highest uptake at around 58%, while Asian or Asian British and Black or Black British groups show substantially lower rates of approximately 15–20%. These gaps are significant and may reflect hesitancy, access barriers, or differential targeting and should be a priority focus for vaccination equity programmes. There is a strong deprivation gradient in COVID vaccine uptake, with the most deprived quintile achieving approximately 43.7% uptake compared to 65.8% in the least deprived quintile. This pattern mirrors flu vaccination inequalities and reinforces the challenge of reaching the most deprived populations through routine vaccination channels.

Caveat: Figures for Covid has restricted on those who are eligible, adults aged 75 years and over, residents in care homes for older adults or individuals aged 6 months and over who are immunosuppressed. This data is from the Spring 2025 COVID vaccination season.

CORE20PLUS5 – CYP

Oral Health

Tooth extractions due to decay for children admitted to hospital aged 10 and under (number of admissions)



Source: SUS Inpatient Dataset

Observations: Due to the relatively low count of tooth extractions due to decay for children admitted to hospital aged 10 and under, there is very little we can infer from the crude rates of tooth extractions from a health inequality perspective. Note that this indicator has a very tightly defined diagnostic criteria, which likely explains the low count.

Diabetes – CYP

Inequalities in percentage of CYP with type 1 and 2 diabetes receiving all the recommended NICE care processes

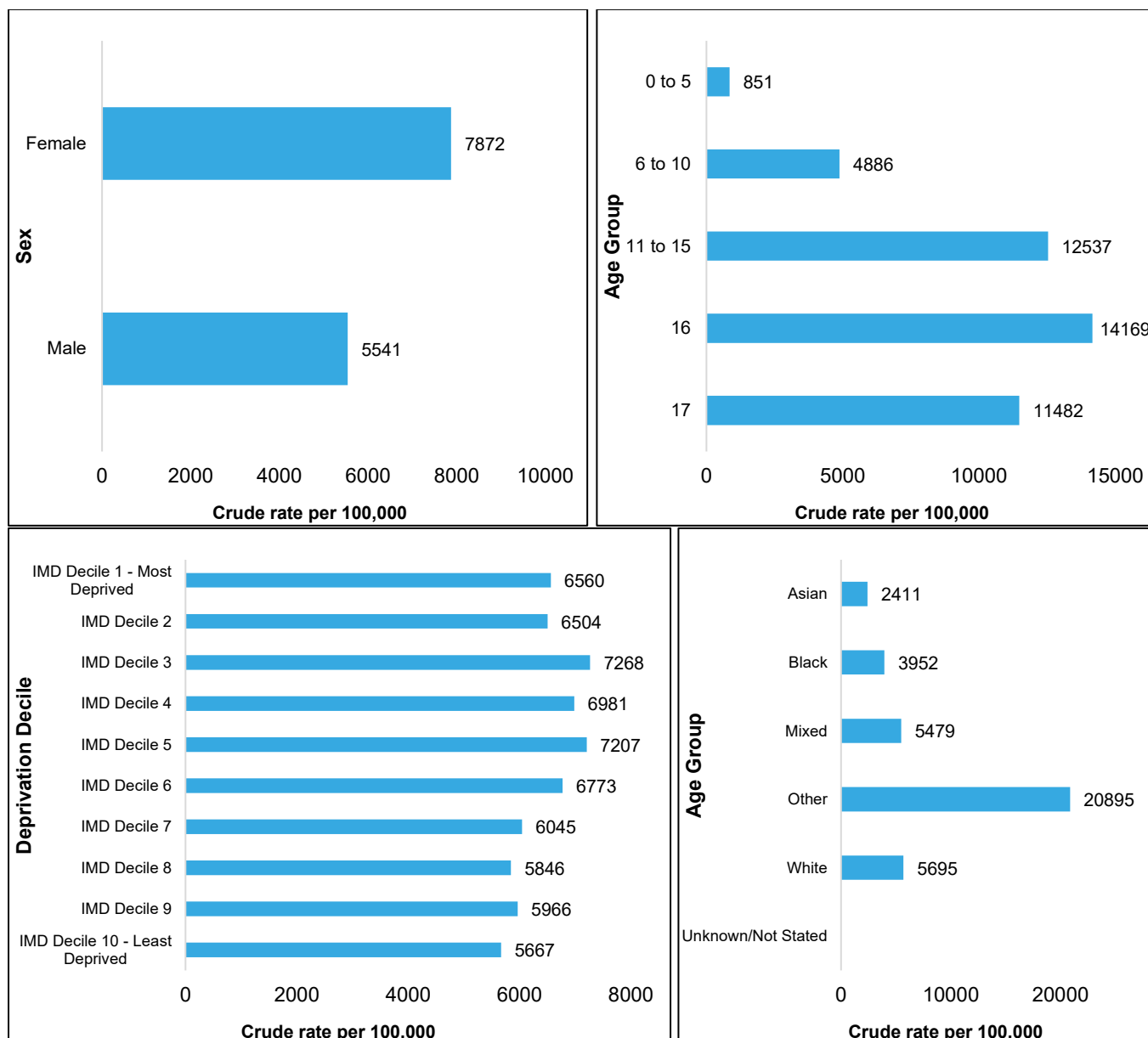
Ethnicity		Deprivation		Age group	
White	88.5% (CYP= 458)	Least deprived	89% (CYP= 200)	<12 years	91.7% (CYP= 189)
	81.6% (CYP= 21689)		81.2% (CYP= 10260)		87.9% (CYP= 10425)
Ethnic minority	91.7% (CYP= 65)	Most deprived	87.7% (CYP= 203)	>=12 years	88.2% (CYP= 335)
	83.8% (CYP= 5135)		82.5% (CYP= 12217)		80.2% (CYP= 17528)

Source: NECS

Observations: Based on quarter 3 data from the Royal College of Paediatrics and Child Health diabetes audit (April 2025 to December 2025), 82.0% of children with type 1 diabetes who received all key health checks. There are small variations between health inequality groups. Compared to Q3 last year, there has been a slight decrease in children with type 1 diabetes receiving all key health checks (89.4% in Q3 24/25).

Mental Health – CYP

Children and Young People's (CYP) Mental Health Access



Source: [Mental Health Bulletin, 2024-25 Annual report](#)

Observations: Between April 2024 and March 2025, there were 6,821 CYP mental health pathways opened per 100,000 where at least one contact with an NHS funded mental health service was made in Derby & Derbyshire. This was slightly lower than the England rate of 6895 per 100,000. The Derby & Derbyshire rate increased from 6,689 CYP mental health pathways opened per 100,000, which was slightly higher than the England average of 6568 per 100,000.

Females had a higher rate of accessing CYP mental health services compared to males. There was a slight increase of the gap between females and males who had at least one contact with an NHS funded mental health service between 23/24 and 24/25; the gap in 23/24 was 2,012 per 100,000 (4,497 per 100,000 for males vs. 6,509 per 100,000 for females), and the gap in 24/25 was 2,331 per 100,000 (5,541 per 100,000 for males vs. 7,872 per 100,000).

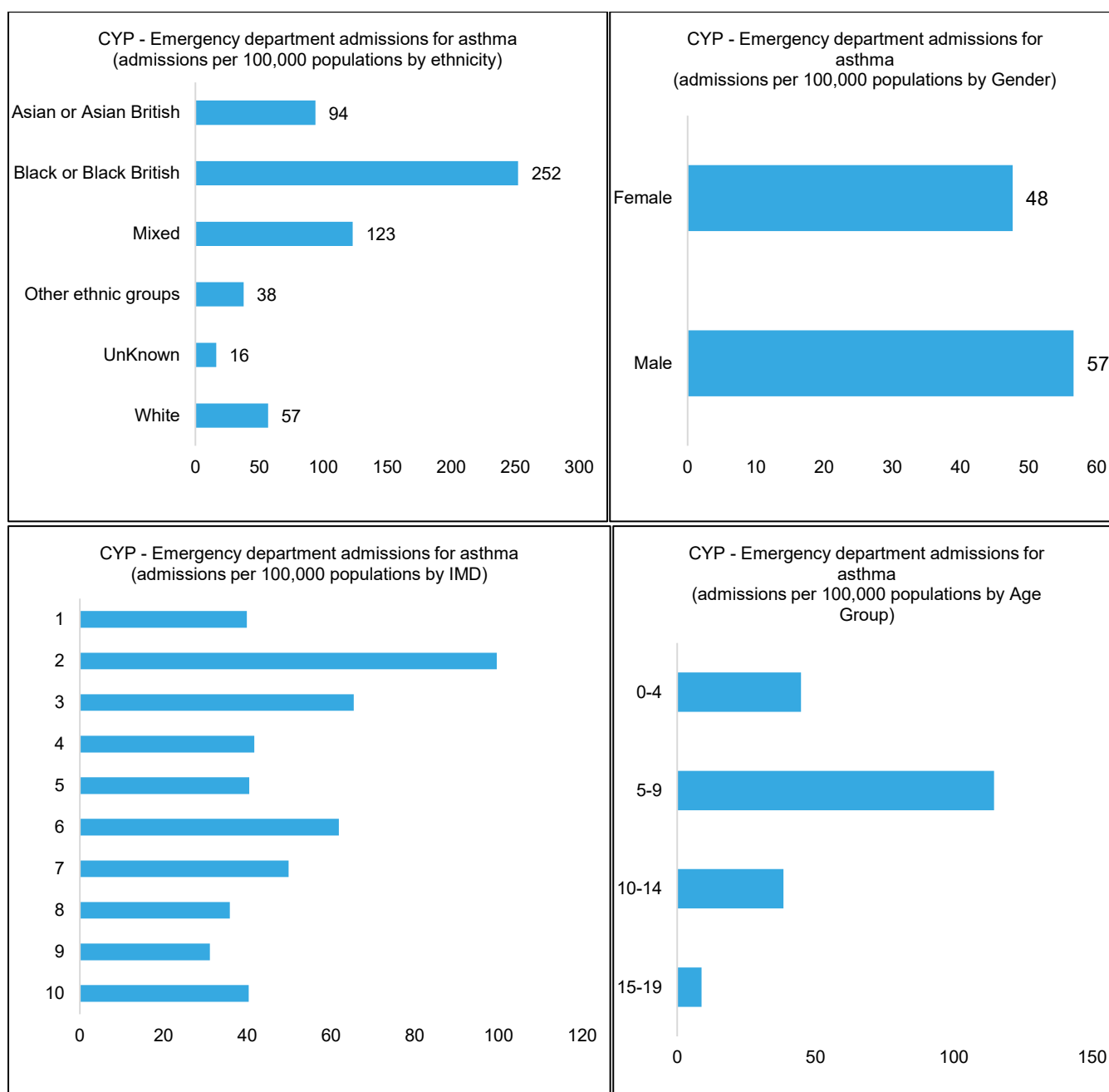
The lowest rates are consistently seen among children aged 0 to 5 years. There has been a notable increase in children aged 17 years, where the Derby & Derbyshire rate increased from 10,043 per 100,000 to 11,482 per 100,000.

The rate of children and young people accessing at least one mental health service increased in some deprivation deciles (IMD deciles 1, 2, 4, 5, 7, 8, and 9), but it decreased in other deprivation deciles (IMD Deciles 3, 6, and 10) between 2022/23 and 2024/25, indicating a general upward trend in service access. The highest rates continue to be seen among those living in the middle-deprived areas. The gap between children living in the most and least deprived decile between 23/24 and 24/25 reversed; in 23/24, children living in the least deprived decile had a higher crude rate (6,851) compared to children living in the most deprived decile (5,692). In 24/25, children living in the least deprived decile had a lower crude rate (5,667) compared to children living in the most deprived decile (6,560).

Caveat: Rates are based on counts of access events rather than distinct CYP, so individuals with multiple contacts may be represented more than once. Additionally, missing data (e.g. Unknown ethnicity or NULL IMD) may affect the apparent distribution across groups.

Respiratory – CYP

Inequalities in emergency department admissions for asthma (CYP)



Source: SUS Inpatient dataset

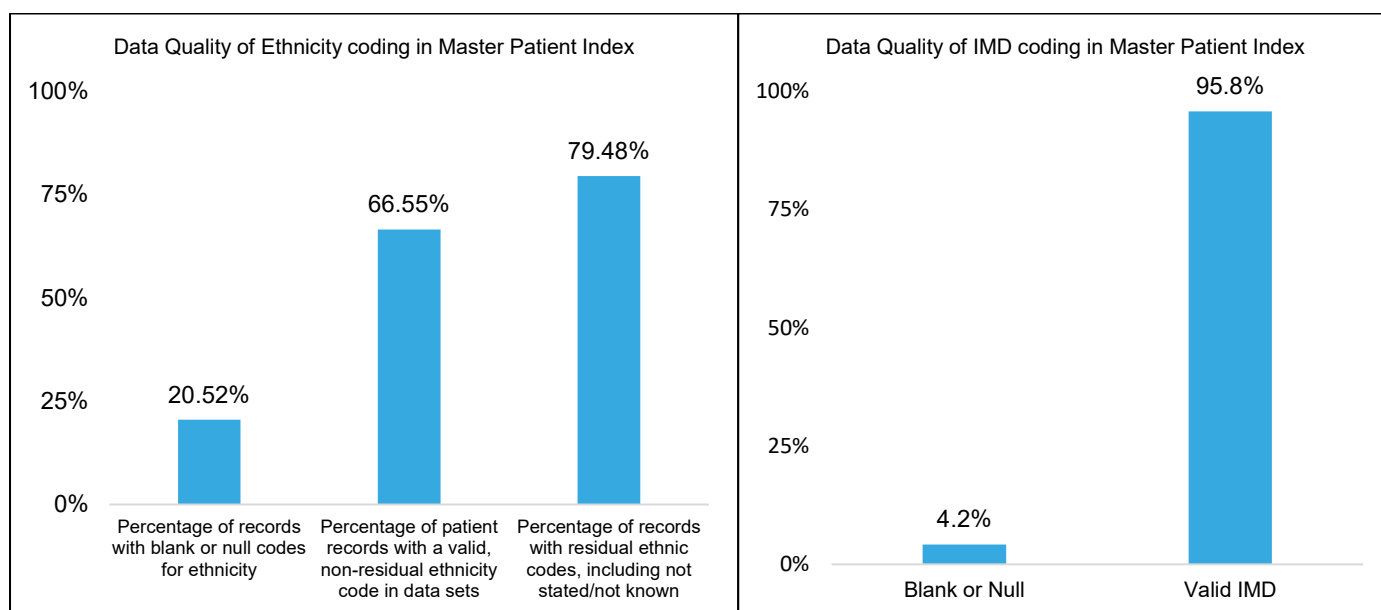
Observations: Asthma emergency admissions among children and young people are highly unequal, with particularly strong disparities by ethnicity, deprivation, age, and (to a lesser extent) gender. Black or Black British children, children living in deprived areas, and children aged 5–9 experience the greatest burden of avoidable emergency care.

Inequalities in dispensing of reliever only inhalers

Data is not currently available at the level required to assess inequalities in reliever-only inhaler prescribing across population groups. This limits the ability to identify and address variation. Work is underway to improve data linkage and reporting capability.

Data Quality

Percentage of patients with a valid, non-residual ethnicity code in data sets



Observation: The data quality for key demographic variables shows a mixed picture, with stronger completeness for deprivation (IMD) than for ethnicity. Ethnicity data presents notable issues: over one fifth of records (20.52%) are missing or null, and while around two thirds (66.55%) contain a valid, non-residual ethnicity code, a substantial proportion of records still fall into residual categories such as “not stated” or “not known” (79.48%). This indicates that although some usable ethnicity data is available, its overall reliability for detailed analysis—particularly for health inequalities—is limited due to high levels of non-specific or missing coding. In contrast, IMD data is of high quality, with only 4.2% of records missing and 95.8% containing a valid deprivation code, supporting more robust and reliable socioeconomic analysis. Overall, while deprivation analyses can be undertaken with confidence, caution should be applied when interpreting ethnicity-based findings due to data completeness and coding limitations.

Case Studies

Derby and Derbyshire ICB



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APPT Health - Cancer

What was the health inequalities issue?

Low uptake of national cervical screening in more deprived communities, leading to unequal access, later diagnosis, and poorer outcomes.

What actions were taken?

- PCNs enrolled in an outreach programme delivered by APPT Health to increase cervical screening uptake.
- APPT Health proactively contacted all individuals who had not responded to screening invitations, offering tailored support and flexible options to book appointments at convenient times.
- Targeted follow-up focused on more deprived communities to reduce barriers to access and improve engagement.
- The initiative was supported by the East Midlands Cancer Alliance, providing strategic oversight and co-ordination.

What was the outcome?

- Early indications of improved data sharing and co-ordination across partners.
- Strengthened relationships between PCNs, outreach providers, and system partners.
- Identification of barriers to uptake, informing ongoing service improvement.



SMI Health Positive Pilot

What was the health inequalities issue?

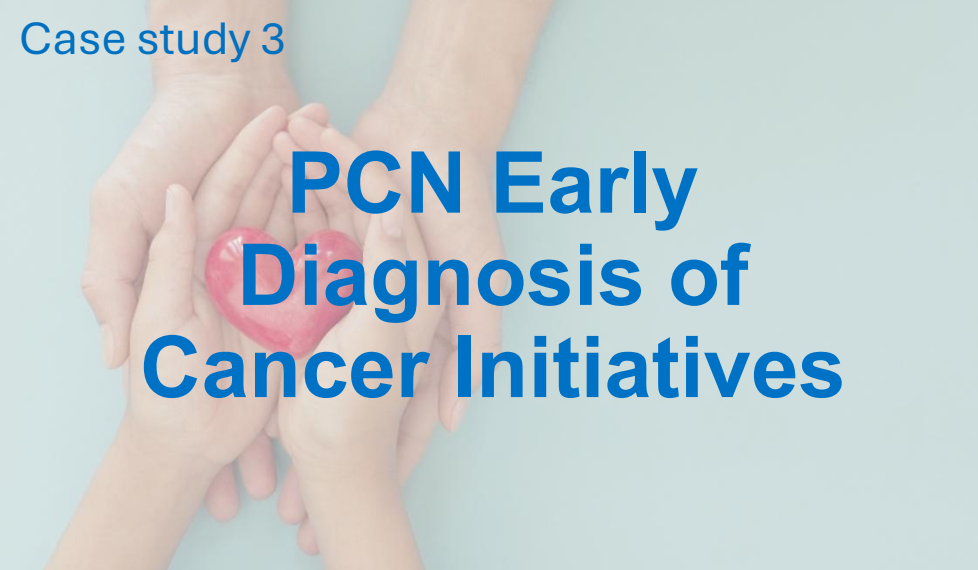
- Increase uptake of vaccinations and annual physical health checks among people with severe mental illness.
- Reduce premature mortality from treatable physical conditions.

What actions were taken?

- Established a team of trained and experienced mental health HCAs to proactively reach people with Severe Mental Illness who had not engaged with GP-led annual physical health checks.
- Delivered flexible, person-centred appointments, including longer time slots, multiple contact attempts, and a choice of location such as home visits.
- Provided trauma-informed, compassionate, and holistic care through staff with expertise in mental health conditions, medication impacts, and the challenges of living with Severe Mental Illness.

What was the outcome?

- Delivered 479 annual physical health checks and 144 vaccinations, with over half of participants accessing a health check for the first time and practices reporting improved uptake among people with SMI.
- Identified 356 previously undiagnosed physical health conditions and facilitated onward referrals and support.
- Improved health confidence and engagement within this cohort.
- Strengthened working relationships between primary and secondary care.



PCN Early Diagnosis of Cancer Initiatives

What was the health inequalities issue?

Inequalities in cancer outcomes driven by low awareness of symptoms, delayed diagnosis, and lower uptake of screening programmes, particularly among more deprived communities.

What actions were taken?

- Developed and implemented a range of PCN led projects to improve early cancer diagnosis and screening uptake.
- Targeted individuals who have never attended cervical screening, with proactive outreach to increase participation.
- Focused efforts to increase uptake of all cancer screening programmes in areas of high deprivation.
- Delivered tailored interventions to improve early diagnosis and screening uptake among people with drug and alcohol dependence and those with learning disabilities.
- Implemented targeted colorectal cancer initiatives in a deprived PCN with above average prevalence, focusing on screening and early diagnosis.
- Introduced proactive case finding for pancreatic cancer in patients with newly diagnosed diabetes.
- Prioritised actions to reduce late-stage cancer diagnoses through earlier identification and intervention

What was the outcome?

- Improved identification of individuals at higher cancer risk (e.g. family history, new onset diabetes), enabling earlier intervention.
- Increased engagement from more deprived populations.
- Improved awareness of cancer symptoms and screening opportunities within targeted communities.
- Strengthened cross-system working within PCNs and between services to support early diagnosis.

Maternity Equity and Equality Action Plan



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What was the health inequalities issue?

Inequalities in maternal and neonatal outcomes, with women from Black, Asian and Mixed ethnic backgrounds and those living in more deprived areas experiencing higher rates of maternal mortality, stillbirth and neonatal death.

What actions were taken?

- Developed and implemented a structured action plan based on two overarching aims and five strategic priorities.
- Applied core principles of proportionate universalism, collaboration, and co-production to guide service design and delivery.
- Embedded equity and equality into the design, delivery, and evaluation of maternity and neonatal services.
- Introduced approaches to ensure care is safe, personalised, and equitable for all population groups.
- Promoted a more inclusive and representative NHS workforce to better reflect and meet the needs of diverse communities.

What was the outcome?

- Longer-term data shows an overall improvement in health inequalities in maternity and neonatal outcomes.
- A reduction in stillbirth and neonatal mortality rates has been observed, with a sustained downward trend following implementation of the action plan (Jan 2023–Dec 2024).
- Early evidence suggests a narrowing of disparities for babies from Black, Asian and more deprived backgrounds, where outcomes were previously worse than national averages.
- Continued community engagement, particularly with ethnic minority groups, has strengthened targeted outreach and improved experiences of maternity and neonatal care



GPPB 0–5-year-old project

What was the health inequalities issue?

Low uptake of childhood immunisations within more deprived groups, leading to unequal protection against preventable diseases and increased risk of poorer health outcomes.

What actions were taken?

- General Practice Provider Board (GPPB) worked with the ICB to identify 34 GP practices in the most deprived areas where childhood vaccination uptake (0–5 years) was below 95%.
- Required practices to develop and implement tailored action plans using innovation and best practice to improve uptake.
- Delivered targeted communications, including materials in multiple languages and culturally appropriate “myth-busting” messaging.
- Undertook proactive outreach to families of children with overdue vaccinations, using child-friendly engagement approaches to improve participation.
- Increased access through additional clinics delivered in community settings and outside standard working hours

What was the outcome?

- Improved uptake of childhood immunisation appointments, particularly among children previously overdue.
- Greater awareness and understanding of vaccinations through targeted, culturally appropriate communication.
- Stronger relationships between GP practices and local communities, supporting ongoing engagement.
- Final evaluation is scheduled to commence in June 2026.



What was the health inequalities issue?

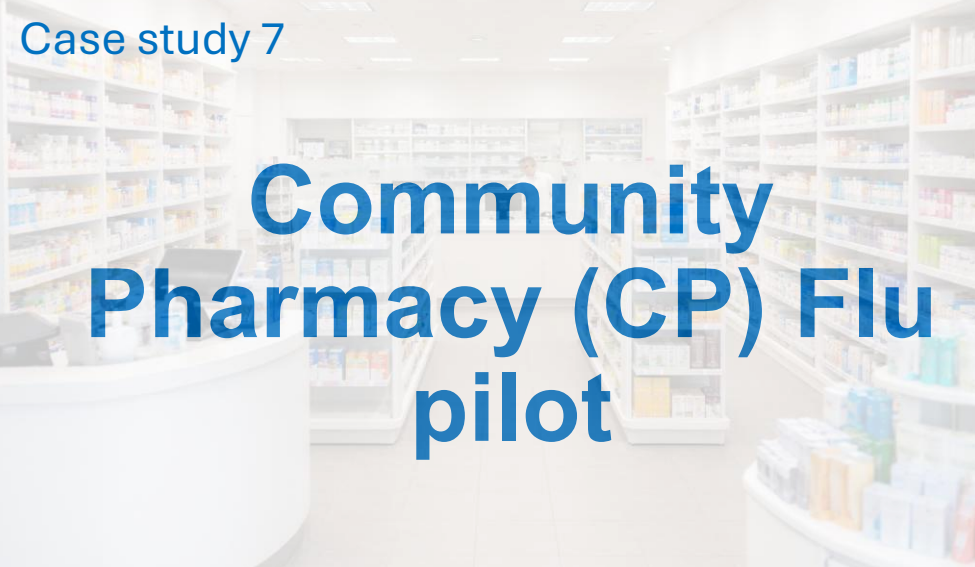
Aims to increase successful vaccine bookings, reduce missed GP appointments, improve access for digitally excluded residents, and generate insight into local barriers affecting vaccine uptake.

What actions were taken?

- Established a personal booking service in Gamesley, enabling residents to access drop-in or telephone support from a Digital Health Administrator.
- Provided one-to-one assistance to help individuals book vaccination appointments and understand appointment details using clear, plain language.
- Arranged free, coordinated transport to and from vaccination appointments to reduce access barriers.
- Promoted the service through a targeted communications campaign, including local leaflet distribution, GP practice engagement, and social media.
- Worked collaboratively with local GP practices to support outreach and improve access to vaccination services.

What was the outcome?

- Improved understanding of vaccination processes through one-to-one, plain language support.
- Strengthened relationships between local communities, GP practices, and support services.
- Increased awareness of available vaccination services through local, targeted communications.
- Final evaluation is scheduled to commence in July 2026.



Community Pharmacy (CP) Flu pilot

What was the health inequalities issue?

Lower uptake of flu vaccination among young children (aged 2–3 years), particularly in most deprived areas, leading to increased vulnerability to influenza and greater risk of serious illness or complications.

What actions were taken?

- NHSE commissioned selected community pharmacies to deliver a one-season pilot programme offering flu vaccinations to children aged 2–3 years, beginning 1 October 2025, to increase access and uptake.

What was the outcome?

- Achieved above average regional average uptake of flu vaccination in 2–3 year olds (49.0% in Derbyshire vs 41.5% regionally).
- Ranked 2nd out of 11 systems in the Midlands for vaccination uptake, demonstrating strong system performance.
- Delivered high levels of workforce engagement, with the second highest number of both GP practices and community pharmacies providing vaccinations.
- Established a broad delivery network, with 77 community pharmacy sites signed up and 75% actively delivering vaccinations.
- Achieved a mid-range position for the number of unvaccinated children, indicating progress while highlighting remaining opportunities for improvement.
- Demonstrated effective mobilisation of community pharmacy provision, contributing to increased access to vaccination services.

Reducing Inequalities in Childhood Immunisations



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What was the health inequalities issue?

Inequalities in childhood immunisation uptake and data quality across practices, with some populations experiencing lower coverage and incomplete records, leading to gaps in protection and wider disparities in health outcomes.

What actions were taken?

- Conducted practice level reviews of CHIS Incomplete Immunisation Reports (IIRs) to identify key cohorts, including non-responders, newly registered children, data errors, and potential “ghost patients.”
- Provided support and tailored advice to help practices prioritise actions, streamline workflows, and reduce backlogs of outstanding immunisations.
- Delivered training, guidance, and resources to clinical and administrative staff to improve immunisation processes, coding accuracy, and effective use of CHIS data.
- Offered a support package to all practices across the footprint, including access to online resources, recommended processes, and virtual training sessions via the IIUT platform.

What was the outcome?

Demonstrated significant improvements in childhood immunisation uptake following targeted practice support.

Increased overall childhood immunisation coverage by 14% within a supported practice.

Achieved gains across key vaccination milestones, including primary vaccinations (+8.9%), 1-year boosters (+8%), and pre-school boosters (+17.5%).

Showed the effectiveness of targeted, practice level interventions in improving uptake and reducing inequalities in immunisation coverage.

Primary Care Health Inequalities Network

What was the health inequalities issue?

Lack of connectivity between professionals and local health inequalities initiatives, reducing overall system impact

What actions were taken?

- Established a health inequalities network in November 2025, hosted through Hub Plus, to facilitate the sharing of quality improvement approaches and best practice.
- Delivered bi-monthly online meetings focused on key health inequalities topics, featuring both internal and external expert speakers (e.g. learning disabilities, frailty, racial bias, and trauma-informed care).
- Enabled ongoing knowledge sharing by circulating local and national updates and examples of best practice through regular email communications.

What was the outcome?

- Strengthened connections between professionals, enabling improved collaboration and sharing of best practice across health inequalities work.
- Facilitated meaningful engagement between local communities, people with lived experience, and researchers, leading to more informed and impactful discussions.
- Improved cross-sector understanding of local needs and challenges, supporting more coordinated approaches to reducing health inequalities.
- Created opportunities for shared learning, helping to amplify and spread effective interventions more widely.

Statement on Information on Health Inequalities

Lincolnshire Integrated Care Board

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

Introduction	4
Lincolnshire Population Profile	5
Impacting on Health Inequalities	5
How do we Measure Deprivation?	6
Summary of 2025/26 Position	7
Summary of 2025/26 Position – Legend	9
Using Data to Understand Health Inequalities.....	10
Understanding Health needs	10
Understanding healthcare access, experience, and outcomes.....	11
Improving data quality	12
Using information on healthcare inequalities.....	13
Publishing information	14
Operational priorities.....	16
Elective Care.....	16
Size and shape of the waiting list; those waiting longer than 18 weeks, and 52 weeks.....	16
Inequalities in annual change in size of waiting list	19
Community.....	20
Inequalities in percentage of people waiting over 18 weeks for community services	20
Urgent and Emergency Care	22
Inequalities in mean time in emergency department	22
Urgent and Emergency care - CYP.....	26
Emergency attendances for under 18s	26
CORE20PLUS5 - Adults	27
Respiratory	27
Inequalities in non-elective bed days occupied by asthma, COPD and CAP	27
Smoking Cessation	29
Inequalities in inpatients making a supported quit attempt with an in-house tobacco dependence treatment service.....	29
Inequalities in inpatients who successfully quit smoking as measured at 28 days after commencing a supported quit attempt	29

Inequalities in percentage of pregnant women identified as smokers at antenatal booking who are identified as non-smokers at 36 weeks gestation.....	30
Mental Health	31
Overall number of severe mental illness (SMI) physical health checks	31
Rates of restrictive interventions	34
NHS Talking Therapies recovery rate.....	36
Talking Therapies Referral Rate	39
Cancer	41
Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex	41
Cardiovascular Disease (CVD)	42
Stroke - rate of non-elective admissions (per 100,000 age standardised).....	42
Myocardial infarction – rate of non-elective admissions (per 100,000 age standardised).....	44
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).....	46
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.....	49
Percentage of patients aged 18 or over with GP recorded atrial fibrillation and a record of CHA2DS2-VASc Score of 2 or more who are currently treated with anti-coagulation drug therapy	52
Diabetes	55
Variation between percentage of people with Type 1 Diabetes receiving all 8 care processes ...	55
Variation between percentage of people with Type 2 Diabetes receiving all 8 care processes ...	58
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	61
Learning Disabilities and Autism	64
Number of people in a mental health inpatient setting who have a learning disability or are autistic.....	64
Percentage of patients aged 14+ on GP learning disability registers who have had an annual health check	64
Percentage of people with suspected autism waiting more than 13 weeks for contact	66
Maternity and Neonatal.....	67
Gestational age at booking	67
Vaccinations	69
Uptake of flu vaccinations.....	69

Uptake of covid vaccinations.....	71
CORE20PLUS5 - CYP	72
Oral Health	72
Tooth extractions due to decay for children admitted to hospital aged 10 and under (number of admissions)	72
Diabetes - CYP	72
Inequalities in percentage of CYP with type 1 and 2 diabetes receiving all the recommended NICE care processes	72
Mental health – CYP	73
Children and Young People’s (CYP) Mental Health Access.....	73
Respiratory - CYP	76
Inequalities in emergency department admissions for asthma.....	76
Inequalities in dispensing of reliever only inhalers.....	78
Data Quality	80
Percentage of patient records with a valid, non-residual ethnicity code in data sets	80
Percentage of records with blank or null codes for ethnicity	81

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.

Lincolnshire 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. Analysts across ICB and ICS (including colleagues from the Arden and GEM Commissioning Support Unit) have 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 Core20Plus5. 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.

Lincolnshire Population Profile

Lincolnshire 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. In April 2026, there were 824,690 patients registered with one of the 81 GP practices in Lincolnshire ICS. 24.3% (200,442/824,690) of the GP registered population are over the age of 65. This is significantly higher than the national average.

17.3% (142,734/824,690) of the GP registered population live in a CORE20 area. There are large areas of deprivation in Lincolnshire, most notably on the east coast, and around the towns of Boston and Gainsborough. Those who live in more deprived areas are more likely to develop long term conditions at a younger age and live in poor health for longer.

Based on the 2021 Census, 89.7% of the Lincolnshire resident population are from a White British/Irish ethnic background. 6.3% are from a White Other background, which includes people who were born in European countries who have migrated to Lincolnshire. The population distribution across Lincolnshire is varied, particularly in the district of Boston where almost 20% of the population are from a White Other background.

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.

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 experience are some ways in which overall outcomes could be improved.

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.

Summary of 2025/26 Position

Domain Indicator	Compared to 24/25 (Lincs average)	Sex	Age	Deprivation	Ethnicity*
Planned Care, Cancer, Diagnostics					
Inequalities in percentage of people waiting 18 weeks or less for elective treatment	↑	↑	↓	↓	↓
Inequalities in percentage of people waiting 52 weeks or less for elective treatment	↓	↔	↓	↔	↔
Inequalities in percentage of people waiting over 18 weeks for community services	New baseline	—	—	—	—
Inequalities in percentage of cancers diagnosed at stage 1 and 2	↔	—	—	—	—
UEC/SCC/EPRR					
Inequalities in mean time in emergency department	New baseline	—	—	—	—
Inequalities in children and young people (CYP) emergency department attendances	New baseline	—	—	—	—
Inequalities in non-elective bed days occupied by asthma, COPD, and CAP	New baseline	—	—	—	—
Inequalities in emergency admissions for stroke	↓	↓	—	↑	—
Inequalities in emergency admissions for myocardial infarction	↓	↓	—	↓	—
Inequalities in CYP asthma – Emergency Department admissions	New baseline	—	—	—	—
Inequalities in CYP asthma – Dispensing of reliver inhalers	New baseline	—	—	—	—
Women/Children and Young People					
Inequalities in elective admissions of hospital-based tooth extractions due to dental caries	Low counts	—	—	—	—
Inequalities in children and young people (CYP) emergency department attendances	New baseline	—	—	—	—
Inequalities in gestational age at booking	New baseline	—	—	—	—
Inequalities in percentage of pregnant women identified as smokers at antenatal booking who are identified as non-smokers at 36 weeks gestation	New baseline	—	—	—	—
Inequalities in access rates to CYP mental health services for 0–17-year-olds	↑	↑	↓	↓	—
Inequalities in CYP asthma – Emergency Department admissions	New baseline	—	—	—	—
Inequalities in CYP asthma – Dispensing of reliver inhalers	New baseline	—	—	—	—

*Unless stated, all ethnic minority groups have been pooled together and compared to the White British/Irish population. Unknown/Not Stated ethnicity aren't included in the comparison.

No health inequalities identified (statistically tested)	No health inequalities identified (not statistically tested)	Health inequalities identified (not statistically tested)	Health inequalities identified (statistically tested)	Not stratified by this characteristic
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Domain Indicator	Compared to 24/25 (Lincs average)	Sex	Age	Deprivation	Ethnicity*
Mental Health					
Inequalities in rates of restrictive interventions in inpatient services (24/25 data)	↑	↓	↑	↑	—
Inequalities in people achieving a Reliable Recovery outcomes for NHS Talking Therapies (24/25 data)	↔	↑	↓	↑	↔
Rates of eligible patients with severe mental illness (SMI) receiving an annual physical health check and action plan	↔	↑	↑	↓	—
Number of people in a mental health inpatient setting who have a learning disability or are autistic	Low counts				
Inequalities in access rates to CYP mental health services for 0–17-year-olds	↑	↑	↓	↓	—
Primary Care/Neighbourhoods/Same Day Care					
Inequalities in inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	New baseline	—	—	—	—
Inequalities in inpatients who successfully quit smoking as measured at 28 days after commencing a supported quit attempt	New baseline	—	—	—	—
Inequalities in percentage of hypertension patients treated to target	↑	↔	↑	↓	↔
Inequalities in percentage of patients who are managed to target for cholesterol	↑	↔	↓	↑	↑
Inequalities in percentage of patients who are managed to target for atrial fibrillation	↔	↔	↔	↔	↓
Uptake of flu vaccinations	New data source/cohorts	—	—	—	—
Uptake of COVID vaccinations	New cohorts	—	—	—	—
Percentage of patients aged 14+ on GP learning disability registers who have had an annual health check	↔	↓	↓	↓	↓
Inequalities in percentage of CYP with type 1 diabetes receiving all the recommended NICE care processes	New baseline	—	—	—	—

*Unless stated, all ethnic minority groups have been pooled together and compared to the White British/Irish population. Unknown/Not Stated ethnicity aren't included in the comparison.

No health inequalities identified (statistically tested)	No health inequalities identified (not statistically tested)	Health inequalities identified (not statistically tested)	Health inequalities identified (statistically tested)	Not stratified by this characteristic
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Summary of 2025/26 Position – Legend

	Increasing and getting better compared to 24/25
	Decreasing and getting better compared to 24/25 – OR the gap between certain groups is reducing and getting better compared to 24/25
	Increasing and getting worse compared to 24/25 – OR the gap between certain groups is increasing and getting worse compared to 24/25
	Decreasing and getting worse compared to 24/25
	No change or extremely small change compared to 24/25
	Can't say if there has been an increase, decrease, or no change due to small counts or no baseline date to compare against (other indicator specific reasons may apply) compared to 24/25
	Increasing (can't say if getting better or worse) compared to 24/25
	Decreasing (can't say if getting better or worse) compared to 24/25
	A health inequality has been identified through statistical testing – the inequality is decreasing and getting better compared to the position at 24/25
	A health inequality has been identified through statistical testing – the inequality is increasing and getting worse compared to the position at 24/25
	A health inequality has been identified through statistical testing – the inequality is similar to the position at 24/25
	No health inequality has been identified through statistical testing – the inequality is decreasing and getting better compared to the position at 24/25
	No health inequality has been identified through statistical testing – the inequality is increasing and getting worse compared to the position at 24/25
	No health inequality has been identified through statistical testing – the inequality is similar to the position at 24/25

Using Data to Understand Health Inequalities

Understanding Health needs

The Lincolnshire Joined Intelligence Dataset collates data (including demographic data) from primary care, secondary care, community services, mental health services, and other health and social care services. This allows users to segment a population by various health inequality characteristics which include, where possible, PLUS groups. This facilitates deep-dive health inequality analyses detailed in this statement to understand disparities in access, outcomes, and experiences with health and social care services in Lincolnshire.

LICB, in partnership with Public Health at Lincolnshire County Council, completed an evidence-based review of all current PLUS groups across Lincolnshire and proposed additional groups to ensure access, experience and outcomes are monitored as part of the Core20Plus5 approach to addressing health inequalities.

During 2025/26, a number of health inequalities 'deep dive' projects were undertaken to strengthen understanding of the health needs and inequalities experienced by local Core20 and Plus population groups. These included:

- **Children and Young People's Mental Health Project** – Analysis using local data identified higher levels of recorded interactions within the CYP Mental Health Liaison Service (a service for children admitted to hospital with physical injuries including self-harm) among children and young people from the most deprived population groups. A set of recommendations was developed and shared with the Mental Health Provider to support further action (see case study 12).
- **SMI Physical Health Checks project** - This project focused on understanding the barriers, challenges and underlying reasons preventing people with alcohol and/or substance use issues and people experiencing homelessness from accessing SMI physical health checks. The project successfully engaged with the identified cohorts, and insights gathered informed recommendations to the SMI Programme to support review and improvement of the future delivery model.
- **Engagement with Inclusion health groups** - Online and face-to-face public engagement with people from inclusion health groups took place in September & October 2025 through a system wide survey and direct engagement. Findings highlighted a consistent range of barriers affecting access, experience and outcomes, particularly difficulties accessing mental health support, long waiting times, transport difficulties, digital exclusion and variation in GP provision. Wider structural issues including stigma, fragmented care, poverty, housing instability, language barriers and limited system navigation skills were also identified as contributing to poor continuity of care and reduced engagement with services.

Intersectionality was a key line of enquiry in all the above projects, ensuring that overlapping and compounding disadvantages were considered throughout the analysis.

In 2025/26 Lincolnshire launched a Health and Care Digital Inclusion Strategy with system wide partners. The vision is for 'Everyone in Lincolnshire who wants to be digitally connected to health and care services and the community will have the skills, accessibility and confidence to do so'. The

Lincolnshire Digital Health Toolkit was used to identify areas at greatest risk of digital exclusion in Lincolnshire and interventions to increase skills, access and confidence have been targeted in these areas (see case study 14).

All service re-designs, business cases, new services and procurement exercises in Lincolnshire undergo a process of Equality Impact Assessment (EQIA) and the use of Health Equity Assessment Template (HEAT) has been embedded within the ICS planning process, investment decisions and ICS governance arrangements since 2024/25.

Understanding healthcare access, experience, and outcomes

We continue to restore, recover and deliver elective services in a fair and equitable way. Our population health management insight reporting has been further developed to support the annual update of the Statement of Information on Health Inequalities and now provides a more detailed equity lens across the elective waiting list, including speciality level analysis. This enhanced approach has enabled a more granular understanding of where inequities persist within elective pathways. As a result, we have been able to:

- Evaluate the impact of elective recovery plans on addressing any identified or unresolved disparities in waiting list or access to services.
- Provide a more granular understanding of where inequity and inequalities offer different challenges and response, and where we can target specific health inequalities across our system.

A comprehensive action plan was developed for 2025/26 aligned to the health inequalities focused actions set out in the NHSE Reforming Elective Care for Patients guidance which sets out to deliver the 18-week standard equitably and inclusively for all adults, children and young people whilst also addressing geographical variation for people living within disadvantaged groups.

A deep dive analysis of elective care 18-week waits was conducted using a bespoke dashboard created to understand where health inequalities are present and persistent. The dashboard identified that a greater proportion of females between the ages of 18-39 were waiting more than 18 weeks driven by urology, ophthalmology, gastroenterology, cardiology, and dermatology. Also, the proportion of over 18-week waits was greater in United Lincolnshire Teaching Hospital (ULTH), compared to other providers Lincolnshire ICB residents used. The findings were presented to the Lincolnshire System Planned Care Board and the Lincolnshire Community Hospital Group (LCHG) Health Inequalities Board, enabling the provider to take forward targeted actions to address the identified imbalance.

In Children and Young People's (CYP) elective care, Lincolnshire remains an outlier for 'Was Not Brought' (WNB) rates (see case study 8). Data analysis highlighted a strong correlation between deprivation and non-attendance with three PCNs identified as accounting for the majority of WNBs. In response a Health Inequalities Elective Care CYP WNB Project was undertaken in 2025/26. Engagement with parents and carers provided valuable insight into the practical and systemic barriers contributing to missed appointments. A key outcome of this work has been the co production and redesign of hospital SMS appointment reminders with people with lived experience. The impact of this intervention will be measured through quantitative analysis of engagement and attendance rates (see case study 8). Further engagement with parents and carers of children and

young people from the most deprived communities explored the drivers higher urgent and emergency care (UEC) utilisation among children and young people. Feedback indicated that attendances were most commonly triggered by perceived urgency of symptoms or advice from NHS 111, alongside limited access to timely GP appointments and out of hours primary care support. This insight is informing work by the Primary Care Network Alliance, in partnership with LCHG, to better manage UEC attendance for under-fives through the expansion of same day access hubs.

The insight will support the Primary Care Network Alliance looks to work with LCHG and better manage UEC attendances for under 5's through expanding same day access hubs.

Local data has been analysed to better understand areas of inequality in access to primary care in several ways. NHS App uptake has been monitored at a geographical level and overlaid against risk of digital exclusion using the Lincolnshire Digital Health Toolkit. This has led to targeted initiatives aiming to increase skills, accessibility and confidence in using digital services and the NHS App in areas that are at high risk of digital exclusion (see case study 14).

There has been a focus on increasing access to Primary Care screening programmes in population groups identified as less likely to attend through uptake data. For example, people with learning disabilities, SMD, SMI and ethnic minority groups have been encouraged to attend cancer screening programmes and annual health checks through a range of initiatives undertaken at PCN level which include more targeted communications, focus groups and collaboration with support workers.

Re-procurement of interpreting services for Primary Care in line with the NHS England Improvement Framework for community language translation and interpreting services, in response to the end of the existing provider contract. This ensured continuity of provision across Lincolnshire, maintaining access to interpreting support and avoiding disruption to services. The re-procurement process was critical in retaining an established and equitable offer for patients, mitigating the risk of reduced access to care for those with language barriers and preventing any widening of health inequalities.

PROMs and PREMs are collected by selected services within Providers in Lincolnshire and used to analyse healthcare inequalities. An example of this is where the ICB has commissioned One You Lincolnshire to deliver Health and Wellbeing Coaches (HWCs) across several Primary Care Networks. As part of this model, HWCs routinely collect the ONS4 wellbeing score, a validated four-question measure assessing life satisfaction, sense of purpose, happiness, and anxiety on a 0–10 scale.

The quarterly report that is produced summarises current ONS4 scores and highlights variations in emotional wellbeing across different population groups. This enables the PCNs to identify where additional support, targeted interventions, or adapted delivery models may be required. Several PCNs are already tailoring their approach to local need as a result of the variation seen in ONS4 scores.

Improving data quality

Targeted work was undertaken with ULTH, as ECDS ethnicity coding was consistently below the national average. An ethnicity coding action plan was developed and implemented by the provider. Improvement in ethnicity coding has been included within ULTH's Schedule 6 for the 2025/26 Data Quality Improvement Plan (DQUIP), issued in September 2025. In addition, the ICB has made accurate and complete ethnicity and protected characteristics coding a key requirement within

Schedule 2N to strengthen the monitoring of health inequalities and support improvements in equitable outcomes.

Lincolnshire Community Health Services (LCHS) realised the ethnicity data in their Community Services Dataset (CSDS) did not return ethnicity data for patients where LCHS had not collected a patient's ethnicity, and published ethnicity data quality figures weren't a true reflection of the organisation's performance. A new process was implemented, an additional report from Systm1 was run to fill gaps where there was missing ethnicity data. Further improvements were achieved using the RINSE data quality system and targeted engagement with users to reinforce the importance of completing ethnicity fields. Work is underway to simplify data collection in urgent care settings, prioritising the capture of key data items including ethnicity.

Details of NHS England's 'Ethnicity Recording Improvement Plan' have been circulated to Lincolnshire NHS providers. This plan sets out practical actions to improve the quality, consistency, and completeness of ethnicity data recorded across the NHS. This will ensure NHS providers are better identifying any potential health inequalities due to ethnicity. One example is to replace the 2001 census ethnic categories currently used in the NHS Data Dictionary with ethnic categories used in the 2021 Census. Practical information for staff to improve confidence and trust with patients when asking about ethnicity is also detailed in the plan.

The Lincolnshire Joined Intelligence Dataset processes data from primary care, secondary care, and other health and social care settings to create a comprehensive joined dataset that documents each patients' health and social care resource use in a 12-month period. Specific cohorts can be selected to understand what may be driving higher healthcare utilisation and spend. A significant benefit of the Lincolnshire Joined Intelligence Dataset is that demographic information can be assigned to a patient based on their interaction with one service, which may not be captured in other services.

[Using information on healthcare inequalities](#)

Information on health inequalities has played a central role in shaping quality improvement within several pathway redesigns during 25/26. One example is the Lincolnshire Pain Management Service whole system service review which was led by the Lincolnshire Academy for Clinical Excellence (LACE). A Health Inequalities representative was embedded within the project team to ensure equity considerations were integrated at every stage of the review and supported completion of the Equity Pause Tool.

A key quality improvement informed by health inequalities representation was a review of referral pathways into the service. The previous model relied primarily on GP referral, unintentionally creating barriers for people not registered with a GP. Health inequalities insight highlighted that this disproportionately affected vulnerable groups, including people experiencing homelessness, transient populations, and those facing barriers to primary care access.

As a result, the service specification was strengthened to include alternative referral routes, such as referrals from Urgent and Emergency Care (UEC) services. This enables people presenting to UEC with pain, who may not be registered with a GP, to access specialist pain management support.

LICB has used health inequalities data and intelligence to inform commissioning the expansion of the High Intensity Use (HIU) service to a further 2 PCNs in Lincolnshire in 2024/25. Analysis of population health data, emergency care usage, deprivation indices, Core20PLUS5 indicators, and Joint Strategic

Needs Assessment evidence identified individuals and communities experiencing frequent, often avoidable use of urgent and emergency care alongside poor health outcomes. LICB commissioned a HIU service focused on proactive, personalised intervention for people most affected by health inequalities, supporting system partners to reduce frequent attendances, improve outcomes, and address the wider determinants driving high service use.

Health inequalities intelligence has also informed the development and implementation of a number of key strategies across Lincolnshire. These include the Joint Forward Plan, the Lincolnshire Older People's Five-Year Strategy, the Lincolnshire Health and Care Digital Inclusion Strategy, the Lincolnshire Dental Strategy and the Integrated Care Partnership Strategy.

In addition, the LICB Statement of Information on Health Inequalities 2024/25 identified priority areas for action in 2025/26. These priorities were embedded within programme plans across the system and progress was reported through relevant programme boards, strengthening accountability for addressing health inequalities.

[Publishing information](#)

The Learning from Lives and Death of People with a Learning Disability and Autistic People (LeDeR) in Lincolnshire Annual report is presented and signed off by LICB Board. The published 2025 LeDeR report summarises the findings from reviews completed in Lincolnshire over the preceding year with the aim to drive strategic action across health and social care. The report also highlights service development, creative approaches and examples of effective practice that have improved outcomes, strengthened system working, and enhanced the experience of people with a learning disability and autistic people across Lincolnshire.

The 2024/25 update of the Statement of Information on Health Inequalities was formally reviewed and signed off by the LICB Board, providing assurance on our current position and approach. As part of this process, key gaps and areas for development were identified, particularly in relation to the use of data, strengthening insight, and demonstrating impact.

A set of improvement priorities for 2025/26 was agreed, including enhancing the quality and depth of data analysis and strengthening how findings are translated into targeted action. These priorities supported a more systematic and evidence-based approach to reducing health inequalities. Health Inequalities was included as a standing item agenda on the LICB Board agenda.

During 2025/26 health inequalities key performance indicators were monitored via the LICB Service Delivery and Performance Committee which provided leadership and direction in supporting the Lincolnshire NHS system to drive forward the delivery of the agreed strategic priorities and monitor the impact of their delivery. The health inequalities data provided insight to the organisation on whether progress was being made on one of its key strategic objectives and, if not, signalled the need for corrective action.

There are several areas with actions plans in place or in development to reduce inequalities in access and quality of care. One example is the Lincolnshire Maternity and Neonatal Programme which is working with the Local Maternity and Neonatal System (LMNS) and wider system partners to improve equity and equality, reducing differences in outcomes and experiences for women and babies across Lincolnshire. Using national evidence to identify where risks are higher, particularly for

Black, Asian and deprived communities, the programme supports improvements in access, safety and personalised care. This work brings together local population health data with direct feedback from women, families and communities, ensuring both quantitative and lived-experience evidence inform system decision-making (see case study 5).

Working collaboratively through the LMNS, this combined intelligence enables partners to identify inequalities, understand where experiences or access to care differ, and highlight points in the maternity and neonatal pathway where outcomes are poorer for specific population groups. The information provides a robust, system-wide evidence base to support coordinated, targeted improvement work, aligned with national equity and equality guidance, and underpins delivery of more responsive, personalised and culturally appropriate maternity and neonatal services across the county.

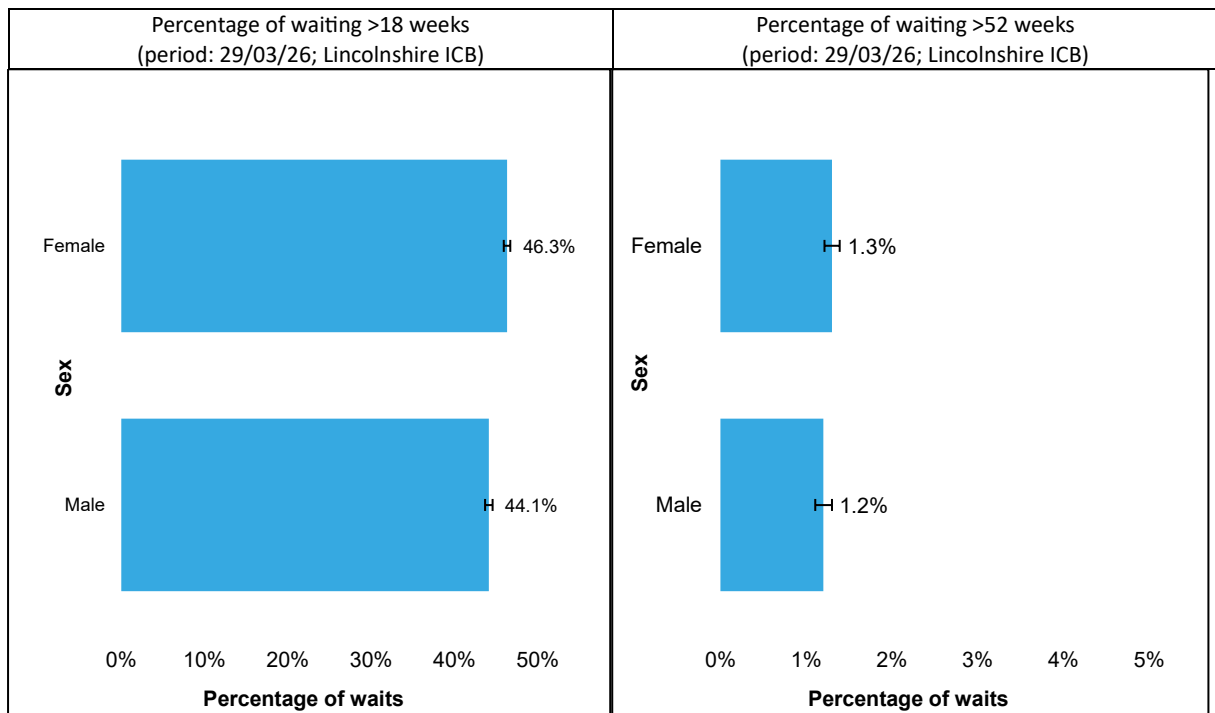
Operational priorities

Elective Care

Size and shape of the waiting list; those waiting longer than 18 weeks, and 52 weeks

Position at 29/03/26

Sex

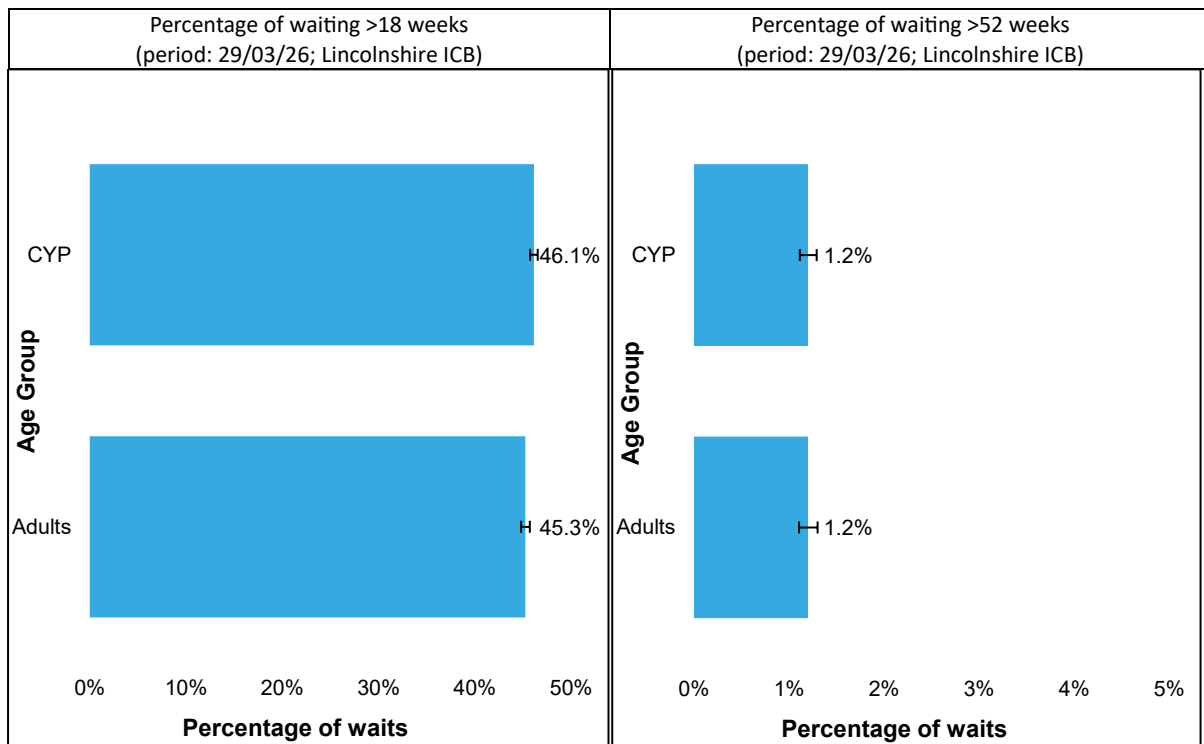


Source: Waiting List Minimum Dataset

Compared to the position at 30/03/25:

- The gap between females and males waiting longer than 18 weeks has widened, with an increasing proportion of females waiting longer than 18 weeks.
- The gap between females and males waiting longer than 52 weeks has stayed the same.

Age

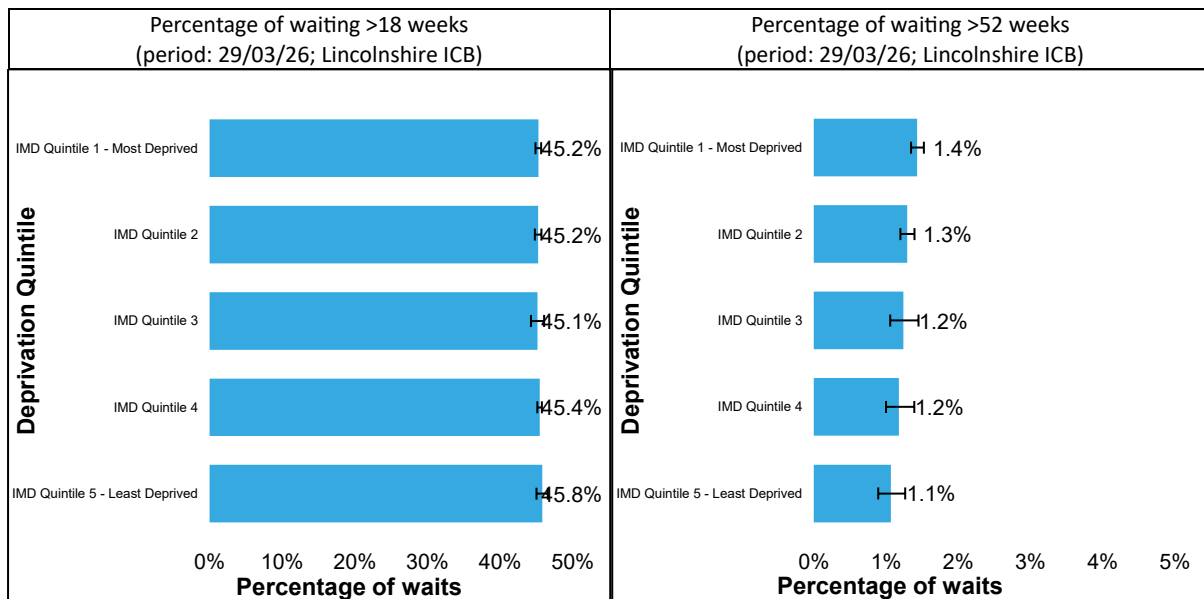


Source: Waiting List Minimum Dataset

Compared to the position at 30/03/25:

- The gap between CYP and adults waiting 18 longer than weeks has narrowed.
- The gap between CYP and adults waiting 52 longer than weeks has narrowed.

Deprivation

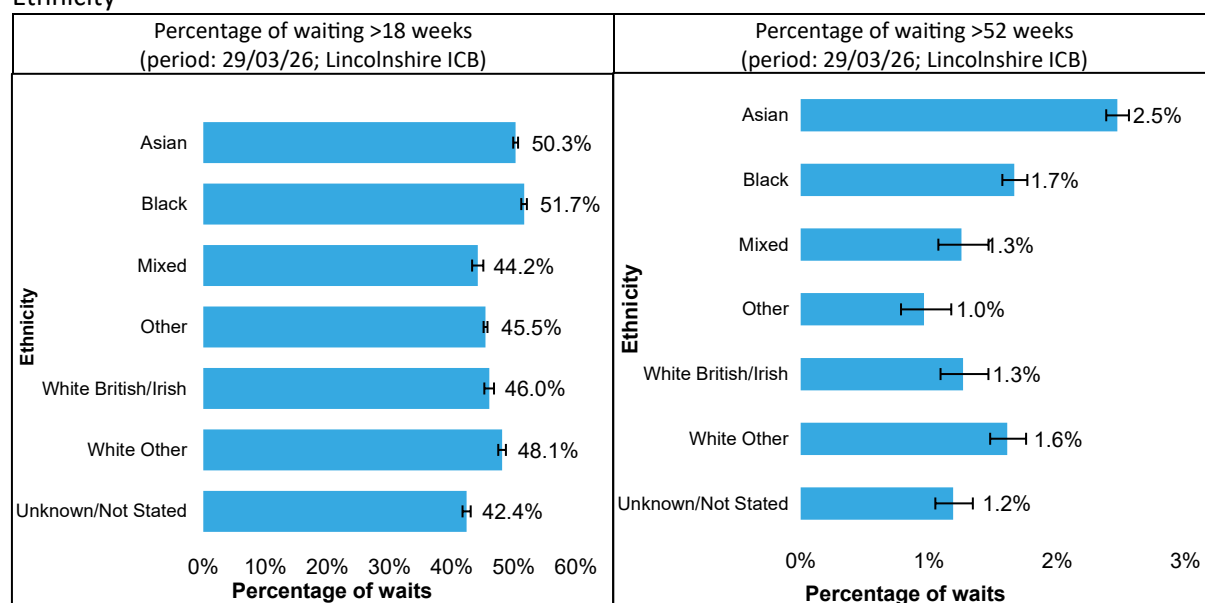


Source: Waiting List Minimum Dataset

Compared to the position at 30/03/25:

- The gap between the most deprived quintile and the least deprived quintile waiting longer than 18 weeks has narrowed, to the point where a lower proportion of those in the most deprived quintile are waiting longer than 18 weeks.
- The gap between the most deprived quintile and the least deprived quintile waiting longer than 52 weeks has slightly widened, but the gap between the two is negligible.

Ethnicity



Source: Waiting List Minimum Dataset

Compared to the position at 30/03/25:

- The gap between the White British/Irish and all other known ethnicities waiting longer than 18 weeks has narrowed.
- The gap between the White British/Irish and all other known ethnicities waiting longer than 52 weeks has narrowed.

Inequalities in annual change in size of waiting list

The overall size of the elective waiting list has fallen year-on-year from 110,717 on 30 March 2025 to 109,374 on 29 March 2026. This represents an overall decrease of 1.2%. The rate of change to the size of the waiting list is uneven across demographic groups. The waiting list has decreased faster for those living in the most deprived areas compared to the least deprived. The waiting list decreased fastest for people of White British/Irish ethnicity compared to all other known ethnic groups. There is a known data quality issue concerning secondary care, so readers should interpret this finding with caution.

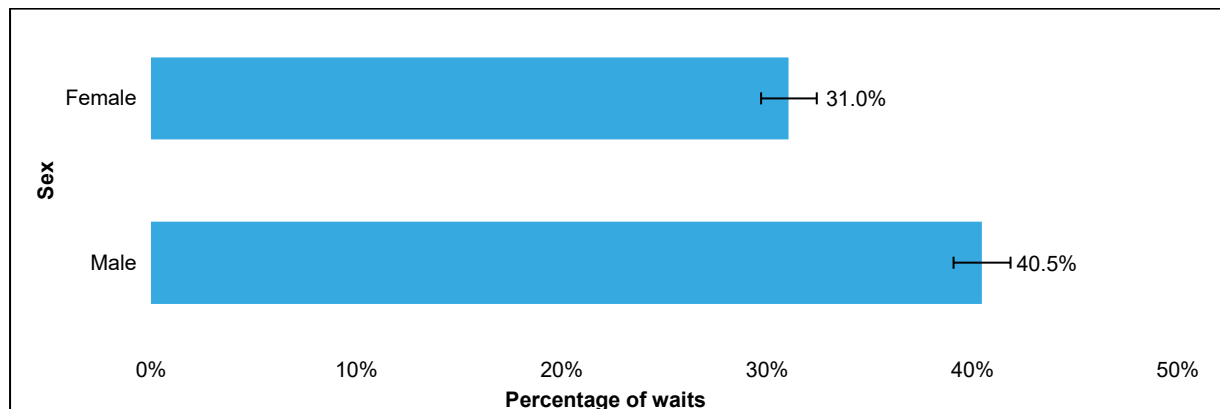
Community

Inequalities in percentage of people waiting over 18 weeks for community services

Position at 28/02/2026

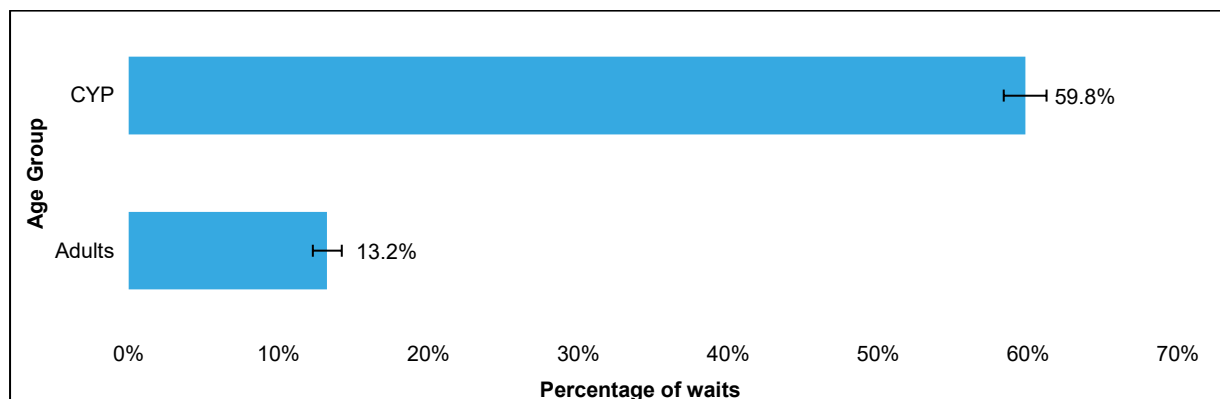
At the end of February 2026, 36.0% of people on a community waiting list have been waiting list for 18 weeks or longer. A significantly higher proportion of males have been waiting longer than 18 weeks compared to females. A significantly higher proportion of children and young people have been waiting longer than 18 weeks compared to adults. A significantly higher proportion of people from the most deprived quintile have been waiting longer than 18 weeks compared to those from the least deprived quintile. A significantly higher proportion of people from a White Other background have been waiting longer than 18 weeks compared to those from a White British/Irish population.

Sex



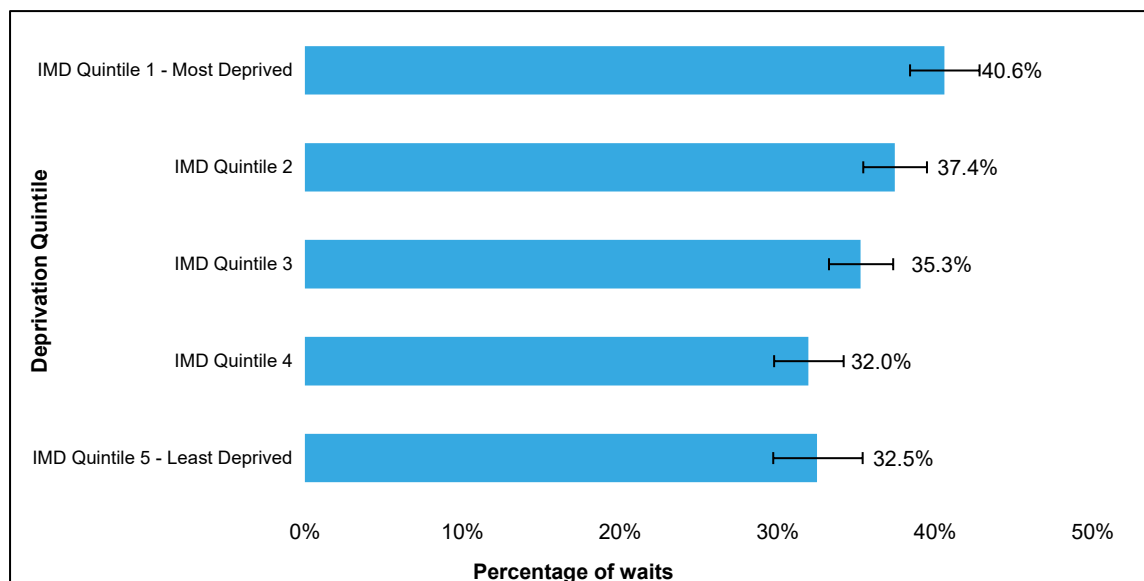
Source: [Lincolnshire Community Waiting List Insights](#)

Age



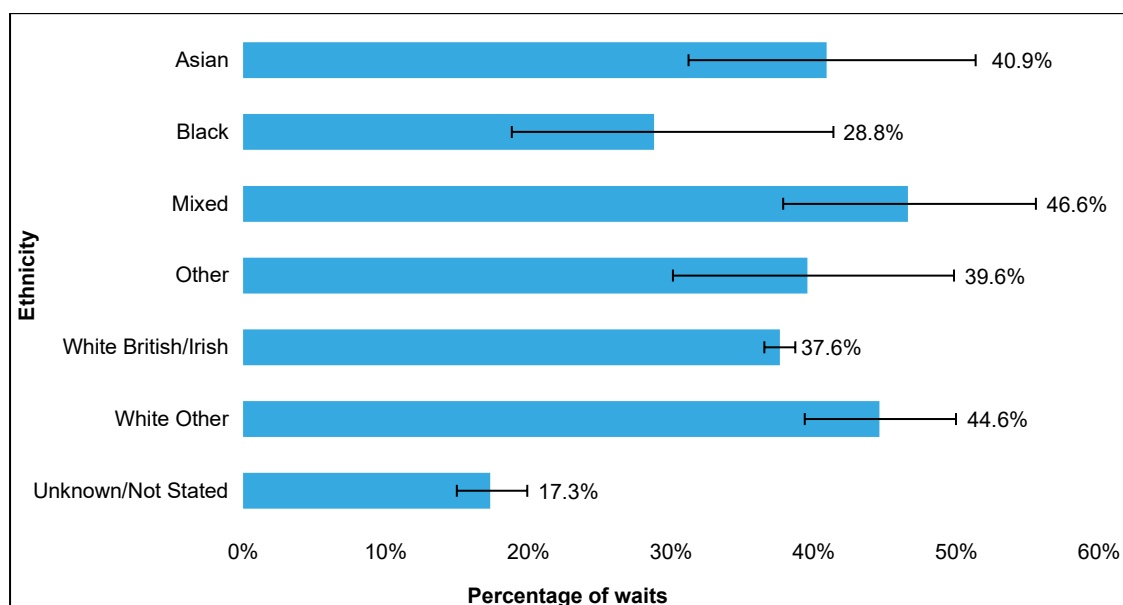
Source: [Lincolnshire Community Waiting List Insights](#)

Deprivation



Source: [Lincolnshire Community Waiting List Insights](#)

Ethnicity



Source: [Lincolnshire Community Waiting List Insights](#)

Urgent and Emergency Care

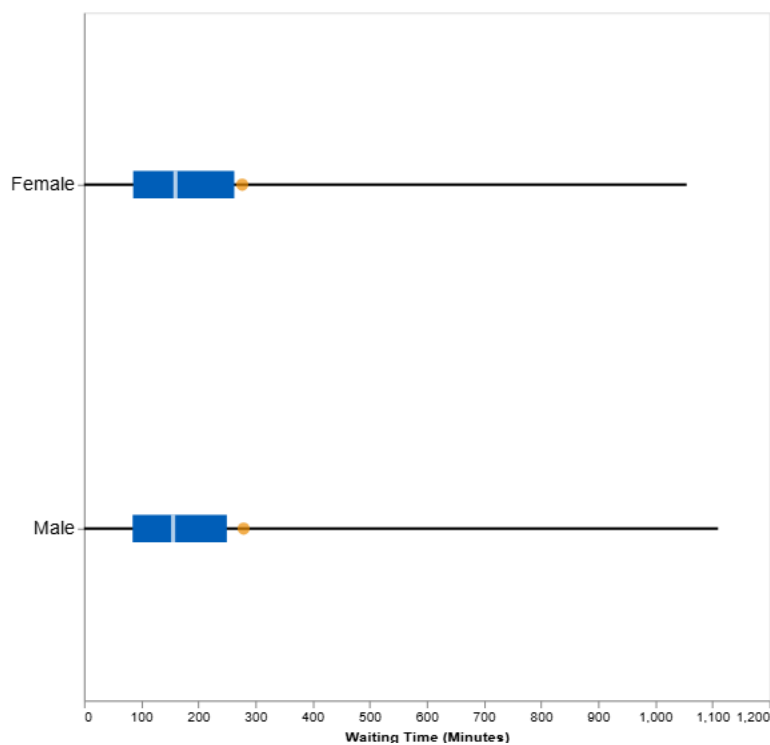
Inequalities in mean time in emergency department

Period: 25/26

The overall mean time spent in an emergency department for attendances in 25/26 was 278 minutes (4 hours and 38 minutes).

Sex

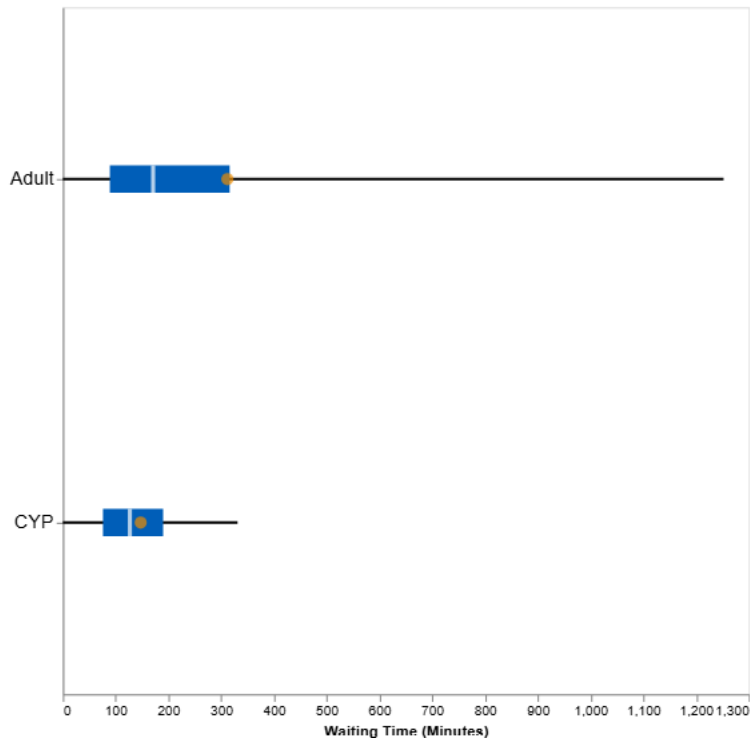
Median wait times were very similar between females (160 minutes) and males (156 minutes), with females experiencing a marginally longer median wait. Mean wait times were also comparable, although males had a slightly higher mean wait (279.4 vs 276.9 minutes).



Source: Emergency Care Dataset

Age

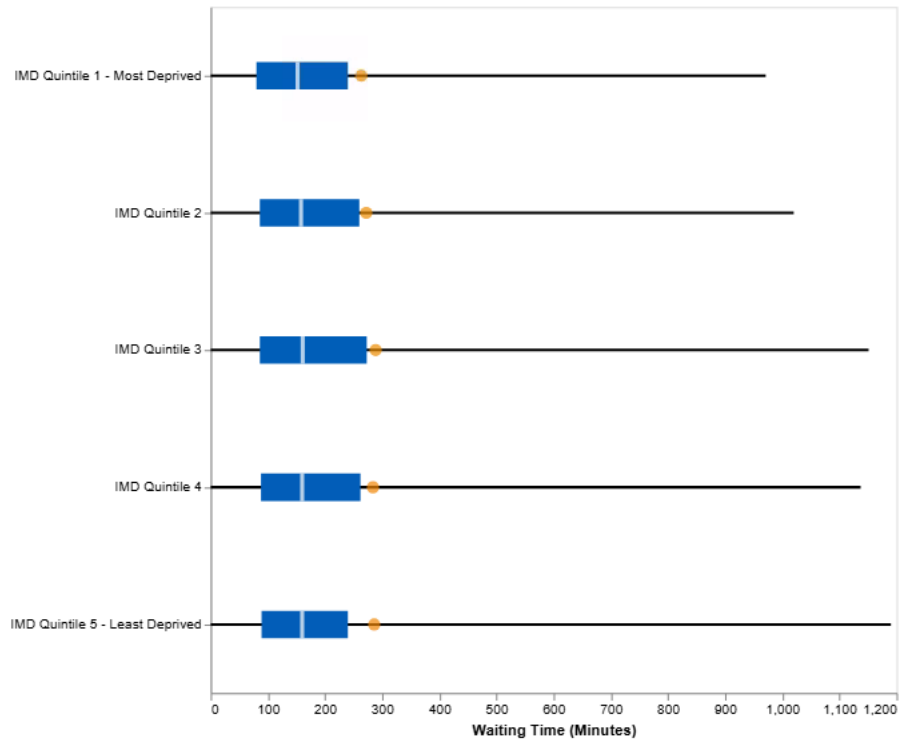
Adults experienced substantially longer waits than CYP across all measures. The median wait for adults was 171 minutes compared to 127 days for CYP, while the mean wait was more than twice as high for adults (311.7 vs 147.5 minutes).



Source: Emergency Care Dataset

Deprivation

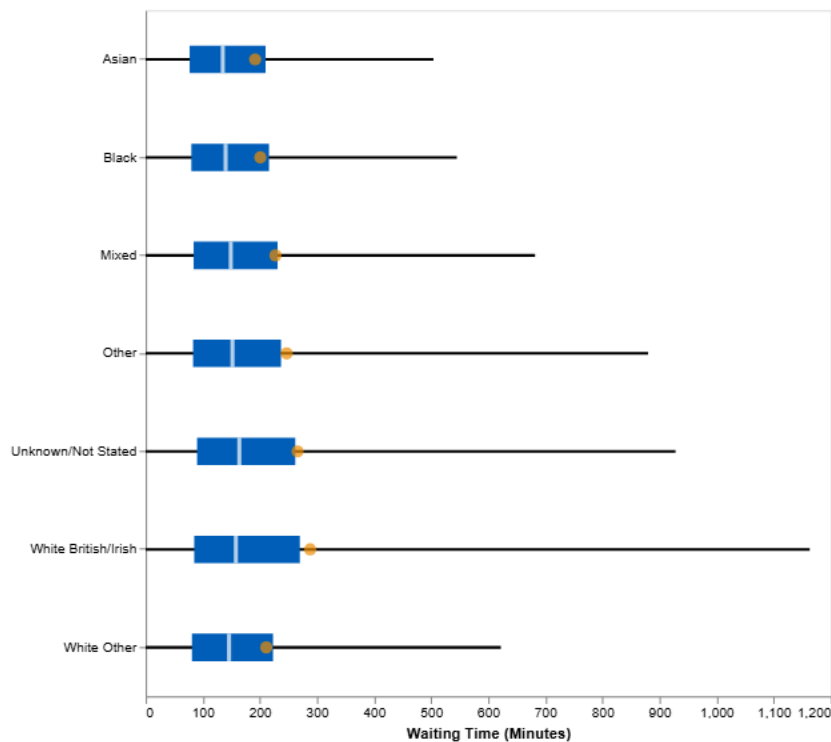
Median wait times were relatively consistent across deprivation quintiles, ranging from 152 minutes in the most deprived quintile to 161 minutes in Quintile 3. Mean wait times were lowest in the most deprived group (263.4 minutes) and generally higher in the less deprived quintiles, peaking at 288 minutes.



Source: Emergency Care Dataset

Ethnicity

White British/Irish patients had the longest median (158 minutes) and mean wait time (288.1 minutes) among ethnic groups, whereas Asian patients had the shortest median (135 minutes) and lowest mean wait (191.7 minutes). Black, Mixed, White Other, and Other ethnic groups also had shorter median and mean waits than the White British/Irish group, indicating comparatively shorter waiting times for most minority ethnic groups.



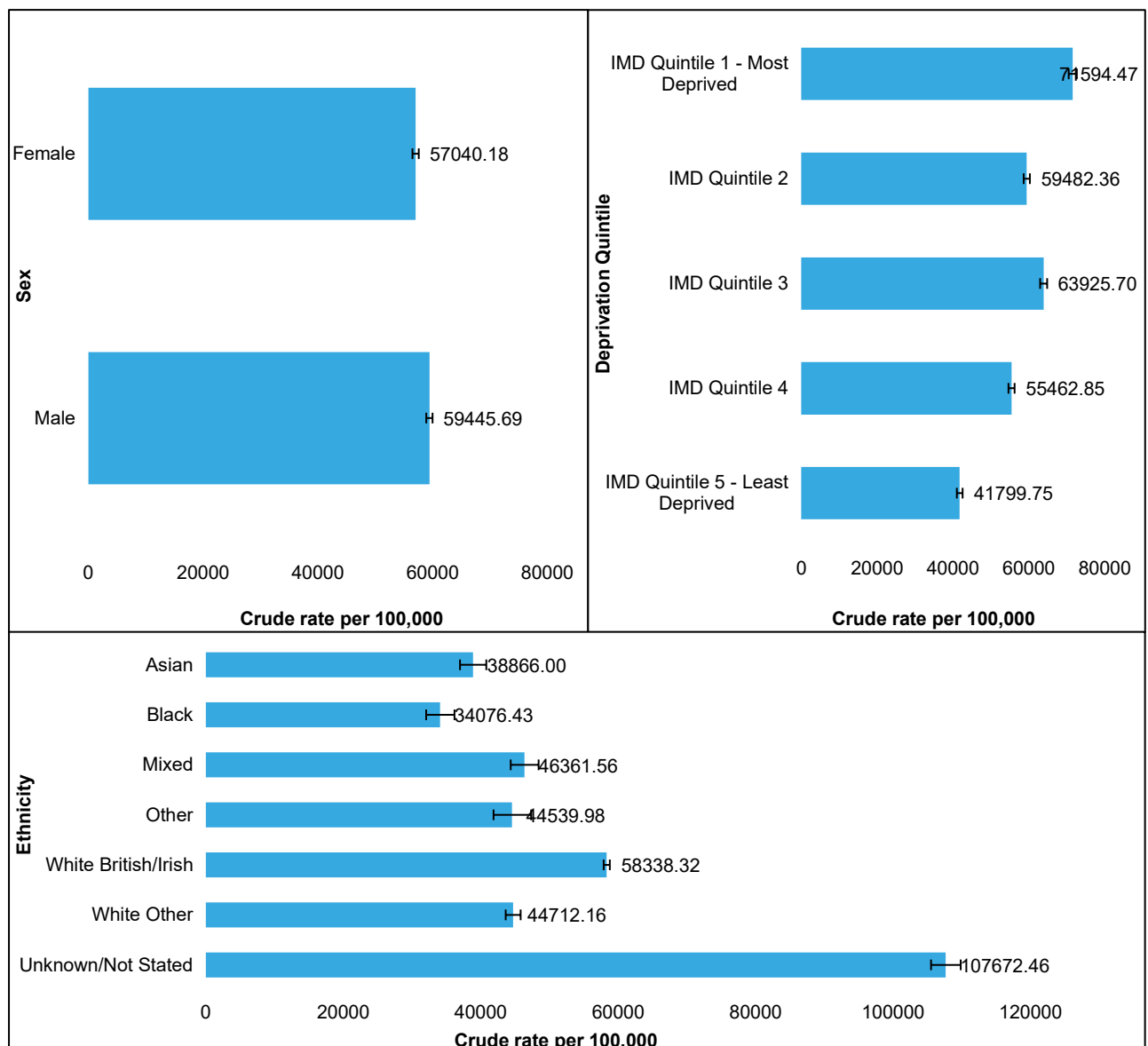
Source: Emergency Care Dataset

Urgent and Emergency care- CYP

Emergency attendances for under 18s

Period: 25/26

In 25/26, there were 87,196 emergency attendances for children between the ages of 0 and 17. This equates to a crude rate of 58,336.8 per 100,000 of the 0–17-year-old population. Males had a higher crude rate of ED attendances than females. Children living in the most deprived quintile had a significantly higher crude rate of ED attendances, approximately 70% higher than children from those living in the least deprived quintile. Excluding those children for whom an ethnicity was not known (or not stated), children from a White British/Irish background had a significantly higher rate of ED attendances than all other ethnic groups.



Source: Emergency Care Dataset

CORE20PLUS5 - Adults

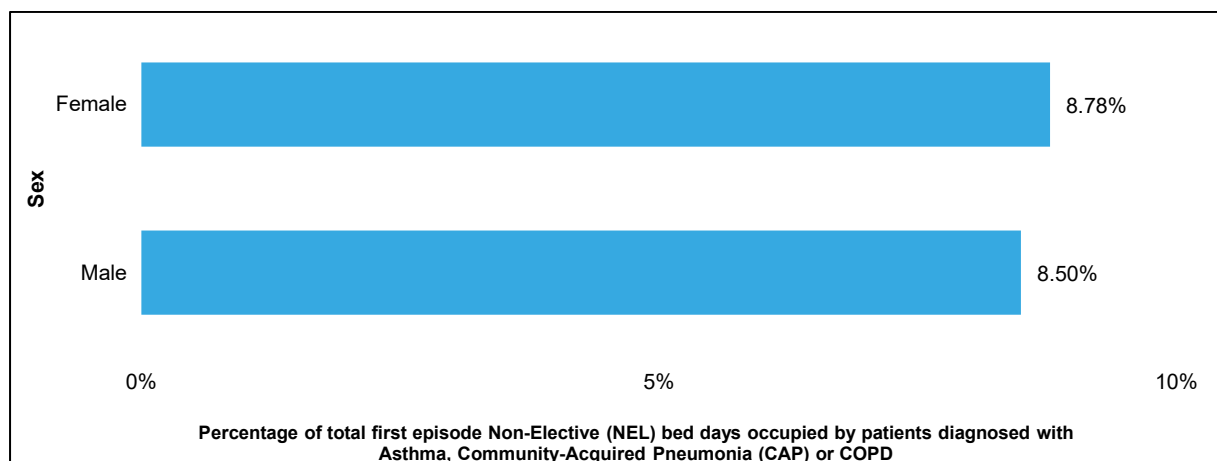
Respiratory

Inequalities in non-elective bed days occupied by asthma, COPD and CAP

Period: 24/25

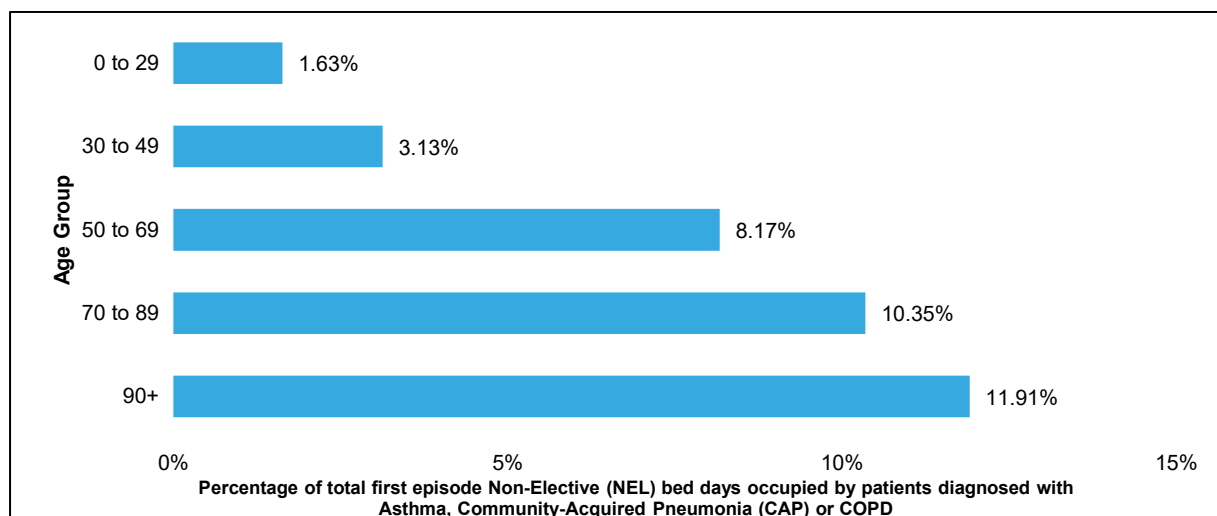
In 24/25, females had a slightly higher proportion of non-elective bed days due to asthma, COPD, and CAP. Further examination for the causes of this may be needed to understand what is driving this increase. Age was a significant predictor, with those over 50 having a much higher rate of non-elective bed days compared to those under 50. This is unsurprising as these respiratory conditions are much more common as age increases. Those living in the most deprived parts of the county had a higher rate of non-elective bed days caused by asthma, COPD and CAP. Due to low counts/data suppression, it is difficult to determine if there are any significant health inequalities

Sex



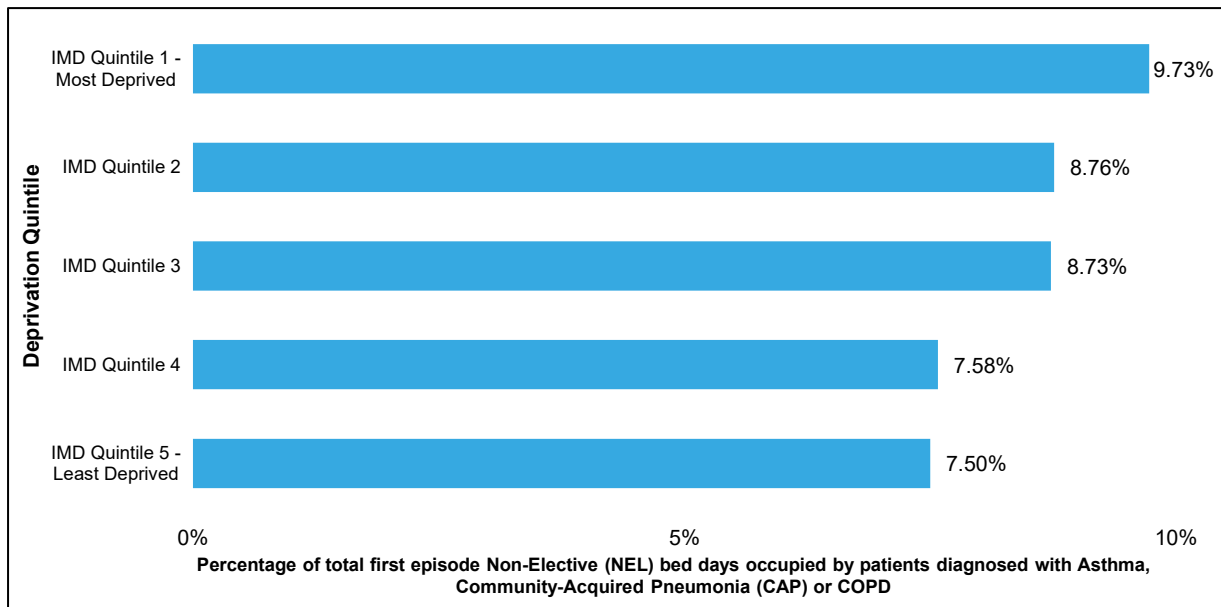
Source: [NHSE Respiratory Programme Dashboard](#)

Age Group



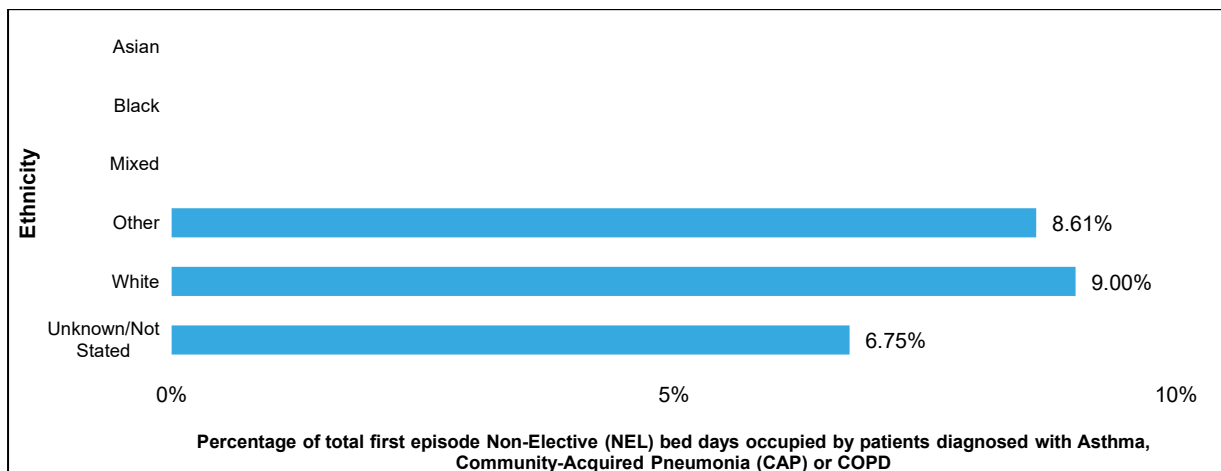
Source: [NHSE Respiratory Programme Dashboard](#)

Deprivation



Source: [NHSE Respiratory Programme Dashboard](#)

Ethnicity

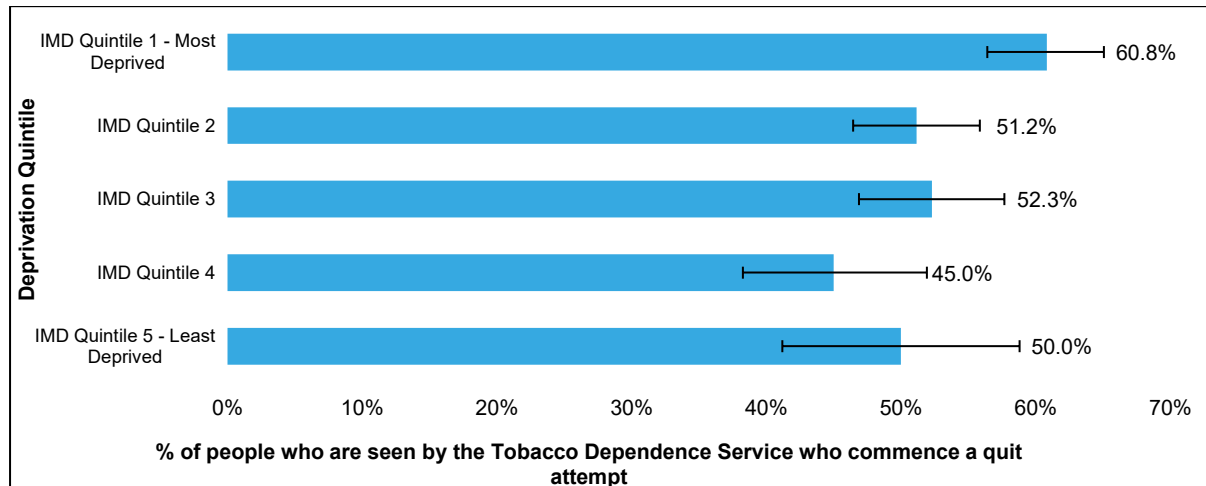


Source: [NHSE Respiratory Programme Dashboard](#)

Smoking Cessation

Inequalities in inpatients making a supported quit attempt with an in-house tobacco dependence treatment service

Deprivation (January to December 2025)

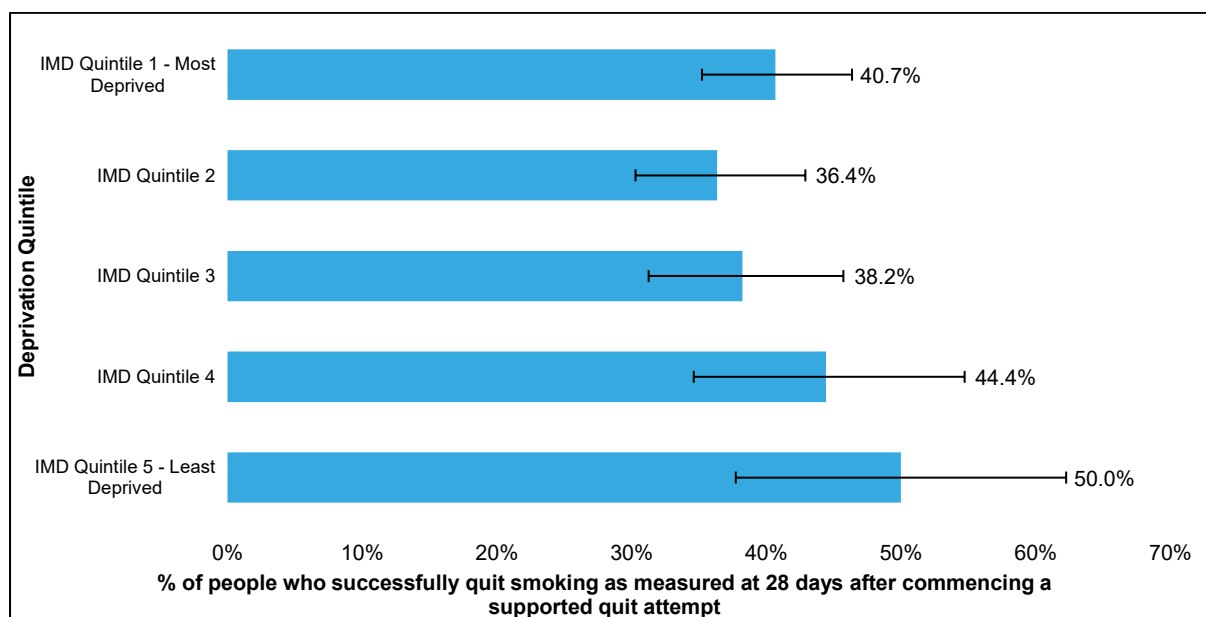


Source: [Tobacco Dependence Services Dashboard](#)

There is no significant difference between those from the most deprived and least deprived populations when it comes to commencing a quit attempt having been seen by the acute inpatient Tobacco Dependence Service (TDS). The Lincolnshire average is better than the England average.

Inequalities in inpatients who successfully quit smoking as measured at 28 days after commencing a supported quit attempt

Deprivation (January to December 2025)



Source: [Tobacco Dependence Services Dashboard](#)

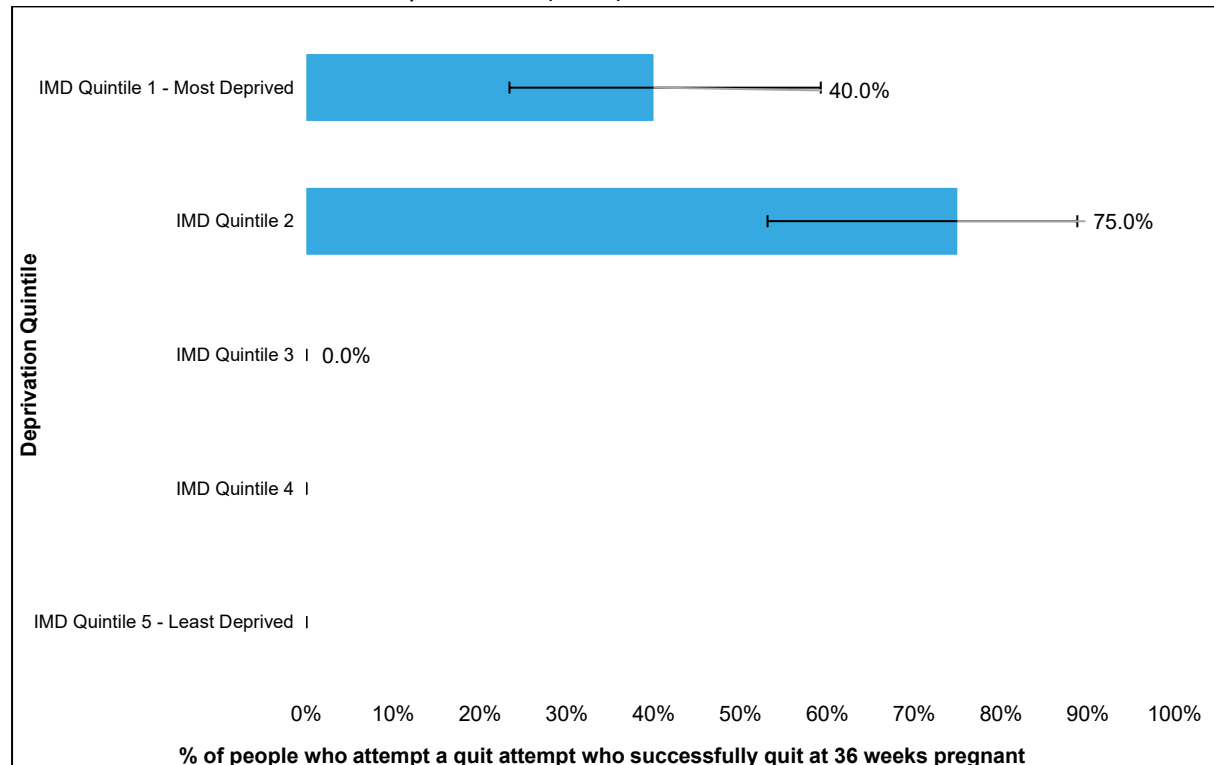
There is no significant difference between those from the most deprived and least deprived populations when it comes to successfully quitting smoking 28 days after commencing a quit attempt

with the acute inpatient Tobacco Dependence Service (TDS). The Lincolnshire average is better than the England average.

Inequalities in percentage of pregnant women identified as smokers at antenatal booking who are identified as non-smokers at 36 weeks gestation

Deprivation (July 2024 to June 2025)

Provider: United Lincolnshire Hospitals Trust (ULTH)



Source: [Tobacco Dependence Services Dashboard](#)

Overall, an estimated 25 pregnant women who commenced a quit attempts successfully quit smoking at 36 weeks pregnant.

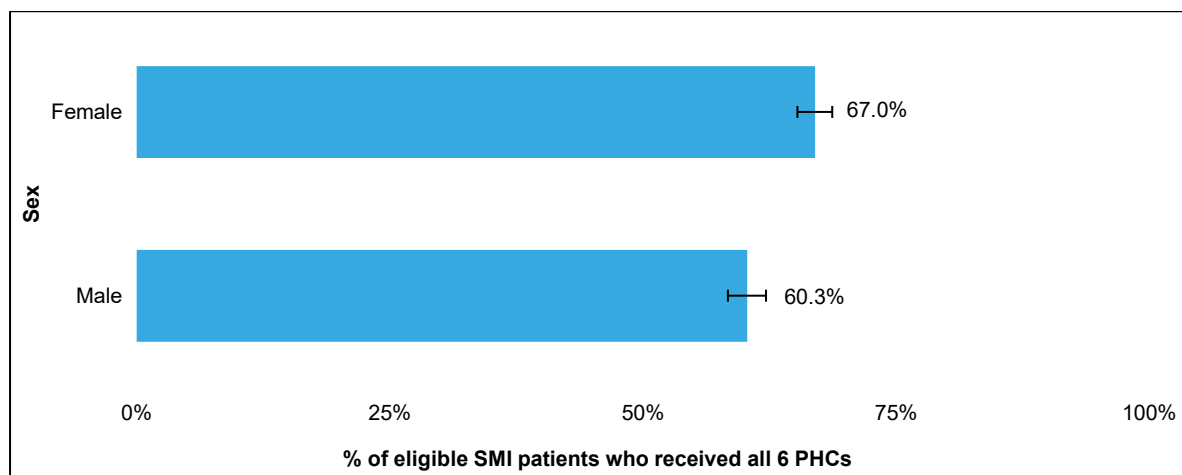
Mental Health

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

Period: 25/26

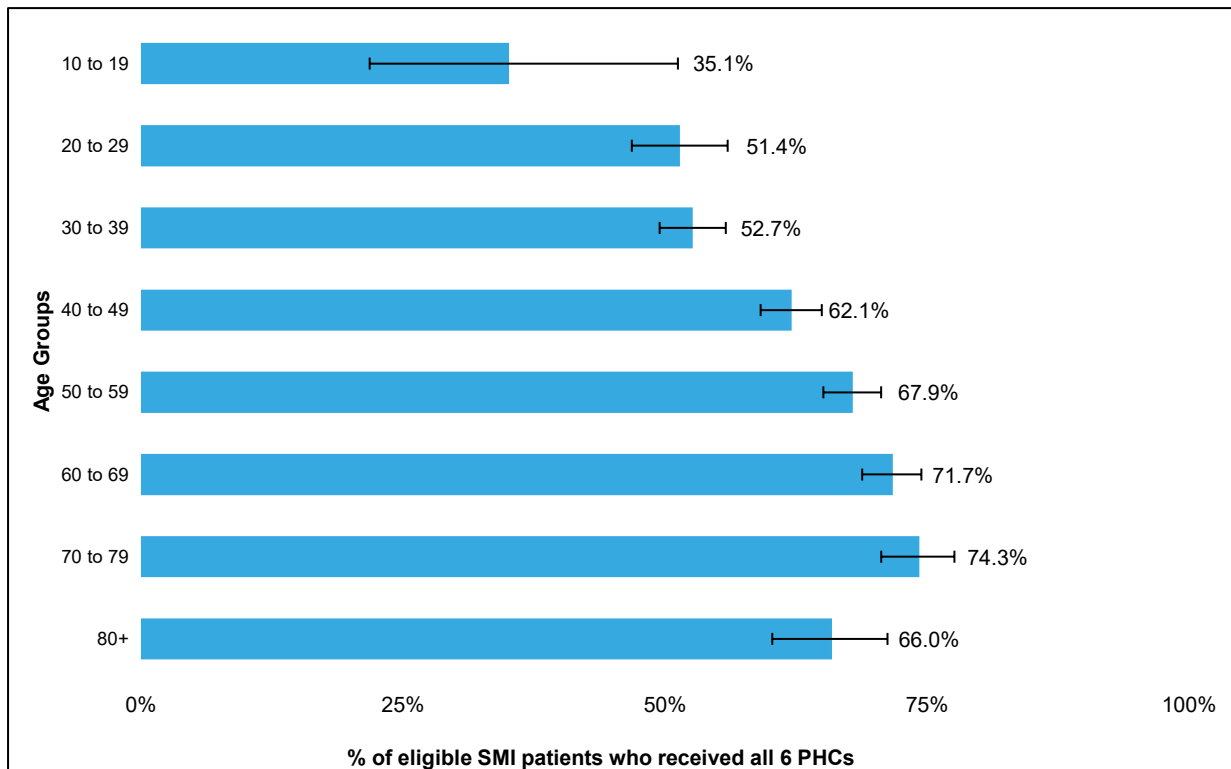
In 25/26, 63.8% of patients with SMI received all 6 physical health checks. This is a very slight decrease from the 24/25 result, where 64.0% (3,314/5,181) of the eligible SMI population received all six physical health checks. Females had a significantly higher uptake compared to males (67.0% for females vs. 60.3% for males). There was an increase in eligible females from 56.9% to 67.0%, and a slight decrease for males (61.4% to 60.3%). Uptake generally increased with age, a trend which mirrored the 24/25 performance. 51.4% of 20-to-29-year-olds received all 6 physical health checks, compared to 74.3% of 70-to-79-year-olds. Uptake was higher in the least deprived population (70.0% - up from 68.7% in 24/25) compared to those living in more deprived parts of the county (57.6% - up from 53.7% in 24/25). The biggest decrease was observed in IMD quintile 4 (67.0% in 24/25, to 63.3% in 25/26). It is difficult to state whether there are any differences when looking at uptake in different ethnic groups due to low counts, and a relatively high count of those whose ethnicity is unknown or has not been stated.

Sex



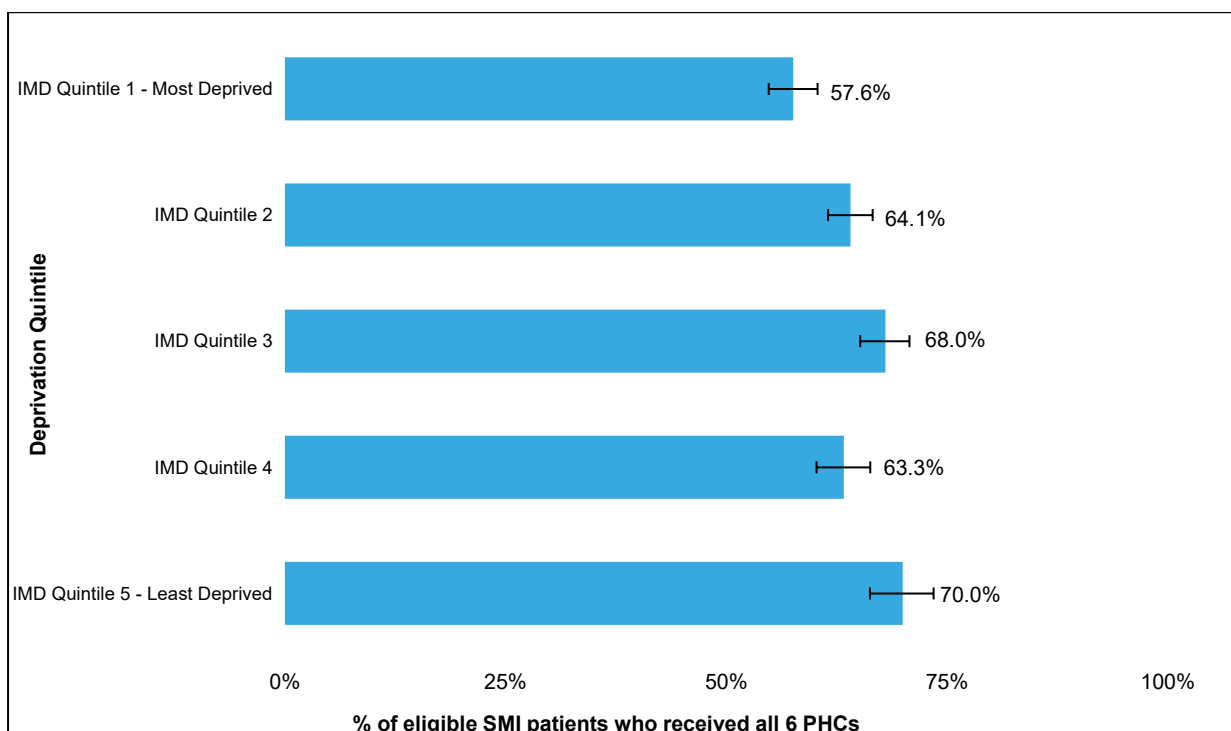
Source: Lincolnshire ICS Joint Intelligence Dataset, NHS Lincolnshire ICB 2026.

Age



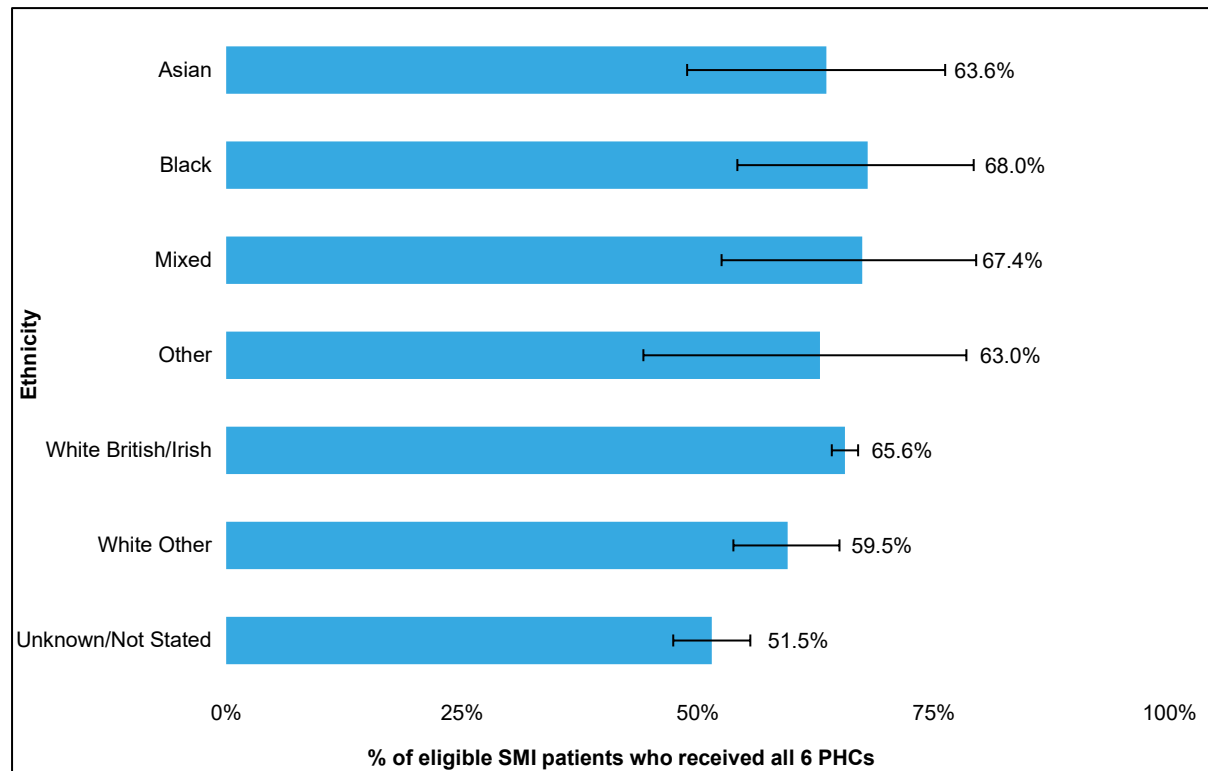
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Deprivation



Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Ethnicity



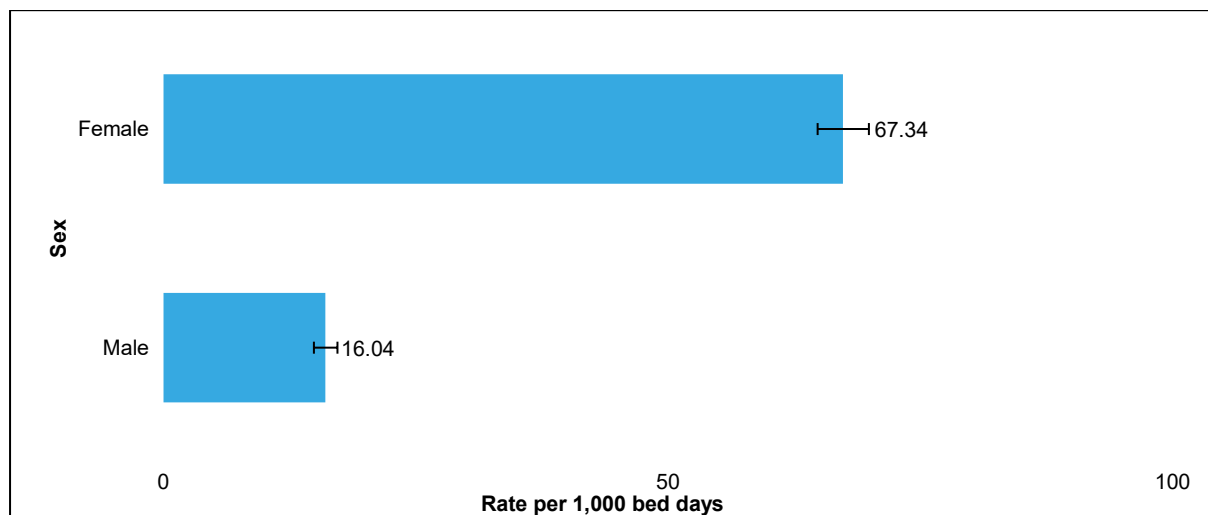
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Rates of restrictive interventions

Period: 24/25

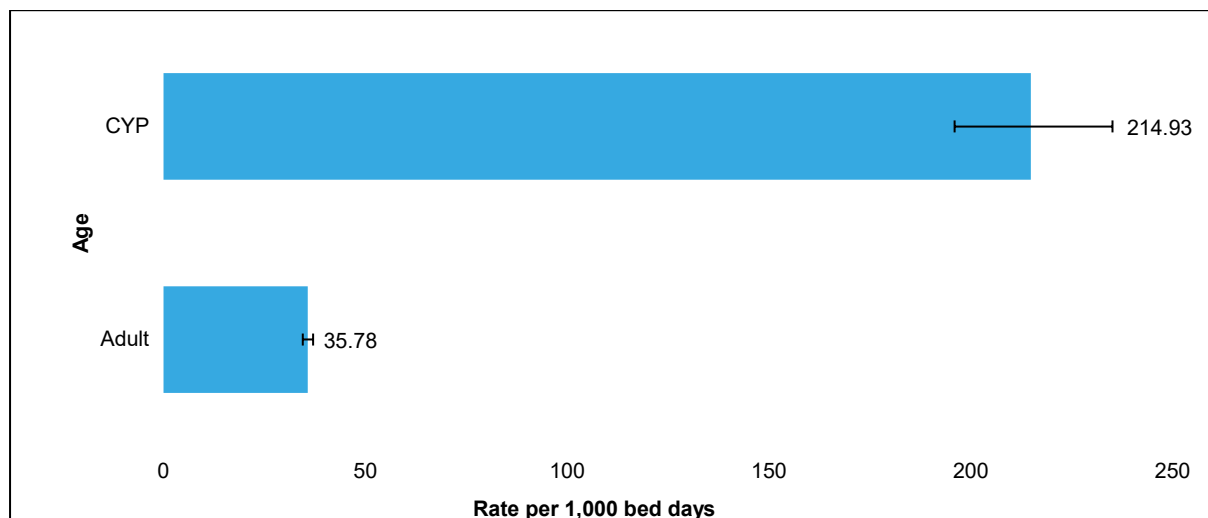
In 24/25, there were 3,515 restrictive interventions in an NHS funded secondary mental health, learning disabilities and autism services for Lincolnshire ICB residents. There were 87,045 bed days in 24/25; this equates to 40.38 restrictive interventions per 1,000 bed days. Females experienced a significantly higher rate of restrictive interventions per 1,000 bed days. Children under the age of 18 also experienced a significantly higher rate of restrictive interventions compared to adults. Those who live in the second most deprived quintile had the highest rate of restrictive interventions per 1,000 bed days, closely followed by those who live in the least deprived quintile. Those from a White population had the highest rate compared to all other ethnic groups. It should be noted that relatively small numbers of patients can have a distorting impact on rates of interventions, especially if the number of patients from that group or bed days is relatively low.

Sex



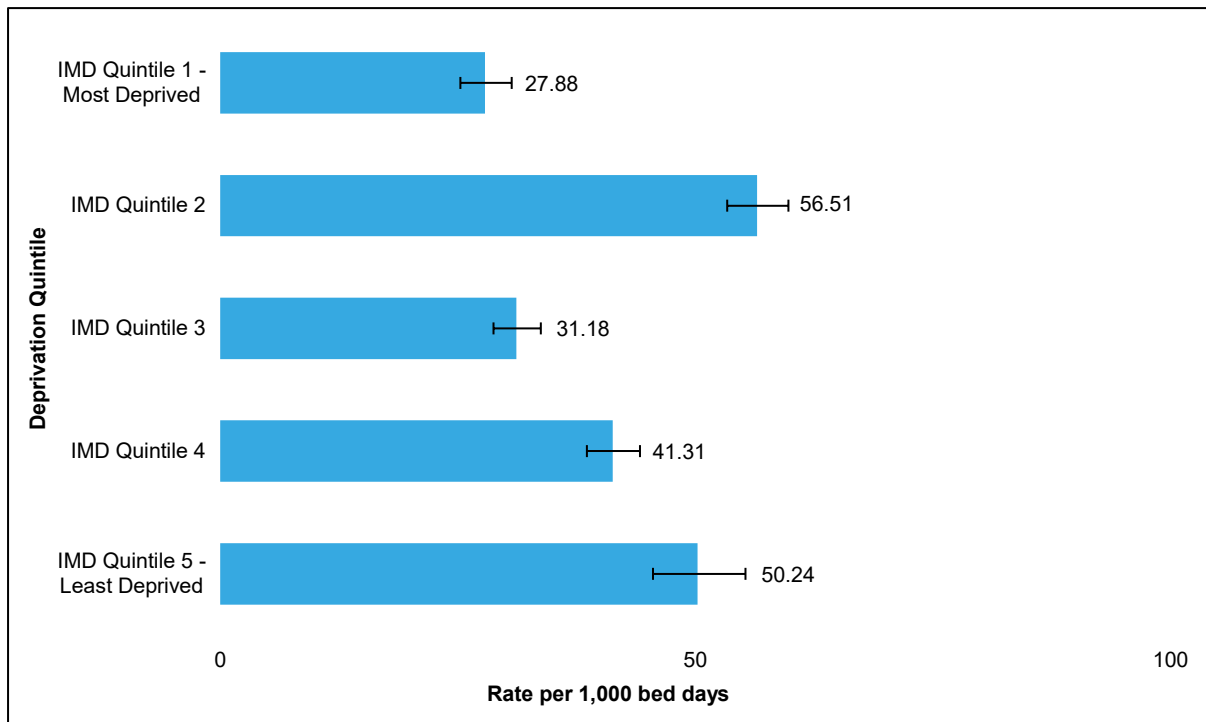
Source: [Mental Health Bulletin, 2024-25 Annual report](#)

Age



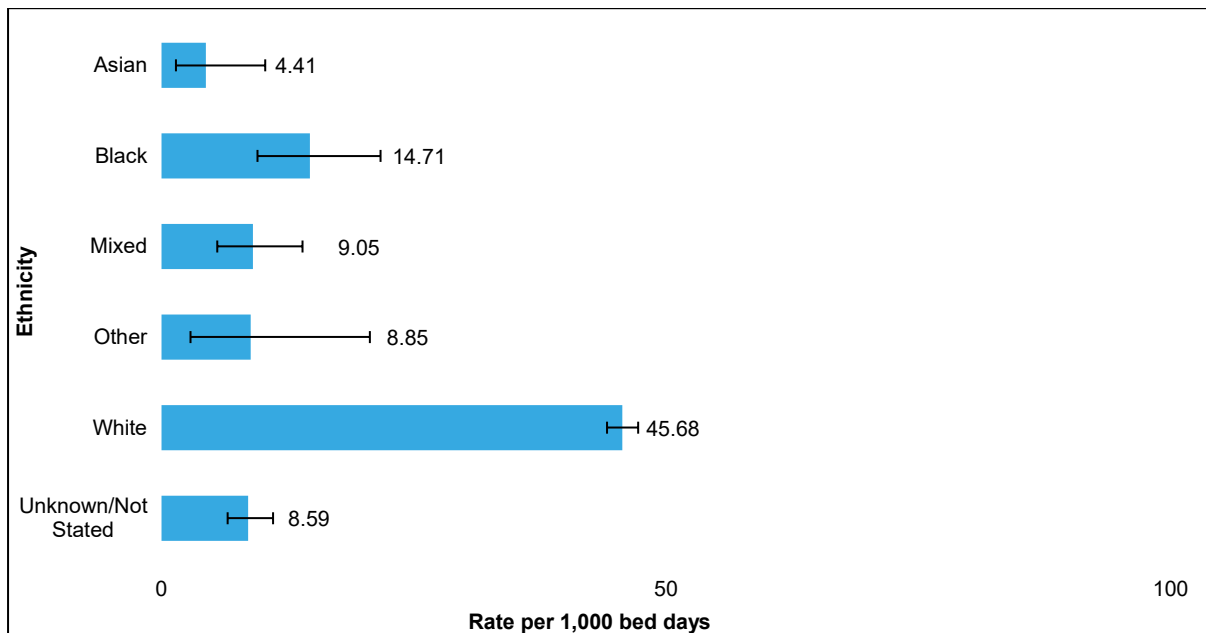
Source: [Mental Health Bulletin, 2024-25 Annual report](#)

Deprivation



Source: [Mental Health Bulletin, 2024-25 Annual report](#)

Ethnicity



Source: [Mental Health Bulletin, 2024-25 Annual report](#)

NHS Talking Therapies recovery rate

Period: 24/25

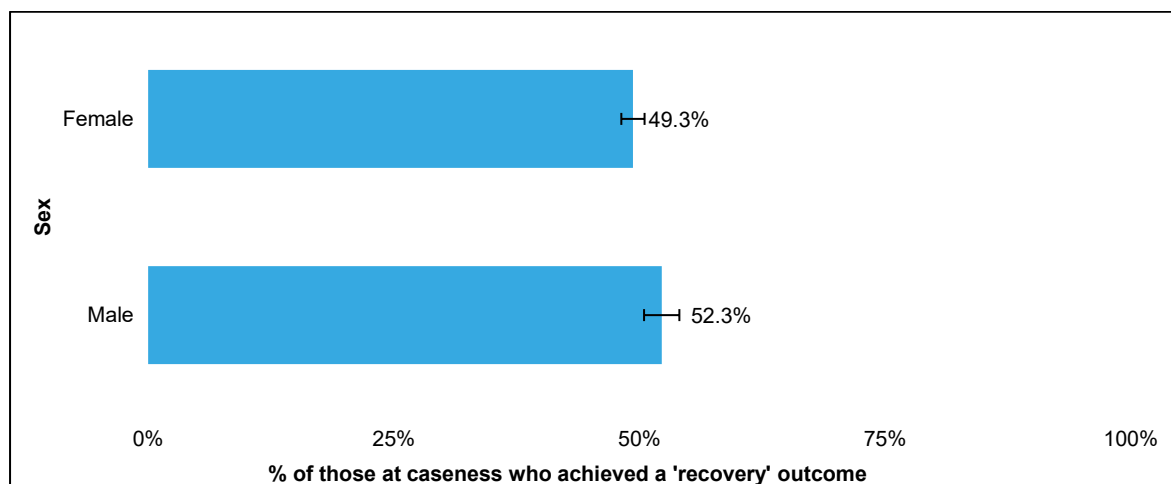
In 24/25, 50% of the population in Lincolnshire ICB who accessed NHS talking therapies had an outcome of 'recovery' - meaning a person who is deemed to be a clinical case at the start of their treatment ('at caseness') and not as a clinical case at the end of their treatment, measured by scores from questionnaires tailored to their specific condition. This is a slight increase from 23/24, where 49% of the population achieved a recovery outcome.

Males experienced a higher proportion achieving a recovery outcome, although this difference was not significant. There was a slight widening in the gap between females and males who achieved a recovery outcome from the 23/24 period, where there was a 2 percentage point gap between females and males.

Generally, the younger populations had a lower proportion achieving a recovery outcome compared to older patients. The gap between those under the age of 25 and those the age of 25 slightly appears to have slightly narrowed from 23/24, however the counts for patients under 25 is generally quite low which makes a comparison between years less robust.

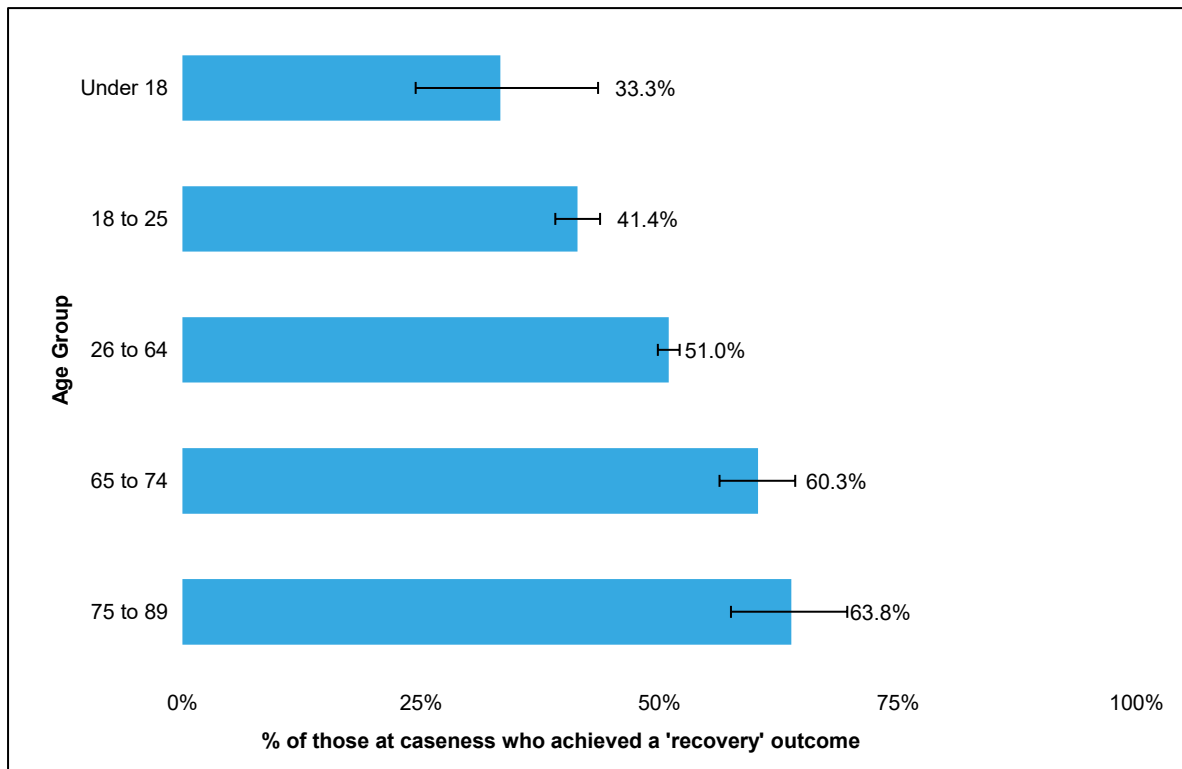
Those from the most deprived quintile experienced a significantly lower proportion who achieved a reliable recovery than those from the least deprived quintile. There was a slight widening in the gap between those from the most deprived and least deprived who achieved a recovery outcome from 23/24 to 24/25, from a 13.2 percentage point difference in 23/24 to a 14.7 percentage point difference in 24/25.

Due to low counts in ethnic minority groups, and a relatively high count of patients whose ethnicity was not known or not stated, it is difficult to infer whether there are any health inequalities due to ethnicity when it comes to achieving a recovery outcome.



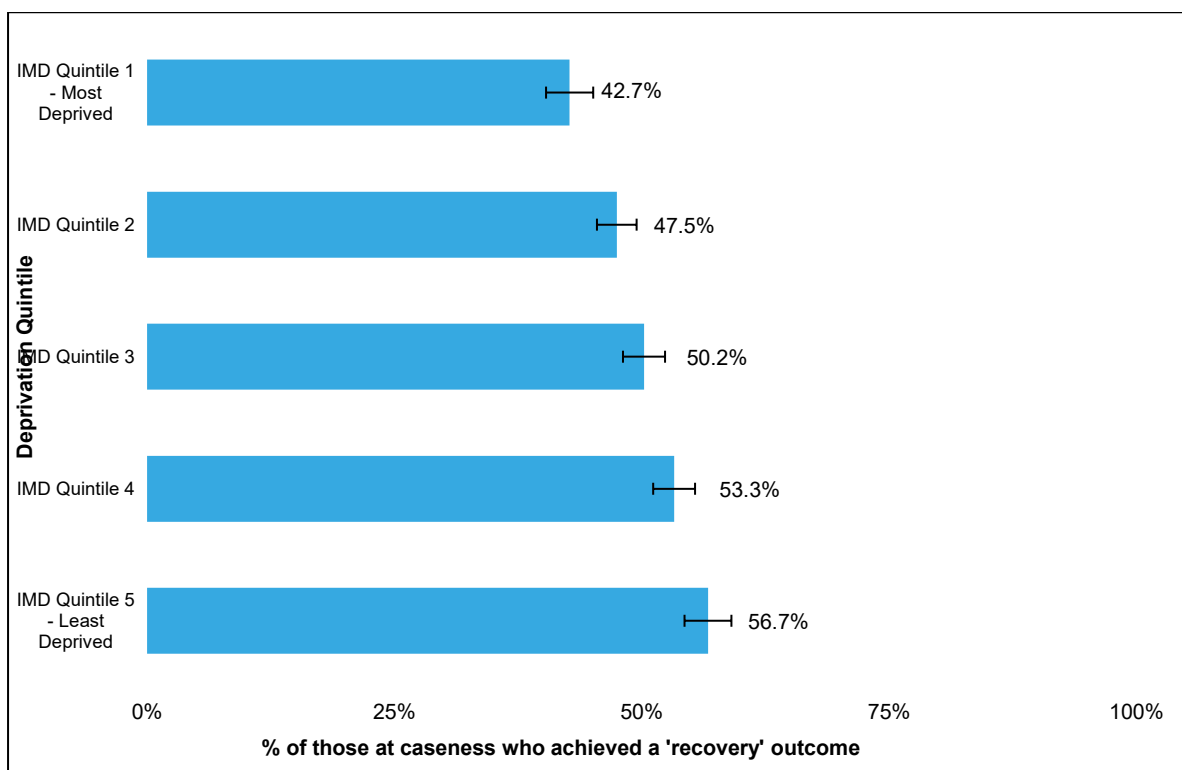
Source: [NHS Talking Therapies, for anxiety and depression, Annual reports, 2024-25](#)

Age Group



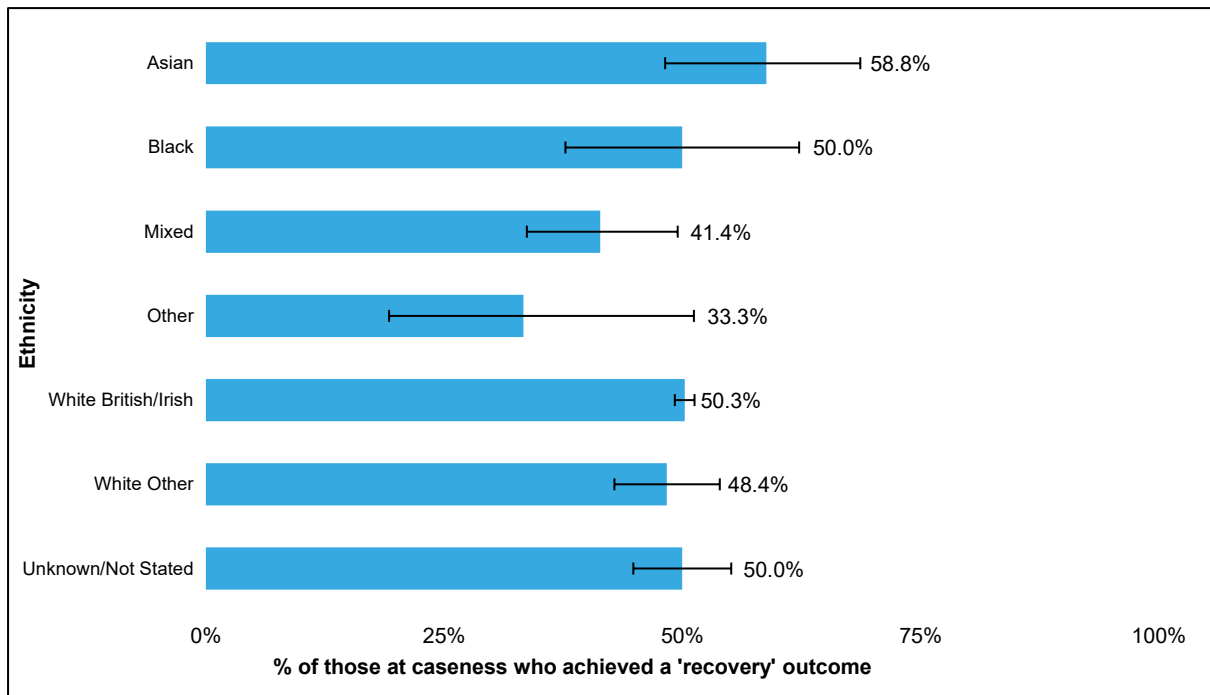
Source: [NHS Talking Therapies, for anxiety and depression, Annual reports, 2024-25](#)

Deprivation Quintile



Source: [NHS Talking Therapies, for anxiety and depression, Annual reports, 2024-25](#)

Ethnicity



Source: [NHS Talking Therapies, for anxiety and depression, Annual reports, 2024-25](#)

Talking Therapies Referral Rate

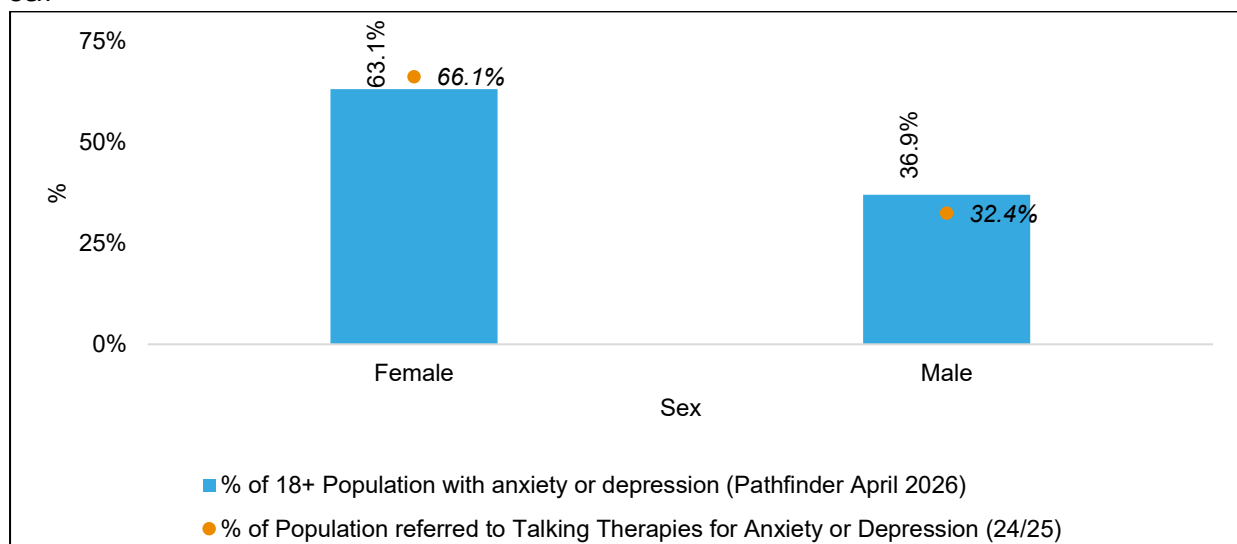
In 2024/25, there were 21,715 referrals made to NHS Talking Therapies for anxiety and/or depression. 66.1% of all referrals to talking therapies in 24/25 were females, which is slightly higher than the estimated population of the population who have anxiety or depression. This suggests that females have a slightly higher rate of referrals to talking therapies than expected, although this is a rough estimation and further exploration is needed to determine if there is a genuine inequity.

The equity split of referral uptake to anxiety/depression prevalence from a deprivation perspective suggests there are proportionately fewer referrals than expected from those who live in IMD quintile 3. It also suggests there are proportionately more referrals than expected from those who live in the least deprived quintile who have anxiety /depression.

It is difficult to reliably infer any insights from expected referrals to talking therapies from the anxiety/depression prevalence when stratifying the data by ethnicity. This is due to relatively low counts in ethnic minority groups, and a high count of people whose ethnicity is not known or not stated.

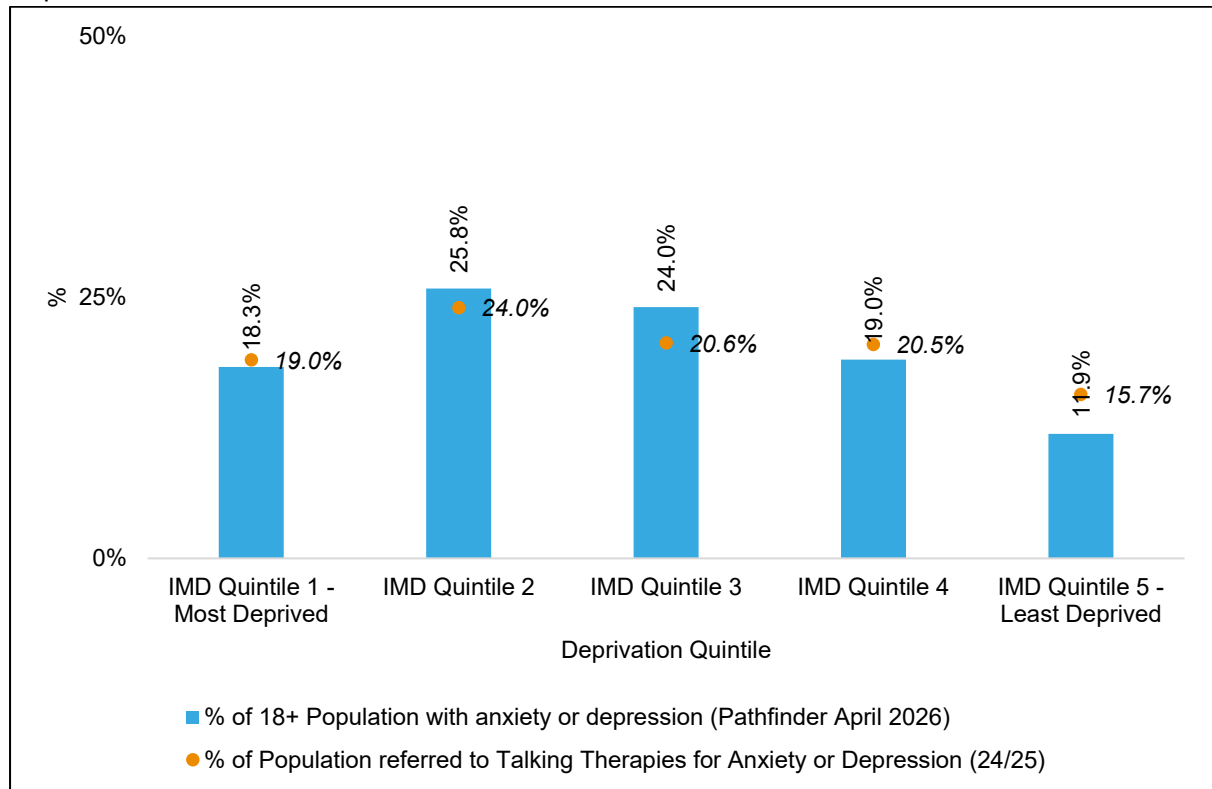
Readers should interpret these findings with caution as this analysis compares data at different time point; if data for the same time period was available for both datasets a different picture may emerge. Anxiety and/or depression prevalence can only be calculated if the relevant code/s are on a patient's health records as well. The blue bars represent the proportion of the adult population split in Lincolnshire of patients with anxiety and/or depression. For example, based on Lincolnshire Joined Intelligence data for April 2026, 213,798 of adults aged 18 and older have either anxiety and/or depression. Of this, 134,813 (63.1%) are females, and 78,978 (36.9%) are males.

Sex



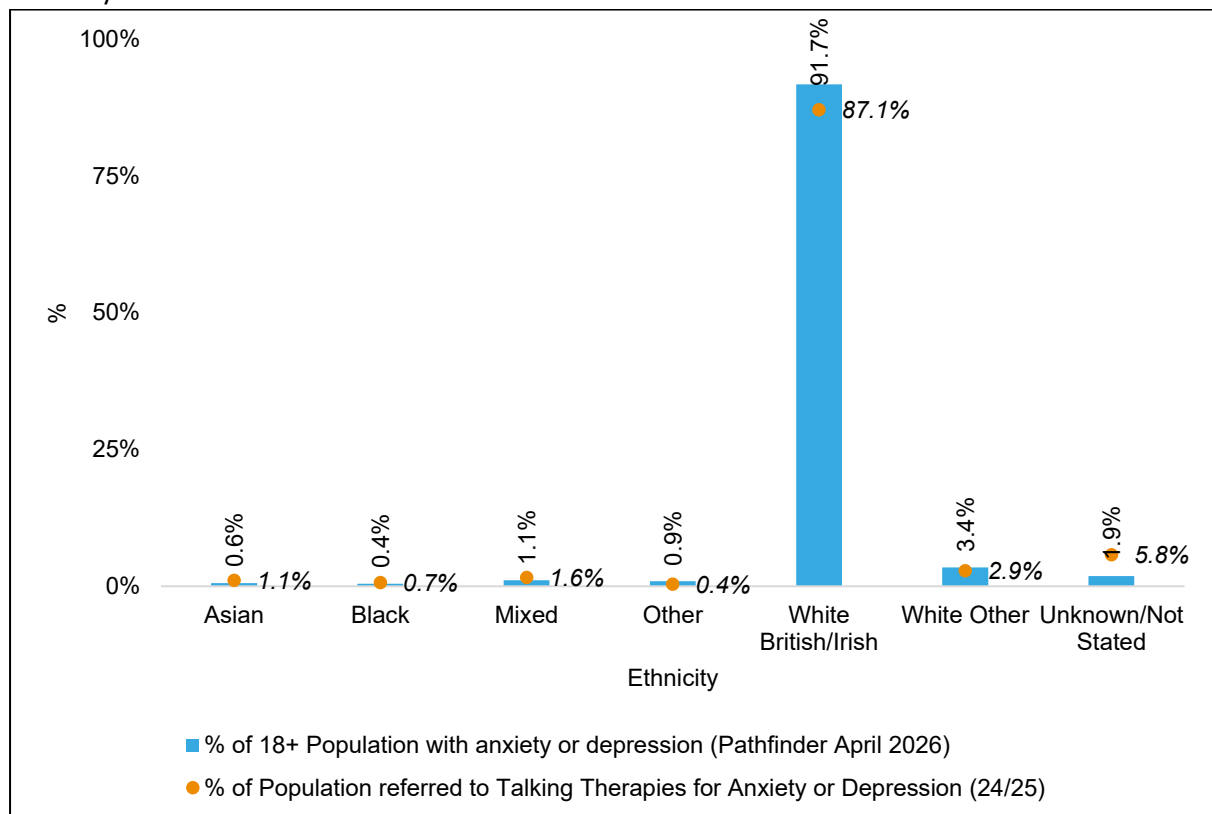
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Deprivation



Source: Lincolnshire ICS Joint Intelligence Dataset, NHS Lincolnshire ICB 2026.

Ethnicity



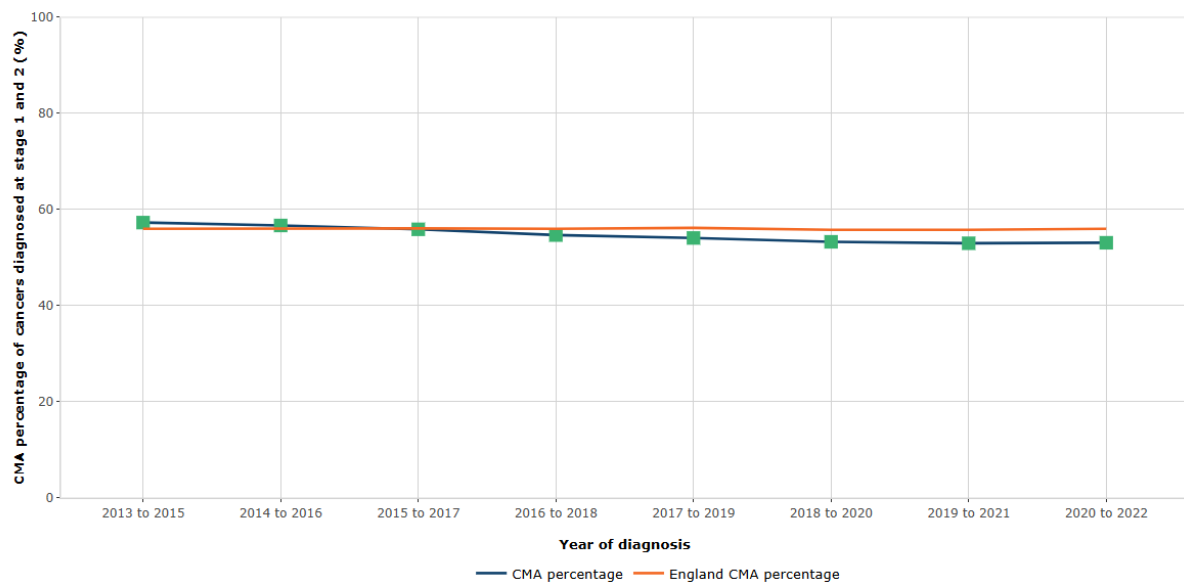
Source: Lincolnshire ICS Joint Intelligence Dataset, NHS Lincolnshire ICB 2026.

Cancer

Period: 2020-2022

In the three-year period 2020-2022, 53.1% of cancers were diagnosed at stage 1 or stage 2 (when a case mix adjustment was conducted). This was lower than the national average of 56%. The Lincolnshire trend appears to have gradually decreased over the past few reporting periods; further examination is needed to understand if this is a genuine decline or indicative of poorer outcomes.

Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex



Source: [Staging data in England \(NDRS\)](#)

Using the '[Rapid Cancer Registration Data: Incidence and Treatment Dashboard](#)', approximately 54% (no numbers available) of all cancers were diagnosed at an early stage (stage 1 or 2) in the 12 months ending December 2025. This is lower (worse) than the national average of 60% in the same period. The East Midlands Cancer Alliance has 56% of all cancers were diagnosed at an early stage (stage 1 or 2) in the 12 months ending December 2025.

Cardiovascular Disease (CVD)

Stroke- rate of non-elective admissions (per 100,000 age standardised)

Period: 2025

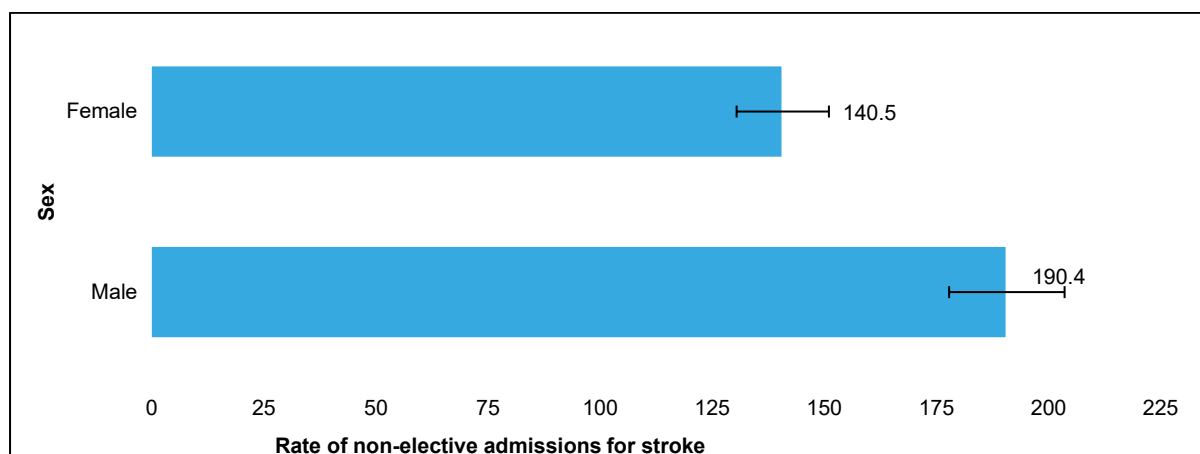
In 2025, there were 1,636 non-elective admissions for strokes in Lincolnshire ICB. This equates to an age standardised rate of 164.4 per 100,000 of the population; a slight decrease in the overall age standardised rate of 174.8 per 100,000 in 2024.

Males experienced a significantly higher rate of non-elective admissions for stroke compared to females (190.4 per 100,000 for males vs. 140.5 per 100,000 for females) – a difference of 49.9 per 100,000. While the difference between males and females has been consistently significantly different for the past three reporting periods, the difference between has slightly reduced between 2024 and 2025. The gap in 2024 was 54.0 per 100,000, compared to a gap of 49.9 per 100,000 in 2025.

Those who lived in the most deprived quintile experienced a significantly higher rate of non-elective admissions for stroke compared to those who lived in the least deprived quintile (207.6 per 100,000 for those living in the most deprived quintile vs. 149.3 per 100,000 for those living in the least deprived quintile) – a gap of 58.3 per 100,000. This marks a slight widening of the gap in the rate of non-elective admissions for stroke between the most and least deprived populations compared to 2024. In 2024, the gap was 44.7 per 100,000 (213.5 per 100,000 for those living in the most deprived quintile vs. 168.8 per 100,000 for those living in the least deprived quintile).

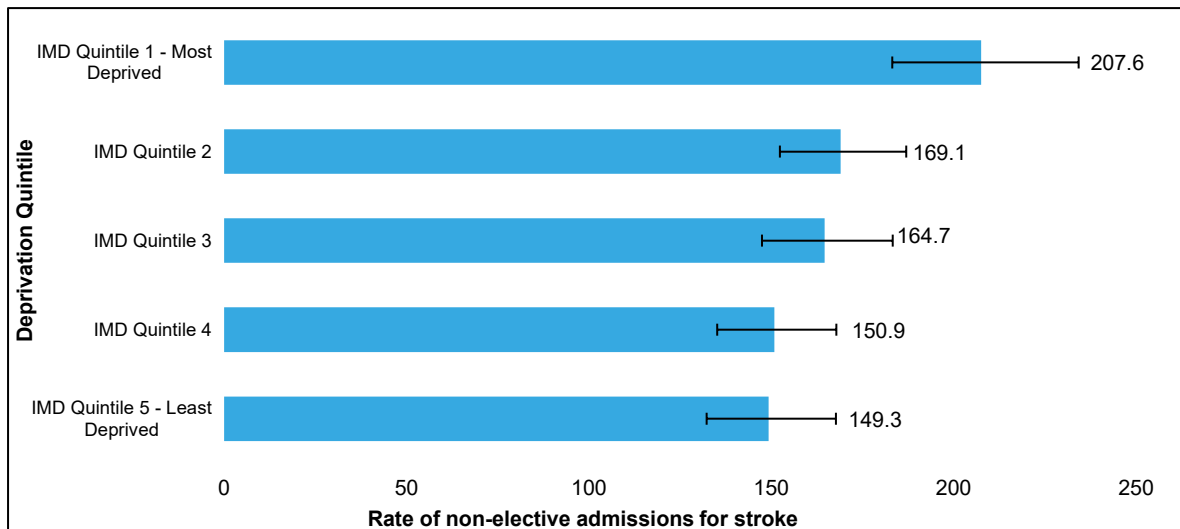
Due to low counts in ethnic minority groups, and a relatively high count of patients whose ethnicity was not known or not stated, it is difficult to infer whether there are any health inequalities due to ethnicity when it comes to rate of non-elective admissions for stroke.

Sex



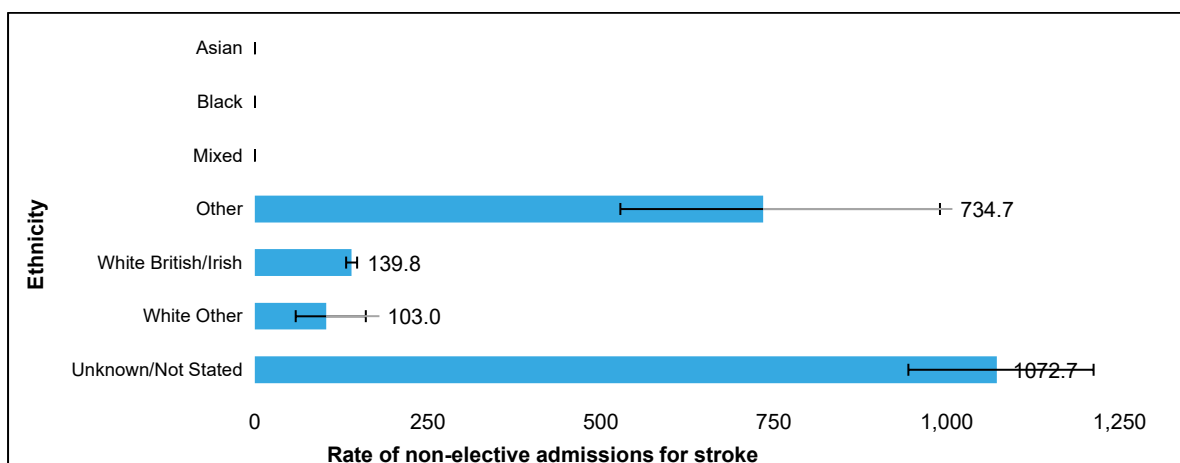
Sources: Secondary Use Services (SUS) Admitted Patient Care dataset; Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Deprivation



Sources: Secondary Use Services (SUS) Admitted Patient Care dataset; Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Ethnicity



Sources: Secondary Use Services (SUS) Admitted Patient Care dataset; Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Myocardial infarction – rate of non-elective admissions (per 100,000 age standardised)

Period: 2025

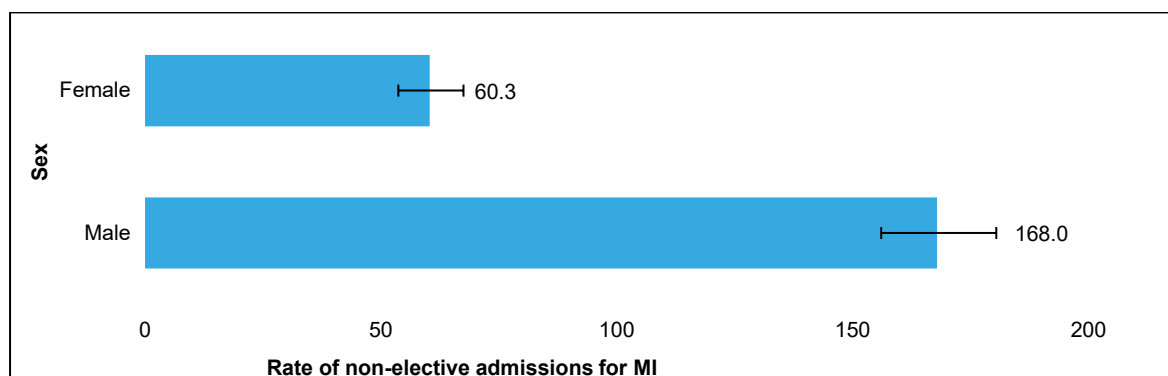
In 2025, there were 1,088 non-elective admissions for myocardial infarctions in Lincolnshire ICB. This equates to an age standardised rate of 112.2 per 100,000 of the population. This marks a slight decrease in the age standardised rate of non-elective admissions for myocardial infarction in 2024 (131.5 per 100,000 in 2024 vs. 112.2 per 100,000 in 2025).

Males experienced a significantly higher rate of non-elective admissions for myocardial infarction compared to females (168.0 per 100,000 for males vs. 60.3 per 100,000 for females) – a difference of 114.7 per 100,000. While the difference between males and females has been consistently significantly different for the past three reporting periods, the difference between has slightly reduced between 2024 and 2025. The gap in 2024 was 114.7 per 100,000, compared to a gap of 107.7 per 100,000 in 2025.

Those who lived in the most deprived quintile experienced a significantly higher rate of non-elective admissions for myocardial infarction compared to those who lived in the least deprived quintile (146.7 per 100,000 for those living in the most deprived quintile vs. 103.8 per 100,000 for those living in the least deprived quintile) – a gap of 42.9 per 100,000. This marks a slight narrowing of the gap in the rate of non-elective admissions for myocardial infarction between the most and least deprived populations compared to 2024. In 2024, the gap was 45.2 per 100,000 (169.0 per 100,000 for those living in the most deprived quintile vs. 123.8 per 100,000 for those living in the least deprived quintile).

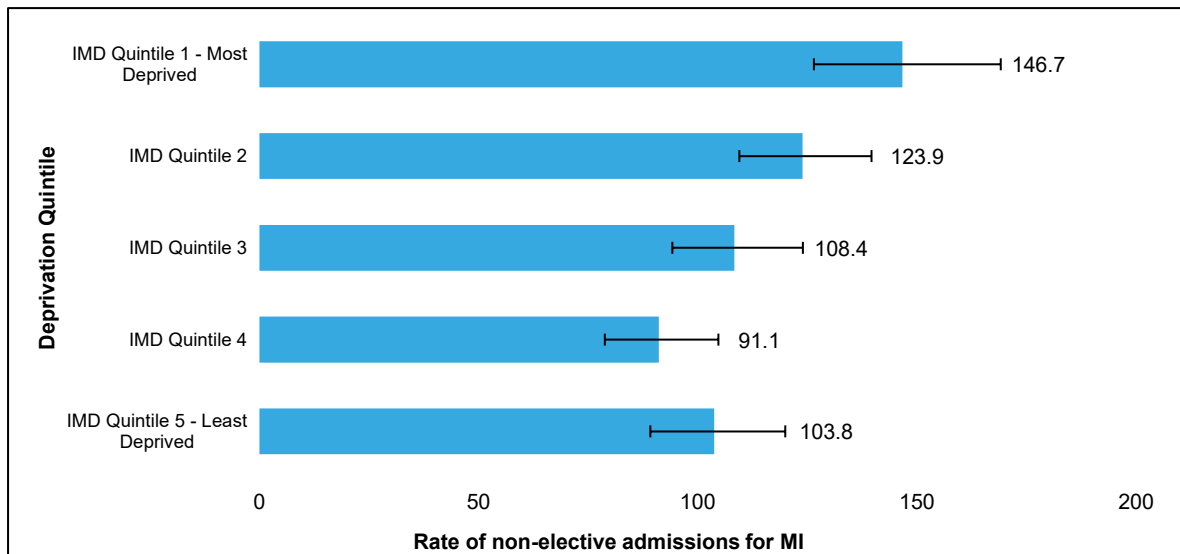
Due to low counts in ethnic minority groups, and a relatively high count of patients whose ethnicity was not known or not stated, it is difficult to infer whether there are any health inequalities due to ethnicity when it comes to rate of non-elective admissions for myocardial infarction.

Sex



Sources: Secondary Use Services (SUS) Admitted Patient Care dataset; Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Deprivation



Sources: Secondary Use Services (SUS) Admitted Patient Care dataset; Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

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)

Period: Jan to Dec 2025

In 2025, 71.8% of those with GP recorded hypertension had their latest blood pressure reading below the appropriate treatment threshold. This is an increase of 2.5 percentage points in 2024.

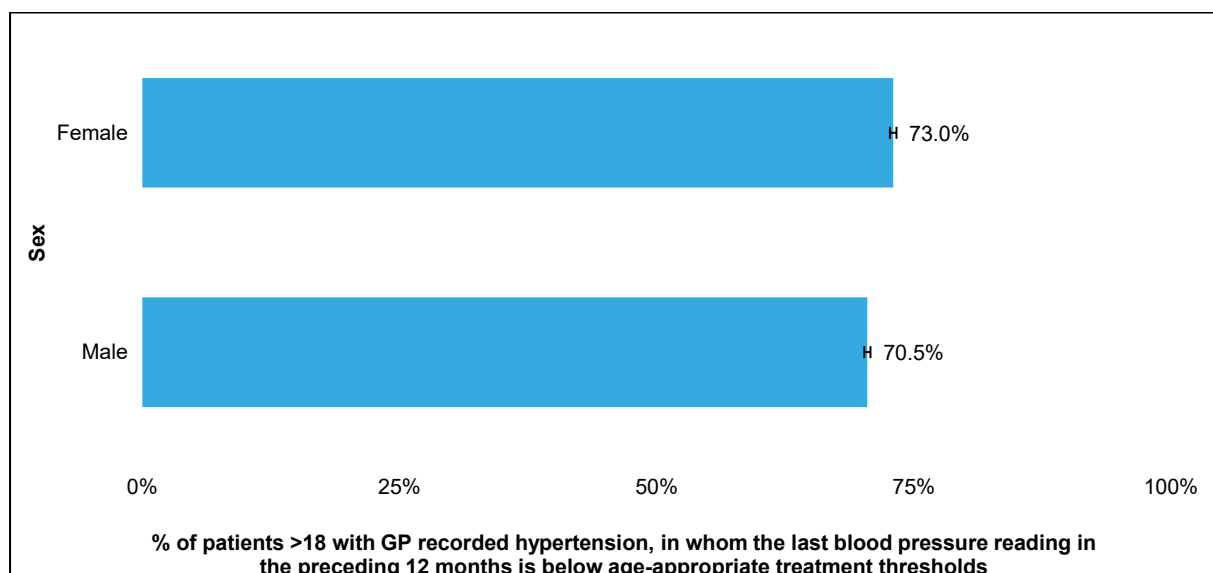
Females experienced a significantly higher proportion of optimal hypertension management than males. The gap between females and males having optimal blood pressure management slightly increased from 2 percentage points in 2024 to 2.5 percentage points in 2025, in favour of females.

Those with GP recorded hypertension under the age of 60 had a significantly lower proportion who had their hypertension optimally managed. The gap between those aged under 60 and over 60 who have their hypertension optimally managed slightly widened from 16.6 percentage points in 2024 to 17.9 percentage points in 2025.

Those with GP recorded hypertension living in the most deprived quintile had a significantly lower proportion who had their hypertension optimally managed than those living in the least deprived quintile. The gap between the most deprived and least deprived populations slightly narrowed from 2024 to 2025, from a 5.1 percentage point difference to a 4.3 percentage point difference.

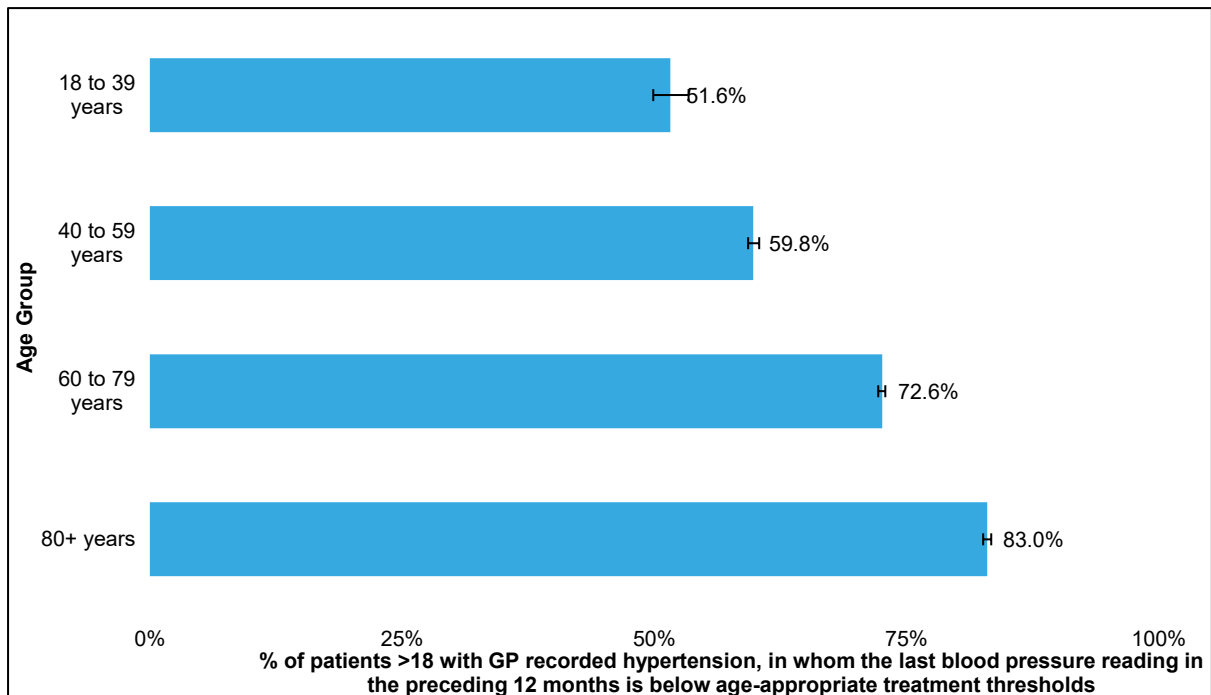
Given the relatively low counts of those from different ethnic minority backgrounds compared to the White population, it is difficult to state with certainty whether there is a genuine inequality in hypertension management based on ethnicity and whether there has been an improving or worsening picture compared to 2024.

Sex



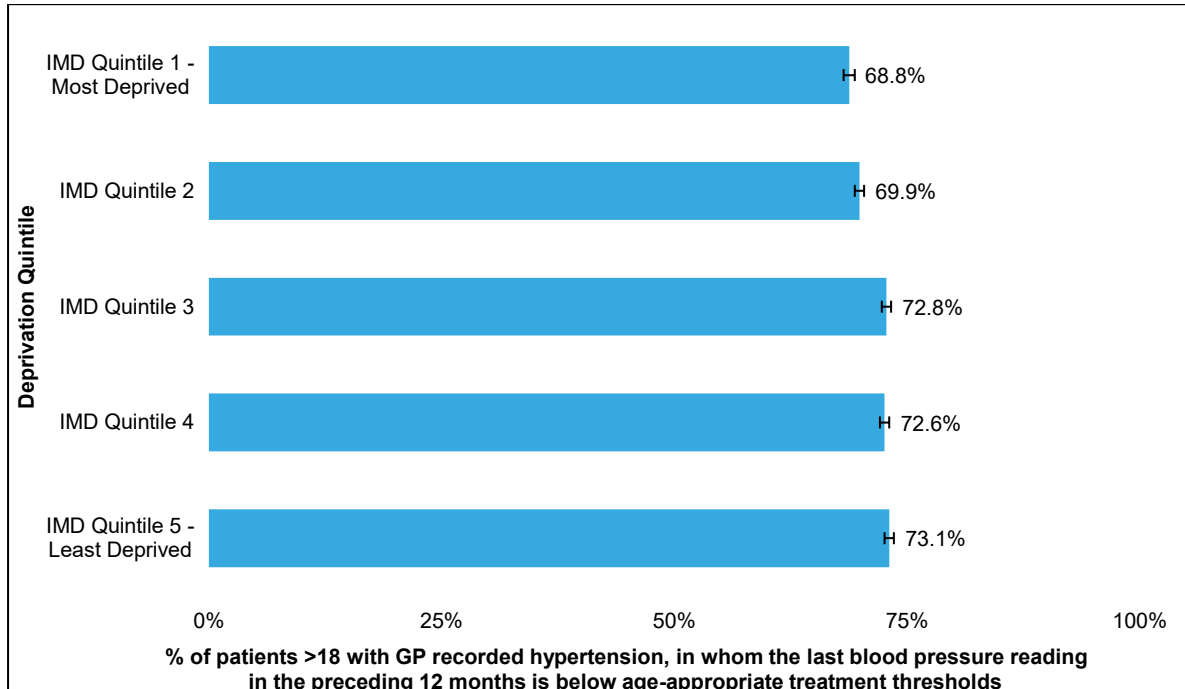
Source: [CVD Prevent Data Explorer \(HYP007\)](#)

Age



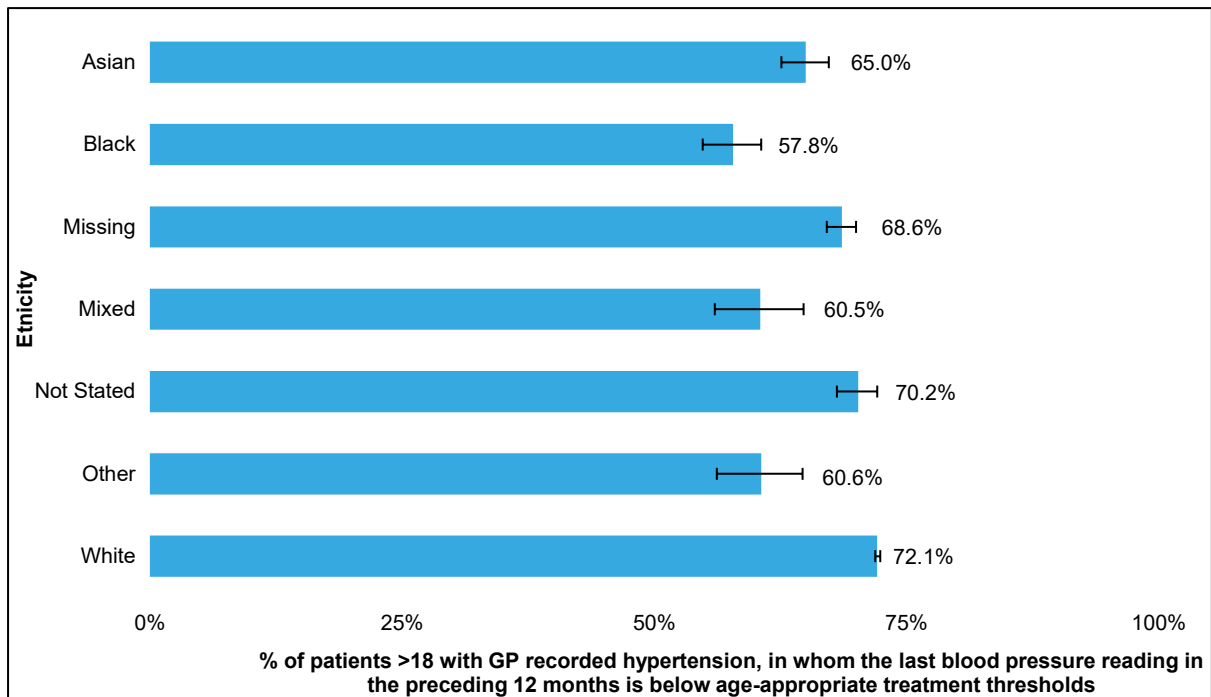
Source: [CVD Prevent Data Explorer \(HYP007\)](#)

Deprivation



Source: [CVD Prevent Data Explorer \(HYP007\)](#)

Ethnicity



Source: [CVD Prevent Data Explorer \(HYP007\)](#)

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

Period: Jan to Dec 2025

In 2025, 66.6% of patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, were being treated with lipid lowering therapy. This is an increase from 2024, where 64.2% of patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, were being treated with lipid lowering therapy.

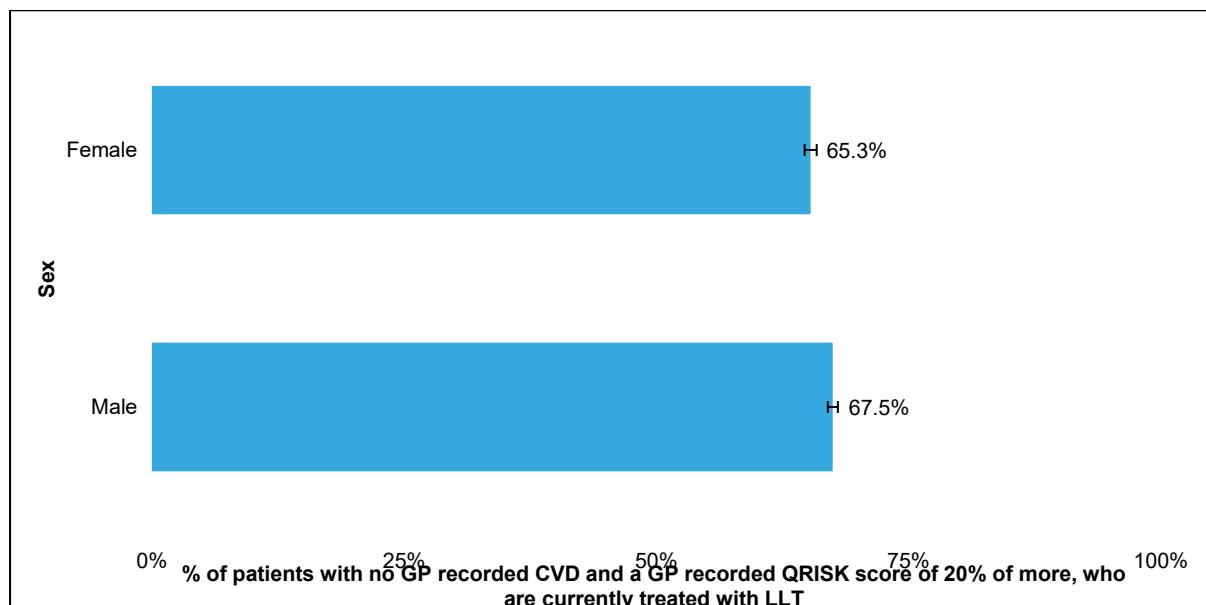
A higher proportion of male patients were on LLT compared to females. There was very little change in the proportion between females and males on LLT from 2024 to 2025 (2.4 percentage point difference in 2024 vs. 2.2 percentage point difference in 2025).

Those under the age of 60 with no GP recorded CVD and a GP recorded QRISK score of 20% or more had a higher proportion of LLT compared to adults over the age of 60. The gap between under 60s and over 60s who received LLT narrowed quite a lot between 2024 and 2025. In 2024, the gap between under 60s and over 60s who received LLT was 13.4 percentage points, compared to 7.4 percentage points in 2025.

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. There was a slight widening in the gap of patients from the most and least deprived quintiles being treated with LLT from 2024 to 2025. In 2024, the gap was 5.9 percentage points, and in 2025 this gap was 7.3 percentage points (with those living in the most deprived quintile having the higher uptake of LLT).

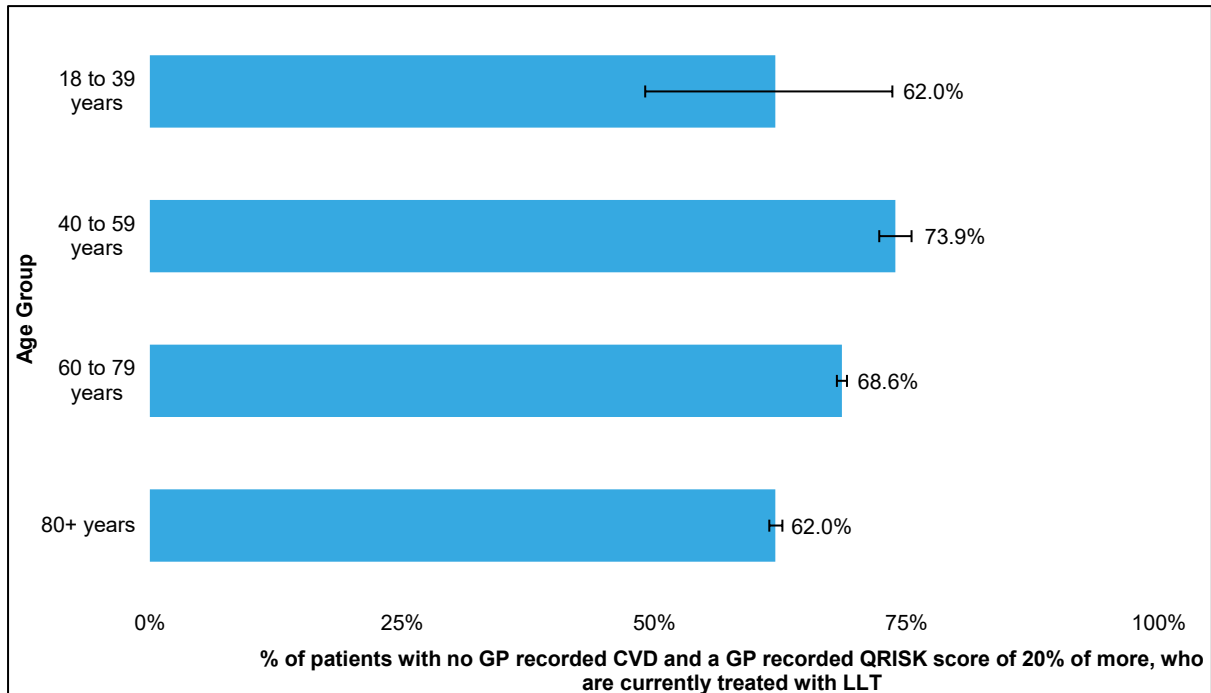
Given the relatively low counts of those from different ethnic minority backgrounds compared to the White population, it is difficult to state with certainty whether there is a genuine inequality in treatment with LLT based on ethnicity.

Sex



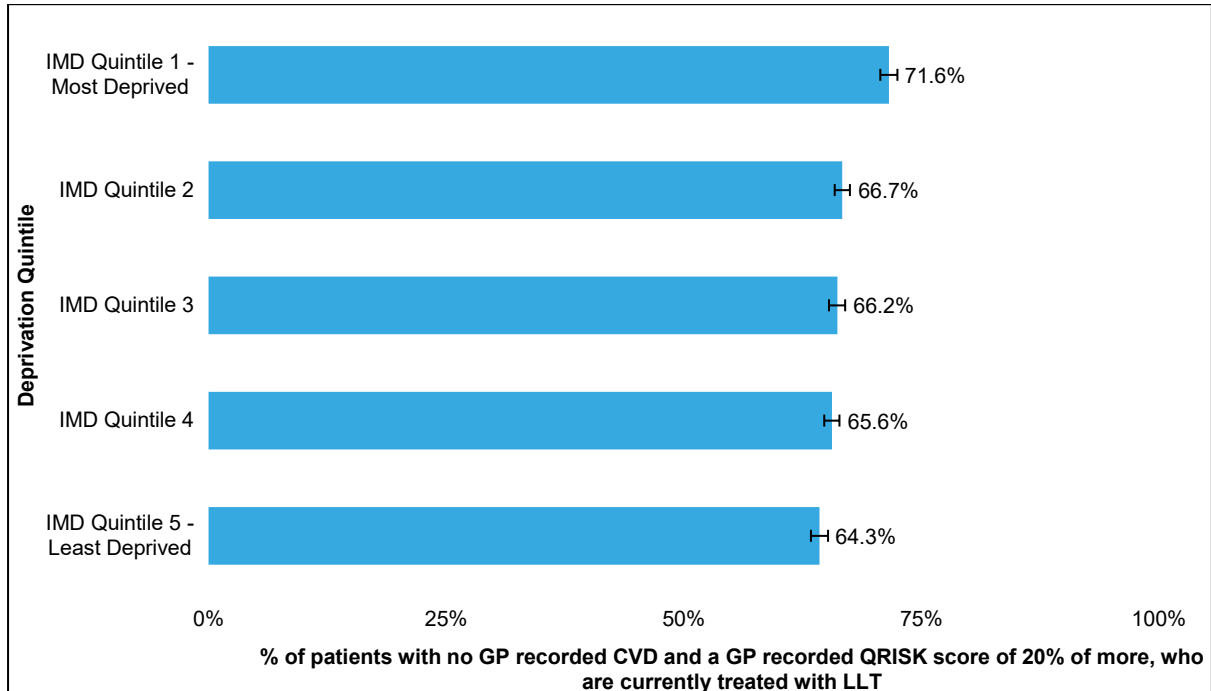
Source: [CVD Prevent Data Explorer \(CHOL003\)](#)

Age



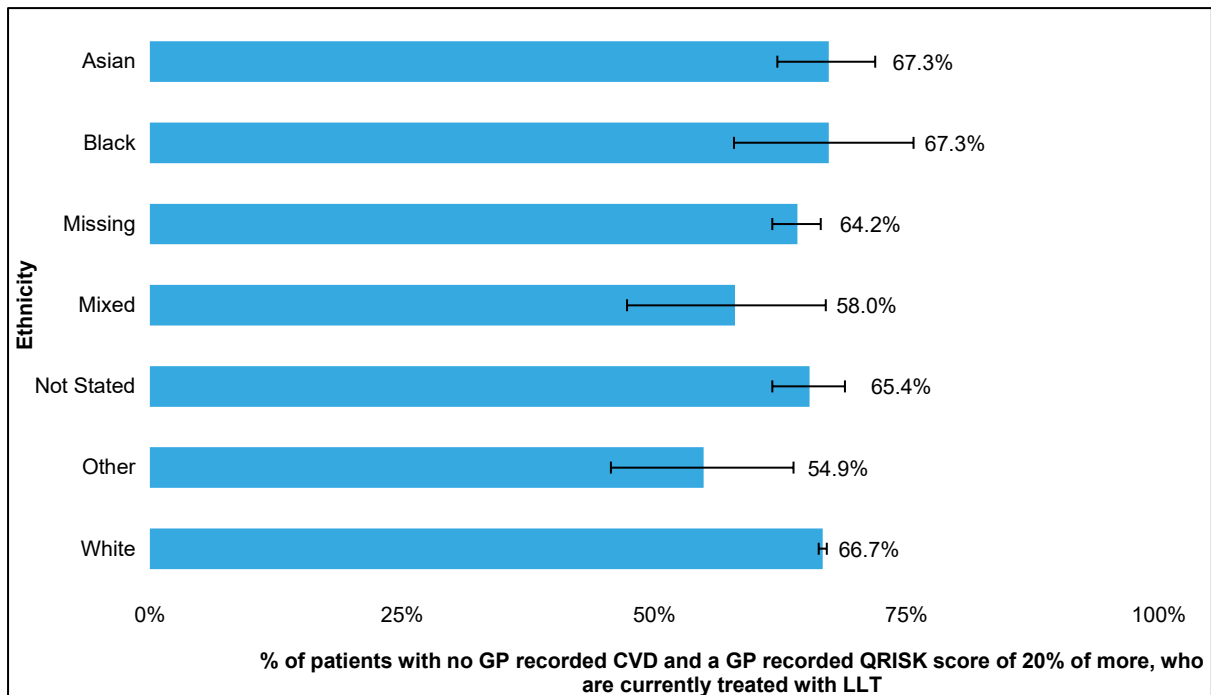
Source: [CVD Prevent Data Explorer \(CHOL003\)](#)

Deprivation



Source: [CVD Prevent Data Explorer \(CHOL003\)](#)

Ethnicity



Source: [CVD Prevent Data Explorer \(CHOL003\)](#)

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

Period: Jan to Dec 2025

In 2025, 94.2% of patients with GP recorded atrial fibrillation and with a CHADS2 or CHA2DS2-VASc score of 2 or more are currently being treated with oral anti-coagulants. This is similar to 2024 (94.1%).

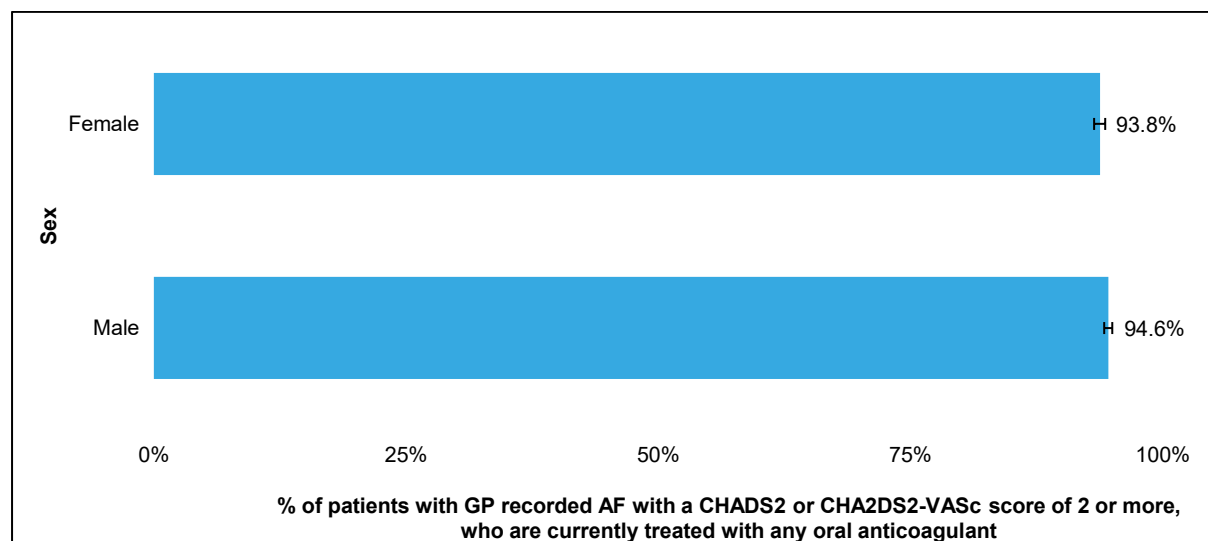
There is no significant difference between females and males, and there was no change in the gap between females and males from 2024 to 2025.

Patients over the age of 60 have a significantly higher uptake compared to under 60s, and there was no change in the gap between under 60s and over 60s from 2024 to 2025.

There is no significant difference between patients from the most deprived and least deprived quintiles, and there was no change in the gap between the most and least deprived quintiles from 2024 to 2025.

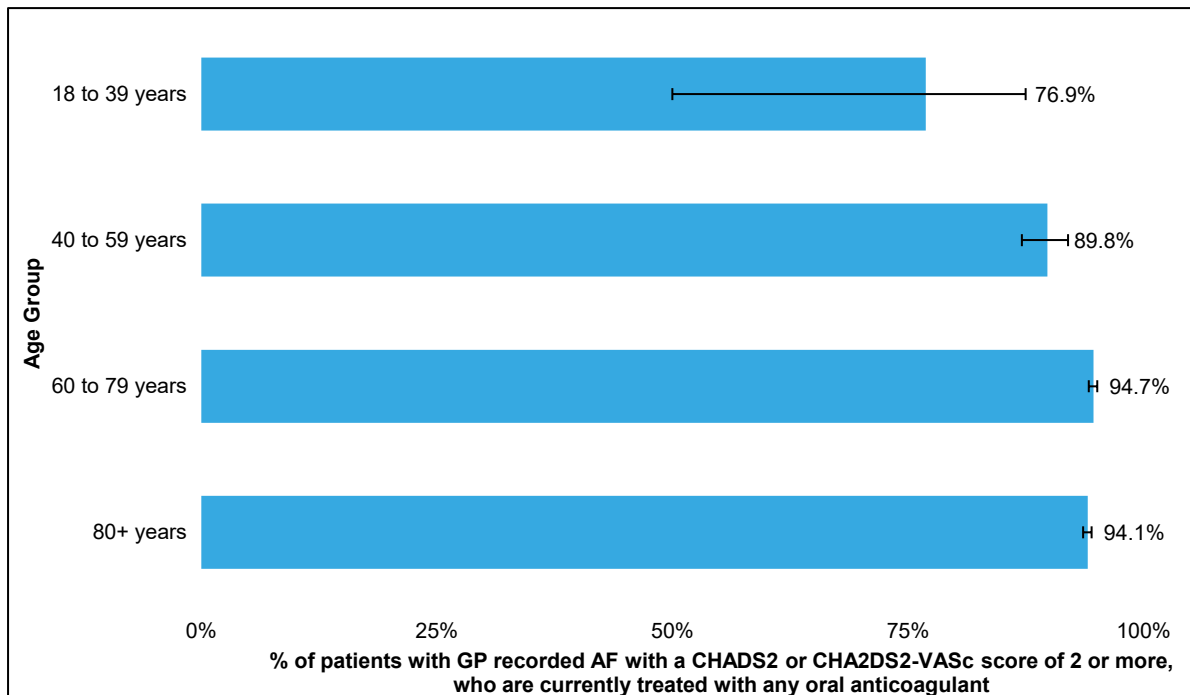
Given the relatively low counts of those from different ethnic minority backgrounds compared to the White population, it is difficult to state with certainty whether there is a genuine inequality in treatment with oral anticoagulants based on ethnicity.

Sex



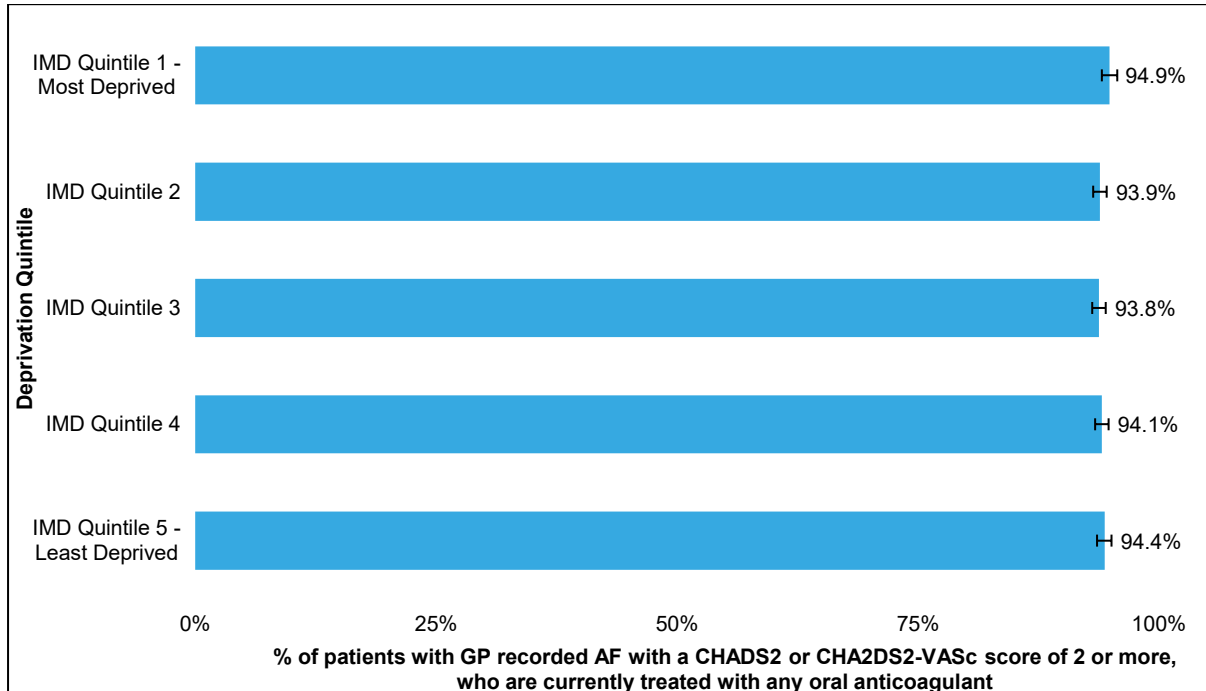
Source: [CVD Prevent Data Explorer \(AF002\)](#)

Age



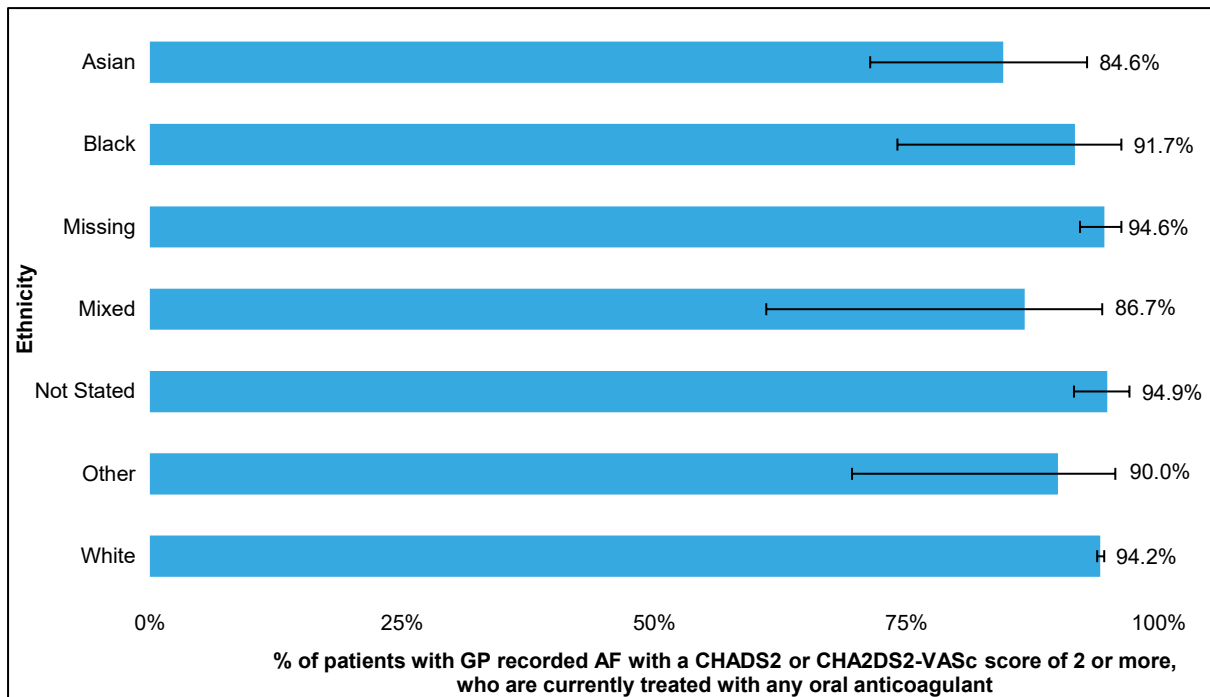
Source: [CVD Prevent Data Explorer \(AF002\)](#)

Deprivation



Source: [CVD Prevent Data Explorer \(AF002\)](#)

Ethnicity



Source: [CVD Prevent Data Explorer \(AF002\)](#)

Diabetes

Variation between percentage of people with Type 1 Diabetes receiving all 8 care processes

Period: 25/26

37.1% (1522/4107) patients with type 1 diabetes received all 8 care processes in the 12-month period from April 2025 to March 2026. This represents a slight increase from the 12-month period from April 2024 to March 2025, when 35.5% of patients with type 1 diabetes received all 8 care processes.

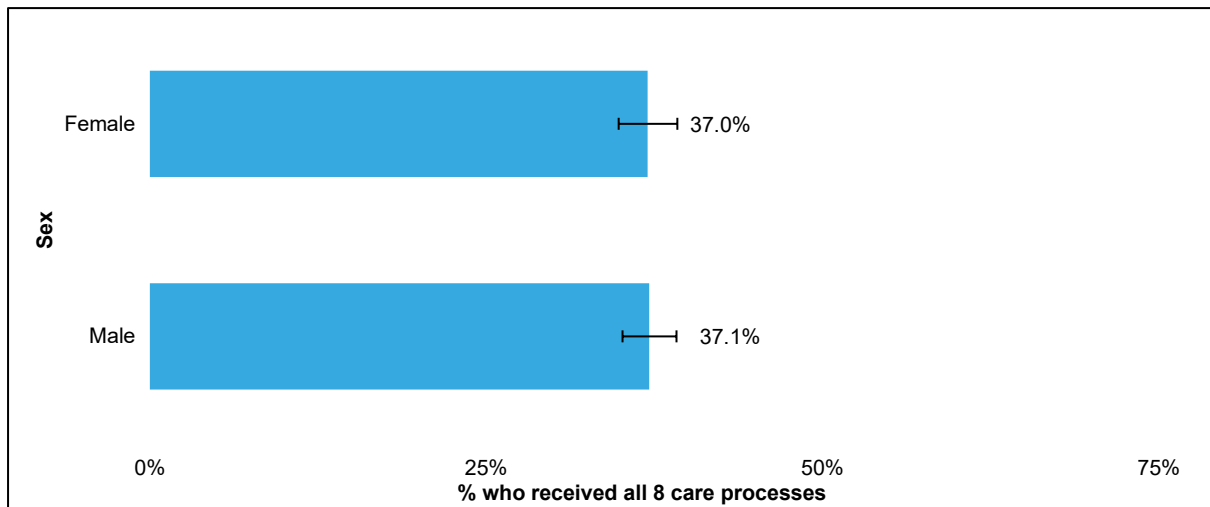
There was only a 0.1 percentage point difference in the proportion of females (37.0%; 695/1,878) and males (37.1%; 826/2,225) with type 1 diabetes who received all 8 care processes in the 25/26 period. The gap slightly closed from the previous 12-month period, when 35.2% (627/1,781) of females and 35.7% (767/2,148) of males with type 1 diabetes received all 8 care processes. This suggests there is no significant difference between the sexes in the uptake of all 8 care processes for patients with type 1 diabetes.

Uptake of all 8 care processes generally increased with age. In the 24/25 period, and the 25/26 period, those aged between 70 and 79 had the highest uptake of all 8 care processes (56.7% in 24/25; 59.2% in 25/26). While the uptake of care processes looks very low in those aged 10 to 19 years, it should be noted diabetes is generally managed in secondary care rather than primary care (this report pulls data from primary care data only). Uptake is generally lowest in adults under the age of 50.

27.7% (185/668) patients with type 1 diabetes who lived in the most deprived quintile in Lincolnshire received all 8 care processes, whereas 42.5% (194/456) patients with type 1 diabetes who lived in the least deprived quintile in Lincolnshire received all 8 care processes; a difference of 14.8 percentage points. This gap has slightly decreased from the 24/25 period, where the gap was 18.8 percentage points. This narrowing appears to be caused by a slight increase in the proportion of those who live in the most deprived quintile who receive all 8 care processes, as well as a slight decrease in the proportion of those who live in the least deprived quintile. The Slope Index of Inequality (SII) in 25/26 was 13.29%, and the Relative Index of Inequality was 1.43%. This suggests those in the least deprived population are about 43% more likely to receive all 8 care processes compared to those in the most deprived population.

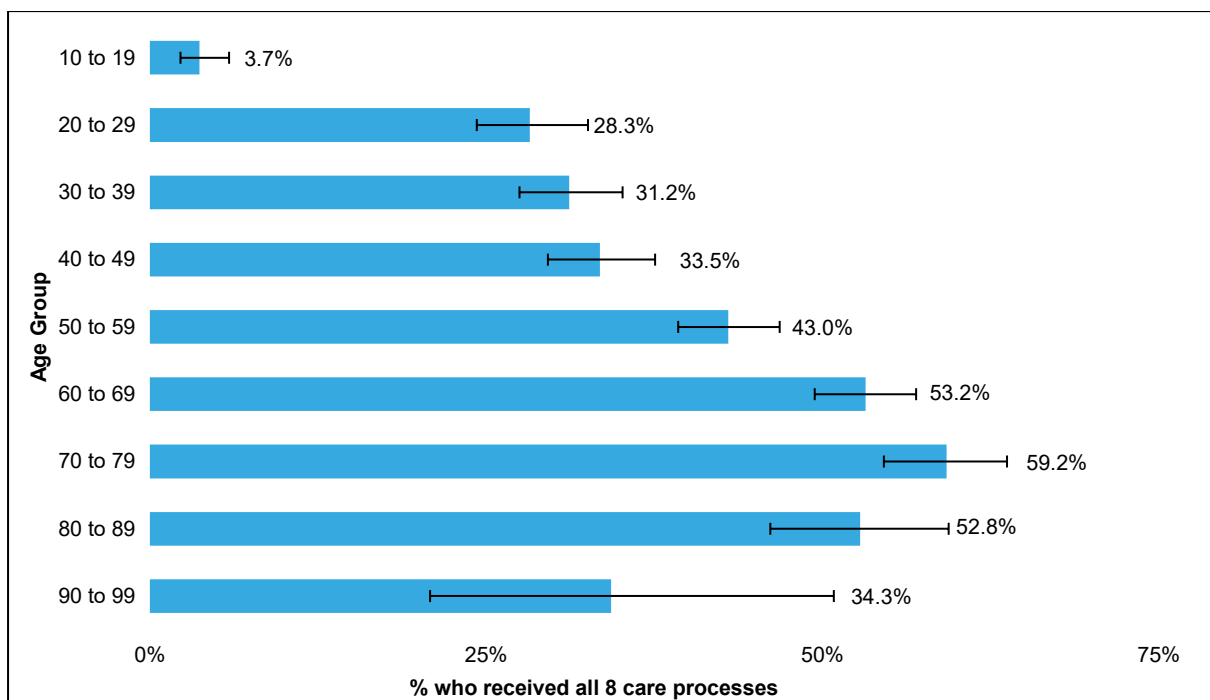
Given the relatively low counts of those from different ethnic minority backgrounds compared to the White British/Irish population, it is difficult to state with certainty whether there is a genuine inequality who receive all 8 care processes.

Sex



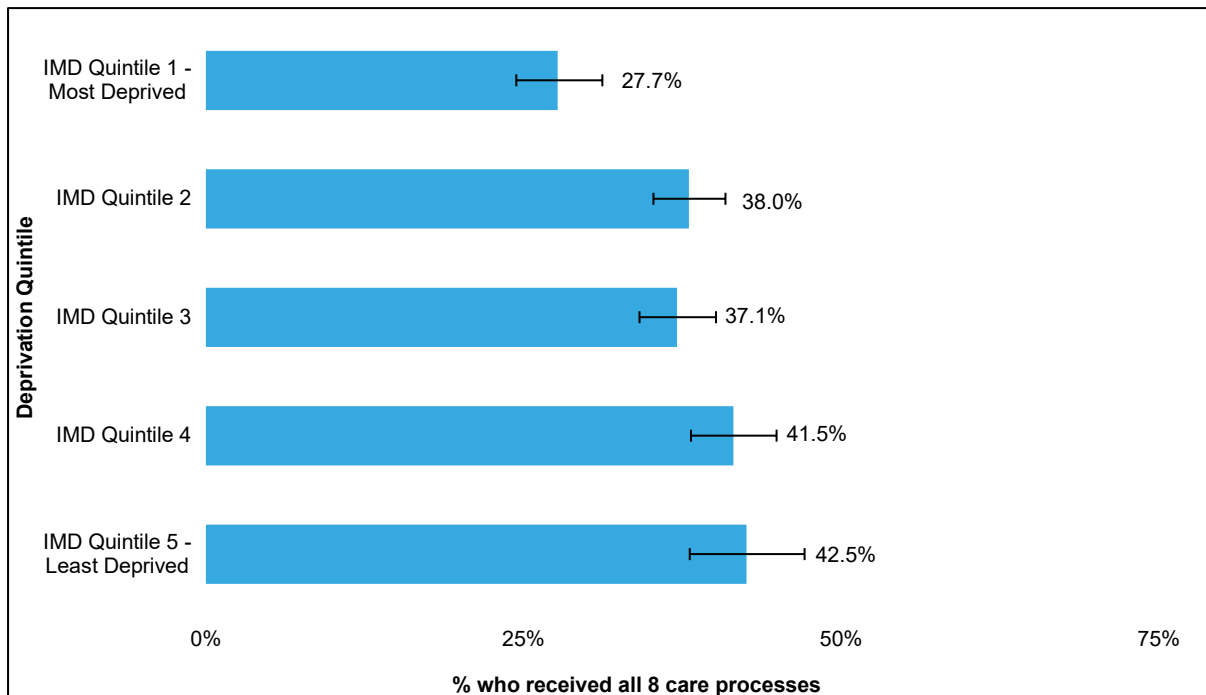
Source: Lincolnshire ICS Joint Intelligence Dataset, NHS Lincolnshire ICB 2026.

Age



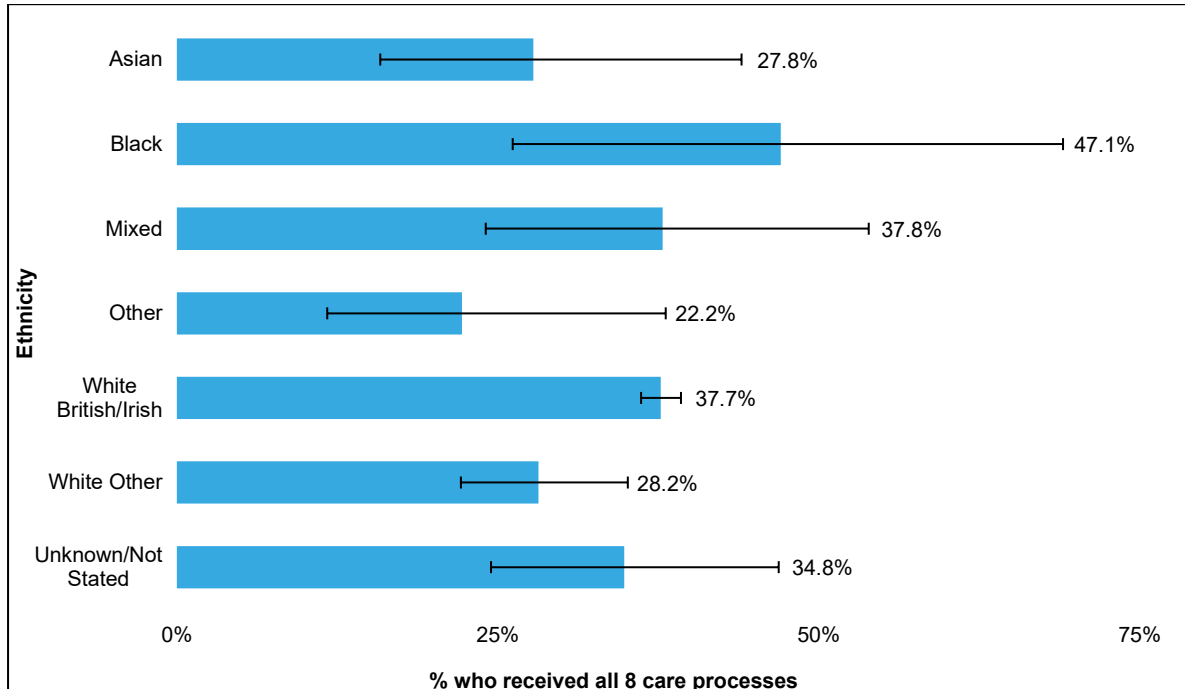
Source: Lincolnshire ICS Joint Intelligence Dataset, NHS Lincolnshire ICB 2026.

Deprivation



Source: Lincolnshire ICS Joint Intelligence Dataset, NHS Lincolnshire ICB 2026.

Ethnicity



Source: Lincolnshire ICS Joint Intelligence Dataset, NHS Lincolnshire ICB 2026.

Variation between percentage of people with Type 2 Diabetes receiving all 8 care processes
Period: 25/26

53.2% (29,432/55,278) of patients with type 2 diabetes received all 8 care processes in the 12-month period from April 2025 to March 2026. This represents a slight increase from the 12-month period from April 2024 to March 2025, when 52.0% of patients with type 1 diabetes received all 8 care processes.

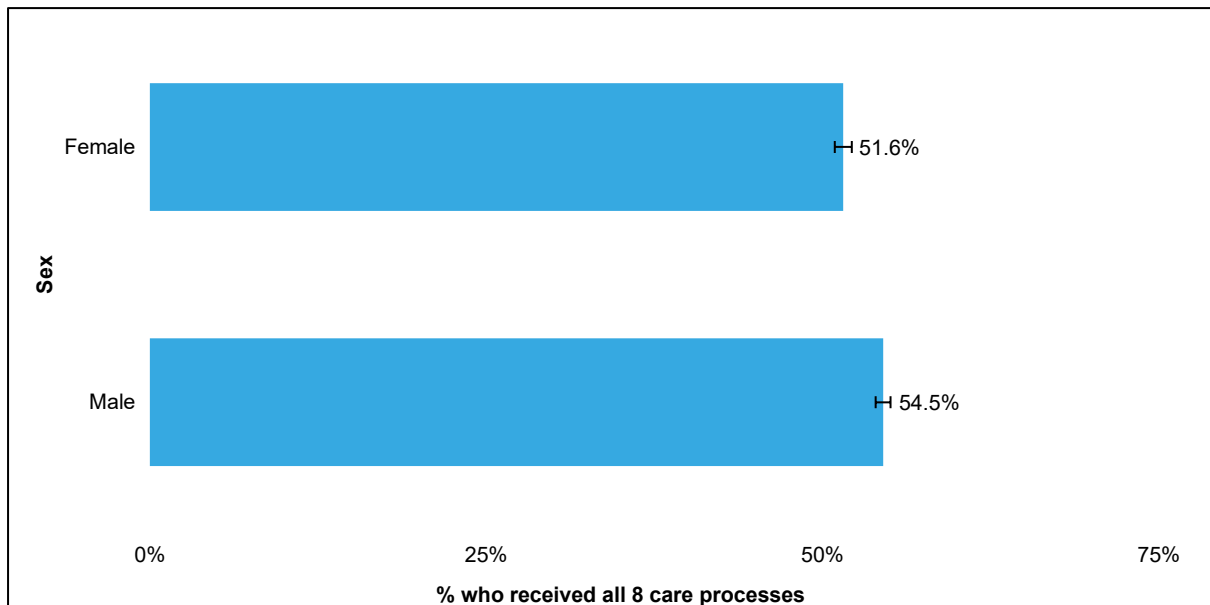
There was a 2.9 percentage point difference in the proportion of females (51.6%; 12,393/24,004) and males (54.5%; 16,992/31,172) with type 2 diabetes who received all 8 care processes in the 25/26 period. The gap of 1.2 percentage points remained from the previous 12-month period, when 50.4% (11,720/23,250) of females and 53.3% (16,992/31,172) of males with type 2 diabetes received all 8 care processes. This suggests there is a significant difference between the sexes in the uptake of all 8 care processes for patients with type 2 diabetes.

Uptake of all 8 care processes generally increased with age. In the 24/25 period, and the 25/26 period, those aged between 70 and 79 had the highest uptake of all 8 care processes (59.3% in 24/25; 60.9% in 25/26). While the uptake of care processes looks very low in those aged 10 to 19 years, it should be noted diabetes is generally managed in secondary care rather than primary care (this report pulls data from primary care data only). Uptake is generally lowest in adults under the age of 50. Those in the 20 to 29 years, and the 30 to 39 years age groups, saw a slight decrease in the proportion who received all 8 care processes, whereas all other age groups experienced an increase in uptake. This may warrant further investigation to understand whether the decrease in younger adults is a blip, or may show indications of a trend.

47.7% (5,106/10,704) of patients with type 2 diabetes who lived in the most deprived quintile in Lincolnshire received all 8 care processes, whereas 62.2% (3,535/5,686) of patients with type 2 diabetes who lived in the least deprived quintile in Lincolnshire received all 8 care processes; a difference of 14.5 percentage points. This gap has slightly increased from the 24/25 period, where the gap was 13.5 percentage points. This widening appears to be caused by a 4.2 percentage point increase in the proportion of those who live in the least deprived quintile who receive all 8 care processes (58.0% in 24/25, to 62.2% in 25/26), whereas those who live in the most deprived quintile had a 3.2 percentage point increase (44.5% in 24/25, to 47.7% in 25/26). The Slope Index of Inequality (SII) in 25/26 was 13.91%, and the Relative Index of Inequality was 1.28%. This suggests those in the least deprived population are about 28% more likely to receive all 8 care processes compared to those in the most deprived population.

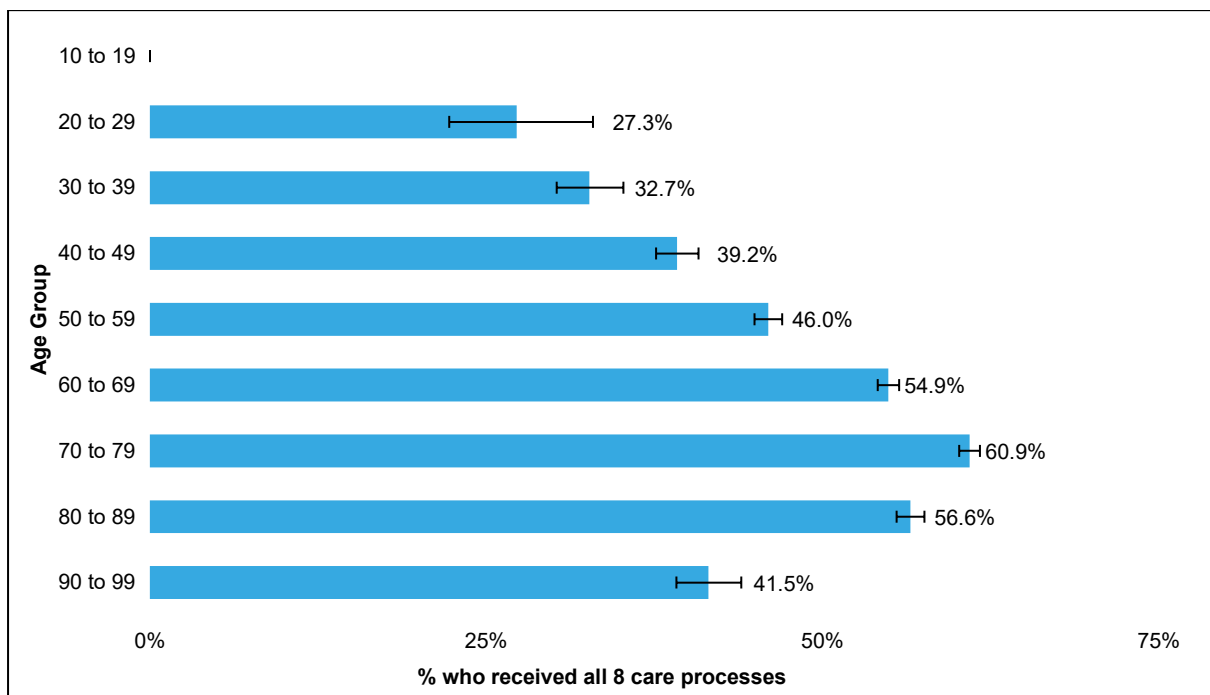
Given the relatively low counts of those from different ethnic minority backgrounds compared to the White British/Irish population, it is difficult to state with certainty whether there is a genuine inequality who receive all 8 care processes.

Sex



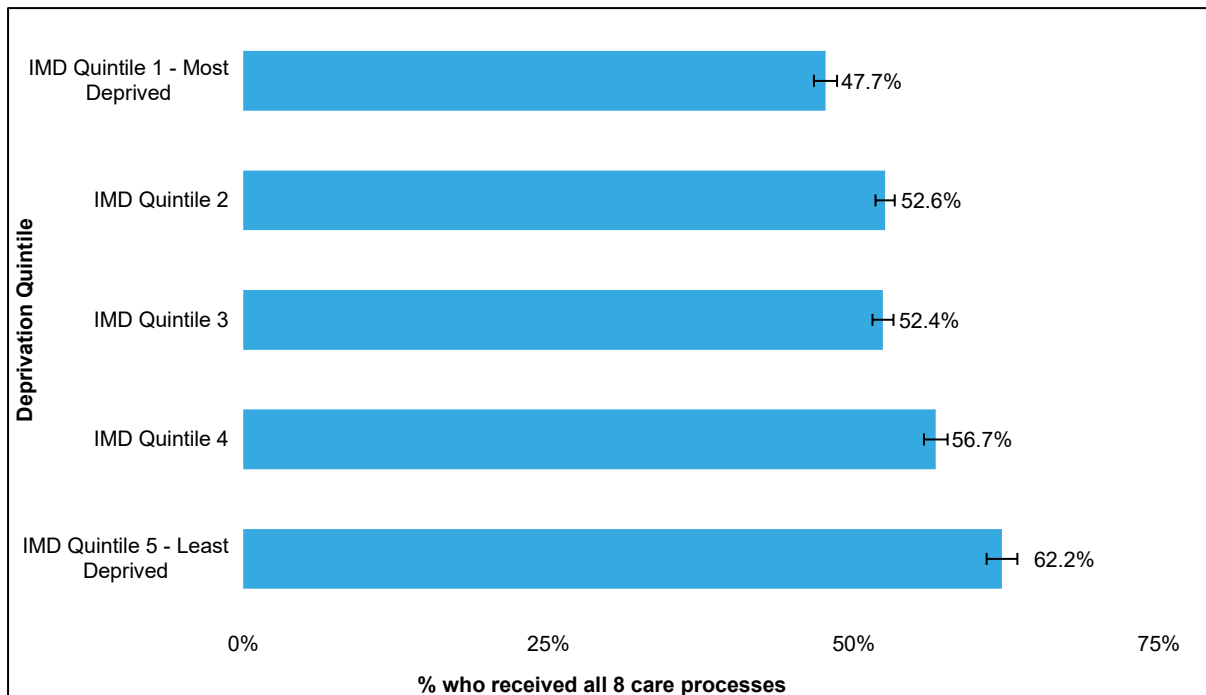
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Age



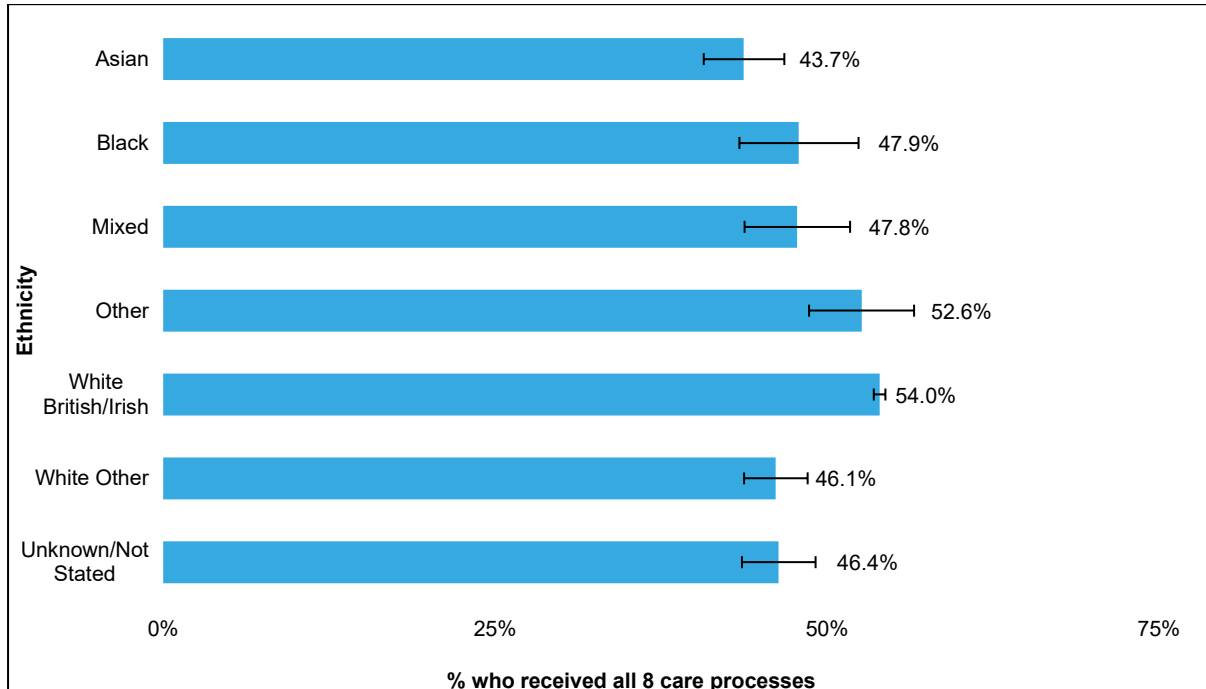
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Deprivation



Source: Lincolnshire ICS Joint Intelligence Dataset, NHS Lincolnshire ICB 2026.

Ethnicity



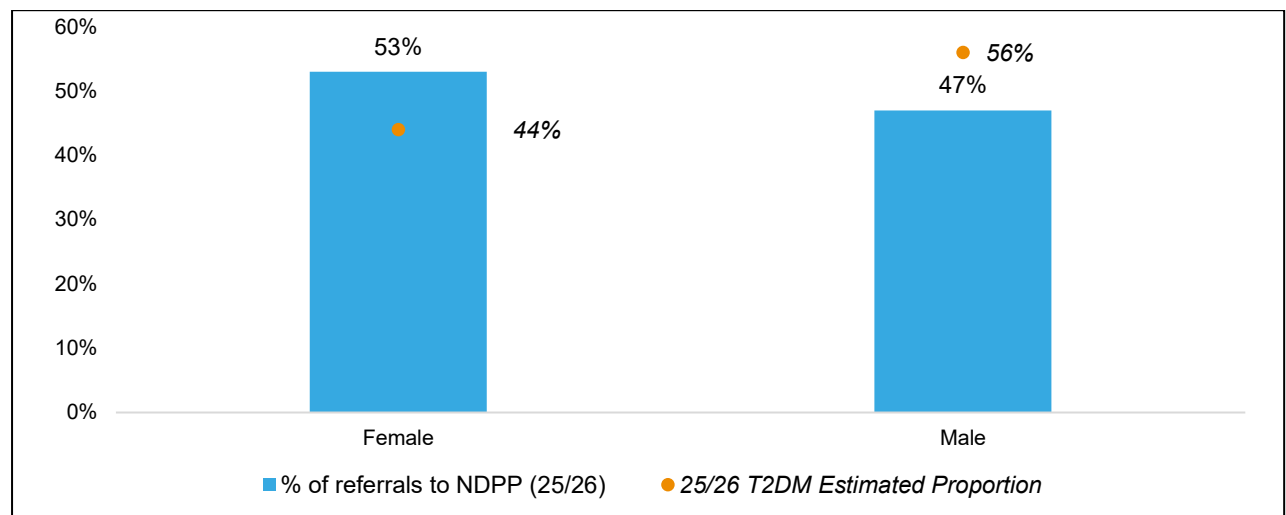
Source: Lincolnshire ICS Joint Intelligence Dataset, NHS Lincolnshire ICB 2026.

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

In 25/26, there were approximately 3,560 people in Lincolnshire referred to the National Diabetes Prevention Programme (NDPP). There are approximately 53,190 people in Lincolnshire who have a diagnosis of type 2 diabetes (T2DM).

Sex

Approximately 44% of the 53,190 people in Lincolnshire who have been diagnosed with T2DM are females. However, in 25/26, females account for 53% of referrals to the NDPP. Approximately 56% of the 53,190 people in Lincolnshire who have been diagnosed with T2DM are males. However, in 25/26, males account for 47% of referrals to the NDPP. This suggests there is an inequity in referrals to the NDPP – proportionately, there are more females than males being referred to the NDPP than males. This is similar to the position in 24/25.



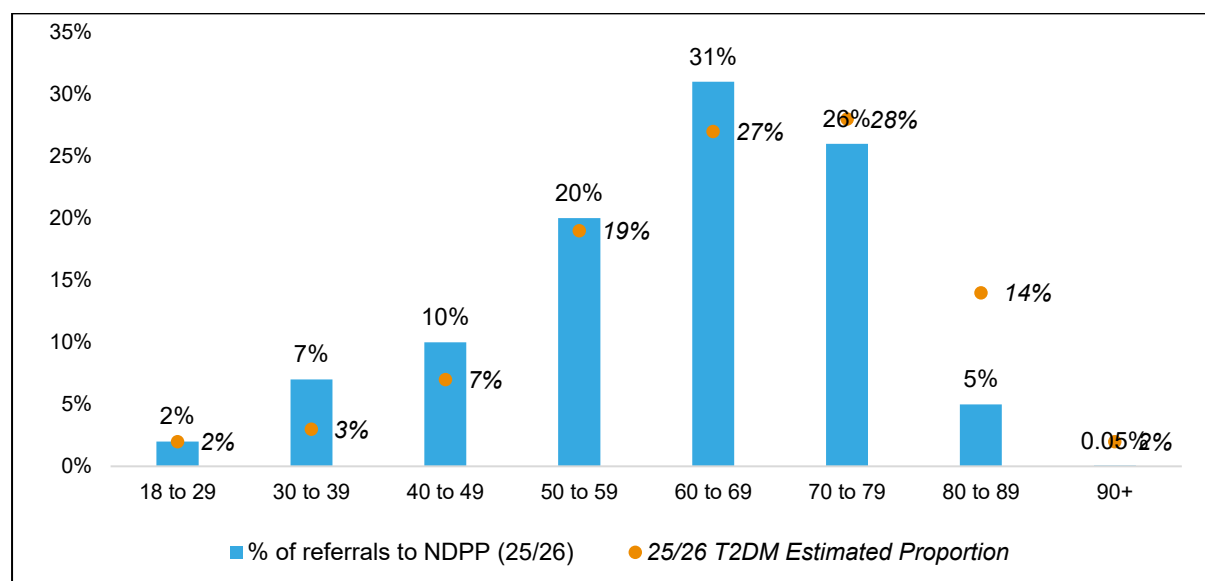
Source: [NDPP referrals dashboard](#)

Age Group

There is variation in referrals between the different age groups. For example, 19% of the 53,190 people in Lincolnshire who have been diagnosed with T2DM are between 50-59 years of age. 50-59-year-olds account for 20% of referrals to the NDPP – roughly what we would expect.

Whereas 14% of the 53,190 people in Lincolnshire who have been diagnosed with T2DM are between 80-89 years of age. However, 80-89-year-olds account for 5% of referrals to the NDPP.

This suggests there is an inequity in referrals to the NDPP by age groups. Proportionately, there are more people in the 30-39, 40-49, 50-59, and 60-69 age groups being referred to the NDPP than those in the 18-29, 80-89, and 90+ age groups.



Source: [NDPP referrals dashboard](#)

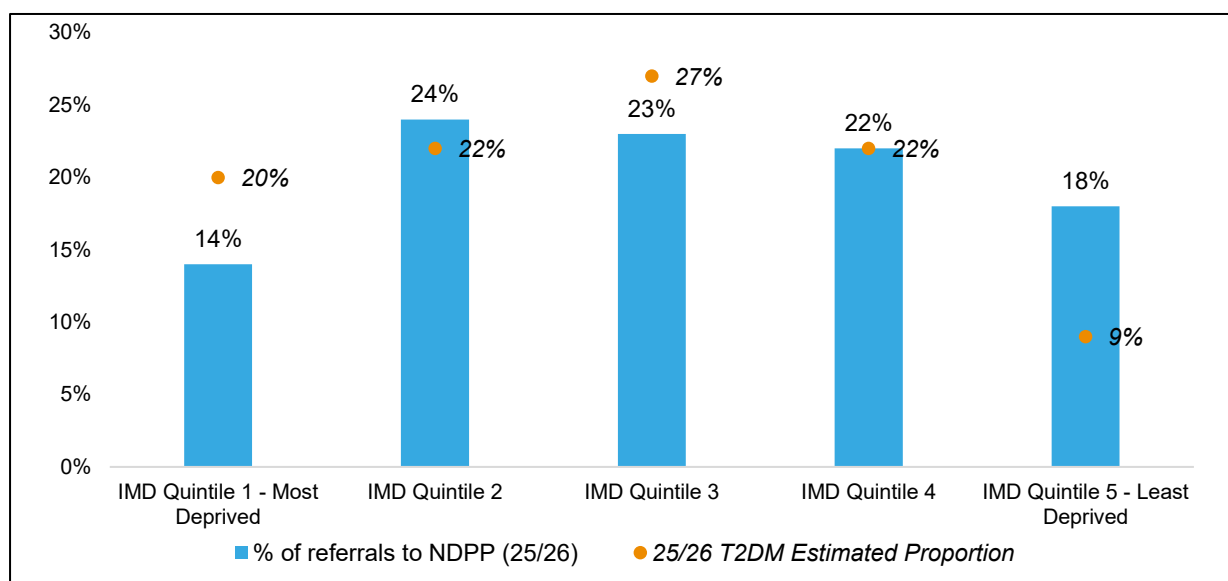
Deprivation

There is variation in referrals between the different deprivation quintiles. For example, 20% of the 53,190 people in Lincolnshire who have been diagnosed with T2DM live in the most deprived quintile. However, those living in the most deprived quintile account for 14% of referrals to the NDPP.

Whereas 9% of the 53,190 people in Lincolnshire who have been diagnosed with T2DM live in the least deprived quintile. However, those living in the least deprived quintile account for 18% of referrals to the NDPP.

This suggests there is an inequity in referrals to the NDPP by deprivation quintile. As those who live in the most deprived quintile account for 20% of people with T2DM in Lincolnshire, we would expect 20% of the referrals made to the NDPP to be from those living in the most deprived quintile. This suggests that, proportionately, there are more people in least deprived quintile being referred to the NDPP than those living in the least deprived quintile.

There has been a slight narrowing of the gap between those from the most and least deprived quintile who are referred to the NDPP compared to 24/25 (11% of all NDPP referrals from those in the least deprived quintile in 24/25 vs. 14% of all NDPP referrals from those in the least deprived quintile in 25/26).



Source: [NDPP referrals dashboard](#)

Learning Disabilities and Autism

Number of people in a mental health inpatient setting who have a learning disability or are autistic

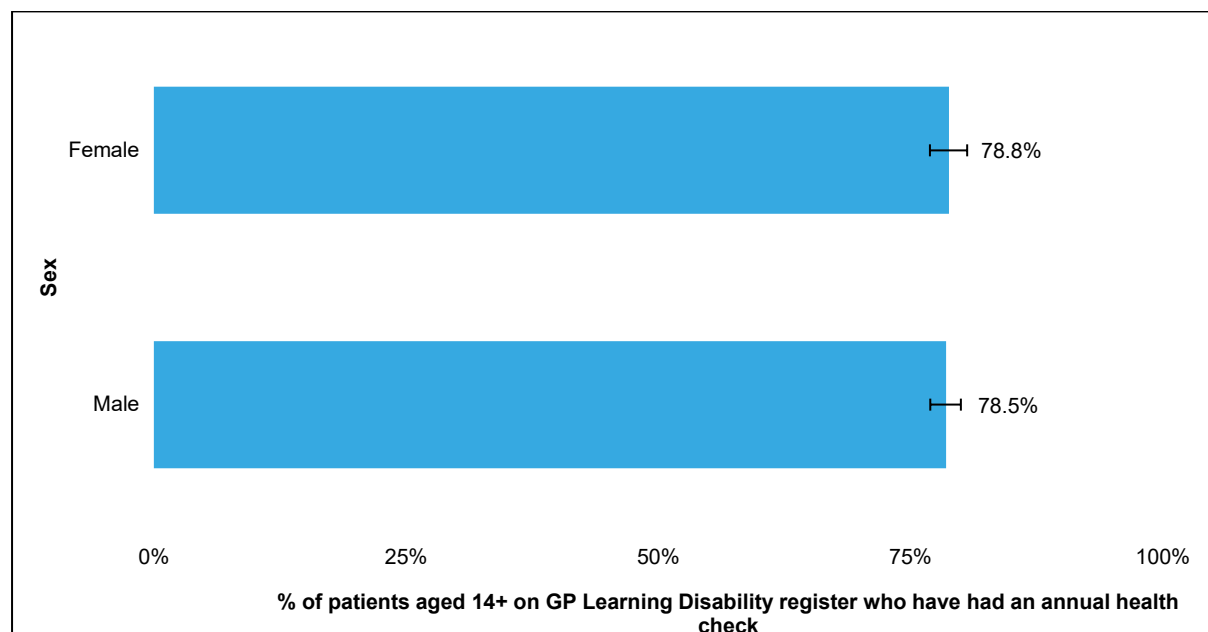
Based on the [Learning Disability: Assuring Transformation Dataset](#), there were 35 mental health inpatients in Lincolnshire ICB who had a learning disability and/or autism at the end of March 2026. This equates to a crude rate of 59 per million of the adult population, which is slightly higher than the England average of 43 per million. 24% of this group had learning disabilities only, 65% 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.

Percentage of patients aged 14+ on GP learning disability registers who have had an annual health check

Period: April 2025 to March 2026

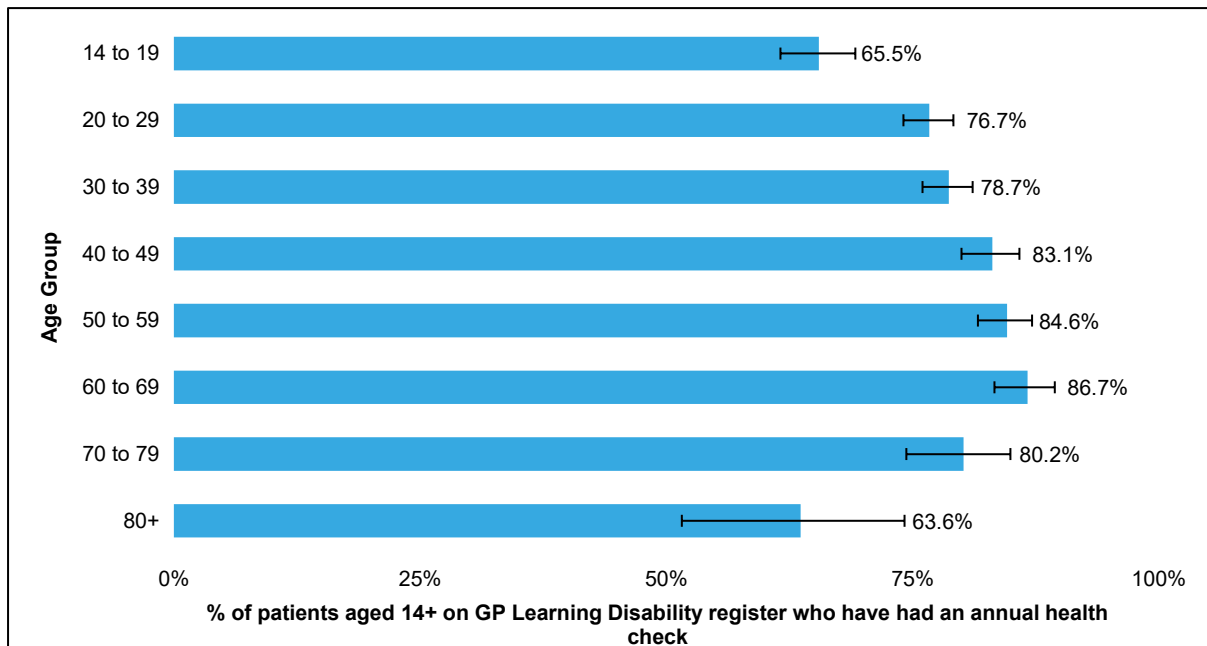
Between April 2025 and March 2026, 78.6% of patients aged 14+ on the GP Learning Disability register received an annual health check. There was no significant difference in the uptake of health checks between females and males (78.8% for females; 78.5% for males). Uptake was generally higher in older age groups; the age group with the lowest uptake was those between the ages of 14 and 19 (65.5%). Those with a learning disability who lived in the least deprived quintile had the lowest uptake (75.2%), whereas those who lived in the most deprived quintile had a higher uptake (79.6%) – although this difference was not statistically significant. It is difficult to infer whether there are any differences when looking at uptake by different ethnic groups due to low counts.

Sex



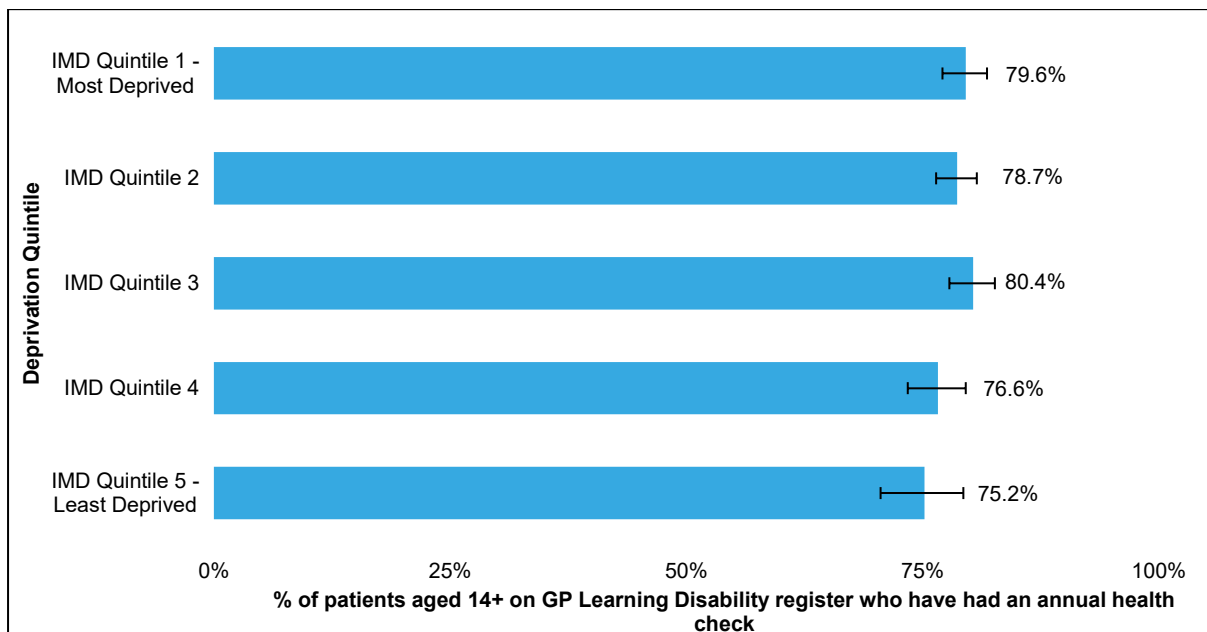
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Age Group



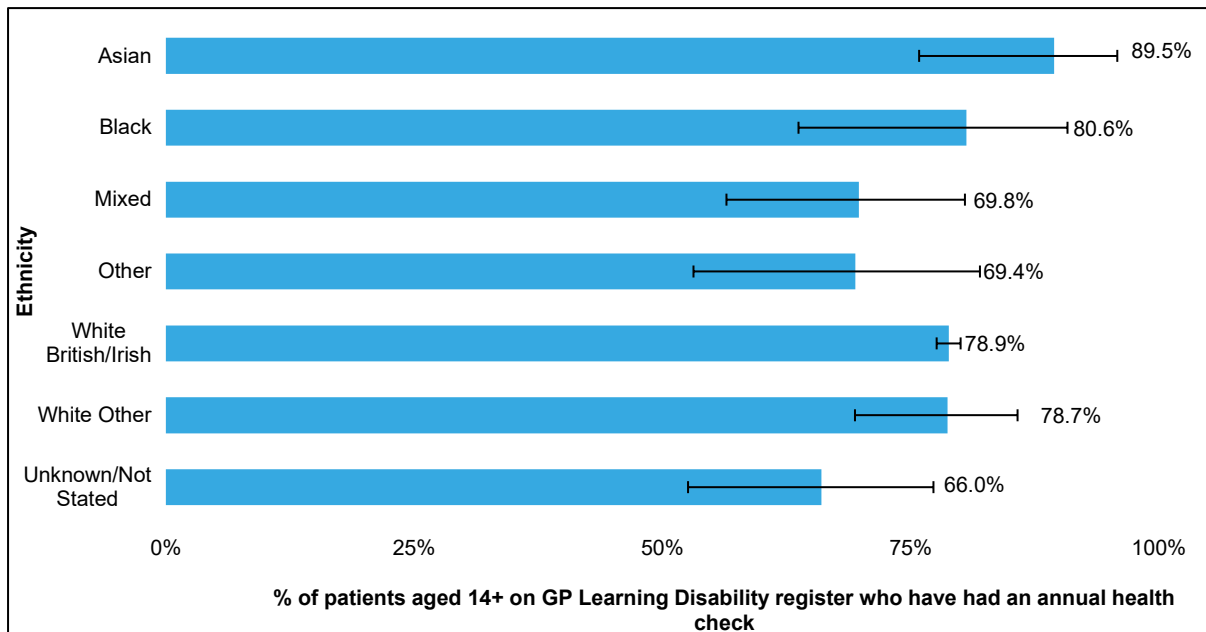
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Deprivation



Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Ethnicity



Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Percentage of people with suspected autism waiting more than 13 weeks for contact

97% of patients with suspected autism registered with a Lincolnshire GP practice were waiting more than 13 weeks for a contact in March 2026. This is worse than for England overall (83%). Data is not yet available to break these down by health inequalities dimensions.

Maternity and Neonatal

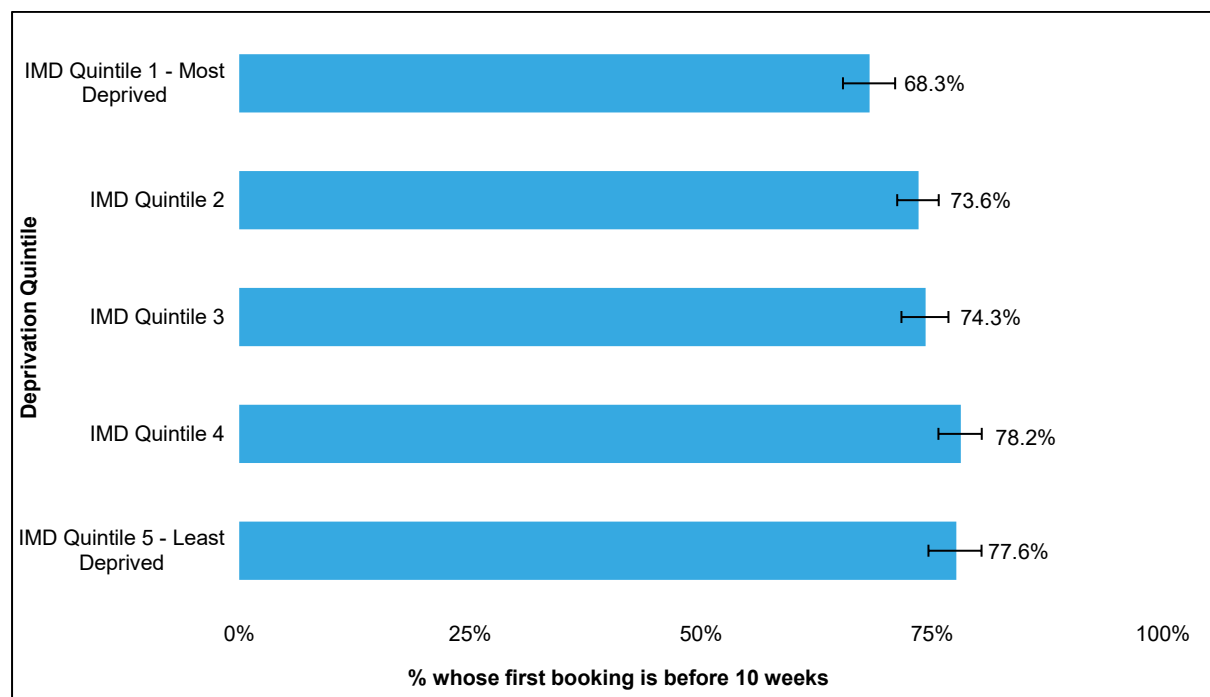
Gestational age at booking

Period: July 2024 to June 2025

Provider: United Lincolnshire Hospitals Trust (ULTH)

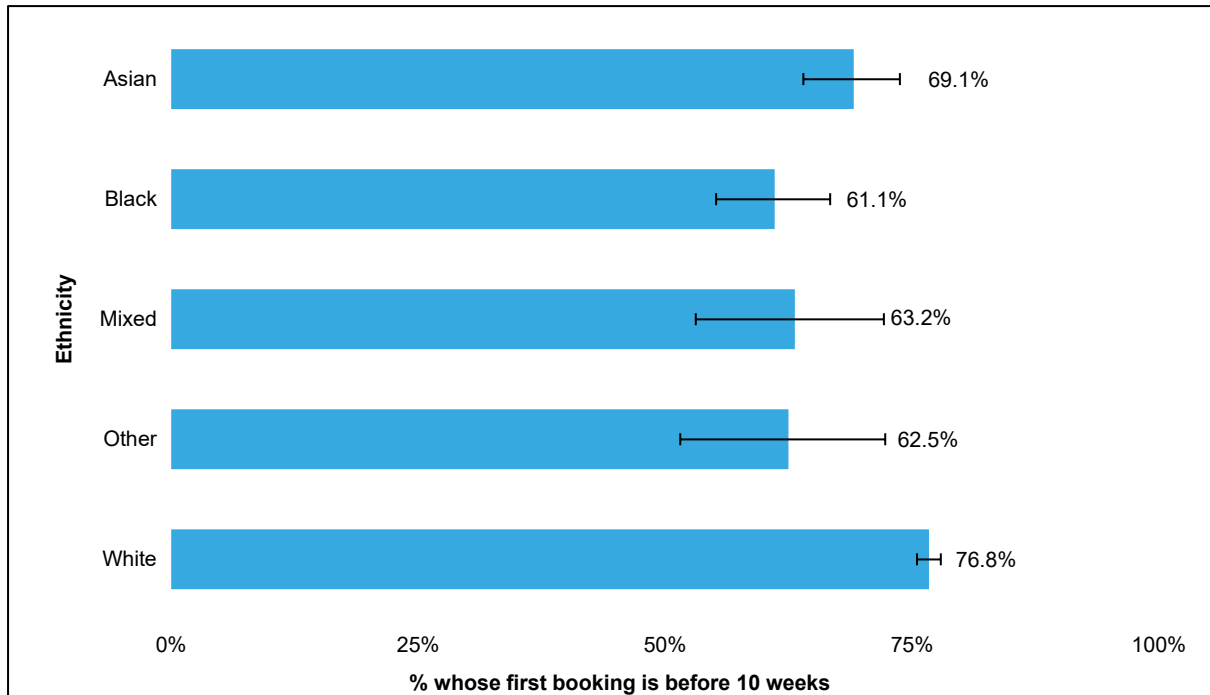
Between July 2024 and June 2025, 74.3% of expectant mothers at ULTH had their first booking appointment before 10 weeks. A significantly lower proportion of expectant mothers from the most deprived quintile had their first booking appointment before 10 weeks compared to expectant mothers who lived in the least deprived quintile. Compared to the White population, it appears a significantly lower proportion of expectant mother from an Asian, Black, Mixed, or Other ethnic background had their first booking appointment before 10 weeks compared to expectant White mothers. However, readers should interpret the ethnicity results with caution as there are small counts in the non-White other ethnic groups. The data source pools those from a White Other background into the White overall category, whereas other data sources used in this document will separate the White British/Irish population and the White Other population.

Deprivation



Source: [Maternity and Neonatal Equalities Dashboard](#)

Ethnicity



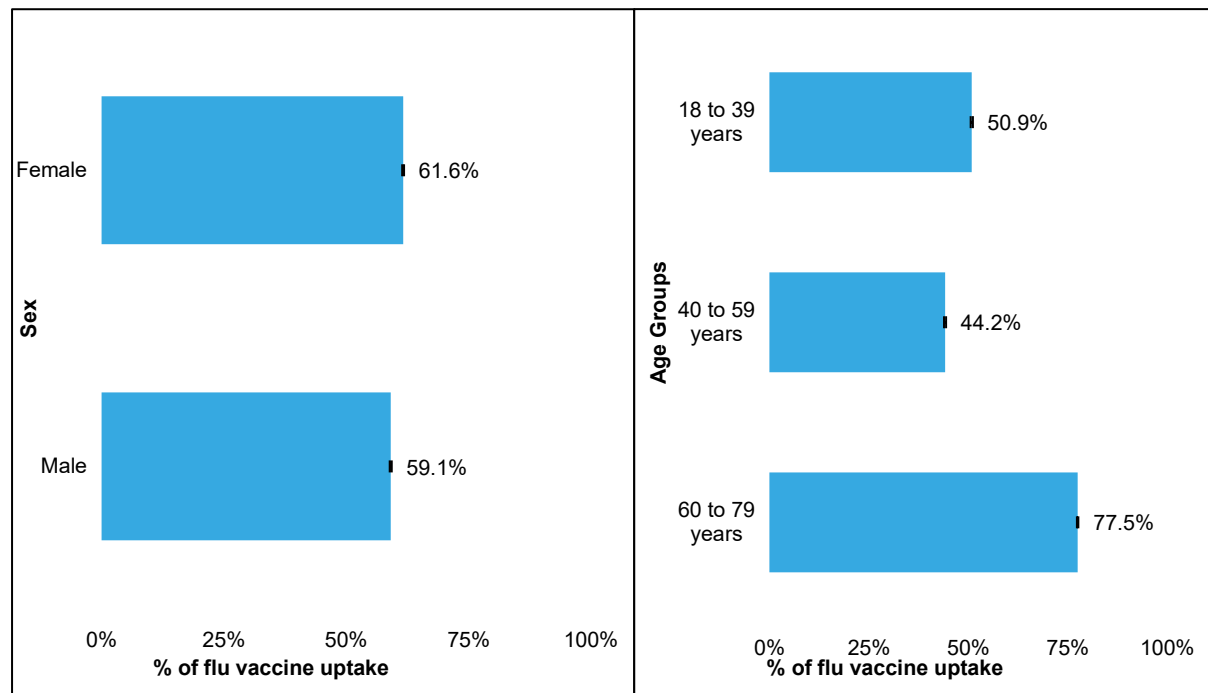
Source: [Maternity and Neonatal Equalities Dashboard](#)

Vaccinations

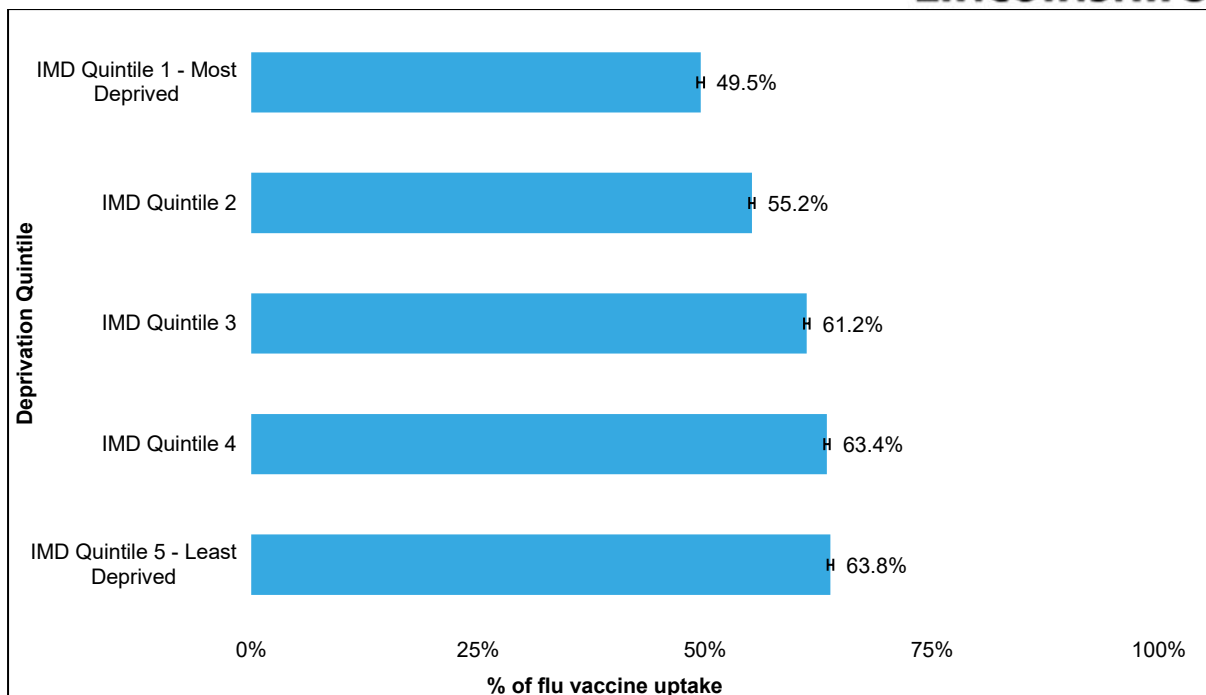
Uptake of flu vaccinations

Period: Autumn/Winter 2025/2026 vaccination season

In the 25/26 flu vaccine season, 60.4% of those eligible to receive a flu vaccine received one (278,169/460,311). Note that only 25/26 flu season data is presented as there has been a change to the data source used to populate this indicator. Also be aware that eligible cohorts change each year, so a year-on-year comparison is not always appropriate. Females had a significantly higher uptake of flu vaccines than males. We can't compare to previous years as previous data sources didn't stratify by sex. Those aged 65 and older had a significantly higher uptake than those aged 0 to 17, and those aged 18 to 64. Each ethnic minority group (individually, and when pooled together) had a significantly lower uptake of flu vaccines compared to the White British/Irish population. Those who lived in the most deprived had a significantly lower uptake of flu vaccines compared to those who lived in the least deprived. The Relative Index of Inequality of 1.33 suggests that those living in the least deprived parts of the county had approximately a 33% higher uptake than those living in the most deprived parts of the county.

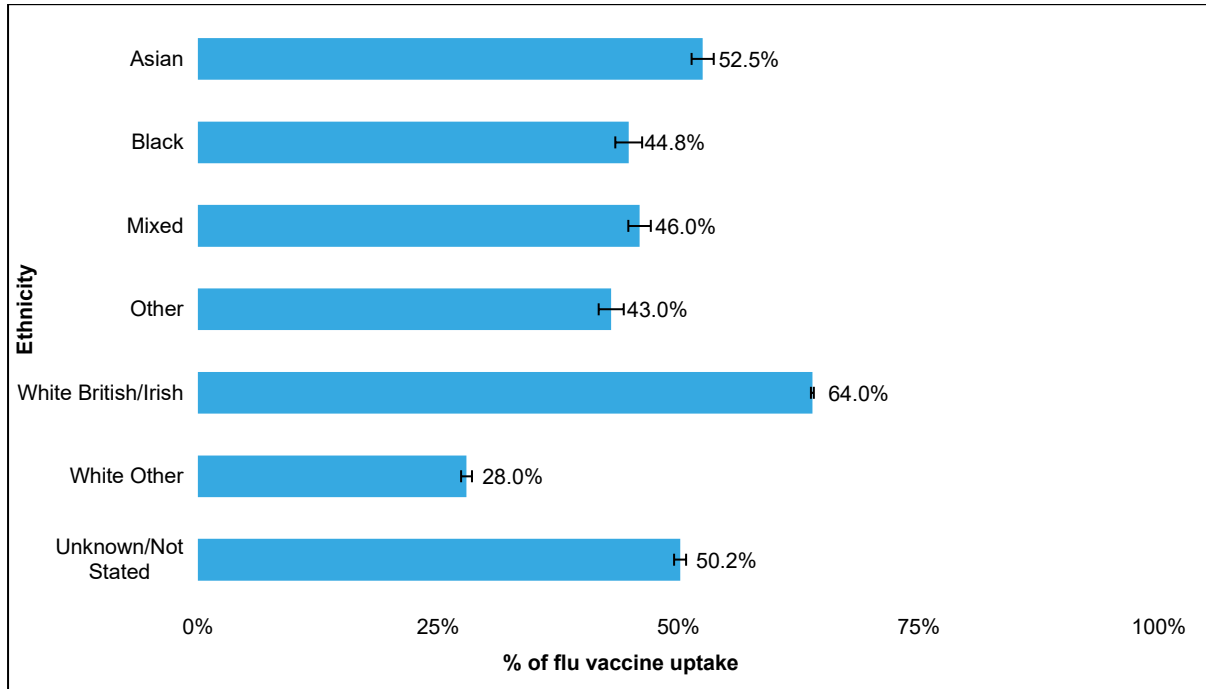


Source: [FDP Flu Vaccinations](#)



Source: [FDP Flu Vaccinations](#)

Ethnicity



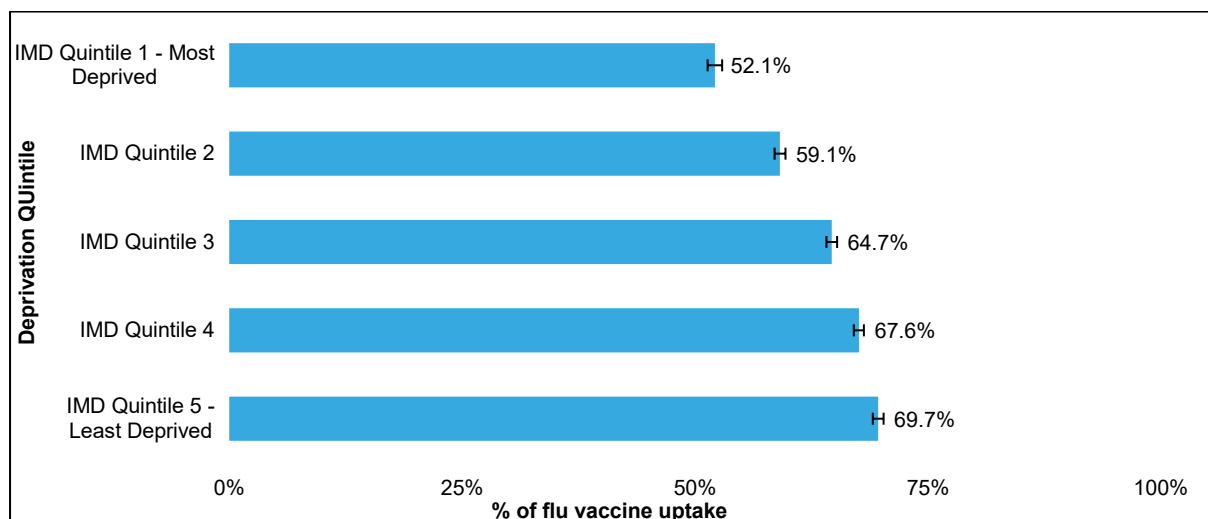
Source: [FDP Flu Vaccinations](#)

Uptake of covid vaccinations

Period: Autumn/Winter 2025/2026 vaccination season

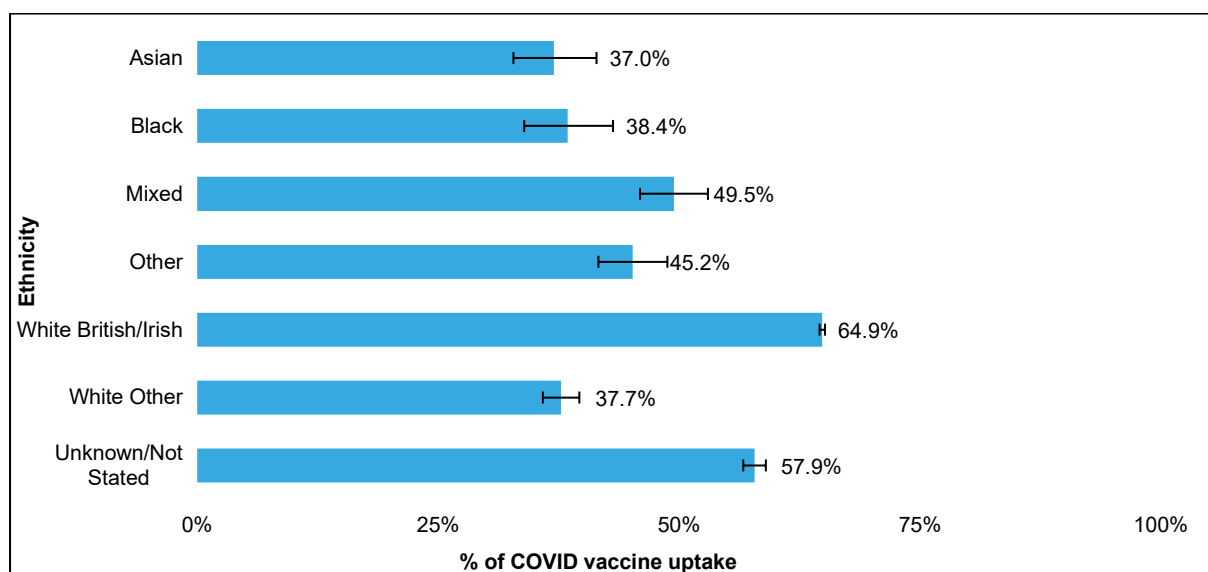
In the 25/26 COVID vaccine season, 63.5% of those eligible to receive a COVID vaccine received one (77,748/122,421). Note that only 25/26 COVID season data is presented as eligible cohorts change each year, so a year-on-year comparison is not always appropriate. Those who lived in the most deprived quintile had a significantly lower uptake of COVID vaccines compared to those who lived in the least deprived. The Relative Index of Inequality of 1.35 suggests that those living in the least deprived parts of the county had approximately a 35% higher uptake than those living in the most deprived parts of the county. Each ethnic minority group (individually, and when pooled together) had a significantly lower uptake of flu vaccines compared to the White British/Irish population except for the Black/Black British – Caribbean population.

Deprivation



Source: [FDP COVID Vaccinations](#)

Ethnicity



Source: [FDP COVID Vaccinations](#)

CORE20PLUS5 - CYP

Oral Health

Tooth extractions due to decay for children admitted to hospital aged 10 and under (number of admissions)

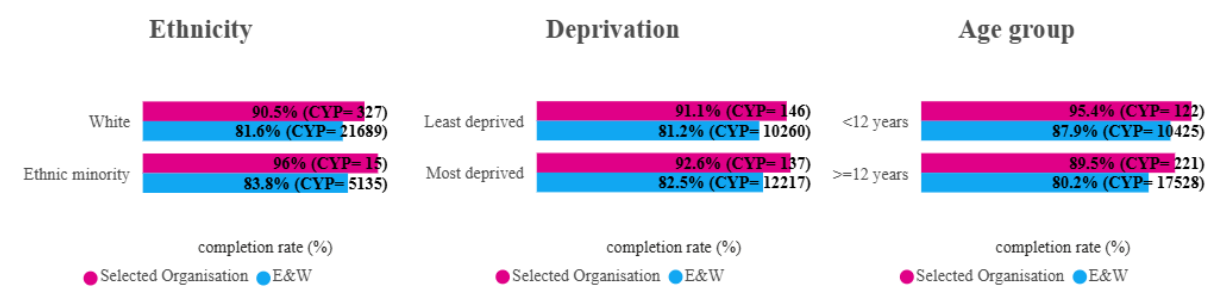
In 25/26, there were only 17 instances where a child between the ages of 0 and 10 were admitted to hospital for a tooth extraction. The low count makes a health inequality analysis unfeasible. Note that this indicator has a very tightly defined diagnostic criteria, which likely explains the low count. Sources: Secondary Use Services (SUS) Admitted Patient Care dataset; Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Diabetes - CYP

Inequalities in percentage of CYP with type 1 and 2 diabetes receiving all the recommended NICE care processes

Based on quarter 3 data from the Royal College of Paediatrics and Child Health diabetes audit (April 2025 to December 2025), 90.8% of children with type 1 diabetes who receive all key health checks. There are small variations between health inequalities groups. Compared to Q3 last year, there has been a slight decrease in children with type 1 diabetes receiving all key health checks (93.3% in Q3 24/25).

90.5% of children from a White ethnicity, and 96% of children from all other ethnic minority backgrounds, received all key health checks. 91.1% of children from the least deprived quintile, and 92.6% of children from the most deprived quintile, received all key health checks. 95.4% of children under 12, and 89.5% of children aged 12 and older, received all key health checks.



Source: [National Paediatric Diabetes Audit](#)

Mental health – CYP

Children and Young People's (CYP) Mental Health Access

Period: 24/25

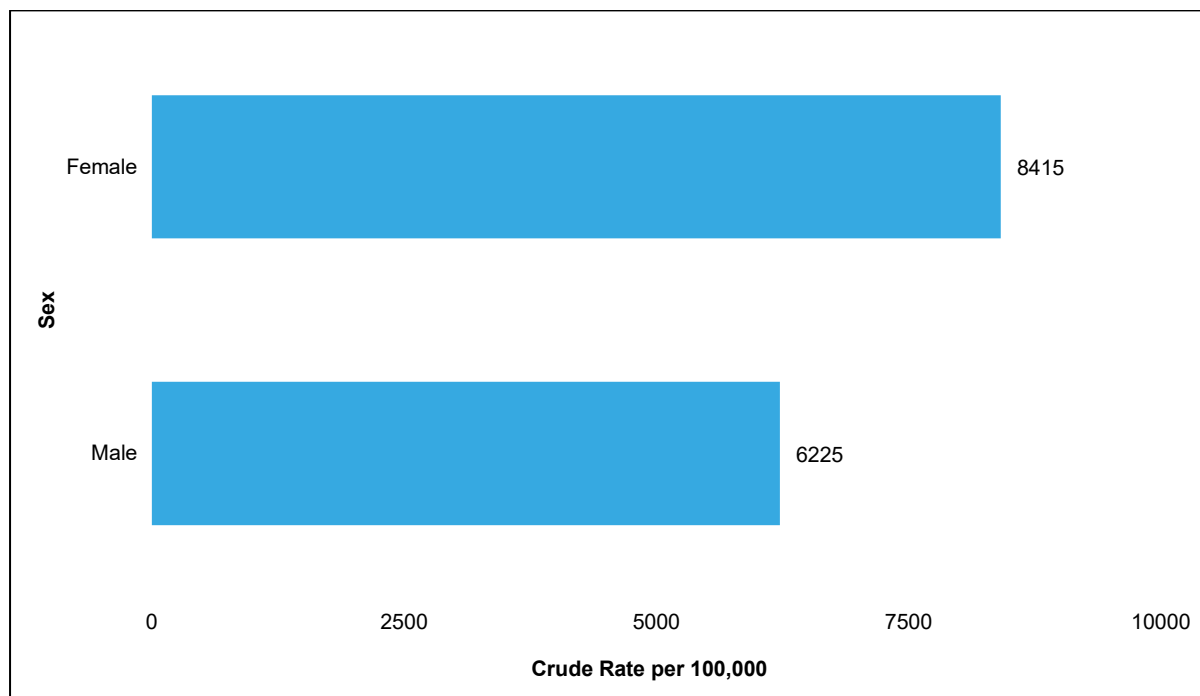
Between April 2024 and March 2025, there were 6617 CYP mental health pathways opened per 100,000 where at least one contact with an NHS funded mental health service was made. This was slightly lower than the England rate of 6895 per 100,000. The Lincolnshire rate increased from 5893 CYP mental health pathways opened per 100,000, which was also lower than the England average of 6568 per 100,000.

Females had a higher rate of accessing CYP mental health services compared to males. There was a slight increase of the gap between females and males who had at least one contact with an NHS funded mental health service between 23/24 and 24/25; the gap in 23/24 was 3715 per 100,000 (4073 per 100,000 for males vs. 7788 per 100,000 for females), and the gap in 24/25 was 3767 per 100,000 (4648 per 100,000 for males vs. 8415 per 100,000). It's interesting to note that the male rate of contact with NHS funded mental health services in Lincolnshire is consistently lower than the national average for males, and the rate for females is consistently higher than the national average for females.

The lowest rates are consistently seen among children aged 0 to 5 years, where there has been a notable increase in children between the ages of 6 and 10 years (especially between 23/24 and 24/25), where the Lincolnshire rate increased from 3,816 per 100,000 to 5,526 per 100,000. The Lincolnshire rate for each reporting period (for 6- to 10-year-olds, and to a lesser extent in 0- to 5-year-olds) is still lower than the national average which may be worth exploring. The rate in 11- to 15-year-olds, and 16-year-olds, appears to have plateaued (although it is much higher compared to other age groups) – and there has been a slight decrease in the rate of 17-year-olds. When comparing to the national rate, it's interesting to note the rate in 16-year-olds in Lincolnshire having at least one contact with NHS funded mental health services is higher than it was in the previous two reporting periods. In contrast, the 17-year-old group rate has slightly decline while the national rate appears to stay consistent across the three reporting periods.

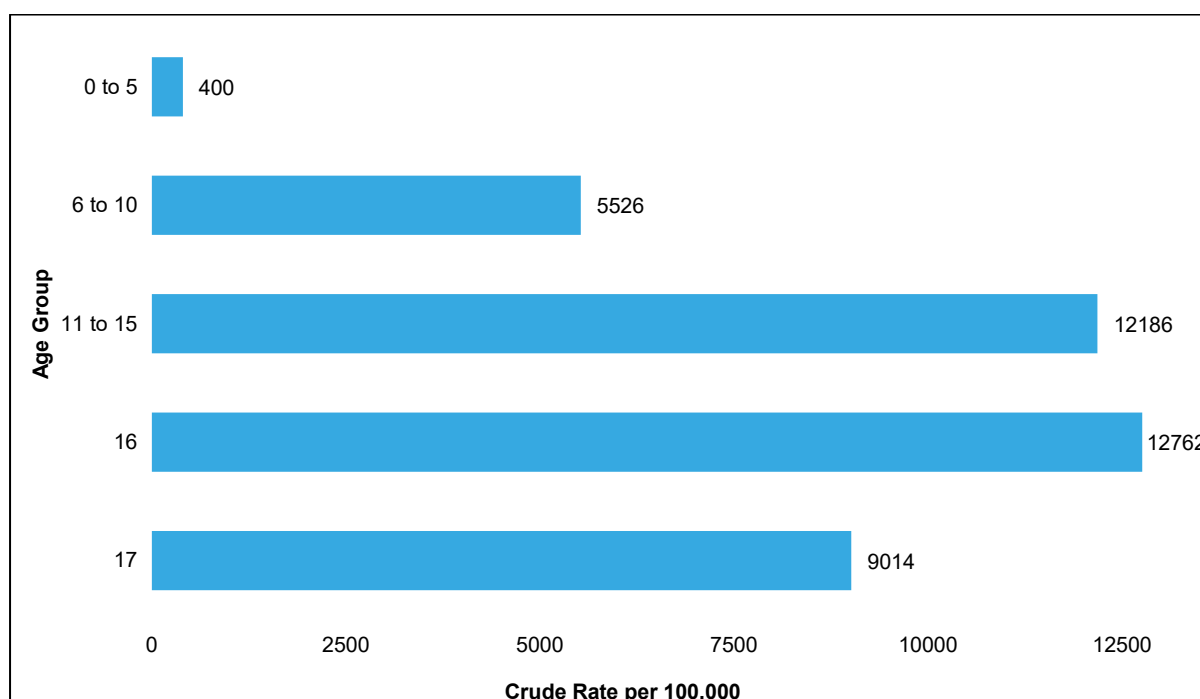
The rate of children and young people accessing at least one mental health service has increased across all deprivation deciles between 2022/23 and 2024/25, indicating a general upward trend in service access. The highest rates continue to be seen among the most deprived groups, with the rate IMD Decile 1 rising from 6,019 per 100,000 in 23/24 to 6,800 per 100,000. The gap between children living in the most and least deprived decile between 23/24 and 24/25 has closed – this appears to be driven by a steeper increase in the rate of children from the two most deprived deciles compared to those in the two least deprived areas. Children living in the least deprived deciles experienced a lower rate in the two previous reporting period, whereas the children living in the most deprived deciles experienced a consistently higher rate of accessing mental health services. The reasons for this increased rate in children from less deprived areas will need exploring but broadly speaking the gap between the most and least deprived appears to have narrowed. It should be noted that, compared to the national average, children living in the more deprived areas have a lower rate of accessing mental health services. This may need to be explored further to understand what is driving this relatively lower rate in children from more deprived areas in Lincolnshire.

Considering the low counts associated with ethnic minorities in Lincolnshire, it is difficult to determine whether there are genuine disparities in children and young people from different ethnic backgrounds who having at least one contact with an NHS funded mental health service.



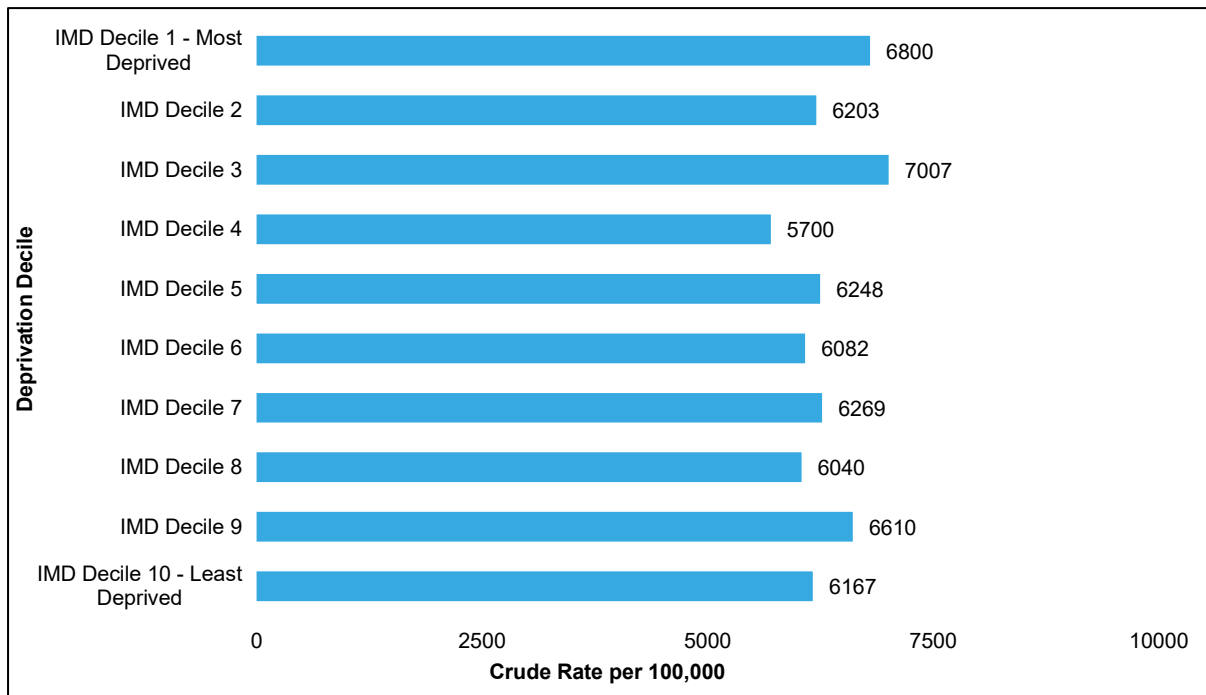
Source: [Mental Health Bulletin, 2024-25 Annual report](#)

Age



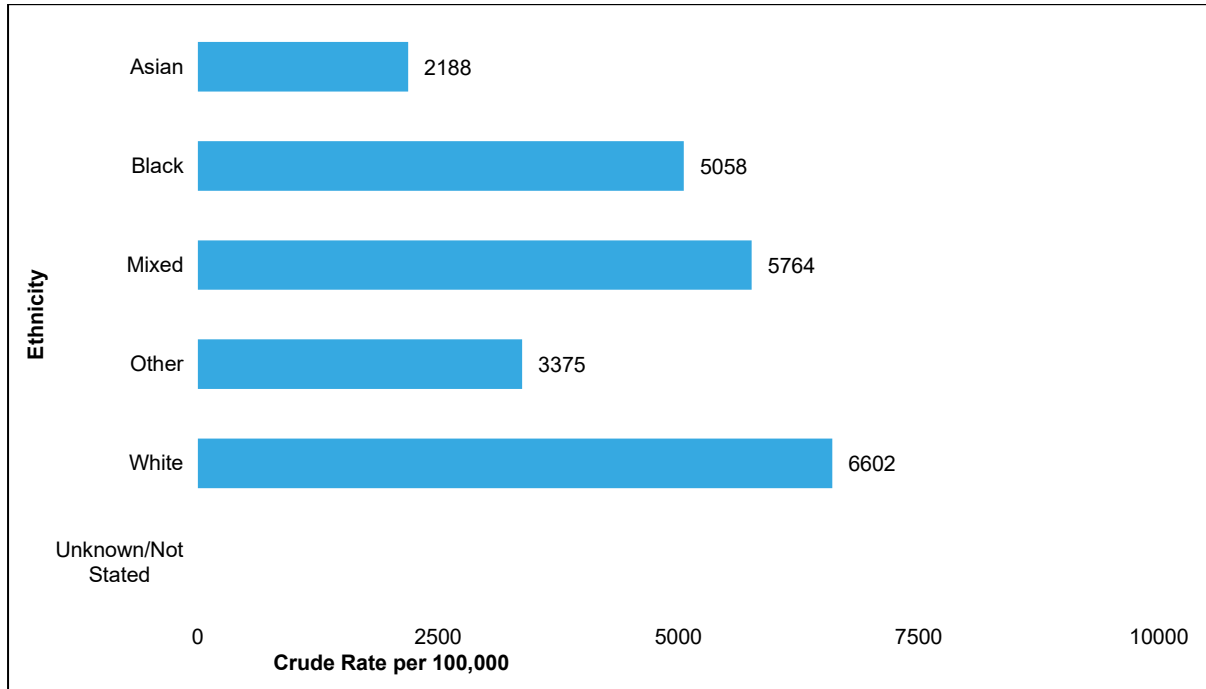
Source: [Mental Health Bulletin, 2024-25 Annual report](#)

Deprivation



Source: [Mental Health Bulletin, 2024-25 Annual report](#)

Ethnicity



Source: [Mental Health Bulletin, 2024-25 Annual report](#)

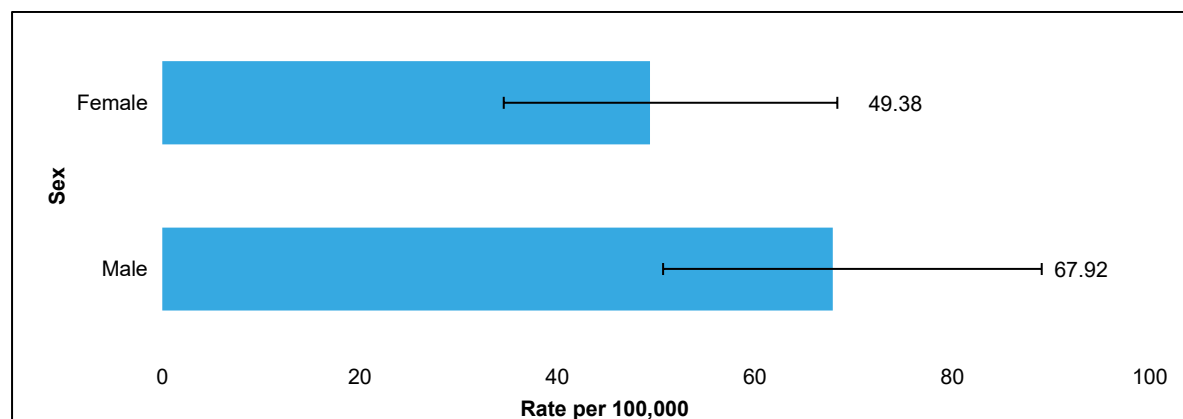
Respiratory - CYP

Inequalities in emergency department admissions for asthma

Period: 25/26

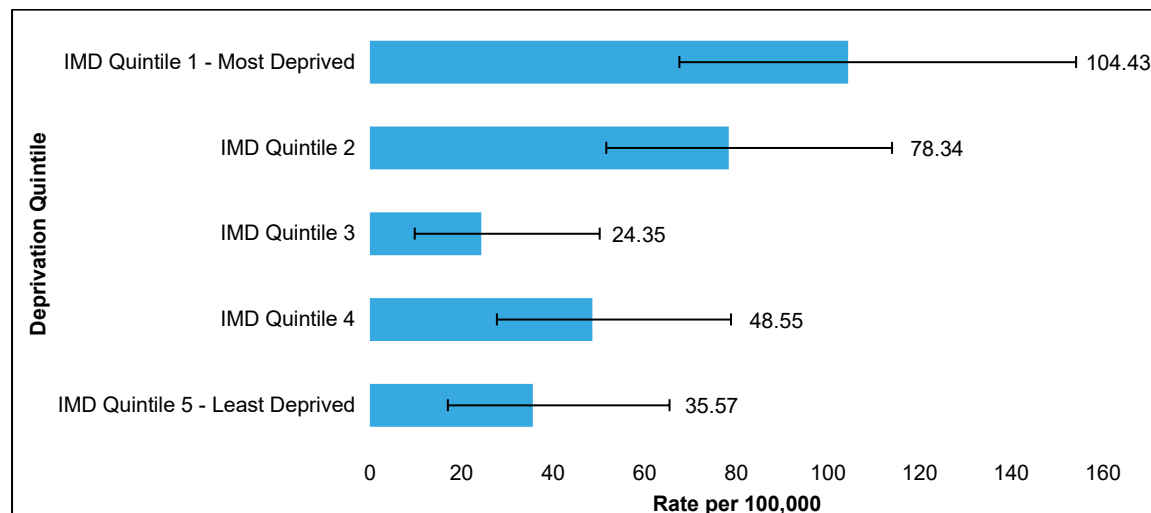
In 25/26, there were 88 emergency admissions for children and young people for asthma. Due to the small number emergency admissions, it is difficult to determine whether there are any health inequalities. This may be due to the tightly defined diagnostic criteria, especially as only the primary diagnosis code is considered.

Sex



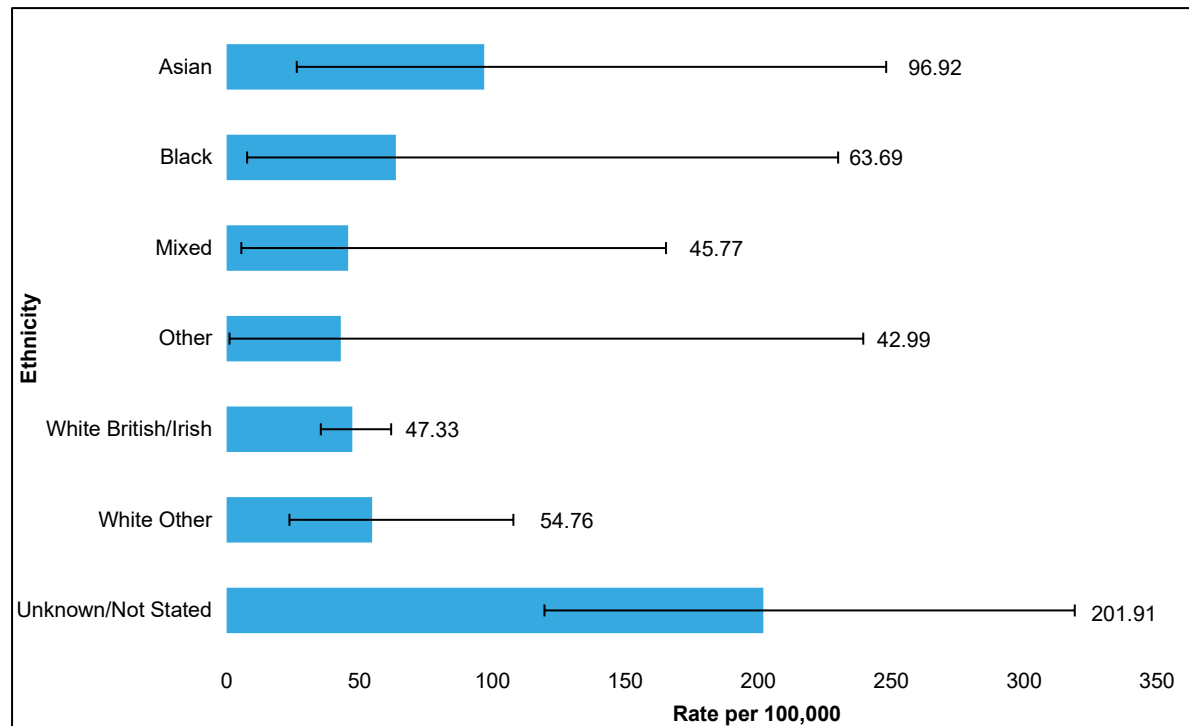
Sources: Emergency Care dataset; Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Deprivation



Sources: Emergency Care dataset; Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Ethnicity

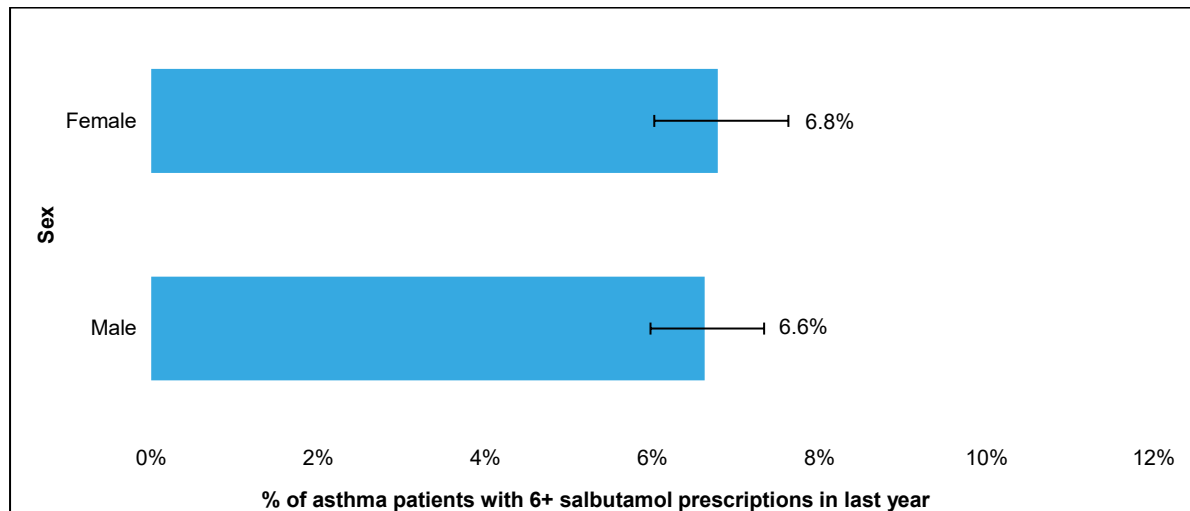


Sources: Emergency Care dataset; Lincolnshire ICS Joint Intelligence Dataset, NHS Lincolnshire ICB 2026.

Inequalities in dispensing of reliever only inhalers

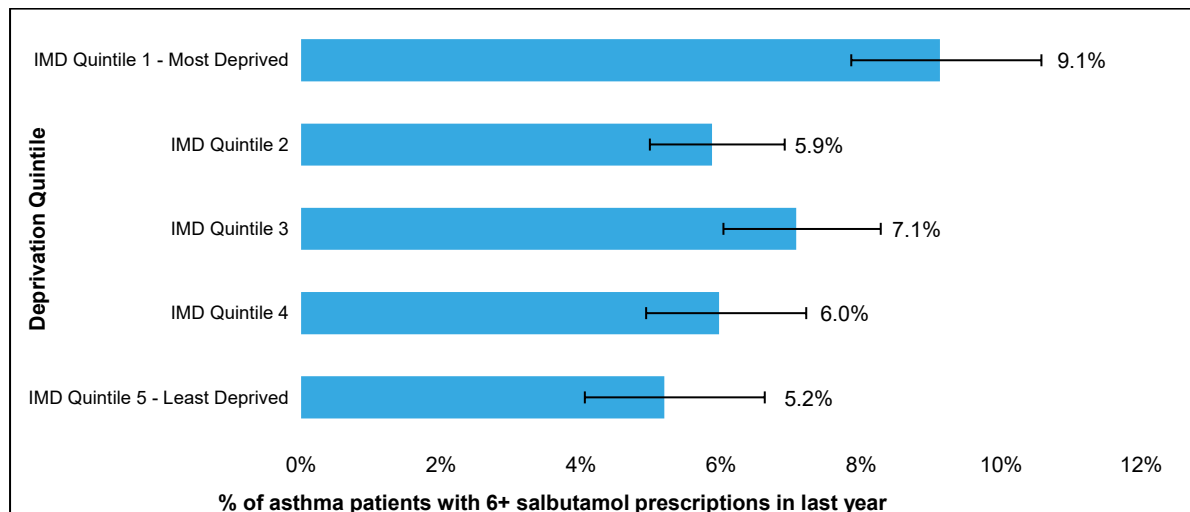
In 2025, there were 6.7% of children between the ages of 0 and 17 were prescribed 6 or more salbutamol inhalers in the past 12 months. There was very little difference between females and males. Children from the most deprived quintile who has asthma had a significantly higher proportion of 6+ salbutamol inhalers in the last 12 months than children from the least deprived quintile. There is no significant differences across different ethnic groups compared to the White British/Irish population.

Sex



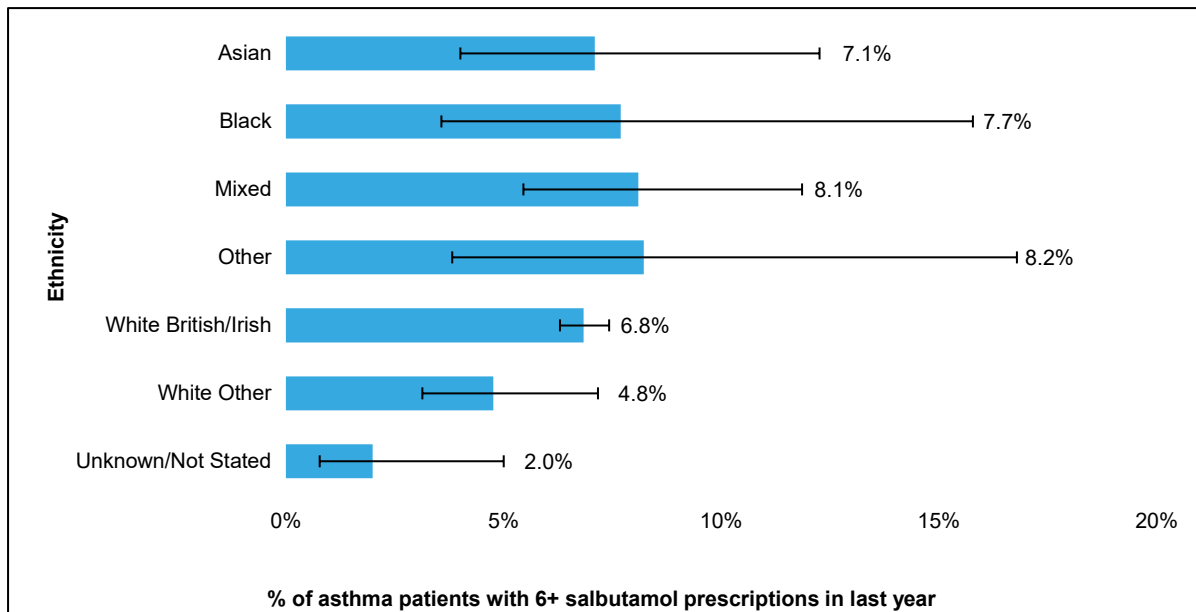
Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Deprivation



Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Ethnicity



Source: Lincolnshire ICS Joined Intelligence Dataset, NHS Lincolnshire ICB 2026.

Data Quality

Percentage of patient records with a valid, non-residual ethnicity code in data sets

Data Set	Provider	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Feb-26 National Average
ECDS (A&E/MIU/UCS)	ULHT	79.1%	78.2%	78.6%	78.6%	79.0%	77.3%	78.6%	78.3%	77.8%	78.5%	79.1%	77.8%	87.4%
	LCHS	89.1%	86.6%	88.1%	88.4%	88.3%	93.8%	95.2%	95.0%	96.0%	95.5%	95.5%	96.0%	87.4%
Outpatients	ULHT	83.0%	82.8%	82.8%	82.4%	82.4%	82.0%	82.1%	81.6%	81.7%	81.8%	81.9%	81.4%	72.0%
APC - Admitted Care	ULHT	85.8%	85.5%	84.6%	85.0%	84.3%	84.3%	83.9%	84.6%	84.2%	83.7%	84.6%	83.1%	87.7%
	LCHS (Low Activity)	91.0%	95.0%	90.7%	92.8%	91.1%	90.7%	92.0%	87.9%	100.0%	91.6%	91.7%	100.0%	87.7%
CSDS – Community Services	ULHT (Low Activity)	60.4%	61.0%	60.1%	62.1%	59.8%	59.5%	61.4%	63.4%	72.6%	64.2%	69.2%	54.7%	70.9%
	LCHS	87.2%	87.4%	87.6%	88.1%	87.1%	87.0%	88.2%	88.4%	88.5%	88.3%	88.4%	88.5%	70.9%
	LCC	94.1%	94.1%	94.2%	94.3%	94.2%	94.3%	94.4%	94.5%	94.6%	94.8%	94.7%	94.8%	70.9%
MHSDS - Mental Health	LPFT	87.5%	87.9%	87.7%	87.3%	86.9%	86.3%	86.2%	86.3%	86.1%	85.8%	86.0%	86.3%	70.7%
IAPT - Talking Therapies	LPFT	97.2%	97.2%	97.2%	97.6%	97.4%	97.7%	97.5%	97.5%	97.4%	97.4%	94.4%	97.3%	95.3%
MSDS - Maternity	ULHT	97.6%	97.8%	97.4%	97.4%	97.6%	97.9%	98.0%	98.2%	98.4%	98.4%	98.5%	98.7%	99.0%

Source: [Data Quality Maturity Index](#)

2% or more lower than national average

Within 2% of the national average

2% or more higher than national average

Percentage of records with blank or null codes for ethnicity

Lincolnshire ICB – United Lincolnshire Hospitals Trust	% of records with an Invalid Ethnicity Recorded (September 2025)
Secondary Use Services – Inpatients (APCS)	% unknown ethnicity: 15.42% % not stated: 0.31% % blank or invalid: 0% % total unknown ethnicity: 15.73% <i>This is worse than the England average of 12.24%.</i>
Secondary Use Services – Accident & Emergency (ECDS)	% unknown ethnicity: 22.53% % not stated: 0.66% % blank or invalid: 0% % total unknown ethnicity: 23.19% <i>This is worse than the England average of 14.29%.</i>
Secondary Use Services – Outpatients (OPA)	% unknown ethnicity: 17.48% % not stated: 0.59% % blank or invalid: 0% % total unknown ethnicity: 18.08% <i>This is worse than the England average of 15.42%.</i>
Mental Health Services Data Set (MHSDS)	% of total unknown ethnicity: 10% <i>This is better than the England average of 12%</i>
General Practice Extraction Service (GPES)	% of total unknown ethnicity: 7.3% <i>This is better than the England average of 9.0%.</i>

Source: [Midlands Ethnicity Reporting](#)

Case Studies

Lincolnshire ICB



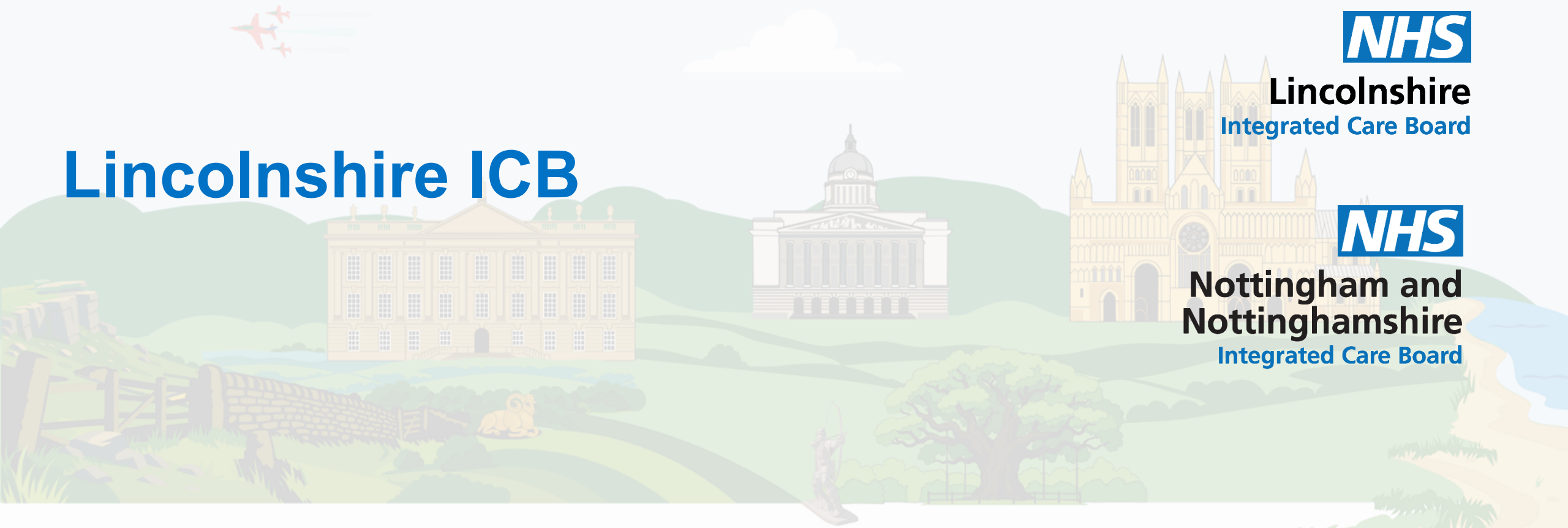
Derby and Derbyshire
Integrated Care Board



Lincolnshire
Integrated Care Board



**Nottingham and
Nottinghamshire**
Integrated Care Board





Smoking Cessation

What was the health inequalities issue?

- Smoking prevalence is significantly higher in more deprived communities and among people experiencing poorer health outcomes.
- Smoking-related illness contributes to avoidable hospital admissions, poorer long-term health outcomes, and reduced life expectancy.

What actions were taken?

- Varenicline was introduced within the Acute Tobacco Dependency Service as an additional quit aid alongside existing behavioural support.
- Implemented the national Maternity incentive scheme for smokers. Implemented opt-out referrals into tobacco dependency treatment and behavioural support services.
- Launched a Mental Health staff vape offer in October 2025
- The Community Inpatient service was relaunched in Louth to take locations up to 3 (plan to relaunch in Spalding by end of June 2026).

What was the outcome?

- Activity and engagement continue to be monitored to improve awareness, access, and uptake.
- Early indications show Lincolnshire ICB outperforming national metrics, with SATOD rates continuing to decline year on year.
- Between October and March, 117 Mental Health staff accessed the vape voucher offer, with 40% reporting they had quit smoking.
- Community inpatient tobacco dependency support has expanded to three locations, with further rollout planned.

Vaccines (adults) Shingles Vaccinations Uptake

What was the health inequalities issue?

- Lower shingles vaccination uptake can increase the risk of illness and complications, particularly among adults who experience barriers accessing routine healthcare and preventative services.
- Targeted support was needed to improve uptake in areas and groups with lower vaccination rates and help reduce inequalities in access to vaccination.

What actions were taken?

- LCHS Vaccination and Rapid Response Team (VRRT) delivered a targeted outreach project between December 2025 and March 2026.
- Worked directly with selected GP practices to identify patients outstanding shingles vaccinations.
- Telephoned eligible patients to discuss vaccination and offer appointments at convenient locations including GP practices and community settings.
- Delivered additional community engagement activity alongside existing primary care vaccination programmes.

What was the outcome?

- 1,232 shingles vaccinations delivered across seven GP practices within IMD 1&2.
- The highest increase in uptake achieved within a practice was 12.23%.
- Improved engagement with eligible patients through proactive outreach and flexible vaccination delivery.
- The project demonstrated the value of targeted, data-led vaccination support working alongside primary care services.

Vaccines (adults) RSV Project

What was the health inequalities issue?

- Lower uptake of RSV and pneumococcal vaccinations among most deprived populations, particularly within East Coast communities.
- Some eligible patients, including respiratory patients, care home residents, housebound residents, and mental health inpatients, were not consistently being reached through routine vaccination pathways.

What actions were taken?

- The Vaccination and Rapid Response Team (VRRT) worked with selected GP practices between July and August 2025 to provide targeted outreach support.
- Patients outstanding RSV or PPV vaccinations were proactively contacted by telephone and offered vaccination appointments.
- Vaccinations were delivered at convenient and flexible locations including GP practices, community venues, care homes, and through home visits.
- The project prioritised low uptake practices, respiratory patients, and communities on the east coast.

What was the outcome?

- VRRT delivered 1,192 vaccinations during the project.
- Practices supported directly by VRRT saw RSV uptake increase by 18.07%.
- Practices undertaking the work themselves without VRRT support saw an 8.8% increase in RSV uptake.
- The project improved access to vaccination for underserved groups and demonstrated the value of proactive outreach and flexible delivery approaches.
- The programme was extended into Skegness following identification of ongoing inequalities in uptake.

Cancer (adults) Oesophageal Cancer Awareness Campaign

What was the health inequalities issue?

- Lower awareness of oesophageal cancer symptoms and later presentation among some rural, coastal, and deprived communities.
- People in underserved communities may be less likely to recognise symptoms early or seek support promptly, contributing to poorer cancer outcomes.

What actions were taken?

- Delivered a targeted awareness campaign in partnership with community organisations and local employers.
- Focused engagement activity within coastal communities and workplaces including farming communities and RAF settings.
- Used community outreach and targeted communications to raise awareness of persistent heartburn and other potential cancer symptoms.
- Worked with local partners to improve reach into groups less likely to engage through traditional healthcare routes.

What was the outcome?

- Increased engagement and awareness through targeted outreach activity and communications.
- Improved visibility of cancer awareness messaging within rural and coastal communities.
- Strengthened partnership working between healthcare, community organisations, and employers to support future awareness activity.

Maternity (adults)

What was the health inequalities issue?

- Maternal and neonatal inequalities were higher within more deprived communities.
- PHM analysis identified Skegness as a priority area with higher levels of risk and modifiable factors such as smoking in pregnancy.
- Some women and families not consistently accessing support at the right time.

What actions were taken?

- Used PHM intelligence and deprivation data to identify risk, variation, and unmet need.
- Developed a targeted, place-based approach which will take place in Skegness to drive improvements and inform the design of future services.
- Aligned maternity, neonatal, primary care, health visiting, smoking cessation, and community services around a shared model of support.
- Introduced annual surveillance of population and outcome indicators.

What was the outcome?

- Skegness identified as a priority area for targeted maternity inequalities work.
- PHM intelligence improved understanding of local risk, deprivation, and variation in outcomes.
- A coordinated framework was established across maternity, neonatal, primary care, and community services.
- Annual surveillance arrangements introduced to support earlier identification of emerging inequalities.

Cancer (adults) Cervical Screening Trailblazer Project & Women's Health Event

What was the health inequalities issue?

- Lower cervical screening uptake among women experiencing barriers to accessing routine screening services in more deprived areas.
- Some underserved groups were less likely to engage with traditional invitation and recall processes.

What actions were taken?

- Delivered a women's health event at Lincoln Central Mosque, sharing culturally appropriate information on cervical screening and enabling open conversations with healthcare professionals in a trusted setting.
- Introduced a dedicated cervical screening nurse role to lead targeted engagement and outreach, supporting women who require additional help to access services in more deprived areas.
- Used tailored, community-focused approaches to engage underserved populations and improve screening uptake.

What was the outcome?

- 356 women supported to access cervical screening in areas of deprivation.
- Improved engagement with underserved populations.
- Increased access to preventative screening services for women facing barriers to attendance.

Cancer (adults) Lung Cancer Screening Programme Development

What was the health inequalities issue?

- Higher rates of late diagnosis and poorer lung cancer outcomes among high-risk and more deprived populations.
- Smoking prevalence and deprivation contribute to increased risk of lung cancer and poorer survival outcomes.

What actions were taken?

- Undertook planning and engagement work to support implementation of targeted lung cancer screening pathways.
- Used national guidance and local intelligence to identify priorities and support pathway development.
- Worked with partners to improve readiness for future targeted screening delivery focused on high-risk populations.

What was the outcome?

- Local service has been commissioned due to launch in 2026/27 which aims to address identified health inequalities issues
- Improved local readiness for targeted lung cancer screening implementation.
- Strengthened partnership and pathway development work supporting future delivery.
- Increased system understanding of local priorities and high-risk populations for lung cancer screening activity.

Core20 (CYP)

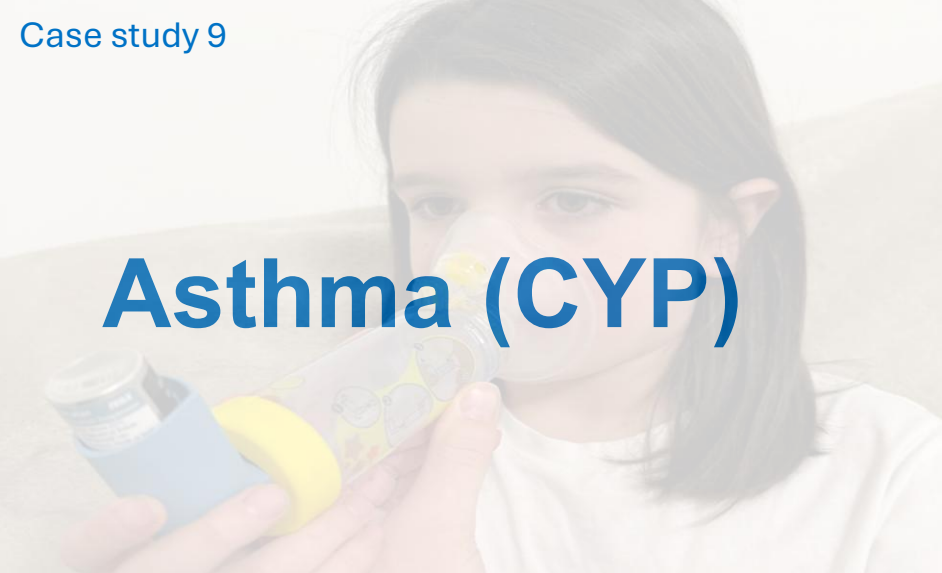
- Some children and young people experience barriers to attending appointments, contributing to poorer access, delayed care, and safeguarding concerns.
- Standard communication approaches may not effectively engage all families.

What actions were taken?

- Used data analysis and pathway review to better understand “was not brought” patterns and barriers.
- Reviewed existing communication processes and patient messaging approaches.
- Engaged across all Lincolnshire hospitals and targeted communities, with patient information translated into the three most widely spoken languages in the county.

What was the outcome?

- SMS communications were redesigned to improve accessibility and family engagement.
- Increased understanding of barriers affecting appointment attendance among some families
- Identification of specific PCN areas contributing to higher ‘was not brought’ rates.
- Supported development of more accessible and responsive communication approaches.



Asthma (CYP)

What was the health inequalities issue?

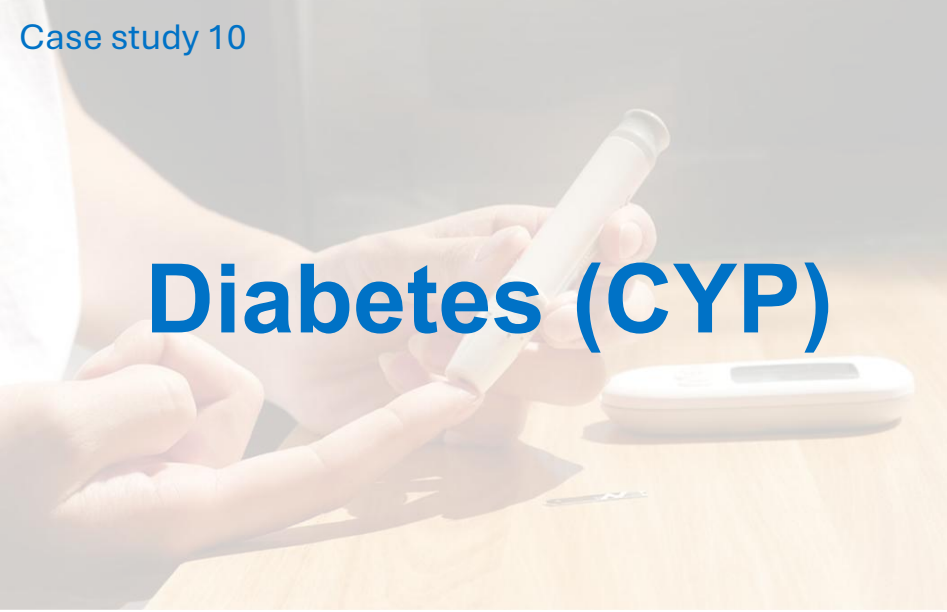
- Asthma is a significant cause of ill health for children and young people in Lincolnshire, with A&E attendance above the England average.
- Children living in fuel poverty were disproportionately affected and there was limited access to diagnostic testing.

What actions were taken?

- Developed a Population Health Management (PHM) informed asthma work plan aligned to the national Core20PLUS5 asthma bundle.
- Introduced a CYP asthma dashboard and developed a primary care asthma pathway to support diagnosis, treatment, and annual reviews.
- Supported implementation of asthma diagnostic testing across Community Diagnostic Centres (CDCs).
- Worked with schools, housing services, and community partners to improve asthma awareness and support.

What was the outcome?

- A CYP asthma dashboard was established to support targeted identification of need across Lincolnshire.
- Skegness CDC was recognised by NHS England as an exemplar site for CYP asthma pathway implementation.
- Referrals into CYP asthma diagnostic clinics increased following implementation.
- Nine schools achieved Asthma Friendly School accreditation and 11 families were supported through the Good Homes Lincs pilot.



Diabetes (CYP)

What was the health inequalities issue?

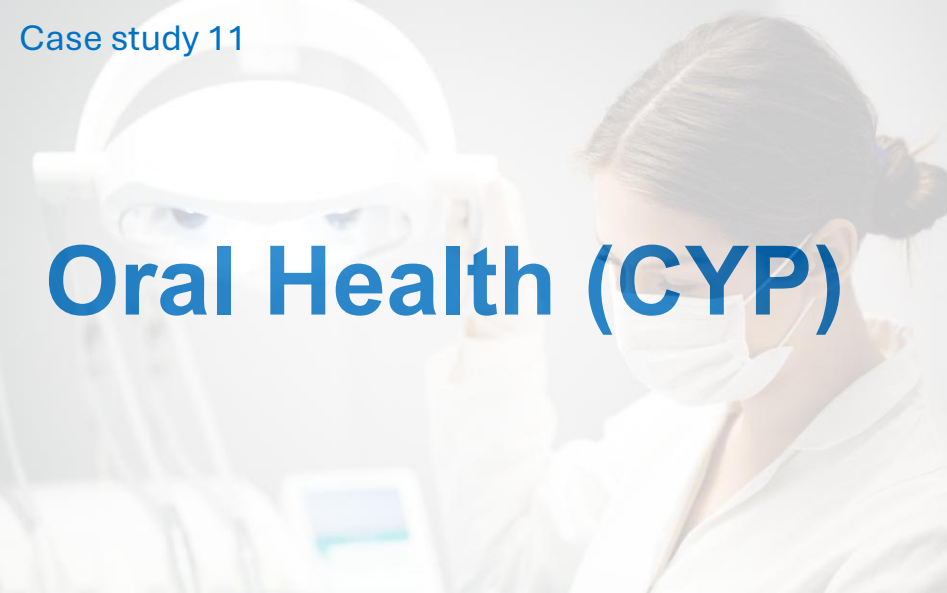
- Some children and young people were presenting late with diabetes symptoms and being diagnosed in diabetic ketoacidosis (DKA), which can result in poorer outcomes and emergency admission.
- Delayed recognition of symptoms can disproportionately affect families experiencing barriers to healthcare access or awareness.

What actions were taken?

- Delivered diabetes awareness training to children's health services, family hubs, and children's centres to improve early recognition of symptoms in CYP.
- Worked with primary care teams to reinforce the need for same-day referral for CYP with possible diabetes symptoms.
- Shared webinars and resources with GP practices across Lincolnshire to improve access to consistent guidance.
- Developed Lincolnshire school guidance on diabetes to improve awareness and support in education settings.

What was the outcome?

- Improved awareness of the signs and symptoms of diabetes across healthcare, community, and education settings.
- Strengthened understanding of the need for rapid identification and same-day referral.
- Supported a more consistent approach to diabetes recognition and referral across Lincolnshire.
- Aimed to reduce inequalities linked to delayed diagnosis and poorer outcomes, although impact on DKA rates had not yet been confirmed.



Oral Health (CYP)

What was the health inequalities issue?

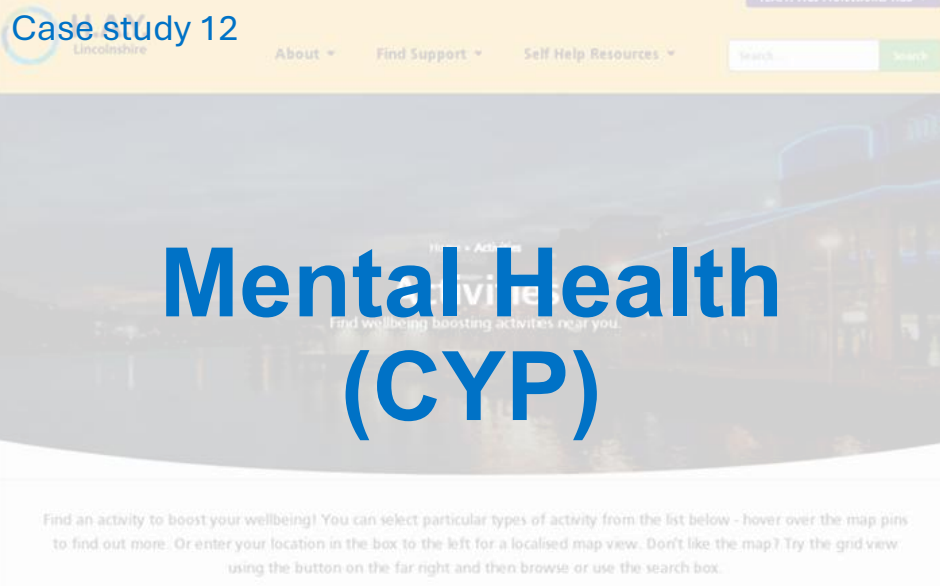
- Children and young people in some communities experience poorer oral health outcomes and higher levels of tooth decay.
- Oral health inequalities are closely associated with deprivation and reduced access to preventative support.

What actions were taken?

- Delivered supervised toothbrushing programmes in early years settings across Lincolnshire to improve oral hygiene habits from a young age.
- Provided oral health promotion and education through Family Hubs and Holiday Activities and Food (HAF) programme settings.
- Increased access to preventative oral health support for children, young people, and families in community settings.
- Supported delivery of the prevention priorities within the Lincolnshire Dental Strategy.

What was the outcome?

- Increased awareness of good oral hygiene among children, young people, and families.
- Supported more children and young people to regularly brush their teeth and develop healthier oral hygiene habits.
- Improved access to preventative oral health support in early years and community settings across Lincolnshire.
- Aimed to reduce oral health inequalities and improve long-term oral health outcomes for CYP.



What was the health inequalities issue?

- Children and young people from deprived communities were disproportionately presenting in crisis.
- Some groups experienced poorer access to early mental health support.

What actions were taken?

- Delivered a data-led, system-wide approach to better understand inequalities within CYP mental health services.
- Used local and postcode-level analysis to identify communities experiencing higher levels of crisis presentation.
- Established a collaborative project group involving system partners, frontline staff, children, young people, and families.
- Gathered lived experience insight to understand barriers to access, engagement, and support.
- Developed practical recommendations to inform future service improvement and business case development.

What was the outcome?

- Improved understanding of local mental health inequalities.
- Identified communities experiencing disproportionately high crisis presentation.
- Strengthened the evidence base for future pathway redesign and targeted support.
- Provided the Mental Health Provider with a recommendations report to support and inform future planning.

Digital Inclusion Lincoln Embracing All Nations (LEAN)

'Empowering people through
digital inclusion in
Lincolnshire'



What was the health inequalities issue?

- Migrant, refugee, and asylum-seeking communities can experience language, digital, and access barriers which reduce access to healthcare services and support.

What actions were taken?

- LICB funded LEAN to provide digital inclusion support to ethnic minority communities via a Health Inequality grant.
- Delivered weekly coffee mornings and English classes alongside practical digital support.
- Supported people to download and use the NHS App and access online healthcare services.
- Provided free SIM cards and support with GP registration, appointments, and prescriptions.
- Delivered support through nine multilingual volunteers alongside healthcare professionals.

What was the outcome?

- Approximately 530 people supported since November 2025
- Around 30–40 people attended weekly sessions.
- Around 80% of people supported were not registered with a GP and were helped access services.
- Feedback showed improved confidence and increased independence in using digital tools.
- Supported previously unregistered individuals to access GP registration and healthcare services.

Digital Inclusion Boston Pilot

'Empowering people to
digital inclusion in
Lincolnshire'



What was the health inequalities issue?

- Communities experiencing digital exclusion in the Boston area can face barriers accessing healthcare services and digital tools such as the NHS App.

What actions were taken?

- As part of the Lincolnshire Health and Care Digital Inclusion Strategy, Boston was identified as a priority area due to having the highest risk of digital exclusion in the county.
- A collaborative project involving the district council, Primary Care Network (PCN), and VCFSE organisation Lincs Digital delivered community-based drop-in sessions and outreach events between September 25 and March 26.
- Provided one-to-one support with downloading and using the NHS App.
- Worked with trusted local organisations and community figures to improve engagement.

What was the outcome?

- 13 drop-in sessions delivered.
- 105 people attended two Wrangle sessions (East Lindsey) and all engaged with the NHS App.
- Over 200 people engaged at the Boston Stump Community Day, including 40 meaningful discussions.
- Feedback showed improved confidence using digital devices and increased willingness to engage with digital healthcare services.
- Learning highlighted stronger engagement through trusted local figures and community-based delivery.

Digital Inclusion SimPal and ULTH Digital Inclusion Pathway

Empowering people through
digital inclusion in
Lincolnshire



What was the health inequalities issue?

- Digital exclusion affecting access to healthcare communication, appointments, and information for people living with cancer.
- Some patients lacked access to devices, data, or digital confidence, limiting their ability to engage with healthcare services.

What actions were taken?

- Developed a partnership pathway providing mobile phones, SIM cards, and data access to patients experiencing digital exclusion.
- Identified patients requiring additional support to access digital healthcare communication and services.
- Provided practical digital support to improve confidence using healthcare technology and communication platforms.
- Embedded digital inclusion support within cancer care pathways.

What was the outcome?

- Established a sustainable pathway supporting digitally excluded cancer patients.
- Improved access to healthcare communication and digital support for patients without reliable digital access.
- Increased awareness among staff of the impact of digital exclusion on access to care.
- Strengthened partnership working to support longer-term digital inclusion approaches within cancer services.

Statement on Information on Health Inequalities

**Nottingham & Nottinghamshire
Integrated Care Board**

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

Table of Contents

Introduction	6
Nottingham and Nottinghamshire Population Profile	7
Impacting on Health Inequalities	8
How do we Measure Deprivation?	9
Indicator overview	10
Operational priorities	11
CORE20Plus5 – Adults	12
CORE20Plus5 – Children and Young People	14
Using Data to Understand Health Inequalities.....	15
Understanding Health needs	15
Understanding healthcare access, experience, and outcomes.....	17
Improving data quality	19
Using information on healthcare inequalities.....	20
Publishing information	22
Operational priorities.....	24
Elective Care.....	24
Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks	24
Inequalities in annual change in size of waiting list	25
Age-standardised rates of elective admissions	25
Age-standardised rates of outpatient attendances.....	26
Age-standardised rates of virtual outpatient attendances	26
Outpatient Did Not Attend (DNA) rates	27
Community.....	27
Inequalities in the percentage of people waiting over 18 weeks, over 52 weeks for community services.....	27
Adults	28
Waits lasting more than 18 weeks	28
Waits lasting more than 52 weeks	28
Children and young people	29
Waits lasting more than 18 weeks	29

Waits lasting more than 52 weeks	29
Urgent and Emergency Care	30
Age-standardised activity rates for emergency admissions.....	30
Age-standardised activity rates for emergency department attendances.....	31
Inequalities in mean time in emergency department	31
CORE20Plus5 - Adults.....	34
Respiratory.....	34
Actions by the ICB	34
Inequalities in non-elective bed days occupied by asthma, COPD and CAP	34
Inequalities in pulmonary rehabilitation completion rates.....	35
Smoking Cessation	36
Actions by the ICB	36
Inequalities in inpatients making a supported quit attempt with an in-house tobacco dependence treatment service.....	36
Inequalities in inpatients who successfully quit smoking as measured at 28 days after commencing a supported quit attempt	37
Mental Health	37
Actions by the ICB	37
Overall number of severe mental illness (SMI) physical health checks and action plan	37
Rates of total Mental Health Act detentions	38
Rates of restrictive interventions	38
NHS Talking Therapies.....	39
Inequalities in access to NHS Talking Therapies.....	39
NHS Talking Therapies recovery rate.....	40
Cancer	41
Actions by the ICB	41
Targeted Lung Health Checks	41
Nottingham City Cancer Early Diagnosis Coordinator programme.....	42
Appt Health intervention	42
Project Compass.....	42
Percentage of cancers diagnosed at stage 1 and 2	42
Cancer screening coverage	43
Bowel cancer screening	43
Breast cancer screening	43
Cardiovascular Disease (CVD)	43
Actions taken by the ICB	44

MBLC (Majority Black Led Churches) Hypertension Project	44
Know your numbers campaign	44
SiSU Health Stations	44
Mid-Notts Hypertension Pro-active Casefinding.....	44
Stroke - rate of non-elective admissions (per 100,000 age-standardised)	45
Myocardial infarction – rate of non-elective admissions (per 100,000 age-standardised)	45
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).....	46
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.....	46
Percentage of patients aged 18 or over with GP recorded atrial fibrillation and a record of CHA2DS2-VASc Score of 2 or more who are currently treated with anti-coagulation drug therapy	47
Diabetes	47
Actions by the ICB	47
Variation between percentage of people with Type 1 and Type 2 Diabetes receiving all 8 care processes.....	48
Deprivation.....	48
Ethnicity	48
Sex	49
Referrals to the National Diabetes Prevention Programme.....	49
Learning Disabilities and Autism	49
Actions by the ICB	49
Number of people in a mental health inpatient setting who have a learning disability or are autistic.....	50
Percentage of patients aged 14+ on GP learning disability registers who have had an annual health check.....	50
Percentage of people with suspected autism waiting more than 13 weeks for contact	51
Maternity and Neonatal.....	51
Actions taken by the ICB	51
Gestational age at booking	52
Pre-term births under 37 weeks	52
Vaccinations	53
Actions by the ICB	53
Uptake of flu vaccinations by age and demographic	53
Uptake of covid vaccinations.....	53
CORE20Plus5 – Children & Young People (CYP).....	55

Urgent and Emergency care – CYP	55
Actions by the ICB	55
Emergency department attendances for under 18s	55
Emergency admissions for under 18s	55
Oral Health	56
Tooth extractions due to decay for children admitted to hospital aged 10 and under (number of admissions)	56
Diabetes - CYP	56
Inequalities in percentage of CYP with type 1 and 2 diabetes receiving all the recommended NICE care processes	56
Mental health – CYP	57
Actions taken by the ICB	57
CAMHS Mental Health Support Team Expansion	57
Mental Health Extended Early Intervention Service	57
Start Well Bassetlaw INT – Mental Health	57
Children and Young People’s (CYP) Mental Health Access	58
Respiratory – CYP	58
Actions by the ICB	58
Inequalities in dispensing of reliever only inhalers	59
Inequalities in emergency admissions for asthma	59
Data Quality	60
Actions by the ICB	60
Data quality indicators	60
NHS Providers	60
Independent sector providers	61

Introduction

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Sex, deprivation, and ethnicity are 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. The statement was updated in November 2025 with a refreshed set of indicators and a new focus on 'Key Lines of Enquiry', which ask ICBs to reflect on the actions they've taken to reduce inequalities in their population. 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.

Nottingham and Nottinghamshire Integrated Care Board (ICB) recognise that good quality, robust data enables the NHS and wider system partners to understand more about the populations we service. The ICB 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.

The core indicators set out by the NHSE Statement on Health Inequalities form the basis of this report. The metrics align with the national five strategic health inequality priorities alongside the clinical areas in the Core20+5. The core indicators presented here are supported by additional, locally determined metrics and case studies of actions taken by the ICB to reduce inequalities.

The data and information provided in this Statement will be used by the 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

1,278,240 patients are registered with a Nottingham and Nottinghamshire Integrated Care Board GP practice.¹

18% of the population are aged 65 and over. Over the last 18 years there has been an increase in total population numbers across the ICB. However there has been a larger increase in older age groups and a decrease in the number of births.

76% of the Nottingham and Nottinghamshire ICB registered population are from a White ethnic group. People of Asian heritage are the second largest ethnic group in Nottingham and Nottinghamshire, making up around 10% of the overall population. 5% are of Black African/Caribbean heritage, 4% are of mixed heritage, and 2% are from other ethnic groups. 4% of registered patients do not have a known ethnicity based on their GP records.

The ethnic makeup of each district varies across the system. Nottingham City is highly diverse, with around 48% of the population being from ethnic groups other than White. This compares with smaller towns and rural communities like Ashfield, Mansfield, and Newark and Sherwood, which are around 90% White.

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 and Nottinghamshire ICB's population is more deprived than England overall, with a quarter (25.5%) of registered patients living in the 20% most deprived areas nationally (IMD quintile 1). 51% of Nottingham City and 15% of the county population live in quintile 1 areas.

People from ethnic minority groups are more likely to live in urban areas, which tend to have higher levels 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.² The life expectancy difference is around 8 years less for those in the most deprived areas of the compared the least deprived areas.³ While life expectancy in Nottinghamshire county is generally similar to England overall, life expectancy for Nottingham city residents is three years lower for men and 2 years lower for women.⁴

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

¹ SAIU, SID06 Health Inequalities Dashboard, Population profile (ICB registered patients), March 2026

² SAIU, SID18 Outcomes Dashboard, Multi-morbidity-free life expectancy by deprivation (locally calculated), 2025

³ SAIU, SID18 Outcomes Dashboard, Life expectancy by deprivation (locally calculated), 2025

⁴ SAIU, SID18 Outcomes Dashboard, ONS life expectancy benchmarking, 2025

longer, they spend more of their lifetimes in poor health. On average, women in Nottingham City will spend 68% of their life in good health compared to 77% for men. Both figures are lower than the England averages of 77% for women and 80% for men. Rates in the Nottinghamshire 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.

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 barriers⁵.

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 ICB, enabling people to become more involved with their care and decision making.

⁵ What are health inequalities? 2022 [What Are Health Inequalities? | The King's Fund \(kingsfund.org.uk\)](https://www.kingsfund.org.uk/publications/what-are-health-inequalities)

- **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 experience are some ways in which overall outcomes could be improved.

Utilising data from the indicators included in this statement can help the system to identify disparities in access to services and patient 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. Quintiles are used to understand differences between the most and least deprived areas.

The English Indices of Multiple Deprivation were refreshed in September 2025. Some of the national data flows used to produce this report have not been updated to the 2025 version of the IMD. Only primary care-based information for March 2026 uses the 2025 English Indices of Multiple Deprivation. Data for all other periods uses the 2019 IMD.

Indicator overview

Where data is available, the Health Inequalities Statement measures are summarised below in a scorecard format.

The scorecard compares indicators for each characteristic to a reference population for that dimension. Values are coloured based on whether they are statistically significantly different to the reference.

- Males and Females are compared against each other
- All ethnic groups are compared against White. For some indicators, such as age-standardised rates of admissions, data quality for ethnicity is not good enough to present accurate statistical analysis.
- All deprivation quintiles are compared against the least deprived (quintile 5).
-

Operational priorities

Legend

No statistically significant difference to reference/is reference	Statistically significantly better than reference	Statistically significantly lower than reference (not better/worse)
Data quality or other issue prevents statistical comparison	Statistically significantly worse than reference	Statistically significantly higher than reference (not better/worse)

Theme	Indicator	Period	ICB Overall		Sex		Ethnicity					IMD Quintile				
			ICB		Female	Male	Asian	Black	Mixed	Other	White (ref.)	1	2	3	4	5 (ref.)
Elective care	Age-standardised rate of Elective Admissions per 100,000 population	2025	16,962		17,460	16,704	8,571	10,748	8,169	28,134	14,147	16,434	17,146	17,598	16,648	16,604
	Age-standardised rate of Outpatients First Attendances per 100,000 population	2025	44,057		50,372	38,291	26,715	30,222	25,426	75,003	37,043	44,270	44,233	44,082	43,538	42,505
	Age-standardised rate of Virtual Outpatient First Attendances per 100,000 population	2025	4,703		5,339	4,122	2,626	3,442	2,619	7,591	3,920	4,688	4,512	4,508	4,389	4,333
	Percentage of first outpatient appointments not attended (DNA)	2025/2026	6.1%		5.6%	6.7%	8.2%	8.8%	9.7%	7.6%	5.4%	8.8%	6.8%	5.4%	4.2%	3.8%
	Waiting <= 18 Weeks	202603	58.6%		57.4%	60.2%	55.4%	56.3%	57.5%	53.5%	58.5%	58.2%	58.3%	59.1%	59.5%	58.1%
	Waiting >18 Weeks (cumulative)	202603	41.4%		42.6%	39.8%	44.6%	43.7%	42.5%	46.5%	41.5%	41.8%	41.7%	40.9%	40.5%	41.9%
	Waiting >52 Weeks (cumulative)	202603	2.3%		2.5%	2.0%	2.4%	2.7%	2.3%	2.7%	2.3%	2.3%	2.0%	2.3%	2.3%	2.5%
	Waiting >65 Weeks (cumulative)	202603	0.1%		0.1%	0.1%	0.0%	0.1%		0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
	Waiting list size	202603	120,105		69,625	50,480	4,504	2,791	1,844	2,419	78,669	31,717	22,463	23,731	19,644	22,550
Urgent and emergency care	Age-standardised rate of Emergency Admissions per 100,000 population	2025	11,499		12,509	10,628	8,476	9,977	7,065	22,821	10,466	14,543	12,291	10,726	9,531	9,370
	Age-standardised rate of Emergency Attendances per 100,000 population	2025	39,548		40,874	38,382	26,173	33,164	26,468	73,956	35,746	46,758	41,255	38,191	35,740	31,533
	Mean time in emergency department	2025/2026	270		271	268	222	232	194	232	279	271	269	263	264	278

CORE20Plus5 – Adults

Legend

No statistically significant difference to reference/is reference	Statistically significantly better than reference	Statistically significantly lower than reference (not better/worse)
Data quality or other issue prevents statistical comparison	Statistically significantly worse than reference	Statistically significantly higher than reference (not better/worse)

Theme	Indicator	ICB Overall	Sex		Ethnicity					IMD Quintile				
		ICB	Female	Male	Asian	Black	Mixed	Other	White (ref.)	1	2	3	4	5 (ref.)
Cancer	Bowel cancer screening coverage (ages 54-74)	70.5%	72.8%	68.0%	61.2%	62.3%	63.2%	61.4%	72.5%	59.9%	66.6%	71.8%	75.3%	78.3%
	Breast cancer screening coverage (ages 50-70)	71.3%	71.3%		63.2%	62.6%	61.5%	59.0%	73.1%	62.4%	68.7%	71.8%	75.9%	77.9%
	Percentage of cancers diagnosed at stage 1 or 2 (Rapid registrations)	61.3%	66.3%	56.6%	71.4%	65.7%	57.5%	68.9%	60.8%	58.9%	59.6%	58.0%	65.1%	64.7%
Cardiovascular disease	Age-standardised rate of Emergency Admissions per 100,000 population - Myocardial Infarction	105	65	147	117			436	84	131	116	106	92	75
	Age-standardised rate of Emergency Admissions per 100,000 population - Stroke	161	138	182	130	101	91	533	141	208	177	156	143	124
	CVDP002AF: Percentage of patients (Age 18+) with Atrial Fibrillation and a CHA2DS2-VASc score of 2 or more treated with an anticoagulant	94.7%	94.6%	94.8%	92.6%	88.1%	93.8%	92.5%	94.8%	94.6%	95.0%	94.8%	94.8%	94.4%
	CVDP003CHOL: Percentage of patients (age 18+) with no CVD and a QRISK score of 20% or more on lipid lowering therapy	61.9%	60.5%	63.0%	66.0%	58.1%	56.9%	57.9%	61.9%	65.7%	64.2%	61.5%	60.0%	58.7%
Diabetes	CVDP007HYP: Percentage of patients (age 18+) with Hypertension in whom the last blood pressure reading is below the age-appropriate treatment threshold	67.6%	69.4%	65.9%	65.6%	57.7%	59.5%	57.9%	68.6%	65.6%	66.2%	68.2%	68.3%	69.9%
	Diabetes 8 Care Processes recorded, last 12 months: Diabetes Type 1	34.8%	33.5%	35.7%	31.7%	37.7%	23.7%	41.4%	35.3%	31.1%	35.2%	37.0%	36.3%	35.9%
	Diabetes 8 Care Processes recorded, last 12 months: Diabetes Type 2	50.9%	49.1%	52.4%	43.5%	48.1%	46.5%	44.2%	52.3%	45.8%	49.2%	51.7%	54.8%	57.5%
	Percentage of prediabetic patients offered a place on a Diabetes Prevention Programme (DPP) (last 12 months)	63.6%	63.6%	63.7%	64.6%	64.5%	62.9%	54.8%	63.7%	59.1%	63.0%	62.6%	68.2%	66.8%
Learning disabilities and autism	Percentage of patients with learning disabilities (age 14+) with all health checks completed (last 12 months)	77.9%	78.7%	77.5%	76.8%	75.3%	72.9%	65.8%	78.5%	74.6%	78.4%	79.4%	80.4%	81.9%

CORE20+5 – Adults continued

Legend

No statistically significant difference to reference/is reference	Statistically significantly better than reference	Statistically significantly lower than reference (not better/worse)
Data quality or other issue prevents statistical comparison	Statistically significantly worse than reference	Statistically significantly higher than reference (not better/worse)

Theme	Indicator	ICB Overall	Sex		Ethnicity					IMD Quintile				
		ICB	Female	Male	Asian	Black	Mixed	Other	White (ref.)	1	2	3	4	5 (ref.)
Maternity	Percentage of births which are preterm (before 37 weeks)	7.6%	7.6%		6.7%	8.2%	9.4%	9.5%	8.7%	9.6%	8.2%	8.8%	7.5%	6.7%
	Percentage of pregnancies with a booking appointment before 10 weeks gestation	58.0%	58.0%		50.0%	40.7%	49.7%	49.4%	63.1%	53.5%	59.3%	60.9%	62.1%	58.8%
Mental health - adult	Crude rate of Mental Health Act Detentions per 100,000 population	79	78	80	41	154	100	107	72	99	97	55	55	48
	Percentage of SMI pats with annual health check complete (L12M)	63.1%	65.7%	60.8%	60.5%	58.0%	56.6%	56.6%	64.6%	61.1%	63.1%	65.1%	64.2%	65.8%
	Rate of restrictive interventions per 1,000 occupied bed days	32.3	61.2	17.3	7.9	21.5	37.3	36.2	36.4	44.4	21.8	13.7	76.6	34.8
	Talking therapies access rates (patients with 2+ contacts per 1,000 pop)	16	22	10	9	17	21	13	16	17	17	16	15	15
	Talking therapies recovery rate	51.6%	50.8%	53.5%	40.3%	47.7%	45.0%	42.8%	53.5%	45.5%	50.5%	53.2%	56.0%	56.7%
Respiratory - adult	Age-adjusted prevalence per 100,000 pop - COPD	2,258	2,087	2,465	725	845	1,476	1,418	2,438	3,873	2,988	2,109	1,598	1,031
	Age-standardised rate of Emergency Admissions per 100,000 population - COPD	209	213	206	58	84	105	221	203	443	261	171	106	70
	Crude rate of pulmonary rehab referrals per 1,000 COPD patients	84	88	81	119	60	663	49	69					
	Mean bed days occupied by non-elective admissions for asthma (age 18+)	4.3	4.5	3.8	4.0	3.2	2.2	5.6	4.5	4.4	4.2	3.6	4.3	4.3
	Mean bed days occupied by non-elective admissions for COPD (age 18+)	6.0	6.4	5.5	6.8	3.1	6.7	7.1	6.0	5.9	6.5	5.4	6.0	6.5
	Mean bed days occupied by non-elective admissions for pneumonia (age 18+)	9.7	9.8	9.6	6.7	9.2	7.0	10.8	9.8	9.5	10.1	9.7	9.3	10.3
	Pulmonary rehab completion rate	35.8%	35.4%	36.1%			19.7%		38.7%	28.1%	38.5%	35.7%	42.6%	40.4%
Vaccinations	Influenza vaccination uptake age 18-64 (current/recent season) (no exceptions)	45.3%	47.2%	42.8%	40.6%	32.3%	32.2%	33.4%	47.5%	38.1%	43.3%	46.1%	50.6%	53.9%
	Influenza vaccination uptake age 65+ (current/recent season) (no exceptions)	76.4%	76.7%	75.9%	58.0%	44.0%	55.9%	49.2%	78.5%	66.3%	73.2%	76.7%	79.4%	82.8%

CORE20Plus5 – Children and Young People

Legend

No statistically significant difference to reference/is reference	Statistically significantly better than reference	Statistically significantly lower than reference (not better/worse)
Data quality or other issue prevents statistical comparison	Statistically significantly worse than reference	Statistically significantly higher than reference (not better/worse)

Theme	Indicator	Period	ICB Overall	Sex		Ethnicity					IMD Quintile				
			ICB	Female	Male	Asian	Black	Mixed	Other	White (ref.)	1	2	3	4	5 (ref.)
Mental health - CYP	Percentage of children and young people with a mental health contact	2025/2026	8.0%	7.2%	7.6%	2.5%	4.0%	8.6%	8.8%	8.3%	8.8%	8.7%	7.7%	7.6%	6.5%
Oral health	Crude rate of tooth extractions in 0-10s per 100,000 population	2025/2026	91	92	89					83	115	99	93	99	
Respiratory - CYP	Crude rate of emergency admissions for asthma in 0-17 year olds per 100,000 population	2025/2026	102	88	115	144	139	144		77	158	103	90	65	53
	Percentage of asthma patients (age 0-17) prescribed 6 or more SABA inhalers (L12M)	202603	8.1%	7.8%	8.3%	10.2%	6.2%	10.7%	5.4%	7.8%	9.9%	10.1%	9.0%	5.9%	4.6%
Urgent and emergency care - CYP	Crude rate of emergency admissions in 0-17 year olds per 100,000 population	2025/2026	6,741	6,492	6,978	5,950	5,453	5,816	9,535	6,518	7,714	6,621	8,247	5,768	4,820
	Crude rate of emergency dept. attendances in 0-17 year olds per 100,000 population	2025/2026	44,973	43,003	46,848	35,033	34,461	38,341	71,615	42,535	52,292	44,340	46,839	40,042	35,198

Using Data to Understand Health Inequalities

Understanding Health needs

Accessing, analysing, and sharing health inequalities data is central to the ICB's work. The Strategic Analytics Intelligence Unit (SAIU) publishes over 20 dashboards, available to NHS, local authority, voluntary sector, and other partners via an online portal. Dashboards cover key clinical areas such as planned care, urgent and emergency care, mental health, and maternity, and are used daily by commissioners to inform decision-making. Increasingly, they present data by health inequalities dimensions. For example, the Clinical Transformation Recommendations Dashboard enables comparisons by age, ethnicity, and deprivation across 70+ measures. The Health Inequalities Dashboard brings together specific measures, including those in this statement and local priority indicators, with breakdowns by age, sex, ethnicity, deprivation, and geography. Other dashboards also allow users to filter by these dimensions for ad hoc analysis.

Alongside using data from the SAIU to deep dive into population profiles across various clinical domains, the ICB has worked with communities across the ICS footprint to obtain qualitative information and understand local communities' experiences of healthcare services and the barriers to access. Specific examples include work with the Majority Black-Led Churches in Nottingham City, further detail of which can be reviewed in Case Study 1 of the accompanying case study document. The approach first used local data from eHealthScope and the SAIU dashboards which outlined the greatest risk of hypertension was in people of a Black African/Caribbean ethnic group, yet people from this ethnicity in the most deprived areas were less likely to have had a recent blood pressure check. Community engagement activities then took place where feedback highlighted barriers including; lack of communication from GPs, poor understanding of hypertension and medications, inconsistent messaging, low trust in the NHS, and perceived institutional racism. Participants emphasised the need for tangible action, funding, and culturally tailored health education. Following on from this work, community blood pressure checks were offered at a MBLC venue, increasing outreach into underserved communities.

Local Forums, engagement groups and co-production groups aim to further seek qualitative experiences and the health needs of our populations from those with lived experience. Particularly the views of people with learning disabilities, ethnic minority groups, experiences of maternity services, children, young people and people living in core 20 areas are included within various groups. Examples of such groups include the Race Health Inequalities Group & Maternity Voices Partnership.

The Targeted Lung Health Check Service demonstrates how a service identified a need for an underserved population (people with SMD - Severe and Multiple Disadvantage) and has adapted to reduce barriers experienced enabling checks to be completed. The service worked closely with support workers and service users to understand what was needed to undertake checks, such as new and different locations. Further detail can be reviewed in case study 4 of the accompanying case study pack.

Data and intelligence tools provide an important foundation for understanding intersectionality between different forms of inequality. The ICB has developed a clinical audit and information tool called eHealthScope which allows users to profile and segment populations based on data from primary care and other sources. This includes health inequalities demographic dimensions like

ethnicity and deprivation, diagnoses including learning disabilities and serious mental illness, and a host of social characteristics such as homelessness and carer status.

eHealthScope's segmentation and profiling functionality provides the basis for local reporting on indicators such as learning disability health checks, and is usually the first step for identifying populations for targeted intervention. Recent examples include a profile of severe mental illness (SMI), personality disorder, and common mental illness patients. Data from this project showed SMI is significantly more prevalent in Black and Mixed ethnicity populations, and that SMI patients have higher rates of lifestyle risk factors such as smoking and obesity which to lead poorer physical health.

Health status and the development of long-term conditions is closely linked to age. In Nottingham and Nottinghamshire, the most deprived quintile has a younger age profile than the least deprived quintile, and the White population tends to be older than ethnic minority populations. When data is only looked at in terms of activity and crude condition prevalence, this can obfuscate the inequalities between demographic groups. To mitigate this, the SAIU uses statistical techniques to better understand correlations between population characteristics and poorer health.

Prevalence and admissions data comparing deprivation quintiles, sex, or ethnic groups is age-standardised to ensure health needs and inequalities are not hidden by different demographic structures. eHealthScope's logistic regression tool allows the SAIU to understand the size of the association between being a member of a specific demographic group and an outcome like hypertension diagnosis, while controlling for other factors such as age, or membership of another protected characteristic such as ethnicity. For example, work undertaken in 2025 for a dementia deep dive was used to show the increased association between deprivation and dementia, particularly for vascular dementia.

In 2019, work was commissioned by Digital Notts to understand high risk areas for digital exclusion. IMD quintile, age, rurality and internet user classification were the metrics used. This work was revisited in 2025 by the ICB using updated information and producing a deeper dive into the 4 place-based partnerships (PBPs) across Nottingham and Nottinghamshire, creating a profile of the digital exclusion risk for each area.

The new analysis firstly frames the risks of digital exclusion into three categories (individual factors, external factors and wider infrastructure) to help the ICS understand how better to target support, both in terms of location and in the design of support offered. For example, Individual risk factors may be unlikely to change but inclusive initiatives can be used to reduce barriers to access and encourage participation. External influences are risk factors which the ICB and ICS partners may be able to influence at a local level through investment, targeted workstreams and tailored programmes which can improve affordability and accessibility of devices, health literacy, digital literacy, attitudes and confidence. Wider infrastructure challenges are issues causing digital exclusion which may require significant investment and longer-term change driven by government. Rurality, type of accommodation and poor signal coverage can all be affected by wider infrastructure challenges. Although these factors may be out of the individual's control and local interventions will not resolve the underlying issues, an understanding infrastructure can help to ensure the population receives information equitably and mitigations are considered for areas which may not have strong digital connections.

Each place profile includes additional data from the SAIU dashboards and external data sources as well as usage of the NHS app, to help identify individual and external risk factors alongside wider infrastructure challenges. The information contained allows the PBPs, digital and commissioning

teams to help target resources to areas of need more accurately and design interventions suited to each local area.

In 2025 The Digital Inclusion Delivery Framework 2025–2030 was published by Digital Notts. The framework sets out a bold and unified system-wide approach to reducing digital exclusion and ensuring every resident and member of the health and care workforce can benefit from digital innovation. The ICB is committed to the delivery of the five key priority themes for the ICS included in the framework and the ICB is also a member of the Digital Inclusion Board.

Understanding healthcare access, experience, and outcomes

The Health Inequalities Dashboard produced by the SAIU provides an overview of the indicators and clinical domains outlined within this statement which can be tracked over time. A scorecard summary is also used to present disparities and trends at a glance and are included within health inequalities reporting. This data is being used to help drive forward change in priority areas in the ICB and promote the targeting of resources to areas of need, particularly where data shows gaps are widening.

Health inequalities information forms part of the ICB reporting processes into the ICB Finance and Performance Committee and System Oversight Group. Further details of which can be reviewed in the 'Publishing Information' section of the KLOES.

The reporting focuses on a range of metrics in line with the Core20Plus5 and the metrics included within this statement which are included in the SAIU Health Inequalities Dashboard. Reporting in this way enables the analysis of trends across a range of ICB domains as well as qualitative reports into actions ongoing across ICB to help reduce inequalities within the five clinical areas. This provides an overview into progress and trends over time and highlights areas which may require more action and investment.

The SAIU have produced dashboards which analyse the performance of elective and urgent and emergency care. Both can be broken down by deprivation, ethnicity, age and sex to allow detailed analysis to take place. More information can be found in the response to the 'Understanding Health needs' section of the KLOEs.

Information from these dashboards is presented to the Urgent and Emergency Care Board Monthly meetings, which are used to support new actions and workstreams. Further detail pertaining to elective care demographic disparities can be reviewed in the 'Operational Priorities' Section of this document, under 'Elective Care' and 'Urgent and Emergency Care' sub-headings.

The ICB recognises that the NHS has a crucial role to play in secondary prevention which will reduce elective care procedures and urgent and emergency care admissions, whilst in the longer term improving the health of those who are most vulnerable. Those living in the most deprived areas of the ICB footprint are at greater risk of multiple morbidity and long-term conditions with a lower healthy life expectancy. They are also more likely to DNA appointments and require urgent and emergency care through condition exacerbation. Through the data, the ICB have identified priority neighbourhoods for a targeted approach to secondary prevention and multi-morbidity, which includes case finding through to management and treatment of long term conditions. This is supported by agreed secondary prevention priority areas.

The Health Inequalities and Innovation Fund (HIIF) outlines the approach and funding model that focuses on people with multimorbidity and clustered risk factors by applying evidence-based

secondary prevention interventions across the following priority areas: CVD, Diabetes, obesity, smoking, alcohol (including liver disease), physical activity, immunisations and vaccinations and screening. The HIF fund has committed £4.5million of recurrent funding for secondary prevention with a proportion of this funding to directly target neighbourhoods with the highest levels of need, focusing on registered populations living in the 20% most deprived areas. The delivery model will proactively identify high risk individuals using population health management approaches and deliver tailored, coordinated interventions through integrated NHS, local authority, community and voluntary sector services. This includes access to diagnostics, multidisciplinary clinical expertise, health coaching and lifestyle support.

The ICB uses eHealthScope to identify high frequency service users and those who attend A&E on a regular basis. An ICS Steering Group was established where members agreed the following definitions and search criteria for eHealthScope:

- High Intensity User: People with 10 or more ED attendances and / or Emergency Admissions in the last 12 months
- High Frequency User: People who have had 2+ unplanned admissions in the last 3 months since their hospital discharge and have not had a hospital readmission, and been prescribed 10+ unique medications in the last 12 months, and where professional judgement has identified individuals requiring additional support.

Once a search has been completed on eHealthScope, results can be analysed across deprivation, ethnicity, age, and sex to explore intersectionality within this population. SAIU colleagues and the Medicines Management team assisted with population segments for analysis.

The search criteria identified 1,660 HIU and 1,330 HFU, 42% and 34% of which respectively were in IMD quintile 1. These findings prompted discussion leading to the organisation of a workshop that brought together the ICB and ICS partners, alongside individuals with lived experience and their support workers.

Services addressing SMD by incorporating care navigators, were highlighted in local case studies as a key factor in supporting individuals and reducing service attendances. Similar findings were also reported in the Changing Futures national evaluation (2025). The workshop identified that support was needed across Primary Care as well as Secondary Care alongside an understanding that there is complexity of presentation in HUI and HIF. The health needs an individual immediately presents with are not always the primary or underlying cause of a high use of services. This is a factor which can be difficult for secondary care alone to address, and a recognition of joined up care and other forms of patient support may be needed.

Across the ICB, we monitor access to Primary Care appointments through the Primary Care Network Dashboard, produced by the SAIU. Over 129,000 more appointments were offered in March 2026 when compared to April 2025. We can review this data by PCN and therefore assess how access to appointments differs across areas of high and low deprivation. In Raleigh PCN, which has the highest level of deprivation across the ICB, around 2,000 more appointments were offered in March 2026 compared to April 2025, equating to a 15% increase.

The ICB can also monitor the percentage of patients with online access to Primary Care. This data indicates that Nottingham City has the lowest percentage of patients with online access to Primary Care and is also an area of high deprivation, potentially indicating risk factors for digital exclusion.

The ICB monitors the uptake of screening programmes through the Primary Care Network Dashboard and combined with national data, review those who are less likely to attend screening programmes. Across the ICB there has been a focus on increasing access to Primary Care screening programmes in people with learning disabilities, SMD, SMI and ethnic minority groups. Promotions with local radio stations, producing information in various languages and formats, holding focus groups and working more closely with support workers are some actions which have taken place to increase uptake. Many PCNs also proactively work to increase screening uptake and may run projects with the support of ICB Place colleagues.

At the strategic level, PROMS for acute trusts form a core part of the ICB's Integrated Care Strategy and are monitored by the ICS Outcomes Group. Patient feedback is also acted on at the commissioning and service design level. For example, changes to children and young people's early intervention mental health service outlined in the children's mental health section are a direct result of patient feedback.

Improving data quality

Improving data quality is a continuous priority for the ICB. The Data Quality Oversight Group brings together teams from across the ICB, including the SAIU, commissioning, contracts and finance. It is responsible for ensuring that data collection and management meet defined quality standards and are applied consistently across functions within the organisation.

To influence external partners, including providers of all sizes from GP practices to acute trusts, the ICB's Chief Clinical Information Officer chairs the Data Leadership Alliance (DLA). A significant part of the DLA's workstream is around clinical coding.

ICB contract and data teams routinely review nationally available assessments of provider data quality, such as the Data Quality Maturity Index, alongside locally agreed data quality metrics. This is complemented by regular, more informal engagement between the Strategic Analytics and Intelligence Unit (SAIU) analysts and provider data teams to better understand the data providers submit.

In line with the NHSE Ethnicity Recording Improvement Plan, the ICB plays a key role in promoting and coordinating system-wide improvements in ethnic category recording to support action on ethnic health inequalities. The ICB publishes a summary of ethnicity recording completeness by dataset and provider, broken down by the categories specified in the Health Inequalities Statement (z, null, and 'Not stated'), as part of the Health Inequalities Dashboard. This dashboard is accessible to all local providers and has been shared directly with community providers through provider meetings to support improvements in ethnicity recording.

Where the ICB has direct influence over data management processes, the SAIU undertakes ongoing work to identify anomalies, improve consistency, and enhance data accuracy. For example, the ICB's data management team recently updated the care homes flag within eHealthScope, the ICB's clinical audit and information tool, to use address matching rather than SNOMED codes as the primary method for identifying care home residency. Care home residents are an important and vulnerable group and this change has improved the accuracy of analyses related to this cohort. Work has also been undertaken to rationalise the ethnic categories available within the eHealthScope profiling tool; while ethnicity recording in primary care is generally good, some patients still have defunct or very old ethnicity codes associated with them which have been grouped to the 5 broad ethnic groups

(White, Black, Asian, Other, Mixed). As a result of these improvements, ethnicity is recorded as 'Unknown' in only 4% of primary care records.

The ICB has developed the information governance frameworks and capacity to link datasets including primary care, secondary care, and mortality data through a Section 251 data sharing agreement. The linked dataset has been instrumental in understanding healthcare access, utilisation, and outcomes for inclusion groups which would be impossible to identify using only a single data source, such as secondary care. Examples of analyses undertaken using the Section 251 linked dataset include:

- Linking primary care data with secondary care data to identify people with Severe Mental Illnesses (SMI) or Personality Disorders (PD) to quantify variation in Did Not Attend (DNA) rates. This intelligence allows us to put in place specific interventions to improve access to care.
- Linking primary care data with mortality data to identify people with learning disabilities (LD) to more accurately estimate the number of deaths in people with LD, understand the gap in life expectancy, and identify the causes of premature mortality for LD patients. This analysis supports the local Learning from Lives and Deaths Review (LeDeR) programme as well as the ICB's overall Learning from Death (LfD) forum. As a result of this work, the ICB has established a working group to undertake a detailed clinical audit and detailed mortality review of SMI and LD deaths.

There are established processes in place to identify and escalate data quality issues with providers as required. The ICB maintains a Data Quality Improvement Plan (DQIP) for each provider, which acts as a formal log of data quality risks and issues that the provider has been tasked with addressing. DQIPs are formal contracting mechanisms that draw on Schedules 4 and 6 of the NHS Standard Contract. They are managed by the ICB's contracting team and are updated through contract variations, providing the necessary authority to formally address and manage poor data quality. The ICB's analytical teams contribute to the development and maintenance of DQIPs, using them to raise issues such as incomplete or poor-quality ethnicity coding. Where necessary, data quality concerns can be escalated through governance structures, starting with the Contract Oversight Group and then the Contract Executive Board. After the Contract Executive Board has agreed a course of actions, the escalation process may result in the issuance of a contract notice to the provider and the application of contractual sanctions.

Using information on healthcare inequalities

The ICB Equality, Quality and Impact Assessment process (EQIA) ensures that health inequalities are considered in decision making for local services. Within the process, commissioners are required to consider the level of impact of new services or service changes on Core20 and Plus populations as well as those with protected characteristics. The EQIA panel includes a quality and health inequalities team representative to review the information contained and suggest any further changes or potential impacts on populations. It is an ICB requirement that the EQIA process is completed before commissioning decisions are approved at the Service Change Review Group ensuring consideration for health inequalities is part of the decision-making processes.

Information on health inequalities highlighted the imperative to focus on secondary prevention, multi-morbidity and healthy life expectancy. This has therefore driven forward the commitment and focus through the ICS strategy and Joint Forward Plan on long term conditions, risk factors supported by eight prevention priorities as mentioned above.

It was agreed by the ICB in 2025/26 to align the Health Inequalities Innovation and Investment Fund (HIIF) to scaling up and improving the delivery of the secondary prevention priorities as a primary mechanism for impacting on and reducing health inequalities. Central to this, was the allocation of a portion of the HIIF to developing a neighbourhood approach, in line with the development of Integrated Neighbourhood Teams (INTs).

Since introduced, the ICB has committed to investing £9m of recurrent funding through the Health Inequalities Innovation Fund (HIIF) and for 2025/26 the funding was identified to support secondary prevention initiatives, outlined as a key priority in the reduction of health inequalities long term. Using data, including Core20, long term condition prevalence and the ICBs Multi-Morbidity Free Life Expectancy Indicator, it's been possible to identify priority neighbourhoods and allocations in order to target resources to population need. The delivery model will be determined locally and will proactively identify high risk individuals using population health management approaches and deliver tailored, coordinated interventions through integrated NHS, local authority, community and voluntary sector services. This initiative supports both local and national plans, including Fit for the Future: Ten Year Health Plan for England.

Ongoing schemes support through the HIIF and include services and partnership arrangements across Nottingham and Nottinghamshire that support those living with SMD, complex weight management in children and young people, targeted family support and increasing uptake of vaccinations. Service outcomes are routinely collected and have helped to inform future commissioning and input into the 2025/26 HIIF proposal.

Specific examples of the ongoing services that are monitored against outcomes are: In Bassetlaw, HIIF funding has been used to develop neighbourhood health approaches in relation to frailty (Aging Well) and children and young people's health (Best Start). National data sets and SAIU local data identified that those in the 20% most deprived areas could benefit from interventions linked to frailty, asthma in children and improving early access to mental health services. All interventions were designed to increase access to early care, prevent hospital admissions and improve management of conditions in turn improving people's lives. Details of the Aging Well project can be found in case study 7 and the Best Start – Asthma and Mental Health projects are detailed in case studies 8 & 9 respectively of the accompanying case study pack.

A further example includes the Tier 2+ Children's weight management service commissioned through the HIIF. A service gap was identified for a children's service which met the needs of children and young people with complex needs such as learning disabilities. The service adapts the programme to meet the needs of each family on a case-by-case basis which positive outcomes such as reducing or maintaining BMI Z-scores have been achieved. More information can be reviewed in case study 10 of the accompanying case study pack.

Nottingham and Nottinghamshire ICB was a part of the Core20 Accelerator Site programme which focussed on the use of quality improvement methods to assist in the reduction of health inequalities. Learning from the programme was incorporated into the CVD workstream and particularly informed the work undertaken with the Majority Black-led churches and a series of hypertension case finding initiatives in Nottingham City. The processes were data informed initially and initiatives taken forward

through INTs and their community links and partnerships, providing valuable insight into community needs and access. Test and Learn approaches and principles of QI have also been used within the SMI workstreams in encouraging uptake of annual health checks.

QSIR (Quality, Service Improvement and Redesign) training was undertaken by the health inequalities team in order to strengthen understanding of QI methodology and drive quality improvement approaches forward throughout the ICB.

An evaluation of the Core20Plus5 approach across the system took place in 2025 in Nottingham and Nottinghamshire due to its role as an accelerator site. The evaluation reported that approach has helped to shift thinking and decision-making across the system to incorporate a greater focus on healthcare inequalities and equity. Interviews from ICB and ICS Partners noted the Core20Plus5 was seen as a credible frame to discuss how existing resources and services can better serve marginalised groups who experience disparities in outcomes.

[Publishing information](#)

The ICB Board Integrated Performance Report featured a dedicated health inequalities section. This included a summary of health inequalities metrics, based on the NHSE measurement framework plus additional metrics which reflected local priorities broken down by sex, deprivation quintile, and ethnicity. The report also featured a deep dive on the data surrounded a given topic (e.g. diabetes, cancer), which presented changes over time and provided information from commissioners on how their services and projects have worked to reduce health inequalities. For the diabetes deep dive, this presented information on how the diabetes Local Enhanced Service, targeted towards areas of higher deprivation, had had a real impact in closing the gap between the most and least deprived for diabetes prevention programme referrals.

The ICB has published a Statement of Information on Health Inequalities for 2023/24 and 2024/25 on the website. Before publishing, the statement is formally reviewed and signed off by the Finance and Performance Committee and the Integrated Care Board, providing assurance on our current position and approach as well as the opportunity for future development.

The CORE20Plus5 framework provides a set of targets and metrics for the ICB to work towards in terms of improving quality of care and reducing health inequalities in access to services. The performance of which are monitored within ICB reporting structures and initiatives are taken forward in the five clinical areas with these targets in mind.

People living with Severe Multiple Disadvantage is highlighted as a Plus population group within the ICB due to high number of individuals falling within the criteria for living with SMD in Nottingham City. As a result of this, the ICS has committed to supporting people with SMD through a number of workstreams and actions to reduce the inequalities faced.

The ICB allocated recurrent funding through the HIIF to continue the commissioning of the Changing Futures Programme, supporting people with SMD. Further improvement plans have also taken place within the service to ensure cultural competency and gender specific care navigators to help further support the diversity amongst service users. In 2025/26 162 people were supported through the programme which is not time limited. People engaging with the programme on a long-term basis reported positive outcomes when assessed through a scoring matrix. Further detail on the programme and the outcomes is provided in case study 6 of the accompanying case study document.

In addition to this, the ICB has commissioned a SMD Local Enhanced Service (LES) within Primary Care until 2026. The purpose of the LES is to improve primary medical services, in particular access to services, for people experiencing SMD. The aim is to increase awareness and understanding among primary care staff and to facilitate the provision of accessible high-quality care, in liaison with other agencies and providers across Nottingham and Nottinghamshire. Payments are made to GP practices to fund capacity for an annual health check for identified patients and quarterly monitoring is required by those practices who have signed up.

People with SMD have also been supported to access screening programmes through the ICB such as the lung health checks due to the increased risk of lung cancer in this population. More information on this can be found in case study 6 of the accompanying case study pack. Through collaboration with multiple agencies, specialist SMD clinics were put in place which have helped to identify cases of lung cancer in people with SMD and facilitate pathways to treatment.

The ICB continues to adapt and develop the SAIU dashboards to monitor a suite of metrics suited to monitoring outcomes of services and improvements. The Outcomes Framework dashboard and Health Inequalities dashboard offer a standardised set of metrics to monitor short terms and longer term aims over time to show where initiatives may have supported service improvements.

The second half of the statement fulfils the ICB's duty to publish health inequalities information. All the core measures defined by NHSE for which data is available to the ICB are presented here alongside supplementary measures chosen by the ICB. Where there are recent, relevant case studies of action taken by the ICB to address health inequalities, these are also summarised in the relevant thematic section. Data is presented by deprivation quintile, ethnic group, and sex where available. Some measures also present information by age or other characteristics.

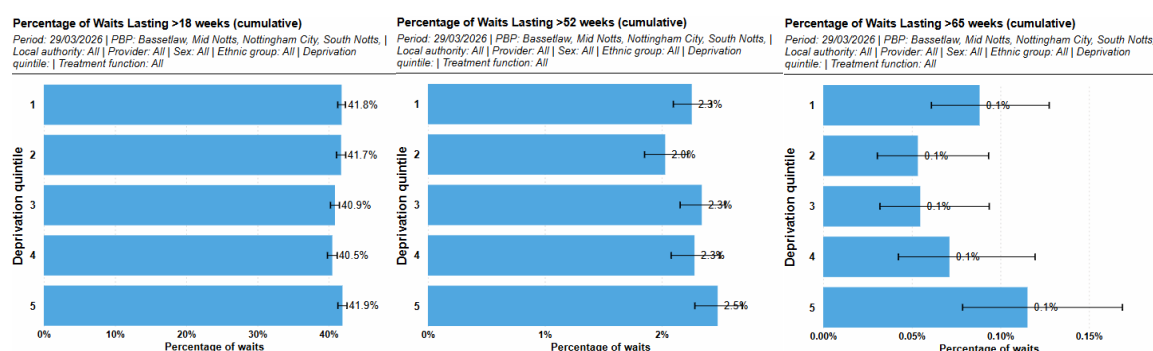
Operational priorities

Elective Care

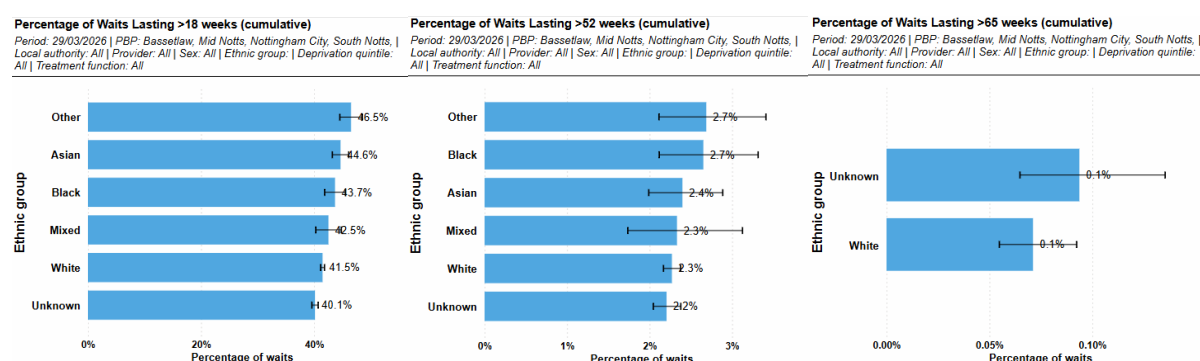
The charts below provide a snapshot of the waiting list at the end of March 2026.

Size and shape of the waiting list; those waiting longer than 18 weeks, 52 weeks and 65 weeks

There is some, relatively minor, variation by deprivation quintile in the percentage of people waiting more than 18 weeks, but it does not show a clear pattern linking levels of deprivation with longer waits: Those living in quintile 4 are around 1.5 percentage points less likely to have been on the waiting list for more than 18 weeks compared to either the most or least deprived. For waits lasting more than 52 or 65 weeks, numbers are relatively small and there is no statistically significant variation by deprivation quintile.

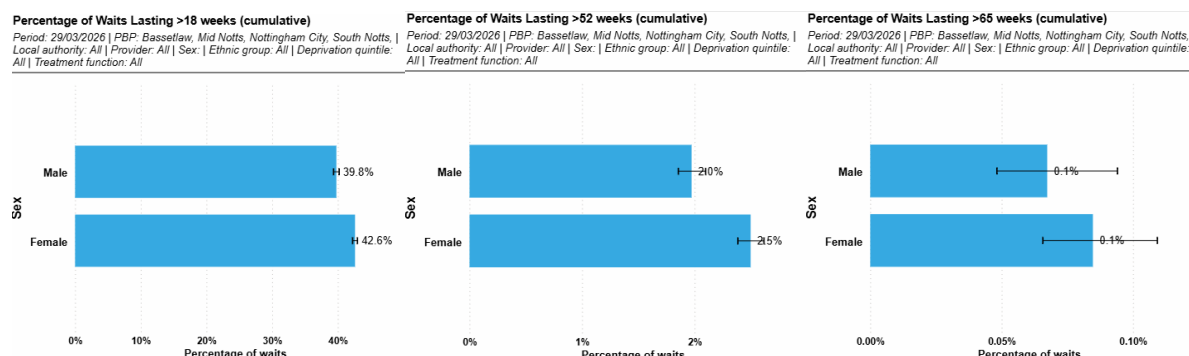


The percentage of waits lasting more than 18 weeks is statistically significantly higher for Black, Asian, and Other ethnic groups than White patients. Although the difference is only a few percentage points, this may suggest either difficulty in access for ethnic minority groups, or differences in the types of specialties people from different ethnic groups are on the waiting list for. There are no statistically significant differences in the longer wait categories.



Waits for female patients make up the majority of the waiting list: 70,000 (58%) of procedures on the waiting list are for women. Women are significantly more likely than men to have been on the waiting list for more than 18 or 52 weeks.

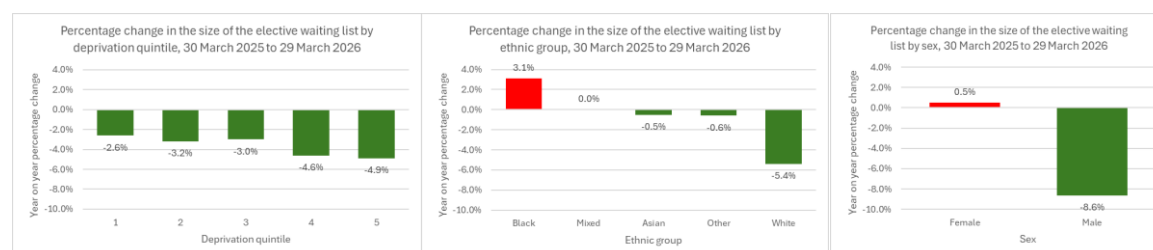
Gynaecology is the largest treatment function by number of waits overall, with 11,354 in total, and almost 6,000 (52%) lasting more than 18 weeks. As a sex-specific service, long waiting times for gynaecological procedures are a major contributor to the inequality in waiting times between men and women. When gynaecology is filtered out, the overall gap between the sexes decreases by two percentage points.



Inequalities in annual change in size of waiting list

The overall size of the elective waiting list has fallen year-on-year from 124,529 on 30 March 2025 to 120,105 on 29 March 2026. This represents an overall decrease of 3.6%. The rate of change to the size of the waiting list is uneven across demographic groups. The waiting list has decreased faster for those living in the least deprived areas compared to the most deprived. The waiting list decreased fastest for people of White ethnicity compared to all known ethnic groups. The number of waits for people of Black ethnicity increased by 3.1%. Men saw the largest fall in the size of the waiting list, with the number of waits decreasing by 8.6%, while the overall number of waits for women increased slightly.

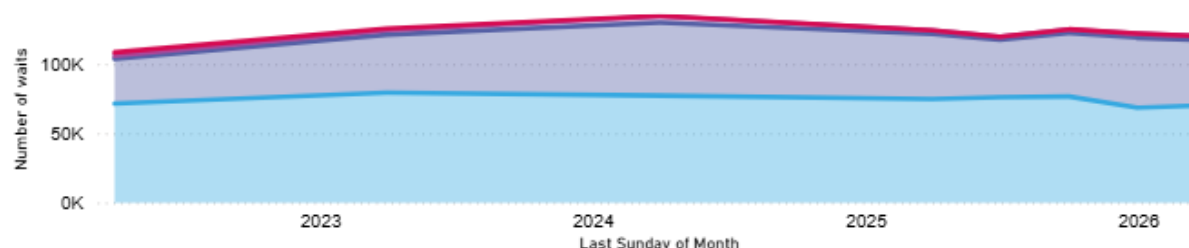
Percentage change in the overall size of the waiting list (all waits) from 30 March 2025 to 29 March 2026 by deprivation quintile, ethnic group, and sex



Waiting List Timeseries

Period: | PBP: Bassetlaw, Mid Notts, Nottingham City, South Notts, | Local authority: All | Provider: All | Sex: | Ethnic group: All | Deprivation quintile: All | Treatment function: All

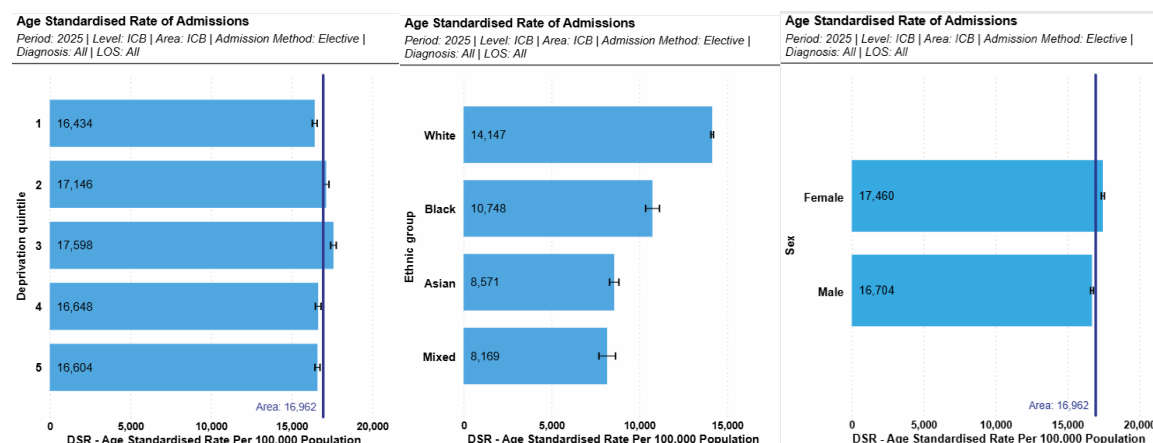
Weeks waiting ● <18 ● 18-51 ● 52-64 ● ≥65



Age-standardised rates of elective admissions

The overall number of elective admissions stayed consistent from 2024 to 2025, at around 208,000 admissions. This equates to an age-standardised rate of 16,962 per 100,000 population. The age-

standardised rate of admissions in 2025 was higher for quintile 3 than for those living in either the most or least deprived areas. Where ethnicity is known, elective admissions are higher for the White ethnic group. However, all information in this report which relies on combining a secondary care numerator with a primary care denominator should be interpreted with caution because of the high numbers of patients with an 'Unknown' ethnic group.

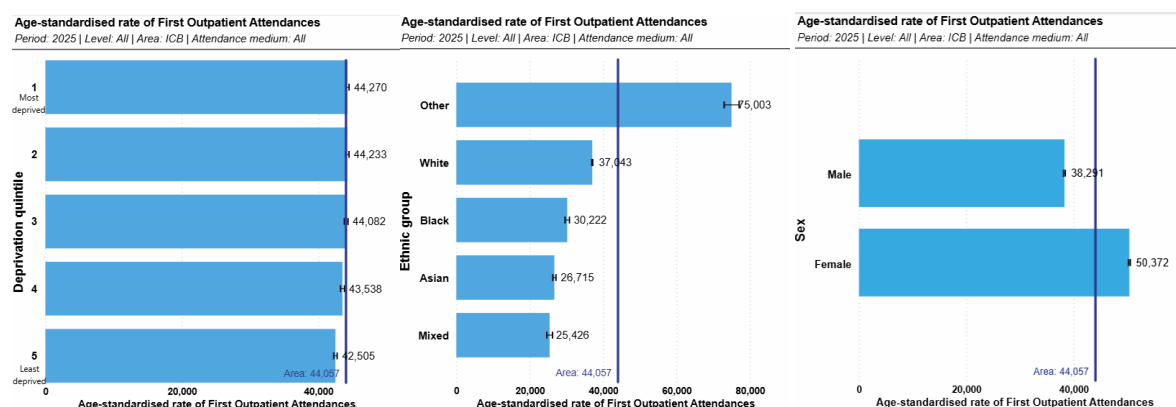


Age-standardised rates of outpatient attendances

The overall number of first outpatient attendances increased from 532,813 in calendar year 2024 to 551,831 in 2025.

The charts below show the age-standardised rate of first outpatient attendances in the most deprived populations is in line with the ICB overall. Those living in less deprived areas have slightly lower age-standardised rates of first outpatient attendances.

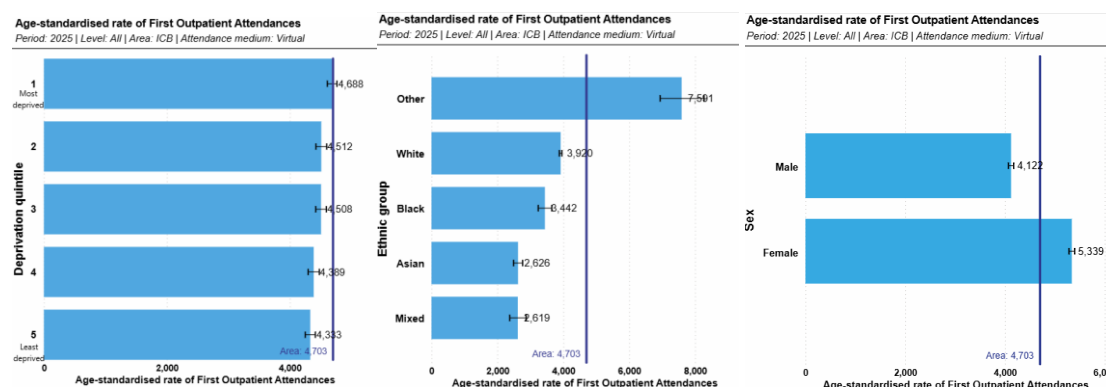
Outpatient attendance rates, where ethnicity is known, are significantly higher in the White population than other ethnic groups. Rates in the White population were around 1.2 times higher than for the Black population and 1.4 times higher than for the Asian population. However, it should be noted that the same issues with ethnicity coding which affect the calculation of rates for admissions also affect outpatient attendances.



Age-standardised rates of virtual outpatient attendances

In 2025 a total of 59,047 first outpatient attendances were attended virtually by the Nottingham and Nottinghamshire ICB population. This equates to an age standardised rate of 4,703 attendances per 100,000 population. This is an increase of around 5,000 attendances in total, or 400 per 100,000 population in comparison to 2024.

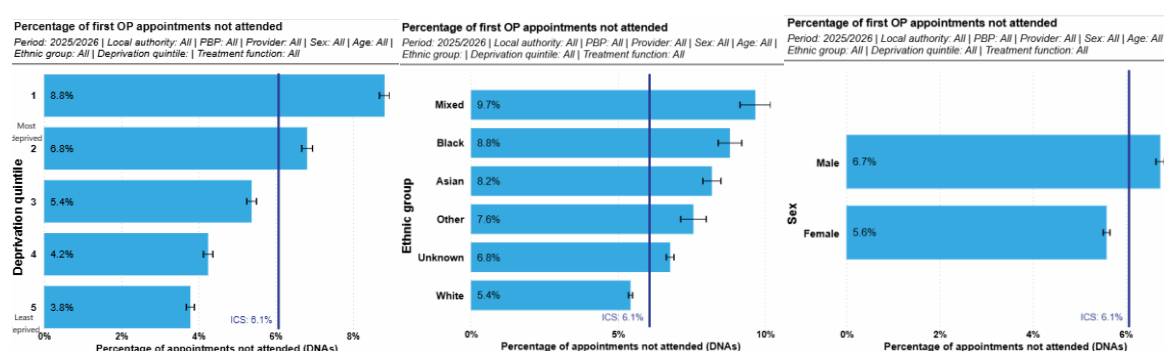
The charts below detail rates of virtual outpatient attendances by deprivation, ethnicity, and sex in 2025. There is a gradient showing that those living in more deprived areas have a higher rate of virtual outpatient attendances. Although virtual attendances have helped to increase access to healthcare 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.



Outpatient Did Not Attend (DNA) rates

The DNA rate for 2025/2026 is similar to the previous year for the ICB overall (6%). DNAs remain one of the most substantial relative inequalities by deprivation and ethnicity. Overall, 8.5% of outpatient first appointments for patients from an ethnic minority background are not attended. This is a DNA rate 1.5 times higher than for White patients. This disparity is found across age groups so is unlikely to be an artefact of the different demographic structures of each ethnic group.

Differences in DNA rates by ethnicity may be related to the higher DNA rates among more deprived populations: 8.8% of first outpatient appointments for patients from the most deprived areas are not attended, which is more than twice the rate of those from the least deprived areas. Men are one percentage point more likely than women to DNA.



Community

Inequalities in the percentage of people waiting over 18 weeks, over 52 weeks for community services

Community services cover a range of short- and long-term interventions delivered in a wide variety of settings. For performance purposes, community waiting times are measured in several ways, including referral to treatment, referral to assessment, and referral to first contact. This makes it difficult to use a single standard measure across all community services. To support comparison, the data below uses 'referral to first contact', which measures the time from referral to the first recorded contact. This first contact may vary by service and could include a phone call, an assessment, or the delivery of care. The information should therefore be treated as experimental and used as a broad

overview of inequalities in waiting times, rather than as a measure of the performance of individual services or providers.

The data used here is sourced from the Community Services Dataset (CSDS). This is the first time the ICB has used this data flow for this purpose. Only data for Nottinghamshire Healthcare NHS Trust (NHT) is available. NHT is the ICB's largest community provider and delivers services mainly to Nottinghamshire county residents. Overall, the data presented below represents around 13,000 referrals, of whom 2,400 (19%) have been waiting for a first contact for more than 18 weeks.

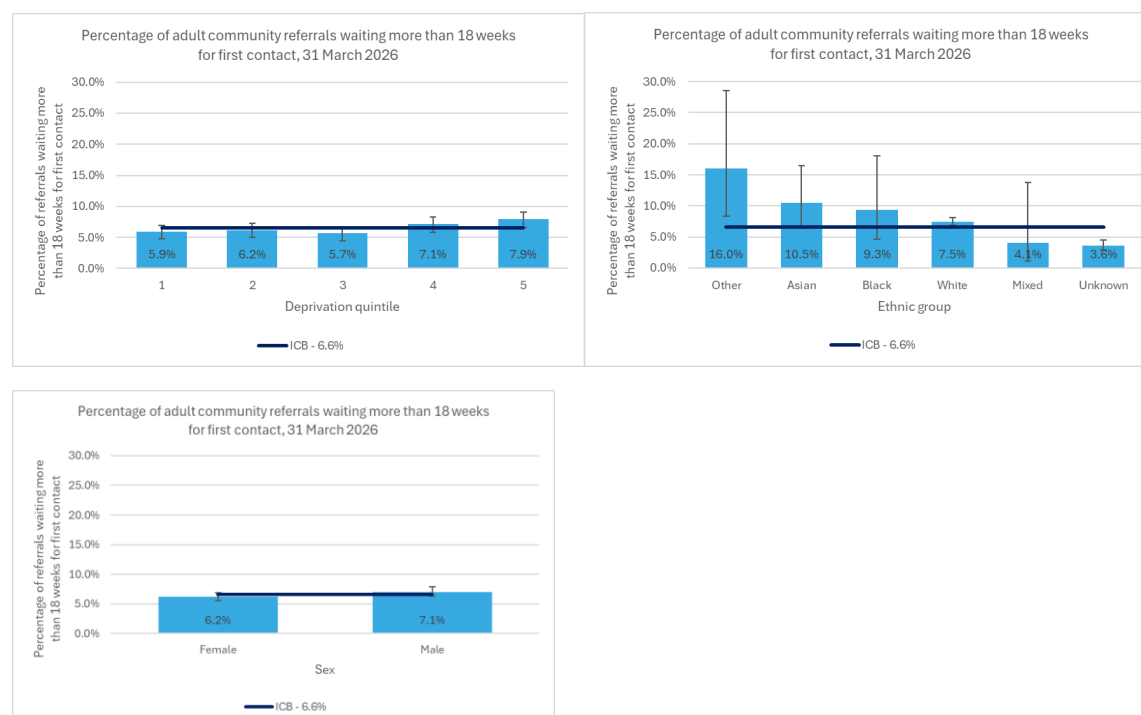
The biggest gap in community waiting times is between children and adults. 43.9% of referrals to community services for 0-17 year olds had been waiting more than 18 weeks for their first contact at the end of March 2026 compared to 6.6% for adults. 6.8% of children referred to community services had been waiting more than 52 weeks compared to just 1.4% of adults. The types of children's services with the largest numbers of children waiting for more than 18 weeks include speech and language therapy, vulnerable children's services, and occupational therapy. Because of this disparity, and the differences in the deprivation and ethnicity profile of children and adults, waits for adults and children's services are presented separately below.

Adults

There were 8,738 referrals to NHT for adults without a first contact at 31 March 2026. 573 of these (6.6%) had been waiting for more than 18 weeks. 137 (1.8%) had been waiting for more than 52 weeks.

Waits lasting more than 18 weeks

There are no statistically significant differences in the percentage of waits for adults lasting more than 18 weeks by deprivation quintile, sex, or between the largest ethnic groups.



Waits lasting more than 52 weeks

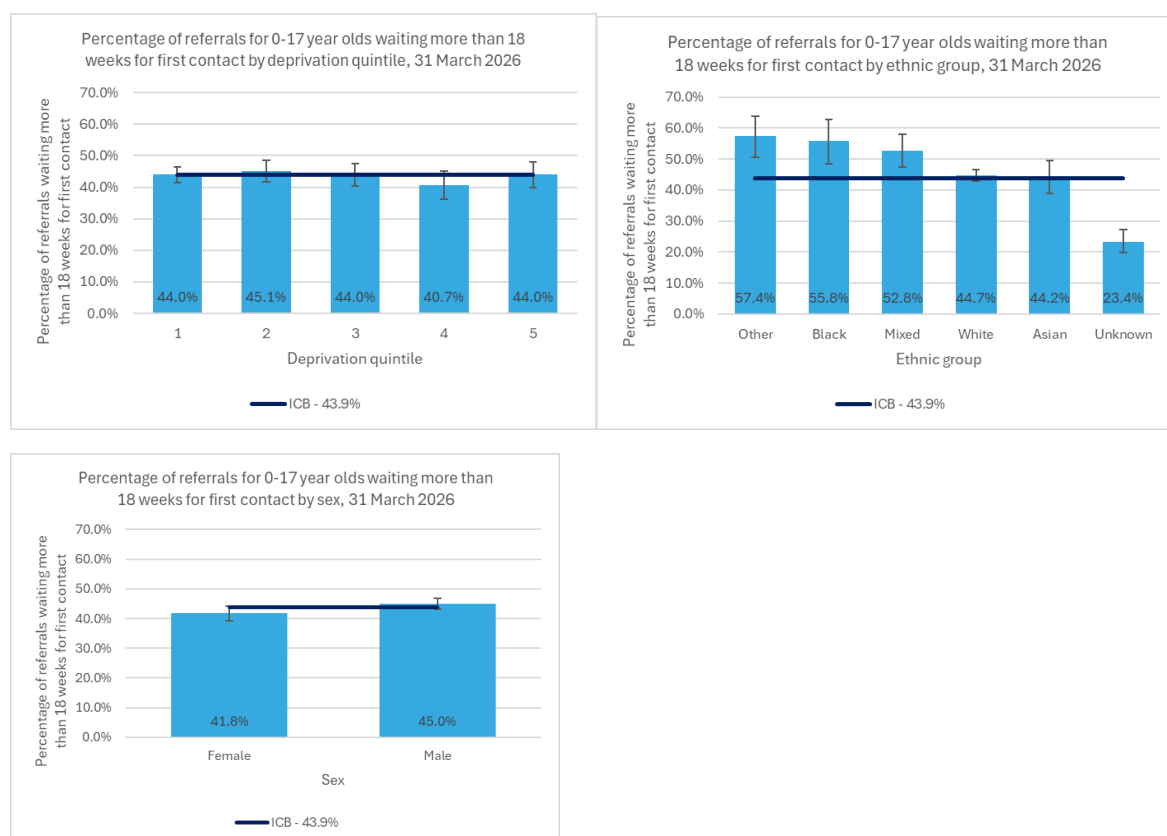
There are no statistically significant differences in the percentage of waits lasting more than 52 weeks by demographic group.

Children and young people

There were 4,210 referrals to NHT for children and young people without for a first contact at 31 March 2026. 1,844 of these (43.9%) had been waiting for more than 18 weeks. 284 (6.8%) had been waiting for more than 52 weeks.

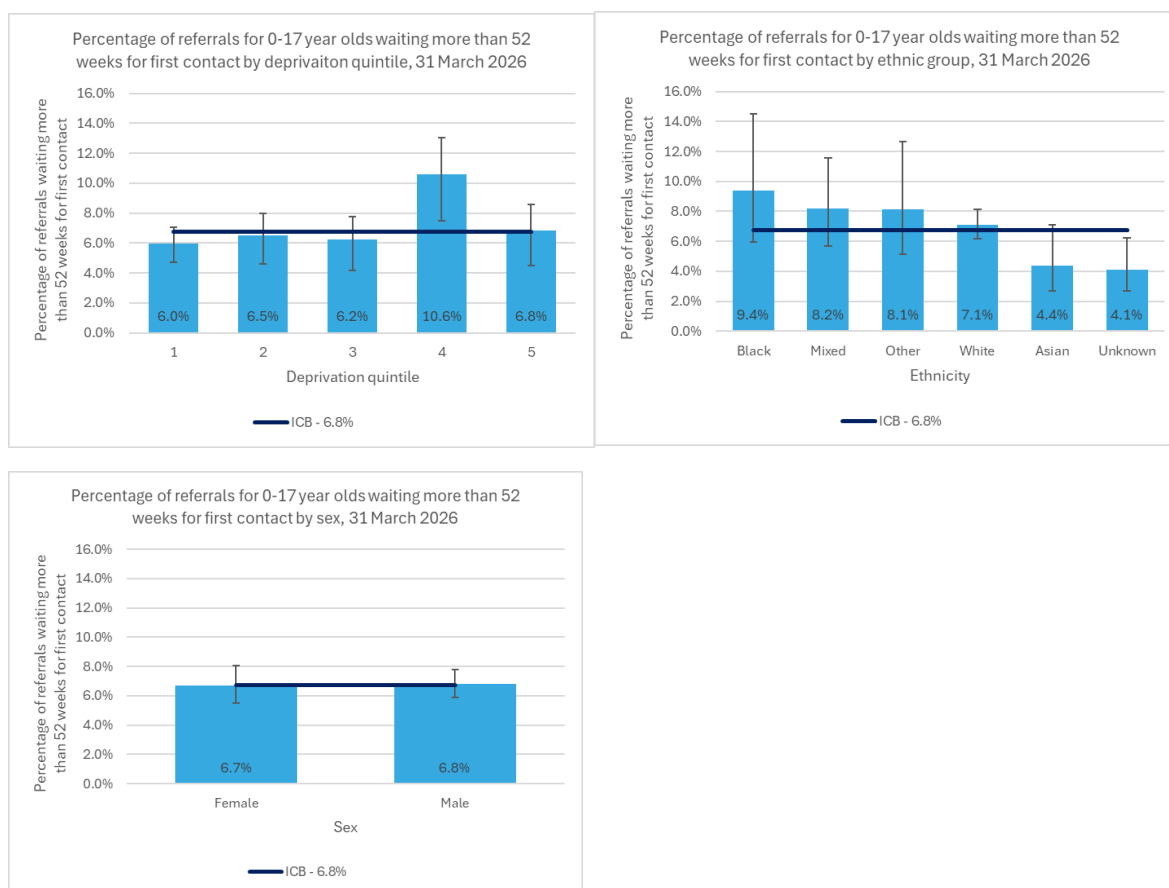
Waits lasting more than 18 weeks

There are no statistically significant differences in the percentage of children and young people waiting more than 18 weeks for a first contact by deprivation or sex. Children of Other or Black ethnicity are significantly more likely than White patients to wait for more than 18 weeks for a first contact. Unusually, patients without a known ethnicity have a significantly lower percentage of waits lasting more than 18 weeks. This may be because Unknown ethnicity patients make up around half of the CYP under the phlebotomy service, which has very low numbers of long waits.



Waits lasting more than 52 weeks

Patients living in deprivation quintile 4 are statistically significantly more likely to have been waiting for more than 18 weeks for a first contact. By ethnic group, only patients with an unknown ethnicity have a statistically significantly lower proportion of waits below 18 weeks. There are no statistically significant differences between boys and girls.



Urgent and Emergency Care

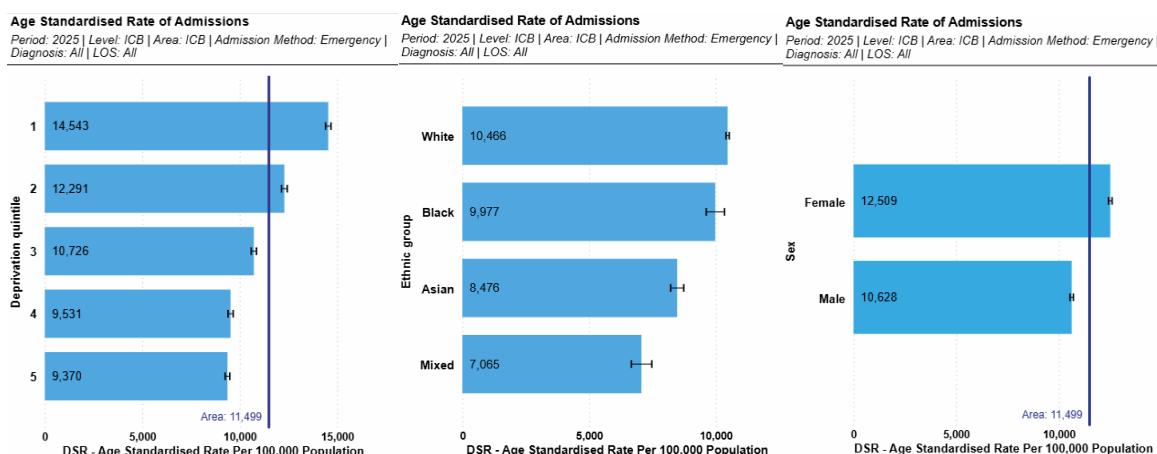
Age-standardised activity rates for emergency admissions

There was a small increase (1.6%) in the age-standardised rate of emergency admissions from calendar year 2024 to 2025.

The age-standardised rate of emergency admissions is significantly higher in more deprived populations compared to less deprived populations, with a gradient from quintile 1 to quintiles 4 and 5. The age-standardised rate of emergency admissions is 1.6 times higher in the most deprived quintile compared to the least.

Caution should be taken when interpreting secondary care-based rates broken down by ethnicity because of the large number of patients with an unknown ethnic group. Among patients with a known ethnicity, rates of emergency admissions are statistically significantly higher in the White and Black populations than other ethnic groups. Rates for these populations were around 1.2 times higher than for the Asian population.

The age-standardised rate of emergency admissions for women is 1.2 times higher than for men. The age-standardised rate of emergency admissions was similar to the previous year for men, but increased by 4% for women, slightly widening the gap.



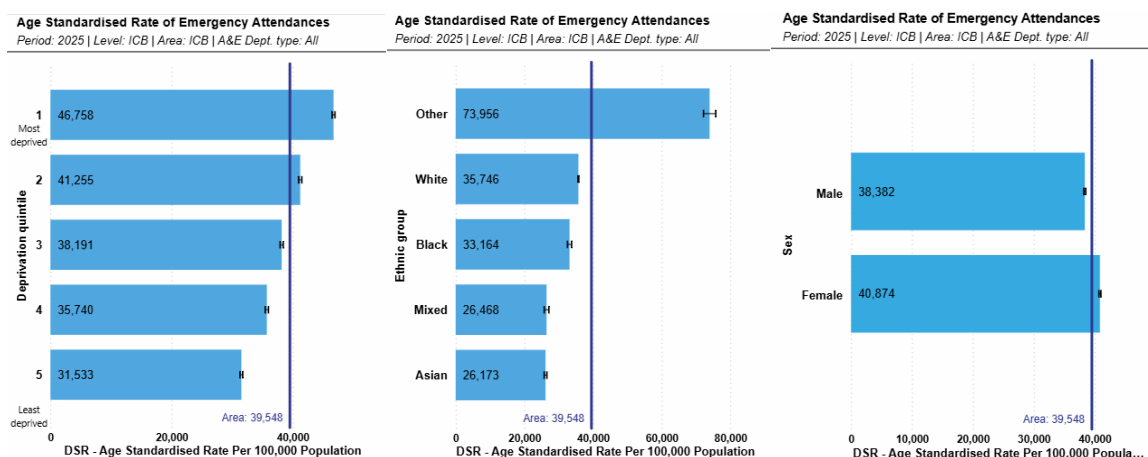
Age-standardised activity rates for emergency department attendances

There were half a million emergency attendances by Nottingham and Nottinghamshire ICB patients in the calendar year 2025, up from 460,000 in 2024.

The age-standardised 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, reporting for this indicator be distorted by higher numbers of attendances with an 'Unknown' ethnicity.

Women have a small but statistically significantly higher age-standardised rate of emergency attendances than men.



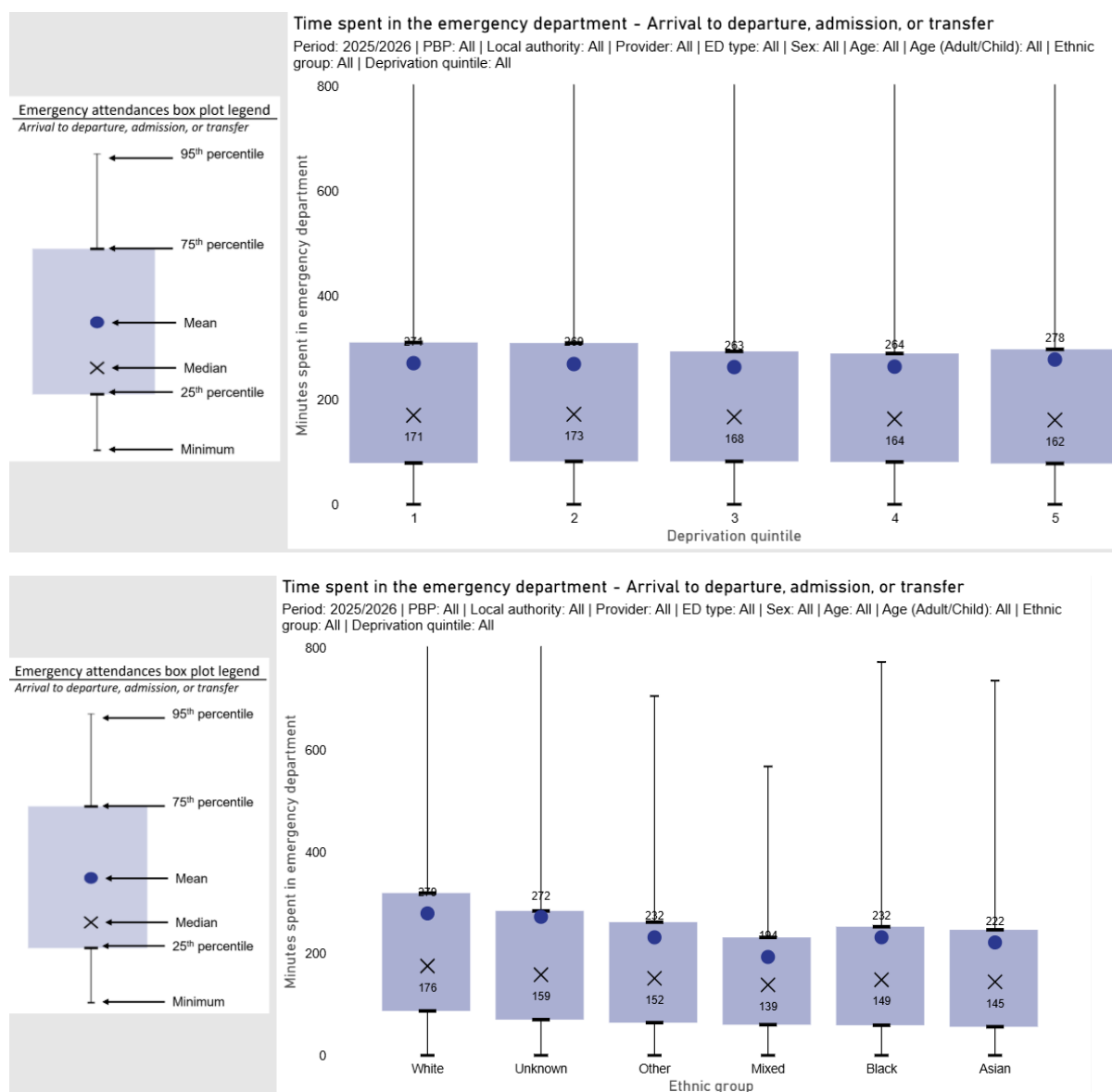
Inequalities in mean time in emergency department

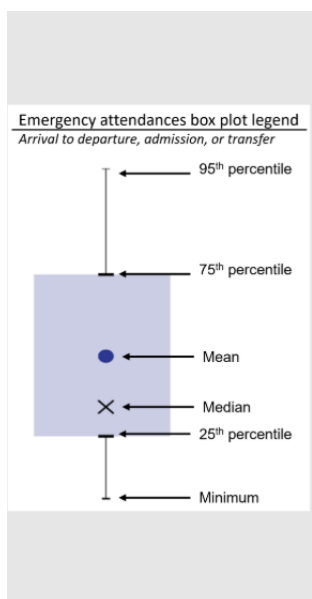
The box plots below show the distribution of time spent in the emergency department for attendances in 2025/2026. The top whisker has been limited to the 95th percentile, although for some categories it is still not visible on the chart due to a small but significant number of very long waits in the emergency department.

The overall mean time spent in an emergency department for attendances was around four and a half hours (270 minutes). This was broadly similar across deprivation quintiles, with the longest average time in emergency departments being 278 minutes (quintile 5), and the shortest 261 minutes, for those living in quintile 3.

By ethnic group, there was more marked variation in the total time spent in the emergency department. White patients spent an average of 270 minutes in the emergency department, which is at least half an hour longer than for all other ethnic groups where ethnicity is known. This may be because the white population tends to be older, and older age groups had substantially longer emergency department visits: those age 90+ spent an average of 640 minutes at the emergency department compared to an average of 211 minutes for someone age 20-24.

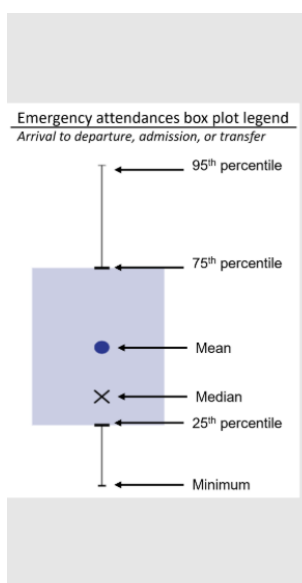
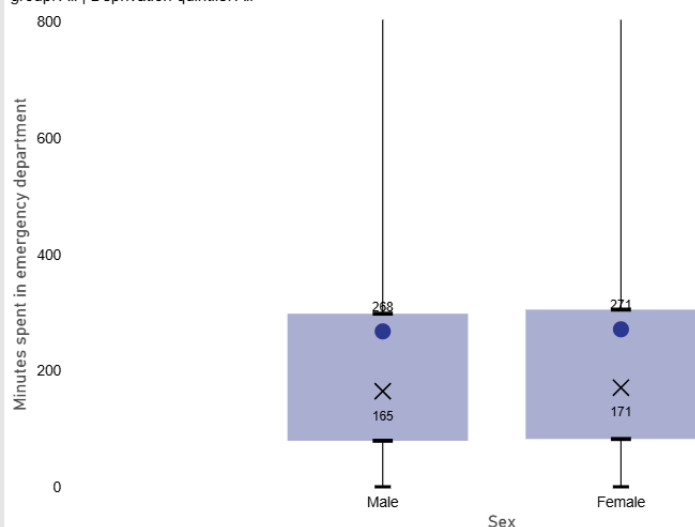
There was no substantial variation by sex, with average time spent in emergency departments at 268 minutes for men and 271 minutes for women.





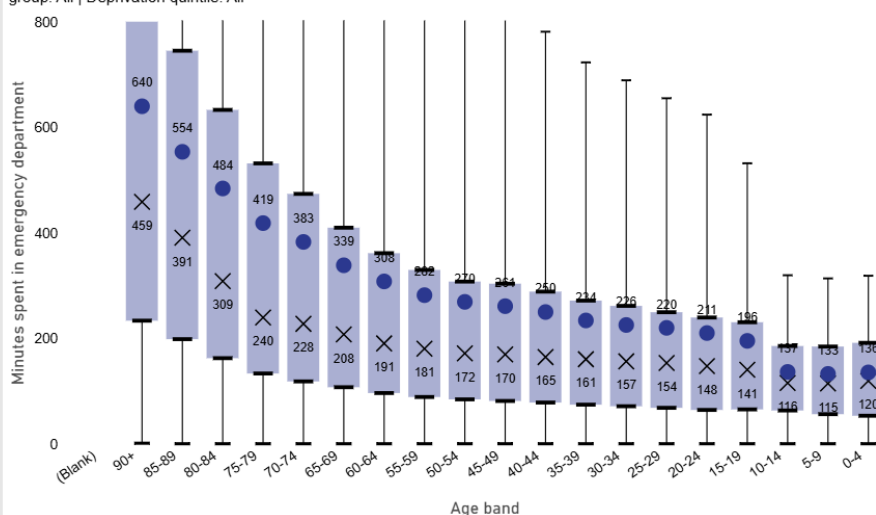
Time spent in the emergency department - Arrival to departure, admission, or transfer

Period: 2025/2026 | PBP: All | Local authority: All | Provider: All | ED type: All | Sex: All | Age: All | Age (Adult/Child): All | Ethnic group: All | Deprivation quintile: All



Time spent in the emergency department - Arrival to departure, admission, or transfer

Period: 2025/2026 | PBP: All | Local authority: All | Provider: All | ED type: All | Sex: All | Age: All | Age (Adult/Child): All | Ethnic group: All | Deprivation quintile: All



CORE20Plus5 - Adults

Respiratory

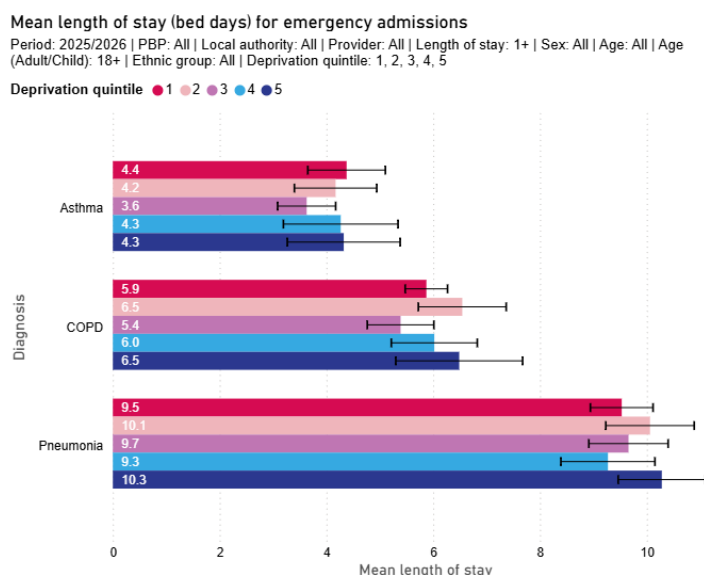
Actions by the ICB

In order to reduce the need for emergency admission for respiratory conditions, early identification and condition management is required. Across the ICB, increasing access to Spirometry testing has been a priority due to the reduction in services over the Covid period resulting in waiting list growth and delays in diagnosis. Mid-Notts PBP utilised integrated neighbourhood working to implement a project increasing access to spirometry testing specifically to smokers without a test undertaken in the last 2 years, with prioritisation to those living in deprivation quintile 1 and 2 areas. An additional 473 patients were seen and testing carried out over 86 clinic days, 51% of patients on average had an abnormal result requiring further investigation. Individual patient case studies highlighted outcomes such as diagnosis of respiratory conditions and one case of lung cancer, diagnosed and treated at an earlier stage. Further detail of the project can be viewed in case study 5 of the accompany case study pack.

Inequalities in non-elective bed days occupied by asthma, COPD and CAP

The charts below show the average length of stay in hospital for adult patients admitted for at least one night with a primary diagnosis of asthma, pneumonia, or COPD. They represent 4,146 admissions and 40,278 bed days for pneumonia, 2,186 admissions and 13,081 bed days for COPD, and 586 admissions and 2,450 for asthma.

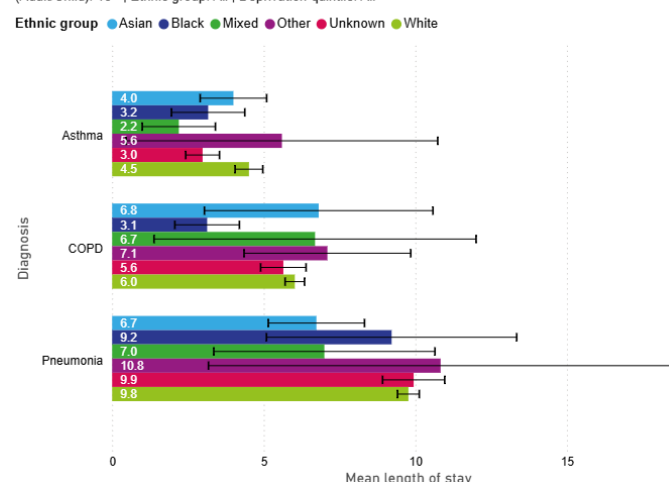
Mean length of stay for emergency admissions shows limited variation across deprivation quintiles although differences are not statistically significant and there is no consistent gradient by deprivation.



Caution should be taken when interpreting information about variation by ethnicity from secondary care sources because of poor ethnicity coding. The chart below has very wide confidence intervals because either the number of patients from minority ethnic backgrounds admitted for these conditions is very small, which could be true considering the relatively small numbers of older people from ethnic minority backgrounds, or because many patients from minority ethnic backgrounds do

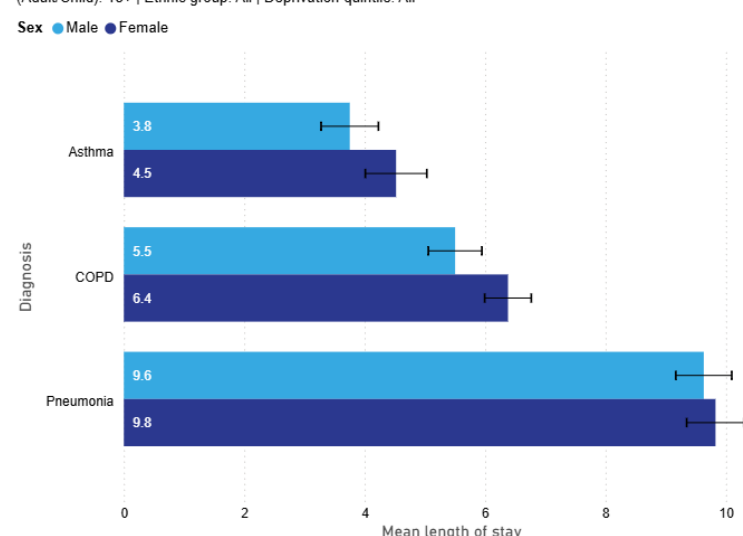
not have a known ethnicity recorded. The only statistically significant differences are a lower average length of stay for Mixed ethnicity patients compared to White patients for asthma, a lower average length of stay for Black patients compared to White patients for COPD, and a lower average length of stay for Asian patients compared to White patients for pneumonia.

Mean length of stay (bed days) for emergency admissions
Period: 2025/2026 | PBP: All | Local authority: All | Provider: All | Length of stay: 1+ | Sex: All | Age: All | Age (Adult/Child): 18+ | Ethnic group: All | Deprivation quintile: All



The only statistically significant difference in length of stay by sex is observed for COPD, where women have an average stay one day longer than men.

Mean length of stay (bed days) for emergency admissions
Period: 2025/2026 | PBP: All | Local authority: All | Provider: All | Length of stay: 1+ | Sex: All | Age: All | Age (Adult/Child): 18+ | Ethnic group: All | Deprivation quintile: All



Inequalities in pulmonary rehabilitation completion rates

Patients living in more deprived areas have higher rates of chronic respiratory illness, particularly Chronic Obstructive Pulmonary Disease. Pulmonary rehabilitation comprises a programme of physical exercise and information that helps people to better understand and manage their condition and symptoms to support better self-management, reduce exacerbations, hospital admissions, and primary care appointments.⁶

Patients are counted as having completed pulmonary rehab if they were discharged with a 'completed' outcome after attending at least one session. The denominator used here is all

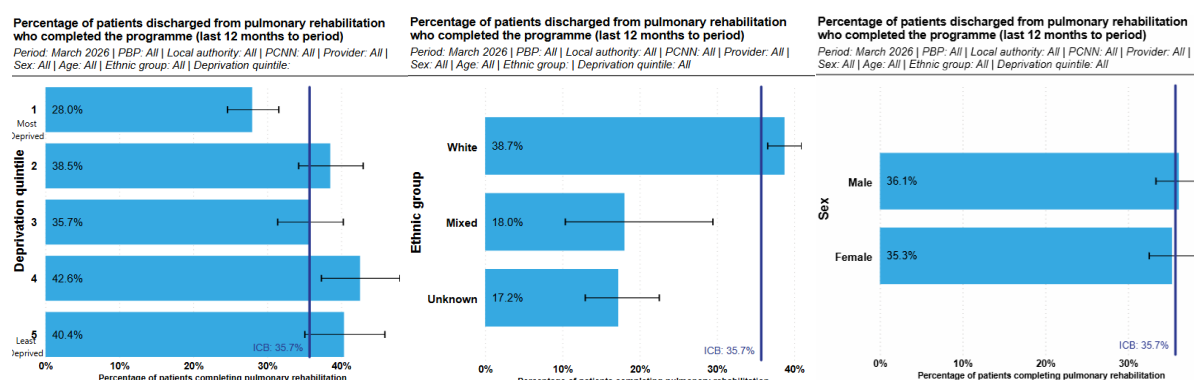
⁶ NHSE, [Pulmonary rehabilitation](#), [Accessed May 2026]

discharged patients. In the 12 months to the end of March 2026, 2,228 Nottingham and Nottinghamshire registered patients were discharged by Nottinghamshire Healthcare Trust or Nottingham City Care, of which 36.7% completed the programme.

The completion rate is significantly lower for those living in the most deprived areas compared to all other deprivation quintiles except quintile 3.

Very small numbers of pulmonary rehab patients are from a minority ethnic background, which makes it difficult to understand variation by ethnic group. However, data shows those of Mixed ethnicity have lower completion compared to than White patients.

Men and women have similar completion rates.



Smoking Cessation

Actions by the ICB

The ICB has commissioned ongoing smoking cessation services within secondary care settings at all trusts within the footprint. The services cover inpatients, maternity services and mental health services.

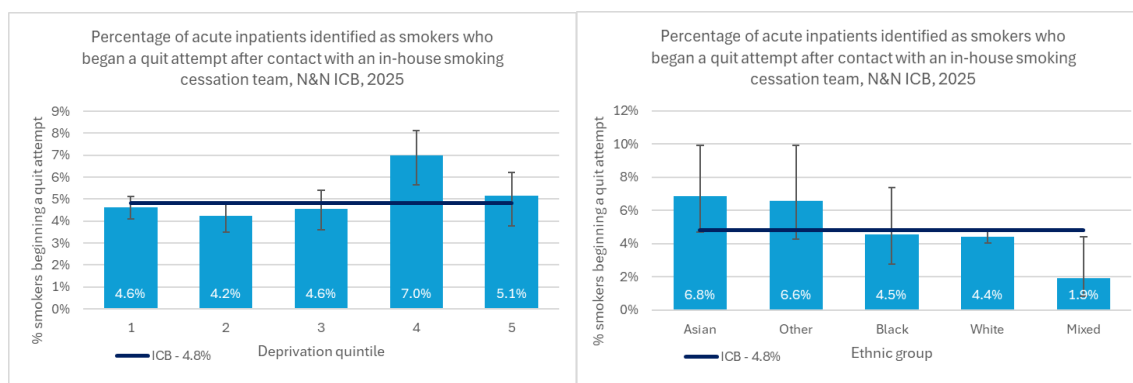
15,000 acute inpatients who were registered with a Nottingham and Nottinghamshire GP were identified as smokers in 2025.⁷ Of these, 725 (4.8%) went on to set a quit date with an in-house smoking cessation team. 430 (59% of those setting a quit date) went on to be smokefree at 28 days.

Incentive schemes within maternity services at Sherwood Forest Hospitals Trust have also proven successful and have reduced the smoking at time of delivery rate further through 2025/26, from 9.1% in April 2025 to 6.7% in April 2026.

Inequalities in inpatients making a supported quit attempt with an in-house tobacco dependence treatment service

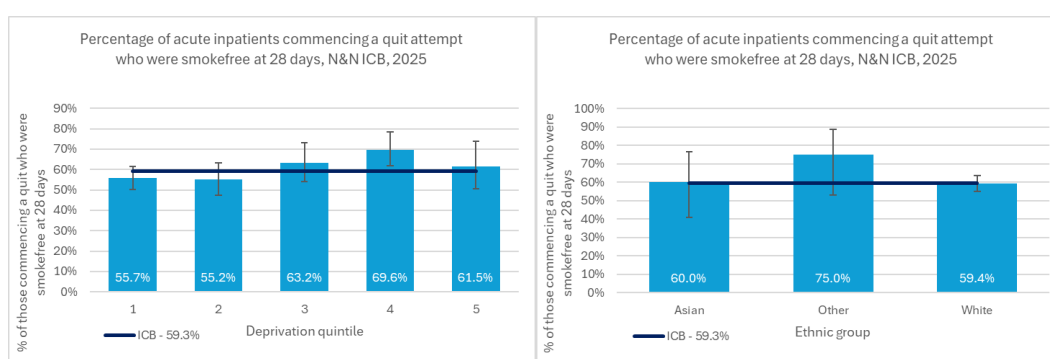
There was no clear overall correlation between deprivation and setting a quit date. However, Smokers living in deprivation quintile 4 were slightly more likely to set a quit date than the most deprived groups. There were no statistically significant differences in the percentage of smokers who set a quit date between the largest ethnic groups.

⁷ NHSE, Tobacco Dependence Services Dashboard, accessed via [NHS Futures](#) [2026]



Inequalities in inpatients who successfully quit smoking as measured at 28 days after commencing a supported quit attempt

Once patients had set a quit date, there was no statistically significant correlation between a patient's deprivation quintile or ethnicity, and their subsequent success at making it to 28 days smokefree.



Mental Health

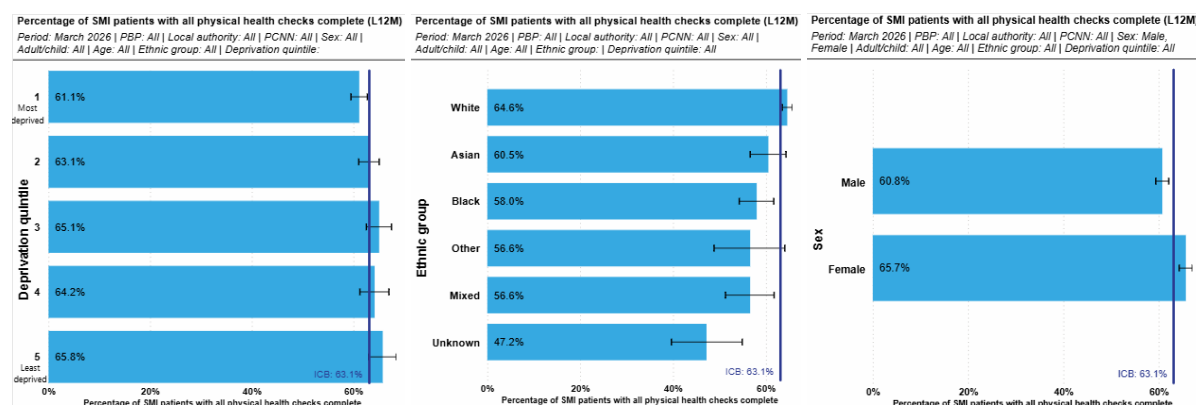
Actions by the ICB

The ICB has committed to increasing uptake to physical health checks for people with severe mental illness (SMI). Ongoing initiatives have increased GP capacity in areas of high need, with Health Improvement Workers in place to offer a more flexible approach to SMI health checks. In Nottingham City, where SMI rates are higher and patients often face more socioeconomic disadvantage, the improvement worker role contacts patients who have not responded to their GP invitation to a health check. Different communication methods are tried and a more personalised care approach offered to health checks, resulting in increased numbers of people receiving their annual health check. Further detail can be found in case study 4 of the accompanying case study pack.

Overall number of severe mental illness (SMI) physical health checks and action plan

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.

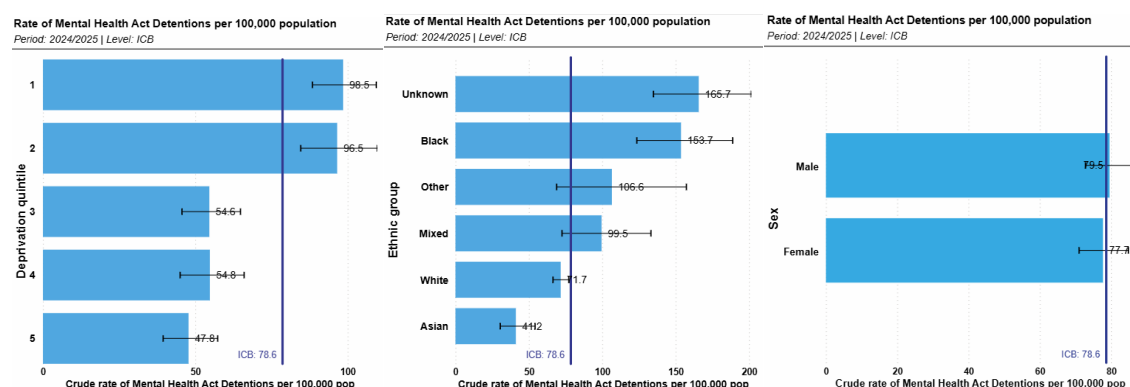
In March 2026, 63% of people with SMI had received a health check in the previous 12 months. The charts below show the breakdown of completed SMI checks by deprivation, ethnicity, and sex. A lower proportion of checks were completed in people from IMD quintile 1, with a 5-percentage point gap in uptake of checks between the most and least deprived populations. By ethnicity, those from Black and Mixed ethnic groups, as well as those without a known ethnicity, are statistically significantly less likely to have a completed check than those from White ethnic groups. Coverage was five percentage points higher in women than men.



Rates of total Mental Health Act detentions

The charts below show the crude rate of detentions under the Mental Health Act. The number of detentions is sourced from the national Mental Health Act Statistics dataset and the GP-registered population is used for the denominator.⁸ The data covers 1,005 detentions in 2024/2025, for an overall rate of 78.6 detentions per 100,000 population.

For those living in more deprived areas (quintiles 1 and 2), rates of detention under the Mental Health Act are double the detention rates for people living in the least deprived areas (quintile 5). People of Black ethnicity are significantly more likely, and those of Asian ethnicity are significantly less likely, to be detained under Mental Health Act. There are no statistically significant differences in the rate of Mental Health Act detentions between men and women.



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.⁹ By using bed days as the denominator, this measure allows us to

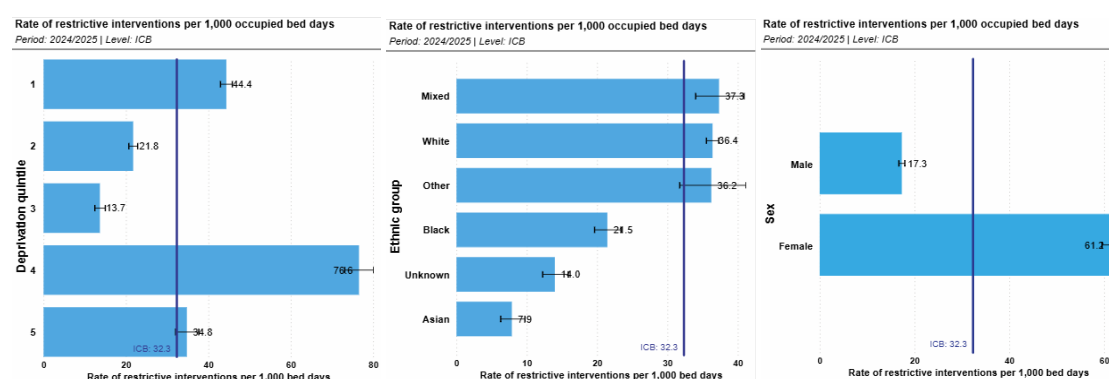
⁸ NHS England, Mental Health Act Statistics Annual figures 2024-25, [Mental Health Act Statistics, Annual Figures, 2024-25 - NHS England Digital](#), (2025)

⁹ NHS England, [Mental Health Bulletin, 2024-25 Annual report - NHS England Digital](#), (2025)

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.

The rate of restrictive interventions for deprivation quintile 4 is extremely high. It should be noted that relatively small numbers of patients can have a distorting impact on rates of interventions, especially if the number of patients from that group or bed days is relatively low. Besides quintile 4, rates of restrictive interventions are higher 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. Rates of restrictive interventions are 3.5 times higher for women than for men. This is consistent with previous years' data.



NHS Talking Therapies

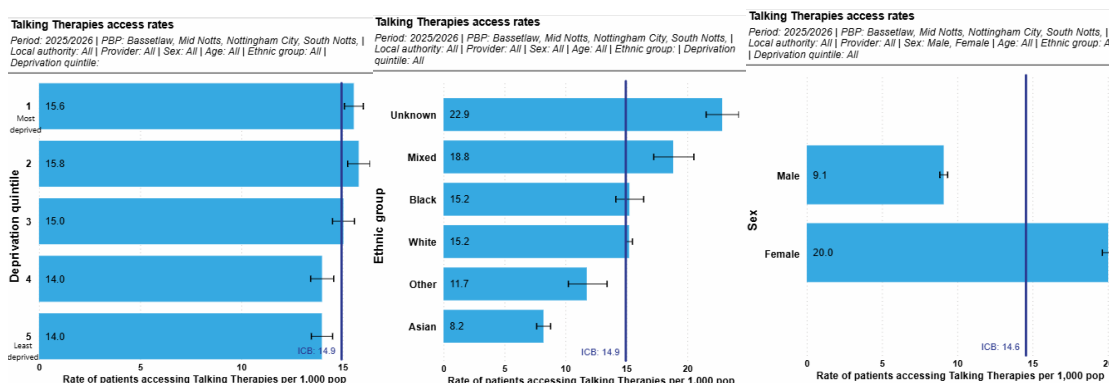
Talking therapies are psychological treatments for mental and emotional problems like stress, anxiety and depression. They are often the first, and sometimes the only, specialist mental health service that people with common mental illnesses encounter. As such, they must be accessible to a broad range of needs and cultural perspectives.

Inequalities in access to NHS Talking Therapies

Access is defined as completing two or more care contacts, even if the patient doesn't finish the full course of therapy. To help understand whether access is equally distributed across the population, data has been presented here as a crude rate of referrals achieving access per 1,000 population age 18+.

The access rate per 1,000 population is higher for those living in more deprived areas (quintiles 1 and 2) than those living in less deprived areas (quintiles 4 and 5). This is likely related to higher prevalence of diagnosed common mental illness in more deprived areas.

People of mixed heritage are more likely to access talking therapies compared to other ethnic groups. Asian people are almost half as likely to access talking therapies, with a rate of 8.2 people accessing talking therapies per 1,000 adults in the population compared to 15.2 for White and Black patients. Women are twice as likely as men to access talking therapies, with a rate of 20 per 1,000 adults compared to 9.1 for men. This is consistent with higher levels of diagnosed mental health prevalence among women.



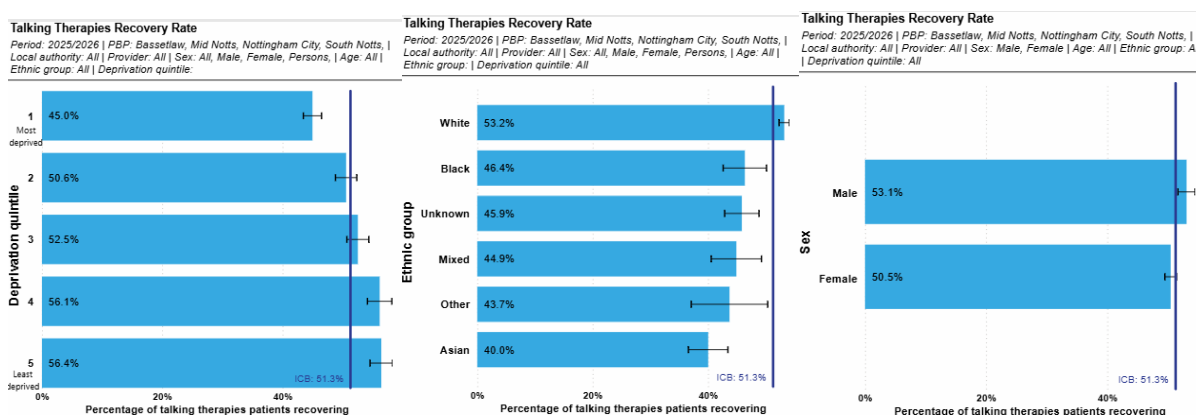
NHS Talking Therapies recovery rate

A talking therapy patient is classed as recovered if they were defined as a clinical case at the start of their treatment ('at caseness') and not as a clinical case at the end of their treatment, as measured by scores from questionnaires tailored to their specific condition.¹⁰

The overall recovery rate is 51.2%, which meets the national target of 50%. More deprived patients have a lower chance of recovery, with 45% of patients from the most deprived areas recovering compared to 56.4% of patients from the least deprived quintile, an 11 percentage point gap.

53% of White patients recover by the end of their treatment. Outcomes are statistically significantly worse for all other ethnic groups; only 40% of Asian patients recover, which is a 13-percentage point gap with White patients.

Men are slightly more likely than women to be marked as recovered at the end of their treatment.



¹⁰ NHS Digital, [IAPT v2.1 Guidance](#) (2021)

Cancer

Cancer is the leading cause of premature death in Nottingham and Nottinghamshire, accounting for just over one third of deaths under the age of 75 in 2025.¹¹ There are significant health inequalities by deprivation, ethnicity, and sex in cancer prevention and early detection.

Actions by the ICB

Targeted Lung Health Checks

The Nottingham and Nottinghamshire Targeted Lung Health Check Programme uses population health intelligence to prioritise PCNs with the highest smoking prevalence and lung cancer burden, reducing inequities in access and outcomes.

A community-based delivery model ensures accessibility, with mobile CT scanners located in supermarket car parks and local community hubs. Clinics operate extended hours (typically 8am–8pm, seven days per week) to accommodate work and caring responsibilities.

An opt-out invitation model simplifies booking and normalises participation. Communications are tailored to local populations, with multi-language materials, community champions, GP practice engagement, and partnerships with voluntary and faith organisations to reach underserved groups. The locations where the scanner was placed were often in easily accessible community locations with free parking such as supermarket car parks.

Active monitoring identified lower uptake among women and younger age groups and recognised that patients with Severe and Multiple Disadvantage (SMD) had increased risks of lung cancer yet faced significant barriers in attending.

In order to meet the needs of patients with SMD the programme has implemented several adaptations:

- Pathway redesign informed by lived experience: Working with the Nottingham SMD Working Group, the programme identified barriers such as lack of transport, fear from previous negative healthcare experiences, complex pathways, and language challenges.
- One-stop, flexible assessments: Mobile CT scanners in city centres and community hubs allow drop-in appointments, same-day lung health checks, scans, and broader health support, removing the need for multiple visits.
- Integrated support: Key workers assist with attendance, registration with GPs, and consent for communication with health teams when patients have no fixed address. The programme also offers stop-smoking support, mental health signposting, housing advice, and immediate clinical care via a street health nurse.
- Collaboration with social prescribers, voluntary organisations, and primary care ensures patients are not only assessed but also supported to navigate follow-up care.

Uptake averages 66.4%, with some areas reaching 75% (national average 51%).

The programme activity is demonstrating improved early-stage diagnosis, with people from deprivation quintile 1 seeing the greatest improvement.

¹¹¹¹ Nottingham and Nottinghamshire ICB Strategic Analytics Intelligence Unit, Outcomes Framework Dashboard, 2026

Nottingham City Cancer Early Diagnosis Coordinator programme

The Nottingham City Cancer Early Diagnosis Coordinator programme was developed in response to data demonstrating lower screening uptake and later stage cancer diagnosis in areas of high deprivation. Population health and deprivation data has been used to focus community-based outreach and support activity in priority neighbourhoods, ensuring resource is targeted towards communities most affected by inequalities in access, awareness, and uptake.

Appt Health intervention

Targeted approaches have been applied to cervical screening through the Appt Health intervention, where screening uptake data was used to identify practices and population groups with historically lower participation. The intervention provides personalised digital engagement and support to address known barriers to cervical screening, including non-attendance following invitation, helping women to make informed choices and supporting improved access and uptake in higher inequality groups.

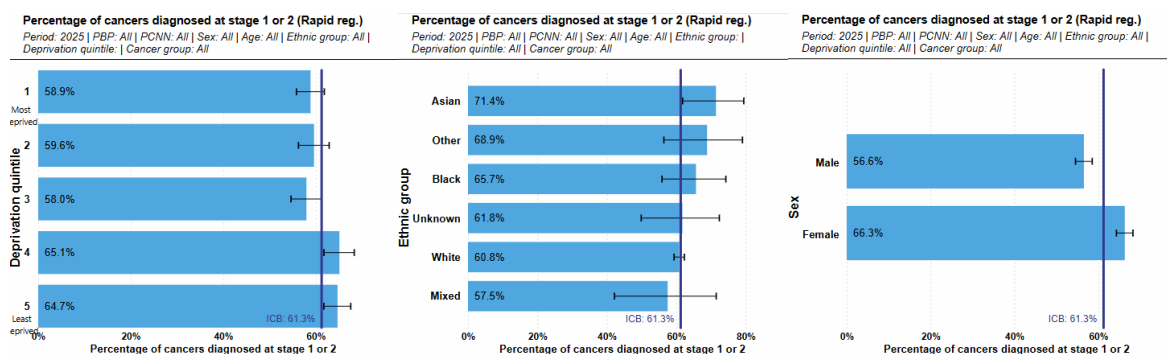
Project Compass

Project COMPASS is a case finding pilot designed to improve earlier diagnosis of oesophageal cancer. Oesophageal cancer is more likely to be diagnosed at a later stage and is strongly associated with deprivation and known risk factors. Intelligence on deprivation, prevalence of risk factors, and patterns of late presentation was used to identify priority locations for the pilot, including Nottingham City and Mansfield. The project uses the capsule sponge test in community pharmacy settings to support earlier identification of patients at risk, with the aim of improving timely referral and reducing inequalities in stage at diagnosis. This approach was complemented by a local heartburn awareness campaign.

Percentage of cancers diagnosed at stage 1 and 2

The Rapid Cancer Registrations (RCRD) data used here is intended to provide an initial estimate of early diagnosis trends. It covers a smaller selection of cancer sites and is published sooner than the finalised data published in the National Cancer Registrations Dataset (NCRD). Rapid registrations are therefore a useful indicator but should be interpreted with some caution, and cannot be directly compared to the NCRD.

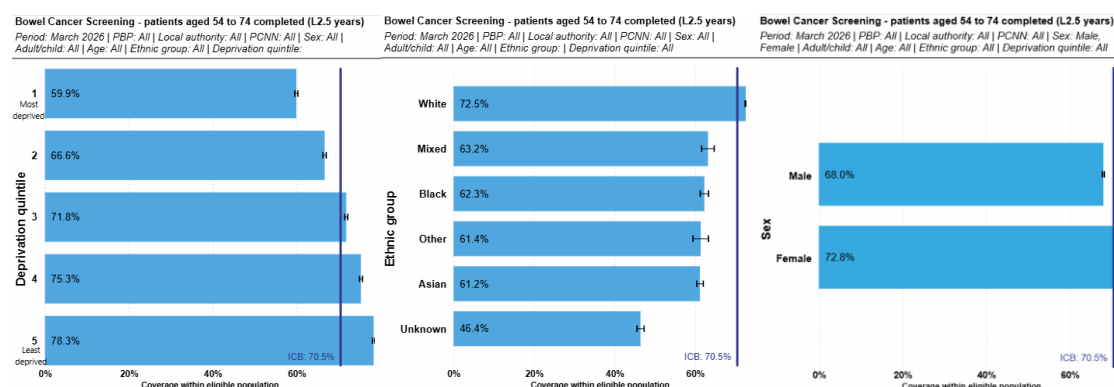
Those living in less deprived areas (quintiles 4 and 5) tend to be more likely to be diagnosed with cancer at an earlier stage than those living in more deprived areas (quintiles 1-3). However, except for quintile 3, these gaps are not statistically significant. Women are more likely to have cancer detected earlier than men. This may be because of the relatively high rates of early diagnosis of breast cancer, often as a result of participation in the breast cancer screening programme. There are no statistically significant gaps by ethnic group.



Cancer screening coverage

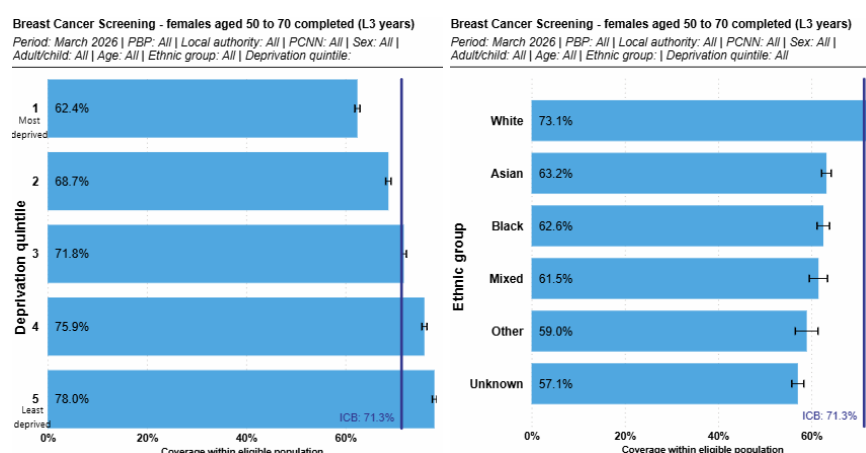
Bowel cancer screening

There is a clear social gradient in bowel cancer screening coverage between the most and least deprived areas, with coverage in deprivation quintile 1 at 60%, almost 20 percentage points behind the 78% coverage in quintile 5. All minority ethnic groups have uptake around ten percentage points lower than the White population at 73%. Women are slightly more likely than men to have completed bowel screening.



Breast cancer screening

Similar to bowel cancer screening, there is a clear correlation between deprivation and uptake of breast cancer screening. 62% of eligible patients in the most deprived quintile have an up to date breast cancer screening. This is 16 percentage points behind those living in the least deprived quintile (78%). There are also significant gaps by ethnic group; almost three quarters (73%) of eligible White patients completed screening in the last three years compared to around 63% for Black and Asian patients.



Cardiovascular Disease (CVD)

Cardiovascular Disease (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 deprived and most deprived areas across Nottingham and Nottinghamshire.¹²

¹² OHID, [Segment Tool Life expectancy gap breakdown 2022-2023](#), (2025)

Actions taken by the ICB

MBLC (Majority Black Led Churches) Hypertension Project

Coverage of appropriate hypertension management is lower in Nottingham's Black communities. Recognising this, the ICB undertook the Majority Black Led Churches Hypertension Project. The project established links with Black-led churches and the communities they serve. The ICB commissioned community engagement activities at the churches, including awareness raising and blood pressure checks.

As well as the direct impacts on attendees, these activities provided the contacts and information required to create more culturally sensitive interventions in the future. Engagement provided insights into health literacy in Black communities, the reasons for mistrust NHS services in these communities, including the perception of systemic biases, and a better understanding of the poor visibility and accessibility of hypertension services. As a result of this engagement, the ICB collaborated with Thriving Nottingham (the city's lifestyle services provider) to develop an interactive map showing local physical activity classes and blood pressure check locations.

Know your numbers campaign

It is estimated Nottingham City has a 7% prevalence of undiagnosed hypertension despite the population being more likely to have associated risk factors. Uptake of blood pressure checks also remains lower in the most deprived areas and in ethnic minority groups. A targeted campaign took place in September 2025 with the aim to increase blood pressure checks in those aged 40+ in Nottingham City, whilst also engaging with those from ethnic minority communities. Over 100 organisations came together to support the campaign and 69% more blood pressure checks were undertaken during the campaign week when compared to an average week. Further project detail and outcomes can be found in case study 1 of the accompanying case study pack.

SiSU Health Stations

SiSU Health Stations deliver rapid, self-guided blood pressure and body mass index (BMI) checks without the presence of a clinician. Two stations have been deployed by the Nottingham City place-based-partnership in collaboration with the ICB and Boots pharmacy. The machines have been placed in areas covered by the Nottingham City and Nottingham West primary care networks, which include areas of very high deprivation, and have large multiethnic populations. They are intended to help to address the low uptake of traditional screening and preventative healthcare in these neighbourhoods (particularly NHS Health Checks) by offering a more casual route for opportunistic screening. The stations offer multilingual, personalised health advice, and guide users to appropriate follow-up care, such as local pharmacies, physical activity and emotional wellbeing support.

Mid-Notts Hypertension Pro-active Casefinding

The Mid-Notts Place Based Partnership received funding to implement a scalable case-finding intervention focused on addressing health inequalities. The districts of Mansfield and Ashfield are located within the PBP and include some of the most deprived areas in the country. A Population Health Medicine (PHM) approach was adopted, leveraging patient data to facilitate a remotely delivered clinical intervention which aimed to target those who don't routinely access healthcare and may therefore be less likely to engage with existing case finding opportunities such as those offered by community pharmacy.

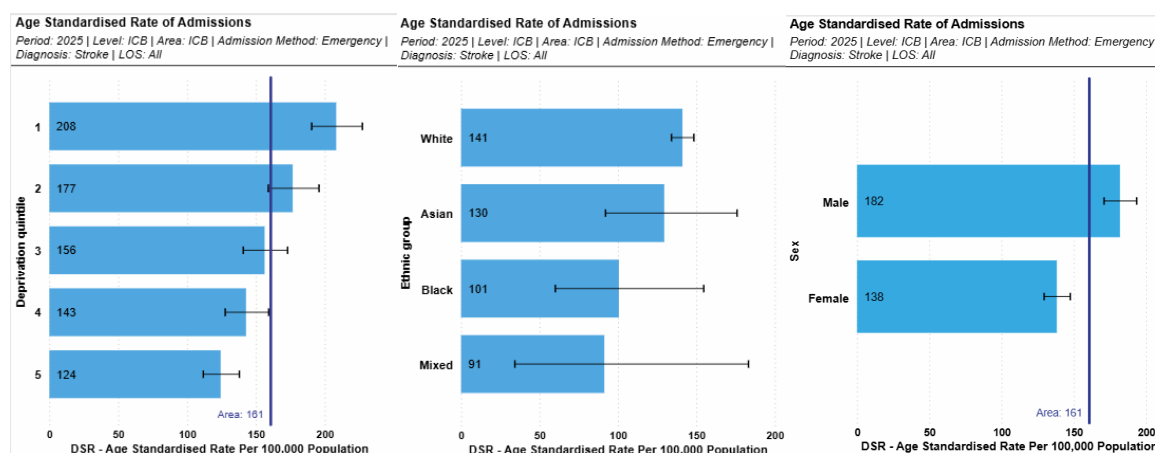
20 of 39 GP practices took part in the programme which was delivered by a GP-owned Primary Care Network healthcare provider. Based on NICE guidance, patients were selected using blood pressure (BP) readings routinely recorded in electronic health records. Eligible patients had no prior diagnosis

of hypertension, were not pregnant or nearing the end of life, and had a most recent clinic BP more than 160/100 or an average home BP more than 155/95 (Stage 2 hypertension). The thresholds were lowered to 140/90 and 135/85 respectively (Stage 1 hypertension) for patients living in the 20% most deprived areas nationally (IMD quintile 1).

Over 9 months the provider attempted to contact 3425 patients (51% female, mean age 60, 27% IMD quintile 1). Of these, 43% of patients returned diaries, and 29% patients were hypertensive. One year after the intervention 22% had been assigned hypertension diagnosis codes, 13% were prescribed antihypertensives. The proportion of patients in IMD quintile 1 was sustained in both diagnosis (27%) and treatment (28%) groups.

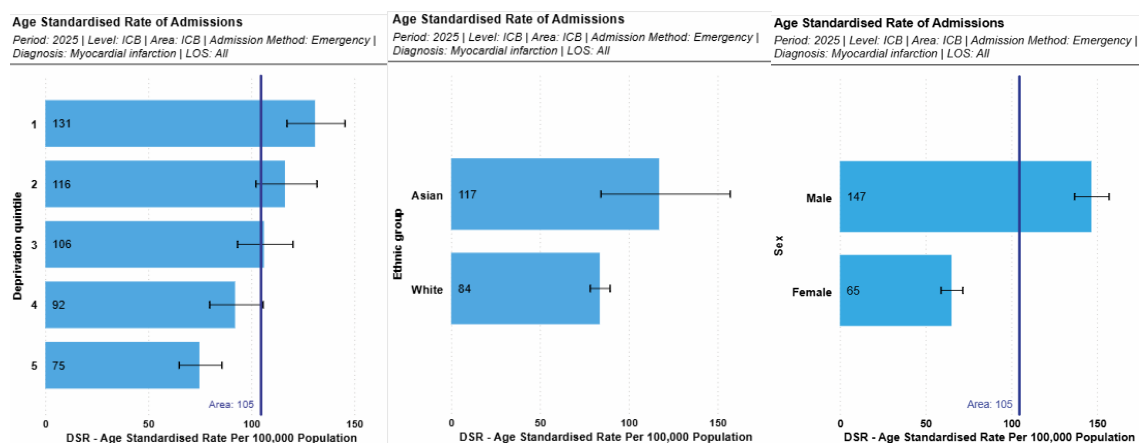
Stroke- rate of non-elective admissions (per 100,000 age-standardised)

Stroke is a form of CVD. The charts below show the age-standardised admission rate 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. Where ethnicity is known, emergency admission rates for Stroke are similar across ethnic groups, although breakdowns this should be treated with caution due to poor ethnicity coding. Rates are significantly higher in males compared to females.



Myocardial infarction – rate of non-elective admissions (per 100,000 age-standardised)

Rates of non-elective admission for myocardial infarction are 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. Rates in males are more than double that in females.

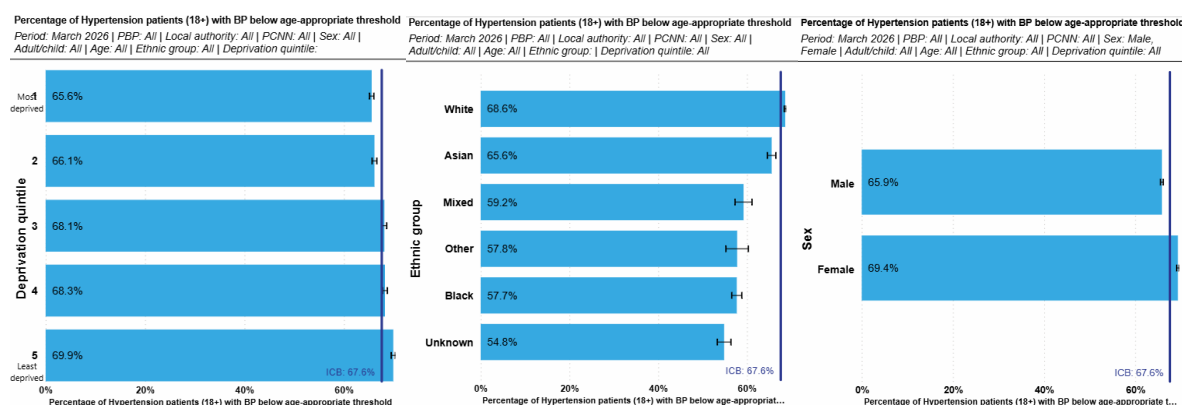


Percentage of patients aged 18 or over with GP recorded hypertension, in whom the last blood pressure reading in the preceding 12 months is below age-appropriate treatment thresholds (indicator of optimal condition management)

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 ICB, 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.

People from White ethnic groups are more likely than those from all other ethnic groups to meet blood pressure management targets. Optimal blood pressure management is particularly low for Black patients at 58%, which is 11 percentage points below the figure for White patients (69%).

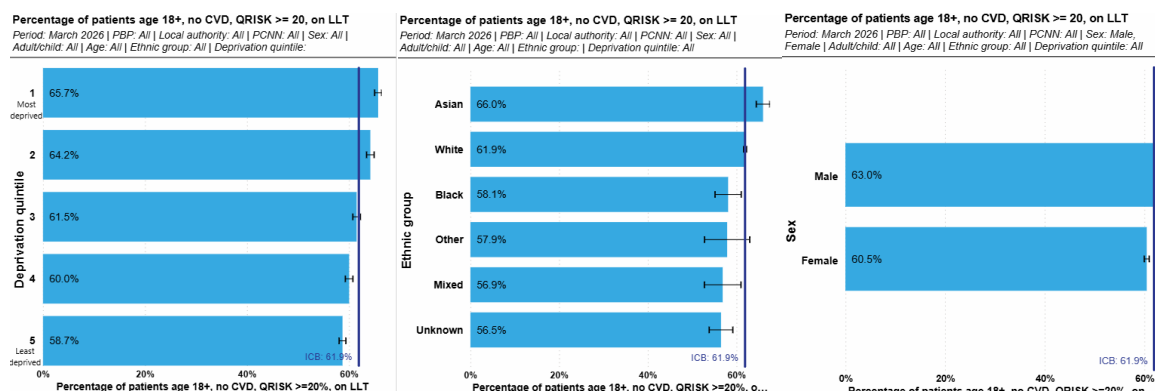


Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy

High cholesterol increases the risk of heart problems and stroke. Lipid lowering therapies (LLTs) are medications used to reduce blood cholesterol. Statins are the most common form of LLT.

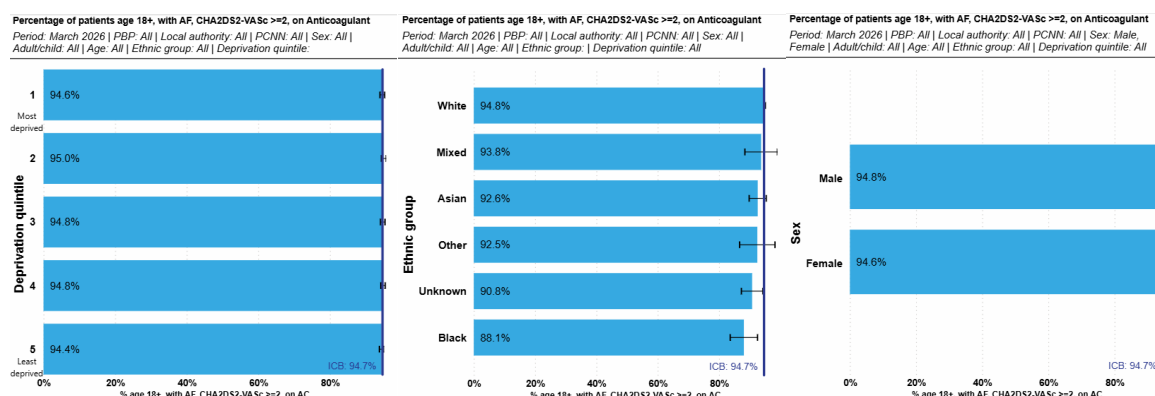
Those living in the most deprived areas are more likely than those living in the least deprived areas to be treated with lipid lowering therapy, reversing the usual link between deprivation and poorer treatment uptake. This pattern is also true for England overall.

Asian patients are the most likely within this cohort to be on lipid lowering therapy. Between the other main ethnic groups (Black and White) there are no statistically significant differences. Men are more likely than women to be on lipid lowering therapy.



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 deprivation quintile or sex for this indicator. By ethnic group, Black patients are statistically significantly less likely than White patients to be properly treated with anticoagulation therapy. The overall performance for this indicator has remained similar over the last 12 months.



Diabetes

Actions by the ICB

In 2025/26, the Nottingham and Nottinghamshire Strategic Prioritisation and Investment Committee approved the alignment of the HIIF to scaling up and improving the delivery of the secondary prevention priorities, as a primary mechanism for impacting on and reducing health inequalities. Diabetes is recognised as a key secondary prevention priority.

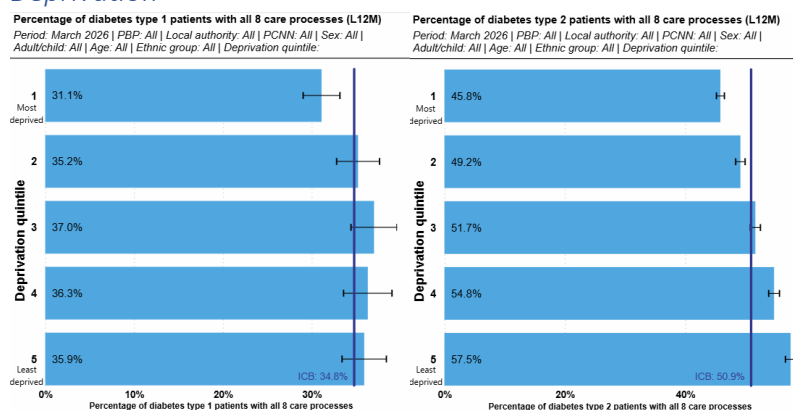
As part of this, the Diabetes Local Enhanced Service (LES) is essential to ensure the effective management of people living with type two diabetes. This directly impacts the delivery of key interventions, including the completion of the eight care processes, appropriate prescribing of GLP-1 receptor agonists, and proactive lifestyle support. Strengthening the LES through HIIF investment targeted at more deprived areas enhances clinical outcomes, reduces variation, and supports earlier intervention to prevent complications. The LES also ensures value for money for primary care while contributing to wider system efficiency and equity of access for areas of highest need.

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 important 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.

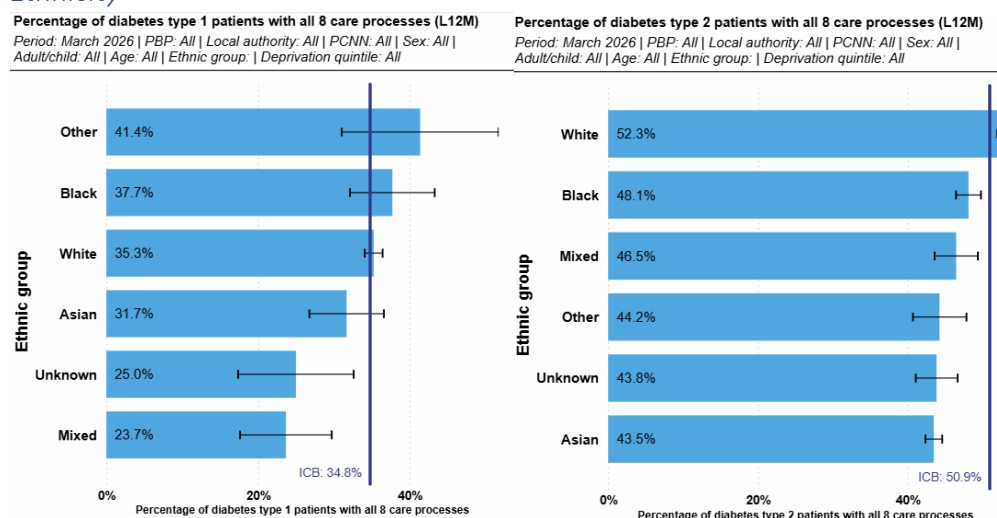
The charts below show the variation in completed 8 care processes for type 1 and type 2 diabetics by deprivation. There is a clear correlation between deprivation and achieving all 8 care processes for type 2 diabetes with those in the least deprived quintile 1.3 times more likely to achieve all eight than those in the most deprived quintile. For type 1 diabetes, there is no clear social gradient, however those in the most deprived quintile are around five percentage points less likely than patients living in any other quintile to have all care processes completed.

Deprivation



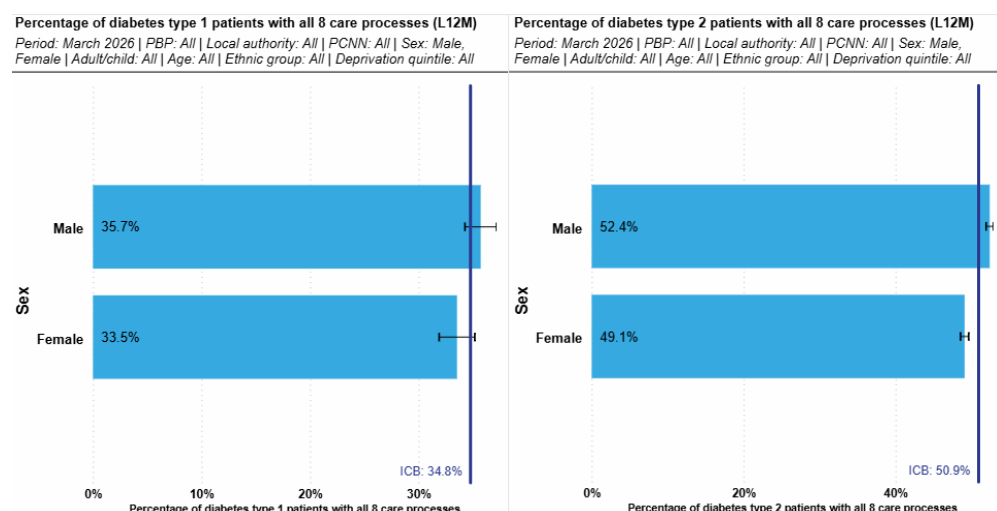
By ethnicity, for type 1 diabetes, those of mixed heritage are less likely to have all care processes completed. For type 2 diabetes, white patients are more likely than all other ethnicities to have all care processes completed. The gap with Asian patients is most stark with a difference of 9 percentage points.

Ethnicity



Sex

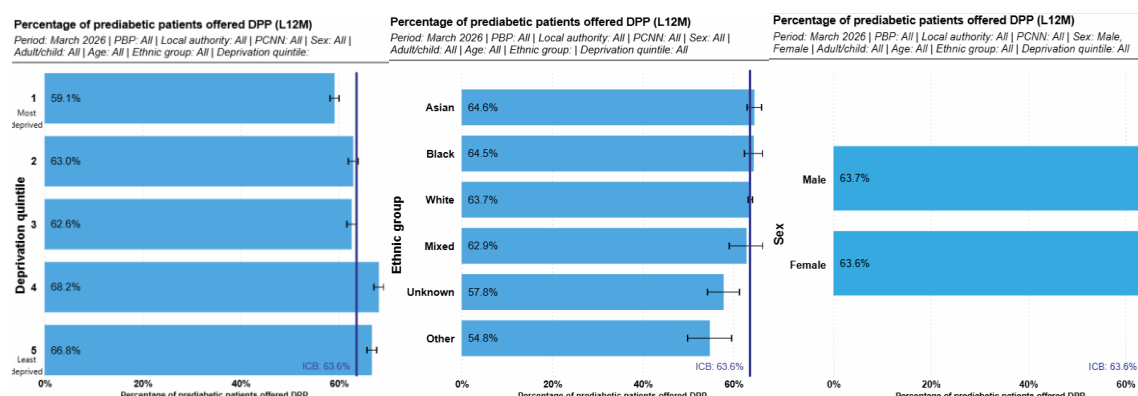
Men with type 2 diabetes are slightly more likely than women to have all care processes completed. For type 1, there is no statistically significant difference.



Referrals to the National Diabetes Prevention Programme

The National Diabetes Prevention Programme (NDPP) identifies 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.

Prediabetic patients living in the most deprived quintile are 10 percentage points less likely to be offered a place on the diabetes prevention programme compared to the least deprived. Those of 'Other' ethnicity are significantly less likely to be offered a place on the NDPP. There are no statistically significant differences by sex.



Learning Disabilities and Autism

Health inequalities are evident in people with Learning Disabilities, with the average life expectancy around 20 years less in this population group. Between 2021 and 2025, nearly 80% of deaths in people with learning disabilities were premature (occurred in people under the age of 75).¹³ This is 2.5 times higher than the general population, for which 32% of deaths were premature.

Actions by the ICB

In 2025, the ICB developed a new website for neurodivergent people, designed to be a central hub for families, carers, and professionals seeking accessible, trustworthy information and guidance. It

¹³ SAIU, SID18 Outcomes Dashboard; PHM Linked Data

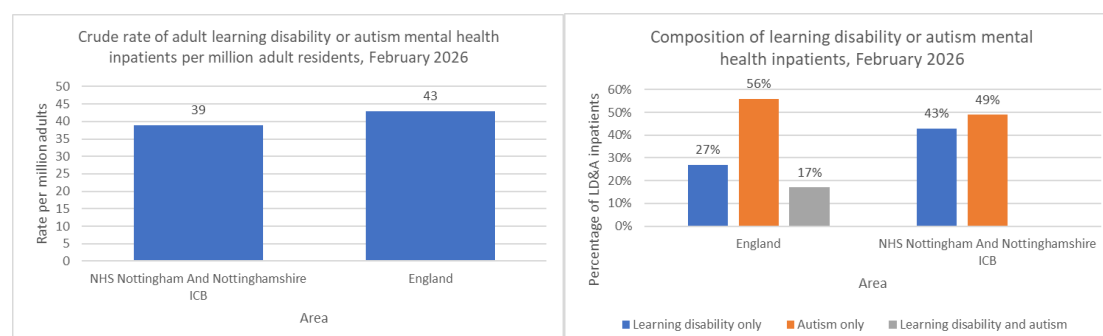
has been co-produced and developed with adults, young people and their families with lived experience, as well as health care professionals and other local stakeholders.

The website, 'Minds of All Kinds' includes; Clear, jargon-free explanations of ADHD, Autism, and other neurodivergent differences, local service directories and referral pathways for Nottingham and Nottinghamshire, practical advice for navigating education, health, and social care systems and personal stories and lived experiences from young people and families.

Local neighbourhood initiatives continue to progress in encouraging people with learning disabilities to attend annual health checks and other national screening programmes where it is noted that people with learning disabilities are less likely to attend. Producing easy read materials, allowing longer appointments and the utilisation of the reasonable adjustments flag highlights where extra support can be provided and thus increasing accessibility to services.

Number of people in a mental health inpatient setting who have a learning disability or are autistic

Based on the Learning Disability: Assuring Transformation Dataset, there were around 35 mental health inpatients who were registered with a Nottingham and Nottinghamshire GP and had a learning disability or autism at the end of February 2026.¹⁴ This equates to 39 per million adult population, which is similar to England overall. 43% of this group had learning disabilities only, 49% 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. Numbers, rates, and composition in Nottingham and Nottinghamshire remain similar to February 2025.

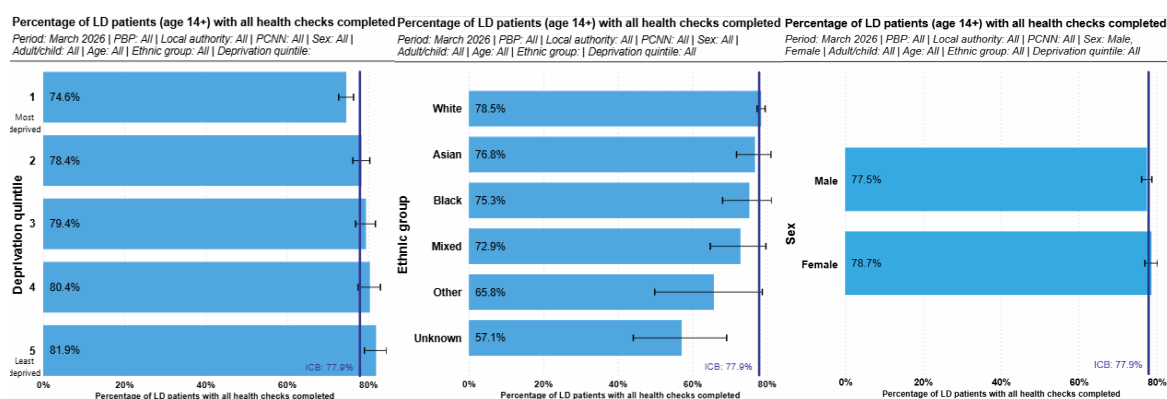


Percentage of patients aged 14+ on GP learning disability registers who have had an annual health check

As of March 2026, 78% of people with a learning disability (age 14+) had an annual health check completed in the previous year. This is a five percentage point decrease compared to the previous year's achievement of 82.3%.

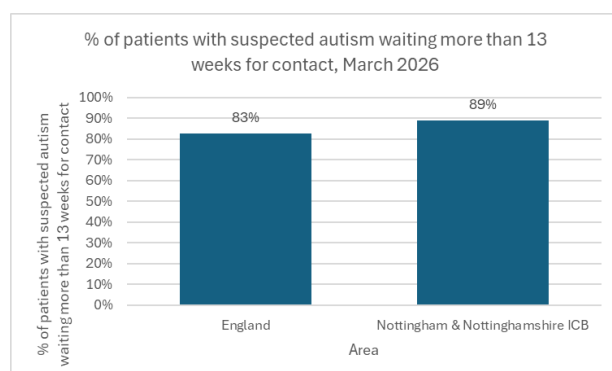
Coverage was lower in the most deprived quintile and fell faster than for the least deprived quintile, widening the gap to 7.5 percentage points. There are no statistically significant differences by ethnic group or by sex.

¹⁴ NHS England, [Statistics on people with a learning disability and autistic people in mental health hospitals, AT: February 2026, MHSDS: January 2026 - NHS England Digital](#)



Percentage of people with suspected autism waiting more than 13 weeks for contact

Almost 9 out of 10 (89%) suspected autism patients registered with a Nottingham & Nottinghamshire GP practice were waiting more than 13 weeks for a contact in March 2026. This is worse than for England overall (83%). Data is not yet available to break these down by health inequalities dimensions.



Maternity and Neonatal

Actions taken by the ICB

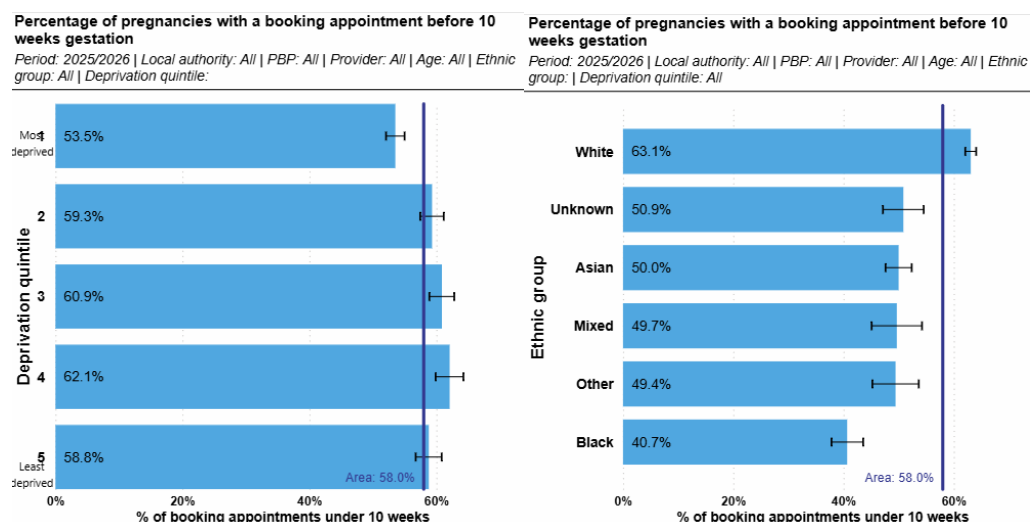
In 2025, Nottingham and Nottinghamshire Local Maternity and Neonatal services refreshed their 2023 Equity Strategy.¹⁵ The strategy highlights the changing deprivation and ethnicity profile of births in Nottingham and Nottinghamshire and sets out four guiding principles for maternity care: Co-production, Partnership working, Equity and inclusion in practice, and Accountability and transparency. Key actions include the publication of multilingual digital resources, covering at least the top 10 community languages to ensure information is accessible and trusted for all, improve health literacy and reduce barriers to care.

In 2025, the Nottingham and Nottinghamshire LMNS formed a Health Inequalities working group alongside ICS partners to come together to assess the current gaps in maternity services and potential improvements which could take place. Through the group, the need for a pilot project of maternity link workers to support families with additional language needs was established. It was identified that Urdu and Polish speaking families in most deprived areas (City, Mansfield, Ashfield) would benefit the most from the pilot initiative initially.

¹⁵Nottingham & Nottinghamshire LMNS, Maternity Equity Strategy, [Maternity - NHS Nottingham and Nottinghamshire ICB](#), (2023)

Gestational age at booking

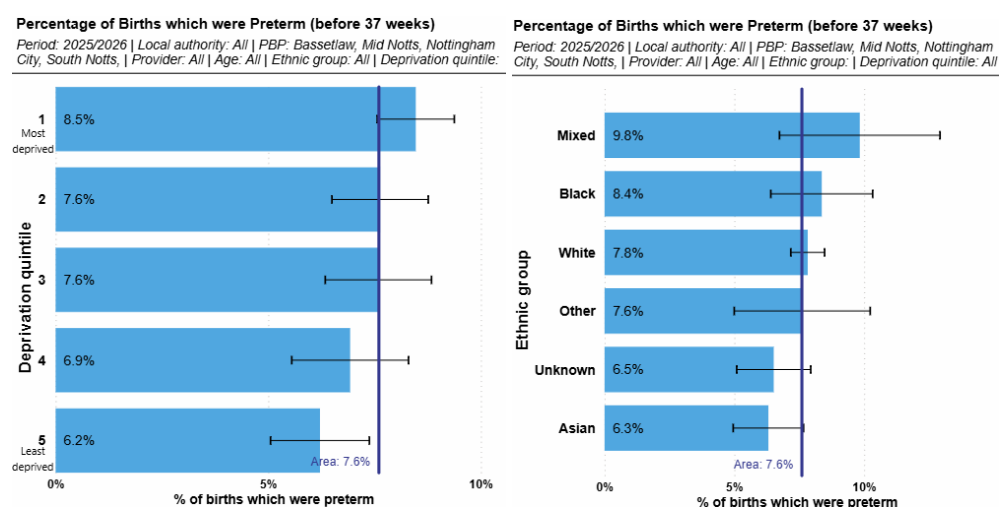
58% of booking appointments in Nottingham and Nottinghamshire take place before 10 weeks gestation. Women living in the most deprived quintile are significantly less likely to have had a booking appointment before 10 weeks. White women are around 20 percentage points more likely to have their booking appointment before 10 weeks compared to Black women, and around 10 percentage points more likely to have their booking appointment before 10 weeks compared to all other ethnic groups. This reveals substantial gaps in access to maternity services by ethnic group.



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.

Those living in the most deprived quintile are 1.4 times as likely to have a preterm birth than those in the least deprived quintile. Pre-term births by ethnic group are also presented, however there are no statistically significant differences.



Vaccinations

Actions by the ICB

Flu and Covid vaccination programmes continue to run annually to protect those who are most vulnerable to infection. Learning from previous campaigns continues to be utilised to help reach vulnerable patients who may experience barriers to access.

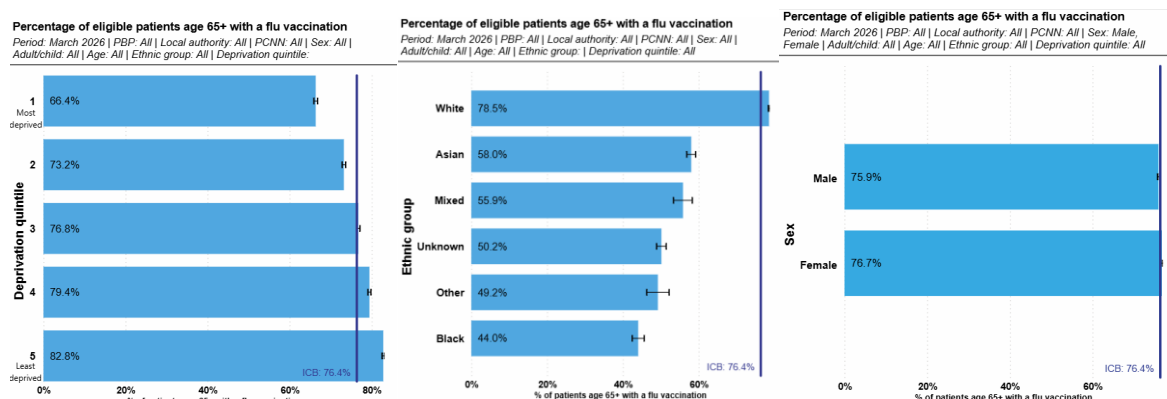
Uptake of flu vaccinations by age and demographic

Flu vaccination rates are lower among working age groups than those age 65+. There are similar patterns in vaccination uptake by deprivation and ethnicity across both age groups: increased deprivation correlates with lower uptake, with uptake around 15 percentage points lower for the most deprived compared to the least deprived for both age groups.

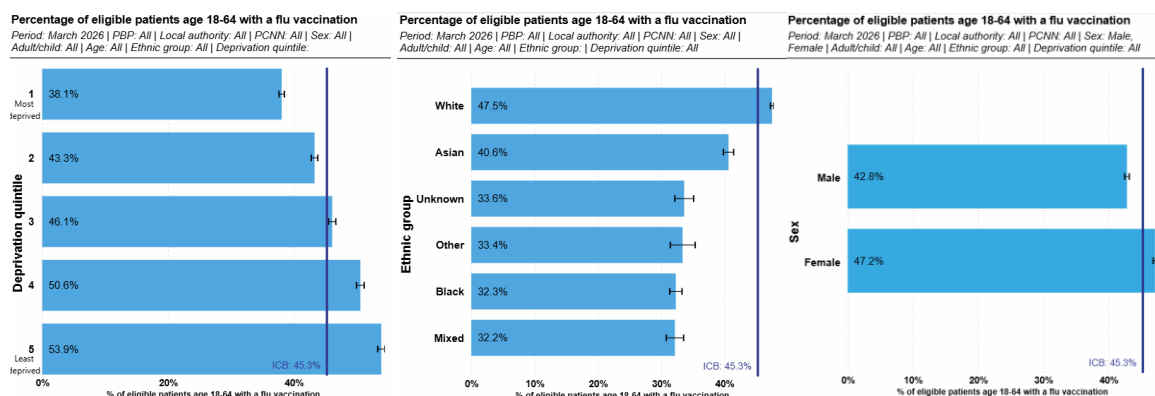
Uptake in the White population is significantly higher than for other ethnic groups. Among those age 65+, almost four in five White patients had had their flu vaccination, compared to just below three in five Asian patients, and less than half of patients of Black or Other ethnicity. Similarly for patients age 18-64, White patients had the highest uptake at 48%, followed by Asian patients at 41%, and only around a third of patients from all other ethnic groups had had their flu vaccinations.

Coverage is similar for men and women age 65+, but lower for men in the 18-64 age group.

Influenza vaccinations, age 65+



Influenza vaccinations, age 18-64



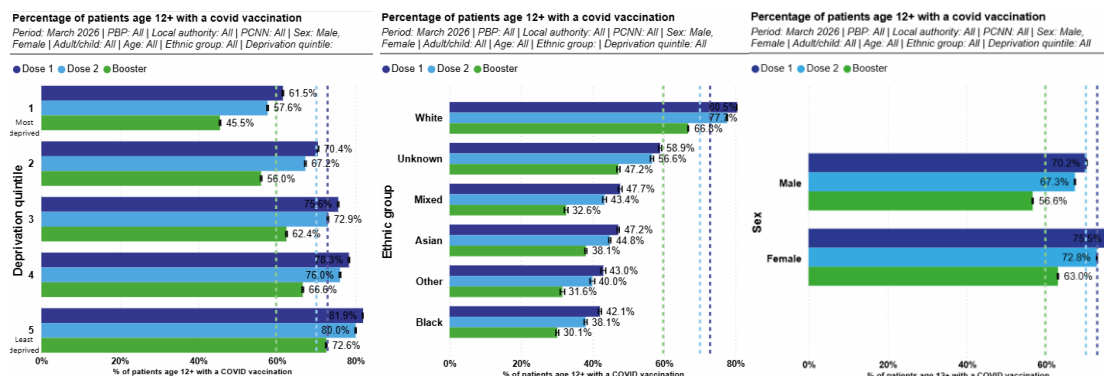
Uptake of covid vaccinations

The charts below show percentage coverage of COVID-19 vaccinations for first, second, and booster doses. They show large disparities in uptake by deprivation and ethnic group.

COVID-19 vaccination coverage is lowest in the most deprived quintile, where around 60% have received doses one and two, and less than half have received a booster. Uptake increases steadily with each quintile. The least deprived quintile has the highest coverage at all stages, with over 80% having received at least one dose, 80% having received two doses, and nearly three-quarters having received a booster.

There is substantial variation in COVID-19 vaccination uptake by ethnic group. Coverage is highest in the White ethnic group, where over 80% have received at least one dose, nearly 78% have received two doses, and around two-thirds have received a booster. In contrast, vaccination uptake is markedly lower across all other ethnic groups, particularly for booster doses. People recorded as Black, Mixed, Asian or Other ethnic groups have first dose coverage at or below around 47%, with booster uptake at 38% for Asian patients, 30% for Black patients.

Women are statistically significantly more likely than men to have had all doses. There is a five percentage point gap between men and women for the first dose, and an eight percentage point gap for booster doses.



CORE20Plus5 – Children & Young People (CYP)

Urgent and Emergency care – CYP

Actions by the ICB

Asthma is a common reason for hospital admission for CYP in the ICB. Initiatives are in place across PBPs to help reduce the need for emergency admissions through condition management. Bassetlaw have successfully reduced hospital admissions through providing additional clinical capacity to undertake asthma reviews and provide support to help families manage conditions better. Further detail on the outcomes and reduction in urgent and emergency care can be reviewed in case study 8.

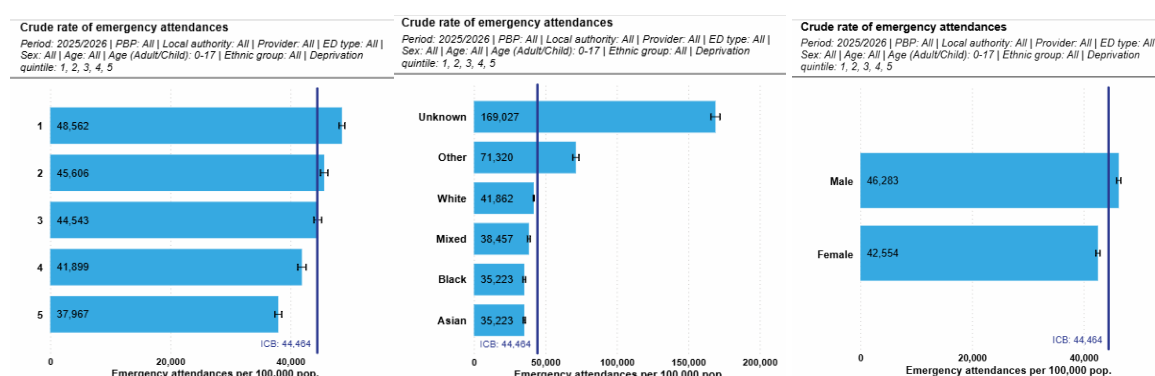
Emergency department attendances for under 18s

There were around 109,000 emergency department attendances for children age 0-17 in 2025/2026. This is an increase of 6,000 attendances on the previous year. The crude rate of emergency attendances for this age group was 44,464 per 100,000 population.

There is a clear relationship between deprivation and emergency department attendances in children: attendances were 1.3 times higher in the most deprived areas compared to the least.

Where ethnicity was known, White children had the highest emergency attendance rates. However, around 10% of attendances did not have an associated known ethnicity code so caution should be taken when interpreting this difference.

The rate of emergency department attendances was statistically significantly higher for boys than girls.



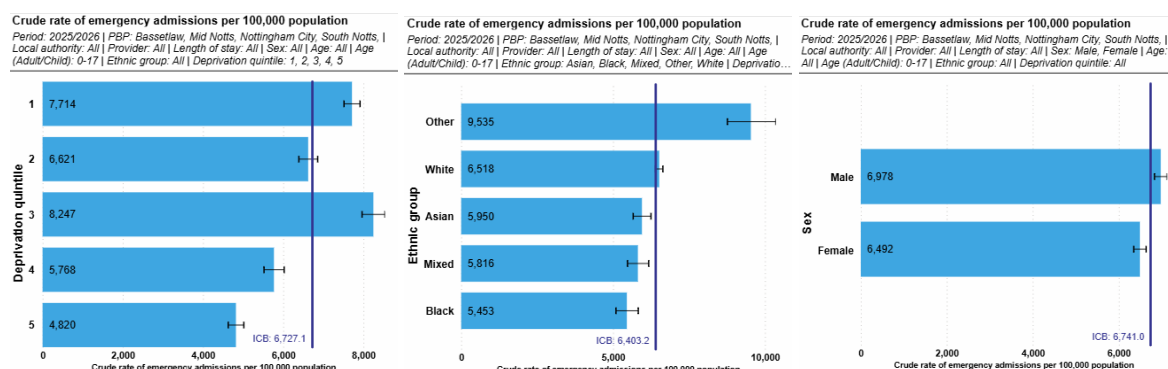
Emergency admissions for under 18s

There were 16,526 emergency admissions for children age 0-17 in 2025/2026. This represents a small decrease of 668 admissions compared to the previous year. The crude rate of admissions for this age group was 6,727 per 100,000 population.

There is a clear link between deprivation and rates of emergency department admissions for children by deprivation. The highest rate is in quintile 3, followed by quintile 1, and lower rates in quintile 4 and 5. Rates of emergency admissions in quintile 1 and 3 are around 1.6 times higher than in quintile 5.

Where ethnicity is known, children with White and Other ethnicity have higher rates. Severe caution should be used when interpreting variation by ethnic group for secondary care-based rates because of poor ethnicity recording.

By sex, boys have a higher rate of emergency admissions than girls, which contrasts with the pattern seen in crude admission rates across almost all adult age groups.

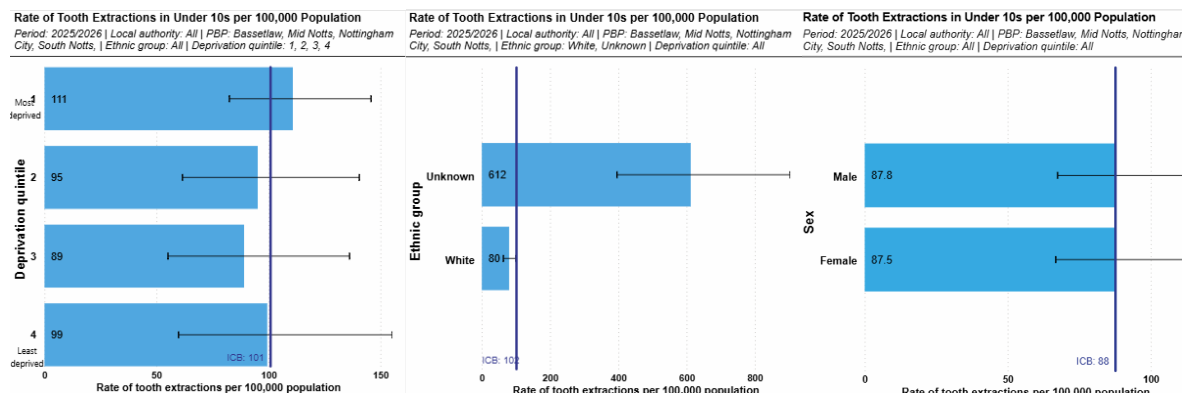


Oral Health

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 for tooth extractions in Nottingham and Nottinghamshire is relatively small, with between 100 and 150 extractions each year. In 2025/2026 there were 123 extractions in under 10s, equating to a rate of 101 per 100,000 0-10 year olds. As numbers are so low, there is no statistically significant variation by deprivation or ethnicity.

There is substantial variation by geography. 61 tooth extractions, around half of the total, were for children registered with a Bassetlaw GP. Bassetlaw place-based partnership had a rate of 428 extractions per 100,000 0-10 years olds, more than seven times higher than the next PBP, Mid Notts with a rate of 59 per 100,000.



Diabetes - CYP

Inequalities in percentage of CYP with type 1 and 2 diabetes receiving all the recommended NICE care processes

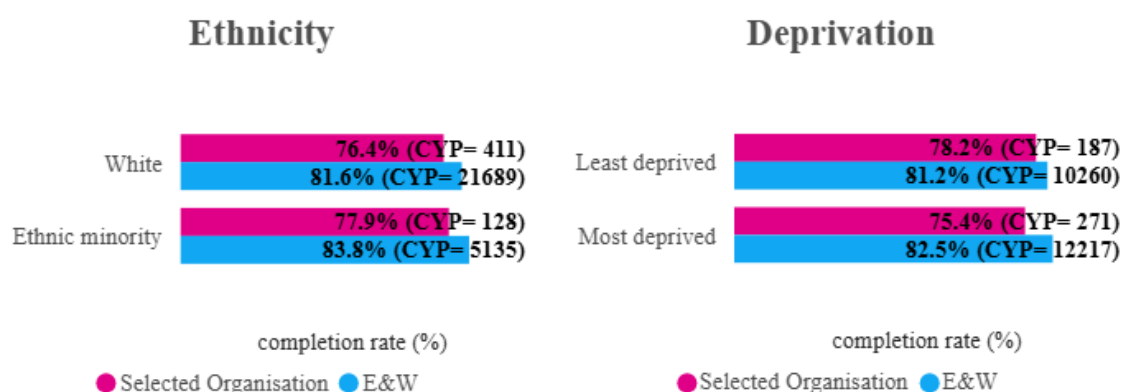
The most recent data from the Royal College of Paediatrics and Child Health Diabetes Audit only goes to quarter 3 2025/2026.¹⁶ It shows that coverage of the recommended NICE diabetes care processes for children and young people are slightly lower for Nottingham and Nottinghamshire ICB children and young people (76.8%) than for England and Wales overall (82%).

Within the Nottingham and Nottinghamshire cohort, there are small variations in the percentage of patients receiving all care processes between health inequalities groups. Those living in the most

¹⁶ Royal College of Paediatrics and Child Health, National Paediatric Diabetes Audit Quarterly Report, Q3 2025/2026

deprived quintile have a slightly lower completion rate (75.4%) than those living in the least deprived quintile (78.2%). White and ethnic minority patients have a similar health check completion rate.

Percentage of CYP Diabetes patients who have received the appropriate health checks based on their age and diabetes type in the last 12 months. Selected Organisation = Nottingham and Nottinghamshire ICB. Quarter 3 2025/2025



Mental health – CYP

Actions taken by the ICB

CAMHS Mental Health Support Team Expansion

The Children and Adolescent Mental Health Services (CAMHS) Mental Health Support Team is an early intervention mental health and wellbeing service in schools which provides support to children, young people and families for low-level emotional wellbeing needs. The team is undergoing a phased expansion. Mental health commissioners chose to take account of health inequalities in the sequencing of the expansion, and selected Nottingham City to be the first area to stand up a mental health support team because it is the ICS's most deprived and ethnically diverse area.

Mental Health Extended Early Intervention Service

The Mental Health Early Intervention Service contract was extended with some variations to ensure the service was accessible to inclusion groups. Changes to the new service were developed based on feedback from patients, and include extended opening hours, work in community settings, and additional work with children and young people in contact with care services and the youth justice system.

Start Well Bassetlaw INT – Mental Health

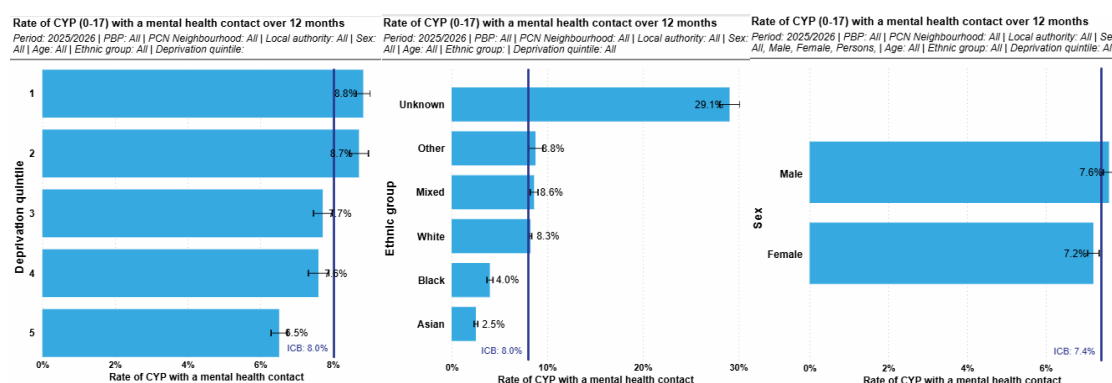
Bassetlaw PBP noted an increase in CAMHS referrals and waiting lists, impacting on access to appointments, meanwhile the severity of referrals and ED attendances appeared to increase. Bassetlaw has areas of high deprivation which can impact mental health and also has significantly higher suicide rates than the England average.

Bassetlaw PBP utilised HIF funding to incorporate Mental Health Improvement workers into their integrated neighbourhood working model. The improvement workers delivered early interventions to children and young people in need, aiming to prevent escalation of mental health conditions. Individual case studies noted that as well as increasing capacity to mental health support, school attendance increase as did involvement in social activities. This model helped to prevent escalation of mental health issues and enable positive outcomes for participants. Further detail can be found in the accompanying case studies pack, slide 13, 'Start Well Bassetlaw INT -Mental Health'.

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 2025/2026 by deprivation, ethnicity, and sex. Overall, around 20,000 individual children had a mental contact over the period. This equates to 8% of all children registered with a Nottingham and Nottinghamshire GP.

Contact rates are higher than the ICB overall in the most deprived IMD quintile (8.8%) and lower than the ICB overall in the least deprived quintile (6.5%). 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. Boys are slightly more likely than girls to have had a mental health contact.



Respiratory – CYP

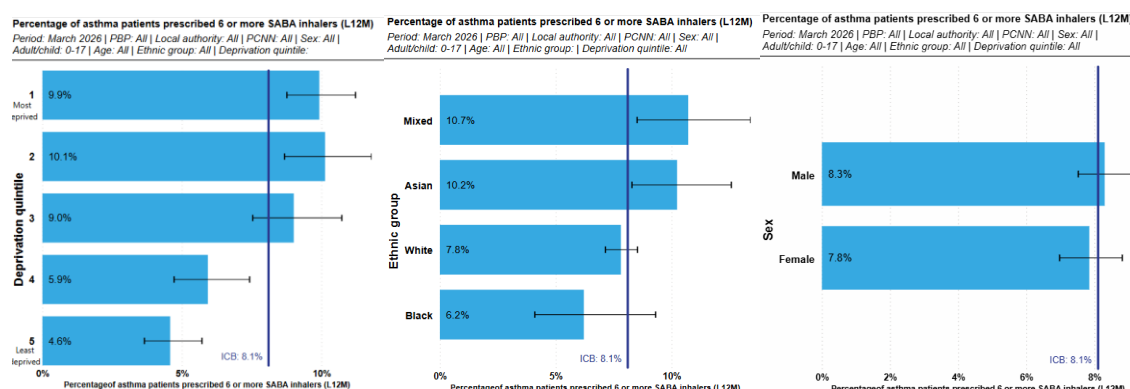
Actions by the ICB

Bassetlaw Start Well INT, identified the need for additional support to children with asthma living in the most deprived areas. Bassetlaw has the highest GP recorded prevalence of Asthma in CYP and has the highest emergency admissions CYP population across the ICB. Areas of Bassetlaw also fall within deprivation quintiles 1 and 2, with a higher proportion of CYP living in a low income or out of work household than the England averages. Respiratory conditions can be exacerbated by living in poor conditions. Through HIF funding, the INT increased capacity for asthma reviews and support through a paediatric nurse. Following the projects commencement, emergency admissions for asthma in CYP in Bassetlaw fell by 12.5%, alongside further positive outcomes such as reduction in SABA inhalers, inhaler technique compliance and increase in asthma annual reviews. Further detail on this case study can be reviewed in case study 8 of the accompany case study pack.

Local schools across the ICB have also signed up to the Asthma Friendly Schools initiative which promotes an asthma friendly environment through training and the adoption of asthma focussed policies and procedures will ensure that CYP are safe while they are in school. In turn this will help to reduce asthma related school absences which can have an impact on health inequalities through educational attainment in the future.

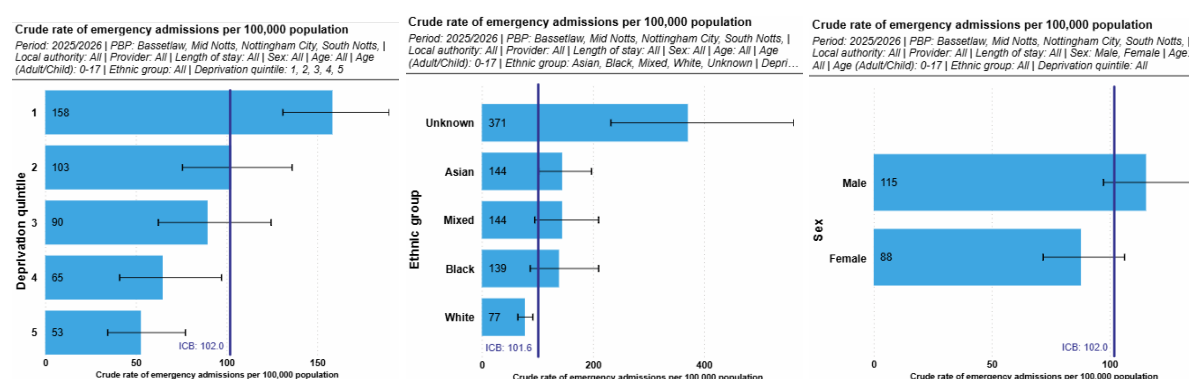
Inequalities in dispensing of reliever only inhalers

Overuse of Short-Acting Beta-Agonist (SABA) inhalers is associated with an increased risk of severe asthma attacks.¹⁷ Primary care prescribing data provides a proxy for overuse by the patient. Overall, 8.1% of children with asthma were prescribed reliever only inhalers six or more times in the year to March 2026. Those living in more deprived areas (quintiles 1-3) were twice as likely to be prescribed inhalers more than six or more times over a year compared to those living in the least deprived areas (quintile 5), which suggests a correlation between deprivation and the overprescription of inhalers. There are no statistically significant differences in the over-provision of inhalers by sex or ethnicity.



Inequalities in emergency admissions for asthma

Even though numbers are relatively small at 250 admissions in total for the ICB in 2025/2026, there is a clear relationship between deprivation and asthma admission rates for children (age 0-17). The crude rate of emergency admissions for asthma in children from the most deprived backgrounds is three times higher than in the least deprived. Asthma admissions are statistically significantly lower in White children than in those from ethnic minority backgrounds. There are no statistically significant differences by sex.



¹⁷ Medicines and Healthcare Products Regulatory Agency, [Short-acting beta 2 agonists \(SABA\) \(salbutamol and terbutaline\): reminder of the risks from overuse in asthma and to be aware of changes in the SABA prescribing guidelines - GOV.UK](#), (2025)

Data Quality

Complete and accurate ethnicity data is essential for understanding equity in access, experience and outcomes.

All NHS data submissions with an ethnic category field should conform to the national mandatory standard of 16+1 valid ethnic categories.¹⁸ All other codes, including 99 (Not known), and nulls are invalid. The '+1' in the 16+1 is 'Z', which means 'Not stated'. 'Not stated' should mean the patient was asked but chose not to disclose their ethnic group. In practice, 'Not stated' is often used to fill in ethnicity information by NHS staff even when patients haven't been asked about their ethnicity. To be useful for analysis, a patient's ethnicity needs to be known. NHS England's Ethnicity Recording Improvement Plan sets out actions for Integrated Care Boards and Trusts to improve ethnicity recording, including by reducing the number 'Not stated' ethnicity records.¹⁹

Actions by the ICB

Actions taken the ICB to improve data quality are outlined in the response to the 'Improving Data Quality' key line of enquiry at the beginning of this document.

Data quality indicators

- Percentage of patient records with a valid, non-residual ethnicity code in data sets
- Percentage of records with blank or null codes for ethnicity
- Percentage of records with residual ethnic codes, including not stated/not known

The tables below collate data from the main commissioning datasets flowed from providers to the ICB via NHS England. They represent around 700,000 records each month. Mental Health Services Dataset (MHSDS) and Community Services Dataset (CSDS) data is based on demographic or patient index tables, Maternity Services Dataset (MSDS) data is based on the mother demographics table, and SUS inpatient, SUS outpatient, and the Emergency Care Dataset (ECDS) data are based on activity submitted for that month.

Ethnicity recording is significantly poorer among independent sector providers compared to NHS providers, so they are reported separately.

NHS Providers

Across all datasets, around 15% of Nottingham and Nottinghamshire ICB patients' records from NHS providers are missing a known and valid ethnic group. The percentage of unknown ethnicity codes is similar for all datasets except the Maternity Services Dataset, which has a significantly lower proportion of records with an unknown ethnic group. There is variation in the use of '99' (not known) and 'Z' (Not stated) across the datasets, with a larger share (9.5%) of the total unknown recorded as the technically valid 'Not Stated' in the MHSDS, compared the greater use of '99' (not known) , which makes is attributed to 13.5% of CSDS records.

There is significant variation by provider. Among the area's acute trusts, Nottingham University Hospitals NHS Trust have an overall unknown percentage close to 20% for inpatient, outpatient, and

¹⁸ NHS England, [NHS Data Model and Dictionary](#), [Accessed May 2025]

¹⁹ NHS England, [Ethnicity Recording Improvement Plan](#), (2025)

emergency care datasets, whereas Sherwood Forest Hospitals NHS Foundation Trust consistently submits data with less than 5% of ethnicity codes are 'unknown'.

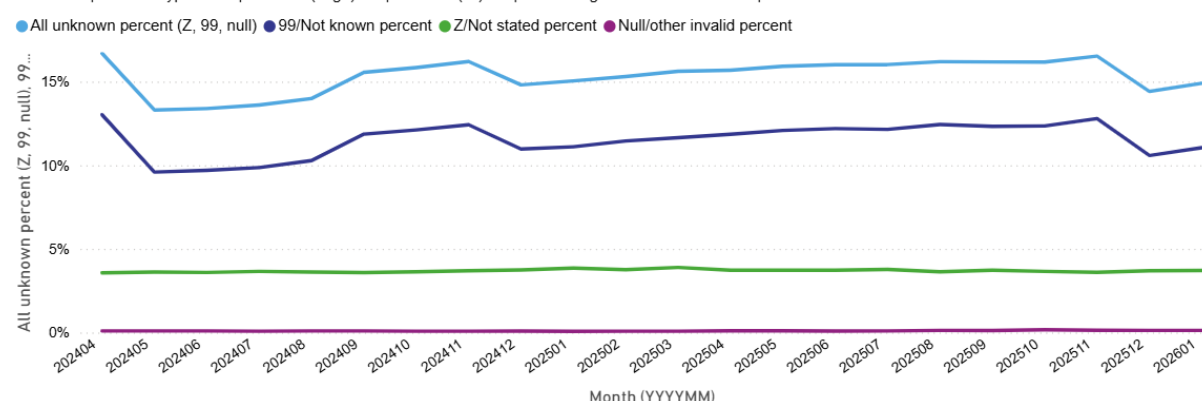
Table: NHS providers, Nottingham & Nottinghamshire ICB patients - Percentage of records with an unknown, not stated, or null ethnic category, by dataset, December 2025

Measure	SUS Outpatient	Mental Health Services Dataset (MHSDS)	SUS Inpatient	Emergency Care Dataset (ECDS)	Community Services Dataset (CSDS)	Maternity Services Dataset (MSDS)
All unknown percent (Z, 99, null)	15.7%	15.5%	14.9%	14.7%	14.4%	4.2%
99/Not known percent	10.1%	6.0%	9.5%	9.6%	13.5%	2.5%
Null/other invalid percent	0.1%	0.0%	0.0%	0.2%	0.2%	0.3%
Z/Not stated percent	5.5%	9.5%	5.4%	5.0%	0.8%	1.4%

Timeseries - NHS

Completeness of ethnicity recording -

Period: All | Provider type: NHS | Provider (large): All | Provider (all): All | Patient registered ICB: Notts ICB | Dataset: All



Independent sector providers

The independent sector contributes a smaller proportion of the overall data the ICB can use to undertake analysis by ethnicity: around 140,000 records each month, with around 100,000 of those belonging to the Community Services Dataset.

Ethnicity data submitted by independent providers for SUS inpatient and outpatient records is substantially less complete than for NHS providers: 81% of SUS inpatient, and 76% of SUS outpatient records did not have a known ethnicity. Emergency care data is less complete too, with one third of records missing a known ethnicity. Mental health data has a similar level of completeness at 16.5%, and community services data is more complete than for NHS providers, with fewer than 10% of records missing a known ethnicity.

Table: Independent providers, Nottingham & Nottinghamshire ICB patients - Percentage of records with an unknown, not stated, or null ethnic category, by dataset, December 2025

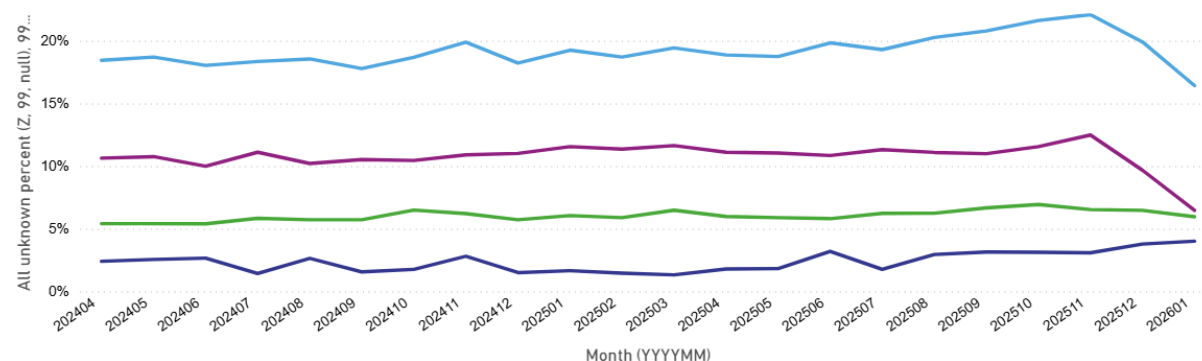
Measure	SUS Outpatient	Mental Health Services Dataset (MHSDS)	SUS Inpatient	Emergency Care Dataset (ECDS)	Community Services Dataset (CSDS)
All unknown percent (Z, 99, null)	75.6%	16.5%	80.5%	33%	8.3%
99/Not known percent	0.2%	5.5%	0.6%	19.50%	3.1%
Null/other invalid percent	26.9%	7.5%	15.8%	3.7%	3.5%
Z/Not stated percent	48.5%	3.6%	64.1%	9.9%	1.7%

Timeseries – Independent Sector

Completeness of ethnicity recording –

Period: All | Provider type: Independent | Provider (large): All | Provider (all): All | Patient registered ICB: Notts ICB | Dataset: All

● All unknown percent (Z, 99, null) ● 99/Not known percent ● Z/Not stated percent ● Null/other invalid percent



Case Studies

Nottingham and Nottinghamshire ICB

NHS
Derby and Derbyshire
Integrated Care Board

NHS
Lincolnshire
Integrated Care Board

NHS
Nottingham and
Nottinghamshire
Integrated Care Board

10/06/2026

Core 20 Plus 5 Adults

Nottingham and Nottinghamshire ICB



Derby and Derbyshire
Integrated Care Board



Lincolnshire
Integrated Care Board



**Nottingham and
Nottinghamshire**
Integrated Care Board



Nottingham City Know Your Numbers Campaign - CVD



What actions were taken?

- A targeted campaign for those aged 40+ without a blood pressure reading in the last year. Campaign focused on accessible and culturally relevant approaches to promote healthier lifestyles and encourage blood pressure checks. 800 leaflets distributed, signposting people to community pharmacy.
- Partnership with community organisations, faith groups, and local community champions to reach underrepresented groups including those from deprived communities and ethnic minority groups where CVD risk is higher.
- A mix of digital and in-person activities ensured broad reach and impact, empowering individuals to understand the risks associated with high blood pressure and take preventative action to reduce the likelihood of heart disease and stroke.
- To maximise engagement, a variety of promotional and educational methods were used, including social media, activities, marketing, podcasts, radio interviews, and television media coverage.

What was the health inequalities issue?

It is estimated Nottingham City has a 7% prevalence of undiagnosed hypertension despite the population being more likely to have associated risk factors. Uptake of blood pressure checks also remains lower in the most deprived areas and in ethnic minority groups.

What was the outcome?

- 100+ organisations came together to support the campaign, strengthening joined up working and partnerships.
- 104 blood pressure checks undertaken by Thriving Nottingham with the following diagnosis:
 - 44 people found to have high blood pressure
 - 4 people found to have a very high blood pressure
 - 69% more blood pressure checks undertaken compared to an average week
- 67 people attended across 7 community blood pressure events
- 11 educational videos produced and shared on social media with 13,487 video views – increasing educational awareness and health literacy and accessibility.
- Community Pharmacy reported 254 additional checks took place during September 2025 compared to the same month in 2024 when no campaign took place.



MBLC (Majority Black Led Churches) Hypertension Project - CVD

What was the health inequalities issue?

Risk of CVD related illness and mortality is higher among men of African and African Caribbean heritage in Nottingham City. However, hypertension prevalence remains low with people in this cohort aged 40+ less likely to have a blood pressure check in the last 5 years yet.

What actions were taken?

- Project commenced in October 2024 and is a collaborative effort between NTU and the MBLC, funded by the NHSE Community Connectors Fund.
- It seeks to raise awareness of hypertension, improve engagement with health services, and ensure culturally responsive interventions for Black communities.
- Stakeholder engagement session involving service providers, community leaders, and researchers to map services, identify gaps, and explore ways to improve awareness and access.
- MBLC members managed recruitment, coordinated volunteers, and conducted marketing and publicity using targeted communications, social media, leaflet drops, and radio/print media.
- Two interactive community workshops were held to explore knowledge of hypertension, access to services, and barriers to engagement. The workshops drew on participatory methods to encourage open discussion.
- Community events, including a Heart Health Event at Pilgrim Church (Sept 12, 2025), offered mini health checks, including blood pressure screenings, education on heart disease risk, and lifestyle guidance. 50 community members attended, and the event received BBC East Midlands Today coverage, amplifying the campaign.

What was the outcome?

- Strengthened the connection between Nottingham’s Black communities and local health services.
- Increased awareness of hypertension risks.
- Provided actionable insights to inform culturally sensitive interventions.
- Enhanced healthcare by fostering trust within communities, improving outreach and engagement, and supporting holistic care that addressed both physical and emotional well-being.
- Demonstrated the value of community-led engagement, media amplification, and tangible follow-up to address longstanding barriers to health equity.
- 33 blood pressure checks were carried out in the community, which would not have been conducted without the community engagement activities.

Lung Cancer Screening Programme



What was the health inequalities issue?

Lung cancer has a high mortality rates and is often diagnosed at a later stage. Some people who have an increased at risk of lung cancer (such as those with SMD) are less likely to access health services. People in the most deprived areas are more likely to risk factors for developing lung cancer such as smoking or occupational hazards yet may experience barriers to accessing healthcare.

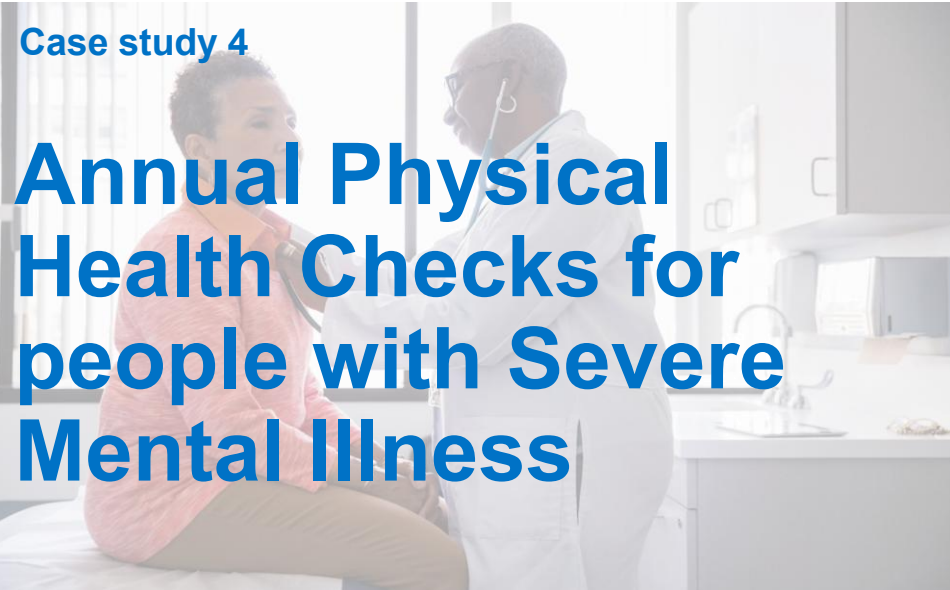
What actions were taken?

- Population health intelligence approaches to prioritise PCNs with the highest smoking prevalence and lung cancer mortality rates and located in supermarket car parks and community hubs.
- Mobile clinics offer extended hours (typically 8am–8pm, seven days per week) and an opt-out invitation system, designed to maximise uptake and reduce barriers to access.
- Targeting high-risk and underserved groups through tailored outreach, multi-language communications, and strong VCSE partnerships. As well as a multi-channel approach to advertising, such as public transport adverts, billboards, social media, local radio, etc.
- The SMD 'one-stop shop' model, combines screening with wider health and social support to address multiple barriers simultaneously, supporting those most at risk to get a check.
- Active monitoring of uptake identified lower participation of women and younger age groups. To address this the programme highlighted female patient case studies to improve engagement, partnered with large employers, and engaged community organisations to reach targeted populations.

What was the outcome?

Outcomes demonstrate high uptake and improved early diagnosis:

- 66.4% average uptake (above national average)
- 500 cancers detected from over 40,000 scans
- 70% diagnosed at early stage (up from 25%)
- Greatest benefit seen in the most deprived populations
- Patient experience is consistently positive, with high satisfaction and inclusive reach across people with additional needs. The programme achieved an EDS Domain 1 score of 45/48 (excelling).
- The first SMD specific clinic saw 13 patients, from which 2 cases of lung cancer were found and patients supported for treatment. Neither patients were showing symptoms prior to the check.



Annual Physical Health Checks for people with Severe Mental Illness

What was the health inequalities issue?

People with Severe Mental Illness (SMI) have a life expectancy 15-20 years shorter than the general population, often from preventable physical health. An annual physical health check helps to identify any problems early and ensure access to appropriate interventions.

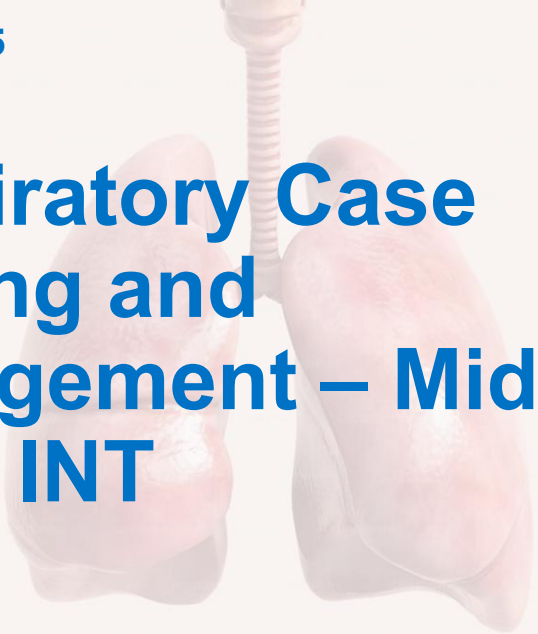
What actions were taken?

- An annual physical health check is offered to everyone on the GP SMI Register.
- Implementation of Health Improvement Workers in the City where health check uptake is low yet SMI rate is higher. They will support patients who don't respond to the GP invitation and are able to undertake home visits, offering more accessible and personalised care.
- Easier access pathways to health checks, e.g. if patient is on a mental health inpatient ward, health checks are completed there, and the health check details are shared with the GP upon discharge to prevent duplication in the community.
- Implementation of the SMI Local Enhanced Service which promotes onward support and referral to other services where a need is identified during an annual health check. E.g. smoking cessation.
- Local authority public health commissioned a behaviour change pathway for SMI patients.
- A 12 month Smoking Harm Reduction Pilot being delivered by Nottinghamshire Healthcare Trust, Public Health, Thriving Nottingham and Your Health Notts is providing additional support to SMI patients to quit smoking - this is an 18 week offer of support rather than the standard 12 weeks.

What was the outcome?

- During 2025/26 65% of patients on the SMI register had all 6 of the core checks completed, and over 90% had at least 1 of the 6 components completed.
- The number of people receiving each of the components has increased every year since 2020/21, except for blood tests that fell slightly in 2025/26.
- Where a need is identified by a health check, patients are more likely to be offered smoking cessation, diabetic interventions or a pharmacological intervention for blood pressure.
- Despite small numbers accessing smoking cessation interventions with Your Health Notts in the county, smoking quit rate for SMI patients is 43% compared to 63% in the general population.
- Lessons have been learnt by the ICB and ICS partners regarding co-ordinated approaches across local authority and NHS care, the requirement for reasonable adjustments and the importance of physical health care as well as mental health care in SMI patients.

Respiratory Case Finding and Management – Mid Notts INT



What actions were taken?

- Utilising data provided by the ICB SAIU function, Ashfield North, Ashfield South and Newark PCNs were identified as having high prevalence rates for respiratory illness and respiratory attendance at both Primary and Secondary Care services.
- Initial casefinding prioritised those in IMD Deciles 1&2, coded as a smoker with no spirometry test in 2 years. Case finding was widened to other deciles later on in the project.
- Project delivered by a Primary Care provider to relieve pressure on PCNs. Patients initially contacted via text with follow up via letter/phonecall.
- 473 patients seen over 86 clinic days. 64% of patients in Ashfield and 53% of patients seen in Newark lived in IMD 1&2

What was the health inequalities issue?

Mid Notts PBP has high smoking rates, has an ex mining community and higher levels of deprivation, increasing the risk of developing respiratory conditions and associated hospital admissions. Smoking rates are higher in areas of deprivation increasing the risk of respiratory conditions for these populations further. Many patients within these categories have not accessed a spirometry test within 2 years. There remains a backlog of spirometry testing reducing access to appointments.

What was the outcome?

- Increased capacity to offer access to spirometry testing for those most at risk.
- 60% of patients in Ashfield and 42% in Newark received an abnormal result requiring further investigation or treatment.
- 1 case of Lung Cancer was identified and treated at an early stage through an initial restrictive spirometry result which received onward referral to a chest x-ray.
- Individual Patient journey mapping and case studies found further outcomes such as referrals to smoking cessation and quitting smoking, other lifestyle support, referrals to social prescribers.
- The project has pathed the way for future INT respiratory projects. Since completion, other local practices have used the model to establish their own spirometry clinics with PICS, demonstrating sustainability and continuation of increased access.

Changing Futures – SMD Programme

What actions were taken?

- Recurrent funding was awarded to Changing Futures through the Health Inequalities Innovation fund in 2023/24, the project entered its second year of HIIF funding in 2025/26.
- The service provides specialised 1:1 'Navigator' support including roles to assist people from minority ethnicities and women. The navigator support is not time limited, recognising the long term support needed for this cohort.
- Facilitation of an MDT to bring together system partners to provide a co-ordinated, partnership response to people with the highest acuity of need
- Development of a Lived Experience Team including peer mentors that puts people's experiences at the heart of planning and delivery. 19 lived experience co-production projects undertaken with 31 lived experience participants in 2025/26.
- Creation of a Practice Development Unit (PDU) providing training and shared learning on approaches that work to all system partners and services. 34 live learning events undertaken by the PDU with 1,322 attending training sessions.
- In 2025/26 162 individuals were supported through the service.
- A national review of changing futures programmes took place in 2025

What was the health inequalities issue?

Nottingham City has one of the highest prevalence of Severe Multiple Disadvantage (SMD) in the country. People who experience SMD often face a cycle of compounded disadvantage, trauma and exclusion, leading to extremely poor health and wellbeing, as well as a very high degree of dependency upon reactive and emergency interventions across our system. Single issue interventions are often ineffective, and practical barriers and responses to trauma can prevent people from gaining access to effective care and support when they need it most.

What was the outcome?

- New Direction Team Scores are used to score individuals level of need across a variety of domains. Average scores show a reduction of around 3 points for individuals on the programme for 12 months and a 6-7 point reduction for those who have been on the programme for 25+ months. Score reduction indicates positive improvements.
- Raising system awareness of the service and needs of those with SMD, educating on bereavement and loss, neurodivergent-affirmative care, psychologically informed environments and trauma-informed care. Resulting in best practice care delivered.
- Embedding co-production with the service and wider system, ensuring voices are heard to provide more suitable and accessible services. Examples within Primary Care.
- Increased employment of individuals with lived and living experience of severe and multiple disadvantage within the local system
- Anecdotal reports of reduced reattendances to the Emergency Department for individuals who have previously been frequent users.



Integrated Neighbourhood Working – Bassetlaw Aging Well

Case study 7

What was the health inequalities issue?

Bassetlaw PBP recognised that older people in the most deprived areas were more likely to be living in poor health, suffering social isolation and have additional factors such as fuel poverty affecting their ability to age well. In 65 to 95 year olds with mild frailty, the risk of hospital, nursing home admission and death almost doubled, noting changes were needed to support those most at risk.

What actions were taken?

- Integrated Neighbourhood working is identified as a way to help increase access to services and provide more joined up care in the community, benefitting those who experience barriers to access.
- Proactive casefinding took place across GP record systems for Patients aged 65+ living within area of deprivation (20% most deprived) and fuel poverty
- In Worksop & Villages: 263 patients reviewed across Q1 (Annual INT Target – 300 reviews).
- In Retford and Villages: Additional focus also included those ages 80+. 101 Structured Medication Reviews completed, 48 referrals to Social Prescribing, 25 into the falls team, and 72 to the district nurse. : In Q1, 107 patients seen across 5 practices

What was the outcome?

- In Worksop and Villages: Patients aged 65+ with a Clinical Frailty Score (CFS) recorded in L12M rose from 6.7% to 9.8%.
Patients with moderate/severe frailty with a falls risk assessment in last 3 years increased from 5.5% to 25.5%
Patients with severe frailty with a CFS recorded in L12M rose from 30.0% to 39.4%
- In Retford & Villages: Patients aged 65+ in IMD 1 or 2 with a Clinical Frailty Score (CFS) recorded in L12M rose from 11.9% to 13.2%
Those aged 65+ with CFS ≥ 6 living alone referred to social prescribing increased from 47.1% to 51%

Frailty records are now more complete and accurate ensuring more people are receiving care needed, enabling annual reviews and ongoing monitoring, preventing hospital admissions and supporting people to live well at home.

10/06/2026

Core 20 Plus 5 Children and Young People

Nottingham and Nottinghamshire ICB



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Start Well Bassetlaw INT - Asthma



What was the health inequalities issue?

CYP living in the most deprived IMD quintile are between 10%-50% at higher risk of an emergency asthma admission in comparison to CYP living in the least deprived quintile. Bassetlaw has the highest GP recorded prevalence of Asthma in CYP and has the highest emergency admissions CYP population across the ICB. In Bassetlaw, a higher proportion of CYP live in a low income or out of work household than the England averages. Respiratory conditions can be exacerbated by living in poor conditions.

What actions were taken?

- Start well is aimed at children and young people (11-24yrs) living within area of deprivation (20% most deprived) and fuel poverty with either, a mental health condition or Identified as obese. Casefinding took place based on these factors.
- The project Increased capacity for asthma reviews through a paediatric asthma nurse. Opportunity for asthma reviews to take place in school settings also incorporated.
- Case finding took place to highlight CYP in need of an asthma annual review and those prescribed a high number of SABA inhalers. Initially prioritising those in the most deprived areas.
- Targeted support for patients with frequent A&E attendances and/or readmissions.
- Targeted community-based support through education

What was the outcome?

- Asthma patients with 6 or more SABA prescriptions reduced by 1.6%
- Number of A&E attendances specifically for asthma for 10-14s in Bassetlaw reduced by 12.5%
- Total repeat attendances for 0-24s in Bassetlaw specifically for asthma reduced by 41%
- Asthma annual reviews increased by 5.5%
- Compliance with asthma inhaler technique increased by 6.9%

Start Well Bassetlaw INT – Mental Health



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What was the health inequalities issue?

Within Bassetlaw, CAMHS referrals and waiting times for the service have increased, reducing access. CAMHS report a higher number of crisis referrals and increased acuity of presentation. Additionally, CYP attendance at ED has increased by 19% for self-harm and 25% for anxiety and associated mental ill health including eating disorders.

Bassetlaw has significantly higher rates of suicide as well as pockets of high deprivation. Access to mental health support is a clinical area of the CYP Core20Plus5.

What actions were taken?

- Start well is aimed at children and young people (11-24yrs) living within area of deprivation (20% most deprived) and fuel poverty with either, a mental health condition. Casefinding took place based on these factors.
- The project provides funding for 2x mental health and wellbeing practitioners. Providing targeted intervention to mental health.
- Case-finding- focus on prioritising higher socio-economic deprivation
- Targeted support for patients with frequent A&E attendances and/or readmissions.
- Development of local self-harm pathway with support from ICB Self-Harm Steering Group and Bassetlaw Children and Young People Mental Health Alliance
- 123 CYP were offered a stage 1 holistic needs review against a target of 60 across Q1 and Q2.
- 40 CYP engaged in stage 2 holistic needs review against a target of 40 in Q2.
- Outreach events in local schools and colleges across Bassetlaw, as well as attending food bank run initiatives to ensure proactive wrap around support for CYP living in families experiencing food/ financial insecurity

What was the outcome?

- 60% of CYP engaged in stage 2 Mental Health Support demonstrate increased score by 3 or more on person-centred goal-based intervention plans
- Increasing access to earlier intervention
- Families empowered to better understand and support their children's mental wellbeing.
- Partnerships formed with social prescribing link workers enabling onward referral to tailored activities supporting wellbeing
- Individual case study highlights increased school attendance, engagement in social activities and prevention of mental health escalation.

Tier 2+ Obesity Service / Choose to Change



What was the health inequalities issue?

Childhood Obesity rates are also higher in areas of high deprivation. A service gap was identified in offering weight management services to CYP with complex needs including learning disabilities.

What actions were taken?

- Service provided via referral by Your Health Notts.
- A multi-disciplinary team: GP, specialist dietician, lifestyle leaders, and a psychologist.
- Group and 1-on-1 sessions are offered in both virtual and face-to-face community settings to create a flexible, family-centered plan.
- The focus is on behavioural science, practical diet/healthy eating guidance, age-appropriate physical activity, and breaking psychological barriers to weight loss.

What was the outcome?

- Across year 1, there were 128 programme starters with additional needs who may not have been able to access other services.
- Patients show strong engagement across 4-week, 10-week, 6-month, and early 12-month reviews.
- Across all review periods, **80–100%** of families report improvements in: healthy eating knowledge, cooking confidence, fruit & veg intake, physical activity, meal routines, sleep hygiene, and overall wellbeing
- **92%** of clients increased physical activity by week 10.
- **75%** maintain or improve BMI Z-scores after completing the programme.
- 100% of families at 6- and 12-month reviews report sustained lifestyle improvements.

Statement of Information on Health Inequalities – Opportunities for Improvement at Place



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Derby & Derbyshire Findings	Effect size			Alignment with 5-year Commissioning System Headline Delivery Targets
A higher proportion of females on a planned care waiting list are waiting >18 weeks than males (April 2026)	1.6 percentage point gap between females and males: 39.8% of females (27,136/68,188) on a waiting list >18 weeks 38.2% of males (19,159/50,170) on a waiting list >18 weeks			National Access Standards Delivered
Where a cancer staging is known, a higher proportion of females have their cancers diagnosed at stages 1 or 2 than males	16.5 percentage point gap between females and males: 61.9% of females have (1,198/1,935) have their cancer diagnosed at stage 1 or 2 45.5% of males (934/2,058) have their cancer diagnosed at stage 1 or 2			National Access Standards Delivered
Emergency hospital attendances and admissions are higher in more deprived areas, with a clear gradient across deprivation deciles	Rate per 100,000	ED Admissions	ED Attendances	- Non-elective admissions reduced by 36% - Emergency Department attendance reduction - Occupied bed days (non-elective acute and community bed days) reduced by 10%
	IMD Decile 1	11,882	44,775	
	IMD Decile 10	6,811	22,732	
	Difference	5,071	22,043	
Males have a significantly higher rate of non-elective admissions for myocardial infarction	Male MI rate: 197 per 100,000 (Total = 643 strokes) Female MI rate: 101 per 100,000 (Total = 334 strokes)			- Non-elective admissions reduced by 36% - Emergency Department attendance reduction - Occupied bed days (non-elective acute and community bed days) reduced by 10%
Emergency hospital attendances are significantly higher for children living in more deprived areas, although the gradient is not perfectly linear across all deciles	A difference of 5,604 per 100,000 between CYP who live in the most and least deprived deciles - IMD Decile 1: 11,715 ED attendances per 100,000 - IMD Decile 10: 6,111 ED attendances per 100,000			- Non-elective admissions reduced by 36% - Emergency Department attendance reduction - Occupied bed days (non-elective acute and community bed days) reduced by 10%

Derby & Derbyshire Findings	Effect size			Alignment with 5-year Commissioning System Headline Delivery Targets
A significantly lower proportion of women from the most deprived quintile have their first booking appointment in the first 10 weeks of pregnancy	A difference of 10.4 percentage points between pregnant women in IMD quintile 1 and IMD quintile 5: 59.6% of women in IMD quintile 1 have their first booking appointment within first 10 weeks of pregnancy 70.0% of women in IMD quintile 5 have their first booking appointment within first 10 weeks of pregnancy			Emergency department attendance reduction
Deprivation is a significant predictor in mental health outcomes	12.4 percentage point difference between most deprived and least deprived quintile achieving a 'recovery' outcome - IMD Quintile 1: 45.8% (1,610/3,515) achieved recovery - IMD Quintile 5: 58.2% (1,935/3,325) achieved recovery			- MH UEC - National Access Standards Delivered
Deprivation is a significant predictor of poorer preventative measures (flu/COVID vaccines, hypertension management) delivered in the community/primary care		IMD Quintile 1	IMD Quintile 5	Emergency department attendance reduction
	Flu vaccines	41.6%	68.9%	
	COVID vaccs	43.7%	65.8%	
	Hyp'tn Mgmt	67.3%	72.4%	
Deprivation is a significant predictor of poorer diabetes management	% receiving 8 CPs	IMD Quintile 1	IMD Quintile 5	Emergency department attendance reduction
	Type 1 Diabetes	39.9%	52.0%	
	Type 2 Diabetes	45.4%	60.1%	

Lincolnshire Findings	Effect size	Alignment with 5-year Commissioning System Headline Delivery Targets
A significantly higher proportion of females on a planned care waiting list are waiting >18 weeks than males (as at 29/03/26)	2.2 percentage points between females and males 46.3% (29,001/62,629) of females on a waiting list for >18 weeks; 44.1% (20,517/46,499) of males on a waiting list for >18 weeks	National Access Standards Delivered
A significantly higher proportion of males, and those living in the most deprived quintile, on a community waiting list are waiting >18 weeks (as at 28/02/26)	10.5 percentage points between males and females 31.0% (1,387/4,467) of females on a community waiting list for >18 weeks; 40.5% (1,941/4,797) of males on a community waiting list for >18 weeks	National Access Standards Delivered
Males have a significantly higher rate of non-elective admissions for strokes and myocardial infarction	Male MI rate: 168.0 per 100,000 (Total = 761 MIs) Female MI rate: 60.3 per 100,000 (Total = 312 MIs) Male Stroke rate: 190.4 per 100,000 (Total = 880 strokes) Female Stroke rate: 140.5 per 100,000 (Total = 755)	- Non-elective admissions reduced by 36% - Emergency Department attendance reduction - Occupied bed days (non-elective acute and community bed days) reduced by 10%
Deprivation is a significant predictor of higher UEC attendance and admissions	CYP from IMD Quintile 1 had 70% higher rate of emergency attendances than CYP from IMD Quintile 5 - IMD Quintile 1: 71,594.5 attendance per 100,000 - IMD Quintile 5: 41,799.8 attendances per 100,000	- Non-elective admissions reduced by 36% - Emergency Department attendance reduction - Occupied bed days (non-elective acute and community bed days) reduced by 10%
Children with asthma from the most deprived backgrounds have a higher rate of being prescribed 6+ salbutamol inhalers	3.9 percentage points between children with asthma in the most deprived quintile and least deprived quintile who were prescribed 6+ salbutamol inhalers in the past 12 months - IMD quintile 1: 158/1,731 - IMD quintile 5: 60/1,156	Emergency Department attendance reduction

Lincolnshire Findings	Effect size			Alignment with 5-year Commissioning System Headline Delivery Targets
Deprivation is a significant predictor in mental health outcomes	14.0 percentage point difference between most deprived and least deprived quintile achieving a ‘recovery’ outcome - IMD Quintile 1: 705/1,650 achieved recovery - IMD Quintile 5: 950/1,675 achieved recovery			MH UEC Hubs across all ICBs for adults and CYP
Significantly higher rates of females accessing CYP Mental Health services than males	2,190 per 100,000 difference between females and males with at least one contact with a CYP mental health service 6,005 females had at least one contact in 24/25 3,470 males had at least one contact in 24/25			- MH UEC Hubs across all ICBs for adults and CYP - Reduce CYP long waits for MH services
Deprivation is a significant predictor of poorer preventative measures (flu/COVID vaccines, hypertension management) delivered in the community/primary care		IMD Quintile 1	IMD Quintile 5	Emergency department attendance reduction
	Flu vaccines	49.5%	63.8%	
	COVID vaccs	52.1%	69.7%	
	Hyp’tn mgmt	68.8%	73.1%	
Younger adults have poorer hypertension management than older adults delivered in the community/primary care	16.4 percentage point different between under 60s and over 60s having hypertension optimally managed Under 60s: 59.2% (19,470/32,915) Over 60s: 75.6% (86,765/114,815)			Emergency department attendance reduction

Nottingham & Nottinghamshire

Nottingham & Nottinghamshire Findings	Effect size	Alignment with 5-year Commissioning System Headline Delivery Targets
Women are statistically significantly more likely than men to have been on the waiting list for more than 18 weeks	2.2 percentage point gap between females and males: 42.6% (29,676/69,625) females on a waiting list for >18 weeks; 39.8% (20,082/50,480) males on a waiting list for >18 weeks (29/03/2026)	National Access Standards Delivered
Cancer diagnoses for those living in the most deprived areas are less likely to be at an early-stage than for those in the least deprived areas.	6 percentage point early diagnosis gap between most and least deprived: - IMD quintile 1 (most deprived) early cancer diagnosis rate – 58.9% - IMD quintile 5 (least deprived) early cancer diagnosis rate – 64.7% (2025 calendar year, provisional rapid registrations data)	National Access Standards Delivered
Women have a significantly higher rate of emergency admissions, and the gap is widening.	Age-standardised rates of emergency admissions were similar to the previous year for Men, but increased by 4% for women, slightly widening the gap. - Female age-standardised rate of emergency admissions per 100,000 population – 12,503 - Male age-standardised rate of emergency admissions per 100,000 population – 10,628 (2025 calendar year)	- Non-elective admissions reduced by 36% - Emergency Department attendance reduction - Occupied bed days (non-elective acute and community bed days) reduced by 10%
Deprivation has a clear and substantial link to the rate of emergency department attendances	Patients living in the most deprived areas have a rate of A&E attendances 1.5 times higher than those living in the least deprived areas. - IMD quintile 1 (most deprived) age-standardised emergency department attendance rate per 100,000 population – 46,758 - IMD quintile 5 (least deprived) age-standardised emergency department attendance rate per 100,000 population – 31,533 (2025 calendar year)	- Non-elective admissions reduced by 36% - Emergency Department attendance reduction - Occupied bed days (non-elective acute and community bed days) reduced by 10%

Nottingham & Nottinghamshire

Nottingham & Nottinghamshire ICB	Effect size	Alignment with 5-year Commissioning System Headline Delivery Targets
Men are half as likely as women to access NHS talking therapies.	NHS Talking Therapies Access rate (patients age 18+ with 2+ contacts per 1,000 population): - Males – 9.1 - Females - 20 (2025/2026)	MH UEC Hubs across all ICBs for adults and CYP
Children from more deprived backgrounds are significantly more likely to have an emergency admission for asthma.	The crude rate of emergency admissions for asthma in children (age 0-17) from the most deprived backgrounds is three times higher than in the least deprived. - IMD quintile 1 (most deprived) crude rate of emergency admissions for asthma per 100,000 population – 158 - IMD quintile 5 (least deprived) crude rate of emergency admissions for asthma per 100,000 population – 53 (2025/2026)	- Non-elective admissions reduced by 36% - Emergency Department attendance reduction - Occupied bed days (non-elective acute and community bed days) reduced by 10%
Vaccination uptake is considerably lower in ethnic minority populations	Percentage of eligible patients age 65+ with a flu vaccination: White – 78.5% <i>All non-White with known ethnicity</i> – 53.1% Asian – 58% Mixed – 55.9% Other – 49.2% Black - 44% (March 2026, most recent season)	Emergency department attendance reduction
Patients with learning disabilities who live in more deprived neighbourhoods are less likely to have their annual physical health check	7.3% percentage point gap in coverage for learning disability physical health checks (age 14+): - IMD quintile 1 (most deprived) percentage coverage for LD health checks – 74.6% - IMD quintile 5 (least deprived) percentage coverage for LD health checks – 81.9% (March 2026)	Emergency department attendance reduction

Nottingham & Nottinghamshire

Nottingham & Nottinghamshire ICB	Effect size	Alignment with 5-year Commissioning System Headline Delivery Targets
Outpatient DNAs remain one of the most substantial relative inequalities by ethnicity.	Patients from an ethnic minority background are 1.5 times more likely to DNA than a White patient. Percentage of first outpatient appointments not attended: • White – 5.3% • <i>All non-White with known ethnicity</i> – 8.5% • Black – 8.8% • Asian – 8.2% • Mixed – 9.7% • Other – 7.6% (2025/2026)	• Total 1st Outpatient Acute Activity reduced by 25% • Total Acute Follow-ups reduced by 25% • <90 day Emergency readmissions reduced by 25%
Women from ethnic minority backgrounds are significantly less likely to have their booking appointment before 10 weeks gestation	Patients of White ethnicity are 1.3 times more likely to have their booking appointments before 10 weeks than a patients from an ethnic minority background. Percentage of booking appointments before 10 weeks: • White – 63.1% • <i>All non-White with known ethnicity</i> – 47.1% • Black – 40.47% • Asian – 50% • Mixed – 49.7% • Other – 49.4% (2025/2026)	• Full population coverage of Neighbourhood Health Services

Statement of Information on Health Inequalities –

Opportunities for Improvement at DLN
Programme Level



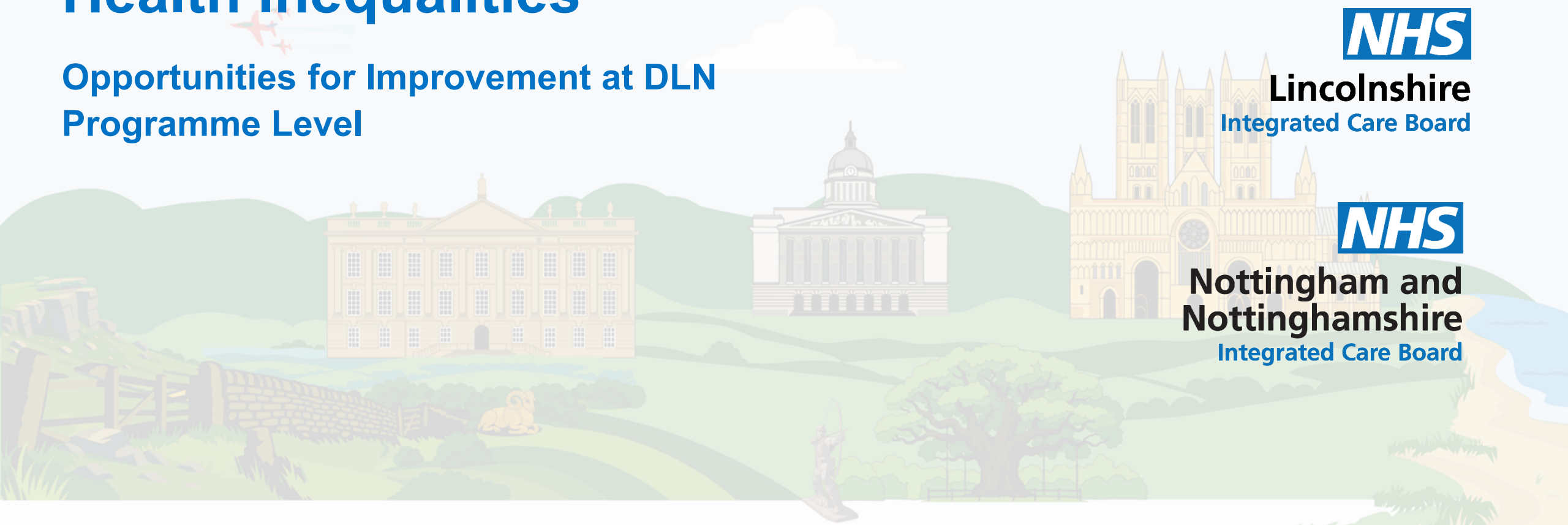
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Programme area	Indicator	Alignment with 5-year Commissioning System Headline Delivery Targets
Planned Care	Females have a significantly higher proportion waiting >18 weeks	National Access Standards Delivered
Cancer	- A higher proportion of cancers in the least deprived populations are diagnosed at stages 1 and 2 compared to those in the most deprived populations (D&D and N&N only – Lincs data not available). - A higher proportion of cancers in females are diagnosed at stages 1 and 2 compared to males (D&D and N&N only – Lincs data not available).	- National Access Standards Delivered - Emergency Department attendance reduction
Urgent and Emergency Care	- Rates of non-elective myocardial infarctions are significantly higher in males - Rates of non-elective strokes are significantly higher in males (Lincs and N&N only – D&D data not available) - Rates of non-elective myocardial infarctions are significantly higher in those living in most deprived quintile. - Rates of non-elective strokes are significantly higher in those living in the most deprived quintile (Lincs and N&N only – D&D data not available) - Age standardised rates for emergency admissions are significantly higher in those living in the most deprived quintile - CYP UEC attendances significantly higher in males than it is in females - CYP UEC attendances significantly higher in those living in the most deprived quintile compared to those living in the least deprived quintile	- Non-elective admissions reduced by 36% <90 day Emergency Readmissions reduced by 25% - Occupied bed days (non-elective acute and community bed days) reduced by 10% - Emergency department attendance reduction
Mental Health	- A significantly lower proportion of those from the most deprived quintile achieved a 'recovery' outcome - A significantly higher proportion of eligible females with SMI received all 6 PHCs than eligible males (Lincs and N&N only – D&D data not available) - Females have a higher rate of accessing Talking Therapies than males (Lincs and N&N only – D&D data not available) - Females have a significantly higher rate of restrictive interventions per 1,000 bed days than males	- MH UEC - National Access Standards Delivered
Learning Disabilities and Autism	As at March 2026, 88%, 97%, and 89% of patients with an open suspected autism referral have been waiting at least 13 weeks for a care contact appointment recorded in D&D, Lincs, and N&N respectively.	National Access Standards Delivered

Programme area	Indicator	Alignment with 5-year Commissioning System Headline Delivery Targets
Maternity	- A significantly lower proportion of women from the most deprived quintile have their first maternity appointment within the first 10 weeks of pregnancy - A significantly lower proportion of women from ethnic minority backgrounds have their first maternity appointment within the first 10 weeks of pregnancy	Emergency department attendance reduction
CYP	- A significantly higher proportion of CYP from the most deprived quintile are waiting >18 weeks for community services (Lincs and N&N only; D&D data not available) - A significantly higher proportion of CYP from the most deprived quintile received 6 or more reliever inhalers in the last year than those from the least deprived quintile (Lincs and N&N only; D&D data not available)	Emergency department attendance reduction
Women's Health	Females have a significantly higher rate of emergency attendances AND admissions (D&D and N&N only – Lincs data not available)	- Non-elective admissions reduced by 36% - Occupied bed days (non-elective acute and community beds) reduced by 10% - Emergency Department attendance reduction
Neighbourhood Health	- Males have a significantly lower proportion whose last blood pressure was below the age-appropriate threshold, compared to females. - Females with T2DM have a significantly lower uptake of all 8 care processes compared to males (Lincs and N&N only; D&D data not available) - A significantly lower proportion those with T1 and T2 diabetes from the most deprived quintile received all 8 care processes compared to those living in the least deprived	Emergency department attendance reduction
Prevention	- A significantly lower proportion of eligible populations from the most deprived quintile received a flu and/or COVID vaccine - A significantly lower proportion of eligible populations from an ethnic minority received a flu and/or COVID vaccine	- Non-elective admissions reduced by 36% - Emergency department attendance reduction

Ethnicity Recording - DLN Provider Overview



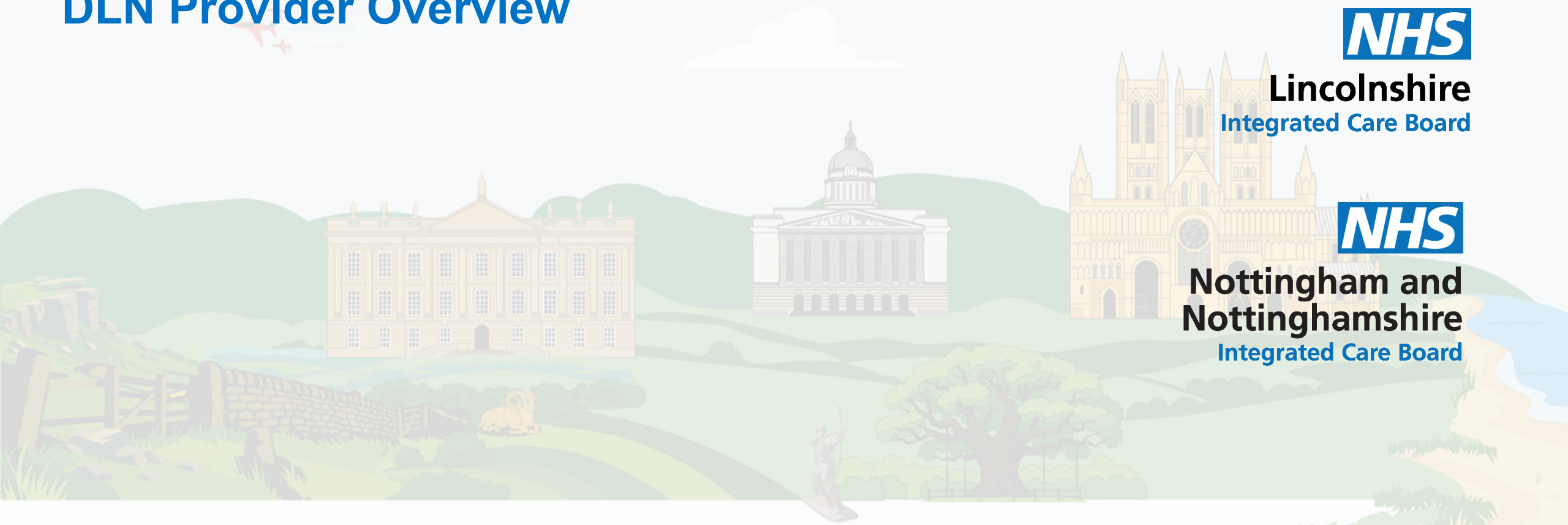
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DLN – Ethnicity Data Quality Admitted Patient Care

NHS Provider	Ethnicity Data Quality % (February 2026)	National % (February 2026)
Chesterfield Royal Hospital NHS Foundation Trust	97.3%	87.7%
Derbyshire Community Health Services NHS Foundation Trust*	94.4%	87.7%
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	95.2%	87.7%
Lincolnshire Community Health Services NHS Trust*	100.0%	87.7%
Nottingham University Hospitals NHS Trust	82.8%	87.7%
Nottinghamshire Healthcare NHS Foundation Trust*	100.0%	87.7%
Sherwood Forest Hospitals NHS Foundation Trust	98.4%	87.7%
United Lincolnshire Teaching Hospitals NHS Trust	83.1%	87.7%
University Hospitals of Derby and Burton NHS Foundation Trust	97.6%	87.7%

* = Low Activity

Source: [NHS Data Quality Maturity Index \(DQMI\)](#)

2% (or more) lower than the national average

Within 2% of the national average

2% (or more) higher than the national average

DLN – Ethnicity Data Quality Community Services Dataset

NHS Provider	Ethnicity Data Quality % (February 2026)	National % (February 2026)
Derbyshire Community Health Services NHS Foundation Trust	63.4%	70.9%
Derbyshire Healthcare NHS Foundation Trust	97.1%	70.9%
Lincolnshire Community Health Services NHS Trust	88.5%	70.9%
Lincolnshire County Council	94.8%	70.9%
Nottinghamshire Healthcare NHS Foundation Trust	86.0%	70.9%
United Lincolnshire Teaching Hospitals NHS Trust*	54.7%	70.9%
University Hospitals of Derby and Burton NHS Foundation Trust*	95.3%	70.9%

* = Low Activity

Source: [NHS Data Quality Maturity Index \(DQMI\)](#)

2% (or more) lower than the national average

Within 2% of the national average

2% (or more) higher than the national average

DLN – Ethnicity Data Quality Emergency Care Dataset

NHS Provider	Ethnicity Data Quality % (February 2026)	National % (February 2026)
Chesterfield Royal Hospital NHS Foundation Trust	98.6%	87.4%
Derbyshire Community Health Services NHS Foundation Trust	89.9%	87.4%
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust	95.7%	87.4%
Lincolnshire Community Health Services NHS Trust	96.0%	87.4%
Nottingham University Hospitals NHS Trust	84.5%	87.4%
Sherwood Forest Hospitals NHS Foundation Trust	95.6%	87.4%
United Lincolnshire Teaching Hospitals NHS Trust	77.8%	87.4%
University Hospitals of Derby and Burton NHS Foundation Trust	95.1%	87.4%

Source: [NHS Data Quality Maturity Index \(DQMI\)](#)

2% (or more) lower than the national average

Within 2% of the national average

2% (or more) higher than the national average

DLN – Ethnicity Data Quality Mental Health Services Dataset

NHS Provider	Ethnicity Data Quality % (February 2026)	National % (February 2026)
Chesterfield Royal Hospital NHS Foundation Trust	94.4%	70.7%
Derbyshire Community Health Services NHS Foundation Trust	70.1%	70.7%
Derbyshire Healthcare NHS Foundation Trust	96.0%	70.7%
Lincolnshire County Council*	94.5%	70.7%
Lincolnshire Partnership NHS Foundation Trust	86.3%	70.7%
Nottingham City Council	100.0%	70.7%
Nottingham University Hospitals NHS Trust*	94.2%	70.7%
Nottinghamshire County Council	93.1%	70.7%
Nottinghamshire Healthcare NHS Foundation Trust	94.0%	70.7%
Sherwood Forest Hospitals NHS Foundation Trust*	98.0%	70.7%
United Lincolnshire Teaching Hospitals NHS Trust	70.0%	70.7%
University Hospitals of Derby and Burton NHS Foundation Trust*	98.7%	70.7%

* = Low Activity

Source: [NHS Data Quality Maturity Index \(DQMI\)](#)

2% (or more) lower than the national average

Within 2% of the national average

2% (or more) higher than the national average

DLN – Ethnicity Data Quality Maternity Services Dataset



NHS Provider	Ethnicity Data Quality % (February 2026)	National % (February 2026)
Chesterfield Royal Hospital NHS Foundation Trust	100.0%	99.0%
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	100.0%	99.0%
Nottingham University Hospitals NHS Trust	93.5%	99.0%
Sherwood Forest Hospitals NHS Foundation Trust*	98.8%	99.0%
United Lincolnshire Teaching Hospitals NHS Trust	98.7%	99.0%
University Hospitals of Derby and Burton NHS Foundation Trust	98.4%	99.0%

* = Low Activity

Source: [NHS Data Quality Maturity Index \(DQMI\)](#)



DLN – Ethnicity Data Quality Outpatients Dataset

NHS Provider	Ethnicity Data Quality % (February 2026)	National % (February 2026)
Chesterfield Royal Hospital NHS Foundation Trust	96.2%	72.0%
Derbyshire Community Health Services NHS Foundation Trust*	93.7%	72.0%
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	96.2%	72.0%
Nottingham University Hospitals NHS Trust	82.5%	72.0%
Sherwood Forest Hospitals NHS Foundation Trust	98.1%	72.0%
United Lincolnshire Teaching Hospitals NHS Trust	81.4%	72.0%
University Hospitals of Derby and Burton NHS Foundation Trust	96.0%	72.0%

* = Low Activity

Source: [NHS Data Quality Maturity Index \(DQMI\)](#)

2% (or more) lower than the national average

Within 2% of the national average

2% (or more) higher than the national average

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	16/07/2026
Paper title:	Risk Management Policy
Paper reference:	ICB CIC 26 038
Paper author:	Lucy Branson, Director of Corporate Governance and Assurance Siân Gascoigne, Assistant Director of Corporate Affairs, NHS Nottingham and Nottinghamshire ICB
Paper sponsor:	Amanda Sullivan, Chief Executive
Presenter:	Lucy Branson

Paper type:
For assurance ☐ For decision ☒ For discussion ☐ For information ☐

Report summary:
Since approval of the joint Risk Management Policy in November 2025, the three ICBs have continued to develop a consistent approach to risk management across the Derbyshire, Lincolnshire and Nottinghamshire partnership. Following a joint Board development session on risk appetite in June 2026, the policy has been reviewed and updated to strengthen the risk appetite framework, revise risk domains, enhance risk scoring arrangements, clarify governance and accountabilities, and align with current good practice. The updated policy provides a clearer and more consistent framework for the identification, assessment, escalation and management of strategic and operational risks across the three ICBs.

Recommendation(s):
The Boards are asked to approve the ICBs' updated Risk Management Policy.

Board Assurance Framework
This paper provides assurance in relation to the management of the following ICB strategic risk(s): • Failure to develop and maintain a comprehensive, evidence-based understanding of local population health needs • Failure to deliver a coordinated transformation of commissioned services, including prevention, community care models, and digital enablement • Failure to involve people and communities meaningfully in commissioning and service design • Failure to allocate resources effectively and shape provider markets to deliver value, productivity and system priorities • Failure to commission services through effective procurement and contract management arrangements, compromising financial sustainability • Failure to systematically improve the quality of healthcare services

Board Assurance Framework

- Failure to ensure timely and equitable access to healthcare services in line with national and local performance standards
- Failure to develop and deploy an effective ICB cluster operating model with the necessary workforce skills and capabilities for strategic commissioning
- Failure to maintain cyber resilience

Relevant statutory duties:

☒ Quality improvement	☒ Public involvement and consultation
☒ Reducing inequalities	☒ Equality and diversity
☒ Financial limits/ breakeven	☒ Effectiveness, efficiency and economy
☒ Integration of services	☒ Wider effect of decisions (triple aim)
☒ Promoting innovation	☒ Promoting research
☒ Patient choice	☒ Obtaining appropriate advice
☒ Promoting education/training	☒ Climate change

Appendices

Appendix 1: Risk Management Policy (DLN-GOV-001 Version 2.0)

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Risk Management Policy

Introduction and context

1. Since the Boards approved the joint Risk Management Policy in November 2025, significant progress has been made in establishing a consistent cluster-wide approach to risk management across NHS Derby and Derbyshire, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire ICBs.
2. This has included implementation of a joint Board Assurance Framework (BAF) and Operational Risk Register (ORR), strengthened risk ownership arrangements, staff training programmes and more consistent risk reporting through formal governance structures. At the time of approval, the Boards agreed that the interim joint risk appetite statement would be reviewed once the partnership arrangements had become more established. This review was undertaken during the joint Board development session on 18 June 2026.
3. The development session considered the nature of risk within a strategic commissioning environment and recognised that achieving improved outcomes, reducing inequalities and maintaining long-term sustainability requires informed decision-making in conditions of uncertainty. Board members acknowledged that both change and inaction carry risk; whilst transformation can introduce short- to medium-term risks, failing to adapt may also adversely affect quality, access, outcomes and overall system performance. The discussion highlighted the importance of a risk management framework that supports informed and proportionate risk-taking, provides greater clarity regarding risk appetite and escalation, and promotes a culture where well-managed risks can be taken to support improvement and innovation.
4. The outcomes of the session have informed a comprehensive review of the joint Risk Management Policy, resulting in proposed updates to the ICBs' risk appetite framework, risk domains, tolerances and supporting risk management arrangements. The updated policy is attached for Board consideration and approval.

Key policy changes

5. The policy has been comprehensively reviewed to reflect the outcomes of the Boards' development session, the maturity of the ICBs' partnership arrangements, developments in good practice and relevant national guidance. The key changes are:
 - a) Introduction of a revised risk appetite framework, including defined appetite levels, risk tolerances and target risk score ranges.

- b) Revision of the risk domains to better reflect the role of the ICBs as strategic commissioners.
- c) Enhancement of the Risk Scoring Matrix through the introduction of revised domain-specific impact descriptors to support more consistent risk assessment and reporting.
- d) Strengthening of governance arrangements to clarify the management of sovereign and partnership risks whilst maintaining the statutory accountability of each ICB.
- e) Clarification of roles, responsibilities and accountabilities across Boards, committees, executives, risk owners and supporting functions.
- f) Enhancement of guidance relating to the risk management lifecycle, including risk identification, assessment, treatment, escalation, monitoring and reporting arrangements.
- g) Streamlining of policy content to improve clarity, consistency and usability, whilst strengthening alignment with ISO 31000 and wider governance best practice.

Revised risk appetite framework

- 6. The revised risk appetite framework has been simplified and aligned to seven strategic risk domains, providing a clearer basis for risk assessment, escalation and assurance across the three ICBs.
- 7. The framework adopts a **cautious** appetite for the 'Quality and Access' and 'Legal and Regulatory Compliance' risk domains, reflecting the Boards' limited tolerance for risks that may adversely affect patient safety, service quality or statutory compliance.
- 8. An **open** appetite has been applied to the 'Health Outcomes and Inequalities', 'Workforce and Organisational Capability', 'Financial Sustainability and Resource Allocation', and 'Partnerships and Social Value' risk domains, recognising the need to balance risk and opportunity in delivering strategic objectives and improving population outcomes.
- 9. An **eager** appetite has been adopted for the 'Planning and Transformation' risk domain, recognising that innovation, service redesign and long-term improvement require managed risk-taking in conditions of uncertainty.
- 10. The framework is supported by defined risk tolerance ranges and an updated Risk Scoring Matrix aligned to the revised domains, promoting greater consistency in risk assessment, escalation and decision-making. Overall, the framework better reflects the role of the ICBs as strategic commissioners and supports informed and proportionate risk-taking within agreed levels of risk appetite and tolerance.

Summary and next steps

11. The revised policy strengthens the ICBs' risk management framework by aligning risk appetite, risk domains, tolerance ranges and risk scoring methodologies within a single, consistent approach to strategic and operational risk management. The changes support more consistent identification, assessment, escalation and management of risk across the three ICBs.
12. Subject to Board approval, the updated framework will be embedded within existing risk management arrangements, including the Board Assurance Framework and Operational Risk Register, with implementation and ongoing effectiveness overseen through the Audit Committees.

Risk Management Policy

July 2026 – July 2029

Policy purpose and key messages
This joint policy sets out how NHS Derby and Derbyshire Integrated Care Board (ICB), NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB manage strategic and operational risks through a common risk management framework developed in support of their formal partnership arrangements. The policy promotes a positive risk culture and supports informed decision-making by establishing consistent arrangements for the identification, assessment, management, escalation and monitoring of risks across the three ICBs. It defines the ICBs' approach to risk appetite and tolerance, outlines the governance, roles and responsibilities that support effective risk management, and describes how strategic, operational and local risks are managed through the Board Assurance Framework, Operational Risk Register, and Risk Logs. The policy supports organisational resilience, delivery of strategic objectives and statutory duties, and provides assurance to Boards, patients, partners and the public that risks are being managed appropriately and proportionately.

CONTROL RECORD	
Title	Risk Management Policy
Reference number	DLN-GOV-001
Version	2.0
Status	Draft
Author	Director of Corporate Governance and Assurance, supported by the Risk Management Team
Sponsor	Amanda Sullivan, Chief Executive
Team	Corporate Governance and Assurance
Amendments	General streamlining of content as appropriate to policy requirements. Specific updates to the ICBs' risk appetite framework and risk domains, following review by the Boards. Associated updates to the Risk Scoring Matrix in Appendix B to align with updated risk domains.
Superseded documents	DLN-GOV-001 Risk Management Policy v1.2
Audience	All staff within NHS Derby and Derbyshire Integrated Care Board, NHS Lincolnshire Integrated Care Board, and NHS Nottingham and Nottinghamshire Integrated Care Board.
Consulted with	Board members
Equality Impact Assessment	September 2025
Approving body	Boards of NHS Derby and Derbyshire Integrated Care Board, NHS Lincolnshire Integrated Care Board, and NHS Nottingham and Nottinghamshire Integrated Care Board
Date approved	To be confirmed
Date of issue	July 2026
Review date	July 2029
Policy retention period	Life of organisations plus six years
This is a controlled document and whilst this policy may be printed, the electronic version available on the ICBs' document management system is the only true copy. As a controlled document, this document should not be saved onto local or network drives.	

Table of Contents

1. Introduction	1
2. Purpose	1
3. Scope.....	2
4. Definitions	2
5. Roles and responsibilities	2
6. Risk appetite and tolerance	4
7. Strategic risk management	7
8. Operational risk management.....	8
9. Risk logs	8
10. Risk management lifecycle	9
11. Fraud risks	13
12. Information risks	14
13. Performance against key delivery priorities	14
14. Management of issues.....	15
15. Equality and diversity statement	15
16. Communication, monitoring and review	15
17. Confidentiality	16
18. Staff training.....	16
19. Interaction with other policies.....	16
20. References	17
21. Equality Impact Assessment.....	18
Appendix A: Definitions and Glossary of Terms.....	22
Appendix B: Risk Scoring Matrix	25

1. Introduction

- 1.1 This is a joint Risk Management Policy of NHS Derby and Derbyshire Integrated Care Board (ICB), NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB ("the ICBs"). The policy has been developed in accordance with the formal partnership arrangements established between the ICBs and sets out a common framework for risk management that enables consistent oversight, assurance and reporting across the organisations, whilst preserving the statutory sovereignty and accountability of each ICB.
- 1.2 The ICBs recognise that effective risk management is essential to the achievement of strategic objectives, the discharge of statutory duties, and the delivery of safe, effective and sustainable services. Effective risk management supports informed decision-making, organisational resilience and the provision of assurance to Boards and stakeholders.
- 1.3 Whilst operating within a formal partnership arrangement, each ICB remains a separate statutory body accountable for its own governance and decision-making. Risk management arrangements therefore support the management of both sovereign risks, which are specific to an individual ICB, and joint risks, where the causes, consequences, controls or mitigations extend across more than one ICB. Definitions of sovereign and joint risks are provided in Appendix A.
- 1.4 Risk management is an integral part of organisational governance, planning, transformation, programme delivery and day-to-day operations. All employees, officers and members share responsibility for identifying and managing risks within their area of responsibility.
- 1.5 The ICBs are committed to maintaining proportionate and effective risk management arrangements that support a positive risk culture and informed risk-taking within agreed levels of risk appetite and tolerance.
- 1.6 This policy is supported by associated procedures, guidance and risk management tools and is aligned to the principles of ISO 31000:2018 Risk Management Guidelines.

2. Purpose

- 2.1 This policy describes the approach of the ICBs to the management of strategic and operational risks across the respective statutory organisations.
- 2.2 The purpose of this policy is to encourage a culture where risk management is viewed as an essential process of the activities of the ICBs. It provides assurance to the public and partner organisations that the ICBs are committed to managing risk appropriately.
- 2.3 This policy aims to achieve several key objectives, including to:

- a) Outline the benefits of risk management.
- b) Explain the risk appetite and approach to tolerance within the ICBs.
- c) Set out the ambition of the ICBs to continuously improve risk management arrangements.
- d) Outline the approach to implementation and monitoring.
- e) Describe the relevant compliance and assurance arrangements regarding risk management within the ICBs.
- f) Ensure there is a robust system in place to manage risk effectively.

3. Scope

- 3.1 This policy covers all employees, including Members of the ICBs' Boards, those appointed by the ICBs, and anyone working within the ICBs on a temporary basis or under a contract for services (either individually or through a third-party supplier), collectively referred to as "individuals".

4. Definitions

- 4.1 Definitions and a glossary of terms referenced in this policy are described in Appendix A.

5. Roles and responsibilities

- 5.1 Accountability for managing risks rests with strategic and operational leaders across the ICBs. Governance forums provide oversight and assurance, whilst the Risk Management Team facilitates the operation of the framework and supports its consistent application. Key responsibilities for specific roles and forums are described in the table below:

Role / Forums	Responsibilities
Boards	The Boards retain overall accountability for the effectiveness of risk management within their respective organisations. The Boards approve the Risk Management Policy, Risk Appetite Statement and Board Assurance Framework, determine whether strategic risks are being managed within agreed risk appetite, and seek assurance that appropriate controls, mitigations and governance arrangements are in place to support the achievement of strategic objectives and statutory duties.
Audit Committees	The Audit Committees provide independent assurance to the Boards regarding the adequacy and effectiveness of the ICBs' risk management framework, systems of internal control and assurance processes. The Committees scrutinise the robustness of arrangements relating to the Board Assurance Framework and

Role / Forums	Responsibilities
	Operational Risk Register and advise the Boards on the effectiveness of risk management arrangements. The Committees do not own or manage risks.
Committees of the Boards	All committees of the Boards are responsible for overseeing strategic and operational risks related to their delegated responsibilities as outlined within their respective terms of reference. This will include monitoring the progress of actions, robustness of controls and timeliness of mitigations. They are also responsible for identifying risks that arise during meeting discussions and ensuring that these are captured on the Operational Risk Register.
Executive Management Team	The Chief Executive has overall responsibility for maintaining a sound system of internal control in support of the ICBs' aims, objectives, and duties. Executive Directors are responsible for ensuring effective systems of risk management, commensurate with this policy, are in place within their respective Directorates. Working collectively, the Executive Management Team (EMT) promotes the risk culture within the ICBs and provides executive oversight of strategic and operational risks. The EMT ensures appropriate ownership and management of risks, scrutinises the effectiveness of mitigating actions, and monitors trends to support proactive risk management and continuous improvement.
Senior Leadership Team	Members of the Senior Leadership Team are responsible for leading risk management arrangements within their teams, which includes, but is not limited to, ensuring that: • Risk Logs are in place, as appropriate, to support delivery of team, place and project/programme objectives. • Operational risks are appropriately escalated from Risk Logs to the Operational Risk Register. • Mitigating actions are in place to manage risks in line with the risk appetite statement. • Staff are suitably trained in relation to risk management.
Risk Owners	Risk Owners are responsible for the effective management of the risks assigned to them. They are responsible for ensuring risks remain accurately described and assessed, controls and mitigations are effective, actions are progressed, and risk records are reviewed and updated in accordance with agreed timescales.
Director of Corporate Governance and Assurance / Risk Management Team	The Director of Corporate Governance and Assurance leads on the implementation of corporate governance and risk and assurance systems across the ICBs. They are supported by a Risk Management Team that facilitates the operation of the risk management framework. The Risk Management Team provides specialist advice, training and support, maintains the Board Assurance Framework and Operational Risk Register, coordinates reporting and review processes, and promotes consistent application of this policy. The Risk Management Team does not own risks or mitigations, which remain the responsibility of designated risk owners.

Role / Forums	Responsibilities
Senior Information Risk Owner	The Senior Information Risk Owner (SIRO) provides Board-level leadership for information risk management and is accountable for ensuring that information risks are appropriately identified, managed and escalated. The SIRO provides assurance to the Boards on the effectiveness of information risk management arrangements and compliance with relevant information governance requirements.
Information Asset Owners	Information Asset Owners (IAOs) are responsible for the management of information risks associated with the information assets under their control. They ensure appropriate controls are in place to protect information, identify emerging risks and incidents, and escalate significant information risks through established governance arrangements.
Information Governance, Data Protection and Cyber Steering Group	Oversees information governance, cyber security and data protection risks and ensures significant information risks are escalated through appropriate governance arrangements.
Individuals	All individuals have a responsibility to identify, manage and report risks arising from their activities and to comply with this policy. Risk considerations should form part of routine decision-making, planning, service delivery, programme management and procurement activities.

6. Risk appetite and tolerance

- 6.1 The ICBs recognise that the achievement of their strategic objectives and statutory responsibilities requires informed and proportionate risk-taking. Risk appetite defines the level and type of risk that the ICBs are willing to accept in pursuit of their objectives and in the interests of improving health outcomes, reducing health inequalities, and commissioning sustainable health services for the populations they serve.
- 6.2 The ICBs are committed to managing risk in a manner that supports innovation, transformation and continuous improvement whilst ensuring that risks are understood, appropriately controlled and remain within agreed levels of tolerance. The ICBs do not seek to eliminate all risk; rather, they seek to make informed decisions that balance potential opportunities and benefits against potential adverse impacts.
- 6.3 A common risk appetite framework has been adopted across the ICBs in support of their formal partnership arrangements. The framework provides a consistent basis for decision-making, prioritisation, escalation and assurance, whilst recognising that each ICB remains responsible for the management of its own sovereign risks and statutory responsibilities.
- 6.4 The Boards approve the risk appetite framework and ensure that it is considered when:

- a) Setting strategic objectives and priorities.
- b) Making significant decisions and investments.
- c) Assessing strategic and operational risks.
- d) Determining the need for additional controls or mitigating actions.
- e) Considering whether risks require escalation through governance arrangements.

6.5 Risk tolerance represents the level of residual risk that the ICBs are willing to accept following the implementation of controls and mitigating actions. Risk tolerance is expressed through target risk score ranges, which provide a practical mechanism for applying the risk appetite framework and determining whether further action is required to reduce risk exposure. The risk appetite matrix and associated risk domain tolerances should be used to support consistent risk assessment, management, escalation and reporting.

6.6 The ICBs' risk appetite is described using five categories, ranging from Averse (little or no appetite for risk) to Significant (high appetite for risk where strong controls and assurance arrangements exist). The associated target risk score ranges provide an indication of the level of residual risk that may be tolerated within each category.

Risk appetite level	Description	Target risk score range*
Averse	Preference for ultra-safe delivery options that avoid or minimise risk as much as possible.	1-5
Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	4-10
Open	Willing to consider all potential delivery options while also providing an acceptable level of reward (and value for money).	8-15
Eager	Seek to be innovative and to choose options offering potentially higher rewards with greater uncertainty (i.e. despite greater inherent risk).	15-20
Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.	25

* Note that there is some overlap in the risk tolerance ranges, as the scores depend on whether the impact or likelihood score is higher. For example, the risk appetite may be classified as 'averse' if the risk is scored as Impact 5 x Likelihood 1, or 'cautious' if the risk is scored as Impact 1 x Likelihood 5.

6.7 The ICBs have determined their appetite and corresponding target risk score ranges across the principal risk domains set out below. These should be used

when assessing risks, determining the appropriateness of mitigating actions, and considering whether risks remain within acceptable limits.

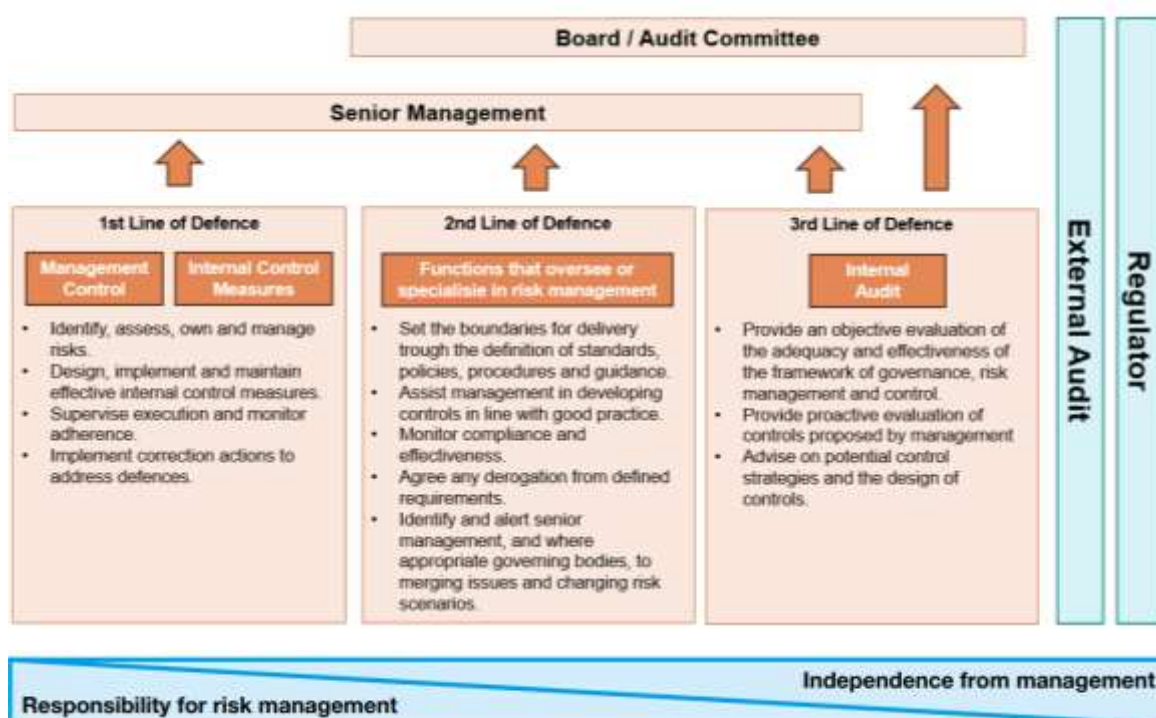
Risk domain	Risk appetite level	Target risk score range
Quality and Access: Risks that people do not receive safe, effective, high-quality and timely care due to failures in quality oversight, service access, capacity, performance or patient experience.	Cautious	4-10
Legal and Regulatory Compliance: Risks of non-compliance with legislation, statutory duties, regulatory requirements, or other mandatory obligations, resulting in enforcement action, legal challenge or loss of public confidence.	Cautious	4-10
Health Outcomes and Inequalities: Risks that the ICBs fail to improve population health outcomes or reduce health inequalities, including failure to target interventions effectively, address unwarranted variation, deliver prevention activity, or achieve improvements in health and wellbeing for the populations served.	Open	8-15
Workforce and Organisational Capability: Risks that the ICBs lack the workforce capacity, capability, leadership, culture or organisational resilience required to deliver its objectives and statutory responsibilities effectively.	Open	8-15
Financial Sustainability and Resource Allocation: Risks that the ICBs fail to achieve financial sustainability or maximise value from available resources, including ineffective resource allocation, poor productivity, inefficiencies, commissioning decisions or inability to meet financial duties.	Open	8-15
Partnerships and Social Value: Risks arising from ineffective leadership, collaboration or stakeholder engagement, leading to reduced system effectiveness, failure to deliver shared objectives, loss of confidence, reputational damage, or reduced social value.	Open	8-15
Planning and Transformation: Risks that the ICBs are unable to effectively plan, design and deliver services, programmes and transformation required to meet current and future population needs, including implementation of new care models, service redesign, strategic planning and major change initiatives.	Eager	15-20

- 6.8 It is recognised that some risks may not be capable of being reduced to the target risk score range. In these circumstances, the focus should be on ensuring that all reasonably practicable controls are in place, that the reasons for the residual exposure are clearly understood, and that appropriate contingency arrangements and governance oversight are maintained.

- 6.9 The risk appetite framework is reviewed periodically by the Boards to ensure that it remains appropriate to the operating environment, strategic priorities and the needs of the populations served.

7. Strategic risk management

- 7.1 Strategic risks are high-level risks that are pro-actively identified and threaten the achievement of the ICB's strategic objectives and key statutory duties. Strategic risks, which are explicitly linked to one or more Board-approved strategic objective, are owned by members of the Executive Management Team and outlined within the Board Assurance Framework (BAF) of the ICBs.
- 7.2 The BAF provides the Boards with confidence that strategic risks have been identified and there are robust systems, policies and processes in place (*controls*) that are effective and driving the delivery of their objectives. It provides confidence and evidence to demonstrate that what needs to be happening is actually happening in practice (*assurances*).
- 7.3 The BAF aligns with the three lines of defence model, where operational management (first line) manages risks day-to-day, oversight functions such as risk and governance teams (second line) provide monitoring and challenge, and internal audit (third line) provides independent assurance. This alignment ensures clear accountability and supports the Boards in making informed decisions on the management of strategic risks.



- 7.4 The BAF plays a key role in informing the production of the ICBs' annual Governance Statements and is the main tool that the Boards should use in discharging overall responsibility for ensuring that an effective system of internal control is in place.
- 7.5 Assurance provides evidence that risks to objectives are being appropriately managed and controlled. Its purpose is to give confidence that risks are effectively mitigated, with higher levels of assurance reflecting greater confidence in risk management. Risk owners and leads achieve this by conducting in-depth assessments of the evidence supporting risk controls. While it is not possible to provide complete or absolute assurance, the concept of positive and negative assurance is applied: positive assurance indicates that controls are effective and risks are being managed as intended, whereas negative assurance indicates that controls are not effective, and risks may not be adequately mitigated.

8. Operational risk management

- 8.1 Operational risks are risks arising from day-to-day activities that may adversely affect the delivery of organisational priorities, statutory duties or operational objectives.
- 8.2 Operational risk management relies upon reactive identification of risks, which are 'dynamic' in nature. Operational risks are managed via additional mitigations and are captured on the Operational Risk Register.
- 8.3 The Operational Risk Register is the central repository for the three ICBs' operational risks. Whilst risks will feature across several processes, it is important that these are captured centrally to provide a comprehensive log of prioritised risks that accurately reflect the risk profiles of the ICBs.
- 8.4 The Operational Risk Register contains details of the risk, the current controls in place and an overview of the actions required to mitigate the risk to the desired level. A named individual (risk owner) is given responsibility for ensuring that mitigating actions are completed by the specified due dates.

9. Risk logs

- 9.1 Risk logs are used to record operational risks at individual team, directorate and programme/project-level.
- 9.2 Oversight of risk logs is the responsibility of the relevant senior manager, who may choose to review them within project or team meetings. Risks that could impact the achievement of ICB priorities must be escalated to the Operational Risk Register. As risk logs are maintained at team or project level, a risk reaching a medium or high score should prompt review and discussion but will

not necessarily result in automatic escalation. This reflects the distinction between risks assessed against team-level objectives and those affecting ICB-wide objectives recorded on the Operational Risk Register. An optional risk log template and guidance, and support on risk logs and escalation, are available from the Risk Management Team.

- 9.3 Directorates may maintain their risk logs using local formats that meet their operational needs. However, all risk logs must apply the ICBs' 5x5 risk scoring matrix, as set out in this policy, to ensure consistency in the identification, assessment, and reporting of risks across the organisations. Risk scores must be derived using the standard definitions of likelihood and impact, enabling comparability and appropriate escalation of risks to the Operational Risk Register where required.

10. Risk management lifecycle

- 10.1 The risk management lifecycle applies to both strategic and operational risks. Whilst the underlying principles remain consistent, strategic risks are managed through the Board Assurance Framework and focus on risks to the achievement of strategic objectives and statutory duties. Operational risks are managed through the Operational Risk Register and Risk Logs and focus on risks arising from day-to-day delivery of services, programmes, and organisational functions.
- 10.2 The main elements of the risk management lifecycle are described below.

Objectives and context

- 10.3 Risks must be identified, assessed and managed in the context of clearly defined objectives. Each risk should be linked to a strategic, operational or local objective to ensure that the potential impact of the risk can be properly understood and managed.
- 10.4 The table below sets out the relationship between organisational objectives, governance arrangements and risk recording mechanisms.

Objective	Oversight	Recording	Risk management role
Strategic	Boards	Board Assurance Framework	Risks are linked to the agreed strategic objectives of the ICBs relating to their role as a strategic commissioner. Updates and assurance are provided by executives to the Boards to support oversight and decision-making.
Operational	Committees of the Boards	Operational Risk Register	Co-ordinated through the Risk Management Team, operational risks relate to high-level corporate priorities

Objective	Oversight	Recording	Risk management role
			and statutory functions. Risk owners provide updates and assurance on mitigation and control measures. Risks can be joint or sovereign ICB risks.
Local	Directorate/ Programme	Risk Log	Managed locally within teams in line with their directorate, team, or programme objectives. Teams identify and monitor risks to achieving these priorities/objectives. Risks may be escalated to the Operational Risk Register through review discussions with the Risk Management Team and relevant senior managers.

Risk identification

- 10.5 Strategic risks are identified proactively by the Boards through consideration of strategic planning processes, environmental scanning, transformation activity, performance and assurance reporting, and consideration of risks to the achievement of strategic objectives and statutory duties. Strategic risks are recorded within the Board Assurance Framework.
- 10.6 Operational risks are identified through day-to-day management activities, including risk assessments, audit findings, incidents, complaints, project delivery, performance monitoring and horizon scanning. Operational risks are recorded within the Operational Risk Register and Risk Logs, as appropriate.
- 10.7 Risks should be identified as early as possible and reviewed regularly to ensure that emerging threats or opportunities are recognised and managed appropriately.
- 10.8 The Boards, their committees, and management teams should consider new and emerging risks as part of their routine business as appropriate.

Risk articulation

- 10.9 Risks should be described clearly and consistently using the cause-event-effect model shown below.

Risk element	Question	Consideration	Wording
Cause	What will cause the risk to occur?	Risks may arise from strategic uncertainties, external factors, operational activities or specific events that could affect the achievement of objectives.	Where the cause is known, use: “As a result of...” . If the cause is uncertain, hypothetical, or conditional, it

Risk element	Question	Consideration	Wording
			may be appropriate to use: "If...".
Event	What can go wrong?	The risk event is the specific thing that could go wrong, potentially disrupting operations or objectives.	There is a risk
Effect	What will be the consequence/ effect if the risk were to materialise?	Risks may negatively impact the organisation and its ability to achieve objectives. The specific objective at risk should be reflected in the wording.	Which may lead to

Risk assessment

- 10.10 Risks should be assessed using the ICBs' 5x5 risk scoring matrix (shown in Appendix C), considering both impact and likelihood.
- 10.11 Impact should be assessed against the relevant objective affected by the risk, while likelihood should be assessed against the probability of the risk materialising within the next 12 to 18 months.
- 10.12 Strategic risks should additionally be assessed with reference to the effectiveness of existing controls, available assurances, and any identified gaps in control or assurance. Operational risks should be assessed with reference to current controls, mitigating actions and residual risk exposure.
- 10.13 Risk scores should be reviewed periodically to ensure that they remain accurate and proportionate. Where appropriate, risk scores may be challenged through management review, governance processes or committee oversight.

Risk treatment

- 10.14 Risk treatment is the process of determining how a risk will be managed. The ICBs adopt the 4T model of risk treatment (terminate, treat, transfer or tolerate), as set out in the table below.

Treatment	Description
Terminate	Opt not to take the risk by terminating the activities that will cause it (more applicable to project risks).
Treat	Take mitigating actions that will minimise the impact of the risk prior to its occurrence and/or reduce the likelihood of the risk occurring.
Transfer	Transfer the risk, or part of the risk, to a third party.

Treatment	Description
Tolerate	Accept the risk and take no further actions. This may be due to the cost of risk mitigation activity not being cost effective or the impact is so low it is deemed acceptable to the organisation. Risks which are tolerated should continue to be monitored as future changes may make the risk no longer tolerable.

- 10.15 Risk owners should implement appropriate treatment actions to reduce risks to a level consistent with the ICBs' risk appetite and target risk score ranges.
- 10.16 For strategic risks, treatment may include strengthening strategic controls, obtaining additional assurance, implementing transformation programmes, revising strategic plans, or enhancing governance arrangements.
- 10.17 Where a risk cannot reasonably be reduced further, it may be accepted through the appropriate governance process provided that the residual exposure is understood and appropriate oversight arrangements remain in place.

Monitoring and reporting

- 10.18 Monitoring risk is a continuous activity that results in the awareness of what is happening across the organisations. Risks are required to be reviewed regularly to ensure that controls remain effective, mitigating actions are delivered, and risk scores remain accurate.
- 10.19 Medium scoring risks are required to be reviewed at least quarterly, with high scoring risks reviewed at least bi-monthly, and extreme scoring risks reviewed at least monthly.
- 10.20 Strategic risks are monitored through the Board Assurance Framework and operational risks are monitored through the Operational Risk Register and Risk Logs.
- 10.21 The BAF will be reported to the Boards twice yearly. This will be supported by bi-annual reporting of the relevant strategic risks to their lead committees. These reports will facilitate the review of controls, assurances, gaps in control and assurance, progress against actions and changes in risk exposure. The Audit Committees will also have a key role in providing independent oversight of the effectiveness of the ICBs' strategic risk management processes through bi-annual risk management reports.
- 10.22 Operational Risk Register reporting arrangements are set out below:
- The ICBs' Boards will oversee all risks with an overall score of 15 or above at each of its meetings.

- b) Committees of the Boards will oversee all risks relevant to their remit with an overall score of 8 or above at each of their meetings.
- c) The Executive Management Team will receive all risks with an overall score of 8 or above on a quarterly basis to support effective matrix working, cross-portfolio visibility, and collective oversight of emerging themes.
- d) The **Audit Committees** will receive bi-annual risk management updates, which will enable any risk themes and trends to be reviewed. This will support their duty to provide the Boards with assurance on the robustness and effectiveness of the ICB's risk management processes.

Archiving of risks

10.23 Archiving risks within the ICBs is a structured process designed to ensure that the risk register remains current, relevant, and aligned with the evolving operational landscape.

10.24 Risks may be archived where:

- a) The risk no longer exists or is no longer relevant.
- b) The risk has been adequately mitigated.
- c) The risk has reduced to an agreed target risk score.
- d) Responsibility for the risk has transferred.
- e) The risk is better managed through an alternative governance mechanism.

10.25 Strategic risks may also be removed from the Board Assurance Framework where the associated objective has been achieved, the risk no longer threatens achievement of the objective, or the risk is more appropriately managed through operational risk management arrangements.

10.26 The rationale for archiving must be recorded and archived risks must be retained for audit and assurance purposes.

11. Fraud risks

11.1 The Government Functional Standard 013: Counter Fraud "Management of counter fraud, bribery and corruption activity" has applied to NHS organisations since April 2021. The standard is part of a suite of standards that promotes consistent and coherent ways of working across government, and provides a stable basis for assurance, risk management and capability improvement.

- 11.2 The NHS Counter Fraud Authority (NHSCFA) is a health authority charged with identifying, investigating and preventing fraud and other economic crime within the NHS. The NHSCFA requires the organisation to undertake a local risk assessment to identify fraud, bribery and corruption risks and to ensure these are recorded and managed in line with its risk management policy.
- 11.3 A separate joint fraud risk register will be maintained by the ICBs and reported to the Audit Committees once a year (as a minimum), to coincide with the Counter Fraud annual planning process.

12. Information risks

- 12.1 Information risk management is led by the Senior Information Risk Owner (SIRO) who is responsible for ensuring that information risks are effectively identified, assessed, and managed. The SIRO also ensures the organisation maintains compliance with all relevant legislation, including the Data Protection Act 2018, UK General Data Protection Regulation (UK GDPR), the Human Rights Act 1998, and other applicable information security and cybersecurity requirements.
- 12.2 The organisations recognise that information risks can arise from the loss, misuse, unauthorised access, or failure to protect information, whether in digital or physical form. These risks can impact the confidentiality, integrity, and availability of information, and must be managed through appropriate controls. Several arrangements are in place to support, manage and mitigate information risks which include, but are not limited to, the Information Asset and Data Flow Mapping registers, information governance incident management arrangements, and Data Protection Impact Assessments (DPIAs).

13. Performance against key delivery priorities

- 13.1 The ICBs monitor performance against key delivery priorities via a separate, but parallel, process to the risk management arrangements.
- 13.2 To minimise duplication, failures to achieve performance standards are not routinely identified as specific risks on the Operational Risk Register. This should not indicate its absence from the organisations' overall risk profile and poor performance from a risk perspective will be referenced as necessary when reporting externally on risks.
- 13.3 The consistent non-delivery of performance standards will be assessed to ensure that any specific risks this poses to the functions of the ICBs (e.g., a detrimental impact on health outcomes, patient safety or experience) are identified and captured on the Operational Risk Register.

14. Management of issues

- 14.1 An issue is a current problem, concern, or event that has already materialised and is impacting the organisations. Unlike a risk, which refers to a potential future event with uncertain outcomes, an issue represents something that is happening now and requires immediate attention or resolution.
- 14.2 Issues are not routinely recorded on the Operational Risk Register as they are managed via the performance management framework. However, senior leads/managers may use discretion as to whether local issues are captured on individual risk logs.
- 14.3 Known issues are an important mechanism to determine if there are any new risks needed to be identified, and captured, within the risk management arrangements.

15. Equality and diversity statement

- 15.1 The ICBs pay due regard to the requirements of the Public Sector Equality Duty (PSED) of the Equality Act 2010 in policy development and implementation, as commissioners and providers of services, as well as employers.
- 15.2 The ICBs are committed to ensuring that the way services are provided to the public and the experiences of staff does not discriminate against any individuals or groups on the basis of their age, disability, gender identity (trans, non-binary) marriage or civil partnership status, pregnancy or maternity, race, religion or belief, gender or sexual orientation.
- 15.3 The ICBs are committed to ensuring that activities also consider the disadvantages that some people in the diverse population experience when accessing health services. Such disadvantaged groups include people experiencing economic and social deprivation, carers, refugees and asylum seekers, people who are homeless, workers in stigmatised occupations, people who are geographically isolated, Gypsies, Roma, and Travellers.
- 15.4 To help ensure that these commitments are embedded in day-to-day working practices, an Equality Impact Assessment has been completed, and is included within this policy.

16. Communication, monitoring and review

- 16.1 This policy will be published and maintained in line with the ICBs' Policy Management Framework.

- 16.2 The policy will be highlighted to new staff as part of the local induction process and made available to all staff through internal communication procedures (and internet/intranet sites).
- 16.3 The Audit Committees will review the effectiveness of this policy, and its implementation, via bi-annual risk management update reports.
- 16.4 Any individual who has queries regarding the content of this policy or has difficulty understanding how this policy relates to their role, should contact the Risk Management Team.

17. Confidentiality

- 17.1 Risk-related information will be managed in accordance with the ICBs' information governance policies and relevant data protection legislation. Access to confidential information will be restricted to those with a legitimate business need and handled in a manner appropriate to its sensitivity.
- 17.2 All individuals are responsible for maintaining the confidentiality of risk information and ensuring it is recorded, stored and shared appropriately.
- 17.3 Where disclosure of a risk may not be in the public interest, the risk may be managed through confidential governance arrangements. Such arrangements should be applied only where necessary and reviewed periodically to ensure continued appropriateness.

18. Staff training

- 18.1 The ICBs are committed to ensuring that individuals have the knowledge and understanding necessary to fulfil their responsibilities under this policy. Appropriate risk management training, guidance and support will be made available to promote the consistent application of risk management principles and processes across the organisations.
- 18.2 Individuals are responsible for familiarising themselves with the requirements of this policy and participating in any training or development activity relevant to their role. Managers should ensure that staff are appropriately supported to discharge their risk management responsibilities.
- 18.3 The effectiveness of risk management training and awareness arrangements will be reviewed periodically as part of the ICBs' broader review of risk management processes and organisational assurance arrangements.

19. Interaction with other policies

- 19.1 This policy should be read alongside the following related ICB policies:
 - a) Standard of Business Conduct Policy.

- b) Health and Safety Policies.
- c) Information Governance Policies.

20. References

20.1 The following references have been used in the formulation of this policy:

- a) HM Treasury. (2012). Assurance Frameworks. London: HM Government.
- b) National Patient Safety Agency (NPSA). (2008). A Risk Matrix for Risk Managers. London: NPSA.
- c) Institute of Risk Management. (2018). A Risk Practitioners Guide to ISO 31000:2018. London: IRM.
- d) NHS Providers. (2015). Board Assurance: A Toolkit for Health Sector Organisations. London: NHS Providers.
- e) HM Treasury. (2020). The Orange Book: Management of Risk – Principles and Concepts. London: HM Government.
- f) NHS England. (2024). Data Security and Protection Toolkit. Retrieved from <https://www.dsptoolkit.nhs.uk>
- g) Institute of Risk Management. (2011). Risk Appetite & Tolerance. London: IRM.
- h) International Organization for Standardization. (2018). ISO 31000:2018 – Risk Management Guidelines. Geneva: ISO.
- i) Healthcare Financial Management Association (HFMA). (2018). NHS Audit Committee Handbook. London: HFMA.
- j) Healthcare Financial Management Association (HFMA). (2017). NHS Governance Handbook. London: HFMA.
- k) Good Governance Institute (GGI). (2012). Risk Appetite for NHS Organisations: A Matrix to Support Better Risk Sensitivity in Decision Taking. London: GGI.
- l) Good Governance Institute (GGI). (n.d.). Risk Appetite. Retrieved from <https://www.good-governance.org.uk>
- m) NHS England. (2025). Risk Management Framework. London: NHS England.
- n) National Quality Board (NQB). (2024). Principles for Assessing and Managing Risks Across Integrated Care Systems. London: NQB.
- o) Financial Reporting Council. (2024). UK Corporate Governance Code. London: FRC.

21. Equality Impact Assessment

Date of assessment:	October 2025			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
Age ¹	There are no actual or expected impacts on the characteristic of age.	Not applicable.	Not applicable.	Not applicable.
Disability (Including: mental, physical, learning, intellectual and neurodivergent) ²	There are no actual or expected impacts on the characteristic of disability.	Not applicable.	Not applicable.	Not applicable.
Gender (including trans, non-binary and gender reassignment) ³	There are no actual or expected impacts on the characteristic of gender.	Not applicable.	Not applicable.	Not applicable.

¹ A person belonging to a particular age (for example 32 year olds) or range of ages (for example 18 to 30 year olds).

² A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

³ The process of transitioning from one gender to another.

Date of assessment:	October 2025			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
Marriage and civil partnership⁴	There are no actual or expected impacts on the characteristic of marriage and civil partnership	Not applicable.	Not applicable.	Not applicable.
Pregnancy and maternity⁵	There are no actual or expected impacts on the characteristic of pregnancy and maternity Status.	Not applicable.	Not applicable.	Not applicable.
Race⁶	There are no actual or expected impacts on the characteristic of race.	Not applicable.	Not applicable.	Not applicable.

⁴ Marriage is a union between a man and a woman or between a same-sex couple.

Same-sex couples can also have their relationships legally recognised as 'civil partnerships'.

⁵ Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

⁶ Refers to the protected characteristic of race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.

Date of assessment:	October 2025			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
Religion or belief⁷	There are no actual or expected impacts on the characteristic of religion or belief	Not applicable.	Not applicable.	Not applicable.
Sex⁸	There are no actual or expected impacts on the characteristic of sex.	Not applicable.	Not applicable.	Not applicable.
Sexual orientation⁹	There are no actual or expected impacts on the characteristic of sexual orientation.	Not applicable.	Not applicable.	Not applicable.

⁷ Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

⁸ A man or a woman.

⁹ Whether a person's sexual attraction is towards their own sex, the opposite sex, to both sexes or none. <https://www.equalityhumanrights.com/en/equality-act/protected-characteristics>

Date of assessment:	October 2025			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
Carers¹⁰	There are no actual or expected impacts on the characteristic of carers.	Not applicable.	Not applicable.	Not applicable.

¹⁰ Individuals within the ICB which may have carer responsibilities.

Appendix A: Definitions and Glossary of Terms

Definitions of key terms referenced in this policy are described in the table below:

Term	Definition
Assurance	Evidence that provides confidence that risks are being effectively managed and that controls are operating as intended.
Board Assurance Framework	A structured framework used by the Boards to identify and manage strategic risks to the achievement of strategic objectives. The BAF records strategic risks, controls, assurances, gaps in control or assurance, and actions required to strengthen risk management and organisational assurance.
Controls	Measures implemented to manage risk by reducing its likelihood, impact or both. Controls may include policies, procedures, systems, behaviours, governance arrangements and oversight mechanisms.
Corporate risks	Operational risks which relate to the delivery of the statutory duties, functions and/or priorities/objectives of an organisation.
Current (or residual) risk score	The numerical assessment of the risk (impact vs. likelihood) after taking into consideration any mitigating controls and/or actions.
Information Asset	An information asset is a body of information, which can be as small as a single document, defined and managed as a single unit so it can be understood, shared, protected, and exploited efficiently. Information assets have recognisable and manageable value, lifecycles, and risks that could impact the confidentiality, integrity and availability of the information.
Initial risk (or inherent) risk score	The numerical assessment of the risk (impact vs. likelihood) prior to considering any additional mitigating controls and/or actions.
Integrated Care Board (ICB)	An ICB is the statutory NHS organisation within the ICS which holds responsibility for NHS functions and budgets.
Joint Risk	A risk that affects more than one ICB and requires coordinated management, oversight or mitigating action across organisations. Joint risks may arise from shared objectives, programmes, partnerships or operational arrangements.

Term	Definition
Operational risk	A risk arising from day-to-day activities that may adversely affect the delivery of organisational priorities, statutory duties or operational objectives.
Operational Risk Register (ORR)	A tool for recording identified 'live' operational risks and monitoring actions to mitigate them.
Operational risk management	Risk management processes which focus on 'live' operational risks which an organisation is potentially facing. It relies upon the identification of risks, which are 'dynamic' in nature and are managed via additional mitigations. Operational risk management processes are centred around the Operational Risk Register.
Risk	There are many definitions of risk, but this policy has adopted the definition set out in ISO 31000 in that a risk is the 'effect of uncertainty on objectives'. The effects can be negative, positive or both. It is measured in terms of impact and likelihood.
Risk appetite	The level and type of risk that an organisation is willing to accept in pursuit of its objectives.
Risk assessment	The process of identifying, analysing and evaluating risks to determine their significance and the need for further action.
Risk culture	The values, beliefs, knowledge and understanding of risk, shared by a group of people with a common intended purpose.
Risk logs	Risk logs are a tool for capturing operational level risks at team/directorate/place/project level which may impact on the delivery of local objectives. Examples of risk logs may include directorate/team specific risk logs, project risk logs and transformation programme risk logs.
Risk management	The arrangements and activities in place that direct and control an organisation regarding risk.
Risk mitigation	Actions or controls implemented to reduce the likelihood or impact of a risk.
Risk owner	The individual accountable for ensuring that a risk is appropriately managed, reviewed and reported. Risk owners are responsible for maintaining risk records, implementing mitigating actions and providing assurance regarding the effectiveness of controls.

Term	Definition
Risk profile	The overall nature, extent and combination of risks faced by an organisation at a particular point in time.
Risk treatment	The process of selecting and implementing suitable measures to modify the risk.
Sovereign ICB risk	A risk that principally affects a single ICB and is managed through that organisation's governance and risk management arrangements. The cause, impact, risk score and mitigations may differ across the three ICBs.
Strategic objectives	Strategic objectives describe a set of clear organisational goals that help establish priority areas of focus. Whilst broad and directional in nature, they need to be specific enough that their achievement can be assured, and progress measured. They should have direct alignment with the (Board) Assurance Framework and an organisation's performance management processes.
Strategic risk management	Risk management processes which support the achievement of the organisation's strategic objectives. It focuses on the proactive identification of 'high level' risks which are managed by an established control framework and planned assurances. Strategic risk management processes are centred around the (Board) Assurance Framework.
Strategic risks	A risk that may prevent the achievement of strategic objectives or statutory duties and is managed through the Board Assurance Framework.
Target risk score	The level of residual risk exposure that an organisation aims to achieve through the implementation of appropriate controls and mitigating actions.
Three lines of defence model	A risk governance framework that splits responsibility for operational risk management across three functions, where operational management (first line) manages risks day-to-day, oversight functions such as risk and governance teams (second line) provide monitoring and challenge, and internal audit (third line) provides independent assurance.

Appendix B: Risk Scoring Matrix

Table 1A: Impact Score (I) Guidance

Impact Score	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Guidance	Negligible impact on objective/s. Day to day operational challenges.	Minor impact on objective/s. Temporary restriction to service delivery with limited impact on stakeholder confidence.	Moderate impact on objective/s. Short term failure to deliver key objectives with temporary adverse local publicity.	Major impact on objective/s. Medium term failure to deliver key objectives with ongoing adverse publicity or negative impact on stakeholder confidence.	Catastrophic impact on objective/s. Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of stakeholder confidence.

Table 1B: Impact Score (I) Further Guidance broken by Risk Domain

The following domain-specific descriptors provide additional guidance to support consistent assessment of impact. They should be applied alongside the general impact score guidance in Table 1A and considered in the context of the objective affected by the risk. Where a risk spans more than one domain, the impact score should reflect the most significant credible consequence.

Risk Domain	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Quality and Access: Risks that people do not receive safe, effective, high-quality and timely care due to failures in quality oversight, service access, capacity, performance or patient experience.	No, or very limited, impact on patient safety, clinical effectiveness, access or patient experience. Any issue is isolated and	Minor or localised impact on access, quality or experience, with limited disruption and no significant risk of harm.	Noticeable deterioration in quality, access or experience affecting a service, pathway or population group, requiring	Significant deterioration in quality, access or experience, with increased risk of avoidable harm, sustained service	Severe or widespread failure in quality, safety, access or experience, with actual or likely serious harm, loss

Risk Domain	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
	readily managed through routine processes.		management action and oversight.	pressures or formal escalation through governance arrangements.	of confidence, or need for urgent system-level intervention.
Legal and Regulatory Compliance: Risks of non-compliance with legislation, statutory duties, regulatory requirements, or other mandatory obligations, resulting in enforcement action, legal challenge or loss of public confidence.	No breach, or minor technical non-compliance, with no material consequence and readily correctable through routine action.	Isolated or low-level non-compliance with limited impact, requiring local corrective action but unlikely to result in enforcement or formal challenge.	Confirmed non-compliance with statutory, regulatory or mandatory requirements, requiring formal action, reporting or external engagement.	Significant or repeated non-compliance, with risk of enforcement action, legal challenge, regulatory intervention or material loss of confidence.	Severe or systemic non-compliance resulting in, or likely to result in, prosecution, major regulatory action, critical findings or significant loss of public confidence.
Health Outcomes and Inequalities: Risks that the ICBs fail to improve population health outcomes or reduce health inequalities, including failure to target interventions effectively, address unwarranted variation, deliver prevention activity, or achieve improvements in health and wellbeing for the populations served.	No material impact on population health outcomes or inequalities; any effect is limited, short-term and easily addressed.	Minor impact on a small group or locality, with limited effect on access, outcomes or inequalities.	Measurable or noticeable impact on outcomes or inequalities for a defined population, pathway or locality, requiring targeted corrective action.	Significant impact on population outcomes or inequalities, with substantial variation in access, experience or outcomes and risk to delivery of strategic objectives.	Severe or widespread deterioration in outcomes or inequalities, with long-term consequences for population health, major inequity or substantial failure to deliver statutory ambitions.
Workforce and Organisational Capability: Risks that the ICBs lack the workforce	Minimal impact on workforce capacity,	Minor workforce or capability pressure	Sustained workforce,	Significant workforce or	Critical workforce or organisational

Risk Domain	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
capacity, capability, leadership, culture or organisational resilience required to deliver its objectives and statutory responsibilities effectively.	capability, leadership, culture or resilience; objectives remain deliverable through routine management.	causing limited disruption to delivery, with manageable local action required.	leadership, cultural or capability pressures affecting delivery of objectives, staff experience or organisational effectiveness.	organisational capability failure, including loss of key capacity, leadership instability, poor culture or reduced resilience affecting delivery of statutory responsibilities.	failure resulting in inability to deliver key functions, maintain safe operations or discharge statutory responsibilities effectively.
Financial Sustainability and Resource Allocation: Risks that the ICBs fail to achieve financial sustainability or maximise value from available resources, including ineffective resource allocation, poor productivity, inefficiencies, commissioning decisions or inability to meet financial duties.	No material financial impact, or negligible effect on resource use, productivity, value for money or financial duties.	Minor financial pressure, inefficiency or resource allocation issue, manageable within existing plans and controls.	Material financial pressure, inefficiency or sub-optimal resource allocation affecting delivery of plans, productivity or value for money.	Significant financial risk affecting delivery of statutory duties, financial balance, investment decisions or ability to allocate resources effectively.	Severe financial failure or unsustainable resource position, with inability to meet financial duties, maintain services or support strategic objectives.
Partnerships and Social Value: Risks arising from ineffective leadership, collaboration or stakeholder engagement, leading to reduced system effectiveness, failure to deliver shared objectives, loss of confidence, reputational damage, or reduced social value.	No material impact on partnership relationships, stakeholder confidence, collaboration or social value.	Minor tensions or limited stakeholder concern, with negligible impact on delivery of shared objectives.	Deterioration in relationships, collaboration or stakeholder confidence affecting coordination, delivery or the ability to realise shared benefits.	Significant breakdown in partnership working, stakeholder engagement or collective leadership, with sustained impact on delivery, confidence or social value.	System-wide failure of collaboration or confidence, causing substantial loss of trust, inability to deliver shared objectives or major reputational damage.

Risk Domain	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Planning and Transformation: Risks that the ICBs are unable to effectively plan, design and deliver services, programmes and transformation required to meet current and future population needs, including implementation of new care models, service redesign, strategic planning and major change initiatives.	No material disruption to planning, programme delivery, transformation or implementation of agreed change.	Minor delay, dependency issue or planning gap, with limited impact on delivery and manageable through routine programme controls.	Noticeable delay, slippage or delivery risk affecting a programme, service redesign or strategic planning objective, requiring formal corrective action.	Significant failure or sustained slippage in planning or transformation, affecting delivery of major change, strategic objectives or expected benefits.	Fundamental failure to plan, deliver or implement major transformation, resulting in long-term inability to meet population needs, deliver strategic objectives or maintain system confidence.

Table 2: Likelihood Score (L)

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency	Probably never happen / recur only in very exceptional circumstances.	Do not expect it to happen / recur but is possible it may do so.	Might happen / recur occasionally.	Will probably happen / recur but is not a persisting issue.	Will undoubtedly happen / recur, expected to occur in most circumstances.
How likely is it to happen?	Less than 1% chance of event happening.	1% - 30% chance of event happening.	31% - 60% chance of event happening.	61% - 95% chance of event happening.	96% to 99% of chance of this occurring.

Table 3: Impact (I) x Likelihood (L) Risk Matrix

Impact ↑	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
		Likelihood →				
	Risk Profile	Very Low (1-3)	Low (4-6)	Medium (8-12)	High (15-20)	Extreme (25)

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	16/07/2026
Paper title:	Committee Highlight Reports
Paper reference:	ICB CIC 26 039
Paper author:	Committee Secretariat
Paper sponsor:	Committee Chairs
Presenter:	Committee Chairs

Paper type:
For assurance ☒ For decision ☐ For discussion ☐ For information ☐

Report summary:
This report provides an overview of the work undertaken by the Boards' committees since the last meeting in May 2026. The report is intended to provide assurance that the committees are discharging their delegated duties and to escalate any matters requiring the Boards' 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.

Recommendation(s):
The Boards are asked to receive the paper for assurance in relation to the work of its committees.

Relevant statutory duties:	
☒ Quality improvement	☒ Public involvement and consultation
☒ Reducing inequalities	☒ Equality and diversity
☒ Financial limits/ breakeven	☒ Effectiveness, efficiency and economy
☒ Integration of services	☒ Wider effect of decisions (triple aim)
☒ Promoting innovation	☒ Promoting research
☒ Patient choice	☒ Obtaining appropriate advice
☒ Promoting education/training	☒ Climate change

Appendices
Appendix 1 – Joint Finance and Performance Committee Highlight Report Appendix 2 – Joint Quality and Service Improvement Committee Highlight Report Appendix 3 – Joint Strategic Commissioning Committee Highlight Report Appendix 4 – Joint Transition Committee Highlight Report Appendix 5 – Audit Committees' Highlight Report Appendix 6 – Description of levels of assurance Appendix 7 – Current high-level operational risks being overseen by the Boards' committees

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Appendix 1: Joint Finance and Performance Committee Highlight Report

Meeting Dates:	03 June 2026 01 July 2026
Committee Chair:	Stephen Jackson, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
ICB Finance Report (Months 1 and 2)	The Committee received monthly reports on the ICBs' financial positions. At month two all three ICBs were continuing to report on-plan financial positions in line with expectations for both in month and full year forecasts. The overall financial position for the three NHS systems was reported as a £61 million deficit against plan. Nottingham and Nottinghamshire providers remained the key driver of this position. The Committee discussed a number of risks to the ICBs' positions, noting that key to delivering the financial plan would be the full implementation of the Efficiency Plan. Other areas of financial pressure requiring oversight were acute activity, mental health and learning disability services, prescribing, Continuing Healthcare and community services. The Committee took assurance that the pressures continued to be actively managed and mitigated through the ICBs' Financial Recovery Group. Noting the ICBs' changed role in relation to monitoring providers' financial positions, members noted that the ICBs would continue to work alongside NHS	Adequate	<i>Adequate (awarded at the meeting held on 03 June 2026)</i>

Item	Summary	Level of Assurance	Previous Level of Assurance
	England to understand providers' respective financial positions, whilst driving funding and activity through the ICBs' commissioning intentions.		
ICB Efficiency Report (Months 1 and 2)	As this programme was the single biggest driver of the ICBs' future financial sustainability, members welcomed a separate and more detailed review of progress within this report. At month two, 102% per cent, of the saving requirement had been identified and year to date delivery was £28 million against a forecast of £29 million. The risk adjusted year end forecast was estimated at £123 million, which was currently a 24% gap to target. However, this was an improving position. Members sought to understand escalation frameworks in areas where progress was not as expected and took assurance on the oversight and reporting regime that had been put in place. Members asked that the report should focus on areas of high risk and the mitigating steps to be taken; and for areas of particular concern to be escalated to the Committee for awareness, emphasising the importance of a candid assessment of progress. Consequently, there was a discussion on whether the management of change process was impacting the ICBs' capacity to implement the efficiency schemes and whether this posed a significant risk to the programme. The committee asked for this issue to be raised at the July meeting of the Joint Transition Committee.	Adequate	Partial <i>(awarded at the meeting held on 03 June 2026)</i>
Commissioning Delivery Report 2026/27	The Committee noted that most service areas remained under sustained pressure, although some areas of good performance were highlighted. The year-end improvement in elective care performance had not been maintained within Nottinghamshire and Lincolnshire; the 62-day cancer performance target and diagnostic performance was off-plan across all ICB areas; and urgent and	Partial	Partial <i>(awarded at the meeting held on 03 June 2026)</i>

Item	Summary	Level of Assurance	Previous Level of Assurance
	emergency care services continued to be under sustained pressure, leading to East Midlands Ambulance Services NHS Trust and Nottingham University Hospitals NHS Trust declaring critical incidents during June. The Committee sought assurance that a robust contract monitoring regime had been established; and noted that the ICBs had set up a Commissioning Oversight Group to monitor providers' compliance with their contractual obligations and any areas of sustained non-compliance would be escalated to a Contract Executive Board. Individual Programme Boards had also been established and had met for the first time during June and July.		
Thematic Commissioning Delivery Review: Urgent and Emergency Care	The report provided an update on the current Urgent and Emergency Care (UEC) position across the ICBs' geographies. The report provided analysis that the primary challenge facing the UEC systems was not front-door access alone and the ability of trusts to manage patient flow effectively was impacting on the resilience of urgent care services. Analysis in the report had also reflected increasing levels of frailty, multimorbidity and complexity within the population, alongside a growing demand for urgent care services. In conclusion the evidence demonstrated that flow through hospital and the availability of community alternatives were the most significant determinants of performance. The report provided detail of the ICBs' UEC Programme, which reflected the national direction of travel by focusing on reducing avoidable emergency activity, supporting people closer to home and improving coordination across primary care, community services, mental health, social care and acute providers.	Partial	<i>Not applicable</i>

Item	Summary	Level of Assurance	Previous Level of Assurance
	The Committee endorsed the strategic commissioning approach focused on neighbourhood-based transformation, admission avoidance and discharge optimisation.		
Board Assurance Framework (BAF) Targeted Report	The Committee reviewed the BAF risks within its remit, which remained stable with appropriate controls and assurances in place. Members agreed that discussions at meetings correlated with the risks and requested that a potential assurance gap relating to wider performance oversight arrangements be considered further by senior management leads.	<i>Not applied</i>	<i>N/A</i>

Other considerations:

Decisions made:
The Committee approved the proposed next steps in relation to a capital investment and noted that further business case development and approvals would be required before subsequent phases could proceed.

Information items and matters of interest:
The Committee also received: a) An update on the status of the 2026/27 contract agreements. It was noted that contract agreement discussions remained ongoing for three providers and members were advised of the ongoing actions being taken to progress these. b) A report on the development of the Neighbourhood Health Centre estates pipeline across the three ICB geographies. The Committee noted that a structured, system-wide process had been undertaken to identify a long list of potential schemes, aligned to

Information items and matters of interest:

neighbourhood footprints, population health need and existing estate strategies. Further work was now underway to refine the highest priority schemes, strengthen deliverability and align with emerging national funding opportunities.

- c) Update on the operational risks within its remit at both meetings. There were currently eight risks on the Committee's risk register, four of which were rated as high, which related to financial stability and underlying deficit positions.

Appendix 2: Joint Quality and Service Improvement Committee Highlight Report

Meeting Dates:	10 June 2026 and 8 July 2026
Committee Chair:	Sharon Robson, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Quality Oversight Report	The Committee received an overview of the quality and safety position across the three ICBs at both meetings. The Committee welcomed the progress made in strengthening quality oversight arrangements, including the development of the System Quality Group and integrated quality reporting. Members supported the escalation of one Trust into enhanced quality oversight and emphasised the importance of ensuring that improvements at providers in escalation were embedded and sustainable. Members discussed the critical role of leadership, workforce culture and organisational capability in driving quality improvement and sought assurance that these issues continued to receive appropriate scrutiny alongside performance and patient safety metrics. The Committee highlighted several quality priorities, including maternity and neonatal safety, corridor care, infection prevention and control, learning disability and autism	Partial	Partial <i>(awarded at the meeting held on 10 June 2026)</i>

Item	Summary	Level of Assurance	Previous Level of Assurance
	services, and Continuing Healthcare. Members emphasised the importance of effective system-wide oversight and triangulation of quality intelligence to support patient safety and reduce variation across the ICBs' footprint.		
Oversight of Mortuary and After Death Care in Provider Organisations	The Committee received assurance on system-wide progress against the Fuller Inquiry recommendations, noting that governance and oversight arrangements were in place across provider organisations. However, further assurance was required to demonstrate the consistent and sustainable implementation of improvements, particularly in relation to estates, security and governance. Members noted one Trust as the primary area of concern, where external reviews had identified ongoing risks relating to workforce resilience, capacity and operational sustainability. The Committee agreed that strengthened oversight and clear escalation of associated quality and reputational risks were required through established governance and assurance arrangements.	Partial	<i>Not applicable</i>
Clinical Leadership and Care Pathway Optimisation	The Committee received assurance that a clinically led, outcome-focused model for care pathway optimisation was in place at system, place and neighbourhood levels, supported by strong clinical stewardship, provider engagement and collaborative leadership arrangements to improve integration,	Adequate	<i>Not applicable</i>

Item	Summary	Level of Assurance	Previous Level of Assurance
	reduce unwarranted variation and align delivery with population health priorities. Members welcomed the strengthened approach to clinical leadership and pathway-based working, while emphasising the need to demonstrate measurable improvements in outcomes, population health and health inequalities through robust evaluation and outcome measures.		
Delivery of Immunisation and Vaccination Programmes	The Committee received assurance that robust governance, delivery arrangements and inequalities-focused investment were supporting vaccination and immunisation performance across the system, with uptake in the Spring 2025/26 COVID-19 campaign exceeding national levels and plans in place to ensure readiness for the 2026/27 winter programmes. The Committee welcomed the progress made in the delivery of vaccination and immunisation programmes, recognising their importance in reducing health inequalities and improving population health outcomes. Members emphasised the need to develop sustainable delivery models beyond traditional GP-led provision, with a greater focus on outreach, market development and improving access for underserved communities.	Adequate	<i>Not applicable</i>
Board Assurance Framework Targeted Report	The Committee received assurance that Strategic Risk 9 (failure to systematically improve the quality of healthcare services) remained stable with no change in risk score, with	Adequate	<i>Not applicable</i>

Item	Summary	Level of Assurance	Previous Level of Assurance
	progress made in strengthening cluster-wide quality oversight arrangements and action plans, while further work continued to support alignment and transition to a single ICB quality framework. The Committee agreed that the mitigating actions, controls and assurance mechanisms in place remained appropriate and provided a clear understanding of the strategic risk within its remit. Members welcomed the quality of the report and the progress made in strengthening oversight and assurance arrangements.		

Other considerations:

Decisions made:
The Committee: a) Approved the refreshed 2026/27 Committee Work Programme, noting its alignment with Board priorities, the increased focus on assurance-based reporting and the importance of maintaining oversight of cross-cutting themes across committees to minimise duplication and support effective governance. b) Approved the ICBs' corroborative statements for the Annual Quality Accounts of several NHS Trust providers.

Information items and matters of interest:
The Committee also received:

Information items and matters of interest:

- a) A thematic report on Special Educational Needs and Disabilities, noting the focus on earlier intervention and partnership working, alongside ongoing demand and workforce pressures and varying levels of assurance across local areas.
- b) An overview of the Ockenden Review of Maternity Services at Nottingham University Hospitals NHS Trust and the Independent Investigation into Maternity and Neonatal Services in England. Members emphasised the importance of maintaining oversight of maternity and neonatal improvement and translating learning into measurable action across the wider quality agenda.
- c) An update on the Strategic Approach to Outcomes. The Committee supported the proposed approach and development of the Clinical Cabinet model, including a six-month testing and engagement phase, and emphasised the importance of alignment with existing governance arrangements.
- d) d) Updates on the risks within its remit, noting changes to the operational risk profile relating to maternity, cancer performance and diagnostic waiting times, and the development of two potential new risks.

Appendix 3: Joint Strategic Commissioning Committee Highlight Report

Meeting Dates:	28 May 2026 25 June 2026
Committee Chair:	Jon Towler, Non-Executive Director – May 2026 (June meeting chaired by Sharon Robson, Non-Executive Director)

Item	Summary	Level of Assurance	Previous Level of Assurance
Assessment of current dental issues, future requirements and potential commissioning options	The Committee received a report that aimed to provide assurance on the current position of dental commissioning across the ICBs. It outlined the operating environment, key risks and mitigations, governance arrangements, and commissioning intentions for 2026/27, with a clear focus on stabilisation and recovery. It further described the future commissioning requirements to improve access, reduce oral health inequalities, and support the sustainable delivery of NHS dental services across the ICBs' footprint. Members discussed ongoing workforce challenges, the utilisation of the dental allocation, and the role of planned independent insight work in shaping future commissioning arrangements, including targeting investment to areas of greatest need to improve access. An assurance rating of 'adequate' was agreed, with recognition that the ICBs were operating in a more agile manner.	Adequate	<i>Not applicable</i>

Item	Summary	Level of Assurance	Previous Level of Assurance
Working with People and Communities Annual Reports	The Committee received a paper that aimed to provide assurance on how the ICBs had discharged their statutory duties in relation to public involvement and consultation, setting out the ways that the ICBs had worked with people and communities from 1 April 2025 to 31 March 2026. This was supported by separate annual reports produced by each ICB in line with their individual statutory governance arrangements. It was anticipated that future reports would be unified in line with national guidance on organisational merger. Future reports would draw on best practice from the three annual reports, with greater emphasis on citizen experience and case studies, particularly in relation to service redesign. An assurance rating of 'adequate' was agreed, noting that future reports should more clearly demonstrate the impact of actions taken.	Adequate	<i>Not applicable</i>
Joint Commissioning Executive Group Assurance Report	Members received reports summarising the broad range of commissioning proposals considered by the Joint Commissioning Executive Group in April and May 2026. A number of decisions were taken supported by appropriate clinical, financial and equality assessments, with none requiring escalation to the Joint Strategic Commissioning Committee.	Full	Full (28 May 2026)
Statements on Information on Health Inequalities	Members received a report that aimed to provide assurance on the ICBs' discharge of their statutory duties in relation to health inequalities and their response to the NHS England Statement on Information on Health Inequalities requirement to collect, analyse and publish information relating to health inequalities. Individual Statements on Information on Health Inequalities were developed for each ICB for 2025/26. The Statements addressed the Key Lines of Enquiry set out by NHS England for ICBs to use to support a self-assessment	Full	<i>Not applicable</i>

Item	Summary	Level of Assurance	Previous Level of Assurance
	of how they had exercised their functions and were supported by relevant case study examples. Members discussed plans to share identified opportunities with relevant programme boards to inform commissioning decisions, emphasised the importance of embedding consideration of health inequalities across all programmes of work, alongside improving the accuracy of ethnicity reporting and noted the development of an oversight framework, which would be presented at a future meeting.		
Arrangements for individual funding requests	Members received a report that provided an overview of current Individual Funding Request (IFR) arrangements across the ICBs and set out the case for developing a single, standardised operating model across the three ICBs. The IFR function supported the ICBs in meeting their statutory duties relating to equitable access to care outside routine commissioning. Alignment across the ICBs would support system efficiency, reduce variation and strengthen the defensibility of decision-making. An assurance rating of 'adequate' was agreed, noting that whilst the current arrangements were robust and compliant, there were risks associated with the development of a single, standardised operating model across the three ICBs.	Adequate	<i>Not applicable</i>
Out of Area Placements Update	The Committee received a paper that aimed to provide assurance that the ICBs knew where all patients placed out of area were currently receiving care and outlined the plans in place to commission services in line with the Inpatient Commissioning Framework, with the aim of eliminating all out of area placements by March 2028.	Adequate	<i>Not applicable</i>

Item	Summary	Level of Assurance	Previous Level of Assurance
	Recognising that oversight of these placements should be strengthened, NHS England had requested that ICBs provide a regular monthly stocktake of individuals in mental health inpatient settings where placements did not align with the ICBs' three-year mental health inpatient plans. NHS England had also requested that ICB Boards receive updates confirming assurance that the ICBs had full visibility of where all patients placed out of area were currently receiving care; and confirmation of the ICBs' plan to eliminate all adult out of area placements by March 2028. An assurance rating of 'adequate' was agreed, noting that whilst the ICBs had full visibility of all out of area placements and clear plans in place to eliminate their use by March 2028, delivery of this ambition remained subject to associated risks.		

Other considerations:

Decisions made:
The Committee: a) Approved its 2026/27 Work Programme, noting that it would remain flexible to respond to emerging requirements. b) Approved the Nottingham and Nottinghamshire Section 117 Aftercare Policy.

Information items and matters of interest:
The Committee:

Information items and matters of interest:

- a) Discussed the strategic position for Neighbourhood Health and Integrated Neighbourhood Teams, noting that further detail on investment requirements, programme governance and progress would be presented at a future meeting.
- b) Discussed the three ICBs' Local Area SEND Strategies, noting that concerns regarding delivery planning for the Nottingham City SEND Strategy would be escalated and that work would be undertaken to clarify respective committee responsibilities for SEND.
- c) Supported the proposed strategic approach to prevention and early intervention across the ICBs, including the alignment of resources and transformation programmes.
- d) Supported the proposed approach to future Digital Transformation Programme reporting, including the development of a single Digital Transformation Strategy and system-specific delivery programmes.
- e) Reviewed the 15 risks within its remit, comprising one high and 14 medium risks, and noted that further work would be undertaken following the Boards' recent development session on risk appetite.

Appendix 4: Joint Transition Committee Highlight Report

Meeting Dates:	02 July 2026
Committee Chair:	Jon Towler, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Transition Finance Update	The Committee received an update on the Transition Programme financial position, noting that £6.3 million of savings had been delivered by the end of March 2026, with a further £44.1 million expected in 2026/27. Transition costs of £22.5 million were largely covered by available non-recurrent funding, with a forecast £6.5 million remaining uncommitted. The Committee was assured that the 2026/27 financial position was largely understood, with costs and savings being closely managed and no additional CSU stranded costs anticipated.	Full	Adequate <i>(awarded at the meeting on 7 May 2026)</i>
Transition Programme Plan update	The Committee received an update on the Transition Programme Plan, noting progress across workforce, CSU transfer and governance, including the transfer of CSU staff on 1 July 2026. Delivery of the Wave Three recruitment programme remained challenging due to the scale of voluntary redundancy exits and job evaluation requirements, although business continuity plans and mitigating actions were in place. Overall, the Committee was assured that	Adequate	Full <i>(awarded at the meeting on 7 May 2026)</i>

Item	Summary	Level of Assurance	Previous Level of Assurance
	programme delivery remained broadly on track, while noting ongoing workforce and financial pressures.		
Board Assurance Framework Targeted Report	The Committee received an update on Board Assurance Framework Risk 11, noting that the risk remained stable with a score of 12 (medium) and that progress was being made to strengthen assurance arrangements. The Committee agreed that the risk score, controls and mitigating actions remained appropriate and emphasised the importance of clearly demonstrating the effectiveness of controls within future assurance reporting.	Adequate	<i>Not applicable</i>

Other considerations:

Information items and matters of interest:
The Committee also: a) Received a verbal update from the Chief Executive on transition progress, including engagement with stakeholders and NHS England regarding future ICB merger arrangements and the evolving strategic commissioning and provider oversight model. b) Discussed the Health Bill and national approach to ICB mergers, noting the implications for future governance, stakeholder engagement and patient voice arrangements. c) Discussed the developing Organisational Development Framework, emphasising the importance of ensuring the future operating model was supported by appropriate skills, capabilities and leadership capacity, alongside a compassionate and realistic approach to workforce transition.

Information items and matters of interest:

- d) Reviewed the Operational Risk Report, noting 15 joint transition risks, including one high-scoring risk relating to CSU transition, alongside emerging workforce capacity pressures. Members noted the mitigating actions being taken and agreed that the potential implications of future ICB merger arrangements should be reflected in ongoing risk review..
- e) Agreed that a full discussion around the Committee's remit and frequency of meetings would take place at the meeting in September 2026.

Appendix 5: Audit Committees' Highlight Report (meeting in common)

Meeting Dates:	16 June 2026
Committees' Chair:	John Dunstan, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Provider Selection Regime Annual Reports 2025/26	The Committees received an end of-year update to the Committees regarding their responsibility for overseeing compliance with the Provider Selection Regime (PSR). The annual reports had concluded that NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB had properly exercised their responsibilities under the PSR. However, there had been some instances of non-compliance in the undertaking of responsibilities under PSR rules within NHS Derby and Derbyshire ICB with regard to the publication of transparency notices and intention to award notices. In seeking to understand the root causes and actions to remedy the non-compliance, members took assurance that all contract award notices had been compliant within NHS Derby and Derbyshire ICB and that robust processes had since been implemented.	Full for LICB and NNICB Partial for DDICB	<i>Not applicable</i>
Financial Stewardship Assurance Report	The report had provided assurance of compliance with the ICBs' Standing Financial Instructions, NHS England governance and HM Treasury's Management of Public Monies across the three ICBs. Overall, the Committees took assurance of	Full	<i>Adequate (awarded at the meeting held on 18</i>

Item	Summary	Level of Assurance	Previous Level of Assurance
	robust control arrangements within each ICB and welcomed the progress towards the alignment of financial procedures. One area highlighted and discussed as an outlier was the over-reliance of NHS Derby and Derbyshire ICB on single tender waivers. Although it was noted that all decisions were compliant, the Committees took assurance that action had already been taken to strengthen arrangements.		<i>February 2025)</i>
Information Governance Assurance Report	The Committees received an update on arrangements to ensure compliance with the Cyber Assurance Framework aligned Data Security and Protection Toolkit. Derby and Derbyshire and Nottingham and Nottinghamshire ICBs were on track to achieve compliance, while additional focus was required in Lincolnshire following recent organisational and service changes, which had created challenges in assembling the required evidence. Members noted that this did not reflect concerns regarding the underlying control environment and welcomed plans to strengthen joint information governance arrangements across the three ICBs.	Partial	<i>Adequate (awarded at the meeting held on 18 February 2025)</i>

Other considerations:

Decisions made:
The Committees approved the Annual Report and Accounts for each ICB for the period 1 April 2025 to 31 March 2026 for onward submission to NHS England ahead of the deadline of 29 June 2026. The Committees also endorsed the signing of the letters 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 Opinions.

Information items and matters of interest:

The Committees received updates and reviewed progress on:

- a) The ICBs' Counter Fraud Plans for 2026/27, noting that good progress was being made overall.
- b) 2025/26 Counter Fraud Annual Reports, noting that all ICBs were compliant with the annual Government Functional Standard 013 Counter Fraud assessment.
- c) The ICBs' Internal Audit Plans for 2026/27, noting that good progress was being made against the agreed plans.
- d) A report on the risks overseen by the Committees was discussed.

Appendix 6 - Description of levels of assurance

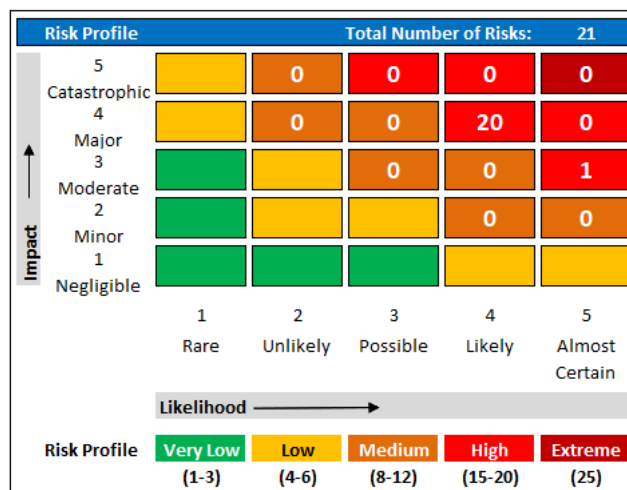
Levels of assurance:	The report demonstrates that:
Full Assurance	- Desired outcomes are being achieved; and/or - Required levels of compliance with duties is in place; and/or - Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required.
Adequate Assurance	- 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	- 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	- 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.

Appendix 7: Current high-level operational risks being overseen by the Boards' committees

Risk Profile

There are 71 risks within the Operational Risk Register. Of these 71 risks, 21 risks are scored at a high-level, accounting for 30% of the total risks. Five of the high scoring risks originate from NHS Derby and Derbyshire ICB, two originate from NHS Lincolnshire ICB, and eight from NHS Nottingham and Nottinghamshire ICB. Six 'joint' high scoring risks have also been identified. The ICB's total risk profile is shown in figure 1 below.

Figure 1



The 21 high-level operational risks do not include any risks classed as confidential. In rare circumstances, a risk may also be held confidential if it relates to sensitive topics, such as ongoing legal matters, contractual negotiations, or personnel issues, where early disclosure could be inappropriate or compromise effective management. The confidential risks are reported separately and excluded from the analysis and detail of this report.

Details of High-Scoring Risks

Operational risk reports continue to be routinely presented to the committees of the Boards, enabling the ongoing review and scrutiny of all risks, including those high-level risks.

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
RR047	NNICB	In pursuit of NHS financial efficiencies and operational delivery for Nottingham and Nottinghamshire, there is a risk that ICB relationships may decline (with ICS partners and wider stakeholders). This may lead to deterioration in collaborative efforts, communication breakdowns and wider stakeholder dissatisfaction.	High 16 (I4 x L4)	Joint Finance and Performance Committee
RR134	LICB	If NHS Lincolnshire ICB is unable to deliver sufficient recurrent financial efficiencies at the required pace, there is a risk that a sustainable underlying deficit (UDL) position will not be achieved, impacting long-term financial resilience and the ability to operate within available resources.	High 16 (I4 x L4)	Joint Finance and Performance Committee
RR003	DDICB	If ambulance handover times at acute trusts within Derby and Derbyshire increase and cause delayed ambulance arrival in the community, there is a risk of potential harm to citizens who are waiting for an ambulance, which may lead to further deterioration of their condition.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR022	NNICB	If ambulance handover times at acute trusts within Nottingham and Nottinghamshire increase and cause delayed ambulance arrival in the community, there is a risk of potential harm to citizens who are waiting for an ambulance, which may lead to further deterioration of their condition.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR023	NNICB	If there are ineffective discharge processes within Nottingham and Nottinghamshire, there is a risk of increased length of stay and potential for individuals to experience harm when leaving the hospital and returning home. This may lead to deconditioning and poor experience.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR029	NNICB	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	High 16 (I4 x L4)	Joint Quality and Service

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
		may lead to compromised quality of care issues which could result in poor experience and adverse health outcomes for the population of Nottingham and Nottinghamshire.		Improvement Committee
RR048	NNICB	If adverse media coverage relating to key health services commissioned by the Nottingham and Nottinghamshire ICB (e.g. maternity, mental health, primary care) persists, public confidence in the ICB may decline. This may lead to reduced trust, and impact on public confidence.	High 16 (14 x L4)	Joint Quality and Service Improvement Committee
RR049	NNICB	If cancer service performance continues to deteriorate due to a combination of factors, including demand pressures, capacity constraints, pathway inefficiencies, and variability in provider performance, the ICB may be unable to fulfil its statutory duty to commission timely and effective services that support the diagnosis and treatment of cancer across Nottingham and Nottinghamshire. This could result in non-compliance with national cancer standards, including the 62-day referral-to-treatment target and the 28-day Faster Diagnosis Standard, leading to poorer clinical outcomes and diminished experience for the population.	High 16 (14 x L4)	Joint Quality and Service Improvement Committee
RR051	NNICB	If operational performance pressures persist due to capacity constraints and rising demand, the ICB may be unable to fulfil its statutory duty to commission hospital and medical services across Nottingham and Nottinghamshire that meet the reasonable requirements of the population. This could result in Trusts being unable to deliver planned levels of elective activity, leading to missed waiting time targets, delayed treatment, poorer health outcomes, and increased reliance on urgent and emergency care pathways.	High 16 (14 x L4)	Joint Quality and Service Improvement Committee
RR089	DDICB	If maternity services across Derby and Derbyshire do not sustain the quality improvements made to date, there is a risk that service standards could deteriorate. This may lead to compromised safety, reduced quality of care, and poor experiences for women, birthing people, their babies, and families.	High 16 (14 x L4)	Joint Quality and Service Improvement Committee

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
RR128	DDICB	If cancer service performance continues to deteriorate due to a combination of factors, including demand pressures, capacity constraints, pathway inefficiencies, and variability in provider performance, the ICB may be unable to fulfil its statutory duty to commission timely and effective services that support the diagnosis and treatment of cancer across Derby and Derbyshire. This could result in non-compliance with national cancer standards, including the 62-day referral-to-treatment target and the 28-day Faster Diagnosis Standard, leading to poorer clinical outcomes and diminished experience for the population.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR129	DDICB	If diagnostic service demand continues to exceed available capacity, the ICB may be unable to fulfil its statutory duty to commission timely and effective diagnostic services across Derby and Derbyshire. This could result in persistent backlogs and extended waiting times, particularly for individuals approaching 78 and 65-week thresholds, leading to poorer clinical outcomes diminished experience for the population and increased pressure across the health and care system.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR130	DDICB	If operational performance pressures persist due to capacity constraints and rising demand, the ICB may be unable to fulfil its statutory duty to commission hospital and medical services across Derby and Derbyshire that meet the reasonable requirements of the population. This could result in Trusts being unable to deliver planned levels of elective activity, leading to missed waiting time targets, delayed treatment, poorer health outcomes, and increased reliance on urgent and emergency care pathways.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR147 (NEW)	All	If the ICBs, as strategic commissioners, do not secure robust contractual arrangements and effective performance monitoring to support delivery of Year 1 Urgent and Emergency Care (UEC) priorities within the five-year Commissioning Plan, there is a risk that these early priorities will not be delivered as intended. This may result in failure to achieve planned access and pathway improvements, leading to delays in care, patient safety risks, and poorer health outcomes.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR148 (NEW)	Lincs ICB	If there are ineffective discharge processes within Lincolnshire, there is a risk of increased length of stay and potential for individuals to experience harm when leaving the hospital and returning home. This may lead to deconditioning and poor experience.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
RR149 (NEW)	All	If discharges for people with a Learning Disability and/or Autism are delayed due to insufficient capacity in appropriate community placements, and individuals are cared for within mental health inpatient settings which are not designed to meet their needs, then patients may remain in restrictive or inappropriate environments for prolonged periods, leading to poor patient experience and potential deterioration in health outcomes across the cluster.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR150 (NEW)	All	If mental health inpatient discharges are delayed due to flow pressures and limited onward care and community support, patients may experience prolonged hospital stays and delays in accessing appropriate care. This may result in reduced quality of care, deterioration in patient safety, and poorer outcomes across the cluster.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR151 (NEW)	All	If demand for autism and ADHD assessments across the cluster ICBs continues to increase, services may not meet demand, leading to unmet health needs, poor experience, and adverse clinical outcomes. This risk affects both adults and children, with a greater impact on adult services.	High 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR072	NNICB	If NHCT lacks the capacity and capability to implement sustainable quality improvements identified through serious incidents, deaths, quality reviews, and broader performance concerns, then similar failures may recur, leading to harm and poor health outcomes for the population of Nottingham and Nottinghamshire.	High 15 (I3 x L5)	Joint Quality and Service Improvement Committee
RR140 (NEW)	All	If sufficient clinical and operational capacity, capability, and dedicated resource are not identified to support the implementation and embedding of digital transformation initiatives, there is a risk that the intended benefits of transformation will not be fully realised, limiting the achievement of anticipated efficiencies.	High 16 (I4 x L4)	Joint Strategic Commissioning Committee
RR079 (NEW)	All	If a policy position on CSU abolition is developed which determines that ICBs must take on all functions, staff and stranded costs for the services they currently buy from CSUs, there is a risk that the current management of change process and financial position will be impacted, with additional staff coming within scope and subsequently further redundancy liabilities.	High 16 (I4 x L4)	Joint ICB Transition Committee