NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

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 17 September 2026 10:00-13:00

Jubilee Conference Centre, Triumph Road, Nottingham, NG7 2TU

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 16 July 2026	Kathy McLean	Decision	✓	✓	✓	✓	-
5.	Action log and matters arising from the meetings in common, held on 16 July 2026	Kathy McLean	Discussion	✓	✓	✓	-	-
	Leadership and operating context							
6.	Chair's Report	Kathy McLean	Information/ Decision	✓	✓	✓	✓	10:05
7.	Chief Executive's Report	Amanda Sullivan	Information	✓	✓	✓	✓	10:15
	Population health and commissioning priorities							
8.	Population Health Strategy Progress Report: Neighbourhood Health	Clair Raybould, Maria Principe, Dr Dave Briggs	Assurance	✓	✓	✓	✓	10:30
	Oversight and delivery of commissioning outcomes							
9.	Citizen experience: Maternity families	Clair Raybould	Discussion	✓	-	-	✓	10:55

Ref	Item	Presenter	Type	DD	L	NN	Enc	Time
10.	Maternity and Neonatal Services: Response to Local and National Reviews and Improvement Priorities	Rosa Waddingham	Assurance	✓	✓	✓	✓	11:10
11.	Quality Oversight Report	Rosa Waddingham	Assurance	✓	✓	✓	✓	11:30
12.	Winter Plan	Maria Principe	Decision	✓	✓	✓	✓	11:45
13.	Commissioning Oversight Report	Maria Principe, Dr Dave Briggs	Assurance	✓	✓	✓	✓	12:00
14.	Finance Report	Bill Shields	Assurance	✓	✓	✓	✓	12:15
	Governance							
15.	Board Assurance Framework	Lucy Branson	Assurance	✓	✓	✓	✓	12:30
16.	Committee Highlight Reports	Committee Chairs	Assurance	✓	✓	✓	✓	12:45
	Items for information							
17.	Boards' Work Programme	-	Information	✓	✓	✓	✓	-
	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:	17/09/2026
Paper title:	**Declaration and management of interests**
Paper reference:	ICB CIC 26 042
Paper author:	Committee Secretariat
Paper sponsor:	Kathy McLean, Chair
Presenter:	Kathy McLean

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

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.
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	✓	✓	✓	Equlity, 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.

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

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	
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.
McLean	Kathy	Chair	✓	✓	✓	Chair of an expert panel conducting an independent review of Betsi Cadwalladr Health Board (funded by NHS Wales)	Role within an NHS, local authority or provider organisation.	✓				01/08/2026	31/10/2026	This interest will be kept under review and specific actions determined as required.
McLean	Kathy	Chair	✓	✓	✓	Paid briefing to independent sector companies on strategic commissioning paid by Newmarket Strateg (health and life sciences consultancy) via Kathy McLean Ltd	Ownership and/or directorship of a private company	✓				21/07/2026	21/07/2026	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.	✓				01/10/2025	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 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.
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.

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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	
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 activitiesand 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 Commision 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 activitiesand 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.
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.

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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.
Simpson	Paul	Local Authority Partner Member	✓	–	–	Chief Executive Officer at Derby City Council	Role within an NHS, local authority or provider organisation.	✓				01/03/2026	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.
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	31/08/2026	*N/A - This interest expired on 31/08/2026 and will be removed from the register on 01/03/2027.*
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.

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

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	
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.
King	Daniel		_	_	✓	Nottingham Trent University	Employee	✓				06/09/2023	Present	This interest will be kept under review and specific actions determined as required.

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

16 July 2026, 10:00-13:00

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

		NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB
Members present:				
Dr Kathy McLean	Chair	✓	✓	✓
John Dunstan	Non-Executive Director (from item ICB CIC 26 027)	✓	✓	✓
Stephen Jackson	Non-Executive Director	✓	✓	✓
Margaret Gildea	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	✓	-	-
Maria Principe	Executive Director of Commissioning	✓	✓	✓
Clair Raybould	Executive Director of Strategy and Citizen Experience	✓	✓	✓
Sharon Robson	Non-Executive Director	✓	✓	✓
Bill Shields	Executive Director of Finance	✓	✓	✓
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	✓	✓	✓
Ellie Houlston	Director of Public Health, Lincolnshire County Council	-	✓	-
Vivienne Robbins	Director of Public Health, Nottinghamshire County Council (on behalf of Adrian Smith)	-	-	✓
Andy Smith	Director People Services, Derby City Council (Interim Local Authority Partner Member)	✓	-	-
Sue Wass	Corporate Governance Officer, NHS Nottingham and Nottinghamshire ICB (Minutes)	✓	✓	✓
Matthew Whittaker	Operational Lead, Team Up, Swadlincote Primary Care Network (for item ICB CIC 26 025)	-	-	-
Jacqui Willis	Chief Executive, Derbyshire Voluntary Action	✓	-	-

		NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB
Apologies:				
Dr Dave Briggs	Executive Director of Outcomes (Medical)	✓	✓	✓
Karen Dunderdale	NHS Trust/ Foundation Trust Partner Member	-	✓	-
Mark Powell	Ordinary Member – Mental Health	✓	✓	✓
Martin Samuels	Local Authority Partner Member	-	✓	-
Adrian Smith	Local Authority Partner Member	-	-	✓

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

Name	Possible	Actual	Name	Possible	Actual
Dr Kathy McLean	2	2	Mark Powell	2	1
Dr Dave Briggs	2	1	Maria Principe	2	2
Karen Dunderdale	2	1	Clair Raybould	2	2
John Dunstan	2	2	Sharon Robson	2	2
Margaret Gildea	2	1	Martin Samuels	2	1
Stephen Jackson	2	2	Bill Shields	2	2
Mehrunnisa Lalani	2	2	Adrian Smith	2	1
Dr Kelvin Lim	2	2	Amanda Sullivan	2	2
John Melbourne	2	2	Jon Towler	2	2
Dr Andrew Mott	2	2	Dr Kevin Thomas	2	2
Stephen Posey	2	2	Rosa Waddingham	2	2

Introductory items

ICB CIC 26 020 **Welcome, introductions and apologies**

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. As the Government was due to make an announcement regarding local government reorganisation later that day, Martin Samuels and Adrain Smith had given apologies at short notice; and Vivienne Robbins was attending the meeting on behalf of Adrian Smith.

Welcome was extended to Andy Smith, who was in attendance pending the appointment of a substantive Chief Executive at Derby City Council; and as the Boards were meeting in Derbyshire, a welcome was also extended to Ellie Houlston and Jacqui Willis.

ICB CIC 26 021 **Confirmation of quoracy**

The meetings were confirmed as quorate.

ICB CIC 26 022 **Declarations and management of interests**

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

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

ICB CIC 26 023 **Minutes of the meeting held on 21 May 2026**

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

ICB CIC 26 024 **Action log and matters arising from the meeting held on 21 May 2026**

One action was highlighted as open and on track for completion by its due date and the remaining actions were confirmed as completed.

Discussing the open item, it was confirmed that the ICBs were awaiting publication of national guidance on how the ICBs should discharge their duties with primary care in relation to Freedom to Speak Up arrangements, which would form part of the alignment of such arrangements within the ICBs.

No other matters were raised.

Leadership and operating context

ICB CIC 26 025 **Citizen Story: Derby and Derbyshire Team Up**

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

a) Clair introduced Matthew Whittaker, Operational Lead for Team Up, Swadlincote/South Derbyshire and Co-Chair of the South Derbyshire Place Alliance. This was an opportune story, which set into context the item later on the agenda relating to frailty and end of life services.

b) Matthew provided a presentation that detailed the experiences of Barbara and her daughter and how the Team Up multi-disciplinary team had been able to co-ordinate care at short notice to allow Barbara to die peacefully in the place of her choice.

c) Matthew explained that the service had delivered positive impacts for local NHS services by helping to avoid accident and emergency attendances, hospital bed days and hospital conveyances. The accompanying report included statistics demonstrating this impact. He also emphasised that the value of citizen stories lay in showing how services affected individuals, both positively and negatively, by highlighting real-world failings and identifying areas for improvement.

The following points were made in discussion:

d) Members noted that the story supported both the national and ICB intention to promote integrated care in neighbourhood settings. They also acknowledged

the excellent end-of-life care provided by the multi-disciplinary team for Barbara. However, members noted that Barbara's daughter had struggled to support her for 18 months before her death. They therefore queried how learning could be taken forward to ensure that individuals and carers were supported at an earlier stage of decline. Matthew acknowledged that, when Team Up was established, there had been a greater ambition for the team to work proactively. However, many patients requiring support remained 'hidden', either because they or their families did not recognise the need for support, or because contact was made only at times of crisis. Members discussed the need to use GP data, local authority intelligence and insight from the voluntary, community and social enterprise sector to support a more proactive approach in future.

e) Members commended Matthew for the strong leadership within the team that had enabled such a rapid and comprehensive response and queried how the team had been developed. In response, Matthew noted that the team had been brought together with initial funding five years ago and had since built a strong team ethos, which enabled members to work across organisational boundaries. However, there had been challenges in terms of organisational barriers, issues such as data sharing, and it had taken time to build relationships.

f) Noting that there was much learning that could be taken from the story, both regarding the operation of neighbourhood teams and how to use community insight in the commissioning of services, the Chair thanked Matthew for his thought-provoking presentation.

The Boards **noted** the Citizen Story.

At this point Matthew Whittaker left the meeting.

ICB CIC 26 026 **Chair's Report**

Kathy McLean introduced the item, highlighting the following points:

a) The publication of the reports arising from Donna Ockenden's independent review into maternity services at Nottingham University Hospitals NHS Trust, together with Baroness Amos' national investigation into maternity and neonatal services, had prompted significant reflection, as both had exposed serious failings. Kathy committed the ICBs to doing everything within their power to support rapid and sustainable improvement.

b) The Nottingham Inquiry had recently concluded its evidence hearings and a report was expected to be released early in 2027. Pending the publication of the report, governance arrangements, including oversight from the NHS Nottingham and Nottinghamshire ICB and regional and national NHS England teams, were in place to monitor quality and regulatory concerns at Nottinghamshire Healthcare NHS Foundation Trust.

c) The ICBs continued to make progress in delivering the nationally required reduction in operating costs and in developing future organisational arrangements across the ICBs. This had been a challenging period for colleagues and the professionalism, resilience and commitment that staff continued to demonstrate was recognised by the Boards.

d) Kathy had continued her round of visits to local services and continued to communicate with local partners, including local authorities, elected representatives and NHS organisations regarding the future development of the NHS operating model.

e) Noting that there had been several communications from NHS England on actions required of ICBs, Kathy had asked that sufficient time be set aside for Board members to absorb the communications and set the strategic direction for the ICBs. She thanked fellow non-executive directors for the additional work that they had undertaken to oversee the ICBs' management of change process and confirmed that, in accordance with NHS England guidance, she had completed the annual 'Fit and Proper Person Test' assessment for each individual Board member and no concerns were raised regarding the fitness and propriety of any member.

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

ICB CIC 26 027 **Chief Executive's Report**

Amanda Sullivan introduced the item, highlighting the following points:

a) Reiterating Kathy's sentiments regarding the publication of Donna Ockenden's independent review into maternity services at Nottingham University Hospitals NHS Trust, and Baroness Amos' national investigation into maternity and neonatal services, Amanda described the reports as very difficult reading and the experiences described were deeply upsetting. She recognised the great strength and courage that affected families had shown in order for the failings to be fully exposed. Whilst both reports contained very difficult messages, they reinforced the importance of listening to women and families, fostering cultures of openness and learning, and continuing collective efforts to improve safety, quality and equity in maternity care, asking the Boards to note she was committed to a relentless focus on driving improvements in the delivery of compassionate care within maternity and neo-natal services.

b) Amanda committed to bringing a full report to the next Board meeting to detail how the ICBs would address the actions from both reports and from NHS England's Ten-Point Maternity Urgent Plan. The report would also describe the key areas of focus for the ICBs in terms of their oversight responsibilities, which would ensure focus on ensuring women, families and carers were actively involved in service oversight, design and improvement, both through the Maternity and Neonatal Voices Partnership and broader engagement.

c) Further to the publication of the two reports described above, NHS England had written to all NHS Trusts and ICBs focusing on mortuary oversight and post-death care; and the ICBs would also ensure oversight of post death care, with a focus on specific actions relating to Nottingham University Hospitals NHS Trust.

d) Lord Mann had published his review into tackling racism and antisemitism within the NHS, with recommendations to support a shared goal of making services safe for all patients, communities and colleagues. All organisations had a set of immediate actions to take. The ICBs had actions to take both within their own organisations and when commissioning services. NHS England had requested confirmation of immediate actions for the ICBs to adopt the International Holocaust Remembrance Alliance's definition of antisemitism and the Government's definition of anti-Muslim hostility. It was confirmed that the Boards had formally adopted the definition of antisemitism at their meeting on 20 November 2025. A further action was to adopt the Government's definition of anti-Muslim hostility, as set out in the report; and for ICB Boards to confirm their commitment to completing the new anti-racism training when it became available.

e) Recognising that cyber security remained one of the greatest risks to NHS organisations, NHS England had recently written to all organisations to ask Boards and executive teams to assure themselves that cyber security risks were being effectively identified, managed and mitigated. A full description of the ICBs' arrangements had been included within the report to provide assurance that cyber security risks were being actively managed, and members were asked to note that further Board time would be spent on this topic at the development session in December.

f) Attention was drawn to Appendix A of the report. NHS England had recently requested that ICB Boards receive an update on the ICBs' plans to eliminate all adult out of area placements by March 2028 and to ensure that they had full visibility of where all patients placed out of area were receiving care. Appendix A provided this assurance to the Boards; and it was noted that plans would continue to be overseen by the ICBs' Joint Strategic Commissioning Committee.

g) The publication of two Frameworks was also highlighted, the 2026/27 NHS Oversight Framework on how NHS England would assess NHS organisations; and a new national NHS Leadership and Management Framework, which described what the NHS expected from its leaders and managers.

h) An interim update on the Modern Service Framework for Palliative Care and End-of-Life Care had also been published, which would be discussed under item ICB CIC 26 028.

i) The ICBs had received grant funding for the delivery of the Work Well Programme, which provided vocational support, health interventions and practical advice to help individuals stay in or return to work. This was a positive

example of how the ICBs were contributing to the fourth aim of Integrated Care Systems to help the NHS support broader social and economic development.

j) The ICBs' Annual Reports and Accounts for the period 1 April 2025 to 31 March 2026 had been published following approval by the ICBs' Audit Committees. Thanks were given to ICB teams who had worked hard to ensure positive outcomes for all three ICBs.

At this point John Dunstan joined the meeting

The following points were made in discussion:

k) Supporting the sentiments of Kathy and Amanda in relation to Donna Ockenden's independent review into maternity services at Nottingham University Hospitals NHS Trust, and Baroness Amos' national investigation into maternity and neonatal services, Board members welcomed a further review of the ICBs' response to the reports at the next meeting.

l) There was a query on how the ICBs received assurance that initiatives to tackle discrimination were having the desired impact. Amanda noted that this would be built into the ICBs' Quality Framework, to be discussed under item ICB CIC 26 029, to ensure that everyone felt heard and included regardless of background.

m) Following on from this point, the importance of Board leadership in setting the culture of the organisations to encourage openness and candour was raised; and this was acknowledged by Kathy as a key area for future discussion with Board members.

n) In relation to the report on mental health inpatient settings, the need for oversight to include the quality of provision in acute mental health settings was also highlighted and acknowledged.

The Boards:

- **Noted** the report.
- **Adopted** the Government's working definition of anti-Muslim hostility.
- **Confirmed** their commitment to completing the new anti-racism training when it became available.

Leadership and operating context

ICB CIC 26 028

Population Health Strategy Progress Report: Frailty and End of Life

Clair Raybould introduced the item, highlighting the following points:

a) This report was the first of a schedule of reports presenting an update on progress made in relation to each of the priorities within the ICBs' Five-Year Population Health Strategy, which had been received by the Boards at their March 2026 meeting. It set out why frailty and end of life services were an important focus and provided an initial baseline assessment for key

performance indicators that would be used to demonstrate progress of delivery. It also provided an overview of current and planned strategic actions that would drive the improvements to be measured by the key performance indicators.

b) Importantly, Board members were asked to note that the report provided a baseline oversight on the current landscape for frailty and end of life services across the ICBs. Each ICB had differing population health management approaches and different levels of data maturity, which would be aligned over time. Future reports would not include the level of detail regarding performance measures, but it was considered important to ensure visibility on how the baselines and performance measures were constructed.

c) An overview of the rationale for why frailty and end of life services were a priority for the ICBs was provided. These patient cohorts used a disproportionate amount of NHS resource; and the quality of care for individuals experiencing frailty and requiring end of life care was variable. Improved frailty and end of life care services would lead to a reduction in carer breakdown, improved bereavement outcomes and would stabilise demand across community services, ambulance conveyances and acute admissions.

d) The report summarised the 2026/27 Neighbourhood Health strategic commissioning actions that would support and drive improvements in frailty and end of life services. The intention was to commission services that could proactively manage individuals experiencing frailty or requiring end of life care, in line with the national direction of travel towards Integrated Neighbourhood Health management.

e) The interventions were in line with the Government's Interim Modern Service Framework for palliative care and the ICBs were in the final stages of developing a Palliative and End of Life Care Strategic Framework that satisfied this national requirement. There was very close alignment between national guidance and the ICBs' strategic intent. Once the finalised Modern Service Framework was released, the ICBs would undertake a further review to ensure that the ICBs' direction of travel continued to meet the national requirements.

The following points were made in discussion:

f) Board members welcomed the report, noting that past challenges around these priorities related to the difficulties of identifying individuals requiring palliative and end of life services at a much earlier stage. Board members also welcomed the approach as being much broader than the traditional focus on cancer services and it was confirmed that it also included children's end of life services. However, data on children's services was not as robust as adult services at the current time.

g) Accepting that the model was heavily reliant on the ICBs being able to enact the Neighbourhood Health Model across thee ICB geographical areas, there was a query as to the risk that the ambition would be diluted if funding needed to be diverted to other potential immediate specific priorities within individual

ICBs. It was noted that the specification for commissioned services related to all three ICBs but would be flexible to respond to the specific challenges within ICB populations to address inequalities and inequity of services.

h) Noting that there were some gaps in the data presented, Board members highlighted the need for good quality data in order to make informed decisions on resource allocation.

i) Board members noted that it was difficult to take assurance that the proposed actions were appropriate without any accompanying narrative on their deliverability, associated risks and barriers, and expected outputs and outcomes. This was acknowledged, and it was agreed that this feedback would be taken into account in future reports.

j) The value of ensuring collaboration with other partners was also raised, particularly in relation to adult social care services and voluntary and community services in terms of outreach.

k) In conclusion, the Chair thanked the ICBs for the report and Clair confirmed that the points raised in discussion would be addressed within future reports. Kathy commended the cross-directorate working between the strategy, data analyst and medical teams in the development of the ICBs' commissioning approaches.

The Boards **received** the report.

Oversight and delivery of commissioning outcomes

ICB CIC 26 029

Approach to Quality

Rosa Waddingham introduced the item, highlighting the following points:

a) The report provided an update on the ICBs' quality approach.

b) The approach built upon the ICBs' existing quality strategies, as well as the emergent National Quality Board guidance and new national quality strategy, which had been published very recently. The approach had been 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.

c) It outlined a key set of seven quality priorities for 2026/27; and through the recently launched System Quality Group, had 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.

d) The quality governance approach for escalation and oversight of commissioned services was outlined, alongside next steps once the ICBs had reviewed the recently published National Quality Board guidance and national Quality Strategy.

The following points were made in discussion:

e) With reference to the discussion earlier on the agenda regarding the need for oversight arrangements to align rather than duplicate the work of regulators, members sought assurance that governance arrangements gave service providers clarity. In response it was noted that the government had been clear that ICBs had a responsibility to commission high quality care; and that responsibility for the provision of high-quality services resided with service providers. The ICBs' oversight arrangements would be underpinned by partnership working, ensuring a more insightful flow of information, which was more than merely 'technical' oversight.

f) Further to this point NHS trust partner members agreed that there should be mutual trust and support and a shared understanding of the biggest risks within individual organisations and how to mitigate and manage them.

g) In response to a query on how the ICBs would ensure consistency of quality services within General Practice, it was noted that these providers were subject to regulation and the ICB would monitor the regulators' reports, rather than seeking to duplicate oversight.

h) Further to this question, there was a query regarding the visibility of General Practice quality issues at Board level. It was noted that the Boards' Quality Oversight Report only referenced those providers within escalated oversight arrangements; however, the report that was scrutinised by the Joint Quality and Service Improvement Committee contained a far greater level of information on all service providers. To provide further assurance, it was agreed that a description of quality oversight arrangements would be included within the upcoming strategic priority report on Strong General Practice.

i) In response to a query on how the ICBs would respond to persistent quality issues within a service, it was noted that the information would be triangulated within the ICB with the Commissioning Teams and action taken with the provider at a much earlier stage; and persistent issues could result in contractual penalties.

The Boards **noted** the report having discussed its content.

Action: Rosa Waddingham to include a description of quality oversight arrangements in the strategic priority report on Strong General Practice, scheduled for presentation at the November meeting of the Board.

ICB CIC 26 030 **Quality Oversight Report**

Rosa Waddingham introduced the item, highlighting the following points:

a) This new 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.

b) The report also reflected the establishment of the ICBs' Quality and Oversight Assurance Group as the operational coordination group for quality oversight of commissioned services, which provided an opportunity to further strengthen coordinated quality governance across the ICBs' footprints. The Group highlighted 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) Members were asked to note that, although there were some discrepancies in data, all quality concerns were triangulated with other intelligence, including 'soft' intelligence and performance concerns.

The following points were made in discussion:

d) Members welcomed the revised reporting arrangements. However, it was considered difficult to distil from the report the most pressing issues for the ICBs and there was a request to amend future reports to bring the most critical quality concerns to the fore, along with the ICBs' commentary on how assured the ICBs were that their concerns would or could be addressed.

e) Members took assurance that quality data and concerns were being considered through the ICBs' Commissioning Oversight Group. It was noted that this would enable potential issues to be identified and triangulated by ICB medical and quality colleagues, supporting assurance on the accuracy and robustness of providers' responses.

f) The use of Summary Hospital-level Mortality Indicators and national clinical audits were also highlighted as a source of valuable data, which should be considered for inclusion within future reports.

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

Action: Rosa Waddingham to amend future reports to bring the most critical quality concerns to the fore, along with the ICBs' commentary on how assured the ICBs were that their concerns would or could be addressed.

ICB CIC 26 031 **Commissioning Oversight Report**

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 2026/27 for NHS Derby and Derbyshire, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire ICBs, as well as an update on the arrangements for commissioning leadership and oversight across the ICBs' areas, and the 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) As described in the last update to the Boards, the revised commissioning oversight approach had now been 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 overseen by the ICBs' Commissioning Oversight Group and a series of cross-ICB Programme Boards.

d) The report provided an overview of the key areas of concern and action being taken. The report also provided national benchmarking data.

The following points were made in discussion:

e) Members urged the ICBs to apply appropriate challenge and scrutiny to some provider responses on underperformance, recognising that anomalies could indicate wider underlying issues. It was noted that these would be the types of matters considered through Programme Boards.

f) The Chair welcomed the revised reporting arrangements and thanked ICB colleagues for their continuing endeavours in this area to continue to refine reporting arrangements.

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

ICB CIC 26 032 **Finance Report**

Bill Shields introduced the item, highlighting the following points:

a) The report outlined the financial position of the ICBs and provider positions, for the two-month period April to May 2026.

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

c) However emerging pressure areas across the three ICBs remained, particularly within continuing healthcare and mental health services. A robust programme management office approach continued to be in place and the ICBs' Financial Recovery Group continued to meet regularly to maintain oversight on efficiency delivery and to actively manage demand pressures to ensure delivery of the financial position over the remainder of the year.

d) At month two, the ICBs' systems were reporting a deficit of £61 million against a planned deficit of £52 million, representing an adverse variance of £9.2 million. Nottinghamshire providers were driving the adverse position.

e) As noted at the last Board meeting, NHS England had resumed responsibility for provider financial oversight arrangements. However, the ICBs would continue to engage with providers to support them in areas of best practice.

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

Governance

ICB CIC 26 033

Annual Reports on Working in Partnership with People and Communities

Clair Raybould introduced the item, highlighting the following points:

a) The paper sought 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.

b) The Working with People and Communities Annual Reports for 2025/26 had been produced separately by each of the three ICBs, with production and governance arrangements remaining on an individual statutory basis throughout the reporting period.

c) The reports demonstrated the breadth of the ICBs' engagement activities; and it was pleasing to see that all ICBs had made progress in engaging with hard-to-reach communities in partnership with local authorities and other agencies. This would be built upon going forward, as the ICBs were committed to ensuring that a strong citizen voice was integral to all commissioning decisions.

d) The reports would be published separately to reflect the individual ICBs to which they related. As a result, each report retained its own stylistic approach; however, it was anticipated that future reports would be unified in line with national guidance on organisational merger.

The following points were made in discussion:

e) Board members encouraged the ICBs to draw on best practice from the strong examples set out across all three reports. They also asked how expectations would be managed as engagement arrangements developed. In response, it was noted that a unified approach to engagement and co-production across the ICBs was being developed. This would set out who the ICBs would communicate with and how engagement would be undertaken, with particular reference to neighbourhood health plans.

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

ICB CIC 26 034 **Annual Statements on Health Inequalities**

Clair Raybould introduced the item, highlighting the following points:

a) The report aimed to provide assurance regarding the delivery of the ICBs' statutory duties to take account of health inequalities issues in the exercise of NHS functions and that the ICBs had responded to the NHS England Statement on Information on Health Inequalities, which required ICBs to collect, analyse and publish information relating to health inequalities.

b) Individual Statements on Information on Health Inequalities had been produced for each of the ICBs for 2025/26. From 2026/27, a single Statement would be produced across the three ICBs.

c) NHS England's updated 2025 Statement had set out a series of Key Lines of Enquiry for ICBs to use to support a self-assessment of how they had exercised their functions. The Statements produced by each ICB addressed all of these Key Lines of Enquiry and were supported by relevant case study examples.

d) The report also outlined the limitations of the health inequalities analysis undertaken and highlighted key issues and proposed actions to strengthen future approaches to addressing health inequalities.

The following points were made in discussion:

d) Following a prompt from Ellie Houlston, Board members discussed whether more could be done in partnership with Public Health colleagues and Health and Wellbeing Boards. They agreed that limitations in the current data should not prevent action to address inequalities and welcomed a broader partnership approach.

The Boards **received** the item for assurance that that the ICBs were complying with statutory, regulatory, and legal obligations.

ICB CIC 26 035 **Risk Management Policy**

Lucy Branson introduced the item, highlighting the following points:

a) The ICBs' joint Risk Management Policy had been updated following its initial approval by the Boards in November 2025, taking account of learning from practice, and in light of discussions regarding risk appetite at the Boards' development session in June.

b) The Policy continued to provide a common framework across the three ICBs for the identification, assessment, escalation and management of risk, while maintaining the distinction between strategic risks managed through the Board Assurance Framework and operational risks managed through the Operational Risk Register and risk logs.

c) The principal changes included the introduction of a strengthened risk appetite framework, revised risk domains, greater clarity regarding governance

arrangements and accountability, and a more consistent approach to risk assessment, escalation and reporting across the partnership.

d) The Policy was intended to support effective decision-making by ensuring risks were appropriately understood, managed and monitored, while enabling innovation and transformation to be pursued within agreed risk parameters.

e) The Audit Committees would continue to oversee the effectiveness of risk management arrangements on behalf of the Boards through established assurance reporting.

The Boards **approved** the ICBs' updated Risk Management Policy.

ICB CIC 26 036 **Committee Highlight Reports**

The report presented an overview of the work of the committees since the Boards' last meeting in May 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) In response to a query on an item discussed at the Joint Quality and Service Improvement Committee, Chair of the Committee, Sharon Robson, asked Board members to note that the Committee had been assured that governance and oversight arrangements were in place across the ICBs' provider organisations regarding progress again the Fuller Inquiry recommendations on after death care. However, further assurance was required to demonstrate the consistent and sustainable implementation of improvements; and a further review would be undertaken following the conclusion of the Human Tissue Authority's audit into reportable incident records.

b) Chair of the Joint Transition Committee, Jon Towler, asked members to note that good progress continued to be made in the implementation of the ICBs' management of change programme. However, a crucial stage had now been reached. Delivery of the wave three recruitment programme remained challenging due to the scale of the numbers of staff affected. Looking forward to a possible merger of the organisations during 2027, the Committee had highlighted the importance of a robust Organisational Development Plan to ensure that the ICBs could appropriately fulfil their roles as strategic commissioners.

c) Further to the discussion, Board members queried how the ICBs would continue to discharge their wide range of statutory duties with a significantly reduced workforce. In response, it was noted that ICB teams had been brought together and that a risk-based approach was being taken to the delivery of some functions, pending completion of the wave three recruitment process.

d) Partner members urged the ICBs to continue to update partners on the management of change process, particularly in relation to key personnel changes, which was agreed and acknowledged.

e) Chair of the Audit Committees, John Dunstan, asked the Boards to note that the Committees had approved the ICBs' final draft annual reports and accounts for 2025/26, with no concerns raised by either the internal or external auditors.

f) On behalf of the Boards, the Chair thanked the finance and governance teams for the production of three reports and accounts at a period of significant change for the organisations, which had included the introduction of a new financial ledger.

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

	Closing items
ICB CIC 26 037	**Risks identified during the course of the meeting** No new risks were identified.
ICB CIC 26 038	**Questions from the public relating to items on the agenda** No questions had been received.
ICB CIC 26 039	**Any other business** No other business was raised, and the meeting was closed.

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Action Log from Board meetings in common, held on 16 July 2026

Meeting date	Agenda item	Action	Lead	Due date	Updates	Status
21.05.2026	ICB CIC 26 008	To progress alignment of Freedom to Speak Up arrangements between the ICBs.	Lucy Branson	17.09.2026	See agenda item 7.	**Closed – action completed**
16.07.2026	ICB CIC 026 029	To include a description of quality oversight arrangements in the strategic priority report on Strong General Practice, scheduled for presentation at the November meeting of the Board.	Rosa Waddingham	19.11.2026	Not yet due.	**Open – on track**
16.07.2626	ICB CIC 026 030	To amend future reports to bring the most critical quality concerns to the fore, along with the ICBs' commentary on how assured the ICBs were that their concerns would or could be addressed.	Rosa Waddingham	17.09.2026	See agenda item 11.	**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:	17/09/2026
Paper title:	**Chair's Report**
Paper reference:	ICB CIC 26 045
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 provides an update on my activities as Chair of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB, including engagement undertaken on behalf of the ICBs and reflections on significant national, local and Board matters.

Recommendation(s):

The Boards are asked to:

- **Note** this paper for information.
- **Approve** the updated terms of reference for the Joint Transition Committee, Joint Finance and Performance Committee, and Audit Committees, as set out at Appendix A.
- **Approve** the minor amendments to the Schemes of Reservation and Delegation, as set out at Appendix B.

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

Appendix A: Terms of reference for the Joint Transition Committee, Joint Finance and Performance Committee, and Audit Committees.
Appendix B: Scheme of Reservation and Delegation – proposed changes

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Chair's Report

Introduction

1. This report is presented at a time of continuing change across the NHS and the wider public sector. Alongside responding to national policy developments and preparing for future organisational arrangements, the ICBs must maintain a clear focus on improving population health, reducing inequalities and securing the quality and sustainability of services for local communities.
2. The Boards' leadership and oversight remain particularly important during this period. We must continue to support our people, sustain effective relationships with partners and communities, and ensure that organisational transition does not distract from the ICBs' statutory responsibilities and core purpose. This report highlights a number of national, local and Board matters relevant to those responsibilities, together with details of recent visits and engagement activities I have undertaken on behalf of the ICBs.

National matters

Neighbourhood health

3. Neighbourhood health remains central to the delivery of the ICBs' Five-Year Population Health Strategy and to the wider national ambition to bring more care closer to people's homes and communities.
4. NHS England has consulted on proposed Multi-Neighbourhood Provider Contracts and Single Neighbourhood Provider Contracts, which are intended to support the development of neighbourhood health arrangements. The consultation considered the potential benefits, risks and practical implications of the proposed models, including their interaction with existing contracting arrangements.
5. The ICBs have contributed their views to the consultation. Further information on local neighbourhood health readiness and delivery is provided in the Chief Executive's Report and the Population Health Strategy Progress Report on Neighbourhood Health presented elsewhere on today's agenda.

Maternity and neonatal services

6. The publication of Baroness Amos' independent investigation into maternity and neonatal services in England and Donna Ockenden's independent review of maternity services at Nottingham University Hospitals NHS Trust is of considerable significance for Boards across the NHS.
7. In response, NHS England has set out a Ten Point Plan of urgent actions for maternity and neonatal services, together with the associated expectations and assurance arrangements for NHS trusts.

8. The immediate priority is delivery of the Ten Point Plan while the national Maternity and Neonatal Taskforce develops a comprehensive action plan. The ICBs' Boards remain committed to maintaining appropriate oversight of the quality and safety of commissioned maternity and neonatal services and to supporting sustained improvement across the three systems.

9. Further information is provided in the Maternity and Neonatal Services Report presented elsewhere on today's agenda.

Community mental health support

10. I welcome the Government's announcement of a significant expansion in community mental health support, intended to enable people to access help earlier and closer to home.

11. The proposals include additional community-based mental health facilities, walk-in support without the need for referral and specialist environments for people experiencing a mental health crisis. Potential locations have been identified across the three ICB areas, although further work is required to confirm the service model, funding arrangements and final locations.

12. The Boards will wish to remain sighted on the development of these proposals and their potential to improve access, experience and outcomes for local people.

Industrial relations

13. The British Medical Association announced in July that consultants had voted in favour of industrial action, with the required turnout threshold having been met. Specialty, associate specialist and specialist doctors also voted in favour, although turnout did not meet the threshold required for industrial action.

14. The Boards will need to remain alert to further national developments and any implications for patients, staff and the resilience of local services.

Local and system matters

Annual Public Meetings

15. I was pleased to chair the ICBs' first Annual Public Meetings held in common on 3 September 2026. The meetings provided an important opportunity for the ICBs to account publicly for their work, reflect on the achievements and challenges of the previous year and hear directly from stakeholders and citizens across the three areas.

16. The meetings were attended by representatives from NHS trusts, local government and the voluntary, community, faith and social enterprise sector, as well as members of the public. Discussion covered service quality and performance, financial pressures and the ICBs' priorities, with questions from

attendees addressing neighbourhood health, public involvement, financial sustainability and the expansion of primary care facilities.

17. The meetings reinforced the importance of maintaining open and transparent relationships with our communities and ensuring that the experience and views of local people continue to inform the work of the ICBs.

Organisational transition

18. Organisational transition continues to create significant uncertainty and change for colleagues. Further information on the workforce implications, job evaluation arrangements and organisational development programme is provided in the Chief Executive's Report.

19. On behalf of the Boards, I would like to thank colleagues for their continued flexibility, resilience and commitment. Their contribution since the national announcements has been vital in enabling the ICBs to continue to discharge their statutory responsibilities and deliver agreed priorities.

20. As future arrangements develop, the Boards must continue to recognise the effect of change on our people and maintain a clear focus on staff wellbeing, organisational resilience and the development of a shared culture.

Future ICB footprints and local government reorganisation

21. NHS England has consulted on future ICB footprints, and the ICBs have engaged with stakeholders across the three areas and submitted their views for national consideration. The wider context continues to evolve following the Government's proposals for devolution, strategic authorities and local government reorganisation.

22. In September 2026, the Government announced a review of the wider Local Government Reorganisation programme and paused implementation activity across a number of areas while it considers updated legal advice and reviews whether existing proposals align with its wider ambitions for devolution and public service reform. This is a national development affecting a range of areas across England.

23. The review creates continued uncertainty for local government, NHS organisations and system partners in a number of areas, including those served by the three ICBs. However, the ICBs will continue to work closely with local authority and wider system partners to improve health outcomes, reduce inequalities and develop neighbourhood health services, irrespective of future organisational arrangements.

Winter preparedness

24. The Winter Plan is presented elsewhere on today's agenda for the Boards' consideration.

25. Winter pressures are increasingly an extension of the sustained operational pressures experienced throughout the year, with additional demand arising from seasonal illnesses, including influenza and Respiratory Syncytial Virus. Stress-test events have been held in each ICB area to inform the final plans. It will be important that the Boards are assured that these are sufficiently robust to respond to seasonal pressures while maintaining safe and effective services.

Visits and engagement

26. Visits to local services continue to provide an important opportunity to hear directly from patients, staff and leaders and to understand the impact of our collective work on local communities.

27. During August, Amanda Sullivan and I visited the Urgent and Emergency Care Department at Lincoln County Hospital. I would like to thank the colleagues who met with us and shared their experience and insight. Colleagues described a range of initiatives intended to reshape urgent and emergency care, including expanding the conditions that can be managed safely at the front door and directing suitable patients to the Urgent Treatment Centre. We also heard about work with the University of Lincoln Medical School to ensure that future medical and nursing curricula reflect emerging models of care and help prepare the future workforce.

28. I was also pleased to speak at a leadership conference at Sherwood Forest Hospitals NHS Foundation Trust, with a particular focus on women in leadership.

Board matters

Committee terms of reference

29. The Joint Transition Committee was established on a time-limited basis to oversee the ICB Transition Programme and implementation of the cluster operating model. With many of the Committee's original objectives now delivered or nearing completion, its terms of reference have been reviewed to ensure that its remit remains aligned with the matters that continue to require dedicated Board oversight and assurance.

30. The revised terms of reference, which have been reviewed and endorsed by the Committee, refocus its remit on providing assurance regarding the final phase of the Transition Programme, the effectiveness and benefits of the new operating model and readiness for future merger arrangements. Other workforce and organisational development matters will continue to be overseen by the Joint Remuneration and Human Resource Committee, providing greater clarity of accountability and assurance.

31. It is proposed that the Transition Committee remains established until at least 31 March 2027, with a further review of its continued necessity to be undertaken during January 2027. That review will inform recommendations regarding the Committee's future role and the appropriate timing of its dis-establishment.

32. The Boards are also asked to consider minor amendments to the terms of reference for the Joint Finance and Performance Committee and Audit Committees following a recent internal audit review of governance arrangements. The review provided a 'Significant Assurance' opinion and identified a low-risk recommendation to ensure complete consistency between delegated responsibilities contained within the Schemes of Reservation and Delegation and those described within associated committee terms of reference. The proposed changes do not alter existing delegations or decision-making responsibilities and are intended to strengthen clarity and consistency across the governance framework.

33. In light of the above, the Boards are asked to approve the revised terms of reference for the Joint Transition Committee, Joint Finance and Performance Committee and Audit Committees, as set out at Appendix A (with changes highlighted in yellow).

Schemes of Reservation and Delegation

34. Minor amendments are also proposed to the ICBs' Schemes of Reservation and Delegation to ensure that the delegated authority arrangements remain clear, current and aligned with the revised organisational structure. The Boards are asked to approve the proposed changes, which clarify responsibility for approving payroll transactions and the applicable approval routes and financial thresholds for off-payroll and agency worker appointments (see Appendix B).

Looking forward

35. The period ahead will require the Boards to maintain effective oversight of organisational transition while remaining focused on the quality, performance and sustainability of services. Strong relationships with staff, partners and communities will continue to be essential as the ICBs fulfil their statutory responsibilities and work to improve outcomes and reduce inequalities for local people.

Appendix A

Transition Committee – Terms of Reference

1. Introduction/ Purpose	The Transition Committee ("the Committee") is a joint committee of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB ("the ICBs"), established in accordance with section 65Z5 and 65Z6 of the National Health Service Act 2006 (as amended by the Health and Care Act 2022). The primary purpose of the Committee is to provide oversight, scrutiny and assurance regarding the final stages of the ICB Transition Programme and preparations for the future ICB merger. The Committee will provide assurance to the Boards regarding the effectiveness and benefits realisation of the cluster operating model, the application of lessons learned from the Transition Programme, and organisational readiness to support future merger implementation in line with national requirements. Due to the nature of the Committee's role, it will be time-limited in its establishment, with the ICBs' Boards determining the appropriate timeframe for the Committee to be dis-established. The Committee is authorised to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee of the ICBs, and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.
2. Duties	The Committee will: a) Oversee completion of the final phase of the Transition Programme and the ongoing effectiveness of programme governance arrangements. b) Receive assurance regarding the effectiveness of the cluster operating model and the extent to which anticipated benefits and organisational outcomes have been achieved. c) Oversee the identification of lessons learned from the Transition Programme and ensure that these are appropriately reflected in future organisational and merger planning. d) Oversee the development and delivery of the programme activities required to support the future ICB merger and/or boundary changes in line with the nationally agreed footprint and timescale. e) Receive assurance regarding organisational readiness for merger implementation in line with national requirements.

	f) Oversee the identification and management of risks relating to the Committee's remit. g) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
3. Membership	The Committee will have six members, all of which have been jointly appointed by the ICBs. The Committee's membership is comprised as follows: a) Three Non-Executive Directors. b) Chief Executive. c) Executive Director of Transition. d) Executive Director of Finance. *Attendees* The Committee may invite a range of senior managers to attend meetings to support the Committee in discharging its responsibilities. This will include the Senior Responsible Officers leading the Transition Programme Workstreams. The jointly appointed Chair of the ICBs will also be invited to attend one meeting each year to gain further assurance regarding the effectiveness of the ICBs' governance arrangements.
4. Chair and deputy	The ICBs' Boards will appoint a Non-Executive Director to be Chair of the Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's non-executive membership will be nominated to deputise for that meeting.
5. Quorum	The Committee will be quorate with a minimum of four members, to include at least one non-executive member and one executive member. To ensure that the quorum can be maintained, the executive members of the Committee are able nominate a suitable deputy to attend a meeting of the Committee that they are unable to attend to speak and vote on their behalf. Committee members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained. If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

6. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. If a consensus agreement cannot be reached, then the item will be escalated to the ICBs' Boards for a decision.
7. Meeting arrangements	Meetings of the Committee will be scheduled on a monthly basis, and the Committee will meet no less than six times per year. Members of the Committee are expected to attend meetings wherever possible. Meetings of the Committee, other than those regularly scheduled above, shall be summoned by the secretary to the Committee at the request of the Chair. The Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including those relating to the quorum (as set out in section 5 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Committee to be open to the public. Secretariat support will be provided to the Committee to ensure the day-to-day work of the Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
8. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Committee at the following meeting.
9. Conflicts of interest management	In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such

	declarations will be formally recorded in the minutes for the meeting. The Chair of the Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
10. Reporting responsibilities	The Committee will provide assurance to the ICBs' Boards that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing an assurance report to the Boards following each of the Committee's meetings; summarising the items discussed, decisions made, and any specific areas of concern that warrant immediate Board attention. b) Providing an annual report to the Boards, summarising how the Committee has discharged its duties across the year, key achievements and any identified areas of required Committee development. This report will be informed by the Committee's annual review of its effectiveness. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
11. Review of terms of reference	The Committee will undertake a formal review of its continued necessity during January 2027 and make recommendations to the Boards regarding the timeframe for its dis-establishment and transfer of any residual responsibilities to another committee.

Finance and Performance Committee – Terms of Reference

1. Introduction/ Purpose	The Finance and Performance Committee ("the Committee") is a joint committee of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB ("the ICBs"), established in accordance with section 65Z5 and 65Z6 of the National Health Service Act 2006 (as amended by the Health and Care Act 2022). The Committee exists to scrutinise arrangements for ensuring the delivery of the ICBs' statutory financial duties in line with sections 223GB to 223N of the NHS Act 2006 (as amended by the Health and Care Act 2022). The Committee is also responsible for scrutiny of business and operational planning, delivery of national and local health targets and performance standards, delivery of estates and infrastructure strategies, and delivery of environmental sustainability plans (including statutory duties as to climate change). The remit of the Committee incorporates the relevant requirements set out within the Delegation Agreements between NHS England and the ICBs, insofar as they relate to finance and performance. The Boards have authorised the Committee to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee of the ICBs, and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. d) Create sub-committees or task and finish groups to take forward specific duties or programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such sub-committees or task and finish group. Any sub-committee or task and finish group established may consist of or include persons who are not Board members or employees of the ICBs.
2. Duties	a) Oversee development of robust financial plans (revenue and capital), ensuring alignment with strategic plans and the requirement to deliver statutory financial balance, and recommend these for approval by the ICBs' Boards. b) Ensure the ICBs' annual budgets are prepared within the limits of available funds and recommend these for approval by the ICBs' Boards. c) Review and scrutinise delivery of financial plans and the ICB's in-year financial position, ensuring that: i) Required efficiencies are identified and delivered. ii) Robust action plans are developed in response to any material variances.

	iii) Expenditure in each financial year does not exceed the aggregate of any sums received within that financial year. iv) Local capital and revenue resource use for each financial year does not exceed the limits specified by NHS England. d) Oversee arrangements for robust prioritisation of future capital resource use and the development of capital funding bids. e) Approve ICB capital investments. f) Scrutinise arrangements for contract management and new payment mechanisms, including demand and utilisation management, ensuring that approaches incentivise quality, efficiency and equitable access. g) Oversee business and operational planning, ensuring financial, workforce, operational performance and activity plans are integrated and support the delivery of improved outcomes and productivity from commissioned services. h) Oversee delivery of national and local performance standards, focussing in detail on specific issues where performance is showing deterioration or where there are issues of concern, and monitoring achievement of agreed recovery trajectories. Any areas of deteriorating performance that could compromise health outcomes or quality of service will be referred to the Quality and Service Improvement Committee for scrutiny of potential harm and appropriate interventions. i) Oversee the development of estates/infrastructure strategies and recommend these for approval by the ICBs' Boards; subsequently scrutinising their delivery. j) Approve the ICBs' estates plans for the GP practices within their areas and scrutinise arrangements for ensuring that the GP practice premises estate is properly managed and maintained. k) Oversee the development of the green plans in line with national guidance and targets and recommend this for approval by the ICBs' Boards; subsequently scrutinising their delivery and progress towards net zero targets. l) Review and approve policies specific to the Committee's remit. m) Oversee the identification and management of risks relating to the Committee's remit. n) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
3. Membership	The Committee will have eight members, all of which have been jointly appointed by the ICBs. The Committee's membership is comprised as follows: a) Three Non-Executive Directors. b) Executive Director of Finance. c) Executive Director of Commissioning. d) Executive Director of Quality (Nursing).

	e) Senior leadership representative from the Outcomes (Medical) Directorate. f) Senior leadership representative from the Strategy and Citizen Experience Directorate. *Attendees* The Committee may invite a range of senior managers to attend meetings to support the Committee in discharging its responsibilities. The jointly appointed Chair of the ICBs will also be invited to attend one meeting each year to gain further assurance regarding the effectiveness of the ICBs' governance arrangements.
4. Chair and deputy	The ICBs' Boards will appoint a Non-Executive Director to be Chair of the Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's non-executive membership will be nominated to deputise for that meeting.
5. Quorum	The Committee will be quorate with a minimum of five members, to include at least one non-executive member and one executive member. To ensure that the quorum can be maintained, the Executive members of the Committee are able nominate a suitable deputy to attend a meeting of the Committee that they are unable to attend to speak and vote on their behalf. Committee members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained. If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
6. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. If a consensus agreement cannot be reached, then the item will be escalated to the ICBs' Boards for a decision.
7. Meeting arrangements	Meetings of the Committee will be scheduled on a monthly basis, and the Committee will meet no less than six times per year. Members of the Committee are expected to attend meetings wherever possible. Meetings of the Committee, other than those regularly scheduled above, shall be summoned by the secretary to the Committee at the request of the Chair. The Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including those relating to the quorum (as set out in section 5 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair.

	There is no requirement for meetings of the Committee to be open to the public. Secretariat support will be provided to the Committee to ensure the day-to-day work of the Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
8. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Committee at the following meeting.
9. Conflicts of interest management	In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
10. Reporting responsibilities and review of committee effectiveness	The Committee will provide assurance to the ICBs' Boards that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing an assurance report to the Boards following each of the Committee's meetings; summarising the items discussed,

	decisions made and any specific areas of concern that warrant immediate Board attention. b) Providing an annual report to the Boards, summarising how the Committee has discharged its duties across the year, key achievements and any identified areas of required Committee development. This report will be informed by the Committee's annual review of its effectiveness. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
11. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the ICBs' Boards for approval.

Issue date:	**Status:**	**Version:**	**Review date:**
September 2026	Draft	1.1	March 2027

Audit Committee – Terms of Reference

1. Purpose	The Audit Committee ("the Committee") exists to oversee the establishment and maintenance of effective integrated governance, risk management, and internal control and assurance systems across all ICB activities. The Committee provides the Board with an independent and objective view of the ICB's financial stewardship arrangements, scrutinises all instances of non-compliance with Standing Orders, the Scheme of Reservation and Delegation and Standing Financial Instructions, and monitors the ICB's standards of business conduct and freedom to speak up arrangements, The Committee also approves internal audit arrangements, reviews audit plans and findings, and monitors the effectiveness of both internal and external audit functions. It oversees counter fraud, bribery, and corruption measures, approves the annual report and accounts, ensures compliance with information governance and cyber security requirements, and monitors adherence to other regulatory and mandatory obligations such as emergency preparedness, health and safety, and statutory training.
2. Status	The Committee is established in accordance with the National Health Service Act 2006 (as amended by the Health and Care Act 2022) and the ICB's Constitution. It is a statutory committee of, and accountable to, the Board. The Board has authorised the Committee to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. d) Create sub-committees or task and finish groups to take forward specific programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such sub-committees or task and finish group. Any sub-committee or task and finish group established may consist of or include persons who are not Board members or ICB employees. The Audit Committee may meet 'in-common' with the Audit Committees of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, NHS Nottingham and Nottinghamshire ICB [to be deleted as appropriate].
3. Duties	*Integrated governance, risk management and internal control* a) The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the ICB's activities, which supports the achievement of its objectives. The Committee will:

	i) Review the adequacy and effectiveness of the ICB's risk management arrangements and all risk and control related disclosure statements (including the annual governance statement) together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances. ii) Review the adequacy and effectiveness of the underlying assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. This will include reviewing the outcome of the annual effectiveness assessment of all committees prior to consideration by the Board. iii) Review of all instances of non-compliance with Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation. iv) Review the reasonableness of the use of emergency powers for urgent decisions on behalf of the Board and its committees, and all instances where Standing Orders have been suspended. v) Oversee the ICB's overarching Corporate Policy Framework, ensuring it is comprehensive and up to date. b) In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from Executive Directors and senior managers, as appropriate. c) The Committee will use the Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it. *Internal audit* d) The Committee will approve arrangements for the provision of internal audit services. e) The Committee will ensure that there is an effective internal audit function established by management that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, ICB Chief Executive, ICB Chair and the Board. This will be achieved by: i) Considering the provision of the internal audit service and the costs involved; ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation. ii) Reviewing and approving of the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the ICB (as identified in the Board Assurance Framework). iii) Considering the major findings of internal audit work (and management's response) and ensuring co-ordination

	between the internal and external auditors to optimise the use of audit resources. iv) Monitoring the effectiveness of internal audit and completing an annual review. *External audit* f) The Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by: i) Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan. ii) Discussing with the external auditors their local evaluation of audit risks and assessment of the organisation and the impact on the audit fee. iii) Reviewing all external audit reports, including the report to those charged with governance and any work undertaken outside of the audit plan, together with the appropriateness of management responses. g) The Committee will also ensure a cost-efficient external audit service. *Counter fraud* h) The Committee will approve arrangements for the provision of counter fraud, bribery and corruption services. i) The Committee will satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption (including cyber-crime) that meet NHS Counter Fraud Authority's standards and will review the outcomes of work in these areas. This will be achieved by: i) Reviewing, approving and monitoring counter fraud work plans; receiving regular updates on counter fraud activity and monitoring the implementation of action plans. ii) Ensuring that the counter fraud service submits an Annual Report, outlining key work undertaken during each financial year and progress in achieving the requirements of the Government Functional Standard 13 for counter fraud. j) The Committee will refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority. *Financial reporting and stewardship* k) The Committee will monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance. l) The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided. m) The Committee will scrutinise the outcome of the annual review of the Standing Financial Instructions, recommending any amendments to the Board for approval.

	n) The Committee will: i) Be notified of any new bank accounts or changes to existing bank accounts, and any arrangements made with the ICB's bankers for accounts to be overdrawn. ii) Approve the use of procurement or other card services by the ICB, including the types of card services that should be allowed, the types of transactions that should be permitted, the individuals who should be issued with a card, and the overall credit and individual transaction limits to be associated with each card. iii) Review the extent to which debt is being managed effectively. iv) Scrutinise any retrospective approvals to commit revenue expenditure. v) Review all losses and special payments (including special severance payments) and approve all write-offs arising from losses. vi) Oversee compliance with the requirements of the NHS Provider Selection Regime (PSR). This will include oversight of annual reporting requirements (as set out in Regulation 25 of the PSR and associated statutory guidance) and oversight of the ICB's monitoring and publication arrangements (in line with Regulation 26 of the PSR), which will include retrospective reporting of all provider representations received in relation to procurement and contract award decisions for healthcare services. vii) Review all instances where competitive tendering requirements have been waived for non-healthcare services. *Annual report and accounts* o) The Committee will review and approve the annual report and accounts, focusing particularly on: i) The wording in the annual governance statement and other disclosures. ii) Changes in, and compliance with, accounting policies, practices and estimation techniques. iii) Unadjusted misstatements in the financial statements. iv) Significant judgements in preparation of the financial statements. v) Significant adjustments resulting from the audit. vi) Letters of representation. vii) Explanations for significant variances. *Information governance* p) The Committee will scrutinise compliance with legislative and regulatory requirements relating to information governance (including data protection and cyber security) and the extent to which associated systems and processes are effective and embedded within the ICB. This will include oversight of the

	ICB's performance against the Cyber Assessment Framework (CAF) aligned Data Security and Protection Toolkit (DSPT) standards. *Other regulatory and mandatory requirements* q) The Committee will also ensure the adequacy and effectiveness of the ICB's arrangements in relation to: i) Compliance with the ICB's Standards of Business Conduct Policy and associated probity arrangements, including the management of conflicts of interest, gifts, and hospitality. ii) Compliance with the ICB's Freedom to Speak Up Policy, including accessibility, confidentiality, independence and the timely escalation of themes and concerns. iii) The role of the ICB in respect of emergencies; overseeing the organisation's compliance against the requirements of the Civil Contingencies Act (2004) (CCA), NHS England's Emergency Preparedness, Resilience and Response (EPRR) Framework and any other mandated guidance pertaining to EPRR and business continuity. iv) The statutory and mandatory requirements for health, safety, security and fire. v) The development and embedment of robust incident management processes, including ensuring that any 'lessons learnt' are routinely identified and appropriate actions are implemented to avoid reoccurrence. vi) The ICB's legal activity, receiving assurance on trends, outcomes and lessons learned. vii) National reviews and inquiries relevant to the ICB, seeking assurance that recommendations and learning are appropriately reflected in local systems and processes. r) The Committee will also review and approve policies specific to the Committee's remit. s) The Committee will monitor the quality of data that informs its work; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
4. Membership	The Committee's membership will be comprised of three Non-Executive Directors of the Board. Between them, the members will possess knowledge, skills and experience in accounting, risk management, internal, external audit, and technical or specialist issues pertinent to the ICB's business. The Chair of the ICB cannot be a member of the Committee. *Attendees* The following will be routine attendees at the Committee's meetings: a) Executive Director of Finance (or a suitable deputy, as appropriate) b) Senior leadership representative for governance and risk management (or a suitable deputy, as appropriate) c) Internal Auditors

	d) External Auditors Other officers may be invited to attend meetings when the Committee is discussing areas of risk or operation that fall within their areas of responsibility. This will include: e) The Chief Executive being invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the annual governance statement. f) The Local Counter Fraud Specialist being invited to attend at least twice per year. The Chair of the ICB will also be invited to attend one meeting each year to gain further assurance regarding the effectiveness of the ICB's governance arrangements.
5. Chair and deputy	The Board will appoint a Non-Executive Director who has qualifications, expertise or experience to enable them to lead on finance and audit matters to be Chair of the Committee. The Deputy-Chair of the ICB cannot be Chair of the Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's membership will be nominated to deputise for that meeting.
6. Quorum	The Committee will be quorate with a minimum of two members present. If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
7. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. If a consensus agreement cannot be reached, then the item will be escalated to the Board for a decision.
8. Meeting arrangements	The Committee will meet no less than six times per year at appropriate times in the reporting and audit cycle. Members of the Committee are expected to attend meetings wherever possible. The Head of Internal Audit and representatives from external audit have a right of direct access to the Chair of the Committee and may request a meeting if they consider that one is necessary. The Committee will meet privately with the internal and external auditors at least once during the year. Meetings of the Committee, other than those regularly scheduled above, shall be summoned by the secretary to the Committee at the request of the Chair. The Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including those relating to the quorum (as set out in section 6 of these terms of

	reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Committee to be open to the public. Secretariat support will be provided to the Committee to ensure the day-to-day work of the Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
9. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Committee at the following meeting.
10. Conflicts of interest management	In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.

11. Reporting responsibilities and review of effectiveness	The Committee will provide assurance to the Board that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing an assurance report to the Board following each of the Committee's meetings; summarising the items discussed, decisions made and any specific areas of concern that warrant immediate Board attention; and b) Providing an annual report to the Board, summarising how the Committee has discharged its duties across the year, key achievements and any identified areas of required committee development. This report will be informed by the Committee's annual review of its effectiveness. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
12. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue date:	**Status:**	**Version:**	**Review date:**
September 2026	Draft	1.3	March 2027

Appendix B: Scheme of Reservation and Delegation – proposed changes

5. Matters delegated to individuals

Ref.	Delegated matter	Delegated to	Additional information	Reference
5.21	Approve payroll transactions, including new starters (and salary justifications where relevant), changes in circumstances, terminations, and staff expenses.	Executive Directors (including the Chief Executive) (Budget Holders)	Budget Holders will define further delegated payroll approval limits to staff within their directorates, as appropriate to roles and responsibilities and in line with their Budget Holder responsibilities. A list of payroll signatories is maintained by the Human Resources Team.	SFI 8.4.2

7. Delegations where financial limits apply

Ref.	Delegated matter	Financial limit	Delegated to	Additional information	Reference
	Off-payroll and agency workers				
7.4	Approval of off-payroll and agency worker appointments	Non-clinical agency/off payroll worker – of any value	Chief Executive or Executive Director of Finance	Subject to NHS England approval	SFI 8.5

Ref.	Delegated matter	Financial limit	Delegated to	Additional information	Reference
		Clinical agency/off payroll worker, less than £500 per day and £50,000 in total	Members of the Senior Leadership Team	Unless the role is of significant influence (see below) Senior Leadership Team members are defined as postholders that report directly to the Executive Directors.	SFI 8.5
		Clinical agency/off payroll worker, less than £750 per day and £50,000 in total	Executive Directors (including the Chief Executive)	Unless the role is of significant influence (see below)	SFI 8.5
		More than £750 per day or more than £50,000 in total	Chief Executive or Executive Director of Finance	Subject to NHS England approval	SFI 8.5
		Role of significant influence	Chief Executive	Subject to NHS England approval	SFI 8.5

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:	17/09/2026
Paper title:	**Chief Executive's Report**
Paper reference:	ICB CIC 26 046
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 the Boards with an update on significant national and local developments relevant to the ICBs, including statutory assurance, organisational transition, workforce, governance, neighbourhood health, quality and service developments.

Recommendation(s):

The Boards are asked to **note** the report for information.

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: Workforce Report
Appendix B: Professor Claire Fuller letter: Neighbourhood Health

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Chief Executive's Report

ICB Annual Assessments 2025/26

1. NHS England has a statutory responsibility under section 14Z59 of the NHS Act 2006 to complete annual assessments of ICBs. The assessments evaluate how effectively the ICBs have discharged their statutory duties, exercised their functions and delivered against national priorities during the year. Drawing on performance and assurance data, annual reporting, stakeholder feedback and ongoing engagement, the assessments identify areas of strength, achievement and opportunities for further improvement.

2. The ICBs have now been informed of the assessment outcomes for 2025/26, with NHS England recognising that the ICBs have operated within an exceptionally challenging environment, characterised by significant operational pressures, financial constraints and continuing organisational change associated with the transition to a new operating model.

3. **NHS Derby and Derbyshire ICB** – Good progress was noted in a number of important areas, including primary care, population health management, governance, partnership working and elective recovery. Particular strengths included delivery of digital primary care requirements, use of community pharmacy to improve access, improvements in vaccination uptake, and strengthening population health intelligence and analytics. The ICB was also recognised for meeting its statutory financial duties and remaining within its running cost allowance. Areas requiring continued improvement included cancer performance, urgent and emergency care, learning disability and autism services, productivity and the pace of improvement in some SEND-related priorities. NHS England also noted the strong leadership provided through the ICB cluster arrangements and the ICB's commitment to public engagement and partnership working.

4. **NHS Lincolnshire ICB** – The assessment concluded that the ICB continued to operate effectively in a challenging environment and demonstrated strong governance, partnership working, and strategic leadership. The assessment highlighted the ICB's mature approach to population health management, progress in addressing health inequalities, improvements in elective recovery, strong performance in primary care, and compliance with all statutory financial duties. The ICB was recognised for delivering a financial surplus, achieving significant productivity improvements, and maintaining robust quality oversight arrangements. Areas identified for further focus included cancer performance, some aspects of mental health and learning disability and autism services, improving vaccination uptake, progressing SEND improvements, and continuing to strengthen strategic commissioning capability. NHS England also

highlighted the positive contribution of the cluster arrangements and the ICB's effective relationships with local authority and system partners.

5. **NHS Nottingham and Nottinghamshire ICB** – The assessment acknowledged progress in primary care, mental health services, population health management, and partnership working. Strengths identified included delivery of primary care digital targets, achievement of mental health activity objectives, the development of preventative and neighbourhood-based approaches to improving population health, strong quality oversight arrangements, and a well-established approach to public involvement and engagement. The assessment also recognised the leadership provided through the ICB cluster and the ICB's continued focus on quality improvement, research and innovation. Areas requiring sustained attention during 2026/27 include urgent and emergency care performance, cancer waiting times, financial recovery, productivity improvement and reducing inequalities in some health outcomes. NHS England further noted the need for continued improvement in communication and engagement arrangements to support external scrutiny and oversight.

6. Overall, NHS England's assessments recognised the significant challenges faced by all three ICBs during 2025/26 and acknowledged the continued delivery of statutory responsibilities, effective system leadership, and progress in a number of key strategic areas. The assessments also identified common priorities for continued improvement, particularly in relation to operational performance, financial sustainability, productivity, and reducing health inequalities as the ICBs continue their transition to a strengthened strategic commissioning role.

7. The full Annual Assessment Letters can be found here: NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB

ICB Workforce Report, Organisational Development and NHS Job Evaluation

8. Key metrics relating to the ICBs' combined workforce continue to be monitored by the Joint Remuneration and Human Resource Committee. Appendix A provides a summary of the workforce metrics presented to the Committee's July 2026 meeting.

9. Workforce oversight continues to focus on the impact of the Management of Change programme and transition to the ICBs' future operating model. Workforce turnover has increased as voluntary redundancy exits progress, with associated reductions in staffing levels across the ICB cluster. Sickness absence remains relatively stable, although anxiety, stress and depression continue to be the most commonly reported causes of absence. Ongoing priorities include supporting staff wellbeing, maintaining organisational

resilience during transition, improving appraisal completion, monitoring workforce equality indicators, and developing the skills and capabilities required for the future strategic commissioning role of the ICBs.

10. Key workforce metrics and assurance reporting will continue to be developed during 2026/27 to align with the requirements of the NHS Staff Standards and the NHS Leadership and Management Framework, providing greater visibility of leadership effectiveness, management quality, staff experience, workforce development and organisational culture.

11. New national requirements relating to NHS Job Evaluation have reinforced the contractual right of Agenda for Change staff to have roles evaluated against accurate and up-to-date job descriptions, and have increased expectations on NHS organisations regarding governance, equal pay assurance and compliance with the Equality Act 2010. Boards are expected to maintain oversight of local job evaluation arrangements, ensure clear executive accountability, receive regular assurance regarding compliance and outcomes, and monitor any associated equal pay risks. Local arrangements are being strengthened as part of the wider transition programme, with routine assurance reporting now incorporated into governance arrangements.

12. Development of a cluster-wide Organisational Development Framework is underway to support the transition towards a strategic commissioning organisation and preparation for a future merger. The proposed framework focuses on building a single organisational culture, strengthening leadership and management capability, developing strategic commissioning skills, supporting staff through ongoing change, embedding shared values and behaviours, and improving organisational effectiveness. A detailed Organisational Development Plan and implementation programme will be developed over the coming months, informed by staff engagement, workforce feedback and national leadership development initiatives.

Alignment of ICBs' Freedom to Speak Up Arrangements

13. Good progress has been made in aligning Freedom to Speak Up (FTSU) arrangements across the ICBs. A single FTSU Policy has been introduced, consolidating the previous local policies and providing a consistent approach across the three organisations that is aligned with national guidance.

14. Interim Guardian arrangements have been in place since June 2026 to maintain continuity during the organisational transition. All Guardians have completed the required training in accordance with national expectations. In addition, the Guardians are active members of the Midlands FTSU Network, providing access to peer support, shared learning, national updates and examples of good practice from across the region. A formal recruitment process

for substantive Guardian arrangements will be undertaken through the management of change process.

15. A dedicated FTSU inbox has been established as the principal route for staff to contact the Guardians. Communications have been shared with staff explaining the interim arrangements, providing clear information about how to speak up and what support staff can expect. Existing FTSU Champions and Ambassadors continue to provide local signposting and support during the interim period, although these roles will be reviewed as the future model develops.

16. Arrangements have been put in place that fulfil national quarterly reporting requirements, whilst also helping to understand themes and trends across the ICBs. By capturing feedback, outcomes and learning from cases, emerging themes can be identified and those insights can be used to inform future improvements.

17. FTSU arrangements for primary care staff remain under development whilst NHS England reviews the future approach during 2026/27. In the interim, the ICBs' Guardians will provide FTSU support to GP practices in Lincolnshire and Nottinghamshire. Derbyshire currently has a separate arrangement delivered through Hub Plus. Discussions are taking place to explore how a coordinated future FTSU model could operate across primary care. Any future arrangements will be informed by the outcome of the NHS England review.

18. A detailed FTSU report is scheduled for presentation to the Boards in November 2026.

Independent assessment of local neighbourhood health readiness and next steps

19. Alongside the national work on future neighbourhood contracting models referenced in the Chair's Report, the ICBs have received an assessment of their local readiness and delivery arrangements.

20. The assessment followed a readiness visit undertaken by an NHS England team led by Professor Claire Fuller. It concluded that, despite the challenges facing the organisations, the ICBs had maintained their focus on neighbourhood health development.

21. Several areas of good practice were identified and the ICBs have been asked to consider how these can be scaled up across the ICBs' geographies. The assessment also recognised the coherence of the overall approach being taken, which allows flexibility to tailor delivery to local needs using strong partnership arrangements.

22. The letter provides a single page assessment of progress and also suggests key areas of focus for the ICBs over the coming months, as follows:

a) Confirm the Derbyshire, Lincolnshire and Nottinghamshire neighbourhood delivery plans and secure approval through the Joint Strategic Commissioning Committee, the ICBs' Boards, and the relevant programme boards.

b) Finalise the neighbourhood boundaries for each county.

c) Review the Five-Year Strategic Commissioning Plan alongside the updated neighbourhood health delivery plans. Confirm priority actions and outcomes for neighbourhood health, elective care, and urgent and emergency care.

d) Agree a minimum integrated neighbourhood team model for Derbyshire, Lincolnshire and Nottinghamshire and set this out in shared service specifications. These should cover priority population groups, the proactive care offer, the multidisciplinary team model, and contributions from social care and the voluntary, community, faith and social enterprise sector. Each place should move towards coverage of at least one percent of its population cohort.

e) Agree a minimum model for coordinating urgent community care across Derbyshire, Lincolnshire and Nottinghamshire. It should cover professional referral routes, clinical risk management, and direct deployment to urgent community response services. It should also include rapid response, virtual wards, hospital at home, intermediate care and reablement.

f) Confirm the community health services situation report baseline. Develop monitoring for the 18-week waiting-time standard, with separate reporting for adults and children. Report neurodevelopmental pathways both with and without exclusions. Agree trajectories for 18-week and 52-week waits.

g) Make data sharing a priority with a full rollout planned and progressing across Derbyshire, Lincolnshire and Nottinghamshire.

h) Develop one shared interface improvement plan aligned with the national Red Tape Challenge and the Getting It Right First Time (GIRFT) checklist.

23. The full assessment letter can be found at Appendix B and further information on the ICBs' progress with neighbourhood health development is included as a later agenda item for today's meeting.

Quality Strategy for NHS-funded care in England

24. In July 2026, NHS England, on behalf of the National Quality Board, published the Quality Strategy for NHS-funded Care in England, establishing quality as the organising principle for NHS-funded services over the next decade. The strategy introduces a single, system-wide framework based on three

interdependent domains of quality: safety, effectiveness and experience, with the aim of improving health outcomes, reducing inequalities and strengthening public confidence in NHS services. Initial priorities include improving outcomes and reducing unwarranted variation, enhancing patient safety, improving experience of care, reducing inequalities, and sustaining improvements in maternity and neonatal services. The strategy will inform future national policy, planning and performance arrangements and provides an important context for the Boards' ongoing oversight of quality across the ICBs' areas.

25. The Joint Quality and Service Improvement Committee will continue to oversee the development and finalisation of the ICBs' Quality Strategy 2027-2030 in line with national requirements.

26. The full Quality Strategy can be found here: https://www.england.nhs.uk/publication/quality-strategy-for-nhs-funded-care-in-england/#heading-1.

Service developments and provider updates

Opening of National Rehabilitation Centre

27. The National Rehabilitation Centre (NRC), located at the Stanford Hall Rehabilitation Estate in Nottinghamshire and operated by Nottingham University Hospitals NHS Trust, has welcomed its first patients. The 70-bed specialist facility will provide intensive rehabilitation for people recovering from life-changing illness or injury and will also support rehabilitation research, innovation, education and workforce development. The development represents a significant national investment in rehabilitation services and is expected to support improved outcomes and independence for patients requiring specialist rehabilitation.

Redeveloped Blossomwood Older People's Mental Health Unit

28. Nottinghamshire Healthcare NHS Foundation Trust has opened the redeveloped Blossomwood site following a £35 million investment programme. The purpose-built facility brings specialist inpatient services for older adults together on a single site and provides modern accommodation and therapeutic environments for people living with dementia and other complex mental health conditions. The redevelopment is expected to improve patient experience, dignity and privacy while supporting the delivery of high-quality specialist mental health care.

New Endoscopy Unit at Lincoln County Hospital

29. The new £26.5 million Endoscopy Unit at Lincoln County Hospital is expected to begin treating patients during September 2026. The purpose-built facility provides four procedure rooms, together with enhanced patient preparation and recovery facilities, dedicated training space and improved staff accommodation.

The investment will increase diagnostic capacity across Lincolnshire, support earlier diagnosis of conditions including cancer and contribute to improving patient experience and reducing waiting times for endoscopy services.

Lincolnshire Partnership NHS Foundation Trust

30. The Care Quality Commission (CQC) has rated Lincolnshire Partnership NHS Foundation Trust as 'Good' for how well-led it is, following an inspection undertaken in June 2026. This was the Trust's first well-led assessment for several years and the first to be undertaken using the CQC's current assessment methodology. The rating reflects progress in leadership, governance and organisational development and provides positive assurance regarding the Trust's ability to support the delivery of high-quality services for local people.

Lincolnshire Community and Hospitals NHS Group

31. Lincolnshire Community Health Services NHS Trust and United Lincolnshire Teaching Hospitals NHS Trust have announced their intention to pursue a formal merger following two years of working together through the Lincolnshire Community and Hospitals NHS Group. The proposal represents a further stage in the development of integrated provider arrangements within Lincolnshire and will be subject to the relevant regulatory and governance processes as plans are developed.

Recent leadership appointments

32. Yvette Cooper was appointed Secretary of State for Health and Social Care on 20 July 2026. The appointment comes at a significant time for the NHS and social care system as implementation of the Ten-Year Health Plan and wider health and care reforms continues.

33. Elaine Baylis has been appointed Chair of Nottingham University Hospitals NHS Trust. She brings extensive public sector leadership experience, including a number of senior NHS Chair roles across Lincolnshire.

Health and Wellbeing Board updates

34. Health and Wellbeing Boards continue to play an important role in overseeing health improvement, prevention and partnership priorities across local systems. A summary of recent meetings is provided below.

35. The Derby City Health and Wellbeing Board met on 24 July 2026. The agenda focussed on climate action and the Air Quality Strategy. The Dementia Strategy for the City was also presented. Papers for the meeting can be found here: https://democracy.derby.gov.uk/Committees/tabid/101/ctl/ViewCMIS_CommitteeDetails/mid/550/id/1931/Default.aspx.

36. The Lincolnshire Health and Wellbeing Board met on 28 July 2026. The meeting focussed on neighbourhood health, an annual update on the progress of the health and wellbeing strategy, and the Better Care Fund. Papers for the meeting can be found here: https://lincolnshire.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=488.

37. The Derbyshire, Nottingham City and Nottinghamshire Health and Wellbeing Boards have not met since the last update.

Appendix A

NHS
Derby and Derbyshire
Integrated Care Board

NHS
Lincolnshire
Integrated Care Board

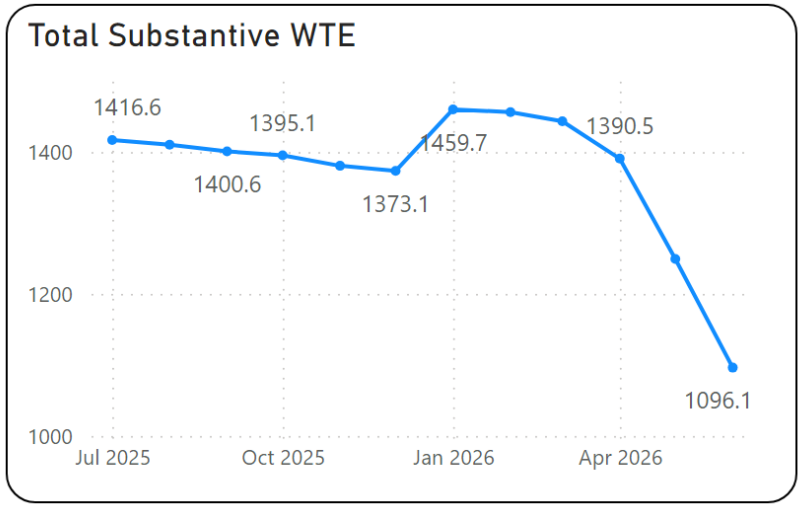
NHS
Nottingham and
Nottinghamshire
Integrated Care Board

DLN Cluster People Report

Reporting Month: June 2026

SAIU
STRATEGIC
ANALYTICS
INTELLIGENCE
UNIT

DLN Cluster Workforce Metrics

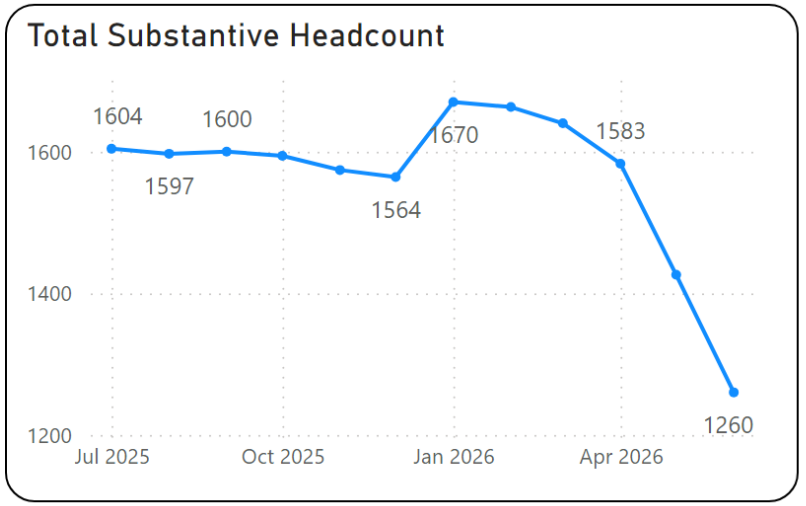


Total Substantive WTE

1,096.1

Monthly Decrease

-153.1

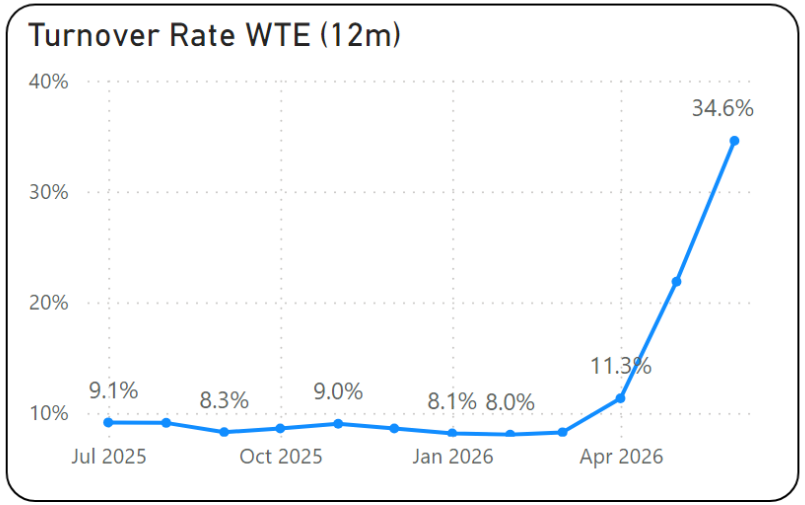


Total Substantive Headcount

1,260

Monthly Decrease

-166

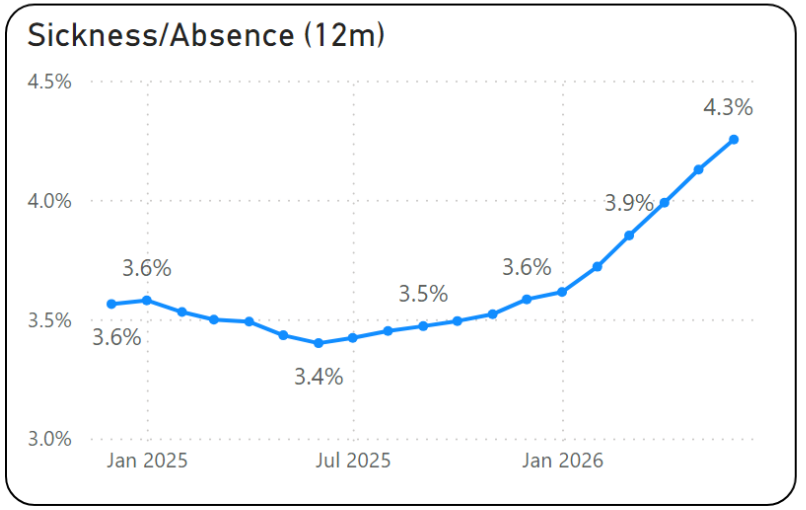


Turnover Rate WTE (12m)

34.6%

Monthly Increase

12.7%



Rolling Absence WTE (12m)

4.3%

Monthly Increase

0.1%

In April 2025 and January 2026, the Continuing Healthcare teams joined Nottingham and Nottinghamshire ICB and Derby and Derbyshire ICB respectively , this accounts for the significant spikes in WTE.

Substantive WTE for the DLN Cluster fell to 1096.1 WTE in June, a change of 153.1 WTE from May, when the total was 1249.3 WTE. Nottingham and Nottinghamshire ICB shows the biggest change, a decrease of 70.8 WTE. The Sickness rate is rose to 4.3%, a rise of 0.13%. Meanwhile, turnover increased to 34.6%, a rise of 12.71% from May (21.9%).

Individual ICB KPI's

ICB Latest WTE

ICB	WTE	Monthly Trend
D&D ICB	404.2	-35.0
Lincs ICB	260.0	-47.4
N&N ICB	431.9	-70.8

ICB Latest Headcount

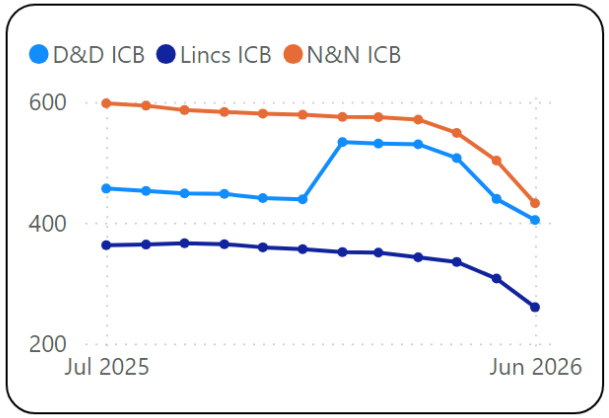
ICB	Headcount	Monthly Trend
D&D ICB	491	-40
Lincs ICB	279	-50
N&N ICB	490	-76

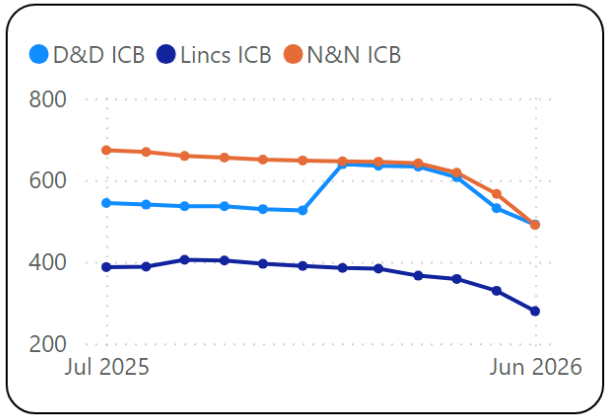
ICB Latest Turnover Rate WTE (12m)

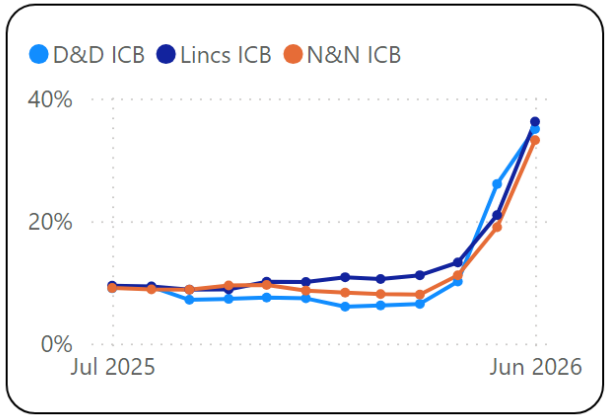
ICB	Turnover	Monthly Trend
D&D ICB	35.0%	9.0%
Lincs ICB	36.2%	15.2%
N&N ICB	33.2%	14.2%

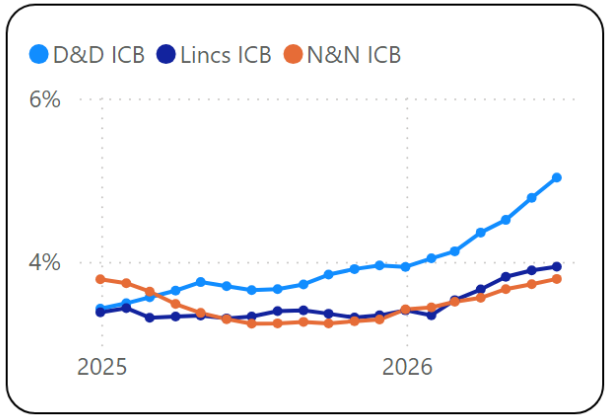
ICB Latest Absence/Sickness (12m)

ICB	Rolling Absence	Monthly Trend
D&D ICB	5.0%	0.2%
Lincs ICB	3.9%	0.0%
N&N ICB	3.8%	0.1%









DLN Cluster Mandatory Training & Appraisal Rate

DLN Cluster

Mandatory Training %

84.7%

ICB Mandatory Training Breakdown

ICB	Mandatory Training %
NHS Derby and Derbyshire ICB	79.4%
NHS Lincolnshire ICB	89.2%
NHS Nottingham and Nottinghamshire ICB	91.1%

DLN Cluster

Appraisal %

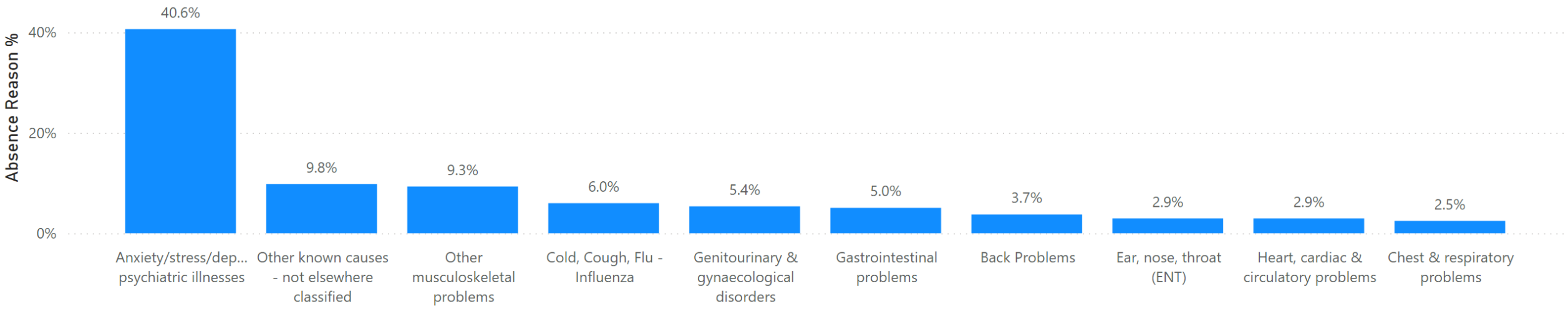
42.5%

ICB Appraisal Breakdown

ICB	Appraisal %
NHS Derby and Derbyshire ICB	45.0%
NHS Lincolnshire ICB	48.9%
NHS Nottingham and Nottinghamshire ICB	36.4%

DLN Cluster Absence Reasons by FTE Days Lost (12m)

Top 10 Absence Reason %



Top 10 Absence Reason by ICB

Derby and Derbyshire ICB Absence Reason

Absence Reason	Absence Reason %
Anxiety/stress/depression/other psychiatric illnesses	41.1%
Other known causes - not elsewhere classified	15.3%
Other musculoskeletal problems	7.1%
Cold, Cough, Flu - Influenza	6.4%
Back Problems	4.6%
Gastrointestinal problems	4.2%
Ear, nose, throat (ENT)	3.5%
Chest & respiratory problems	2.9%
Heart, cardiac & circulatory problems	2.8%
Benign and malignant tumours, cancers	2.3%

Nottingham and Nottinghamshire ICB Absence Reason

Absence Reason	Absence Reason %
Anxiety/stress/depression/other psychiatric illnesses	38.4%
Other musculoskeletal problems	10.9%
Genitourinary & gynaecological disorders	8.7%
Gastrointestinal problems	6.7%
Cold, Cough, Flu - Influenza	5.8%
Other known causes - not elsewhere classified	5.1%
Heart, cardiac & circulatory problems	3.7%
Pregnancy related disorders	3.6%
Back Problems	2.8%
Injury, fracture	2.5%

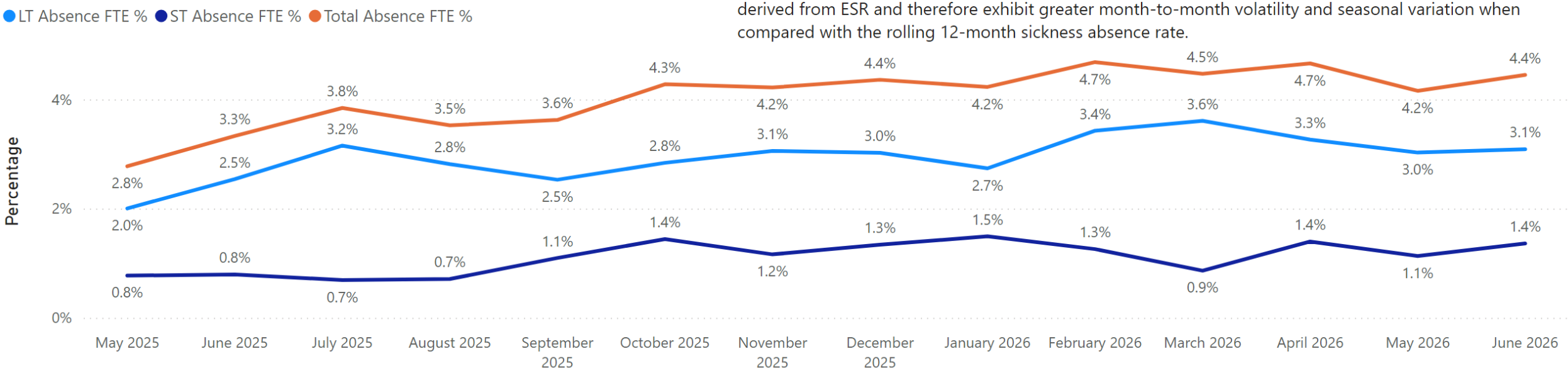
Lincoln ICB Absence Reason

Absence Reason	Absence Reason %
Anxiety/stress/depression/other psychiatric illnesses	43.3%
Other musculoskeletal problems	10.7%
Other known causes - not elsewhere classified	7.6%
Genitourinary & gynaecological disorders	5.8%
Cold, Cough, Flu - Influenza	5.6%
Gastrointestinal problems	3.8%
Chest & respiratory problems	3.7%
Back Problems	3.5%
Ear, nose, throat (ENT)	3.4%
Headache / migraine	2.9%

DLN Cluster Long Term and Short Term Absence In-Month FTE %

DLN In-Month Absence FTE %

Long-term, Short-term and Total Absence figures are calculated as single-month (in-month) measures derived from ESR and therefore exhibit greater month-to-month volatility and seasonal variation when compared with the rolling 12-month sickness absence rate.

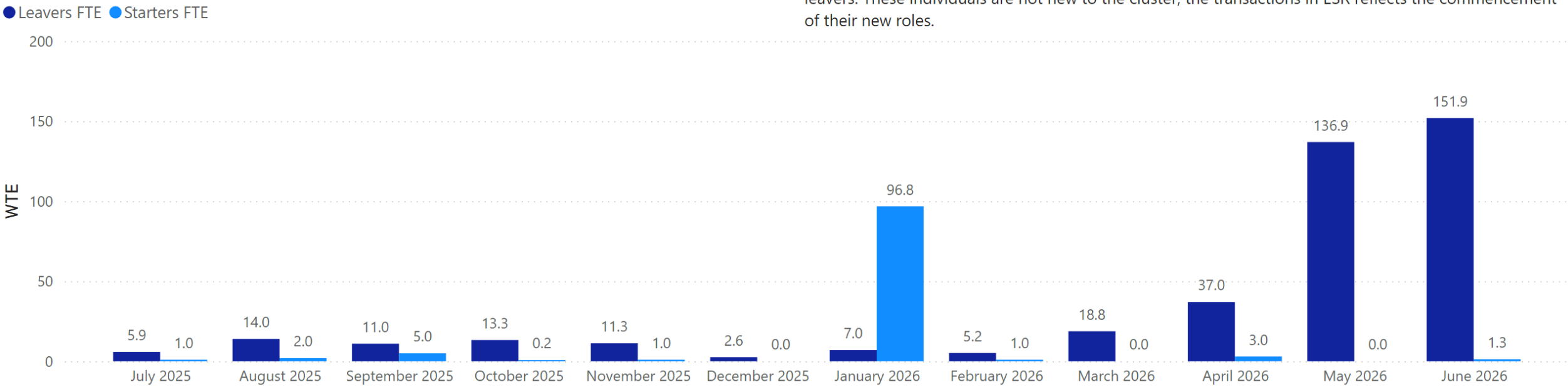


Long Term and Short Term Absence In-Month FTE % by ICB

ICB	Derby and Derbyshire ICB		Lincolnshire ICB		Nottingham and Nottinghamshire ICB	
Month	Long Term Absence FTE %	Short Term Absence FTE %	Long Term Absence FTE %	Short Term Absence FTE %	Long Term Absence FTE %	Short Term Absence FTE %
September 2025	2.4%	1.1%	1.8%	1.2%	3.1%	1.0%
October 2025	2.7%	1.4%	2.4%	1.3%	3.2%	1.5%
November 2025	2.9%	1.4%	3.3%	1.3%	3.0%	0.9%
December 2025	2.9%	1.5%	2.9%	1.4%	3.2%	1.2%
January 2026	3.3%	1.9%	2.3%	1.6%	2.4%	1.1%
February 2026	4.5%	1.4%	3.0%	1.5%	2.7%	1.0%
March 2026	4.1%	1.3%	3.9%	0.8%	2.9%	0.5%
April 2026	3.8%	1.9%	3.4%	1.4%	2.7%	0.9%
May 2026	4.2%	1.8%	2.6%	0.8%	2.2%	0.7%
June 2026	4.2%	1.8%	2.9%	0.7%	2.2%	1.4%

Cluster Starters and Leavers

DLN Starters and Leavers by Month

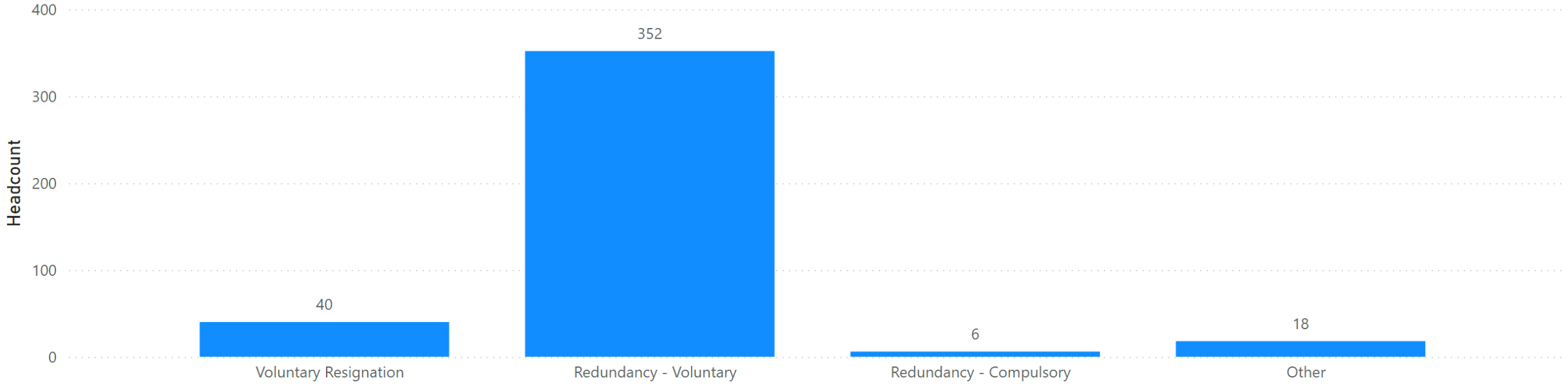


Following the new cluster arrangement, some roles previously aligned to an ICB have transitioned to new roles covering the cluster. These changes will appear in ESR as new starters; and in some instances leavers. These individuals are not new to the cluster, the transactions in ESR reflects the commencement of their new roles.

Starters and Leavers by ICB

	July 2025	August 2025	September 2025	October 2025	November 2025	December 2025	January 2026	February 2026	March 2026	April 2026	May 2026	June 2026
Derby and Derbyshire ICB												
Leavers FTE	0.9	5.8	1.6	4.7	4.1	0.0	1.0	2.8	4.1	15.1	67.7	33.2
Starters FTE			0.2	0.2			95.8					
Lincolnshire ICB												
Leavers FTE	2.0	3.0	2.6	2.8	4.6	1.6	4.0	1.0	7.2	6.8	25.8	48.0
Starters FTE	1.0	2.0	3.8				1.0			3.0		
Nottingham and Nottinghamshire ICB												
Leavers FTE	3.0	5.2	6.8	5.8	2.6	1.0	2.0	1.4	7.5	15.2	43.4	70.8
Starters FTE			1.0		1.0			1.0				1.3

DLN Reasons for Leaving



Reason for Leaving Headcount by ICB

ICB	Other	Redundancy - Compulsory	Redundancy - Voluntary	Voluntary Resignation
Derby and Derbyshire ICB	9	1	129	13
Lincoln ICB	4	3	78	18
Nottingham and Nottinghamshire ICB	5	2	145	9

Reason for Leaving Headcount by Band

Pay Grade	Other	Redundancy - Compulsory	Redundancy - Voluntary	Voluntary Resignation
Band 3	3		7	4
Band 4	3		26	5
Band 5	2		46	5
Band 6	2		56	3
Band 7			87	8
Band 8 - Range A	1		49	6
Band 8 - Range B			45	1
Band 8 - Range C	1	1	15	1
Band 8 - Range D	1		15	
Band 9	1		4	
Non-AFC	4	5	2	7

- The ICBs' whole time equivalent (WTE) has decreased by 153.1WTE compared to May. NHS Nottingham and Nottinghamshire ICB shows the biggest change a decrease of 70.8WTE.

- There have been 151.9 individuals leave across the ICBs (33.2 in Derby and Derbyshire, 48 in Lincolnshire and 70.8 in Nottingham and Nottinghamshire). In addition, there have been 1.3 starters totalling 0.64WTE in Nottingham and Nottinghamshire who have commenced in Director roles in the Outcomes Directorate.

- Overall turnover is 34.6% a rise of 12.7% compared to May. This is linked to the ongoing management of change process. Numbers leaving organisations through voluntary redundancy is now increasing, as exits began in April. We expect this to continue to over the next 2 months.

- Overall sickness absence has increased by 0.13% to 4.3% compared to the previous month. Anxiety, stress and depression remains the most common cause of absence across all 3 ICBs, with each having a similar rate of absence. A level of data cleansing is required as Other Known Causes is the second highest category in Derby and Derbyshire and third highest in Lincolnshire. Derby and Derbyshire continues to have the highest level of sickness at 5% and increase of 0.2% compared to May and a 0.5% increase since April 26.

- Long term absence continues to be higher than short term absence. Whilst this has increased in Lincolnshire both Nottingham and Nottinghamshire and Derby and Derbyshire have remained static. Short term, absence has decreased in Lincolnshire, remains stable in Derby and Derbyshire but has increased in Nottingham and Nottinghamshire by 0.7%.

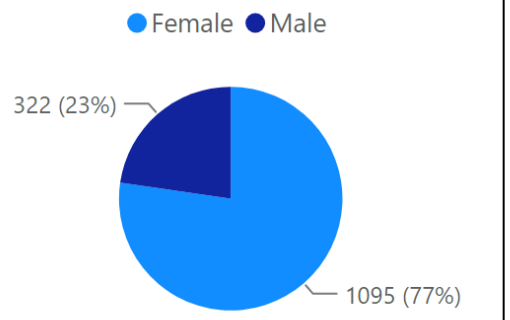
- The rate of completed of mandatory training stands at 84.7%, a decrease of 1.1% compared to May, with Nottingham and Nottinghamshire above 90% and Lincolnshire at 89%.

- 42.5% of staff have completed appraisals across the cluster a decrease of 5.9% compared to May. Lincolnshire has the highest completion rate at 48.9%, Derby and Derbyshire and Nottingham and Nottinghamshire have shown a decrease in completion rate.

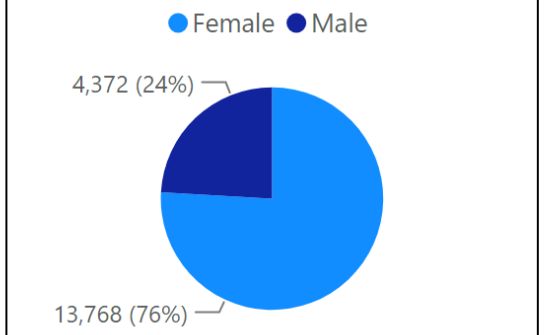
DLN Cluster Workforce EDI metrics

EDI metrics has been grouped in line with NHS England methodology to ensure consistency with national reporting standards. For disclosure-control purposes, any protected group with fewer than five individuals has been suppressed. As a result, some EDI groups present within the Cluster may not appear in this report if their numbers fall below the suppression threshold.

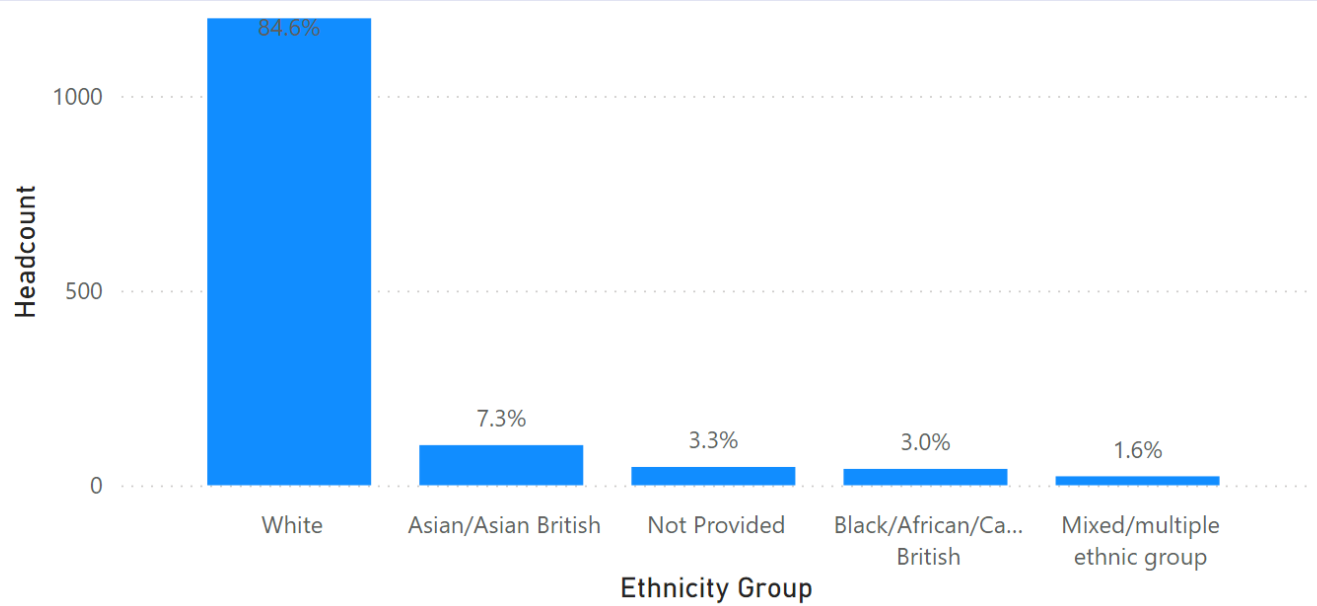
DLN Cluster Gender



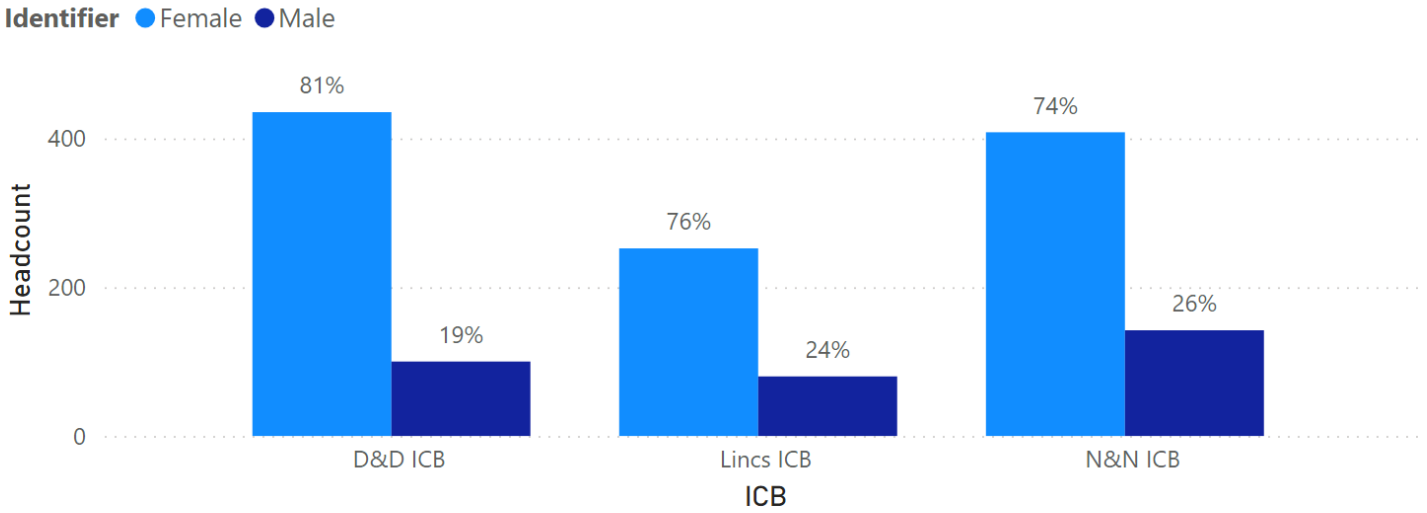
NHSE All ICBs Total Gender



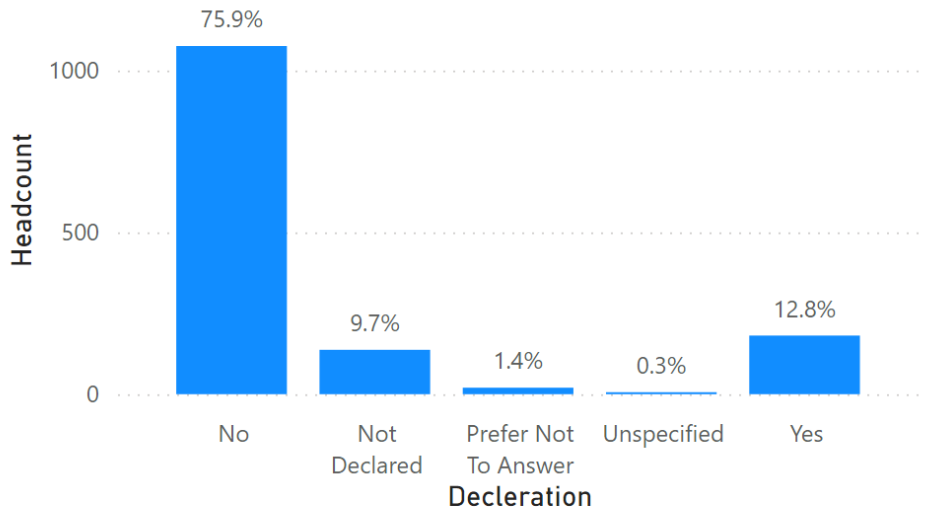
DLN Ethnicity Grouped



ICBs Gender Headcount

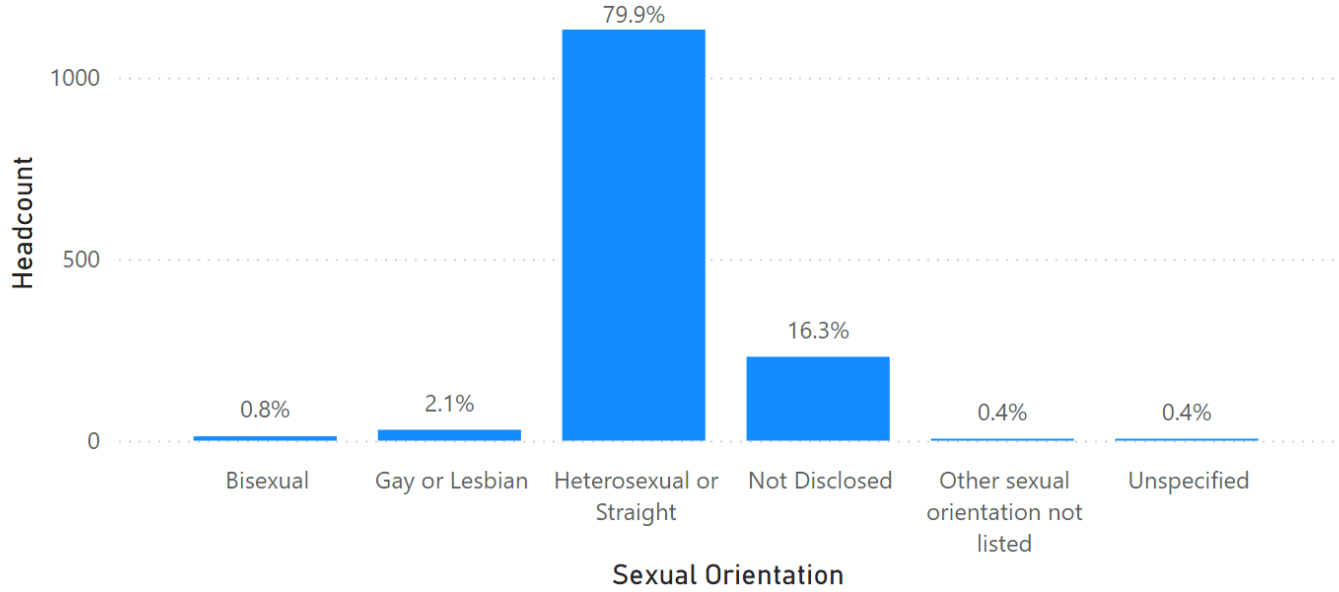


DLN Disability or Long Term Condition

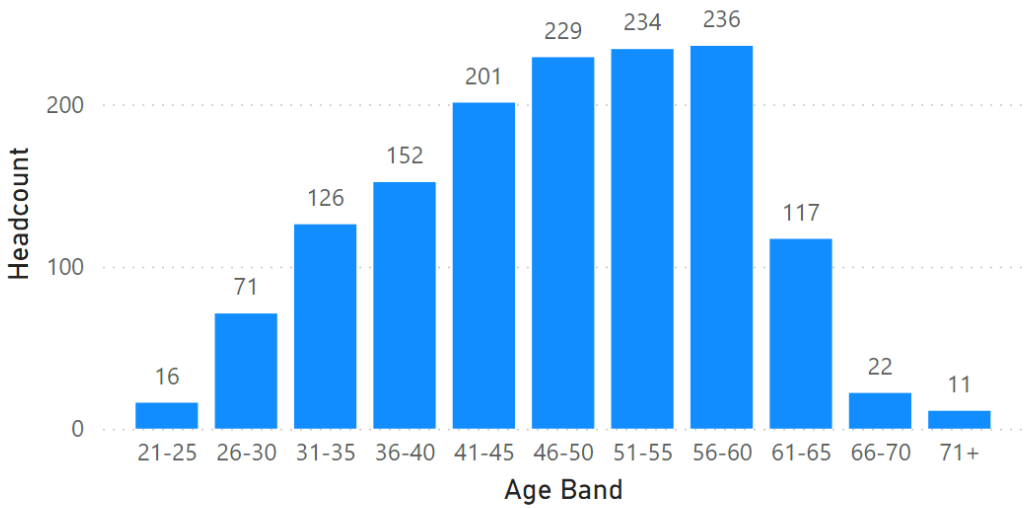


DLN Cluster Workforce EDI metrics

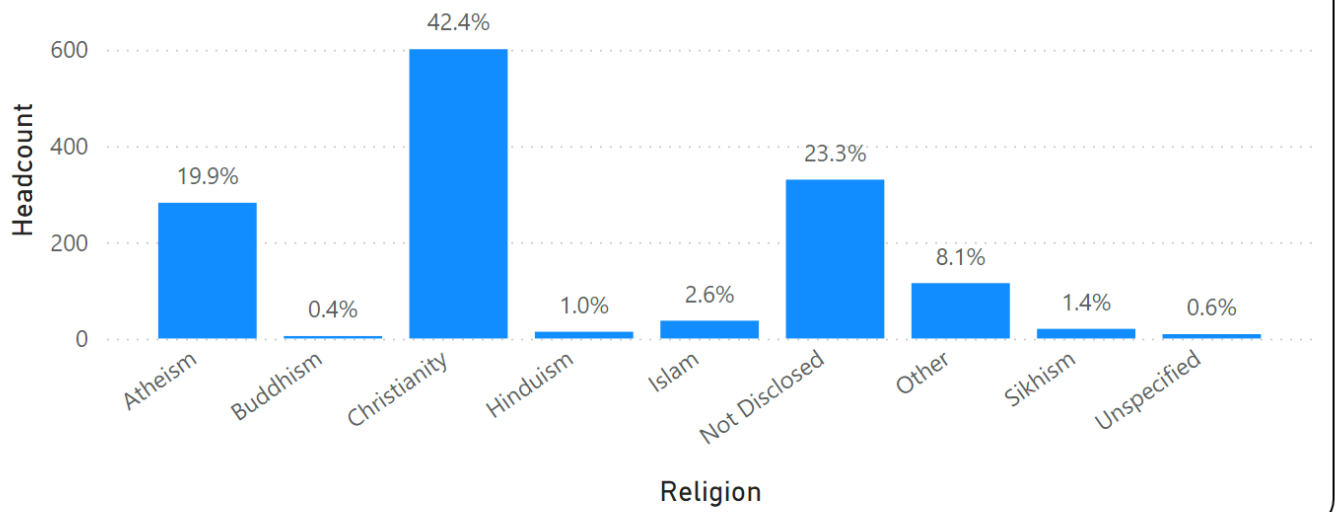
DLN Sexual Orientation



DLN Age Band



DLN Religious Belief



- The ICBs are comprised of 23% male employees and 77% female. This is comparable with the data for ICBs across the country that show a split of 24% male and 76% female. Derby and Derbyshire shows the largest variance from this with 81% of staff being female and 19% male.

- The majority of staff are within age bands 41-60 with significantly less staff ages 21 -30.

- Our workforces span 29 ethnic groups, with colleagues identifying as White being the largest group (84.6%) an increase of 0.1% compared to the previous quarter. 'Unknown/Not stated' accounts for 3.3% of all Ethnicity records a decrease of 0.4%.

- Our diverse workforce is represented by 9 different religions and beliefs. The most commonly recorded religion is Christianity with 42% of colleagues selecting this as their religion (unchanged from the previous quarter). 23.3% of colleagues have not disclosed their belief, an increase of 0.1% since the previous quarter. Nottingham and Nottinghamshire ICB having the highest proportion of undeclared religion at 29%, and Lincolnshire ICB the lowest 14%.

- 79.9% of staff have declared that that are straight/heterosexual and increase of 0.7% compared to the previous quarter. 2.1% declared as gay or lesbian (unchanged from previous quarter) and 0.8% bisexual (0.4% reduction from the previous quarter). The percentage of staff declaring themselves as gay or lesbian is line with national data. Data from the office of national statistics that indicates in 2024 2.1% of the UK population over 16 identified as gay or lesbian. However, the reduction in staff declaring themselves as bisexual means we are no longer in with national statistics which cite that 1.6% of individuals identified as bisexual. 16.3%of colleagues have not declared their sexual orientation a deterioration of 6.1%.

- 75.9% declared they did not have a long-term condition or disability (a decrease of 0.5% from the previous quarter) with 12.8% stating they had (an increase of 0.5% from the previous quarter. This is significantly below the national average. 11.4% of staff did not indicate whether or not they have a long-term condition or disability.

- Overall, the data shows that the turnover is beginning to change the diversity profile across the ICBs.

- Data for disability/long-term condition, religious belief and sexual orientation show a large percentage of staff that have not declared a response, prefer not to answer or are unspecified. Historically across the NHS staff have been reticent to declare answers for a number of reasons but predominately because they do not know/are concerned how the data will be used. Further work will need to be undertaken to understand the reasons across the cluster and provide information to support staff to feel able to declare these characteristics.

ICB Chief Executive
ICB Chair

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

8 September 2026

Dear Kathy and Amanda

Neighbourhood Health – Derby and Derbyshire, Lincolnshire, Nottingham and Nottinghamshire

Thank you to you and your team for meeting with us to discuss progress following the recent Neighbourhood Health Readiness Visit.

We appreciated the continued openness and constructive engagement from you and your colleagues. The follow – up discussion provided an opportunity to further review progress and consider the system's trajectory as neighbourhood health continues to develop.

Despite an exceptionally challenging period of change, the Derby and Derbyshire, Lincolnshire, Nottingham and Nottinghamshire (DLN) Cluster has continued to make strong progress in developing neighbourhood heath and care services. This has been achieved while bringing together three ICBs into a single cluster, significant impacts of the maternity and Nottingham attacks inquiries on system leadership capacity and clinical behaviours, being good partners during Local Government Reorganisation across all areas and helping to stabilize some trusts with significant financial pressures.

Despite these headwinds, you have created a coherent approach to neighbourhood development across three very different systems. Through a shared commissioning framework, you have defined the core features, services and outcomes that residents can expect, whether they live in coastal Mablethorpe, the Derbyshire Dales or inner-city Nottingham. This is enabling local provider collaboratives the flexibility to develop and to tailor delivery to local needs, based on strong general practice and local communities, building out from integrated neighbourhood team working.

Guided by detailed population health intelligence and evidence-based interventions, you are building on strong existing arrangements. At the same time, you are developing strong relationships with emerging strategic authorities and positioning health and care as an active partner in wider public service reform. In short, despite considerable challenges, the DLN

Cluster has remained focused on delivering sustainable neighbourhoods that improve outcomes for local people.

During my visit, I saw several strong examples of good practice across the DLN cluster, and I was impressed by the scale of ambition shown, despite your operating context. I would encourage you to consider how you scale these types of best practice across the cluster footprint:

- Team Up is Derby and Derbyshire's integrated neighbourhood model for supporting housebound people, those with complex needs, and care home residents. We saw that this brings together general practice, community health, mental health, social care and voluntary sector partners to provide more joined-up, person-centred care at home. This model has resulted in over 7,000 home visits each month, around 3,500 hours of GP time released, more than 9,000 urgent two-hour responses, strengthened care home support, improved falls response, and a 7% reduction in ED attendances for people aged 65+ with moderate or severe frailty.

- Lincolnshire's approach provides a model for delivering neighbourhood-based frailty care. We saw that delivery is embedded through early identification and risk stratification with PCN-led service models live in all 14 PCNs including targeted frailty clinics, care coordination, shared assessment tools and links to community support. The approach is supported by system-wide engagement, workforce training, population health data and local clinical leadership. The service is resulting in increasing access, clinical outcomes and patient experience, and staff satisfaction is also of note.

- The expansion of the Community Dermatology pathway across Nottingham and Nottinghamshire has shown to reduce unequal access and pressure on acute services. Your new hub-and-spoke community dermatology model, using system-wide triage to direct patients to community clinics, secondary care or GP management, supported by shared-care protocols and expanded local capacity has seen 43% of referrals redirected to community care, routine demand down 15%, and waiting times reduced from 52 weeks to 2–3 weeks.

Taking together the visit and follow-up process, alongside the subsequent system and Place level self - assessments, the accompanying single page summary provides an agreed reflection of the system's current position.

We would encourage you to share the agreed single-page summary with your Board and system partners to support local oversight of neighbourhood health priorities, agreed next steps and future delivery.

As discussed, some of the key areas of focus over the coming months are to:

1. Confirm the DLN Neighbourhood delivery plans through SCC, ICB and relevant programme board routes.

2. Finalise neighbourhood footprints for Derbyshire, Lincolnshire and Nottinghamshire.

3. Review Five-year commissioning plan alongside updated delivery plans for neighbourhood health to confirm priority delivery actions and outcomes for NbH, elective and UEC

4. Agree the DLN minimum INT model via DLN service specifications, including priority cohorts, expected proactive care offer, MDT model, social care and VCFSE contribution, and how each place will move towards coverage minimum 1% population cohort.

5. Agree the DLN minimum model for urgent community coordination, including professional referral routes, clinical risk holding, direct deployment to UCR, rapid response, virtual ward, hospital at home, intermediate care and reablement.

6. Confirm the CHS SitRep baseline, monitoring in development for 18 ww, separate adult and children's waits, report neurodevelopmental pathways both included and excluded, agree 18-week and 52-week trajectories.

7. Data sharing is priority action with full roll out planned and progressing across DLN

8. Develop one DLN interface priority plan aligned to the red tape challenge and GIRFT checklist

Thank you again for the time and commitment shown by you and your teams throughout both the visit and follow-up process. We look forward to continuing to work with you as neighbourhood health develops across the footprint.

Yours sincerely

Professor Claire Fuller MRCGP DRCOG MBBS
National Priority Programme Director – Neighbourhood Health

Annex:

Single slide summary

DLN ICB Cluster: Derby and Derbyshire, Lincolnshire, Nottingham and Nottinghamshire

4 September 2026

ICB at a glance

ICB CEO	Amanda Sullivan (substantive Cluster CEO across the three ICBs from October 2025)
ICB Chair	Dr Kathy McLean OBE (substantive Cluster Chair from 1 October 2025)
Registered population	approx. 2.97m registered; 3.25m people and 4,500 sq miles per the visit deck
Places	3 systems, 6 Places, two per system (Lincolnshire one today, two on LGR). 5 HWBs today, 6 on LGR. Below Place: 7 PBPs, 54 PCN footprints
Footprint	Peak District to the Lincolnshire coast; urban Nottingham, Derby, Lincoln; large rural and coastal

Local authorities	5 upper-tier (2 unitary, 3 county with 22 districts). LGR in train; Lincolnshire to two unitaries by March 2028, alongside the ICB merger from April 2027
Providers	Acute: UHDB, Chesterfield Royal, NUH, SFH, ULHT within LCHG; DBTH and NLAG cross-border. Community/MH: DHCFT, DCHS, NHFT, LPFT, LCHS within LCHG, Nottingham CityCare, DHU. Ambulance: EMAS and EEAST.
Trusts in regulatory action	1: Nottinghamshire Healthcare NHS FT, statutory inquiry, new CEO post-inquiry (HSJ, March 2026)
2024/25 position	Lincolnshire in deficit, forecasting breakeven or surplus in 2025/26 (IFG 2025). D&D and N&N not evidenced in the source pack
NNHIP / NHC Wave 1	NNHIP Wave 1: 1 of 6 Places (Nottingham City, 1 of 43); 3 of 4 applications not selected. NHC Wave 1: Long Eaton, 1 of 27, £2.4m, opening 2027

Places

Place	Derby City & Derbyshire County - PLACE SCORE 34		Lincolnshire + Lincolnshire 2nd Place on LGR - PLACE SCORE 44		Nottingham City & Nottinghamshire County - PLACE SCORE 38	
System	Derby City	Derbyshire	Lincolnshire	Lincolnshire (future)	Nottingham City	Nottinghamshire
Population	c.365k	c.760k	c.830k	From LGR, March 2028	c.390k	c.835k across 3 PBPs
PBPs beneath	1: Derby City	1: Derbyshire County	1: Lincolnshire	To be determined	1: Nottingham City	3: South Notts c.380k, Mid Notts c.335k, Bassetlaw c.120k
Neighbourhood footprints	5 PCNs	12 PCNs; 7 district Neighbourhood Alliances	14 PCNs, avg ~56k	To be determined	9 PCN's	15 PCNs
HWB sign-off	N; not determined	N; not determined	N; not determined	N; not determined	N; not determined	N; not determined
GP at-scale vehicle	GPPB	GPPB	LPCNA, 81 of 81 practices	LPCNA	NCGPA, in GPFP	PICS and Partners Health and Bassetlaw Federation, in GPFP

Place maturity: MATURING / DEVELOPING / MOBILISING / PRE-MOBILISING. This is the Place maturity scale, not the NNHIP four-point scale (Mobilising / Developing / Maturing / Optimising), whose order is inverted. Columns are the 6 Places, two per system; Lincolnshire is one Place today and two once LGR creates a Lincoln City unitary and a Lincolnshire unitary by March 2028. No Place is rated above MOBILISING, because no neighbourhood footprint has yet been determined or agreed at a Health and Wellbeing Board.

Examples of best practice across places

D&D – GPPB commissioned as a single collective voice to represent general practice, strong foundation for load bearing service at scale, inc with LMC support Team Up service is model for supporting vulnerable people, with 7000 home visits per month and a 7% reduction in ED attends in frail 65+ cohort. **N&N** – Expansion of community dermatology pathways into NbH showing positive results – 43% of referrals redirected to NbH services and waiting times reduced from 52 weeks to 2-3 weeks. **Lincs** – Strong alliance model with the 14 PCN's and care delivered in practices, example of OPIP weight management £3.7m contract covering 2700 patients. Cluster level governance clear and concise with route to Boards / HWBB and provider boards. Clear forward look in terms of LGR impact, preparation in place for future impact on delivery.

Five Goals (RAG vs England; see Annex B for scores)

G1 Health outcomes 2.42	G2 GP access and experience 2.00	G3 Planned care 1.85	G4 Urgent and emergency care 2.32	G5 Patient and staff satisfaction 1.58

Cluster mean 2.03, every Goal below the England mean of 2.48. Strongest G1 2.42, weakest G5 1.58. The per-ICB pattern is divergent rather than uniform: Lincolnshire holds the only Amber-Green position in the cluster, G4 3.00 on A&E four-hour 81.26% (rank 6/42); N&N holds the only Red, G5 1.00 with all four NHS Staff Survey 2025 themes bottom-quartile (motivation rank 41/42); D&D is weakest on G4 at 1.67 on virtual ward capacity 10.2 per 100k (rank 41/42). All three ICBs Q4 on RTT 18-week.

Enablers (Section 4)

Enabler	Key point (fill = rating)
Data	Three shared care records and three PHM platforms (Derbyshire SCR with RAIDR; Notts Care Record with eHealthscope; Lincolnshire DARS with Optum). Each reasonably mature individually; cluster consolidation is the Roll-out of SAIU PHM risk stratification model across D&D underway. [IN PROGRESS]
Workforce	No cluster NbH workforce plan and no named NbH SRO in any cluster-supplied document. Mandated cost reduct absorb change capacity. 450-plus ARRS staff deployed in Lincolnshire. [EARLY STAGE]
Finance	No ring-fenced cluster NbH investment line. Devolved budgets at 2 of 4 N&N PBPs (£3.28m, £3.5m); none in Lincolnshire. Transformation fund stated at roughly £33m a year, 2026/27 funds diverted to acute pressures. [EA STAGE]
Digital	. NHS App uptake in Derby's is 75%, in Lincs 71% and in Notts 75%. NHS Notify plans. PFDS support. Ambient A programme in development FDP in D&D only. Cluster Digital Director Tom Sara appointed 2026.. [IN PROGRESS]
Estates	5 surgical hubs, 10 CDCs, 24 family hubs, 1 NHS Neighbourhood Health Service site. Pride in Place: 9 Phase 1 towns, 8 Phase 2 neighbourhoods, £7.5m Impact Fund. Archetype mix, LIFT and RDEL case pending. [EARLY STAGE]

Ref	Stage 1 minimum requirement (2026/27): Ref fill shows rating	Self-assessed score
S1	Reduce non-elective admissions via UCR and reablement	5
S2	Reduce variation; improve access to general practice	5
S3	Neighbourhood footprints agreed	3
S4	INTs for high-priority cohorts; devolved budgets	4
S5	Neighbourhood approach to elective pathways	3
S6	18-week community waits; eliminate 52-week waits	1
S7	BCF pooled funding plans confirmed with LAs	4
S8	Primary / secondary care interface (RTC)	5
S9	Organisational ownership of planned deliverables	3
S10	Data-sharing arrangements for patient identification	4
Stage 1 overall (average of 3 total place scores):		**39**

Stage 2 NbH Plan: seven-step readiness (cluster overall EARLY STAGE)

1	National objectives via the three reform agendas [EARLY STAGE]
2	Support wider local goals and public service reform [EARLY STAGE]
3	Local objectives informed by JSNA [EARLY STAGE]
4	Confirm final geographies [EARLY STAGE]
5	Confirm organisational delivery responsibilities [EARLY STAGE]
6	Confirm governance and operational arrangements [EARLY STAGE]
7	Align other initiatives (Family Hubs, Pride in Place, MH hubs, employment) [EARLY STAGE]

Forward look - Key actions over next 6 months:

1. Confirm the DLN Neighbourhood delivery plans through SCC, ICB and relevant programme board routes.
2. Finalise neighbourhood footprints for Derbyshire, Lincolnshire and Nottinghamshire.
3. Review Five-year commissioning plan alongside updated delivery plans for neighbourhood health to confirm priority delivery actions and outcomes for NbH, elective and UEC
4. Agree the DLN minimum INT model via DLN service specifications, including priority cohorts, expected proactive care offer, MDT model, social care and VCFSE contribution, and how each place will move towards coverage minimum 1% population cohort.
5. Agree the DLN minimum model for urgent community coordination, including professional referral routes, clinical risk holding, direct deployment to UCR, rapid response, virtual ward, hospital at home, intermediate care and reablement.
6. Confirm the CHS SitRep baseline, monitoring in development for 18 ww, separate adult and children's waits, report neurodevelopmental pathways both included and excluded, agree 18-week and 52-week trajectories.
7. Data sharing is priority action with full roll out planned and progressing across DLN
8. Develop one DLN interface priority plan aligned to the red tape challenge and GIRFT checklist

Forward look – Key actions over next 18 months

1. Host, anchor or integrator arrangements agreed for each place and reflected in commissioning and delivery arrangements.
2. Footprints formally agreed and operational across DLN, with clear named leadership, VCFSE and adult social care input in each neighbourhood, and evidence that community and mental health services are aligned to neighbourhood footprints wherever feasible
3. Commissioning intentions translated into contracts, specifications or delivery agreements that support INT development, proactive care, interface improvement and neighbourhood outcomes, inc. for UEC & elective care
4. Data-sharing arrangements operational across statutory partners, with progressive inclusion of VCFSE, community pharmacy, optometry and dental partners.
5. BCF and wider pooled investment clearly aligned to neighbourhood priorities, with scheme-level inequalities measures, public HWB reporting and funding decisions feeding the next planning cycle.
6. Interface reform embedded across priority providers, with red tape challenge actions implemented, a clinical leadership development programme active, and neighbourhood-facing specialist input reflected in workforce or job planning where appropriate.

Meeting title	Integrated Care Boards: Open Session (meeting in common)
Meeting date	17/09/2026
Paper title	**Population Health Strategy Progress Report: Neighbourhood Health**
Paper reference	ICB CIC 26 047
Paper author	Tom Diamond, Director of Population Health Strategy Fiona Callaghan – Deputy Director of Neighbourhood Commissioning, NHS Nottingham and Nottinghamshire ICB
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 Neighbourhood Health Programme is a key component of the ICBs' response to the NHS Ten-Year Plan and Neighbourhood Health agenda and provides the principal mechanism for translating the ambitions of the ICBs' Population Health Strategy into practical delivery within local communities.

A common core Integrated Neighbourhood Team specification, programme governance and a working architecture of 55 Primary Care Network footprints are established. The national readiness assessment gives the ICBs a developmental baseline of 39/100. Strengths include access to general practice, Better Care Fund arrangements and the primary-secondary care interface. Priorities for improvement include neighbourhood footprints, Integrated Neighbourhood Team maturity, elective pathways, organisational accountability, data sharing and community waiting times.

The key priority for 2026/27 is establishing the foundations of delivery at sufficient scale to demonstrate impact. This means quantifying the initial end-of-life, frailty and multiple long-term conditions cohorts; agreeing each Integrated Neighbourhood Team's population coverage and provider contributions; agreeing longer-term footprints with the five Health and Wellbeing Boards; aligning existing contracts; and establishing shared outcomes, data flows and enabling infrastructure. Same Day Access, planned care left shift and a proposed community Single Point of Access and Referral Support Service will develop alongside Integrated Neighbourhood Team development.

The Neighbourhood Health 'roadmap' proposes build and mobilisation in 2026/27, transitional testing and clearer accountability in 2027/28, and more integrated population-based commissioning from 2028/29 where readiness support it. Key risks relate to Local Government Reorganisation, provider and primary care readiness, contractual and procurement change, and the infrastructure needed to measure impact.

Report summary

This report provides assurance on progress made to date, highlights the key risks and dependencies that require active management, and sets out the phased approach through which the ICBs intend to demonstrate measurable improvements in outcomes, experience, inequalities and utilisation through neighbourhood-based care.

The Boards are asked to note progress and risks, support implementation at scale with clear provider accountability, and endorse the continued development of the financial, contractual and commissioning arrangements required to support neighbourhood health over the coming years.

Recommendation(s)

The Boards are asked to **receive** the paper for assurance in relation to the progress made in establishing the foundations for neighbourhood health across the ICBs' footprints; and to:

- Endorse the 2026/27 focus on delivering the core Integrated Neighbourhood Team specification, agreeing Integrated Neighbourhood Team population coverage, quantifying priority populations and establishing clear provider commitments for delivery.
- Note that Single Neighbourhood Providers and Multi-Neighbourhood Providers represent an emerging direction of travel rather than any agreed future organisational or contractual model, and that any specific proposals will be subject to evidence, engagement, market testing and appropriate formal decision making.
- Support the continued development of the commissioning, contractual and financial framework required to underpin neighbourhood health, including service mapping, shadow budgets and outcome-based funding approaches, subject to appropriate governance and formal approval processes.
- Note the key strategic risks and dependencies, including Local Government Reorganisation, provider readiness, primary care capacity, contractual change, data and digital infrastructure, and support the mitigation actions set out within the programme.

Appendices

None.

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.

Population Health Strategy Progress Report: Neighbourhood Health

Purpose and strategic position

1. This paper updates the Board on progress in developing neighbourhood health across Derbyshire, Lincolnshire and Nottinghamshire (DLN), and sets out the route to a mature approach to neighbourhood commissioning.
2. A common core Integrated Neighbourhood Team specification, working neighbourhood architecture, programme governance and emerging delivery framework are now in place. External assurance has recognised the strength and consistency of the strategic approach, whilst emphasising that the next phase must demonstrate implementation and impact.
3. The immediate task is to translate the specification into consistent delivery; define the populations each Integrated Neighbourhood Team will support; quantify need at neighbourhood level; agree provider coverage and contributions; and develop the contractual, financial, workforce, digital and analytical infrastructure required.
4. Single Neighbourhood Provider contracts and Multi-Neighbourhood Provider contracts will play a key role in the future commissioning of neighbourhood health across DLN. Progression will depend on evidence, readiness, market testing, Local Government Reorganisation and formal decision-making.

Current architecture and delivery foundations

5. DLN comprises three systems and seven places, currently aligned around five Health and Wellbeing Boards.
6. At neighbourhood level, the current working architecture comprises 55 Primary Care Network footprints.

System	Strategic planning	Place delivery	Working neighbourhood footprints
Derby and Derbyshire	Derby City Health and Wellbeing Board	Derby City Place Based Partnership	5 Primary Care Networks
	Derbyshire County Health and Wellbeing Board	Derby County Place Based Partnership	12 Primary Care Networks

System	Strategic planning	Place delivery	Working neighbourhood footprints
Lincolnshire	Lincolnshire Health and Wellbeing Board	Lincolnshire Place	14 Primary Care Networks
Nottingham and Nottinghamshire	Nottingham City Health and Wellbeing Board	Nottingham City Place Based Partnership	9 Primary Care Networks
	Nottinghamshire County Health and Wellbeing Board	South Notts Place Based Partnership Mid Notts Place Based Partnership Bassetlaw Place Based Partnership	6 Primary Care Networks 6 Primary Care Networks 3 Primary Care Networks

7. Primary Care Network footprints and registered populations provide the practical starting point for implementation. The longer-term geography is being worked through with all five Health and Wellbeing Boards so that it reflects population need, local authority and community geographies, existing partnerships and Local Government Reorganisation. A DLN subgroup will validate Primary Care Network -to- Integrated Neighbourhood Team relationships, complete mapping and ensure coherence.

8. Progress achieved:

   a) Core Integrated Neighbourhood Team Specification developed iteratively with providers, focused on required delivery and outcomes rather than prescribing organisational form.

   b) Working neighbourhood architecture, broad Integrated Neighbourhood Team model and initial priority cohorts agreed.

   c) Priority populations are being quantified at Primary Care Network /neighbourhood level and a common outcomes framework is in development.

   d) Three neighbourhood delivery plans are nearing completion; infrastructure, contractual and enabling requirements have been identified.

   e) A DLN Neighbourhood Oversight Group is coordinating delivery across commissioning, outcomes, strategy and finance.

Readiness and the implementation gap

9. The national self-assessment gives DLN a combined baseline of 39/100, broadly in the middle of the national range. It should be treated as a developmental baseline rather than a judgement of final capability. Relative strengths are access to general practice and oversight, Better Care Fund arrangements, and collaboration across the primary and secondary care interface. Development is required in neighbourhood footprints, Integrated Neighbourhood Teams for priority cohorts, elective pathways, organisational ownership and data sharing; community waiting times are a consistent weakness. Each gap will be converted into evidenced actions within the relevant delivery plan, with an accountable lead and assurance route.

Readiness area	Nottinghamshire	Lincolnshire	Derbyshire
Overall score	38	44	34
Stronger foundations	GP access; interface; data	Urgent/rehab; footprints; interface; data	GP access; interface
Priority development	Community waits; footprints; ownership	Elective pathways; community waits	Data sharing; Integrated Neighbourhood Teams; community waits

Priority populations and delivery model

10. Neighbourhood health is ultimately a whole-population health approach. Initial implementation will focus effort where proactive, coordinated care is most likely to improve outcomes, maintain independence and reduce avoidable escalation and will progressively support the wider priorities set out in the DLN Population Health Strategy.

Initial cohort	Operational focus	Intended effect
End of life	Earlier identification, anticipatory and personalised planning, coordinated care	Care aligned to individual preferences wherever possible
Frailty	Proactive identification, risk management and earlier response to deterioration	Maintain independence and reduce avoidable crisis and hospital use
Multiple long-term conditions (3+)	Coordinate care for people with three or more conditions whose needs cross services	Reduce fragmentation and organise care around the person

11. Care-home residents and housebound people will be reflected through implementation because of their overlap with these cohorts. End-of-life and frailty cohort sizing has begun; multiple long-term conditions analysis will follow. Each neighbourhood will define its starting population, planned expansion and expected impact, using population health intelligence and risk stratification to prioritise proactive multidisciplinary intervention.

    Delivery logic: intelligence → identify need and inequality → quantify cohorts → agree Integrated Neighbourhood Team coverage and intervention → proactive multidisciplinary care → improved outcomes and independence → reduced avoidable escalation and acute utilisation.

Phased roadmap

Phase	Primary objective	Key deliverables / decision gate
2026/27 Build, align and mobilise	Move from where specification to delivery	Implement core Integrated Neighbourhood Team Specification; quantify and agree cohort coverage; agree longer-term footprints with Health and Wellbeing Boards; align existing contracts; establish outcomes and data flows; assess maturity and mobilisation needs; specify Same Day Access; progress initial left-shift pathways; develop Single Neighbourhood Provider / Multi-Neighbourhood Provider readiness framework.
2027/28 Transition and test	Establish clearer accountability and test integration	Test transitional Single Neighbourhood Provider arrangements and Same Day Access accountability; expand left shift where evidence supports it; undertake market engagement, provider-readiness assessment and testing of financial, contractual and governance arrangements.
2028/29 onwards Commission at scale	Progress population-based commissioning justified	Mobilise formal Single Neighbourhood Provider / Multi-Neighbourhood Provider arrangements only where evidence, readiness and formal approvals support them; progressively align suitable services; move towards population accountability and integrated commissioning.

Related delivery programmes

12. *Same Day Access*: define the model, map current provision, identify gaps and duplication, clarify interfaces and align existing contracts during 2026/27.

13. *Planned-care left shift*: progress Advice and Guidance and lead-provider approaches initially in dermatology, musculoskeletal services and gynaecology. The test is a genuine shift in pathway, activity and cost, not relocation of an unchanged model.

14. *Community Single Point of Access and Referral Support Service*: a business case is in development for the initial planned-care pathways from April 2027, including clinical referral review, Advice and Guidance and routing to community or secondary care. Procurement, legal and Provider Selection Regime advice is being sought.

15. *Clinical leadership*: contracting with GP providers from October 2026 will enable multiprofessional neighbourhood clinical leadership, with locally flexible delivery but with clear priorities, deliverables, feedback and contractual accountability.

Outcomes, infrastructure and financial model

16. A single DLN neighbourhood outcomes framework will test whether neighbourhood working changes outcomes rather than simply creating new structures. A focused measure set is being developed across population outcomes; prevention; patient, carer and workforce experience; avoidable acute utilisation; flow; and inequalities. Over time this should become the basis for assessing Integrated Neighbourhood Team, Single Neighbourhood Provider and potentially Multi-Neighbourhood Provider delivery.

17. Delivery depends on actionable neighbourhood intelligence, shared information, workforce capability, strong general practice, clinical leadership and effective use of estates. Cohort-level measurement requires the three DLN data environments to be brought together, information-governance and data-flow issues resolved, storage capacity increased and coding consistency improved. Development will therefore be phased from nationally available metrics to comparable local data and, ultimately, linked population datasets.

18. The financial and contractual model will map current services and expenditure against the core Integrated Neighbourhood Team Specification, establish the current cost of supporting priority cohorts and develop indicative shadow budgets. Options include weighted population funding, a minimum or fixed-payment element and outcome-related payments. Shadow budgets are an analytical and developmental tool and do not delegate or transfer funding. Any contractual implementation will require formal governance and testing.

Key risks and assurance

Risk / dependency	Board-level implication	Approach
Local Government Reorganisation and footprints	Future local authority, Health and Wellbeing Board and place arrangements may change	Use Primary Care Network footprints now; define Primary Care Network-Integrated Neighbourhood Team relationships; agree longer-term geographies with Health and

Risk / dependency	Board-level implication	Approach
		Wellbeing Boards during 2026/27; retain flexibility.
Provider and primary care readiness	Integrated Neighbourhood Team maturity and capacity vary; a common timetable could destabilise delivery	Baseline maturity; targeted mobilisation; readiness-led progression; strengthen general practice.
Contractual and market change	Service movement could have material financial, workforce, procurement and provider consequences	Use existing levers first; undertake market testing; introduce new forms only where they add value.
Data and infrastructure	Weak data flows, coding or information sharing could prevent credible impact measurement	Phased data plan, named ownership, governance, and cautious use of proxy measures.
Over-engineering	Structures could displace focus from delivery and outcomes	Judge success by outcomes, earlier intervention, reduced fragmentation and changed utilisation.

Overall position

19. The programme has moved materially from concept and design towards implementation. The common direction, core Integrated Neighbourhood Team Specification and working architecture are established. The priority for 2026/27 is to turn these foundations into consistent delivery for defined populations, across agreed neighbourhood footprints, with explicit provider contributions and the infrastructure to demonstrate impact.

20. During 2027/28, subject to progress and readiness, the programme would test clearer Single Neighbourhood Provider-level accountability and the case for more integrated commissioning. Formal Single Neighbourhood Provider / Multi-Neighbourhood Provider arrangements would follow only where evidence, readiness, engagement and formal decision-making support them. The central shift is from designing neighbourhoods to delivering through them.

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	17/09/2026
Paper title:	**Citizen experience: Maternity families**
Paper reference:	ICB CIC 048
Paper author:	Julie Cuthbert, Head of Communications, Nottingham and Nottinghamshire 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:

This report shares the impact of Nottingham maternity failings on one local family. Sarah Sissons will join the Board meeting to talk about her maternity experiences and the ongoing consequences for their family of having a child who survived, but with lifelong injuries.

Sarah has campaigned tirelessly for two decades for accountability and support and she now acts as an advocate for other families who have children who were harmed by maternity services at Nottingham University Hospitals NHS Trust.

The report also details some of the work that has taken place to engage with families harmed by maternity services, hear their voices and experiences, and involve them in the improvement programme. This report relates to the next item about the maternity improvement programme.

Recommendation(s):

The Boards are asked to **discuss** this item.

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

None

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No

Citizen experience: Maternity families

Introduction

1. The Independent Maternity Review at Nottingham University Hospitals NHS Trust (NUH) was published in June 2026. Both this review, and the national maternity review by Baroness Amos published shortly afterwards, showed that families have been failed both locally and nationally.
2. Sarah Sissons from Long Eaton will talk about her family's experiences of poor maternity care at NUH, including the ongoing impact of supporting a child who survived with lifelong injuries.

Sarah's experience

3. Sarah's son Ryan was born healthy in 2007 but three days after his birth, a sequence of poor care and delays in treatment at Nottingham City Hospital caused him to suffer a catastrophic brain injury. Ryan was eventually diagnosed with hypoxic-ischaemic encephalopathy, cerebral palsy and global developmental delay and Sarah was told that he would never be able to walk or talk.
4. Ryan is now 19 and, thanks to privately funded support, he has been able to defy expectations by walking, talking, riding a bike and attending school and college.
5. However, Sarah and her family have faced two decades of significant personal advocacy and ongoing battles with multiple services to obtain diagnoses, treatments and support. They have campaigned tirelessly for the support Ryan needs, as well as for accountability for the injuries he suffered.
6. The family have experienced physical and mental health impacts arising from the trauma, alongside the ongoing emotional burden of continually advocating for support.
7. They have also faced issues with Special Educational Needs and Disability services, including availability of educational opportunities and specialist provision, lack of mandatory brain injury training in schools, challenges around the process of transition into adulthood, and reduced options for college courses and day opportunities for disabled young people.
8. Sarah and other families have also experienced financial and practical burdens, such as being charged for supporting documentation from GPs, payment for incontinence pads and transport costs to college.
9. Ryan was the first child and the oldest child in the Independent Maternity Review led by Donna Ockenden. Sarah is concerned that the review has

focused mainly on the bereaved families and that evidence supplied by the family was not properly reflected in the final report.

10. Sarah believes there is insufficient follow-up support for families who have harmed children as a result of the maternity failings. She feels that having a single point of contact for families to deal with ongoing problems across health, education and social care services would make a positive difference.

11. Sarah has shown an incredible amount of courage and determination in her battles with different organisations throughout Ryan's life and she now acts as an advocate for other families who have children who were harmed by NUH maternity services.

Engagement with maternity families

12. Work has been taking place with families who have been affected by poor maternity care to ensure they are supported, involved in improvement work, and feel assured that changes are being made.

13. NHS Nottingham and Nottinghamshire ICB has been engaging with Sarah and other families with harmed children and bereaved families about their maternity and neonatal experiences and to learn how more support can be provided for these families in the future.

14. This engagement so far has involved finding out preferred ways of working together, understanding the needs of different families, and discussing how families could input into future developments.

15. Other families have also been included in assurance exercises and they have reviewed evidence submitted by NUH to prove compliance with the immediate and essential actions from the Independent Maternity Review. An insight visit to NUH is also being considered with families.

16. The ICB has recruited a Maternity and Neonatal Voices Partnership Strategic Lead and two engagement leads to increase the numbers and diversity of volunteers across the system. Some of the maternity families were involved in the recruitment to these roles which has helped build relationships with the Maternity and Neonatal Voices Partnership and the families.

17. The Nottingham Maternity Families Group also shared their experiences at last week's Joint Quality and Service Improvement Committee. These experiences are being used to frame the discussions around maternity and neonatal care, oversight and next steps for the Committee.

18. There is still a great deal of work to do with the families harmed by maternity services in Nottingham, as there are a large number of people with different needs and unique experiences who will be supported to have their voices heard. This is an opportunity to understand the impact of maternity failings on

local communities, build relationships and repair trust and begin to consider what ongoing support may need to look like with those families affected.

19. It is with the collaboration of brave people like Sarah, and other families who share their experiences, which will help to shape improvements to maternity services.

Meeting title	Integrated Care Boards: Open Session (meeting in common)
Meeting date	16/09/2026
Paper title	**Oversight and Assurance Arrangements for Derby and Derbyshire, Nottingham and Nottinghamshire, and Lincolnshire Perinatal Services**
Paper reference	ICB CIC 26 049
Paper author	Rhonda Christian, Assistant Director for Quality Jo Hunter Director of Quality, Safeguarding, CHC and Partnerships
Paper sponsor	Rosa Waddingham, Executive Director Quality (Nursing)
Presenter	Rosa Waddingham

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

Report summary

This report builds on the initial briefing provided to the Boards at their July meeting in response to the Nottingham Independent Maternity Inquiry and the Amos report. The ICBs' Joint Quality and Service Improvement Committee has had detailed briefings on both reports and has reviewed maternity and neonatal oversight across NHS Derby and Derbyshire, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire ICBs (DLN).

The report provides a further update, noting that a more comprehensive assurance assessment will be made after formal assurance reports have been presented to each of the DLN's NHS provider trust boards in relation to the NHS England Ten-Point Maternity Urgent Plan and additional oversight of post death care following previous assurances in relation to the Fuller review.

The report also provides detail on Nottingham University Hospitals NHS Trust's implementation of actions and oversight arrangements, although these too are subject to further approval by the Trust's Board.

The key areas that the DLN ICBs will focus on moving forward, which have been discussed and agreed by the ICBs' Quality and Service Improvement Committee are:

- Perinatal oversight and reporting;
- Listening to women, families and carers;
- Racism, discrimination and wider Equality, Disability and Inclusion priorities;
- Inequalities in maternity outcomes as a patient-safety priority;
- Better use of data through the DLN quality management system;
- Patient Safety Incident Response Framework (PSIRF) capability for ICB executives and non-executive directors.

Recommendation(s)

The Boards are asked to **receive** the report for assurance on the establishment of oversight and assurance arrangements for Derby and Derbyshire, Nottingham and Nottinghamshire, and Lincolnshire Perinatal Services.

Appendices

None

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
- 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.

Oversight and Assurance Arrangements for Derby and Derbyshire, Nottingham and Nottinghamshire, and Lincolnshire Perinatal Services

Background and Introduction

1. In June 2026, two major national reviews highlighted significant concerns about maternity and neonatal services. Donna Ockenden's Independent Maternity Review of Nottingham University Hospitals NHS Trust (NUH) examined more than 2,500 family cases and identified widespread care failures resulting in avoidable harm to mothers and babies. Baroness Valerie Amos' National Maternity and Neonatal Investigation reviewed services across 12 NHS Trusts and identified wider national challenges.
2. A communication from NHS England (NHSE) subsequently set out additional actions relating to post-death care and mortuary oversight following the publication of the Fuller Review.
3. NHSE's Ten-point plan for Maternity and Neonatal Services provided an immediate response to these reviews and sets immediate priorities ahead of a comprehensive National Action Plan due in December 2026.
4. Together, these developments will have significant implications for maternity assurance, quality oversight and improvement across Nottingham and Nottinghamshire, Derbyshire and Lincolnshire (DLN), reinforcing the need for strong safety oversight, effective organisational learning, robust investigation processes, reduction of inequalities, meaningful involvement of women and families, and a continued focus on openness, speaking up and continuous improvement.
5. This paper is presented for assurance on maternity and neonatal oversight across the NHS Derby and Derbyshire, NHS Lincolnshire and NHS Nottingham and Nottinghamshire ICBs (the ICBs). It covers:
    a) A DLN update in relation to the NHSE Ten-point Maternity Urgent Plan.
    b) Additional oversight of post death care following previous assurances in relation to the Fuller review.
    c) Progress on the Nottingham University Hospitals implementation of action.
    d) Areas of focus for the Integrated Care Boards moving forwards:
        i. DLN perinatal oversight and reporting
        ii. Listening to women, families and carers
        iii. Racism, discrimination and wider Equality, Disability and Inclusion (EDI) priorities
        iv. Inequalities in maternity outcomes as a patient-safety priority
        v. better use of data through the DLN quality management system
        vi. Patient Safety Incident Response Framework (PSIRF) capability for Non-Executive Directors and executives

DLN-wide position: NHS England ten-point plan and stocktake

6. All five maternity providers within Derbyshire, Lincolnshire and Nottinghamshire gave a position update to the DLN Perinatal Partnership Group in August 2026. Each confirmed commitment to the ten-point plan. At that point, provider plans were at different stages of completion and approval, and several updates were verbal pending consideration through their own trust governance processes.

7. The Perinatal Partnership review identifies four recurring DLN-wide dependencies: workforce capacity and sustainability; digital infrastructure and interoperability; rising caesarean section demand and theatre capacity; and reliance on primary care and wider system partners to implement the Maternity Care Bundle. These issues require collective system action rather than provider-only mitigation.

8. Since the initial stocktake, NHSE has issued further guidance has been issued on reporting requirements and delivery timelines. The ICBs are aligning the provider returns and assurance route with that guidance. A full DLN ten-point plan stocktake will be presented to the ICBs' Quality and Service Improvement Committee in October 2026, including confirmed provider positions, exceptions, cross-system dependencies and required escalations.

Fuller Review and Post-Death Care

9. The ICBs' Quality and Service Improvement Committee received assurance in relation to post-death care and NHS trusts' response to the Fuller Review in June and July 2026, noting particularly the concerns at NUH and the recommendations of the Human Tissue Authority and noted the ICBs' oversight of improvements prior to the publication of the review.

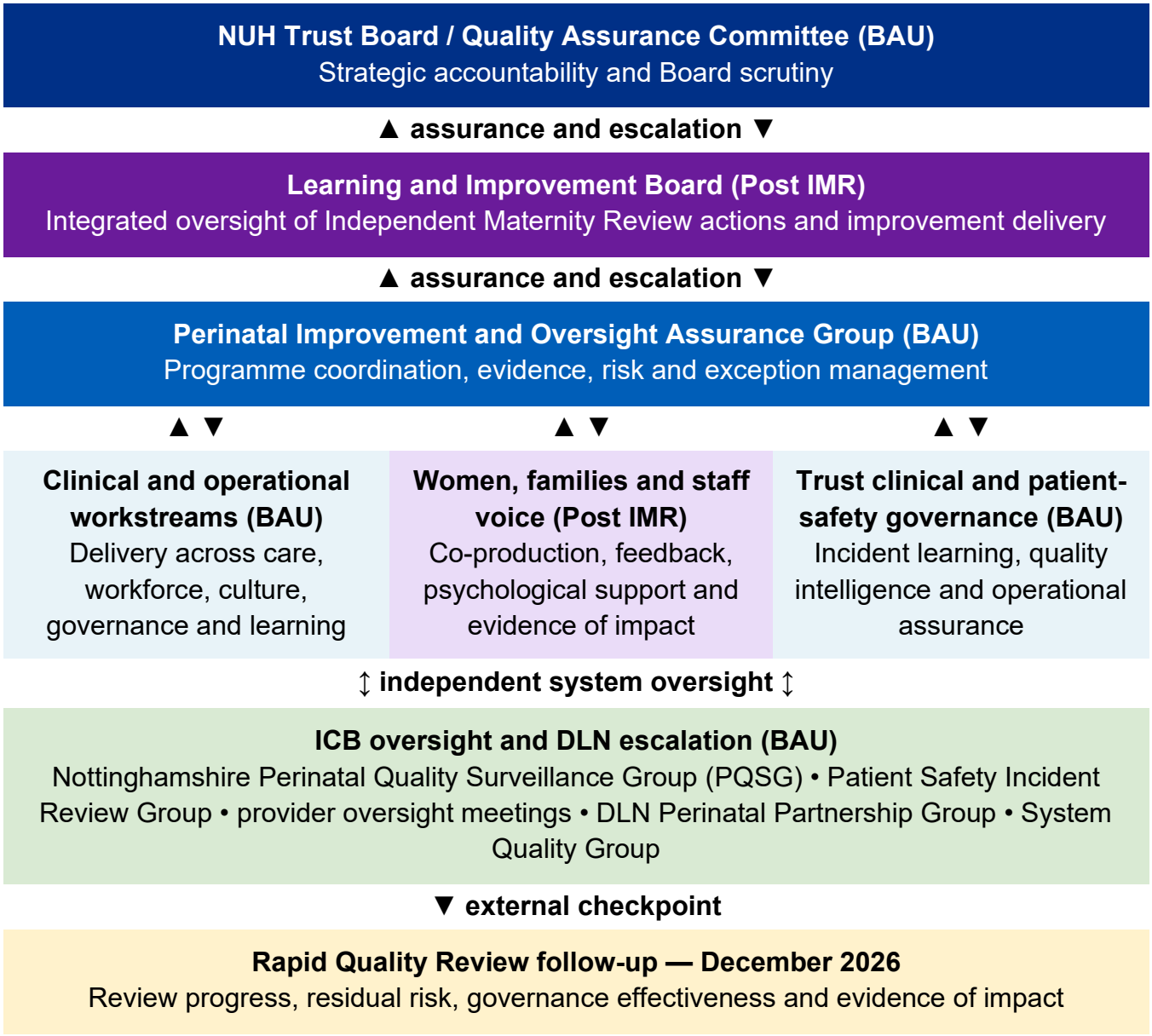
10. Every NHS provider trust board with mortuary service within DLN has assured itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve, and have completed and returned an assurance statement confirming this.

11. The submission guidance for the ten-point plan also includes assurance of actions in relation to post death care; and further assurance will be provided to Quality and Service Improvement Committee at their meeting in October 2026.

Nottingham University Hospitals: Independent Maternity Review actions

12. NUH is establishing strengthened arrangements to coordinate, deliver and assure the actions arising from the Independent Maternity Review. The developing model brings together executive accountability, programme delivery, clinical and patient-safety governance, family voice and external or system assurance. A Learning and Improvement Board is expected to become operational from October 2026, supported by the existing Perinatal Improvement and Oversight Assurance Group and Trust governance routes.

Figure 1. NUH improvement and assurance model



Immediate assurance priorities for NUH

13. The immediate assurance priorities for NUH are:

    a) Clear mapping of every review action, evidence requirement and completion date to an accountable executive and a delivery lead,

    b) A single view of risks, dependencies, overdue actions and escalation decisions.

    c) Trust triangulation of patient incidents, complaints, claims, coronial processes, staff intelligence and family experience.

    d) Evidence that improvement changes practice and outcomes, rather than relying on action completion alone.

    e) Transparent reporting to families and the ICB on progress, constraints and unresolved concerns.

Family involvement and stocktake

14. The ICB continues to work with families impacted by NUH maternity services and whose cases were part of the Independent Review. We have involved these families in the stock take and assurance approach. We continue to strengthen relationships through the Maternity and Neonatal Voices Partnership, ensuring the continuing practical, emotional and psychological needs of these families and children are considered. Family involvement should be evidenced as a patient-safety intervention and not treated solely as an engagement activity.

ICB oversight and external follow-up

15. The ICB will maintain oversight through attendance at the Nottinghamshire Perinatal Quality Surveillance Group and attendance at NUH oversight and assurance meetings, and escalation through the DLN Perinatal Partnership Group and System Quality Group where required. The planned December 2026 maternity follow-up to the Rapid Quality Review will provide an additional checkpoint on delivery, residual risks and the effectiveness of the strengthened arrangements.

16. The following six areas are proposed as the ICBs' core contribution. They align maternity assurance with the emerging DLN approach to quality and place women, families, equity and demonstrable improvement at the centre of oversight.

Area	ICB action	Evidence to Committee
1. DLN perinatal oversight and reporting	Implement a consistent assurance and escalation model for all five providers, with clear lines from local Perinatal Quality Surveillance Groups and contract quality routes to the DLN Perinatal Partnership Group, System Quality Group, Joint Committee and regional or national escalation. Use the updated reporting template and rules-based triggers to distinguish local management, Rapid Quality Review and formal improvement intervention.	Consistent provider return; clear escalation rationale; actions, owners and dates; evidence of closure.
2. Listening to women, families and carers	Embed meaningful involvement in oversight, service design, investigations and improvement. Strengthening Maternity and	Representation from seldom-heard groups; feedback-to-action audit trail; family

Area	ICB action	Evidence to Committee
	Neonatal Voices Partnership reach and representation, retain direct routes for families affected by the Nottingham review, and demonstrate how lived experience changes decisions and care.	support needs identified and acted upon.
3. Racism, discrimination and wider EDI priorities	Use the three Local Maternity and Neonatal System equality and equity plans as the delivery basis, aligned with wider ICB EDI objectives. Require providers to address racism, stereotyping and differential experience through workforce, clinical and patient-experience action.	Shared measures across access, experience and outcomes; provider action and exception reporting; evidence of co-production.
4. Inequalities in maternity outcomes as a patient-safety priority	Establish a joint outcomes and quality workstream using population-health intelligence to identify unwarranted variation, prioritise groups experiencing poorer outcomes and monitor whether interventions reduce harm.	Agreed inequality priorities; stratified outcome measures; named interventions; evaluation and escalation of adverse trends.
5. Better use of data through the DLN quality management system	Build maternity into the DLN quality management system so that planning, control, assurance and improvement are connected. Triangulate quantitative data (NHSE Regional Heatmap) with incidents (Maternity Signal System), complaints, claims, staff voice and lived experience, using a single risk and action view.	Common dashboard and narrative; traceable escalation decisions; improvement measures linked to patient outcomes and experience.
6. PSIRF capability for non executives and executives	Develop a focused PSIRF development offer for Non-Executive Directors and executives across the three ICBs. It should strengthen Board-level understanding of compassionate engagement, proportionate response, systems-based learning, oversight and assurance.	Agreed learning objectives; attendance and evaluation; refreshed Board assurance questions; follow-up through committee development plans.

Proposed governance and reporting route

17. The proposed governance and reporting route is as below:

Joint ICB Board in Common / Joint Quality and Service Improvement Committee
▲ escalation | assurance ▼

DLN System Quality Group and DLN Perinatal Partnership Group
▲ escalation | assurance ▼

Local ICB Perinatal Quality Surveillance Groups and contract quality routes
▲ escalation | assurance ▼

Provider Boards, quality committees and maternity / neonatal governance
▲ escalation | assurance ▼

Intelligence: outcomes, incidents, complaints, claims, workforce, regulation and lived experience

Where thresholds are met:
Situation, Background, Assessment, Recommendation (SBAR) → Rapid Quality Review → Quality Improvement Group or other formal intervention

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	17/09/2026
Paper title:	**Quality Oversight Report**
Paper reference:	ICB CIC 26 050
Paper author:	Rebecca Neno, Director of Quality, Safety and Improvement Jo Hunter, Director of Quality Safeguarding and Partnerships
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.

Key areas requiring continued focus include providers subject to enhanced oversight, variation in patient safety reporting, urgent and emergency care pressures, Continuing Healthcare referral timeliness, maternity outcomes and infection prevention and control.

Oversight will continue to triangulate performance data with qualitative intelligence, patient safety learning and regulatory information to assess whether improvement is embedded and sustained.

Recommendation(s):

The Boards are asked to receive this report for **assurance**.

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

Appendix 1: Quality Performance Report August 2026

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Quality 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.

Quality Performance (data to the end of August 2026)

4. The August 2026 quality performance position presents a mixed but material system risk picture across the three ICBs. The underlying National Oversight Framework (NOF) assessment is strongest for Derby and Derbyshire, mixed for Lincolnshire and most challenged for Nottingham and Nottinghamshire. At provider level, the position has worsened, with five trusts in NOF segment four and five in NOF segment three at Quarter Four 2025/26. This creates a clear distinction between the relatively stronger ICB-level position in Derby and Derbyshire and the wider provider and pathway pressures evident across Lincolnshire and Nottinghamshire.

Areas of Escalated Oversight

Provider	NOF	Status	Key Issue	Current Assurance Mechanism
Chesterfield Royal Hospital NHS Foundation Trust	4	Ongoing	Rapid Quality Review undertaken in July 2026. Quality Improvement Group to be established.	Improvement programme Regional Oversight Quality Improvement Group Clinical Quality Review Group (CQRG, quality commissioning meeting)

Provider	NOF	Status	Key Issue	Current Assurance Mechanism
University Hospitals of Derby and Burton NHS Foundation Trust	4	Ongoing	Maternity oversight	Improvement programme Regional oversight Quality Improvement Group Clinical Quality Review Group
Northern Lincolnshire and Goole NHS Foundation Trust	4	Ongoing	Elective recovery, workforce and flow	Improvement programme Regional oversight
Nottinghamshire Healthcare NHS Foundation Trust	4	Ongoing	Mental health delivery	Improvement programme Regional oversight
Nottingham University Hospitals NHS Trust	4	Ongoing	Mortuary, Urgent and Emergency Care, Maternity and corridor care	Improvement programme Regional oversight

Areas of Enhanced Oversight

Theme	Current Position	Key Assurance
Learning Disability and Autism	Performance variable across Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire	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

Urgent and Emergency Care

5. The most significant cross-cutting concerns are urgent and emergency care flow, discharge delays, corridor care, workforce experience, health inequalities, and the ability of organisations to sustain safe and effective care whilst operating under capacity pressure. The July 2026 experimental corridor-care data records 4,769 entries across the selected providers, of which 3,480 (73%) occurred in emergency departments. Derby and Derbyshire accounts for the largest ICB volume and University Hospitals of Derby and Burton NHS Foundation Trust the highest provider total.

6. The July 2026 experimental corridor-care dataset provides a useful quality signal because it exposes the extent to which patients are being cared for in non-designated areas.

ICB / provider	July entries	Key observation
Derby and Derbyshire	2,945	Largest ICB volume; 2,315 emergency department and 630 adult entries.
Lincolnshire	616	564 emergency department and 52 adult entries.
Nottingham and Nottinghamshire	1,208	601 emergency department and 607 adult entries.
University Hospitals of Derby and Burton NHS Foundation Trust	1,866	Highest provider total; 1,236 emergency department and 630 adult.
Chesterfield Royal Hospital NHS Foundation Trust	1,079	All recorded entries were emergency department.
Nottingham University Hospitals NHS Trust	1,208	607 adult and 601 emergency department.

7. The 4,769 entries are dominated by emergency department activity (3,480; 73%), with no paediatric corridor-care entries reported. This is a new experimental metric and should be treated as immature while completeness and validation improve. Nevertheless, the concentration of activity in emergency departments and the accompanying narrative on discharge and flow indicate a material quality risk that operational constraints can translate into privacy, dignity, timeliness and safety risks and is of upmost importance as we move into the winter period. Quality is integrated within winter planning and the sharing of good practice in relation to corridor care and temporary escalation spaces will be a focus for the next System Quality Group.

Maternity

8. Maternity data shows significant variation between providers.

Provider	10-week booking	NND / 1,000	Stillbirth / 1,000	Tears / 1,000	PPH / 1,000
Nottingham University Hospitals NHS Trust	61%	1.99	3.42	49.0	36.0
Sherwood Forest Hospitals NHS Foundation Trust	68%	2.87	1.01	36.0	19.0
United Lincolnshire Teaching Hospitals NHS Trust	70%	1.03	2.94	34.0	26.0
Chesterfield Royal Hospital NHS Foundation Trust	65%	1.18	2.84	33.0	42.0
University Hospitals of Derby and Burton NHS Foundation Trust	68%	0.91	2.89	44.0	39.0

9. The principal concern is not a single cluster-wide maternity failure but a set of provider-specific patterns. NUH has the broadest concern profile, with a 61% booking rate and high morbidity measures; its deep dive identifies 20% of women self-referring after eight weeks, limiting the ability to secure booking before ten weeks. ULHT has identified an increase in stillbirths and reports that all cases are undergoing detailed review. Chesterfield increasing rates of postpartum haemorrhage and is reviewing booking data because screening data suggest materially better compliance than the reported metric. UHDB has comparatively high tears and postpartum haemorrhage and remains behind trajectory for the Perinatal Pelvic Health Service.

Infection, Prevention and Control

10. The ICBs are developing an interim Infection, Prevention and Control assurance model using a combined resource, with a shared Healthcare-Associated Infection reduction work plan being developed with the regional Infection, Prevention and Control lead. This is strategically important because the reported C. difficile infection year-to-date position is above plan at every listed provider.

Provider	C. difficile YTD actual	YTD plan	Variance
Chesterfield Royal Hospital NHS Foundation Trust	15	11	+4
Nottingham University Hospitals NHS Trust	46	38	+8
Sherwood Forest Hospitals NHS Foundation Trust	18	17	+1
United Lincolnshire Teaching Hospitals NHS Trust	27	23	+4
University Hospitals of Derby and Burton NHS Foundation Trust	45	40	+5

11. The consistency of adverse C. difficile variance across providers suggests a geographical-level issue rather than isolated provider underperformance. A shared assurance approach is therefore appropriate, but that ICBs will retain provider-specific root-cause analysis and action plans.

Continuing Healthcare

12. There were 31 incomplete standard NHS Continuing Healthcare referrals beyond 28 days during Quarter One 2026/27, with one over 12 weeks and none over 26 weeks. Nottingham and Nottinghamshire accounts for 26 cases and has increased 63% from Quarter Four 2025/26. Derby and Derbyshire has three and Lincolnshire two.

13. Although the absolute numbers are modest, the concentration and deterioration in Nottingham and Nottinghamshire is significant and a recovery plan is in place to restore performance.

Prevention of Future Deaths

14. Three Regulation 28 Prevention of Future Deaths reports are identified for Quarter One 2026/27, all associated with Nottingham and Nottinghamshire. Themes include incident response and duty of candour, allergy de-labelling, advice on fitness to drive, abnormal radiology follow-up after emergency department discharge, discharge-summary quality and missed opportunities for earlier diagnosis. The themes reinforce the wider system concerns around communication, continuity and diagnostic follow-up.

15. The ICBs' aggregate Summary Hospital-level Mortality Indicator is 1.057 compared with an England baseline of 1.000. Nottingham University Hospitals NHS Trust is reported as higher than expected at 1.1677, whilst all other providers are within the 'as expected' band. The report notes that Nottingham University Hospitals NHS Trust has a high percentage of invalid diagnosis codes, so the value requires cautious interpretation and work to address data quality is underway.

Conclusion

16. The ICBs' principal quality challenge is the interaction between operational pressure and quality outcomes. Flow constraints, discharge delays and capacity limitations are visible through corridor-care activity and are also reflected in the NOF focus areas. Provider deterioration increases the importance of strong system-level oversight because organisational resilience and pathway performance are interdependent.

17. A second theme is variation. The maternity position demonstrates that the same headline metric can have different causes and improvement requirements across providers. Similarly, care-home pressures differ by geography, and Continuing Healthcare backlog is heavily concentrated in Nottingham and Nottinghamshire. Therefore, restorative quality actions often require local quality assurance and oversight, supported by transformation and improvement initiatives aligned to our strategic and local commissioning plans.

SAIU

STRATEGIC ANALYTICS INTELLIGENCE UNIT

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Quality Performance Report

August 2026

Version: v3
Date: 27th August 2026
Prepared By: Rachel Jeffery
Reviewed By: Simon Frampton

Service Delivery Access

August 2026 Published Data

Service Delivery Access: August 2026 published data

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

							NHS Derby and Derbyshire ICB					NHS Lincolnshire ICB					NHS Nottingham and Nottinghamshire ICB				
Programme	Metric	Category	OP Plan Ref	% / Value	Period	DQ	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	%	Jun-26		66.5%	68.7%	2.2%	✓		61.0%	62.5%	1.5%	✓		72.0%	67.6%	-4.4%	✗	
	RTT <18 Weeks (%)	Ops Plan	E.B.40	%	Jun-26		64.4%	64.2%	-0.2%	✗		61.8%	62.0%	0.2%	✓		64.7%	66.9%	2.2%	✓	
	RTT >52 Weeks (%)	Ops Plan	E.B.18	%	Jun-26		1.5%	1.6%	0.1%	✗		1.0%	1.5%	0.5%	✗		1.0%	1.9%	0.9%	✗	
	RTT >65 Weeks (No.)	Nat Std		Value	Jun-26		0	51	51	✗		0	27	27	✗		0	88	88	✗	
	RTT Waiting List Size	Ops Plan	E.B.3a	Value	Jun-26		111,687	113,889	2,202	✗		106,666	109,670	3,004	✗		119,800	120,073	273	✗	
Cancer	Cancer Faster Diagnosis <28 Days (%)	Ops Plan	E.B.27	%	Jun-26		80.0%	78.0%	-2.0%	✗		80.1%	74.0%	-6.1%	✗		80.0%	81.3%	1.3%	✓	
	Cancer Treatment <31 Days (%)	Ops Plan	E.B.38	%	Jun-26		94.1%	89.5%	-4.6%	✗		93.0%	90.1%	-2.9%	✗		94.0%	94.1%	0.1%	✓	
	Cancer Referral-to-Treatment <62 Days (%)	Ops Plan	E.B.35	%	Jun-26		76.5%	64.2%	-12.3%	✗		74.1%	60.3%	-13.8%	✗		76.2%	65.7%	-10.5%	✗	
Diagnostics	Diagnostics >6 Weeks (%)	Ops Plan	E.B.28x	%	Jun-26	⚠	17.1%	27.4%	10.3%	✗		32.8%	52.1%	19.3%	✗		22.6%	29.3%	6.7%	✗	
Urgent Care	A&E <4 Hours (%)	Ops Plan	E.M.13	%	Jul-26	⚠	74.9%	74.2%	-0.7%	✗		74.6%	79.4%	4.8%	✓		78.4%	69.0%	-9.4%	✗	
	A&E >12 Hours (%)	Ops Plan	E.M.13g	%	Jul-26	⚠	4.4%	12.2%	7.8%	✗		9.3%	15.6%	6.3%	✗		7.8%	10.5%	2.7%	✗	
	Ambulance Cat 2 Mean Response (mins)	Ops Plan	E.B.23c	Value	Jul-26		00:25:00	00:28:38	00:03:38	✗		00:25:00	00:41:15	00:16:15	✗		00:25:00	00:26:41	00:01:41	✗	
	Average Handover Time	Ops Plan	E.B.42	Value	Jul-26		00:30:51	00:28:11	-00:02:43	✓		00:28:54	00:35:04	00:06:10	✗		00:23:33	00:28:21	00:04:45	✗	
Primary Care	GP Appointments Delivered	Ops Plan	E.D.19	Value	Jun-26		570,998	655,686	84,688	✓		482,881	535,202	52,321	✓		635,227	769,989	134,762	✓	
	Same Day Urgent GP Appointments (%)	Ops Plan	E.D.27	%	Jun-26		70.0%	75.0%	5.0%	✓		68.7%	71.3%	2.6%	✓		75.0%	78.9%	3.9%	✓	
	Dental UDAs Delivered	Ops Plan	E.D.24	Value	Jul-26		124,614	124,350	-264	✗		88,579	74,770	-13,809	✗		168,847	153,999	-14,848	✗	
	Pharmacy First Consultations	Ops Plan	E.D.26	Value	May-26		11,201	13,467	2,266	✓		6,812	8,545	1,733	✓		13,864	15,773	1,909	✓	
Community	Adult Community Waits >52 Weeks	Ops Plan	E.T.9b	Value	Jun-26		92	4	-88	✓		0	0	0	✓		0	0	0	✓	
	CYP Community Waits >52 Weeks	Ops Plan	E.T.9a	Value	Jun-26		62	803	741	✗		1,326	1,326	0	✓		250	257	7	✗	
Mental Health	Inappropriate OAPs (Adult Acute)	Ops Plan	E.A.5	Value	Jun-26	⚠	7	*				1	*				8	10	2	✗	
	MH Inpatient Mean LOS Adult and PICU	Ops Plan	E.H.38	Value	Jun-26		54.5	55.0	0	✗		20.7	22.0	1	✗		48.6	46.0	-3	✓	
	MH Inpatient Mean LOS Older Adult	Ops Plan	E.H.39	Value	Jun-26		81.5	78.0	-4	✓		57.7	137.0	79	✗		77.2	93.0	16	✗	
	IPS Access (Rolling 12-month)	Ops Plan	E.H.34	Value	Jun-26		847	950	103	✓		680	740	60	✓		1,375	1,595	220	✓	
	EIP <2 Weeks (%)	Nat Std		%	Jun-26		60.0%	74.0%	14.0%	✓		60.0%	65.0%	5.0%	✓		60.0%	71.0%	11.0%	✓	
	Talking Therapies Reliable Recovery (%)	Ops Plan	E.A.4a	%	Jun-26		47.2%	50.3%	3.1%	✓		50.3%	50.4%	0.1%	✓		50.4%	52.1%	1.7%	✓	
	Talking Therapies Reliable Improvement (%)	Ops Plan	E.A.4b	%	Jun-26		68.8%	69.6%	0.8%	✓		69.9%	72.2%	2.3%	✓		68.4%	73.3%	4.9%	✓	
	CYP MH Access	Ops Plan	E.H.9	Value	Jun-26		14,620	14,915	295	✓		12,451	12,715	264	✓		21,840	22,300	460	✓	
	CYP ED Routine <4 Weeks (%)	Nat Std		%	Jun-26		95.0%	93.0%	-2.0%	✗		95.0%	50.0%	-45.0%	✗		95.0%	86.0%	-9.0%	✗	
	CYP MH Waits >104 Weeks	Ops Plan	E.A.7	Value	Jun-26		1,160	1,300	140	✗		99	1,010	911	✗		680	360	-320	✓	
LD&A	LD/Autism Adult Inpatients	Ops Plan	E.H.32/33	Value	Jul-26		31	36	5	✗		34	26	-8	✓		35	37	2	✗	
	LD/Autism CYP Inpatients	Ops Plan	E.K.1c	Value	Jul-26		3	4	1	✗		2	1	-1	✓		3	2	-1	✓	
	LD Annual Health Checks with HAP (Qtr)	Ops Plan	E.K.3	Value	Jun-26	⚠	754	785				566	614	48	✓		855	1,031	176	✓	

Headline Priorities

NHS
Derby and Derbyshire
Integrated Care Board

NHS
Lincolnshire
Integrated Care Board

NHS
Nottingham and Nottinghamshire
Integrated Care Board

National Oversight Framework

Quarter 4 2025/26

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STRATEGIC ANALYTICS INTELLIGENCE UNIT

ICB Assessments 2025-26

Derby and Derbyshire Integrated Care Board

Lincolnshire Integrated Care Board

Nottingham and Nottinghamshire Integrated Care Board

ICB Assessments Q4 2025-26 – Overall position, themes of positive positions and areas to work on

Overall position: DDICB has the strongest relative profile, LICB is mixed, and NNICB is the most challenged overall.

Main themes:
Positive positions cluster around waiting lists, cancer diagnosis, CHC referrals, prescribing and staff survey indicators
Focus areas are access, discharge flow, productivity, workforce experience and health inequalities.

DDICB Summary

Position: Above average or better in access, experience, safety and workforce; finance is the key lowest-quartile risk.

Positive themes: Improved waiting list position, cancer diagnosis, CHC referrals, mental health OAPS, GP appointments and staff survey scores.

Focus: GP booking satisfaction, discharge delays, antibiotic prescribing, implied productivity and healthy-years inequality.

LICB Summary

Position: Strongest in safety, finance and population health, but below average for access, experience and workforce.

Positive themes: CHC referrals, NICE hypertension and cardiovascular treatment, cancer staging, stroke admission gap and financial plan performance.

Focus: Cancer diagnosis stage, discharge delays, GP appointment access, neonatal still-births, breast screening and workforce leaver rate.

NNICB Summary

Position: Access, experience and finance sit in the lowest quartile; workforce and population health are below average.

Positive themes: CHC referral waits, CYP antibiotic prescribing and some prevention activity around smoking, weight management and diabetes.

Focus: GP booking satisfaction, discharge delays, diabetes care processes, productivity, staff survey concerns and cancer staging.

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ICB Assessments Q4 2025-26

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

- DDICB: 4 out of 5 above average or highest scoring
- LICB: 3 out of 6 below average
- NNICB 5 out of 6 below average or lowest scoring

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

System Performance Indicators	DDICB	LICB	NNICB
A&E 4 Hours	75.40% Below national target but improved on 24/25	75.20% Below national target and deteriorated from 24/25	65.30% Below national target and deteriorated from 24/25
18 week RTT	63.90% Below national target but improved on 24/25	61.16% Below national target but improved on 24/25	64.03% Below national target but improved on 24/25
62 day cancer	67.04% Below national target and deteriorated from 24/25	61.52% Below national target and deteriorated from 24/25	65.96% Below national target but improved on 24/25
System Finance	Deficit Plan and significantly adverse to plan	Break even or surplus plan and on track	Deficit Plan and significantly adverse to plan
GP Satisfaction	75.53% Above national average and improved on 2024	72.51% Below national target and deteriorated from 24/25	74.15% Below national target but improved on 24/25
SMI Healthchecks	66% Above national average but deteriorated from 24/25	66% Above national average and improved on 2024	65% Above national average but deteriorated from 24/25

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

ICB Assessments Q4 2025-26

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

NOF Domains	DDICB	Summary of Assessment - Positive Positions	Areas of Focus Needed
Access	Above Average	Positive change in WL, improved cancer diagnosis.	GP Booking satisfaction
Experience	Highest scoring quartile	CHC referrals 28 days, MH OAPs, GP appts with preferred professional, hypertension NICE treatments	LD&A Inpatients, days to discharge from DRD
Safety	Above Average	Staff survey raising concerns score	CYP (0-9) antibiotic prescribing
Finance	Lowest scoring quartile	Plan YTD, combined finance score, deficit as % allocation	Implied productivity growth
Workforce	Above Average	Staff survey always learning score	GP Leaver Rate and rising sickness absence rate
Population Health	Below Average	CYP MMR	Healthy years life expectancy, Obesity referrals to DWMS and diabetes prevention programme
Social Value (addn Info)	No Scoring		Staff survey EDI and Inclusion score. Population economically inactive and Greener NHS Programme

NOF Domains	LICB	Summary of Assessment - Positive Positions	Areas of Focus Needed
Access	Below Average	GP Booking satisfaction	Reduced cancer diagnosis stage
Experience	Below Average	CHC referrals 28 days, hypertension NICE treatments, GP cardiovascular NICE	LD&A Inpatients, days to discharge from DRD,GP appts with preferred professional
Safety	Highest scoring quartile	Staff survey, raising concerns, CYP (0-9) antibiotic prescribing	Neonatal still-births
Finance	Highest scoring quartile	Plan YTD, combined finance score, deficit as % allocation, implied productivity	
Workforce	Below Average		GP Leaver Rate
Population Health	Highest scoring quartile	LDA AHCs, cancer staging, stroke admission deprivation gap	Breast screening coverage
Social Value (addn Info)	No Scoring	NHS Staff inclusion score	Staff survey EDI . Population economically inactive and Greener NHS Programme mostly met

NOF Domains	NNICB	Summary of Assessment - Positive Positions	Areas of Focus Needed
Access	Lowest scoring quartile		GP Booking satisfaction Rate
Experience	Lowest scoring quartile	CHC referrals 28 days	LD&A Inpatients. All eight diabetes care processes
Safety	Above Average	CYP (0-9) antibiotic prescribing	Staff survey raising concerns, neonatal still-births
Finance	Lowest scoring quartile		Implied productivity
Workforce	Below Average		Staff engagement, staff always learning, sickness absence rate, GP leaver rate
Population Health	Below Average	% pregnant women stopping smoking, referrals to digital weight management services, Diabetes prevention programme	CYP MMR, Cancer staging
Social Value (addn Info)	No Scoring		Staff survey EDI . Population economically inactive and Greener NHS Programme mostly met

Provider NOF Assessments Q4 2025-26

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Provider Assessments:

- At Q4 2025-26 there are 5 trusts in segment 4, 5 trusts in segment 3 and 1 trust in segment 2.
- There has been some significant movement in the ranking and segmentation of the NHS Providers across DLN during Q4.
  - EMAS dropped 2 segment levels – from 2 to 4 – largest change from Effectiveness and Experience metrics, fell from 1 to 4.
  - UHDB fell 28 places in the ranking and moved to segment 4. 5th in the trusts with the largest reductions nationally – changes to all domains to level 4 apart from effectiveness and experience
  - SFHT fell 22 places in the ranking and moved to segment 3. 9th in the trusts with the largest reductions nationally. Patient safety and people and workforce moved from 1 to 3. Finance moved from 3 to 4. Effectiveness and experience however moved from 3 to 2.
  - LCHS fell 17 places in the ranking and moved to segment 3. Patient safety moved from 2 to 3.
  - DCHS fell 12 places in the ranking and moved to segment 2. Effectiveness and experience moved from 3 to 4, and people and workforce moved from 2 to 3.
- **Overall position:** The overall position of the providers across DLN has worsened. With 5 trusts in the lowest segment, and some of the largest movements occurring within the cluster.

Select Quarter	Q4 2025-26

ICB Name	Provider Name	Type	Access to Services	Finance & Productivity	Effectiveness & Experience	Patient Safety	People & Workforce	Population Health	Org Delivery Score	Average Score	Org Rank	Org Rank Mvmt	Finance override	Trust in NPIP	Final Segment	Segment Mvmt
Nottingham & Nottinghamshire	Nottinghamshire Healthcare NHS Foundation Trust	MH&Comm	3	4	2	4	4		4	2.99	57	4	Yes	No	4	0
Nottingham & Nottinghamshire	Nottingham University Hospitals NHS Trust	Acute	4	4	3	4	3		4	3.04	130	-2	Yes	No	4	0
Lincolnshire	United Lincolnshire Hospitals NHS Trust	Acute	4	1	3	4	4		4	2.62	104	-5	No	No	4	0
Derby & Derbyshire	Chesterfield Royal Hospital NHS Foundation Trust	Acute	3	4	2	1	3		4	2.64	105	-5	Yes	No	4	0
Derby & Derbyshire	University Hospitals of Derby and Burton NHS Foundation Trust	Acute	4	4	3	4	4		4	2.89	125	28	Yes	No	4	1
Lincolnshire	Lincolnshire Partnership NHS Foundation Trust	MH	2	3	1	4	3		3	2.53	43	9	Yes	No	3	0
Nottingham & Nottinghamshire	Sherwood Forest Hospitals NHS Foundation Trust	Acute	3	4	2	3	3		3	2.4	82	22	Yes	No	3	0
Derby & Derbyshire	Derbyshire Healthcare NHS Foundation Trust	MH	4	1	4	2	3		3	2.46	40	-1	No	No	3	0
Lincolnshire	Lincolnshire Community Health Services NHS Trust	Comm	1	3	1	3	4		3	2.49	41	17	No	No	3	1
EMAS	East Midlands Ambulance Service NHS Trust	Amb	4	1	2	3	4		3	2.46	7	4	No	No	3	2
Derby & Derbyshire	Derbyshire Community Health Services NHS Foundation Trust	Comm	1	2	4	1	3		2	2.12	18	12	No	No	2	1

Provider NOF Assessments Q4 2025-26

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

NHS Oversight Framework		NHSE NOF Assessments Q4 Q4 25-26 NOF				NHSE Quarter 4 Programme Tiering			
Organisation	**Type**	**Rating**		**NPIP**		**Elective**	**Diagnostics**	**Cancer**	**UEC**
Provider Assessments									
Nottinghamshire Healthcare (NHT)	MH & Comm	4	↑		↑	-	-	-	-
Nottingham University Hospitals (NUH)	Acute	4	↔		↑	2		1	
United Lincolnshire Hospitals (ULTH)	Acute	4	↔		↔				3
Chesterfield Royal Hospital (CRH)	Acute	4	↔		↔				
University Hospitals of Derby and Burton (UHDB)	Acute	4	↓		↔				
Sherwood Forest Hospitals (SFH)	Acute	3	↔		↔				
Lincolnshire Partnership (LPFT)	MH	3	↔		↔	-	-	-	-
Derbyshire Healthcare (DHcFT)	MH	3	↔		↔	-	-	-	-
Lincolnshire Community Health Services (LCHS)	Comm	3	↓		↔	-	-	-	-
East Midlands Ambulance Service	Amb	3	↓		↔	-	-	-	-
Derbyshire Community Health Services (DCHS)	Comm	2	↓		↔	-	-	-	-

NHSE NOF Assessments 2025/26							
NOF Ratings				Recovery Support			
Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
4	4*	4*	4*	N	Y	Y	Y
4	4	4*	3*	N	N	Y	Y
4	4	4	4	N	N	N	N
4	4	3	3	N	N	N	N
4	3	3	4	N	N	N	N
3	3	3	3	N	N	N	N
3	3	3	3	N	N	N	N
3	3	3	4	N	N	N	N
3	2	4	3	N	N	N	N
3	1	1	1	N	N	N	N
2	1	1	2	N	N	N	N

Oversight Arrangements	Key: NOF Ratings	Key: Programme Tiering (distance from plan)
NHSE Led IOAG, ICB attend	NOF4* - National Conditions Applied	Significant failure - supports NPIP determination
NHSE led monthly PRM, T1 national fortnightly reviews, ICB attend	NOF 4 - Nationally led support offer by NHSE	Tier 1 - Nationally led support offer by NHSE
NHSE led monthly PRM, T2 regional reviews through system forums	NOF 3 - Regionally led support offer by NHSE	Tier 2 - Regionally led support offer by NHSE
ICB led through system forums and contractual governance	NOF 2 - Access to NHSE support offer as required/agreed	Tier 3 - Access to NHSE support offer as required / agreed
ICB led through system forums and contractual governance	NOF 1 - local oversight no escalation required	Tier 4 - local oversight no escalation required

Colour with number = confirmed Tiering Q4

Colour alone = Q3 tiering

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Patient Safety

Patient Safety - Regulation 28 Reports

Derby and Derbyshire Integrated Care Board

Lincolnshire Integrated Care Board

Nottingham and Nottinghamshire Integrated Care Board

Q1 – 2026/27

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

Overall position: 3 Regulation 28 reports identified; NNICB has the highest volume (3), DDICB and LICB have none recorded for quarter one 2026/27

Main themes:
Clinical communication, Diagnostic follow-up, Documentation and duty of candour, Patient safety governance, Pathway implementation and assurance.

Notes

- Includes Regulation 28s directed to the ICB and/or commissioned organisations for full system oversight.
- Reporting date based on date published to the judiciary website.

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 (0)

Reports: 0 total.

Themes: No Regulation 28 reports recorded.

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

NNICB Summary (6)

Reports: 3 total — highest volume across the cluster.

Themes: Incident response and duty of candour, allergy de-labelling pathways, consistent advice on fitness to drive, and reliable follow-up of abnormal radiology findings after Emergency Department discharge. Concerns regarding poor-quality discharge summaries and missed opportunities for earlier diagnosis further highlight the importance of effective communication and continuity between acute, primary and community care.

Focus: Clinical governance, communication, diagnostic follow-up and patient safety pathways. Continue progress with allergy de-labelling pathway.

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Patient Safety - SHMI

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

April 2025 – March 2026 Summary Hospital-level Mortality Indicator (SHMI)

At a glance: 1 higher than expected, 4 as expected SHMI position. Local aggregate SHMI 1.057 vs England baseline 1.000.

England baseline	Trust median / mean	National banding	Local aggregate
SHMI 1.000	**1.061 / 1.0573**	**11 higher · 99 expected · 8 lower**	**1.057**

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.	164,135	4,350	3,725	**1.1677**	+0.168	+625
Sherwood Forest Hospitals	As expected	65,630	2,215	2,075	**1.0680**	+0.068	+140
United Lincolnshire Teaching Hospitals	As expected	91,045	3,510	3,375	**1.0398**	+0.040	+135
Chesterfield Royal Hospital	As expected	49,690	1,895	1,785	**1.0618**	+0.062	+110
UH Derby & Burton	As expected	141,820	4,570	4,815	**0.9490**	−0.051	−245

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.

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Urgent and Emergency Care

Corridor care: daily averages (July returns)

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

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Why this matters

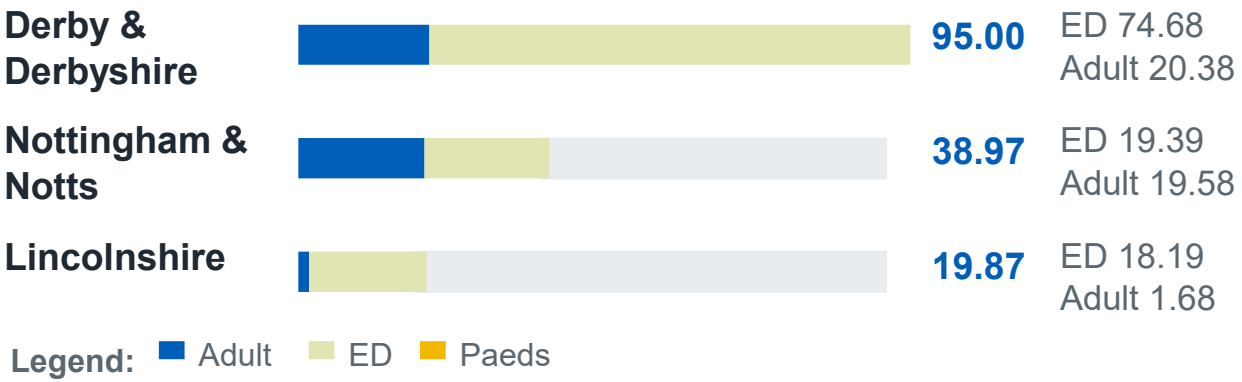
National publication creates visibility of patients cared for in **non-designated areas**, where privacy and safe, dignified care can be compromised.

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

16.72	22.45
England ED avg	Cluster ED avg
5.28	**8.32**
England adult avg	Cluster adult avg

Daily average by ICB and subject

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



Provider daily averages

Provider-level detail

Provider	Adult	ED	Total
UHDB	20.32	39.87	60.19
NUH	19.58	19.39	38.97
Chesterfield	0.00	34.81	34.81
ULHT	1.68	18.19	19.87
Sherwood	0.00	0.00	0.00

Key readout: ED is 73% of the selected daily average (112.26 of 153.84). Overall usage - Highest provider: UHDB 60.19/day; highest ICB: Derby & Derbyshire 95.00/day.

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/corridor-care-urgent-and-emergency-care-daily-situation-reports/

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Corridor care by provider and subject

July 2026 experimental data – Total figures

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Derby & Derbyshire **2,945**

ED 2,315 | Adult 630 | Paeds 0

Lincolnshire **616**

ED 564 | Adult 52 | Paeds 0

Nottingham & Notts **1,208**

ED 601 | Adult 607 | Paeds 0

Provider matrix — Adult, Peads and ED

ICB	Provider	Adult	Peads	ED	Total	Subject mix
D&D	**Chesterfield Royal**	0	0	1,079	1,079	
D&D	**UH Derby & Burton**	630	0	1,236	1,866	
Lincs	**United Lincolnshire**	52	0	564	616	
Notts	**Nottingham UH**	607	0	601	1,208	
Notts	**Sherwood Forest**	0	0	0	0	

All selected providers

4,769 **total corridor care entries**

ED 3,480 | Adult 1,289 | Peads 0

Key readouts

ED is the largest area: 3,480 of 4,769 entries (73%). **Peads is zero across all five providers.** Adult activity is concentrated in NUH and UHDB.

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/corridor-care-urgent-and-emergency-care-daily-situation-reports/

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Urgent and Emergency Care

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Headlines

Urgent and Emergency Care services continue to experience sustained operational pressure across the cluster, driven by ongoing demand, patient flow challenges and capacity constraints across acute, community and ambulance pathways. Whilst partners continue to work collaboratively to maintain patient safety and service resilience, pressures remain evident across the system and require continued focus on flow, discharge and alternative care pathways. Quality and Urgent and Emergency Care colleagues remain closely aligned through regular communication, shared escalation processes and joint oversight arrangements, ensuring that performance challenges are considered alongside emerging quality and patient safety risks. This coordinated approach supports early identification of concerns, system-wide situational awareness and timely implementation of mitigating actions where required. Despite continued pressure, there remains a strong focus on maintaining safe, effective care, with system partners working collectively to balance operational delivery, quality oversight and improvement activity across the urgent and emergency care pathway.

							University Hospitals of Derby and Burton					Chesterfield Royal Hospital					United Lincolnshire				
Programme	Metric	Category	OP Plan Ref	% / Value	Period	DQ	Plan	Actual	Variance	V	A	Plan	Actual	Variance	V	A	Plan	Actual	Variance	V	A
Urgent Care	A&E <4 Hours (%)	Ops Plan	E.M.13	%	Jul-26	⚠	74.4%	69.3%	-5.1% ✗			76.4%	69.6%	-6.8% ✗			58.9%	71.3%	12.4% ✓		
	A&E >12 Hours	Ops Plan	E.M.13g	Value	Jul-26	⚠	1,926	3,325	1,399 ✗			276	705	429 ✗			1,614	2,415	801 ✗		
	A&E Mental Health >24 hours	Nat Std		Value	Jul-26	⚠	0	25	25 ✗			0	*				0	50	50 ✗		
	Ambulance handovers >15 min (%)	Ops Plan	E.B.48	%	Jul-26		71.8%	78.7%	6.9% ✗			50.5%	45.2%	-5.3% ✓			70.2%	86.7%	16.5% ✗		
	G&A Overnight Beds Occupied (%)	Ops Plan	E.M.30	%	Jul-26		94.7%	94.6%	-0.1% ✓			92.1%	95.7%	3.6% ✗			92.0%	91.2%	-0.8% ✓		
	7+ day LOS as proportion of Total G&A beds Occupied (%)	Nat Std		%	Jul-26		41.0%	42.9%	1.9% ✗			41.0%	47.8%	6.8% ✗			41.0%	49.4%	8.4% ✗		
	21+ day LOS as proportion of Total G&A beds Occupied (%)	Nat Std		%	Jul-26		13.0%	13.0%	-0.0% ✓			13.0%	10.5%	-2.5% ✓			13.0%	20.8%	7.8% ✗		
	Non-Elective LOS	Ops Plan	E.B.43	Value	Jun-26		8.4	8.1	-0 ✓			6.2	6.6	0 ✗			7.3	8.0	1 ✗		
	Discharge Ready Date (%)	Ops Plan	E.B.45	%	Jun-26		80.9%	81.4%	0.5% ✓			84.8%	85.7%	0.9% ✓			80.2%	79.6%	-0.6% ✗		
	Average Discharge Delay	Ops Plan	E.B.46	Value	Jun-26		4.7	6.0	1.3 ✗			5.2	5.7	0.5 ✗			4.8	5.7	0.9 ✗		

							Sherwood Forest Hospitals					Nottingham University Hospitals				
Programme	Metric	Category	OP Plan Ref	% / Value	Period	DQ	Plan	Actual	Variance	V	A	Plan	Actual	Variance	V	A
Urgent Care	A&E <4 Hours (%)	Ops Plan	E.M.13	%	Jul-26	⚠	81.7%	71.2%	-10.5% ✗			76.0%	67.5%	-8.5% ✗		
	A&E >12 Hours	Ops Plan	E.M.13g	Value	Jul-26	⚠	242	770	528 ✗			1,997	2,580	583 ✗		
	A&E Mental Health >24 hours	Nat Std		Value	Jul-26	⚠	0	15	15 ✗			0	60	60 ✗		
	Ambulance handovers >15 min (%)	Ops Plan	E.B.48	%	Jul-26		30.2%	74.2%	44.0% ✗			70.7%	75.5%	4.8% ✗		
	G&A Overnight Beds Occupied (%)	Ops Plan	E.M.30	%	Jul-26		95.6%	94.6%	-1.0% ✓			93.6%	94.6%	1.0% ✗		
	7+ day LOS as proportion of Total G&A beds Occupied (%)	Nat Std		%	Jul-26		41.0%	48.2%	7.2% ✗			41.0%	62.2%	21.2% ✗		
	21+ day LOS as proportion of Total G&A beds Occupied (%)	Nat Std		%	Jul-26		13.0%	16.1%	3.1% ✗			13.0%	25.5%	12.5% ✗		
	Non-Elective LOS	Ops Plan	E.B.43	Value	Jun-26		7.6	7.8	0 ✗			8.2	8.8	1 ✗		
	Discharge Ready Date (%)	Ops Plan	E.B.45	%	Jun-26		80.0%	79.5%	-0.5% ✗			79.2%	77.0%	-2.2% ✗		
	Average Discharge Delay	Ops Plan	E.B.46	Value	Jun-26		3.6	4.0	0.4 ✗			4.9	4.7	-0.2 ✓		

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Maternity

Maternity

DLN Cluster view

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Indicative RAG
Green Amber Red

Provider	Overall	10-week booking ↑	NND ↓	Stillbirths ↓	Tears ↓	PPH ↓
Nottingham University Hospitals	🔴	61%	1.99	3.42	49.0	36.0
Sherwood Forest Hospitals	🟠	68%	2.87	1.01	36.0	19.0
United Lincolnshire Teaching Hospitals	🟢	70%	1.03	2.94	34.0	26.0
Chesterfield Royal Hospital	🟠	65%	1.18	2.84	33.0	42.0
University Hospitals of Derby & Burton	🔴	68%	0.91	2.89	44.0	39.0

Executive narrative

🟢 **Strongest overall**

United Lincolnshire leads on booking and performs favourably on NND, tears and PPH, although stillbirths remain comparatively high.

🔴 **Broadest concern**

Nottingham University Hospitals has the lowest booking rate and the highest stillbirth and tears rates, with NND also relatively high.

🟠 **Mixed profiles**

Sherwood Forest is strongest for stillbirths and PPH but has the highest NND rate. Chesterfield performs well on tears and mortality but has the highest PPH rate.

🔵 **Targeted focus**

Derby & Burton has the lowest NND rate, but comparatively high tears and PPH indicate a maternal morbidity focus.

Interpretation caveat Relative position only, not performance against national thresholds or statistical control limits. Review mortality measures alongside case numbers, denominators, case mix and variation.

SAIU STEGIC LYTICS LLIGENCE

Maternity

Nottingham University Hospitals NHS Trust

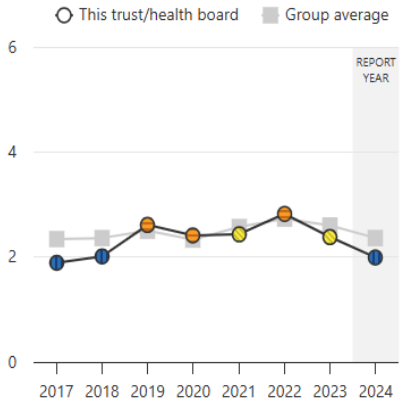
NUH's neonatal mortality (1.99 per 1,000 live births) and stillbirth rate (3.42 per 1,000 births) remain below MBRRACE group averages, demonstrating continued improvement in key mortality outcomes. However, performance remains challenging in relation to early booking (61%), 3rd/4th degree tears (49.0 per 1,000 births) and severe postpartum haemorrhage (36.0 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	Neonatal Deaths	Stillbirths	3rd/4th Degree Tears	PPH >= 1,500 ml
% of total bookings	Per 1,000 live births	Per 1,000 births	Per 1,000 births	Per 1,000 births
May 2026	2024	2024	May 2026	May 2026
61%	1.99	3.42	49.0	36.0

Neonatal Deaths

Mortality rates, by year

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

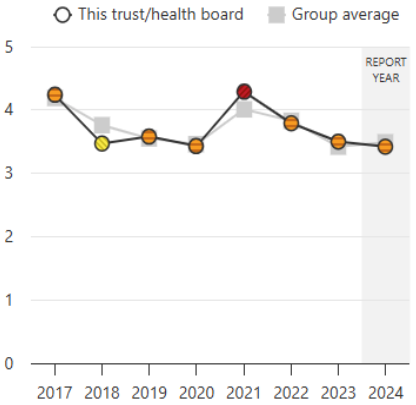


2024
This trust/health board: **1.99**
Group average: **2.36**

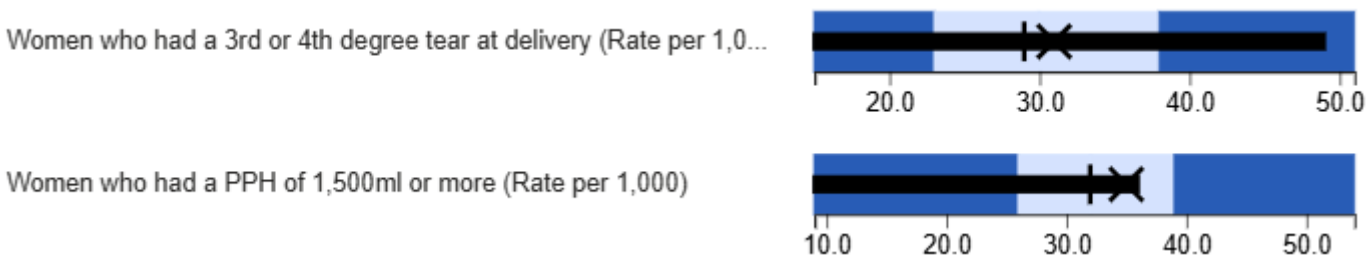
Stillbirths

Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births



2024
This trust/health board: **3.42**
Group average: **3.49**



Trust value	49.0
National value	29.0
MBRRACE group value	31.0

Trust value	36.0
National value	32.0
MBRRACE group value	35.0

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

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 68% of women booked by 10 weeks gestation, below the NMPA ambition of 80%.

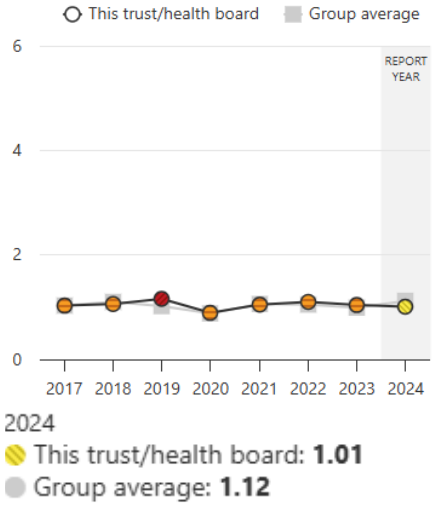
The Trust has demonstrated strong performance in relation to PPH, with rates lower than both national and peer group benchmarks. However, rates of 3rd/4thdegree perineal tears remain above national and MBRRACE averages, and improvement activity continues through implementation of the OASI Care Bundle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

Bookings at 10 weeks	Neonatal Deaths	Stillbirths	3rd/4th Degree Tears	PPH >= 1,500 ml
% of total bookings	Per 1,000 live births	Per 1,000 births	Per 1,000 births	Per 1,000 births
April 2026	2024	2024	April 2026	April 2026
68%	2.87	1.01	36.0	19.0

Neonatal Deaths

Mortality rates, by year

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

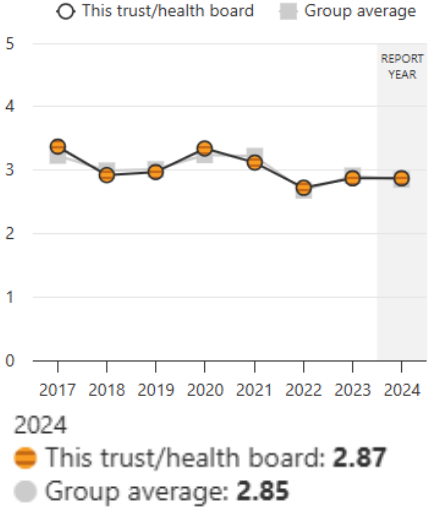


2024
This trust/health board: **1.01**
Group average: **1.12**

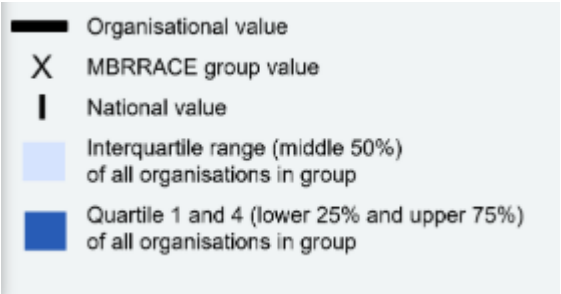
Stillbirths

Mortality rates, by year

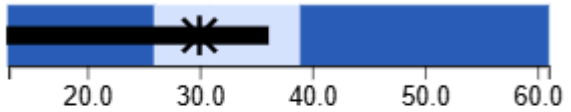
Stabilised & adjusted stillbirth rate per 1,000 total births



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



Women who had a 3rd or 4th degree tear at delivery (Rate per 1,0...



Trust value 36.0
National value 30.0
MBRRACE group value 30.0

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

Trust value 19.0
National value 31.0
MBRRACE group value 29.0

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Maternity

United Lincolnshire Teaching Hospitals NHS Trust

ULHT stillbirth rate (2.94 per 1,000 births) increase in stillbirth rates has been identified and is currently above national threshold. All cases are undergoing detailed review via PMRT, supported by thematic analysis at trust and system level.

Booking by 10 weeks is 70% which is above the target of 69%.

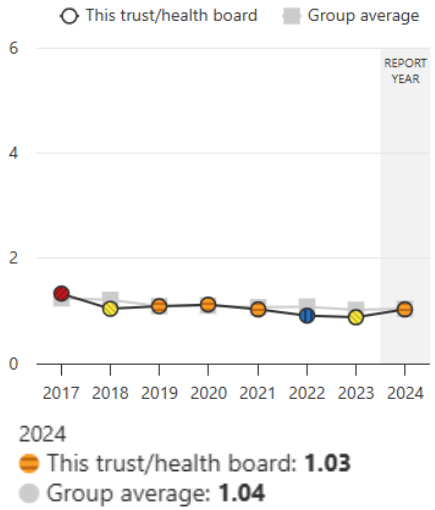
3rd and 4th degree rates are slightly above the national average and MBRRACE group value but not an outlier. PPH Rates over 1500mls is under the national and MBRRACE group comparator average. A thematic analysis involving human factors, themes and trends rather than looking at individual cases was recently put in place to support learning opportunities.

Bookings at 10 weeks	Neonatal Deaths	Stillbirths	3rd/4th Degree Tears	PPH >= 1,500 ml
% of total bookings May 2026	Per 1,000 live births 2024	Per 1,000 births 2024	Per 1,000 births May 2026	Per 1,000 births May 2026
70%	1.03	2.94	34.0	26.0

Neonatal Deaths

Mortality rates, by year

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

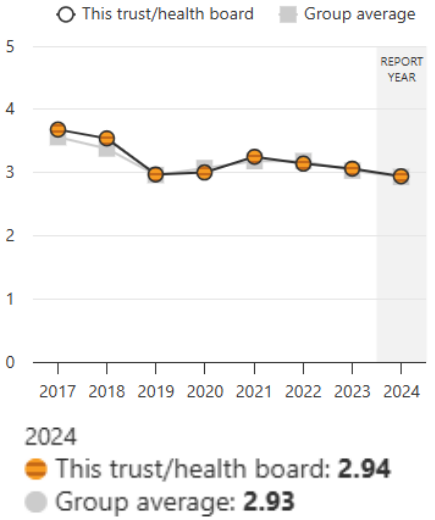


2024
This trust/health board: **1.03**
Group average: **1.04**

Stillbirths

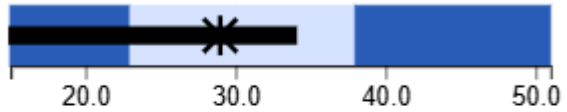
Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births



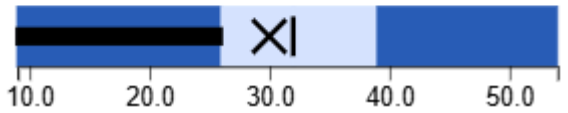
2024
This trust/health board: **2.94**
Group average: **2.93**

Women who had a 3rd or 4th degree tear at delivery (Rate per 1,0...



Trust value 34.0
National value 29.0
MBRRACE group value 29.0

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



Trust value 26.0
National value 32.0
MBRRACE group value 30.0

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Maternity

Chesterfield Royal Hospital NHS Foundation Trust

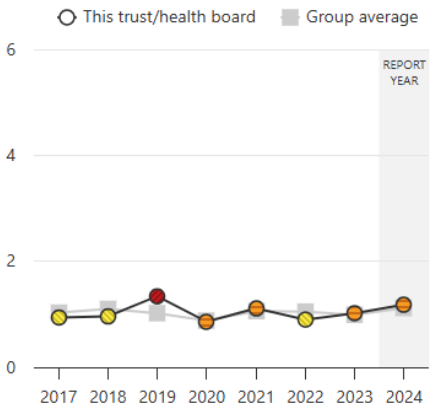
- Perinatal mortality rates remain below national average.
- PPH >1500mls remains raised and is under trust review. Guideline reviewed to recognise early identification, risk assessment and early escalation . OBSUK has led to more accurate measurement and a decrease in blood product use and ICU admission. 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
- 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	Neonatal Deaths	Stillbirths	3rd/4th Degree Tears	PPH >= 1,500 ml
% of total bookings	Per 1,000 live births	Per 1,000 births	Per 1,000 births	Per 1,000 births
May 2026	2024	2024	May 2026	May 2026
65%	1.18	2.84	33.0	42.0

Neonatal Deaths

Mortality rates, by year

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

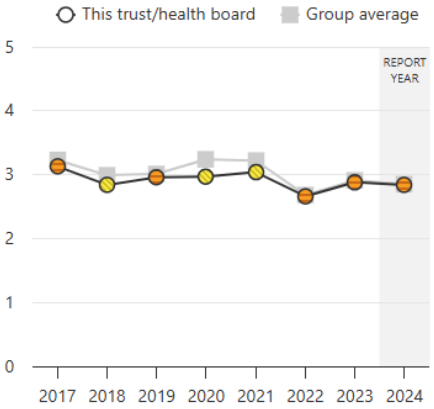


2024
This trust/health board: **1.18**
Group average: **1.12**

Stillbirths

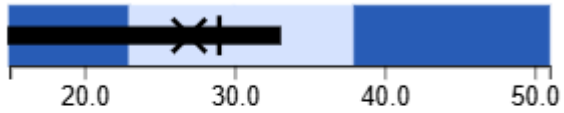
Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births



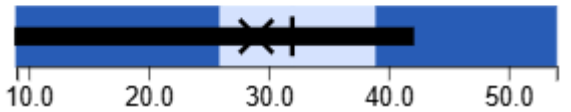
2024
This trust/health board: **2.84**
Group average: **2.85**

Women who had a 3rd or 4th degree tear at delivery (Rate per 1,0...



Trust value 33.0
National value 29.0
MBRRACE group value 27.0

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



Trust value 42.0
National value 32.0
MBRRACE group value 29.0

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Maternity

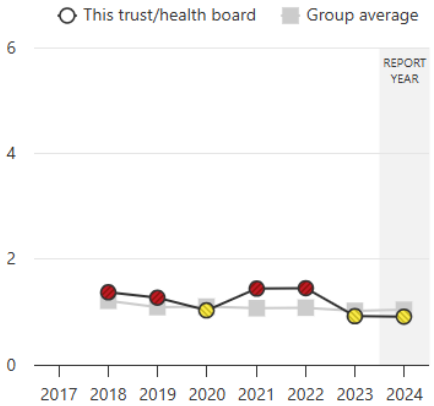
University Hospitals of Derby and Burton NHS Foundation Trust

- NHSE Maternity and Neonatal Improvement Support Team provided targeted support until July 2026
- Perinatal mortality rates remain below national average
- 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.

Neonatal Deaths

Mortality rates, by year

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

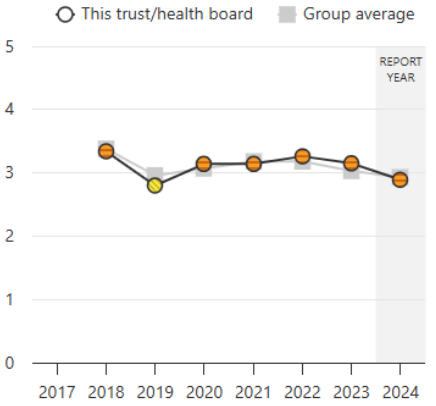


2024
This trust/health board: **0.91**
Group average: **1.04**

Stillbirths

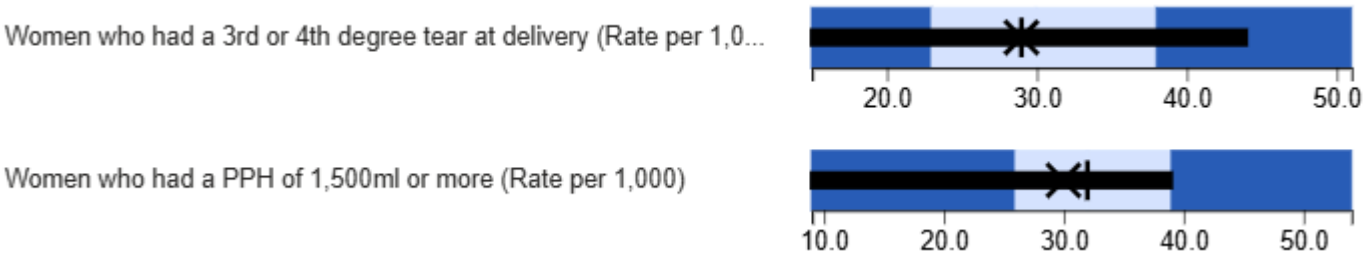
Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births



2024
This trust/health board: **2.89**
Group average: **2.93**

Bookings at 10 weeks	Neonatal Deaths	Stillbirths	3rd/4th Degree Tears	PPH >= 1,500 ml
% of total bookings	Per 1,000 live births	Per 1,000 births	Per 1,000 births	Per 1,000 births
May 2026	2024	2024	May 2026	May 2026
68%	0.91	2.89	44.0	39.0



Trust value 44.0
National value 29.0
MBRRACE group value 29.0

Trust value 39.0
National value 32.0
MBRRACE group value 30.0

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Infection, Prevention and Control

Infection, Prevention and Control

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

June 2026

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	15	11	+4	30.31 ↑	0	0	0.00 -	1	4	12.76 ↓
NNICB Nottingham University Hospitals NHS Trust	13	13	0	46	38	+8	34.93 ↓	1	2	1.59 -	10	36	23.64 ↑
NNICB Sherwood Forest Hospitals NHS Trust	5	6	-1	18	17	+1	35.78 ↓	1	1	1.21 ↑	4	10	12.86 ↑
LICB United Lincolnshire Teaching Hospitals NHS Trust	12	8	4	27	23	+4	34.28 ↓	0	0	1.21 -	4	13	16.38 ↑
DDICB University Hospitals of Derby and Burton NHS Foundation Trust	20	14	+6	45	40	+5	34.60 ↓	0	0	0.77 -	5	13	12.50 ↓

Source: Workbook: Healthcare Associated Infections (HCAI) Dashboard

STRATEGIC ANALYTICS INTELLIGENCE UNIT

Learning Disabilities and Autism

Learning Disability and Autism

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

							NHS Derby and Derbyshire ICB					NHS Lincolnshire ICB					NHS Nottingham and Nottinghamshire ICB				
Programme	Metric	Category	OP Plan Ref	% / Value	Period	DQ ⓘ	Plan	Actual	Variance	V	A	Plan	Actual	Variance	V	A	Plan	Actual	Variance	V	A
LD&A	LD/Autism Adult Inpatients	Ops Plan	E.H.32/ 33	Value	Jul-26		31	36	5 ✗			34	26	-8 ✓			35	37	2 ✗		
	LD Adult MH Inpatients	Ops Plan	E.H.32	Value	Jul-26		15	19	4 ✗			12	9	-3 ✓			19	22	3 ✗		
	Autistic Adult MH Inpatients	Ops Plan	E.H.33	Value	Jul-26		16	17	1 ✗			22	17	-5 ✓			16	14	-2 ✓		
	LD/Autism CYP Inpatients	Ops Plan	E.K.1c	Value	Jul-26		3	4	1 ✗			2	1	-1 ✓			3	2	-1 ✓		
	LD Annual Health Checks with HAP	Ops Plan	E.K.6	Value	Jul-26	⚠	364	456	92 ✓			259	333	74 ✓			433	529	96 ✓		
	LD Annual Health Checks with HAP (Qtr)	Ops Plan	E.K.3	Value	Jun-26	⚠	754	785	31 ✓			566	614	48 ✓			855	1,031	176 ✓		
	LD/Autism Long MH Stays	Ops Plan	E.K.4	Value	Jul-26		18	15	-3 ✓			15	15	0 ✓			22	20	-2 ✓		
	MH Admission Rate – LD/Autism Adults	Ops Plan	E.K.5a	Value	Jul-26	⚠	23.0	36.0	13.0 ✗			35.0	57.0	22.0 ✗			16.0	12.0	-4.0 ✓		
	MH Admission Rate – LD/Autism CYP	Ops Plan	E.K.5b	Value	Jul-26	⚠	42.0	47.0	5.0 ✗			47.9	*				10.0	43.0	33.0 ✗		

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 many 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.

SAIU STRATEGIC ANALYTICS INTELLIGENCE

Mental Health

Mental Health

Data Note: Plans for Derbyshire MHST are assigned to DHT in error, these services are provided by Compass.

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

							Derbyshire Healthcare					Lincolnshire Partnership					Nottinghamshire Healthcare				
Programme	Metric	Category	OP Plan Ref	% / Value	Period	DQ	Plan	Actual	Variance	V	A	Plan	Actual	Variance	V	A	Plan	Actual	Variance	V	A
Mental Health	Inappropriate OAPs (Adult Acute)	Ops Plan	E.A.5	Value	Jun-26	⚠	7	*				1	*				10	10	0 ✓		
	MH Inpatient Mean LOS Adult and PICU	Ops Plan	E.H.38	Value	Jun-26		54.5	54.0	-0 ✓			22.1	25.0	3 ✗			44.7	45.0	0 ✗		
	MH Inpatient Mean LOS Older Adult	Ops Plan	E.H.39	Value	Jun-26		81.5	79.0	-2 ✓			57.7	137.0	79 ✗			80.0	93.0	13 ✗		
	IPS Access (Rolling 12-month)	Ops Plan	E.H.34	Value	Jun-26		847	935	88 ✓			680	740	60 ✓			1,375	1,440	65 ✓		
	EIP <2 Weeks (%)	Nat Std		%	Jun-26		60.0%	75.0%	15.0% ✓			60.0%	63.0%	3.0% ✓			60.0%	72.0%	12.0% ✓		
	Perinatal MH Access	Ops Plan	E.H.15	Value	Jun-26		1,400	1,320	-80 ✗			720	790	70 ✓			1,315	1,355	40 ✓		
	Adult MH inpatient discharges followed up within 72 hours (%)	Nat Std		%	Jun-26		80.0%	89.0%	9.0% ✓			80.0%	82.0%	2.0% ✓			80.0%	84.0%	4.0% ✓		
	Talking Therapies Reliable Recovery (%)	Ops Plan	E.A.4a	%	Jun-26							50.3%	50.5%	0.2% ✓							
	Talking Therapies Reliable Improvement (%)	Ops Plan	E.A.4b	%	Jun-26							69.9%	72.3%	2.4% ✓							
	CYP MH Access	Ops Plan	E.H.9	Value	Jun-26			3,420					8,500					9,735			
	CYP ED Routine <4 Weeks (%)	Nat Std		%	Jun-26		95.0%	96.0%	1.0% ✓			95.0%	45.0%	-50.0% ✗			95.0%	87.0%	-8.0% ✗		
	CYP MH Waits >104 Weeks	Ops Plan	E.A.7	Value	Jun-26		93	185	92 ✗			45	45	0 ✓			70	120	50 ✗		
	CYP Accessing MHST	Ops Plan	E.A.6	Value	Jun-26	⚠	4,737					2,553	2,620	67 ✓			2,620	2,575	-45 ✗		

							Vita - DDICB					Vita - NNICB				
Programme	Metric	Category	OP Plan Ref	% / Value	Period	DQ	Plan	Actual	Variance	V	A	Plan	Actual	Variance	V	A
Mental Health	Talking Therapies Reliable Recovery (%)	Ops Plan	E.A.4a	%	Jun-26		47.2%	50.3%	3.1% ✓			50.4%	51.9%	1.5% ✓		
	Talking Therapies Reliable Improvement (%)	Ops Plan	E.A.4b	%	Jun-26		68.8%	69.1%	0.3% ✓			68.4%	73.1%	4.7% ✓		

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Continuing Healthcare

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

2026/27 quarterly position | standard NHS CHC (non-Fast Track)

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

What the 28-day clock means

Start: earliest notification that full assessment is required.
Process: MDT/DST recommendation, then ICB decision.
End: eligibility decision or referral discounted.
Do not pause for consent forms or missing Checklist information.

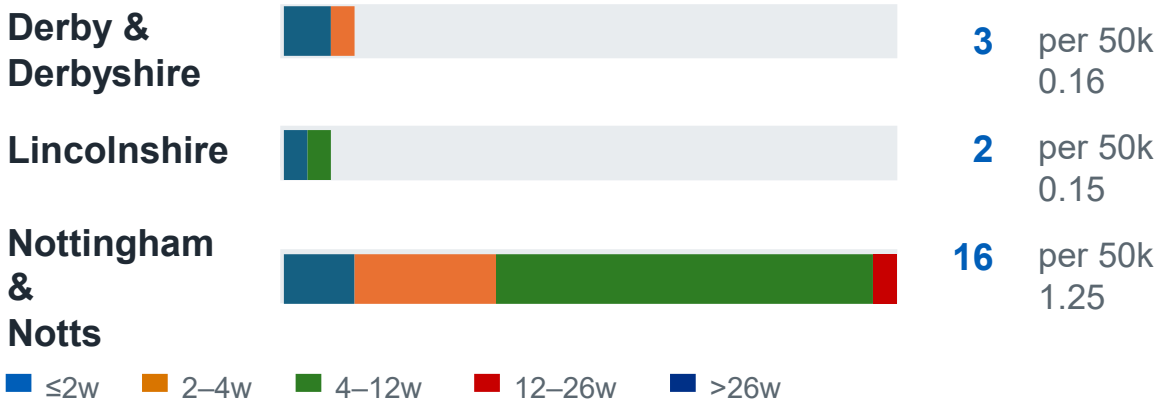
31
Q1 total
incomplete >28d

1
Over 12 weeks
Q1 across the cluster

26
Notts Q1
highest ICB

+63%
Notts change
from Q4 2025/26

Latest quarter: where the >28-day backlog sits



Quarterly trend by ICB

Nottingham & Nottinghamshire remains highest; +63% from Q4 2025/26

	2025/26				2026/27
ICB	Q1	Q2	Q3	Q4	Q1
Derby & Derbyshire	0	1	1	5	3
Lincolnshire	4	0	2	0	2
Nottingham and Nottinghamshire	12	31	22	16	26

Executive Summary: Q1 shows 31 incomplete referrals over 28 days across the three ICBs; one is over 12 weeks. None are over 26 weeks. Nottingham & Nottinghamshire accounts for 26 and should remain the focus.

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-chc-fnc/

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Care Homes

Care Homes

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

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

Flu vaccination uptake among care home residents reached 79.2%, against a target of 82%, placing Derby and Derbyshire ICB first in the Midlands region

COVID-19 vaccination uptake among care home residents was 69.36%, ranking fifth in the Midlands region.

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.

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Care Quality Commission (CQC)

CQC Provider Ratings

DLN at a glance

1,126
provider locations in view

76%
rated Good or Outstanding

170
Require improvement / Inadequate

Organisation type	Total number of providers	Outstanding ☆	Good	Requires improvement	Inadequate	Not rated
Care Homes	822	54	605	151	5	7
Acute	5	-	3	2	-	-
Community	2	2	-	-	-	-
Mental Health	2	-	2	-	-	-
GP Practices	295	34	243	17	-	1

[1] https://www.cqc.org.uk/about-us/improving-how-we-work
[2] https://www.cqc.org.uk/provider/RHA
[3] https://www.cqc.org.uk/system/files/2026-08/04_August_2026_Latest_ratings.ods

Notes

1. New CQC rules mean some multi-service locations (such as adult social care, independent health and primary care) 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]

3. CQC are moving to a new digital model to store and update directory of care services. As such, there will be delays in release of updated reports. In the meantime, whilst every effort has been made to ensure the most recent and accurate ratings are reported, this data should be viewed with caution until the new data models are available. [3]

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

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	289	28	211	47	2	1
GP Practices	112	16	93	3	0	0

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

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	279	11	215	50	0	3
GP Practices	106	16	84	5	0	0

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

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	19 August 2026	Inspected under the new assessment criteria. Provider domains unavailable.					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	182	50	3	3
GP Practices	77	2	66	9	0	0

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Meeting title	Integrated Care Boards: Open Session (meeting in common)
Meeting date	17/09/2026
Paper title	**Winter Plan 2026/27**
Paper reference	ICB CIC 26 051
Paper author	Corie Holland, Operational Resilience and Performance Manager, UEC, NHS Derby and Derbyshire ICB
Paper sponsor	Maria Principe, Executive Director - Commissioning
Presenter	Maria Principe

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

Report summary

The Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire (DLN) Winter Plan 2026/27 has been developed in response to NHS England's national expectations and assurance framework and reflects a whole-system approach to winter preparedness across health and care partners. The plan has been produced collaboratively with providers, primary care, local authorities, ambulance services, community services, mental health services and the voluntary sector, with a focus on maintaining safe, effective and sustainable services throughout periods of increased seasonal demand.

The plan is underpinned by a comprehensive assessment of anticipated demand, available capacity and system risks, and has been designed to support delivery of urgent and emergency care performance, maintain elective recovery, improve patient flow and reduce avoidable admissions. Consistent with NHS England requirements, the plan considers baseline, surge and extreme surge scenarios and incorporates arrangements for escalation, mutual aid and operational coordination through the system coordination centre operating seven days per week using the OPEL framework.

A key focus of the plan is strengthening care closer to home through utilisation of primary care, urgent community response, virtual wards, Hospital at Home services, community pharmacy and out-of-hours provision. The plan also includes actions to support resilient mental health crisis services, enhanced discharge and intermediate care pathways, social care capacity and infection prevention and control measures across health and social care settings.

Recognising the learning from previous winters, the plan places significant emphasis on proactive prevention and demand management, including vaccination uptake, support for vulnerable populations, workforce resilience, patient flow improvement and discharge optimisation. Providers are expected to implement national urgent and emergency care improvement standards, maintain robust escalation arrangements, and ensure staff welfare and wellbeing are prioritised throughout the winter period.

Report summary

To provide assurance regarding system readiness, the DLN winter planning programme includes a series of planned stress-testing and tabletop exercises during August and September 2026. The three exercises assessed system resilience across a range of scenarios including workforce pressures, discharge and flow failure, infection prevention and control incidents, mental health and primary care demand, and wider operational pressures. Findings and actions have been incorporated into final winter plans to strengthen preparedness ahead of winter. Regional NHS England assurance processes and Board Assurance Statements will provide further governance oversight, we have an NHS England winter assurance visit on 22 September at the Queens Medical Centre with Nottingham and Nottinghamshire providers. Final plans submission to NHS England by 7 October 2026.

The Boards are asked to note the progress made in developing the DLN Winter Plan 2026/27, support the continuing refinement of system-wide actions and risk mitigations, and receive assurance that arrangements are in place to deliver a coordinated and resilient response to winter pressures across the health and care system.

System partners and providers are aware there is no additional funding for winter as a result are developing plans to develop further schemes within current resources to ensure the system has maximised its resources to ensure a safe winter for patients.

Whilst a number of mitigations have been identified across the system, resulting in up to 244 additional beds between October and March across DLN, a residual bed gap remains in parts of the winter period, particularly in October and January. Partners continue to review and strengthen mitigation plans, with further modelling work underway across acute and community services to identify additional capacity opportunities and reduce the remaining gap as far as possible ahead of winter. Further detail is provided within the embedded content and supporting appendices attached.

The ICBs' Joint Finance and Performance Committee endorsed the draft plan at its September meeting, noting the comprehensive and robust approach taken towards its development.

Recommendation(s)

The Boards are asked to **approve** the Winter Plan 2026/27, noting:

- The proposed approach to winter preparedness, associated delivery actions, governance arrangements, and assurance process.
- The continued development and implementation of the plan, ahead of final submission to NHS England.

Appendices

Appendix A – Bed Gap and Mitigations
Appendix B – Final Draft Winter Plan
Appendix C – Self Assessment Template

Board Assurance Framework

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

- 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.

Winter Plan 2026/27

Introduction

1. The purpose of this paper is to share the development of a single Winter Plan for 2026/27 across Derbyshire, Lincolnshire and Nottinghamshire. It describes progress in developing provider and partner actions, including system-wide vaccination and infection prevention and control arrangements and the latest available planning intelligence for winter demand, including influenza, COVID-19, RSV and other seasonal pressures. It discusses the principal strategic and operational risks identified through the planning process and provides a summary of the current position, governance arrangements and next steps towards delivery.

Development of the system-wide Winter Plan

2. The winter planning process commenced in April 2026, bringing together partners across Derbyshire, Lincolnshire and Nottinghamshire. Providers and system partners reviewed lessons from Winter 2025/26 before commencing planning for Winter 2026/27. The review considered successes, challenges and actions to carry forward. The plan has also been informed by national and international epidemiological intelligence, demand forecasting and system-wide confirm-and-challenge activity.

3. A single plan across the three ICB geographies has been developed around three demand scenarios: Baseline, Surge and Super Surge. It incorporates transformation programmes, non-elective admission reduction, capacity and resilience planning, escalation arrangements, workforce, Infection, Prevention and Control (IPC) and elective protection.

4. Provider and system plans have been tested through a structured programme of exercises covering workforce shortages, infectious disease outbreaks, digital disruption, deterioration in flow and discharge, mental health pressures and major incidents.

5. The plan has been developed within a highly challenging financial and operational context. It focuses on maximising existing resources, productivity, pathway transformation and collective stewardship, with no opportunity for additional investment. In developing the winter plan acute trusts were asked to ensure they acknowledged the position in relation to the Transformation Funding which has been included in acute baseline positions this year totalling £22.9 million.

Acute Trust	Transformation Funding
Chesterfield Royal Hospital NHS foundation Trust (CRH)	£2M
University Hospitals of Derby and Burton NHS Foundation Trust (UHDB)	£4M
United Lincolnshire Hospitals NHS Trust (ULHT)	£7.9M
Nottingham University Hospitals NHS Trust (NUH)	£2M
Sherwood Forest Hospitals NHS Foundation Trust (SFHFT)	£7M
Total	**£22.9M**

6. On this basis there are limited additional system mitigations in place that are commissioned over and above the existing baseline position. Collective ownership remains essential. Delivery will require coordinated action across NHS providers, ICBs, local authorities, primary care, ambulance services, community and mental health services, and voluntary, community and social enterprise partners.

Key actions from system providers and partners, and vaccination plan

DLN Wide Approach

Actions are grouped around four common priorities: reducing avoidable demand, increasing capacity and alternatives, improving flow and discharge, and maintaining workforce, IPC and operational resilience.

7. Acute providers:

   a) The current position remains subject to ongoing review and refinement, with partners continuing to challenge assumptions and identify further mitigation opportunities ahead of final plan submission. Further detail is available within Appendix A; bed gap and mitigations summary.

Winter Plan - Total Bed Mitigations by Provider

Provider	Oct	Nov	Dec	Jan	Feb	Mar
CRH	0	0	0	0	0	53
UHDB	20	22	21	20	20	23
ULTH	44	44	54	54	54	54
NUH	47	49	51	79	80	72
SFH	53	55	55	44	44	42

Provider	Oct	Nov	Dec	Jan	Feb	Mar
DLN TOTAL	**165**	**170**	**181**	**197**	**198**	**244**

Winter Plan - Provider Winter Bed Gap

Provider	Oct	Nov	Dec	Jan	Feb	Mar
CRH	-5	22	-4	5	5	32
UHDB	42	21	20	-6	42	52
ULTH	-3	-4	0	-10	22	28
NUH	-28	-13	19	-42	-39	-7
SFH	-16	-5	-7	-24	-17	-18
DLN Total	**-11**	**20**	**28**	**-77**	**13**	**86**

b) Key actions include additional winter and escalation capacity, expansion or optimisation of Same Day Emergency Care (SDEC), ambulatory care, Urgent Treatment Centre (UTC) streaming, Virtual Wards and front-door admission avoidance.

c) Providers will maintain daily flow and discharge grip through senior reviews, board rounds, length-of-stay work, discharge tracking and closer management of P1, P2 and P3 pathways.

d) Elective, cancer and clinically urgent activity will be protected wherever possible, supported by escalation arrangements designed to minimise avoidable disruption to planned care.

8. Derbyshire actions:

a) UHDB: Central Navigation Hub deflection, SDEC and UTC streaming, Virtual Wards, ambulatory care, frailty and diagnostics workstreams, and planned incremental capacity from October to March.

b) CRH: 27 Medicine and Emergency Care winter beds for eight weeks, two paediatric beds from September, improved UTC utilisation, length-of-stay meetings, board rounds and exploration of Community Virtual Ward expansion.

c) Derbyshire Community Health Services NHS Foundation Trust (DCHS): 4 additional temporary escalation bed spaces, Care Transfer Hub direct placement, P2 processes, reverse boarding and strengthened digital oversight.

d) DHU Healthcare (DHU): increased NHS111 clinical capacity, additional Central Navigation Hub clinicians, UTC clinical sessions, enhanced

queue management and multidisciplinary review of Virtual Ward capacity.

e) Derbyshire Healthcare NHS Foundation Trust (DHCFT): NHS111 Mental Health Option 2, crisis alternatives, daily discharge profiling, standardised ward rounds, discharge tracking and work to reduce out-of-area placements.

f) Derby City Council and Derbyshire County Council: prevention, reablement, Home First and Discharge to Assess pathways, care-market resilience, brokerage and strengthened integration with community services.

9. Lincolnshire actions:

a) Lincolnshire Community Hospitals Group: Hospital at Home, OPAT, IV therapy, Virtual Wards, OPTO digital triage, UCR, integrated home visiting, D2A flexibility, Transitional Care surge assumptions and community hospital transformation.

b) Flow actions include the Newton programme, Single Point of Referral, earlier stroke transfers, reduced fracture neck of femur length of stay, Trusted Assessor models and planned Optica discharge oversight.

c) Lincolnshire County Council Adult Social Care: community and proportionate assessments, daily monitoring of people not meeting criteria to reside, Transfer of Care Hub participation and flexible deployment of staff, including weekend staffing where required.

d) LPFT: maintenance of urgent mental health services, least restrictive care, MADE events, early discharge programmes, staff wellbeing support and use of temporary workforce where necessary.

10. Nottingham and Nottinghamshire actions:

a) NUH: SDEC expansion, UTC streaming, Pharmacy First, GIRFT long length-of-stay work, medicine and surgery Virtual Ward expansion, two winter wards and additional QMC capacity.

b) SFH: call-before-convey, direct clinical advice, extended Clinical Assessment Unit hours, weekend trauma lists, escalation and overspill space, and potential decant capacity.

c) Community providers: maximise UCR, Virtual Wards, D2A, community beds, reablement and timely P1/P2 discharge, supported by Transfer of Care Hub functionality and senior pathway leadership.

d) Mental health services: daily Crisis multi-disciplinary teams (MDTs) and escalation forums, senior clinical review, crisis alternatives, inpatient flow, review of flex-bed and surge options, and escalation of post-clinically-ready-for-discharge delays.

e) CityCare and transport partners: strengthen urgent community pathways, care-home support, discharge coordination, patient transport planning, mobility reviews and seasonal workforce resilience.

11. East Midlands Ambulance Service:

a) Across the DLN geography, optimise clinical assessment, Hear and Treat, See and Treat and alternative pathways, alongside workforce, fleet, adverse weather, business continuity and escalation arrangements.

b) Maintain optimum operational resource levels through workforce planning, bank and overtime arrangements, dynamic deployment and fleet readiness.

c) Use escalation frameworks, business continuity plans, adverse weather arrangements and winter assurance command where required.

d) Work with acute, community, primary care and mental health partners to improve handovers, access to alternatives and seven-day flow.

e) Maintain non-essential patient transport resilience through absence monitoring, relief and third-party capacity where required, accurate bookings and coordination of expected demand.

12. Community services:

a) Maximise Urgent Community Response, Virtual Wards, Hospital at Home, OPAT, IV therapy, community nursing and integrated home visiting.

b) Strengthen Home First, D2A, reablement, intermediate care and P1/P2/P3 pathways to support recovery outside hospital and flex resources appropriately based on demand pressures.

c) Utilise the Transfer of Care Hub arrangements to support direct placement, reduce delay and improve shared oversight across the cluster.

d) Maintain flexible community and bedded capacity, including planned escalation arrangements where demand exceeds assumptions.

e) Use Technology Enabled Care, neighbourhood models and prevention initiatives to support independence and reduce avoidable admission.

f) Work with local authorities, primary care, care homes and VCSE partners to strengthen discharge, admission avoidance and care closer to home.

13. Mental health:

a) Strengthen crisis alternatives, 24/7 access routes, NHS111 Mental Health Option 2 and daily Crisis MDT arrangements to reduce avoidable admission.

b) Maintain timely mental health liaison and senior clinical review across urgent and emergency care pathways.

c) Improve inpatient flow through daily discharge profiling, standardised ward rounds, escalation forums and active management of barriers.

d) Reduce reliance on out-of-area and private placements where possible and maintain executive oversight of long stays and delayed discharge.

e) Review flex-bed, surge and community capacity options to respond to periods of exceptional demand.

f) Use least restrictive care, safe havens and community support to protect patient safety and reduce pressure on acute pathways.

14. Primary Care and Neighbourhood services:

a) There is a significant amount of work underway with developing our INT model across the cluster, there are some early signs that this will support some of our high-risk cohorts of patients through a risk stratified approach to support attendance and admission avoidance.

b) Maximise Pharmacy First at every opportunity throughout winter.

c) Ensure we utilise NHS111, clinical assessment and advice routes, direct booking into UTC access and alternatives to Emergency Departments at every opportunity.

d) Strengthen same-day urgent care, direct referral routes and access to community, SDEC and ambulatory pathways.

e) Use risk stratification, personalised care, proactive case management and prevention to support people safely at home.

f) Work with ambulance services to support clinical decision-making, safe non-conveyance and navigation to appropriate local pathways.

g) Align neighbourhood, community and social care arrangements to support increased reablement, discharge and home-based capacity across health and social care.

h) Primary Care Networks, GP Collaboratives and community services will work proactively to support patients most at risk of deterioration through targeted respiratory, frailty and long-term condition management. This includes delivery of the proactive ARI scheme, COPD reviews, vaccination promotion, medicines optimisation and enhanced multidisciplinary care to reduce avoidable hospital attendances and admissions while supporting people to remain independent at home

15. Local authorities and social care:

    a) Support Home First and Discharge to Assess pathways through integrated working with NHS partners and Care Transfer Hubs.

    b) Identify and proactively support care homes with a high risk of conveyance to ED to identify and provide earlier support to care home residents and staff.

    c) Maintain reablement, brokerage and care-market resilience, with flexible workforce deployment in response to changing demand.

    d) Improve pathway flow through earlier assessment, proportionate decision-making and timely escalation of barriers.

    e) Maximise Technology Enabled Care, prevention and community support to maintain independence and avoid unnecessary admission.

    f) Monitor delayed discharge and people not meeting criteria to reside, working jointly to reduce abandoned or avoidable delays.

    g) Maintain business continuity, staff wellbeing and Christmas and New Year cover arrangements.

16. Children and young people:

    a) Maintain paediatric front-door and assessment capacity, including additional paediatric beds at CRH and extended Clinical Assessment Unit arrangements at SFH.

    b) Use system escalation and regional collaboration to respond to changing paediatric demand and specialist bed pressures.

    c) Monitor influenza, RSV, COVID-19 and other infectious disease pressures affecting children and young people.

    d) Maximise childhood vaccination uptake, including eligible two- and three-year-olds, children in clinical risk groups and school-aged children.

    e) Use targeted communications and clear access routes to help families reach appropriate services and avoid unnecessary Emergency Department attendance.

Seasonal vaccination plan

17. Key actions within the plan are to:

    a) Maintain clear cluster governance through the DLN Vaccination and Immunisation Programme Board and related place and programme structures. Monitor vaccine supply, uptake variation, workforce capacity and hesitancy, with flexible mitigations where delivery is affected.

b) Offer flu vaccination to all eligible cohorts in line with the national programme and maximise uptake, particularly among older adults, clinical risk groups, pregnant women, children and young people.

c) Ensure frontline health and care workers are offered flu vaccination through accessible organisational programmes, supported by workforce trajectories and monitoring.

d) Deliver year-round RSV vaccination and the seasonal COVID-19 programme for eligible populations through primary care, community pharmacies, outreach services and NHS providers.

e) Use onsite clinics, roving vaccinators, outreach and walk-in opportunities to improve access for staff, patients, care-home residents and underserved groups.

f) Address inequalities through targeted outreach, communication, engagement and accessible delivery models.

g) A national supply issue affecting one provider may delay clinics for the under-65 cohort and could reduce timely coverage if influenza peaks earlier than anticipated.

Latest intelligence on winter demand, including COVID-19 and influenza

Current Position

The slide deck states that influenza activity is expected to be broadly consistent with trends observed in the Southern Hemisphere last year. Further vaccination and disease-modelling guidance is expected from JCVI in September 2026. The dedicated influenza forecast slide remains a placeholder pending additional information.

18. Planning assumptions are informed by national and international epidemiological intelligence, local surveillance and demand forecasting. The system will use real-time surveillance, laboratory reporting, outbreak monitoring and dashboards to identify respiratory infections and healthcare-associated infections early. Plans include laboratory PCR, point-of-care and rapid diagnostic testing where appropriate to support timely isolation, cohorting and patient placement.

19. The winter plan retains flexibility to respond to influenza, COVID-19, RSV, norovirus and other emerging threats, including scenarios in which infectious disease activity exceeds planning assumptions.

Scenario planning and stress testing

20. The plan is structured around Baseline, Surge and Super Surge demand scenarios. Three localised exercises have taken place across the DLN footprint to test organisational and system plans before final approval.

21. Testing challenged leadership, command and control, escalation, collective decision-making, mutual aid, patient safety and service continuity. Scenarios included workforce shortages and exhaustion, infectious disease outbreaks, digital or cyber disruption, flow and discharge failure, mental health and primary care pressures, and major incidents.

22. Learning will be captured and incorporated into final Winter Plans and Board assurance processes and actions arising from KLOE feedback and testing will be tracked through established winter governance, including preparation for the National Winter Testing Exercise on 10 September 2026.

System oversight and daily operational management

23. System Coordination Centres (SCC) provide a central operational platform across all three systems, supporting shared situational awareness, capacity management, coordinated action and mutual aid.

24. The SCC operates from 08:00 to 18:00, seven days a week on 364 days of the year, with out-of-hours on-call arrangements and clinical support available 24/7.

25. A Winter Monitoring Group will be established from September 2026 to track demand, additional capacity, delivery, benefits and emerging risks.

26. Assurance will be obtained through provider daily calls, the regional coordination call, UEC Delivery Board and fortnightly Winter Monitoring Group.

27. The Urgent and Emergency Care Delivery Board will oversee delivery of the plan, with key metrics and risks also reported through ICB governance.

28. DLN partners are working towards a consistent cluster Surge and Escalation Framework, supported in the interim by shared local arrangements, central reporting, agreed triggers and clear escalation routes.

Workforce resilience

29. Providers are at varying stages of workforce planning maturity, with work focused on high-risk staffing gaps, reduced agency reliance and better use of available resources.

30. Historical absence, staffing pressure and fill-rate information is being used to inform winter workforce assumptions and rostering. Annual leave, particularly

across Christmas and New Year, will be managed against expected demand, staffing availability and service resilience.

31. Providers will maintain industrial action contingency and business continuity arrangements, including engagement with staff-side representatives and identification of critical services.

32. Fortnightly winter meetings and daily operational calls will maintain shared oversight and enable rapid mitigation and escalation. Health, wellbeing, vaccination and visible leadership offers will support staff resilience during prolonged operational pressure.

Key risks

33. As part of the development of the winter plans with all system partners, key risks have been shared and assessed. As a system the following risks are presented as the highest risk areas across all system partners plans:

    a) Workforce capacity and organisational change, including the impact of NHS England and ICB restructuring on resilience and retention of winter-planning expertise.

    b) Potential industrial action affecting service delivery, flow and operational performance.

    c) Financially challenged system which is a position reflected across all provider organisations limiting the ability to fund additional capacity or interventions.

    d) Urgent and emergency care demand exceeding available acute, community, mental health and social care capacity.

    e) Deterioration in ambulance response, handover, Emergency Department performance and progress to reduce corridor care.

    f) Mental health pressures, including national and regional scrutiny, inpatient flow and access to appropriate alternatives.

    g) Staff sickness, vacancies, recruitment and retention challenges and lower-than-planned staff vaccination uptake.

    h) Influenza, COVID-19, respiratory infection or other outbreaks exceeding forecast assumptions, compounded by severe weather

    i) Estates and infrastructure constraints limiting safe and flexible use of capacity.

    j) Disruption to elective recovery, cancer pathways and clinically urgent planned care if emergency pressures cannot be mitigated.

k) Delayed discharge, insufficient intermediate care and overuse of temporary residential placements, with a risk of deterioration and loss of independence.

l) National vaccine supply constraints affecting timely delivery to the under-65 cohort.

Next steps

34. All system partners are continuing to refine plans, demand and capacity assumptions, residual bed gaps, mitigations and interventions. The remaining IPC and influenza forecast information will be completed and updated national guidance will be incorporated when available.

35. All Providers are working to a deadline of 30th September 2026 to get their internal Board sign off and submit their Board Assurance Statements by 7th October 2026.

36. From 1 September 2026, delivery will commence delivery through fortnightly system-wide winter oversight meetings. Performance, demand, capacity and risks will be monitored against Baseline, Surge and Super Surge scenarios.

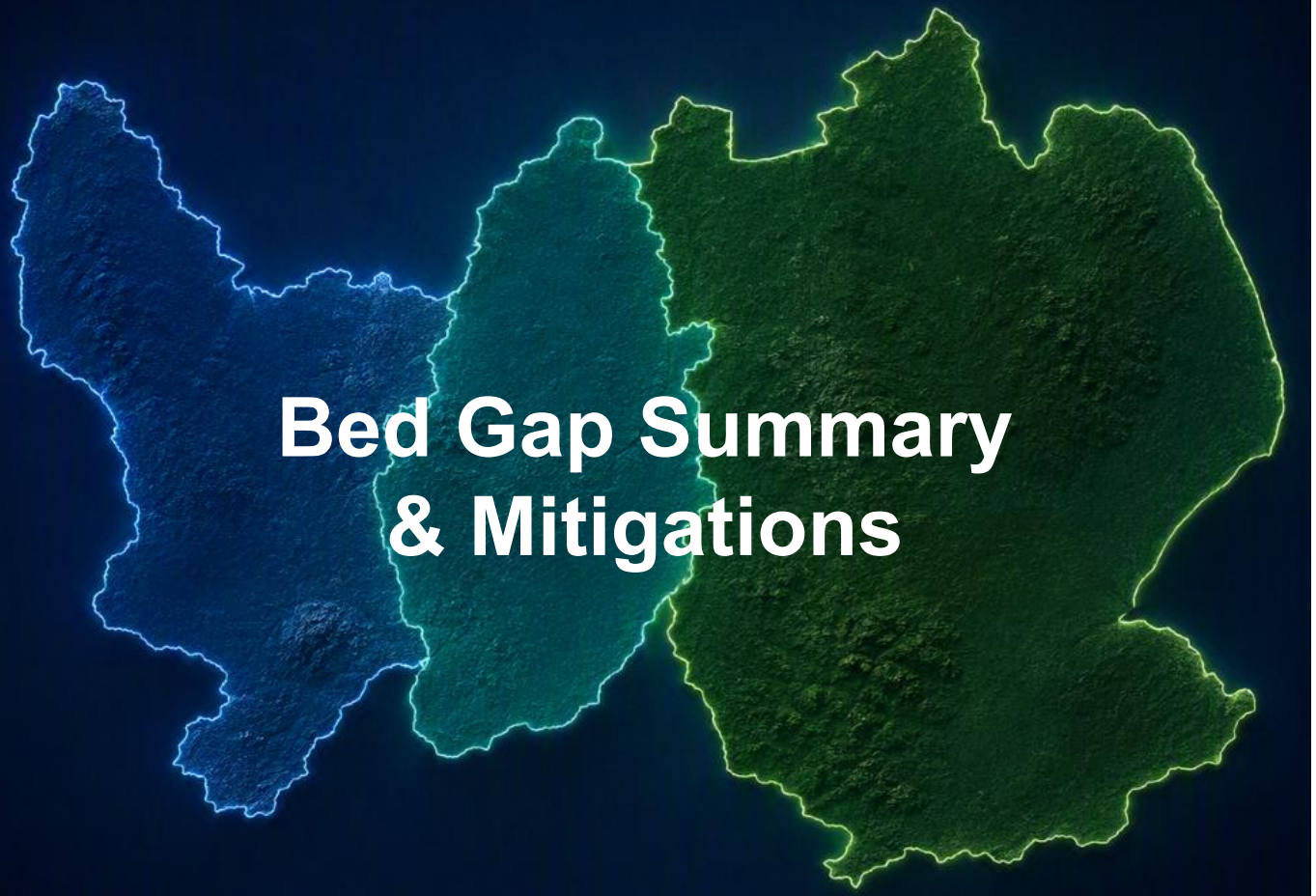
37. The meetings will track the delivery and impact of winter interventions, adapting or stopping activity where expected benefits are not realised.

38. The Winter Plan will be maintained as a live document, with reporting and escalation through the System Control Centre, the Winter Monitoring Group, the UEC Delivery Board and ICB governance.

Source and status note

This summary has been prepared from the attached FINAL DRAFT DLN 2026/27 Winter Plan. Where the source deck identifies placeholders, outstanding information or ongoing refinement, this has been retained transparently. This paper will be updated alongside the final approved plan and associated provider submissions.

Appendix A



Bed Gap Summary & Mitigations

2026/27 DLN Winter plan

Key capacity/demand mitigations for Winter 26/27

The overall position demonstrates an improvement compared with previous months, and we continue to work closely with providers and system partners to further reduce the remaining bed gap over the coming weeks as we progress towards final Board sign-off.

A range of mitigations and interventions are currently being refined and developed across the system to support winter resilience and capacity. These will be reflected in our final submission once this work has been completed and agreed with partners.

The information provided at this stage presents the current bed gap position by provider and should be viewed as an interim position, with further refinement and mitigation planning ongoing.

2026/27 DLN Winter plan

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Board Level Summary: Highest Impact Mitigations Against the Bed Gap

Across the DLN footprint, the mitigations most likely to reduce the residual bed gap are:

Out of Hospital

- Virtual Wards / Hospital at Home
- UCR expansion
- OPAT / IV Therapy
- D2A and Home First pathways
- Care Transfer Hub and Transfer of Care Hub models
- Mental health admission avoidance and crisis alternatives
- Community and intermediate care bed capacity
- Winter 2026/27 Proactive Acute Respiratory Infection (ARI) Scheme

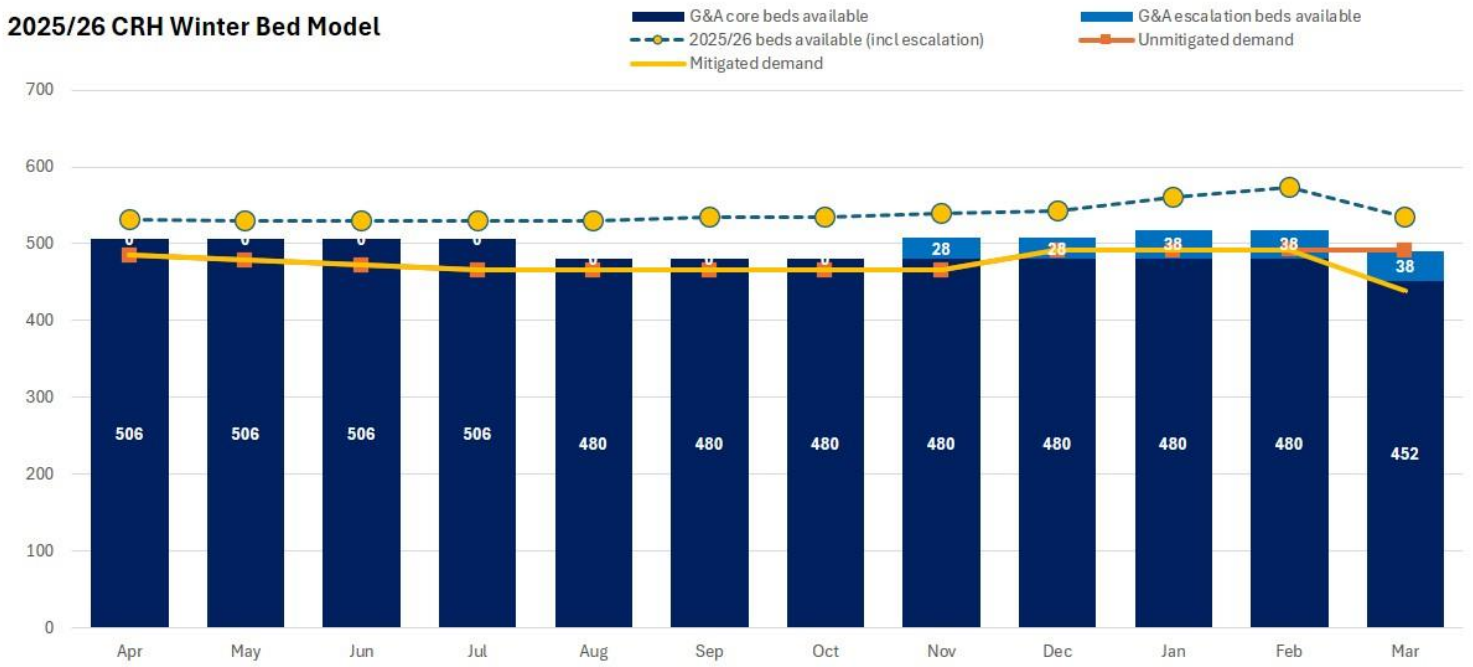
In Hospital

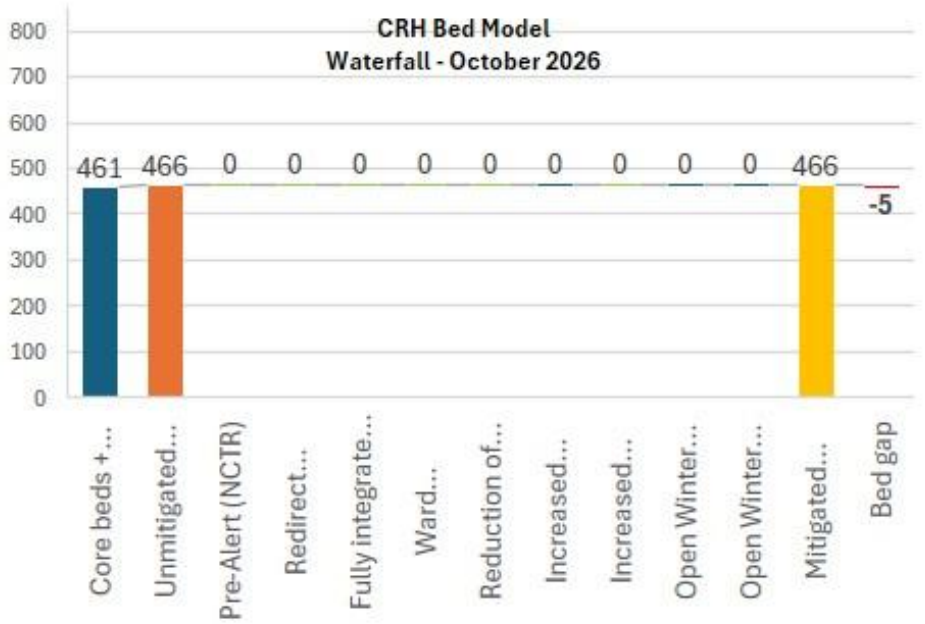
- Winter wards and incremental acute bed capacity
- Escalation/overflow capacity
- SDEC and ambulatory care expansion
- Front-door streaming and admission avoidance
- LOS reduction programmes
- Daily discharge grip and discharge coordination
- Improved patient flow through P1/P2/P3 pathways

2026/27 DLN Winter plan

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

CRH - Key capacity/demand mitigations for Winter 26/27



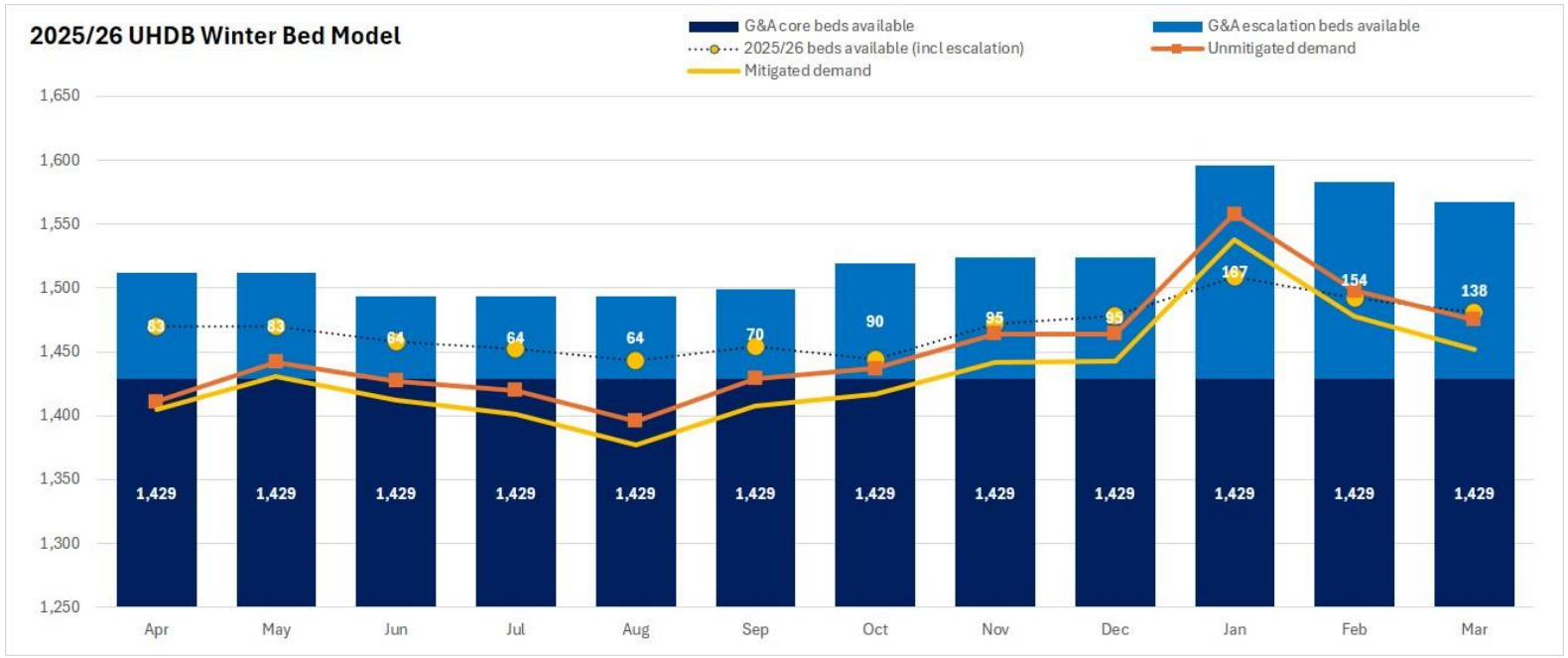


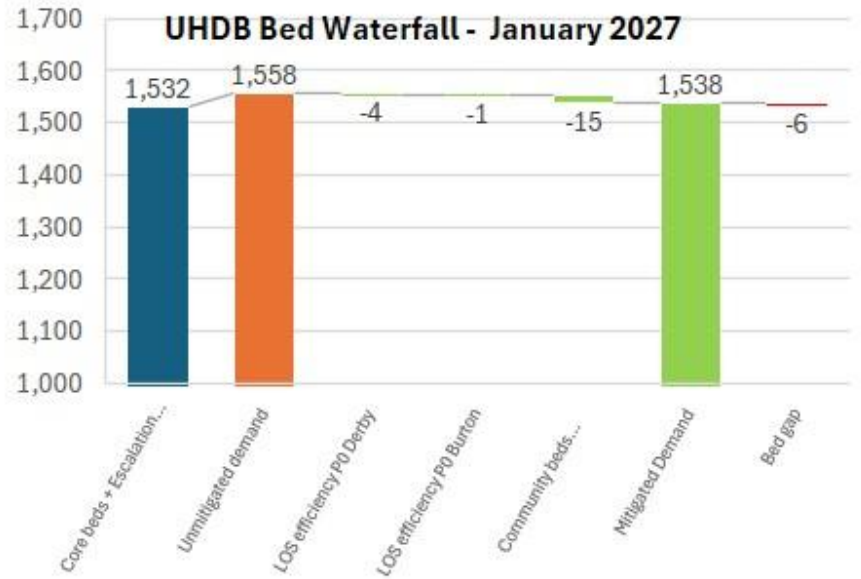
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27 Operational Plan	2026/27 planned beds available (incl escalation)	506	506	506	506	506	480	480	480	509	509	509	509
	2026/27 planned beds occupied (incl escalation)	485	479	472	466	466	466	466	466	492	492	492	492
	2026/27 % beds occupied (incl escalation)	95.9%	94.6%	93.3%	92.1%	92.1%	97.1%	97.1%	97.1%	96.6%	96.6%	96.6%	96.6%
Unmitigated demand		485	479	472	466	466	466	466	466	492	492	492	492
Demand mitigations		0	0	0	0	0	0	0	0	0	0	0	53
Mitigated demand		485	479	472	466	466	466	466	466	492	492	492	439
G&A core beds available		506	506	506	506	480	480	480	480	480	480	480	452
G&A escalation beds available		0	0	0	0	0	0	0	28	28	38	38	38
Bed Shortfall (based on adjusted occupancy)		0	7	13	20	-5	-5	-5	22	-4	5	5	32

2026/27 DLN Winter plan

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

UHDB - Key capacity/demand mitigations for Winter 26/27





		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27 Operational Plan	2026/27 planned beds available (incl escalation)	1,495	1,495	1,497	1,499	1,495	1,505	1,512	1,520	1,507	1,581	1,581	1,581
	2026/27 planned beds occupied (incl escalation)	1,411	1,442	1,427	1,420	1,396	1,429	1,437	1,464	1,464	1,558	1,498	1,475
	2026/27 % beds occupied (incl escalation)	94.4%	96.5%	95.3%	94.7%	93.4%	95.0%	95.0%	96.3%	97.1%	98.5%	94.8%	93.3%
Unmitigated demand		1,411	1,442	1,427	1,420	1,396	1,429	1,437	1,464	1,464	1,558	1,498	1,475
Demand mitigations		7	11	15	19	19	21	20	22	21	20	20	23
Mitigated demand		1,404	1,431	1,412	1,401	1,377	1,408	1,417	1,442	1,443	1,538	1,478	1,452
G&A core beds available		1,429	1,429	1,429	1,429	1,429	1,429	1,429	1,429	1,429	1,429	1,429	1,429
G&A escalation beds available		83	83	64	64	64	70	90	95	95	167	154	138
Bed Shortfall (based on adjusted occupancy)		**47**	**20**	**21**	**33**	**56**	**31**	**42**	**21**	**20**	**-6**	**42**	**52**

Derby & Derbyshire Mitigations / Interventions to Support Flow this Winter

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Admission Avoidance / Reducing Demand

- NHS111 and Clinical Assessment Service (CAS) capacity increases.
- Central Navigation Hub (CNH) deflection and call-before-convey pathways.
- Virtual Wards and Ambulatory Care expansion.
- Mental Health Option 2, crisis alternatives and admission avoidance pathways.
- SDEC

Additional Capacity

- Additional acute winter capacity at UHDB. 27 winter Medicine & Emergency Care beds at CRH for 8 weeks.
- Additional paediatric bed capacity at CRH.
- Temporary escalation spaces within community pathways –4 TES spaces opening for Winter on community hospital.
- Voluntary Sector Services

Improving Flow / Releasing Beds

- Care Transfer Hub direct placement into community beds.
- Home First MDT triage.
- Daily discharge profiling, board rounds and LOS reviews.
- Reverse boarding protocol and improved discharge tracking.
- Enhanced discharge coordination and pathway management.

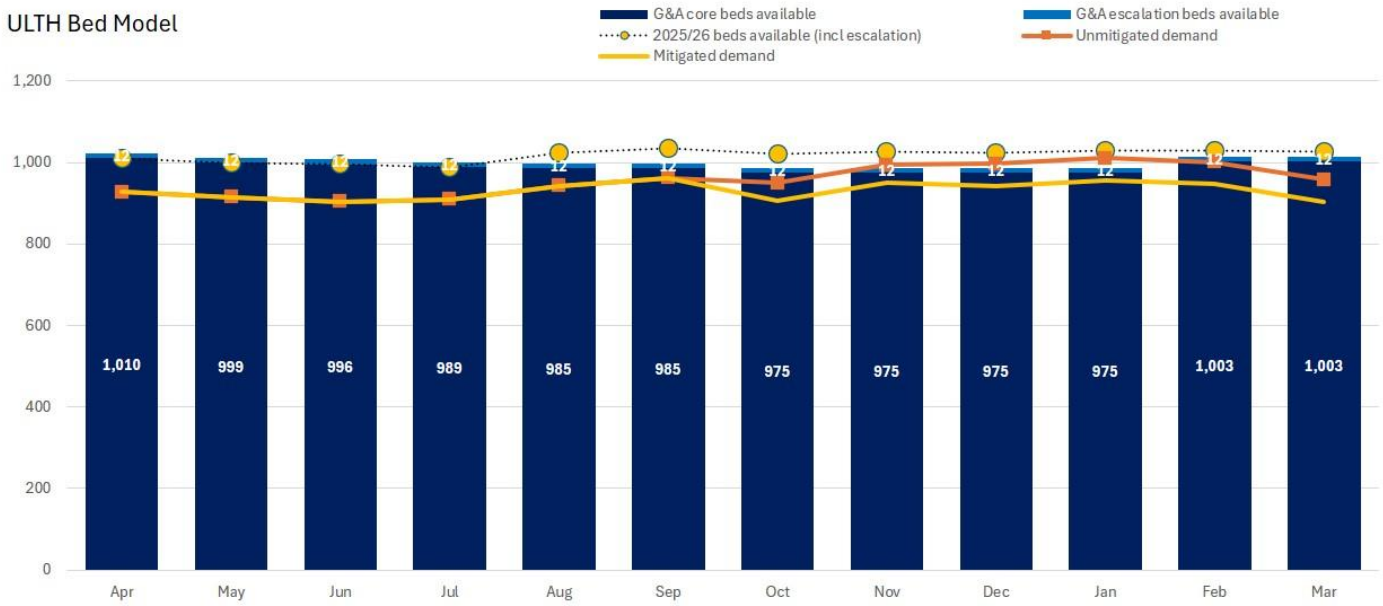
Community Alternatives

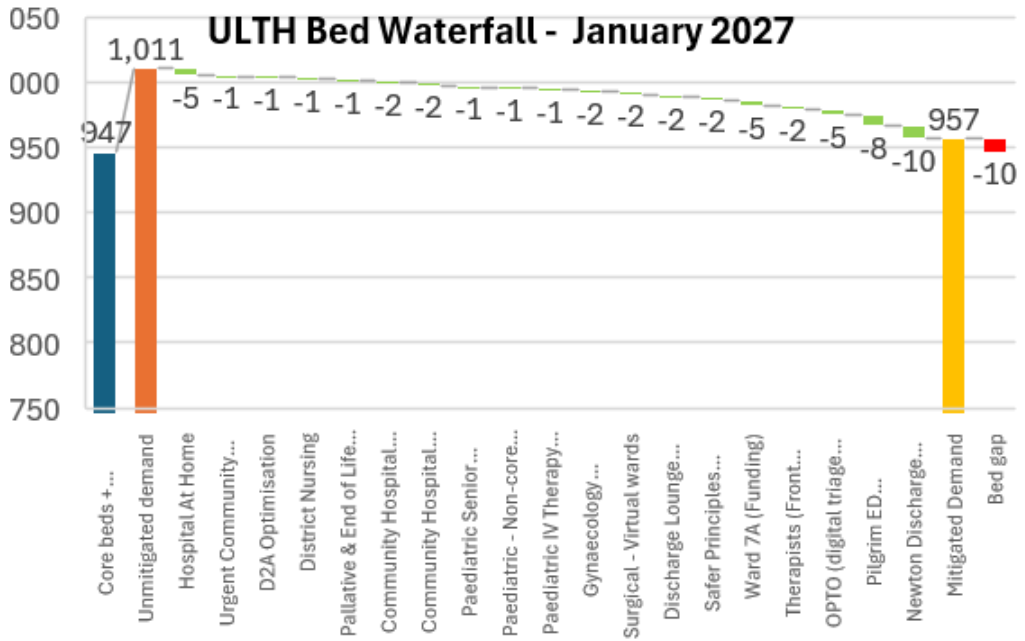
- Urgent Community Response optimisation.
- UTC optimisation.
- Community First and Technology Enabled Care.
- Increased community and intermediate care capacity.

2026/27 DLN Winter plan

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

ULTH - Key capacity/demand mitigations for Winter 26/27





		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27 Operational Plan	2026/27 planned beds available (incl escalation)	1,010	999	996	989	1,025	1,035	1,038	1,037	1,043	1,054	1,048	1,043
	2026/27 planned beds occupied (incl escalation)	928	915	904	910	943	962	950	994	997	1,011	1,001	958
	2026/27 % beds occupied (incl escalation)	91.9%	91.6%	90.8%	92.0%	92.0%	92.9%	91.5%	95.9%	95.6%	95.9%	95.5%	91.9%
Unmitigated demand		928	915	904	910	943	962	950	994	997	1,011	1,001	958
Demand mitigations		0	0	0	0	0	0	44	44	54	54	54	54
Mitigated demand		928	915	904	910	943	962	906	950	943	957	947	904
G&A core beds available		1,010	999	996	989	985	985	975	975	975	975	1,003	1,003
G&A escalation beds available		12	12	12	12	12	12	12	12	12	12	12	12
Bed Shortfall (based on adjusted occupancy)		11	11	11	11	-26	-35	-3	-4	0	-10	22	28

Lincolnshire Mitigations / Interventions to Support Flow this Winter

Derby and Derbyshire Integrated Care Board
Lincolnshire Integrated Care Board
Nottingham and Nottinghamshire Integrated Care Board

Admission Avoidance / Reducing Demand

- Hospital at Home
- OPAT and IV Therapy services.
- Virtual Wards operating at maximum utilisation.
- OPTO digital triage.
- UCR, home visiting and integrated CEMS/LIVES pathways.
- Paediatric and cardiology front-door support

Additional Capacity

- Flexible D2A capacity.
- Transitional Care surge arrangements.
- Community hospital transformation.
- Ability to mobilise additional community beds if demand exceeds planning assumptions.
- Weekend staffing and workforce redeployment arrangements.

Improving Flow / Releasing Beds

- Newton flow improvement programme.
- Single Point of Referral (SPoR).
- Earlier stroke transfers.
- Reduced FNOF length of stay.
- Trusted Assessor model.
- Optica dashboard for discharge oversight.
- Daily monitoring of delayed discharges through Transfer of Care Hub processes.

Community Alternatives

- Early discharge programmes.
- MADE events.
- Executive oversight of out-of-area beds.
- Least restrictive care options to reduce pressure on acute pathways.

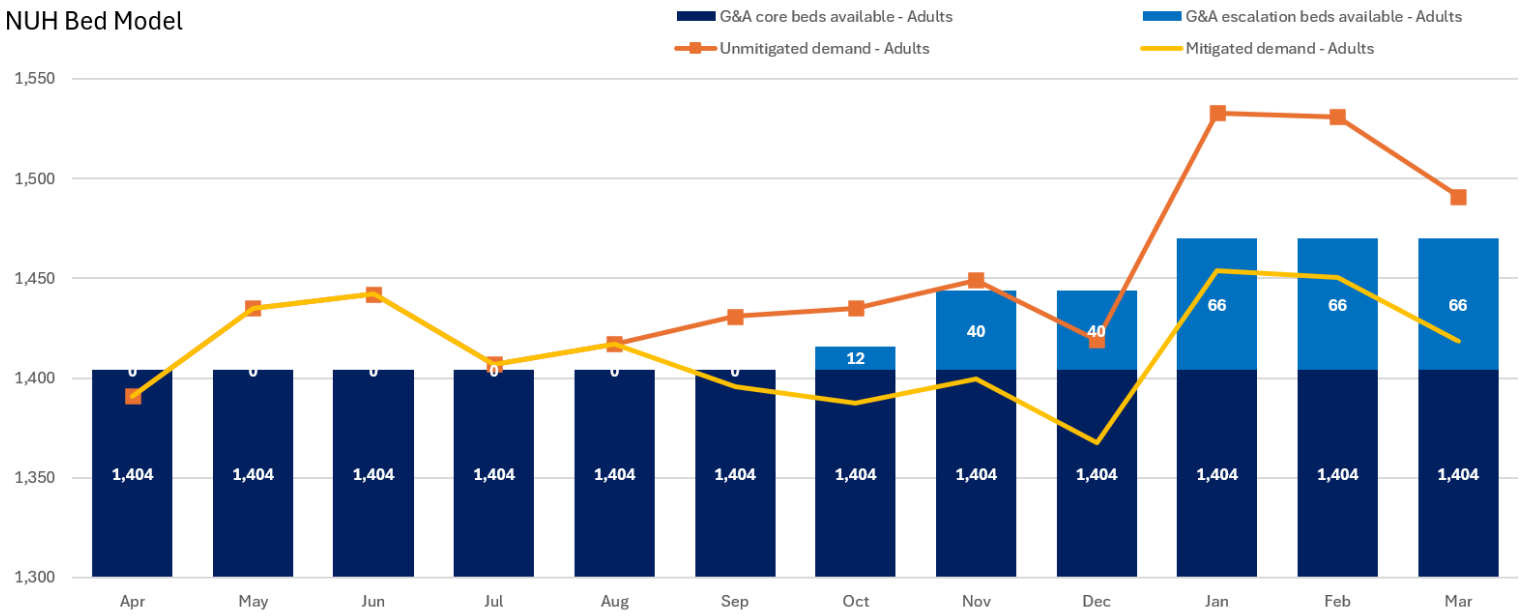
2026/27 DLN Winter plan

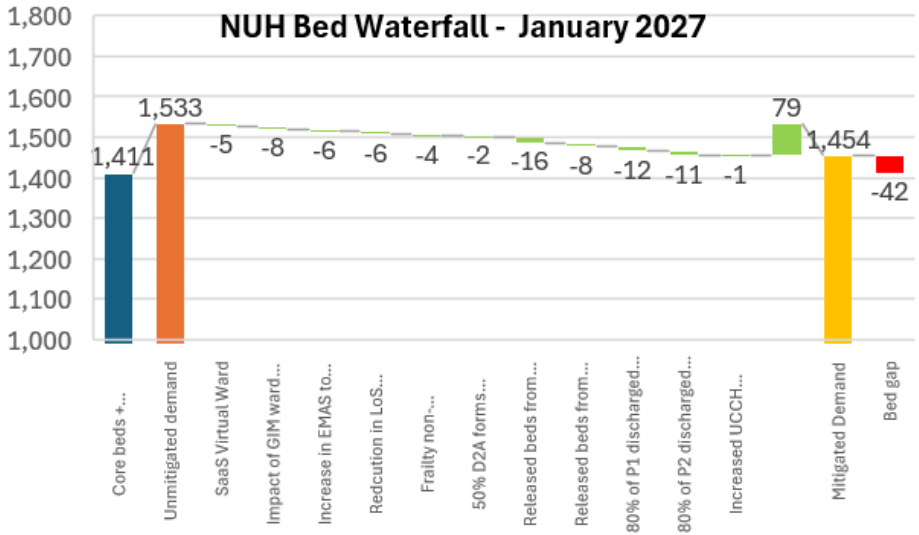
NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

NUH - Key capacity/demand mitigations for Winter 26/27



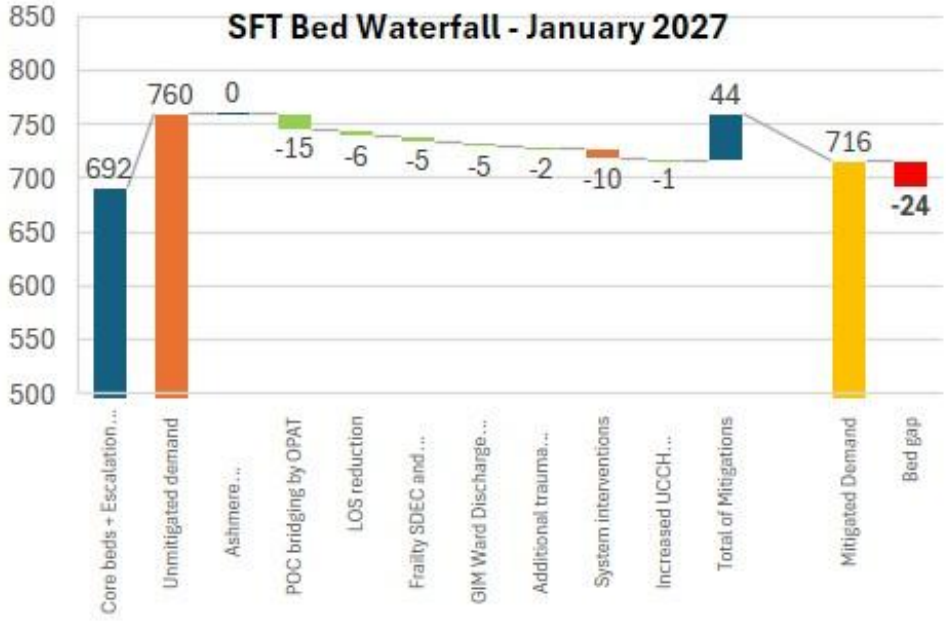


		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27 Operational Plan	2026/27 planned beds available (incl escalation)	1,736	1,748	1,736	1,724	1,720	1,723	1,737	1,751	1,751	1,772	1,773	1,772
	2026/27 planned beds occupied (incl escalation)	1,603	1,630	1,648	1,613	1,594	1,620	1,649	1,658	1,631	1,680	1,667	1,671
	2026/27 % beds occupied (incl escalation)	92.3%	93.2%	94.9%	93.6%	92.7%	94.0%	95.0%	94.7%	93.2%	94.8%	94.0%	94.3%
Unmitigated demand - Adults		1,391	1,435	1,442	1,407	1,417	1,431	1,435	1,449	1,419	1,533	1,531	1,491
Demand mitigations - Adults		0	0	0	0	0	35	47	49	51	79	80	72
Mitigated demand - Adults		1,391	1,435	1,442	1,407	1,417	1,396	1,388	1,400	1,368	1,454	1,451	1,419
G&A core beds available - Adults		1,404	1,404	1,404	1,404	1,404	1,404	1,404	1,404	1,404	1,404	1,404	1,404
G&A escalation beds available - Adults		0	0	0	0	0	0	12	40	40	66	66	66
Bed Shortfall (based on adjusted occupancy)		-43	-87	-94	-59	-69	-48	-28	-13	19	-42	-39	-7

2026/27 DLN Winter plan

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

SFH - Key capacity/demand mitigations for Winter 26/27



		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27 Operational Plan	2026/27 planned beds available (incl escalation)	680	680	680	680	680	680	685	685	690	700	695	685
	2026/27 planned beds occupied (incl escalation)	646	648	654	650	660	653	664	665	665	665	665	661
	2026/27 % beds occupied (incl escalation)	95.0%	95.3%	96.2%	95.6%	97.1%	96.0%	96.9%	97.1%	96.4%	95.0%	95.7%	96.5%
Unmitigated demand		697	701	691	685	710	692	720	711	725	760	753	740
Demand mitigations		23	23	23	23	23	23	53	55	55	44	44	42
Mitigated demand		674	678	668	662	687	669	667	656	670	716	709	698
G&A core beds available		622	622	622	622	622	622	622	622	622	622	622	622
G&A escalation beds available		0	0	0	0	0	0	29	29	41	70	70	58
Bed Shortfall (based on adjusted occupancy)		-52	-56	-46	-40	-65	-47	-16	-5	-7	-24	-17	-18

Nottingham & Nottinghamshire Mitigations / Interventions to Support Flow this Winter

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Admission Avoidance / Reducing Demand

- SDEC expansion.
- UTC streaming.
- Pharmacy First.
- Call-before-you-convey pathways.
- Direct advice lines.
- Daily Crisis MDTs and alternatives to mental health admission.
- UCR, D2A and community pathway optimisation.

Additional Capacity

- Two NUH winter wards.
- Additional QMC capacity.
- Medicine and Surgery Virtual Ward expansion.
- Extended Clinical Assessment Unit (CAU) hours at SFH.
- Weekend trauma lists
- Escalation and overspill spaces.
- Potential decant ward capacity.
- Flexible community capacity and safe over-occupancy of Virtual Wards.
- Review of mental health flex-bed and surge options..

Improving Flow / Releasing Beds

- GIRFT long length of stay work.P1/P2/P3 flow KPIs.
- Zero tolerance approach to avoidable abandoned discharges.
- Transfer of Care Hub functionality.
- Dedicated leadership oversight of discharge pathways.
- Focus on reducing post-CRFD delays.
- Daily senior clinical reviews and escalation processes.

Community Alternatives

- UCR maximisation.
- Expansion and optimisation of Virtual Wards.
- Community bed utilisation.
- Strengthened care-home support.
- Reablement and discharge services.

Appendix B

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

DRAFT DLN Winter Plan

2026/27 DLN Winter Plan

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

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2026/27 DLN Winter Plan

Executive Summary

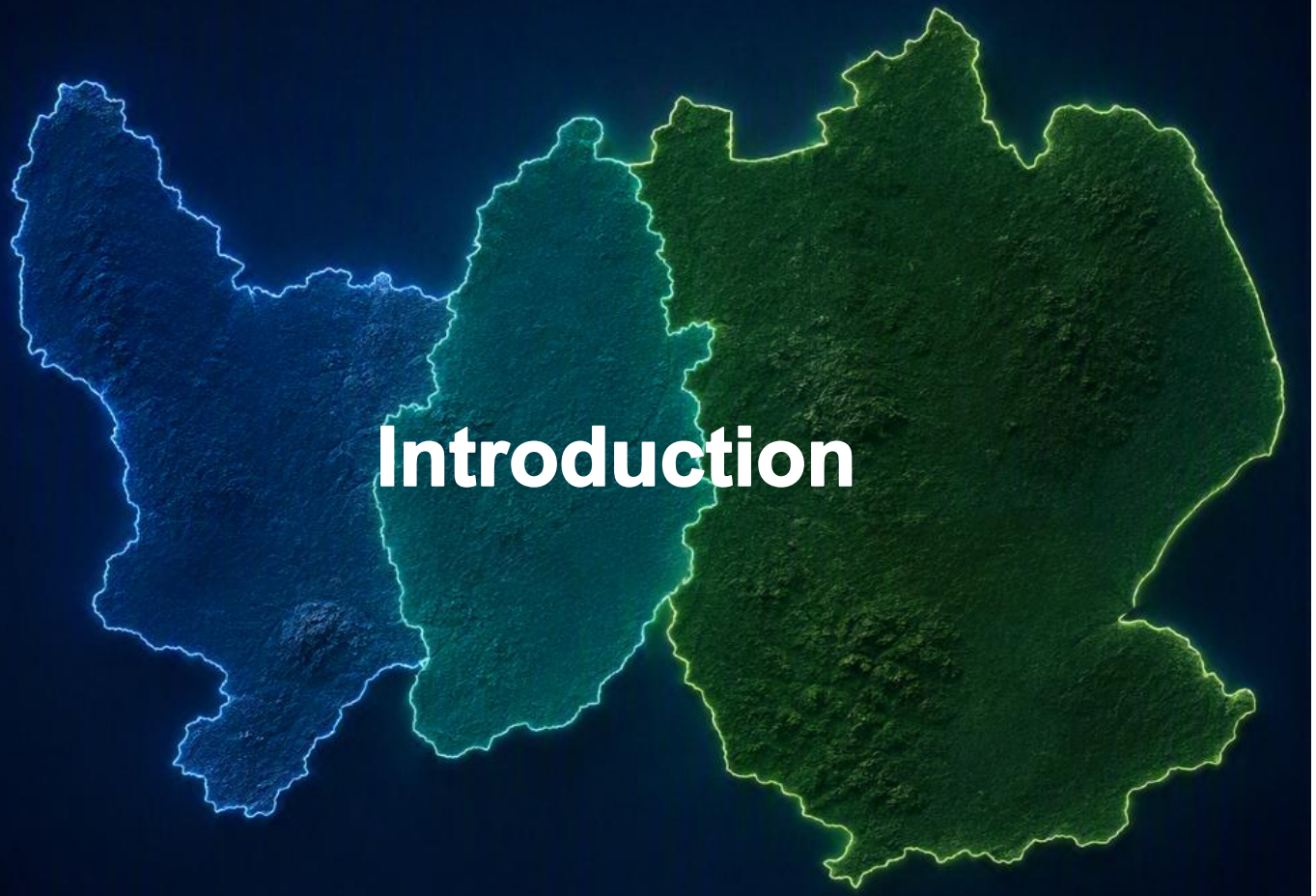
The DLN Cluster Winter Planning process commenced in April 2026, bringing together partners across Derbyshire, Lincolnshire and Nottinghamshire to develop a coordinated response to Winter 2026/27. The plan has been informed by national and international epidemiological intelligence, demand forecasting and system-wide confirm-and-challenge sessions.

A single cluster-wide plan has been developed around three demand scenarios, incorporating transformation programmes, actions to reduce non-elective admissions, capacity and resilience planning, and escalation arrangements. The plan reflects the significant financial challenges facing the system whilst providing assurance that all opportunities within available resources have been maximised to support safe patient care.

The plan was tested throughout July and August, refined following NHSE feedback, and reviewed through system governance processes. Residual risks, including national uncertainties such as potential industrial action, have been identified and mitigated where possible.

Next Steps (from 1 September 2026):

- Commence delivery through fortnightly system-wide Winter oversight meetings.
- Monitor performance, demand, capacity and risks against the three planning scenarios.
- Track delivery and impact of winter schemes, adapting or stopping interventions where benefits are not realised.
- Maintain a live Winter Plan with ongoing reporting through system governance and escalation structures.
- Continue collaborative working across partners to ensure a coordinated response to emerging pressures throughout Winter 2026/27.



Introduction

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

- Key messages
- Principles of the Winter Plan
- Key System Risks within Winter Plan
- Key Metrics - how success will be measured

2026/27 DLN Winter Plan

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Key messages

- The DLN Winter Plan represents a single, whole-system approach across Derbyshire, Lincolnshire and Nottinghamshire, setting out how partners will work collectively to ensure patients receive the right care, in the right place, first time throughout Winter 2026/27.

- The plan incorporates key actions and commitments from NHS providers, local authorities and system partners across all three ICBs, supported by strong collaboration and shared accountability.

- Developed within a highly challenging operational and financial context, the plan aligns with existing Integrated Care System priorities and focuses on maximising impact from available resources.

- The system has modelled three winter demand scenarios Baseline, Surge and Super Surge to ensure preparedness for escalating levels of demand, with system-wide testing and validation undertaken to assess resilience and response arrangements.

- National and international epidemiological intelligence has informed demand forecasting and planning assumptions, enabling targeted preparations for anticipated winter pressures and seasonal disease activity.

- Current intelligence suggests influenza activity is likely to be broadly consistent with trends observed in the Southern Hemisphere, with further vaccination and disease modelling guidance expected from JCVI in September to refine forecasts.

- A significant focus of the plan is the reduction of avoidable acute admissions through strengthened community, mental health and demand management services, alongside investment in admission avoidance and Emergency Department alternative pathways.

- Delivery of the Winter Plan will be supported through robust governance and central oversight, including fortnightly system-wide Winter meetings, regular performance reviews and escalation processes, with assurance and risks reported through established UEC governance structures.

2026/27 DLN Winter Plan

Principles of the Winter plan

Derby and Derbyshire Integrated Care Board | Lincolnshire Integrated Care Board | Nottingham and Nottinghamshire Integrated Care Board

- **System-Wide Partnership** – Health and care partners across the cluster will work collectively to ensure patients receive the right care, in the right place, at the right time.
- **Patient Safety First** – Patient safety, quality of care and balanced clinical risk underpin all decision-making across the patient pathway.
- **Maximising Existing Resources** – In the context of limited additional investment, partners will optimise existing capacity through efficiency, productivity and pathway transformation to reduce unnecessary non-elective demand.
- **Prevention and Population Health** – A targeted approach will be taken to increase vaccination uptake and reduce avoidable winter pressures.
- **Protecting Planned Care** – The impact on elective recovery, patient experience, income and performance will be minimised, with cancer and other clinically urgent services prioritised and protected.
- **Collective Stewardship of Resources** – Partners will work together to mitigate avoidable system costs and make best use of health and social care resources.
- **Clear Communication** – Proactive and timely communication with patients, staff and partners will support service access, operational response and public confidence.
- **Co-ordinated System Leadership** – The System Coordination Centre (SCC) will provide oversight of UEC flow, bringing partners together through a shared daily operational cadence and response.
- **Data-Led Decision Making** – Real-time system intelligence and performance monitoring will be used to identify emerging risks, inform actions and support rapid escalation where required.
- **Supporting Our Workforce** – The health, wellbeing and resilience of staff remain critical to delivering safe and sustainable services throughout the winter period.
- **Agility and Resilience** – The system will maintain the flexibility to respond rapidly to changing demand and infectious disease outbreaks, including influenza, COVID-19, norovirus and other emerging threats.

2026/27 DLN Winter Plan

Key system risks

- **Workforce Capacity and Organisational Change** – Ongoing workforce reductions and significant NHS England and ICB restructuring may impact organisational capacity, resilience and retention of winter planning expertise from Winter 2025/26.
- **Industrial Action** – Potential industrial action across health and care services during Winter 2026/27 may adversely affect service delivery, patient flow and operational performance.
- **System Financial Pressures** – The challenging financial position across ICBs and provider organisations represents the most significant strategic risk to delivery of the Winter Plan and limits opportunities for additional investment.
- **Demand Exceeding Available Capacity** – Sustained growth in urgent and emergency care demand may outstrip available capacity across health and social care services, increasing pressure across the whole patient pathway.
- **Urgent and Emergency Care Performance** – There is a risk that improvements in ambulance handovers, response times and corridor care are not sustained through winter, resulting in deterioration of performance and increased patient safety concerns.
- **Mental Health System Pressures** – Ongoing regional and national scrutiny of mental health services may place additional demands on system capacity and operational management.
- **Workforce Availability and Resilience** – Staff sickness, vacancies, recruitment and retention challenges, alongside lower-than-planned staff vaccination uptake, may reduce workforce resilience during periods of peak demand.
- **Severe Weather and Infectious Disease Surges** – Demand may exceed forecast planning assumptions due to significant respiratory illness, influenza, COVID-19 or other infectious disease outbreaks, compounded by severe weather events.
- **Estates and Infrastructure Constraints** – Physical estate limitations, including cubicle availability, inpatient capacity and timing of bed reconfiguration programmes, may restrict the system's ability to respond flexibly to surges in demand.
- **Impact on Elective Recovery** – Failure to mitigate emergency bed pressures may require higher bed occupancy levels, increasing the risk of disruption to elective activity, cancer pathways and associated performance standards.
- **Discharge and Intermediate Care Risks** – Increased use of temporary residential placements may lead to deterioration in patient condition, delayed recovery and poorer outcomes for individuals who could otherwise have returned directly home with appropriate support.
- **National Vaccination Supply for Under 65s –** Due to a national supply issue affecting one vaccine provider, there is a risk that flu vaccination clinics for the under-65 cohort will be delayed. Should the flu season peak earlier than anticipated, this could result in a proportion of the eligible population not being vaccinated within the optimal timeframe, reducing vaccine coverage and increasing the risk of higher demand on health and care services during periods of winter pressure.

2026/27 DLN cluster Winter Plan

Key Metrics –How success will be measured

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Key metrics will be reported via the UEC Board and ICB Board including:

- Winter Delivery Governance – Monthly Winter Delivery Meetings (September 2026–February 2027) will monitor progress against all agreed actions, expected benefits and provider delivery milestones.
- Executive Oversight – Key winter metrics and risks will be reported through the UEC Board and ICB Board, with escalation where delivery deviates from plan.
- Elective Recovery – Elective, cancer and clinically urgent activity is maintained throughout the winter period.
- Demand and Capacity Management – Actual activity, capacity and demand are monitored against winter planning assumptions and system trajectories.
- Urgent and Emergency Care Performance – Emergency Department performance, ambulance response times and handover standards are maintained in line with winter plan expectations.
- Corridor Care Reduction – Progress towards the elimination of corridor care is monitored through agreed system measures and trajectories.
- Home First Delivery – The number of people placed in short-term residential care where needs could be met at home is minimised and monitored.
- Bed Occupancy – Acute, community and intermediate care bed occupancy remains within agreed planning assumptions and safe operating thresholds.
- Urgent Community Response – Delivery of the two-hour UCR standard is maintained throughout the winter period.
- Workforce Resilience – System workforce metrics, including sickness absence and workforce availability, are monitored against plan.
- Winter Bed Escalation – Additional winter capacity is deployed in line with agreed trigger points and demand thresholds to support both operational and financial sustainability.
- Performance Recovery Action – Immediate corrective action is taken where indicators suggest delivery is off track, ensuring rapid response to emerging risks and maintaining overall system performance.

Lessons Learnt from Winter 2025/26 and Plans Brought into Winter 26/27

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

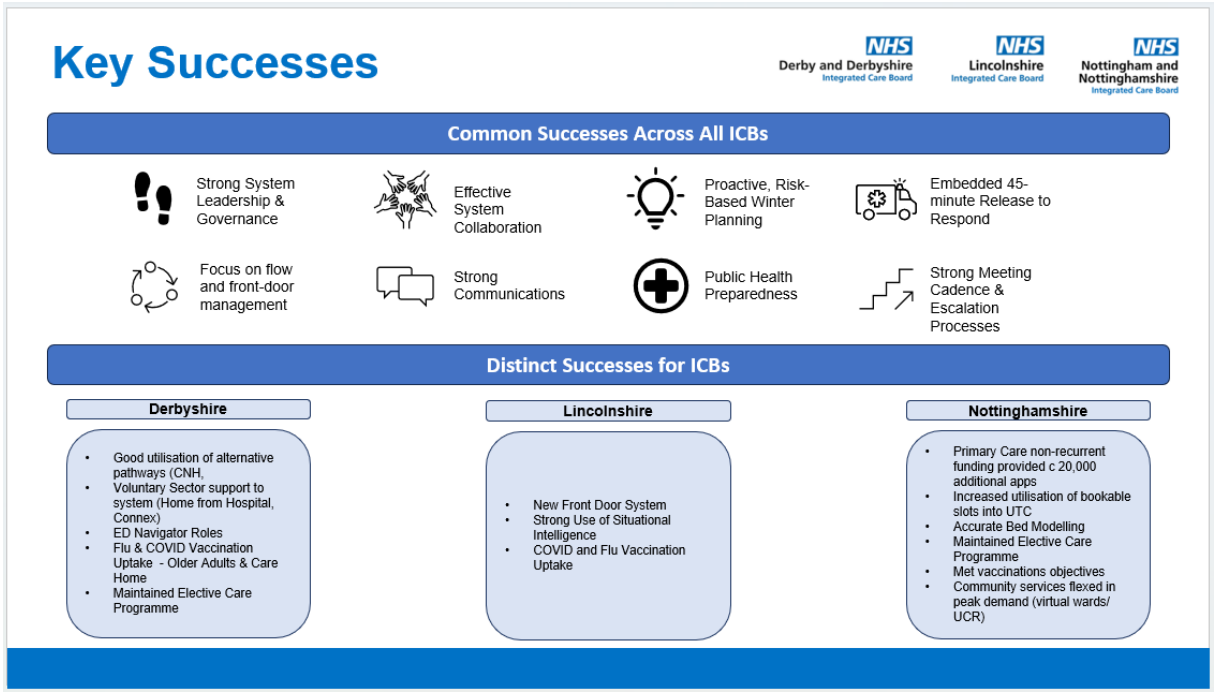
NHS Nottingham and Nottinghamshire Integrated Care Board

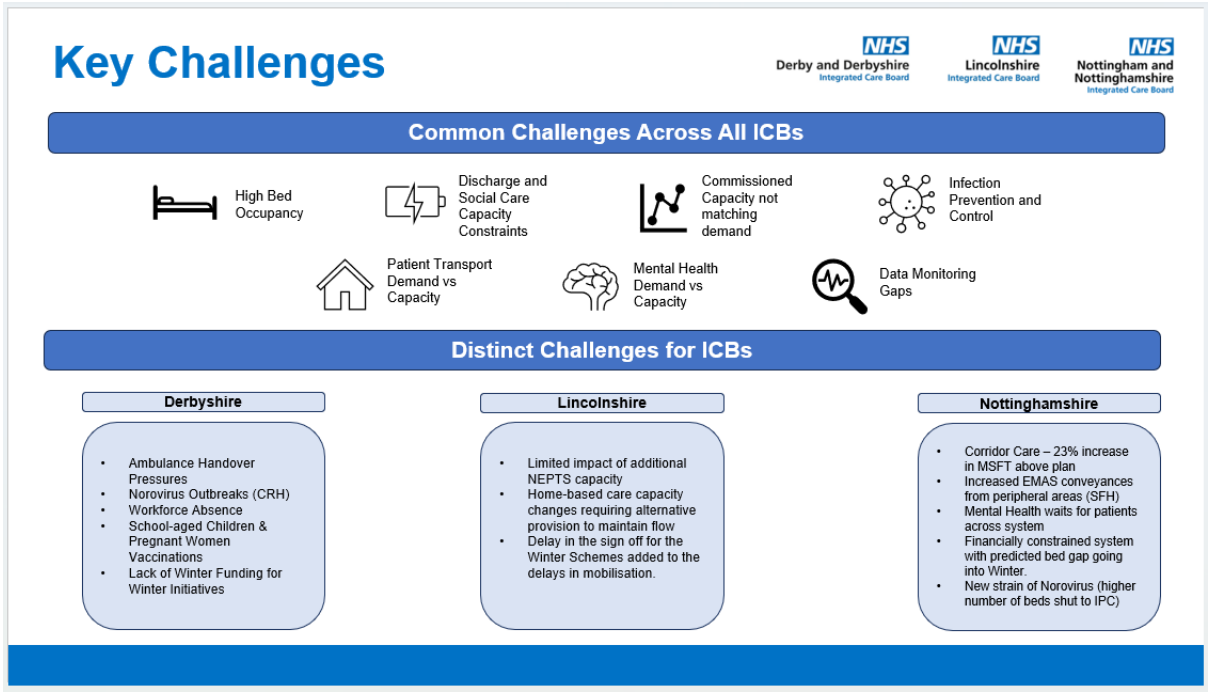
- Key Successes & Challenges
- Lessons Learnt per ICB
- Actions/ Recommendations

2026/27 DLN Winter Plan

Lessons learned 25/6

All providers and system partners were asked in March 2026 to review and consider lessons learned from Winter 25/6 before commencing planning for Winter 26/27. The outcome document of the review are included within Appendix 2.





2026/27 DLN Winter Plan

Lessons learned 25/6

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Lessons Learned

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Derbyshire

- Prevention and early intervention needs to be strengthened – particularly for frail older adults and those with respiratory disease
- Voluntary sector contributions were critical enablers of flow.
- Strong utilisation of alternative pathways, preventing admissions
- Capacity was fragile, with limited headroom to absorb infection-related bed losses or workforce absences.
- Planned vs Actual data was not always timely or consistent.
- Vaccination programmes performed well overall, but gaps remained (RSV in pregnancy, school-aged children, and staff uptake in some settings)

Lincolnshire

- To complete winter planning with defined outcomes for funded schemes and specific KPIs.
- Focus on maximising all out of hospital capacity and pathways of care.
- Due to an earlier than expected influenza season that was less prevalent than 2024, this impacted on ARI as the scheme was commenced after the start of the season and therefore did not have maximum effect.

Nottinghamshire

- Understand why MSFT were 23% above plan to aid future planning.
- Refine system approach to frailty in line with GIRFT recommendations.
- P1 capacity /demand work to be reviewed including review of Hucknall demographics.
- Identify space at acute trusts to be able to flex up and down bed base to meet patient needs during peak periods.
- Planning winter capacity mitigations as early as possible (Spring/Summer) across all providers with acute providers giving earlier indications on Winter bed capacity plans .
- Improve primary care respiratory virus recognition and use of diagnostics in care homes .
- Ensure that ambulatory and admission avoidance pathways are maximised in readiness for Winter 2026/27.
- System wide two prong approach required to prevent attendances to acute setting but improve wait times from hub to discharge before next winter .

2026/27 DLN Winter Plan

Lessons learned 25/6

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Actions/ Recommendations to take forward - 2026/27 Winter plan

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Continue systematic review of Australian flu trends and UKHSA modelling

Derbyshire

- Shift further upstream through pro-active, neighbourhood-based care
  - Strengthen frailty-focused pathways
  - PCN-led proactive respiratory care model ahead of Winter, reducing avoidable admissions
- Embed and expand what worked well
  - Central Navigation Hub
  - Virtual Wards
  - Care Transfer Hub and Home First approaches
- Continue to prioritise vaccination and IPC resilience
  - Maintain early, system-wide vaccination planning with targeted actions for underperforming cohorts
- Continue to plan early for Winter
  - Request data Spring/early summer from providers in line with NHSE ask

Lincolnshire

- Repeat process of circulating PH situational brief weekly to all system partners from September
- System to be prepared for early Flu season 2026/27
- Ongoing implementation of UEC programme projects as mitigations to demand growth and improved patient flow
- Winter Planning to commence spring/simmer across all providers
- Winter bed capacity plans grom Group to support winter planning discussions
- Maximising alternative pathways by increased use of Call before Convey
  - Maintain mandatory use of Call before Convery for Care Homes
- Implementation of Frail-tED recommendations
- Winter Communication plans in place

Nottinghamshire

- System to be prepared for an early flu season.
- Roll out RSV vaccinations to care homes for over 80's.
- Embed inpatient vaccinations for long stay patients/discharges to care homes in the acute trusts.
- Maintain NUH additional winter ward capacity and plans to reduce/eliminate corridor care.
- SFH and Bassetlaw to replicate what worked well this winter.
- Ongoing implementation of UEC programme projects as mitigations to demand growth and improved patient flow
- Development and implementation of the Waiting Well Pack .
- Home for Xmas scheme at Lings Bar and IPC prevention messages and 'winter packs' to support care homes .
- Promotion of Pharmacy First.
- Continued improvements in community mental health capacity and crisis capacity to better support patients at home.

Key Risks - Supporting Vulnerable Populations During Winter

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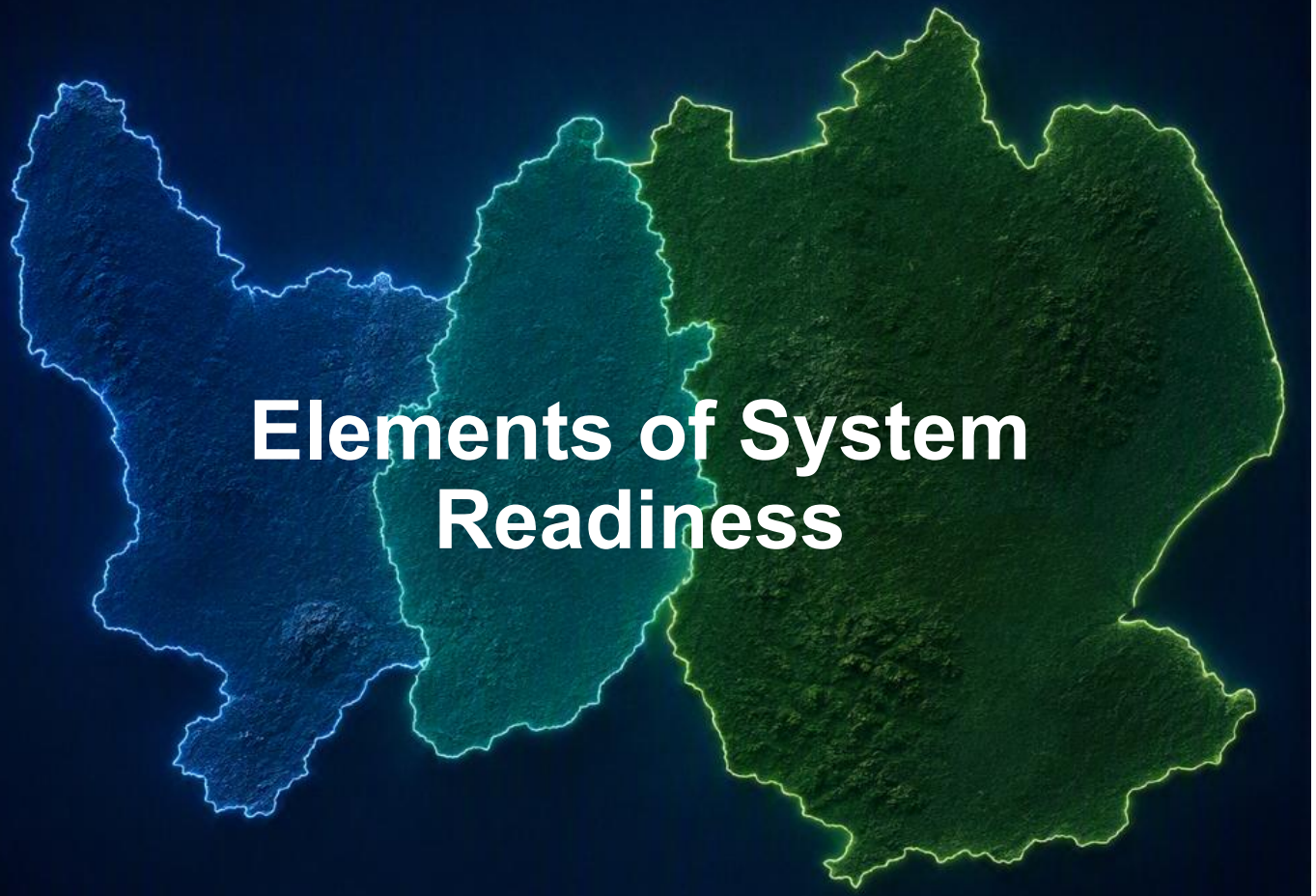
2026/27 DLN Winter Plan

Key system risks –Supporting vulnerable patients /groups

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

- **People with Learning Disabilities** are at increased risk of respiratory illness, poorer winter health outcomes and avoidable hospital admissions. Risks will be mitigated through annual health checks, targeted vaccination programmes, health promotion and reasonable adjustments across all care settings.
- **People with Severe Mental Illness (SMI)** may experience worsening mental health, increased crisis presentations and longer waits for appropriate care during periods of system pressure. Expansion of mental health capacity, strengthened crisis services and improved access to community support will help mitigate these risks.
- **People Experiencing a Mental Health Crisis** face a heightened risk of prolonged Emergency Department stays and delayed access to specialist support. Enhanced crisis pathways, 24/7 crisis access and additional inpatient capacity will support timely assessment and treatment.
- **Children, Young People and Adults at Risk of Admission** may experience poorer outcomes if preventative support is not available. Dynamic Support Registers and proactive case management will be used to identify individuals at risk and implement early interventions to avoid hospital attendance or admission.
- **People from Underserved and Deprived Communities** may experience disproportionately poorer outcomes due to barriers in access, lower vaccination uptake and wider health inequalities. A population health management approach will be used to target support and resources to areas of greatest need.
- **People Requiring Hospital Care with Additional Needs** may be at risk of poorer experience and outcomes if reasonable adjustments are not made. Learning Disability and Mental Health liaison services will support personalised care, communication needs and discharge planning.
- **People Awaiting Discharge or Community Support** are at risk of deterioration, deconditioning and loss of independence if discharge pathways are delayed. System oversight and escalation arrangements will focus on removing barriers and maintaining flow through the patient pathway.
- **Infectious Disease and Winter Pressures** have the potential to disproportionately impact clinically vulnerable groups, including older people, people with multiple long-term conditions, those with learning disabilities and individuals with severe mental illness.



Elements of System Readiness

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

- Winter Diseases and Influenza
- Vaccinations /Immunisation plans and IPC
- Scenario planning and stress testing
- System wide demand and capacity modelling
- Elective position

2026/27 DLN Winter Plan

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Seasonal Vaccination Plan 26/7

The **National Flu Immunisation Programme 2026/27** requires systems to:

- Offer flu vaccination to 100% of all eligible cohorts in line with the national programme.
- Maximise uptake across all eligible groups, with particular focus on:
    - Adults aged 65 years and over.
    - Individuals in clinical risk groups.
    - Pregnant women.
    - Children and young people, including 2- and 3-year-olds, children in clinical risk groups, and school-aged children.

- Support the national ambition to increase vaccination uptake and reduce variation across populations, contributing to reduced winter demand, hospitalisations and mortality.
- Ensure all frontline healthcare workers are offered flu vaccination as part of organisational infection prevention and workforce resilience arrangements.
- Maintain robust plans to identify and address health inequalities, improving access and uptake amongst underserved communities and reducing unwarranted variation.
- Target newly eligible and underserved populations, including people experiencing homelessness, ensuring proactive outreach and improved access to flu, COVID-19 and pneumococcal vaccination programmes where eligible, as part of wider efforts to reduce health inequalities and improve protection for vulnerable groups.
- Deliver vaccination programmes in a safe, timely and equitable manner through effective system-wide collaboration and governance arrangements.

The **Winter Plan Letter** requires systems to:

- Include comprehensive vaccination delivery plans within their winter plans, demonstrating how vaccination programmes will support the reduction of winter demand and protect patients and staff.
- Develop and implement workforce vaccination plans and trajectories, setting out how staff vaccination uptake will be promoted and monitored throughout the winter period.
- Have plans in place to maximise vaccine uptake amongst all eligible cohorts, recognising vaccination as a key intervention to improve system resilience over winter.
- Establish clear governance arrangements for monitoring vaccination delivery, providing assurance that programmes are being effectively managed and delivered.
- Maintain robust Infection Prevention and Control (IPC) arrangements to manage outbreaks and minimise operational impact across health and care services during periods of increased pressure.

2026/27 DLN Winter Plan

Influenza Forecast

- Placeholder for information – Steve Clapton providing once able to.
- National supply issues that will impact both delivery plans and overall uptake. ICB Execs aware and the vaccination team continue to keep everyone sighted and updated on this matter.

Seasonal Vaccination Delivery Model 26/27

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

	1) Flu Vaccination	2) COVID Vaccination	3) RSV Vaccination
Start Date	• 1st September 2026 – children & Pregnant women • 1st October – all other groups	• From 1st October 2026	• Year round offer & catch up
Eligible Cohorts	• All children aged 2 or 3 years • Primary and secondary school children • Pregnant women • 6 months to 64 yrs in risk groups • Over 65s • Residents in care homes • Homeless community • Carers & close contacts of immunocompromised individuals • Front line NHS HCWs & SCWs	• Adults aged 75 years and over • Residents in a care home for older adults irrespective of age • Individuals aged 6 months and over who are immunosuppressed	• Individuals aged over 75 yrs • Resident in an older adult care home irrespective of age • Pregnant women at >28-week gestation • Individuals aged 65 to 74 with a chronic respiratory condition or who have a suppressed immune system – From September 2026.
Eligible Population	• Circa – 1.7m	• Circa – 417k	Circa – 351k (Excluding any over 65's eligible from Sept 26.)
Delivery Model	• General Practice • Community Pharmacies • Outreach service • School Aged Immunisation Service (Reception to Year 11) • NHS Hospital Trusts (for staff vaccinations) • Independent Sector Providers • Local Authorities	• Opted in GP's • Community Pharmacies • Outreach service • NHS Hospital Trusts	• General Practice • NHS Hospital Trusts (for maternity)

Delivery Action Plan

Eligible Cohort	Detailed Actions	Owner / Stakeholder	Timeline
2–3-year-olds	• Work with practices where uptake is below 20% to encourage an improved programme of delivery. • Engagement with Health visitors prior to the campaign. • Proactive engagement with family hubs to promote the flu vaccination. • Monitor uptake. • Nottinghamshire County Council to produce a video and other communication materials focussing on the impact a flu outbreak had on babies and young children attending a nursery in the County. To share cluster wide. • GP letter to encourage vaccination prior to the CP offer which commencing in October 2026. • Monitor CP sign up and activity. • Active promotion for community pharmacy offer from 1st October 26.	ICB, GP's, CP's, Public Health, NHSE, Health visitors, Early years education settings.	Jun - Dec 26
School aged children	• The school visit programme has been planned well in advance • Engagement with schools to promote vaccinations, via head teacher briefings. • Target work from public health with some low uptake schools. • Introduction of MAVIS, a new digital consent platform from Sept. • Engagement for 1st Oct CP offer for at risk children and 1st Dec for all healthy school age children.	ICB, CP's, Public Health, NHSE, Health visitors, Schools, SAIS.	May – Dec 26
Maternity	• Vaccinations are offered within maternity services at trusts, from a wide range of clinic locations across the cluster. • 24/7 access to vaccination available through the maternity triage service (Lincs). • NHSE as the commissioner will be responsible for monitoring uptake and contract management. • Offer Royal Society of Public Health Increasing Vaccination Uptake training to maternity and antenatal staff, to encourage conversations about vaccinations throughout pregnancy (Notts). • A & I funding for trusts to increase uptake (Derby).	ICB, GP's, Public Health, NHSE, Health visitors, Maternity services	N/A as year-round offer
Under 65s at risk	• Proactive and tailored communications for specific cohorts. • Dedicated visits for the homeless communities across Lincolnshire. • Engage with providers to encourage uptake from health inequalities areas. • Opportunistic outpatient vaccinations for those who haven't been vaccinated are invited to a clinic (Notts). • A & I funding for trusts to increase uptake (Derby).	ICB, GP's, CP's, Public Health, NHSE, Trusts.	Jul – Dec 2026
Over 65s	• Main programme delivery by GP and CP, plans in place across the cluster. • Engaging with hospital trusts to develop vaccination offer for patients when discharged to a care home. • Outreach Team to deliver these for LCHS and LPFT. There is no capacity within ULTH, so the team liaise with the discharge to access team to ensure these patients are offered a vaccination as soon to discharge as possible (Lincs). • Funding additional engagement and outreach activity beyond core contractual delivery, including targeted patient engagement, flexible delivery models, and community-based interventions via GPPB (Derby).	ICB, GP's, CP's, Public Health, NHSE, Trusts, care homes.	Jul – Aug 2025

Delivery Action Plan 26/27

Eligible Cohort	Detailed Actions	Owner / Stakeholder	Timeline
H/SCWs	• To work with trusts to ensure accessible occupational health vaccination offer to staff throughout the entire flu campaign, including onsite bookable and walk-in appointments. • Lincolnshire County Council staff will be offered flu vaccination at dedicated clinics run by LCHS (Lincs). • Nottinghamshire County Council will provide on-site clinics for staff to access the vaccination and provide staff with vouchers to be redeemed at community pharmacies. • Nottingham City Council will provide vouchers to staff to be redeemed at community pharmacies. (Notts) • Derbyshire County Council to produce a health care worker video for staff. • Sign post private social care staff to the network of community pharmacies (Derby) • Engagement with care home managers. • Staff can access vaccination via a CP or their GP. • Monitoring uptake is only possible in the trusts due to the available data.	ICB, GP's, CP's, Public Health, NHSE, trusts	Jan – Dec 26
Communications and engagement for all cohorts	• Develop a communication plan and supporting materials for Autumn 26 using all material developed by the ICB last year. • Include all cohorts. • Use of social media. • Banners printed and given to GP's to specifically encourage over 65's, maternity , and childhood vaccinations (Lincs).	ICB, GP's, CP's, Public Health, NHSE, trusts	May – Jan 27
Training and Education	• LCHS attend head teachers briefing alongside LCC. • LINCA conference attended to encourage vaccinations in care homes. • GP summer fair attended to educate staff and patients on vaccinations. • Practice nurse conference attended to engage with primary care nurses. • Health visitor training delivered. • Involvement with vaccination updates delivered by the Lincolnshire training hub. • Dedicated GP vaccination training (Notts). • CHIS provided general vaccination training.	ICB, Trusts, Public Health, Lincolnshire training hub, GP's	May – Aug 26
Data Monitoring	• DPIA arrangements undertaken when any data between providers is shared. • Uptake data shred within internal platforms, not for public domain unless ratified by NHSE. • Uptake data is monitored throughout the winter programmes. • Weekly uptake report for seasonal group (Notts). • Health protection board uptake.	ICB	Oct – Mar 26

2026/27 DLN Winter Plan

Seasonal Vaccinations Plan 26/27

NHS Derby and Derbyshire Integrated Care Board
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NHS Nottingham and Nottinghamshire Integrated Care Board

Frontline Healthcare Workers Vaccination

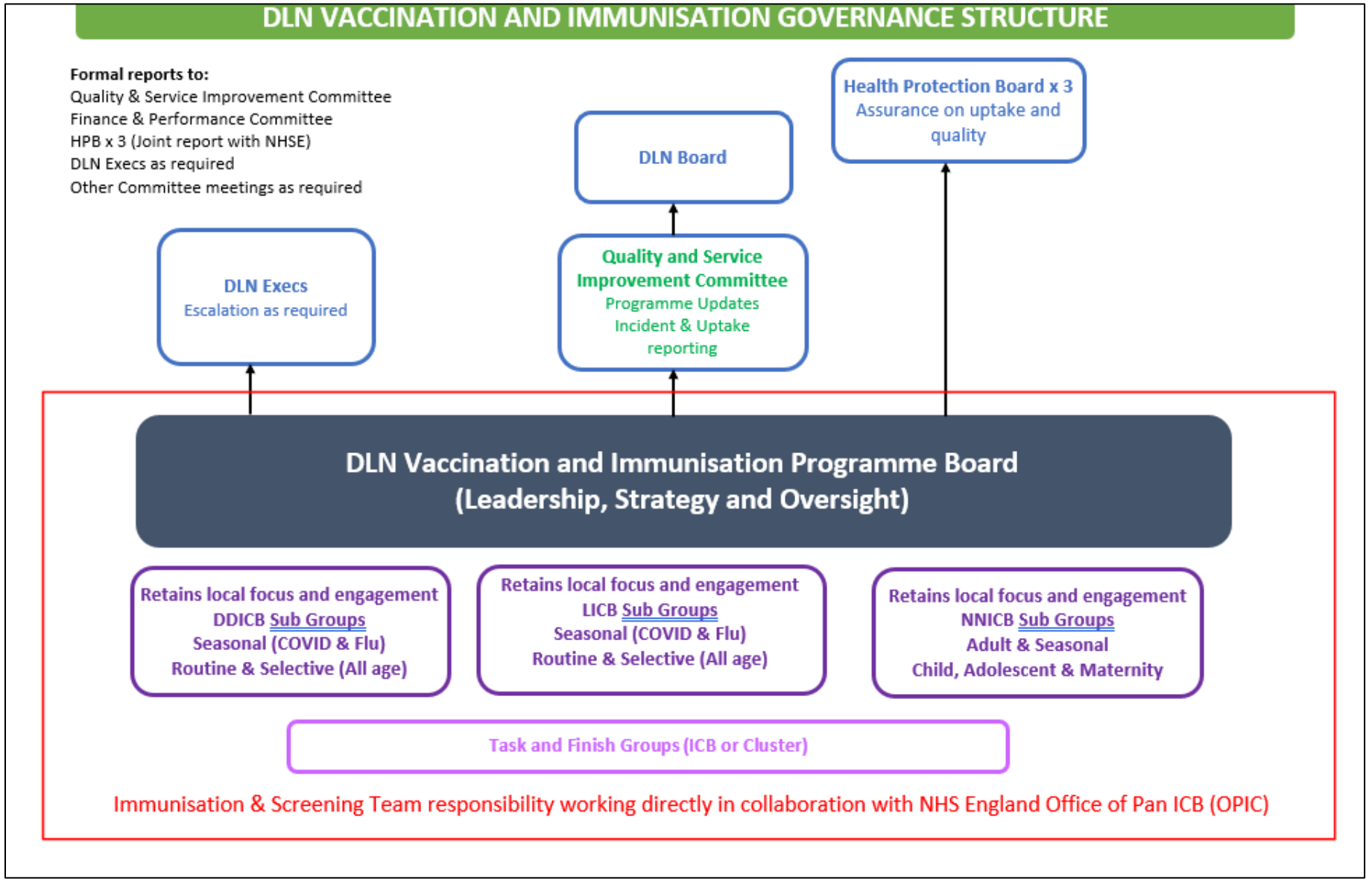
- Vaccinating front-line health and care staff ahead of Winter is a key part of supporting our workforce this winter, primarily to keep them safe and well but also to manage our sickness levels this Winter.
- There has been a consistent decline in staff vaccination rates since COVID and there is a 3-year national aspiration to have uptake in this cohort at 65% by 28/29.
- Each provider/partner across the cluster has plans to vaccinate as many front-line staff as possible.

	2025/26 uptake			2026/27 Target	
ICB	Frontline Workers	Flu Vaccination	Uptake	National Uptake	Additional No of vaccinations
LINCS	11,717	6,511	55.6%	60%	519
DERBY	21,890	11,890	54.3%	60%	1244
NOTTS	26,807	12,881	48.19%	60%	3203

2026/27 DLN Winter Plan

Seasonal Vaccinations Plan 26/27

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board



2026/7 DLN Winter Plan

IPC Readiness

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

7-Day IPC Coverage and System Resilience

- The Derbyshire, Lincolnshire and Nottinghamshire (DLN) Cluster maintains a robust Infection Prevention and Control (IPC) model to support safe, effective care delivery throughout winter periods of increased demand.
- Acute providers have established IPC arrangements with specialist advice available seven days a week, supported by on-call microbiology services and escalation pathways.
- Access to IPC advice is enabled across community providers and the ICB. This is supported through five-day IPC services and UKHSA provision.
- IPC teams are integrated within operational flow and capacity management processes, ensuring infection risks are considered within daily operational decision-making, including weekends and periods of system escalation.
- Governance arrangements are supported through provider IPC committees, Health Protection structures, system quality forums and the Healthcare IPC System Assurance Group (HSIPCAG), providing oversight of emerging risks, outbreaks and winter preparedness activities.
- Real-time surveillance systems, including laboratory reporting, outbreak monitoring and system dashboards, support early identification of respiratory infections and healthcare-associated infections, enabling timely intervention and risk mitigation.

Cohorting, Isolation and Capacity Management

- Cohorting, isolation and surge plans form a core component of winter preparedness across providers and have been reviewed to incorporate learning from previous winters.
- Capacity is managed dynamically through designated cohort areas, isolation facilities and flexible zoning arrangements, supported by ongoing IPC risk assessments and multidisciplinary review processes.
- Escalation triggers and outbreak response arrangements are clearly defined, with actions including cohorting, isolation, enhanced cleaning, outbreak control meetings and operational restrictions where required. IPC teams work closely with operational leads to minimise bed closures, maximise safe bed utilisation and maintain patient flow.
- Cleaning protocols, enhanced decontamination standards and escalation processes are embedded within operational plans to support rapid turnaround of clinical areas.
- System-wide discharge pathways include agreed arrangements for the safe transfer of patients with confirmed or suspected respiratory infections, ensuring continuity of care and reducing delays across the pathway.

2026/7 DLN Winter Plan

IPC Readiness

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Respiratory Testing and Point of Care Diagnostics

- The Cluster continues to utilise a mixed respiratory testing model, combining laboratory-based PCR testing with point of care and rapid diagnostic testing where appropriate.
- Point of care testing has demonstrated benefits in supporting early diagnosis, appropriate patient placement, timely isolation decisions and improved patient flow.
- Testing arrangements are embedded across admission pathways, emergency departments and inpatient settings, with results supporting IPC decision-making regarding cohorting, isolation and outbreak management.
- Providers are working to maintain surge testing capacity during periods of increased demand through workforce training, enhanced IPC oversight and utilisation of emerging diagnostic technologies.
- UKHSA and IPC teams are supporting care homes with lateral flow device (LFD) rollout to enable early detection and improved respiratory outbreak management over winter.
- The continued use of rapid testing is expected to support admission avoidance where clinically appropriate, facilitate safe management of respiratory illness in care home residents and reduce unnecessary hospital admissions during periods of winter pressure.

Vaccination Programmes

- The Cluster will continue to deliver a coordinated vaccination programme for both staff and patients during winter 2026/27.
- Delivery models include onsite clinics, roving vaccinators, outreach services and walk-in opportunities designed to maximise uptake across healthcare settings.
- Targeted approaches are in place to support vulnerable groups, care home residents, inpatients and underserved populations. Learning from previous vaccination campaigns has informed improvements in communication, engagement and accessibility, with a continued focus on reducing health inequalities and increasing vaccination coverage.
- Risks associated with vaccine supply, uptake variation, workforce capacity and vaccine hesitancy are monitored through established governance arrangements, with mitigation plans supporting flexible delivery models and ongoing performance oversight.

2026/7 DLN Winter Plan

IPC Readiness

Care Home and Community IPC Preparedness

- Recognising the seasonal impact of respiratory infections within care homes, the Cluster maintains a comprehensive community IPC offer to support prevention, preparedness and outbreak management.
- Winter preparedness measures include IPC winter packs, updated outbreak management guidance, quality assurance audits, regular communication bulletins and targeted support for care homes.
- Community IPC teams work closely with providers, primary care, local authorities and the UKHSA to support outbreak management, early intervention and safe discharge pathways. UKHSA will provide LFD this year to support earlier detection and management of flu and COVID-19 outbreaks. Nottingham Citycare are trialling 4 plex LFD testing in homes with pathway beds to improve outbreak prevention.
- Intelligence from local epidemiology, surveillance systems and national reporting is used to identify emerging threats and support proactive system planning.
- Arrangements remain in place to provide specialist support for influenza and COVID-19 management, including access to antiviral pathways and outbreak response mechanisms where required.

System Escalation and Learning from Previous Winters

- IPC remains fully integrated within system escalation arrangements, with risks and pressures escalated through HSIPCAG, provider governance structures and winter operational command frameworks.
- Monthly outbreak reporting and surveillance information support system situational awareness and coordinated responses during periods of increased demand.
- Learning from previous winters has highlighted the importance of minimising patient moves, reducing use of temporary escalation spaces where possible, maintaining effective communication across organisational boundaries and ensuring timely identification of infectious patients.
- Continued emphasis will be placed on early testing, appropriate patient placement, adherence to national IPC guidance and proactive outbreak prevention measures to reduce healthcare-associated infections and maintain patient flow.
- The Cluster will continue to use surveillance data, local epidemiology and operational intelligence to inform winter planning assumptions, support capacity modelling and strengthen resilience throughout the 2026/27 winter period.

2026/7 DLN Winter Plan

IPC Readiness - providers

Nottingham University Hospitals Trust (NUHT)

- Well established 7-day IPC cover. Weekends both campus covered 8-4 1 IPC specialist at each campus with back up from a band 8. Out of hours on call medical microbiologist is available
- Point of care testing in place in all main admission areas to QMC (ED, acute medical admission area) and City (specialist receiving unit, respiratory admission unit) when epidemiology changes and there is evidence of increased community cases of Flu A, B and RSV. COVID testing available all year round. Any sample of loose stool from ED, geriatric admission unit is tested for norovirus
- Operational meetings daily for escalation of cleaning delays/issues
- Cohorting plans detailed in NUH isolation policy, respiratory virus policy and norovirus policy

Sherwood Forest Hospitals Foundation Trust (SFHFT)

- Well established 7-day IPC cover 8-4. Out of hours on call microbiologist is available
- Point of care testing in place in ED when epidemiology changes and there is evidence of increased community cases of Flu A, B and RSV
- IPC attendance at flow meetings three times a day to assist with any IPC concerns. Medirest have contracted times to achieve cleans
- Risk assessment led cohorting in place. Daily sit reps in use for respiratory viruses/ norovirus with end dates for isolation to support cubicle use

Nottinghamshire Healthcare Foundation Trust (NHCFT)

- Out of hours and weekend cover via on call manager to UKHSA
- LFD testing in high-risk areas only. PCR testing via NUH lab
- Deep cleans are pre-booked. Issues escalated to cleaning manager
- Risk assessed cohorting in place as part of outbreak management policies

Doncaster and Bassetlaw Teaching Hospitals (DBTH)

- Have 5-day IPC service provision with Consultants in Infection providing on-call support including weekend**s** to cover Bassetlaw Hospital
- Point of care testing in place
- Risk assessed cohorting plans in place.

Lincolnshire Community and Hospitals NHS Group (LCHG)

- IPC cover Saturdays and bank holidays 8-1. Out of hours cover is provided by the on call medical microbiologist
- All PII and outbreaks are subject to a multi-disciplinary team approach with a risk-based approach to cohorting
- The IPC team undertake a risk assessment to determine the cleaning levels required, alongside operational capacity to ensure cleaning measures are proportionate and effective

2026/7 DLN Winter Plan

IPC Readiness

Lincolnshire Partnership Foundation Trust (LPFT)

- 5 day IPC cover with additional out of hours and weekend cover from Microbiology Consultants and UKHSA.
- IPC policies and information packs to support risk assessment and out of hours decision making are in place.
- Point of care testing via 4 assay LFD in use for early detection and improved management of respiratory viruses to reduce outbreaks. PCR testing is available.

University Hospitals Derby and Burton (UHDB)

- 7-day IPC cover from December to February with capacity extended beyond this period where operational pressures or epidemiological risks require. Outside of this the on-call microbiologist is available, and detailed plans are developed and published in the weekend/bank holiday plan to those areas with closed beds to facilitate the safe opening of beds
- Surveillance of seasonal respiratory viruses including Influenza, RSV and other circulating pathogens, to identify increasing trends and inform escalation requirements.
- Robust testing and patient placement pathways are established across the urgent and emergency care pathway and inpatient wards to support the timely identification and management of respiratory and infectious patients. Point of care testing is embedded within urgent care pathways. PCR laboratory testing remains available for inpatient pathways and urgent care settings outside of the winter surveillance period
- Patient placement algorithms in place that provide a clear escalation framework, progressing from single room isolation to bay cohorting, with escalation to cohort wards when needed. A de-escalation protocol is in place to guide the safe discontinuation of isolation precautions.
- Environmental disinfection available 24/7 on all sites. Cleaning requirements, escalation and priorities are discussed at site management meetings

Chesterfield Royal Hospital (CRH)

- Plans for 7-day IPC cover over winter, agreement needed on format. Out of hours cover through tactical on call and strategic on call and consultant microbiologists
- Point of care testing during winter
- Daily review and prioritisation of cleaning to prevent delays
- Risk based approach to cohorting, daily reviews in place

Derbyshire Community Health Services (DCHS)

- 5-day IPC cover is in place with option to flex to 7 days as an exception. Out of hours support and escalation is via on-call managers and IPC lead
- PCR testing is available with a 24-hour turnaround.
- IPC outbreak management processes include cohorting arrangements. Deep clean teams are available for enhanced cleaning as required.

2026/27 DLN Winter Plan

DLN Cluster Winter 2026/27 Stress Testing Programme

Aim

The DLN Cluster has established a comprehensive winter stress-testing programme to provide assurance that system and provider Winter Plans are sufficiently robust to maintain patient safety, operational resilience and service continuity during periods of sustained winter pressure. The exercises are designed to identify risks, dependencies and mitigation actions before plans are finalised and approved by Boards.

Objectives

- Test system resilience and leadership arrangements under prolonged high-pressure conditions, including command and control, escalation processes, decision-making and mutual aid arrangements.
- Assess the ability to maintain safe and effective patient care during periods of exceptional demand and operational challenge.
- Identify gaps, risks and dependencies within winter plans and strengthen preparedness ahead of Winter 2026/27.
- Challenge assumptions within current plans and ensure mitigations are in place for a range of potential winter scenarios.

Stress Testing Approach

- Three separate stress-testing exercises have been scheduled across the DLN Cluster to test plans at system and provider level.
- Exercises will use realistic winter scenarios based on prolonged operational pressures where planned resilience measures have already been implemented and demand continues to exceed capacity.
- Scenarios will test responses to:
    - Workforce shortages
    - Infectious disease outbreaks
    - Digital disruption/cyber incidents
    - Deterioration in flow and discharge performance
    - Mental health pressures
    - Major incidents and escalation requirements

Expected Outcomes

- Increased assurance that winter plans are deliverable and resilient.
- Identification of further actions required before Board sign-off.
- Strengthened system-wide working across ICBs, providers, ambulance services, primary care, mental health, community and local authority partners.
- Learning from the exercises will be incorporated into final Winter Plans and Board assurance processes.

Overall Position: The DLN Cluster has developed a structured stress-testing programme, comprising three planned exercises, to rigorously challenge winter plans, test leadership and operational resilience arrangements, and ensure systems are as prepared as possible for Winter 2026/27

2026/27 DLN Winter Plan

Scenario Planning

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

A programme of localised winter preparedness exercises has been scheduled to test the robustness of organisational, and system plans under a range of escalating operational pressures. The exercises are designed to challenge assumptions within current Winter 2026/27 plans and assess the effectiveness of governance, escalation, workforce resilience and patient safety arrangements during periods of sustained demand. Building on the Exercise Aegis 2026 framework, testing will be undertaken across baseline, surge and super-surge scenarios to identify risks, dependencies and opportunities for improvement ahead of final plan sign-off.

Scenarios have been selected to reflect the most significant risks anticipated during winter and will include:

Mental Health and Primary Care Pressures – testing the ability of partners to manage increasing demand across community, primary care and mental health services while maintaining access, flow and safe care pathways. This will assess whole-system responses to rising demand and the impact on urgent and emergency care services.

Staff Exhaustion and Workforce Resilience – exploring the effect of prolonged operational pressures on workforce capacity, leadership resilience and service sustainability, including the effectiveness of workforce mitigations and escalation arrangements when resilience measures have been exhausted.

Discharge and Patient Flow Failure – testing system responses to deterioration in patient flow and discharge performance, including the management of capacity constraints, escalation processes and collective decision-making to maintain safe and effective care across the system.

Workforce Crisis – assessing the system's ability to respond to significant staffing shortages, including the activation of mutual aid arrangements, prioritisation of limited resources and maintenance of essential services during periods of exceptional demand.

IPC and Infection Outbreak Pressures – examining the resilience of services during infectious disease outbreaks and increased infection prevention and control requirements, including the impact on capacity, workforce availability, patient flow and operational delivery.

Learning identified through each exercise will be formally captured and incorporated into final winter plans to strengthen preparedness, ensure risks and dependencies are appropriately mitigated, and provide assurance that organisations can work collectively to maintain patient safety and system resilience throughout Winter 2026/27

2026/27 DLN Winter plan

Key capacity/demand mitigations for Winter 26/27

The overall position demonstrates an improvement compared with previous months, and we continue to work closely with providers and system partners to further reduce the remaining bed gap over the coming weeks as we progress towards final Board sign-off.

A range of mitigations and interventions are currently being refined and developed across the system to support winter resilience and capacity. These will be reflected in our final submission once this work has been completed and agreed with partners.

The information provided at this stage presents the current bed gap position by provider and should be viewed as an interim position, with further refinement and mitigation planning ongoing.

2026/27 DLN Winter plan

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Board Level Summary: Highest Impact Mitigations Against the Bed Gap

Across the DLN footprint, the mitigations most likely to reduce the residual bed gap are:

Out of Hospital

- Virtual Wards / Hospital at Home
- UCR expansion
- OPAT / IV Therapy
- D2A and Home First pathways
- Care Transfer Hub and Transfer of Care Hub models
- Mental health admission avoidance and crisis alternatives
- Community and intermediate care bed capacity
- Winter 2026/27 Proactive Acute Respiratory Infection (ARI) Scheme

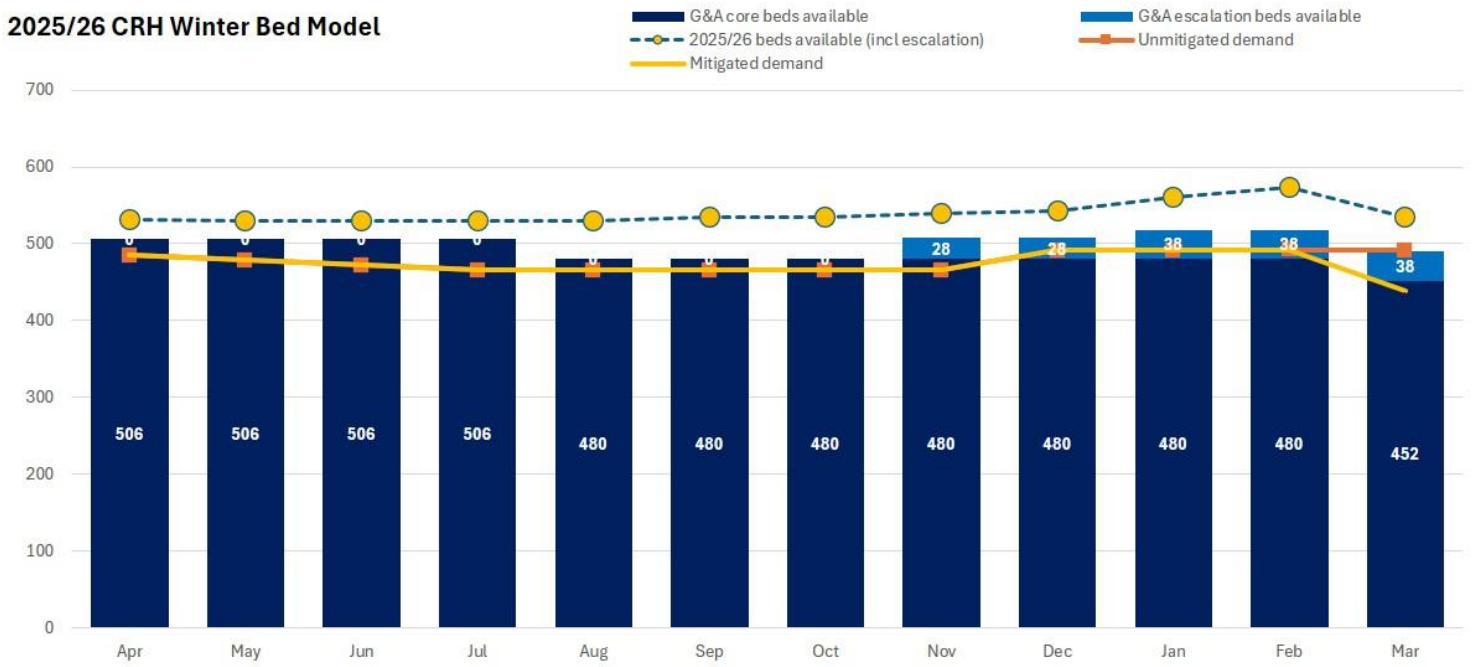
In Hospital

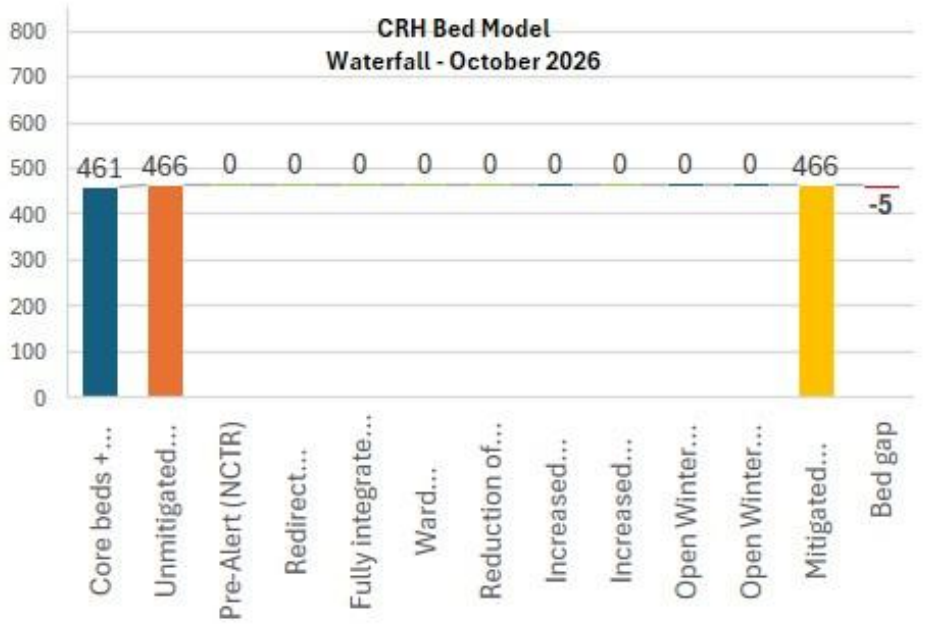
- Winter wards and incremental acute bed capacity
- Escalation/overflow capacity
- SDEC and ambulatory care expansion
- Front-door streaming and admission avoidance
- LOS reduction programmes
- Daily discharge grip and discharge coordination
- Improved patient flow through P1/P2/P3 pathways

2026/27 DLN Winter plan

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

CRH - Key capacity/demand mitigations for Winter 26/27



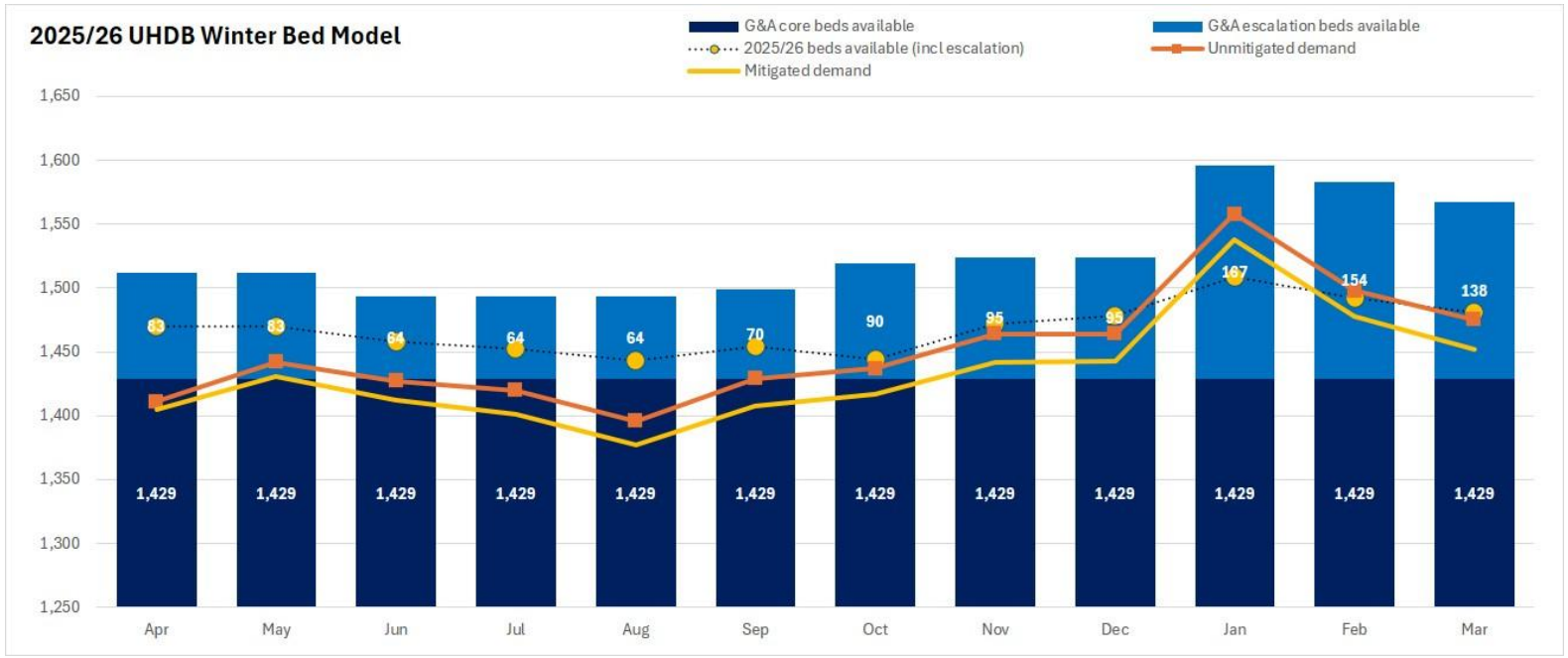


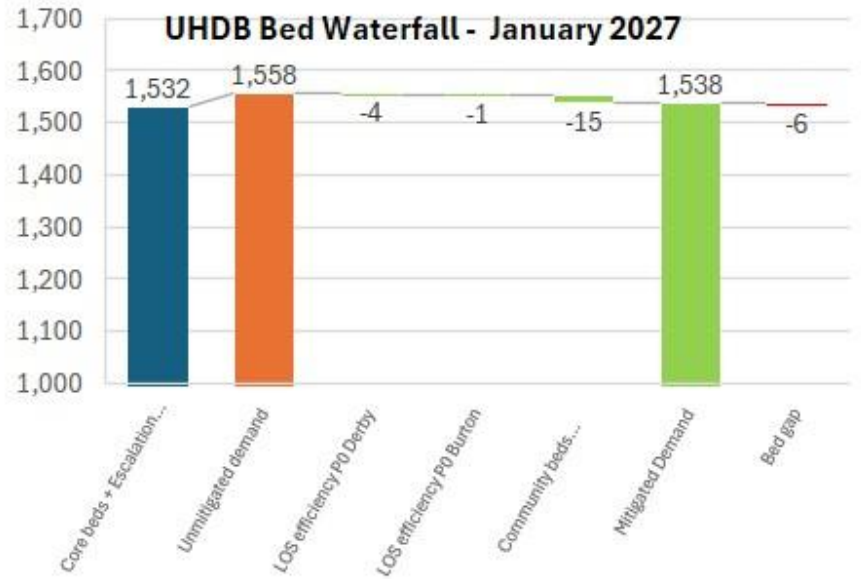
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27 Operational Plan	2026/27 planned beds available (incl escalation)	506	506	506	506	506	480	480	480	509	509	509	509
	2026/27 planned beds occupied (incl escalation)	485	479	472	466	466	466	466	466	492	492	492	492
	2026/27 % beds occupied (incl escalation)	95.9%	94.6%	93.3%	92.1%	92.1%	97.1%	97.1%	97.1%	96.6%	96.6%	96.6%	96.6%
Unmitigated demand		485	479	472	466	466	466	466	466	492	492	492	492
Demand mitigations		0	0	0	0	0	0	0	0	0	0	0	53
Mitigated demand		485	479	472	466	466	466	466	466	492	492	492	439
G&A core beds available		506	506	506	506	480	480	480	480	480	480	480	452
G&A escalation beds available		0	0	0	0	0	0	0	28	28	38	38	38
Bed Shortfall (based on adjusted occupancy)		0	7	13	20	-5	-5	-5	22	-4	5	5	32

2026/27 DLN Winter plan

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

UHDB - Key capacity/demand mitigations for Winter 26/27





		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27 Operational Plan	2026/27 planned beds available (incl escalation)	1,495	1,495	1,497	1,499	1,495	1,505	1,512	1,520	1,507	1,581	1,581	1,581
	2026/27 planned beds occupied (incl escalation)	1,411	1,442	1,427	1,420	1,396	1,429	1,437	1,464	1,464	1,558	1,498	1,475
	2026/27 % beds occupied (incl escalation)	94.4%	96.5%	95.3%	94.7%	93.4%	95.0%	95.0%	96.3%	97.1%	98.5%	94.8%	93.3%
Unmitigated demand		1,411	1,442	1,427	1,420	1,396	1,429	1,437	1,464	1,464	1,558	1,498	1,475
Demand mitigations		7	11	15	19	19	21	20	22	21	20	20	23
Mitigated demand		1,404	1,431	1,412	1,401	1,377	1,408	1,417	1,442	1,443	1,538	1,478	1,452
G&A core beds available		1,429	1,429	1,429	1,429	1,429	1,429	1,429	1,429	1,429	1,429	1,429	1,429
G&A escalation beds available		83	83	64	64	64	70	90	95	95	167	154	138
Bed Shortfall (based on adjusted occupancy)		**47**	**20**	**21**	**33**	**56**	**31**	**42**	**21**	**20**	**-6**	**42**	**52**

Derby & Derbyshire Mitigations / Interventions to Support Flow this Winter

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Admission Avoidance / Reducing Demand

- NHS111 and Clinical Assessment Service (CAS) capacity increases.
- Central Navigation Hub (CNH) deflection and call-before-convey pathways.
- Virtual Wards and Ambulatory Care expansion.
- Mental Health Option 2, crisis alternatives and admission avoidance pathways.
- SDEC

Additional Capacity

- Additional acute winter capacity at UHDB. 27 winter Medicine & Emergency Care beds at CRH for 8 weeks.
- Additional paediatric bed capacity at CRH.
- Temporary escalation spaces within community pathways.80 P2B beds and 115 P2A/CSB beds through DCHS.
- Voluntary Sector Services

Improving Flow / Releasing Beds

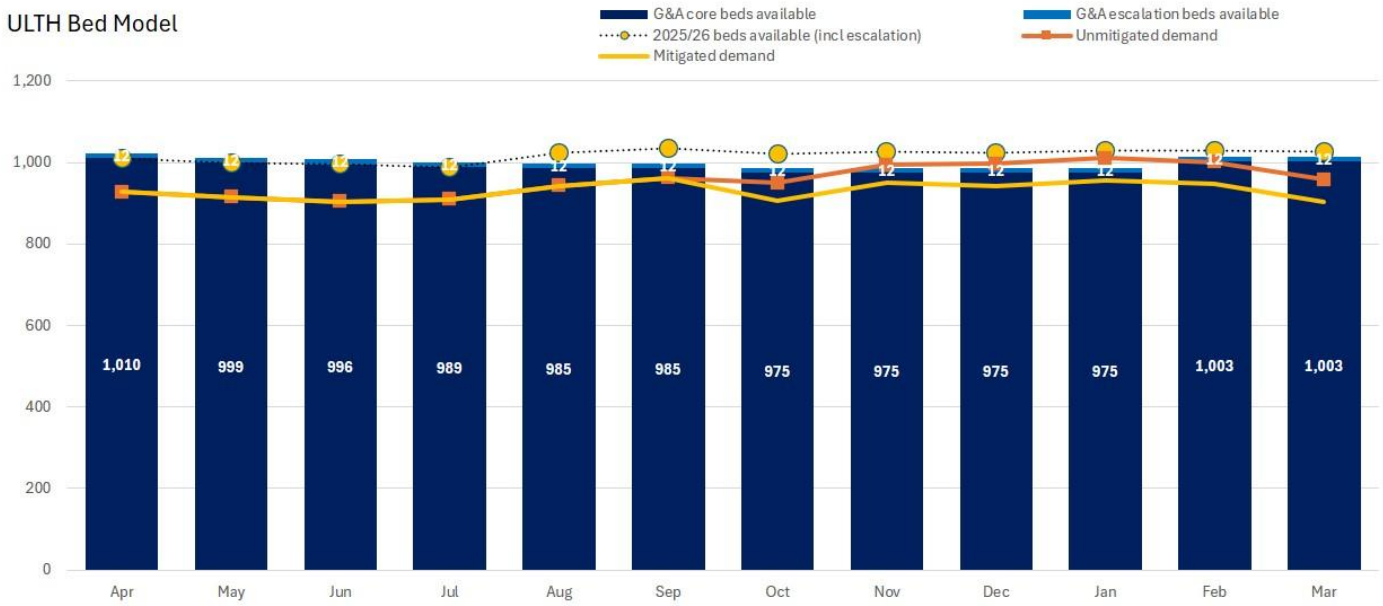
- Care Transfer Hub direct placement into community beds.
- Home First MDT triage.
- Daily discharge profiling, board rounds and LOS reviews.
- Reverse boarding protocol and improved discharge tracking.
- Enhanced discharge coordination and pathway management.

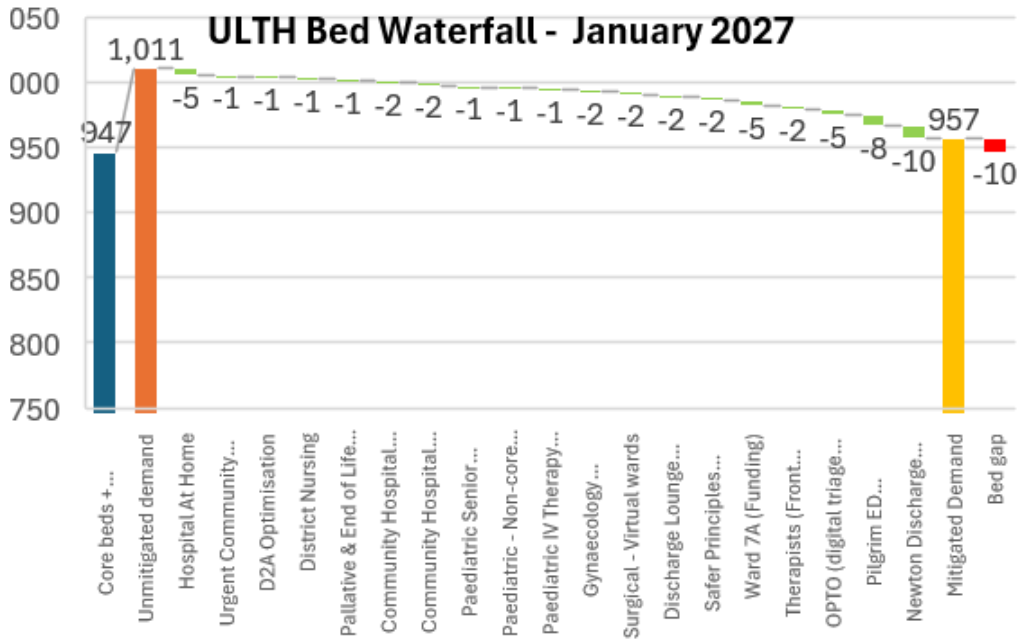
Community Alternatives

- Urgent Community Response optimisation.
- UTC optimisation.
- Community First and Technology Enabled Care.
- Increased community and intermediate care capacity.

2026/27 DLN Winter plan

ULTH - Key capacity/demand mitigations for Winter 26/27





		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27	2026/27 planned beds available (incl escalation)	1,010	999	996	989	1,025	1,035	1,038	1,037	1,043	1,054	1,048	1,043
Operational	2026/27 planned beds occupied (incl escalation)	928	915	904	910	943	962	950	994	997	1,011	1,001	958
Plan	2026/27 % beds occupied (incl escalation)	91.9%	91.6%	90.8%	92.0%	92.0%	92.9%	91.5%	95.9%	95.6%	95.9%	95.5%	91.9%
Unmitigated demand		928	915	904	910	943	962	950	994	997	1,011	1,001	958
Demand mitigations		0	0	0	0	0	0	44	44	54	54	54	54
Mitigated demand		928	915	904	910	943	962	906	950	943	957	947	904
G&A core beds available		1,010	999	996	989	985	985	975	975	975	975	1,003	1,003
G&A escalation beds available		12	12	12	12	12	12	12	12	12	12	12	12
Bed Shortfall (based on adjusted occupancy)		11	11	11	11	-26	-35	-3	-4	0	-10	22	28

Lincolnshire Mitigations / Interventions to Support Flow this Winter

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Admission Avoidance / Reducing Demand

- Hospital at Home
- OPAT and IV Therapy services.
- Virtual Wards operating at maximum utilisation.
- OPTO digital triage.
- UCR, home visiting and integrated CEMS/LIVES pathways.
- Paediatric and cardiology front-door support

Additional Capacity

- Flexible D2A capacity.
- Transitional Care surge arrangements.
- Community hospital transformation.
- Ability to mobilise additional community beds if demand exceeds planning assumptions.
- Weekend staffing and workforce redeployment arrangements.

Improving Flow / Releasing Beds

- Newton flow improvement programme.
- Single Point of Referral (SPoR).
- Earlier stroke transfers.
- Reduced FNOF length of stay.
- Trusted Assessor model.
- Optica dashboard for discharge oversight.
- Daily monitoring of delayed discharges through Transfer of Care Hub processes.

Community Alternatives

- Early discharge programmes.
- MADE events.
- Executive oversight of out-of-area beds.
- Least restrictive care options to reduce pressure on acute pathways.

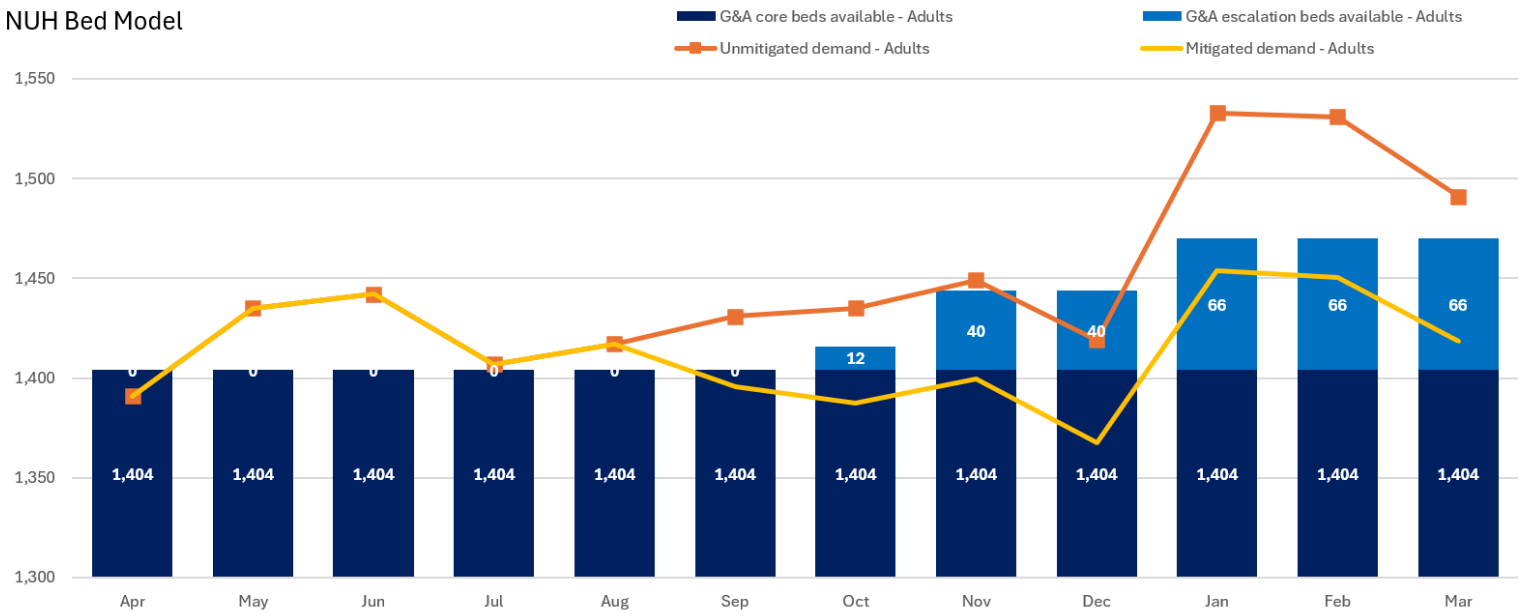
2026/27 DLN Winter plan

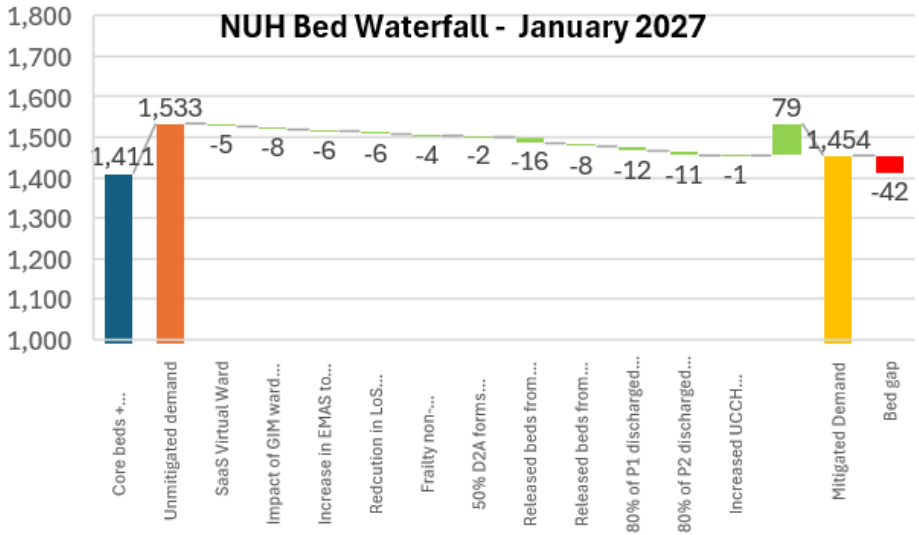
Derby and Derbyshire Integrated Care Board

Lincolnshire Integrated Care Board

Nottingham and Nottinghamshire Integrated Care Board

NUH - Key capacity/demand mitigations for Winter 26/27



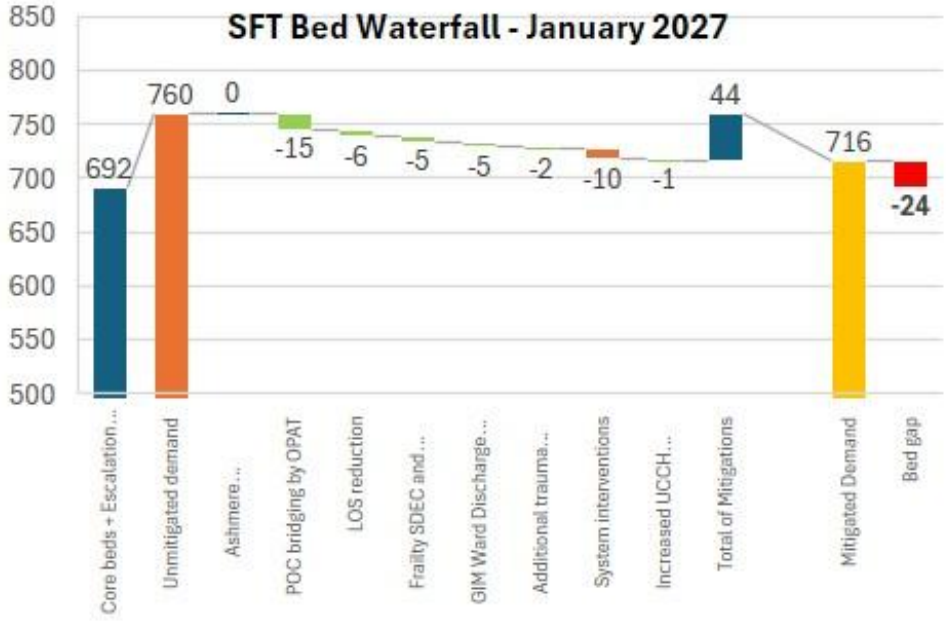


		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27 Operational Plan	2026/27 planned beds available (incl escalation)	1,736	1,748	1,736	1,724	1,720	1,723	1,737	1,751	1,751	1,772	1,773	1,772
	2026/27 planned beds occupied (incl escalation)	1,603	1,630	1,648	1,613	1,594	1,620	1,649	1,658	1,631	1,680	1,667	1,671
	2026/27 % beds occupied (incl escalation)	92.3%	93.2%	94.9%	93.6%	92.7%	94.0%	95.0%	94.7%	93.2%	94.8%	94.0%	94.3%
Unmitigated demand - Adults		1,391	1,435	1,442	1,407	1,417	1,431	1,435	1,449	1,419	1,533	1,531	1,491
Demand mitigations - Adults		0	0	0	0	0	35	47	49	51	79	80	72
Mitigated demand - Adults		1,391	1,435	1,442	1,407	1,417	1,396	1,388	1,400	1,368	1,454	1,451	1,419
G&A core beds available - Adults		1,404	1,404	1,404	1,404	1,404	1,404	1,404	1,404	1,404	1,404	1,404	1,404
G&A escalation beds available - Adults		0	0	0	0	0	0	12	40	40	66	66	66
Bed Shortfall (based on adjusted occupancy)		-43	-87	-94	-59	-69	-48	-28	-13	19	-42	-39	-7

2026/27 DLN Winter plan

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

SFH - Key capacity/demand mitigations for Winter 26/27



		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2026/27 Operational Plan	2026/27 planned beds available (incl escalation)	680	680	680	680	680	680	685	685	690	700	695	685
	2026/27 planned beds occupied (incl escalation)	646	648	654	650	660	653	664	665	665	665	665	661
	2026/27 % beds occupied (incl escalation)	95.0%	95.3%	96.2%	95.6%	97.1%	96.0%	96.9%	97.1%	96.4%	95.0%	95.7%	96.5%
Unmitigated demand		697	701	691	685	710	692	720	711	725	760	753	740
Demand mitigations		23	23	23	23	23	23	53	55	55	44	44	42
Mitigated demand		674	678	668	662	687	669	667	656	670	716	709	698
G&A core beds available		622	622	622	622	622	622	622	622	622	622	622	622
G&A escalation beds available		0	0	0	0	0	0	29	29	41	70	70	58
Bed Shortfall (based on adjusted occupancy)		-52	-56	-46	-40	-65	-47	-16	-5	-7	-24	-17	-18

Nottingham & Nottinghamshire Mitigations / Interventions to Support Flow this Winter

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Admission Avoidance / Reducing Demand

- SDEC expansion.
- UTC streaming.
- Pharmacy First.
- Call-before-you-convey pathways.
- Direct advice lines.
- Daily Crisis MDTs and alternatives to mental health admission.
- UCR, D2A and community pathway optimisation.

Additional Capacity

- Two NUH winter wards.
- Additional QMC capacity.
- Medicine and Surgery Virtual Ward expansion.
- Extended Clinical Assessment Unit (CAU) hours at SFH.
- Weekend trauma lists
- Escalation and overspill spaces.
- Potential decant ward capacity.
- Flexible community capacity and safe over-occupancy of Virtual Wards.
- Review of mental health flex-bed and surge options..

Improving Flow / Releasing Beds

- GIRFT long length of stay work.P1/P2/P3 flow KPIs.
- Zero tolerance approach to avoidable abandoned discharges.
- Transfer of Care Hub functionality.
- Dedicated leadership oversight of discharge pathways.
- Focus on reducing post-CRFD delays.
- Daily senior clinical reviews and escalation processes.

Community Alternatives

- UCR maximisation.
- Expansion and optimisation of Virtual Wards.
- Community bed utilisation.
- Strengthened care-home support.
- Reablement and discharge services.

2026/27 DLN Winter Plan

System Elective position

All Nottingham and Nottinghamshire provider trusts remain committed to ensuring that elective recovery programmes are protected throughout Winter 2026/27, and that planned care activity is maintained wherever possible. Winter planning has been developed with the clear expectation that elective services should continue alongside the management of seasonal demand pressures, supporting delivery of national recovery ambitions and local operational priorities.

Key elements of the system's approach include:

- All trusts are committed to ensuring elective recovery programmes are not compromised during Winter 2026/27.
- The elective winter plan will mirror the approach taken during Winter 2024/25, with elective activity continuing as normal rather than converting surgical wards to support emergency pressures.
- For SFH the intention remains to provide sufficient mitigation against anticipated winter demand pressures, enabling elective operating activity to continue throughout the year.
- NUH and SFH have jointly committed to delivering a range of challenging operational performance standards by March 2027, in line with the system's annual planning requirements.
- While both organisations are broadly aligned to national expectations across key performance measures, delivery during the winter period remains challenging. Performance may be affected should demand exceed planned capacity assumptions or if available winter capacity proves insufficient to manage periods of increased viral and seasonal demand.

Overall, the Nottingham and Nottinghamshire system approach seeks to balance winter resilience with the continued delivery of elective recovery ambitions, minimising disruption to planned care whilst maintaining safe and effective responses to emergency demand.

2026/27 DLN Winter Plan

System Elective position

For Derbyshire, the key elective priorities remain delivery of the operational plan trajectories, reducing the overall waiting list size, continued reduction in long waits, and maintaining improvements in cancer performance. Particular focus is being maintained on sustaining delivery of constitutional standards, including cancer targets, while managing ongoing demand pressures and seasonal impacts.

Key areas of work include:

- Delivering planned reductions in PTL size through productivity, pathway improvement and demand management initiatives.
- Further reducing long wait cohorts and preventing new long waits from developing through targeted specialty recovery plans.
- Maintaining and improving cancer performance against national standards, with continued focus on earlier diagnosis and timely treatment pathways.
- Delivering elective recovery and constitutional standards through a combination of outpatient transformation, diagnostic optimisation, advice and guidance, PIFU and improved referral management.
- Working with providers to maximise capacity, improve utilisation and minimise the impact of winter pressures on planned care activity.
- Continuing to develop alternative and community-based models where appropriate to support patient choice and ensure acute capacity is used for those who need it most.

Overall, Derbyshire remains focused on maintaining elective recovery throughout Winter 2026/27, balancing seasonal demand pressures with delivery of operational plan trajectories. While performance remains challenging, the system will continue to maximise capacity, protect planned care activity, reduce waiting times and sustain improvements in cancer performance to support timely access to care.

2026/7 DLN Winter Plan

System Elective position

For Lincolnshire, the key elective priorities for Winter 2026/27 are to protect planned care while continuing to reduce the waiting list and long waits, maintain cancer and diagnostic performance, and deliver the operational plan. The approach must also reflect local seasonal pressures, including East Coast demand, workforce constraints and patient flow across acute, community and social care.

Key areas of work include:

- Protecting elective capacity across Lincolnshire providers, with clinically led escalation that minimises avoidable disruption to planned care during peaks.
- Reducing PTL size and long waits through specialty recovery plans, list validation, productivity improvement and stronger theatre and outpatient utilisation.
- Maintaining cancer and diagnostic pathways, with continued focus on earlier diagnosis, timely treatment and effective use of available capacity.
- Using outpatient transformation, advice and guidance, PIFU, referral management and community alternatives to reduce avoidable acute demand.
- Linking discharge, intermediate care and home-based support with elective protection so patient-flow constraints do not crowd out planned activity.
- Operating through joint system governance, clear escalation triggers and real-time monitoring, applying learning from Lincolnshire's previous winter plans.

Overall, Lincolnshire remains focused on maintaining elective recovery throughout Winter 2026/27 while responding to seasonal demand. The system will work across NHS and local authority partners to maximise capacity, protect planned activity, reduce waits and sustain timely access to cancer and diagnostic care.

Workforce Resilience & Availability

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

2026/27 DLN Winter Plan

Workforce Resilience

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

- Providers are at varying stages of workforce planning maturity; however, planning discussions are already underway across organisations to support a coordinated and proactive approach. This includes a focus on mitigating high-risk staffing gaps, reducing reliance on agency workforce, and maximising the effective use of available staffing resources. Workforce assumptions and planning are being informed by historical data, including previous years' absence rates, staffing pressures, and workforce fill-rate trends, to strengthen preparedness and resilience.

- Workforce resilience will be a key focus throughout the winter period, recognising the additional pressures associated with Christmas and New Year, seasonal illness, and adverse weather events.

- Providers will work collaboratively through fortnightly winter planning meetings and regular in-system daily operational calls to maintain oversight of workforce capacity, identify emerging risks, and implement mitigations at pace.

- Organisations will utilise demand and capacity modelling, alongside lessons learned from previous winters, to inform workforce planning and rostering arrangements, ensuring staffing resources are aligned to anticipated demand. This will be supported by a range of staff health and wellbeing initiatives designed to promote workforce resilience, reduce sickness absence, and support staff wellbeing during periods of sustained operational pressure.

- Together, these measures will enable a coordinated system-wide approach to maintaining safe and effective service delivery throughout the winter period.

2026/27 DLN Winter Plan

Workforce Resilience

- Providers will proactively manage annual leave through established leave management processes, with clear approval arrangements and workforce planning controls in place to ensure safe staffing levels are maintained throughout peak winter periods. Annual leave requests, particularly over Christmas and New Year, will be reviewed against anticipated demand, staffing availability and service resilience requirements, with mitigations implemented where necessary to minimise operational risk and maintain service continuity.

- Providers will maintain robust industrial action contingency plans throughout the winter period, ensuring preparedness for any potential workforce disruption. This includes ongoing engagement with staff-side representatives, regular review and testing of business continuity arrangements, identification of critical service priorities, and implementation of workforce mitigations to maintain safe service delivery. System-wide oversight through winter planning meetings and operational calls will support early identification of risks, coordinated responses, and timely escalation where required to minimise impact on patients and services.

System Oversight and Daily Management of the Winter Plan

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

- System Coordination Centre
- System Oversight & Monitoring
- Winter Directors
- Surge & Escalations Plan

2026/27 DLN Winter Plan

System Co-ordination Centre

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

The System Co-ordination Centres (SCC) provide an operational platform across Derby & Derbyshire, Lincolnshire and Nottingham and Nottinghamshire for the health and care system, including local authority, primary care, voluntary, community and social enterprise partners.

The SCC is responsible for supporting interventions across the ICS on key systemic issues that influence patient flow. This includes a concurrent focus on UEC and the system's wider capacity including, but not limited to, NHS111, Primary Care, Intermediate Care, Social Care, Urgent Community Response and Mental Health services.

The SCC operates 0800-1800, 7 days a week 364 days of the year (exception of Christmas day), with on-call providing out of hours support and clinical support available 24/7. The SCC supports proactive co-ordination of a system response to operational pressures and risks. Additionally, the SCC lead on system planning including but not limited to bank holidays, the Christmas and New Period and supporting the EPRR team with industrial action planning.

Key outcomes are:

- **Improved situational awareness:** senior operational and clinical leaders, will have an aligned picture of the performance of the region, systems, and providers – and will drive action to improve performance as needed.
- **Holistic and real-time management of capacity and performance:** system-wide view of capacity across the acute providers, community, and mental health providers, leading to a collaborative effort, led at a system-level, to manage capacity, flow, and performance.
- **Coordinated action and mutual aid:** by placing shared data analytics as a central function of the SCCs, trends, and emergent issues across the region and ICBs will be visible and actionable. In turn, support will be diverted or offered from one place in the region or system to another.
- **Improved clinical outcomes:** resulting from optimised admissions, assessments, treatments, and discharge pathways – facilitated by the placement of patients in the right setting at the earliest opportunity.

2026/27 DLN Winter Plan

System Oversight & Monitoring

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

- A Winter Monitoring Group will be established from September 2026.

- Demand, and the delivery of plans to create additional capacity, will be tracked and monitored weekly throughout the winter period to ensure system partners have a shared understanding; and enabling the system to respond dynamically to emerging risk.

Assurance throughout Winter will be sought in a variety of ways including:

- Provider Daily system calls
- Daily Regional RCC call
- UEC Delivery Board
- Fortnightly Winter Monitoring Group

The delivery of the Cluster Plan will be overseen by the Urgent and Emergency Care Delivery Board.

Winter Directors

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

AEO/ Executive Director
Maria Principe

DLN System Winter Director
Gemma Whysall

Derby & Derbyshire	Lincolnshire	Nottingham & Nottinghamshire
UHDB: Andrew Sidebotham	**Group Acute:** Lee-Anne Taylor	**NUH:** Andrew Hall
CRH: Michelle Veitch	**Group Community:** Nikki Pownall	**SFH:** Simon Illingworth
DCHS: Dean Wallace	**LCC:** Andrea Kingdom	**NHT:** Becky Sutton
DHcFT: Lee Ryan-Doyle	**LPFT:** Lee Wing	**CityCare:** Helen Woodiwiss
DHU: Kirsty Osborn	**EMAS:** Sue Cousland	**EMAS:** Greg Cox
EMAS: Craig Whyles		**NEMS:** Lucy Dadge
Derbyshire County Council: James Winson		**Nottingham County Council:** Emma Shand
Derby City Council: Andy Muirhead		**Nottingham City Council:** Tricia O'Connell

2026/27 DLN Winter Plan

Surge & Escalation Plan

All DLN systems are working towards a consistent, cluster-wide Surge and Escalation Framework. In the interim, each ICB has shared and socialised its existing surge and escalation arrangements across partner organisations to ensure clarity of roles, responsibilities, escalation routes, and the agility required to respond effectively to periods of increased system pressure. This approach reflects our commitment to delivering an integrated health and care response, rather than a health-only response, ensuring collective ownership across all partners.

The Incident Response Plan and Operational Pressures Handbook continue to support on-call teams with timely, informed decision-making during periods of heightened operational pressure, particularly outside normal working hours. Both documents will be reviewed and refreshed ahead of winter to ensure they remain current and aligned with system requirements.

The System Coordination Centre (SCC) operates seven days a week between 08:00 and 18:00 and provides the central route for system escalation across the Derbyshire, Lincolnshire and Nottinghamshire (DLN) footprint. Through centralised daily reporting and real-time data feeds, the SCC maintains oversight of system pressures, enabling the early identification of emerging risks, bottlenecks and capacity constraints. This supports a coordinated multi-agency response, allowing partners to work collectively to resolve issues and mitigate risks before they escalate further. While system surges were historically associated with winter pressures, demand fluctuations are increasingly experienced throughout the year, driven by factors such as adverse weather, infectious disease outbreaks, public holidays and major events.

All health and social care organisations across DLN maintain local escalation plans, incorporating clear escalation and de-escalation processes alongside robust on-call arrangements. These local arrangements underpin and contribute to the overarching DLN Surge and Escalation Plan, which forms a key component of the wider DLN Winter Plan 2026/27.

The DLN Surge and Escalation Plan sets out how the health and care system will:

- Work proactively and collaboratively to make shared decisions in response to current and anticipated demand pressures.
- Apply a consistent assessment process, using agreed escalation triggers to determine system escalation levels and support coordinated decision-making across primary care, community services, acute providers, mental health services and social care.
- Respond effectively to periods of increased demand arising from seasonal illness, infectious disease outbreaks, public events, adverse weather conditions and other operational pressures through a planned, coordinated and system-wide approach.
- Maximise available capacity and resources across the health and care system to maintain patient safety, service continuity and timely access to care, particularly during the winter period.

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Summary of Key Actions for Winter 2026/27 by System Providers/Partners

2026/27 DLN Winter Plan

Derbyshire system summary: key winter themes

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

1 Reduce avoidable demand

Access the right care first time and strengthen admission avoidance.

NHS111/CAS capacity, Pharmacy First, UTC use and self-care messaging
Mental health option 2, crisis alternatives, safe havens and liaison pathways
Community First, Technology Enabled Care and prevention in social care
CNH/call-before-convey and direct pathways to reduce avoidable ED attendance

2 Increase capacity and alternatives

Maximise community, virtual, urgent and bedded capacity.

Additional acute winter capacity at CRH and planned incremental UHDB capacity
Virtual Ward, SDEC, Ambulatory Care, UTC and UCR optimisation
DCHS P2 bedded care, temporary escalation spaces and flexible community capacity
Diagnostics, pharmacy, therapies and frailty workstreams targeted to pressure points

3 Improve flow and discharge

Move people through pathways safely and reduce delays.

Care Transfer Hub, Home First MDT triage and direct placement into community beds
Daily discharge profiling, LOS meetings, board rounds and discharge tracking
ASC/DCHS integration and P1/P2/P3 pathway improvement
System escalation and MADE-style operational grip during pressure periods

4 Workforce, IPC and resilience

Maintain safe staffing, infection control and operational oversight.

Winter rotas, Christmas/New Year plans, bank-first approaches and senior cover
Accessible staff flu vaccination and targeted uptake improvement plans
IPC winter plans, testing, outbreak response, cohorting and isolation arrangements
OPEL triggers, business continuity, adverse weather and system escalation plans

2026/27 DLN Winter Plan

Derbyshire provider contribution matrix

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Provider / partner	Lead winter contribution	Key actions / schemes	Main system dependency or ask
UHDB	Acute capacity, front-door streaming, discharge and diagnostics	CNH deflection; SDEC/UTC streaming; Virtual Wards and Ambulatory Care; frailty workstream; planned incremental capacity Oct-Mar; diagnostics resource.	Even ambulance conveyance; strong primary care and alternatives; increased P2/P2A and community pathways.
CRH	Acute winter beds, discharge and flow	27 M&EC winter beds for 8 weeks; 2 paediatric beds from September; UTC utilisation; LOS meetings and board rounds; CVW expansion exploration.	Weekend discharge coordinator funding; DHU CVW capacity; GP/EMAS admission avoidance and discharge support.
DCHS	Community capacity, CTH and P2 flow	Care Transfer Hub direct placement; P2 TES process (4 additional spaces); reverse boarding protocol; Optica and dashboard focus.	ASC support to unblock P2 delays; additional discharge funding where available; system flow support and public messaging.
DHU	NHS111, UTC, CAS and Virtual Ward support	Increase NHS111 clinical capacity; additional CNH clinicians; UTC clinical sessions; enhanced queue management; MDT review of VW capacity.	Timely DoS updates and referrals; primary care capacity information; real-time operational and discharge intelligence.
DHCFT	Mental health alternatives, crisis and inpatient flow	111 Mental Health Option 2; crisis alternatives; daily discharge profiling; standardised ward rounds and discharge tracking; reduce out-of-area placements.	LA/ICB support for complex discharge, housing and placements; acute ED interface support; EMAS alternative pathways.
Derby City Council	ASC prevention, reablement and care market resilience	Technology Enabled Care and OT prevention; PVI sector sustainability; Community First and reablement with DCHS; 24/7 ASC services.	Support for crisis, rapid response and IST capacity; continued DCHS alignment and clear public/PVI communications.
EMAS NEPTS	Transport resilience and correct resource use	Staff absence monitoring; overtime/relief cover; third-party use when needed; winter welfare vans; correct patient/correct resource approach.	Open communication, accurate bookings and coordination to avoid avoidable transport pressure.
EMAS 999	Emergency ambulance resilience and alternative pathways	Maximise CAS, Hear & Treat, See & Treat and alternative care pathways; optimise frontline resources through workforce planning, overtime/bank use and dynamic deployment; maintain REAP, Clinical Safety Plan, adverse weather and business continuity arrangements.	Improved patient flow and ambulance handovers; seven-day discharge and flow arrangements; access to alternative community pathways; timely operational intelligence and senior clinical decision-making.
Derbyshire County Council	Discharge pathways, reablement and community care capacity	Support Home First and Discharge to Assess pathways; coordinate Care Transfer Hub, DART and brokerage services; flex workforce resources across discharge and community teams; strengthen discharge processes and pathway flow.	Continued partnership working across the Care Transfer Hub; shared visibility of capacity and demand; timely escalation of system pressures; improved information sharing and digital interoperability; support for Home First principles.

2026/27 DLN Winter Plan

Lincolnshire system summary: key winter themes

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

1 Reduce avoidable demand

Admission avoidance, right care first time and front-door alternatives.

LCHG: Hospital at Home, OPAT, IV therapy, Virtual Wards, OPTO digital triage, UCR, CEMS/LIVES and home visiting integration
LCHG: paediatric front-door specialist support, cardiology front-door capacity, bladder and bowel trusted assessor and CGA models
LA: community assessments, proportionate assessments and ASC support for admission avoidance
LPFT: maintain urgent care services and use least restrictive care options to reduce acute ED and GP pressure
EMAS: clinical hub optimisation and partner communications to support appropriate pathways and right service use

2 Increase capacity and alternatives

Community, virtual, workforce and surge capacity before bed expansion.

LCHG: optimise Virtual Ward at 100% occupancy and flex capacity to demand
LCHG: D2A flexibility, Transitional Care surge assumptions, community hospital transformation and 7-day District Nursing model
LCHG: additional community beds remain an option if demand exceeds assumptions, but transformation is preferred first
LA: move staff across teams, add weekend staffing where needed and provide strategic cover across Christmas/New Year
LPFT/EMAS: use bank/agency or private providers where necessary to maintain critical services and safe response

3 Improve flow and discharge

Reduce length of stay, discharge delays and pressure on temporary care environments.

LCHG: Newton programme to reduce non-ideal decisions, streamline pathways and reduce acute length of stay
LCHG: Single Point of Referral, community transformation, earlier stroke transfers, reduced FNOF length of stay and Trusted Assessor models
LCHG: Optica dashboard planned to provide one version of truth for supported discharge oversight
LA: daily monitoring of NCTR, participation in Transfer of Care Hub and escalation where needed
LPFT: MADE events, early discharge programmes, exec oversight of out-of-area beds and system pressure responses

4 Workforce, IPC and resilience

Staffing, wellbeing, vaccination, escalation and command arrangements.

LCHG: rosters finalised in advance, annual leave controls, bank/temporary workforce, wellbeing roadshows and senior leadership visibility
LCHG/LPFT: IPC plans, outbreak policies, staff flu campaigns, vaccination offers and cohorting/isolation/zoning arrangements
LA: staff wellbeing policies, team manager touchpoints and LCC communications routes
EMAS: DOP calls, tactical plans, adverse weather, BCPs, REAP/OPEL, winter assurance and command arrangements
System: Winter Resilience Group requested to coordinate demand, capacity, flow, escalation and mutual aid

2026/27 DLN Winter Plan

Lincolnshire provider and partner contribution matrix

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Provider / partner	Lead winter contribution	Key actions / schemes	Main system dependency or ask
Lincolnshire Community Hospitals Group	Community/acute flow, admission avoidance and virtual/community alternatives	Hospital at Home, OPAT, IV Therapy and Virtual Wards; OPTO digital triage; UCR, home visiting and CEMS/LIVES integration; D2A, TC surge assumptions, SPoR, District Nursing, Community Hospital transformation, Newton flow work, pediatric and cardiology front-door support.	System Winter Resilience Group; shared ownership of admission avoidance and discharge; ASC, primary care, EMAS and VCSE support; potential funding decision if additional community beds required.
Lincolnshire County Council ASC	Admission avoidance, NCTR oversight and social care flow	Community and proportionate assessments; daily NCTR monitoring; participation in Transfer of Care Hub; movement of staff across teams; possible weekend staffing; provider contact through contracts/commercial teams and LincA community of practice.	Financial support if additional inpatient areas open; continued system partner engagement to improve flow and reduce LoS.
LPFT / Mental Health and LD	Maintain urgent mental health services and reduce acute pressure	Maintain staffing levels; least restrictive care; MADE events and early discharge programmes; IPC outbreak support; staff flu campaign; EAP, wellbeing hub, TRiM and talking therapies; bank/agency use over Christmas/New Year if needed.	Updates on flu/COVID numbers; awareness of plans affecting MH services; support with Boston urgent care pressure where service offer is more limited.
EMAS	Ambulance resilience, patient pathways and surge response	Protect A&E/NEPTS performance; optimise clinical hub pathways; maintain optimum resource levels, commander visibility, fleet availability and staff welfare; surge/escalation, adverse weather, BCP and major incident arrangements; winter assurance command when required.	Partner sharing of strategic/tactical plans; acute collaboration on timely turnarounds; demand management support; data to pre-identify surge hotspots; UEC Delivery Board coordination.

2026/27 DLN Winter Plan

Nottingham and Nottinghamshire system summary: key winter themes

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

1 Reduce avoidable demand

Strengthen front-door alternatives and admission avoidance.

NUH: SDEC expansion, UTC streaming, Pharmacy First and GIRFT LLOS improvement
SFH: call-before-you-convey, direct advice lines and admission avoidance at the front door
Community Health: UCR, D2A, Virtual Ward and appropriate pathway use
Mental Health: daily Crisis MDTs and alternatives to admission through crisis pathways

2 Increase capacity and alternatives

Use acute, community, virtual and specialist capacity more effectively.

NUH: two winter wards, QMC additional capacity, medicine and surgery Virtual Ward expansion
SFH: CAU extended hours, trauma theatre lists, escalation/over spaces and possible decant ward
Community Health: flexible community capacity, Virtual Ward over-occupancy where safe and UCR resource maximisation
Mental Health: crisis service capacity, community team capacity and reduced use of private/OOA beds

3 Improve flow and discharge

Reduce delays and manage pathway capacity before winter peaks.

NUH: KPIs for P1/P2/P3, zero tolerance for avoidable abandoned discharges and flow improvement
SFH: improvement programme, discharge transport focus and demand/capacity modelling across the pathway
Community Health: Transfer of Care Hub functionality, P1/P2 leadership oversight and timely discharge support
Mental Health: system escalation of post-CRFD delays, bed prioritisation and long length of stay meetings

4 Workforce, IPC and resilience

Maintain safe staffing, winter communications and escalation grip.

NUH and SFH: vaccination plans, IPC guidance, respiratory testing/cohorting and OPEL/full capacity protocols
Community Health: visible leadership, wellbeing offer, occupational health and BAU Christmas/New Year cover
Mental Health: winter wellness campaign, gold/silver/bronze on-call and severe weather communications
System: demand modelling, daily operational oversight and consistent public/partner messaging

2026/27 DLN Winter Plan

Nottingham and Nottinghamshire provider contribution matrix

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Provider / partner	Lead winter contribution	Key actions / schemes	Main system dependency or ask
NUH	UEC demand mitigation, acute capacity and discharge flow	SDEC pathway expansion; UTC streaming; Pharmacy First; GIRFT LLOS work; medicine/surgery Virtual Ward expansion; two winter wards; QMC GIM model; corridor care elimination action plan.	Whole-pathway demand and capacity modelling; 5% non-elective attendance reduction; ED alternatives; MH waits reduction; P1-P3 backlog and capacity support.
Sherwood Forest Hospitals (SFH)	Acute resilience, paediatric access, trauma and escalation capacity	Call-before-you-convey; admission avoidance; extended CAU hours; weekend trauma lists; escalation/over spaces; potential decant and ward capacity; improvement programme.	Appropriate conveyance and patient transport; adequate out-of-hospital capacity; prevention focus; equitable use of system capacity across providers.
Notts Community Health	Community capacity, UCR, D2A, Virtual Ward and P1/P2 flow	Flexible use of community capacity; Virtual Ward over-occupancy where clinically safe; UCR maximisation; timely P1/P2 discharge; dedicated senior leadership for urgent community pathways.	Transfer of Care Hub functionality; primary care support for community nursing; LA and wider system support for timely discharge.
Notts Mental Health	Crisis alternatives, inpatient flow and discharge escalation	Daily Crisis MDTs for admission referrals; daily clinical escalation forum; daily senior review; focus on timely barriers to admission/discharge; review of flex beds/surge options.	Timely system response to post-CRFD delays; alternative accommodation for delayed MH discharges; redesign of older adult MH pathway.
CityCare	Community capacity, UCR, Virtual Ward and discharge support	Maximise UCR, Virtual Wards, community beds and reablement services; review UTC bookable slots and introduce e-triage; strengthen care-home support, discharge processes, IPC arrangements and workforce resilience.	Earlier discharge identification and referrals; improved utilisation of Virtual Ward capacity; resolution of transport and TTO delays; timely social care support and system-wide coordination.
EMED	Patient transport resilience and discharge support	Advanced patient communications; portal training and mobility reviews; prioritisation of high-demand activity; PTLO support across acute sites; use of bank staff and third-party capacity to maintain transport services	Advance notice of increased outpatient and discharge demand; accurate mobility assessments; reduction in aborted journeys; patients ready for collection; coordinated planning for seasonal service changes.

2026/27 DLN Winter Plan

Summary of interventions and mitigations

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

OUT OF HOSPITAL: prevent, divert and support discharge

1. Reduce avoidable demand

Right care, first time

- NHS111/CAS and clinical hub optimisation
- Pharmacy First, self-care and public messaging
- Call-before-convey and direct advice lines
- Mental health option 2, crisis alternatives and safe havens

2. Maximise community alternatives

Treat more people at, or closer to, home

- Virtual Wards, Hospital at Home, OPAT and IV therapy
- UCR, community nursing and home visiting models
- D2A, P2A/P2B, reablement and care market resilience
- Technology Enabled Care and prevention in social care

IN HOSPITAL: additional capacity, improve flow and maintain safety

3. Expand acute response capacity

Absorb unavoidable winter peaks

- Winter wards, incremental beds and paediatric capacity
- SDEC, ambulatory care and UTC streaming
- Temporary escalation, over-spaces and decant options
- Diagnostics, therapies, pharmacy and frailty focus

4. Improve flow and discharge

Release capacity safely and earlier

- Daily discharge profiling, LOS meetings and board rounds
- Care Transfer Hub and Transfer of Care Hub functionality
- P1/P2/P3 pathway grip, Home First and direct placement
- Discharge tracking, transport focus and escalation of delays

Enabling mitigations

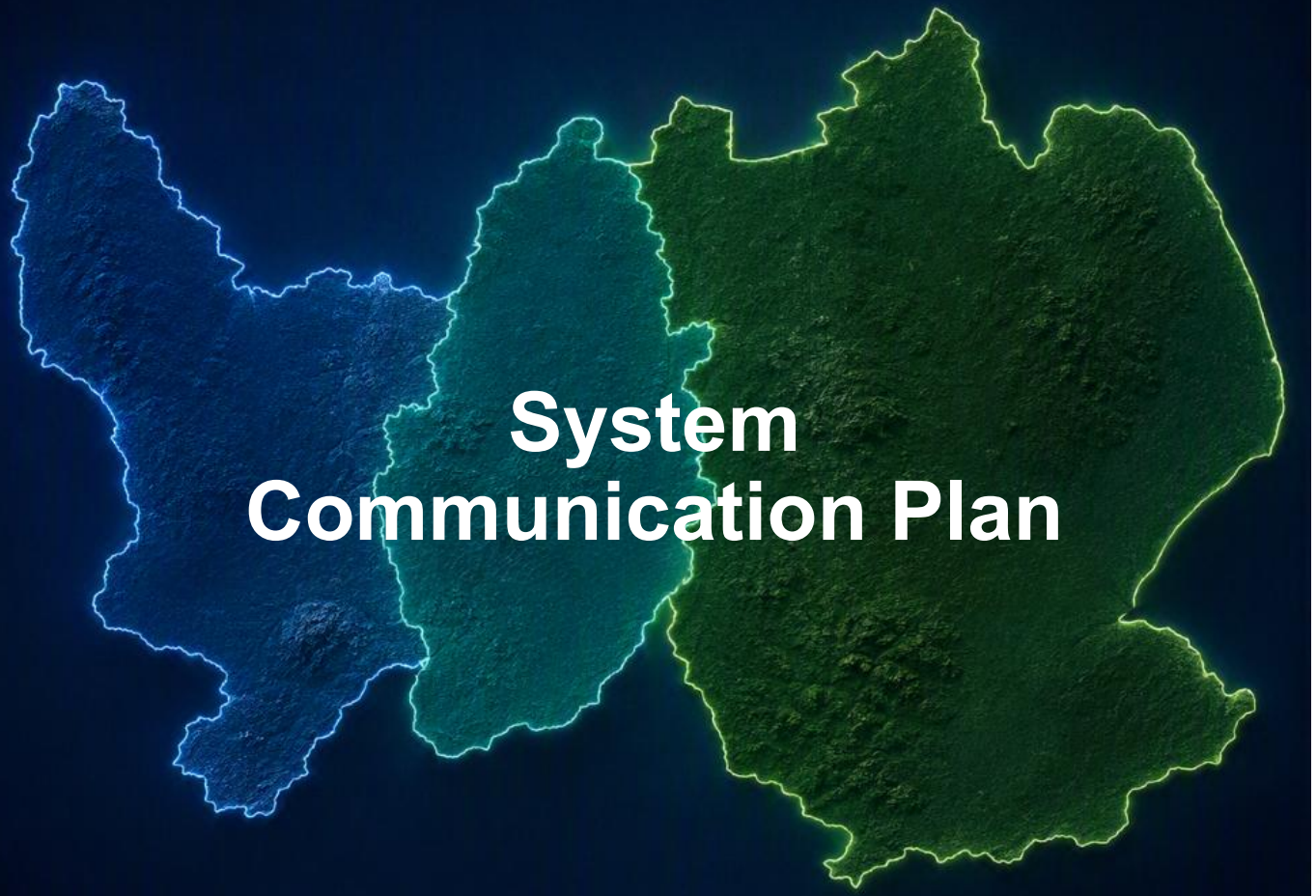
Workforce and senior cover
Winter rotas, bank/agency use, Christmas/New Year plans and visible leadership.

IPC and vaccination
Flu campaigns, testing, cohorting, isolation and outbreak response arrangements.

Escalation and command
OPEL/REAP, BCPs, adverse weather, tactical plans and daily operational oversight.

System coordination
Winter Resilience Group, shared intelligence, partner messaging and mutual aid.

How this supports operational pressure: Avoid admissions → Create alternatives → Free capacity → Maintain safe services → Escalate early



System Communication Plan

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

2026/27 DLN Winter Plan

System Communication Plan

NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

This communications plan sets out the approach to delivering proactive and reactive communications across the DLN cluster ICB footprint and to support the ICS wide plan for winter resilience in 2026/27. We will use our established communications channels, and those of our local partners, to support the key areas of focus to help people get the help they need in the right place at the right time.

Communications protocol

- Organisations will update the **shared activity planner** with details of planned communications activity. This will provide a system-wide view and support collaboration.
- NHS organisations will inform the ICB and NHSE about broadcast media activity.
- Organisations will not publicly brief against other parts of the health and care system.
- Organisations will use messaging that seeks to positively influence behaviours and enhance patient care rather than the reputation of organisations.
- Organisations will avoid benchmarking as it can lead to league tables and can be disruptive to other parts of the system e.g. “our ambulance turnaround times are the best in the region”.
- Organisations will maximise the reach of networks and seek to influence these via our own staff where possible.
- Organisations will provide reassurance that services are here for people, are responsive and safe.

Key messages - ICB

- Your NHS is here for you this winter.
- Contact NHS111 online or phone 111 to be directed to the right service for your needs.
- Use the NHS App to book appointments with your GP team, order repeat prescriptions or find health information.
- Find out more about the range of services available to you this winter by visiting the ICB website for your area.
- Stay well this winter by taking up your offer of vaccination for winter illnesses if you are eligible.
- Pharmacy First can help with a range of common conditions without the need to see a GP
- Staff communications around vaccination take up etc

Neighbourhood Support to Winter

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Neighbourhood support to winter

A joined-up neighbourhood model to prevent deterioration, keep people safely at home, avoid conveyance and maintain flow through winter pressure.

Winter contribution: risk stratification + urgent response + care at home + discharge capacity + prevention

1 Proactive INTs

- Target frailty, long-term conditions and complex need
- Web of support for those at highest risk of avoidable admission
- Draft specification supports consistency across the cluster

2 Care closer to home

- BCF sustains integrated, preventative services
- Reablement, intermediate care, D2A/P2/P3 and short-term assessment
- Technology-enabled care and prevention strategies strengthen independence

3 Urgent care front door

- 111/CAS/UCCH/UCR/OOH route people to the right local pathway
- Single urgent care access point and 24/7 models where in place
- ED validation and alternatives: UTC, SDEC, GP, pharmacy first and self-care

4 Hospital avoidance & flow

- BCF strategically deployed across Community and Neighbourhood Services to enhance capacity and support care closer to home
- Virtual wards, community beds, Hospital Avoidance Response Team and transitional care increase capacity
- Rapid response manages acute episodes in the community
- Enhanced discharge support enables recovery in usual place of residence

5 System resilience

- Clinical decision-making with ambulance services supports safe non-conveyance
- Community connectors and VCSE prevention widen support
- Ongoing alignment with neighbourhood care plans strengthens winter resilience

Collective impact for winter

Reduce
avoidable unplanned admissions and ambulance conveyance

Maximise
care delivered at home and in community settings

Improve
patient flow, discharge and recovery outside hospital

Strengthen
coordination across neighbourhood, urgent and social care services

Core message: neighbourhood working is supporting delivery architecture for winter — combining proactive support, urgent community response and discharge capacity to keep people safer, independent and out of hospital wherever clinically appropriate.

Children & Young People Support to Winter

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Children and young people: winter position

A credible, established CYP response aligned to forecast demand, with clear pathways, surge arrangements and system oversight.

Winter position: forecast demand understood + established mitigations + alternative pathways + escalation + regional oversight

1 Forecast demand

- Midlands CYP forecast and anticipated rises in respiratory illness, RSV and fever-related presentations are reflected in planning assumptions.
- Forecast intelligence reinforces, rather than fundamentally changes, the current winter response.

2 Acute surge capacity

- Escalation beds and extended assessment capacity are included within provider surge arrangements.
- Workforce flex, additional staffing and regional mutual aid support escalation when required.

3 Care outside hospital

- Same-day primary care access and Pharmacy First support lower-acuity demand.
- Community paediatric nursing, 24/7 CAMHS crisis provision and continuing care strengthen alternatives and oversight.

4 Prevention & oversight

- Vaccination, self-care and targeted family messaging support prevention and appropriate service use.
- Regional critical care surge plans and daily CYP bed monitoring provide oversight of PICU and HDU demand.

Collective assurance for winter

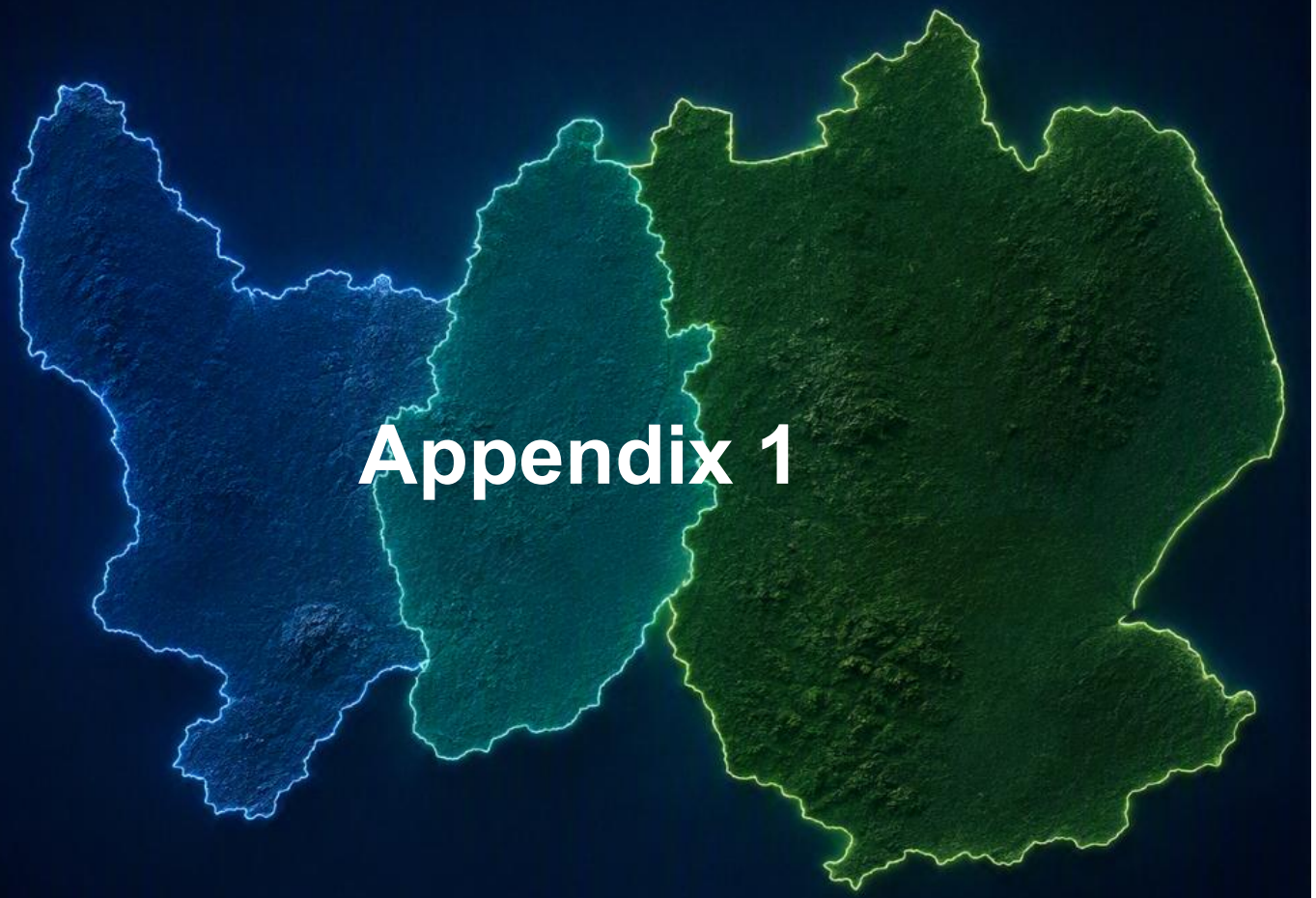
Anticipate
respiratory and seasonal demand through established planning assumptions

Respond
with acute surge capacity, workforce flex and mutual aid

Divert
appropriate presentations to primary, community and mental health pathways

Escalate
using surveillance, daily bed oversight and system governance

Core message: the CYP winter response is established and proportionate to forecast demand, with clear prevention, alternative pathway, surge and escalation arrangements already in place.



Appendix 1

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

- DLN System Provider Plans on a Page

DLN System Provider Plans on a Page

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Derbyshire

1 Provider plan
CRH

2 Provider plan
UHDB

3 Provider plan
DCHS

4 Provider plan
DHCFT

5 Provider plan
DHU

6 Provider plan
Derby City Council

7 Provider plan
EMAS NEPTS

8 Provider plan
EMAS 999

9 Provider plan
DCC

Lincolnshire

1 Provider plan
LPFT

2 Provider plan
LCH Group

3 Provider plan
LAs

4 Provider plan
EMAS

Nottinghamshire

1 Provider plan
NUH

2 Provider plan
NCHS

3 Provider plan
NHcFT

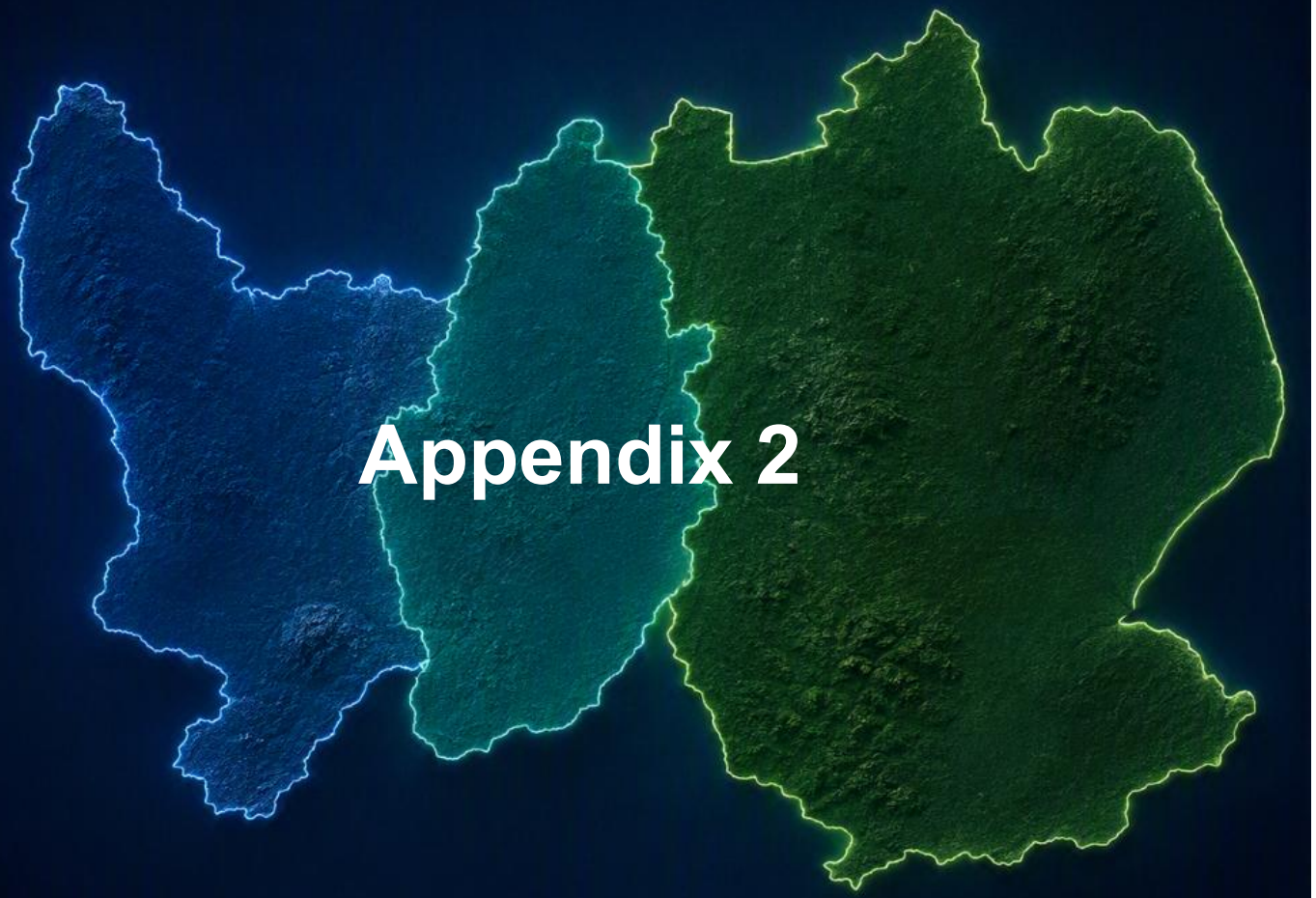
4 Provider plan
SFH

5 Provider plan
CityCare

6 Provider plan
EMAS 999

7 Provider plan
EMED

8 Provider plan
NEMS



NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

- Detailed Provider **DRAFT** Full Winter plans (final plans to be signed off)

DRAFT Full Detailed Provider Winter Plans

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Derbyshire

1 Provider plan
CRH

2 Provider plan
UHDB

3 Provider plan
DHCFT

4 Provider plan
DCHS

5 Provider plan
DHU

6 Provider plan
Derbyshire County Council

7 Provider plan
Derby City Council

8 Provider plan
DLN EMAS 999 & NEPTS

Lincolnshire

1 Provider plan
ULTH Group

2 Provider plan
LPFT

3 Provider plan
LCC

Nottinghamshire

1 Provider plan
SFH

2 Provider plan
NUH

3 Provider plan
NCHS

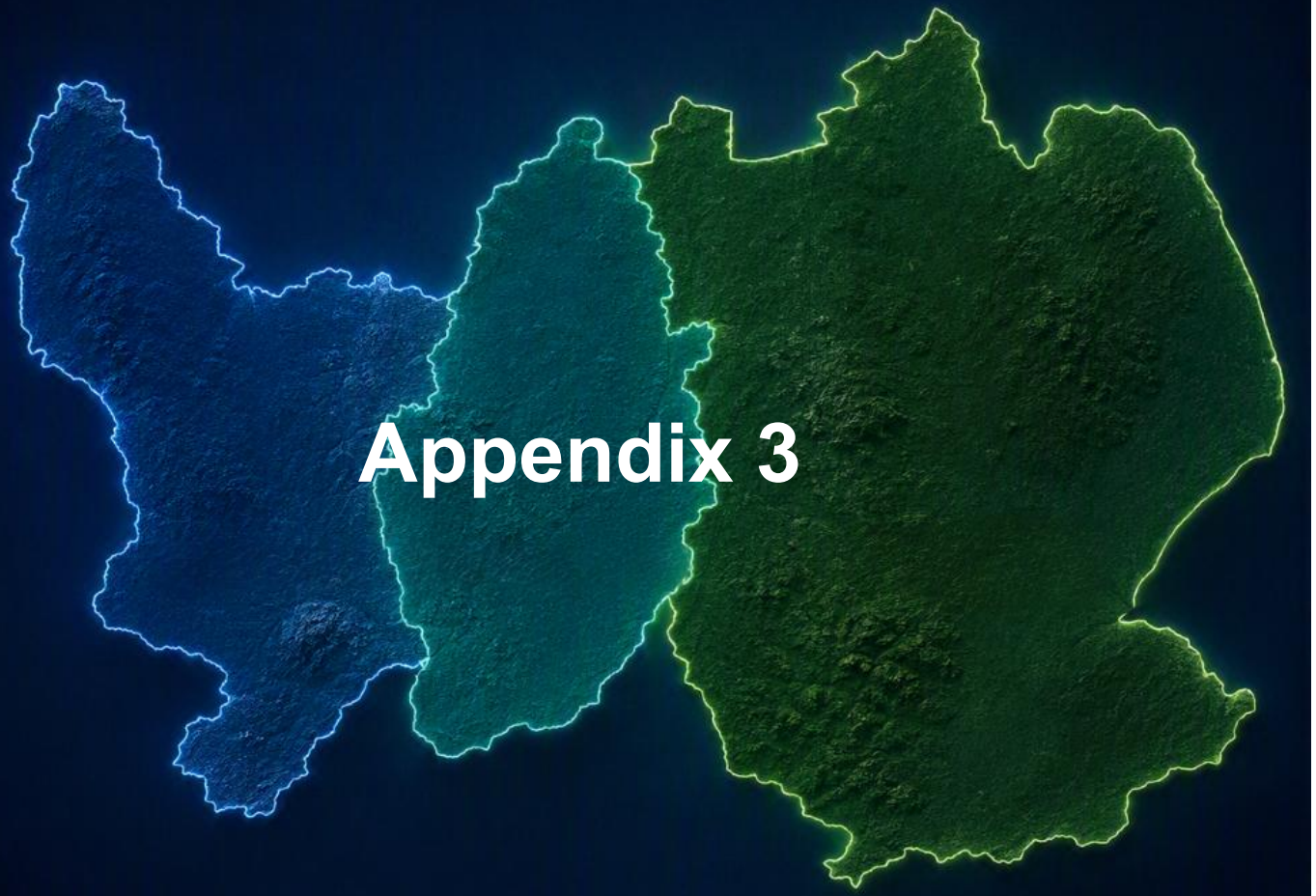
4 Provider plan
NCHS Mental Health

5 Provider plan
CityCare

6 Provider plan
EMED

7 Provider plan
NEMS

Please note: These documents are a draft position and remain under active development. Further narrative, figures, assumptions, mitigations and interventions continue to be refined ahead of final publication.



Appendix 3

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

- Acute Provider Bed Modelling

Acute Trust Bed Modelling Templates

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Derbyshire

1 Provider plan

CRH

2 Provider plan

UHDB

Lincolnshire

1 Provider plan

LCHG

Nottinghamshire

1 Provider plan

NUH

2 Provider plan

SFH

Please note: These documents are a draft position and remains under active development. Further narrative, figures, assumptions, mitigations and interventions continue to be refined ahead of final publication.

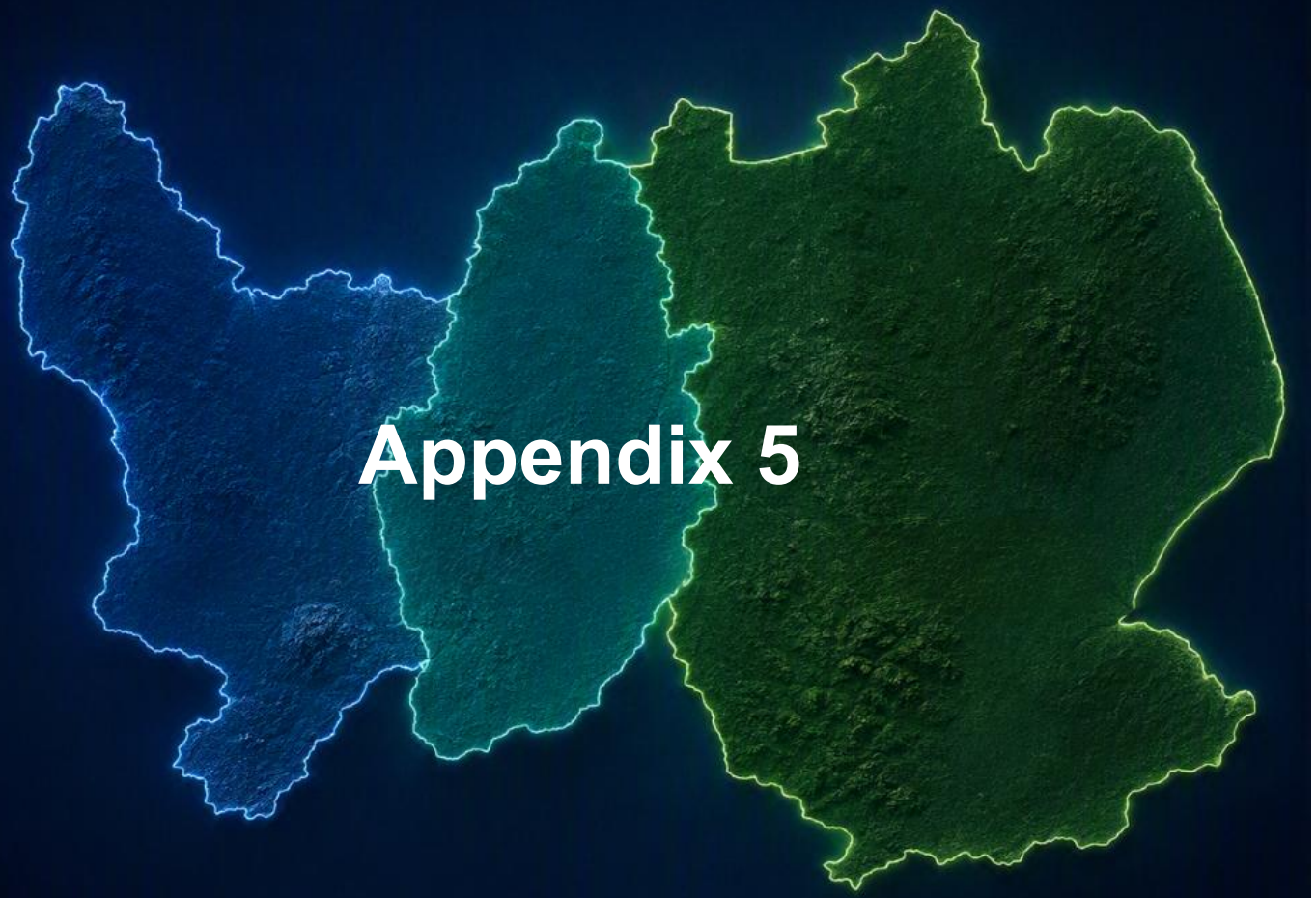
Appendix 4

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

- NHSE feedback following submission of draft Winter plan



Appendix 5

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

- DLN Key Lines of Enquiry inc. NHSE feedback

KLOE submission inc. NHSE feedback

The Key Lines of Enquiry (KLOE) submission has provided a valuable opportunity to test the robustness of the DLN Cluster's Winter 2026/27 planning arrangements and gain independent feedback from NHS England. The submission demonstrated several strengths across system planning, governance, resilience and collaborative working, whilst also highlighting areas where further assurance and detail would strengthen the overall position. NHS England's feedback has been welcomed as part of a continuous improvement approach to winter preparedness, helping to ensure that plans are not only comprehensive but also deliverable and measurable.

To support this, a dedicated log has been developed to capture all recommendations and areas identified for strengthening through the KLOE review process. These actions will be incorporated into the wider Winter Planning and Monitoring Framework, ensuring clear ownership, oversight and regular review throughout the planning and delivery phases. This approach will enable the cluster to evidence progress against each recommendation, provide ongoing assurance to NHS England, and ensure that learning is embedded into operational plans ahead of winter.

Progress against the log will be monitored through established winter governance arrangements, alongside local and cluster-wide testing exercises. Findings from these activities will also inform discussions and assurance processes associated with the National Winter Testing Exercise scheduled for 10 September 2026, ensuring that identified risks, mitigations and areas for improvement continue to be actively reviewed, tested and strengthened. Through this iterative approach, the DLN Cluster will be able to demonstrate a clear line of sight from NHS England feedback through to implementation, monitoring and operational delivery, providing confidence in system readiness for winter 2026/27.

KLOE Submission
nc. NHSE feedbacl

Winter Planning 26/27
Board Assurance Statement (BAS)
Integrated Care Board (ICB)

1. Purpose
The purpose of the Board Assurance Statement is to ensure the ICB's Board has oversight that all key considerations have been met. It should be signed off by both the ICB Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement
Please include the Integrated Care Board's (ICB) name at the top of the tab.
This section gives ICBs the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist
This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026.**

Winter Planning 26/27
Section A: Board Assurance Statement (BAS)

This section gives ICBs the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Integrated Care Board (ICB):	OTHER - Please write below
If Other, write ICB Name here:	*Derby & Derbyshire, Lincolnshire and Nottingham & Nottinghamshire (DLN) ICB*
Contact details (email, phone number):	nnicb-nn.dlnspoc@nhs.net
Date:	17/09/2026

Please complete these sections

		Assurance statement	Is this in place? (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance					
1	1.1	The Board has assured the ICB Winter Plan for 2026/27.	Yes	The Winter Plan has been developed through the DLN Cluster governance process and presented through organisational governance routes for	None identified at present
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the ICB's plan and this has been reviewed by the Board.	Yes	A Quality and Equality Impact Assessment (QEIA) informed development of the plan. The QEIA was reviewed by the QEIA Panel on 8 September 2026 and approved with no changes required to services.	None identified at present
	1.3	The Board is assured that the ICB's plan was developed with active engagement and input of all system partners, including primary care, 111 providers, Community Health Service Providers (including NHS and non-NHS providers), acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.	Yes	The plan has been developed collaboratively with providers and partners across Derbyshire, Lincolnshire and Nottinghamshire, including acute, community, mental health, ambulance, primary care and local authority partners. Contributions have been sought through winter planning groups, operational forums and system governance arrangements.	None identified at present
	1.4	The Board has identified a named Executive Winter Sponsor with clear accountability for winter preparedness, delivery, escalation and system oversight.	Yes	Maria Principe has been identified as the Executive Winter Sponsor for DLN. Executive oversight is supported through system and organisational winter governance structures, with regular reporting through executive, operational and Board assurance routes.	None identified at present
	1.5	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Regional and local winter preparedness testing exercises have been undertaken during August and September 2026. Learning and actions identified have been incorporated into winter planning, operational response arrangements and escalation processes.	None identified at present
	1.6	The Board is assured that clear winter governance arrangements, escalation processes and operational leadership arrangements are in place across the system.	Yes	Comprehensive governance arrangements are in place across the DLN Cluster, including system coordination centres, winter planning groups, operational oversight meetings and executive escalation routes. These arrangements support operational leadership, decision-making, escalation and performance monitoring throughout the winter period.	None identified at present
	1.7	The Board is assured that fit testing arrangements, PPE provision and other key infection prevention and control mitigations, as set out in the Health and Social Care Act 2008: code of practice on the prevention and control of infections are in place across the system and are supported by plans to scale rapidly in response to infectious disease surges, ensuring continuity of safe care and workforce protection.	Yes	Robust Infection Prevention and Control (IPC) arrangements are established across the system, supported by provider IPC committees, Health Protection structures, HSIPCAG and operational escalation processes. Measures including surveillance, testing, cohorting, isolation, outbreak management and vaccination programmes are in place to support continuity of safe care and workforce resilience through periods of increased infectious disease activity	None identified at present
	1.8	The Board has received assurance that health protection governance, escalation processes, and provider response arrangements are effective and support timely management of infectious disease incidents and outbreaks, as set out in the ICB Commissioning Guidance - https://www.england.nhs.uk/long-read/clinical-response-outbreaks-of-infectious-disease-commissioning-guidance-icbs/	Yes	Health protection governance is supported through provider IPC governance, Health Protection Boards, system quality forums and Healthcare System Infection Prevention and Control Assurance Group (HSPICAG) . Robust surveillance, outbreak management, escalation processes and 7-day IPC arrangements are in place to support the timely management of infectious disease incidents and outbreaks across the DLN system.	None identified at present

Winter Planning 26/27

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.

		Section B: 26/27 Winter Plan checklist	Please complete these sections Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention and vulnerable cohorts					
1	1.1	The Board is assured that those eligible have access to priority vaccination programmes, including childhood vaccinations. This includes 1. RSV vaccination for pregnant women, older adults aged 75 years and over, and older adult care home residents; 2. pneumococcal vaccination for all adults aged 65 years and over and children and adults in a clinical risk group; 3. the annual winter flu and COVID-19 vaccination campaigns.	Yes	The DLN Cluster has established arrangements to support delivery of seasonal vaccination programmes, including RSV, pneumococcal, flu and COVID-19 vaccinations in line with national eligibility criteria. Delivery is supported through primary care, community services, care homes, outreach provision and targeted approaches for vulnerable and underserved populations. Vaccination governance and oversight arrangements are established across the system to support uptake and monitor delivery.	None identified at present.
	1.2	The Board is assured that a risk-stratified approach is in place to identify individuals at increased risk of winter-related deterioration or admission, including those with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses, younger people with significant co-morbidities, and other vulnerable cohorts. Targeted interventions are in place, including vaccination, pre-winter health checks, personalised care planning, access to antivirals where appropriate, and community-based support to reduce avoidable admissions and support continuing care in the community.	Yes	Risk-stratified approaches are in place to identify and support vulnerable cohorts, including vaccination, anticipatory care planning, frailty services, community support and admission avoidance schemes. ARI hubs have been commissioned to provide rapid assessment and treatment for patients with respiratory illness, helping to avoid unnecessary admissions and support care closer to home during winter pressures.	Continued focus on vaccination uptake and engagement of vulnerable groups to maximise the effectiveness of preventative interventions.
Flow, occupancy and discharge					
2	2.1	The Board is assured there are clear operational plans and daily processes to reduce avoidable bed occupancy and improve patient flow seven days a week, including pre-winter review of bed demand and capacity, delivery of model discharge pathway requirements, and executive oversight of required and actual daily discharges, patients with no criteria to reside by pathway, discharge performance and long discharge delays.	Yes	System partners have established operational flow and discharge arrangements to improve patient flow seven days a week. Demand and capacity modelling has informed winter planning, including identification of bed gaps, escalation requirements and discharge assumptions. Daily operational management processes, executive oversight, System Coordination Centre arrangements and discharge monitoring processes are in place to support reductions in avoidable occupancy and long length of stay.	None identified at present.
	2.2	The Board is assured that system partners have agreed and implemented measures to eliminate corridor care, with defined patient safety thresholds, supported by coordinated patient flow, discharge and escalation arrangements, with system level oversight and mitigation of risk during periods of increased demand.	Yes	System partners have agreed escalation frameworks and patient flow arrangements to manage periods of increased demand safely. Short-Term Escalation Capacity has been reviewed as part of winter planning, with defined safety, operational and governance processes supporting implementation where required. System oversight arrangements are established to monitor risk, patient flow and occupancy pressures across	Ongoing review of capacity positions and mitigation delivery to minimise reliance on escalation capacity during peak demand periods.
	2.3	The Board is assured that discharge planning is being undertaken jointly with local authorities and social care partners, with effective system discharge coordination arrangements, clear processes to identify, escalate and resolve discharge delays, and real-time visibility of demand and community capacity.	Yes	Discharge planning is undertaken jointly with local authorities, community providers and wider system partners through established discharge governance arrangements. System discharge coordination processes, escalation routes and oversight forums provide visibility of demand, delays and community capacity, supporting timely discharge and flow across pathways.	Continued system focus on workforce and community capacity to support sustained discharge performance through peak winter demand.
	2.4	The Board is assured that providers have baselined current discharge arrangements against the model discharge pathway, identified gaps, and agreed improvement actions across acute, community and social care partners.	Yes	Providers have reviewed current discharge arrangements against model discharge principles and identified improvement actions through winter planning processes. Actions include strengthening discharge pathways, improving utilisation of community capacity, reducing avoidable delays and enhancing system oversight of long length of stay patients and no criteria to reside cohorts.	None identified at present.
	2.5	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans have been agreed and will be implemented.	Yes	Pre-Christmas, Christmas and New Year resilience arrangements are incorporated within provider and system winter plans. Bank Holiday and festive period operational plans will support continuity of discharge services, senior decision-	Continued coordination across partners to ensure festive period operational plans remain aligned and responsive to emerging system pressures.
Demand, capacity, and surge management					
3	3.1	The board is assured that whole system demand and capacity modelling has informed winter planning and that tested surge and extreme surge response arrangements are in place to support safe operational delivery during periods of increased demand.	Yes	Whole-system demand and capacity modelling has informed winter planning across the DLN Cluster, including identification of baseline and peak bed requirements, residual gaps and mitigating actions. Surge and extreme surge arrangements have been reviewed through winter planning processes and testing exercises, with escalation frameworks, operational command arrangements and	Continued monitoring of modelled capacity gaps and delivery of agreed mitigations ahead of peak winter demand.
	3.2	The Board is assured that workforce, NHS 111 and mutual aid arrangements are sufficient to respond safely to sustained periods of increased demand.	Yes	Workforce, NHS 111 and mutual aid arrangements form part of provider and system winter preparedness planning. Existing escalation processes support deployment of additional workforce capacity, utilisation of bank and agency	Workforce availability remains a national challenge and will continue to be monitored through provider resilience arrangements.
	3.3	The Board is assured that bed escalation capacity arrangements have been agreed and tested across system partners.	Yes	Bed escalation capacity arrangements have been identified and agreed across system partners as part of winter planning. Providers have reviewed escalation capacity requirements, including Short-Term Escalation Capacity, and	Ongoing work continues to strengthen mitigations and reduce reliance on escalation capacity wherever possible.
Primary Care, NHS 111 and admission avoidance					

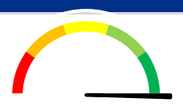
4	4.1	The Board is assured that anticipated general practice demand has been assessed, and that: •sufficient capacity has been commissioned, including for surge periods (e.g. ARI hubs) •robust escalation process are in place •through the IUC Clinical Assessment Service (or equivalent), sufficient capacity will be commissioned for out of hours general practice, including weekends and bank holidays.	Yes	Anticipated primary care demand has been considered through winter planning processes. Capacity arrangements include ARI Hubs, urgent same day care services, enhanced access provision and out-of-hours services. Escalation processes are in place across primary care and urgent care pathways to support management of increased demand during winter periods.	None identified at present.
	4.2	The Board is assured that practices are compliant with contractual requirements, including opening hours, use of online consultation, clinically urgent same day appointments (working towards 90% target) and practices making 1 appointment per 3,000 registered population available to NHS 111 for direct booking.	Yes	Primary Care Networks and practices continue to work towards national access requirements, including same day urgent access, online consultation and utilisation of multidisciplinary teams. Performance and access arrangements are monitored through established commissioning and primary care governance processes.	Continued monitoring of access performance and variation across localities.
	4.3	The Board is assured that PCN enhanced access appointments are available and that PCNs make available to NHS 111 any unused on the day slots as per DES requirements.	Yes	PCN Enhanced Access arrangements are established across the system and support additional appointment capacity outside core hours. Processes are in place to maximise utilisation of available capacity, including booking routes through NHS 111 where appropriate and in line with national requirements.	None identified at present.
	4.4	The Board is assured that unscheduled dental care delivery is monitored as part of the mandated number of urgent dental care appointments.	Yes	Urgent dental care provision forms part of wider system resilience planning and is monitored through commissioned dental services and contractual oversight arrangements. Access to urgent dental appointments supports diversion from urgent	Ongoing monitoring of urgent dental capacity and demand.
	4.5	The Board is assured that for community pharmacy, demand, activity and capacity has been assessed, including sufficient out of hours provision across the ICB footprint; and delivery of Pharmacy First and the Discharge Medicines service.	Yes	Community pharmacy plays a key role in managing winter demand through Pharmacy First, minor illness management, medicines optimisation and support for timely discharge through the Discharge Medicines Service. Out-of-hours pharmaceutical provision is available across the system footprint and is supported through NHS 111 referral pathways.	Continued promotion of Pharmacy First and self-care messaging to maximise utilisation.
	4.6	The Board is assured that the NHS 111 Directory of Services profiles are accurate, regularly reviewed, and aligned to available capacity across primary care and community services.	Yes	NHS 111 Directory of Services arrangements are in place and subject to routine review to ensure service availability, opening hours and referral pathways accurately reflect commissioned provision. Accurate Directory of Services information supports effective navigation of patients to appropriate services across the system.	None identified at present.
	4.7	The Board is assured that for all provision, both in and out of hours, there will be communications activity to ensure the public is aware of what services are available.	Yes	Communications and engagement activity forms part of winter preparedness arrangements and includes promotion of vaccination programmes, Pharmacy First, urgent care services, NHS 111, self-care messaging and appropriate	Continued coordinated communications activity across system partners during periods of increased demand.
Community Health Capacity					
5	5.1	The Board is assured that sufficient urgent community capacity, including UCR, Virtual Wards, Hospital at Home and community diagnostic interventions where applicable, has been commissioned, is monitored and utilised effectively to support admission avoidance and discharge, with appropriate escalation arrangements in place and access to senior clinical decision-making through SPOAs at least 12 hours a day, 7 days a week.	Yes	Community health services form a key component of the system's winter response,including Urgent Community Response (UCR), Hospital at Home, Virtual Wards, community nursing and community-based diagnostic and treatment services. These services support admission avoidance, timely discharge and ongoing care closer to home. Single points of access and senior clinical decision-making arrangements are in place to support rapid assessment, escalation and deployment of community capacity seven days a week.	Continued monitoring of community workforce and capacity utilisation during peak demand periods.
Whole System Response					
6	6.1	The Board is assured that a system wide approach is in place to optimise the use of out-of-hospital capacity and admission avoidance pathways to reduce avoidable admissions and support timely discharge.	Yes	A whole-system approach is in place to maximise the use of out-of-hospital capacity and admission avoidance pathways. This includes Virtual Wards, Hospital at Home, UCR services, ARI Hubs, community beds, discharge pathways, enhanced primary care services and community pharmacy interventions. System partners work collaboratively through established operational and discharge governance	Continued focus on optimisation of community capacity and timely access to discharge pathways during periods of sustained system pressure.
Leadership, operational grip and resilience					
7	7.1	The Board is assured that on-call arrangements are in place and have been tested. Staff on-call have access to medical and nursing leaders for urgent advice if needed.	Yes	Robust on-call arrangements are in place across provider organisations and system partners, supported by established executive, managerial, medical and nursing on-call rotas. These arrangements have been incorporated into winter	None identified at present.
	7.2	The Board is assured there will be an appropriately skilled and resourced operating model for system co-ordination over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.	Yes	A System Coordination Centre (SCC) model will operate throughout winter to support whole-system oversight, coordination and escalation management. Arrangements facilitate the sharing of operational intelligence, capacity information, risks and mitigations across partners, enabling collective management of pressures and system risk balancing.	Continued monitoring of system pressures and resource utilisation across the winter period.
	7.3	The Board is assured that tested command, control and escalation arrangements are in place, including OPEL reporting, EPRR arrangements and clearly defined leadership responsibilities.	Yes	Tested command, control and escalation arrangements are in place across the DLN Cluster, supported by EPRR frameworks, OPEL reporting arrangements and clearly defined leadership responsibilities. These arrangements have been exercised through winter preparedness and resilience exercises, with	None identified at present.
	7.4	The Board is assured that mutual aid arrangements, business continuity plans, severe weather preparedness arrangements and industrial action contingencies have been reviewed and tested where appropriate.	Yes	Mutual aid arrangements, business continuity plans, severe weather preparedness processes and industrial action response plans are established across organisations and have been reviewed as part of winter preparedness planning. Existing resilience frameworks provide mechanisms for escalation, coordinated	Ongoing review of emerging national and local risks through established resilience governance arrangements.
	7.5	The Board is assured thatplans are in place to support staff welfare through periods of high demand.	Yes	Staff wellbeing and workforce resilience remain a key component of winter preparedness. Organisations have arrangements in place to support staff welfare during periods of sustained operational pressure, including access to wellbeing support, occupational health services, flexible workforce deployment, escalation	Continued focus on workforce wellbeing and resilience throughout periods of increased winter demand.
System Co-ordination Centres					

8	8.1	The Board is assured that SCCs will be proactive in resolving operational pressures in hours, and that ICBs will maintain on-call functions for the oversight and resolution of operational pressures and patient flow and safety out of hours.	**Yes**	The System Coordination Centre (SCC) provides proactive oversight of operational pressures, patient flow, discharge performance and escalation management across the system. Out-of-hours arrangements are supported through established executive, operational and clinical on-call functions, ensuring timely	None identified at present.
	8.2	The Board is assured that SCCs will be fully operational 08:00 to 18:00 7 days per week and have the ability to extend hours of operation during periods of extreme pressure.	**Yes**	SCC arrangements are established to provide daily system oversight throughout the winter period, with the ability to scale operational support and coordination arrangements in response to escalating system pressures. Escalation frameworks and command arrangements support flexible extension of	None identified at present.
	8.3	The Board is assured that ICB SCCs will maintain proactive engagement and communication with NHSE Regional teams.	**Yes**	The SCC will maintain regular engagement with NHS England regional teams through established reporting and escalation mechanisms. System pressures, performance, risks, mitigations and escalation requirements are shared through routine operational reporting, OPEL processes and regional coordination arrangements to ensure alignment and timely support where required.	None identified at present.

BAS Self-Assessment Dashboard

ICB

Overall Assessment Rating: 5 - Full assurance



		Rating
Section A	Governance	5 - Full assurance
Section B	Prevention and vulnerable cohorts	5 - Full assurance
	Flow, occupancy and discharge	5 - Full assurance
	Demand, capacity, and surge management	5 - Full assurance
	Primary Care, NHS 111 and admission avoidance	5 - Full assurance
	Community Health Capacity	5 - Full assurance
	Whole System Response	5 - Full assurance
	Leadership, operational grip and resilience	5 - Full assurance

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the ICB Accountable Officer and Chair.

Integrated Care Board (ICB) name:	Derby & Derbyshire, Lincolnshire & Nottingham & Nottinghamshire
ICB CEO/AO name:	
Date reviewed:	
ICB Chair name:	
Date reviewed:	

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)
Maria Principe maria.principe@nhs.net

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.
Maria Principe has reviewed and approved all documents & associated content.

Please confirm date reviewed
11/09/2026

Meeting title	Integrated Care Boards: Open Session (meeting in common)
Meeting date	17/09/2026
Paper title	**Commissioning Delivery Oversight Report**
Paper reference	ICB CIC 26 052
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

The September report presents a mixed but generally improving delivery position across the Derbyshire, Lincolnshire and Nottinghamshire (DLN) geographical area. Performance remains positive in several areas, particularly elective Referral to Treatment (RTT) targets, primary care access and adult community waits. However, significant risks remain across diagnostics, cancer treatment, Children and Young People's community services, and urgent and emergency care flow.

Diagnostics remains the principal cross-cutting constraint on elective and cancer recovery, whilst waiting-list growth and activity below plan mean that sustained elective improvement will increasingly depend on additional throughput, productivity and pathway transformation. Urgent-care performance continues to be affected by discharge delays, bed occupancy and wider patient-flow pressures. Outside acute services, the main challenges relate to Children and Young People's community pathways, dental activity and mental health inpatient flow.

The September statistical process control-based assessment identifies 61 headline metric instances failing against required targets or plans. 15 show sustained low performance or deterioration, 13 remain off plan but are improving, and 33 require a step change in delivery. These findings are informing targeted commissioner oversight through programme governance and the Provider Performance Framework process.

A particular priority is assurance over the relationship between funded activity growth, provider delivery and operational performance. The Provider Commissioning Oversight Group meeting will consider areas where activity remains below the assumptions underpinning provider plans and associated funding. Specific acute providers where delivery is below planned levels have been asked for confirmation as to their ability to return to plan. This will test the credibility and recoverability of delivery trajectories and determine whether proportionate performance, contractual or commissioning action is required.

Report summary

Particular focus is being given to the preparation for winter and improving accident and emergency department performance and discharges, improving handovers and ensuring arrangements are enhanced across primary care ahead of the winter period.

Overall, the immediate priority is to convert strengthened oversight into demonstrable improvement, ensuring that provider plans are credible, funded activity is delivered and timely intervention is taken where recovery remains off trajectory.

Recommendation(s)

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

Appendices

None.

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 Oversight Delivery Report – September 2026

Purpose of the report

1. The report provides an overview of current delivery across the Derbyshire, Lincolnshire and Nottinghamshire (DLN) footprint against 2026/27 operational plan requirements, highlighting delivery performance, emerging risks, recovery trajectories and mitigating actions across the major commissioning programmes.
2. The report also describes how the DLN Commissioning Oversight Framework is being used to strengthen commissioner assurance over operational, financial, contractual, quality and data quality performance. Through Programme Boards, Provider Commissioning Oversight Group and escalation arrangements, the framework provides a structured approach to identifying risks, overseeing recovery and holding providers to account for delivery against agreed plans.
3. The report highlights areas of improvement and success, current delivery challenges, key recovery actions and the principal risks requiring commissioner intervention. It also provides an update on provider escalation arrangements, NHS Oversight Framework assessments, data quality assurance and the continued rollout of the strengthened governance framework to support delivery recovery and improvement during 2026/27.

Executive summary

4. The September Commissioning Delivery Oversight Report presents a mixed but generally improving position across the Derbyshire, Lincolnshire and Nottinghamshire (DLN) footprint. Several operational plan measures remain below trajectory, but there is increasing evidence of stronger commissioner grip, more mature recovery planning and closer alignment between performance management, pathway transformation and contractual intervention.
5. **Elective performance** is comparatively stable. In June, Lincolnshire delivered 62.0% against a 61.8% 18-week Referral to Treatment (RTT) plan and Nottingham and Nottinghamshire delivered 66.9% against 64.7%; Derbyshire was marginally below plan at 64.2% against 64.4%. However, waiting lists remained above plan by 2,202 patients in Derbyshire, 3,004 in Lincolnshire and 273 in Nottingham and Nottinghamshire, and all three systems were above trajectory for waits over 52 weeks. Sustainable recovery will therefore depend on increased activity, productivity and pathway transformation, rather than validation and waiting-list management alone. Providers have been asked to confirm their ability to recover to contracted activity levels to deliver the

performance required, following which targeted commissioner actions will be determined to ensure activity is delivered across the sector as required.

6. Pathway transformation is demonstrating tangible benefit. Between January and July 2026, Nottinghamshire community dermatology triaged 989 Nottingham University Hospitals referrals, redirecting 42% to community services and contributing to a reported 15% reduction in routine dermatology demand. Similar left-shift approaches are being developed across ophthalmology, musculoskeletal and gynaecology pathways.

7. **Diagnostics** remains the most significant cross-cutting risk to elective and cancer recovery. In June, the proportion waiting over six weeks was 27.4% in Derbyshire against a 17.1% plan, 52.1% in Lincolnshire against 32.8%, and 29.3% in Nottingham and Nottinghamshire against 22.6%. Diagnostic activity was also below plan in all three systems, with pressures concentrated in audiology, MRI, echocardiography, non-obstetric ultrasound and endoscopy. Recovery actions include modality-level plans, Community Diagnostic Centre expansion, additional capacity, workforce development and infrastructure investment.

8. **Cancer** Faster Diagnosis performance is improving. Nottingham and Nottinghamshire achieved its June trajectory at 81.3% against an 80.0% plan, while Derbyshire delivered 78.0% and Lincolnshire 74.0%. The 62-day standard remains below trajectory across all three ICBs, at 64.2% in Derbyshire, 60.3% in Lincolnshire and 65.7% in Nottingham and Nottinghamshire, reflecting continuing diagnostic, oncology workforce and treatment-capacity constraints. Recovery remains focused on the tumour sites contributing most to backlog and delay, alongside pathway redesign and innovation such as Skin AI.

9. **Urgent and Emergency Care** performance remains mixed and is principally constrained by system flow. Lincolnshire exceeded its June four-hour trajectory at 79.4% against 74.6%; Derbyshire was close to plan at 74.2% against 74.9%, subject to a recognised data-quality caveat; and Nottingham and Nottinghamshire remained below plan at 69.0% against 78.4%. Twelve-hour waits were above plan in all three systems, with discharge delays, high occupancy and ambulance pressures continuing to limit recovery. Commissioner action is focused on Transfer of Care, admission avoidance, discharge pathways, winter resilience and shared learning across systems.

10. **Community services** remain strong for adult long waits. Lincolnshire and Nottingham and Nottinghamshire reported no adults waiting over 52 weeks, and Derbyshire reported four against a plan of 92. Children and Young People's community waits remain the main challenge: Derbyshire reported 803 waits over 52 weeks against a plan of 62, Lincolnshire 1,326 against 1,326, and Nottingham and Nottinghamshire 257 against 250. Recovery is concentrating on community paediatrics, neurodevelopmental, Speech and Language

Therapy and Occupational Therapy pathways, supported by validation, demand-and-capacity analysis and stronger contract oversight.

11. **Primary care** remains one of the strongest programmes. All three ICBs exceeded their June trajectories for clinically urgent same-day appointments and delivered GP appointment activity above plan - by 84,688 appointments in Derbyshire, 52,321 in Lincolnshire and 134,762 in Nottingham and Nottinghamshire. Dental activity is the principal risk, with a combined shortfall of almost 29,000 Units of Dental Activity in June. Recovery actions include the 110% delivery scheme, rebasing and recommissioning opportunities.

12. **Mental Health and Learning Disability and Autism** (MHLDA) services continue to perform positively across several access and recovery measures, including Individual Placement and Support, Early Intervention in Psychosis and annual health checks. The thematic review presented to Finance and Performance Committee in September identified continuing risks relating to inpatient flow, older adult length of stay, crisis responsiveness, Learning Disability and Autism inpatient reduction and long-stay cohorts. Recovery is dependent not only on provider action but also on coordinated solutions across community capacity, housing, supported accommodation, social care and specialist provider markets. The MHLDA Programme Board will provide the principal assurance route, with increasing emphasis on whether transformation and financial recovery are producing measurable improvements in access, crisis response, admission avoidance, discharge and patient outcomes.

Oversight arrangements

13. Exception reporting across all programmes identified 61 headline metric instances failing against required targets or plans. 15 show concerning variation because of sustained low performance or deterioration, 13 remain off plan but are improving, and 33 show common-cause variation where a step change is required. The main areas of concern are diagnostics, community waiting times and system flow and discharge.

14. The Provider Performance Escalation process was implemented during July and August. Escalated concerns identified across acute providers have been triangulated through the Commissioning Oversight Group with finance, quality and contractual intelligence. Management arrangements include coordinated working with NHS England tiering processes, formal recovery planning and time-limited enhanced oversight, tailored to individual provider circumstances.

15. Commissioners are strengthening assurance over the relationship between funded activity growth, provider delivery and operational performance. Further assurance will be undertaken through Provider Commissioning Oversight Group where activity delivery remains below the assumptions underpinning provider plans and associated funding assumptions. Providers who are under

activity plans have been asked for confirmation on their ability to return to planned levels. This will assess the credibility of delivery trajectories, the extent to which current shortfalls can be recovered within the planning period and whether existing commissioning and funding assumptions remain appropriate. Where recovery is not supported by a credible and achievable plan, commissioners will consider proportionate performance, contractual and commissioning action through the established governance arrangements. NHS England made a targeted visit to understand the arrangements put in place to manage and improve the current levels of activity and associated delivery of performance. The ICBs need to ensure that activity is increased in the final half of the year.

16. The NHS Oversight Framework assessment provides a wider view of relative strength and challenge. Derbyshire has the strongest overall profile, Lincolnshire is mixed, and Nottingham and Nottinghamshire is the most challenged. Common areas for focus include access, discharge flow, productivity, workforce experience and health inequalities. Quarter 1 of 2026/27 will be the first period assessed against the new framework, with segmentation to be incorporated when published by NHS England.

17. A DLN-wide Data Quality Framework is now in place, linking local ownership and central Systems Analytical and Intelligence Unit oversight through formal governance and escalation. At the end of August 2026, 31 active issues were recorded, including 22 relating to acute data and nine to non-acute data. Emergency department reporting issues affect all three systems, with most relating to Type 3 attendance reporting. Improved visibility and escalation of these issues is essential to confidence in performance, activity, financial and contractual assurance.

18. Overall, the ICBs have strengthened the foundations for commissioner-led recovery through programme governance, provider escalation, pathway transformation and data-quality assurance. The immediate priority is to convert this strengthened oversight into demonstrable delivery improvement, ensuring that provider plans are credible, funded activity is delivered and proportionate intervention is taken where recovery remains off trajectory. Focus will remain on diagnostics, cancer, Children and Young People's community waits and urgent-care flow, while protecting the stronger performance evident in elective RTT, primary care and adult community services.

SAIU

STRATEGIC ANALYTICS INTELLIGENCE UNIT

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Commissioning Delivery Oversight Report

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

Integrated Care Boards: Open Session (meeting in common)
September 2026

Date: 17th September 2026
Prepared By: SAIU Performance Team
Supported By: SAIU Team

DLN Commissioning Oversight Delivery Report - Contents

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

1. The September Commissioning Delivery Oversight Report demonstrates a system delivering a mixed but generally improving position across several key programmes. Whilst several operational plan measures remain below trajectory, there is increasing evidence of stronger commissioner grip, more mature recovery planning and a greater focus on sustainable improvement rather than short-term performance management.

2. Elective care remains relatively stable compared with several other operational programmes, with RTT performance broadly on trajectory across much of the cluster. Lincolnshire and Nottingham and Nottinghamshire achieved their June RTT trajectories, whilst Derbyshire remained only marginally below plan. However, all three systems remain above plan for waiting list size and long waits, highlighting that sustained recovery will increasingly depend upon activity growth, productivity improvement and successful pathway transformation rather than waiting list management alone

3. Pathway transformation continues to demonstrate tangible benefits. Community dermatology in Nottingham and Nottinghamshire has redirected 42% of referrals into community services and reduced routine dermatology demand by approximately 15%, providing a practical example of how left shift can improve access whilst releasing capacity within acute services. Similar approaches are now being developed across ophthalmology, MSK and gynaecology pathways.

4. Diagnostics remains the most significant cross-cutting delivery risk across the cluster. Performance against DM01 remains below trajectory in all three ICBs, with pressure across audiology, MRI, NOUS, ECHO and endoscopy services. Diagnostic activity also remains below plan, directly affecting both elective and cancer recovery. Encouragingly, CDC expansion, workforce development and targeted recovery plans continue to progress and provide a stronger foundation for longer-term improvement

5. Cancer performance continues to improve in some areas, particularly within Faster Diagnosis pathways. Nottingham and Nottinghamshire achieved its June trajectory and is reporting continued improvement through July and August. However, all three ICBs remain below trajectory for the 62-day standard, reflecting ongoing challenges relating to diagnostics, oncology capacity and treatment pathway performance. Targeted recovery plans remain in place across all systems and tumour sites

6. Urgent and Emergency Care performance remains mixed. Lincolnshire continues to demonstrate positive four-hour performance despite demand significantly above plan, whilst Derbyshire remains close to trajectory. Nottingham and Nottinghamshire continues to experience more significant pressures across the urgent care pathway. Across all three systems, the principal challenge remains patient flow, discharge and prolonged waits rather than front-door performance alone.

7. There are encouraging indications of stronger whole-system coordination across urgent care, with progress being made in admission avoidance services, discharge pathways, Transfer of Care development and winter planning. However, continued improvement in flow and reduction in delayed discharges will remain essential to achieving sustained operational recovery during the remainder of the year.

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

1. Community services continue to provide a strong foundation for system delivery, particularly in adult services where performance against the 52-week standard remains positive. Children and Young People's services remain the principal area of challenge; however, improvements in some therapy pathways provide a stronger platform for recovery during the second half of the year.

2. Primary care remains one of the strongest performing programmes within the operational plan. All three ICBs exceeded their same-day urgent access trajectories and delivered GP appointment activity above plan. Dental access remains the main challenge and continues to require significant commissioner focus; however, recovery arrangements are in place across all three systems.

3. Mental Health and Learning Disability & Autism services continue to deliver positively across many core access and recovery measures, including IPS, Early Intervention in Psychosis and Annual Health Checks. Inpatient flow, older adult length of stay and out-of-area placements remain areas requiring continued focus, although commissioner and provider recovery activity is in place to support improvement.

4. Overall, the September position reflects a system that continues to face significant operational challenges, particularly across diagnostics, cancer, community waits and system flow. However, there is increasing evidence of stronger commissioner oversight, more mature recovery planning and greater alignment between performance management, pathway transformation and contractual intervention. Whilst several performance measures remain below trajectory, there are encouraging signs of improvement in a number of areas and continued progress will depend on converting recovery actions into sustained delivery gains during the second half of 2026/27

1.3 Contract Delivery – Executive Summary

1. The ICB has implemented a Provider Performance Escalation process during July and August. The process identified areas of 'Escalated' Concern across providers which were discussed and reviewed through the ICB Commissioning Oversight Group to enable triangulation with other issues including finance and quality. Recommendations were then discussed with regional colleagues and ICB Executives to agree most appropriate interaction with the providers based on the assessments reached.

2. There is a clear need to ensure triangulation with NHS England as it is developing its approach to provider performance frameworks to ensure that collectively both the ICB and NHS England can fulfil their respective responsibilities for provider contractual management and provider oversight, while co-ordinating interactions and outputs required from providers concerned. Further assurance will be undertaken through Provider COG where activity delivery remains below the assumptions underpinning provider plans and associated funding assumptions. This will test the credibility and recoverability of delivery trajectories and inform any proportionate performance, contractual or commissioning action required.

Provider	NOF	PROM	ERF	Areas of Concern and agreed Management Approach
UHDB	**4** (T2 EL & Cancer) National RAP	**Pause** UEC & Diagnostics **PROM Paused EMT 27.7.26** – shadow RAP requested instead with 8-week review commenced (August)	**Increased**	**Concerns:** UEC and Diagnostics were of primary concern, however the trust has since moved to all areas of cancer and electives being off plan and triggering 'Escalated' concerns. **Agreed Management Approach:** The ICB has requested a Shadow RAP from the Trust targeting the 4 programme areas of concern, followed by a fortnightly improvement progress discussion for 8 weeks, following which a decision will be taken as to whether to progress to a CPN and the Provider Recovery Oversight Meeting (PROM) process as per the Provider Performance Escalation Process.
CRH	**4**	**Pause** UEC, Cancer **PROM Paused : Pending RQR (review 18.9.26)**	**Review**	**Concerns:** UEC and Cancer initially, increasing concerns regarding 62 day which has triggered 'Escalated' concern. **Agreed Management Approach:** PROM paused for Rapid Quality Review process duration. SAIU is working with CRH on the UEC ED reporting issues with a clear workplan to be enacted during September.
ULTH	**4** (T2 EL & Cancer)	**Pause** Diagnostics (CPN already in place pre-PROM) UEC, Cancer, EI **PROM Paused: NHSE 27.7.26**	**Increased**	**Concerns:** Diagnostics most significant area of concern, electives, UEC and Cancer have 'Escalated' Concern. **Agreed Management Approach:** NHS England to lead the performance improvement discussions through the tiering meetings. The ICB had issued a CPN specifically for diagnostics prior to the ICB Performance escalation process which is being monitored through fortnightly meetings with the trust.
NUH	**4** (T2 EL, Diagnostics & Cancer, T1 UEC)	**Pause** UEC & Diagnostics **PROM Paused NHSE – progress through Tiering 27.7.26**	**Escalated**	**Concerns:** UEC, Diagnostics, Electives and cancer are areas of 'escalated' concern. **Agreed Management Approach:** NHS England to lead the performance improvement discussions through the tiering meetings which the ICB are invited to attend. Cancer has seen some improvements in the reported positions.
SFHT	**3** (National RAP)	**Yes** UEC & Diagnostics CPN 3.7.26	**Routine**	**Concerns:** UEC and Diagnostics initial areas of 'escalated' concern. **Agreed Management Approach:** The Trust entered the ICB Escalation process on the 3rd July, being issued a CPN for UEC and Diagnostics, which has been supported with fortnightly meetings since that time. Both UEC and Diagnostics have improved in the last month reported position.

2.1 Operational Plan: Delivery Risk Key Headlines 2026/27

DDICB	LICB	NNICB	Programme Performance Headlines
1. Elective Care & Waiting Times			
			•**18-Week RTT**: NNICB and LICB achieved plan in June 2026, however DDICB were marginally below plan
			•**Long Waits (52+ Weeks)**: All three ICBs are off plan for reducing long waits. All ICBs are working to eradicate 65-week waits. NNICB risk due to PICS gynae patient transfers
			•**PTL (Patient Tracking List)**: DDICB, LICB and NNICB are worse than plan at the end of June 2026, although NNICB have improved to 273 away from 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 DDICB and LICB, NNICB achieved the plan. 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 DDICB and NNICB, with acute trusts facing challenges, for ED performance, 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 June at all three ICBs. Dental UDA plans have not been met in July 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 are achieving the 52ww CYP plan.
			•**Mental Health & LD&A**: Access targets are being met in several areas, but challenges persist in out-of-area placements for NNICB and acute bed utilisation for DDICB and LICB. LD&A adult inpatient numbers are behind trajectory in DDICB and NNICB, with DDICB identified through SPC exception reporting. LD&A CYP inpatients are achieving plan in LICB and NNICB.
6. Vaccinations			
			•**Vaccinations**: Spring campaign concluded in June with uptake above regional and national averages.
7. NHS Oversight Framework Q3			
			•**Q4 assessments** have led to NHT, NUH, ULH, CRH, and UHDB being rated NOF 4.

Forecast Delivery RAG

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	%	Jun-26		66.5%	68.7%	2.2% ✓			61.0%	62.5%	1.5% ✓			72.0%	67.6%	-4.4% ✗		
	RTT <18 Weeks (%)	Ops Plan	E.B.40	%	Jun-26		64.4%	64.2%	-0.2% ✗			61.8%	62.0%	0.2% ✓			64.7%	66.9%	2.2% ✓		
	RTT >52 Weeks (%)	Ops Plan	E.B.18	%	Jun-26		1.5%	1.6%	0.1% ✗			1.0%	1.5%	0.5% ✗			1.0%	1.9%	0.9% ✗		
	RTT >65 Weeks (No.)	Nat Std		Value	Jun-26		0	51	51 ✗			0	27	27 ✗			0	88	88 ✗		
	RTT Waiting List Size	Ops Plan	E.B.3a	Value	Jun-26		111,687	113,889	2,202 ✗			106,666	109,670	3,004 ✗			119,800	120,073	273 ✗		
Cancer	Cancer Faster Diagnosis <28 Days (%)	Ops Plan	E.B.27	%	Jun-26		80.0%	78.0%	-2.0% ✗			80.1%	74.0%	-6.1% ✗			80.0%	81.3%	1.3% ✓		
	Cancer Treatment <31 Days (%)	Ops Plan	E.B.38	%	Jun-26		94.1%	89.5%	-4.6% ✗			93.0%	90.1%	-2.9% ✗			94.0%	94.1%	0.1% ✓		
	Cancer Referral-to-Treatment <62 Days (%)	Ops Plan	E.B.35	%	Jun-26		76.5%	64.2%	-12.3% ✗			74.1%	60.3%	-13.8% ✗			76.2%	65.7%	-10.5% ✗		
Diagnostics	Diagnostics >6 Weeks (%)	Ops Plan	E.B.28x	%	Jun-26	⚠	17.1%	27.4%	10.3% ✗			32.8%	52.1%	19.3% ✗			22.6%	29.3%	6.7% ✗		
Urgent Care	A&E <4 Hours (%)	Ops Plan	E.M.13	%	Jul-26	⚠	74.9%	74.2%	-0.7% ✗			74.6%	79.4%	4.8% ✓			78.4%	69.0%	-9.4% ✗		
	A&E >12 Hours (%)	Ops Plan	E.M.13g	%	Jul-26	⚠	4.4%	12.2%	7.8% ✗			9.3%	15.6%	6.3% ✗			7.8%	10.5%	2.7% ✗		
	Ambulance Cat 2 Mean Response (mins)	Ops Plan	E.B.23c	Value	Jul-26		00:25:00	00:28:38	00:03:38 ✗			00:25:00	00:41:15	00:16:15 ✗			00:25:00	00:26:41	00:01:41 ✗		
	Average Handover Time	Ops Plan	E.B.42	Value	Jul-26		00:30:51	00:28:11	-00:02:43 ✓			00:28:54	00:35:04	00:06:10 ✗			00:23:33	00:28:21	00:04:45 ✗		
Primary Care	GP Appointments Delivered	Ops Plan	E.D.19	Value	Jun-26		570,998	655,686	84,688 ✓			482,881	535,202	52,321 ✓			635,227	769,989	134,762 ✓		
	Same Day Urgent GP Appointments (%)	Ops Plan	E.D.27	%	Jun-26		70.0%	75.0%	5.0% ✓			68.7%	71.3%	2.6% ✓			75.0%	78.9%	3.9% ✓		
	Dental UDAs Delivered	Ops Plan	E.D.24	Value	Jul-26		124,614	124,350	-264 ✗			88,579	74,770	-13,809 ✗			168,847	153,999	-14,848 ✗		
	Pharmacy First Consultations	Ops Plan	E.D.26	Value	May-26		11,201	13,467	2,266 ✓			6,812	8,545	1,733 ✓			13,864	15,773	1,909 ✓		
Community	Adult Community Waits >52 Weeks	Ops Plan	E.T.9b	Value	Jun-26		92	4	-88 ✓			0	0	0 ✓			0	0	0 ✓		
	CYP Community Waits >52 Weeks	Ops Plan	E.T.9a	Value	Jun-26		62	803	741 ✗			1,326	1,326	0 ✓			250	257	7 ✗		
Mental Health	Inappropriate OAPs (Adult Acute)	Ops Plan	E.A.5	Value	Jun-26	⚠	7	*				1	*				8	10	2 ✗		
	MH Inpatient Mean LOS Adult and PICU	Ops Plan	E.H.38	Value	Jun-26		54.5	55.0	0 ✗			20.7	22.0	1 ✗			48.6	46.0	-3 ✓		
	MH Inpatient Mean LOS Older Adult	Ops Plan	E.H.39	Value	Jun-26		81.5	78.0	-4 ✓			57.7	137.0	79 ✗			77.2	93.0	16 ✗		
	IPS Access (Rolling 12-month)	Ops Plan	E.H.34	Value	Jun-26		847	950	103 ✓			680	740	60 ✓			1,375	1,595	220 ✓		
	EIP <2 Weeks (%)	Nat Std		%	Jun-26		60.0%	74.0%	14.0% ✓			60.0%	65.0%	5.0% ✓			60.0%	71.0%	11.0% ✓		
	Talking Therapies Reliable Recovery (%)	Ops Plan	E.A.4a	%	Jun-26		47.2%	50.3%	3.1% ✓			50.3%	50.4%	0.1% ✓			50.4%	52.1%	1.7% ✓		
	Talking Therapies Reliable Improvement (%)	Ops Plan	E.A.4b	%	Jun-26		68.8%	69.6%	0.8% ✓			69.9%	72.2%	2.3% ✓			68.4%	73.3%	4.9% ✓		
	CYP MH Access	Ops Plan	E.H.9	Value	Jun-26		14,620	14,915	295 ✓			12,451	12,715	264 ✓			21,840	22,300	460 ✓		
	CYP ED Routine <4 Weeks (%)	Nat Std		%	Jun-26		95.0%	93.0%	-2.0% ✗			95.0%	50.0%	-45.0% ✗			95.0%	86.0%	-9.0% ✗		
	CYP MH Waits >104 Weeks	Ops Plan	E.A.7	Value	Jun-26		1,160	1,300	140 ✗			99	1,010	911 ✗			680	360	-320 ✓		
LD&A	LD/Autism Adult Inpatients	Ops Plan	E.H.32/33	Value	Jul-26		31	36	5 ✗			34	26	-8 ✓			35	37	2 ✗		
	LD/Autism CYP Inpatients	Ops Plan	E.K.1c	Value	Jul-26		3	4	1 ✗			2	1	-1 ✓			3	2	-1 ✓		

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.

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 (%)	Jun-26	26/36	121/148	108/148	34/36	117/148	12/36	69/148	94/148
	RTT <52 Weeks (%)	Jun-26	25/36	94/129	104/129	22/36	86/129	29/36	105/129	69/129
	RTT <65 Weeks	Jun-26	13/36	69/88	33/88	10/36	27/88	20/36	62/88	-
Cancer	Cancer Faster Diagnosis <28 Days (%)	Jun-26	28/26	104/122	58/122	30/36	109/122	11/36	56/122	47/122
	Cancer Referral-to-Treatment <62 Days (%)	Jun-26	34/36	124/133	59/133	35/36	121/133	25/36	109/133	75/133
Diagnostics	Diagnostics >6 Weeks (%)	Jun-26	25/36	116/134	49/134	36/36	133/134	27/36	124/134	41/134
Urgent Care	A&E <4 Hours (%)	Jul-26	21/36	75/122	52/122	4/36	29/122	31/36	104/122	89/122

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.

2.1 Operational Plan - Latest Activity Position

Latest Month Only	Derby and Derbyshire ICB Population						Lincolnshire ICB Population						Nottingham and Nottinghamshire ICB Population					
	June 2026 Only				Jun 26 v Jun 25		June 2026 Only				Jun 26 v Jun 25		June 2026 Only				Jun 26 v Jun 25	
	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance
First OP Attendances (Consultant Led)	36,612	36,315	-297	-0.8%	703	2.0%	26,218	24,929	-1,289	-4.9%	-763	-3.0%	31,291	31,191	-100	-0.3%	-1,009	-3.1%
Follow Up OP Attendances (Consultant Led)	83,159	78,470	-4,689	-5.6%	1,192	1.5%	42,276	42,738	462	1.1%	-1,405	-3.2%	60,506	66,638	6,132	10.1%	102	0.2%
Elective Day Case Spells	15,474	14,814	-660	-4.3%	30	0.2%	10,435	9,654	-781	-7.5%	-363	-3.6%	15,014	15,960	946	6.3%	1,050	7.0%
Elective Ordinary Admissions	2,307	2,302	-5	-0.2%	334	17.0%	1,587	1,563	-24	-1.5%	37	2.4%	2,365	2,344	-21	-0.9%	127	5.7%
Diagnostic Tests Performed	48,888	45,351	-3,537	-7.2%	2,356	5.5%	44,089	38,270	-5,819	-13.2%	3	0.0%	52,784	51,798	-986	-1.9%	4,172	8.8%
A&E Attendances (total)	57,924	57,058	-866	-1.5%	-866	-1.5%	29,295	30,714	1,419	4.8%	1,294	4.4%	42,771	42,920	149	0.3%	1,413	3.4%

Year to Date	Derby and Derbyshire ICB Population						Lincolnshire ICB Population						Nottingham and Nottinghamshire ICB Population					
	April 2026 - June 2026				YTD 26/27 v YTD 25/26		April 2026 - June 2026				YTD 26/27 v YTD 25/26		April 2026 - June 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)	101,514	100,645	-869	-0.9%	-600	-0.6%	72,696	70,887	-1,809	-2.5%	-3,033	-4.1%	94,787	87,445	-7,342	-7.7%	-2,078	-2.3%
Follow Up OP Attendances (Consultant Led)	230,576	221,978	-8,598	-3.7%	-4,830	-2.1%	117,220	122,843	5,623	4.8%	-7,226	-5.6%	188,798	189,726	928	0.5%	-5,200	-2.7%
Elective Day Case Spells	42,874	42,084	-790	-1.8%	-2,103	-4.8%	27,985	28,023	38	0.1%	-1,787	-6.0%	45,876	45,616	-260	-0.6%	674	1.5%
Elective Ordinary Admissions	6,398	6,501	103	1.6%	332	5.4%	4,253	4,315	62	1.5%	-117	-2.6%	7,264	6,671	-593	-8.2%	110	1.7%
Diagnostic Tests Performed	135,554	130,457	-5,097	-3.8%	3,932	3.1%	124,041	110,597	-13,444	-10.8%	-2,614	-2.3%	146,355	148,157	1,802	1.2%	5,853	4.1%
A&E Attendances (total)	173,091	169,678	-3,413	-2.0%	-3,413	-2.0%	88,594	95,477	6,883	7.8%	6,367	7.1%	128,170	126,939	-1,231	-1.0%	3,321	2.7%

2.1 Operational Plan – Exception Reporting

Go back >>

Concerning Variation **15**

Metric	Org	Period	V	A	Actual
RTT Admitted Pathways	NNICB	Jun-26			4,359
Cancer Faster Diagnosis <28 Days (%)	LICB	Jun-26			74.0%
Diagnostics >6 Weeks (%)	LICB	Jun-26			52.1%
Diagnostics >6 Weeks (%)	NNICB	Jun-26			29.3%
G&A Overnight Beds Occupied (%)	NNICB	Jul-26			94.6%
Total Non-Elective Spells (0 Day)	LICB	Jun-26			3,543
Discharge Ready Date (%)	DDICB	Jun-26			82.6%
Discharge Ready Date (%)	NNICB	Jun-26			77.7%
Average Discharge Delay	DDICB	Jun-26			5.9
Average Discharge Delay	LICB	Jun-26			5.7
Community Waits >52 Weeks (Total)	NNICB	Jun-26			257
CYP Community Waits >52 Weeks	NNICB	Jun-26			257
Talking Therapies Completing a Course of Treatment	DDICB	Jun-26			1,040
Talking Therapies Completing a Course of Treatment	NNICB	Jun-26			1,280
LD/Autism Adult Inpatients	DDICB	Jul-26			36

Overall, there are **61 metric** instances which are 'Failing' in the assurance of delivery to the targets and plans required, from the key headline metrics.

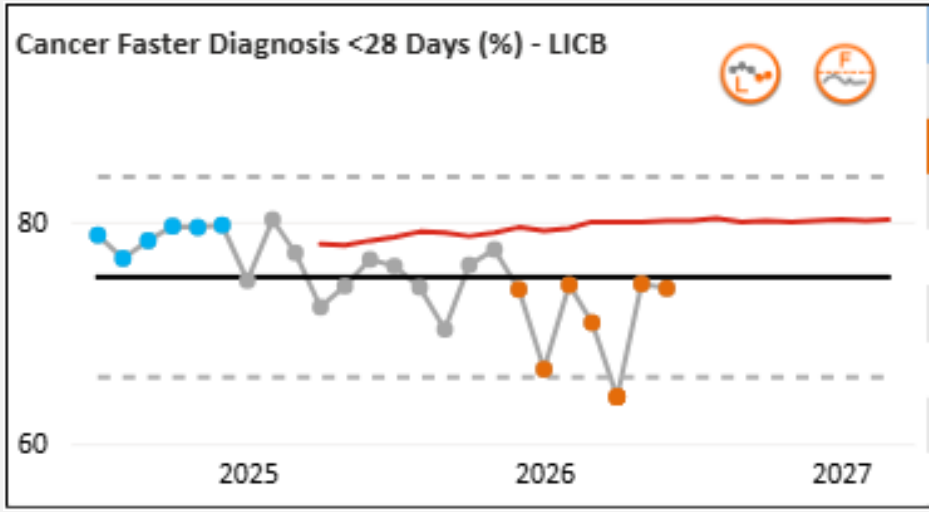
15 are failing and are of concerning variation for continued low performance or a deteriorating position. These areas have been outlined on the table to the left, and exception reports have been provided.

13 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.

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

The most significant clusters of concern relate to Cancer Faster Diagnosis, Diagnostics, Community Waiting Times and System Flow & Discharge. Further detail on all other metrics with concerning variation is provided on slide 14

2.1 Operational Plan – Exception Reporting
i. Cancer 28 Day Faster Diagnosis



Latest Position
Jun-26
74.0%
Plan
80.1%
Assurance
Fail
SPC Variation
Concerning - Low

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	Jun-26	78.0%	80.0%			
Cancer Faster Diagnosis <28 Days (%)	UHDB	Jun-26	74.6%	77.2%			
Cancer Faster Diagnosis <28 Days (%)	CRH	Jun-26	81.0%	75.7%			
Cancer Faster Diagnosis <28 Days (%)	LICB	Jun-26	74.0%	80.1%			
Cancer Faster Diagnosis <28 Days (%)	ULTH	Jun-26	73.4%	80.1%			
Cancer Faster Diagnosis <28 Days (%)	NNICB	Jun-26	81.3%	80.0%			
Cancer Faster Diagnosis <28 Days (%)	SFH	Jun-26	81.8%	80.4%			
Cancer Faster Diagnosis <28 Days (%)	NUH	Jun-26	81.2%	77.4%			

Benchmarks:

- LICB ranks 30/36 ICBs
- NNICB ranks 11/36 ICBs
- DDICB ranks 28/36 ICBs

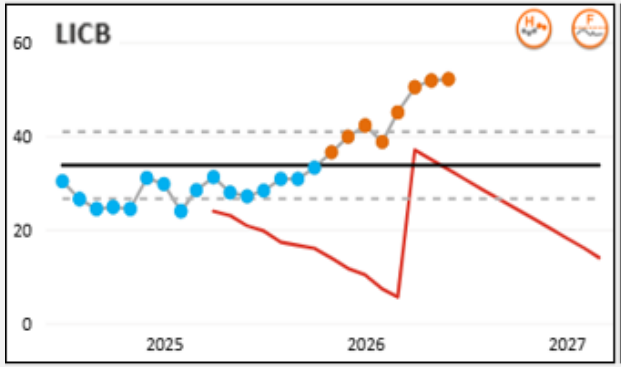
Commissioner and Provider Actions:

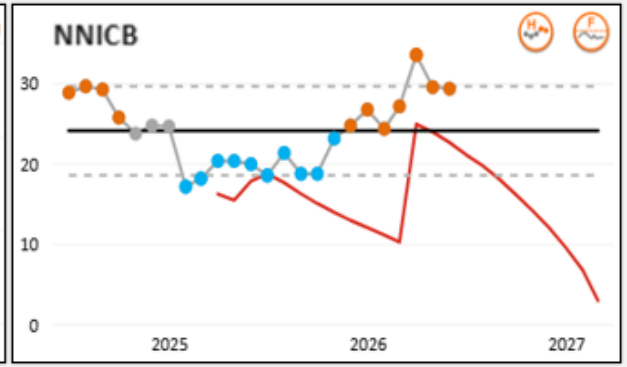
1. LICB: United Lincolnshire Hospitals is under Tier 2 with NHS England, for which fortnightly review meetings are being held and ICB Commissioners attend. Breast is showing some recovery with reductions in backlogs and return to plan is expected by September and ***overall FDS to have returned to plan by November.*** Targeted specialty deep dives are being undertaken, using detailed data analysis and stakeholder engagement to identify improvement opportunities and address pathway pressures. Work is also focused on improving earlier diagnosis through initiatives that promote screening uptake and raise public awareness of cancer screening programmes. 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.

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 by March 2027 (LICB 14%; NNICB 2.9%).

KPI	Org	Latest Month	Actual	Plan	V	A	DQ
Diagnostics >6 Weeks (%)	DDICB	Jun-26	27.4%	17.1%			
Diagnostics >6 Weeks (%)	UHDB	Jun-26	33.3%	26.7%			
Diagnostics >6 Weeks (%)	CRH	Jun-26	12.8%	17.2%			
Diagnostics >6 Weeks (%)	LICB	Jun-26	52.1%	32.8%			
Diagnostics >6 Weeks (%)	ULTH	Jun-26	56.6%	23.0%			
Diagnostics >6 Weeks (%)	NNICB	Jun-26	29.3%	22.6%			
Diagnostics >6 Weeks (%)	SFH	Jun-26	11.2%	8.4%			
Diagnostics >6 Weeks (%)	NUH	Jun-26	41.4%	29.2%			

Benchmarks:

- LICB lowest ranking 36/36
- NNICB ranks 27/36
- DDICB ranks 25/36

Commissioner and Provider Actions:

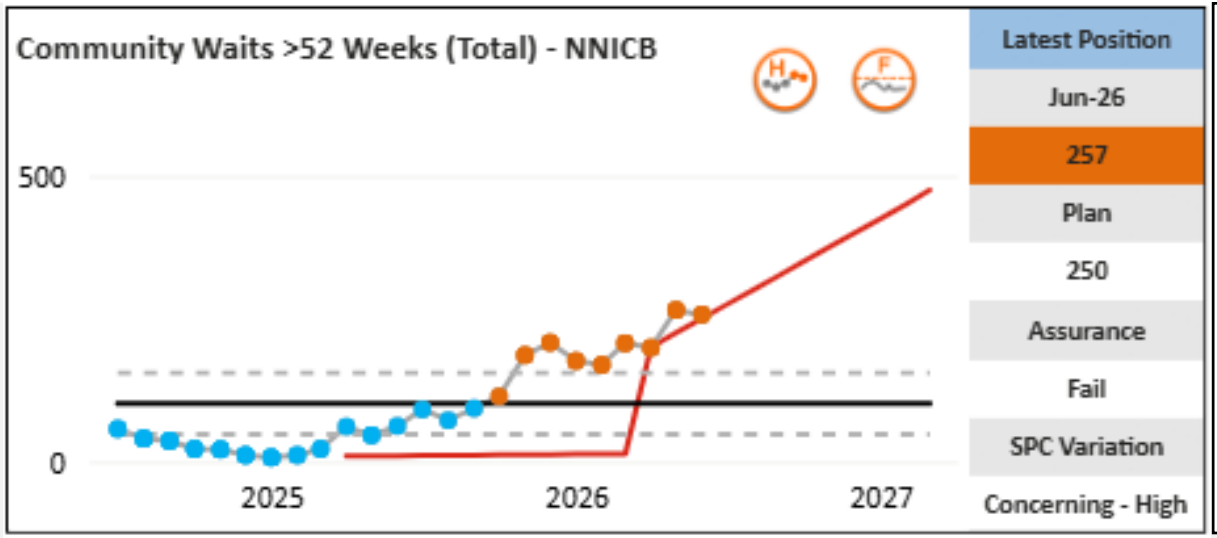
1. LICB: United Lincolnshire Hospitals has had a Contract Performance notice issued by the LICB for a formal recovery plan request due to low and deteriorating performance. Main areas of concern include audiology assessments, cystoscopy, MRI and NOUS. There are a significant number of waits over 13 weeks across NOUS as well as other areas, and a volume of audiology patients waiting over 104 weeks. Audiology, MRI and NOUS were 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. NNICB: 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 has been extended to support continued recovery. Echo has deteriorated in recent weeks due to the loss of locum and substantive workforce. The Trust are also needing to address increasing 13-week backlogs, significant increases in CT and NOUS. Additional CT capacity has been approved nationally from November and will support future recovery. 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. Community 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	Jun-26	807	154			
Community Waits >52 Weeks (Total)	CRH	Jun-26	2	0			
Community Waits >52 Weeks (Total)	DHCFT	Jun-26	803	572			
Community Waits >52 Weeks (Total)	DCHS	Jun-26	2	0			
Community Waits >52 Weeks (Total)	LICB	Jun-26	1,326	1,326			
Community Waits >52 Weeks (Total)	ULTH	Jun-26	1,326	1,326			
Community Waits >52 Weeks (Total)	LCHS	Jun-26	0	0			
Community Waits >52 Weeks (Total)	NNICB	Jun-26	257	250			
Community Waits >52 Weeks (Total)	SFH	Jun-26	0	0			
Community Waits >52 Weeks (Total)	NUH	Jun-26	20	0			
Community Waits >52 Weeks (Total)	NHT	Jun-26	237	350			
Community Waits >52 Weeks (Total)	CityCare	Jun-26	0	0			

Commissioner and Provider Actions:

NNICB: 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 continues to work with providers to deliver the N&N Neighbourhood Health 18-month delivery plan, including finalisation of the Core Integrated Neighbourhood Teams (INT) specification, population cohort modelling and development of neighbourhood dashboards. Preparation of the DLN Neighbourhood self-assessment is underway, supported through established programme governance and commissioning delivery groups. In relation to CYP waiting times, the ICB is maintaining targeted contract and performance oversight and continues to implement strategic commissioning interventions to support recovery in therapy services. Although performance remains off plan, there has been a reduction in CYP 52-week waits compared with the previous month, indicating some early progress.

Quality and Clinical Actions:
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.

Oversight of clinical harm review process for those waiting more than 52 weeks through quality schedules requirements and reporting.

Oversight of the Minimum Standards for Planned Patient Care launched on 06/07/26.

2.1 Operational Plan – Exception Reporting

1. **RTT Admitted Pathways (NNICB)** reported 4,359 pathways against a plan of 5,599, an adverse variance of 1,240 pathways. The metric is failing with concerning variation, indicating that admitted pathway delivery is below trajectory, and the underlying position is deteriorating. The position reflects continued elective recovery pressures and reinforces the need to increase elective throughput and productivity. Commissioners continue to seek assurance that provider recovery plans will deliver sustainable activity improvement, rather than relying predominantly on waiting list validation and management activity.

2. **Discharge** performance continues to show signs of deterioration across the cluster, with both **Discharge Ready Date and Average Discharge Delay** identified through SPC analysis as failing with concerning variation. NNICB reported a Discharge Ready Date performance of 77.7% against a plan of 79.4%, whilst DDICB achieved 82.6% against a plan of 82.0%. Average discharge delays were also above plan in both DDICB (5.9 days against a plan of 4.8 days) and LICB (5.7 days against a plan of 4.8 days). Together these measures indicate ongoing challenges in maintaining timely patient flow through inpatient pathways and progressing patients through discharge once clinically ready. The position reflects continued pressures relating to discharge planning, availability of onward care and community capacity. Recovery activity remains focused on reducing delays, strengthening discharge oversight and improving system flow, with commissioners maintaining close assurance of recovery plans and their impact on reducing discharge-related pressures.

3. **G&A Overnight Beds Occupied (%) (NNICB)** was 94.6% against a plan of 94.2%, 0.4 percentage points above plan. Although the numerical variance is relatively small, the metric is failing with concerning variation, indicating sustained pressure and a deteriorating pattern over time. High occupancy reduces operational flexibility and increases the risk of congestion across urgent and emergency care pathways. Recovery remains focused on improving patient flow, reducing discharge delays and strengthening system-wide capacity management.

4. **Total Non-Elective Spells, 0 Day (LICB)** reported 3,543 spells against a plan of 3,224, an adverse variance of 319 spells (9.9%). Performance remains off trajectory with activity continuing to increase, indicating ongoing pressure across urgent and emergency care pathways. Whilst delivery of same-day emergency care can support avoidance of longer inpatient stays, the scale of activity growth suggests demand is currently exceeding planned levels and may be placing additional pressure on system capacity. This position reinforces the importance of continuing to strengthen admission avoidance services, urgent community response, neighbourhood health models and alternative pathways for patients who do not require acute hospital care. Commissioners are maintaining oversight of activity trends and working to better understand the underlying drivers of demand, ensuring recovery actions remain focused on delivering sustainable reductions in avoidable non-elective activity.

5. **LD/Autism Adult Inpatients (DDICB)** reported 36 inpatients against a plan of 31, an adverse variance of five patients. The metric is failing with concerning variation, indicating that the inpatient population is above trajectory and the position is deteriorating. Recovery activity remains focused on preventing avoidable admissions, progressing individual discharge plans and strengthening suitable community alternatives.

6. **Talking Therapies Completing a Course of Treatment (DDICB & NNICB)** is failing with concerning variation in both DDICB and NNICB, indicating delivery is below expected trajectory and continuing to deteriorate. DDICB recorded 1,040 completed courses against a plan of 1,169, whilst NNICB recorded 1,280 against a plan of 1,388, adverse variances of 129 and 108 completed courses, respectively. The position highlights ongoing challenges in supporting patients to complete treatment pathways and achieve planned outcomes. Improvement activity remains focused on maintaining engagement, reducing attrition and ensuring sufficient clinical capacity is available to support treatment completion.

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

1. Delivery Summary:
2. Whilst 18 weeks RTT trajectories have been achieved in parts of the cluster, current performance continues to be supported by validation and waiting-list management activity. In June, Lincolnshire delivered 62.0% against a 61.8% plan and Nottingham and Nottinghamshire delivered 66.9% against 64.7%. Derbyshire was only marginally below plan at 64.2% against 64.4%, a variance of 0.2 percentage points. This provides a positive foundation for recovery, although sustained delivery will depend on activity increasing sufficiently to reduce the overall waiting list.
3. Long waits remain a priority for continued improvement. Derbyshire reported 1.6% of patients waiting over 52 weeks against a 1.5% plan, Lincolnshire 1.5% against 1.0%, and Nottingham and Nottinghamshire 1.9% against 1.0%. The position is therefore slightly above plan in Derbyshire and more challenged in Lincolnshire and Nottingham and Nottinghamshire.
4. Waiting lists were above plan across all three systems, with Derbyshire 2,202 patients above plan, Lincolnshire 3,004 above plan, and Nottingham and Nottinghamshire 273 above plan. Nottingham and Nottinghamshire is closest to its planned position, while the wider cluster position reinforces the need to move from maintaining RTT performance towards sustained waiting-list reduction.
5. First outpatient activity improved during June but remained below plan, with Derbyshire 0.8% below, Lincolnshire 4.5% below, and Nottingham and Nottinghamshire 0.3% below. The comparatively small gaps in Derbyshire and Nottingham and Nottinghamshire provide a platform for recovery, while Lincolnshire requires a stronger improvement in throughput.
6. Community dermatology continues to demonstrate the potential benefit of pathway transformation in Nottinghamshire. Between January and July 2026, 989 NUH referrals were triaged and 42% redirected to community services, contributing to a reported 15% reduction in routine dermatology demand. A review also identified 575 of 1,081 patients, or 53%, as suitable for community-based management.

7. Key Programme Delivery Risks:
8. Current RTT performance will become increasingly difficult to sustain if activity remains below plan.
9. Waiting-list growth and long waits continue to require focused recovery, particularly in high-volume specialties.
10. Diagnostic constraints in MRI, endoscopy and NOUS continue to affect elective throughput.
11. Validation is supporting management of the current position, but recurrent activity and productivity improvement are required to secure sustainable recovery.

12. Commissioner Response and Mitigating Actions:
13. Commissioners are maintaining enhanced oversight of elective recovery through programme governance, contract management and specialty-level assurance processes. This includes regular review of RTT trajectories, waiting list growth, long-wait cohorts and activity delivery to ensure emerging risks are identified early and recovery actions can be accelerated where required.
14. A stronger focus is being placed on the relationship between activity delivery and waiting list reduction. Provider recovery plans are being challenged to demonstrate how additional outpatient, diagnostic and inpatient activity will translate into sustainable reductions in PTLs and long-wait cohorts rather than short-term maintenance of RTT performance alone.
15. Commissioners continue to use contractual and performance framework mechanisms proportionately where delivery remains significantly below trajectory. This includes strengthened monitoring arrangements and escalation through established governance routes where sufficient improvement is not being achieved.
16. Significant focus is being made on pathway redesign and left shift programmes, including community dermatology, ophthalmology, MSK and gynaecology services. Early results in dermatology in Nottinghamshire demonstrate the potential for these approaches to reduce avoidable acute demand, improve access and create additional capacity within hospital services.
17. Commissioners are also developing a more coordinated DLN approach to independent sector utilisation and activity repatriation, ensuring activity is delivered in the most clinically appropriate and financially sustainable setting whilst supporting delivery of elective recovery trajectories

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

1. Delivery Summary:
2. Diagnostics remains an important focus for recovery across the cluster. In June, Derbyshire reported 27.4% of patients waiting over six weeks against a 17.1% plan, Nottingham and Nottinghamshire 29.3% against 22.6%, and Lincolnshire 52.1% against 32.8%. Whilst performance remains off trajectory across all systems, Nottingham and Nottinghamshire is comparatively closer to planned levels.
3. Diagnostic activity remained below plan, with Derbyshire 7.2% below, Lincolnshire 13.2% below, and Nottingham and Nottinghamshire 1.9% below. The relatively small activity variance in Nottingham and Nottinghamshire is encouraging and suggests recovery actions are beginning to support throughput more effectively.
4. Pressure remains concentrated within a limited number of modalities, including audiology, MRI, ECHO, NOUS and endoscopy. This provides a clearer focus for targeted recovery activity and capacity investment.
5. CDC development continues to provide positive opportunities for recovery. Lincolnshire's CDC programme remains approximately six weeks ahead of schedule, while Mansfield CDC is delivering more than 95% of planned activity and continuing to expand capacity.
6. Longer-term capacity is being strengthened through workforce investment, including recruitment of trainee sonographers and planned replacement of diagnostic infrastructure, helping support a more sustainable recovery trajectory

7. Key Programme Delivery Risks:
8. Delivery against DM01 remains below trajectory across all three systems.
9. Workforce and reporting constraints continue to limit sustainable recovery.
10. Temporary capacity solutions remain important but may not provide a recurrent solution.
11. Diagnostic performance continues to constrain elective and cancer pathway recovery.
12. Failure to improve activity delivery risks prolonging waiting list growth.

13. Commissioner Response and Mitigating Actions:
14. Commissioners continue to apply enhanced contractual and performance oversight to diagnostic recovery, with a particular focus on the modalities contributing most significantly to six-week waits and delays across cancer and elective pathways.
15. NHS England diagnostic deep-dive findings are being used proactively to identify opportunities to improve productivity, utilisation and pathway performance, with recommendations incorporated into modality-specific recovery plans.
16. Additional capacity continues to be secured through CDC utilisation, mobile diagnostic units, insourcing and targeted additional sessions, ensuring recovery efforts remain focused on areas of greatest operational impact.
17. Longer-term sustainability is being supported through workforce development, infrastructure improvements and equipment replacement programmes. Expansion of CDC provision across the cluster remains a key strategic component of future recovery.
18. Commissioners are strengthening the alignment between diagnostic recovery, elective care and cancer delivery to ensure activity is coordinated through a pathway-based approach rather than relying on isolated organisational interventions.
19. Continued emphasis is being placed on value for money and ensuring recovery actions support both operational performance and longer-term service sustainability.

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

1. Delivery Summary:
2. Faster Diagnosis performance is showing encouraging signs of improvement in parts of the cluster. Nottingham and Nottinghamshire achieved its June trajectory at 81.3% against an 80.0% plan, demonstrating delivery against the operational target. Derbyshire delivered 78.0% against 80.0%, whilst Lincolnshire delivered 74.0% against 80.1%, indicating that further improvement is still required but with recovery plans in place across all systems.
3. The 62-day standard remains the principal area requiring improvement across the cluster. Derbyshire delivered 64.2% against a plan of 76.5%, Lincolnshire 60.3% against 74.1%, and Nottingham and Nottinghamshire 65.7% against 76.2%. Whilst performance remains below trajectory across all three systems, this reflects common challenges relating to diagnostics, workforce availability and treatment capacity rather than isolated organisational issues
4. Pathway-level improvement is beginning to emerge within a number of tumour sites. Breast pathways have shown significant improvement in Faster Diagnosis performance in Nottingham, with similar methodologies now being replicated within urology pathways. Improvements are also being reported within gynaecology services, although urology continues to represent 24.8% of the current backlog, indicating the need for continued focus
5. Innovation and pathway transformation continue to support delivery. Skin AI is now live in Nottinghamshire and around one-third of patients are being discharged directly from the pathway, helping reduce unnecessary demand on specialist services and improving pathway efficiency. The equivalent pathway is ready for roll out in Lincolnshire. Across the cluster, recovery programmes increasingly focus on pathway redesign, earlier diagnosis and reducing unwarranted variation in performance

6. Key Programme Delivery Risks:
7. Recovery of the 62-day standard remains dependent on sustained improvement in diagnostic, oncology and treatment capacity.
8. Demand continues to grow across a number of tumour sites, increasing pressure on diagnostics, workforce and pathway management.
9. Diagnostic turnaround times continue to affect pathway progression within several key tumour groups.
10. Oncology workforce and treatment capacity constraints remain evident across breast, urology, colorectal, lung and gynaecology services.
11. Significant backlog cohorts remain within a small number of pathways, particularly urology, creating ongoing delivery risk.
12. Without continued improvement in Faster Diagnosis and treatment capacity, recovery trajectories may become increasingly difficult to achieve.

13. Commissioner Response and Mitigating Actions:
14. Commissioners continue to strengthen tumour-site accountability through regular recovery meetings, contract management arrangements and NHS England oversight processes, ensuring clear ownership of delivery and targeted intervention where performance remains below trajectory.
15. Recovery resources are increasingly being focused on the pathways contributing most significantly to backlog growth and performance variance, including urology, gynaecology, colorectal and skin pathways. Programme governance is ensuring these interventions remain aligned to delivery of both Faster Diagnosis and 62-day standards.
16. Additional capacity, backlog reduction initiatives and pathway redesign programmes remain central to provider recovery plans. Commissioners are maintaining close oversight to ensure these actions translate into sustained improvement and not solely short-term reductions in backlog.
17. Innovation continues to support pathway improvement, including Skin AI and other digitally enabled solutions designed to improve triage, pathway control and earlier decision making. Opportunities to spread successful approaches across additional tumour sites are being actively explored.
18. Recovery planning is increasingly focused on whole-pathway improvement, ensuring diagnostics, oncology capacity and treatment delivery are aligned and collectively support achievement of national standards.
19. Commissioners continue to work closely with NHS England and provider cancer teams to ensure best practice is identified, shared and implemented consistently across the cluster, supporting sustainable improvements in both access and patient outcomes.

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

Delivery Summary:

1. Urgent and Emergency Care performance remains mixed across the cluster, with positive delivery evident in parts of the system despite ongoing flow pressures. In June, Lincolnshire delivered 79.4% against a plan of 74.6%, exceeding trajectory by 4.8 percentage points, while Derbyshire delivered 74.2% against 74.9%, remaining close to plan despite the recognised data quality caveat affecting emergency care reporting. Nottingham and Nottinghamshire delivered 69.0% against a plan of 78.4%, reflecting continued pressure across the urgent care pathway
2. The principal challenge continues to be system flow rather than front-door performance alone. Twelve-hour waits remained above plan across all three systems, with Derbyshire reporting 12.2% against 4.4%, Lincolnshire 15.6% against 9.3%, and Nottingham and Nottinghamshire 10.5% against 7.8%. This highlights the ongoing impact of discharge delays, bed occupancy and inpatient flow on overall urgent care performance.
3. Ambulance performance continues to be affected by wider system pressures. Category 2 response times remained above trajectory in all three systems, with Derbyshire 3 minutes 38 seconds above plan, Lincolnshire 16 minutes 15 seconds above plan, and Nottingham and Nottinghamshire 1 minute 41 seconds above plan. Whilst improvement initiatives are underway, ambulance responsiveness continues to be influenced by delays elsewhere within the urgent care pathway
4. Lincolnshire continues to demonstrate positive operational resilience despite significant demand. Type 1 attendances were reported at 5.3% above plan, whilst four-hour performance remained above trajectory. This reflects the benefit of established front-door streaming arrangements and admission avoidance approaches, although downstream pressures remain evident through ambulance handover delays and prolonged waits
5. Across the cluster there are encouraging signs of stronger system coordination and oversight. Progress with discharge pathways, Transfer of Care development, admission avoidance services and winter planning provides a more robust platform for recovery, although sustained improvement will depend on continued whole-system focus on flow and capacity.
6. Key Programme Delivery Risks:
7. Twelve-hour waits remain above plan across all three systems and continue to present a significant system flow challenge.
8. Ongoing discharge delays and high bed occupancy are limiting the pace of recovery and reducing operational resilience.
9. Ambulance response times and handover delays remain under pressure across the cluster.
10. Recruitment and mobilisation challenges within discharge and admission avoidance services may delay recovery.
11. Increased seasonal demand may place additional pressure on already constrained pathways if improvements in flow are not sustained.
12. Commissioner Response and Mitigating Actions:
13. Commissioners are strengthening whole-system oversight through refreshed governance arrangements that bring together providers, local authorities and system partners to focus collectively on patient flow, discharge performance, ambulance handovers and admission avoidance. This approach is providing greater visibility of operational risks and supporting more coordinated delivery across organisations.
14. Development of a single Transfer of Care Hub remains a key strategic priority and is expected to improve coordination across discharge pathways, reduce duplication of process and provide greater visibility of available capacity across health and social care partners. Work on service design and mobilisation planning continues through the commissioning programme.
15. Commissioners are reviewing admission avoidance, intermediate care and discharge pathways through the DLN commissioning programme to ensure future service models are aligned to neighbourhood delivery, population need and value for money principles. Focus is being given to reducing avoidable admissions and supporting earlier discharge
16. Planning for winter resilience is well advanced, with systems using current operational intelligence to identify delivery risks, strengthen resilience and ensure mitigations are implemented ahead of anticipated seasonal pressures. Learning from current performance is being incorporated into winter planning assumptions across the cluster.
17. Positive operational practice is increasingly being shared across organisations, including learning from front-door streaming, admission avoidance and discharge initiatives. Whilst recognising local differences in demand and capacity, the cluster is working to replicate successful approaches where they can deliver sustainable improvement in patient flow and urgent care performance.

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

Delivery Summary:

1. Adult community performance remains a positive area across the cluster. Lincolnshire and Nottingham and Nottinghamshire reported zero adults waiting over 52 weeks, whilst Derbyshire reported only 4 waits against a plan of 92, remaining materially better than trajectory. This demonstrates continued delivery of the adult waiting time standard despite wider pressures across health and care services.
2. Children and Young People's waiting times remain the principal community delivery challenge. Derbyshire reported 803 CYP waits over 52 weeks against a plan of 62, Lincolnshire reported 1,326 waits against a plan of 1,326, and Nottingham and Nottinghamshire reported 257 waits against a plan of 250. While pressure remains significant, the position varies considerably across the cluster and reflects differing demand, pathway and capacity challenges.
3. Lincolnshire is delivering its agreed trajectory, although the absolute backlog remains substantial at 1,326 waits, reinforcing the importance of maintaining recovery activity and securing a credible long-term reduction plan
4. Nottingham and Nottinghamshire remains close to plan and reported improvement compared to the previous month. CYP waits were 257 against a plan of 250, with reductions reported in Occupational Therapy waits and continued focus on Speech and Language Therapy recovery. This provides encouraging evidence that targeted intervention and oversight are beginning to deliver improvement
5. Community services continue to play an increasingly important role in wider system transformation. Across the cluster, neighbourhood delivery models, integrated care approaches and system-wide pathway redesign programmes continue to mature, supporting a longer-term shift towards prevention, earlier intervention and care closer to home

6. Key Programme Delivery Risks:
7. Sustained growth in CYP demand continues to exceed available workforce and service capacity across several pathways.
8. Community Paediatrics, Speech and Language Therapy, Occupational Therapy and neurodevelopmental services continue to experience significant pressure.
9. Derbyshire's CYP waiting list position remains materially above trajectory and requires continued validation and recovery activity.
10. Whilst Lincolnshire is achieving its agreed trajectory, the overall backlog remains substantial and presents an ongoing delivery challenge.
11. Workforce availability, recruitment challenges and increasing complexity of need may reduce the pace of recovery.
12. Delivery remains closely linked to wider SEND, neighbourhood and system transformation programmes, creating dependencies outside direct provider control.

13. Commissioner Response and Mitigating Actions:
14. Commissioners are prioritising validation and assurance of CYP waiting list positions across the cluster to ensure recovery actions are informed by accurate and consistent pathway-level intelligence. This is helping provide a clearer understanding of demand, capacity and the drivers of long waits
15. Additional assurance is being sought from providers where recovery trajectories remain unclear or where confidence in the pace of improvement is limited. Formal contract management and programme governance arrangements are being utilised to strengthen delivery oversight and maintain organisational accountability.
16. Recovery planning is increasingly focused on developing sustainable solutions rather than relying solely on short-term capacity measures. Commissioners are working with providers to understand pathway demand, workforce requirements and opportunities for service redesign that can support long-term improvement.
17. Community recovery is being aligned with wider neighbourhood health, SEND and transformation programmes to support a more integrated approach to improving outcomes for children and young people. This is intended to reduce fragmentation and strengthen coordination across health, education and care services.
18. Demand and capacity modelling is being used to support future commissioning decisions across therapy, neurodevelopmental and paediatric services. This will help ensure future investment and service developments are targeted towards areas of greatest need and risk. Providers continue to be supported and challenged to develop credible recovery trajectories with clear milestones, measurable improvements and demonstrable reductions in long-wait cohorts. Commissioners will maintain close oversight to ensure recovery plans remain realistic, deliverable and focused on achieving sustainable improvement

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

Delivery Summary

1. Primary care access continues to be a positive area of delivery across the cluster. All three ICBs exceeded their June trajectories for clinically urgent same-day appointments. Derbyshire delivered 75.0% against a plan of 70.0%, Lincolnshire 71.3% against 68.7%, and Nottingham and Nottinghamshire 78.9% against 75.0%. This demonstrates continued progress towards the national ambition and reflects sustained focus on improving timely access to general practice services.
2. Strong same-day access performance is supported by delivery of overall GP appointment activity. Derbyshire delivered 84,688 appointments above plan, Lincolnshire 52,321 above plan, and Nottingham and Nottinghamshire 134,762 above plan. This indicates that systems are delivering both urgent and routine activity at scale and are maintaining access despite ongoing workforce pressures.
3. Dental services remain the principal area requiring improvement. In June, Derbyshire was 264 UDAs below plan, Lincolnshire 13,809 below plan, and Nottingham and Nottinghamshire 14,848 below plan, giving a combined shortfall of almost 29,000 UDAs across the cluster. While recovery programmes are underway, access to NHS dentistry continues to present a significant challenge nationally and locally.
4. Practice-level variation continues to be monitored closely. Whilst the overall cluster position remains positive, commissioners recognise the importance of ensuring improvements are delivered consistently across practices and population groups, with ongoing work to improve coding quality, reporting accuracy and adoption of best practice.
5. Primary care continues to play an important role in wider system transformation. Delivery of same-day access, Pharmacy First and digital access initiatives are supporting demand management across urgent care pathways and helping to ensure patients can access support through the most appropriate route.

Key Programme Delivery Risks

1. Workforce pressures across general practice, dentistry and community pharmacy continue to present a risk to sustaining current levels of delivery and access.
2. Variation in practice-level performance and adoption of access models may result in inconsistent patient experience across systems.
3. Dental activity remains below trajectory across all three ICBs and continues to represent the most significant primary care delivery risk.
4. Continued demand growth may place additional pressure on practices, particularly where recruitment and workforce availability remain challenging.
5. Reliance on alternative access routes, including Pharmacy First and digital services, requires sustained provider engagement and public uptake to support wider system demand management.

Commissioner Response and Mitigating Actions

1. Commissioners are maintaining strong oversight of primary care access delivery and continue to support progress towards the national ambition for clinically urgent same-day access through regular performance review, targeted engagement with practices and system-wide monitoring of access measures. This is helping ensure positive performance is sustained and that emerging risks are identified at an early stage.
2. Detailed practice-level analysis is being used to identify unwarranted variation in access performance and support targeted improvement activity where required. This approach allows commissioners to provide focused support to practices whilst sharing learning from those consistently delivering strong performance.
3. Data quality and coding remain important priorities across the cluster. Commissioners continue to work with practices to improve consistency in appointment recording and reporting, providing greater confidence that reported performance accurately reflects patient access and operational delivery.
4. Dental access remains a major commissioning priority. Recovery activity includes implementation of the 110% delivery scheme, UDA rebasing and recommissioning opportunities designed to maximise available contractual capacity and improve access to NHS dental services. Commissioners are maintaining oversight of delivery to ensure available resource translates into additional patient activity.
5. Ongoing review of programme outcomes is helping identify where further intervention may be required and ensuring that investment supports sustainable improvements in access, utilisation and patient experience. This includes monitoring variation, uptake and delivery across local providers.
6. Primary care recovery continues to be aligned with broader neighbourhood health, Pharmacy First and digital access programmes. This supports wider system objectives around demand management, prevention and ensuring patients can access support through the most appropriate setting.

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

Delivery Summary:

1. Mental health delivery remains positive across several core access and recovery measures. Performance against Individual Placement and Support (IPS), Early Intervention in Psychosis (EIP) and Talking Therapies recovery standards remains strong across much of the cluster, reflecting continued focus on access, early intervention and recovery-focused care.
2. Out-of-area placement performance remains encouraging in Derbyshire and Lincolnshire. Both systems reported zero inappropriate out-of-area placements, supporting progress towards the national ambition of eliminating inappropriate placements by March 2028. Nottingham and Nottinghamshire reported 10 placements against a plan of 8, remaining above trajectory but with active management arrangements in place to support recovery.
3. Inpatient flow and length of stay remain the principal operational challenge. Derbyshire reported an older adult mean length of stay of 78.0 days against a plan of 81.5 days, performing better than trajectory. Nottingham and Nottinghamshire reported 93.0 days against a plan of 77.2 days, whilst Lincolnshire reported 137.0 days against 57.7 days, reflecting the continued complexity of discharge arrangements and the availability of appropriate community support and placements.
4. Children and Young People's mental health services continue to demonstrate positive access delivery, although some specialist pathways remain under pressure. CYP Eating Disorder routine waiting time performance delivered 93% in Derbyshire, 86% in Nottingham and Nottinghamshire and 50% in Lincolnshire, against the national standard of 95%. Small numbers of patients accessing the services and patient choice to delay treatments remain key drivers of the position.
5. Learning Disability and Autism performance remains broadly positive. Annual Health Check delivery is ahead of plan across all three ICBs, with Derbyshire 31 above plan, Lincolnshire 48 above plan, and Nottingham and Nottinghamshire 176 above plan. However, inpatient flow remains an important area of focus, particularly where discharge complexity and community placement availability continue to affect trajectory delivery.
6. Key Programme Delivery Risks:
7. Inpatient flow and Learning Disability and Autism inpatient reduction are increasingly constrained by system-wide dependencies, including housing, supported accommodation, social care, rehabilitation, specialist provider-market capacity and suitable community alternatives. These issues cannot be resolved through provider action alone and require coordinated commissioner, provider and local-authority intervention.
8. Older adult length of stay continues to remain above trajectory in parts of the cluster and is limiting progress towards improved inpatient flow and bed utilisation.
9. Urgent and crisis responsiveness remains variable across the cluster, reinforcing the need for more consistent same-day access, crisis alternatives, home treatment and onward pathways. CYP Eating Disorder performance also remains below the national standard across all three systems.
10. Delivery of Learning Disability and Autism inpatient reduction trajectories remains dependent upon the availability of community accommodation, supported living provision and timely discharge arrangements.
11. Commissioner Response and Mitigating Actions:
12. Commissioners are maintaining close oversight of inpatient flow and discharge through MADE processes, delayed transfer reviews and strengthened partnership working across providers, local authorities and community services. These arrangements are helping ensure barriers to discharge are identified earlier and escalated appropriately where system intervention is required.
13. Additional leadership oversight of Section 117 arrangements and discharge planning processes is supporting more timely decision making in complex cases. This work is designed to improve patient flow, reduce avoidable inpatient delays and strengthen delivery against length-of-stay trajectories across the cluster.
14. Recovery plans are actively monitored for Talking Therapies completion rates, CYP Eating Disorder performance and other measures where delivery remains below trajectory. Commissioners continue to work closely with providers to ensure recovery actions remain realistic, evidence-based and focused on sustainable improvement.
15. Programme assurance will increasingly test whether transformation is delivering measurable changes in access, crisis demand, admissions, length of stay, delayed discharge and reliance on out-of-area or independent-sector care. Development of a single integrated MHLDA dashboard, using common definitions and place-level trajectories, will support exception-led assurance across performance, finance, quality, inequalities and programme delivery.
16. The MHLDA Programme Board provides the principal cluster-wide route for integrating performance, transformation, finance, quality, inequalities and risk. Local contract arrangements retain responsibility for first-line provider recovery, with unresolved or cross-system issues escalated through the Programme Board and, where required, to the Commissioning Oversight Group. Financial recovery will be managed alongside service transformation, with schemes expected to demonstrate clinically credible activity change, quality and equality impact, clear milestones and realised benefit.

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

1. Delivery Summary:
2. CYP delivery remains mixed but broadly positive across the cluster, with a number of key access measures performing well and strengthened programme governance now supporting more coordinated oversight. The DLN CYP Programme Board and Delivery Board are fully established and are providing greater focus on recovery, escalation and delivery across system partners.
3. Derbyshire continues to deliver positive CYP mental health access performance, with activity remaining ahead of plan. The principal area requiring continued improvement relates to community waiting times, particularly within Community Paediatrics and Community Physiotherapy pathways, where validation and recovery activity is ongoing to better understand demand and target intervention appropriately.
4. Lincolnshire is also delivering CYP mental health access ahead of trajectory and continues to maintain Learning Disability and Autism inpatient numbers within tolerance. The main challenge remains within Community Paediatric neurodevelopmental pathways, which account for the majority of CYP 104-week waits. The recent inclusion in the national GIRFT Neurodevelopmental Pathway programme provides a positive opportunity to support pathway redesign and longer-term recovery.
5. Nottingham and Nottinghamshire continues to demonstrate positive delivery across several priority measures. CYP mental health access remains on track, while 104-week wait recovery is progressing in line with expectations. Within therapy pathways, Occupational Therapy waits reduced from 103 to 90, demonstrating encouraging progress. However, Speech, Language and Communication Needs waits increased from 87 to 118, reflecting sustained demand pressures and providing a clear focus for further recovery activity.
6. The programme is increasingly supporting a more coordinated cluster-wide approach to CYP recovery. Opportunities presented through Experts at Hand funding, pathway redesign and collaborative commissioning arrangements are helping strengthen early intervention, improve pathway alignment and support more consistent delivery across the DLN footprint.
7. Key Programme Delivery Risks:
8. Demand across CYP services continues to increase, particularly within neurodevelopmental, speech and language therapy and occupational therapy pathways.
9. Significant long-wait cohorts remain within a number of community-based services, with continued pressure on assessment capacity and workforce availability.
10. Derbyshire community waiting times require continued validation and recovery activity to ensure performance improvement actions are appropriately targeted.
11. Lincolnshire's recovery remains dependent upon long-term improvement within neurodevelopmental pathways and continued delivery of GIRFT recommendations.
12. Growing demand, workforce challenges and increasing case complexity continue to affect recovery across several CYP pathways.
13. Strong interdependencies remain with SEND services, community provision, local authority partners and wider system transformation programmes, creating risks that cannot be addressed through provider action alone.
14. Commissioner Response and Mitigating Actions:
15. Commissioners are utilising the DLN CYP Programme Board to provide stronger strategic oversight, delivery assurance and escalation across the cluster. The governance model is creating clearer accountability, improving visibility of delivery risks and supporting more coordinated system-wide action.
16. A more pathway-based commissioning approach is being adopted, recognising that many of the current challenges are driven by demand growth, workforce pressures and SEND-related factors that require whole-system solutions rather than isolated provider interventions. Commissioners are therefore working across organisational boundaries to support sustainable recovery.
17. Targeted recovery work continues across Community Paediatrics, Speech and Language Therapy, Occupational Therapy and neurodevelopmental pathways. Demand and capacity analysis is being used to improve understanding of service pressures and inform future recovery priorities, commissioning decisions and workforce planning.
18. Commissioners continue to support service redesign, workforce initiatives and pathway improvement programmes aimed at reducing long waits and improving access. This includes work on referral criteria, triage processes, discharge pathways, digital solutions and optimisation of existing workforce capacity.
19. Development of enhanced performance reporting and dashboard arrangements will provide greater visibility of recovery progress, support improved assurance and enable earlier identification of emerging delivery risks. This is expected to strengthen commissioner challenge and support more effective decision making across the programme.

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

1. Delivery Summary:
2. The DLN Women's Health Programme has continued to progress from programme development into implementation, providing a stronger foundation for delivery of national and regional priorities across the three ICBs. A shared cluster-wide approach is now established, with increasing focus on translating strategic ambitions into operational delivery and measurable improvement.
3. Development of neighbourhood-based Women's Health models continues to advance across the cluster. Current priorities include gynaecology, heavy menstrual bleeding, pelvic pain and urogynaecology pathways, with a focus on improving access, reducing inequalities and delivering more care closer to home where clinically appropriate. These developments have the potential to reduce pressure on acute services whilst improving patient experience and outcomes.
4. The programme is increasingly drawing upon population health intelligence and health equity assessments to support decision making. This is providing a stronger evidence base for future commissioning decisions and helping ensure that improvement activity is targeted towards areas of greatest need, variation and health inequality.
5. Positive progress has also been made in developing enabling infrastructure for future delivery. This includes engagement with the CLEAR Women's Health Neighbourhood Transformation Programme, development of digital support solutions, strengthened programme reporting arrangements and work to establish a Women's Health Alliance to support stakeholder engagement and co-production.
6. Whilst the programme is not yet supported by a mature set of operational performance measures, foundations are now being established to support future reporting and assurance. The focus during this phase is appropriately centred on implementation, governance, pathway development and creation of a robust performance framework that will support measurable delivery in future reporting cycles.
7. Key Programme Delivery Risks:
8. National policy and guidance continue to evolve, creating the potential for further refinement of local priorities, programme structures and delivery plans.
9. Delivery remains dependent upon sufficient programme, clinical and operational capacity across partner organisations to support implementation at pace.
10. Progression of neighbourhood-based Women's Health models remains dependent upon agreement across the DLN footprint regarding commissioning arrangements, funding models and service specifications.
11. The programme remains at a relatively early stage of maturity compared with more established operational programmes, with ongoing dependency on development of reporting frameworks, baseline measures and benefit realisation arrangements.
12. Commissioner Response and Mitigating Actions:
13. Commissioners have established a shared DLN Women's Health Programme and Delivery Plan, providing a stronger foundation for delivery of national priorities and ensuring greater consistency of approach across Derbyshire, Lincolnshire and Nottingham and Nottinghamshire. Programme governance arrangements continue to mature, supporting stronger accountability and oversight of delivery.
14. Implementation of the Women's Health Delivery Plan is creating clearer ownership of workstreams, delivery milestones and performance expectations. Commissioners are using these arrangements to provide greater assurance that programme activity remains focused on delivering measurable improvements in access, outcomes and patient experience.
15. Development of neighbourhood-based Women's Health models remains a major strategic priority. Commissioners are working with providers and system partners to develop sustainable pathways for gynaecology, pelvic pain, heavy menstrual bleeding and urogynaecology services, supporting delivery closer to home and reducing unnecessary reliance on acute hospital services.
16. Population health intelligence, health equity assessments and local needs analysis continue to inform programme priorities and commissioning decisions. This approach is helping ensure resources and transformation activity are directed towards areas of greatest opportunity and greatest inequality.
17. Work is ongoing to develop dashboards, reporting arrangements, key performance indicators and benefits realisation measures. These developments will strengthen future performance oversight and provide a more comprehensive understanding of programme impact across the cluster.

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 i**mproved 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.

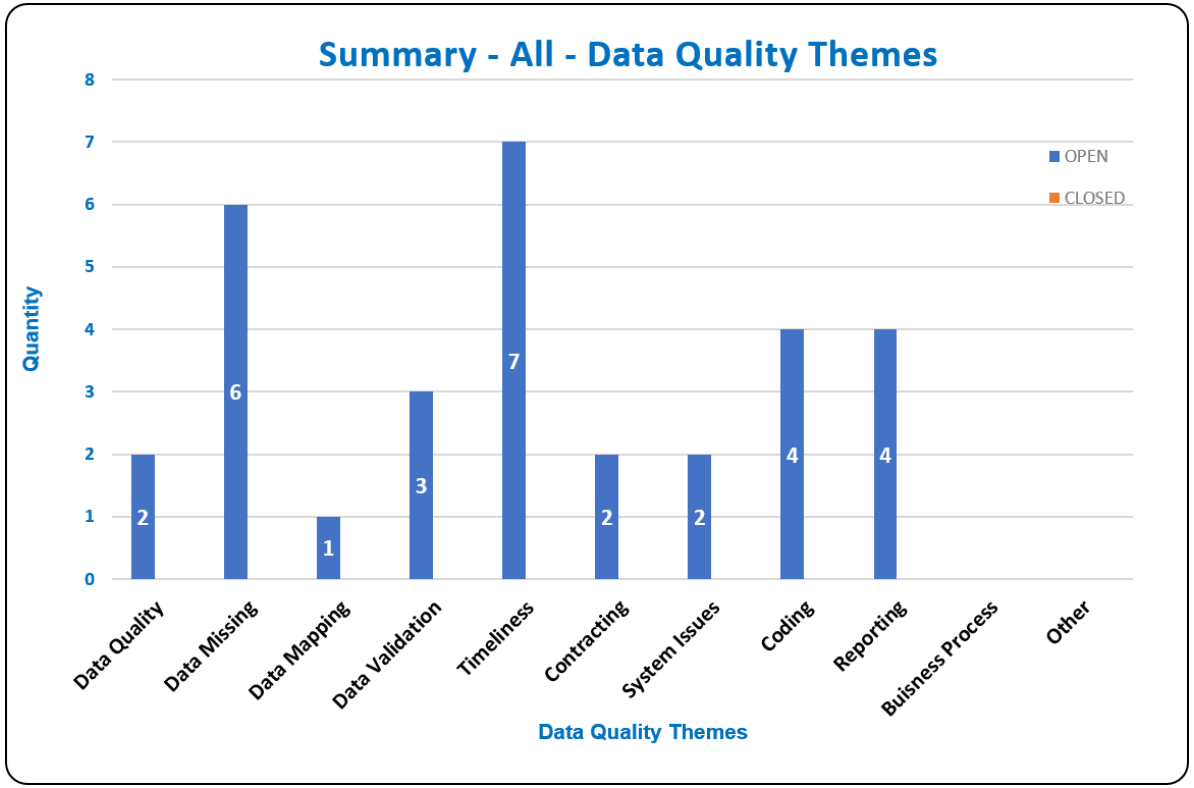
6. Q1 2026/27 will be the first quarter assessed against the new framework. Segmentation will be included in future reports when published by NHSE.

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

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 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: 31 active data quality issues across the cluster, of which 22 relate to acute data, with 9 relating to non acute. Across acute and non-acute care, there are 6 issues relating to missing data and 7 relating to timeliness of data received. 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 chart below summarises the volume and type of issues logged on the data quality register at the end of August 2026; most issues relate to inaccurate or late 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 attendance reporting.



Meeting title	Integrated Care Boards: Open Session (meeting in common)
Meeting date	17/09/2026
Paper title	**Finance Report**
Paper reference	ICB CIC 26 053
Paper author	Rebecca McCauley, Senior Finance Business Partner, NHS Derby and Derbyshire ICB
Paper sponsor	Bill Shields, Executive Director of Finance
Presenter	Bill Shields, Executive Director of Finance

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 four-month period April 2026 to July 2026.

All three ICBs continue to forecast delivery of their planned full-year financial positions. The ICBs are reporting a £3.7 million adverse year-to-date position at Month four in line with plans. The full-year forecast remains aligned to plan across all organisations to deliver a break-even position.

The ICBs continue to forecast delivery of their £163.1 million efficiency programme. However, £5.7 million of recurrent efficiency under delivery is currently being offset by non-recurrent savings, resulting in a deterioration in the underlying position.

The ICBs are reporting gross forecast risks of £77.0 million, principally relating to efficiency delivery (£33.2 million), additional cost pressures (£24.8 million), prescribing and continuing healthcare expenditure (£13.3 million). Identified mitigations fully offset these risks, resulting in a net nil risk position. Delivery of the forecast remains dependent on the successful implementation and maturity of these mitigating actions.

Whilst the overall financial position remains in line with plan, continued focus is required on recurrent efficiency delivery, management of demand-led cost pressures and the delivery of planned mitigations to maintain financial sustainability and achieve year-end objectives.

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

Joined Up Care Derbyshire

NHS Lincolnshire

Integrated Care System
Nottingham & Nottinghamshire

Finance Report July 2026 (Month 4)

Contents

Systems Overview

System Provider Metrics Month 4

Organisation	I&E Postion Including Deficit Support Funding			
	YTD Plan £'m	YTD Actual £'m	YTD Variance £'m	
DD ICS	(18.8)	(18.9)	(0.1)	R
L ICS	(12.6)	(12.4)	0.2	G
NN ICS	(38.7)	(70.0)	(31.3)	R
Grand Total DLN	(70.1)	(101.3)	(31.2)	R

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

At month 4, the DLN ICS is reporting a deficit of £101.3m against a planned deficit position of £70.1m, an adverse variance of £31.2m. Lincolnshire are ahead of plan at month 4 with Derbyshire £0.1m adverse to plan and Nottinghamshire reporting a £31.3m adverse variance.

VARIANCE

KEY DRIVERS

The primary drivers of the variance within Nottinghamshire are, Nottingham University Hospitals (£17.6m adverse), reflecting pay cost pressures and under-delivery of efficiencies, Sherwood Forest Hospitals (£6.9m adverse) with under-delivery of efficiencies and other cost pressures, and Nottinghamshire Healthcare (£6.8m adverse), driven by both pay and non-pay pressures.

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

Efficiencies

£11.5m BEHIND PLAN

At Month 4, efficiency delivery is £11.5m behind the planned £150.5m. All systems are reporting behind plan, with Derbyshire £8.5m adverse (University Hospitals Derby and Burton at £5.3m and the ICB £4.1m), Lincolnshire £0.4m behind plan (across all providers), and Nottinghamshire £2.6m behind plan, driven by Nottingham University Hospitals (£4.2m) and Sherwood Forest Hospitals (£3.0m).

DELIVERY

FULL-YEAR PLAN

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

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

ICBs (1 of 3)

All three ICBs forecast delivery of plan; sustainability remains dependent on mitigations and recurrent efficiency delivery.

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	(4.1)	R	1.1	G	3.0	G	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G
Spend of Capital Allocation	0.0	G	0.3	G	0.0	G	0.3	G	0.0	G	0.0	G	0.0	G	0.0	G
Spend of Running Cost Allocation	0.9	G	0.6	G	0.8	G	2.3	G	2.7	G	1.7	G	2.3	G	6.8	G
Mental Health Investment Standard	N/A	-	N/A	-	N/A	-	N/A	-	0.1	G	0.0	G	0.0	G	0.1	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	-	22.8	G	(15.2)	R	(10.8)	R	(3.2)	R
Better Payment Practice Code	>95%	G	>95%	G	>95%	G	>95%	G	>95%	G	>95%	G	>95%	G	>95%	G

DELIVERY

ON PLAN

All three ICBs and the forecast plan delivery, including full-year efficiency plans.

RISK

FULLY MITIGATED

£77.0m of gross forecast risk is fully offset by mitigations, with delivery requiring continued oversight.

WATCHPOINT

SUSTAINABILITY

Delivery remains reliant on mitigations and recurrent efficiency improvement; reduce dependence on one-off measures.

ICBs (2 of 3)

Plan remains deliverable; major pressures are offset, but efficiency recovery and mitigation delivery remain critical.

FINANCIAL PRESSURES

£23.9m adverse Prescribing

£19.6m adverse MHLDA

£3.3m adverse CHC

Demand growth, pricing, complex care packages and efficiency delivery remain the key drivers.

LARGEST OFFSETS

£28.0m favourable Other Programme Services

£10.4m favourable Specialised Commissioning

£3.9m favourable Other primary care

These offsets continue to support the balanced forecast.

EFFICIENCY WATCHPOINT

£163.1m Full-year efficiency plan

£5.7m Recurrent under-delivery

£33.2m Risk-adjusted shortfall fully mitigated

£5.7m of recurrent efficiency under-delivery is currently being replaced by non-recurrent savings, creating an ongoing sustainability risk.

The ICBs remain on track to deliver plan; £77.0m of gross forecast risk is fully mitigated within forecast positions, although delivery remains dependent on mitigation delivery, recurrent efficiency recovery and active management of prescribing, Mental Health, Learning Disabilities and Autism (MHLDA) and Continuing Healthcare (CHC) pressures.

ICBs (3 of 3)

Risks remain fully mitigated; sustainability depends on mitigation delivery and improved recurrent efficiency performance.

RISK & SUSTAINABILITY

£77.0m gross forecast risk fully mitigated

£3.2m deficit Indicative proxy underlying

Reliance on non-recurrent efficiencies remains a sustainability concern.

The £3.2m proxy position is subject to further review and validation as the underlying data and assumptions are worked through.

CASH & WORKING CAPITAL

Cash remains within the available envelope but is £91.3m overdrawn against a straight-lined profile due to timing of payment and phasing of efficiency schemes.

£10.6m overdue payables

£2.3m overdue receivables

Unvalidated BPPC position

A national reporting issue is under review. Reported performance may change materially when corrected and could fall below the 95% target; a validated update will follow.

BOARD FOCUS

- Maintain oversight of prescribing, MHLDA and CHC pressures.
- Monitor delivery and maturity of mitigations supporting the balanced forecast.
- Improve recurrent efficiency delivery and reduce reliance on non-recurrent measures.
- Review underlying-position and run-rate reporting at Month 5.

Appendix 1 –System Income and Expenditure

TOTAL Income and Expenditure Summary	Net Expenditure									
	Year to Date					Full Year				
	Plan	Actual	Variance			Plan	Actual	Variance		
	£m	£m	£m	%		£m	£m	£m	%	
Revenue Resource Limit	(1,907.5)					(5,799.7)				
Acute Services	1,366.2	1,364.6	1.7	0.1%	G	4,034.5	4,032.8	1.6	0.0%	G
Acute services - NHS	1,290.5	1,288.1	2.4	0.2%	G	3,830.4	3,827.2	3.1	0.1%	G
Acute services - Independent/commercial sector	65.5	66.3	(0.7)	(1.1%)	R	188.6	189.6	(1.0)	(0.5%)	R
Acute services - Other non-NHS	6.0	6.4	(0.4)	(6.3%)	R	17.9	18.3	(0.4)	(2.1%)	R
Acute Services - Other Net Expenditure	4.2	3.9	0.3	7.9%	G	(2.5)	(2.3)	(0.2)	6.5%	G
Community Health Services	250.3	250.3	0.0	0.0%	G	737.5	737.2	0.3	0.0%	G
Mental Health Services	311.1	321.7	(10.6)	(3.4%)	R	923.4	942.9	(19.6)	(2.1%)	R
MH Services - NHS	194.7	197.1	(2.4)	(1.2%)	R	577.5	585.1	(7.5)	(1.3%)	R
MH Services - Independent / Commercial Sector	67.6	67.2	0.4	0.6%	G	200.1	199.5	0.6	0.3%	G
MH Services - Other non-NHS	46.6	58.1	(11.6)	(24.9%)	R	141.5	159.1	(17.6)	(12.4%)	R
MH Services - Other net expenditure	2.3	(0.7)	3.0	132.8%	G	4.3	(0.7)	5.0	116.5%	G
Continuing Care Services	129.6	130.8	(1.2)	(0.9%)	R	382.4	385.7	(3.3)	(0.9%)	R
Prescribing	198.0	209.8	(11.8)	(5.9%)	R	590.4	614.3	(23.9)	(4.1%)	R
Delegated Primary Medical Services	239.5	239.1	0.5	0.2%	G	722.6	722.2	0.4	0.1%	G
Delegated Dental, Ophthalmic and Pharmacy	103.7	101.9	1.9	1.8%	G	348.3	347.5	0.7	0.2%	G
Dental Services	59.3	58.3	1.0	1.7%	G	212.4	212.4	0.0	0.0%	G
Ophthalmic Services	11.4	10.8	0.6	5.3%	G	35.1	34.5	0.6	1.7%	G
Pharmacy Services	33.0	32.8	0.2	0.7%	G	100.7	100.6	0.1	0.1%	G
Other Primary Care Services	34.0	32.4	1.5	4.6%	G	97.3	93.4	3.9	4.0%	G
Delegated Specialised Commissioning	283.3	279.8	3.5	1.2%	G	886.3	875.9	10.4	1.2%	G
Other Programme Services	27.3	14.0	13.3	48.7%	G	78.0	50.0	28.0	35.9%	G
Reserves/Contingencies	(1.5)	(2.8)	1.3	(81.0%)	R	107.4	106.0	1.5	1.4%	G
Total Programme	**2,941.5**	**2,941.5**	**0.0**	**0.0%**	G	**8,908.0**	**8,908.0**	**0.0**	**0.0%**	G
Running Costs	14.3	14.3	0.0	0.0%	G	43.0	43.0	0.0	0.0%	G
Grand Total	**2,955.8**	**2,955.8**	**0.0**	**0.0%**	G	**8,951.0**	**8,951.0**	**0.0**	**0.0%**	G
Surplus/(Deficit)	(3.7)	(3.7)	**0.0**	**0%**	G	**0.0**	**0.0**	**0.0**	**0%**	G
Less Non Recurrent Deficit Support Funding	(1.4)	(1.4)	**0.0**	**0%**	G	(4.3)	(4.3)	**0.0**	**0%**	G
Surplus/(Deficit) excluding Non-Recurrent Deficit Support Funding	(5.2)	(5.2)	**0.0**	**0%**	G	(4.3)	(4.3)	**0.0**	**0%**	G

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	17/09/2026
Paper title:	**Board Assurance Framework: Mid-year update**
Paper reference:	ICB CIC 26 054
Paper author:	Siân Gascoigne, Assistant Director of Corporate Affairs, NHS Nottingham and Nottinghamshire ICB Lucy Branson, Director of Corporate Governance and Assurance
Paper sponsor:	Amanda Sullivan, Chief Executive
Presenter:	Lucy Branson

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

Report summary:

The joint Board Assurance Framework provides reasonable assurance that appropriate controls and assurance arrangements are in place across the nine strategic risk groupings, with no significant control or assurance gaps identified. Four risks are within appetite and five remain above appetite: population health intelligence, financial sustainability and contracts, quality improvement, access and performance, and cyber resilience. Priority action is focused on strengthening and aligning controls in these areas, improving assurance regarding control effectiveness, and supporting merger readiness.

Recommendation(s):

The Boards are asked to:

- **Receive** and scrutinise the mid-year position of the joint Board Assurance Framework, noting the five risks above appetite and the priority actions set out in Appendix A.
- **Approve** the revised narrative for Risk 11.

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: Summary strategic risk position
Appendix B: 2026/27 Board Assurance Framework

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Board Assurance Framework: Mid-year update

Introduction

1. The joint Board Assurance Framework (BAF) is the Boards' primary mechanism for overseeing the principal strategic risks to the delivery of the ICBs' objectives and statutory duties. It brings together the controls, sources of assurance, and mitigating actions for each risk to enable the Boards to assess the effectiveness of governance, risk management and internal control arrangements.
2. Since the BAF was last reported to the Boards in March 2026, further reviews have been undertaken with Executive Directors, senior leaders, and through the Boards' committee structure. This has included implementation of the Boards' revised risk appetite framework and completion of the first cycle of committee-based BAF reviews.
3. This report presents the mid-year assurance position, summarises changes to the strategic risks, and highlights the principal control developments, assurance messages and priorities for further action. The full BAF is attached at Appendix B.

Overall Board assurance position

4. The BAF indicates that appropriate controls and assurance arrangements are in place across all strategic risks and that no significant control or assurance gaps have been identified. Application of the Boards' risk appetite framework shows that four strategic risks are operating within appetite and five remain above appetite, namely the strategic risks relating to population health intelligence, financial sustainability, quality, access, and cyber resilience. These risks continue to be actively managed through Executive oversight, committee scrutiny and mitigating actions.
5. The dashboard below summarises the overall assurance position against the ICBs' agreed risk appetite framework, and is intended to help the Boards answer three key questions:
    a) Do we have a sound control environment?
    b) Do we have robust assurance arrangements?
    c) What are the assurances received to date telling us?
6. Overall, the BAF provides reasonable assurance regarding the ICBs' arrangements for strategic risk management and internal control. The position for each risk, including the key issues and next area of focus, is summarised in Appendix A.

Board Assurance Framework (BAF) Mid-Year Dashboard

September 2026

Overall Board Assurance Opinion

REASONABLE ASSURANCE

Controls and assurance arrangements are in place across the BAF, with no significant control or assurance gaps identified. Continued Board focus is required on five strategic risks currently operating above appetite.

1 Sound control environment?

Substantial assurance

Controls identified across all strategic risks. No material control failures identified; further maturity required in selected areas.

2 Right assurances planned/received?

Reasonable assurance

All risks have mapped assurance sources. Future reporting should evidence effectiveness, impact and outcomes.

3 What are assurances telling us?

Reasonable assurance with exceptions

Governance is operating, but five strategic risks remain above the Boards' agreed risk appetite.

9/9	4	5	0	0
Strategic risks have mapped assurance sources	Risks within appetite	Risks above appetite	Significant assurance gaps identified	Significant control gaps identified

RISK APPETITE POSITION

4 within appetite

5 above appetite

Board focus: population health intelligence, financial sustainability, quality, access and cyber resilience.

ASSURANCE SOURCES

80% internal

20% external

105 internal and 27 external assurance sources mapped across the strategic risk portfolio.

STRATEGIC RISK HEAT SUMMARY

R1 Population health intelligence	R2-5 Commissioning strategy	R6 Public and community involvement
R7a Resource prioritisation	R7b Financial sustainability	R9 Quality
R10 Access	R11 Workforce and transition	R12 Cyber resilience

Within appetite Above appetite

Use the BAF appendix for detailed controls, assurances and actions by risk.

Changes to strategic risks

7. The strategic risks remain broadly unchanged from those reported in March 2026 and continue to reflect the key risks to delivery of the ICBs' objectives and statutory duties. However, following review with Executive Directors and through committee discussions, a change is proposed to the narrative of Risk 11.

8. Previously, Risk 11 focused primarily on the development of the cluster operating model and the establishment of a collaborative and supported workforce across the three ICBs. The risk has now been broadened to reflect the current strategic context and next phase of transition to a single merged ICB.

9. The revised narrative for Risk 11 is:

   Failure to develop and implement an effective operating model and workforce capability to support the transition to a merged ICB *(Risk that the ICBs do not build and maintain the strategic commissioning skills, capabilities and operating model required to support the transition to a merged ICB, while supporting the wellbeing of the combined workforce).*

10. Moving forward, oversight of Risk 11 will be provided jointly through the Joint Transition Committee and Joint Remuneration and Human Resource Committee in line with their respective remits and terms of reference.

Development of the control environment

11. Since the establishment of the ICBs' formal partnership arrangements, significant progress has been made in strengthening the control environment that supports the management of the joint strategic risks.

12. Key enhancements include:

    a) Implementation of the Joint Decision-Making Framework, establishment of the Joint Commissioning Review Group, and delivery of associated training, to support more robust and consistent commissioning decisions.

    b) Strengthening of population health management and strategic commissioning capability through ongoing development of Strategic Analytics and Intelligence Unit (SAIU) arrangements, progression of research governance arrangements, and development of outcomes, audit and monitoring assurance frameworks to support evidence-based commissioning decisions.

c) Development of the ICBs' Commissioning Oversight Framework as a single, integrated approach for translating the Five-Year Population Health Strategy and Strategic Commissioning Plan into delivery, provider accountability, assurance and continuous improvement, supported through new commissioning governance and escalation arrangements.

d) Establishment of a more mature provider oversight and contract management framework, including implementation of a single cluster-wide contract management database, Contract Delivery Review and Oversight Meetings (CDROMs), and supporting provider assurance arrangements to strengthen oversight of provider performance, quality, activity and finance.

e) Implementation of a cluster-wide primary care governance model, including a Primary Care Operational Scheme of Delegation and associated governance arrangements, following the dis-establishment of previous East Midlands-wide arrangements.

f) Development of a more mature quality governance framework through agreement of shared quality priorities for 2026/27, implementation of a cluster-wide quality approach, establishment of the System Quality Group, and further alignment of commissioning and quality oversight arrangements.

g) Development of strategic commissioning arrangements to support neighbourhood health, prevention and provider market management, including supporting governance, clinical leadership and oversight arrangements.

h) Continued development of organisational development, workforce support and wellbeing arrangements, and implementation of management of change processes to support organisational transition and merger preparedness.

13. While the maturity, consistency and effectiveness of controls across the three ICBs has improved, further alignment activity continues. Further work is underway to:

a) Improve the consistency of data and intelligence arrangements across the ICBs, including population health management, outcomes and research governance arrangements.

b) Embed neighbourhood health, prevention and provider market management frameworks.

c) Establish a cluster-wide Quality Strategy and Quality Management System.

d) Further develop organisational and strategic commissioning capability and strengthen commissioning oversight and escalation arrangements.

e) Develop a more risk-based contract management approach.

f) Align System Co-ordination Centre operating models.

g) Align cyber strategies across the ICBs.

14. Whilst the design of many of these arrangements is now established, several areas have moved into an implementation and embedding phase. In some instances, progress remains dependent on the confirmation of future roles, responsibilities and accountabilities through the ongoing organisational transition and workforce change programme, to enable the consistent implementation of arrangements across the three ICBs.

Assessment of assurance arrangements

15. Progress has also been made in strengthening the breadth and independence of assurance arrangements. Assurance mapping has confirmed that approximately 20% of identified assurance sources are derived from independent external assurance providers, including internal audit, external audit, NHS England oversight and other external reviews.

16. Annual work programmes for the Boards' committees have also been refreshed to strengthen the link between strategic risks and planned internal assurance activity. However, a recurring theme emerging from committee discussions is the need to increase the maturity of assurance reporting. Whilst current assurances largely demonstrate that governance arrangements and controls are in place, future assurance activity needs to increasingly focus on demonstrating the effectiveness, impact and outcomes of those arrangements, providing greater confidence regarding the extent to which strategic risks are being successfully managed.

Analysis of assurances received

17. Assurances received to date support the conclusion that governance arrangements are established and operating; however, they also confirm that the ICBs continue to face significant strategic challenges in several areas where residual risk exposure remains above the Boards' target tolerance levels. These risks are recognised within the BAF and continue to be subject to focused management and committee scrutiny.

18. Importantly, reviews of strategic risk positions by the Boards' committees found no evidence that mitigating actions had materially stalled or that there were immediate concerns regarding delivery of agreed improvement programmes. Actions remain in progress and continue to be refined in response to emerging risks and changing organisational priorities.

Next steps

19. The BAF will continue to be refreshed on a quarterly basis with Executive Directors and reviewed through the Boards' committee structure to ensure that strategic risks, controls, assurances and mitigating actions remain aligned to the changing operating environment.

20. Over the remainder of 2026/27, work will focus on:

    a) Further strengthening controls and mitigating actions in those areas currently operating above the Boards' agreed risk appetite, namely population health intelligence, financial sustainability, quality, access, and cyber resilience.

    b) Supporting delivery of the merger programme, including organisational development, workforce planning and implementation of the future operating model.

    c) Increasing the maturity of assurance reporting, with a greater emphasis on demonstrating the effectiveness, impact and outcomes of established controls rather than evidencing the existence of governance arrangements and processes.

21. The BAF will be further refined through future review cycles and reported back to the Boards in accordance with the agreed risk management framework.

Appendix A: Summary strategic risk position

Risk	Current Score	Target	Appetite Position	Key Issue	Next Focus
Risk 1: Population Health Intelligence	16	12	🔴 Above appetite	Data, intelligence, research and evidence arrangements are not yet fully aligned across the cluster.	Implement shared data architecture, align SAIU processes and establish the Strategic Research Board and Research and Evidence Framework.
Risk 2-5: Commissioning Strategy and Transformation	16	16	🟢 Within appetite	Significant transformation programme remains at an early stage of maturity.	Embed neighbourhood health and prevention frameworks, implement outcomes and assurance arrangements, and continue development of digital and data strategies.
Risk 6: Engagement and Co-production	12	12	🟢 Within appetite	Engagement, co-production and EDI arrangements require further alignment across the three ICBs.	Develop the Communications and Engagement Strategy, Co-production Framework and aligned EDI arrangements.
Risk 7a: Provider Markets and Resource Prioritisation	12	12	🟢 Within appetite	Further maturity required in market management arrangements.	Develop the provider market development approach and continue embedding provider assurance arrangements.
Risk 7b: Financial Sustainability and Contracts	16	12	🔴 Above appetite	Provider oversight and contract management arrangements require further consistency and embedding across the cluster.	Implement the risk-based contract management framework, CDROM model, escalation arrangements and payer controls framework.
Risk 9: Quality Improvement	16	8	🔴 Above appetite	Need stronger evidence of effectiveness and sustained improvement.	Develop and implement the Quality Management System and continue rationalisation of quality oversight arrangements.
Risk 10: Access and Performance Standards	16	8	🔴 Above appetite	Continued performance challenges against access standards.	Further embed commissioning oversight arrangements and align System Co-ordination Centre operating models.
Risk 11: Merger Readiness and Workforce Capability	12	12	🟢 Within appetite	Dependencies on national decisions and future footprint.	Deliver the OD programme, strategic commissioning capability development and merger readiness workstreams.
Risk 12: Cyber Resilience	12	8	🔴 Above appetite	Multiple IT environments and differing security arrangements.	Develop a single Cyber Security Strategy, align governance arrangements and complete critical system assurance and testing activity

Note: Risk 8 was removed by the Boards as a standalone risk in March 2026.

NHS
Derby and Derbyshire
Integrated Care Board

NHS
Lincolnshire
Integrated Care Board

NHS
Nottingham and
Nottinghamshire
Integrated Care Board

Appendix B: Board Assurance Framework

September 2026

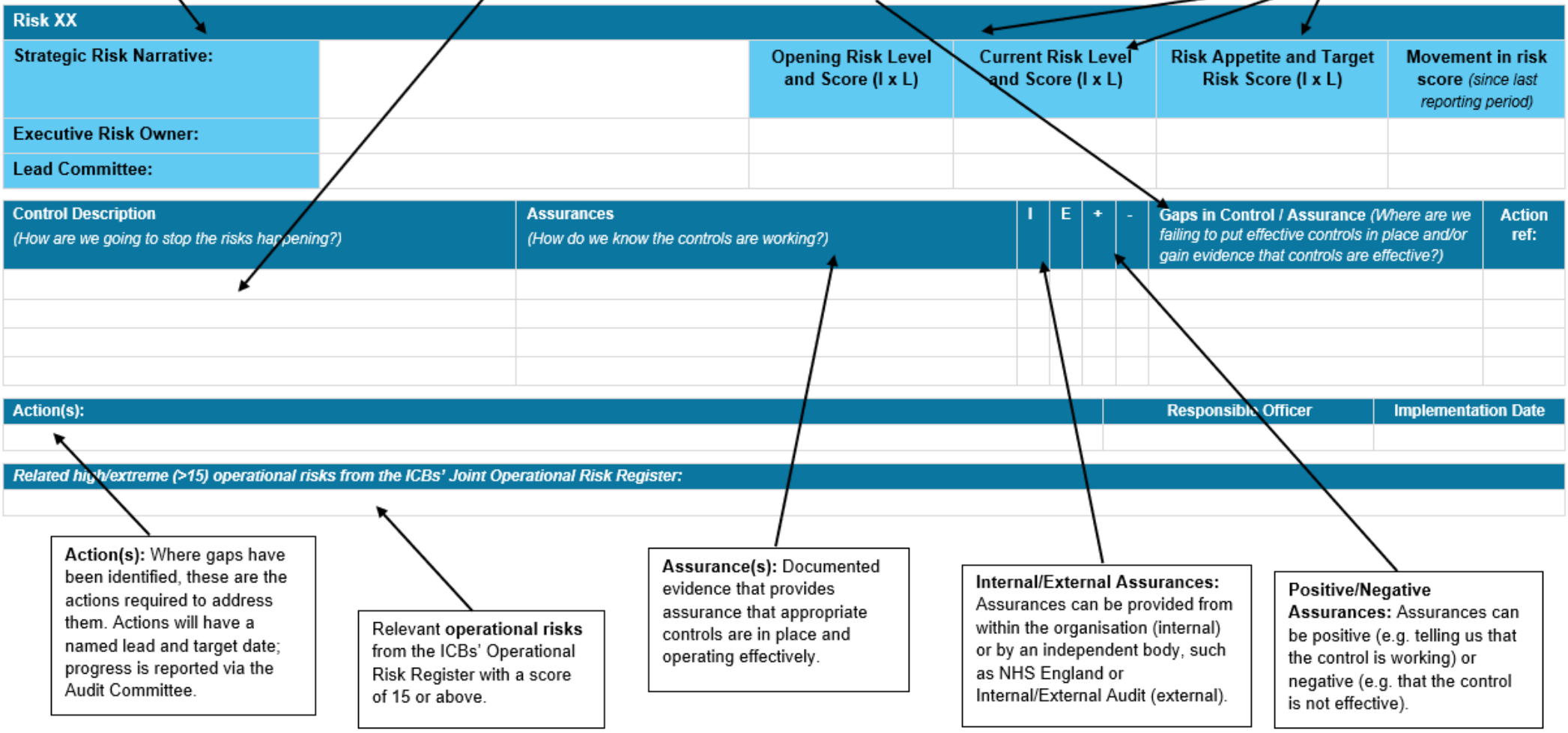
How to navigate the Board Assurance Framework

Strategic risks: High-level risks that threaten the achievement of the ICBs' joint aims/objectives and/or statutory duties.

Controls: The mechanisms put in place by management to mitigate potential risks. These can be joint controls, across the cluster, or specific to each individual ICB.

Gaps in control or assurance: These are identified where an additional/enhanced system or process is needed to better control the risk, or where there is a lack of evidence that controls are effective (e.g. where no assurances been, or are planned to be, received).

Risk score(s): These are the opening and current risk ratings for each period which consider the controls that are in place (e.g. those remedial actions to reduce the impact/likelihood). The target risk score is set by the relevant Executive, in line with risk appetite.



Risk XX					
Strategic Risk Narrative:		**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:					
Lead Committee:					

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**

Action(s):	**Responsible Officer**	**Implementation Date**

Related high/extreme (>15) operational risks from the ICBs' Joint Operational Risk Register:

Action(s): Where gaps have been identified, these are the actions required to address them. Actions will have a named lead and target date; progress is reported via the Audit Committee.

Relevant **operational risks** from the ICBs' Operational Risk Register with a score of 15 or above.

Assurance(s): Documented evidence that provides assurance that appropriate controls are in place and operating effectively.

Internal/External Assurances: Assurances can be provided from within the organisation (internal) or by an independent body, such as NHS England or Internal/External Audit (external).

Positive/Negative Assurances: Assurances can be positive (e.g. telling us that the control is working) or negative (e.g. that the control is not effective).

Risk 1 – Failure to develop and maintain a comprehensive, evidence-based understanding of local population health needs					
Strategic Risk Narrative:	Risk that the ICBs do not use joined-up, person-level data and intelligence to identify current and future needs, drivers of risk, and underserved communities, leading to ineffective or inequitable commissioning decisions.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Executive Director of Commissioning, Executive Director of Outcomes	High (4 x 4)	High (4 x 4)	Medium (4 x 3)	No change.
Lead Committee:	Joint Strategic Commissioning Committee			Open	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Establishment and embedding of a **structured, data-sharing architecture** to ensure equitable access to appropriately shared data across all three geographies. This includes formal data-sharing arrangements, federated or integrated platform capability, and robust information governance controls. Alignment of **SAIU analytical processes** across the three geographies to ensure data availability is routinely assessed and that shared data is systematically analysed to support population health management, predictive analytics and strategic decision-making.	Information Sharing Framework and Supporting Agreements (including Joint Controller Agreement and Aggregated Data Memorandum of Understanding) to the Information Governance, Data Protection and Cyber Steering Group (April 2026) Population Health Outcomes Framework and Population Health Improvement Plan Update to the Joint Strategic Commissioning Committee (November 2025, January 2026 and *pending*) Population Health Strategy and Commissioning Plan, to the Boards (February 2025, February 2026 and *pending March 2027*) Population Health Strategy and Commissioning Plan to the Joint Strategic Commissioning Committee (January 2026)	✓ ✓ ✓ ✓		✓ ✓ ✓ ✓		To implement a structured, system-wide data-sharing architecture and aligned SAIU analytical processes across all three geographies. To improve the consistency and comparability of source data used across the three ICBs, enabling reliable cluster-wide reporting and analysis.	1.1 1.3
The development of **Joint Strategic Needs Assessment (JSNA)** arrangements, with ICBs contributing as statutory NHS partners, using joined-up data and insight to shape strategic commissioning priorities.	Annual review of the robustness of processes and progress on health needs assessments update to the Joint Strategic Commissioning Committee *(pending)*	✓				None identified.	
The establishment and embedment of a **research and evidence framework**, ensuring that commissioning decisions across the cluster are informed by high-quality research, national guidance, local evaluation, and evidence, to support effective, equitable, and value-based service planning and delivery. The framework is underpinned by delivery of the three **ICS Research Strategies**, a cluster-wide **Strategic Research Board**, and governance arrangements that promote the systematic use of research and evidence within strategic commissioning, programme delivery and service redesign.	Improvement, learning and innovation report (incl. research) to the Boards *(pending, Nov 2026)* Arrangements for the promoting and using evidence from research update to the Joint Strategic Commissioning Committee (July 2026) DLN Strategic Approach to Outcomes to the Quality and Service Improvement Committee (July 2026) DLN Outcomes Audit Monitoring Assurance Approach to the Joint Quality and Service Improvement Committee (Sept 2026)	✓ ✓ ✓ ✓		 ✓ ✓ ✓		To align research and evidence arrangements across the cluster. To implement the cluster-wide Research and Evidence Framework and associated governance arrangements, including establishment of the Strategic Research Board.	1.2 1.4

Action(s):	**Responsible Officer**	**Implementation Date**
1.1: To implement a structured, system-wide data-sharing architecture and aligned SAIU analytical processes across all three geographies.	Executive Director of Commissioning	March 2027
1.2: To align research and evidence arrangements across the cluster.	Executive Director of Outcomes	Complete
1.3 To improve the consistency and comparability of source data used across the three ICBs, enabling reliable cluster-wide reporting and analysis.	Executive Director of Commissioning	April 2027

1.4 To implement the cluster-wide Research and Evidence Framework and associated governance arrangements, including establishment of the Strategic Research Board.	Executive Director of Outcomes	April 2027

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:
No high scoring ORR risks identified.

Risk 2-5 – Failure to deliver a coordinated transformation of commissioned services, including prevention, community care models, and digital enablement					
Strategic Risk Narrative:	Risk that the ICBs do not develop or implement a robust, long-term, outcomes-focused commissioning strategy; fail to shift system focus from sickness to prevention; do not redesign services to deliver integrated care closer to home; and do not adopt or embed digital technologies. Taken together, these could result in missed opportunities to improve population health and reduce inequalities, persistent reliance on reactive and hospital-based care, poor patient experience, inefficiencies, and an inability to achieve system priorities or national expectations.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Executive Director of Strategy and Citizen Experience, Executive Director of Commissioning, Executive Director of Outcomes (Medical), Executive Director of Finance	High (4 x 4)	High (4 x 4)	High (4 x 4)	No change.
Lead Committee:	Joint Strategic Commissioning Committee			Eager	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
The implementation and alignment of a **Population Health Management (PHM) approach** across the three ICBs, using linked datasets and predictive analytics to proactively identify at-risk cohorts, understand unwarranted variation and population need, and inform the tailoring of equitable, preventative and value-based commissioning interventions.	Population Health Strategy and Commissioning Plan presented to the Boards (Feb 2025, Feb 2026 and *pending, March 2027)* Population Health Strategy and Population Health Outcomes Framework updates to the Joint Strategic Commissioning Committee (November 2025 and January 2026, *pending July 2026)* Population Health Strategy Progress Report: Frailty and End of Life presented to the Boards (July 2026)	✓ ✓ ✓		✓ ✓ ✓		To embed and scale the use of the Strategic Analytics and Intelligence Unit (SAIU) consistently across all three ICBs. To develop and align a consistent Population Health Management (PHM) approach across the cluster.	2.1 2.2
The development of the **Five-Year Population Health Strategy**, which sets out the ICBs' long-term vision, priorities and ambitions for improving population health outcomes, access to high-quality care and reducing health inequalities across the cluster. *The development of the Five-year Population Health Strategy has been informed by the three Integrated Care Strategies which exist across the three ICSs.*	Population Health Strategy and Commissioning Plan presented to the Boards (Feb 2025, Feb 2026 and *pending, March 2027)* and Joint Strategic Commissioning Committee (January 2026) Population Health Strategy Progress Report: Frailty and End of Life presented to the Boards (July 2026) Rolling programme of strategic priority updates to the Boards (each meeting) Annual statement on health inequalities to the Boards (July 2026) Population Health Improvement Plan updates to the Joint Strategic Commissioning Committee (November 2025 and January 2026) Clustered System Review Meetings (SRMs) with NHSE Regional Teams (monthly) DLN Internal Audit Reviews – Strategic commissioning (inc. strategy oversight) *(pending, TBD)*	✓ ✓ ✓ ✓	 ✓ ✓	✓ ✓ ✓ ✓ ✓	 ✓	None identified.	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Establishment of an Executive-led **Strategy and Planning Coordination Group,** which has senior ICB leadership representative from strategy, commissioning, planning, performance and finance has the responsibility to ensure alignment across the ICBs' planning outputs.	Strategic Commissioning Plan approved through the Joint Strategic Commissioning Committee (January 2026) Medium-Term Planning Framework presented to the Joint Strategic Commissioning Committee (November 2025)	✓ ✓		✓ ✓		To refocus the Strategy and Planning Coordination Group from strategy development to oversight of operational delivery.	2.3
The development of the **Five-Year Commissioning Plan (Population Health Improvement Plan),** which translates the strategic ambitions of the Population Health Strategy into actionable, resourced, and measurable commissioning programmes across the three ICBs. *The development of the Five-year Commissioning Plan has been informed by the three Joint Forward Plans which exist across the three ICSs.*	Population Health Strategy and Commissioning Plan presented to the Boards (Feb 2025, Feb 2026 and *pending, March 2027)* and Joint Strategic Commissioning Committee (January 2026) Medium-Term Planning Framework presented to the Joint Strategic Commissioning Committee (November 2025) DLN Internal Audit Reviews – Strategic commissioning (inc. strategy oversight) *(pending, TBD)*	✓ ✓	 ✓	✓ ✓		None identified.	
Establishment and ongoing development of a **comprehensive commissioning oversight and transformation framework** across the DLN cluster to support delivery of an outcomes-focused commissioning strategy and associated transformation priorities, including prevention, service redesign, neighbourhood development, integrated care closer to home and digital enablement. This includes: • A defined governance and escalation architecture, including the **Commissioning Oversight Group, Joint Commissioning Executive Group** and **associated commissioning forums**, providing strategic oversight of commissioning priorities, transformation programmes and system outcomes, and enabling timely escalation of issues requiring strategic commissioning action. • **Management-led transformation and commissioning oversight forums** across key domains (including finance, quality, commissioning, strategy, outcomes, digital, and vaccinations and immunisations), supporting the development and implementation of commissioning approaches, preventative models of care, service redesign and system-wide transformation priorities. • Formalised programme governance and transformation oversight through **Programme Boards**, providing strategic oversight of transformation programmes, monitoring delivery of agreed outcomes, benefits and milestones, managing programme risks and dependencies, and ensuring commissioning intentions are translated into sustainable service transformation, integrated models of care and improved population outcomes.	Population Health Strategy and Commissioning Plan presented to the Boards (Feb 2025, Feb 2026 and *pending, March 2027)* and Joint Strategic Commissioning Committee (January 2026) Medium-Term Planning Framework presented to the Joint Strategic Commissioning Committee (November 2025) Commissioning Oversight Delivery Report to the Joint Finance and Performance Committee and Boards (each meeting) Thematic Commissioning Delivery Review – Urgent and Emergency Care presented to the Joint Finance and Performance Committee (July 2026) Assessment of current dental issues, future requirements and potential commissioning options update to the Joint Strategic Commissioning Committee (February 2026) Assurance on Specialised Commissioning Delegation update to the Joint Strategic Commissioning Committee (May 2026)	✓ ✓ ✓ ✓ ✓		✓ ✓ ✓ ✓ ✓		To develop and implement the cluster Commissioning Oversight and Escalation Framework.	2.4
Establishment of a cluster-wide **Outcomes Framework**, incorporating measurable indicators across quality, population health and health inequalities, underpinned by regular performance reporting, to evaluate and evidence the impact of delivery of the Strategy and Commissioning Plan.	Population Health Strategy and Commissioning Plan presented to the Boards (Feb 2025, Feb 2026 and *pending, March 2027)* and Joint Strategic Commissioning Committee (January 2026) Population Health Strategy Progress Report: Frailty and End of Life presented to the Boards (July 2026) Rolling programme of strategic priority updates to the Boards (each meeting)	✓ ✓ ✓		✓ ✓ ✓		To finalise the cluster-wide Outcomes Framework and operational oversight of delivery of the Strategy. See 1.3 above.	2.5

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Development and implementation of a **cluster-wide neighbourhood model**, supported by a defined implementation framework, **clinical and professional leadership arrangements**, and **place-based partnership governance**, to enable integrated neighbourhood working and inform commissioning decisions that shift care towards prevention, population health improvement and community-based services.	Strategic approach to neighbourhood health development presented to the Joint Strategic Commissioning Committee (February 2026) Delivery approach to neighbourhood health development presented to the Joint Strategic Commissioning Committee (April 2026) Neighbourhood Health and Integrated Neighbourhood Teams Strategic Position presented to the Joint Strategic Commissioning Committee (May 2026) Neighbourhood Health update to Boards' Development Session (February 2026) Neighbourhood Health strategic priority update to the Boards (May 2026; September 2026 and *pending, January 2027)* Hucknall Neighbourhood Health Hub Development presented to the Joint Finance and Performance Committee (July 2026)	✓ ✓ ✓ ✓ ✓ ✓		✓ ✓ ✓ ✓ ✓ ✓		To review the strategic approach to neighbour health development following the publication of national guidance. To implement the cluster-wide neighbourhood framework and supporting clinical leadership arrangements.	2.6 2.10
Development of a cluster-wide **strategic approach to prevention**, incorporating population health insights, evidence-based interventions, and outcome measures, to guide commissioning decisions, reduce health inequalities, and support the shift from sickness to proactive, preventative care across the system.	Strategic Approach to Prevention and Early Intervention presented to the Joint Strategic Commissioning Committee (March 2026) Population Health Strategy Progress Report: Frailty and End of Life presented to the Boards (July 2026). Annual Statements on Health Inequalities to the Boards (July 2026). Working with People and Communities Annual Reports presented to the Joint Strategic Commissioning Committee (May 2026). Annual Reports on Working in Partnership with People and Communities presented to the Boards (July 2026).	✓ ✓ ✓ ✓ ✓		✓ ✓ ✓ ✓ ✓		To establish the cluster-wide strategic approach to prevention.	2.7
Development and implementation of a **DLN outcomes, audit and monitoring assurance approach**, including an integrated dashboard and prioritisation framework, to triangulate clinical audit, outcomes and population health intelligence; identify inequalities and unwarranted variation; and inform commissioning, pathway improvement and preventative interventions.	DLN Outcomes Audit Monitoring Assurance Approach, to the Joint Quality and Service Improvement Committee (September 2026).	✓		✓		To implement the DLN outcomes and assurance framework to inform commissioning priorities and reduce unwarranted variation.	2.11
Development and implementation of a **cluster-wide digital and data strategy and associated delivery framework**, aligned to strategic commissioning priorities, supporting digital transformation, interoperability, digital inclusion, innovation and the use of technology-enabled care. This includes the integration of digital solutions within commissioning, pathway redesign, neighbourhood development, prevention and transformation programmes across the three ICBs.	Joint Strategic Commissioning Committee: Emerging Strategic Approach to Digital Transformation across DLN (April 2026) Population Health Strategy and Commissioning Plan presented to the Boards (February 2025, February 2026 and *pending March 2027*) and Joint Strategic Commissioning Committee (January 2026) Digital Technology Strategic Priority Update to the Boards *(pending January 2027)* NNICB Internal Audit Review – Delivering Digital Transformation (Significant Assurance)	✓ ✓ ✓	 ✓	✓ ✓ ✓		To develop cluster-wide Digital and Data Strategy, based on existing Strategies across the three ICBs.	2.8
Establishment and ongoing development of **cluster-level digital governance arrangements** to support oversight, prioritisation and coordination of digital transformation initiatives across the three ICBs, ensuring alignment with strategic commissioning priorities, service	Joint Strategic Commissioning Committee: Emerging Strategic Approach to Digital Transformation across DLN (April 2026) Digital Technology Strategic Priority Update to the Boards (*pending January 2027)*	✓ ✓		 ✓		To align digital transformation governance arrangements across the cluster.	2.9

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
redesign, interoperability requirements and wider transformation programmes.	NNICB Internal Audit Review – Delivering Digital Transformation (Significant Assurance) Senior Information Risk Owner (SIRO) Annual Report to the Audit Committee (April 2026) and Board (May 2026) Information Governance Assurance Reports to the Audit Committee (February and June 2026)	✓ ✓	✓	✓ ✓ ✓			

Action(s):	Responsible Officer	Implementation Date
2.1: To embed and scale the use of the Strategic Analytics and Intelligence Unit (SAIU) consistently across all three ICBs.	Executive Director of Commissioning	~~November 2026~~ March 2027
2.2: To develop and align a consistent Population Health Management (PHM) approach across the cluster.	Executive Director of Commissioning	~~November 2026~~ March 2027
2.3: To refocus the Strategy and Planning Coordination Group from strategy development to oversight of operational delivery.	Executive Director of Strategy and Citizen Experience	~~September 2026~~ Superseded
2.4: To develop and implement the cluster Commissioning Oversight and Escalation Framework.	Executive Director of Commissioning	September 2026
2.5: To finalise the cluster-wide Outcomes Framework and operational oversight of delivery of the Strategy.	Executive Director of Strategy and Citizen Experience / Executive Director of Outcomes / Executive Director of Commissioning	April 2027
2.6 To review the strategic approach to neighbour health development following the publication of national guidance.	Executive Director of Strategy and Citizen Experience	~~August 2026~~ March 2027
2.7: To establish the cluster-wide strategic approach to prevention.	Executive Director of Outcomes	November 2026
2.8: To develop cluster-wide Digital and Data Strategy, based on existing Strategies across the three ICBs.	Executive Director of Finance	~~September 2026~~ March 2027
2.9: To align digital transformation governance arrangements across the cluster.	Executive Director of Finance	~~October 2026~~ March 2027
2.10 To implement the cluster-wide neighbourhood framework and supporting clinical leadership arrangements.	Executive Director of Strategy and Citizen Experience / Executive Director of Outcomes	April 2027
2.11 To implement the DLN outcomes and assurance framework to inform commissioning priorities and reduce unwarranted variation.	Executive Director of Outcomes	April 2027

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:
RR140 – Insufficient DLN cluster capacity and resource risks delayed digital transformation and reduced efficiencies.

Risk 6 – Failure to involve people and communities meaningfully in commissioning and service design					
Strategic Risk Narrative:	Risk that the ICBs do not systematically co-produce solutions with service users, carers, and communities, leading to services that do not meet local needs or legal requirements for engagement.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Executive Director of Strategy and Citizen Experience	Medium (4 x 3)	Medium (4 x 3)	Medium (4 x 3)	No change.
Lead Committee:	Joint Strategic Commissioning Committee			Open	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Development of a robust **Engagement Strategy** across all three ICBs, aligned with the Strategic Commissioning Framework's requirement for systematic community involvement and co-production.	Citizen Stories presented to the ICB Boards (each meeting) Arrangements for public and patient involvement update to the Joint Strategic Commissioning Committee (February 2026) Annual Working with People and Communities Report to the Joint Strategic Commissioning Committee (May 2026) Working with People and Communities Strategy updates to the Joint Strategic Commissioning Committee *(pending)*	✓ ✓ ✓ ✓		✓ ✓ ✓ ✓		To produce an aligned, cluster-wide Engagement Strategy.	6.1
The establishment and embedding of **Directorate governance arrangements** to provide oversight of community engagement activity, ensure learning and insight from engagement is reviewed, and support alignment between citizen feedback, strategic development and commissioning decisions.	Arrangements for public and patient involvement update to the Joint Strategic Commissioning Committee (February 2026) Annual Working with People and Communities Report to the Joint Strategic Commissioning Committee (May 2026) Ad-hoc commissioning proposals, assessed via patient and public involvement and engagement processes.	✓ ✓ ✓		✓ ✓		To formalise and embed Directorate governance arrangements for oversight of community engagement activity.	6.2
Development of a **Co-production Framework** to provide a consistent, structured approach for involving service users, carers, and communities. The framework will define how engagement activity integrates with co-production, ensuring that lived experience systematically informs strategy, service design, and commissioning decisions.	Statement of intent and co-production arrangements for children, young people and families reported via Joint Quality and Service Improvement Committee (July 2026) Arrangements for personalised care update to the Joint Strategic Commissioning Committee (May 2026 and *pending, November 2026)* Evidence of co-production through programme-specific commissioning proposals and service redesigns.	✓ ✓ ✓		✓ ✓		To produce an aligned, cluster-wide Co-production Framework.	6.3
Maintenance of a system-wide **Patient and Public Involvement (PPI) infrastructure** across all three ICBs, providing structured mechanisms, including patient and citizen panels, public meetings, online engagement platforms, Public and Patient Partners, communities of practice, and engagement steering groups, to support bespoke engagement activities.	Arrangements for public and patient involvement update to the Joint Strategic Commissioning Committee (February and June 2026 and *pending, Oct 2026 and February 2027)* Annual Working with People and Communities Report to the Joint Strategic Commissioning Committee (May 2026) DDICB Internal Audit Review – Public Involvement (Moderate assurance)	✓ ✓	 ✓	✓ ✓ ✓		None identified.	
Completion and review of **Equality and Quality Impact Assessments (EQIA/QIA)** for all proposed service changes and commissioning decisions, ensuring that identified potential impacts on service users, carers, and communities inform the design and focus of engagement activities.	Annual Equality Assurance Report to the Boards (May 2026) Equality Delivery System update to the Joint Strategic Commissioning Committee (April 2026) DLN Approach to EDI for 2026/2027 to the Joint Strategic Commissioning Committee (September 2026)	✓ ✓ ✓		✓ ✓ ✓		To align EDI policies, processes and procedures across the cluster, building on existing arrangements within the three ICBs.	6.4

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
	Annual Statement on Information on Health Inequalities Assurance Report presented to the Joint Strategic Commissioning Committee (June 2026) NHS Core20PLUS5 Adults update through the Joint Strategic Commissioning Committee work programme *(pending, October 2026)* NHS Core20PLUS5 Children and Young People update through the Joint Strategic Commissioning Committee work programme *(pending, November 2026)*	✓ ✓ ✓		✓			
Formalised partnerships and engagement with **Voluntary, Community and Social Enterprise (VCSE) organisations, Healthwatch, Local Authorities, Primary Care Networks (PCNs), and Health and Overview Scrutiny Committees (HOOSCs)** to support neighbourhood-level engagement, gather local insights, and ensure community intelligence systematically informs service design and commissioning decisions.	Strategic approach to neighbourhood health development update to the Joint Strategic Commissioning Committee (April 2026) Delivery approach to neighbourhood health development update to the Joint Strategic Commissioning Committee (April 2026) Annual Working with People and Communities Report to the Joint Strategic Commissioning Committee (May 2026) Evidence of Health Overview and Scrutiny Committee engagement arrangements reported through Public and Patient Involvement updates (February 2026 and *pending)*	✓ ✓ ✓ ✓		✓ ✓ ✓		None identified.	

Action(s):	**Responsible Officer**	**Implementation Date**
6.1: To produce an aligned, cluster-wide Communications and Engagement Strategy.	Executive Director of Strategy and Citizen Experience	November 2026
6.2: To formalise and embed Directorate governance arrangements for oversight of community engagement activity	Executive Director of Strategy and Citizen Experience	~~September 2026~~ December 2026
6.3: To produce an aligned, cluster-wide Co-production and Engagement Framework.	Executive Director of Strategy and Citizen Experience / Executive Director of Quality	~~January 2027~~ March 2027
6.4: To align EDI policies, processes and procedures across the cluster, building on existing arrangements within the three ICBs.	Executive Director of Quality	~~September 2026~~ March 2027

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:
RR048 – Ongoing negative media and workforce changes risk damaging public trust in local NHS services.

Risk 7a – Failure to allocate resources effectively and shape provider markets to deliver value, productivity and system priorities					
Strategic Risk Narrative:	Risk that the ICBs do not align funding to population needs, optimise resource use, or proactively shape and manage provider markets. This could result in poor value for money, reduced productivity, inequitable access, and an inability to achieve national and local priorities or deliver sustainable improvement in health outcomes.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Executive Director of Commissioning, Executive Director of Finance, Executive Director of Strategy and Citizen Experience	Medium (4 x 3)	Medium (4 x 3)	Medium (4 x 3)	No change.
Lead Committee:	Joint Strategic Commissioning Committee			Open	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Development and delivery of a cluster-wide **Medium Term Financial Plan**, aligning future resource allocation with strategic commissioning priorities, population need and financial sustainability. The Plan supports the shift towards neighbourhood health, community-based services and prevention, whilst maintaining provider sustainability and system affordability.	Medium Term Planning updates to the Boards (December 2025 and January 2026)	✓		✓		None identified.	
	Operational and Financial Plan updates to the Joint Finance and Performance Committee	✓		✓			
	Financial and efficiency reports to the Joint Finance and Performance Committee (each meeting)	✓		✓	✓		
	Clustered System Review Meetings (SRMs) with NHSE Regional Teams (monthly)		✓	✓	✓		
	System Review Meetings (QSRMs) with NHSE Regional Teams (quarterly)		✓	✓	✓		
Development and implementation of a cluster-wide, aligned **commissioning decision-making process** (phase one), with a planned transition to a more refined approach, including a weighted prioritisation methodology (phase two). The **weighted value framework** (phase two) will be based on criteria including strategic 'fit' and anticipated benefits aligned with the commissioning priorities identified in the Five-Year Population Health Strategy, Five-Year Strategic Commissioning Plan, and the ICBs' Outcomes Framework.	Joint Decision-Making Framework and establishment of a Joint Commissioning Review Group update to the Joint Strategic Commissioning Committee (February 2026)	✓		✓		To finalise and implement the phase 2 weighted value framework to strengthen commissioning decision-making and prioritisation.	7a.1
	Joint Commissioning Executive Group Assurance Reports to the Joint Strategic Commissioning Committee (each meeting)	✓		✓			
	360 Assurance Internal Audit Review - Governance Arrangements (August 2026, Significant Assurance)		✓	✓			
Implementation of **evidence-based commissioning approaches to support resource allocation and prioritisation decisions.** Commissioning proposals are informed by population health intelligence, outcomes, service performance, clinical evidence and value-for-money considerations to ensure resources are directed towards interventions that deliver the greatest benefit.	Joint Commissioning Executive Group Assurance Reports to the Joint Strategic Commissioning Committee (each meeting)	✓		✓		See action 1.2	
Role, remit and operating framework of the **Joint Commissioning Executive Group (JCEG)**, supported by the **Joint Commissioning Review Group (CRG),** to ensure commissioning decisions are	Joint Decision-Making Framework and establishment of a Joint Commissioning Review Group update to the Joint Strategic Commissioning Committee (February 2026)	✓		✓		To deliver training to embed understanding of aligned commissioning decision-making	7a.2

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
evidence-based, prioritised against population need, and subject to robust scrutiny, enabling effective allocation of resources and delivery of population outcomes.	Joint Commissioning Executive Group Assurance Reports to the Joint Strategic Commissioning Committee (each meeting) Ad-hoc commissioning proposals, developed in line with cluster-wide commissioning decision-making and prioritisation processes. 360 Assurance Internal Audit Review - Governance Arrangements (August 2026, Significant Assurance)	✓ ✓	 ✓	✓ ✓		processes and governance structures across the cluster.	
Development and implementation of a **provider market strategy** to identify service gaps, stimulate innovation, and ensure sufficient provider capacity, supporting prioritised investment and resource allocation.	Arrangements for shaping and managing the provider market update to the Joint Strategic Commissioning Committee *(pending)* Strategic Commissioning Plan delivery and transformation programme assurance reports to the Joint Strategic Commissioning Committee *(pending)* Commissioning delivery reports to the Boards and Joint Finance and Performance Committee (each meeting). DLN Palliative End of Life Care Strategic Commissioning Framework to the Joint Strategic Commissioning Committee (Sept 2026)	✓ ✓ ✓ ✓		 ✓ ✓	 ✓	To develop a provider market development approach across the cluster to identify service gaps, stimulate innovation and support sufficient provider capacity to meet future system priorities. To implement an aligned framework for provider oversight, contract management and performance assurance across the cluster.	7a.4 7a.5
Develop and embed a **joint procurement framework** across the three ICBs to ensure all provider selection, contract award, and contract management processes are PSR-compliant, deliver value for money, and are consistently applied; as described within the ICBs' joint Procurement and PSR Policy. The framework supports appropriate market assessment, due diligence, governance scrutiny and consideration of affordability, value for money, and strategic fit. Development of a comprehensive, automated **contract management database** across the three ICBs for secondary care contracts, providing a single record of contractual arrangements and proactively identifying contracts approaching review, expiry or procurement. This enables timely planning and decision-making, supports compliance with procurement and Provider Selection Regime requirements.	Provider Selection Regime Annual Report to the Audit Committees (April 2026) Joint Commissioning Executive Group Assurance Reports to the Joint Strategic Commissioning Committee (each meeting) DDICB Internal Audit Review – Provider Selection Regime (Significant assurance) NNICB Internal Audit Review – Provider Selection Regime (Significant assurance) DLN Internal Audit Reviews – Procurement *(Q3/Q4)*	✓ ✓	 ✓ ✓ ✓	✓ ✓ ✓		None identified.	

Action(s):	**Responsible Officer**	**Implementation Date**
7a.1: To finalise and implement the phase 2 weighted value framework to strengthen commissioning decision-making and prioritisation.	Executive Director of Commissioning	Complete
7a.2: To deliver training to embed understanding of aligned commissioning decision-making processes and governance structures across the cluster.	Executive Director of Commissioning	Complete
7a.3: To develop and implement a provider market strategy across the cluster to identify gaps, stimulate innovation, and ensure sufficient provider capacity to meet system priorities.	Executive Director of Finance	Superseded
7a.4 To develop a provider market development approach across the cluster to identify service gaps, stimulate innovation and support sufficient provider capacity to meet future system priorities.	Executive Director of Strategy and Citizen Experience	November 2026
7a.5 To implement an aligned framework for provider oversight, contract management and performance assurance across the cluster, supporting delivery of the provider market strategy.	Executive Director of Commissioning	December 2026

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:
No high scoring ORR risks identified.

Risk 7b – Failure to commission services through effective procurement and contract management arrangements, compromising financial sustainability					
Strategic Risk Narrative:	Risk that the ICBs do not utilise robust procurement frameworks, contracting mechanisms, or contract management processes, leading to inefficiencies, unmanaged demand, poor provider performance, increased financial risk, or inability to deliver statutory financial duties and long-term sustainability.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Executive Director of Commissioning, Executive Director of Finance	High (4 x 4)	High (4 x 4)	Medium (4 x 3)	No change.
Lead Committee:	Joint Finance and Performance Committee			Open	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
The development and delivery of a t**hree-year operational plan for 2026/27 to 2028/29**, including integrated revenue, workforce, and operational performance and activity plans. The plan sets out how the ICBs will deliver statutory duties, meet performance standards, manage resources, and align financial, workforce, and operational arrangements.	Medium Term Planning updates to the Boards (December 2025 and January 2026) *(open and/or confidential sessions)*	✓		✓		None identified.	
	Opening budgets reported to the Boards (annually)	✓		✓			
	Operational and Financial Plan update to the Joint Finance and Performance Committee (Jan 2026 and, *pending Jan and Feb 2027)*	✓		✓			
	Finance reports to the Boards (each meeting)	✓		✓	✓		
	Finance reports presented to the Joint Finance and Performance Committee (each meeting)	✓		✓	✓		
	Commissioning delivery reports presented to both the Boards and the Joint Finance and Performance Committee (each meeting)	✓		✓	✓		
	Thematic commissioning delivery reviews to the Joint Finance and Performance Committee (Sept *and pending, Dec 2026 and Jan 2027)*	✓					
	360 Assurance – Internal Audit Review, Financial ledger and reporting *(pending, Q3)*		✓	✓	✓		
	Clustered System Review Meetings (SRMs) with NHSE Regional Teams (monthly)		✓	✓	✓		
	System Review Meetings (QSRMs) (including Providers) with NHSE Regional Teams (quarterly)		✓				
	Ad-hoc Assurance Meetings with NHSE Regional Team (bi-monthly)						
Develop and embed a **joint contract management framework** across the three ICBs to ensure all provider contracts are actively monitored, outcomes and KPIs are assessed, and payments are aligned to services delivered. This includes the establishment of **provider-specific Contract Delivery Review and Oversight Meetings (CDROMs)** as the principal commissioner-provider forum for contractual accountability and oversight. CDROMs provide a single, integrated mechanism for monitoring contractual delivery across quality, operational performance	Contract Management Reports to the Joint Finance and Performance Committee (September 2026, *pending February 2027)* Commissioning Delivery Reports to the Boards and Joint Finance and Performance Committee (each meeting) Finance Reports to the Joint Finance and Performance Committee (each meeting)					To establish a single, shared contract management database across the ICBs to support consistent contract recording and monitoring. To develop and implement a standardised and aligned approach to contract management across the ICBs, including	7b.3 7b.4

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
and finance; identifying and escalating provider risks; overseeing recovery and improvement plans; reviewing contract variations; and supporting future contract development and negotiation. The framework will also include the establishment of a formal control framework for **payer mechanisms** to ensure providers are paid appropriately for services delivered, supported by robust validation, reconciliation and contract management processes	Thematic Commissioning Delivery Reviews to the Joint Finance and Performance Committee (September 2026, *pending December 2026 and January 2027)* DLN Internal Audit Review – Contract Management (planned)					contract tiering, governance arrangements, and defined management responsibilities proportionate to contract risk and value. To develop and embed a formal control framework for payer mechanisms once national guidance is published.	7b.2
Alignment and development of **performance management, contractual oversight and productivity monitoring controls** across the cluster to oversee provider performance and system outputs, supporting delivery of operational plans, improved productivity and value for money. This includes: • **Activity, Pricing and Payment Technical Groups** operating beneath each CDROM to provide detailed oversight of activity delivery, financial performance, pricing, payment reconciliation, coding, counting, data quality, contract variations and recurrent financial impacts. • An overarching **Activity, Finance and Performance Group**, providing strategic oversight of commissioning and operational plan delivery, with alternating focus on Acute services and Mental Health and Community services. • Provider-specific **Contract Delivery Review and Oversight Meetings (CDROMs)** which monitor contractual, activity, quality, operational and financial performance, consider risks and interdependencies collectively, and oversee agreed corrective actions and recovery plans. • **Performance Recovery and Oversight Meetings** where sustained underperformance is identified, providing structured oversight of provider recovery plans and a clear route into formal contractual escalation where sufficient improvement is not demonstrated. • Escalation of material performance, quality, operational or financial concerns through established contractual management arrangements, including **Contract Performance Notices, remedial action plans** and executive-level intervention, where required.	Contract Management Reports to the Joint Finance and Performance Committee (September 2026; pending February 2027) Commissioning Delivery Reports to the Boards and Joint Finance and Performance Committee (each meeting) Thematic Commissioning Delivery Reviews to the Joint Finance and Performance Committee (September 2026, *pending December 2026 and January 2027)* Operational and Financial Plan Updates to the Joint Finance and Performance Committee (January 2026, *pending January and February 2027)* DDICB Internal Audit Review – Data Quality and Performance Management Framework (Advisory) DLN Internal Audit Reviews – Contract Management and Data Quality (planned)					See action 2.4. See action 7b.1.	
Alignment and embedment of robust 'grip and control' measures across the three ICBs to oversee financial performance, alongside routine monitoring of budgets, efficiency programmes, and compliance with the ICBs' Standing Financial Instructions, Scheme of Reservation and Delegation and other financial governance requirements. This includes:	Finance Reports to the Joint Finance and Performance Committee (each meeting) Savings and Efficiency Reports to the Joint Finance and Performance Committee (September 2026 and ongoing) Operational and Financial Plan Updates to the Joint Finance and Performance Committee (January 2026, *pending January and February 2027)*	✓ ✓ ✓		✓ ✓ ✓	✓ ✓	None identified.	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
• The ICBs' **Financial Recovery Meeting (FRM),** providing CEO-chaired, Executive-led oversight of delivery of the ICBs' financial recovery plans and efficiency programmes, including monitoring achievement of financial recovery trajectories, reviewing significant financial risks and pressures, and overseeing actions to improve delivery confidence. • The ICBs' **Savings and Efficiency Group (SEG),** providing detailed programme-level oversight of delivery of the ICBs' efficiency programmes and cost improvement initiatives, including review of scheme delivery, identification and resolution of barriers to delivery, monitoring progress against agreed savings plans and escalation of risks requiring Executive intervention.	DDICB Internal Audit Review – Cost Improvement Plan (Significant Assurance) Internal Audit Reviews – Financial Ledger and Reporting *(planned).* External Audit – Year-end Financial Accounts Reviews Clustered System Review Meetings (SRMs) with NHSE Regional Teams (monthly) System Review Meetings (QSRMs) (including Providers) with NHSE Regional Teams (quarterly)		✓ ✓ ✓ ✓ ✓	✓ ✓ ✓	 ✓ ✓		

Action(s):	Responsible Officer	Implementation Date
7b.1: To establish an aligned contract management framework across the ICBs.	Director of Commissioning / Director of Finance	Superseded (see 7b.3 and 7b.4)
7b.2: To develop and embed a formal control framework for payer mechanisms once national guidance is published.	Director of Finance	~~September 2026~~ December 2026 *(dependent on national guidance publication)*
7b.3 To establish a single, shared contract management database across the ICBs to support consistent contract recording and monitoring.	Director of Finance	Complete
7b.4 To implement and embed a consistent provider oversight and contract management framework across the cluster, including Contract Delivery Review and Oversight Meetings (CDROMs), associated escalation arrangements and risk-based contract management processes.	Director of Finance / Director of Commissioning	November 2026

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:
RR151 – Rising demand for autism and ADHD assessments risks unmet need, poor experience and adverse outcomes. *RR165 – Delays to replacement Derbyshire Urgent Treatment Centre services could disrupt urgent care delivery, reducing access and increasing pressure.* *RR134 – Insufficient recurrent financial efficiencies risk slower improvement in underlying deficit and reduced ability to meet population needs in Lincolnshire.*

Risk 9 – Failure to systematically improve the quality of healthcare services					
Strategic Risk Narrative:	Risk that the ICBs do not effectively monitor, evaluate and drive improvement in commissioned services, limiting their ability to both restore quality where standards fall below expectations and deliver transformative quality improvement to achieve better outcomes and experience.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Executive Director of Quality (Nursing)	High (4 x 4)	High (4 x 4)	Medium (4 x 2)	No change.
Lead Committee:	Joint Quality and Service Improvement Committee			Cautious	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Development and alignment of the ICBs' approach to quality across the cluster, through the establishment of a formal **Quality Strategy** and clear, **shared priorities for 2026/27** aligned to commissioning intentions and statutory duties, including: • Access and capacity: Ensuring timely and equitable access to services. • Patient safety and experience: Reducing harm, learning from incidents, and improving user experience, with particular focus on maternity and mental health. • Reducing health inequalities: Targeted interventions for underserved groups, using population health management approaches. • Workforce: Focusing on training, retention, sickness management, and staff wellbeing to support quality delivery. • Clinical effectiveness: Ensuring evidence-based care, pathway redesign, and robust outcome measurement. • Digital maturity: Leveraging technology for safer, more effective care, with attention to CHC transformation. • Safeguarding and health protection: Maintaining robust frameworks for vulnerable groups, including children and people with mental health conditions, learning disabilities, and autism (LDA).	Derbyshire, Lincolnshire and Nottinghamshire Quality Approach update to the Joint Quality and Service Improvement Committee (January 2026) Quality Strategy update to the Joint Quality and Service Improvement Committee (February 2026 and ongoing through the 2026/27 work programme) Quality Improvement Priorities and Plans presented to the Joint Quality and Service Improvement Committee (February 2026 and ongoing) Quality Priorities 2026/27 update to the Joint Quality and Service Improvement Committee (February 2026) Delivery of Quality Improvement Plans reporting to the Joint Quality and Service Improvement Committee (July and *pending, November 2026*) Clustered System Review Meetings (SRMs) with NHS England Regional Teams (monthly)	✓ ✓ ✓ ✓ ✓	✓	✓ ✓ ✓ ✓ ✓ ✓	✓	To develop clear, measurable plans to oversee delivery of the quality priorities. To establish and implement a cluster-wide quality approach for 2026/27, including agreed priorities, aligned oversight arrangements and consistent reporting across the three ICBs, as an interim position ahead of a full strategy. To develop and embed a Quality Management System (QMS) approach across the future single ICB, aligned to the national quality strategy and informed by delivery of the 2026/27 quality priorities.	9.2 9.5 9.6

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Establishment and ongoing development of the **ICBs' quality oversight and commissioning framework**, ensuring systematic monitoring, evaluation and improvement of commissioned services in line with statutory duties, including: • The ICBs' **quality framework, commissioning processes and integrated quality reporting arrangements**, including the development and use of quality dashboards and Integrated Performance Reports, which provide systematic oversight of quality, safety, performance and patient outcomes, drive quality improvement in line with statutory responsibilities, and ensure services are routinely assessed against required quality and safety standards. • Development and implementation of robust **quality schedules for 2026/27**, embedded within contract management arrangements, providing structured mechanisms for quality assurance and continuous improvement across commissioned providers • Continued embedment of **the Patient Safety Incident Response Framework (PSIRF)**, establishing consistent systems and processes for responding to patient safety incidents, supporting organisational learning and improvement.	Quality Oversight Reports to the Joint Quality and Service Improvement Committee (each meeting) Thematic Quality Reports to the Joint Quality and Improvement Committee (every other meeting) Learning, Safety and Continuous Improvement Reports (including PSIRF and patient safety intelligence) to the Joint Quality and Service Improvement Committee (May and *pending, November 2026*) The Patient Safety Incident Response Framework to the Joint Quality and Service Improvement Committee (May 2026) Health Protection Report to the Joint Quality and Service Improvement Committee (May 2026) Oversight of Mortuary and After Death Care in Provider Organisations to the Joint Quality and Service Improvement Committee (May 2026) Education Quality Summary Report to the Joint Quality and Service Improvement Committee (May 2026) Provider Quality Accounts Corroborative Statements to the Joint Quality and Service Improvement Committee (May 2026) Modern Slavery Statements to the Joint Quality and Service Improvement Committee (May 2026) LICB Internal Audit Review – Patient Safety NNICB Internal Audit Review – Patient Safety Incident Response Framework (PSIRF) DLN Internal Audit Review – Quality oversight arrangements (*pending*) DLN Internal Audit Review – Safeguarding arrangements (*pending*)	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	 ✓ ✓ ✓ ✓	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	✓	To develop robust quality schedules and associated monitoring arrangements (in conjunction with contracting colleagues).	9.3
Implementation of an **aligned quality oversight, assurance and improvement framework**, enabling the ICBs to systematically monitor, evaluate and improve the quality of commissioned services, identify areas where standards fall below expectations, oversee delivery of improvement actions, and escalate concerns where quality, safety, outcomes or patient experience are at risk. This includes: • The **System Quality Group**, acting as the central forum for quality and safety oversight, triangulating intelligence from provider reporting, patient safety, safeguarding, complaints, quality surveillance and commissioning assurance arrangements. • **Routine quality oversight through provider quality forums and quality review meetings**, enabling detailed scrutiny of quality performance, patient safety incidents, complaints, regulatory concerns and thematic risks, and agreeing actions to improve the quality and safety of commissioned services.	Quality Oversight Reports to the Joint Quality and Service Improvement Committee (each meeting) Focused reports on NOF 3 and 4 providers to the Joint Quality and Service Improvement Committee (January and May 2026 and *pending, September 2026*) Thematic Quality Reports to the Joint Quality and Improvement Committee (every other meeting) Learning, Safety and Continuous Improvement Reports (including PSIRF and patient safety intelligence) to the Joint Quality and Service Improvement Committee (May and *pending, November 2026*) Thematic Quality Report – Learning Disabilities and Autism to the Joint Quality and Service Improvement Committee (April 2026) Deep Dive into Quality Escalations – maternity at NUH and UHDB to the Joint Quality and Service Improvement Committee (May 2026) Primary and Neighbourhood Care Quality and Improvement Plans to the Joint Quality and Service Improvement Committee (May 2026)	✓ ✓ ✓ ✓ ✓ ✓ ✓		✓ ✓ ✓ ✓ ✓ ✓ ✓	✓ ✓ ✓	To review and rationalise operational quality oversight arrangements, ensuring the balance of ICB-level and cluster-wide oversight is appropriate.	9.4

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
• Routine commissioning assurance through **Contract Review Meetings (CRMs),** monitoring delivery against contractual quality requirements and agreed improvement trajectories. • **Contract Delivery Review and Oversight Meetings (CDROMs),** providing integrated oversight of significant quality, safety and delivery risks, ensuring quality concerns identified through surveillance, assurance and review processes are considered alongside wider delivery risks and supported by clear improvement and recovery actions. • Formal escalation and intervention through **Contract Executive Board(s),** providing senior commissioner-provider leadership oversight where quality concerns require formal escalation. • **Mental Health, Learning Disability and Autism (MHLDA) Programme Board**, providing cluster-wide commissioning assurance and oversight of service quality, outcomes, access, patient experience and improvement delivery across mental health, learning disability and autism services, with responsibility for escalating significant quality and delivery risks through the wider commissioning governance framework. • Regular **safeguarding assurance forums** (including children and adults), ensuring statutory safeguarding responsibilities are met and risks to vulnerable groups are identified, escalated and managed effectively. • **Maternity quality oversight and perinatal assurance arrangements,** including DLN-wide maternity governance through the Perinatal Partnership Group and associated quality assurance processes, together with provider-specific quality oversight, surveillance and escalation forums for Nottingham University Hospitals (NUH) and University Hospitals of Derby and Burton (UHDB). • **Primary care and delegated commissioning quality forums**, ensuring consistent oversight of quality, safety and patient experience across GP, dental, pharmacy and optometry services. • **Quality surveillance and escalation arrangements** aligned with regional and national NHS England processes, supporting the sharing of intelligence, coordinated responses to emerging concerns and system-wide improvement activity.	Salivary Gland Assessment and Management Pathway Assurance to the Joint Quality and Service Improvement Committee (April 2026) Safeguarding Vulnerable Adults updates to the Joint Quality and Service Improvement Committee (*pending, September 2026*) Safeguarding Children updates to the Joint Quality and Service Improvement Committee (*pending, October 2026*) Regional LMNS oversight and performance meetings with NHS England Regional Learning Disability and Autism (LDA) oversight and performance meetings with NHS England Clustered System Review Meetings (SRMs) with NHS England Regional Teams (monthly) Quality System Review Meetings (QSRMs) (including providers) with NHS England Regional Teams (quarterly)	✓ ✓ ✓	 ✓ ✓ ✓ ✓	✓ ✓ ✓ ✓ ✓	 ✓ ✓ ✓ ✓		

Action(s):	Responsible Officer	Implementation Date
9.1: To develop and implement a formal cluster-wide Quality Strategy, establishing agreed priorities and mechanisms for quality oversight and reporting across the three ICBs.	Director of Quality (Nursing)	Superseded (see 9.5 and 9.6)
9.2: To develop clear, measurable plans to oversee delivery of the quality priorities.	Director of Quality (Nursing)	~~September 2026~~ Complete

9.3: To develop robust quality schedules and associated monitoring arrangements (in conjunction with contracting colleagues).	Director of Quality (Nursing)	~~June 2026~~ Complete
9.4: To review and rationalise operational quality oversight arrangements, ensuring the balance of ICB-level and cluster-wide oversight is appropriate.	Director of Quality (Nursing)	November 2026
9.5 To establish and implement a cluster-wide quality approach for 2026/27, including agreed priorities, aligned oversight arrangements and consistent reporting across the three ICBs, as an interim position ahead of a full strategy.	Director of Quality (Nursing)	~~April 2026~~ Complete
9.6 To develop and embed a Quality Management System (QMS) approach across the future single ICB, aligned to the national quality strategy and informed by delivery of the 2026/27 quality priorities.	Director of Quality (Nursing)	April 2027

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:
RR150 – Delays in MH discharges causing flow issues across ED and inpatient settings impacting patient safety and quality across the cluster.
RR149 – LDA patients in inappropriate inpatient settings due to discharge delays impacting quality and outcomes across the cluster.
RR161 – Ineffective cluster wide discharge processes, may increase length of stay and cause harm, deconditioning, and poor experience.

Risk 10 – Failure to ensure timely and equitable access to healthcare services in line with national and local performance standards					
Strategic Risk Narrative:	Risk that the ICBs do not rigorously monitor, evaluate, and adapt services, resulting in persistent non-delivery of access targets.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Executive Director of Commissioning	High (4 x 4)	High (4 x 4)	Medium (4 x 2)	No change.
Lead Committee:	Joint Finance and Performance Committee			Cautious	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
The development and delivery of a t**hree-year operational plan for 2026/27 to 2028/29**, including integrated revenue, workforce, and operational performance and activity plans. The plan sets out how the ICBs will deliver statutory duties, meet performance standards, manage resources, and align financial, workforce, and operational arrangements.	Medium Term Planning updates to the Boards (December 2025 and January 2026) *(open and/or confidential sessions)*	✓		✓		None identified.	
	Operational and Financial Plan update to the Joint Finance and Performance Committee (Jan 2026 and, *pending Jan and Feb 2027)*	✓		✓			
	Commissioning delivery reports presented to both the Boards and the Joint Finance and Performance Committee (each meeting)	✓		✓	✓		
	Thematic commissioning delivery reviews to the Joint Finance and Performance Committee (Sept, *pending Dec 2026 and Jan 2027)*	✓					
	NNICB Internal Audit Review – Delivery of Operational Plans (Significant assurance)		✓	✓			
	Clustered System Review Meetings (SRMs) with NHSE Regional Teams (monthly)		✓	✓	✓		
	System Review Meetings (QSRMs) (including Providers) with NHSE Regional Teams (quarterly)		✓	✓	✓		
	Ad-hoc Assurance Meetings with NHSE Regional Team (bi-monthly)		✓	✓	✓		
Establishment and ongoing development of a **comprehensive commissioning oversight and commissioning delivery framework** across the DLN cluster, enabling systematic monitoring, evaluation, escalation and adaptation of commissioned services to support delivery of operational plans and access standards, including: • A defined governance and escalation architecture, including the **Commissioning Oversight Group** and **Joint Commissioning Executive Group,** providing oversight of commissioning delivery, performance and risk, and enabling timely escalation of issues requiring system-level intervention or commissioning action. • **Management-led oversight forums** across commissioning domains (including finance, quality, commissioning, strategy, outcomes, digital, and vaccinations and immunisations), ensuring coordinated and thematic review of delivery and supporting adaptation of services in response to emerging risks and system priorities.	Contract Management Reports presented to the Joint Finance and Performance Committee (June 2026, and *pending Oct 2026 and Feb 2027)*	✓				See action 2.4. See action 7b.1.	
	Commissioning delivery reports presented to both the Boards and the Joint Finance and Performance Committee (each meeting)	✓		✓	✓		
	Thematic commissioning delivery reviews to the Joint Finance and Performance Committee (Sept, *pending Dec 2026 and Jan 2027)*	✓					
	NHS England delegated functions updates (Specialised Services) to the Joint Strategic Commissioning Committee *(pending)*	✓					
	NHS England delegated functions updates (Dental, Ophthalmic and Pharmaceutical Services) to the Joint Strategic Commissioning Committee *(pending)*	✓					
	DDICB Internal Audit Review – Data Quality and Performance Management Framework (Advisory)		✓				
	DLN Internal Audit Reviews, including: Data quality of a Board-level indicator (indicative) and Contract management *(pending, Q2)*		✓				

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
• Formalised programme and delivery oversight through **Programme Boards**, providing routine monitoring of delivery trajectories, milestones and risks, and ensuring commissioning plans are translated into deliverable transformation and service change programmes. • An integrated **Activity, Finance and Performance (AFP) oversight model**, comprising: - **Activity, Finance and Performance Technical Group(s),** responsible for detailed monitoring and triangulation of activity, finance and delivery metrics, identifying emerging risks, variation from plan and areas requiring intervention - **DLN Activity, Finance and Performance Group**, providing consolidated oversight of commissioning delivery and operational plan trajectories, with structured focus across Acute services and Mental Health and Community services. • Routine commissioning delivery oversight through **Contract Review Meetings (CRMs)**, monitoring delivery against contractual, activity, quality and financial requirements, and enabling early identification and management of underperformance against agreed trajectories. • Formal escalation and intervention through **Contract Executive Board(s),** bringing together ICB and provider leadership to review delivery concerns, agree recovery actions, and oversee implementation of improvement plans where services are not delivering in line with commissioning expectations. • A **Commissioning Delivery Dashboard**, incorporating metrics aligned to national standards, operational planning requirements and strategic commissioning priorities, enabling consistent monitoring of delivery against trajectories and early identification of variance. • Defined **escalation triggers and a formal escalation framework**, enabling proportionate and timely response to deterioration in delivery, including escalation through ICB governance and, where required, NHSE oversight arrangements. • Joined-up commissioning delivery and financial recovery oversight, including the **Financial Recovery Meeting**, ensuring activity, performance and financial position are considered collectively, with coordinated escalation and agreement of mitigation actions where material variance from plan is identified.							
Implementation of a **Primary Care Operational Scheme of Delegation,** establishing a consistent framework across the three ICBs for the discharge of NHS England delegated primary care functions, including clear accountabilities, delegated decision-making arrangements, oversight of Primary Medical, Dental, Ophthalmic and Pharmaceutical	Commissioning delivery reports presented to both the Boards and the Joint Finance and Performance Committee (each meeting) Primary Medical Care Services Assurance Report to the Joint Strategic Commissioning Committee (January 2026)	✓ ✓		✓	✓	To establish a consistent, cluster-wide model for primary care operational governance, aligning contract management and performance oversight across the three ICBs.	10.1

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Services, contract management, quality oversight, provider performance management, commissioning decisions and escalation arrangements. Delivery is supported through the **Joint Primary Care Commissioning Group,** operating as a sub-committee of the Joint Strategic Commissioning Committee with responsibility for exercising delegated primary care commissioning functions and receiving assurance regarding provider quality, performance and contractual management arrangements.							
Daily system calls and On-call arrangements, alongside alignment of the System Co-ordination Centres (SCC) across the cluster; the purpose of which is to ensure the safest and highest quality of care possible for the entire population across every area by balancing the clinical risk within and across all health and care settings. Operational Pressures Escalation Level (OPEL) Framework across primary and secondary care providers.	Commissioning delivery reports presented to both the Boards and the Joint Finance and Performance Committee (each meeting)	✓		✓	✓	To align and integrate the three System Co-ordination Centres (SCCs) into a single, consistent cluster-wide operating model.	10.2

Action(s):	**Responsible Officer**	**Implementation Date**
10.1: To establish a consistent, cluster-wide model for primary care operational governance, aligning contract management and performance oversight across the three ICBs.	Director of Commissioning	~~October 2026~~ Complete
10.2: To align and integrate the three System Co-ordination Centres (SCCs) into a single, consistent cluster-wide operating model.	Director of Commissioning	~~September 2026~~ December 2026

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:
RR151 – Rising demand for autism and ADHD assessments risks unmet need, poor experience and adverse outcomes.
RR073 – Mental health bed shortages risk inappropriate placements and pressure on urgent care.
RR165 – Delays to replacement Derbyshire Urgent Treatment Centre services could disrupt urgent care delivery, reducing access and increasing pressure.

Risk 11 – Failure to develop and implement an effective operating model and workforce capability to support the transition to a merged ICB					
Strategic Risk Narrative:		**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Executive Director of Transition	Medium (4 x 3)	Medium (4 x 3)	Medium (4 x 3)	No change.
Lead Committee:	Joint Transition Committee / Joint Remuneration and Human Resources Committee			Open	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
The establishment and ongoing delivery of a jointly agreed **ICB Transition Programme Plan**, providing a structured and coordinated approach to managing the transition across the three ICBs. The Programme Plan includes development of the future operating model and strategic commissioning arrangements, including assessment of future ICB functions, commissioning capability requirements and organisational design needed to support future cluster and merger arrangements. The Plan is underpinned by defined workstreams, with assigned Senior Responsible Officers (SROs) including: • the **Estates workstream**, which is responsible for delivering efficiencies and establishing future corporate HQ and satellite space. • the **Commissioning Support Unit (CSU) Transition workstream**, which is responsible for reviewing CSU functions and determining proposals for future delivery models. • the **Finance workstream**, which is responsible for monitoring budgets, allocations, and cost efficiencies. • the **Governance workstream**, which is responsible for ensuring robust decision-making, oversight, and risk management. • the **Communications and Engagement workstream**, which is responsible for supporting staff and stakeholder communications, including consultation processes. • the **Management of Workforce Change workstream**, which is responsible for overseeing staff transition, voluntary redundancy planning, and associated consultation processes. • the development and implementation of a **structured merger readiness and due diligence workstream and associated**	Transition programme updates to the ICB Boards (each meeting) *(open and/or confidential sessions)* Transition Programme Plan delivery and risk reporting updates to the Joint Transition Committee (each meeting) Operating model development updates to the Joint Transition Committee, including a focused update in Q3 2026/27 on plans (where relevant) for the transfer of ICB functions to other NHS bodies (each meeting) Strategic Commissioning Development Plan updates to the Joint Transition Committee (May 2026, *and pending)* Summary of the NHS Reform Bill to the Joint Transition Committee (July 2026) Assessment of merger/boundary change preparation requirements to the Joint Transition Committee *(pending),* subject to confirmation of future ICB footprints in line with the anticipated timetable for local government reorganisation decisions. Merger/boundary change plan updates to the Joint Transition Committee *(pending),* with delivery updates in Q4 2026/27. Merger plan delivery updates to the Boards and Joint Transition Committee *(pending)* 360 Assurance Internal Audit – Independent support and assurance on transition and merger due diligence *(Q4)* 360 Assurance Internal Audit Review - Governance Arrangements (August 2026, Significant Assurance) Clustered System Review Meetings (SRMs) with NHSE Regional Teams (monthly) System Review Meetings (QSRMs) (including Providers) with NHSE Regional Teams (quarterly)	✓ ✓ ✓ ✓ ✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓ ✓ ✓		To develop and implement detailed merger plans once the future ICB footprint is confirmed, informed by the publication of the NHS Reform Bill and aligned with local government reorganisation decisions. To establish a structured merger and due diligence workstream to support the planned merger, including defined assurance reporting to the Joint Transition Committee and Boards.	11.1 11.2

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
governance arrangements to assess operational implications of any future merger or boundary change arrangements.							
Development and delivery of a **Management of Change process and supporting business case**, providing a structured approach to aligning the ICBs workforce structures, roles and capacity across the cluster to enable safe and effective transition. Ongoing **engagement and consultation with recognised Trade Unions and staff representatives** to support transparency, fairness and staff engagement throughout workforce change and transition processes.	Organisational Development Framework update to the Joint Transition Committee (July 2026) Workforce Change and Exit Plan progress updates to the Joint Transition Committee (each meeting) Workforce Reports to the Joint Remuneration and HR Committee (each meeting) Workforce and Organisational Capability Risk Reports to the Joint Remuneration and HR Committee and Joint Transition Committee (each meeting) Trade Union engagement and consultation updates through Workforce Change Programme reporting (each meeting) Voluntary Redundancy Scheme Progress Reports to the Remuneration and HR Committee (January 2026) Management of Change Process Progress Reports to the Remuneration and HR Committee (January 2026) Equality Impact Assessment updates relating to workforce transition proposals (April 2026 and as required) Strategic Commissioning Competency Framework self-assessment findings reported to the Joint Transition Committee *(pending)* NHS Staff Survey results to the Remuneration and HR Committee (April 2026) Freedom to Speak Up report to the Audit Committees *(pending, October 2026)* Freedom to Speak Up report to the Boards *(pending, November 2026)* DLN Internal Audit Review: Support Mechanisms for Staff (Q4 2026/27)	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	 ✓ ✓ ✓	✓ ✓ ✓ ✓ ✓	 ✓ ✓	None identified.	
Development and delivery of a **cluster-wide Organisational Development Framework and Strategic Commissioning Development Programme**, informed by organisational capability assessments, the commissioning competency framework and self-assessment process. This will address system capability, leadership development, cultural alignment and skills requirements necessary to support transition and the future operating model.	Organisational Development Framework update to the Joint Transition Committee (July 2026 and future updates). Strategic Commissioning Competency Framework self-assessment findings to the Joint Transition Committee *(pending)* Strategic Commissioning Development Plan updates to the Joint Transition Committee *(pending).* Workforce and Organisational Capability Risk Reports to the Joint Remuneration and HR Committee and Joint Transition Committee (each meeting).	✓ ✓ ✓ ✓		✓ ✓		To develop and implement a cluster-wide Organisational Development (OD) Plan, informed by the commissioning competency framework and self-assessment.	11.2
Staff support and wellbeing arrangements to support the management of change process, including occupational health, Employee Assistance Programmes, HR advice and mental health support, ensuring workforce wellbeing is maintained during transition.	Development of ICBs' shared values and behaviours (Board Development Session, April 2026) NHS Staff Survey results to the Remuneration and HR Committee (April 2026) Freedom to Speak Up report to the Audit Committees *(pending, October 2026)* Freedom to Speak Up report to the Boards *(pending, November 2026)*	✓ ✓ ✓	 ✓	✓ ✓	 ✓	None identified.	

Control Description *(How are we going to stop the risks happening?)*	Assurances *(How do we know the controls are working?)*	I	E	+	-	Gaps in Control / Assurance *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	Action ref:
	DLN Internal Audit Review: Support Mechanisms for Staff (Q4 2026/27)		✓	✓	✓		

Action(s):	Responsible Officer	Implementation Date
11.1: To develop and implement detailed merger plans once the future ICB footprint is confirmed, informed by the publication of the NHS Reform Bill and aligned with local government reorganisation decisions.	Director of Transition	~~September 2026~~ October 2026
11.2: To develop and implement a cluster-wide Organisational Development (OD) Plan, informed by the commissioning competency framework and self-assessment.	Director of Transition	December 2026
11.3: To establish a structured merger and due diligence workstream to support the planned merger, including defined assurance reporting to the Joint Transition Committee and Boards.	Director of Transition	October 2026

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:
No high scoring ORR risks identified.

Risk 12 – Failure to maintain cyber resilience					
Strategic Risk Narrative:	Risk that the ICBs do not establish robust cyber security arrangements, which could compromise delivery of core functions and disrupt access to critical data and systems.	**Opening Risk Level and Score (I x L)**	**Current Risk Level and Score (I x L)**	**Risk Appetite and Target Risk Score (I x L)**	**Movement in risk score** *(since last reporting period)*
Executive Risk Owner:	Executive Director of Outcomes (Medical)/SIRO, Executive Director of Finance	Medium (4 x 3)	Medium (4 x 3)	Medium (4 x 2)	No change.
Lead Committee:	Audit Committee			Cautious	

Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
Development and implementation of a **cluster-wide Cyber Security Strategy**, informed by national NHS cyber security policy and existing organisational strategies, to establish a consistent approach to cyber governance, assurance, risk management and resilience across the three ICBs. This includes alignment of cyber oversight arrangements, assurance reporting, and provider transition plans, supporting increased digital collaboration and readiness for the future single ICB while safeguarding systems, information assets and service continuity.	Information Governance Assurance Reports to the Audit Committee (February and June 2026) Senior Information Risk Owner (SIRO) Annual Report to the Audit Committee (April 2026) Senior Information Risk Owner (SIRO) Annual Report to the Board (May 2026) National Cyber Security Centre (NCSC) NHS cyber security training *(Board Development Session, pending Dec 2026)* IT Providers' Cyber Essentials and Cyber Essentials Plus Accreditations Dionach pen testing reported to the SIRO (complete, all three ICBs) 2026/27 DLN Internal Audit Reviews – IT Disaster Recovery/Business Continuity *(Q2)(Significant Assurance)* NHS England (NHSE) phishing exercise reported to the SIRO *(pending)*	✓ ✓ ✓	 ✓ ✓ ✓ ✓ ✓	✓ ✓ ✓ ✓ ✓ ✓		To review existing cyber security strategies across the three ICBs and develop a single, aligned cluster-wide Cyber Security Strategy. See action 2.8	12.1
Role and remit of the ICBs' **Data Protection & Security (DP&S) Steering Group**, which is a cluster-wide operational forum that coordinates and strengthens information governance, data protection and cyber security arrangements across the three ICBs. The Group is responsible for: • coordinating and overseeing cyber resilience and information security assurance across the cluster. • monitoring and assessing each ICB's compliance with the Cyber Assurance Framework (CAF) through the CAF-aligned Data Security and Protection Toolkit (DSPT), in line with the annual profile set by NHS England. • providing collective oversight of cyber and information security risks. • supporting the proactive management of cyber security threats, vulnerabilities and incidents across the cluster.	Information Governance Assurance Reports to the Audit Committee (February 2026 and June 2026*),* including updates in relation to the ICBs' compliance with the DSPT. Cyber Security Updates to the Data Protection & Security (DP&S) Steering Group, which summarise cyber security progress and cyber risk mitigations, including patching, password hygiene, and strategic infrastructure upgrades (to every other meeting) Communications via the ICBs; Staff News relating to cyber security (as per IG Comms Plan and TNA) 2025/26 Internal Audit Review (DDICB) – DSPT (Low risk) 2025/26 Internal Audit Review (NNICB) – DSPT (Low risk) 2025/26 Internal Audit Review (LICB) – DSPT (Very high risk)	✓ ✓ ✓	 ✓ ✓ ✓	 ✓ ✓	 ✓	To deliver the Lincolnshire ICB DSPT Improvement Plan and strengthen compliance with DSPT requirements through completion of agreed improvement actions.	12.4
Alignment of existing digital and cyber governance structures across the three ICBs, adopting a common NHIS-aligned approach to governance,	Senior Information Risk Owner (SIRO) Annual Report to the Audit Committee (April 2026)	✓		✓		To review, align, and consolidate digital and cyber governance arrangements across the three ICBs.	12.2

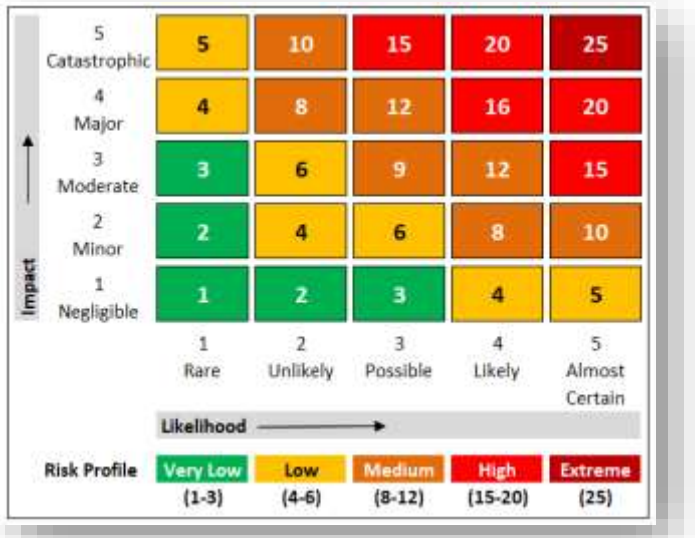
Control Description *(How are we going to stop the risks happening?)*	**Assurances** *(How do we know the controls are working?)*	**I**	**E**	**+**	**-**	**Gaps in Control / Assurance** *(Where are we failing to put effective controls in place and/or gain evidence that controls are effective?)*	**Action ref:**
assurance and oversight for digital services, cyber security and technology investment. This will support the transition of Derby and Derbyshire ICB and Lincolnshire ICB digital functions into the NHIS operating model, provide consistent governance arrangements across the cluster, and strengthen readiness for the future single ICB. *It should be noted that existing arrangements continue to exist at the current IT providers until the transition to NHIS.*	Senior Information Risk Owner (SIRO) Annual Report to the Board (May 2026) Information Governance Assurance Reports to the Audit Committee (February and June 2026), including updates in relation to the ICBs' compliance with the DSPT. 2026/27 DLN Internal Audit Reviews – IT Disaster Recovery/Business Continuity *(Q2)(Significant Assurance)*	✓ ✓	 ✓	✓ ✓	 ✓	See action 2.8	
Role of the **joint Senior Information Risk Owner (SIRO**) for the three ICBs, responsible for overseeing and managing information governance and cyber security risks across the cluster. The SIRO ensures organisational data is protected, cyber threats are mitigated, and compliance with legal, regulatory, and NHS cyber standards is maintained across all three ICBs.	Senior Information Risk Owner (SIRO) Annual Report to the Audit Committee (April 2026) Senior Information Risk Owner (SIRO) Annual Report to the Board (May 2026) National Cyber Security Centre (NCSC) NHS cyber security training *(Board Development Session, pending Dec 2026)*	✓ ✓		✓ ✓		None identified.	
Role of the **Emergency Preparedness, Resilience and Response (EPRR) Team** across the three ICBs, ensuring that **Business Impact Assessments (BIA)** identify critical digital systems and services across the cluster. This will enable the cluster to understand cyber risks and maintain continuity plans that support rapid recovery from cyber disruptions.	Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Report to the Boards *(pending, Jan 2027)* Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity updates to the Audit Committee (December 2025 and May 2026) DDICB Internal Audit Review – Business Continuity (Significant assurance) EPRR NHSE Core Standards Self-Assessment (all three ICBs) 2026/27 DLN Internal Audit Reviews – IT Disaster Recovery/Business Continuity *(Q2)(Significant Assurance)*	✓ ✓ ✓	 ✓ ✓ ✓	 ✓ ✓ ✓ ✓		To undertake testing across all ICBs' BIA critical systems.	12.3

Action(s):	**Responsible Officer**	**Implementation Date**
12.1: To review existing cyber security strategies across the three ICBs and develop a single, aligned cluster-wide Cyber Security Strategy.	Director of Finance	~~October 2026~~ June 2027
12.2: To review, align, and consolidate digital and cyber governance arrangements across the three ICBs.	Director of Finance	~~October 2026~~ June 2027
12.3: To undertake testing across all ICBs' BIA critical systems.	Director of Finance	~~June 2026~~ January 2027
12.4 To deliver the Lincolnshire ICB DSPT Improvement Plan and strengthen compliance with DSPT requirements through completion of agreed improvement actions.	Executive Director of Outcomes (Medical)/SIRO	December 2026

Related high/extreme (≥15) operational risks from the ICBs' Joint Operational Risk Register:
No high scoring ORR risks identified.

Annex 1: Alignment of BAF Strategic Risks to ICBs' Joint objectives/core aims

Strategic Risks *(What could prevent us from achieving our strategic aims/objectives and statutory duties?)*	To improve outcome in population health and healthcare.	To tackle inequalities in outcomes, experience, and access.	To enhance productivity and value for money.	To help the NHS support social and economic development.
Risk 1: Failure to develop and maintain a comprehensive, evidence-based understanding of local population health needs *Risk that the ICBs do not use joined-up, person-level data and intelligence to identify current and future needs, drivers of risk, and underserved communities, leading to ineffective or inequitable commissioning decisions.*	✓	✓		
Risk 2, 3, 4 and 5: Failure to deliver system transformation through delivery of a long-term, outcomes-focused commissioning strategy *Risk that the ICBs do not establish or implement a robust, evidence-based commissioning strategy that delivers the three strategic shifts of the 10-Year Health Plan: from sickness to prevention, from hospital to community-based care, and from analogue to digital; resulting in missed opportunities to improve health outcomes, reduce inequalities, and deliver system priorities.*	✓	✓	✓	✓
Risk 6: Failure to involve people and communities meaningfully in commissioning and service design *Risk that the ICBs do not systematically co-produce solutions with service users, carers, and communities, leading to services that do not meet local needs or legal requirements for engagement.*	✓	✓		
Risk 7a: Failure to prioritise resources and shape provider markets to meet local needs *Risk that the ICBs do not prioritise investment or allocate resources according to local needs, resulting in inefficiencies, reduced productivity, and an inability to deliver services that meet population needs.*			✓	✓
Risk 7b: Failure to manage contracts effectively and achieve financial sustainability *Risk that the ICBs do not effectively manage contracts or ensure providers deliver agreed services, leading to poor value for money and inability to achieve financial balance.*	✓	✓	✓	✓
Risk 9: Failure to systematically improve the quality of healthcare services *Risk that the ICBs do not effectively monitor, evaluate and drive improvement in commissioned services, limiting their ability to both restore quality where standards fall below expectations and deliver transformative quality improvement to achieve better outcomes and experience.*	✓	✓		
Risk 10: Failure to ensure timely and equitable access to healthcare services in line with national and local performance standards *Risk that the ICBs do not rigorously monitor, evaluate, and adapt services, resulting in persistent non-delivery of access targets.*	✓	✓	✓	
Risk 11: Failure to develop and implement an effective operating model and workforce capability to support the transition to a merged ICB *Risk that the ICBs do not build and maintain the strategic commissioning skills, capabilities and operating model required to support the transition to a merged ICB, while supporting the wellbeing of the combined workforce.*			✓	
Risk 12: Failure to maintain cyber resilience *Risk that the ICBs do not establish robust cyber security arrangements, which could compromise delivery of core functions and disrupt access to critical data and systems.*	✓	✓	✓	


Impact
5 Catastrophic
4 Major
3 Moderate
2 Minor
1 Negligible
5 10 15 20 25
4 8 12 16 20
3 6 9 12 15
2 4 6 8 10
1 2 3 4 5
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:	17/09/2026
Paper title:	**Committee Highlight Reports**
Paper reference:	ICB CIC 26 055
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 July 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 – Joint Remuneration and Human Resources Committee 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:	02 September 2026
Committee Chair:	Stephen Jackson, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
ICB Finance Report (Month 4)	At month four, all three ICBs continued to report on-plan financial positions, both in-month and for the full-year forecast. The wider NHS systems reported a combined deficit of £101.3 million against a planned deficit of £70.1 million, representing an adverse variance of £31.2 million. Providers in Nottingham and Nottinghamshire were the principal drivers of the adverse variance. The Committee discussed in detail a number of risks to the ICBs' positions, notably acute activity, mental health and learning disability services, prescribing, Continuing Healthcare and community services; and the actions that were being taken to mitigate these cost pressures. Members took assurance that the pressures continued to be actively managed and mitigated through the ICBs' Financial Recovery Group.	**Adequate**	*Adequate* *(awarded at the meeting held on 01 July 2026)*
ICB Efficiency Report (Month 4)	To date, £173.8 million of savings had been identified equating to 106.5% of the requirement. The risk adjusted year end forecast was estimated to be a £29.8 million gap to target. This represented a £6 million improvement in the risk adjusted position since the last report. The Committee heard that work continued to improve the risk adjusted position and a line-by-line review of the highest risk schemes was being	**Adequate**	Adequate *(awarded at the meeting held on 01 July 2026)*

Item	Summary	Level of Assurance	Previous Level of Assurance
	undertaken to close remaining risks, assess the precise delivery forecasts and build certainty in terms of the overall end of year delivery.		
Contract Management Report	The report provided an overview on the establishment and initial operation of the Contract Delivery Review and Oversight Meeting framework across the ICBs. It summarised the key issues identified through the first round of meetings with providers, the actions and interventions established through the contract management framework and the assurance this provided regarding the ICBs' ability to identify, manage and escalate provider performance, financial and service sustainability risks. Welcoming the report, members considered that it further strengthened the ICBs' financial control framework.	**Adequate**	*Not applicable*
Commissioning Delivery Report 2026/27	Overall performance remained mixed. Diagnostic performance continued to be a significant concern. In planned care, 65-week waits had not been eliminated across all three systems, and recovery action plans were in place to improve performance against the 62-day cancer standard. Urgent and emergency care services also remained under sustained pressure. The Committee had welcomed the additional information within the report regarding contract delivery and the actions being taken to manage performance; and supported the commitment to continue strengthening reporting processes.	**Partial**	*Partial* *(awarded at the meeting held on 01 July 2026)*
Thematic Commissioning Delivery Review: Mental Health and Learning	The report provided an in-depth review of mental health, learning disability and autism services across the three ICB geographies, examining the current performance position; key risks and mitigations; and the 2026/27 Delivery Plan, which aimed to improve access, flow, outcomes, quality and financial sustainability.	**Partial**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
Disabilities and Autism	The Committee heard that overall, performance remained mixed. There were a number of services performing well. However, the most significant concerns related to inpatient flow and prolonged stays, urgent and crisis responsiveness and community capacity. Assurance was taken that the development of a robust delivery plan, and establishment of a Programme Board for these services, provided a sound basis for overseeing the transformation of services across Derbyshire, Lincolnshire and Nottinghamshire. However, as the programme was in its infancy, at this stage an assurance rating of partial was considered appropriate.		
Estates and Capital Resource Use Update	Members received an update on capital resource use and priority estates programmes across Derbyshire, Lincolnshire and Nottinghamshire. The capital programme remained broadly on track to fully utilise the allocation, with a current year-end forecast of full expenditure against plan. However, as with all capital programmes, there had been some movement since the plan had been approved. In order to ensure full utilisation of the allocation, approval for the proposed changes was requested (see 'decisions made' below).	**Adequate**	*Not applicable*

Other considerations:

Decisions made:
The Committee: a) **Endorsed** the joint 2026/27 Winter Plan and recommended it to the Boards for approval. The plan set out a whole-system approach to winter preparedness across the three ICB areas and had been stress tested against a range of demand scenarios. The Committee

Decisions made:
noted that a residual acute bed gap remained in Nottinghamshire, although the position had improved compared with previous years and work was ongoing to mitigate it. b) **Approved** the proposed changes to the ICBs' Capital Resource Programme. The changes reflected movements since the original plan was approved and were intended to support full utilisation of the available capital allocation.

Discussion and information items:
The Committee reviewed and discussed the six operational risks within its remit, noting a reduction of two since the previous report. Members considered whether any new or emerging risks arose from the matters discussed and requested further consideration of the financial aspects of the risk relating to autism and ADHD assessments and of an emerging financial risk arising from NHS England's approach to performance monitoring.

Appendix 2: Joint Quality and Service Improvement Committee Highlight Report

Meeting Dates:	09 September 2026
Committee Chair:	Sharon Robson, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Oversight and Assurance Arrangements for Derby and Derbyshire, Nottingham and Nottinghamshire, and Lincolnshire Perinatal Services	The Committee received a report on oversight and assurance arrangements for perinatal services across the three ICBs. It was advised that all five maternity providers were progressing implementation of the NHS England 10-point Maternity Urgent Plan, with ongoing oversight of challenges including workforce capacity, digital interoperability and service demand. The report also covered post-death care arrangements across providers in the three ICB areas and proposed priorities to strengthen maternity assurance, family engagement, the reduction of inequalities and the use of quality intelligence. Members emphasised the importance of robust contractual oversight, independent verification of provider progress and evidence that actions were translating into sustained improvements in outcomes and organisational culture. They discussed concerns regarding organisational culture and experiences of racism within maternity services and	Limited	Not applicable

Item	Summary	Level of Assurance	Previous Level of Assurance
	highlighted the importance of triangulating performance data with family, patient and staff experience. While oversight arrangements were in place and progress was evident, the Committee took limited assurance regarding the ICBs' ability to secure sustained improvement where provider performance remained below expectations. It sought greater clarity on the contractual and commissioning levers available to secure timely improvement and address identified concerns.		
Quality Oversight Report and Integrated Performance Report	The Committee received assurance that quality oversight arrangements remained in place across the three ICBs. Members noted that progress was being made across SEND reforms and improvement programmes, with local area partnerships due to receive reform reports by the end of September. Members noted that work continued to address key quality priorities across the three ICBs, including infection prevention and control, learning disability and autism services, and the strengthening of quality intelligence and performance reporting arrangements.	**Partial**	Partial *(awarded at the meeting held on 8 July 2026)*
DLN Outcomes, Audit and Monitoring Assurance approach	The Committee received assurance that a new DLN Outcomes, Audit and Monitoring Assurance Framework had been developed to strengthen the use of national audit, outcomes and benchmarking data in quality improvement and	**Adequate**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
	strategic commissioning. The approach will provide a single view of performance across the three ICBs, enabling audit findings, data quality concerns and unwarranted variation to be validated, prioritised and routed through existing quality, commissioning and contractual governance arrangements. Members welcomed the approach as an innovative model for linking clinical audit intelligence, quality oversight, contractual levers and best practice tariffs to drive measurable improvements in care and outcomes across the three ICBs, supported by enhanced reporting and dashboarding arrangements to provide a comprehensive view of performance, monitor improvement priorities and track progress over time.		
Medicines Safety and Optimisation Report	The Committee received assurance that effective medicines safety and optimisation arrangements were in place across the three ICBs, supported by strong system collaboration in responding to national alerts, medicines shortages, antimicrobial stewardship priorities and controlled drugs oversight. The Committee noted continued improvement in key safety indicators and prescribing practices, alongside ongoing work to strengthen incident reporting, digital medicines safety and governance arrangements across the three ICBs for 2026/27.	**Adequate**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
	Members discussed the principal medicines safety risks across the three ICBs, including antimicrobial resistance, high-risk opioid prescribing, under-reporting of medication incidents and digital interoperability challenges, highlighting the importance of robust oversight, shared learning, education and the development of digital solutions to support safe and effective medicines management across increasingly integrated neighbourhood services.		

Other considerations:

Decisions made:
The Committee **endorsed** the proposed DLN Outcomes, Audit, Monitoring and Assurance Approach, including implementation of the integrated dashboard and prioritisation framework and the use of existing governance arrangements for assurance and escalation.

Discussion and information items:
a) The Committee heard directly from members of the Nottingham Maternity Families Group about their experiences of maternity care and their work with the ICB to support safer, more transparent and compassionate maternity and neonatal services. Members acknowledged the significant contribution these families have made to improving maternity safety and assurance arrangements and supported their continued involvement in the ICB's oversight, engagement and improvement work. b) The Committee also reviewed and discussed the 27 operational risks within its remit, noting the consolidation of several ICB-specific risks into joint risks across the three ICBs and the addition of two newly identified risks. Members also considered whether any new or emerging risks arose from the matters discussed at the meeting.

Appendix 3: Joint Strategic Commissioning Committee Highlight Report

Meeting Dates:	30 July 2026 and 3 September 2026 (extraordinary meeting)
Committee Chair:	Jon Towler, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
ICB Research Assurance Report	Members received assurance that each of the three ICBs are meeting their statutory research duties. The report covered progress since April 2025 in delivering each ICB's approved five-year research strategy for 2024–2029; collaboration across the three ICBs; the integration of research and evidence into strategic commissioning; current and proposed ICB governance arrangements; and future opportunities, risks and mitigations. Members noted the ICBs' ambitions for research, alongside evidence of increasing research activity and ongoing partnership working. Members also acknowledged that demonstrating the impact and value of research, and ensuring findings were translated into practice, remained a key challenge and would be a focus of future reporting. Noting the current uncertainties and challenges, an assurance rating of adequate was agreed.	**Adequate**	*Not applicable*
Palliative and End of Life Care Strategic	At its meeting on 30 July 2026, members received an update on the development of a Strategic Commissioning Framework for Palliative and End of Life Care across the three ICBs. This covered progress to date, including completion of the diagnostic phase and initial stakeholder engagement; the implications for the emerging framework; and key milestones for its	**Partial**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
Commissioning Framework	development, testing and endorsement. Work was underway to finalise the framework alongside local commissioning plans, with a second phase of engagement with system partners and patient representatives scheduled for August 2026. Members sought assurance regarding the challenges, actions and resources required to achieve a more consistent approach across the ICBs and suggested that the next update include a clear explanation of the next steps, supported by a plan setting out the actions required over the next 12 to 24 months to address the barriers identified through the diagnostic work and maximise opportunities for service improvement. Noting that the work remained at an early stage and the full strategic framework had yet to be developed, an assurance rating of partial was agreed.		
Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire All Age Continuing Care Position, Governance and Assurance	Members received a report setting out the national and local context for All Age Continuing Care. This included Children and Young People's Continuing Care, NHS Continuing Healthcare, Fast Track and NHS-funded Nursing Care, together with the associated statutory, governance, commissioning and financial stewardship functions. The report also described the ICBs' current operating models and the governance arrangements supporting effective clinical, operational and financial oversight. Members noted the development of an 18-month transformation programme to implement a single service model across the ICBs, including clinical oversight, statutory responsibilities and business transformation. Delivery would be supported through collaboration with finance and digital colleagues, with a focus on quality, service delivery, financial sustainability and digitisation, alongside the	**Adequate**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
	establishment of appropriate governance and oversight arrangements to support the programme's delivery. An assurance rating of adequate was agreed.		
Joint Commissioning Executive Group Assurance Report	Members received a report summarising the broad range of commissioning proposals considered by the Joint Commissioning Executive Group in June 2026. It detailed the number of decisions taken and confirmed that these were supported by appropriate clinical, financial and equality assessments. The meeting also demonstrated active scrutiny, with two matters requiring ongoing oversight. In both cases, members requested further work before agreeing longer-term commissioning arrangements, and the associated risks would be reviewed to ensure that they were appropriately reflected in the ICBs' Risk Register. Members agreed an assurance rating of full.	**Full**	Full *(25 June 2026)*
Board Assurance Framework Targeted Report	Members received a targeted review of Board Assurance Framework strategic Risks 1, 2, 6 and 7a. The report set out the current position for each risk, including changes to scores or narratives, and summarised the effectiveness of the controls and assurances in place. A comprehensive framework of controls was in place or being further embedded to support a more consistent approach to strategic commissioning across the three ICBs; however, alignment in some areas would require a phased approach. Assurances received to date provided reasonable confidence that governance arrangements, strategic frameworks, programmes and oversight mechanisms were being established and aligned across the three ICBs; however, most of the current assurances were focused on demonstrating progress in developing and implementing these arrangements, rather than evidencing their effectiveness and impact.	**Adequate**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
	Members acknowledged the scale of work required to address the identified gaps, noted the comprehensive programme of actions in place, and recognised the impact of the ongoing organisational transition. An assurance rating of adequate was agreed.		

Other considerations:

Decisions made:
The Committee: a) **Endorsed** the ICBs' Commissioning Oversight Framework, including the proposed governance, delivery and assurance arrangements, noting that future reports would provide focused assurance on Programme Board delivery, provider performance, financial delivery, benefits realisation, risks and recovery actions. b) **Approved** proposed variations to the Primary Care Operational Scheme of Delegation and associated Terms of Reference. c) **Approved** the Strategic Commissioning Framework for Palliative and End of Life Care at the extraordinary meeting held in September 2026. The Framework sets the strategic commissioning direction across the three ICBs and will inform local commissioning plans, service specifications, contracts and provider improvement plans. It also enables Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire to tailor their approach to local population needs, provider landscapes and service configurations.

Discussion and information items:
The Committee:

Discussion and information items:	
a)	Discussed the interim arrangements to support the continued management of Out of Area Treatment (OAT) referrals across the three ICBs during the organisational change period, along with the longer-term ambition to establish a single OATs service across the ICBs, aligned with the Individual Funding Request and Continuing Healthcare panel processes.
b)	Noted the NHS Lincolnshire ICB Mental Health Inpatient Quality Transformation Programme Year Two Report and Summary and agreed that the Year Two update would not be published as a standalone report, noting that it was an internal programme assurance report and that future public reporting would be aligned across the three ICBs.
c)	Reviewed and discussed the 15 operational risks within its remit, comprising 13 joint risks across the three ICBs and two risks relating specifically to NHS Nottingham and Nottinghamshire ICB. Members also considered whether any new or emerging risks arose from the matters discussed at the meeting.

Appendix 4: Joint Transition Committee Highlight Report

Meeting Dates:	03 September 2026
Committee Chair:	Jon Towler, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Transition Finance Update	The Committee received assurance that the Transition Programme remained on track to deliver the required £52.9m savings and achieve the target cost reduction, with £36.2m of annualised savings realised by July 2026 and further savings anticipated through the completion of Voluntary Redundancy and Wave 3 workforce changes. Members noted ongoing uncertainty relating to final workforce numbers, CSU transfer costs and non-pay savings delivery, but were assured that the agreed future structure was defined and remained affordable within the financial framework.	**Full**	Full *(awarded at the meeting on 2 July 2026)*
Transition Programme Plan update	The Committee received an update on the Transition Programme Plan and noted good overall progress. However, completion of the Wave 3 recruitment and alignment process had been reprofiled from September to the end of October 2026. This reflected the complexity of the job evaluation activity, the volume of job descriptions requiring refinement and the capacity required from Human Resources, managers	**Adequate**	Adequate *(awarded at the meeting on 2 July 2026)*

Item	Summary	Level of Assurance	Previous Level of Assurance
	and Trade Union representatives to maintain a safe and legally robust process. Members noted that the extended timeline increased the risk of prolonged uncertainty for staff, delays to full implementation of the new operating model, continued pressure on business continuity and workforce capacity, and slower realisation of some transition benefits; however, critical leadership posts had been filled and mitigating actions were in place to maintain programme momentum and organisational resilience pending completion of Wave 3. Members also noted progress in developing the Midlands Procurement Hub and the future corporate estate model, highlighting the need to carefully manage associated implementation, workforce and travel-related risks as these programmes progress.		

Other considerations:

Decisions made:
The Committee **endorsed** proposed changes to its terms of reference that refocussed its remit on oversight of transition delivery, benefits realisation and lessons learned and recommended them to the Boards for approval.

Discussion and information items:
The Committee also: a) Received a verbal update from the Chief Executive on transition progress, including progress with Wave 3 recruitment, development of the Strategic Commissioning Framework and emerging national policy developments affecting ICB mergers, devolution, and NHS operating arrangements. Members noted that planning was underway for a range of potential future organisational scenarios pending further national guidance expected in September 2026. b) Reviewed the 15 live joint transition risks. Members noted that a risk relating to CSU staff, functions and associated costs had reduced following further assessment and had subsequently been archived. They also noted a new risk relating to delays to Wave 3 recruitment and emerging risks associated with proposed merger arrangements and the procurement hub.

Appendix 5: Joint Remuneration and Human Resource Committee Highlight Report

Meeting Dates:	23 July 2026
Committee Chair:	Margaret Gildea, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Workforce Report	Members received a report that provided an overview of the ICBs' workforce metrics for June 2026, including whole time equivalent, head count, sickness, turnover including aggregated reason for leaving, mandatory training, appraisals and equality, diversity and inclusion. Members discussed ongoing work to support a more consistent and effective appraisal process and requested that future reports include trend analysis, benchmarking and enhanced narrative on mitigating actions to strengthen assurance. Further analysis of sickness absence data was also requested to provide greater insight into the staff groups affected and the factors contributing to current absence levels.	**Partial**	**Adequate** *(23 April 2026)*
Management of Change Programme Plan Update	Members received a report that aimed to provide assurance on progress against the Management of Change Programme being undertaken across NHS Derby and Derbyshire, NHS Lincolnshire and NHS Nottingham and Nottinghamshire ICBs, including key actions completed and planned next steps. Members reflected positively on the progress achieved to date, highlighting the value of strong governance, transparent communication and staff engagement, and received assurance that the programme remained on track despite	**Adequate**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
	challenging timelines, with contingency arrangements in place to mitigate risks associated with job evaluation and workforce transition activities.		
Agenda for Change Non-Pay Deal Recommendations – NHS Job Evaluation	Members received a paper on the updated job evaluation requirements under Agenda for Change, highlighting employers' responsibilities to ensure roles were evaluated appropriately, pay arrangements were equitable and compliant with equal pay obligations, and workforce redesign was effectively managed. Assurance was provided that delivery remained on track despite the additional demands of implementation alongside the Management of Change Programme, supported by strengthened leadership, workforce training and robust governance arrangements to enable successful delivery and ongoing Board oversight.	**Adequate**	*Not applicable*

Other considerations

Decisions made:
The Committee: a) Approved its refreshed annual work programme 2026/27. b) Approved the appointments and proposed remuneration for several senior leadership roles. c) Approved an uplift and pay arrangements for NHS Lincolnshire ICB employees on non-NHS terms and conditions.

Discussion and information items:
The Committee:

Discussion and information items:	
a)	Discussed the proposed Organisational Development Framework, which would inform the development of a shared Organisational Development Plan to support workforce engagement, organisational capability and strategic commissioning across the three ICBs.
b)	Reviewed and discussed the six operational risks within its remit, all of which were joint risks across the three ICBs. These related principally to the management of organisational change, establishment of the future ICB operating model and the impact of the transition on business-as-usual delivery. Members also considered whether any new or emerging risks arose from the matters discussed at the meeting.

Appendix 6 - Description of levels of assurance

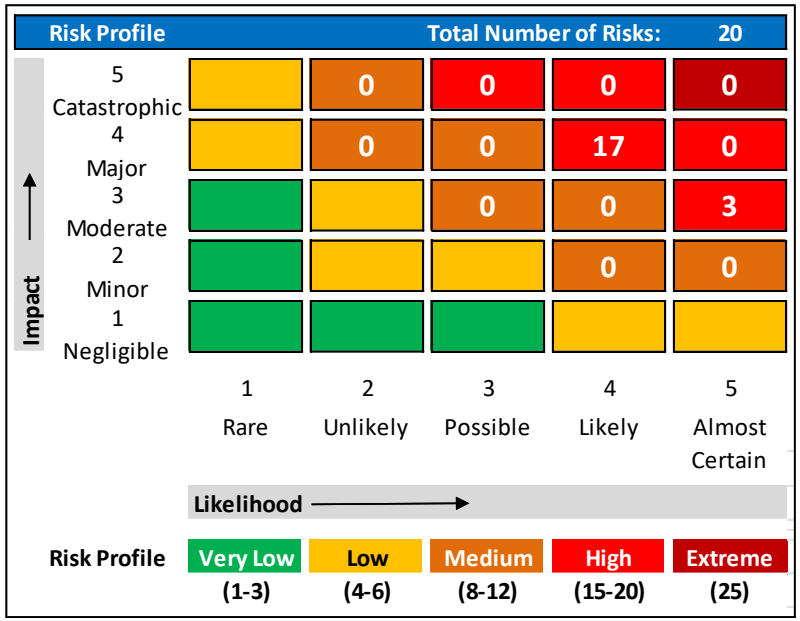
Levels of assurance:	The report demonstrates that:
Full Assurance	• Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives 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 64 risks within the Operational Risk Register. Of these, 20 are scored at a high level, accounting for 31% of the total. Three of the high-scoring risks originate from NHS Derby and Derbyshire ICB, one from NHS Lincolnshire ICB, seven from NHS Nottingham and Nottinghamshire ICB, and nine are joint risks across the three ICBs.

The three ICBs' total high-level risk profile is shown in figure 1 below.



The 20 high-level operational risks do not include any risks classified as confidential. In exceptional circumstances, a risk may be designated as confidential where it relates to sensitive matters, such as ongoing legal proceedings, commercial or contractual negotiations, or personnel issues, and where wider disclosure could be inappropriate or prejudice effective management of the

issue. Any confidential risks are reported separately and are excluded from the analysis and detail presented within this report. At the time of writing, no confidential risks are held by the ICBs.

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
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

Risk Ref.	ICB	Risk Description	Score	Responsible 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 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.	**High** 16 (I4 x L4)	Joint Quality and Service 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 (I4 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 (I4 x L4)	Joint Quality and Service Improvement Committee

Risk Ref.	ICB	Risk Description	Score	Responsible 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 (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	Joint	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

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
RR149	Joint	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	Joint	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	Joint	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

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
RR159 (NEW)	Joint	If cancer service performance continues to deteriorate due to demand pressures, capacity constraints, pathway inefficiencies, and variation in provider performance, the ICBs may be unable to commission timely and effective cancer services. This could lead to 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
RR160 (NEW)	Joint	If diagnostic service demand continues to exceed available capacity, the ICBs may be unable to fulfil their statutory duty to commission timely and effective diagnostic services across the cluster. 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
RR161 (NEW)	Joint	If there are ineffective discharge processes across the cluster, 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
RR165 (NEW)	Joint	Notice has been received by DCHS on the delivery of 4 Derbyshire Urgent Treatment Centre services. Failure to commission alternative services within required timescales may	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
		result in a risk of disruption to same day urgent care provision in the county, resulting in reduced capacity to meet the urgent care needs of patients within a community setting and potentially increasing pressure on other local urgent care service providers.		
RR071 (NEW)	NNICB	If NHCT's leadership capacity, capability, and organisational culture do not fully support effective improvement and responsive decision-making, then the Trust may be unable to meet operational and strategic demands, resulting in challenges across Nottingham and Nottinghamshire in delivering safe, high-quality services and achieving regulatory compliance.	**High** 15 (I3 x L5)	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)	a) Joint Quality and Service Improvement Committee
RR073	NNICB	If mental health bed capacity issues persist amid rising demand in Nottingham and Nottinghamshire, individuals in crisis may be placed in inappropriate or out-of-area settings. This may lead to increased distress and disrupted care continuity for individuals and delayed discharges.	**High** 15 (I3 x L5)	Joint Quality and Service Improvement Committee

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
RR140	Joint	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

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	17/09/2026
Paper title:	**Joint Board Annual Work Programme**
Paper reference:	ICB 26 056
Paper author:	Lucy Branson, Director of Corporate Governance and Assurance
Paper sponsor:	Kathy McLean, Chair
Presenter:	-

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

Report summary:

The work programme sets out a cycle of business for meetings from May 2026 to March 2027, in line with the Boards' duties. The programme is designed to be flexible, allowing for adaptation as the ICBs' clustering arrangements evolve.

Recommendation(s):

The Boards are asked to **note** the work programme for information.

Appendices

Appendix A: Joint Board Work Programme 2026/27

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

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Appendix A: 2026/27 Joint Board Work Programme

Agenda item (See Annex 1 for purpose and content)	21 May	16 Jul	17 Sep	19 Nov	21 Jan	18 Mar	Link to BAF	Notes
Introductory items	✓	✓	✓	✓	✓	✓	Not applicable	See note 1
Citizen Story	✓	✓	✓	✓	✓	✓	Not applicable	See note 2
Leadership and operating context								
Chair's Report	✓	✓	✓	✓	✓	✓	Not applicable	See note 3
Chief Executive's Report	✓	✓	✓	✓	✓	✓	Not applicable	See note 4
Population health and commissioning priorities								
Refresh of Five-Year Population Health Strategy, Five-Year Strategic Commissioning Plan, and Three-Year Operational Plan	-	-	-	-	-	✓	Strategic risks 2-5	See note 5
Reports on Strategic Priorities:							Strategic risks 2-5	See note 6
• Neighbourhood Health	✓	-	✓	-	✓	-	-	-
• Frailty	-	✓	-	-	-	-	-	-
• End of Life	-	✓	-	-	-	-	-	-
• Long-Term Condition Management	-		✓	-	-	-	-	-
• Strong General Practice	-	-	-	✓	-	-	-	-
• Immunisations, Vaccinations and Screening Programmes	-	-	-	✓	-	-	-	-
• Digital Technology	-	-		-	✓	-	-	-
• Children and Young People – Obesity	-	-	-	-	-	✓	-	-
• Children and Young People – Mental Health	-	-	-	-	-	✓	-	-
Improvement, learning and innovation Report (incorporating research)	-	-	-	✓	-	-	Strategic risks 1 and 9	See note 7

Agenda item (See Annex 1 for purpose and content)	21 May	16 Jul	17 Sep	19 Nov	21 Jan	18 Mar	Link to BAF	Notes
Commissioning oversight and delivery								
2027/28 Opening Budgets	-	-	-	-	-	✓	Strategic risks 7a and 7b	See note 8
Finance Report	✓	✓	✓	✓	✓	✓	Strategic risks 7a and 7b	See note 9
Commissioning Delivery Report	✓	✓	✓	✓	✓	✓	Strategic risk 10	See note 10
Quality Strategy	-	✓	-	-	-	-	Strategic risk 9	See note 11
Quality Report	✓	✓	✓	✓	✓	✓	Strategic risk 9	See note 12
Governance and compliance								
Transition Report	-	✓	-	✓	-	✓	Strategic risk 11	See note 13
Board Assurance Framework	-	-	✓	-	-	✓	All risks	See note 14
Annual Equality Assurance Report	✓	-	-	-	-	-	Strategic risks 2-5, 6, 9 and 10	See note 15
Senior Information Risk Owner (SIRO) Annual Report	✓	-	-	-	-	-	Strategic risk 12	See note 16
Annual Report on Working in Partnership with People and Communities	-	✓	-	-	-	-	Strategic risk 6	See note 17
Annual Statement on Health Inequalities	-	✓	-	-	-	-	Strategic risks 2-5, 6, 9 and 10	See note 18
Freedom to Speak Up Annual Report	-	-	-	✓	-	-	Strategic risk 11	See note 19
Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Report	-	-	-	-	✓	-	Strategic risk 12	See note 20
Committee Highlight Reports	✓	✓	✓	✓	✓	✓	All risks	See note 21
Closing items	✓	✓	✓	✓	✓	✓	Not applicable	See note 22

Board Seminars and Development Sessions:

Topic	16 Apr	18 Jun	15 Oct	17 Dec	18 Feb
• Development of ICBs' shared values and behaviours • 2026/27 priorities, planning and contracting update	✓	-	-	-	-
• Review of ICBs' shared risk appetite • Strategic Commissioning Capability Self-Assessment	-	✓	-	-	-
• Review of recent and upcoming legislative changes as appropriate to ICBs	-	-	✓	-	-
• National Cyber Security Centre (NCSC) NHS cyber security training	-	-	-	✓	-
• To be confirmed	-	-	-	-	✓

Annex 1: Purpose and content of agenda items

No.	Agenda item	Purpose
1.	**Introductory items**	This section of the meeting will include: • A copy of members' registered interests for consideration and agreement of how any real or perceived conflicts of interest are required to be managed. • The previous meeting's minutes for agreement (and any matters arising). • The Boards' Action Log for review.
2.	**Citizen Story**	To present a citizen story at the outset of each meeting of the Boards, with the purpose of grounding the following discussions at each meeting in the reality of patient care and putting citizens at the heart of Board decisions. The stories will demonstrate a range of examples of healthcare provision, what matters to people, their experience of healthcare services, learning points and improvement actions.
3.	**Chair's Report**	To present a summary briefing for Board members of the Chair's reflections, actions, and activities since the previous meeting of the Boards. As appropriate, this will include updates on key governance developments, and on an annual basis this will present the Boards' Annual Work Programme and include a review of the skills, knowledge, and experience of Board members (when taken together) to ensure the Boards can effectively carry out their functions.
4.	**Chief Executive's Report**	To present a summary briefing on recent local and national developments and areas of interest for Integrated Care Boards (ICB) and wider Integrated Care Systems (ICS), along with key updates from system partners and formal partnership arrangements, including Integrated Care Partnerships and Health and Wellbeing Boards. On a quarterly basis, the reports will include the latest segmentation ratings under the NHS Oversight Framework. The report will also include key updates regarding the ICBs' workforce on a periodic basis, including NHS staff survey results and wider workforce indicators. As appropriate, the report may also include specific items requiring approval or for noting by Board members.
5.	**Refresh of Five-Year Population Health Strategy, Five-Year Strategic Commissioning Plan, and Three-Year Operational Plan**	To present the annual refresh of the Five-Year Population Health Strategy, Five-Year Strategic Commissioning Plan, and Three-Year Operational Plan for approval. *Note: Development of the refreshed strategy and plans will be overseen by the Joint Strategic Commissioning Committee and Joint Finance and Performance Committee.*
6.	**Reports on Strategic Priorities**	To provide the Boards with a collective and integrated view of progress against delivery of the Population Health Strategy priorities and Neighbourhood Health Plan, bringing together contributions from across strategy, commissioning, finance, quality and outcomes. Reports will focus on the intended population outcomes, target cohorts and inequalities, and demonstrate how delivery activity is contributing to measurable improvement, supported by triangulated evidence including performance, financial, quality, safety, provider insight and citizen experience. The reports will be action□focused and decision□orientated, identifying risks, gaps, resource implications and trade□offs to enable the Boards to support delivery, unblock issues and hold the system to account. The reports will have collective executive ownership and draw on input from all directorates to present a single, coherent position on priority delivery.

No.	Agenda item	Purpose
		Note: The Joint Strategic Commissioning Committee and Joint Quality and Service Improvement Committee and will have in-year oversight of these arrangements.
7.	**Improvement, learning and innovation Report (incorporating research)**	To receive an annual assurance report on the ICBs' arrangements for improvement, learning and innovation (including research). *Note: The Joint Quality and Service Improvement Committee and Joint Strategic Commissioning Committee will have in-year oversight of these arrangements.*
8.	**2026/27 Opening Budgets**	To present the ICBs' 2027/28 opening budgets for approval. *Note: The opening budgets will be reviewed by the Joint Finance and Performance Committee prior to presentation to Board.*
9.	**Finance Report**	To present the ICBs' and wider NHS systems' financial positions, covering revenue and capital, and including delivery updates against financial sustainability and productivity and efficiency plans. *Note: The Joint Finance and Performance Committee will have monthly oversight of these arrangements.*
10.	**Commissioning Delivery Report**	To receive routine assurance reports regarding the key operational service delivery targets for 2026/27. Reports will set out the latest performance, alongside actions being taken to address any areas where required standards are not being met. *Note: The Finance and Performance Committee will have monthly oversight of these arrangements.*
11.	**Quality Strategy**	To present the ICBs' Quality Strategy for approval. *Note: In-year delivery of the strategy will be overseen by the Joint Quality and Service Improvement Committee (updates for Board assurance will be included in the routine Quality Reports and Committee Highlight Reports).*
12.	**Quality Report**	To present quality oversight reports, including performance against key quality targets. *Note: The Joint Quality and Service Improvement Committee will have monthly oversight of these arrangements.*
13.	**Transition Report**	To receive assurance reports in relation to the delivery of the ICBs' Transition Programme. *Note: The Joint Transition Committee will have monthly oversight of these arrangements.*
14.	**Board Assurance Framework**	To present in-year and year-end positions of the Board Assurance Framework. This will include annual approval of the ICBs' strategic risks. *Note: The Boards' Committee will oversee the strategic risks during the year via focussed updates from each executive director.*
15.	**Annual Equality Assurance Report**	To receive an annual assurance report on the ICBs' arrangements for meeting the Public Sector Equality Duty. *Note: The Joint Strategic Commissioning Committee and Joint Remuneration and Human Resource Committee will have in-year oversight of these arrangements.*
16.	**Senior Information Risk Owner (SIRO) Annual Report**	To present an annual report from the SIRO to provide assurance regarding the management of information risks and incidents, including arrangements for cyber security. *Note: This will be reviewed by the Audit Committees prior to presentation to Board, with in-year Committee oversight of these arrangements.*

No.	Agenda item	Purpose
17.	**Annual Report on Working in Partnership with People and Communities**	To receive an annual assurance report on the ICBs' arrangements for working with people and communities. *Note: The Joint Strategic Commissioning Committee will have in-year oversight of these arrangements.*
18.	**Annual Statement on Health Inequalities**	To present the ICBs' annual statement on health inequalities. *Note: This will be reviewed by the Joint Strategic Commissioning Committee prior to presentation to Board.*
19.	**Freedom to Speak Up Report**	To receive an annual assurance report on the ICBs' freedom to speak up arrangements. *Note: The Audit Committees will have in-year oversight of these arrangements.*
20.	**Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Report**	To receive an annual assurance report on the ICBs' arrangements for EPRR and business continuity. *Note: The Audit Committees will have in-year oversight of these arrangements.*
21.	**Highlight Reports from the:** • **Audit Committees** • **Joint Remuneration and Human Resource Committee** • **Joint Finance and Performance Committee** • **Joint Quality and Service Improvement Committee** • **Joint Strategic Commissioning Committee**	To present an overview of the work of the Boards' committees to provide assurance that the committees are effectively discharging their delegated duties and to highlight key messages for the Boards' attention. This includes the committees' assessments of the levels of assurance they have gained from the items received and the actions instigated to address any areas where low levels of assurance have been provided. Also included is a summary of the high-level operational risks currently being oversighted by the committees.
22.	**Closing items**	This section of the agenda at each meeting will be used to share items that are for information only, which will not be individually presented, although questions may be taken by exception at the discretion of the Chair. These will include routine sharing of the Boards' Work Programme. This section of the meeting will also include the following verbal items: • Risks identified during the course of the meeting. • Questions from the public relating to items on the agenda. • Any other business