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 19 November 2026 10:00-13:00

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

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 17 September 2026	Kathy McLean	Decision	✓	✓	✓	✓	-
5.	Action log and matters arising from the meetings in common, held on 17 September 2026	Kathy McLean	Discussion	✓	✓	✓	✓	-
	Leadership and operating context							
6.	Chair's Report	Kathy McLean	Information	✓	✓	✓	✓	10:05
7.	Chief Executive's Report	Amanda Sullivan	Information	✓	✓	✓	✓	10:10
	Population health and commissioning priorities							
8.	Citizen's experience: primary care access and patient involvement	Clair Raybould	Discussion	✓	✓	✓	✓	10:25
9.	Report on Strategic Health Priorities: Strong General Practice	Maria Principe	Assurance	✓	✓	✓	✓	10:40

Ref	Item	Presenter	Type	DD	L	NN	Enc	Time
10.	Report on Strategic Health Priorities: Immunisations, Vaccinations and Screening Programmes	Dr Dave Briggs	Assurance	✓	✓	✓	✓	11:00
11.	Intensive and Assertive Community Mental Health Services and the Mental Health Personalised Care Framework: Progress Report	Maria Principe	Assurance	✓	✓	✓	✓	11:20
	Oversight and delivery of commissioning outcomes							
12.	Quality Oversight Report	Rosa Waddingham	Assurance	✓	✓	✓	✓	11:40
13.	Commissioning Oversight Report	Maria Principe	Assurance	✓	✓	✓	✓	11:55
14.	Finance Report	Marcus Pratt	Assurance	✓	✓	✓	✓	12:10
	Governance							
15.	Transition Programme Report	Clair Raybould, Rosa Waddingham	Assurance	✓	✓	✓	✓	12:25
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**

** These items are for information only and will not be individually presented. Questions will be taken by exception*

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)

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:	19/11/2026
Paper title:	**Declaration and management of interests**
Paper reference:	ICB CIC 26 062
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.

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	Executive 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.

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	
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.
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)	External role or association (non-NHS), declared for transparency.	✓				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.

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	
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.
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.
Pratt	Marcus	Interim Executive Director of Finance	✓	✓	✓	Registered patient at Mapperley Practice	Use of NHS services commissioned by the ICB (registered patient).			✓		01/07/2024	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.
Pratt	Marcus	Interim Executive Director of Finance	✓	✓	✓	Local Public Sector Director for Lift Co. Boards in North Nottinghamshire, Greater Nottinghamshire & Southern Derbyshire	External role or association (non-NHS), declared for transparency.		✓			01/11/2025	Present	This interest will be kept under review and specific actions determined as required.
Principe	Maria	Executive 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	Executive 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	Executive 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.

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	
Raybould	Clair	Executive 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.
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.
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.
Sullivan	Amanda	Chief Executive Officer	✓	✓	✓	Brother is employed by Cruse Bereavement Support within the West Midlands, in a role that incorporates recruitment to deliver contracts in the East Midlands area.	External role or association (non-NHS), declared for transparency.			✓		01/08/2026	Present	This interest will be kept under review and specific actions determined as required.
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.

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	
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	This interest will be kept under review and specific actions determined as required.
Waddingham	Rosa	Executive Director of Quality (Nursing)	✓	✓	✓	Member of the Advisory Board at NHS Professionals, an NHS staff bank, owned by the Department of Health and Social Care.	Role within an NHS, local authority or provider organisation.		✓			01/09/2023	Present	This interest will be kept under review and specific actions determined as required.
Waddingham	Rosa	Executive 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	Executive 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	Executive 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 individuals 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.
Dillistone	Helen	Executive Director of Transition	✓	✓	✓	No relevant interests declared	No interests declared.					_	_	Not applicable
Garnett	Wynne	Voluntary, Community and Social Enterprise Sector Representative	✓	-	-	Self-employed independent contractor who could potentially undertake other work with partners	External role or association (non-NHS), declared for transparency.	✓				01/04/2021	Present	This interest will be kept under review and specific actions determined as required.
Grant	Trudi	Public Health Representative	-	✓	-	No relevant interests declared	No interests declared.					_	_	Not applicable
Gutherson	Paul	Voluntary, Community and Social Enterprise Sector Representative	-	✓	-	No relevant interests declared	No interests declared.					_	_	Not applicable

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

17 September 2026, 10:00-13:00

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

		NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB
Members present:				
Dr Kathy McLean	Chair	✓	✓	✓
Dr Dave Briggs	Executive Director of Outcomes (Medical)	✓	✓	✓
John Dunstan	Non-Executive Director	✓	✓	✓
Margaret Gildea	Non-Executive Director	✓	✓	✓
Stephen Jackson	Non-Executive Director	✓	✓	✓
Mehrunnisa Lalani	Non-Executive Director	✓	✓	✓
Dr Kelvin Lim	Primary Care Partner Member	-	-	✓
Jon Melbourne	NHS Trust/ Foundation Trust Partner Member	-	-	✓
Maria Principe	Executive Director of Commissioning	✓	✓	✓
Clair Raybould	Executive Director of Strategy and Citizen Experience	✓	✓	✓
Sharon Robson	Non-Executive Director	✓	✓	✓
Martin Samuels	Local Authority Partner Member	-	✓	-
Bill Shields	Executive Director of Finance	✓	✓	✓
Adrian Smith	Local Authority Partner Member	-	-	✓
Amanda Sullivan	Chief Executive	✓	✓	✓
Jon Towler	Non-Executive Director	✓	✓	✓
Rosa Waddingham	Executive Director of Quality (Nursing)	✓	✓	✓
In attendance:				
Lucy Branson	Director of Corporate Governance and Assurance	✓	✓	✓
Helen Johnstone	Consultant in Public Health, Nottingham City Council	-	-	✓
Daniel King	Chair, Nottinghamshire Voluntary and Community Sector Alliance	-	-	✓
Sarah Sissons	Citizen experience (for item ICB CIC 26 048)	-	-	-
Tony Sissons	Citizen experience (for item ICB CIC 26 048)	-	-	-
Sue Wass	Corporate Governance Officer, NHS Nottingham and Nottinghamshire ICB (Minutes)	✓	✓	✓
Apologies:				
Karen Dunderdale	NHS Trust/ Foundation Trust Partner Member	-	✓	-

		NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB
Dr Andrew Mott	Primary Care Partner Member	✓	-	-
Stephen Posey	NHS Trust/ Foundation Trust Partner Member	✓	-	-
Mark Powell	Ordinary Member – Mental Health	✓	✓	✓
Dr Kevin Thomas	Primary Care Partner Member	-	✓	-

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

Name	Possible	Actual	Name	Possible	Actual
Dr Kathy McLean	3	3	Mark Powell	3	1
Dr Dave Briggs	3	2	Maria Principe	3	3
Karen Dunderdale	3	1	Clair Raybould	3	3
John Dunstan	3	3	Sharon Robson	3	3
Margaret Gildea	3	2	Martin Samuels	3	2
Stephen Jackson	3	3	Bill Shields	3	3
Mehrunnisa Lalani	3	3	Adrian Smith	3	2
Dr Kelvin Lim	3	3	Amanda Sullivan	3	3
John Melbourne	3	3	Jon Towler	3	3
Dr Andrew Mott	3	2	Dr Kevin Thomas	3	2
Stephen Posey	3	2	Rosa Waddingham	3	3

Introductory items

ICB CIC 26 040 **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.

ICB CIC 26 041 **Confirmation of quoracy**

The meetings were confirmed as quorate.

ICB CIC 26 042 **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 26 043 **Minutes of the meeting held on 16 July 2026**

With a correction to Ellie Houlston's Job title to state '*Director of Public Health, Derbyshire County Council'* the minutes were agreed as an accurate record of the discussions held.

ICB CIC 26 044 **Action log and matters arising from the meeting held on 16 July 2026**

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

No other matters were raised.

Leadership and operating context

ICB CIC 26 045 **Chair's Report**

Kathy McLean introduced the item, highlighting the following points:

a) Highlighting the breadth of topics on the agenda, including the immediate focus on preparing for winter pressures, following a very challenging summer, Kathy noted that future long-term planning would likely also need to address pressures experienced during the summer months.

b) Neighbourhood health remained central to the ICBs' ambitions, and an update on progress would be presented later in the meeting.

c) This meeting also provided an opportunity to consider maternity services, where significant focus and improvement were required. Kathy and the Boards' Non-Executive Directors had attended the ICBs' Joint Quality and Service Improvement Committee in September and heard directly from two families who had experienced poor care in Nottingham's hospitals. It was therefore important for the ICBs to use their influence to improve the safety, quality and equity of maternity care across their areas. An item on today's agenda would enable the Boards to assess how the ICBs could support delivery of NHS England's Ten-Point Plan of urgent actions for maternity and neonatal services.

d) The ICBs' Annual Public Meetings had been held in common on 3 September 2026, providing 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.

e) Kathy asked members to note that the Local Government Reorganisation programme had been paused, in turn, creating uncertainty for the ICBs' transition programme. It was hoped that an announcement expected at the end of September would provide greater clarity.

f) Kathy provided an overview of the visits she had undertaken over the summer months.

g) Approval was sought for several changes to the ICBs' governance arrangements. Following a recent review, amendments were proposed to the terms of reference for the Joint Transition Committee; the Joint Finance and Performance Committee; and the ICBs' Audit Committees. Minor amendments were also proposed to the ICBs' Schemes of Reservation and Delegation to

ensure that the delegated authority arrangements remained clear, current and aligned with the revised organisational structure.

The following points were made in discussion:

h) Members welcomed the Government's announcement of a significant expansion in community mental health support and sought clarity on how the ICBs could implement the proposals in practice. In response, it was noted that further guidance was awaited, particularly on the co-location of services. However, it was felt that the proposals aligned well with the development of neighbourhood health plans.

The Boards **noted** the Chair's Report for information and **approved** the updated terms of reference for the Joint Transition Committee, Joint Finance and Performance Committee, and Audit Committees, and the amendments to the Schemes of Reservation and Delegation.

ICB CIC 26 046 **Chief Executive's Report**

Amanda Sullivan introduced the item, highlighting the following points:

a) NHS England had recently completed its annual assessments of the ICBs. The assessments had acknowledged the challenging environment in which the ICBs were operating, highlighted the strengths of each individual ICB and also the areas requiring future focus and improvement.

b) Following NHS England's assessment of the ICBs' neighbourhood health readiness, a follow up report had given a positive view of the progress made, whilst again recognising the challenges the ICBs were facing. It also identified helpful areas for future focus, which would now be progressed.

c) The quarterly report on the ICBs' workforce metrics indicated an increased staff turnover as colleagues continued to leave on voluntary redundancy. Although sickness absence levels remained stable, wellbeing support continued to be prioritised during a period of considerable uncertainty for staff.

d) A national requirement to focus on job evaluations provided an opportunity to strengthen and harmonise arrangements across the three ICBs. A new Organisational Development Framework had also been produced with the aim of supporting a single organisational culture and strengthening leadership and management capability.

e) Progress had been made in aligning the ICBs' Freedom to Speak Up arrangements and a more detailed report would be presented to the Boards later in the year.

f) The publication of the National Quality Strategy was welcomed. The ICBs' Quality Framework was fully aligned to the strategy and work would continue to finalise the ICBs' own Quality Strategy in accordance with national requirements.

g) The completion of several major capital build projects was highlighted, including the opening of the National Rehabilitation Centre.

h) Lincolnshire Partnership NHS Foundation Trust was congratulated on achieving a rating of 'Good' in the well-led domain, following an inspection undertaken by the Care Quality Commission in June 2026.

The following points were made in discussion:

i) Margaret Gildea, Chair of the ICBs' Joint Remuneration and Human Resource Committee, asked the Boards to note that the Committee continued to monitor sickness absence rates, with stress and anxiety remaining the most common causes. Members also sought assurance on actions being taken to improve appraisal rates. It was noted that the ICBs continued to monitor absence trends and would take targeted action where these were identified, alongside promoting the available wellbeing support. Although undertaking appraisals during organisational restructure remained challenging, the process was being initiated as staff moved into their new posts. The Chair requested that further assurance on implementation of the appraisal process be presented to the Joint Remuneration and Human Resource Committee.

j) In response to a query on future commissioning arrangements for the National Rehabilitation Centre, it was noted that discussions were continuing between the ICBs, NHS England and Nottingham University Hospitals NHS Trust.

The Boards **noted** the report.

Action: Lucy Branson to add an assurance report on the ICBs' appraisal process to the Remuneration and Human Resource Committee's Annual Work Programme.

Population health and commissioning priorities

ICB CIC 26 047

Population Health Strategy Progress Report: Neighbourhood Health

Clair Raybould introduced the item, supported by Maria Principe and Dave Briggs; the following points were highlighted:

a) The Neighbourhood Health Programme was a key component of the ICBs' response to the Ten-Year Health Plan and provided the principal mechanism for translating the ambitions of the ICBs' Population Health Strategy into practical delivery within local communities.

b) The report provided assurance on progress, highlighting the key risks and dependencies that required management, and set out the phased approach to the development of the financial, contractual and commissioning arrangements required to support the implementation of neighbourhood-based care.

c) A common core Integrated Neighbourhood Team specification, working neighbourhood architecture, programme governance and emerging delivery

framework were now in place. External assurance had recognised the strength and consistency of the strategic approach, whilst emphasising that the next phase must demonstrate implementation and impact.

d) The immediate task was to translate the specification into consistent delivery; define the populations each Integrated Neighbourhood Team would support; quantify need at neighbourhood level; agree provider coverage and contributions; and develop the contractual, financial, workforce, digital and analytical infrastructure required.

e) Single neighbourhood provider contracts and multi-neighbourhood provider contracts would play a key role in the future commissioning of neighbourhood health. However, their progression would depend on several interdependencies, including the compilation of the evidence base, readiness, market testing, and the outcome of Local Government Reorganisation.

f) Implementation would focus effort where proactive, coordinated care was most likely to improve outcomes. Thus, the initial focus would be on services for end of life, frailty and multiple long-term conditions, identified as priorities within the ICBs' Population Health Strategy.

g) In summary, the programme had moved from concept towards implementation stage, and the priority for 2026/27 was to ensure delivery for the populations defined across agreed neighbourhood footprints.

The following points were made in discussion:

h) Board members sought clarification on the engagement undertaken to date. It was explained that the nature and extent of engagement had varied between stakeholder groups. This had included engagement with general practitioners, other primary care providers, and partners operating within primary care network footprints, which would provide the initial basis for defining neighbourhood boundaries. There had also been strong engagement with Health and Wellbeing Boards, which would lead on the development of neighbourhood strategies.

i) Board members discussed the next steps for defining neighbourhoods or communities, recognising that these would not necessarily follow Primary Care Network footprints. They emphasised that achieving a positive impact would ultimately require the integration of all public services. Whilst this was acknowledged as the long-term aim, a pragmatic starting point was needed to meet the national requirement for the NHS to progress their neighbourhood health plans.

j) Given the uncertainty created by the pause in Local Government Reorganisation, Board members sought assurance that the ICBs continued to engage with local authorities. It was confirmed that collaboration was continuing in areas including future joint commissioning and the co-development of guidance.

k) In response to a query about how resources, including staff, would move from secondary to community care, it was explained that the approach would involve

commissioning for outcomes rather than commissioning services. This transition would be challenging and would initially require significant support from the ICBs. Programme Boards would provide a collaborative forum to support the work. It was emphasised that secondary care colleagues were willing to make the approach succeed, although implementation would remain challenging.

l) Board members discussed the need for a shared vision for the programme, including a clear and compelling description of neighbourhood healthcare that the public could understand and support.

m) Board members acknowledged that delivering the programme would be complex, as similar ambitions had existed for many years and had never been fully realised. They emphasised the need to proceed pragmatically, learn from implementation, and build on progress. Members welcomed and supported the progress made to date.

The Boards **received** the report for assurance in relation to the progress made in establishing the foundations for neighbourhood health across the ICBs' footprints.

Oversight and delivery of commissioning outcomes

ICB CIC 26 048

Citizen experience: maternity families

Clair Raybould introduced the item, and welcomed Sarah and Tony Sissons, who shared how maternity failings within Nottingham University Hospitals NHS Trust had impacted their lives:

a) In 2007 Sarah had given birth to a healthy son, Ryan. However, a sequence of poor care and delays in treatment had caused him to suffer a catastrophic brain injury.

b) Sarah described the continuing difficulties the family had faced in securing diagnoses, treatment and support from a range of services. Alongside caring for Ryan, Sarah and Tony had experienced physical and mental health impacts arising from the trauma, as well as the continuing emotional burden of repeatedly advocating for the support Ryan needed.

c) Examples were given of the recurring financial and practical barriers faced by the family, including charges for supporting documentation from GPs, and the cost of incontinence pads and transport to college.

d) In addition, Sarah expressed concern that the Independent Maternity Review led by Donna Ockenden had focused mainly on the bereaved families and that evidence supplied by her family had not been adequately reflected in the final report. She considered there had been insufficient follow-up support for families whose children had been harmed as a result of the maternity failings, describing these as "Nottingham's forgotten children".

e) Looking to the future, Sarah considered that a single point of contact for families would help resolve ongoing problems across health, education and social care services.

The following points were made in discussion:

f) On behalf of the Boards, Kathy thanked Sarah and Tony for their powerful and moving accounts that highlighted multiple failings across health, education and social care services.

g) The Boards discussed the issues raised at length and agreed that the ICBs should convene relevant partners to consider how to ensure improvements to pathways were implemented and ensure more coordinated support for affected families.

h) Noting that the ICBs' Executive Director of Quality (Nursing) had already begun work to determine how the ICBs could respond to the issues raised, the Chair requested that a report on actions taken and their impact be presented to the Boards in a year's time.

The Boards **noted** the report.

Action: Lucy Branson to add a report to the Boards' work programme for September 2027 to examine the actions taken in response to the maternity families citizen experience paper and the impact they have had.

ICB CIC 26 049 **Maternity and Neonatal Services: Response to Local and National Reviews and Improvement Priorities**

Rosa Waddingham introduced the item, highlighting the following points:

a) The paper built on the briefing presented to the Boards at their July meeting, which had considered the findings of the Nottingham Independent Maternity Review and Baroness Amos' national maternity and neonatal investigation.

b) The ICBs' Joint Quality and Service Improvement Committee had received detailed briefings on both reports and had reviewed maternity and neonatal oversight across the ICBs' areas. A further update would be provided once the relevant NHS trusts' Boards had received and approved their individual action plans to meet the aims of the NHS England Ten-Point Maternity Urgent Plan. This was expected to be completed by the end of September and would allow the ICBs to triangulate progress.

c) The report also highlighted the priority areas that the ICBs would focus on, which included making patient safety a priority; listening to women, families and carers; improving data quality; and addressing racism and discrimination.

The following points were made in discussion:

d) Board members asked how the ICBs could address the recurring concern about poor culture within maternity services identified by the reviews. Rosa Waddingham confirmed that this and other common themes would be considered in detail by the ICBs' Quality and Service Improvement Committee

and translated into a plan setting out the actions the ICBs could take to support quality improvement.

e) Referring to the discussion under item ICB CIC 26 048, members supported the suggestion to enable student midwives and existing maternity services staff to hear directly from citizens about their experiences.

f) Members noted that the ICBs' Quality and Service Improvement Committee had assigned a rating of 'limited assurance' to the report that had been presented to the Committee and queried whether the ICBs had sufficient influence to drive continuous improvement. In response, members were advised that the Committee would maintain oversight of the development and implementation of a credible action plan.

g) In further discussion, it was acknowledged that there was a broader requirement for the ICBs to ensure they have the capability and capacity to fulfil their statutory duties.

The Boards **received** the report for assurance on the establishment of oversight and assurance arrangements for Derby and Derbyshire, Nottingham and Nottinghamshire, and Lincolnshire maternity and neonatal services.

ICB CIC 26 050 **Quality Oversight Report**

Rosa Waddingham introduced the item, highlighting the following points:

a) The report provided a summary of the quality issues affecting commissioned services across the three ICB areas. The status and progress of improvement plans for those providers within the highest level of NHS England's National Oversight Framework was also provided.

b) Key areas of continuing focus remained on providers subject to enhanced oversight, addressing variations in patient safety reporting, monitoring urgent and emergency care pressures, continuing healthcare referral timeliness, maternity outcomes, and above plan infection prevention and control trajectories.

The following points were made in discussion:

c) Members welcomed the revised reporting arrangements but found it difficult to identify the specific actions being taken, the timescales for delivery and when evidence of improvement was expected.

d) In discussing the corridor care metrics, members sought assurance about the action being taken to minimise patient harm. It was explained that corridor care was directly linked to hospital flow and discharge processes, and that the ICBs continued to work with trusts to improve discharge arrangements. Members nevertheless emphasised that treating any patient in a corridor was unacceptable and urged the ICBs to ensure that corridor care did not become an accepted feature of winter pressures.

e) Noting that Nottingham University Hospitals NHS Trust was reporting a higher-than-expected Summary Hospital-level Mortality Indicator, the Chair urged the ICBs to examine all possible underlying causes rather than attributing the position solely to data quality issues.

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

Action: Rosa Waddingham to make more explicit in future Quality Oversight Reports the specific actions being taken, the timescales for delivery, and when evidence of improvement could be expected.

ICB CIC 26 051 **Winter Plan**

Maria Principe introduced the item, highlighting the following points:

a) The joint winter plan for Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire had been developed using an approach previously adopted in Nottingham and Nottinghamshire. It responded to NHS England's national expectations and assurance framework and reflected a whole-system approach to winter preparedness across health and care partners.

b) The plan was underpinned by a comprehensive assessment of anticipated demand, available capacity and system risks, and had been designed to support delivery of urgent and emergency care performance, maintain elective recovery, improve patient flow and reduce avoidable admissions.

c) Recognising learning from previous winters, the plan placed significant emphasis on proactive prevention and demand management, including vaccination uptake, support for vulnerable populations, workforce resilience, patient flow improvement, and discharge optimisation.

d) In line with national expectations, the plan had been stress tested using three different scenarios and learning had been incorporated into the development of this final version.

e) There remained a residual baseline acute bed gap going into winter and work was ongoing to mitigate this. Over the next two weeks, the acute trusts would be taking the plan to their respective Boards for approval of their final bed modelling proposals. All providers were aware that there was no additional funding available to mitigate winter pressure and it was incumbent upon all partners to maximise resources to ensure a safe winter for patients.

The following points were made in discussion:

f) Noting the potential for the voluntary sector to support earlier discharge of patients, Daniel King undertook to discuss how the sector could help outside of the meeting.

The Boards **approved** the Winter Plan.

ICB CIC 26 052 **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.

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) Diagnostics remained the principal cross-cutting constraint on elective and cancer recovery, whilst waiting-list growth and below planned activity rates meant that sustained improvement would increasingly depend on additional throughput, productivity and pathway transformation.

d) Urgent-care performance continued to be affected by discharge delays, high bed occupancy and wider challenges with patient-flow.

e) Beyond acute services, the main challenges related to community pathways for children and young people, dental activity and mental health inpatient flow.

f) The Provider Performance Escalation process, implemented over the summer, brought together escalated concerns about acute providers with financial, quality and contractual intelligence. The associated management arrangements included coordinated working with NHS England, formal recovery planning, and time-limited enhanced oversight tailored to each provider's circumstances.

g) The next priority was to translate the strengthened oversight arrangements into demonstrable improvements in delivery. This would require credible provider plans, delivery of funded activity, and proportionate intervention where recovery remained persistently off trajectory.

The following points were made in discussion:

e) The Chair welcomed the strengthened reporting arrangements but emphasised that the enhanced oversight must translate into sustained improvements in performance.

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

ICB CIC 26 053 **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 period April to July 2026.

b) At month four, a £3.7 million adverse year-to-date position for the ICBs was being reported, which was in line with plans, and all three ICBs continued to forecast delivery of their planned full-year financial positions.

c) However, there were emerging risks to this position forecast at £77 million, principally relating to the delivery of the efficiency plan, and additional cost pressures, notably within prescribing, mental health services and continuing healthcare. A robust programme management office approach continued to be in place and discussion would take place to determine whether a formal financial turnaround approach should be taken.

d) At month four, the ICBs' systems were reporting a deficit of £101 million against a planned deficit of £70 million, representing an adverse variance of £31 million. Nottinghamshire providers were driving the adverse position, with under-delivery of efficiencies and other cost pressures cited as the main causes for the position.

The following points were made in discussion:

e) As Chair of the Joint Finance and Performance Committee, Stephen Jackson asked members to note that the Committee had taken assurance on the robust management of the ICBs' financial oversight and would scrutinise the specific actions proposed to mitigate the risk to the ICBs' financial positions at its October meeting.

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

Governance

ICB CIC 26 055 **Board Assurance Framework**

Lucy Branson introduced the item, highlighting the following points:

a) The report provided a mid-year position of the joint Board Assurance Framework, noting that overall, there was a reasonable level of assurance that appropriate controls and assurance arrangements were in place, with no significant gaps in the ICBs' control environment.

b) The strategic risks remained largely unchanged from those reported to the Boards in March 2026 and continued to reflect the key risks to delivery of the ICBs' objectives and statutory duties. However, one change was proposed to the narrative of risk 11. This risk had focused primarily on the development of the cluster operating model and the establishment of a collaborative and supported workforce across the three ICBs. After discussion with the ICBs' Executive Team, it is proposed that this risk should be broadened to reflect the current strategic context and next phase of transition to a single merged ICB. The proposed revised narrative was included in the report.

c) The report also provided the progress made in year to strengthen the ICBs' control environment, which included the implementation of more mature commissioning governance and escalation arrangements and strengthened provider oversight and contract management arrangements.

d) Going forward, work would now focus on demonstrating the effectiveness, impact and outcomes of established controls in order to enhance assurance and move the risks closer to their target scores.

The Boards **received** the mid-year position of the joint Board Assurance Framework; and **approved** the revised narrative for Risk 11.

ICB CIC 26 056 **Committee Highlight Reports**

The report presented an overview of the work of the committees since the Boards' last meeting in July 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 no further points were raised.

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

ICB 26 056 **Boards' Work Programme**

The workplan was noted.

Closing items

ICB CIC 26 057 **Risks identified during the course of the meeting**

No new risks were identified.

ICB CIC 26 058 **Questions from the public relating to items on the agenda**

No questions had been received.

ICB CIC 26 059 **Any other business**

Reflecting on the meeting, members emphasised that equality, diversity and inclusion should remain central to Board discussions. The Chair acknowledged the importance of this and suggested that a future Board development session be used to discuss how well these principles are embedded across all aspects of the ICBs' work. This would be taken forward when establishing the boards' work programme for 2027/28.

Members also highlighted the value of continuing to hear directly from citizens at Board meetings, particularly when considering areas where services faced challenges.

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 17 September 2026

Meeting date	Agenda item	Action	Lead	Due date	Updates	Status
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	See agenda item 9.	**Closed – action completed**
17.09.2026	ICB CIC 026 046	To add an assurance report on the ICBs' appraisal process to the Remuneration and Human Resource Committee's Annual Work Programme.	Lucy Branson	19.11.2026	Added to the Committee's work programme for its 27 January 2027 meeting.	**Closed – action completed**
17.09.2026	ICB CIC 026 048	To add a report to the Boards' work programme for September 2027 to examine the actions taken in response to the maternity families citizen experience paper and the impact they have had.	Lucy Branson	19.11.2026	Added to the forward plan for the Boards' 2027/28 Annual Work Programme.	**Closed – action completed**
17.09.2026	ICB CIC 026 050	To make more explicit in future Quality Oversight Reports the specific actions being taken, the timescales for delivery, and when evidence of improvement could be expected.	Rosa Waddingham	19.11.2026	See agenda item 12.	**Closed – action completed**

Key:

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

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/11/2026
Paper title:	**Chair's Report**
Paper reference:	ICB CIC 26 065
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.

Appendices

None.

Board Assurance Framework

Not applicable

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Chair's Report

Introduction

1. Over recent weeks I have had a number of opportunities to engage with colleagues, partners and communities across our three systems. These conversations continue to reinforce the value of working across organisational and geographical boundaries, while remaining connected to the different needs and strengths of the communities we serve.
2. Against a changing national backdrop, the Boards have an important role in providing clear and consistent leadership, maintaining a strong focus on the needs of our populations while continuing to develop our role as strategic commissioners. This report highlights some of the developments and engagement that have particularly informed my reflections since our last meeting.

Health Bill and related national developments

3. The Health Bill continues its passage through Parliament and is currently being considered at Committee stage in the House of Lords. During its passage, changes have been made to a number of the Bill's original proposals, including those relating to the future composition of ICB Boards, with local authority representation being reinstated, alongside Mayoral Strategic Authority representation.
4. Separately, the Secretary of State for Health and Social Care announced further changes to the future national and regional NHS operating model on 4 November. Subject to the passage of the Bill, NHS England will be brought into the Department of Health and Social Care from 1 April 2027, with an NHS Group established within the Department focused on NHS operational delivery.
5. NHS England's seven regional teams will not transfer into the Department at that point. Instead, they will be supported through a transitional Special Health Authority, allowing regional teams to remain close to the organisations and communities they support while work continues towards a more devolved model. The Secretary of State also confirmed that Healthwatch will be retained and strengthened and announced the establishment of a Patient Experience Director and a Clinical Council to strengthen patient and clinical input into national decision-making.
6. Taken together, these developments reinforce the direction of travel towards stronger strategic commissioning, greater devolution, and closer alignment across health and care. As the arrangements continue to develop, maintaining strong partnerships and a clear focus on the needs of our populations will remain particularly important.

National leadership engagement

7. I recently participated in a meeting with national NHS leaders which provided an opportunity to discuss some of the key priorities and challenges facing the NHS. A strong theme was the importance of commissioning decisions delivering demonstrable improvements for local populations, with a clear focus on the outcomes those decisions are intended to achieve.

8. The discussion also reflected the increasing focus on urgent and emergency care as we move into winter, alongside emerging learning from Primary Care Network test areas. We have one of these test areas in Lincolnshire, providing an opportunity to consider the impact of this work locally as the national approach develops.

Quarterly System Review Meeting

9. In October, we held our quarterly System Review Meeting with NHS England Midlands, providing an opportunity to reflect on progress across the three ICBs and agree the areas requiring particular focus during the remainder of 2026/27. The review recognised positive progress in improving population health outcomes and access, translating our Population Health Strategy into strategic commissioning and neighbourhood delivery, strengthening our commissioning capability, and increasingly using the scale of the three ICBs to address longstanding challenges.

10. For the remainder of the year, our priorities include maintaining a strong focus on financial recovery and operational performance, while protecting critical investment in elective recovery and winter resilience. Alongside this, we will continue to progress our strategic commissioning priorities, particularly the development of integrated neighbourhood working, with an early focus on frailty and palliative and end-of-life care, where there are opportunities both to improve outcomes and reduce avoidable pressure on hospital services.

11. Winter preparedness will be particularly important over the coming months, with work focused on preventing avoidable demand, maximising community alternatives to hospital admission, improving flow and discharge, maintaining sufficient acute capacity and continuing vaccination delivery. We will also maintain close oversight of significant quality and system challenges, including maternity improvement in Nottingham and the sustainability of improvements arising from the Nottingham Inquiry.

Visits and engagement

12. Visits to local services continue to provide valuable opportunities to hear directly from patients, staff and leaders and to understand the impact of our collective work on local communities.

13. I recently hosted the latest Healthy Conversations podcast, focused on long-term conditions, with Sarah Barley McMullan, health advocate and former academic, and Michael Ryan, who leads work on long-term conditions across Nottingham and Nottinghamshire. The conversation explored the realities of managing ongoing health needs and the importance of developing services around the individual rather than individual conditions. It also considered how the NHS can support people to stay well, maintain their independence and have greater control over their health, particularly through more preventative and joined-up neighbourhood working. The podcast can be found here: Healthy Conversations - Long Term Conditions • Healthy Conversations with Dr Kathy McLean.

14. Immediately after the September Board meetings, I addressed the East Midlands Moving Well Conference at the University of Nottingham, speaking about our Population Health Strategy, neighbourhood working, and the importance of prevention as everyone's business. The event brought together colleagues from health and care, local government, Active Partnerships and voluntary and community organisations to explore how movement can help create healthier communities, reduce inequalities and support people to remain independent for longer.

15. I also visited Boston and Mablethorpe to see how local organisations are using physical activity, education, leisure, healthcare and community partnerships to support prevention and improve health and wellbeing. The visits demonstrated how local assets and partnerships can help people stay active, connected, and independent, including through accessible leisure opportunities, stronger links between community facilities and health services, and initiatives addressing social isolation and digital inclusion. They also highlighted continuing challenges associated with rurality, transport and health inequalities.

Board development

16. I am pleased that our Boards have accepted an invitation from NHS England to participate in Cohort 2 of the NHS Board Development Programme.

17. This 12-month, fully funded programme will provide an important opportunity to build on the development work already undertaken by our Boards and support our continuing development as we work increasingly closely across the three ICBs.

18. The programme will be shaped around the particular needs of our Boards. We expect the development sessions to explore effective governance and oversight, constructive challenge and accountability, leading improvement and transformation, and further developing the Boards' role in strategic commissioning.

19. The next step will be an initial discussion between the Chief Executive, me and the programme team to consider our development needs and priorities, followed by a further discussion to agree the overall development journey. Three facilitated, in-person whole-Board sessions will then take place during 2027. We are working with the programme team to align these, where possible, with our existing Board development programme dates.

Looking forward

20. The discussions and engagement reflected in this report reinforce the importance of maintaining momentum as we move through the remainder of the year. Our immediate focus will be on the priorities identified through the Quarterly System Review, including winter resilience, operational and financial recovery, and progressing our longer-term priorities, while continuing to learn from the communities, partners and services with whom we engage.

21. The coming months will also provide opportunities to strengthen how we work collectively across the three ICBs. As we do so, our focus will remain firmly on the difference our decisions make for our populations and the outcomes we are seeking to improve.

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/11/2026
Paper title:	**Chief Executive's Report**
Paper reference:	ICB CIC 26 066
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.

Appendices

Appendix A: ICB Workforce Report (September 2026)

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Chief Executive's Report

Publication of the Thirwell Inquiry Report

1. In September 2023, Lady Justice Thirlwall was appointed to chair an inquiry into events at the Countess of Chester Hospital. The final report, published in September 2026, examined the circumstances surrounding the crimes of Lucy Letby and the wider response of NHS organisations.

2. The Inquiry identified significant failings in leadership, governance, safeguarding and the handling of concerns raised by staff. Its findings emphasise the importance of recognising and acting on patterns of concern; effective Board oversight and professional challenge; strong safeguarding and speaking-up arrangements; effective use of data and intelligence; and openness, candour and engagement with families. A key message is that assurance should focus not simply on whether actions have been completed, but on whether changes are embedded and demonstrably improving safety and experience. The full Inquiry Report can be accessed here: https://thirlwall.public-inquiry.uk/the-report/.

3. NHS England subsequently wrote to all NHS trusts and ICBs setting out a number of immediate actions. All trusts with neonatal units were asked to confirm that the Sudden and Unexpected Death in Childhood process applies to every qualifying unexpected death or collapse leading to death. Confirmation has been received that this has been completed by all relevant trusts across the ICBs' areas. Trusts with neonatal units are also required to meet insulin access-control and storage requirements by 31 March 2027.

4. Trusts and ICBs are also required to review safeguarding training and escalation arrangements; strengthen bereavement care; consider how assurance is provided to parents and support is provided to staff working in psychologically demanding neonatal services; and review the Inquiry's findings at their next available public Board meeting, including consideration of whether similar events could occur locally.

5. The Joint Quality and Service Improvement Committee considered the Inquiry findings and the ICBs' response at its October meeting. The Committee received assurance regarding existing quality, safeguarding, maternity and neonatal arrangements, including arrangements for responding to clinical concerns, Freedom to Speak Up and the prioritisation of patient safety. It nevertheless recognised that further testing and scrutiny are required to demonstrate that learning is embedded and improvements sustained, including work to test and standardise child-death oversight arrangements across the three ICBs.

6. The Committee assigned an overall assurance rating of 'adequate' and emphasised the importance of effective commissioning levers, professional curiosity and challenge, protection for those raising concerns, and the triangulation of data, lived experience and family feedback. Progress will continue to be overseen through the Committee and reported to the Boards through the established assurance arrangements.

National Audit Office report on the restructuring of ICBs

7. The National Audit Office (NAO) has published a report examining the restructuring of ICBs. The report describes the substantial scale and pace of change, including the requirement to reduce annual running costs by £908 million, equivalent to 43% of previous levels. NHS England estimates that approximately 8,000 full-time-equivalent posts, around one-third of the ICB workforce, will need to be removed to achieve these savings.

8. The NAO found that ICBs have restructured at considerable pace. However, it is not yet clear whether they will retain the skills, capacity and capability needed to operate effectively as strategic commissioners. The report also identifies the impact of restructuring and redundancies on staff morale and relationships with local partners, together with the significant upfront costs of change and the need to demonstrate that anticipated savings are sustainable and represent value for money.

9. While recognising the potential benefits of clustering, the report questions whether ICBs will retain sufficient capacity and capability, following substantial reductions in costs, headcount and organisational duplication, to fulfil their intended role and deliver sustainable improvements in population health.

10. The full report can be found here: https://www.nao.org.uk/wp-content/uploads/2026/11/restructuring-of-integrated-care-boards.pdf.

11. The findings are directly relevant to the transition across Derbyshire, Lincolnshire and Nottinghamshire, including the need to maintain sufficient organisational capacity, capability and resilience through implementation of the future operating model. Further detail is provided in the Transition Programme Report at item 15 on this agenda.

ICB CEO Delivery Compact

12. ICB Chief Executives have collectively agreed a 2026/27 ICB CEO Delivery Compact, setting out a small number of areas where ICBs will work together to achieve greater impact, consistency and value. The Compact is not intended to replace individual ICBs' statutory responsibilities or local strategies, but to use the collective commissioning power of ICBs to accelerate transformation, reduce unwarranted variation and improve outcomes and value.

13. The Compact supports delivery of the 10 Year Health Plan for England, including the shifts from hospital to community, treatment to prevention, and analogue to digital. It signals an increasingly strategic approach to commissioning around populations and whole pathways, with a particular focus on neighbourhood health and prevention; quality, outcomes and inequalities; best-practice pathways; modern commissioning and contracting; stronger collaboration with local government; and improved understanding of cost, value and productivity.

14. The initial collective delivery priority is neighbourhood health and frailty, with a focus on earlier identification and proactive management of people at risk, alternatives to hospital admission and supporting earlier discharge. This aligns strongly with our developing approach across Derbyshire, Lincolnshire and Nottinghamshire, including work to strengthen neighbourhood delivery and to identify opportunities for greater consistency and shared learning across pathways.

Unauthorised, inappropriate and unjustifiable access to confidential patient information

15. Following widespread reports of NHS staff accessing confidential patient information without a legitimate reason, Sir Jim Mackey, Chief Executive of NHS England, has written to all NHS trusts and ICBs. The letter makes clear that unauthorised, inappropriate or unjustifiable access to patient records will, in almost all circumstances, be unlawful and constitute gross misconduct, for which summary dismissal will usually be justified. NHS England has adopted a zero-tolerance approach and requires all trusts and ICBs to implement the updated guidance with immediate effect. The full letter can be found here: https://www.england.nhs.uk/long-read/unauthorised-inappropriate-and-unjustifiable-access-to-confidential-patient-information/.

16. In response, the ICBs are taking a number of actions to reinforce expectations and seek assurance across the system:

    a) While the ICBs do not themselves hold patient records, some staff have access to records held by other organisations where this is required as part of their roles. All ICB staff will therefore be reminded in writing of their responsibilities when accessing confidential patient information and that any access must be necessary, appropriate and justifiable for the purpose of their role. As part of this communication, ICB staff will also be asked to ensure that they are up to date with the latest national Data Security Awareness training, which has recently been updated to specifically address unlawful access to health and care records.

    b) The System Quality Group will consider the actions being taken by NHS trusts in response to the letter. The ICBs also intend to reflect associated

requirements within the 2027/28 contract quality schedules, with delivery overseen through established quality oversight arrangements.

c) For general practice, guidance has been provided through the ICB-commissioned Data Protection Officer functions to support practices in understanding and responding to the requirements of the letter, including recommending that practice staff complete the updated national training.

Additional capacity within urgent and emergency care

17. The Government has announced £140 million of investment in urgent-care schemes intended to help reduce pressure on emergency services during winter. Within the ICBs' areas, East Midlands Ambulance Service NHS Trust has received £6.35 million for 40 additional double-crewed ambulances, while Nottingham University Hospitals NHS Trust has received £12.9 million for a new same-day emergency-care facility at Queen's Medical Centre.

18. The investment has been announced against a background of sustained pressure on urgent and emergency care. On 20 October, Nottingham University Hospitals NHS Trust declared a critical incident because of the volume of patients attending its emergency department, reporting that it had treated approximately 2,000 more patients during September than in the same month in 2025. System-response arrangements were activated during the incident to support the maintenance of essential services.

19. The additional investment is welcomed, although continuing demand and operational pressure will require close oversight through the established urgent and emergency-care oversight arrangements during the winter period.

Care Quality Commission inspections at Nottingham University Hospitals NHS Trust

20. The Care Quality Commission (CQC) has published reports following unannounced inspections at Nottingham University Hospitals NHS Trust during April and May 2026.

21. Medical care at both Queen's Medical Centre and City Hospital was rated 'good' across all five assessment domains. Overall care at City Hospital was rated 'good', while Queen's Medical Centre was rated 'requires improvement'. Urgent and emergency care also remains rated 'requires improvement', although the CQC found that the requirements of the previous Section 29A warning notice had mostly been met.

22. Areas requiring further improvement included safety and risk management, infection control, staffing, medicines management, patient experience and aspects of governance and speaking up. Positive findings included an open

safety culture, evidence-based care, skilled staff, effective multidisciplinary working and respect for patients' consent rights.

23. The Trust is responding to the findings and required actions. The ICBs will continue to seek assurance on delivery through their established quality oversight arrangements.

ICB Workforce Report

24. 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 considered at the Committee's October 2026 meeting.

25. Workforce oversight continues to focus on the impact of the management of change programme and transition to the future operating model. Turnover remains elevated, predominantly reflecting planned workforce reductions associated with organisational change. Sickness absence also remains relatively high, with anxiety, stress and depression continuing to be the most frequently reported causes of absence across the three ICBs.

26. Although the available data does not establish a direct causal relationship between organisational change and sickness absence, managers are being encouraged to maintain regular conversations with staff to support wellbeing and engagement, particularly where interim arrangements mean that future roles, responsibilities and objectives have not yet been fully confirmed.

27. Workforce demographic indicators remain broadly stable, although data-quality limitations continue to constrain assurance regarding the full impact of organisational change on workforce diversity. The capability requirements associated with the future operating model will become clearer as placement, recruitment and redeployment activity progresses and will inform the emerging Organisational Development Plan.

28. Further detail on the management of change programme is provided in the Transition Programme Report at item 15 on this agenda.

Extension of Martha's Rule

29. NHS England has announced plans to introduce Martha's Rule in every emergency department in England by the end of March 2028. This patient-safety initiative enables patients, families, carers and staff to request a rapid review by an independent clinician where they are concerned that a person's condition is deteriorating and believe that their concerns are not being heard.

30. The expansion follows testing in seven NHS trusts and will apply across adult and paediatric emergency care, including waiting rooms, resuscitation areas,

corridors and other temporary escalation spaces. Each emergency department will receive £10,000 to support implementation, alongside national guidance and support from local Patient Safety Collaboratives.

31. The ICBs will work with relevant providers to understand local implementation requirements and seek assurance on readiness as the national programme develops.

Independent review of mental health, ADHD and autism

32. Professor Peter Fonagy's independent review published its final report in October. It found that referrals and diagnoses for attention deficit hyperactivity disorder (ADHD) and autism have risen significantly, whilst population-level prevalence appeared broadly stable. The review also found a substantial increase in children's mental distress and identified several potential contributing factors, including social media, poor sleep, reduced feelings of connection and belonging, financial insecurity and greater uncertainty about the future. The full report can be found here: https://www.gov.uk/government/publications/independent-review-into-mental-health-conditions-adhd-and-autism-final-report.

33. In response, the Government has committed to strengthening regulation of ADHD and autism assessments and reviewing advertising practices. It also intends to move towards earlier, needs-led support for children, young people and adults experiencing mental distress, enabling them to receive broader support and advice at the earliest opportunity without waiting for a clinical diagnosis. Further detail on this major overhaul of mental health support will be set out in a forthcoming national mental health strategy, with a renewed focus on prevention and early intervention.

34. A dedicated session will be scheduled for the Boards to consider the report in more detail and inform future strategic commissioning for these and other mental health conditions.

Chief Medical Officer's annual report 2026: health in rural areas and small towns

35. Professor Chris Whitty's annual report examines health and wellbeing in England's small towns and rural areas, where older, faster-ageing populations require services tailored to local needs rather than urban models.

36. The report highlights barriers to access and hidden deprivation. It recommends flexible appointments, community transport and local evidence to identify need, alongside appropriate telemedicine, supported digital access and continued face-to-face care.

37. It also calls for a sustainable rural workforce through training placements, reduced professional isolation and better career development. Rural GPs and communities should help shape commissioning, with support for community hospitals, outreach, mental health services and prevention of agricultural workplace injuries.

38. Overall, it advocates locally designed action, extending beyond healthcare and backed by national support, to ensure equitable care for rural residents.

39. The full report can be found here: https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2026-health-in-rural-areas-and-small-towns.

Be Ready campaign

40. The Government has launched the Be Ready campaign to help people prepare for disruption caused by emergencies such as severe weather and cyber-attacks. It provides practical guidance on personal and community preparedness, including information about Priority Services Registers for people who may require additional support during disruption.

41. The Boards will hold a dedicated development session on cyber security during December 2026 and will receive an assessment of the ICBs' Emergency Preparedness, Resilience and Response arrangements at their next formal meeting in January 2027.

New community and mental health facilities

42. The new £15 million Babington Health Centre in Belper opened to patients on 17 August 2026 and was formally opened by Elizabeth Fothergill CBE, HM Lord-Lieutenant of Derbyshire on 16 October 2026. The purpose-built facility provides modern community healthcare facilities for people in Belper and surrounding areas, bringing together outpatient and community health services previously provided from the former Babington Hospital.

43. A new Mental Health Urgent Assessment Centre opened at the Royal Derby Hospital site on 28 September 2026. Operated by Derbyshire Healthcare NHS Foundation Trust, the 24-hour, seven-day-a-week service provides rapid specialist assessment in a more appropriate environment for people attending the Emergency Department who identify as experiencing a mental health crisis. Initially, referrals are made through existing clinical teams and the centre does not accept walk-in patients.

Health and Wellbeing Board updates

44. Health and Wellbeing Boards continue to provide an important forum for local authority, NHS, and wider partners to oversee health improvement, prevention and wider determinants of health. Recent activity across the ICBs' areas includes:

    a) The Derby Health and Wellbeing Board met on 3 September 2026 and considered progress towards adopting a Marmot health equity approach for Derby, the development of the Derby Neighbourhood Health Plan, the annual report of the Child Death Overview Panel and the Healthwatch Derby Annual Report. The Board also received updates on the COVID-19 Inquiry findings relating to procurement and the work of the Derbyshire Health Protection Board.

    b) The Derbyshire Health and Wellbeing Board met on 1 October 2026 and considered the work of the Derbyshire Dales Locality Health and Wellbeing Partnership and the continuing development of neighbourhood health arrangements, including the Board's role and terms of reference. It also considered mental health neighbourhood working, the Derby and Derbyshire Self-harm and Suicide Prevention Strategic Framework 2026–30, and the public health approach to the emotional wellbeing of children and young people.

    c) The Lincolnshire Health and Wellbeing Board met on 10 November 2026 and considered the development of neighbourhood health across Lincolnshire, proposed changes to Healthwatch arising from the Health Bill 2026, the 2026/27 Better Care Fund, and health protection assurance and priorities for 2026/27.

    d) The Nottingham City Health and Wellbeing Board met on 30 September 2026 and considered the development of Nottingham's Strategic Neighbourhood Health and Wellbeing Plan and the annual report of the Nottingham City Safeguarding Adults Board. It also considered a series of Joint Strategic Needs Assessments covering healthy weight and nutrition, alcohol-related harm, adolescents aged 11–19, and HIV, to inform local priorities, commissioning and delivery under the Joint Local Health and Wellbeing Strategy.

    e) The Nottinghamshire Health and Wellbeing Board met on 23 September and 4 November 2026. In September, the Board reviewed delivery of the Joint Health and Wellbeing Strategy, with particular focus on giving every child the best chance to maximise their potential and ensuring people can access the right support to improve their health. It also agreed the 2026/27 Joint Strategic Needs Assessment work programme. In November, the Board considered community safety, the Mansfield Long-Term Rough Sleeper Partnership Plan, the health impacts of flooding and

wider work to improve health outcomes across Nottinghamshire, alongside further assurance on delivery of the Joint Health and Wellbeing Strategy.

45. Links to the respective meeting papers are available through the relevant local authority websites.

NHS
Derby and Derbyshire
Integrated Care Board

NHS
Lincolnshire
Integrated Care Board

NHS
Nottingham and
Nottinghamshire
Integrated Care Board

DLN Cluster People Report

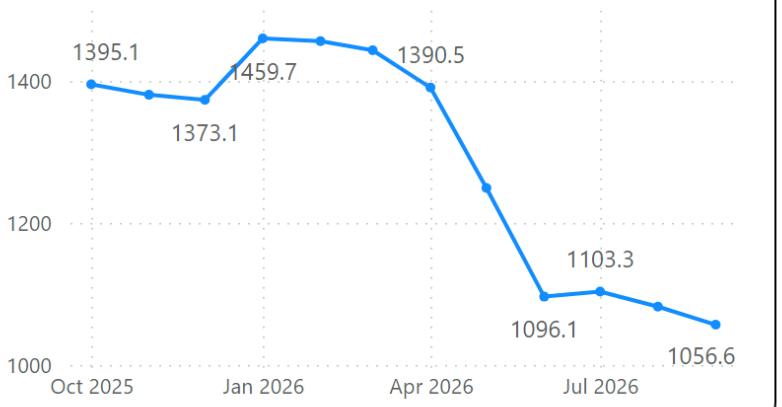
Reporting Month: September 2026



SAIU
STRATEGIC
ANALYTICS
INTELLIGENCE
UNIT

DLN Cluster Workforce Metrics

Total Substantive WTE



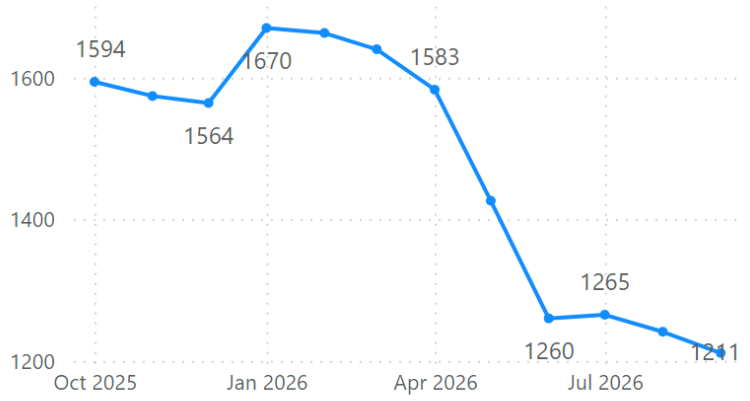
Total Substantive WTE

1,056.6

Monthly Decrease

-25.4

Total Substantive Headcount



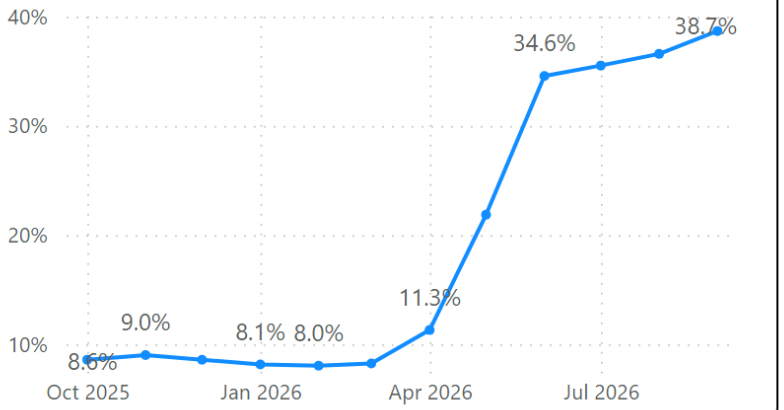
Total Substantive Headcount

1,211

Monthly Decrease

-30

Turnover Rate WTE (12m)



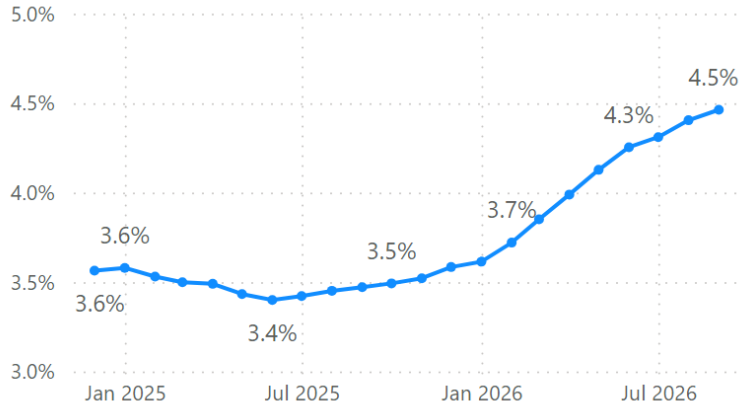
Turnover Rate WTE (12m)

38.7%

Monthly Increase

2.1%

Sickness/Absence (12m)



Rolling Absence WTE (12m)

4.5%

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 1056.6 WTE in September, a change of 25.4 WTE from August, when the total was 1082.1 WTE. Nottingham and Nottinghamshire ICB shows the biggest change, a decrease of 11.1 WTE. The Sickness rate has risen to 4.5%, with a rise of 0.06%. Meanwhile, turnover increased to 38.7%, an increase of 2.10% from August (36.6%).

Individual ICB KPI's

ICB Latest WTE

ICB	WTE	Monthly Trend
D&D ICB	386.6	-8.3
Lincs ICB	258.3	-6.0
N&N ICB	411.8	-11.1

ICB Latest Headcount

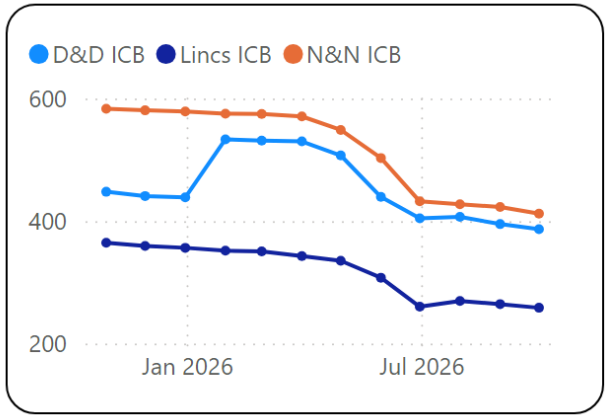
ICB	Headcount	Monthly Trend
D&D ICB	471	-8
Lincs ICB	274	-9
N&N ICB	466	-13

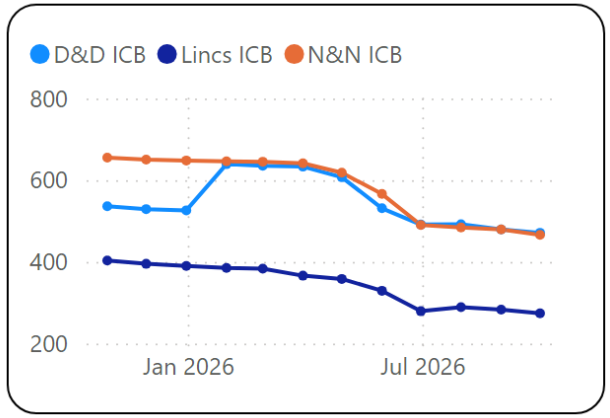
ICB Latest Turnover Rate WTE (12m)

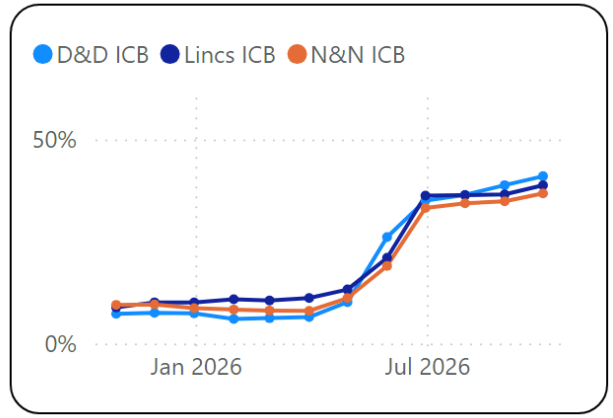
ICB	Turnover	Monthly Trend
D&D ICB	40.9%	2.2%
Lincs ICB	38.7%	2.2%
N&N ICB	36.8%	1.9%

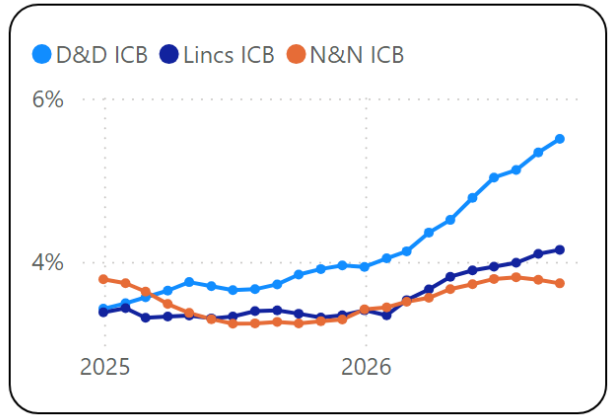
ICB Latest Absence/Sickness (12m)

ICB	Rolling Absence	Monthly Trend
D&D ICB	5.5%	0.2%
Lincs ICB	4.1%	0.1%
N&N ICB	3.7%	-0.0%









DLN Cluster Mandatory Training & Appraisal Rate

DLN Cluster

Mandatory Training %

85.0%

ICB Mandatory Training Breakdown

ICB	Mandatory Training %
NHS Derby and Derbyshire ICB	80.8%
NHS Lincolnshire ICB	88.1%
NHS Nottingham and Nottinghamshire ICB	90.4%

DLN Cluster

Appraisal %

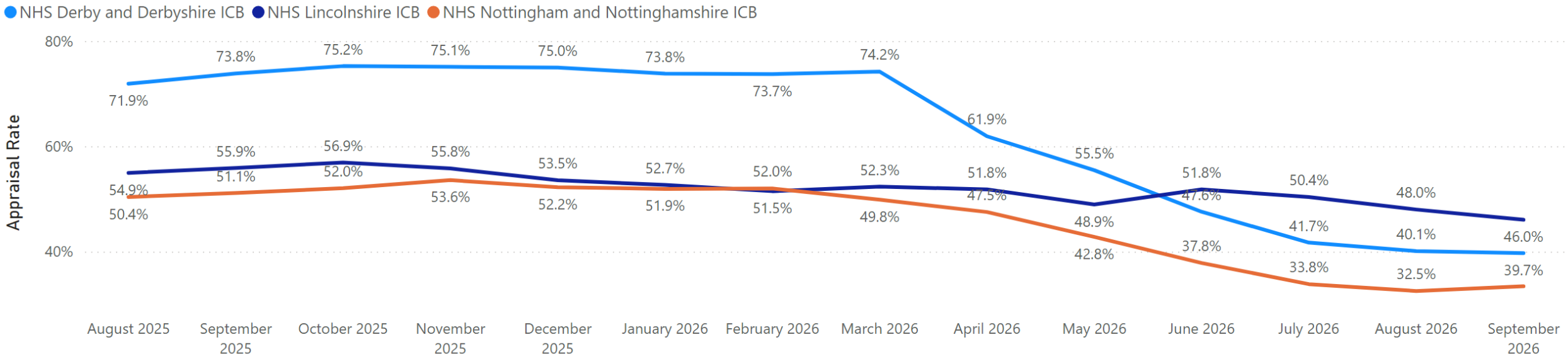
38.6%

ICB Appraisal Breakdown

ICB	Appraisal %
NHS Derby and Derbyshire ICB	39.7%
NHS Lincolnshire ICB	46.0%
NHS Nottingham and Nottinghamshire ICB	33.4%

DLN Appraisal Rate

Appraisal rate by ICB



DLN Cluster Monthly Change

Monthly Decrease

-0.2%

DLN Cluster Yearly Change

Yearly Decrease

-21.3%

ICB Appraisal Breakdown

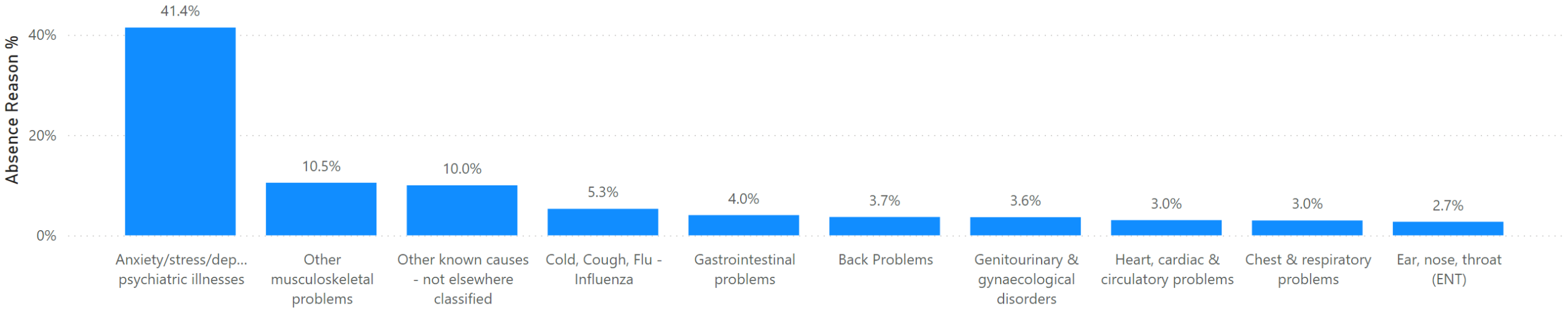
ICB	Appraisal %	Monthly Change	Yearly Change
D&D ICB	39.7%	-0.4%	-34.1%
Lincs ICB	46.0%	-1.9%	-9.8%
N&N ICB	33.4%	0.9%	-17.7%

Appraisal rate by ICB

Month	NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB
November 2025	75.1%	55.8%	53.6%
December 2025	75.0%	53.5%	52.2%
January 2026	73.8%	52.7%	51.9%
February 2026	73.7%	51.5%	52.0%
March 2026	74.2%	52.3%	49.8%
April 2026	61.9%	51.8%	47.5%
May 2026	55.5%	48.9%	42.8%
June 2026	47.6%	51.8%	37.8%
July 2026	41.7%	50.4%	33.8%
August 2026	40.1%	48.0%	32.5%
September 2026	39.7%	46.0%	33.4%

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	42.2%
Other known causes - not elsewhere classified	13.6%
Other musculoskeletal problems	8.1%
Back Problems	5.8%
Cold, Cough, Flu - Influenza	5.1%
Gastrointestinal problems	3.9%
Chest & respiratory problems	3.8%
Ear, nose, throat (ENT)	3.1%
Heart, cardiac & circulatory problems	2.4%
Endocrine / glandular problems	2.4%

Nottingham and Nottinghamshire ICB Absence Reason

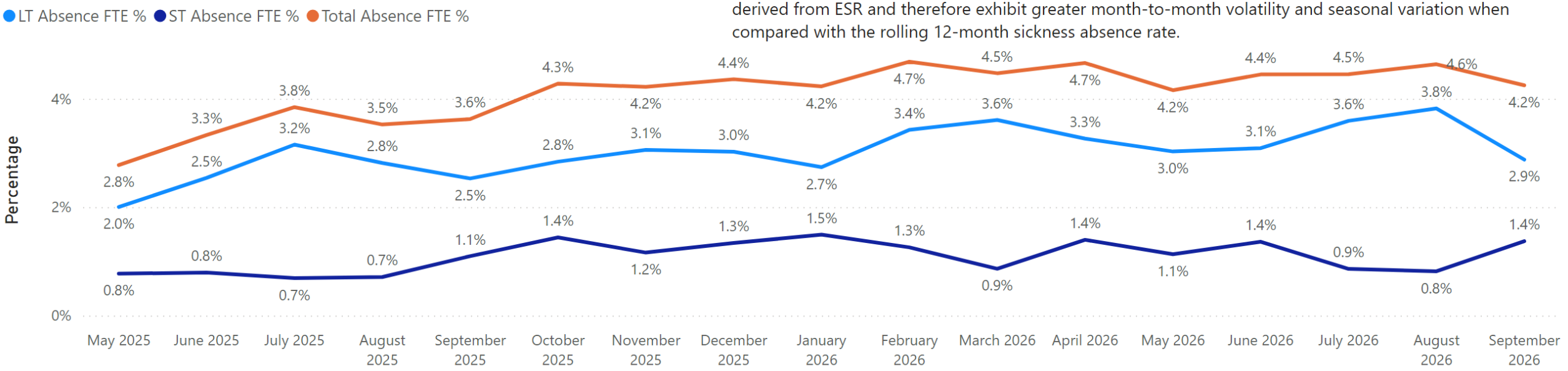
Absence Reason	Absence Reason %
Anxiety/stress/depression/other psychiatric illnesses	36.5%
Other musculoskeletal problems	12.1%
Other known causes - not elsewhere classified	6.4%
Genitourinary & gynaecological disorders	6.4%
Cold, Cough, Flu - Influenza	5.6%
Pregnancy related disorders	5.1%
Heart, cardiac & circulatory problems	5.0%
Gastrointestinal problems	4.8%
Eye problems	3.0%
Benign and malignant tumours, cancers	2.5%

Lincoln ICB Absence Reason

Absence Reason	Absence Reason %
Anxiety/stress/depression/other psychiatric illnesses	47.1%
Other musculoskeletal problems	12.8%
Other known causes - not elsewhere classified	8.3%
Cold, Cough, Flu - Influenza	5.1%
Chest & respiratory problems	4.3%
Headache / migraine	3.6%
Genitourinary & gynaecological disorders	3.5%
Gastrointestinal problems	3.1%
Ear, nose, throat (ENT)	2.5%
Eye problems	2.2%

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

DLN In-Month Absence FTE %



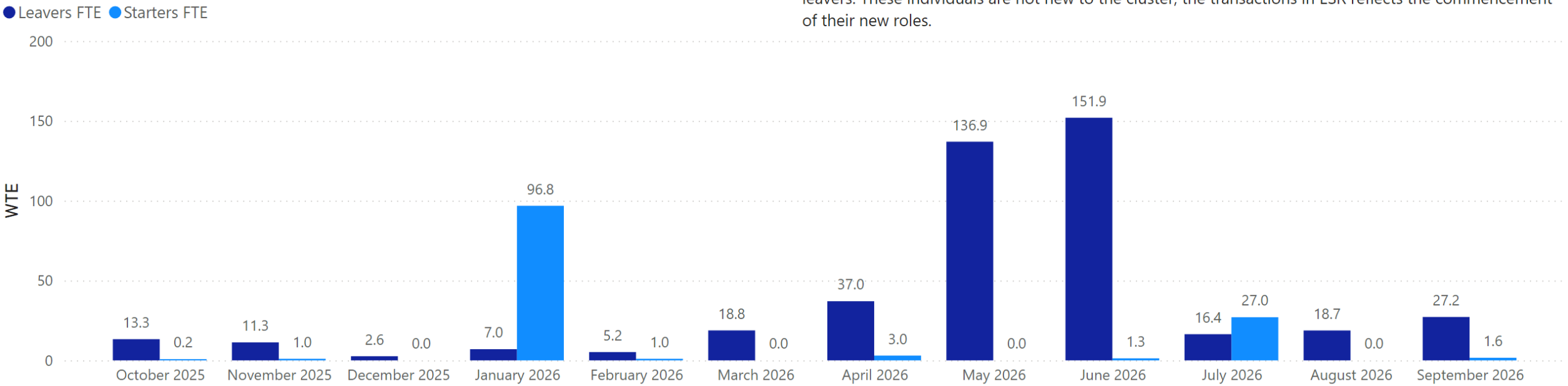
Long-term, Short-term and Total Absence figures are calculated as single-month (in-month) measures derived from ESR and therefore exhibit greater month-to-month volatility and seasonal variation when compared with the rolling 12-month sickness absence rate.

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 %
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%
July 2026	4.6%	1.2%	3.0%	0.8%	2.9%	0.5%
August 2026	5.5%	1.0%	3.1%	1.2%	2.6%	0.4%
September 2026	4.1%	1.5%	2.2%	1.1%	2.2%	1.5%

Cluster Starters and Leavers

DLN Starters and Leavers by Month



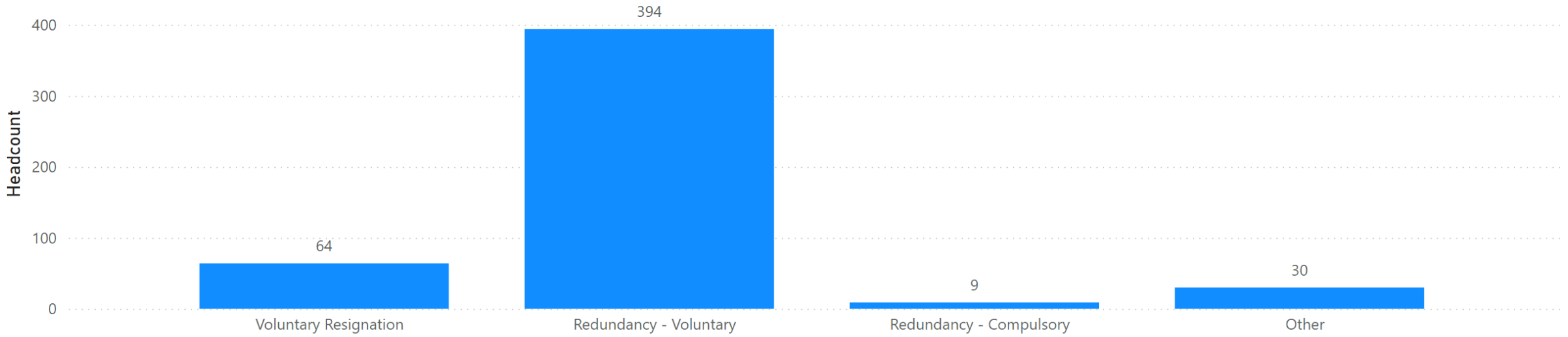
Following the new cluster arrangement, some roles previously aligned to an ICB have transitioned to new roles covering the cluster. These changes will appear in ESR as new starters; and in some instances leavers. These individuals are not new to the cluster, the transactions in ESR reflects the commencement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

Starters and Leavers by ICB

	October 2025	November 2025	December 2025	January 2026	February 2026	March 2026	April 2026	May 2026	June 2026	July 2026	August 2026	September 2026
Derby and Derbyshire ICB												
Leavers FTE	4.7	4.1	0.0	1.0	2.8	4.1	15.1	67.7	33.2	5.4	10.7	7.1
Starters FTE	0.2			95.8						11.9		
Lincolnshire ICB												
Leavers FTE	2.8	4.6	1.6	4.0	1.0	7.2	6.8	25.8	48.0	4.0	2.7	7.4
Starters FTE				1.0			3.0			12.2		
Nottingham and Nottinghamshire ICB												
Leavers FTE	5.8	2.6	1.0	2.0	1.4	7.5	15.2	43.4	70.8	7.0	5.3	12.7
Starters FTE		1.0			1.0				1.3	2.9		1.6

Cluster Reasons for Leaving - January 2026 onwards

DLN Reasons for Leaving



Reason for Leaving Headcount by ICB

ICB	Other	Redundancy - Compulsory	Redundancy - Voluntary	Voluntary Resignation
Derby and Derbyshire ICB	15	3	143	24
Lincoln ICB	8	3	87	22
Nottingham and Nottinghamshire ICB	7	3	164	18

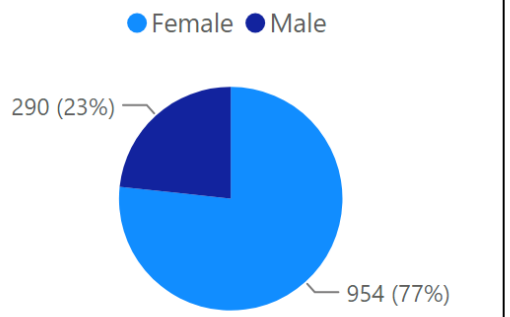
Reason for Leaving Headcount by Band

Pay Grade	Other	Redundancy - Compulsory	Redundancy - Voluntary	Voluntary Resignation
Band 2	1			1
Band 3	4		19	8
Band 4	3		27	9
Band 5	3		49	6
Band 6	7		60	5
Band 7	1		96	13
Band 8 - Range A	1		50	9
Band 8 - Range B	2		48	1
Band 8 - Range C	1	1	16	2
Band 8 - Range D	1		16	1
Band 9	1	1	4	
Non-AFC	5	7	9	9

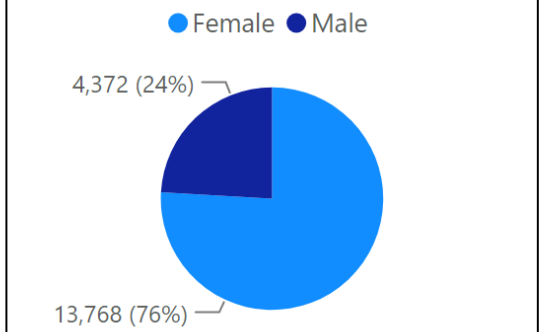
DLN Cluster Workforce EDI metrics

EDI metrics have 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.

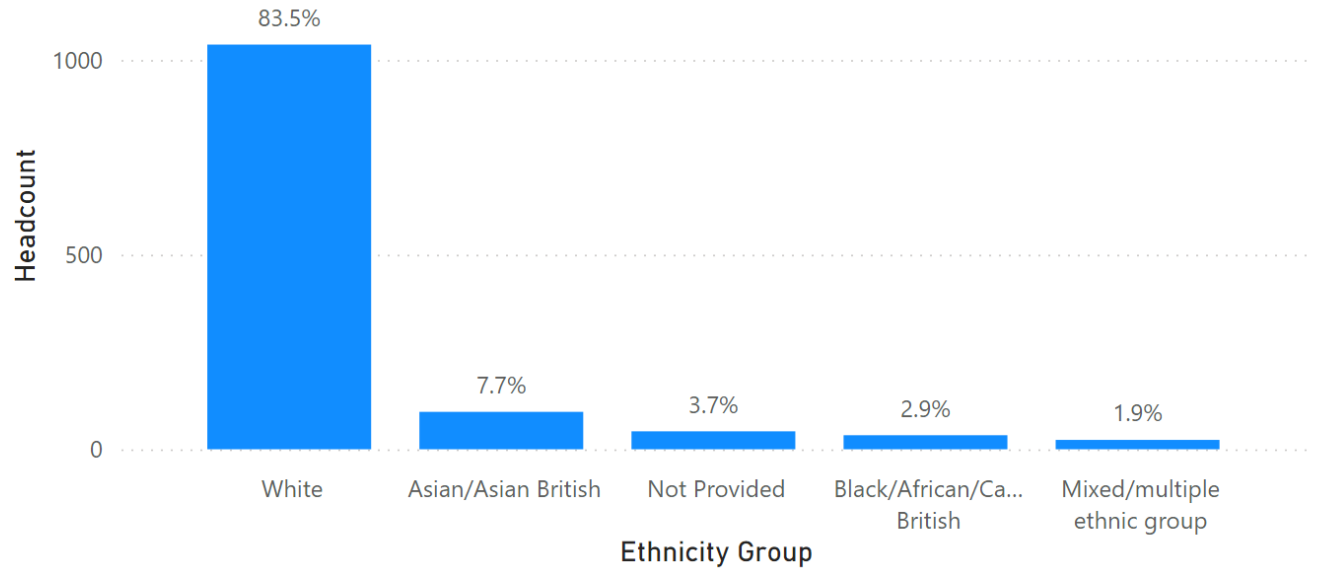
DLN Cluster Gender



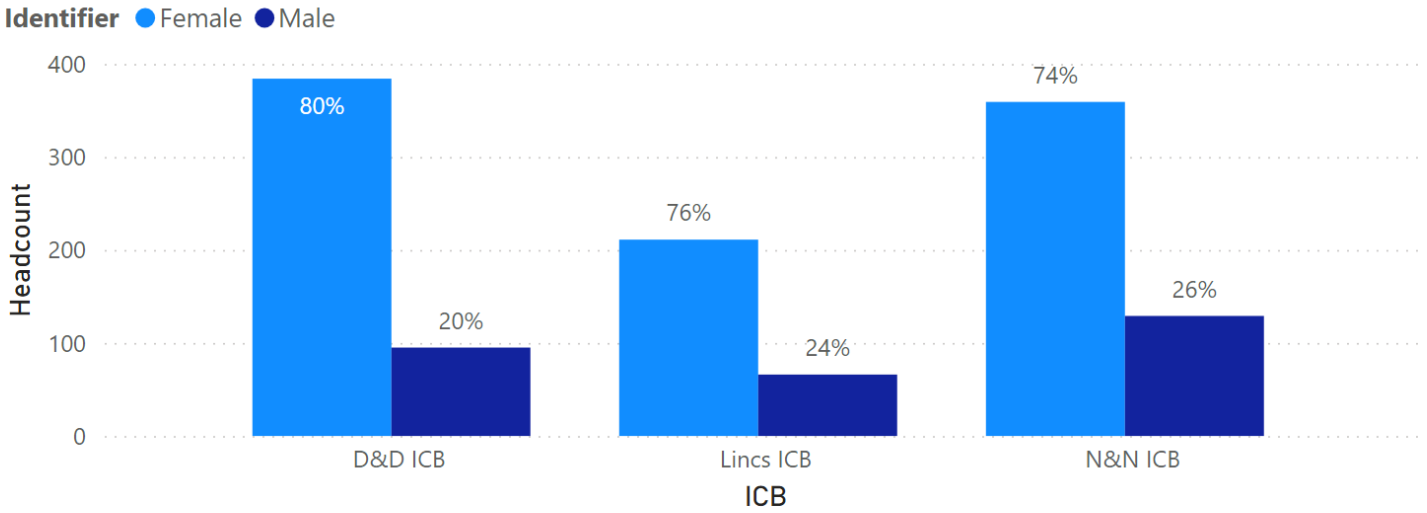
NHSE All ICBs Total Gender



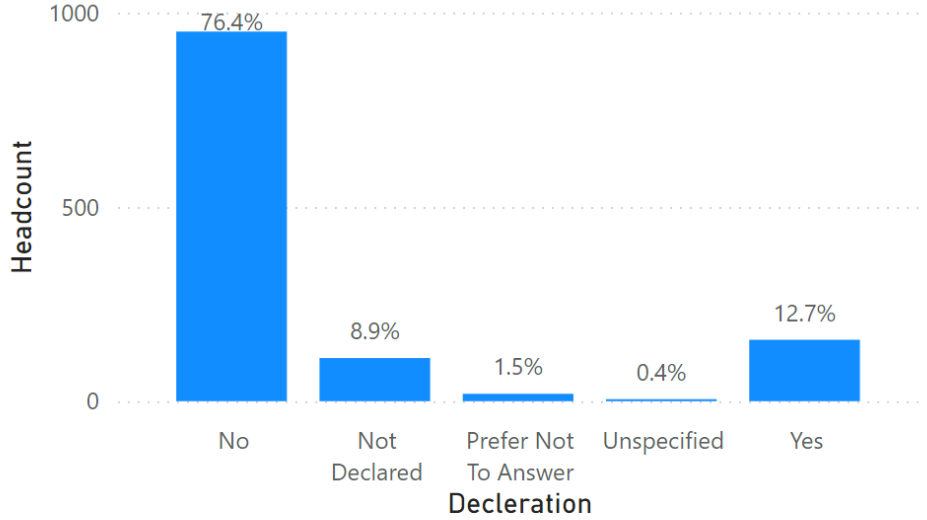
DLN Ethnicity Grouped



ICBs Gender Headcount

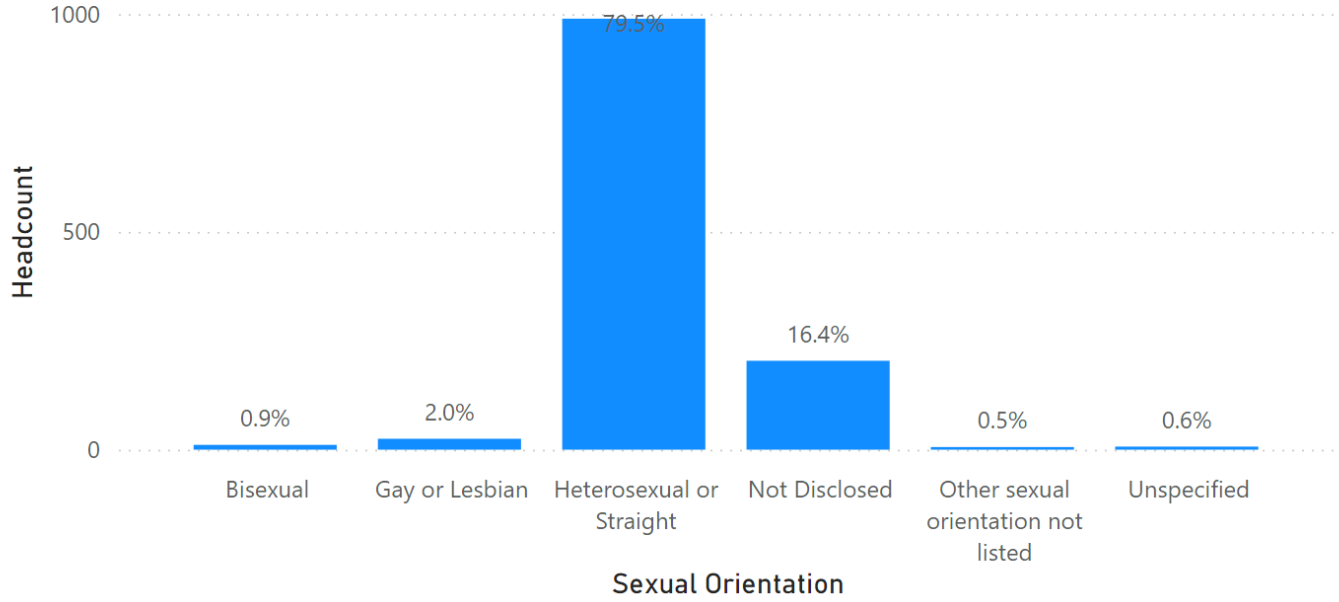


DLN Disability or Long Term Condition

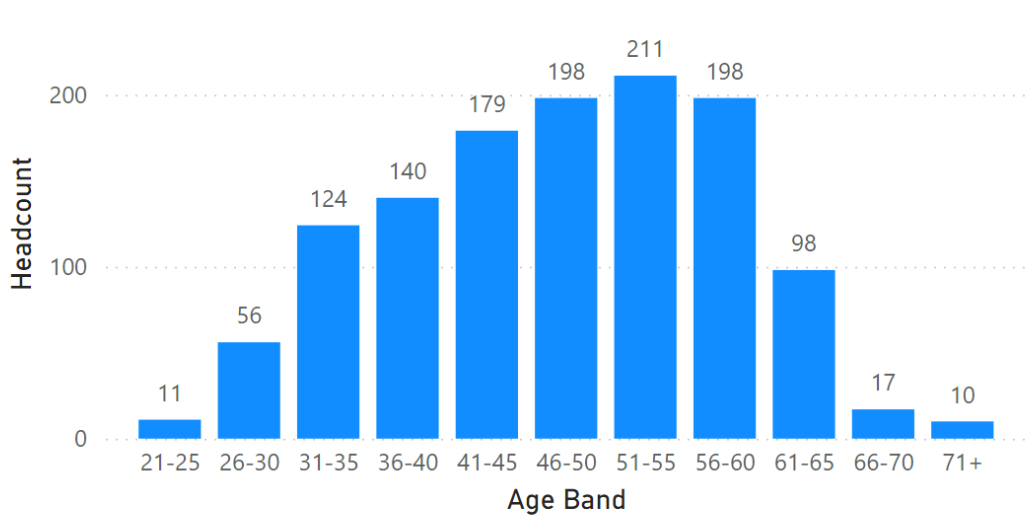


DLN Cluster Workforce EDI metrics

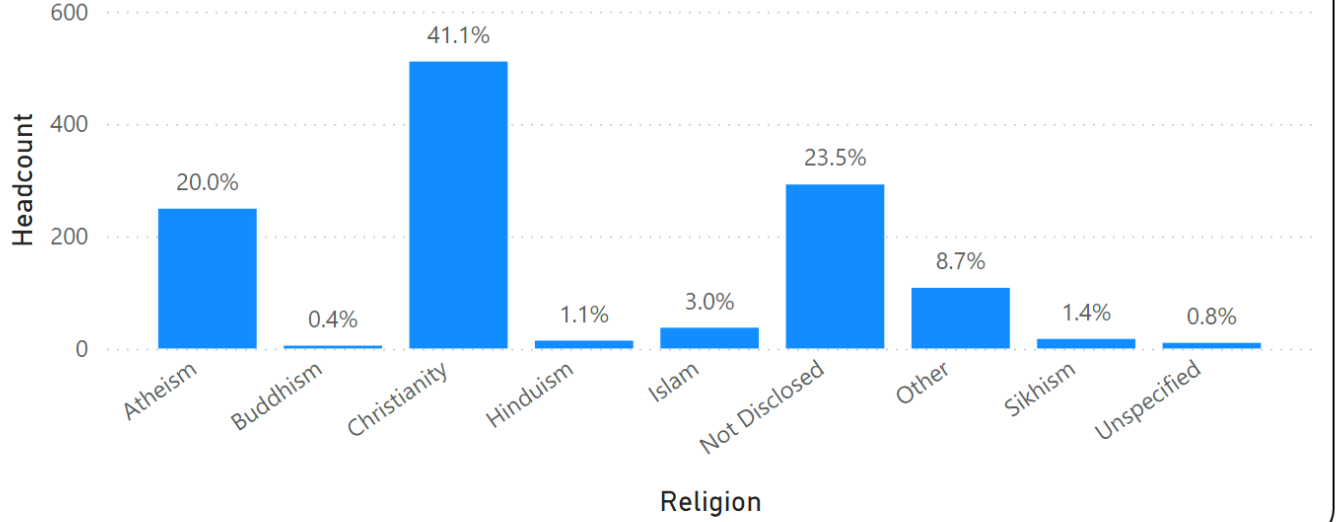
DLN Sexual Orientation



DLN Age Band



DLN Religious Belief



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:	19/11/2026
Paper title:	**Citizen's experience: primary care access and patient involvement**
Paper reference:	ICB CIC 26 067
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 a citizen's experience of accessing primary care at Stamford Surgery and of representing patients through the practice's Patient Participation Group (PPG).

John MorphyGodber joins the Boards to describe the significant improvements patients have experienced following the introduction of total triage, whilst also highlighting opportunities to strengthen peer support, accessibility and patient involvement.

His experience demonstrates how service changes can improve access, but also how involving patients earlier can help identify barriers, support implementation and ensure that services work for people with different needs.

Recommendation(s):

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

Appendices

None

Board Assurance Framework

Not applicable.

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No

Citizen story: Primary care access and patient involvement

Introduction

1. John MorphyGodber is Chair of the Patient Participation Group (PPG) at Stamford Surgery. The PPG gathers patients' experiences through regular drop-in sessions at the practice's two sites, an email group, and feedback received directly from local people. Issues and recurring themes are raised with the practice through regular meetings.
2. John joins the Boards today to share his experiences, and the experiences of the PPG, in relation to primary care access and patient involvement.

Improving access through total triage

3. The introduction of total triage and the Anima online system has led to significant improvements at Stamford Surgery. Before the change, the PPG regularly heard concerns about difficulty contacting the practice, obtaining appointments and navigating reception processes.
4. Since total triage was introduced, the PPG has received much more positive feedback. Patients have reported completing an online form and being contacted quickly with an appropriate response or appointment. The change has also enabled reception staff to pass patients' information to clinicians for assessment, rather than having to make judgements about their clinical needs themselves.
5. Some patients remain less comfortable with technology or would prefer to explain their needs directly to a member of staff and the practice are supporting those people who are less digitally confident.
6. John's experience also shows the importance of ensuring digital systems are fully accessible. As a screen-reader user, he encountered a question in the Anima form that could not be completed without using a mouse. This created an avoidable barrier within a system that was otherwise intended to improve access.
7. His experience reinforces the need to retain supported access routes and to involve people with different accessibility needs when digital services are designed and tested.

The value of peer support

8. A second area highlighted by John is the value of local peer-support groups for people living with long-term health conditions.

9. Peer groups can complement clinical care by providing social and emotional support grounded in people's lived experience.

10. Although information about peer support groups is displayed in waiting rooms, the PPG would like clinicians and other practice staff to mention relevant groups proactively when speaking to patients.

11. John has personal experience of the benefits of the diabetes peer support. The group provides time and space for people to talk about living with the condition, including its emotional impact and the practical challenges associated with diet, exercise and managing health readings. Members can hear from others facing similar issues in a setting that is not constrained by the limited time available during a clinical appointment.

12. The PPG intends to continue encouraging the practice to signpost patients more actively to appropriate local groups and to monitor whether more people hear about these opportunities through the practice.

Involving patients earlier

13. The third theme is the opportunity to make fuller and earlier use of the PPG when changes are being planned.

14. The PPG currently gathers feedback from patients and raises recurring concerns with the practice. The practice responds constructively when issues are brought forward, but the relationship can be reactive. The PPG would like to be involved before changes are introduced, rather than primarily being asked to respond after patients have encountered a problem.

15. The introduction of total triage provides an example. Although the change has delivered significant benefits, the PPG believes it could have supported the practice more effectively if members had been involved and briefed earlier. They could have helped explain the change locally, supported patients to understand the new arrangements and identified accessibility concerns such as the screen-reader issue before implementation.

16. The PPG also has access to wider community networks. Members can share information through local email lists and social media groups, helping the practice communicate with residents in a direct and trusted way. Earlier engagement could therefore help practices understand likely concerns, test proposed changes and communicate with patients more effectively.

Summary

17. John's experience and the experiences of the PPG demonstrate that primary care services can make substantial improvements while continuing to listen and learn.

18. And whilst the overall experience at Stamford Surgery is positive, patient insight can help build on this improvement and ensure that future changes are accessible, understandable and shaped with the communities they affect.

Meeting title	Integrated Care Boards: Open Session (meeting in common)
Meeting date	19/11/2026
Paper title	**Report on Strategic Health Priorities: Strong General Practice**
Paper reference	ICB CIC 26 068
Paper author	Sarah Starbuck, Associate Programme Director Commissioning
Paper sponsor	Maria Principe, Executive Director of Commissioning Dave Briggs. Executive Director of Outcomes (Medical) Clair Raybould, Executive Director for Strategy and Citizen Experience
Presenter	Maria Principe

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

Report summary

NHS Derby and Derbyshire, NHS Lincolnshire and NHS Nottingham and Nottinghamshire ICBs' Five-Year Population Health Strategy was approved by the Boards in March 2026. This report provides the first strategic assurance assessment of the Strong General Practice priority and establishes an initial reference position against which future progress and impact can be assessed.

The overall direction of travel is generally positive, with most strategic indicators improving across the three ICB areas. Appointment capacity and a number of long-term condition outcomes have improved. However, the aggregate position masks significant variation between Primary Care Networks and continuing inequalities associated with deprivation. Increased activity has also not consistently translated into improved patient experience, with access, continuity, navigation, communication and coordination of care remaining important areas for improvement.

Established commissioning and quality arrangements continue to provide oversight across the three ICBs, alongside developing common arrangements for quality management, strategic commissioning and use of intelligence. Digital infrastructure is well established, with future assurance increasingly focused on effective use and impact rather than deployment alone.

Taken together, the evidence provides a generally positive but qualified position. Future Board assurance will increasingly focus on delivery and impact, including progress against the strategic indicators, reduction in unwarranted variation and inequalities, and evidence that the developing commissioning and improvement response is delivering measurable improvements in patient outcomes and experience.

Recommendation(s)

The Boards are asked to **receive** the paper for assurance regarding the current position and direction of travel for the Strong General Practice priority.

Appendices

Appendix 1: Strong General Practice Strategic Performance Indicators
Appendix 2: Citizen and Patient Insight Evidence Synthesis
Appendix 3: Strong General Practice – Supporting Delivery and Assurance Arrangements

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

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Report on Strategic Health Priorities: Strong General Practice

Introduction

1. NHS Derby and Derbyshire, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire ICBs' ("the ICBs") Five-Year Population Health Strategy was approved by the Boards in March 2026. A programme of reporting has subsequently been established to provide the Boards with strategic assurance on progress against the priorities within the Strategy. This report focuses on Strong General Practice, which is fundamental to prevention, early diagnosis, long-term condition management, continuity of care, and effective navigation across health and care services.
2. The report provides an initial assessment of the current position and recent direction of travel for Strong General Practice, drawing on the latest available data for the agreed strategic indicators alongside citizen insight, analysis of variation and inequalities, and the developing commissioning, quality, and digital response. As the indicators draw on different datasets and reporting periods, they should not be interpreted as a single 2025/26 baseline. They do, however, provide an initial reference position against which future progress can be assessed.

Performance, variation and inequalities

Performance and outcomes

3. The Strong General Practice priority is underpinned by nine strategic indicators covering access, continuity of care, patient experience, and outcomes for people with long-term conditions. Taken together, these provide a strategic view of whether general practice is becoming more accessible, effective and responsive to population need.
4. Performance across the three ICB areas shows a generally improving direction of travel, with eight of the nine strategic indicators improving in both Derby and Derbyshire and Nottingham and Nottinghamshire, and seven of nine improving in Lincolnshire over the reporting period. However, the aggregate position masks significant variation between Primary Care Networks (PCNs), demonstrating the importance of looking beyond ICB-level averages when assessing progress.
5. Access capacity has increased across all three ICB areas, with General Practice appointments per 1,000 weighted patients increasing and each area exceeding operational planning expectations. However, this is not consistently reflected in people's experience of access. Same-day access for clinically urgent patients has deteriorated in Derby and Derbyshire and Lincolnshire, while improving in Nottingham and Nottinghamshire.

6. Patient experience is improving overall, particularly experience of contacting General Practice, although performance remains below national benchmarks in a number of areas. Continuity of care also remains an area for attention. Derby and Derbyshire and Nottingham and Nottinghamshire show improvement, while Lincolnshire has reduced to 38% of patients able to see or speak to their preferred General Practitioner (GP) or healthcare professional, compared with the 40% national benchmark.

7. Clinical outcomes provide further evidence of progress. Hypertension control has improved across all three ICB areas and diabetes indicators demonstrate particularly positive improvement in Lincolnshire. However, some diabetes outcomes in Nottingham and Nottinghamshire remain below national benchmarks and variation between PCNs remains evident.

8. The indicators should not be interpreted in isolation. Confidence in individual measures varies: GP appointment data is affected by recognised limitations relating to coding, mapping, completeness and timeliness; the same-day urgent access measure has a comparatively short reporting history; and GP Patient Survey measures are annual, sample-based and necessarily lag current experience. Performance information is therefore triangulated with quality intelligence, patient experience and local insight to provide a more rounded assessment.

Variation and inequalities

9. Analysis at PCN level demonstrates that the overall ICB position can mask significant local variation. This is important both from a quality perspective and in assessing whether improvement is being experienced equitably across different communities.

10. The initial inequalities analysis identifies an association between higher deprivation and poorer performance across a number of measures, although the strength of the relationship differs by indicator. The association is more evident for overall patient experience and some hypertension and diabetes outcomes, while it is weaker for appointment volumes and continuity and no clear association has been identified for same-day urgent access. Deprivation therefore appears relevant to some of the variation observed but does not, in itself, explain all differences in performance.

11. The analysis is necessarily limited by the data currently available. Nationally available General Practice access and experience data does not support consistent analysis across the full range of health inequalities characteristics, and the assessment has therefore principally used PCN-level deprivation as an initial indicator of inequality. The current position should consequently be regarded as an early assessment rather than a comprehensive analysis of equity. Further analysis, including consideration of CORE20PLUS5 population

groups and other relevant characteristics, will be undertaken as population health intelligence develops.

12. The analysis demonstrates association rather than causation. Wider evidence indicates that access barriers, multimorbidity, workforce capacity and the wider determinants of health may contribute to the differences observed, but further analysis will be required to understand the relative contribution of these factors locally.

13. The strategic response will therefore focus both on improving overall performance and identifying and addressing unwarranted variation. PCN-level intelligence will increasingly be used to inform commissioning priorities and target support where outcomes, access or patient experience are falling behind the wider system position.

14. Detailed performance against the nine strategic indicators, including the position within each ICB area, PCN-level variation and the supporting analysis of deprivation, is provided at Appendix 1.

Citizen insight and learning

15. Quantitative performance data has been considered alongside a wide range of citizen and patient insight, including the GP Patient Survey, local engagement, complaints and concerns, Healthwatch evidence and Patient Participation Group feedback.

16. Across the three ICB areas, people generally report positive experiences of compassionate and effective care once they reach the appropriate professional. The more consistent concerns relate to the route into and through General Practice, including obtaining appointments, telephone and digital access, navigating triage and maintaining continuity of care.

17. People also describe difficulties with communication and coordination across organisational boundaries, including referrals, test results, medicines and follow-up, with some patients experiencing the need to chase information, repeat their story or coordinate different parts of their care themselves. Continuity is particularly important for people with long-term or complex conditions and carers.

18. Digital access is valued where it makes access easier and more convenient, but the evidence reinforces the importance of maintaining appropriate telephone, face-to-face and supported routes. The key learning from the combined evidence is therefore that activity alone is not a sufficient measure of Strong General Practice. Assessment of progress needs to consider experience, equity, continuity, navigation and clinical outcomes alongside appointment volumes. This was a central conclusion of the earlier Strong General Practice analysis.

19. A detailed synthesis of the citizen and patient insight informing this assessment is provided at Appendix 2.

Strategic commissioning and improvement response

20. The findings from the performance, inequalities and patient insight evidence are informing the developing strategic commissioning and improvement response across the three ICBs. The approach seeks to establish greater consistency in commissioning expectations, quality oversight and the use of intelligence, while retaining sufficient flexibility to respond to differing population needs and local circumstances.

Commissioning response

21. The commissioning response will increasingly focus on outcomes, equity, patient experience and reduction in unwarranted variation, with the Strong General Practice strategic indicators providing a common framework for assessing progress.

22. Priorities include clearer expectations for blended access across telephone, digital and face-to-face routes; strengthened safety and equality assurance for triage; improved continuity and choice for people with complex or long-term needs; and greater reliability of referrals, results, medicines and follow-up across organisational boundaries. Workforce, estates, digital capability and investment will increasingly need to reflect population need and local patterns of inequality.

Quality assurance and improvement

23. Established General Practice quality assurance arrangements remain in place across the three ICB areas, covering 316 practices and combining performance and quality intelligence, professional review, provider engagement and escalation where concerns are identified. These arrangements provide ongoing assurance but have developed separately, with joint assurance currently principally exception-based.

24. Primary Care Quality teams are therefore working towards a common Quality Management System, supported by increasingly consistent performance and quality intelligence. This will provide a stronger basis for identifying unwarranted variation, targeting improvement and escalating material concerns.

25. Development of the wider General Practice, Pharmacy, Optometry and Dentistry Quality Framework is an important dependency in establishing consistent quality oversight across delegated primary care services. The intention is to strengthen consistency in quality domains, intelligence,

accountability and escalation while retaining effective local provider relationships and proportionate responses to emerging risk.

Digital enablement

26. Digital infrastructure provides an established platform for improvement. Across the three ICBs, 98% of relevant practices are configured for prospective online GP record access, around 2.13 million patients aged 13 and over are registered with the NHS App, and all practices have access to cloud-based telephony and online consultation tools.

27. The assurance focus is therefore increasingly moving from deployment to effective use and impact. This includes whether digital capability is improving access, productivity and patient experience while maintaining accessible non-digital routes and avoiding widening inequalities. Future activity will focus not simply on the availability of digital tools, but on their effective use, the experience of patients and practices and demonstrable impact on access and capacity.

Financial and resource considerations

28. Available primary care resources are being managed within current allocations, with budgets expected to be substantially utilised during 2026/27. Future commissioning will need to demonstrate increasingly clear alignment between investment, population need and the Strong General Practice priorities, while balancing wider efficiency requirements and the sustainability of General Practice.

29. The financial assurance focus will therefore increasingly be on whether existing and future resources are being deployed in ways that support the identified priorities and deliver demonstrable improvement and value.

Added value of cluster working

30. Working across the three ICBs provides an opportunity to strengthen General Practice through common strategic indicators, shared intelligence and greater consistency in commissioning and quality oversight, while retaining local delivery where appropriate. This creates a stronger basis for identifying unwarranted variation, sharing learning and targeting improvement and investment according to population need.

31. The value of joint working will ultimately need to be demonstrated through impact rather than the development of common arrangements in themselves. This will include evidence of reduced unwarranted variation and inequalities,

more consistent quality and patient experience, improved outcomes and more effective use of available resources.

32. Further detail on the current and developing quality assurance arrangements, digital enablement and financial and commissioning context is provided at Appendix 3.

Next steps and future assurance

33. Taken together, the evidence provides a generally positive but qualified position: most strategic indicators are improving, while continuing variation between PCNs, inequalities and limitations in some of the available data mean that further assurance will be required on delivery and impact.

34. The next phase will focus on translating the emerging strategic commissioning and quality arrangements into measurable delivery. This will include:

    a) Establishing agreed baselines and thresholds for the strategic indicators and determining where variation requires further investigation or intervention.

    b) Implementing the common Quality Management System and associated primary care quality framework.

    c) Strengthening the use of population health intelligence to identify inequalities and target improvement.

    d) Aligning commissioning and investment decisions more explicitly with the Strong General Practice priorities.

    e) Continuing to triangulate performance with patient experience, quality and safety intelligence.

    f) Establishing measures that demonstrate whether interventions are achieving improvement in outcomes, access and experience rather than solely measuring activity.

35. Future Board assurance will therefore increasingly be determined by evidence of delivery and impact: whether the developing arrangements have been implemented effectively, whether unwarranted variation and inequalities are reducing, and whether measurable improvement is being experienced by patients.

Appendix 1: Strong General Practice Strategic Performance Indicators

NHS Derby and Derbyshire ICB

Derby and Derbyshire ICB Headline Strategic Key Performance Indicator Overview

- Eight of the nine measures improving over the reporting period and only one indicator moving in an adverse direction, although there is significant variation among PCNs
- Access activity has increased, with GP appointments per 1,000 weighted patients rising across 14 PCNs
- Patient experience and clinical quality indicators demonstrate encouraging improvement

1. GP Appointments per 1,000 patients (weighted & registered)

DDICB: 5,948 (Aug '25) to 6,145 (Aug '26)



Overall: Improvement at system level & across 14 PCNs.
National Benchmark: This measure exceeds operational plan expectations.
IMD: KPI correlation between lower performing PCNs and deprivation is weak for both GPAD measures.

2. % of clinically urgent appointments seen on the same day

DDICB: 74% (Aug '25) to 73.2% (Aug '26)



Overall: deterioration at system level & across 14 PCNs. However, metric was not monitored in previous years.
National Benchmark: This measure exceeds operational plan expectations.

3. % reporting overall experience as good/very good

DDICB: 75.5% (2025) to 75.8% (2026)



Overall: improvement at system level & across 11 PCNs.
National benchmark: This measure falls below the national result of 77%.
IMD: Moderate correlation between lower performing PCNs and deprivation.

4. % reporting experience of contacting the practice as good/very good

DDICB: 67.8% (2025) to 68.5% (2026)



Overall: improvement at system level & across 11 PCNs.
National benchmark: This measure falls below the national result of 73%.
IMD: KPI correlation between lower performing PCNs and deprivation is weak

5. % able to see/speak to preferred GP HCP

DDICB: 34.7% (2025) to 36.5% (2026)



Overall: mixed variation at system level with improvement across 9 PCNs.
National benchmark: This measure falls below the national result of 40%.
IMD: KPI correlation between lower performing PCNs and deprivation is very weak

6. % patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)

DDICB: 69.1% (2024/25) to 72.7% (2025/26)



National benchmark: Achievement above the national result of 72.3% (including PCAs)
IMD: Moderate correlation between lower performing PCNs and deprivation.

7. % patients aged 80 years or over, with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (or equivalent home blood pressure reading).

DDICB: 82.5% (2024/25) to 84.4% (2025/26)



National benchmark: Achievement above the national result of 83.6% (including PCAs)
IMD: KPI correlation between lower performing PCNs and deprivation is weak

8. % patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months.

DDICB: 57.3% (2024/25) to 60.2% (2025/26)



National benchmark: Achievement below the national result of 60.6% (including PCAs)
IMD: Moderate correlation between lower performing PCNs and deprivation

9. % of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months.

DDICB: 81.1% (2024/25) to 82.1% (2025/26)



National benchmark: Achievement below the national result of 82.7% (including PCAs)
IMD: Moderate correlation between lower performing PCNs and deprivation

Current position

At ICB level, the strong general practice indicators show an overall positive picture for Derby and Derbyshire ICB, with eight of the nine measures improving over the reporting period and only one indicator moving in an adverse direction.

Access activity has increased, with GP appointments per 1,000 weighted patients rising from 5,948 to 6,145 by August 2026, demonstrating improved appointment availability across 14 of the 18 PCNs. Patient experience metrics have also improved, with the proportion of patients reporting an overall good or very good experience increasing from 75.5% to 75.8%, and satisfaction with contacting the practice rising from 67.8% to 68.5%. Continuity of care has strengthened, with the percentage of patients able to see or speak to their preferred GP or healthcare professional increasing from 34.7% to 36.5%.

The only indicator showing deterioration is the proportion of clinically urgent appointments seen on the same day, which fell from 74.0% to 73.2%. However, this measure was not routinely monitored historically, limiting the ability to determine whether this reflects a genuine decline in performance or changes in recording and demand patterns.

Clinical quality indicators demonstrate encouraging improvement. Blood pressure control has increased from 69.1% to 72.7% for patients aged 79 years and under with hypertension, and from 82.5% to 84.4% for patients aged 80 years and over. Diabetes management has also improved, with the proportion of patients achieving recommended HbA1c levels increasing from 57.3% to 60.2%, while cholesterol control improved from 81.1% to 82.1%.

Overall, the indicators suggest that Derby and Derbyshire ICB is delivering measurable improvements in access, patient experience, continuity of care and long-term condition management. Whilst variation remains between PCNs and deprivation-related inequalities persist, the direction of travel is largely positive and provides clear evidence of improvement across most measures.

Derby & Derbyshire ICB	Highest performance	Lowest performance	Highest improvement	Highest deterioration
GP appointments per 1,000 weighted population	1. PCCO: **11,599** 2. Glossop: **8,983** 3. North Hardwick and Bolsover: **7,467**	1. Derby City North: **4,083** 2. High Peak and Buxton: **5,339** 3. Erewash: **5,491**	1. PCCO: **+2,730** 2. North Derbyshire: **+883** 3. Oakdale Park: **+542**	1. Erewash: **-455** 2. Swadlincote: **-241** 3. High Peak and Buxton: **-135**
GP appointments per 1,000 crude population	1. PCCO: **11,599** 2. Glossop: **8,983** 3. North Hardwick and Bolsover: **7,467**	1. Derby City North: **4,083** 2. High Peak and Buxton: **5,339** 3. Erewash: **5,491**	1. PCCO: **+2,730** 2. North Derbyshire: **+883** 3. Oakdale Park: **+542**	1. Erewash: **-455** 2. Swadlincote: **-241** 3. High Peak and Buxton: **-135**
Same-day appointments	1. Chesterfield and Dronfield: **83.1%** 2. Belper: **80.5%** 3. Glossop: **78.8%**	1. Oakdale Park: **53.2%** 2. Greater Derby: **60.1%** 3. Erewash: **65.9%**	1. North Hardwick and Bolsover: **+5.5%** 2. High Peak and Buxton: **+4.9%** 3. Derby City South: **+3.6%**	1. Oakdale Park: **-13.8%** 2. Unaligned: **-9.0%** 3. North Derbyshire: **-8.2%**

Derby & Derbyshire ICB	Highest performance	Lowest performance	Highest improvement	Highest deterioration
Overall patient experience with GP practice	1. High Peak and Buxton: **89.7%** 2. Derbyshire Dales: **88.4%** 3. Glossop: **86.1%**	1. PCCO: **61.2%** 2. Derby City South: **62.9%** 3. North Derbyshire: **65.2%**	1. North Hardwick and Bolsover: **+4.8%** 2. North East Derbyshire: **+4.7%** 3. High Peak and Buxton: **+4.0%**	1. Swadlincote: **-5.4%** 2. Erewash: **-3.2%** 3. Unaligned: **-2.2%**
Patient experience of contacting GP practice	1. High Peak and Buxton: **85.2%** 2. Derbyshire Dales: **84.9%** 3. North East Derbyshire: **80.5%**	1. PCCO: **52.4%** 2. North Derbyshire: **54.7%** 3. Oakdale Park: **55.0%**	1. PCCO: **+7.6%** 2. North East Derbyshire: **+6.5%** 3. North Derbyshire: **+6.2%**	1. Swadlincote: **-9.2%** 2. Belper: **-4.1%** 3. Oakdale Park: **-3.8%**
Able to see or speak with preferred healthcare professional	1. PCCO: **50.4%** 2. North East Derbyshire: **49.3%** 3. Chesterfield and Dronfield: **47.5%**	1. North Derbyshire: **13.8%** 2. Oakdale Park: **22.6%** 3. Derby City North: **27.0%**	1. PCCO: **+23.0%** 2. Alfreton, Ripley, Crich and Heanor: **+9.2%** 3. Chesterfield and Dronfield: **+9.2%**	1. Erewash: **-11.4%** 2. Swadlincote: **-7.3%** 3. Oakdale Park: **-3.9%**
Hypertension control: patients aged 79 and under	1. Unaligned: **82.0%** 2. Glossop: **78.1%** 3. North Derbyshire: **77.6%**	1. Derby City North: **64.8%** 2. Greater Derby: **67.8%** 3. North East Derbyshire: **69.3%**	1. Swadlincote: **+8.3%** 2. PCCO: **+5.4%** 3. Glossop: **+5.4%**	High Peak and Buxton: **-1.2%**
Hypertension control: patients aged 80 and over	1. Unaligned: **89.6%** 2. Glossop: **87.5%** 3. North Derbyshire: **87.0%**	1. Greater Derby: **81.4%** 2. Derby City South: **82.9%** 3. North East Derbyshire: **83.1%**	1. Glossop: **+4.7%** 2. Derby City North: **+4.0%** 3. Unaligned: **+3.8%**	North Derbyshire: **-0.2%**
Diabetes control in patients with frailty	1. Derbyshire Dales: **69.4%** 2. Glossop: **67.2%** 3. Chesterfield and Dronfield: **66.0%**	1. Derby City North: **51.2%** 2. Greater Derby: **55.9%** 3. Alfreton, Ripley, Crich and Heanor: **56.7%**	1. Swadlincote: **+6.1%** 2. Chesterfield and Dronfield: **+4.7%** 3. Oakdale Park: **+4.6%**	No deterioration reported
Diabetes control in patients without frailty	1. Derbyshire Dales: **88.8%** 2. Glossop: **88.7%** 3. Unaligned: **85.5%**	1. Derby City North: **76.9%** 2. Derby City South: **77.2%** 3. Erewash: **78.7%**	1. Swadlincote: **+4.0%** 2. Alfreton, Ripley, Crich and Heanor: **+3.4%** 3. Greater Derby: **+2.6%**	1. North Hardwick and Bolsover: **-3.4%** 2. North Derbyshire: **-2.1%** 3. Chesterfield and Dronfield: **-1.0%**

NHS Lincolnshire ICB

Lincolnshire ICB Headline Strategic Key Performance Indicator Overview

- Seven of the nine measures improving over the reporting period and two indicators moving in an adverse direction, although there is significant variation among PCNs
- Access has increased, with GP appointments per 1,000 weighted patients above operational plan expectations. Patient experience and clinical outcomes generally continue to improve.
- Same-day urgent access and continuity of care remain key areas requiring further improvement.

1. GP Appointments per 1,000 patients (weighted & registered)

LICB: 6,350 (Aug'25 to 6,714 (Aug '26)



Overall: Improvement at system level & across 10 PCNs.
National Benchmark: This measure exceeds operational plan expectations.
IMD: KPI correlation between lower performing PCNs and deprivation is weak for both GPAD measures.

2. % of clinically urgent appointments seen on the same day

LICB: 73.1% (Aug '25) to 70.4% (Aug '26)



Overall: deterioration at system level & across 10 PCNs. However, metric was not monitored in previous years.
National Benchmark: This measure exceeds operational plan expectations.

3. % reporting overall experience as good/very good

LICB: 72.5% (2025) to 74.1% (2026)



Overall: improvement at system level and across 2 PCNs. Most PCN results remained largely the same.
National benchmark: This measure falls below the national result of 77%.
IMD: Moderate correlation between lower performing PCNs and deprivation.

4. % reporting experience of contacting the practice as good/very good

LICB: 68.3% (2025) to 70.8% (2026)



Overall: improvement at system level & across 3 PCNs. Most PCNs result remained largely the same.
National benchmark: This measure falls below the national result of 73%.
IMD: KPI correlation between lower performing PCNs and deprivation is weak

5. % able to see/speak to preferred GP HCP

LICB: 41.2% (2025) to 38% (2026)



Overall: deterioration at system level with deterioration across 8 PCNs.
National benchmark: This measure falls below the national result of 40%.
IMD: KPI correlation between lower performing PCNs and deprivation is very weak

6. % patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)

LICB: 68.5% (2024/25) to 72.9% (2025/26)



National benchmark: Achievement above the national result of 72.3% (including PCAs)
IMD: Moderate correlation between lower performing PCNs and deprivation

7. % patients aged 80 years or over, with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (or equivalent home blood pressure reading).

LICB: 82.8% (2024/25) to 84.9% (2025/26)



National benchmark: Achievement above the national result of 83.6% (including PCAs)
IMD: KPI correlation between lower performing PCNs and deprivation is weak

8. % patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months.

LICB: 57.7% (2024/25) to 61.2% (2025/26)



National benchmark: Achievement above the national result of 60.6% (including PCAs)
IMD: Moderate correlation between lower performing PCNs and deprivation

9. % of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months.

LICB: 82.1% (2024/25) to 83.8% (2025/26)



National benchmark: Achievement above the national result of 82.7% (including PCAs)
IMD: Moderate correlation between lower performing PCNs and deprivation

Current position

At ICB level, the strong general practice indicators present a mixed but generally positive picture, with seven of the nine measures improving and two measures deteriorating over the reporting period.

Access remains strong, with GP appointments per 1,000 weighted patients increasing from 6,350 to 6,714, exceeding operational plan expectations and showing improvement across 10 PCNs. Patient experience has also improved, with the proportion of patients reporting a good or very good overall experience increasing from 72.5% to 74.1%, and satisfaction with contacting the practice improving from 68.3% to 70.8%. However, both experience measures remain below their respective national benchmarks of 77% and 73%.

Clinical outcomes continue to improve. Blood pressure control increased from 68.5% to 72.9% among patients aged 79 years or under with hypertension and from 82.8% to 84.9% among those aged 80 years or over. Diabetes management also improved, with the proportion of patients achieving recommended HbA1c control increasing from 57.7% to 61.2%, and cholesterol control improving from 82.1% to 83.8%. All four clinical quality indicators are above national benchmark levels.

Two indicators have moved in the wrong direction. The percentage of clinically urgent appointments seen on the same day decreased from 73.1% to 70.4%, while the proportion of patients able to see or speak to their preferred GP or healthcare professional declined from 41.2% to 38.0%, falling below the national benchmark of 40%. Both measures deteriorated across multiple PCNs. In addition, patient experience outcomes, although improving overall, remain below national averages.

Overall, the indicators suggest improvement in access volumes and long-term condition management, particularly for hypertension and diabetes outcomes. The main challenges relate to same-day urgent access and continuity of care, where performance has deteriorated.

Lincolnshire ICB	**Highest performance**	**Lowest performance**	**Highest improvement**	**Highest deterioration**
GP appointments per 1,000 weighted population	1. Four Counties (**13,230**) 2. Imp (**8,418**) 3. Meridian Medical (**7,784**)	1. First Coastal (**4,260**) 2. Spalding PCN (**5,586**) 3. Trent Care (**5,706**)	1. Four Counties (**+2,694**) 2. Lincoln Health Partnership (**+1,378**) 3. Imp (**+1,377**)	1. East Lindsey (**-185**) 2. Apex (**-170**) 3. South Lincolnshire Rural (**-123**)
GP appointments per 1,000 crude population	1. Four Counties (**12,714**) 2. Meridian Medical (**8,963**) 3. Imp (**8,889**)	1. Spalding PCN (**5,200**) 2. First Coastal (**5,685**) 3. Apex (**5,804**)	1. Four Counties (**+2,601**) 2. Imp (**+1,477**) 3. Lincoln Health Partnership (**+1,236**)	1. East Lindsey (**-187**) 2. Apex (**-166**) 3. South Lincolnshire Rural (**-117**)
Same-day appointments	1. Four Counties (**91.4%**) 2. Grantham & Rural (**82.7%**) 3. K2 Healthcare Sleaford (**78.7%**)	1. Meridian Medical (**54.6%**) 2. Apex (**58.6%**) 3. East Lindsey (**58.8%**)	1. Four Counties (**+10.5%**) 2. Lincoln Health Partnership (**+8.8%**) 3. East Lindsey (**+0.6%**)	1. Meridian Medical (**-21.4%**) 2. Spalding PCN (**-12.7%**) 3. South Lincolnshire Rural (**-7.9%**)

Lincolnshire ICB	Highest performance	Lowest performance	Highest improvement	Highest deterioration
Overall patient experience with GP practice	1. Apex (**84.6%**) 2. Imp (**83.3%**) 3. K2 Healthcare Sleaford (**78.1%**)	1. Lincoln Health Partnership (**62.3%**) 2. Trent Care (**68.5%**) 3. South Lincolnshire Rural (**70.0%**)	1. Four Counties (**+15.4%**) 2. Imp (**+10.0%**) 3. Meridian Medical (**+7.0%**)	1. Lincoln Health Partnership (**-7.9%**) 2. South Lincoln (**-4.9%**) 3. K2 Healthcare Sleaford (**-4.0%**)
Patient experience of contacting GP practice	1. Apex (**80.7%**) 2. Imp (**79.8%**) 3. K2 Healthcare Sleaford (**76.1%**)	1. Trent Care (**58.0%**) 2. Four Counties (**60.6%**) 3. Lincoln Health Partnership (**63.1%**)	1. Four Counties (**+10.1%**) 2. Imp (**+9.7%**) 3. Boston (**+7.0%**)	1. Trent Care (**-4.7%**) 2. South Lincoln (**-4.5%**) 3. East Lindsey (**-4.4%**)
Able to see or speak with preferred healthcare professional	1. South Lincoln (**46.6%**) 2. Grantham & Rural (**46.0%**) 3. K2 Healthcare Sleaford (**45.1%**)	1. Lincoln Health Partnership (**27.9%**) 2. Meridian Medical (**32.0%**) 3. First Coastal (**32.1%**)	1. Four Counties (**+14.4%**) 2. Spalding PCN (**+4.4%**) 3. K2 Healthcare Sleaford (**+1.9%**)	1. Lincoln Health Partnership (**-25.1%**) 2. South Lincolnshire Rural (**-8.3%**) 3. East Lindsey (**-8.2%**)
Hypertension control: patients aged 79 and under	1. Apex (**78.6%**) 2. Meridian Medical (**76.9%**) 3. Imp (**76.8%**)	1. Trent Care (**64.9%**) 2. Lincoln Health Partnership (**65.3%**) 3. Grantham & Rural (**69.2%**)	1. Apex (**+7.4%**) 2. First Coastal (**+7.2%**) 3. Imp (**+6.4%**)	Lincoln Health Partnership (**-2.4%**)
Hypertension control: patients aged 80 and over	1. Imp (**88.6%**) 2. K2 Healthcare Sleaford (**88.1%**) 3. Apex (**87.4%**)	1. Lincoln Health Partnership (**81.8%**) 2. South Lincolnshire Rural (**81.9%**) 3. Trent Care (**82.0%**)	1. Imp (**+5.4%**) 2. First Coastal (**+4.2%**) 3. Meridian Medical (**+3.4%**)	1. Lincoln Health Partnership (**-2.3%**) 2. Trent Care (**-1.2%**)
Diabetes control in patients without frailty	1. K2 Healthcare Sleaford (**66.9%**) 2. Four Counties (**63.7%**) 3. Grantham & Rural (**63.6%**)	1. Lincoln Health Partnership (**56.2%**) 2. Spalding PCN (**56.5%**) 3. Trent Care (**58.3%**)	1. Four Counties (**+5.8%**) 2. Lincoln Health Partnership (**+5.1%**) 3. Grantham & Rural (**+4.6%**)	Meridian Medical (**-0.2%**)
Diabetes control in patients with frailty	1. South Lincolnshire Rural (**87.9%**) 2. K2 Healthcare Sleaford (**87.6%**) 3. Trent Care (**87.0%**)	1. Lincoln Health Partnership (**78.2%**) 2. First Coastal (**80.2%**) 3. Boston (**80.9%**)	1. South Lincoln (**+5.8%**) 2. Spalding PCN (**+5.0%**) 3. First Coastal (**+3.6%**)	1. Apex (**-3.2%**) 2. K2 Healthcare Sleaford (**-0.8%**) 3. Lincoln Health Partnership (**-0.4%**)

NHS Nottingham and Nottinghamshire ICB

Nottingham and Nottinghamshire ICB Headline Strategic Key Performance Indicator Overview

- Eight of nine indicators have improved, demonstrating overall progress across the strategic KPI's
- Access continues to improve, with increasing appointment availability and improved same-day access for clinically urgent patients.
- Patient experience and long-term condition outcomes are generally improving, although variation between PCNs and gaps to some national benchmarks remain.

1. GP Appointments per 1,000 patients (weighted & registered)

NNICB: 6,031 (Aug '25) to 6,562 (Aug '26)



Overall: Improvement at system level & across 20 PCNs.
National Benchmark: This measure exceeds operational plan expectations.
IMD: KPI correlation between lower performing PCNs and deprivation is weak for both GPAD measures.

2. % of clinically urgent appointments seen on the same day

NNICB: 74.4% (Aug '25) to 76.9% (Aug '26)



Overall: deterioration at system level & across 8 PCNs. However, metric was not monitored in previous years.
National Benchmark: This measure exceeds operational plan expectations.

3. % reporting overall experience as good/very good

NNICB: 74.2% (2025) to 74.3% (2026)



Overall: very marginal improvement at system level which no significant change across most PCNs
National benchmark: This measure falls below the national result of 77%.
IMD: Moderate correlation between lower performing PCNs and deprivation.

4. % reporting experience of contacting the practice as good/very good

NNICB: 67.7% (2025) to 69.3% (2026)



Overall: improvement at system level & across 11 PCNs.
National benchmark: This measure falls below the national result of 73%.
IMD: KPI correlation between lower performing PCNs and deprivation is weak

5. % able to see/speak to preferred GP HCP

NNICB: 38.4% (2025) to 38.8% (2026)



Overall: marginal improvement at system level; variation across PCNs is mixed with 10 showing improvement.
National benchmark: This measure falls below the national result of 40%.
IMD: KPI correlation between lower performing PCNs and deprivation is very weak

6. % patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)

NNICB: 66.2% (2024/25) to 69.3% (2025/26)



National benchmark: Achievement below the national result of 72.3% (including PCAs)
IMD: Moderate correlation between lower performing PCNs and deprivation

7. % patients aged 80 years or over, with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (or equivalent home blood pressure reading).

NNICB: 82% (2024/25) to 84% (2025/26)



National benchmark: Achievement above the national result of 83.6% (including PCAs)
IMD: KPI correlation between lower performing PCNs and deprivation is weak

8. % patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months.

NNICB: 56.8% (2024/25) to 57.5% (2025/26)



National benchmark: Achievement below the national result of 60.6% (including PCAs)
IMD: Moderate correlation between lower performing PCNs and deprivation

9. % of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months.

NNICB: 81.8% (2024/25) to 80.3% (2025/26)



National benchmark: Achievement below the national result of 82.7% (including PCAs)
IMD: Moderate correlation between lower performing PCNs and deprivation

Current position

At ICB level, the strong general practice indicators demonstrate a generally positive direction of travel, with eight of the nine measures improving over the reporting period. Improvements have been seen across access, patient experience and several key clinical quality measures, although there is variation between PCNs.

Access activity has increased, with GP appointments per 1,000 weighted patients increasing from 6,031 to 6,562, exceeding operational plan expectations and showing improvement across most PCNs. The proportion of clinically urgent appointments seen on the same day also increased, from 74.4% to 76.8%, remaining above operational plan expectations. However, as this measure was not monitored in previous years, caution should be exercised when interpreting changes over time.

Patient experience measures have also improved, with the proportion of patients reporting a good or very good overall experience increasing from 74.2% to 74.3%, and satisfaction with contacting the practice increasing from 67.7% to 69.3%. Despite this progress, both measures remain below national benchmark levels.

Continuity of care has improved slightly, with the proportion of patients able to see or speak to their preferred GP or healthcare professional increasing from 38.4% to 38.8%, although performance remains below the national benchmark of 40%.

Clinical quality measures show mixed results. Blood pressure control improved for patients with hypertension aged both under 80 and 80 years and over, while diabetes control, measured through HbA1c, improved from 56.8% to 57.5%. However, cholesterol control among patients with diabetes deteriorated slightly, falling from 81.8% to 80.3%.

Overall, the indicators suggest improvement across most areas, particularly access, patient experience and long-term condition management. The main areas requiring focus are cholesterol control in patients with diabetes and reducing variation in outcomes between PCNs.

Nottingham and Nottinghamshire ICB	Highest performance	Lowest performance	Highest improvement	Highest deterioration
GP appointments per 1,000 weighted population	1. Larwood & Bawtry (**10,501**) 2. Newgate (**9,945**) 3. Arnold & Calverton (**9,613**)	1. Unity (Nottm) (**3,488**) 2. Byron (**4,674**) 3. Radford & Mary Potter (**4,725**)	1. Larwood & Bawtry (**+1,875**) 2. Synergy Health (**+1,822**) 3. Newgate (**+1,296**)	1. Sherwood (**-105**) 2. Rosewood (**-73**) 3. Unity (Nottm) (**-56**)
GP appointments per 1,000 crude population	1. Larwood & Bawtry (**11,358**) 2. Newgate (**11,238**) 3. Arnold & Calverton (**9,761**)	1. Unity (Nottm) (**2,567**) 2. Radford & Mary Potter (**4,050**) 3. Byron (**4,953**)	1. Larwood & Bawtry (**+2,030**) 2. Synergy Health (**+1,794**) 3. Newgate (**+1,499**)	1. Sherwood (**-117**) 2. Rosewood (**-43**)
Same-day appointments	1. Newgate (**96.0%**) 2. Retford & Villages (**91.4%**) 3. Larwood & Bawtry (**91.1%**)	1. Synergy Health (**56.5%**) 2. Mansfield North (**57.7%**) 3. Raleigh (**58.0%**)	1. Aspire (**+14.4%**) 2. Unity (Nottm) (**+10.2%**) 3. Rushcliffe (**+8.1%**)	1. City South (**-8.4%**) 2. Synergy Health (**-5.8%**) 3. Mansfield North (**-1.9%**)

Nottingham and Nottinghamshire ICB	Highest performance	Lowest performance	Highest improvement	Highest deterioration
Overall patient experience with GP practice	1. Unity (Nottm) (**86.2%**) 2. Rushcliffe (**85.3%**) 3. Ashfield South (**83.0%**)	1. Larwood & Bawtry (**50.1%**) 2. Aspire (**62.7%**) 3. Byron (**63.4%**)	1. Synergy Health (**+10.0%**) 2. Bulwell & Top Valley (**+4.4%**) 3. Clifton & Meadows (**+4.3%**)	1. Larwood & Bawtry (**-8.2%**) 2. Sherwood (**-6.4%**) 3. Ashfield North (**-5.5%**)
Patient experience of contacting GP practice	1. Unity (Nottm) (**93.0%**) 2. Rushcliffe (**80.4%**) 3. Ashfield South (**78.5%**)	1. Larwood & Bawtry (**44.7%**) 2. Byron (**54.0%**) 3. Newgate (**54.7%**)	1. Aspire (**+10.2%**) 2. Newark (**+6.9%**) 3. Clifton & Meadows (**+6.7%**)	1. Sherwood (**-4.9%**) 2. Nottingham West **(-4.3%**) 3. Ashfield North (**-3.2%**)
Able to see or speak with preferred healthcare professional	1. Unity (Nottm) (**77.5%**) 2. Ashfield South (**50.6%**) 3. Raleigh (**48.9%**)	1. Newgate (**16.4%**) 2. Byron (**20.8%**) 3. Synergy Health (**26.4%**)	1. Larwood & Bawtry (**+28.1%**) 2. Radford & Mary Potter (**+24.9%**) 3. Arnold & Calverton (**+15.4%**)	1. Sherwood (**-17.6%**) 2. Nottingham West **(-13.1%)** 3. Unity (Nottm) **(-8.6%)**
Hypertension control: patients aged 79 and under	1. Rushcliffe **(76.3%)** 2. Ashfield North **(75.5%)** 3. Raleigh **(73.7%)**	1. Radford & Mary Potter **(57.5%)** 2. Aspire **(60.1%)** 3. Byron **(64.1%)**	1. Synergy Health (+8.8%) 2. Raleigh **(+8.0%)** 3. Arnold & Calverton **(+5.3%)**	1. Newgate **(-3.6%)** 2. Clifton & Meadows **(-0.7%)**
Hypertension control: patients aged 80 and over	1. Ashfield North **(88.3%)** 2. Rushcliffe **(87.3%)** 3. Retford & Villages **(86.4%)**	1. Radford & Mary Potter **(77.8%)** 2. Arrow Health **(80.0%)** 3. Larwood & Bawtry **(80.2%)**	1. Unity (Nottm) **(+8.8%)** 2. Synergy Health **(+7.0%)** 3. Aspire **(+6.2%)**	1. Newgate **(-5.1%)** 2. Larwood & Bawtry **(-0.2%)**
Diabetes control in patients without frailty	1. Retford & Villages **(64.8%)** 2. Rushcliffe **(63.4%)** 3. Larwood & Bawtry **(61.9%)**	1. Radford & Mary Potter **(45.2%)** 2. Aspire **(46.5%)** 3. Nottingham City East **(48.1%)**	1. Mansfield North **(+4.7%)** 2. Ashfield South **(+4.1%)** 3. Rosewood **(+3.9%)**	1. Unity (Nottm) **(-5.2%)** 2. Clifton & Meadows **(-3.9%)** 3. Arrow Health **(-3.1%)**
Diabetes control in patients with frailty	1. Unity (Nottm) **(100.0%)** 2. Larwood & Bawtry **(90.0%)** 3. Retford & Villages **(88.2%)**	1. Radford & Mary Potter **(72.2%)** 2. Rosewood **(72.8%)** 3. Nottingham City East **(74.0%)**	1. Synergy Health **(+5.1%)** 2. Larwood & Bawtry **(+4.7%)** 3. Ashfield South **(+3.2%)**	1. Clifton & Meadows **(-6.0%)** 2. Bestwood & Sherwood **(-5.8%)** 3. Radford & Mary Potter **(-5.5%)**

Data quality, timeliness or completeness issues that affect confidence

GP appointment data is sourced from the nationally published GP Appointment Data Set (GPAD) which is recognised to have data quality caveats including:

- Inconsistent appointment coding
- National category mapping errors
- Appointment mode inaccuracies
- Missing or unknown fields
- Data timeliness- Data is published monthly, meaning dashboards and reports lag behind operational activity.

In addition, differences in coding within practices can influence reported performance against the same day clinically urgent appointments measure. This metric was also not monitored until April 2026, therefore comparisons with previous years should be interpreted with caution.

GP patient survey is annual and is restricted to a limited sample size. The fieldwork for the survey was compiled in January to March 2026 and so there is a five month lag between the fieldwork and publication of results.

Appendix 2: Citizen and Patient Insight Evidence Synthesis

1. Background

This paper has been produced in response to a request to provide a clear, consolidated view of General Practice insights across Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire (DLN).

This paper brings together citizen experience and insight from separate pieces of work already undertaken within each DLN area, including national evidence, local insights and engagement activities. These sources have been reviewed and synthesised to identify common themes, areas of alignment and notable differences across the cluster, with a particular focus on General Practice lived experience of accessing and navigating health services.

The synthesis is informed by the underlying citizen insight reports for each of the three ICB areas. These reports are held by the ICBs and can be made available on request. The local reports have been reviewed and synthesised rather than reproduced in full. The findings presented below therefore focus on the common themes, material local differences and implications for commissioning and assurance.

2. Key similarities across the DLN cluster

Across Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire, people commonly report good, compassionate and effective care once they reach the right member of the general practice team. However, the route into and through services is often difficult. Despite differences in population, geography and service configuration, the same core issues recur across the cluster:

- **Access is the dominant concern:** Long telephone waits, limited appointment availability, difficulty booking ahead and inconsistent face-to-face access remain the most frequent issues. Across the reports, people describe early-morning telephone queues, online systems closing when capacity is reached, uncertain callback times and difficulty obtaining both routine and urgent appointments. These barriers can lead to delayed treatment, worsening conditions, increased use of urgent care and some people giving up seeking help.
- **Care is generally viewed positively once accessed:** People value clinicians and staff who listen, show compassion, explain decisions and involve them in care. Positive examples across all three areas include prompt assessments, investigations and referrals; proactive follow-up; effective support from nurses, pharmacists and social prescribers; and staff making adjustments for anxiety,

disability or communication needs. This distinction between access and the quality of the clinical interaction is consistent across the cluster.

- **Choice and inclusion matter:** Telephone, online and face-to-face routes are all valued, but digital-first processes can disadvantage older people, disabled people, carers, people with sensory or language needs and those with limited digital confidence. The reports also identify barriers for housebound people, rural communities and those without reliable internet access. Digital tools are welcomed where they add convenience, but people want non-digital alternatives, accessible information, interpreter and British Sign Language (BSL) support, proxy access and communication preferences to be recorded and acted upon consistently.
- **Continuity supports better care:** Seeing a known clinician is particularly important for people with long-term conditions, complex needs and caring responsibilities. Continuity helps patients avoid repeatedly explaining their history, supports trust and personalised decision-making, and provides clearer ownership of follow-up. People also recognise the role of wider multidisciplinary teams but want clarity about professional roles and confidence that they can see a GP when this is clinically appropriate.
- **Communication and coordination are inconsistent:** People report chasing results, referrals, prescriptions and follow-up, repeating their story and being unclear which organisation is responsible. Evidence includes delayed, rejected or lost referrals; inconsistent records; medication authorisation problems; and poor information flow between general practice, hospitals, pharmacies and community services. People want clear next steps, timely updates, shared records and a named point of ownership when care crosses organisational boundaries.
- **Workforce and infrastructure constrain improvement:** Rising demand, staff shortages, estates pressures and variable systems affect appointment availability and service consistency. Population growth and housing development are adding pressure in some areas, while rural geography, transport and limited clinical space create additional constraints. Delivering faster access, longer or more holistic consultations, continuity and prevention will require coordinated investment in recruitment, retention, training, premises, digital systems and the wider primary care team.
- **Prevention and neighbourhood working are supported:** People value proactive reviews, pharmacy, social prescribing and joined-up community services where routes are clear and escalation back to a GP remains available. The reports support targeted case finding, earlier diagnosis, vaccination, long-term condition management and care closer to home through stronger links between general practice, community services, mental health, social care, hospitals, local authorities and VCSE organisations. People also want a “no

wrong door" approach and assurance that investment in prevention will not reduce the safety or accessibility of services already under pressure.

- **Patient Experience:** Derby and Derbyshire's contact experience ranged from 52% to 85% across PCNs; Lincolnshire recorded 1,575 GP-related Patient Experience contacts from 2023 onwards; and Nottingham City delivered 2.13 million appointments in the year to June 2026 while access experience remained below national results. Together, these findings show that activity and positive clinical interactions do not, on their own, guarantee simple or equitable access.

3. Key differences across the DLN cluster

While the core issues are shared across the cluster, local context shapes how these challenges are experienced and where pressure is felt most.

Derby and Derbyshire: The 2026 GP Patient Survey provides a clear quantitative baseline: 76% reported a good overall experience, while 68% reported a good experience of contacting their practice, five percentage points below the national result. Contact experience varied markedly across the 17 PCNs, from 52% to 85%. Recent Healthwatch evidence places additional emphasis on triage safety and transparency, medication reliability, complaints responsiveness, carer recognition and the routine use of reasonable adjustments. People described online or AI-supported triage as difficult where complex circumstances could not be explained, and parents, older people and carers reported that unspecified callbacks or online-only processes could be hard to manage. Medication feedback included omitted repeat items, delayed authorisation, difficulties arranging reviews and inconsistent arrangements between general practice, hospitals and pharmacies. Positive examples included prompt blood tests and referrals, accommodating care for anxiety, proactive follow-up and effective PCN pharmacy support, demonstrating that good practice is present but not consistently experienced across the area.

For Derby and Derbyshire, the issue is the combination of wide variation in contact experience with concerns about triage, medication reliability, complaints handling, carer recognition and reasonable adjustments. This creates a clear case for targeted PCN-level improvement and stronger assurance of the processes that support access before and after a clinical appointment.

Lincolnshire: Lincolnshire evidence places additional emphasis on rurality, transport, parking, population growth, estate capacity and accessibility for people with sensory loss. Complaints intelligence identified 1,575 GP-related records from 2023 onwards, with recurring concerns about access, communication, medication, referrals, results and support for housebound or vulnerable people. Sensory loss engagement found that telephone-first models, early-morning call queues and inaccessible online systems could make booking harder than attending an appointment. Recorded communication preferences were not always followed,

accessible letters and messages were inconsistent, and some deaf people experienced difficulty securing BSL interpreters. Evidence also identified delayed, rejected or lost referrals and uncertainty between general practice, hospitals, pharmacies and diagnostic services. Local Patient Participation Groups (PPGs) evidence provides important improvement assets: some practices report effective total triage, call-back systems, digital support, successful vaccination and prevention activity, and close patient-practice relationships. However, patient experience and digital usability remain inconsistent.

In Lincolnshire the challenge is to deliver consistent access across a large and varied geography while responding to rural transport barriers, sensory and communication needs, population growth, workforce pressures and limited premises. Strong PPG relationships, digital support and examples of effective total triage provide practical foundations for improvement, but these strengths need to be applied more consistently across practices and PCNs.

Nottingham and Nottinghamshire: Nottingham and Nottinghamshire evidence shows high activity and improving digital uptake alongside persistent access concerns. Nottingham City delivered 2.13 million appointments in the year to June 2026, including more than 953,000 on the same day, while online consultations grew by around 80%. Once care was received, experience was positive: 86% felt listened to, 92% had confidence and trust, and May 2026 Friends and Family Test responses were 93% positive. However, telephone, website and app experience remained below national results, with substantial PCN variation: ease of reaching a practice by telephone ranged from 25% to 85%, and 63% of respondents in Bulwell and Top Valley said telephone contact was fairly or very difficult. Support for long-term conditions also varied widely, from 54% to 91% across PCNs, and only 42% reported a conversation about what mattered to them in managing their condition. NHS App registration rose from 64.9% to 76.4% between October 2025 and August 2026, but active use was much lower and uneven between areas, showing that registration alone does not demonstrate benefit. The evidence therefore reveals a marked gap between aggregate activity and the consistency of people's experience across communities and PCNs.

In Nottingham and Nottinghamshire, the issue is the gap between high levels of activity and digital uptake and the continuing variation in access, continuity and personalised support. The area therefore needs to focus less on volume and registration measures and more on whether different communities can use services effectively, receive coordinated follow-up and experience consistent support across PCNs.

4. What this means for Commissioning

The evidence requires commissioning to move beyond monitoring activity and adopt a consistent, outcomes-based approach to access, quality and equity. Expectations

should be explicit in contracts and improvement plans, supported by transparent practice- and PCN-level intelligence, proportionate improvement support and clear accountability for delivery.

- **Commission a clear blended access standard** that defines minimum expectations for telephone, online and face-to-face access throughout the working day, urgent and routine appointments, advance booking, callbacks, response times and accessible information. Compliance should be assessed through patient experience, repeat contact, abandoned calls, timeliness and equality of access—not appointment volume alone.
- **Target improvement using joined-up local intelligence** by combining GP Patient Survey results, complaints, local and PPG insight, provider data and equality information at practice and PCN level. Commissioners should identify unwarranted variation, agree time-bound improvement actions with weaker performers, provide practical support and spread learning from practices with consistently strong experience.
- **Require triage to be safe, understandable and personalised**, with clinical oversight, clear escalation, safety-netting and routes for people to explain complexity. Assurance should include monitoring repeat contact, redirection to urgent care, overridden decisions, delays and differential outcomes for people with complex conditions or those less able to navigate or challenge the system.
- **Protect continuity, choice and reasonable adjustments** by specifying continuity offers for people with long-term or complex needs, carers and those requiring coordinated follow-up. Practices should record communication and access needs once and use them consistently, with interpreter and BSL provision, proxy access, longer appointments where required and reliable non-digital routes routinely audited.
- **Commission reliable end-to-end pathways** with clear ownership and service standards for communicating results, confirming referrals, reconciling medicines, providing follow-up and acknowledging and responding to complaints. Contracts and quality reviews should test whether information flows effectively between general practice, hospitals, pharmacies, community services and the ICB, and whether patients know what will happen next.
- **Align capacity and investment with neighbourhood delivery** through integrated workforce, estates, technology and community capacity plans that reflect demand, deprivation, rurality and population growth. Commissioning should enable multidisciplinary teams, pharmacy, mental health, social care and VCFSE partners to provide prevention and care closer to home, while retaining clear escalation to general practice and assuring that transformation does not weaken existing access or safety.

  Implementation should combine a common DLN framework with locally tailored priorities. Derby and Derbyshire should focus on contact experience, triage

assurance, carer recognition, medication reliability and complaints learning. Lincolnshire should address rural and sensory access, transport, premises and workforce constraints, alongside variable PCN and PPG engagement. Nottingham and Nottinghamshire should reduce unwarranted variation, strengthen personalised support for long-term conditions and test whether digital registration translates into active use and improved experience. Progress should be reported regularly through measurable PCN-level outcomes and visible “you said, we did” updates.

5. Points for consideration

The findings of this evidence synthesis may be used to develop a defined programme of action. Change could be visible at practice, PCN, place and cluster level, with named ownership, agreed timescales and measures that show whether people experience easier access, safer navigation and more reliable follow-up.

- **Develop a shared DLN outcomes framework** to track timely access, patient choice, continuity, communication, equality and experience alongside appointment activity. Measures could include contact experience, response and callback times, repeat contact, abandoned calls, referral and results follow-up, continuity for priority groups and variation between practices and PCNs.
- **Consider quarterly PCN-level insight and improvement packs**, bringing together survey results, complaints, local and PPG feedback, provider information and equality data. Each pack could help identify priority gaps, named actions, delivery leads, timescales and evidence of impact, with targeted support and escalation where improvement is not sustained.
- **Digital and AI-supported triage supporting common safety and equality assurance**, including clinical oversight, escalation routes, safety-netting and monitoring of repeat contact, urgent-care redirection and overturned decisions. Telephone, face-to-face and supported access could remain available, and digital success may be measured through active use and outcomes rather than registration alone.
- **Managing service expectations where experience breaks down**, including covering callbacks, results, referrals, repeat prescriptions, medicines reconciliation, complaints acknowledgement, carer identification and reasonable adjustments. Providers may wish to consider clear ownership, timely updates and closure of the loop with patients.
- **Consider how cluster area delivery plans may translate the common framework into local action**. In particular, Derby and Derbyshire to consider addressing contact and triage variation, carers, medicines and complaints learning; Lincolnshire to consider rural and sensory access, transport, workforce, premises and PCN engagement; and Nottingham and

Nottinghamshire to consider the unwarranted variation, continuity, personalised support and effective digital use.

- **Consider how public accountability and shared learning may be strengthened** through regular “You said, we did” reporting, meaningful involvement of patients, PPGs, VCFSE, carers and communities, and a DLN mechanism for spreading effective approaches. Reporting could provide an explanation of what has changed, where experience has been improved and what further action may be required.

6. Future priorities across the DLN cluster

The reports identify the following emerging themes which may be considered in the development of priorities for the next phase of Strong General Practice development across the cluster:

- **Reduce unwarranted variation in access and experience.** Agree a common access offer while using practice- and PCN-level intelligence to target local gaps. Improvement should be judged by how easily different groups obtain appropriate care, not simply by total appointment numbers.
- **Develop safe, inclusive and understandable access routes.** Retain telephone, face-to-face and supported routes alongside digital options; test triage for safety and equality; and make interpreter, BSL, proxy access and reasonable adjustments routine.
- **Protect continuity and personalised care.** Prioritise continuity for people with long-term or multiple conditions, carers and those needing coordinated follow-up, supported by proactive reviews and conversations about what matters to the person.
- **Improve reliability across referrals, results and medicines.** Establish clear ownership, shared information and timely communication between general practice, hospitals, pharmacies and community services so that patients do not have to coordinate their own care.
- **Build sustainable workforce and infrastructure.** Align recruitment, retention, training, estates, technology and clinical space with deprivation, rurality, population growth and future demand, while explaining the contribution of the wider primary care team.
- **Accelerate prevention and integrated neighbourhood working.** Strengthen links with community services, pharmacy, mental health, social care, local authorities and VCFSE partners to support early diagnosis, proactive care, vaccination, social prescribing and care closer to home.
- **Make learning and public accountability routine.** Use complaints, PPG and local intelligence alongside survey and operational data, publish progress and

outcomes, and involve communities in testing whether changes work for people facing the greatest barriers.

7. Conclusion

The three reports point to a consistent direction: improve timely and inclusive access now while developing a more preventative, integrated and neighbourhood-based model of general practice. People do not judge services by activity alone. They also expect straightforward routes into care, communication that closes the loop, continuity where it matters, genuine choice, and additional support where barriers are greatest. Delivery will depend on sufficient workforce and infrastructure, reliable cross-service processes and visible evidence that public insight leads to change.

8. Underlying evidence

This synthesis draws on the following local evidence reports:

- Derby and Derbyshire Strong General Practice Citizen Insight Report, October 2026.
- Lincolnshire Insights for Strong General Practice, October 2026.
- Nottingham and Nottinghamshire GP Services Insights Report, October 2026.

The underlying reports and supporting source material are held by the respective ICBs and can be made available on request.

Appendix 3: Strong General Practice – Supporting Delivery and Assurance Arrangements

Purpose

1. This appendix provides supporting detail on the commissioning, quality, digital and financial arrangements underpinning delivery of the Strong General Practice priority. It should be read alongside the strategic assessment in the main report and provides further detail on the arrangements currently in place, those being developed across the three ICBs, and the key dependencies affecting future assurance.
2. Detailed performance against the Strong General Practice strategic indicators, including PCN-level variation and the supporting analysis of deprivation, is provided at Appendix 1. The supporting citizen and patient insight evidence is provided at Appendix 2.

Current General Practice quality assurance arrangements

3. The three ICB areas have established General Practice quality assurance arrangements covering 316 practices: 109 in Derby and Derbyshire, 81 in Lincolnshire and 126 in Nottingham and Nottinghamshire. Each approach brings together performance and quality intelligence, professional review, provider engagement and escalation of identified concerns.
4. The differing arrangements reflect the governance and provider relationships historically developed within each ICB area. They continue to provide local oversight and escalation while more consistent arrangements are developed across the three ICBs.

ICB area	Core approach	Governance and escalation	Key features
Derby and Derbyshire	Primary Care Quality Team; General Practice quality visits; dashboard and deep-dive review; established escalation methodology.	Primary Care Quality Operational Group; Primary Care Commissioning Group; joint quality oversight arrangements; System Quality Group; and Joint Quality and Service Improvement Committee.	Provider review and regulatory liaison, including Care Quality Commission (CQC) intelligence and wider Pharmacy, Optometry and Dentistry oversight.

ICB area	Core approach	Governance and escalation	Key features
Lincolnshire	Quality Early Warning Score aligned to National Quality Board domains; provider self-assessment; system dashboard and thematic analysis.	Primary Care Quality Assurance Group; Primary Care Commissioning Group; joint quality oversight arrangements; System Quality Group; and Joint Quality and Service Improvement Committee.	Structured early-warning approach; alignment with patient experience; supportive visits; Link Practitioner networks.
Nottingham and Nottinghamshire	Primary Care Quality Assurance and Improvement Framework; quarterly dashboard; risk matrix and RAG methodology.	Primary Medical Services Quality Group; Primary Care Commissioning Group; joint quality oversight arrangements; System Quality Group; and Joint Quality and Service Improvement Committee.	Integrated place-based intelligence; defined support actions; and quarterly quality and delivery risk profiles.

Joint oversight and escalation

5. During transition, routine quality and performance monitoring continues through the established arrangements in each ICB, with significant or emerging concerns managed through established local and joint escalation routes.

6. The Quality Integrated Performance Report provides increasingly consistent reporting on performance, emerging quality issues and matters requiring escalation. Primary Care Quality teams maintain oversight of patient safety, clinical effectiveness and patient experience through relevant commissioning, contracting, quality and system forums.

7. Material concerns can be escalated through the ICBs' quality governance arrangements and reported to the Joint Primary Care Commissioning Group, Joint Quality and Service Improvement Committee and System Quality Group, as appropriate.

8. These arrangements maintain essential quality oversight during transition. Joint assurance is, however, currently principally exception-based and draws on the performance and quality intelligence available to identify emerging concerns. Further development is required to establish common quality domains, risk thresholds and expectations for surveillance, intervention and escalation.

Developing quality management arrangements

9. The developing approach will bring quality assurance, quality control, planning and improvement together within a more consistent Quality Management System. For General Practice, this will connect practice and neighbourhood-level intelligence with ICB-level assurance, while retaining appropriate local ownership of provider relationships, improvement support and action.

10. The approach will develop iteratively as neighbourhood health models, commissioning arrangements and the ICB operating model develop. The proposed levels of support and oversight are:

Level	Quality support and oversight
Practice / provider	Baseline quality assessment and risk rating; identification and review of quality concerns and unwarranted variation in quality outcomes; agreed improvement actions; follow-up evidence of sustained change; and triangulation of complaints, incidents, safeguarding, patient experience and regulatory intelligence.
Place / neighbourhood	Triangulation of local intelligence, professional review, improvement support and early intervention.
Primary Care Quality function	Moderation, risk assessment, thematic analysis, quality improvement support and escalation across the three ICB areas.
Formal governance	Oversight through the Joint Primary Care Commissioning Group, Joint Quality and Service Improvement Committee, System Quality Group and other relevant governance routes.
Contractual and regulatory interface	Contract management, liaison with the Care Quality Commission and formal action where required.

11. The effectiveness of the developing arrangements will be assessed through evidence that:

    a) Practices have current baseline quality assessments and reviewed risk ratings.

    b) Concerns are identified, assessed and acted upon promptly.

    c) Improvement plans have clear ownership, milestones and follow-up.

    d) Changes are sustained and result in better quality, access, experience or outcomes.

    e) Unwarranted variation and inequalities are identified and addressed.

    f) Providers participate appropriately and the process remains proportionate.

    g) Material risks are escalated through the appropriate governance route.

General Practice, Pharmacy, Optometry and Dentistry Quality Framework

12. The future development of primary care quality assurance will extend beyond General Practice to include Pharmacy, Optometry and Dentistry (POD) within the quality framework. This will support a more consistent approach to quality oversight across delegated primary care services, while recognising differences in contractual, regulatory and provider arrangements.
13. The framework will set out:
    a) Common quality domains and intelligence requirements.
    b) Governance arrangements, reporting routes and accountabilities.
    c) Thresholds and escalation arrangements for identified concerns.
    d) The relationship between commissioning, contracting, professional leadership and quality functions.
    e) Arrangements to support quality assurance and continuous improvement.
14. It will bring together quality indicators, performance, patient experience, complaints, incidents, safeguarding and regulatory intelligence to support earlier identification of risk and unwarranted variation and a more coordinated approach to improvement.
15. The framework will also connect provider-level oversight with developing neighbourhood models by supporting assessment of quality, access, outcomes and inequalities across neighbourhood populations. Development of the framework is therefore an important dependency in embedding a consistent Quality Management System across the three ICBs. In the interim, essential oversight will continue through established local and joint arrangements.

Digital enablement

16. Digital infrastructure provides an established platform for improving access, productivity and patient experience across General Practice.
17. Across the three ICB areas:
    a) 98% of relevant practices have their organisational settings configured to provide patients with prospective online access to new information added to their GP health record.
    b) 2.13 million patients aged 13 and over are registered with the NHS App, equivalent to approximately 76% of the eligible population.
    c) NHS England reported full practice compliance with cloud-based telephony by February 2026.
    d) All practices have access to online consultation tools.

18. NHS App registration is approximately 76% in Derby and Derbyshire, 72% in Lincolnshire, and 77% in Nottingham and Nottinghamshire. Monthly GP record sessions have increased by 4% in Derby and Derbyshire, 4% in Lincolnshire and 5% in Nottingham and Nottinghamshire.

19. Cloud-based telephony provides functionality including call queuing, callback, routing and real-time analytics. Telephony data is being used to identify variation and target practice-level improvement, with data-quality issues investigated where they arise.

20. Online consultation information is incorporated into primary care delivery planning and monitoring of demand, capacity and total-triage arrangements. Provider feedback indicates an average satisfaction score of 7 out of 10 across 183 responses, although multiple online consultation platforms are currently in use.

21. The next phase will focus on whether digital infrastructure is being used effectively and is contributing to demonstrable improvements in access, productivity and patient experience. Priorities include:

    a) Improving effective use of online access and consultation tools.

    b) Extending appropriate use of the NHS App and NHS Notify.

    c) Exploring automation and ambient voice technology where these can safely release clinical or administrative capacity.

    d) Improving the use of data to understand demand, capacity and variation.

    e) Using common intelligence to target support where digital capability or patient experience is weaker.

22. Digital inclusion will remain an important consideration. People who cannot or do not wish to use digital services must continue to have appropriate telephone, face-to-face or supported access routes. Assurance should therefore consider active use, accessibility and patient outcomes rather than relying solely on technology deployment or registration measures.

Financial and commissioning resources

23. The ICBs have a range of financial resources available to support General Practice, including the delegated General Practice contract allocation, Additional Roles Reimbursement Scheme allocation, locally commissioned enhanced services and out-of-hours service budgets.

24. During 2026/27, these resources are being managed within available allocations and budgets. The current position indicates that the resources available to support primary care will be substantially utilised, with limited underspending anticipated at year end.

25. Alongside core contractual expenditure, funding has supported targeted initiatives, including Acute Respiratory Infection schemes and Health Inequalities and Innovation Funding initiatives. These investments are intended to strengthen General Practice and support wider system priorities within a challenging financial environment.

26. Future commissioning will need to demonstrate clearer alignment between deployment of primary care resources, population need and the Strong General Practice priorities. This should include consideration of whether existing resources can be used differently, where this would provide greater value, improve outcomes or strengthen the sustainability of General Practice.

27. Working across the three ICBs also provides an opportunity to align commissioning expectations, reduce unnecessary duplication and identify where a common approach or collective scale could provide better value, while retaining local flexibility where population need or provider circumstances differ.

28. Primary care will need to contribute to the wider efficiency requirements facing the ICBs. This will require a structured approach to identifying opportunities, demonstrating value and protecting the safety, accessibility and sustainability of frontline services.

Meeting title	Integrated Care Boards: Open Session (meeting in common)
Meeting date	19/11/2026
Paper title	**Report on Strategic Health Priorities: Immunisations, Vaccinations and Screening Programmes**
Paper reference	ICB CIC 26 069
Paper author	Hazel Buchanan, Deputy Director of Clinical Effectiveness and Outcomes
Paper sponsor	Dave Briggs. Executive Director of Outcomes (Medical) Clair Raybould, Executive Director for Strategy and Citizen Experience
Presenter	Dave Briggs

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

Report summary

The ICBs' Five-Year Population Health Strategy was approved by the Boards in March 2026. A programme of reporting has subsequently been established to provide the Boards with collective assurance on progress against each of the strategy priorities.

This report focuses on Vaccination and Screening and provides:

- An assessment of the current position and direction of travel against the strategic key performance indicators.
- An assessment of variation and inequalities, including the populations and places requiring particular commissioning focus.
- The key findings from citizen and community insight and the implications for commissioning.
- An overview of the strategic commissioning response across the three shifts of sickness to prevention, hospital to community and analogue to digital.
- The added value of working collectively across the ICBs.
- The key risks, priorities and areas requiring ongoing Board assurance.

Recommendation(s)

The Boards are asked to **receive** the paper for assurance regarding the current position and direction of travel for the Immunisations, Vaccinations and Screening Programmes priority.

Appendices

1: Detailed Vaccination and Screening Priority Assessment
2: Vaccination and Screening Programmes
3: Summary of Derby and Derbyshire ICB, Lincolnshire ICB and Nottingham and Nottinghamshire ICB Immunisations, Vaccinations and Screening Programmes Strategic KPIs
4: Vaccination and Screening Insights across Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire, Evidence Synthesis October 2026

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

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Report on Strategic Health Priorities: Immunisations, Vaccinations and Screening Programmes

Introduction

1. Immunisations, vaccinations and screening programmes are a cross-cutting prevention priority within the ICBs' Five-Year Population Health Strategy. They support prevention of avoidable illness, earlier diagnosis, reduced demand on health services and the reduction of health inequalities. The priority spans the life course, from maternal and childhood programmes through to adult screening and winter protection.

2. The strategic ambition is to improve uptake and participation while reducing inequalities, with a minimum 10% relative reduction in the inequality gap between higher- and lower-performing populations and places by 2030/31. Improvement will be supported through proportionate targeting of lower-uptake populations and neighbourhoods while maintaining universal provision.

3. This cover paper summarises the principal findings and assurance considerations. The detailed supporting assessment is provided at Appendix 1, and the vaccination and screening programmes and eligible populations covered by this priority are summarised in Appendix 2.

Performance, variation and inequalities

Initial assessment of strategic key performance indicators

4. The current position is mixed. Some screening and adolescent vaccination measures are improving, but routine childhood vaccination and older-adult winter protection remain areas of concern. ICB-level averages also mask significant variation between Primary Care Networks (PCNs) and population groups. Key performance headlines are:

    a) Measles, Mumps, and Rubella (MMR) coverage has deteriorated slightly in Lincolnshire and Nottingham and Nottinghamshire, with significant variation at PCN level.

    b) Human papillomavirus (HPV) uptake has improved strongly in Nottingham and Nottinghamshire but declined in Derby and Derbyshire and Lincolnshire.

    c) Screening performance is mixed. Breast screening has improved in Lincolnshire and Nottingham and Nottinghamshire, while cervical screening has declined slightly in both areas.

    d) Winter protection remains a concern, with flu vaccination in people aged 65+ and COVID vaccination in people aged 75+ declining across all three

ICB areas. Flu vaccination in at-risk people aged under 65 has improved slightly but remains comparatively low.

Equity and variation summary

5. Variation between populations and places is material. The reported PCN range represents an 18.8 percentage-point gap in MMR coverage and a 36.8 percentage-point gap in cervical screening participation. Deprivation is associated with lower uptake across a number of programmes.

6. Quantitative analysis, supported by ICB insight, identifies wider barriers relating to rurality, ethnicity, language and culture, disability, digital exclusion, transport and personal circumstances. The commissioning response will therefore use CORE20PLUS5 and proportionate universalism to identify populations and places requiring enhanced support alongside the universal offer.

7. The detailed performance position, including variation by programme and between ICBs and PCNs, is set out in Appendix 3.

Citizen insight

8. Citizen and community insight demonstrates a consistent picture across the ICBs. Trust and personalised conversations matter; access extends beyond appointment availability; information needs to be clear and culturally accessible; and practical barriers including transport, work and caring responsibilities, digital exclusion, language and disability can influence participation. Flexible community provision and targeted support can improve access for populations experiencing greater barriers.

9. The insight supports the strategic commissioning direction of a strong universal offer combined with proportionate targeted support, trusted community partnerships, accessible communication, reasonable adjustments and effective non-digital alternatives. Continued evaluation will be required to demonstrate the extent to which individual interventions translate into improved uptake and reduced inequality gaps.

10. The supporting evidence synthesis, including common and locally distinctive findings across the three ICB areas, is provided in Appendix 4.

Strategic commissioning response

11. Strategic commissioning action is being developed through the three Population Health Strategy shifts: sickness to prevention, hospital to community and analogue to digital. This includes greater use of population segmentation and targeted outreach; community, pharmacy, school and home-based approaches; and digital reminders and follow-up, while maintaining appropriate

non-digital routes and reasonable adjustments.

12. Delivery is undertaken through integrated working between ICBs and local authority Public Health partners. Detailed actions, milestones and delivery risks are managed through established programme governance, with Board reporting focused on strategic progress, outcomes, inequalities and material issues requiring escalation.

13. Further detail on the strategic ambition, commissioning response and developing measurement framework is set out in Appendix 1.

Added value of the ICBs' clustering arrangements

14. Working at scale enables common population health intelligence, shared measures and commissioning expectations, comparison of variation across and within the three ICB areas, and systematic identification and spread of effective approaches while retaining locally responsive delivery.

15. The cross-wide synthesis of citizen insight is an early example of this added value, enabling common barriers and commissioning implications to be identified alongside locally distinctive issues requiring neighbourhood-level responses.

Risk summary

16. Principal risks are continued declines in uptake and preventable disease; widening inequalities masked by system averages; access barriers including digital exclusion; variable data quality and timeliness; fragmented accountability across nationally commissioned and locally delivered services; and preparedness for the planned transfer of commissioning responsibilities from April 2027.

17. These risks will continue to be managed through established ICB and local authority programme governance arrangements, with material issues escalated through Board reporting where required. Current priorities include close monitoring of programme performance, targeted action for populations experiencing lower uptake and continued development of commissioning and provider arrangements.

Appendix 1: Detailed Vaccination and Screening Priority Assessment

Introduction and context

1. This report reviews progress in delivering immunisation and screening as a cross-cutting priority of the Five-Year Population Health Strategy. It considers population outcomes, variation and inequalities, the commissioning actions under way, citizen and partner insight, and the added value of working across Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire.
2. The baseline shows mixed progress: some screening and adolescent vaccination measures are improving, but routine childhood and winter protection coverage remain areas of concern. The commissioning response prioritises lower-uptake communities while maintaining universal provision.
3. Vaccination and screening are a cross-cutting prevention priority within the Five-Year Population Health Strategy. Vaccination reduces the risk of preventable infection and serious complications; screening enables earlier identification of disease and risk, supporting timely intervention. Both contribute to better population outcomes, fewer avoidable demands on health services and narrower health inequalities.
4. The priority encompasses multiple cohorts across the life course: pregnant women and newborn babies; infants, preschool children and adolescents; adults eligible for cancer and other screening; older adults; and people with clinical risk factors or specific programme eligibility. The programme-level eligible cohorts are described in Appendix 2. A consolidated count of eligible residents by programme and protected characteristic is not provided in the source paper and should be developed as part of the population health intelligence work.
5. The strategic ambition over the five years of the Population Health Strategy is to increase appropriate uptake and participation in vaccination and screening programmes, reduce inequalities between communities, prevent avoidable illness and support earlier diagnosis. A key measure of success will be a minimum 10% reduction in the inequality gap between the highest and lowest-performing practices and priority population groups by the end of the five-year strategy period. This will be achieved through targeted, proportionate improvements in uptake among lower-performing populations and places, while maintaining performance in areas already achieving higher levels of uptake. Progress will be monitored annually, with commissioning interventions and resources prioritised towards populations experiencing the greatest inequalities. This represents a locally determined ambition to narrow inequalities, alongside continued progress towards national programme targets.

6. Progress is considered through four connected lenses: strategic commissioning (how resources and delivery models are influenced); quality and safety (effective, accessible, equitable delivery); digital enablement (better invitations, segmentation and follow-up without excluding people); and population outcomes (coverage, inequalities and downstream effects). From April 2027, planned transfer of local commissioning and performance management responsibilities from NHS England to ICBs will increase local accountability; national programme policy, eligibility and many primary care contractual arrangements remain nationally determined.

Headline strategic key performance indicators

7. Due to the nature of the programmes across vaccination and screening, local and national trends show variable trends in outcomes. Positive movement in HPV uptake and some cancer screening programmes demonstrates scope for improvement but falls in childhood MMR coverage and older-adult winter vaccination uptake are inconsistent with the intended direction. System averages also conceal pronounced PCN-level gaps. The baseline should therefore guide proportionate commissioning action, not simply be read as a relative ranking against national averages.

Indicator	Derby and Derbyshire	Lincolnshire	Nottingham and Nottinghamshire	Interpretation / response
MMR at age 2	93.72% ↑ 1.19pp	90.69% ↓ 0.37pp	88.96% ↓ 0.21pp	Mixed; target low-uptake practices and review recall
HPV Year 8	73.55% ↓ 1.87pp	66.8% ↓ 1.80pp	72.19% ↑ 6.05pp	Spread approaches associated with improvement
Bowel screening	75.58% ↑ 0.15pp	75.97% ↑ 0.49pp	74.89% ↓ 0.18pp	Small changes; address deprived-area gaps
Breast screening	76.65% ↓ 0.60pp	75.71% ↑ 3.59pp	78.03% ↑ 6.92pp	Explore and spread effective invitation/access models
Cervical screening	74.11% ↑ 0.10pp	72.35% ↓ 0.30pp	71.51% ↓ 0.58pp	Target persistent lower participation
Flu aged 65+	78.68% ↓ 2.59pp	77.50% ↓ 0.82pp	76.38% ↓ 0.64pp	Declining in all areas; prioritise winter protection
Flu at risk under 65	44.61% ↑ 0.42pp	44.48% ↑ 0.26pp	40.57% ↑ 0.74pp	Improving slightly; absolute uptake remains low
COVID aged 75+	67.56% ↓ 5.03pp	68.05% ↓ 5.63pp	63.14% ↓ 4.05pp	Declining in all areas; targeted outreach needed

8. Arrows compare the periods reported in the source headline table; pp = percentage points.

Ambition

9. The strategic ambition over the five years of the Population Health Strategy is to increase appropriate uptake and participation in vaccination and screening programmes, reduce inequalities between communities, prevent avoidable illness and support earlier diagnosis. A key measure of success will be to achieve a minimum 10% relative reduction in the inequality gap between higher- and lower-performing populations and places by 2030/31, while maintaining or improving overall uptake.

10. Recognising the different starting positions, levels of uptake and barriers to participation across vaccination and screening programmes, a phased approach to improvement will be adopted. This will aim to achieve a cumulative reduction in the baseline inequality gap of 1% in 2026/27, 3% by 2027/28, 5% by 2028/29, 7.5% by 2029/30 and at least 10% by 2030/31.

11. These milestones will provide a common strategic ambition across DLN, with programme-specific improvement trajectories developed using baseline performance, population health intelligence and neighbourhood-level insight. This will enable proportionate commissioning interventions to be targeted towards populations and places experiencing the greatest inequalities, recognising that the scale and pace of achievable improvement will vary between programmes. Progress will be reviewed annually, with commissioning approaches adjusted in response to performance and emerging evidence.

Developing the measurement framework

Time horizon	Illustrative measures	Purpose
Leading indicators	Invitations delivered; response to reminders; outreach contacts; reasonable adjustments; uptake by deprivation and other available characteristics	Test whether commissioned changes are reaching intended populations
Quarterly outputs	Measures at practice and PCN level. Will be brought into dashboards. Programme coverage/uptake; PCN and neighbourhood variation; gap between lowest and highest uptake; follow-up completion	Assess pace of delivery and direct corrective action. To review through neighbourhood, primary care and imms/vaccs and screening programme boards.
Longer-term outcomes	Vaccine-preventable disease and complications; avoidable	Evaluate contribution to population health ambitions.

Time horizon	Illustrative measures	Purpose
	admissions; earlier diagnosis; reduction in inequality gaps	Population Health Cabinet and Steering Group

Equity and variation summary

12. The CORE20PLUS5 approach provides the framework for identifying the most disadvantaged 20% of the population and relevant PLUS groups, with attention to locally applicable clinical priorities. PLUS groups include people experiencing homelessness, who have been identified as a priority cohort for the 2026/27 winter vaccination programme. Analysis demonstrates a strong or moderate relationship between deprivation and lower uptake across several programmes. Deprivation data is complemented by population health intelligence and local insight at neighbourhood and Primary Care Network (PCN) level, enabling a more comprehensive understanding of population needs, barriers to access and opportunities for targeted interventions to reduce inequalities.

13. The observed PCN spread is material: MMR coverage ranges from 77.9% (Aspire, Nottingham and Nottinghamshire) to 96.7% (reported in Derby and Derbyshire and Lincolnshire), a gap of 18.8 percentage points. Among the PCNs listed, cervical screening ranges from 42.8% (Unity, Nottingham) to 79.6% (Glossop), a gap of 36.8 percentage points. These are descriptive cross-PCN comparisons rather than adjusted inequality estimates and should be interpreted alongside cohort size and data quality.

14. Places meriting enhanced review include Derby City North, Spalding and Boston, Lincoln Health Partnership, and a number of Nottingham City PCNs including Radford and Mary Potter, Aspire and Unity. These are examples from the source tables, not a final resource allocation decision. Prioritisation should consider deprivation, absolute numbers unprotected, trajectory, clinical risk and feasibility of effective intervention.

15. The insight themes supplied in the feedback identify barriers for ethnic minority communities, refugees and asylum seekers, rural residents, housebound people, carers, people with learning or sensory disabilities and people experiencing digital exclusion. The quantitative analysis is supported by insight gathered across the ICBs (Appendix 4) and further evidence from Derby and Derbyshire. This reinforces that inequalities in uptake are impacted by barriers in access and experience including locally available services, trust, language and culture, disability, digital exclusion, transport and wider personal circumstances. These findings support the use of CORE20PLUS5 and proportionate universalism to identify populations and places requiring enhanced commissioning focus. Where robust quantitative data is not yet available for specific population groups, this should continue to be treated as an intelligence gap and developed through the DLN population health approach.

16. Positive variation should also inform improvement: Four Counties and North Hardwick and Bolsover report strong MMR coverage; Nottingham and Nottinghamshire shows substantial improvement in breast screening; and Lincolnshire reports improved breast screening uptake. DLN should examine the delivery mechanisms behind these results before proposing replication.

Strategic commissioning action

17. Although national policy and existing commissioning arrangements limit some direct ICB contractual levers during 2026/27, DLN can influence outcomes through targeted resource deployment, partnership leadership, population health intelligence, quality expectations, neighbourhood delivery and preparation for the 2027 commissioning transfer. The test of strategic commissioning is whether these levers measurably improve access and uptake, particularly in populations experiencing the greatest inequalities.

Strategic shift	Established / described in source	2026/27 commissioning development and intended lever
Sickness to prevention	National routine and seasonal offers; additional access and inequalities funding targeted to vulnerable groups	Use PCN-level segmentation, proactive call/recall and targeted outreach; monitor improvement in lower-performing cohorts; resource allocation and provider accountability
Hospital to community	GP, pharmacy, school-age immunisation, community, maternity, mobile screening and outreach provision	Strengthen neighbourhood coordination, community and home-based access and school/college catch-up; shape local delivery models and quality expectations
Analogue to digital	Existing programme invitations and local intelligence; digital exclusion identified as a barrier	Improve digital consent, SMS reminders and automated follow-up where appropriate; retain non-digital routes, language support and reasonable adjustments; digital enablement and evaluation

18. In all cases, driving forward the strategic approach and uptake on immunisations, vaccinations and screening involves integrated working with Public Health colleagues across all Local Authorities to support local action and

impact. Governance and assurance is linked to the statutory responsibilities for Public Health, with reporting into the Health Protection Board and action driven through the ICB Programme Board and sub-groups in each ICB area.

Insight and confidence

What we have heard

19. The DLN insight work (Appendix 4), supported by additional Derby and Derbyshire evidence, demonstrates a consistent picture across the ICBs. Six themes recur: trust and personalised conversation matter; access means more than appointment availability; information needs to be clear, consistent and culturally accessible; misinformation, safety concerns and previous experiences affect confidence; flexible community delivery can improve engagement; and universal services need proportionate targeted support for people facing greater barriers.

What this means for provision

20. Trust and established community relationships should be treated as delivery assets. Service expectations should address accessibility and reasonable adjustments as well as capacity; targeted outreach should complement universal offers; communication and follow-up should be more responsive; and population data should show whether underserved communities are benefiting.

21. The insight supports a commissioning approach based on proportionate universalism, combining a strong universal offer with enhanced support for populations and neighbourhoods experiencing the greatest inequalities. This includes targeted outreach, flexible and community-based access, appropriate reasonable adjustments, trusted community partnerships, accessible communication and digital approaches that retain effective non-digital alternatives.

What has changed or is proposed to change

22. Commissioning of screening programmes and immunisations and vaccinations is nationally driven and the ICB focus on a targeted approach, working closely with Local Authorities. Action is dependent on the type of programme i.e. school aged vs adult vaccinations and diabetic eye screening vs bowel screening. Examples include targeted outreach, education programmes, communications campaigns. Working with the Local Authorities links in with Derby and Derbyshire's Trusted Leaders, Trusted Voices and Trusted Spaces approach. These represent a combination of implemented approaches and emerging learning for wider consideration.

Overall confidence

23. Overall, the available citizen, community and partner insight provides a sound basis for the strategic commissioning direction described in this report. There is good consistency in the themes emerging across the ICBs and the additional Derby and Derbyshire evidence. Continued evaluation will be required to demonstrate the extent to which individual interventions translate into improved uptake and reduced inequality gaps.

Added Value of working in an ICB cluster arrangement

24. A cluster approach enables consistent interpretation of population health intelligence, shared measures and expectations, and systematic comparison of variation between and within ICB areas. It provides an opportunity to identify effective models, spread them appropriately, reduce duplicated analysis and establish common quality and digital principles while allowing local delivery to reflect geography and population need.

25. The cluster-wide synthesis of insight described in the feedback is an early example of this added value: common barriers can inform shared commissioning expectations, while locally distinctive issues can guide neighbourhood responses. Further benefit should be evidenced through a common KPI specification, a shared improvement and evaluation process, and clear decisions on where joint provider engagement or market shaping offers advantage.

Board action and risk summary

26. Principal risks are continued declines in uptake and preventable disease; widening inequalities masked by ICB averages; access barriers including digital exclusion; variable data quality and delayed intelligence; fragmented accountability across nationally commissioned and locally delivered services; and insufficient preparation for the April 2027 commissioning transfer. Risks should be managed through targeted action, routine review of variation, inclusive service design, evaluation of interventions and explicit ownership across commissioners and providers.

27. The immediate priorities are to continue to monitor all programmes closely, working with the Office of Pan ICB Commissioning (OPIC), along with the ongoing development of plans with providers as well as commissioning additional activities to support a targeted approach. Detailed actions, milestones and delivery risks will continue to be managed through established ICB and local authority programme governance arrangements, with material risks or issues escalated through Board reporting where required.

Appendix 2: Vaccination and Screening Programmes

National NHS Screening and Immunisation Programmes – England

1. National screening programmes

National screening programmes aim to identify diseases, conditions or risk factors in people who may not yet have symptoms, enabling earlier intervention and treatment.

Screening programme	Description and purpose	Eligible population
Abdominal Aortic Aneurysm (AAA)	Ultrasound screening to identify enlargement of the abdominal aorta, reducing the risk of rupture and premature death.	Men in the year they turn 65.
Bowel Cancer	Faecal Immunochemical Test (FIT) to detect small amounts of blood in stools, which may indicate bowel cancer or precancerous changes.	Adults aged 50–74, every two years.
Breast Cancer	Mammography to detect breast cancer at an early stage, before symptoms develop.	Women aged 50–71 invited every three years, with invitations generally ending before their 71st birthday.
Cervical Cancer	Cervical screening using high-risk HPV testing to identify those at risk of developing cervical cancer.	Women and people with a cervix aged 25–64, generally every five years following a negative HPV test.
Diabetic Eye Screening	Retinal photography to identify diabetic retinopathy and prevent avoidable sight loss.	People aged 12 and over with diabetes, excluding gestational diabetes; frequency based on risk.
Antenatal and Newborn Screening	A group of programmes identifying maternal infections, fetal conditions and health conditions in newborn babies.	Pregnant women and newborn babies, depending on the programme.

The antenatal and newborn programmes comprise several distinct national screening programmes, which are set out below.

Antenatal and newborn screening programmes

Screening programme	Description and purpose	Eligible population
Fetal Anomaly Screening (FASP)	Screening for Down's, Edwards' and Patau's syndromes and an ultrasound scan to identify specified physical conditions affecting the fetus.	Pregnant women, usually at 10–14 and 18–20+6 weeks.
Infectious Diseases in Pregnancy (IDPS)	Blood tests for HIV, hepatitis B and syphilis to enable treatment and reduce transmission to the baby.	All pregnant women, ideally early in pregnancy.

Screening programme	Description and purpose	Eligible population
Sickle Cell and Thalassaemia (SCT)	Identifies carriers and affected pregnancies to inform reproductive choices and enable appropriate care.	Pregnant women, with partner testing where indicated; newborn sickle cell screening is included in blood spot screening.
Newborn Blood Spot (NBS)	Heel-prick blood sample to detect rare but serious inherited, metabolic and endocrine conditions, enabling early treatment.	Newborn babies, normally around day five.
Newborn Hearing Screening (NHSP)	Identifies possible hearing loss early to support timely audiological assessment and intervention.	All newborn babies.
Newborn and Infant Physical Examination (NIPE)	Examination of eyes, heart, hips and testes to identify congenital abnormalities requiring investigation.	Newborns within 72 hours and again at 6–8 weeks.

Lung Cancer Screening is being implemented nationally but has not been incorporated into the national screening policy and is commissioned locally.

Programme	Description and purpose	Eligible population
Lung Cancer Screening	Uses lung health assessment and low-dose CT scanning to identify lung cancer earlier in people at increased risk.	People aged 55–74 with a history of smoking, subject to risk assessment and phased rollout towards 2030.

2. Routine childhood and adolescent immunisation programmes

These programmes prevent infectious diseases, reduce serious complications and, for some infections, contribute to herd immunity.

Immunisation programme	Description and purpose	Routine eligibility / timing
6-in-1 (DTaP/IPV/Hib/HepB)	Protects against diphtheria, tetanus, whooping cough, polio, Haemophilus influenzae type b and hepatitis B.	At 8, 12 and 16 weeks; additional 18-month dose for eligible birth cohorts.
Rotavirus	Oral vaccine preventing severe rotavirus gastroenteritis, diarrhoea, dehydration and hospitalisation.	At 8 and 12 weeks.
Meningococcal B (MenB)	Protects against meningococcal group B infection, which can cause meningitis and septicaemia.	At 8 and 12 weeks, with a booster at 12 months.
Pneumococcal (PCV)	Protects against pneumococcal infections including pneumonia, meningitis and sepsis.	At 16 weeks and 12 months.

Immunisation programme	Description and purpose	Routine eligibility / timing
MMRV (Measles, Mumps, Rubella and Varicella)	Protects against four viral infections, including chickenpox, reducing serious complications and transmission.	At 12 months, with the second dose at 18 months or preschool age depending on birth cohort.
Preschool booster (dTaP/IPV)	Reinforces protection against diphtheria, tetanus, pertussis and polio before starting school.	Around 3 years and 4 months.
Human Papillomavirus (HPV)	Prevents HPV-related cancers, including cervical, anal and some head and neck cancers, and genital warts.	All children aged 12–13, normally school year 8.
Meningococcal ACWY (MenACWY)	Protects against meningococcal groups A, C, W and Y, reducing the risk of meningitis and septicaemia.	Around age 14, school year 9.
Teenage Td/IPV booster	Boosts protection against tetanus, diphtheria and polio.	Around age 14, school year 9.
Childhood influenza	Annual vaccination to prevent influenza infection, complications and transmission within schools, families and communities.	Eligible children each autumn/winter, according to the annual programme.

The schedule reflects changes introduced during 2026, particularly the introduction of MMRV and changes to the 18-month immunisation appointment. Catch-up arrangements vary according to birth cohort and vaccination history.

3. Adult and older people's immunisation programmes

Immunisation programme	Description and purpose	Eligible population
Seasonal Influenza	Annual vaccination to reduce influenza infections, hospital admissions, complications and deaths.	Adults aged 65+, pregnant women, people with specified clinical risk factors and other eligible groups.
COVID-19	Seasonal vaccination to reduce severe illness, hospitalisation and death, particularly among vulnerable populations.	Eligible older adults, immunosuppressed people and other groups as defined for each campaign.
Pneumococcal (PPV/PCV)	Protects against serious pneumococcal disease, including pneumonia, bloodstream infection and meningitis.	Adults aged 65+ and younger people with specified risk conditions.
Shingles (Herpes Zoster)	Reduces shingles and complications such as post-herpetic neuralgia, which can cause prolonged severe pain.	Eligible older adults, including people turning 65, people aged 70–79, and severely immunosuppressed adults aged 18+.

Immunisation programme	Description and purpose	Eligible population
Respiratory Syncytial Virus (RSV)	Prevents serious RSV-related respiratory disease, including pneumonia and hospitalisation.	Adults aged 75+, older adult care-home residents and certain at-risk adults aged 65–74.
HPV catch-up and targeted vaccination	Prevents HPV-related cancers and other HPV-associated disease among those not vaccinated routinely or at increased risk.	Eligible unvaccinated younger adults and specified higher-risk groups.

These programmes are particularly relevant to secondary prevention and reducing avoidable hospital admissions among people with frailty, multimorbidity and long-term conditions.

4. Maternal, targeted and selective vaccination programmes

Programme	Description and purpose	Eligible population
Maternal Pertussis	Vaccination during pregnancy provides passive protection to newborn babies against whooping cough until they can receive their own vaccinations.	Pregnant women, ideally from 20 weeks, following the recommended schedule.
Maternal RSV	Protects newborn babies against severe RSV infection, bronchiolitis and hospitalisation during early infancy.	Pregnant women from 28 weeks, in every pregnancy.
Maternal Influenza	Protects pregnant women against influenza complications and provides some protection for babies.	Pregnant women during the influenza vaccination season.
Hepatitis B – selective programme	Prevents hepatitis B infection, particularly transmission from mother to baby and infection in other higher-risk groups.	Babies born to mothers with hepatitis B and other eligible at-risk individuals.
BCG (Tuberculosis)	Protects infants at increased risk of tuberculosis, particularly severe childhood TB such as TB meningitis.	Eligible babies based on local TB incidence or family background and other risk criteria.
Mpox	Reduces the risk of mpox infection and severe disease in populations at increased exposure risk.	Specified higher-risk groups and eligible contacts.
MenB for gonorrhoea prevention	Targeted use of MenB vaccination to provide partial protection against gonorrhoea in eligible higher-risk populations.	Eligible individuals assessed through sexual health services.

Eligibility for seasonal and targeted programmes can change through JCVI recommendations and national policy decisions. These tables describe the main programmes rather than every clinical indication or catch-up schedule.

Appendix 3: Summary of Derby and Derbyshire ICB, Lincolnshire ICB and Nottingham and Nottinghamshire ICB Immunisations, Vaccinations and Screening Programmes Strategic KPIs

Summary of Derby and Derbyshire ICB Vaccination and Screening Priorities

Derby and Derbyshire ICB Vaccination Overview

- Five of the six measures have deteriorated over the reporting period with one indicator improving, although there is significant variation among PCNs
- Uptake has improved for flu vaccinations for those aged under 65 and at risk, however uptake for all other vaccinations has fallen
- There is a strong or moderate correlation between PCNs with lower uptake and deprivation

1. MMR vaccination coverage

DDICB: 94% (2024-25) to 93% (2025-26)



Overall: slight deterioration at system level & across 14 PCNs.
National Benchmark: Uptake exceeds the national uptake of 87.9%.
IMD: There is a moderate correlation between uptake at lower performing PCNs and deprivation.

2. HPV vaccination uptake

DDICB: 75.4% (2024-25) to 73.6% (2025-26)



Overall: deterioration at system level. PCN and GP practice level is not available.

National Benchmark: No national level data is available.

3. 'Winter protection' vaccination uptake - Flu (aged 65+)

DDICB: 79.3% (2024-25) to 78.7% (2025-26)



Overall: deterioration at system level & across 15 PCNs.
National benchmark: This measure exceeds the national result of 74.5%.
IMD: There is a strong correlation between lower performing PCNs and deprivation.

4. 'Winter protection' vaccination uptake - Flu (age <65, at risk)

DDICB: 44.2% (2024-25) to 44.6% (2025-26)



Overall: improvement at system level & across 11 PCNs.
National benchmark: This measure exceeds the national result of 40.6%.
IMD: There is a strong correlation between lower performing PCNs and deprivation.

5. 'Winter protection' vaccination uptake - COVID

DDICB: 72.6% (2024-5) to 67.6% (2025-6)



Overall: deterioration at system level with deterioration across all PCNs.

National Benchmark: No national level data is available.
IMD: There is a strong correlation between lower performing PCNs and deprivation.

6. 'Winter protection' vaccination uptake - RSV

DDICB: 47.1% (2024-25) to 37.8% (2025-26)



Overall: Deterioration at system level and all PCNs.

National Benchmark: No national level data is available.

IMD: There is a moderate correlation between uptake at lower performing PCNs and deprivation.

Summary of Derby and Derbyshire ICB Vaccination and Screening Priorities

Derby and Derbyshire ICB Screening Overview

- Four of the seven screening measures improving over the reporting periods and three indicators moving in an adverse direction, although there is significant variation among PCNs
- Screening uptake has improved for bowel and cervical screening but deteriorated for breast cancer.
- The proportion of early cancer diagnosis diagnosed at stages 1 or 2 has improved; however the 28 day faster diagnosis and 62 day treatment standards have deteriorated.

1. Bowel Cancer Screening Uptake

DDICB: 75.4% (Feb '25) to 75.6% (Feb '26)



Overall: Improvement at system level & across 13 PCNs.
National Benchmark: This measure exceeds the national uptake of 73%.
IMD: There is a very strong correlation between lower performing PCNs and deprivation.

2. Breast Cancer Screening Uptake

DDICB: 77.2% (Mar '25) to 76.6% (Mar '26)



Overall: deterioration at system level with mixed variation across PCNs.
National Benchmark: This measure exceeds the national uptake of 74.1%.
IMD: There is a strong correlation between lower performing PCNs and deprivation.

3. Cervical Cancer Screening Uptake

DDICB: 74% (2024-25) to 74.1% (2025-26)



Overall: slight improvement at system level with mixed variation across PCNs.
National Benchmark: This measure exceeds the national result of 69.3%.
IMD: Moderate correlation between lower performing PCNs and deprivation.

4. Proportion of staged cancers diagnosed at stage 1 or 2, by date of diagnosis, in rolling 12 months

DDICB: 52.2% (May'25) to 53.4% (May '26)



Overall: Improvement at system level.
Data is not available at PCN or national level.

5. % of urgent cancer referrals meeting 28-day Faster Diagnosis Standard (FDS)

DDICB: 82.5% (Jul '25) to 79.2% (Jul '26)



Overall: Deterioration at system level.
Data is not available at PCN or national level.

6. % of urgent cancer referrals meeting 31-day Treatment Standard

DDICB: 89.2% (Jul '25) to 92.3% (Jul '26)



Overall: Improvement at system level.
Data is not available at PCN or national level.

7. % of urgent cancer referrals meeting 62-day Treatment Standard

DDICB: 70.6% (Jul '25) to 65.3% (Jul '26)



Overall: Deterioration at system level.
Data is not available at PCN or national level.

Derby and Derbyshire ICB	Highest performance	Lowest performance	Highest improvement	Highest deterioration
% of children at aged 2 who have received at least one dose of MMR/MMRV	North Hardwick and Bolsover 96.7% Erewash 96.0% Chesterfield And Dronfield 95.7%	Derby City North 82.1% Glossop 85.7% PCCO 85.9%	North Hardwick And Bolsover +5.0% Erewash +0.2% Greater Derby +0.0%	PCCO -3.5% North Derbyshire -3.4% Derby City South -2.2%
Flu Vaccination People aged 65+	Belper 83.3% Derbyshire Dales 82.7% Chesterfield And Dronfield 82.4%	Derby City North 66.1% PCCO 70.5% North Derbyshire 75.2%	PCCO +0.5% North Hardwick And Bolsover +0.2% Swadlincote +0.1%	Glossop -1.8% Oakdale Park -1.5% North Derbyshire -1.5%
Flu Vaccination people at Risk aged Under 65	Derbyshire Dales 53.7% Belper 53.3% Chesterfield And Dronfield 49.3%	Derby City North 33.2% PCCO 38.8% North Hardwick And Bolsover 40.9%	PCCO +2.7% North Hardwick And Bolsover +2.0% Chesterfield And Dronfield +1.9%	Glossop -3.3% North Derbyshire -1.6% Unaligned -1.5%
Covid Vaccination age 75+ Autumn uptake	Chesterfield And Dronfield 75.0% Belper 74.3% Derbyshire Dales 74.2%	Derby City North 55.7% PCCO 57.7% Erewash 61.0%	No improvement recorded	North Derbyshire -7.4% North East Derbyshire -7.1% Erewash -7.0%
RSV Vaccination uptake age 75+	North Derbyshire 51.0% Glossop 50.1% Belper 48.3%	Derby City North 26.3% Swadlincote 27.4% Derby City South 28.1%	No improvement recorded	PCCO -19.6% Oakdale Park -16.3% Derbyshire Dales -16.1%
Bowel cancer screening (Age 60 - 74)	Derbyshire Dales 80.2% Belper 79.9% Unaligned 78.0%	Derby City North 62.7% North Derbyshire 69.4% PCCO 69.7%	PCCO +1.7% Swadlincote +0.8% High Peak And Buxton +0.5%	North Derbyshire -0.6% Alfreton Ripley Crich And Heanor -0.5% Oakdale Park -0.5%
Breast cancer screening	North East Derbyshire 82.0% Derbyshire Dales 81.0% Belper 80.9%	Derby City North 66.5% Erewash 68.9% PCCO 71.5%	PCCO +2.9% Derby City North +2.8% High Peak And Buxton +1.8%	Erewash -9.8% Oakdale Park -4.6% Glossop -1.0%
Cervical cancer screening	Glossop 79.6% Belper 78.9% North East Derbyshire 78.9%	Derby City North 59.6% PCCO 67.1% North Derbyshire 70.7%	PCCO +5.6% Unaligned +1.6% Oakdale Park +0.9%	North East Derbyshire -0.8% Derby City South -0.8% North Derbyshire -0.7%

Summary of Lincolnshire ICB Vaccination and Screening Priorities

Lincolnshire ICB Vaccination Overview

- Five of the six measures have deteriorated over the reporting period with one indicator improving, although there is significant variation among PCNs
- Uptake has improved for flu vaccinations for those aged under 65 and at risk, however uptake for all other vaccinations has fallen
- There is a strong or moderate correlation between PCNs with lower uptake and deprivation

1. MMR vaccination coverage

LICB: 91.1% (2024-25) to 90.7% (2025-26)

Overall: slight deterioration at system level & across 8 PCNs.
National Benchmark: Uptake exceeds the national uptake of 87.9%.
IMD: There is a moderate correlation between uptake at lower performing PCNs and deprivation.

2. HPV vaccination uptake

LICB: 75.4% (2024-25) to 73.6% (2025-26)

Overall: Deterioration at system level.

Data is not available at PCN or national level.

3. 'Winter protection' vaccination uptake - Flu (aged 65+)

LICB: 78.3% (2024-25) to 77.5% (2025-26)

Overall: deterioration at system level & across 12 PCNs.
National benchmark: This measure exceeds the national result of 74.5%.
IMD: There is a strong correlation between lower performing PCNs and deprivation.

4. 'Winter protection' vaccination uptake - Flu (age <65, at risk)

LICB: 44.2% (2024-25) to 44.5% (2025-26)

Overall: improvement at system level & with mixed variation across PCNs.
National benchmark: This measure exceeds the national result of 40.6%.
IMD: There is a strong correlation between lower performing PCNs and deprivation.

5. 'Winter protection' vaccination uptake - COVID

LICB: 73.7% (2024-5) to 68.1% (2025-6)

Overall: deterioration at system level with deterioration across all but one PCNs.

National Benchmark: No national level data is available.
IMD: There is a strong correlation between lower performing PCNs and deprivation.

6. 'Winter protection' vaccination uptake - RSV

LICB: 49.8% (2024-25) to 40.8% (2025-26)

Overall: deterioration at system level and across all PCNs.

National Benchmark: No national level data is available.
IMD: There is a moderate correlation between uptake at lower performing PCNs and deprivation.

Summary of Lincolnshire ICB Vaccination and Screening Priorities

Lincolnshire ICB Screening Overview

- Two of the seven screening measures have improved over the reporting periods and five indicators moving in an adverse direction, although there is significant variation among PCNs
- Screening uptake has improved for bowel and breast screening but deteriorated for cervical cancer.
- The proportion of early cancer diagnosis diagnosed at stages 1 or 2 has deteriorated; along with all three national standards when compared to the same period last year.

1. Bowel Cancer Screening Uptake

LICB: 75.5% (Feb '25) to 76% (Feb '26)



Overall: Improvement at system level & across 11 PCNs.
National Benchmark: This measure exceeds the national uptake of 73%.
IMD: There is a very strong correlation between lower performing PCNs and deprivation.

2. Breast Cancer Screening Uptake

LICB: 72.1% (Mar '25) to 75.7% (Mar '26)



Overall: improvement at system level and across all but one PCN,
National Benchmark: This measure exceeds the national uptake of 74.1%.
IMD: There is a strong correlation between lower performing PCNs and deprivation.

3. Cervical Cancer Screening Uptake

LICB: 72.7% (2024-25) to 72.4% (2025-26)



Overall: slight deterioration at system level & across 9 PCNs.
National Benchmark: This measure exceeds the national result of 69.3%.
IMD: Moderate correlation between lower performing PCNs and deprivation.

4. Proportion of staged cancers diagnosed at stage 1 or 2, by date of diagnosis, in rolling 12 months

LICB: 54.1% (May'25) to 54% (May '26)



Overall: slight deterioration at system level.
Data is not available at PCN or national level.

5. % of urgent cancer referrals meeting 28-day Faster Diagnosis Standard (FDS)

LICB: 80.4% (Jul '25) to 69.7% (Jul '26)



Overall: deterioration at system level.
Data is not available at PCN or national level.

6. % of urgent cancer referrals meeting 31-day Treatment Standard

LICB: 89.9% (Jul '25) to 88.1% (Jul '26)



Overall: deterioration at system level.
Data is not available at PCN or national level.

7. % of urgent cancer referrals meeting 62-day Treatment Standard

LICB: 62.7% (Jul '25) to 57.3% (Jul '26)



Overall: deterioration at system level.
Data is not available at PCN or national level.

Lincolnshire ICB	Highest performance	Lowest performance	Highest improvement	Highest deterioration
% of children at aged 2 who have received at least one dose of MMR/MMRV	Four Counties 96.7% East Lindsey 96.1% Imp 93.8%	Spalding PCN 80.6% Boston 83.4% Trent Care 87.0%	Four Counties +5.1% East Lindsey +2.7% Lincoln Health Partnership +2.7%	Spalding PCN -5.5% First Coastal -2.5% Meridian Medical -2.1%
Flu Vaccination People aged 65+	K2 Healthcare Sleaford 82.0% South Lincoln 81.7% Apex 80.4%	First Coastal 70.6% Lincoln Health Partnership 71.6% Boston 73.3%	Imp +0.2% East Lindsey +0.1%	Lincoln Health Partnership -2.6% Grantham and Rural -1.6% South Lincoln -1.6%
Flu Vaccination people at Risk aged Under 65	K2 Healthcare Sleaford 51.5% South Lincoln 50.4% South Lincolnshire Rural 46.8%	Lincoln Health Partnership 37.5% Boston 39.3% Spalding PCN 40.0%	Boston +2.4% Imp +2.2% First Coastal +1.3%	Grantham and Rural -2.1% Spalding PCN -1.8% K2 Healthcare Sleaford -1.2%
Covid Vaccination age 75+ Autumn uptake	K2 Healthcare Sleaford 73.9% Four Counties 73.8% Trent Care 71.5%	First Coastal 54.9% Lincoln Health Partnership 64.9% Boston 66.6%	Apex +1.9%	First Coastal -8.0% Meridian Medical -6.9% Boston -6.5%
RSV Vaccination uptake age 75+	South Lincoln 47.7% Imp 47.1% Apex 44.4%	First Coastal 34.1% Four Counties 35.8% Meridian Medical 37.4%		Grantham and Rural -16.0% East Lindsey -14.2% K2 Healthcare Sleaford -13.1%
Bowel cancer screening (Age 60 - 74)	South Lincoln 79.0% K2 Healthcare Sleaford 78.9% South Lincolnshire Rural 77.9%	Lincoln Health Partnership 69.0% Boston 72.1% First Coastal 72.2%	Boston +1.6% Four Counties +1.1% K2 Healthcare Sleaford +0.9%	Lincoln Health Partnership -0.4% Grantham and Rural -0.3%
Breast cancer screening	South Lincolnshire Rural 80.6% Four Counties 79.2% South Lincoln 79.1%	Lincoln Health Partnership 66.1% Boston 67.7% First Coastal 70.8%	Boston +6.6% Lincoln Health Partnership +6.4% Apex +5.5%	Trent Care -1.1% K2 Healthcare Sleaford -0.1%
Cervical cancer screening	K2 Healthcare Sleaford 77.6% South Lincolnshire Rural 76.7% Spalding PCN 76.6%	Lincoln Health Partnership 57.8% Boston 63.7% First Coastal 65.8%	Lincoln Health Partnership +1.2% Imp +0.8% Meridian Medical +0.7%	Trent Care -1.3% Boston -1.3% Grantham and Rural -1.3%

Summary of Nottingham and Nottinghamshire ICB Vaccination and Screening Priorities

Nottingham and Nottinghamshire ICB Vaccination Overview

- Four of the six measures have deteriorated over the reporting period with two indicators improving, although there is significant variation among PCNs
- Uptake has improved for HPV and flu vaccinations for those aged under 65 and at risk, however uptake for all other vaccinations has fallen
- There is a strong or moderate correlation between PCNs with lower uptake and deprivation

1. MMR vaccination coverage

NNICB: 89.2% (2024-25) to 89% (2025-26)

Overall: slight deterioration at system level & across 15 PCNs.
National Benchmark: Uptake exceeds the national uptake of 87.9%.
IMD: There is a moderate correlation between uptake at lower performing PCNs and deprivation.

2. HPV vaccination uptake

NNICB: 66.1% (2024-25) to 72.2% (2025-26)

Overall: Improvement at system level.

Data is not available at PCN or national level.

3. 'Winter protection' vaccination uptake - Flu (aged 65+)

NNICB: 77% (2024-25) to 76.4% (2025-26)

Overall: deterioration at system level & across all but one PCN.
National benchmark: This measure exceeds the national result of 74.5%.
IMD: There is a strong correlation between lower performing PCNs and deprivation.

4. 'Winter protection' vaccination uptake - Flu (age <65, at risk)

NNICB: 39.8% (2024-25) to 40.6% (2025-26)

Overall: improvement at system level & across 16 PCNs.
National benchmark: This measure is in line with the national result of 40.6%.
IMD: There is a strong correlation between lower performing PCNs and deprivation.

5. 'Winter protection' vaccination uptake - COVID

NNICB: 67.2% (2024-5) to 63.1% (2025-6)

Overall: deterioration at system level with deterioration across all but one PCN.
National Benchmark: No national level data is available.

IMD: There is a strong correlation between lower performing PCNs and deprivation.

6. 'Winter protection' vaccination uptake - RSV

NNICB: 43.9% (2024-25) to 37.7% (2025-26)

National Benchmark: No national level data is available.

IMD: There is a moderate correlation between uptake at lower performing PCNs and deprivation.

Summary of Nottingham and Nottinghamshire ICB Vaccination and Screening Priorities

Nottingham and Nottinghamshire ICB Screening Overview

- Three of the seven screening measures have improved over the reporting periods and four indicators moving in an adverse direction, although there is significant variation among PCNs
- Screening uptake has improved for breast screening but deteriorated for bowel and cervical cancer.
- The proportion of cancers diagnosed early and performance against the 31-day treatment standard have improved; however, the Faster Diagnosis Standard and 62-day standards have deteriorated.

1. Bowel Cancer Screening Uptake

NNICB: 75.1% (Feb '25) to 74.9% (Feb '26)



Overall: deterioration at system level & across 19 PCNs.
National Benchmark: This measure exceeds the national uptake of 73%.
IMD: There is a very strong correlation between lower performing PCNs and deprivation.

2. Breast Cancer Screening Uptake

NNICB: 71.1% (Mar '25) to 78% (Mar '26)



Overall: improvement at system level and across 19 PCNs.
National Benchmark: This measure exceeds the national uptake of 74.1%.
IMD: There is a strong correlation between lower performing PCNs and deprivation.

3. Cervical Cancer Screening Uptake

NNICB: 72.1% (2024-25) to 71.5% (2025-26)



Overall: deterioration at system level and across 21 PCNs.
National Benchmark: This measure exceeds the national result of 69.3%.
IMD: Moderate correlation between lower performing PCNs and deprivation.

4. Proportion of staged cancers diagnosed at stage 1 or 2, by date of diagnosis, in rolling 12 months

NNICB: 61.5% (May'25) to 62.2% (May '26)



Overall: Improvement at system level.

Data is not available at PCN or national level.

5. % of urgent cancer referrals meeting 28-day Faster Diagnosis Standard (FDS)

NNICB: 81.3% (Jul '25) to 66.5% (Jul '26)



Overall: deterioration at system level.

Data is not available at PCN or national level.

6. % of urgent cancer referrals meeting 31-day Treatment Standard

NNICB: 89.2% (Jul '25) to 92.3% (Jul '26)



Overall: Improvement at system level.

Data is not available at PCN or national level.

7. % of urgent cancer referrals meeting 62-day Treatment Standard

NNICB: 63.6% (Jul '25) to 60.9% (Jul '26)



Overall: deterioration at system level.

Data is not available at PCN or national level.

Nottingham and Nottinghamshire ICB	Highest performance	Lowest performance	Highest improvement	Highest deterioration
% of children at aged 2 who have received at least one dose of MMR/MMRV	Rushcliffe 94.5% Arnold & Calverton 93.9% Unity (Nottm) 93.9%	Aspire 77.9% Radford & Mary Potter 78.6% Bulwell & Top Valley 78.8%	Radford & Mary Potter +6.6% Newgate +3.4% Unity (Nottm) +3.1%	Byron -3.0% Newark -2.8% Bulwell & Top Valley -2.7%
Flu Vaccination People aged 65+	Unity (Nottm) 83.6% Rushcliffe 83.1% Arnold & Calverton 80.2%	Radford & Mary Potter 50.8% Raleigh 63.4% Nottingham City East 64.9%	Mansfield North +0.4% Arnold & Calverton +0.3% Rushcliffe +0.2%	Radford & Mary Potter -2.6% Rosewood -2.3% Clifton & Meadows -2.2%
Flu Vaccination people at Risk aged Under 65	Rushcliffe 49.8% Arnold & Calverton 45.2% Newark 44.9%	Radford & Mary Potter 26.7% Nottingham City East 33.2% Clifton & Meadows 33.3%	Unity (Nottm) +3.7% Newark +3.5% Mansfield North +3.5%	Clifton & Meadows -2.5% Nottingham City East -1.1% Ashfield South -1.0%
Covid Vaccination age 75+ Autumn uptake	Rushcliffe 74.7% Unity (Nottm) 71.7% Newark 71.5%	Radford & Mary Potter 30.7% Raleigh 44.8% Nottingham City East 44.9%	Radford & Mary Potter +2.3% +0.0% +0.0%	Clifton & Meadows -6.5% Newgate -6.1% Retford And Villages -5.9%
RSV Vaccination uptake age 75+	Unity (Nottm) 59.3% Rushcliffe 51.1% Nottingham West 47.0%	Radford & Mary Potter 19.3% Raleigh 22.5% Rosewood 26.0%	Nottingham West +0.6% Rushcliffe +0.6% Aspire +0.4%	Radford & Mary Potter -18.4% Rosewood -15.9% Arrow Health -15.8%
Bowel cancer screening (Age 60 - 74)	Rushcliffe 81.0% Newark 78.5% Nottingham West 78.5%	Radford & Mary Potter 57.9% Raleigh 63.4% Aspire 64.3%	Larwood & Bawtry +0.6% Newgate +0.5% Ashfield North +0.3%	Unity (Nottm) -1.4% Synergy Health -1.0% City South -1.0%
Breast cancer screening	Sherwood 84.8% Ashfield South 82.7% Rushcliffe 82.4%	Radford & Mary Potter 65.5% Nottingham City East 65.9% Aspire 66.0%	Rushcliffe +28.6% Synergy Health +14.4% Clifton & Meadows +11.7%	Ashfield North -0.6% Unity (Nottm) -0.2% Rosewood -0.2%
Cervical cancer screening	Rushcliffe 79.3% Arnold & Calverton 77.5% Arrow Health 77.5%	Unity (Nottm) 42.8% Radford & Mary Potter 46.0% City South 60.9%	Unity (Nottm) +1.9% Rosewood +1.2% Larwood & Bawtry +0.4%	Nottingham City East -2.6% Aspire -1.9% Synergy Health -1.4%

Appendix 4: Vaccinations and Screening Insights across Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire

Evidence synthesis October 2026

Background

1. This paper has been produced in response to a request to provide a clear, consolidated view of Vaccinations and Screening insights across Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire (DLN). This paper therefore brings together citizen experience and insight from separate pieces of work already undertaken within each DLN area, including national evidence, local insights and engagement activities. These sources have been reviewed and synthesised to identify common themes, areas of alignment and notable differences across the ICBs, with a particular focus on lived experience of accessing vaccination and screening health services.

Key similarities across the ICBs

2. Across Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire, vaccination and screening experiences show substantial alignment. Despite differences in population, geography and service configuration, the same core issues recur across the ICBs.

    a) **Trust and personalised dialogue:** Healthcare professionals, NHS services, community organisations, faith and community leaders, schools, pharmacies and peer networks are consistently trusted. People value non-judgemental conversations, opportunities to ask questions and advice tailored to their circumstances more than one-way campaigns.

    b) **Access is broader than appointment availability:** Common barriers include transport, distance, rurality, work and caring commitments, limited appointment flexibility, digital exclusion, language needs, anxiety, disability and difficulty navigating between organisations. Housebound and clinically vulnerable people may need clearer and more reliable arrangements.

    c) **Clear, consistent and accessible information:** Uncertainty about eligibility, vaccination history, service locations, pathways, responsibility, results and next steps is widespread. Information needs to be timely, concise, culturally appropriate and available in multiple languages and accessible formats.

    d) **Hesitancy is shaped by safety concerns and misinformation:** Concerns about side effects, ingredients, effectiveness, disease risk and changing guidance continue to affect decisions. Previous poor

experiences, feeling dismissed and mistrust of institutions can further reduce confidence.

e) **Flexible community delivery can improve participation:** School and college clinics, community venues, pharmacies, mobile provision, home visits, sensory-friendly clinics, direct outreach and text-based booking have helped reach people who may not engage through standard routes.

f) **Inequalities require targeted as well as universal approaches:** Barriers are greater for some ethnic minority communities, refugees and asylum seekers, rural and deprived communities, people with learning or sensory disabilities, people affected by trauma, carers and those who need reasonable adjustments.

g) **Follow-up, continuity and data quality matter:** Delays in results, referrals and follow-up undermine confidence. Better recording of programme, equality, locality, vaccination history and contact information is needed to target activity, monitor reach and understand variation.

Key differences across the ICBs

3. While the core issues are shared across the ICBs, local context shapes how these challenges are experienced and where pressure is felt most acutely.

4. **Derby and Derbyshire:** The evidence is dominated by broad community-led engagement across vaccination, women's health, screening and primary care, involving more than 3,200 residents. It places particular emphasis on trust as long-term public health infrastructure, culturally competent services and the 3Ts model of Trusted Leaders, Trusted Voices and Trusted Spaces. Local learning also links strong general practice to continuity, feeling listened to and trusted relationships, rather than capacity alone. Community insight has already informed co-produced action plans, community champion approaches and primary care inclusion resources.

5. **Lincolnshire:** Lincolnshire's rural geography makes distance, transport and local availability especially prominent. The evidence includes substantial positive feedback about efficient clinics, professional staff, pharmacies and community outreach, alongside practical learning from targeted programmes. School-based MMR delivery vaccinated 411 children, the 16–18 catch-up campaign delivered more than 500 vaccinations, and targeted shingles outreach delivered 1,232 vaccinations. Distinctive challenges include variable practice engagement, incomplete or overseas vaccination records, outdated contact details, digital exclusion and limited coding of screening concerns, meaning the complaints evidence should not be used to infer screening performance or prevalence.

6. **Nottingham and Nottinghamshire:** Nottingham and Nottinghamshire show marked variation in uptake and a strong focus on intelligence-led, adapted delivery. Both MMR doses have been received by 71.8% of children in Nottingham and 84.4% in Nottinghamshire, below the 95% target; 2025 outreach resulted in 1,200 vaccinations and 611 children becoming fully immunised. Lung cancer screening reaches around 67% uptake, above the 52% national rate, and has expanded to approximately 95% of the eligible population, but breast and cervical screening remain lower in Nottingham and vary by age, ethnicity and deprivation. Distinctive local models include relaxed sensory vaccination clinics, targeted lung screening for people experiencing severe and multiple disadvantage, community pharmacy case-finding, automated SMS cervical screening invitations and cancer awareness outreach. People with learning disabilities remain a priority because screening uptake is substantially lower and services often require accessible information, longer appointments and reasonable adjustments.

What this means for commissioning

7. Taken together, the evidence shows that improving vaccination and screening uptake across the ICBs will require more than additional service capacity or information campaigns alone. People are more likely to engage when services are accessible, communication is clear and consistent, and trusted professionals and community partners offer personalised, non-judgemental discussion. Local priorities vary, from rural access in Lincolnshire and sustained community-led infrastructure in Derby and Derbyshire to marked inequalities in uptake in Nottingham and Nottinghamshire, but the overall commissioning direction is consistent. The following considerations reflect shared direction while allowing delivery to respond to local circumstances:

    a) **Treat trust as a strategic asset:** Continue investing in trusted community organisations, community champions and peer-led approaches; build long-term relationships rather than short-term engagement programmes; and embed community voice in service design and improvement.

    b) **Consider access in the broadest sense:** Commission around service location, transport, appointment flexibility, work and caring responsibilities, digital exclusion and community-based delivery, rather than focusing only on appointment availability.

    c) **Provide clear and consistent communication:** Improve information about eligibility, access routes, organisational responsibilities and next steps, with timely updates when referrals, appointments or requests are delayed.

d) **Maintain flexible and targeted delivery:** Continue using community venues, outreach, education-based provision, mobile services and other adapted models to improve access and reduce inequalities.

e) **Build accessibility and reasonable adjustments into routine provision:** Ensure reliable arrangements for housebound and clinically vulnerable people, digitally excluded populations and people who need accessible information, longer appointments or sensory adjustments.

f) **Strengthen insight and accountability:** Improve follow-up, recording and data quality so that commissioners can understand variation, target activity and evaluate whether services are reaching underserved communities.

8. These considerations support a neighbourhood approach to prevention and early intervention that combines provision with targeted action for communities experiencing lower uptake or additional barriers. This should include flexible and community-based delivery, routine reasonable adjustments, and stronger follow-up and data quality.

What will change as a result?

9. The evidence identifies both practical improvements already informed by engagement and priorities for further action. Across the ICBs, the next phase should build on existing community partnerships and targeted delivery while maintaining universal provision, improving access, strengthening follow-up and reducing inequalities.

Future priorities across the DLN ICBs

10. **Target lower uptake:** Focus targeted vaccination and screening activity on communities and population groups where uptake remains below recommended levels. In Nottingham and Nottinghamshire, this should be supported by accessible, culturally appropriate information and intelligence-led delivery that responds to variation by age, ethnicity, deprivation and other barriers.

11. **Build confidence through trusted dialogue:** Provide clear, evidence-based information through healthcare professionals, trusted organisations and community networks, with opportunities for people to ask questions and discuss safety, side effects and perceived risk.

12. **Expand and evaluate accessible delivery:** Build on mobile screening, home visits, school-based initiatives, community outreach and sensory-friendly clinics to reach underserved populations, including people with learning disabilities

and families not engaged with routine immunisation and prevention programmes.

13. Citizen insight should continue to be considered alongside performance data to identify variation, evaluate whether flexible and community-based models are reaching underserved groups, and inform ongoing service improvement. This combined evidence base will support more responsive services and help reduce inequalities in prevention and early diagnosis across the ICBs.

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	19/11/2026
Paper title	**Intensive and Assertive Community Mental Health Services and the Mental Health Personalised Care Framework: Progress Report**
Paper reference	ICB 26 070
Paper author	Clare Fox, Senior Mental Health Commissioning Manager
Paper sponsor	Maria Principe, Executive Director of Commissioning
Presenter	Maria Principe

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

Report summary

By the end of November 2026, NHS England requires providers and Integrated Care Boards (ICBs) to report to their Boards on progress in improving intensive and assertive community mental health services and establishing plans to implement the Mental Health Personalised Care Framework. This paper provides an update on both requirements, following previous reports to the Boards in November 2024 and May 2025.

Provider self-assessments demonstrate progress across Derbyshire, Lincolnshire and Nottinghamshire since August 2025, with strengthened arrangements for identifying and overseeing people who may require intensive and assertive community support. However, the position varies across the three systems, with areas requiring further improvement including workforce and service capacity, family and carer involvement, partnership working and demonstrating the impact of changes.

The Mental Health Personalised Care Framework, published in July 2026, replaces the Care Programme Approach and establishes a consistent approach to personalised care and support planning for adults and older adults living with severe mental health problems. Each of the three mental health providers has an approved, phased implementation plan in place, with completion currently expected between quarter four of 2026/27 and quarter four of 2027/28.

Providers remain accountable for delivering their agreed improvement and implementation plans. The ICBs, as commissioners, will oversee progress through established mental health, commissioning and quality governance arrangements, review evidence of impact and consider whether commissioned service models and capacity are sufficient to meet identified need. Assurance will increasingly focus on whether improvements are reliably embedded in practice and are delivering measurable benefits in people's experience, safety, continuity of care and outcomes.

Recommendation(s)

The Boards are asked to **receive** this paper for assurance regarding the progress being made to strengthen intensive and assertive community mental health services and implement the Mental Health Personalised Care Framework, noting the areas where further improvement and assurance are required.

Appendices

None.

Board Assurance Framework

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

- Failure to deliver a coordinated transformation of commissioned services, including prevention, community care models, and digital enablement
- Failure to systematically improve the quality of healthcare services

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Intensive and Assertive Community Mental Health Services and the Mental Health Personalised Care Framework: Progress Report

Introduction

1. This paper provides an update on progress across Derbyshire, Lincolnshire and Nottinghamshire in strengthening intensive and assertive community mental health services. It summarises the progress since the August 2025 and May 2026 provider self-assessments, the priority areas for further improvement, and the arrangements for continued oversight.
2. The paper also outlines the requirements of the Mental Health Personalised Care Framework and how its implementation will be aligned with the continued development of intensive and assertive community mental health services.
3. The paper responds to NHS England's requirement for providers and ICBs to report to their Boards by the end of November 2026 on progress in these two areas.
4. The ICBs are responsible for commissioning and overseeing the quality and effectiveness of local mental health services, including considering whether commissioned service models and capacity are sufficient to meet identified need; responsibility for service delivery and clinical management remains with providers.

Background and national policy context

5. Many people experiencing psychosis respond well to evidence-based care and treatment, enabling recovery from an acute episode or supporting them to live a meaningful life whilst managing ongoing symptoms. However, some people, particularly those experiencing paranoia, may find it difficult to access or remain engaged with services. This may arise because services are not sufficiently adapted to meet their individual needs, because of the impact of their symptoms, or because the person does not recognise that they are unwell.
6. People requiring this level of support may be particularly vulnerable to self-harm, exploitation, neglect or harm from others. For a very small number, deterioration or relapse may also be associated with an increased risk of harm to others. This reinforces the need for early identification, sustained engagement, continuity of care, effective safety planning and coordinated multidisciplinary working, with appropriate involvement of families, carers and wider system partners.
7. National policy for community mental health services has evolved considerably over time. Earlier models of assertive outreach were based primarily on dedicated specialist teams; however, subsequent national policy moved

towards greater integration of these functions within wider community mental health services. More recent national guidance has reinforced the importance of ensuring that people with severe mental health problems who may be difficult to engage do not become lost from services, and that systems have effective arrangements for identifying and maintaining contact with this cohort.

8. Against this evolving national policy context, the 2024/25 NHS Planning Guidance required ICBs and providers to strengthen their approach to intensive and assertive community mental health care and to review their plans periodically. This has included three nationally mandated self-assessments reported to NHS England, designed to assess systems' progress in identifying, maintaining contact with and meeting the needs of people who may require intensive and assertive community care and follow-up.

9. The most recent self-assessment, undertaken in May 2026, identified three priority areas for further improvement in each of the ICB areas. These priorities, together with progress since the August 2025 assessment, are considered later in this report.

10. The Mental Health Personalised Care Framework, published in July 2026, forms part of this developing national approach. It establishes expectations for personalised and coordinated care for people receiving secondary mental health services and has particular relevance to people who require intensive and assertive support. Its implementation is therefore being considered alongside the wider intensive and assertive community mental health improvement programme.

11. The development of intensive and assertive community mental health services and implementation of the Mental Health Personalised Care Framework support the ICBs' strategic commissioning priorities for mental health, particularly the shift towards proactive, personalised and integrated community-based care for people with complex needs. This requires the ICBs to consider whether commissioned service models, workforce capacity and pathways are sufficient to identify and respond to the relevant cohort, maintain continuity of care, and support effective working across organisational boundaries.

12. The implications of this work will be reflected in programme delivery planning and in the development of commissioning intentions across Derbyshire, Lincolnshire and Nottinghamshire.

Provider self-assessments

14. The nationally mandated self-assessments aimed to support systems to review and update their intensive and assertive community mental health action plans and were designed to be light touch.

15. The August 2025 provider self-assessment rated nine key areas using Red, Amber, and Green (RAG) ratings. As the ratings were based on individual provider self-assessment, some variation in scoring and interpretation should be recognised when considering the results below:

	Derbyshire	Lincolnshire	Nottinghamshire
Partnership working	Green	Amber	Amber
Workforce	Amber	Amber	Amber
Access and oversight	Amber	Green	Green
Key working arrangements and caseload management	Amber	Amber	Amber
Out of hours provision	Amber	Amber	Amber
Care delivery	Green	Green	Amber
Information sharing	Amber	Amber	Amber
Family and carer involvement	Amber	Green	Amber
Demonstrating impact	Amber	Green	Amber

16. At this time, Derbyshire had made progress in strengthening governance, policy and clinical oversight, with particularly strong care planning and an assertive outreach policy in place. However, it could not provide full assurance, with significant gaps in workforce capacity and caseloads, inconsistent community pathways and information sharing, limited out-of-hours arrangements and variable family/carer involvement. The preferred solution was a dedicated county-wide assertive outreach service, requiring significant additional investment.

17. Lincolnshire had made progress in strengthening governance and oversight, with a dedicated task and finish group, Board-level reporting, clear identification of the cohort and strong arrangements for access and family/carer involvement. However, it was not able to provide full assurance that it could meet the needs of the cohort. The principal constraint was the absence of a dedicated intensive/assertive function and insufficient workforce capacity, with people managed within mixed community mental health caseloads; further gaps remained around caseload management, information sharing, care planning, out-of-hours coordination and demonstrating outcomes specifically for this cohort. Additional investment was considered necessary to deliver the required model.

18. Nottinghamshire had strengthened quality, safety and oversight of the Assertive Outreach cohort, including clear cohort identification, weekly oversight, dashboards and strong care-planning compliance. However, full assurance had not been achieved, with key gaps remaining around dedicated

workforce/caseload capacity, partnership and information sharing, out-of-hours provision, family/carer involvement and demonstrating outcomes.

19. The NHS England Midlands Mental Health Team assumed responsibility for progress assurance in May 2026. This provider self-assessment focussed particularly on areas where challenges remained following the August 2025 provider self-assessment. Although the assessment retained the same broad headings as previous reviews, the key lines of enquiry had changed. The results are therefore not directly comparable with those from earlier assessments.

20. The assessment comprised 45 areas of focus across ten domains, which included the addition of a 'Governance and oversight' domain, requiring a score of 1-5 for each area of focus as follows:

Progression to assurance				
1	**2**	**3**	**4**	**5**
Not in place/ significant gaps	**Making forward progress but significant gaps still exist**	**Some aspects in place but incomplete**	**80% in place**	**In place and functional**

21. The table below summarises the % scores for the areas of focus within the ten domains, but as per the previous self-assessment, scoring was subject to individual interpretation and variance between providers.

	Derbyshire	Lincolnshire	Nottinghamshire
Partnership working	86%	63%	77%
Workforce	56%	80%	76%
Community based care	91%	89%	96%
Key working arrangements and caseload management	80%	100%	100%
Out of hours provision	73%	100%	60%
Care delivery	98%	88%	90%
Information sharing	90%	100%	90%
Family and carer involvement	80%	100%	60%
Demonstrating impact	90%	100%	83%
Governance and oversight	100%	100%	80%

25. The May 2026 provider self-assessments demonstrated further improvement across Derbyshire, Lincolnshire and Nottinghamshire. They provided increased assurance that arrangements are in place to identify, maintain contact with and

respond to the needs of this cohort. Providers scored themselves between 79-87% overall.

Priority areas for further improvement

26. Providers focused on strengthening quality, safety and oversight during 2025/26, as reflected in the May 2026 self-assessments. Each system identified three priority areas for further improvement, implementation or assurance. Collectively, these demonstrate a focus during 2026/27 on refining service models, building capacity and capability, strengthening personalised and partnership approaches, and beginning to demonstrate impact.

System	Priority 1	Priority 2	Priority 3
Derbyshire	Workforce: increase capacity	Families and carers: develop more proactive approaches to engagement	Information sharing: improve interoperability and timeliness
Lincolnshire	Demonstrating impact: embed system developments and demonstrate their effect	Care delivery: strengthen personalised care and support planning	Community-based care: embed new care pathways
Nottinghamshire	Community-based care: progress towards a standalone intensive and assertive community team	Families and carers: deliver the identified quality improvement initiative	Partnership working: strengthen place-based partnerships

27. Since May 2026, Derbyshire has strengthened its understanding and oversight of the intensive and assertive cohort, with a Management and Supervision Tool (MaST) identifying significant additional potential demand and the Trust escalating assertive outreach capacity as a major strategic and operational risk. Work against the three May 2026 priorities is ongoing. An 18-month transformation programme, scheduled to commence in November, provides a route for further development. An update of the self-assessment scoring increased their overall score to 87%.

28. Lincolnshire reports progress since May 2026 against all three priorities identified in May. System developments had been implemented to improve identification and oversight of the assertive/intensive cohort; personalised care and Multidisciplinary Team arrangements had been strengthened through cohort reviews, outcome measures and revised discharge pathways; and targeted Psychosis and Bipolar and Longer-Term Care pathways have been introduced within local mental health teams. However, while this demonstrates

implementation and embedding activity, evidence of the impact of these changes on patient and service outcomes remains less developed. Their overall scoring following a self-assessment update remains at 87% in November 2026.

29. For Nottinghamshire, progress since May 2026 is evident in strengthening place-based partnership arrangements and supporting infrastructure, including implementation of a MaST. However, the standalone intensive/assertive community team remains dependent on further workforce and investment, which is a consideration in the current 2027/28 ICB planning round, whilst the family and carer quality improvement priority remains ongoing. Their updated self-assessment increased their overall score to 85%.

Demonstrating impact

27. The next phase of improvement will focus on whether the changes introduced are operating reliably in practice and delivering measurable benefits for people who require intensive and assertive community mental health support. Evidence that a policy, pathway, tool or governance arrangement has been introduced does not, by itself, demonstrate that people consistently receive effective care or experience improved safety, continuity and outcomes.

28. Providers will therefore be expected to demonstrate impact across the following areas:

Assurance theme	Quantitative and qualitative evidence to be considered
Identification and engagement	Reliable identification and oversight of the appropriate cohort; maintenance of contact where engagement is difficult; and analysis of loss of contact and patterns of disengagement.
Personalised and continuous care	Care adapted to individual needs and circumstances; continuity through a named and trusted professional; and the quality, currency and responsiveness of personalised care and support plans.
Safety and responsiveness	Timely responses to deterioration or increased risk; effective safety assessment and planning; and learning from incidents, complaints, safeguarding reviews and other quality processes.
Families and partnership working	Appropriate involvement of families, carers and support networks, and effective coordination with primary care, local authorities, housing, the police, the voluntary sector and other system partners.
Experience, outcomes and equality	Patient and carer experience; use of relevant clinical and personal outcome measures; and evidence of equality in access, experience and outcomes.

29. This evidence will inform ongoing provider oversight and enable the ICBs to identify where further improvement, commissioning action or escalation may be required.

Mental Health Personalised Care Framework

31. The Mental Health Personalised Care Framework was published in July 2026. It replaces the Care Programme Approach and establishes a consistent approach to personalised care and support planning for adults and older adults living with severe mental health problems.

32. The Framework requires care to be coordinated through an appropriate named worker and a co-produced care and support plan that reflects the person's needs, goals, strengths and preferences. It emphasises reviews of care and support plans as needs and circumstances change, effective safety planning, timely re-access to services, measurement of experience and outcomes, and appropriate involvement of families and carers.

33. The Framework is particularly relevant to people requiring intensive and assertive community mental health support, for whom continuity of care, sustained therapeutic relationships and responsive support can be especially important. Its implementation will therefore be considered alongside, rather than separately from, the Intensive and Assertive Community Mental Health improvement programme.

34. Each of the ICBs' three mental health providers has developed a phased plan for implementing the Framework, with progress and timescales summarised below.

Provider Personalised Care Implementation Plans

36. Derbyshire Healthcare NHS Foundation Trust, Lincolnshire Partnership NHS Foundation Trust and Nottinghamshire Healthcare NHS Foundation Trust are at different stages of implementation, but each has a phased implementation plan in place that has been approved through its relevant internal governance arrangements. The plans provide for the Framework to be embedded within clinical practice, workforce development, digital and documentation arrangements, and governance and assurance.

37. Derbyshire Healthcare NHS Foundation Trust's implementation plan has recently been agreed by its Board and is aligned with neighbourhood mental health and community transformation. Programme governance has been established and mobilisation is commencing, with implementation expected to be completed during quarter four of 2027/28.

38. Lincolnshire Partnership NHS Foundation Trust has commenced implementation, with the Framework socialised across care groups and reflected in policy, training and quality assurance arrangements. The next phase focuses on wider workforce implementation, revised assessment arrangements and embedding consistent practice, with full implementation planned by the end of quarter four of 2026/27.

39. Nottinghamshire Healthcare NHS Foundation Trust has made progress in establishing the foundations for implementation, including personalised care planning, training and review of key clinical processes. The next phase focuses on embedding these changes consistently across services, including assessment, multidisciplinary team and named worker arrangements, workforce development and strengthened quality assurance. Completion of implementation is expected by the end of quarter two of 2027/28.

40. While the approach and pace of implementation reflect local circumstances, ICB oversight will consider both delivery against the agreed provider plans and, as implementation matures, evidence that the Framework is embedded in practice and contributing to coordinated, personalised and responsive care.

Risks and dependencies

43. Delivery remains dependent on sufficient workforce capacity; effective clinical infrastructure, including cohort identification, information sharing and case-management systems; and consistent partnership working with families, carers and wider system partners. Where changes to service models are required, the ICBs will also need to ensure that sustainable commissioning and funding arrangements are in place.

44. The principal risk is that implementation does not translate consistently into improved experience, safety, continuity of care and outcomes. This will remain a key focus of ongoing assurance.

Governance and next steps

45. Providers remain accountable for delivering their agreed improvement and implementation plans. The ICBs, as commissioners, will oversee progress through their established mental health, commissioning and quality governance arrangements, review evidence of impact, and consider whether commissioned service models and capacity are sufficient to meet identified need.

46. Oversight, via the Mental Health Programme Board, will focus particularly on the three priorities identified by each system through the May 2026 self-assessment and on implementation of the Mental Health Personalised Care Framework. It will increasingly move beyond confirmation that actions have

been completed to consideration of whether improvements are reliably embedded and are delivering measurable benefits in people's experience, safety, continuity of care and outcomes.

47. Where progress is delayed, milestones are not achieved, quality or safety concerns emerge, or sufficient assurance cannot be demonstrated, the matter will be escalated through the relevant ICB governance and risk arrangements. Systems will also continue to share relevant learning across Derbyshire, Lincolnshire and Nottinghamshire.

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/11/2026
Paper title:	**Quality Oversight Report**
Paper reference:	ICB CIC 26 071
Paper author:	Rebecca Neno, Director of Quality, Safety and Improvement,
Paper sponsor:	Rosa Waddingham, Executive Director of Quality (Nursing)
Presenter:	Rosa Waddingham

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

Report summary:

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 subject to enhanced or escalated oversight, in line with the NHS Oversight Framework and National Quality Board guidance alongside analysis of the ICBs' Quality Performance Report for October 2026.

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.

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.

Appendices

Appendix 1: Quality Performance Report October 2026

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

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No

Quality Report

Introduction

1. This paper provides detail of the most significant current quality escalations across the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs' footprints. It sets out the current position in relation to providers subject to enhanced or escalated oversight, in line with the NHS Oversight Framework and National Quality Board guidance alongside analysis of the ICB's Quality Performance Report for October 2026.

Quality oversight arrangements including governance structures

2. The ICBs' approach to quality for 2026/27, which was presented to the Boards in July 2026, outlines the current approach to quality oversight whilst the ICBs' Quality Strategy for 2027-2030 is developed.

3. At the centre of the ICBs' Quality Strategy will be the development and embedding of a Quality Management System (QMS). This will bring together the activities of quality planning, quality control, quality assurance and quality improvement, which will move the role of quality oversight and assurance from reactive to proactive in line with strategic commissioning responsibilities across the totality of the commissioning cycle as outlined in the table below.

QMS component	Core question	Commissioning application
Quality Planning	What quality do we need?	Population need, inequalities, evidence, experience and quality requirements.
Quality Control	What is happening?	Performance, feedback, incidents, outcomes, workforce and professional insight.
Quality Assurance	Are we meeting the standards?	Contractual, statutory, regulatory and clinical assurance.
Quality Improvement	What could be better?	Address variation, reduce risk, improve outcomes and experience.

4. The embedding of a QMS will provide a consistent framework across the ICBs while allowing proportionate responses to local population need, service context and risk.

5. This new approach to quality, including the QMS, will reshape how quality assurance and oversight is achieved and will also provide a mechanism to ensure that patient experience is used to improve services.

6. The ICBs' Quality Strategy for 2027-2030 will be presented for Board approval in March 2027.

7. The ICBs have defined quality governance oversight process with Terms of Reference outlining each meeting's role and responsibilities which are aligned with the ICBs' Commissioning Oversight Framework. In addition, a mechanism for immediate escalation of concerns via a 'SBAR' (Situation, Background, Assessment, Recommendation) is also in place as outlined in *Figure One*.

8. Contractual oversight of quality is provided through regular Quality Assurance meetings with Providers (including NHS England Quality Improvement Groups). These report through to the individual Provider Contract Delivery Review and Oversight Meetings and the ICBs' Oversight and Assurance Group. This Oversight and Assurance Group acts as a sub meeting of the ICBs' Joint Quality and Service Improvement Committee and receives oversight of risks, outcomes and data metrics (as outlined in *Figure Two*).

9. The ICBs' Quality Risk Escalation Policy sets out the approach to effective system escalation to enable effective Quality Risk Management across the ICBs as per the National Quality Board's Guidance on Quality Risk Response and Escalation in Integrated Care Systems (July 2022).

10. This provides a Risk Escalation Process using a stepped oversight and intelligence model which is aligned with the National Quality Board Risk Escalation Triggers and Thresholds.

Figure One

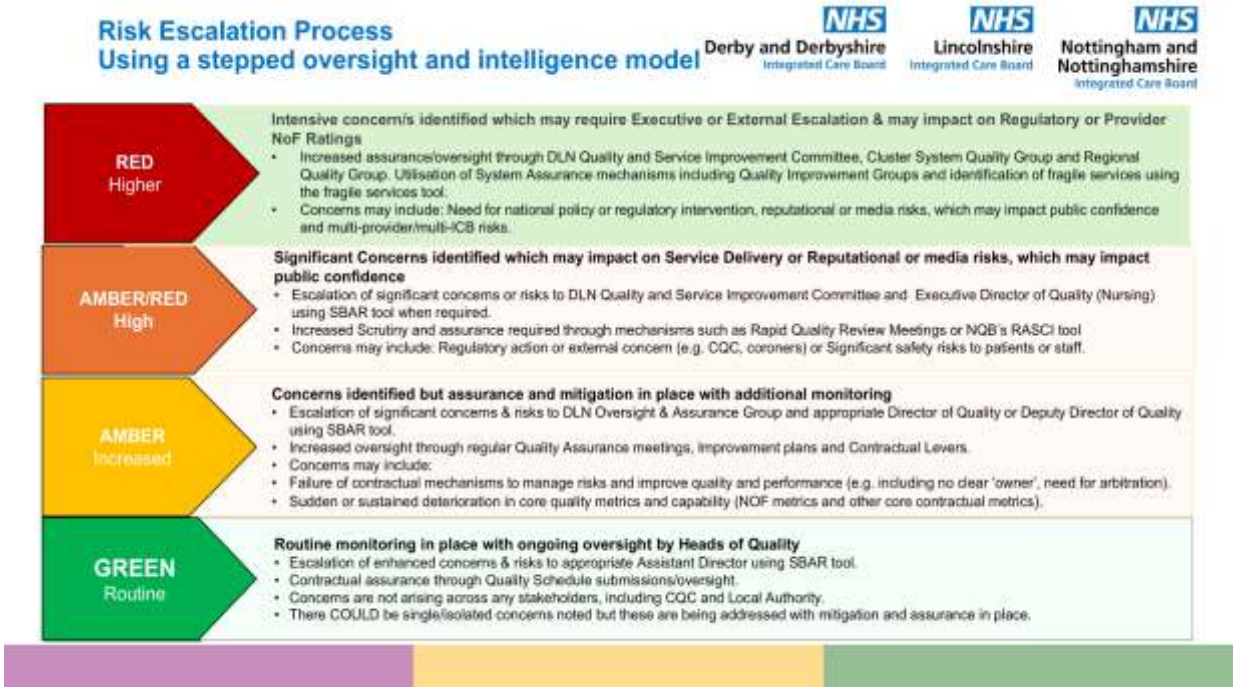
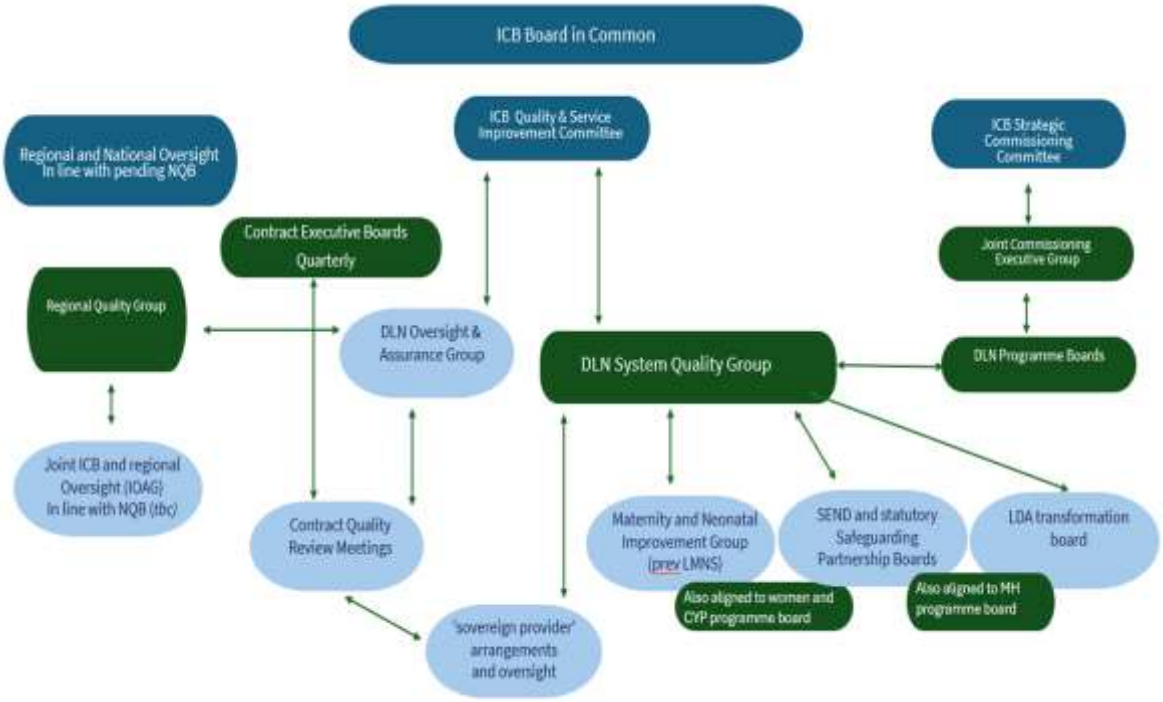


Figure Two



Areas of escalated oversight

11. Three acute providers and one mental health trust are currently subject to escalated quality oversight. No community providers or GP practices are in escalation; details of current primary care quality oversight can be found in the Supporting Strong General Practice paper, which can be found at item 9 on this agenda. Neighbourhood contracting schedules, inclusive of quality and outcome requirements are currently in development across the ICBs.

Area	Assurance	Principal risk themes
United Hospitals Derby and Burton NHS Foundation Trust: Maternity services	Limited	Workforce and leadership capacity; triage and obstetric review; obstetric anal sphincter injury (and postpartum haemorrhage / major obstetric haemorrhage; neonatal mortality review; cross site variation; governance and incident closure.
Chesterfield Royal Hospital NHS Foundation Trust	Limited	Maternity harm; urgent and emergency care /corridor care; Infection Prevention Control, water and ventilation; incident learning; data quality and mortality; theatres and workforce.
Nottingham University Hospitals NHS Trust	Limited	Governance sustainability; urgent and emergency care /corridor care; mortality and coding; incident learning; maternity; Infection Prevention Control /estates; fragile services; data, information governance and culture.

Area	Assurance	Principal risk themes
Nottinghamshire Healthcare NHS Foundation Trust	Limited	Regulatory action; self-harm controls; flow and out-of-area beds; culture; governance; workforce; evidence that Section 48/Themis actions are embedded.

12. When examining these issues, it is evident that there is clear linkages to the Board Assurance Framework risks: failure to involve people and communities meaningfully in commissioning and service design; failure to systematically improve healthcare quality; and failure to ensure timely and equitable access in line with national and local standards. The provider concerns below are mapped to these risks, noting that leadership and cultural maturity can impact on the ability to improve at the pace needed.

Risk / theme	Applies to	Connection
Systematic improvement in quality	United Hospitals Derby and Burton NHS Foundation Trust Chesterfield Royal Hospital NHS Foundation Trust Nottingham University Hospitals NHS Trust Nottinghamshire Healthcare NHS Foundation Trust	Failure to embed learning, governance and improvement consistently; regulatory and patient-safety risk.
Timely and equitable access	United Hospitals Derby and Burton NHS Foundation Trust Chesterfield Royal Hospital NHS Foundation Trust Nottingham University Hospitals NHS Trust Nottinghamshire Healthcare NHS Foundation Trust	Triage and review delays; corridor care; elective waits; mental health access, delayed discharge and out-of-area care.
People and communities	United Hospitals Derby and Burton NHS Foundation Trust Nottingham University Hospitals NHS Trust Nottinghamshire Healthcare NHS Foundation Trust	Family engagement, patient/carer involvement, culturally safe care, staff speaking up and experience intelligence.

University Hospitals of Derby and Burton NHS Foundation Trust: maternity services

13. Maternity-only escalated focus. Targeted national support concluded in July 2026, with continuing ICB, NHS England and Trust oversight. Progress is evident, but several clinical, workforce, governance and cross-site issues

require continued assurance. Monthly assurance meetings continue with a focus on the following areas to embed assurance:

a) Evidence that improvements are consistent across both sites and sustained over time.

b) A reconciled, Board-level view of clinical outcomes, patient experience, audit, workforce and incident learning.

c) Demonstrable impact of recruitment and workforce redesign on safe staffing and obstetric review times.

d) Clear evidence that the inequalities identified in mortality and service-user feedback are translated into targeted action.

Limited Assurance	Controls and formal oversight are in place, but improvement is not consistently embedded, sustained under pressure, or evidenced through improved outcomes.

Chesterfield Royal Hospital NHS Foundation Trust

14. The Trust remains under escalated oversight following the 31 July 2026 Rapid Quality Review, which identified positive governance features and areas of progress, but concluded that time-limited enhanced assurance and improvement should continue. A monthly Quality Improvement Group with NHS England has been established and a further rapid quality review will be undertaken during quarter 4 of 2026/27. The immediate focus of the Quality Improvement Group includes:

a) Evidence of risk reduction, not only completion of actions.

b) Validated data and a single Board-owned view of quality risk.

c) Sustained reduction in corridor care, infection risk, and maternity harm.

d) Clarity on estates funding, delivery dates and residual risk during winter and surge pressures.

Limited Assurance	Controls and formal oversight are in place, but improvement is not consistently embedded, sustained under pressure, or evidenced through improved outcomes.

Nottingham University Hospitals NHS Trust

15. The Trust remains under the highest level of oversight. The 21 August 2026 Rapid Quality Review recognised progress but maintained the requirement for ongoing scrutiny through the Quality Improvement Group and Provider Review Meeting. The central risk is whether governance and improvement changes are embedded consistently across care groups as financial, workforce and operational pressures intensify. The impact of culture across quality risks is also a growing concern and the scale and persistence of concerns across

speaking up, governance, data loss, information governance, learning, data quality, operational delivery and workforce pressures mean that cultural improvement cannot yet be regarded as embedded or reliably translating into safer care. The Quality Improvement Group is meeting monthly with a further rapid quality review planned in quarter 4 of 2026/7 to assess progress and with an immediate focus on:

a) Evidence that governance reform changes day-to-day practice in all care groups.

b) Independent assurance that mortality signals are explained and that incident learning prevents recurrence.

c) Delivery against corridor-care, Infection Prevention Control, maternity and workforce trajectories.

d) Clear quality impact assessment and surveillance of financial and workforce recovery actions.

Limited Assurance	Controls and formal oversight are in place, but improvement is not consistently embedded, sustained under pressure, or evidenced through improved outcomes.

Nottinghamshire Healthcare NHS Foundation Trust

16. The Trust has moved to National Oversight Framework segment 3, and there is evidence of improvement. However, the regulatory position remains challenging, and assurance is not yet sufficient that improvements are consistently embedded and sustainable across services. Quality is a key focus of the monthly performance review meeting, and a monthly Contractual Quality Review Group is being introduced during quarter 3 to reflect the ICB's focus as strategic commissioner. The focus of the Contractual Quality Review Group will include:

a) Independent evidence that actions remain effective under pressure and beyond the most intensively scrutinised wards.

b) Demonstrable improvement in patient safety, experience and carer involvement.

c) Clear relationship between transformation, financial recovery, and quality impact.

d) Sufficient workforce and leadership capacity to sustain improvement.

Limited Assurance	Controls and formal oversight are in place, but improvement is not consistently embedded, sustained under pressure, or evidenced through improved outcomes.

Areas of enhanced oversight

Summary Hospital-level Mortality Indicator (SHMI)

17. For June 2025 to May 2026, the local aggregate SHMI is reported as 1.064 against the England baseline of 1.000. One of the five local trusts is reported as having a SHMI higher than expected. Nationally, the presentation reports 14 trusts higher than expected, 95 as expected and nine lower than expected.

18. Nottingham University Hospitals NHS Trust has a high percentage of invalid diagnosis codes and its values should be interpreted with caution. The aggregate position should therefore be considered alongside this coding caveat and the underlying provider-level review.

Urgent and emergency care

19. Urgent and emergency care services continue to experience sustained operational pressure across the cluster as a result of ongoing demand, patient-flow challenges and capacity constraints across acute, community and ambulance pathways. Partners are maintaining regular communication, shared escalation processes and joint oversight between quality and urgent care colleagues. A Clinical Cabinet has been developed by colleagues within the ICBs' Outcomes Directorate supported by quality as a mechanism to manage clinical quality Urgent and Emergency Care risks as we move into the winter months.

20. Corridor care continues to be a concern across all acute providers with all providers having submitted an action plan, as part of winter planning, to provide assurance of eradication, and where this is not possible, minimisation and control via effective governance. These action plans are monitored, and oversight is through the governance arrangements with each provider as detailed earlier.

Maternity and neonatal safety

21. Following the Boards' meeting in September 2026, which included a focus on maternity oversight, all of the ICBs' relevant providers have now submitted their Ten-Point Plan for Maternity and Neonatal services.

22. The maternity overview compares the ICBs' five acute providers against national and 'MBRRACE' (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) peer benchmarks. However, it is worthy of note that the data periods are not uniform: mortality measures relate to 2024, whilst other measures are reported mainly for August 2026, with Sherwood Forest Hospitals NHS Foundation Trust and University Hospitals of

Derby and Burton NHS Foundation Trust using July 2026. All maternity quality oversight is via contractual quality oversight mechanisms previously described.

23. Across the five providers, early booking is below the 80% ambition. Perineal tears exceed both national and peer benchmarks at Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust, United Lincolnshire Teaching Hospitals NHS Trust and United Hospitals Derby and Burton NHS Foundation Trust. Postpartum Haemorrhage is above both comparators at Chesterfield Royal Hospital NHS Foundation Trust and United Hospitals Derby and Burton NHS Foundation Trust. Nottingham University Hospitals NHS Trust's Postpartum Haemorrhage is at the peer value (35.0) but above the national value (33.0).

Provider	Booking by 10 weeks	Neonatal deaths / 1,000	Stillbirths / 1,000	3rd/4th degree tears / 1,000	Postpartum Haemorrhage ≥1,500 ml / 1,000
Nottingham University Hospitals NHS Trust	67%	1.99	3.42	52.0	35.0
Sherwood Forest Hospitals NHS Foundation Trust	66%	1.01	2.87	28.0	32.0
United Lincolnshire Teaching Hospitals NHS Trust	69%	1.03	2.94	37.0	28.0
Chesterfield Royal Hospital NHS Foundation Trust	61%*	1.18	2.84	27.0	40.0
United Hospitals Derby and Burton NHS Foundation Trust	69%	0.91	2.89	41.0	38.0

**Chesterfield Royal's booking figure is under review: screening data suggests 83%, compared with 61% in the booking measure. The source notes a potential data-entry, access and notification issue*.

24. Nottingham University Hospitals NHS Trust: Neonatal mortality (1.99) and stillbirth rate (3.42) are below MBRRACE group averages. Early booking is 67%; severe tears are 52.0 compared with national 27.0 and peer 32.0; Postpartum Haemorrhage is 35.0 compared with national 33.0 and peer 35.0. A deep dive found 20% of women self-refer after eight weeks, making booking before ten weeks difficult. The Trust plans to support earlier engagement. Obstetric Anal Sphincter Injury Care Bundle relaunch and the Perinatal Pelvic Health Service are part of improvement activity.

25. Sherwood Forest Hospitals NHS Foundation Trust: Neonatal mortality is 1.01, below the peer average. Stillbirth rate is 2.87, broadly in line with comparators. Booking by ten weeks is 66%. Severe tears are 28.0, above national 27.0 and peer 26.0. Postpartum Haemorrhage is reported as 32.0 in the table, below national 33.0 but above peer 30.0; the source flags a narrative/benchmark discrepancy. Obstetric Anal Sphincter Injury and pelvic health improvement work continues.

26. United Lincolnshire Teaching Hospitals NHS Trust: Stillbirth rate is 2.94 and is described as above the national threshold. All cases are undergoing detailed review through the Perinatal Mortality Review Tool, with thematic analysis at trust and system level. Booking is 69%, in line with the stated local target. Severe tears are 37.0, above national 27.0 and peer 25.0; Postpartum Haemorrhage is 28.0, below national 33.0 and peer 31.0.

27. Chesterfield Royal Hospital NHS Foundation Trust: Perinatal mortality rates are reported below the national average. Postpartum Haemorrhage is raised at 40.0 against national 33.0 and peer 31.0; the Trust has reviewed its guideline and reports that OBSUK has improved measurement, blood product use and Intensive Care Unit admission. Assurance is required that actions are embedded. Severe tears are 27.0, equal to national and peer values, and are reported to be reducing following education. Workforce pressures include increased maternity leave; recruitment support and a Birthrate Plus report are noted. Booking data requires reconciliation with screening data.

28. United Hospitals Derby and Burton NHS Foundation Trust: Postpartum Haemorrhage

Infection, prevention and control

29. September 2026 data shows a sustained challenge against Infection Prevention Control plans. The table below reports case counts, with year-to-date (YTD) counts covering April to September 2026 against plan. Variances are actual minus plan; a positive variance means cases are above plan. The annual variance is YTD actual minus the full-year threshold and is not a forecast.

Infection	DDICB YTD actual vs plan	NNICB YTD actual vs plan	LICB YTD actual vs plan	Interpretation
C. difficile	231 vs 166.02 (+64.98)	218 vs 150 (+68)	131 vs 84 (+47)	Above YTD plan in all three ICBs.
MRSA BSI	7 vs 0 (+7)	17 vs 0 (+17)	1 vs 0 (+1)*	Cases reported against a zero plan in all three ICBs.

Infection	DDICB YTD actual vs plan	NNICB YTD actual vs plan	LICB YTD actual vs plan	Interpretation
E. coli BSI	560 vs 407.52 (+152.48)	599 vs 495 (+104)	311 vs 265 (+46)	Above YTD plan in all three ICBs.
Klebsiella BSI	146 vs 109.5 (+36.5)	177 vs 141 (+36)	104 vs 84 (+20)	Above YTD plan in all three ICBs.
Pseudomonas BSI	40 vs 40.5 (−0.5)	59 vs 47 (+12)	44 vs 27 (+17)	DDICB marginally below plan; NNICB and LICB above.
MSSA BSI	141 cases	177 cases	91 cases	Surveillance only; no plan or threshold supplied.

30. C. difficile remains a significant challenge, with all three ICBs above YTD plan. The source identifies healthcare-associated infection, complex patient risk factors and wider system pressures including corridor care as contributory context.

31. E. coli BSI is above YTD plan across all three ICBs. Gram-negative BSI is predominantly community-onset and identifies older age, comorbidity and urinary sources as important contributory factors, not all cases are healthcare-associated.

Learning disabilities and autism

32. Monitoring and reporting of inpatients with a learning disability and/or autism continues. Work is underway to strengthen best practice and improve grip on monitoring processes. The intention is to streamline ICB and NHS England (Midlands) monitoring and reporting across the ICBs.

Care homes and home care

33. The care-home and home-care position is mixed across the ICBs' footprint, with risk-based oversight arrangements in place and increased escalation reported in parts of Nottinghamshire.

Area	Position reported	Board interpretation
Lincolnshire	102 nursing and residential care home providers contracted under AQP arrangements, plus four domiciliary care zone providers. One care home is suspended; none of the AQP-contracted care homes are subject to suspension.	A single suspension is reported.

Area	Position reported	Board interpretation
Derby and Derbyshire	103 nursing homes monitored: 78 (76%) routine, 23 (22%) enhanced and two (2%) intensive oversight. One formal contract suspension, two voluntary suspensions and one provider with admission restrictions.	Most providers remain in routine oversight, but around one quarter require enhanced or intensive attention.
Nottingham and Nottinghamshire	Oversight levels increased this quarter, including high-risk home-care providers and homes in County and City, particularly North Notts. Two nursing homes have formal contract suspensions and three have voluntary pauses on admissions. Sponsorship licence revocations have increased in the home-care market.	Increased escalation and admission pauses indicate quality and capacity pressures requiring continued joint oversight with local authorities.

Overall assurance conclusion

34. Formal escalation, governance, and improvement arrangements are established across all four providers in quality escalation which is inclusive of the themes identified within the ICBs' Quality Performance Report.

35. There is credible evidence of progress, particularly in the visibility of risk, strengthened oversight, and development of improvement plans. The principal weakness is that evidence of sustained impact is variable. The Boards can take assurance that the risks are recognised and actively managed but should retain escalated scrutiny until providers demonstrate measurable risk reduction, consistent frontline implementation and sustainability under operational and financial pressure.

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

October 2026

Version: v1
Date: 26 October 2026
Prepared By: Rachel Jeffery
Reviewed By: Simon Frampton

NHS
Derby and Derbyshire
Integrated Care Board

NHS
Lincolnshire
Integrated Care Board

NHS
Nottingham and Nottinghamshire
Integrated Care Board

Patient Safety



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

June 2025 – May 2026 Summary Hospital-level Mortality Indicator (SHMI)

Headlines

1 of 5 local trusts higher than expected
*see note below

1.064 local aggregate SHMI vs England 1.000

National banding
Nationally: 14 higher • 95 expected • 9 lower

Local provider view with national baseline comparison

Organisation	Position	Provider Spells	Obs. deaths	Exp. deaths	SHMI value	vs baseline	Obs. vs exp
NHS DERBY AND DERBYSHIRE INTEGRATED CARE BOARD							
Chesterfield Royal Hospital NHS Foundation Trust	As expected	46,810	1,895	1,735	1.0912	+ 0.0912	+ 160.
University Hospitals of Derby and Burton NHS Foundation Trust	As expected	142,600	4,535	4,770	0.95	- 0.05	- 235.
NHS LINCOLNSHIRE INTEGRATED CARE BOARD							
United Lincolnshire Teaching Hospitals NHS Trust	As expected	90,635	3,510	3,345	1.0492	+ 0.0492	+ 165.
NHS NOTTINGHAM AND NOTTINGHAMSHIRE INTEGRATED CARE BOARD							
Nottingham University Hospitals NHS Trust	Higher than expected	163,735	4,295	3,670	1.1707	+ 0.1707	+ 625.
Sherwood Forest Hospitals NHS Foundation Trust	As expected	66,000	2,195	2,070	1.0599	+ 0.0599	+ 125.

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 National calculations based on 118 trusts

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

NHS
Derby and Derbyshire
Integrated Care Board

NHS
Lincolnshire
Integrated Care Board

NHS
Nottingham and
Nottinghamshire
Integrated Care Board

Urgent and Emergency Care

SAIU
STRATEGIC
ANALYTICS
INTELLIGENCE
UNIT

Urgent and Emergency Care

Headlines

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

							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	%	Sep-26	⚠	76.6%	67.5%	-9.1%	✗		78.3%	71.8%	-6.5%	✗		61.0%	68.8%	7.8%	✓	
	A&E >12 Hours (%)	Ops Plan	E.M.13g	%	Sep-26	⚠	8.6%	14.1%	5.5%	✗		9.0%	7.6%	-1.4%	✓		9.7%	15.1%	5.4%	✗	
	A&E Attendances (total)	Ops Plan	E.M.13e	Value	Sep-26	⚠	31,754	32,437	683	✗		11,262	12,110	848	✗		20,597	22,024	1,427	✗	
	A&E <4 Hours (%) - Children under 16	Ops Plan	E.M.13f	%	Sep-26	⚠	95.0%	85.7%	-9.3%	✗		95.0%	87.2%	-7.8%	✗		87.5%	82.8%	-4.7%	✗	
	A&E >12 Hours	Ops Plan	E.M.13g	Value	Sep-26	⚠	1,865	3,225	1,360	✗		425	605	180	✗		1,616	2,530	914	✗	
	A&E <4 Hours (%) - Type 1	Ops Plan	E.M.13a	%	Sep-26		59.9%	53.9%	-6.0%	✗		63.0%	51.4%	-11.6%	✗		61.0%	63.6%	2.6%	✓	
	A&E <4 Hours (%) - Other	Ops Plan	E.M.13b	%	Sep-26	⚠	100.0%	99.9%	-0.1%	✗		98.2%	98.7%	0.5%	✓		89.4%	89.1%	-0.3%	✗	
	A&E Mental Health >24 hours	Nat Std		Value	Sep-26	⚠	0	45	45	✗		0	10	10	✗		0	40	40	✗	
	Ambulance handovers >15 min (%)	Ops Plan	E.B.48	%	Sep-26		74.1%	80.5%	6.4%	✗		50.6%	42.7%	-7.9%	✓		71.3%	87.8%	16.5%	✗	
	Ambulance Handovers >45 min (%)	Ops Plan	E.B.47	%	Sep-26		16.1%	24.6%	8.5%	✗		0.9%	3.0%	2.1%	✗		9.7%	23.9%	14.2%	✗	
	G&A Overnight Beds Occupied (%)	Ops Plan	E.M.30	%	Sep-26		95.0%	94.4%	-0.6%	✓		97.1%	95.1%	-2.0%	✓		92.9%	92.2%	-0.7%	✓	
	7+ day LOS as proportion of Total G&A beds Occupied (%)	Nat Std		%	Sep-26		41.0%	51.2%	10.2%	✗		41.0%	46.1%	5.1%	✗		41.0%	49.0%	8.0%	✗	
	21+ day LOS as proportion of Total G&A beds Occupied (%)	Nat Std		%	Sep-26		13.0%	15.1%	2.1%	✗		13.0%	10.1%	-2.9%	✓		13.0%	20.0%	7.0%	✗	
	Non-Elective LOS	Ops Plan	E.B.43	Value	Aug-26		8.5	8.3	-0	✓		6.1	6.8	1	✗		7.2	7.9	1	✗	
	Total Non-Elective Spells (Specific Acute)	Ops Plan	E.M.11	Value	Aug-26		7,772	7,459	-313	✓		2,848	2,325	-523	✓		6,056	6,083	27	✗	
	Total Non-Elective Spells (0 Day)	Ops Plan	E.M.11a	Value	Aug-26		2,593	2,362	-231	✓		591	298	-293	✓		2,527	2,752	225	✗	
	Total Non-Elective Spells (1+ Days)	Ops Plan	E.M.11b	Value	Aug-26		5,179	5,097	-82	✓		2,257	2,027	-230	✓		3,529	3,331	-198	✓	
	Discharge Ready Date (%)	Ops Plan	E.B.45	%	Aug-26		80.7%	81.0%	0.3%	✓		84.7%	84.5%	-0.2%	✗		79.3%	79.4%	0.1%	✓	
	Average Discharge Delay	Ops Plan	E.B.46	Value	Aug-26		4.8	5.7	0.9	✗		5.2	5.3	0.1	✗		5.0	6.5	1.5	✗	

							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	%	Sep-26	⚠	81.0%	74.4%	-6.6%	✗		78.3%	66.2%	-12.1%	✗	
	A&E >12 Hours (%)	Ops Plan	E.M.13g	%	Sep-26	⚠	2.0%	6.4%	4.4%	✗		14.3%	15.2%	0.9%	✗	
	A&E Attendances (total)	Ops Plan	E.M.13e	Value	Sep-26	⚠	16,798	17,182	384	✗		24,510	27,799	3,289	✗	
	A&E <4 Hours (%) - Children under 16	Ops Plan	E.M.13f	%	Sep-26	⚠	95.0%	92.6%	-2.4%	✗		91.3%	85.4%	-5.9%	✗	
	A&E >12 Hours	Ops Plan	E.M.13g	Value	Sep-26	⚠	228	715	487	✗		2,274	3,105	831	✗	
	A&E <4 Hours (%) - Type 1	Ops Plan	E.M.13a	%	Sep-26		74.5%	68.6%	-5.9%	✗		65.4%	44.6%	-20.8%	✗	
	A&E <4 Hours (%) - Other	Ops Plan	E.M.13b	%	Sep-26	⚠	94.7%	85.3%	-9.4%	✗		98.0%	85.7%	-12.3%	✗	
	A&E Mental Health >24 hours	Nat Std		Value	Sep-26	⚠	0	10	10	✗		0	85	85	✗	
	Ambulance handovers >15 min (%)	Ops Plan	E.B.48	%	Sep-26		30.3%	70.0%	39.7%	✗		73.5%	78.0%	4.5%	✗	
	Ambulance Handovers >45 min (%)	Ops Plan	E.B.47	%	Sep-26		0.0%	9.9%	9.9%	✗		10.8%	26.8%	16.0%	✗	
	G&A Overnight Beds Occupied (%)	Ops Plan	E.M.30	%	Sep-26		96.0%	95.4%	-0.6%	✓		94.0%	95.0%	1.0%	✗	
	7+ day LOS as proportion of Total G&A beds Occupied (%)	Nat Std		%	Sep-26		41.0%	47.3%	6.3%	✗		41.0%	56.9%	15.9%	✗	
	21+ day LOS as proportion of Total G&A beds Occupied (%)	Nat Std		%	Sep-26		13.0%	18.7%	5.7%	✗		13.0%	24.3%	11.3%	✗	
	Non-Elective LOS	Ops Plan	E.B.43	Value	Aug-26		7.6	8.0	0	✗		7.4	8.5	1	✗	
	Total Non-Elective Spells (Specific Acute)	Ops Plan	E.M.11	Value	Aug-26		3,803	3,810	7	✗		9,551	8,762	-789	✓	
	Total Non-Elective Spells (0 Day)	Ops Plan	E.M.11a	Value	Aug-26		1,287	1,371	84	✗		3,894	3,635	-259	✓	
	Total Non-Elective Spells (1+ Days)	Ops Plan	E.M.11b	Value	Aug-26		2,516	2,439	-77	✓		5,657	5,127	-530	✓	
	Discharge Ready Date (%)	Ops Plan	E.B.45	%	Aug-26		80.0%	80.0%	0.0%	✓		78.3%	79.7%	1.4%	✓	
	Average Discharge Delay	Ops Plan	E.B.46	Value	Aug-26		3.6	4.8	1.2	✗		5.2	4.7	-0.5	✓	

Urgent and Emergency Care services continue to experience sustained operational pressure across the ICBs, 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.

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

SAIU
STRATEGIC ANALYTICS INTELLIGENCE UNIT

Maternity: executive overview

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

Provider values and benchmarks

Indicative RAG **R Worse** **A Equal / mixed** **G Better** compared with the benchmark(s) shown

Provider	10-week booking % of bookings	Neonatal deaths per 1,000 live births	Stillbirths per 1,000 births	3rd/4th degree tears per 1,000 births	Post Partum Haemorrhage (PPH) ≥1,500 ml per 1,000 births
Nottingham University Hospitals (NUH)	R 67% Ambition 80%	G 1.99 Peer 2.36	G 3.42 Peer 3.49	R 52.0 Nat 27.0 / Peer 32.0	A 35.0 Nat 33.0 / Peer 35.0
Sherwood Forest Hospitals (SFH)	R 66% Ambition 80%	G 1.01 Peer 1.12	R 2.87 Peer 2.85	R 28.0 Nat 27.0 / Peer 26.0	A 32.0 Nat 33.0 / Peer 30.0
United Lincolnshire Teaching Hospitals (ULHT)	R 69% 80% (local 69%)	G 1.03 Peer 1.04	R 2.94 Peer 2.93	R 37.0 Nat 27.0 / Peer 25.0	G 28.0 Nat 33.0 / Peer 31.0
Chesterfield Royal Hospital (CRH)	R 61%† Ambition 80%	R 1.18 Peer 1.12	G 2.84 Peer 2.85	A 27.0 Nat 27.0 / Peer 27.0	R 40.0 Nat 33.0 / Peer 31.0
University Hospitals of Derby and Burton (UHDB)	R 69% Ambition 80%	G 0.91 Peer 1.04	G 2.89 Peer 2.93	R 41.0 Nat 27.0 / Peer 25.0	R 38.0 Nat 33.0 / Peer 31.0

Board focus

Maternal morbidity

Tears: NUH, SFH, ULHT and UHDB exceed both benchmarks.
PPH: CRH and UHDB.

Assurance and learning

CRH: PPH and workforce actions. ULHT: stillbirth reviews. UHDB: pelvic health delivery.

2024 mortality. Other measures: August 2026 (SFH and Derby & Burton: July). Nat = national. Peer = MBRRACE group.
†CRH bookings: 61% vs 83% screening, under review. SFH mortality follows charts/text (table transposed).
RAG compares stated values only, not outlier status. SFH PPH: narrative and benchmark panel differ. Booking: 80% NMPA ambition.

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

Nottingham University Hospitals NHS Trust (NUH)

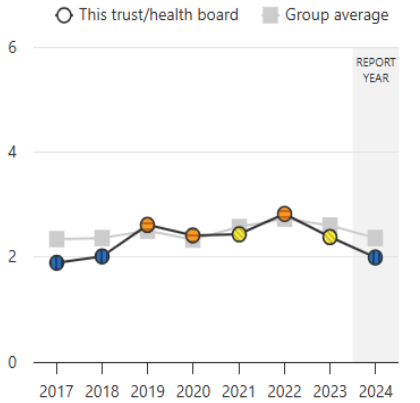
NUH's neonatal mortality (1.99 per 1,000 live births) and stillbirth rate (3.42 per 1,000 births) remain below MBRRACE group averages, demonstrating continued improvement in key mortality outcomes. However, performance remains challenging in relation to early booking (67%), 3rd/4th degree tears (52.0 per 1,000 births) and severe postpartum haemorrhage (35.0 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 post partum haemorrhage rates 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
August 2026	2024	2024	August 2026	August 2026
67%	1.99	3.42	52.0	35.0

Neonatal Deaths

Mortality rates, by year

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

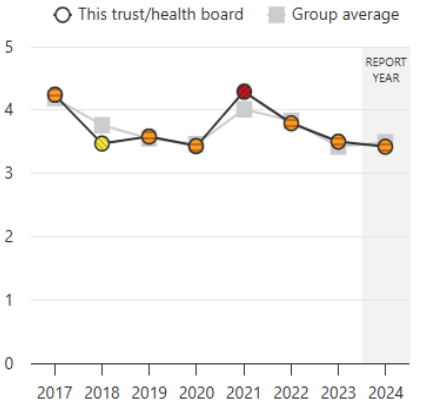


2024
This trust/health board: **1.99**
Group average: **2.36**

Stillbirths

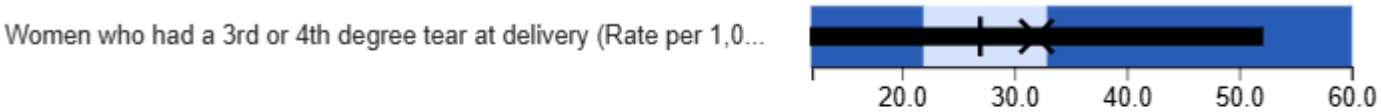
Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births



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





Trust value 52.0
National value 27.0
MBRRACE group value 32.0



Trust value 35.0
National value 33.0
MBRRACE group value 35.0

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

Sherwood Forest Hospitals NHS Foundation Trust (SFH)

SFH 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' (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) group average. Early access to maternity care remains a focus, with 66% of women booked by 10 weeks gestation, below the NMPA (National Maternity and Perinatal Audit) ambition of 80%.

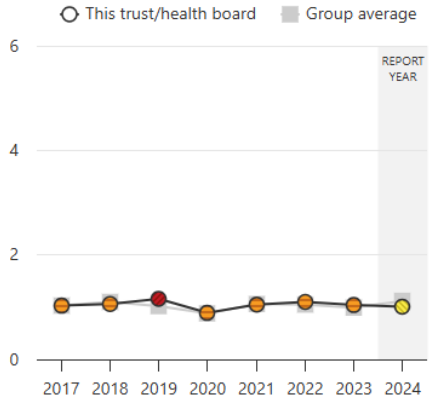
The Trust has demonstrated strong performance in relation to post partum haemorrhage, with rates lower than both national and peer group benchmarks. However, rates of 3rd/4thdegree perineal tears remain above national and MBRRACE averages, and improvement activity continues through implementation of the Obstetric Anal Sphincter Injury 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
July 2026	2024	2024	July 2026	July 2026
66%	2.87	1.01	28.0	32.0

Neonatal Deaths

Mortality rates, by year

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

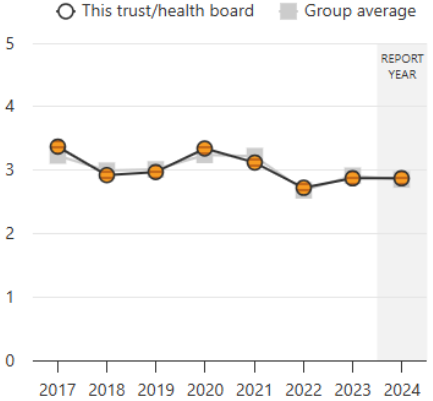


2024
This trust/health board: **1.01**
Group average: **1.12**

Stillbirths

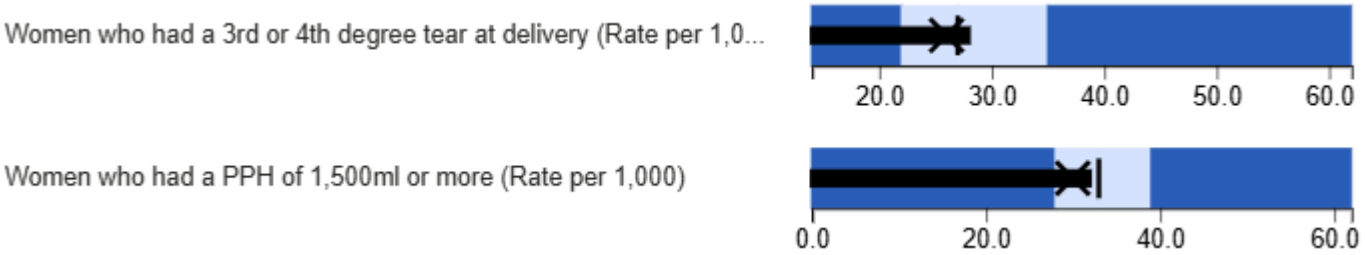
Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births



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





Trust value 28.0
National value 27.0
MBRRACE group value 26.0

Trust value 32.0
National value 33.0
MBRRACE group value 30.0

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

United Lincolnshire Teaching Hospitals NHS Trust (ULHT)

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 the Perinatal Mortality Review Tool, supported by thematic analysis at trust and system level.

Booking by 10 weeks is 69% which is in line with the target of 69%.

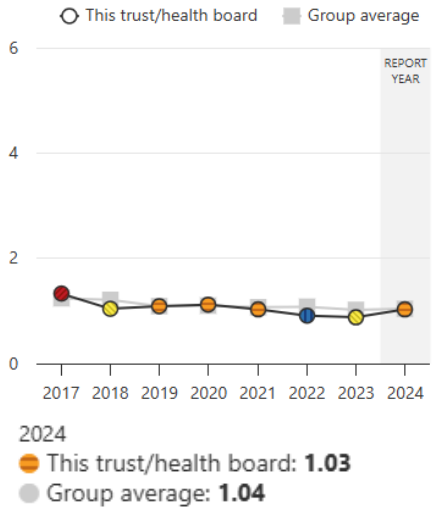
3rd and 4th degree rates are above the national average and MBRRACE group value but not an outlier. Post partum haemorrhage Rates over 1500mls is under the national and MBRRACE group comparator average. A thematic analysis involving human factors, themes and trends rather than looking at individual cases 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 August 2026	Per 1,000 live births 2024	Per 1,000 births 2024	Per 1,000 births August 2026	Per 1,000 births August 2026
69%	1.03	2.94	37.0	28.0

Neonatal Deaths

Mortality rates, by year

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

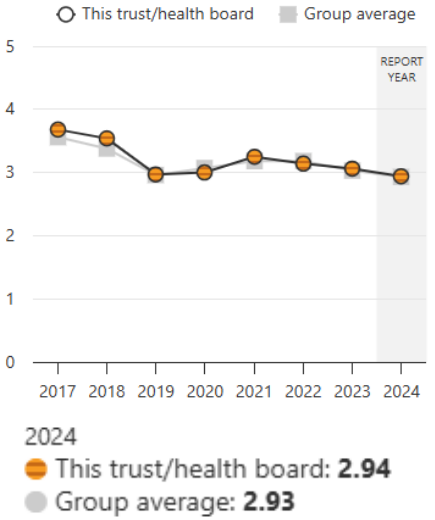


2024
This trust/health board: **1.03**
Group average: **1.04**

Stillbirths

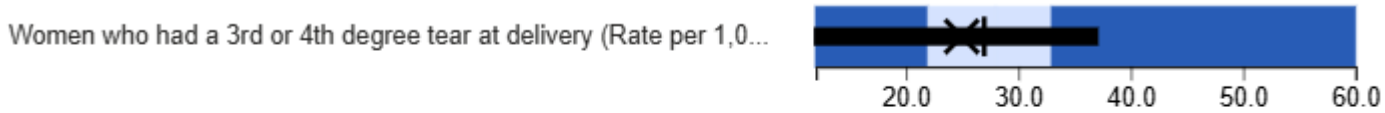
Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births



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





Trust value 37.0
National value 27.0
MBRRACE group value 25.0



Trust value 28.0
National value 33.0
MBRRACE group value 31.0

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

Chesterfield Royal Hospital NHS Foundation Trust (CRH)

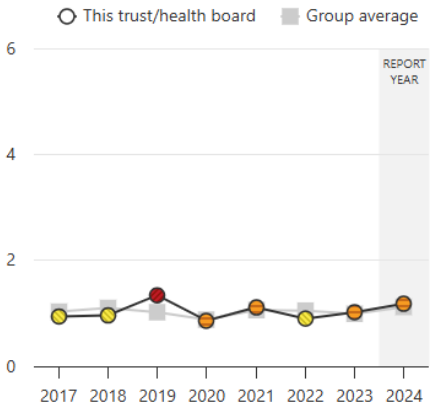
- Perinatal mortality rates remain below national average.
- Post partum haemorrhage >1500mls remains raised and is under trust review. Guideline reviewed to recognise early identification, risk assessment and early escalation . The Obstetric Bleeding Study UK has led to more accurate measurement and a decrease in blood product use and intensive care unit 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 August 2026	Per 1,000 live births 2024	Per 1,000 births 2024	Per 1,000 births August 2026	Per 1,000 births August 2026
61%	1.18	2.84	27.0	40.0

Neonatal Deaths

Mortality rates, by year

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

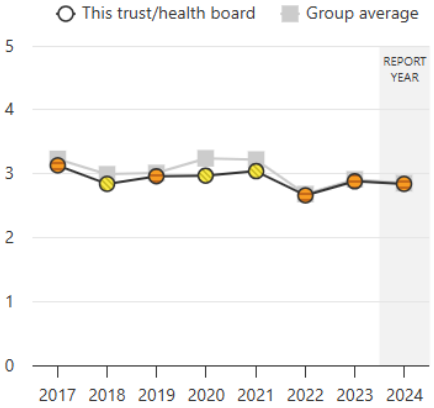


2024
This trust/health board: **1.18**
Group average: **1.12**

Stillbirths

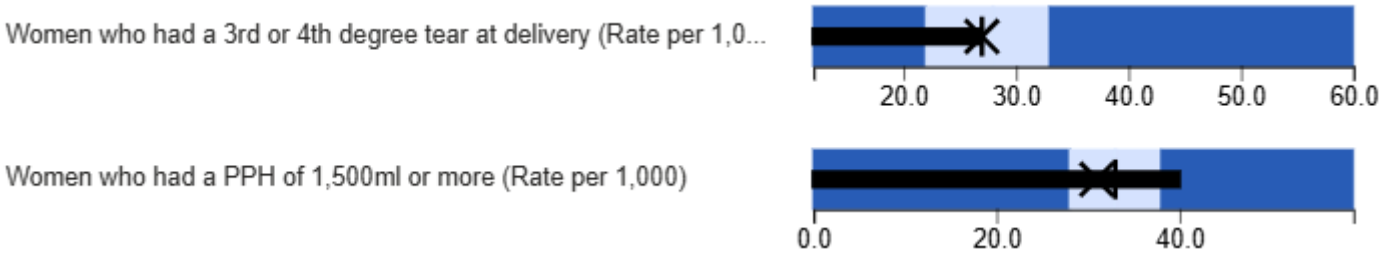
Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births



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





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

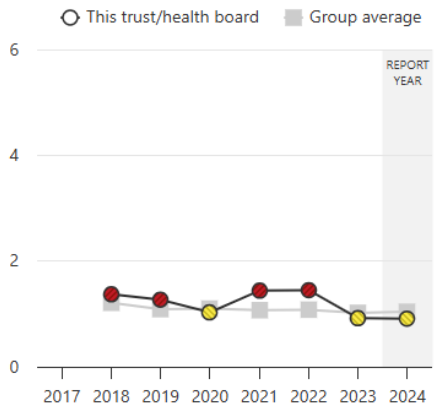
University Hospitals of Derby and Burton NHS Foundation Trust

- NHSE Maternity and Neonatal Improvement Support Team provided targeted support until July 2026
- Perinatal mortality rates remain below national average
- The Perinatal Pelvic Health Service was fully implemented in September 2026.
- 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

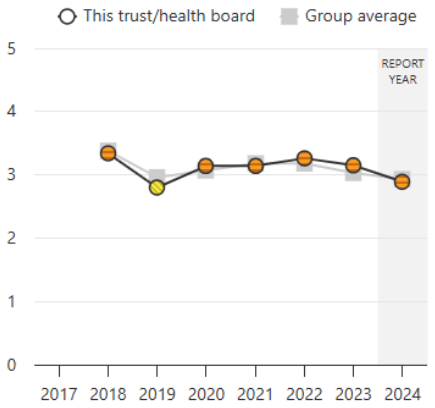


2024
This trust/health board: **0.91**
Group average: **1.04**

Stillbirths

Mortality rates, by year

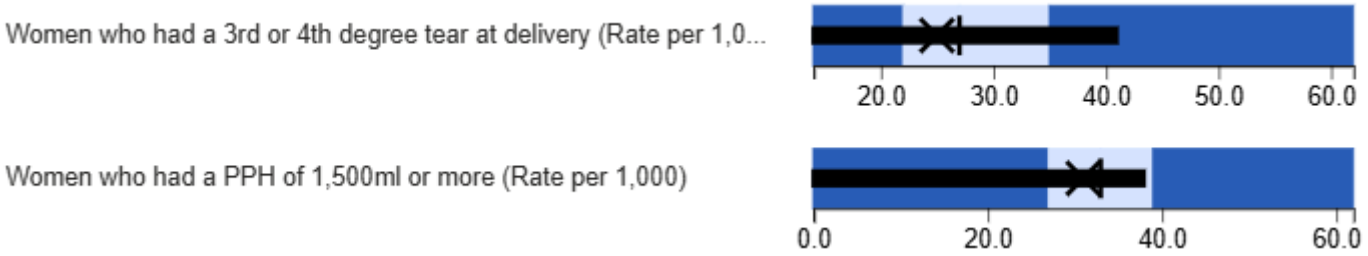
Stabilised & adjusted stillbirth rate per 1,000 total births



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 July 2026	Per 1,000 live births 2024	Per 1,000 births 2024	Per 1,000 births July 2026	Per 1,000 births July 2026
69%	0.91	2.89	41.0	38.0





Trust value 41.0
National value 27.0
MBRRACE group value 25.0

Trust value 38.0
National value 33.0
MBRRACE group value 31.0

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

NHS
Derby and Derbyshire
Integrated Care Board

NHS
Lincolnshire
Integrated Care Board

NHS
Nottingham and
Nottinghamshire
Integrated Care Board

Infection, Prevention and Control

SAIU
STRATEGIC
ANALYTICS
INTELLIGENCE
UNIT

Infection, Prevention and Control

September 2026

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Clostridioides difficile (C.difficile)

C.difficile remains a significant challenge both locally and nationally. Performance continues to exceed planned trajectories despite targeted IPC interventions. The position reflects a combination of healthcare-associated infection, complex patient risk factors and wider system pressures including corridor care. Targeted provider quality improvement work is ongoing, focused on case review, antimicrobial stewardship, timely identification and management, environmental standards and IPC fundamentals.

	ICB / Provider	September 2026			YTD			Fin year 2026/27	
		Actual	Plan	Var	Actual	Plan	Var	Threshold	Var
DDICB	**Derby and Derbyshire Integrated Care Board (all)**	**44**	**27.67**	● **+16.33**	**231**	**166.02**	● **+64.98**	**332.04**	● **−101.04**
DDICB	Chesterfield Royal Hospital	6	3.67	● **+2.33**	42	21.98	● **+20.02**	44	● **−2**
DDICB	University Hospitals of Derby and Burton	21	13.58	● **+7.42**	97	81.48	● **+15.52**	163	● **−66**
NNICB	**Nottingham and Nottinghamshire Integrated Care Board (all)**	**31**	**25**	● **+6**	**218**	**150**	● **+68**	**303**	● **−85**
NNICB	Nottingham University Hospitals	20	13	● **+7**	100	78	● **+22**	152	● **−52**
NNICB	Sherwood Forest Hospitals	4	5	● **−1**	38	31	● **+7**	65	● **−27**
LICB	**Lincolnshire Integrated Care Board (all)**	**22**	**14**	● **+8**	**131**	**84**	● **+47**	**167**	● **−36**
LICB	United Lincolnshire Teaching Hospitals	16	7.5	● **+8.5**	74	45	● **+29**	163	● **−89**

● Red: above plan ● Amber: equal to plan ● Green: below plan RAG uses the variance sign, with no tolerance band.

Figures = reported case counts. Month = September 2026. YTD = April–September 2026 actual cases versus the supplied YTD plan.
Month / YTD Var = actual minus the corresponding plan. Fin year Var = YTD actual minus the full 2026/27 annual threshold (plan).
Fin year shows annual headroom or exceedance so far. No year-end forecast implied. Plans and variances display up to 2 decimal places.

Source: https://hcaidcs.ukhsa.gov.uk/

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Infection, Prevention and Control

September 2026

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

MRSA Bloodstream Infection (BSI)

MRSA BSI remains a significant challenge both locally and nationally. Chesterfield continues to perform well with zero cases reported to date. Providers continue to undertake detailed case reviews following their Patient Safety Incident Response Plans, with learning informing targeted actions around decolonisation, device management, wound care and consistent application of IPC fundamentals. Nottinghamshire Healthcare Trust as a community provider, does not have an allocated trajectory. However, they are leading two MRSA BSI case reviews in patients receiving care from the Trust.

	ICB / Provider	September 2026			YTD			Fin year 2026/27	
		Actual	Plan	Var	Actual	Plan	Var	Threshold	Var
DDICB	**Derby and Derbyshire Integrated Care Board (all)**	**2**	**0**	**● +2**	**7**	**0**	**● +7**	**0**	**● +7**
	Chesterfield Royal Hospital	0	0	● 0	0	0	● 0	0	● 0
	University Hospitals of Derby and Burton	1	0	● +1	2	0	● +2	0	● +2
NNICB	**Nottingham and Nottinghamshire Integrated Care Board (all)**	**5**	**0**	**● +5**	**17**	**0**	**● +17**	**0**	**● +17**
	Nottingham University Hospitals	2	0	● +2	4	0	● +4	0	● +4
	Sherwood Forest Hospitals	3	0	● +3	5	0	● +5	0	● +5
LICB	**Lincolnshire Integrated Care Board (all)**	**5**	**0**	**● +5**	**1**	**0**	**● +1**	**0**	**● +1**
	United Lincolnshire Teaching Hospitals	1	0	● +1	2	0	● +2	0	● +2

● Red: above plan ● Amber: equal to plan ● Green: below plan RAG uses the variance sign, with no tolerance band.

Data flag: Lincolnshire Integrated Care Board (all): September 5 exceeds YTD 1. Supplied figures retained for SME review.

Month = September 2026. YTD = April–September 2026 cases versus supplied YTD plan. Month / YTD Var = actual minus that period's plan. Fin year = full 2026/27 threshold (plan) versus YTD cases. Fin year Var = YTD actual minus annual threshold. No year-end forecast implied.

Source: https://hcaidcs.ukhsa.gov.uk/

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Infection, Prevention and Control

September 2026

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

E. Coli Bloodstream Infection (BSI)

E. coli BSI remains a significant challenge both locally and nationally. Performance is above plan in ICB and provider areas, although some month improvement was evident in several providers. Gram-negative BSI continues to be predominantly community-onset, with older age, comorbidities and urinary sources important contributory factors, not all cases have healthcare association. Provider reviews are informing targeted quality improvement work with a focus on urinary tract infection (UTI) prevention, hydration, timely recognition and treatment, appropriate sampling and antimicrobial stewardship.

	ICB / Provider	September 2026			YTD			Fin year 2026/27	
		Actual	Plan	Var	Actual	Plan	Var	Threshold	Var
DDICB	**Derby and Derbyshire Integrated Care Board (all)**	**74**	**67.92**	● **+6.08**	**560**	**407.52**	● **+152.48**	**815.04**	● **−255.04**
DDICB	Chesterfield Royal Hospital	6	5.08	● **+0.92**	47	30.48	● **+16.52**	60.96	● **−13.96**
DDICB	University Hospitals of Derby and Burton	17	15.25	● **+1.75**	114	76.25	● **+37.75**	183	● **−69**
NNICB	**Nottingham and Nottinghamshire Integrated Care Board (all)**	**84**	**79**	● **+5**	**599**	**495**	● **+104**	**963**	● **−364**
NNICB	Nottingham University Hospitals	23	24	● **−1**	179	148	● **+31**	292	● **−113**
NNICB	Sherwood Forest Hospitals	10	6	● **+4**	55	39	● **+16**	72	● **−17**
LICB	**Lincolnshire Integrated Care Board (all)**	**52**	**44**	● **+8**	**311**	**265**	● **+46**	**529**	● **−218**
LICB	United Lincolnshire Teaching Hospitals	11	9	● **+2**	63	54	● **+9**	108	● **−45**

● Red: above plan ● Amber: equal to plan ● Green: below plan RAG uses the variance sign, with no tolerance band.

Figures = reported case counts. Month = September 2026. YTD = April–September 2026 actual cases versus the supplied YTD plan.
Month / YTD Var = actual minus the corresponding plan. Fin year Var = YTD actual minus the full 2026/27 annual threshold (plan).
Fin year shows annual headroom or exceedance so far. No year-end forecast implied. Plans and variances display up to 2 decimal places.

Source: https://hcaidcs.ukhsa.gov.uk/

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Infection, Prevention and Control

September 2026

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

Klebsiella spp Bloodstream Infection (BSI)

Klebsiella BSI remains a significant challenge both locally and nationally.
Performance is above plan in a number of ICB and provider areas. Provider quality improvement activity continues through case review, antimicrobial stewardship, line management and reinforcement of IPC fundamentals.

	ICB / Provider	September 2026			YTD			Fin year 2026/27	
		Actual	Plan	Var	Actual	Plan	Var	Threshold	Var
DDICB	**Derby and Derbyshire Integrated Care Board (all)**	**26**	**18.25**	● **+7.75**	**146**	**109.5**	● **+36.5**	**219**	● **−73**
DDICB	Chesterfield Royal Hospital	2	1.5	● **+0.5**	11	9	● **+2**	18	● **−7**
DDICB	University Hospitals of Derby and Burton	6	4.67	● **+1.33**	34	27.98	● **+6.02**	56	● **−22**
NNICB	**Nottingham and Nottinghamshire Integrated Care Board (all)**	**33**	**23**	● **+10**	**177**	**141**	● **+36**	**274**	● **−97**
NNICB	Nottingham University Hospitals	18	10	● **+8**	86	50	● **+36**	120	● **−34**
NNICB	Sherwood Forest Hospitals	2	1	● **+1**	14	5	● **+9**	15	● **−1**
LICB	**Lincolnshire Integrated Care Board (all)**	**19**	**14**	● **+5**	**104**	**84**	● **+20**	**167**	● **−63**
LICB	United Lincolnshire Teaching Hospitals	5	3.5	● **+1.5**	24	21	● **+3**	42	● **−18**

● Red: above plan ● Amber: equal to plan ● Green: below plan RAG uses the variance sign, with no tolerance band.

Figures = reported case counts. Month = September 2026. YTD = April–September 2026 actual cases versus the supplied YTD plan.
Month / YTD Var = actual minus the corresponding plan. Fin year Var = YTD actual minus the full 2026/27 annual threshold (plan).
Fin year shows annual headroom or exceedance so far. No year-end forecast implied. Plans and variances display up to 2 decimal places.

Source: https://hcaidcs.ukhsa.gov.uk/

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Infection, Prevention and Control

September 2026

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

Pseudomonas aeruginosa Bloodstream Infection (BSI)

Pseudomonas BSI remains above ICB plan. Some month improvements were achieved across providers and Chesterfield continue to report zero cases. Provider case reviews continue to explore infection source, complex patient factors, antimicrobial exposure and environmental risks, with learning informing targeted quality, IPC and estates actions.

	ICB / Provider	September 2026			YTD			Fin year 2026/27	
		Actual	Plan	Var	Actual	Plan	Var	Threshold	Var
DDICB	**Derby and Derbyshire Integrated Care Board (all)**	**9**	**6.75**	**● +2.25**	**40**	**40.5**	**● −0.5**	**81**	**● −41**
	Chesterfield Royal Hospital	0	0.75	● −0.75	0	4.5	● −4.5	9	● −9
	University Hospitals of Derby and Burton	2	2.08	● −0.08	15	12.48	● +2.52	25	● −10
NNICB	**Nottingham and Nottinghamshire Integrated Care Board (all)**	**10**	**7**	**● +3**	**59**	**47**	**● +12**	**89**	**● −30**
	Nottingham University Hospitals	4	5	● −1	26	25	● +1	59	● −33
	Sherwood Forest Hospitals	0	1	● −1	7	5	● +2	9	● −2
LICB	**Lincolnshire Integrated Care Board (all)**	**6**	**4**	**● +2**	**44**	**27**	**● +17**	**51**	**● −7**
	United Lincolnshire Teaching Hospitals	0	1.25	● −1.25	12	7.5	● +4.5	15	● −3

● Red: above plan ● Amber: equal to plan ● Green: below plan RAG uses the variance sign, with no tolerance band.

Figures = reported case counts. Month = September 2026. YTD = April–September 2026 actual cases versus the supplied YTD plan.
Month / YTD Var = actual minus the corresponding plan. Fin year Var = YTD actual minus the full 2026/27 annual threshold (plan).
Fin year shows annual headroom or exceedance so far. No year-end forecast implied. Plans and variances display up to 2 decimal places.

Source: https://hcaidcs.ukhsa.gov.uk/

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Infection, Prevention and Control

September 2026

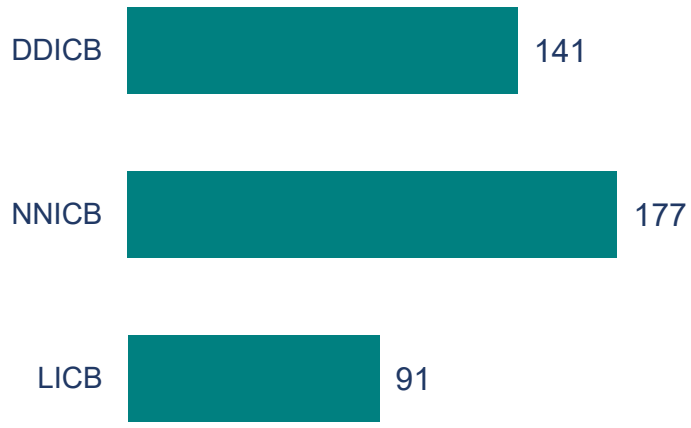
NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

MSSA

MSSA BSI remains under surveillance across the ICBs, although there is currently no national NHS England threshold. Provider case reviews continue to identify learning and inform targeted quality improvement, particularly around vascular device management, skin and wound care and IPC fundamentals. Local variation continues to be monitored.

	ICB / Provider	September 2026	YTD
		Actual	Actual
DDICB	**Derby and Derbyshire Integrated Care Board (all)**	**28**	**141**
DDICB	Chesterfield Royal Hospital	0	6
DDICB	University Hospitals of Derby and Burton	10	30
NNICB	**Nottingham and Nottinghamshire Integrated Care Board (all)**	**29**	**177**
NNICB	Nottingham University Hospitals	9	67
NNICB	Sherwood Forest Hospitals	3	21
LICB	**Lincolnshire Integrated Care Board (all)**	**13**	**91**
LICB	United Lincolnshire Teaching Hospitals	5	30

ICB totals: Yeatr to date cases



Whole-ICB totals, not a sum of the listed providers

Figures = reported MSSA case counts. Month = September 2026. YTD = April–September 2026 cumulative actual cases.
The workbook supplies no MSSA plan or annual threshold, so no variance or RAG rating applies. ICB totals cover the whole ICB.

Source: https://hcaidcs.ukhsa.gov.uk/

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

NHS
Derby and Derbyshire
Integrated Care Board

NHS
Lincolnshire
Integrated Care Board

NHS
Nottingham and
Nottinghamshire
Integrated Care Board

Learning Disabilities and Autism

SAIU
STRATEGIC
ANALYTICS
INTELLIGENCE
UNIT

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	Sep-26		31	34	3 ✗			33	31	-2 ✓			35	36	1 ✗		
	LD Adult MH Inpatients	Ops Plan	E.H.32	Value	Sep-26		15	16	1 ✗			12	11	-1 ✓			19	22	3 ✗		
	Autistic Adult MH Inpatients	Ops Plan	E.H.33	Value	Sep-26		16	18	2 ✗			21	20	-1 ✓			16	14	-2 ✓		
	LD/Autism CYP Inpatients	Ops Plan	E.K.1c	Value	Sep-26		3	3	0 ✓			2	0	-2 ✓			3	2	-1 ✓		
	LD Annual Health Checks with HAP	Ops Plan	E.K.6	Value	Sep-26	⚠	364	392	28 ✓			259	252	-7 ✗			434	363	-71 ✗		
	LD Annual Health Checks with HAP (Qtr)	Ops Plan	E.K.3	Value	Sep-26	⚠	1,092	1,176	84 ✓			777	835	58 ✓			1,300	1,223	-77 ✗		
	LD/Autism Long MH Stays	Ops Plan	E.K.4	Value	Sep-26		18	15	-3 ✓			15	15	0 ✓			22	20	-2 ✓		
	MH Admission Rate – LD/Autism Adults	Ops Plan	E.K.5a	Value	Sep-26	⚠	23.0	38.0	15.0 ✗			35.0	51.0	16.0 ✗			16.0	13.0	-3.0 ✓		
	MH Admission Rate – LD/Autism CYP	Ops Plan	E.K.5b	Value	Sep-26	⚠	42.0	38.0	-4.0 ✓			47.9	*				10.0	39.0	29.0 ✗		

Headlines

The monitoring and reporting of inpatients with a Learning Disability and/or Autism continues. Work is underway to support 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

NHS
Derby and Derbyshire
Integrated Care Board

NHS
Lincolnshire
Integrated Care Board

NHS
Nottingham and
Nottinghamshire
Integrated Care Board

Care Homes and Home Care

SAIU
STRATEGIC
ANALYTICS
INTELLIGENCE
UNIT

Care Homes and Home Care

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Lincolnshire ICB

Lincolnshire currently has 102 nursing and residential care home providers contracted under the AQP arrangements in Lincolnshire, together with four domiciliary care zone providers.

While one care home in Lincolnshire is currently suspended, none of the AQP-contracted care homes are subject to suspension.

Derby and Derbyshire ICB

There are a total of 103 care homes with nursing in Derby and Derbyshire that are monitored by the Care Home Quality team. Of these, 78 providers (76%) remain within routine quality monitoring arrangements, 23 providers (22%) are subject to enhanced monitoring due to identified quality, safety or governance concerns and 2 providers (2%) require intensive oversight and targeted intervention owing to significant quality risks. One provider is subject to a formal contract suspension, two providers have voluntary suspension arrangements in place and one provider is operating with admission restrictions while improvement actions and assurance requirements are progressed. Overall, the care home sector remains stable, with most providers requiring routine oversight. Quality monitoring arrangements continue to be applied proportionately according to risk, ensuring resources are focused on providers requiring increased support, assurance and improvement.

Nottingham and Nottinghamshire ICB

Oversight levels have increased this quarter, with an increase in high-risk (enhanced oversight) home care providers and homes in the County and in the City.
County services show growing operational pressures, increase in oversight particularly in North Notts. Increase in voluntary pause on admissions to enable services to rectify concerns and implement improvement plans. City services demonstrate comparatively stable with a slight increase in escalation levels. There are currently 2 nursing homes with formal contract suspensions and 3 nursing home with a voluntary pause on admissions. There has been an increase in sponsorship licence revocation across the Home Care market, however we have a significant number of providers on the AQP framework and therefore market capacity should not become an issue. There has been further sponsorship licence revocations since the last report.
Joint system working continues, with close links to both County and City Local Authorities.

SAIU STRATEGIC ANALYTICS INTELLIGENCE UNIT

Care Quality Commission (CQC)

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

CQC Provider Ratings

DLN at a glance

1,135
provider locations in view

84%
rated Good or Outstanding

170
Require improvement / Inadequate

Organisation type	Total number of providers	Outstanding ☆	Good	Requires improvement	Inadequate	Not rated
Care Homes	832	57	611	152	5	7
Acute	5	-	3	2	-	-
Community	2	2	-	-	-	-
Mental Health	2	-	2	-	-	-
GP Practices	294	34	243	16	-	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/2026-10/01_October_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	286	29	210	43	3	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	283	11	219	50	0	3
GP Practices	105	16	83	5	0	1

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	264	17	184	58	2	3
GP Practices	77	2	67	8	0	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

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/11/2026
Paper title:	**Commissioning Delivery Oversight Report – November 2026**
Paper reference:	ICB CIC 26 072
Paper author:	Robert Taylor – Associate Director of Performance Reporting and Oversight
Paper sponsor:	Maria Principe - Executive Director of Commissioning
Presenter:	Maria Principe

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

Report summary:

The Commissioning Delivery Oversight Report sets out a mixed position across the NHS Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire ICBS (DLN), with two ICB-programme assessments rated Green, 14 Amber and eight Red.

Commissioner oversight is becoming more coordinated and outcomes focused, with recovery plans increasingly tested against activity trajectories, clear milestones and measurable in-year improvement. Provider Improvement Meetings and proportionate contractual escalation are being used where assurance remains insufficient, alongside closer working with NHS England. The focus is now on demonstrating that these actions translate into sustained activity recovery, improved access and patient flow, and appropriate financial reconciliation where commissioned activity has not been delivered.

Data quality assurance has also strengthened through the DLN-wide Data Quality Framework and risk register. At the end of October, 44 active data-quality issues were recorded, comprising 28 relating to acute services, 12 to non-acute services and four affecting both.

Overall, the report reflects significant delivery challenge alongside a more developed platform for improvement. The priority for the remainder of 2026/27 is to translate recovery plans, additional capacity, winter interventions and pathway transformation into sustained improvements in activity, access, waiting times, patient flow and outcomes, supported by clear evidence that commissioner and provider actions are having the intended impact.

Recommendation(s):

The Boards are asked to **receive** the paper for assurance in relation to service delivery against the operational plans.

Appendices

A: Commissioning Delivery Oversight Report

Board Assurance Framework

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

Board Assurance Framework

- Failure to ensure timely and equitable access to healthcare services in line with national and local performance standards

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Commissioning Oversight Delivery Report

Purpose of the Report

1. The report provides the Boards with an overview of current delivery across the Derbyshire, Lincolnshire and Nottinghamshire ICBs (DLN) against 2026/27 operational plan requirements, highlighting performance, emerging risks, recovery trajectories and mitigating actions across the major commissioning programmes.
2. It also describes how the DLN Commissioning Oversight Framework is strengthening commissioner assurance across operational, financial, contractual, quality and data-quality performance. Programme Boards, the Commissioning Oversight Group, provider oversight and escalation arrangements provide a structured route for identifying risk, testing recovery plans and holding providers to account for delivery.
3. The report highlights areas of positive delivery, the principal challenges requiring sustained improvement and the actions being taken by commissioners and providers. It also updates the Boards on provider escalation, NHS Oversight Framework assessments and data-quality assurance.

Executive Summary

4. **Elective care** remains below plan across all three ICBs, although Nottingham and Nottinghamshire is achieving its first outpatient trajectory and there are examples of pathway redesign and referral optimisation supporting recovery. Referral to Treatment (RTT) performance, 52-week waits and total waiting-list size remain adverse to trajectory. Recovery action plans have been received from Nottingham University Hospitals NHS Trust, University Hospitals of Derby and Burton NHS Foundation Trust and United Lincolnshire Teaching Hospitals NHS Trust, providing a basis for more focused oversight, but they do not yet provide sufficient activity-based assurance. Strengthened plans are being sought with clearer trajectories, delivery dates and quantified gaps, alongside continued work on productivity, additional capacity and pathway transformation.
5. **Diagnostics** continues to constrain both elective and cancer recovery, although investment in capacity and Community Diagnostic Centre development provides a stronger platform for improvement. The proportion waiting more than six weeks is 33.0% in Derbyshire against a plan of 16.5%, 53.2% in Lincolnshire against 28.6%, and 31.6% in Nottingham and Nottinghamshire against 19.7%. Activity is below plan in Derbyshire and Lincolnshire, whilst Nottingham and Nottinghamshire is above activity plan. Recovery action includes mobile and independent-sector capacity, equipment

investment and additional insourced non-obstetric ultrasound activity in Lincolnshire. Commissioner action is focused on maximising utilisation and converting this additional capacity into measurable reductions in 6- and 13-week waits.

6. **Cancer** performance remains challenging, particularly for treatment standards, but Faster Diagnosis performance provides an area of relative strength. Nottingham and Nottinghamshire is achieving its Faster Diagnosis trajectory at 84.0% against 80.0%, while Derbyshire and Lincolnshire remain below plan. 31 and 62-day treatment performance are below trajectory across all three ICBs, with 62-day performance ranging from 61.4% to 66.4%. Recovery continues through tumour-site and pathway-level oversight, patient tracking list validation, pathway redesign and targeted diagnostic and treatment capacity, with the focus on translating earlier diagnosis into timely treatment.

7. **Urgent and Emergency Care** remains pressured as winter demand increases, although Lincolnshire continues to achieve its four-hour trajectory and strengthened winter and discharge arrangements provide a clearer route to improvement. Derbyshire and Nottingham and Nottinghamshire remain below their four-hour plans, while twelve-hour waits, Category Two ambulance response and ambulance handovers require further recovery focus. Whole-system action is being coordinated through winter delivery arrangements, discharge improvement, admission avoidance, Urgent Community Response and Same Day Emergency Care, with assurance focused on sustained reductions in delays, occupancy and handover times.

8. **Community services** continue to show a clear area of strength in adult pathways, with no adults waiting over 52 weeks in Derbyshire or Lincolnshire and three in Nottingham and Nottinghamshire against a zero trajectory. Children and young people's community waits remain the principal challenge: Derbyshire reports 614 waits over 52 weeks against a plan of 48, Lincolnshire 1,406 against 1,381, while Nottingham and Nottinghamshire is performing better than trajectory at 240 against 300. Recovery is focused on community paediatrics, neurodevelopmental, Speech and Language Therapy and Occupational Therapy pathways, while protecting the stronger adult position.

9. **Primary care** remains the strongest operational programme overall. Same-day urgent GP access and Pharmacy First are above plan across all three ICBs, and GP appointment activity is above plan in Lincolnshire and Nottingham and Nottinghamshire, although marginally below plan in Derbyshire. Units of Dental Activity delivery remains the principal shared gap, but action has moved into implementation: additional recurrent dental capacity has been commissioned for 59 providers, with a further 90 eligible to deliver through the 110% overperformance scheme. Commissioners will monitor whether this translates into sustained activity and improved access.

10. **Mental Health and Learning Disability and Autism** performance remains mixed, with several important areas of positive delivery. Individual Placement Support access is above plan across all three ICBs, and Learning Disability and Autism children and young people's inpatient numbers are at or better than plan. Pressures continue in children and young people's eating disorder access, inpatient flow, inappropriate adult acute out-of-area placements and selected Talking Therapies measures. Recovery is being overseen through programme and contractual arrangements, discharge processes, individual case management and multi-agency working.

11. **Children and young people's Mental Health** access remains above plan across all three ICBs, providing a positive foundation for the programme. However, very long waits remain significant for community services and routine eating disorder access is below standard in Lincolnshire and Nottingham and Nottinghamshire. Recovery is being directed through the DLN Children and Young People's Programme Board, supported by improved reporting, clearer outcome measures, waiting-list validation, demand-and-capacity modelling and pathway redesign. The Women's Health programme is also progressing from mobilisation into implementation, with governance and workstream leadership established, priority pathway development under way and the performance framework in development.

12. Exception reporting shows that most metrics are not demonstrating concerning variation, with 16 of the 272 metric instances tracked monthly showing concerning variation because of sustained low performance or deterioration. A further 26 measures are off plan but improving, while 55 show common-cause variation where a step change in performance is required to achieve the planned level. The most significant areas requiring continued recovery focus remain diagnostics, urgent and emergency care, system flow and discharge, and mental health inpatient pathways

13. **Provider oversight** is becoming more coordinated, evidence based and outcome focused. Recovery Action Plans from Nottingham University Hospitals NHS Trust, University Hospitals of Derby and Burton NHS Foundation Trust and United Lincolnshire Teaching Hospitals NHS Trust have created a clearer basis for scrutiny, although stronger trajectories and delivery assurance are still required. Actions include progression to a Contract Performance Notice for University Hospitals of Derby and Burton, an Executive-to-Executive escalation with Nottingham University Hospitals, and an NHS England-led Rapid Quality Review of diagnostics at United Lincolnshire Teaching Hospitals. This more aligned approach should support earlier intervention and clearer accountability where improvement is not secured.

14. At its meeting on 23 October 2026, the Commissioning Oversight Group reviewed provider delivery, financial risk and quality concerns across the ICBs' geography, strengthening the link between performance scrutiny, contractual

accountability and recovery action. Recovery plans are being assessed against activity trajectories, accountable actions, milestones and measurable in-year improvement, with Provider Improvement Meetings and proportionate contractual escalation used where assurance remains insufficient. Oversight is being coordinated with NHS England, with particular attention to patient safety, winter readiness and the reliability of performance data. The immediate test is whether this more developed approach produces sustained activity recovery, improved access and patient flow, and appropriate financial reconciliation where commissioned activity has not been delivered.

15. **The Quarter One NHS Oversight Framework** assessment shows a varied provider position, including areas of relative strength within community services. Derbyshire Community Health Services is in Segment 1 and Lincolnshire Community Health Services in Segment 2; seven providers are in Segment 3 and two in Segment 4. Nottingham University Hospitals records the most challenged acute position, ranked 133 of 134 providers. Financial deficits are reported by seven of the 11 DLN providers assessed, contributing to the level of oversight required.

16. **Data-quality** assurance has strengthened through the DLN-wide Data Quality Framework and the Data Quality Oversight Group-managed risk register, providing improved visibility and more consistent escalation of risk. At the end of October, 44 active data-quality issues were recorded across the cluster: 28 relating to acute services, 12 to non-acute services and 4 affecting both. An independent external audit is planned during Quarter 3, with findings due to the Audit Committee in February 2027. This work should further improve confidence in the activity, performance and financial information used for commissioning decisions.

17. Overall, the report reflects significant delivery challenge, but also areas of strong performance and a more developed platform for improvement. Primary care access, adult community pathways, Faster Diagnosis performance in Nottingham and Nottinghamshire, and selected mental health and children and young people’s measures provide a positive base. The priority for the remainder of 2026/27 is to convert recovery plans, additional capacity, winter interventions and pathway transformation into sustained improvements in activity, access, waiting times, patient flow and outcomes. Focus will remain measurable delivery, credible recovery trajectories and evidence that commissioner and provider actions are having the intended impact.

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

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

November 2026

Date Prepared: 30th October 2026
Prepared By: Robert Taylor; SAIU Performance
Supported By: SAIU Team

DLN Commissioning Oversight Delivery Report - Contents

Item	Contents	Page Number
1.0	Executive Summary	3-4
1.3	Contract Delivery Executive Summary	5
2.1	Operational Plan Overview	6-13
	Programme Overviews:	
3.1	Elective	14
3.2	Diagnostics	15
3.3	Cancer	16
3.4	Urgent and Emergency Care	17
3.5	Community	18
3.6	Primary Care	19
3.7	Mental Health & LD&A	20
3.8	CYP and Women's Health	21-22
4.0	Provider Oversight Framework	23
5.0	Data Quality Framework and Assurance	24

1.0 Commissioning Oversight Delivery Report – Executive Summary (1)

1. The November Commissioning Delivery Oversight Report presents a mixed delivery position across the DLN cluster, with 2 ICB-programme assessments rated Green, 14 Amber and 8 Red. There remain clear areas of positive delivery, particularly within primary care access, adult community pathways and selected cancer, UEC, mental health and CYP measures. At the same time, elective recovery, diagnostics, cancer treatment, patient flow and long waits remain the principal areas requiring sustained improvement.

2. Elective care remains one of the most significant cluster-wide delivery challenges, with RTT, 52-week waits and waiting-list size not achieving plan across all three ICBs. Recovery Action Plans have now been received from NUH, UHDB and ULTH and are being reviewed through commissioner and NHS England oversight arrangements, with a focus on the credibility of activity trajectories, specialty-level actions and expected performance improvement. Commissioner action combines challenge of provider recovery plans with pathway redesign, referral optimisation and left-shift opportunities, including dermatology, MSK and gynaecology, alongside use of additional and independent-sector capacity where required. Assurance is focused on whether these interventions, together with productivity improvement, translate into sustained reductions in waiting-list size and long waits.

3. Diagnostics remains a significant cross-cutting constraint on both elective and cancer recovery. Six-week waits remain above plan across all three ICBs, with Lincolnshire showing the largest gap and diagnostic activity below plan in both Derbyshire and Lincolnshire. There are, however, positive developments in recovery, including continued CDC development, additional insourced NOUS capacity in Lincolnshire, mobile and independent-sector capacity and equipment investment. Evaluation of CDC delivery is also underway, with a particular focus on utilisation of available capacity and the extent to which this is supporting backlog reduction and improved diagnostic performance. Commissioner oversight remains focused on maximising available capacity and securing measurable reductions in six- and 13-week waits by modality.

4. Cancer performance remains challenging, particularly for treatment standards. Nottingham and Nottinghamshire continues to provide an area of relative strength through delivery of the Faster Diagnosis trajectory, while Derbyshire and Lincolnshire remain below plan. 31-day and 62-day treatment performance remain below trajectory across all three ICBs, with 62-day treatment the principal area of concern. Recovery continues through tumour-site and pathway-level oversight, PTL validation, pathway redesign and targeted diagnostic and treatment capacity.

5. Urgent and Emergency Care presents a mixed picture, with Lincolnshire achieving its four-hour trajectory and some other measures providing areas of relative strength. However, prolonged waits, ambulance response, handover performance and patient flow continue to require recovery focus across the cluster. Increasing winter demand adds further risk, making timely discharge, admission avoidance and effective use of community capacity central to maintaining system resilience.

6. Whole-system coordination is strengthening through winter delivery arrangements, discharge improvement, admission avoidance, Urgent Community Response, Same Day Emergency Care and closer working across acute, community, primary care, mental health, ambulance and local authority partners. Commissioner assurance is increasingly focused on whether these interventions produce measurable and sustained improvements in flow, rather than short-term or seasonal gains

7. Community services continue to show important areas of strength, particularly for adult long waits. Derbyshire and Lincolnshire report no adults waiting over 52 weeks, while Nottingham and Nottinghamshire reports three against a zero trajectory. CYP community waits remain the principal challenge, with significant pressure in Derbyshire and a smaller adverse variance in Lincolnshire, while Nottingham and Nottinghamshire is performing better than its CYP trajectory. Recovery remains focused on paediatric, occupational therapy and neurodevelopmental pathways.

1.0 Commissioning Oversight Delivery Report – Executive Summary (2)

1. Primary Care remains the strongest operational programme overall. Same-day urgent GP access and Pharmacy First are above plan across all three ICBs, while GP appointment delivery is above plan in Lincolnshire and Nottingham and Nottinghamshire but below plan in Derbyshire. Dental UDA delivery remains the principal common delivery gap. Commissioner action includes additional commissioned dental capacity through recurrent contract uplifts and the 110% overperformance scheme, redistribution of available UDA capacity and service redesign. Wider action includes the commissioned proactive respiratory scheme for higher-risk patients, alongside continued development of primary care capacity and demand-management interventions to support winter resilience.

2. Mental Health and Learning Disability and Autism performance remains mixed, with IPS access above plan across all three ICBs and areas of positive delivery within Talking Therapies and inpatient measures. Pressures remain in CYP Eating Disorder access, inpatient flow and length of stay. Recovery is supported by established programme and contractual oversight, discharge arrangements, case management and multi-agency working.

3. CYP Mental Health access remains a positive area of delivery, achieving plan across all three ICBs. However, very long waits remain a significant challenge and Eating Disorder access remains below standard in Lincolnshire and Nottingham and Nottinghamshire, while Derbyshire is achieving the standard. Recovery is being overseen through the DLN CYP Programme Board, including focus on Eating Disorder performance alongside neurodevelopmental and community pathways, long-term conditions and transition. Improved performance reporting and clearer outcome measures are being developed to strengthen assurance over delivery.

4. The Women's Health programme continues to progress from mobilisation into implementation. Programme governance and workstream leadership are established, with priority pathway development and the cluster delivery plan progressing and the performance framework in development. Commissioner work is increasingly focused on translating this programme infrastructure into pathway change, including community-based models, prevention, screening and measurable improvements in access, outcomes and inequalities.

5. Provider oversight is becoming more coordinated and outcome focused. COG concluded that the Recovery Action Plans received from NUH, UHDB and ULTH do not yet provide sufficient activity-based assurance, and strengthened plans with measurable trajectories, delivery dates and quantified gaps are being sought. Contractual and NHS England escalation is being aligned to delivery risk, with further intervention where sufficient assurance or improvement is not secured.

6. Data quality assurance has also strengthened through the DLN-wide Data Quality Framework, with clearer governance, standardised controls and a DQOG-managed risk register. At the end of October, 44 active data-quality issues were recorded across the cluster, comprising 28 relating to acute services, 12 to non-acute services and four affecting both, providing greater visibility of data risks requiring action.

7. Overall, the November position combines significant delivery challenge with a more developed platform for improvement. Stronger performance in primary care access, adult community pathways and selected measures across cancer, UEC, mental health and CYP provides a positive base to build from. The priority for the remainder of 2026/27 is to convert recovery plans, additional capacity and pathway transformation into sustained improvements in activity, waiting times, patient flow and outcomes, with commissioner assurance increasingly focused on measurable delivery and evidence that recovery actions are having the intended impact.

1.3 Acute Contract Delivery – Executive Summary

1. October COG agreed the following escalations; NUH, UHDB and ULTH recovery plans require stronger trajectories and delivery assurance:
   - UHDB – progress to CPN for electives
   - NUH – Executive to Executive escalation to be held at the end of November
   - ULTH – NHSE led Rapid Quality Review to be undertaken on Diagnostics
   - NHT – P1 discharges – pre-CPN recovery plan to be requested
   - NEMS – Pre-CPN for PC24 performance delivery
   - EMAS – to agree approach to be taken next month following further discussion with NHSE

Provider	NOF	PIM	Contract Escalation	ERF	Areas of Concern
UHDB	3	**TOP (EL, Cancer, Diagnostics) National RAP**	**Pre-CPN** 7.8.26 ICB Request for RAP for UEC, RTT, Cancer & Diagnostics (8-week review) **AQN** issued 9.9.26	**Escalated**	UEC/Diagnostics concern, all areas of cancer and electives are off plan, and electives position continues to deteriorate; ERF 'Escalated' and WL is increasing; DQ: U-codes/ED reporting review. Elective CPN to be enacted in November as progress is not being made as required.
CRH	3	**None**	No Escalations formally raised	**Routine**	PROM paused for RQR, concerns relating to cancer 62 day and UEC; ERF routine; Derby ED data issue may affect UEC reporting, ICB review complete, workplan to be taken forward. Recovery plan to be requested for UEC and Cancer.
ULTH	4	**Medium (Elective, Diagnostic, Cancer)**	**Pre-CPN** Cancer - Breast **CPN** Diagnostics – Audiology **AQN** issued 9.9.26	**Increased**	Diagnostics significant concern, electives deteriorating; ERF 'Escalated'; £1.5m contract gap; ED reporting discrepancies including SDEC reporting and Grantham & District Hospital activity - issue being reviewed. NHSE Rapid Quality Review to be undertaken on Diagnostics.
NUH	4	**High (Electives, Cancer, Diagnostic, UEC)**	**No Pre-CPNs or CPNs issued** Recovery plans provided through NHSE Tiering. Exec to Exec to be held	**Increased**	UEC/Diagnostics/Community waits concern; improvements in cancer position; ERF 'Increased'; WL is improving; U-Codes activity levels and DQ issues relating to waiting lists. Community waits now at 'Escalated' threshold. NUH IAP not yet agreed. Significant DQ issues Exec to Exec escalation to be held in November.
SFHT	3	**Medium (Cancer, UEC) National RAP**	**CPN** UEC 3.7.26 Diagnostics closed 23.10.26	**Routine**	UEC/Diagnostics CPN - position has improved in the last month reported position; Cancer 62 and 52ww now escalated. ERF routine; £3.6m contract activity gap; ED NerveCentre issue improving. SFHT IAP not yet agreed. Recovery plan to be requested for electives. Diagnostic CPN closed as performance improvement has been achieved.

CPN = Contract Performance Notice | Pre-CPN = initial request for a recovery plan | PIM = NHSE Provider Improvement Meeting

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

Key delivery risk headlines

Programme assurance by ICB, supported by headline metric achievement counts.

2	ICB-programme assessments Green
14	ICB-programme assessments Amber
8	ICB-programme assessments Red

Assessment approach — ICB RAG reflects materiality, breadth of delivery and recovery confidence. Counts show measures achieved.

Programme	DDICB	LICB	NNICB	Key message
Electives	0/5	0/5	1/5	Elective recovery remains challenged across the cluster, with RTT, long waits and waiting-list size adverse to plan. Nottingham and Nottinghamshire is achieving its First Outpatient trajectory.
Diagnostics	0/3	0/3	1/3	Six-week waits remain significantly above plan across all three ICBs, with the largest gap in Lincolnshire. Activity is below plan in Derbyshire and Lincolnshire; Nottingham and Nottinghamshire is above activity plan but waits remain high.
Cancer	0/3	0/3	1/3	Performance remains challenged, particularly for 62-day treatment. Nottingham and Nottinghamshire is achieving Faster Diagnosis, while Derbyshire and Lincolnshire remain below trajectory. Thirty-one and 62-day treatment remain below plan across all three ICBs.
UEC	0/4	1/4	0/4	Performance remains pressured across the cluster. Lincolnshire is achieving its four-hour trajectory, but prolonged waits, Category 2 response and ambulance handovers remain adverse. Derbyshire and Nottingham and Nottinghamshire remain below plan across the headline measures.
Community	1/2	1/2	1/2	Adult long waits remain comparatively well controlled. CYP waits continue to drive delivery risk, particularly in Derbyshire, with Lincolnshire slightly above trajectory. Nottingham and Nottinghamshire is performing better than plan for CYP waits.
Primary Care	3/7	4/7	4/7	Primary Care remains comparatively strong. Same-day urgent access and Pharmacy First are above plan across all three ICBs, while GP appointments are below plan only in Derbyshire. Dental activity remains the main common delivery gap.
Mental Health & LD&A	6/8	4/8	6/8	Performance remains mixed. IPS access is above plan across all three ICBs, while Talking Therapies varies between systems. CYP Eating Disorders remain a key pressure, while LD/Autism CYP inpatient performance is comparatively strong.
CYP	2/3	1/3	2/3	Mental Health access is above plan across all three ICBs, but very long waits remain a significant challenge. Eating Disorder access is above standard in Derbyshire but remains below standard in Lincolnshire and Nottingham and Nottinghamshire

ICB RAG is an assurance judgement, not a calculation from the count alone. Metric-level pages retain binary red/green status against plan.

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

Headline metric achievement

The individual measures driving each programme position. Status reflects achievement against the latest available ICB plan or standard.

GREEN Achieving plan RED Below plan

Electives	DD	LI	NN
Headline measure	ICB status		
First outpatient <18 weeks	🔴	🔴	🟢
RTT <18 weeks	🔴	🔴	🔴
RTT >52 weeks	🔴	🔴	🔴
RTT >65 weeks	🔴	🔴	🔴
Waiting-list size	🔴	🔴	🔴

Diagnostics	DD	LI	NN
Headline measure	ICB status		
Diagnostics Tests Performed	🔴	🔴	🟢
Six-week waits	🔴	🔴	🔴
Thirteen-week waits	🔴	🔴	🔴

Cancer	DD	LI	NN
Headline measure	ICB status		
Faster Diagnosis	🔴	🔴	🟢
31-day treatment	🔴	🔴	🔴
62-day treatment	🔴	🔴	🔴

UEC	DD	LI	NN
Headline measure	ICB status		
A&E <4 hours	🔴	🟢	🔴
A&E >12 hours	🔴	🔴	🔴
Category 2 response	🔴	🔴	🔴
Ambulance handovers >45mins	🔴	🔴	🔴

Community	DD	LI	NN
Headline measure	ICB status		
Adult waits >52 weeks	🟢	🟢	🔴
CYP waits >52 weeks	🔴	🔴	🟢

Primary Care	DD	LI	NN
Headline measure	ICB status		
GP appointments	🔴	🟢	🟢
Same-day urgent access	🟢	🟢	🟢
Dental UDAs	🔴	🔴	🔴
Dental UDAs (%)	🔴	🔴	🔴
Adults Seen by NHS Dentist	🟢	🟢	🟢
Children Seen by NHS Dentist	🔴	🔴	🔴
Pharmacy First	🟢	🟢	🟢

Mental Health & LD&A	DD	LI	NN
Headline measure	ICB status		
IPS Access	🟢	🟢	🟢
EIP <2 weeks	🟢	🟢	🟢
Talking Therapies recovery	🟢	🔴	🟢
Talking Therapies improvement	🟢	🔴	🟢
CYP Eating Disorder <4 weeks	🟢	🔴	🔴
CYP MH Waits >104 weeks	🔴	🔴	🟢
LD/Autism adult inpatients	🔴	🟢	🔴
LD/Autism CYP inpatients	🟢	🟢	🟢

CYP	DD	LI	NN
Headline measure	ICB status		
Mental health access	🟢	🟢	🟢
Eating Disorder <4 weeks	🟢	🔴	🔴
MH waits >104 weeks	🔴	🔴	🟢

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

2.1 Operational Plan - Latest Delivery Position – National Benchmarking

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 (%)	Aug-26	23/36	120/145	99/145	33/36	104/145	22/36	110/145	97/145
	RTT >52 Weeks (%)	Aug-26	24/36	115/145	108/145	23/36	99/145	32/36	132/145	96/145
	RTT >65 Weeks	Aug-26	9/36	116/145	1/145	13/36	74/145	17/36	103/145	55/145
Cancer	Cancer Faster Diagnosis <28 Days (%)	Aug-26	24/36	93/132	97/132	36/36	119/132	3/36	29/132	26/132
	Cancer Referral-to-Treatment <62 Days (%)	Aug-26	29/36	116/132	112/132	34/36	123/132	30/36	96/132	99/132
Diagnostics	Diagnostics >6 Weeks (%)	Aug-26	31/36	132/154	86/154	36/36	143/154	27/36	136/154	29/154
Urgent Care	A&E <4 Hours (%)	Sep-26	20/36	109/139	84/139	5/36	107/139	29/36	115/139	69/139

Top Quartile
Bottom Quartile

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.

Upper Quartile: best 25%

- 7 of 56 positions rank in the best 25% (1 is best).
- Long RTT waits: CRH ranks 1/145 and DDICB 9/36 for RTT >65 weeks.
- Faster cancer diagnosis: NNICB ranks 3/36, SFHT 26/132 and NUH 29/132.
- Other strengths: LICB ranks 5/36 for A&E <4 hours. SFHT ranks 29/154 for diagnostics >6 weeks.

Lower Quartile: worst 25%

- 24 of 56 positions rank in the worst 25%.
- Main weaknesses: 62-day cancer treatment has 6 of 8 organisations in the lower quartile. Diagnostics has 5 of 8.
- ICBs: LICB has 4 lower-quartile positions, NNICB 3 and DDICB 2.
- Providers: UHDB has 6 of 7 metrics in the lower quartile. ULH and NUH each have 4, CRH has 1 and SFHT has none.

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

2.1 Operational Plan - Latest Activity Position

Latest Month Only	Derby and Derbyshire ICB Population						Lincolnshire ICB Population						Nottingham and Nottinghamshire ICB Population					
	August 2026 Only				Aug 26 v Aug 25		August 2026 Only				Aug 26 v Aug 25		August 2026 Only				Aug 26 v Aug 25	
	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance
First OP Attendances (Consultant Led)	33,283	31,387	-1,896	-5.7%	1,091	3.6%	23,835	21,171	-2,664	-11.2%	-1,513	-6.7%	30,546	28,148	-2,398	-7.9%	1,936	7.4%
Follow Up OP Attendances (Consultant Led)	75,599	67,486	-8,113	-10.7%	741	1.1%	38,433	34,847	-3,586	-9.3%	-3,646	-9.5%	59,719	58,738	-981	-1.6%	512	0.9%
Elective Day Case Spells	14,055	13,815	-240	-1.7%	128	0.9%	9,961	8,773	-1,188	-11.9%	-608	-6.5%	15,699	14,649	-1,050	-6.7%	343	2.4%
Elective Ordinary Admissions	2,098	2,084	-14	-0.7%	43	2.1%	1,514	1,454	-60	-4.0%	42	3.0%	2,373	2,206	-167	-7.0%	-9	-0.4%
Diagnostic Tests Performed	44,444	43,434	-1,010	-2.3%	1,281	3.0%	42,085	37,437	-4,648	-11.0%	339	0.9%	47,985	49,074	1,089	2.3%	4,067	9.0%
A&E Attendances (total)	55,984	53,847	-2,137	-3.8%	-2,137	-3.8%	29,693	31,367	1,674	5.6%	1,009	3.3%	39,624	41,842	2,218	5.6%	2,619	6.7%

Year to Date	Derby and Derbyshire ICB Population						Lincolnshire ICB Population						Nottingham and Nottinghamshire ICB Population					
	April 2026 - August 2026				YTD 26/27 v YTD 25/26		April 2026 - August 2026				YTD 26/27 v YTD 25/26		April 2026 - August 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)	173,072	169,547	-3,525	-2.0%	1,075	0.6%	123,941	117,248	-6,693	-5.4%	-6,224	-5.0%	159,917	148,968	-10,949	-6.8%	952	0.6%
Follow Up OP Attendances (Consultant Led)	393,113	371,433	-21,680	-5.5%	-2,461	-0.7%	199,851	201,694	1,843	0.9%	-13,335	-6.2%	316,704	322,504	5,800	1.8%	-178	-0.1%
Elective Day Case Spells	73,113	71,472	-1,641	-2.2%	-2,302	-3.1%	48,381	46,849	-1,532	-3.2%	-2,577	-5.2%	78,112	77,171	-941	-1.2%	1,846	2.5%
Elective Ordinary Admissions	10,909	10,879	-30	-0.3%	481	4.6%	7,354	7,426	72	1.0%	76	1.0%	12,081	11,178	-903	-7.5%	-17	-0.2%
Diagnostic Tests Performed	231,109	220,190	-10,919	-4.7%	4,812	2.2%	210,215	188,825	-21,390	-10.2%	-1,935	-1.0%	249,524	250,225	701	0.3%	14,438	6.1%
A&E Attendances (total)	288,209	282,476	-5,733	-2.0%	-5,733	-2.0%	148,926	159,393	10,467	7.0%	9,060	6.0%	211,480	212,811	1,331	0.6%	7,172	3.5%

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

2.1 Operational Plan – Exception Reporting

Go back >>

Concerning Variation **16**

Metric	Org	Period	V	A	Actual
RTT Admitted Pathways	NNICB	Aug-26			4,146
Diagnostics >6 Weeks (%)	LICB	Aug-26			53.2%
Diagnostics >6 Weeks (%)	NNICB	Aug-26			31.6%
A&E Attendances (total)	LICB	Sep-26			32,231
A&E >12 Hours	NNICB	Sep-26			3,820
Ambulance handovers >15 min (%)	NNICB	Sep-26			74.1%
G&A Overnight Beds Occupied (%)	NNICB	Sep-26			95.1%
Non-Elective LOS	LICB	Aug-26			8.8
Total Non-Elective Spells (0 Day)	LICB	Aug-26			3,479
Discharge Ready Date (%)	NNICB	Aug-26			79.8%
Average Discharge Delay	DDICB	Aug-26			5.6
Average Discharge Delay	LICB	Aug-26			6.5
Inpatients with No Criteria to Reside (%)	NNICB	Sep-26			38.5%
MH Inpatient Mean LOS Adult and PICU	LICB	Aug-26			52.0
MH Inpatient Mean LOS Older Adult	NNICB	Aug-26			104.0
Talking Therapies Completing a Course of Treatment	NNICB	Aug-26			1,120

Overall, there are **97 metric** instances which are 'Failing' in the assurance of delivery to the targets and plans required from a total of 272 metrics that are tracked monthly for the 3 ICBs.

16 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.

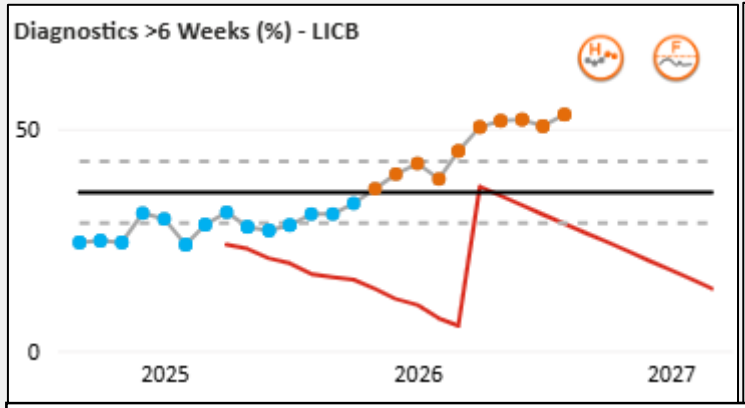
26 are improving indicating that although they remain unlikely to achieve plan on current assessments, they are reporting areas of improvement, these include long elective waits, cancer treatments, CYP mental health access and LD/ Autism inpatients.

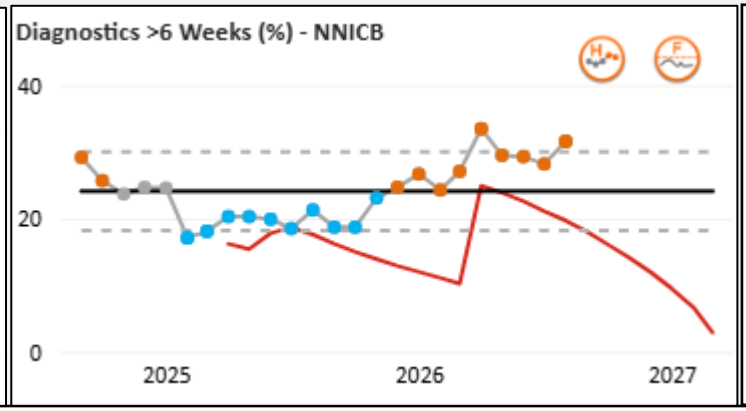
55 are common cause meaning that there is no discernible change in their performance when a stepped improvement is required.

The most significant clusters of concerning variation relate to diagnostics, urgent and emergency care, system flow and discharge, and mental health inpatient pathways. Further detail on all other metrics with concerning variation is provided on slides 11-13

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

2.1 Operational Plan – Exception Reporting
ii. Diagnostics 6 week waits – LICB and NNICB





Metric Overview: The objective is to reduce the percentage of patients 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	Aug-26	33.0%	16.5%			
Diagnostics >6 Weeks (%)	UHDB	Aug-26	40.2%	24.9%			
Diagnostics >6 Weeks (%)	CRH	Aug-26	21.7%	16.6%			
Diagnostics >6 Weeks (%)	LICB	Aug-26	53.2%	28.6%			
Diagnostics >6 Weeks (%)	ULTH	Aug-26	57.5%	21.0%			
Diagnostics >6 Weeks (%)	NNICB	Aug-26	31.6%	19.7%			
Diagnostics >6 Weeks (%)	SFH	Aug-26	7.9%	8.0%			
Diagnostics >6 Weeks (%)	NUH	Aug-26	43.3%	27.5%			

Commissioner and Provider Actions:

1. **LICB:** Diagnostic performance deteriorated in August, with 53.2% of patients waiting over six weeks, 2.6 percentage points worse than July. Although the overall diagnostic waiting list reduced by 5.6%, the over-six-week cohort reduced by only 0.3%, with ULTH investigating whether this reflects patient acuity or booking order. ULTH performance fell by 3 percentage points, alongside a 6.6% reduction in activity. Audiology, Echocardiography, MRI and NOUS remain the most challenged modalities and are subject to targeted recovery activity, with Audiology and NOUS expected to require a longer recovery period. For NOUS, additional insourced capacity is delivering around 1,500 tests per month, contributing to increased activity and reductions in long waits. Performance continues to be monitored through regular provider oversight and monthly NHS England Performance Improvement Meetings, which continue oversight of the Contract Performance Notice. The forthcoming NHS England deep-dive report will inform an agreed improvement plan, while continued assurance is required that modality-level recovery actions deliver sustainable reductions in long waits. Focus requested on Paediatric audiology.

2. **Lincs CDC delivery** remains relatively strong, while the Boston CDC remains ahead of schedule and on budget for completion in March 2027. Oversight remains focused on maximising available CDC capacity and ensuring additional activity supports diagnostic waiting-list reduction and wider elective and cancer recovery. The Patient Services Hub remains affected by workforce and operational issues, presenting an ongoing risk to booking effectiveness and activity across elective, cancer and diagnostic pathways.

3. **NNICB:** Diagnostic performance deteriorated in August, with performance against the six-week standard falling by 3.4 percentage points. Although the overall waiting list reduced, the number of patients waiting over six weeks increased. NUH performance fell by 2.7 percentage points, with Urodynamics, NOUS, MRI, CT and Echocardiography representing the main areas of pressure, driven by workforce and equipment constraints. NUH is reviewing pathways and validating waiting lists, maximising productivity and using mobile capacity to support recovery. Options are also being explored to transfer additional outpatient activity to the Treatment Centre and secure an interim replacement for CT4 ahead of the wider Emergency Department redesign. SFH continues to perform close to plan, while Mansfield CDC is delivering more than 98% of planned activity. Construction of the Broad Marsh CDC remains on course for expected completion in August 2027, although interim CDC activity is currently at 82.3% of plan and is being reviewed to identify underperforming modalities and opportunities to maximise capacity.

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

2.1 Operational Plan – Exception Reporting

1. **RTT Admitted Pathways (NNICB)** reported 4,146 pathways against a plan of 5,090, an adverse variance of 944 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. **A&E Attendances (LICB):** Urgent and Emergency Care performance remains challenging as activity increases in line with expected winter demand, although four-hour performance continues to be above plan. Ambulance handover performance has deteriorated and remains an area of concern, with EMAS and ULTH working jointly to identify and address the barriers affecting handovers. Reporting inconsistencies also continue to affect assurance on activity and performance, including data quality issues within LCHS reporting and revised local reporting arrangements for SDEC direct admissions, which have increased reported ULTH activity compared with the methodology used when plans were established. The implementation of the Nerve Centre at ULTH is also contributing to additional capacity pressures within ED. Winter Delivery Groups are in place across system providers to monitor emerging pressures and coordinate recovery actions, with continued oversight focused on activity, capacity, ambulance handovers and wider system flow as winter demand increases.

3. **A&E 12 Hour Waits (NNICB):** Urgent and Emergency Care performance remains challenged, with all key metrics currently behind plan and continued pressure across patient flow and discharge pathways. Increased winter demand presents a risk of further deterioration in performance and wider system resilience. Commissioner oversight is focused on strengthening performance management of existing services and delivery of winter plans, with Contract Performance Notices and Remedial Action Plans being used where appropriate across admission avoidance and discharge services. Additional funding has been provided to support Discharge to Assess capacity and improve flow, while further demand-avoidance schemes and expansion of existing services are being considered with system partners. Reviews of key UEC services have also commenced in line with the five-year cluster commissioning plan.

4. **Ambulance Handovers (NNICB):** Ambulance handovers remain part of a wider challenged Urgent and Emergency Care position, with all key NNICB metrics currently behind plan and patient flow, particularly across discharge pathways, remaining a significant pressure. Increasing winter demand presents a further risk to ED capacity, flow and overall system resilience. Commissioner action is focused on strengthening contractual oversight across admission avoidance and discharge services, including the use of Contract Performance Notices and Remedial Action Plans where appropriate. Additional funding has been provided to support Discharge to Assess capacity and improve flow, with further demand-avoidance schemes and expansion of existing services being considered with system partners.

5. **G&A Overnight Beds Occupied (%) (NNICB):** Bed occupancy and patient flow remain under pressure, particularly across discharge pathways, contributing to the wider challenged UEC position. Increasing winter demand presents a further risk to capacity, flow and overall system resilience. Commissioners are strengthening contractual oversight across admission avoidance and discharge services, using Contract Performance Notices and Remedial Action Plans where appropriate. Additional funding has been provided to increase Discharge to Assess capacity and improve flow, while further demand-avoidance schemes and expansion of existing services are being considered with system partners.

6. **Total Non-Elective Spells, 0 Day/LOS (LICB):** Urgent and Emergency Care activity continues to increase in line with expected winter demand, while four-hour performance remains above plan. Revised local reporting arrangements for SDEC direct admissions have increased reported ULTH activity compared with the methodology used when operational plans were established, creating a need for caution when assessing activity against plan. Wider system pressures remain, including deteriorating ambulance handovers and additional ED capacity pressures associated with implementation of the Nerve Centre at ULTH. Winter Delivery Groups are in place to monitor emerging pressures and coordinate recovery actions, with continued oversight of activity, capacity and system flow as winter demand increases.

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

2.1 Operational Plan – Exception Reporting (continued)

6. **Discharges (All ICBs):** Discharge and patient flow remain significant pressures across the DLN cluster, with longer stays and discharge delays continuing to constrain flow in Derbyshire and patient flow, particularly across discharge pathways, remaining a key concern in Nottinghamshire. In Lincolnshire, increasing winter demand is adding pressure across ED capacity, ambulance handovers and wider system flow. Recovery activity remains focused on strengthening discharge and intermediate care capacity, with additional Discharge to Assess capacity funded in Nottinghamshire and system partners working across acute, community, primary care, mental health and local authority services to improve flow. Commissioner oversight continues through established UEC governance and contractual arrangements, with recovery plans monitored against operational trajectories and further demand-management measures considered as winter pressures increase.

7. **Inpatients with no Criteria to Reside (NNICB):** Inpatient flow and timely discharge remain important areas of focus, with length of stay and patients clinically ready for discharge subject to ongoing commissioner and provider oversight. Key dependencies include the availability of appropriate social care packages, community capacity and effective multi-agency working. Recovery activity includes regular provider meetings, MADE arrangements and bed-flow processes to identify and address barriers to discharge, with commissioners seeking measurable reductions in length of stay and avoidable inpatient stays.

8. **MH Inpatient Mean LOS Adult and PICU (LICB):** Inpatient length of stay remains an area of focus, with discharge and flow subject to regular commissioner and provider oversight. Length of stay and Criteria for Referral for Discharge performance are reviewed weekly through System MADE meetings to identify discharge opportunities and address delays. Recovery is supported by individualised discharge planning, close management of inpatient pathways and work with system partners to develop appropriate community provision, with continued assurance focused on reducing avoidable inpatient stays and supporting timely discharge.

9. **MH Inpatient Mean LOS Older Adult (NNICB):** Older adult inpatient length of stay remains a key area of concern, driven by patient complexity and limited availability of appropriate social care packages and placements. Recovery activity includes a rapid action plan, bed-flow management and MADE reviews to support improvement in length of stay and discharge, alongside joint working with adult social care to improve access to appropriate packages of care. The PATH programme is also supporting improvements in inpatient flow and length of stay. Commissioner oversight should remain focused on demonstrating sustained reductions in length of stay and improved patient flow.

10. **Talking Therapies Completing a Course of Treatment (NNICB):** Talking Therapies completed courses of treatment remains a key area of concern, with performance showing sustained deterioration and a recovery plan in place. Recruitment and training delays continue to affect delivery, while commissioners maintain oversight of the recovery plan through established Mental Health, Learning Disability and Autism governance arrangements. Recovery is expected to return performance to plan by March 2027, with continued assurance required that recovery actions translate into sustained improvement in treatment completion.

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

3.1 PROGRAMME OVERVIEW | ELECTIVES

Electives: delivery, recovery and assurance

OVERALL: AMBER / RED

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	%	Sep-26	⚠	68.9%	68.6%	-0.3% ✗			62.0%	61.2%	-0.8% ✗			72.0%	75.5%	3.5% ✓		
	RTT <18 Weeks (%)	Ops Plan	E.B.40	%	Aug-26		65.8%	63.7%	-2.1% ✗			62.9%	62.4%	-0.5% ✗			66.4%	63.9%	-2.5% ✗		
	RTT >52 Weeks (%)	Ops Plan	E.B.18	%	Aug-26		1.3%	1.7%	0.4% ✗			1.0%	1.6%	0.6% ✗			1.0%	2.3%	1.3% ✗		
	RTT >65 Weeks (No.)	Nat Std		Value	Aug-26		0	36	36 ✗			0	57	57 ✗			0	95	95 ✗		
	RTT Waiting List Size	Ops Plan	E.B.3a	Value	Aug-26		109,920	116,650	6,730 ✗			104,810	109,727	4,917 ✗			116,741	127,125	10,384 ✗		

Current position and movement

Elective performance remains below plan across the cluster, although Nottingham and Nottinghamshire is above trajectory for first outpatient performance at 75.5% against 72.0%. First outpatient performance remains below trajectory in Derbyshire and Lincolnshire, while RTT performance, 52-week waits and total waiting-list size are adverse to plan across all three ICBs. Waiting-list size remains above plan in each system, with Nottingham and Nottinghamshire showing the largest numerical variance at 10,384 pathways. Overall, recovery has not yet translated consistently across the principal waiting-list measures.

Recovery and commissioner response

Commissioners are applying enhanced oversight through Recovery Action Plans, NHS England Performance Improvement Meetings and regular provider assurance arrangements. Submitted plans are being challenged against monthly activity and performance trajectories, year-end residual positions, specialty-level actions and winter deliverability. The ICBs are scrutinising first-outpatient, admitted and non-admitted activity, RTT, PTL size and long-wait cohorts to test whether additional capacity and productivity actions deliver measurable improvement. Oversight also covers PTL validation, referral optimisation, Advice and Guidance, PIFU, clinic-template utilisation and opportunities for mutual aid or independent-sector capacity. Alongside provider recovery plans, commissioners are progressing pathway redesign and left-shift opportunities, including ophthalmology, MSK, dermatology and gynaecology, with procurement and specification development progressing towards more consistent commissioning approaches across the cluster.

Progress, dependencies and assurance

Assurance remains dependent on sustainable activity growth rather than validation alone. Key dependencies include diagnostic recovery, outpatient and theatre capacity, workforce resilience and effective booking processes. Across the cluster, commissioners continue to focus on strengthening waiting-list and PTL assurance, maximising available capacity and addressing operational constraints that can limit delivery. Recovery will ultimately be judged by whether these actions translate into sustained reductions in waiting-list size and long waits.

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

3.2 PROGRAMME OVERVIEW | DIAGNOSTICS

Diagnostics: delivery, recovery and assurance

OVERALL: RED

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
Diagnostics	Diagnostic Tests Performed	Ops Plan	E.B.26x	Value	Aug-26	⚠	44,444	43,434	-1,010 ✗			42,085	37,437	-4,648 ✗			47,985	49,074	1,089 ✓		
	Diagnostics >6 Weeks (%)	Ops Plan	E.B.28x	%	Aug-26	⚠	16.5%	33.0%	16.5% ✗			28.6%	53.2%	24.6% ✗			19.7%	31.6%	11.9% ✗		
	Diagnostics Waits Over 13 weeks	QI		Value	Aug-26		0	2,609	2,609 ✗				11,131				0	3,261	3,261 ✗		

Current position and movement

Diagnostics remains significantly below plan across all three ICBs. The proportion of patients waiting more than six weeks is 33.0% in Derbyshire against a plan of 16.5%, 53.2% in Lincolnshire against 28.6%, and 31.6% in Nottingham and Nottinghamshire against 19.7%. Diagnostic activity is also below plan in Derbyshire and Lincolnshire, by 2.3% and 11.0% respectively, while Nottingham and Nottinghamshire is 2.3% above plan. Thirteen-week waits remain substantial, particularly in Lincolnshire with 11,131 patients and Nottingham and Nottinghamshire with 3,261. The position therefore remains materially off trajectory, with the activity gap in Lincolnshire particularly significant.

Recovery and commissioner response

Commissioners are maintaining modality-level oversight across the cluster, linking activity, six- and 13-week waits with demand, capacity, workforce, booking and equipment resilience. Recovery plans are being challenged to demonstrate measurable and sustainable improvement, supported by pathway and capacity review, waiting-list validation and targeted additional capacity. CDC evaluation is also underway, focusing on utilisation at site and modality level and opportunities to maximise available capacity. This includes mobile, insourced and independent-sector provision, with additional NOUS capacity supporting recovery in Lincolnshire. Assurance will focus on whether these actions deliver sustained reductions in backlogs and waiting times and provide the diagnostic capacity needed to support wider elective and cancer recovery.

Progress, dependencies and assurance

CDC development strengthens the recovery platform, with Lincolnshire reporting activity across its operational CDC sites at 93% of plan and the Boston development progressing through construction. In Nottingham, Mansfield CDC is reported as delivering above planned activity, while temporary Broad Marsh capacity continues during construction. Sustainable recovery nevertheless remains dependent on workforce, equipment reliability, booking processes and demonstrable conversion of additional capacity into reductions in six-week waits and diagnostic backlogs.

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

3.3 PROGRAMME OVERVIEW | CANCER

Cancer: delivery, recovery and assurance

OVERALL: AMBER / RED

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
Cancer	Cancer Faster Diagnosis <28 Days (%)	Ops Plan	E.B.27	%	Aug-26		80.0%	76.6%	-3.4% ✗			80.3%	71.3%	-9.0% ✗			80.0%	84.0%	4.0% ✓		
	Cancer Treatment <31 Days (%)	Ops Plan	E.B.38	%	Aug-26		94.1%	91.0%	-3.1% ✗			93.3%	92.3%	-1.0% ✗			94.1%	92.9%	-1.2% ✗		
	Cancer Referral-to-Treatment <62 Days (%)	Ops Plan	E.B.35	%	Aug-26		77.2%	66.4%	-10.8% ✗			75.5%	61.4%	-14.1% ✗			77.0%	66.4%	-10.6% ✗		

Current position and movement

Cancer performance remains below plan across the majority of headline measures. Faster Diagnosis is above plan in Nottingham and Nottinghamshire at 84.0% against 80.0% but remains below trajectory in Derbyshire at 76.6% and Lincolnshire at 71.3%. Thirty-one-day treatment performance is below plan in all three ICBs, although Nottingham and Nottinghamshire is comparatively close at 92.9% against 94.1%. The greatest challenge remains 62-day treatment, with performance at 66.4% in Derbyshire, 61.4% in Lincolnshire and 66.4% in Nottingham and Nottinghamshire, against plans of 77.2%, 75.5% and 77.0% respectively. Overall, Faster Diagnosis provides an area of relative strength in Nottingham and Nottinghamshire, but this has not yet translated into achievement of treatment standards.

Recovery and commissioner response

Commissioners are applying tumour-site and pathway-level assurance across Faster Diagnosis, 31-day and 62-day delivery. Provider recovery plans are being challenged through regular oversight, PTL validation, demand-and-capacity analysis and review against timed pathways, with contractual and NHS England escalation aligned to delivery risk. Commissioner scrutiny is focused on whether additional diagnostic, treatment and pathway capacity is directed towards the tumour sites contributing most to the delivery gap and whether actions have clear trajectories and measurable benefits. Focus remains on securing sustainable improvement in 62-day performance rather than improvement at individual pathway stages alone.

Progress, dependencies and assurance

Pathway redesign, straight-to-test models, improved triage and targeted work in priority tumour sites provide a stronger platform for recovery. Sustainable improvement remains dependent on diagnostic turnaround, histology and radiology capacity, oncology workforce, theatre access and timely progression between pathway stages. Commissioners will continue to review performance by tumour site and provider, testing whether improvements in Faster Diagnosis translate into reductions in backlogs and sustained improvement in 62-day treatment.

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

3.4 PROGRAMME OVERVIEW | URGENT AND EMERGENCY CARE

UEC: delivery, recovery and assurance

OVERALL: AMBER / RED

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
Urgent Care	A&E <4 Hours (%)	Ops Plan	E.M.13	%	Sep-26	⚠	77.0%	73.6%	-3.4% ✗			75.5%	77.9%	2.4% ✓			79.4%	69.3%	-10.1% ✗		
	A&E >12 Hours (%)	Ops Plan	E.M.13g	%	Sep-26	⚠	4.6%	12.5%	7.9% ✗			9.7%	15.1%	5.4% ✗			9.2%	12.1%	2.9% ✗		
	Ambulance Cat 2 Mean Response (mins)	Ops Plan	E.B.23c	Value	Sep-26		00:25:00	00:29:46	00:04:46 ✗			00:25:00	00:42:15	00:17:15 ✗			00:25:00	00:27:58	00:02:58 ✗		
	Ambulance Handovers >45 min (%)	Ops Plan	E.B.47	%	Sep-26		11.3%	17.4%	6.1% ✗			9.7%	28.1%	18.4% ✗			6.6%	19.5%	12.9% ✗		

Current position and movement

Urgent and Emergency Care performance remains mixed but pressured across the cluster. Four-hour performance is above plan in Lincolnshire at 77.9% against 75.5%, but below trajectory in Derbyshire at 73.6% against 77.0% and Nottingham and Nottinghamshire at 69.3% against 79.4%. Twelve-hour waits are above plan in all three ICBs and are highest in Nottingham and Nottinghamshire at 12.1% against a plan of 9.2%. Category 2 ambulance response is also materially above trajectory across all three systems. Ambulance handovers over 45 minutes are particularly challenged in Lincolnshire at 28.1% against 9.7%, and Nottingham and Nottinghamshire at 19.5% against 6.6%. Overall, the data indicates sustained pressure across both acute flow and ambulance interfaces, despite stronger four-hour delivery in Lincolnshire.

Recovery and commissioner response

Commissioners are focusing recovery on whole-system flow through established UEC governance, winter delivery arrangements, contractual management and recovery-plan oversight. The ICBs are scrutinising prolonged waits, ambulance handovers, occupancy and discharge, alongside the contribution of admission avoidance, Same Day Emergency Care, Urgent Community Response and NHS 111 pathways. Commissioner action includes coordinating acute, community, primary care, mental health, ambulance and local authority partners, strengthening contractual oversight of admission avoidance and discharge services, and funding additional Discharge to Assess capacity in Nottinghamshire to support patient flow. Commissioners are also reviewing key UEC services against the commissioning plan and considering further demand-avoidance schemes and expansion of existing services where capacity constraints continue to affect hospital flow. In Lincolnshire, commissioners are working with providers to reconcile emergency activity reporting. Assurance is focused on whether winter and recovery plans contain clear milestones and produce measurable improvements in flow.

Progress, dependencies and assurance

Strengthened discharge arrangements, admission avoidance, urgent community response and winter planning provide the principal routes to improvement. However, sustainable recovery remains dependent on community and social care capacity, workforce availability and consistent coordination between system partners. Commissioners will focus on whether these interventions deliver sustained reductions in 12-hour waits, discharge delays, occupancy pressure and ambulance handover times rather than short-term or seasonal improvement.

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

3.5 PROGRAMME OVERVIEW | COMMUNITY

Community: delivery, recovery and assurance

OVERALL: AMBER

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
Community	Adult Community Waits >52 Weeks	Ops Plan	E.T.9b	Value	Aug-26		72	0	-72 ✓			0	0	0 ✓			0	3	3 ✗		
	CYP Community Waits >52 Weeks	Ops Plan	E.T.9a	Value	Aug-26		48	614	566 ✗			1,381	1,406	25 ✗			300	240	-60 ✓		

Current position and movement

Adult community long waits remain a clear area of relative strength. Derbyshire have no adult waits over 52 weeks against a plan of 72, while Lincolnshire also report none and Nottingham and Nottinghamshire have three against a plan of zero. The principal pressure remains within CYP community services. Derbyshire has 614 CYP waits over 52 weeks against a plan of 48 and Lincolnshire 1,406 against 1,381, while Nottingham and Nottinghamshire is performing better than trajectory at 240 against a plan of 300. The overall position therefore remains strong for adult pathways, but with a significant CYP long-wait challenge in Derbyshire and a smaller adverse variance in Lincolnshire.

Recovery and commissioner response

Commissioners are taking a pathway-specific approach to recovery, combining waiting-list validation, provider recovery plans, demand-and-capacity assessment and service redesign. Oversight is focused on Community Paediatrics, autism and ADHD assessment, Speech and Language Therapy, Occupational Therapy and other pathways contributing most to long waits. Provider plans are being tested against credible trajectories and measurable reductions in long-wait cohorts, with commissioners also using procurement and pathway redesign where additional or alternative capacity is required. Across the cluster, the objective is to reduce CYP waits while protecting comparatively strong adult performance.

Progress, dependencies and assurance

Targeted recovery initiatives and improved waiting-list intelligence are providing a stronger basis for improvement. Sustainable delivery remains dependent on specialist workforce and assessment capacity, management of demand growth and effective partnership working across health, education and local authority services. Commissioner assurance will continue to focus on actual reductions in pathway-level long waits and delivery against agreed trajectories rather than additional activity alone.

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

3.6 PROGRAMME OVERVIEW | PRIMARY CARE

Primary care: delivery, recovery and assurance

OVERALL: GREEN / AMBER

							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
Primary Care	GP Appointments Delivered	Ops Plan	E.D.19	Value	Aug-26		558,440	552,093	-6,347 ✗			433,524	460,407	26,883 ✓			620,386	654,054	33,668 ✓		
	Same Day Urgent GP Appointments (%)	Ops Plan	E.D.27	%	Aug-26		70.0%	76.4%	6.4% ✓			68.7%	71.9%	3.2% ✓			75.0%	77.4%	2.4% ✓		
	Dental UDAs Delivered	Ops Plan	E.D.24	Value	Sep-26		124,614	118,505	-6,109 ✗			88,580	75,800	-12,780 ✗			161,506	154,583	-6,923 ✗		
	UDAs Delivered (%)	Ops Plan	E.D.28	%	Sep-26		100%	92.0%	-8.0% ✗			100%	80.0%	-20.0% ✗			100%	93.0%	-7.0% ✗		
	Adults Seen by NHS Dentist (%)	Ops Plan	E.D.22	%	Sep-26		40.0%	44.4%	4.4% ✓			36.3%	37.3%	1.0% ✓			40.7%	41.8%	1.1% ✓		
	Children Seen by NHS Dentist (%)	Ops Plan	E.D.23	%	Sep-26		69.5%	68.5%	-1.0% ✗			63.7%	59.9%	-3.8% ✗			72.2%	66.3%	-5.9% ✗		
	Pharmacy First Consultations	Ops Plan	E.D.26	Value	Aug-26		11,425	14,537	3,112 ✓			6,563	7,824	1,261 ✓			13,864	14,944	1,080 ✓		

Current position and movement

Primary care remains comparatively strong, although the latest data shows variation between measures. GP appointment delivery is above plan in Lincolnshire and Nottingham and Nottinghamshire, but marginally below plan in Derbyshire at 552,093 against 558,440. Same-day urgent GP access is above trajectory across all three ICBs. Dental UDA delivery remains below plan in each system, at 118,505 against 124,614 in Derbyshire, 75,800 against 88,580 in Lincolnshire and 154,583 against 161,506 in Nottingham and Nottinghamshire. Pharmacy First consultations are above plan across all three ICBs. Overall, access through general practice and community pharmacy remains strong, while dental activity continues to represent the principal common delivery gap.

Recovery and commissioner response

Commissioners are maintaining oversight of GP access, clinically urgent same-day access, appointment coding, Dental UDA delivery and Pharmacy First utilisation, with targeted support where practice-level variation is identified. Commissioner action on dental access has moved into delivery. Additional NHS dental capacity has been commissioned across the DLN cluster, with 59 providers receiving recurrent increases to contracted UDA activity and a further 90 providers eligible to deliver additional activity through the 110% overperformance scheme during 2026/27. Increased activity requirements were incorporated into contracts from September 2026, while released UDA capacity continues to be targeted towards areas of greatest need. Commissioners will monitor whether this additional commissioned capacity translates into sustained increases in activity and improved patient access.

Progress, dependencies and assurance

General practice and Pharmacy First provide a strong platform for access and demand management. Dental recovery remains dependent on workforce availability, provider engagement, successful commissioning action and effective utilisation of available capacity. Commissioners will continue to monitor delivery and variation to determine whether dental interventions are translating into sustained increases in activity and improved patient access while maintaining performance across the wider primary care programme.

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

3.7 PROGRAMME OVERVIEW | MENTAL HEALTH and LD&A

Mental Health and LD&A: delivery, recovery and assurance

OVERALL: AMBER

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
Mental Health	Inappropriate OAPs (Adult Acute)	Ops Plan	E.A.5	Value	Aug-26	⚠	6	*				1	*				6	10	4 ✗		
	IPS Access (Rolling 12-month)	Ops Plan	E.H.34	Value	Aug-26		905	995	90 ✓			690	745	55 ✓			1,375	1,640	265 ✓		
	EIP <2 Weeks (%)	Nat Std		%	Aug-26		60.0%	67.0%	7.0% ✓			60.0%	75.0%	15.0% ✓			60.0%	76.0%	16.0% ✓		
	Talking Therapies Reliable Recovery (%)	Ops Plan	E.A.4a	%	Aug-26		48.2%	50.4%	2.2% ✓			49.4%	45.4%	-4.0% ✗			50.8%	50.9%	0.1% ✓		
	Talking Therapies Reliable Improvement (%)	Ops Plan	E.A.4b	%	Aug-26		68.9%	72.7%	3.8% ✓			70.1%	69.8%	-0.3% ✗			68.6%	69.6%	1.0% ✓		
	CYP MH Access	Ops Plan	E.H.9	Value	Aug-26		14,620	14,845	225 ✓			12,555	13,125	570 ✓			21,860	22,320	460 ✓		
	CYP ED Routine <4 Weeks (%)	Nat Std		%	Aug-26		95.0%	96.0%	1.0% ✓			95.0%	54.0%	-41.0% ✗			95.0%	86.0%	-9.0% ✗		
	CYP MH Waits >104 Weeks	Ops Plan	E.A.7	Value	Aug-26		900	1,275	375 ✗			81	960	879 ✗			660	560	-100 ✓		
LD&A	LD/Autism Adult Inpatients	Ops Plan	E.H.32/ 33	Value	Sep-26		31	34	3 ✗			33	31	-2 ✓			35	36	1 ✗		
	LD/Autism CYP Inpatients	Ops Plan	E.K.1c	Value	Sep-26		3	3	0 ✓			2	0	-2 ✓			3	2	-1 ✓		

* Data Nationally Suppressed

Current position and movement

Mental Health and LD&A performance remains mixed across the cluster. IPS access is above plan across all three ICBs, while Talking Therapies performance varies between systems. CYP Eating Disorder access remains a key pressure, particularly in Lincolnshire. Inappropriate adult acute out-of-area placements are also above plan for NNICB, data for DDICB and LICB is suppressed nationally due to low numbers. LD/Autism CYP inpatient numbers are at or better than plan, while adult inpatient performance remains mixed. Overall, the position shows areas of achievement alongside continuing pressure in inpatient pathways, Eating Disorder access and selected Talking Therapies measures.

Recovery and commissioner response

Commissioners are combining programme oversight, contractual management and individual case review across inpatient flow, discharge, inappropriate out-of-area placements, Section 117 and specialist pathways. Length of stay and patients clinically ready for discharge are being reviewed through provider meetings, MADE arrangements and bed-flow processes, with barriers relating to social care, accommodation and community packages escalated where required. Commissioner oversight also includes recovery trajectories for Talking Therapies and CYP Eating Disorders and active case management to reduce inappropriate placements and avoidable inpatient stays. LD&A oversight remains case-specific, using discharge planning, Dynamic Support Register processes and community alternatives to reduce avoidable admission and long stays.

Progress, dependencies and assurance

Partnership arrangements, discharge oversight and case-management processes provide the basis for recovery, but delivery remains dependent on community capacity, suitable accommodation, social care packages, specialist workforce and effective multi-agency working. Commissioners will continue to distinguish genuine operational deterioration from known data or methodology effects while focusing on measurable reductions in length of stay, inappropriate placements and reliance on inpatient care.

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

3.8 PROGRAMME OVERVIEW | CYP

Children and young people: delivery, recovery and assurance

OVERALL: AMBER / RED

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
Mental Health	CYP MH Access	Ops Plan	E.H.9	Value	Aug-26		14,620	14,845	225 ✓			12,555	13,125	570 ✓			21,860	22,320	460 ✓		
	CYP ED Routine <4 Weeks (%)	Nat Std		%	Aug-26		95.0%	96.0%	1.0% ✓			95.0%	54.0%	-41.0% ✗			95.0%	86.0%	-9.0% ✗		
	CYP MH Waits >104 Weeks	Ops Plan	E.A.7	Value	Aug-26		900	1,275	375 ✗			81	960	879 ✗			660	560	-100 ✓		

Current position and movement

CYP performance combines strong access with continuing long-wait and Eating Disorder pressures. Mental Health access is above plan in all three ICBs, with Derbyshire reporting 14,845 against 14,620, Lincolnshire 13,125 against 12,555 and Nottingham and Nottinghamshire 22,320 against 21,860. Routine Eating Disorder access remains below the 95% standard in Lincolnshire and Nottingham and Nottinghamshire, at 54.0% and 86.0% respectively, while Derbyshire is above standard at 96.0%. The table also shows CYP Mental Health waits over 104 weeks materially above plan across all three ICBs, most notably Derbyshire at 1,275 against a plan of 900 and Lincolnshire at 960 against 81. Overall, access volumes remain strong, but very long waits and Eating Disorder performance continue to be the principal areas requiring recovery.

Recovery and commissioner response

Commissioners are directing recovery through the DLN CYP Programme Board and its priority workstreams, supported by development of a cluster-wide performance dashboard and clearer outcome measures. The ICBs are challenging provider trajectories for community, neurodevelopmental, therapy, Eating Disorder and very-long-wait pathways. Actions include waiting-list validation, demand-and-capacity modelling, neurodevelopmental pathway redesign, GIRFT-supported improvement and targeted capacity interventions. Commissioner assurance is focused on whether these actions produce measurable reductions in long-wait cohorts while maintaining Mental Health access.
Workstreams are being developed to tackle key areas including Long Term Conditions and smooth transitions into adult services at the appropriate ages.

Progress, dependencies and assurance

Strengthened governance, improved reporting and pathway redesign provide a stronger platform for recovery. The DLN CYP Programme Board is seeking sub-group leads from within the system to take these forward. Progress remains dependent on specialist workforce, assessment and diagnostic capacity, referral demand and effective partnership working across health, education and local authority organisations. Assurance will focus on delivery milestones and reductions in long waits, with appropriate qualification where small cohorts or patient choice materially affect headline measures.

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

3.9 PROGRAMME OVERVIEW | WOMEN'S HEALTH

Women's Health: programme implementation and assurance

OVERALL: AMBER

Programme milestone	Status
DLN Programme and governance established	Complete
Workstream leadership in place	Complete
Priority pathway development	In progress
Cluster delivery plan	In progress
Performance framework and outcome measures	In development

Current position and movement

The Women's Health programme remains milestone-based rather than being assessed through routine operational performance measures. Programme governance and workstream leadership are recorded as complete, while priority pathway development and the cluster delivery plan remain in progress and development of the performance framework and outcome measures is ongoing. The current position therefore reflects continued transition from mobilisation into implementation, with assurance focused on delivery of programme milestones until sufficiently mature outcome and performance measures are available.
Gynaecology RTT can be measured and is reported, reflecting the performance challenges faced by all RTT specialties.

Recovery and commissioner response

Commissioners are moving the programme from governance and mobilisation into deliverable pathway change. Workstream reporting cycles, accountability reviews and programme assurance arrangements are being strengthened to provide a clearer line of sight from activity to outcomes. Commissioner-led work includes development of future commissioning approaches, benefits realisation, movement to community-based services, baseline and outcome measures, equality impact assessment and engagement and coproduction. The emphasis is now on translating the programme architecture into clearly owned pathway changes with measurable benefits.
The next Women's Health Programme Board will include a focus on Prevention, with particular emphasis on screening programmes and HPV vaccination.

Progress, dependencies and assurance

Delivery remains dependent on consistent partner engagement and decision-making, sufficient transformation capacity, clinical leadership and completion of baseline and outcome measures. The establishment of a Women's Health Alliance is key to these. Until routine operational measures mature, assurance should remain milestone based, with a clear line of sight between delivery of the programme workstreams and intended improvements in access, outcomes, inequalities and patient experience.

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

4.0 NHS Oversight Framework: Provider Delivery Overview

The NHS Oversight Framework 2026/27 is NHS England's approach to assessing and overseeing ICB and provider performance. It combines national priorities with broader measures of outcomes, inequalities, quality, workforce and finance to support accountability, improvement and proportionate oversight. Assessment outcomes help determine the level of support and autonomy provided to organisations throughout the year.

The Q1 2026/27 assessment shows a varied provider position across the DLN cluster. Derbyshire Community Health Services has the strongest overall result, achieving Segment 1, while Lincolnshire Community Health Services is in Segment 2. Seven providers are in Segment 3 and two are in Segment 4, with Nottingham University Hospitals recording the most challenged acute position at 133rd of 134 providers. Financial deficits are reported by seven of the eleven DLN providers assessed, contributing to the level of oversight required. Overall, the results highlight pressure across acute services, alongside comparatively stronger positions within parts of community and mental health provision.

Please Note: ICB Q1 NOF scores have not yet been released, there has been a pause in the national publication.

Select Quarter	Q1 2026-27

ICB Name	Provider Name	Type	Access to Services	Patient Safety	Finance, Productivity and Innovation	People	Experience of Care	Effectiveness of Care and Population Health	Overall Segment	Financial Deficit	Average Metric Score	Provider Rank
			Quartile									
Nottingham & Nottinghamshire	Nottingham University Hospitals NHS Trust	Acute	4	4	4	4	3	4	4	Yes	**3.02**	133 / 134
Lincolnshire	United Lincolnshire Hospitals NHS Trust	Acute	4	4	4	4	4	1	4	No	**2.86**	124 / 134
Derby & Derbyshire	University Hospitals of Derby and Burton NHS Foundation Trust	Acute	4	3	3	3	3	2	3	Yes	**2.73**	109 / 134
Derby & Derbyshire	Chesterfield Royal Hospital NHS Foundation Trust	Acute	3	1	2	4	2	4	3	Yes	**2.56**	87 / 134
Nottingham & Nottinghamshire	Nottinghamshire Healthcare NHS Foundation Trust	MH&Comm	1	4	4	4	3	2	3	Yes	**2.49**	41 / 58
Lincolnshire	Lincolnshire Partnership NHS Foundation Trust	MH	1	4	3	2	3	4	3	Yes	**2.49**	41 / 58
Derby & Derbyshire	Derbyshire Healthcare NHS Foundation Trust	MH	4	3	1	4	3	3	3	Yes	**2.46**	39 / 58
Nottingham & Nottinghamshire	Sherwood Forest Hospitals NHS Foundation Trust	Acute	2	2	4	2	2	4	3	Yes	**2.44**	72 / 134
EMAS	East Midlands Ambulance Service NHS Trust	Amb	3	3	1	3	3	3	3	No	**2.35**	7 / 10
Lincolnshire	Lincolnshire Community Health Services NHS Trust	Comm	1	4	2	2	3	4	2	No	**2.24**	26 / 58
Derby & Derbyshire	Derbyshire Community Health Services NHS Foundation Trust	Comm	1	1	2	1	1	2	1	No	**1.78**	4 / 58

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

5.0 Data Quality Position

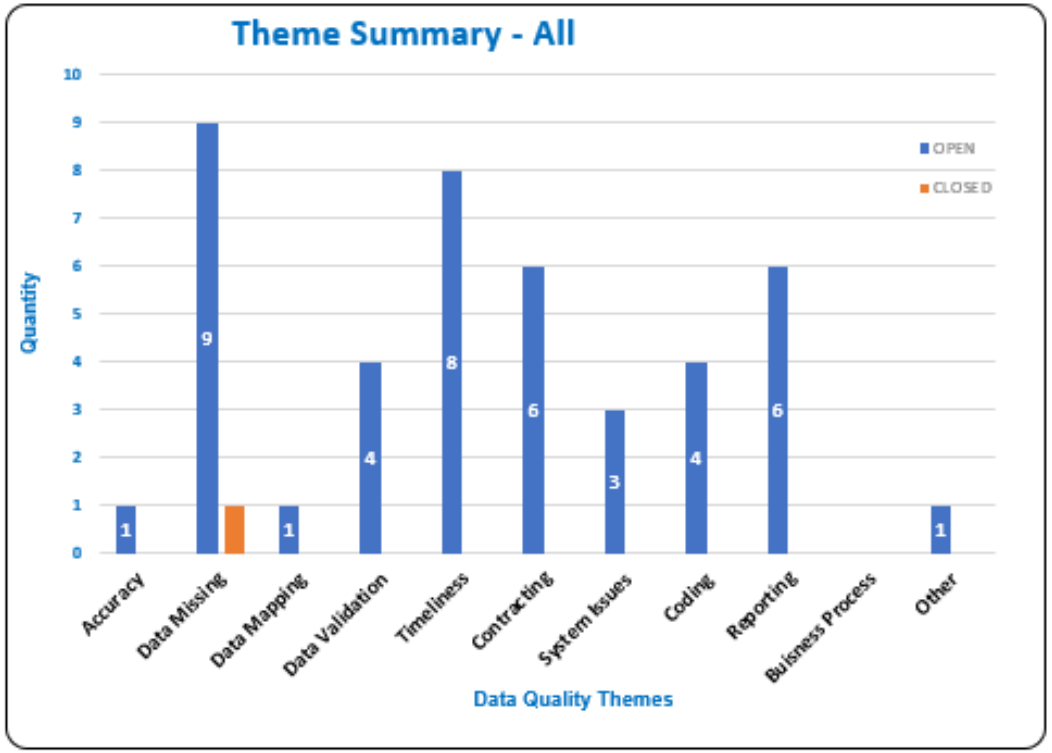
1. A DLN-wide Data Quality Framework has been established to strengthen the consistency, reliability and assurance of data used across performance reporting, commissioning and contract management. The framework introduces clear governance, roles and accountabilities, linking operational data processes to system-level oversight through DQOG, AF&P and COG, ensuring data quality is managed as a core delivery enabler rather than a technical function.

2. The framework standardises data quality processes across the cluster, embedding both preventative controls, including validation and coding assurance, and detective controls such as scrutiny, exception monitoring and audit. Assurance is currently delivered through a combination of local ownership, central SAIU oversight, formal reporting routes and structured governance. This will be supplemented by the independent external Data Quality Audit during Q3 2026/27.

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 where required. Findings and recommendations from the independent external audit will subsequently be reviewed alongside register risks to provide additional assurance over the effectiveness of controls and identify recurring or emerging themes. At the end of October 2026, 44 active data quality issues were recorded across the DLN cluster, of which 28 relate to acute services and 12 relate to non-acute services, and 4 to both acute and non-acute. The largest themes are missing data (9 issues), timeliness of submissions and Contracting (6 issues) and Reporting (6 issues), demonstrating 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 upon consistently and explicitly linked to performance and delivery risks. This is strengthening confidence in system reporting and improving alignment between activity, performance and financial management, which is critical to effective commissioning oversight.

5. Independent Data Quality Audit: An independent external audit of the DLN Data Quality Framework will take place during Q3 2026/27, providing additional assurance over the quality, completeness and reliability of data used for performance reporting, contract management and commissioning decisions. The audit will review key data flows, local policies and procedures, validation controls and governance arrangements, including a walkthrough of the checks applied to provider activity data. Findings will identify areas of good practice and opportunities for improvement, with the final audit report scheduled for presentation to the Audit Committee in February 2027. Actions arising from the review will be incorporated into improvement plans and monitored through the established data quality governance arrangements.



Meeting title	Integrated Care Boards: Open Session (meeting in common)
Meeting date	19/11/2026
Paper title	**Finance Report**
Paper reference	ICB CIC 26 073
Paper author	Rebecca McCauley, Senior Finance Business Partner
Paper sponsor	Marcus Pratt, Interim Executive Director of Finance
Presenter	Marcus Pratt

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 six-month period April 2026 to September 2026.

All three ICBs continue to forecast delivery of their planned full-year financial positions. However, delivery remains dependent on the full and timely implementation of £98.5 million of mitigating actions, recovery of the £9.0 million recurrent efficiency shortfall and prompt corrective action where schemes or offsets do not deliver as planned.

The principal forecast pressures are mental health services (£34.3 million adverse to planned position), prescribing (£21.9 million adverse to planned position), continuing healthcare (£12.4 million adverse to planned position) and community services (£10.6 million adverse to planned position). These pressures are currently offset by reserves, financial solutions and other favourable programme movements.

The ICBs continue to forecast delivery of their £163.1 million efficiency programme, with £71.5 million delivered year to date. The £9.0 million recurrent under-delivery is being offset by non-recurrent savings, creating an ongoing sustainability risk. Whilst the £28.6 million risk-adjusted delivery shortfall remains dependent on identified mitigating actions. The reported underlying position is a £25.7 million deficit, £28.4 million adverse to plan, and remains subject to further organisation-level validation.

The year-to-date monthly expenditure run rate of £739.6 million is broadly aligned with the £738.8 million average required over the remaining six months. Delivery of the forecast nevertheless requires planned reductions, efficiencies and financial solutions to be achieved during the second half of the year. Cash is being managed within ICB envelopes, with aged non-NHS payables and rising NHS and local authority receivables remaining the principal working-capital risks.

Across the three ICB systems, the Month six deficit position is £132.6 million against a planned deficit of £79.5 million, an adverse variance of £53.2 million and £12.5 million worse than in month five. Derbyshire remains ahead of plan, whilst Lincolnshire is £7.7 million

Report summary

adverse and Nottinghamshire £47.1 million adverse, driven predominantly by acute provider pressures.

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

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 September 2026 (Month 6)

19th November 2026

Contents

Systems Overview – slide 2
ICBs' Financial Positions – slides 3–5
Appendix –Summary Income and expenditure – slide 6

Systems Overview

System Provider Metrics Month 6

Organisation	Income and expendutire postion (including Deficit Support Funding)			
	Year to date Plan £'m	Year to date Actual £'m	Year to date Variance £'m	
Derby and Derbyshire ICS	(19.8)	(18.2)	1.6	G
Lincolnshire ICS	(13.6)	(21.3)	(7.7)	R
Nottingham and Nottinghamshire ICS	(46.1)	(93.1)	(47.1)	R
Grand Total DLN	(79.5)	(132.6)	(53.2)	R

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

At Month 6, the DLN ICS' reports a £132.6m deficit against a planned £79.5m deficit—£53.2m adverse and £12.5m worse than Month 5. Derbyshire is £1.6m favourable; Lincolnshire and Nottinghamshire are £7.7m and £47.1m adverse tp forecast.

VARIANCE

KEY DRIVERS

The adverse variance is concentrated in acute provider pressures: Nottingham University Hospitals £31.9m, Sherwood Forest Hospitals £10.2m and United Lincolnshire Teaching Hospitals £5.3m. Pay cost pressures and under-delivery of efficiencies remain the principal drivers.

All organisations continue to forecast delivery of their full-year financial plans.

Efficiencies

£23.3m BEHIND PLAN

At Month 6, efficiency delivery is £23.3m (9.4%) behind the planned £247.3m. Derbyshire is £8.6m behind plan, Lincolnshire £7.2m and Nottinghamshire £7.5m. Delays in schemes entering delivery and savings phasing remain the main causes.

DELIVERY

FULL-YEAR PLAN

Current adverse variances reflect delayed schemes, phasing and provider cost pressures.

All organisations continue to forecast delivery of their full-year efficiency plans.

ICBs (1 of 3)

ICBs forecast break-even at Month 6; delivery depends on evidenced mitigations, recurrent efficiency recovery and corrective action.

ICB Key Metrics	Variance to Plan - Surplus / (Deficit)															
	Year to Date								Full Year							
	DDICB £m		LICB £m		NNICB £m		DLN Cluster 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	(6.7)	R	(0.9)	R	1.0	G	(6.6)	R	0.0	G	0.0	G	0.0	G	0.0	G
Spend of Capital Allocation	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G	0.0	G
Spend of Running Cost Allocation	1.8	G	0.9	G	1.3	G	3.9	G	3.2	G	1.7	G	2.4	G	7.4	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	-	4.6	G	(11.6)	R	(18.7)	R	(25.7)	R
Better Payment Practice Code — Volume	89.6%	R	94.9%	R	84.8%	R			92.5%	R	93.6%	R	84.1%	R		
Better Payment Practice Code — Value	96.0%	G	95.0%	G	98.7%	G	N/A	-	97.2%	G	97.9%	G	95.1%	G	N/A	-

DELIVERY

ON PLAN

All three ICBs and the Cluster forecast break-even and full-year delivery.

RISK

FULLY MITIGATED

£98.5m of identified risk is matched by mitigations; delivery evidence remains critical.

WATCHPOINT

SUSTAINABILITY

A £9.0m recurrent efficiency gap and £25.7m underlying deficit remain key sustainability risks.

ICBs (2 of 3)

Break-even remains forecast, but delivery depends on service recovery, evidenced mitigations and recurrent efficiency improvement.

FINANCIAL PRESSURES

£34.3m adverse Mental health

£21.9m adverse Prescribing

£12.4m adverse Continuing Healthcare

Community services add a £10.6m adverse pressure; recovery action and forecast discipline remain critical.

LARGEST OFFSETS

£56.1m favourable Reserves/contingencies

£10.4m favourable Specialised Commissioning

£4.6m favourable Other Programme Services

These offsets are central to the reported break-even forecast and require assurance on timing and sustainability.

EFFICIENCY WATCHPOINT

£163.1m Full-year efficiency plan

£9.0m Recurrent under-delivery

£28.6m Risk-adjusted shortfall fully mitigated

The recurrent gap is being offset by non-recurrent savings, increasing the sustainability risk.

The ICBs continue to forecast break-even; £98.5m of identified risk is matched by mitigations, but delivery depends on service recovery, recurrent efficiency improvement and validation of reserves and other offsets.

ICBs (3 of 3)

Break-even is forecast, but assurance is needed on mitigations, recurrent efficiency, the underlying position and working capital.

RISK and SUSTAINABILITY

£98.5m identified risk matched by mitigations

£25.7m deficit Reported underlying position

A £9.0m recurrent efficiency gap is being covered by non-recurrent savings.

Underlying-position deep-dive validation continues before the result is used as a planning baseline.

CASH and WORKING CAPITAL

Cash is managed within ICB envelopes, but is £147.5m overdrawn against profile (3.3%).

£2.1m overdue payables

£3.5m overdue receivables

Below 95% Better Practice Payment Code (BPPC) volume

BPPC value measures meet target for all ICBs. Priority actions are aged non-NHS payables and Derbyshire NHS and council receivables.

BOARD FOCUS

- Maintain service recovery on mental health, prescribing, Continuing Healthcare and community pressures.
- Evidence and transact £98.5m mitigations.
- Close the £9.0m recurrent efficiency gap and replace delayed schemes.
- Complete underlying-position validation and hold spend to the £738.8m monthly requirement.

Appendix 1 – Income and Expenditure (Month 6)

TOTAL Summary	Net Expenditure									
	Year to Date					Full Year				
	Plan	Actual	Variance			Plan	Actual	Variance		
	£m	£m	£m	%		£m	£m	£m	%	
Revenue Resource Limit	(4,432.8)					(8,870.2)				
Acute Services	2,069.0	2,059.5	9.5	0.5%	G	4,099.0	4,096.4	2.6	0.1%	G
Acute services - NHS	1,943.2	1,936.0	7.2	0.4%	G	3,862.9	3,851.8	11.1	0.3%	G
Acute services - Independent/commercial sector	110.4	106.5	3.9	3.6%	G	209.5	205.6	4.0	1.9%	G
Acute services - Other non-NHS	9.1	9.5	(0.4)	(4.9%)	R	18.2	18.6	(0.4)	(2.4%)	R
Acute Services - Other Net Expenditure	6.2	7.4	(1.2)	(19.2%)	R	8.5	20.5	(12.0)	(141.5%)	R
Community Health Services	364.8	362.5	2.3	0.6%	G	720.8	731.4	(10.6)	(1.5%)	R
Mental Health Services	465.9	486.1	(20.3)	(4.3%)	R	928.8	963.1	(34.3)	(3.7%)	R
MH Services - NHS	292.8	296.2	(3.3)	(1.1%)	R	584.5	591.0	(6.5)	(1.1%)	R
MH Services - Independent / Commercial Sector	99.3	101.0	(1.7)	(1.7%)	R	197.8	201.2	(3.4)	(1.7%)	R
MH Services - Other non-NHS	70.8	89.0	(18.2)	(25.7%)	R	142.8	167.7	(24.9)	(17.4%)	R
MH Services - Other net expenditure	2.9	(0.1)	3.0	103.2%	G	3.7	3.2	0.4	11.5%	G
Continuing Healthcare (CHC)	196.0	198.8	(2.8)	(1.5%)	R	382.5	394.8	(12.4)	(3.2%)	R
Prescribing	294.7	307.6	(12.8)	(4.4%)	R	589.8	611.7	(21.9)	(3.7%)	R
Delegated Primary Medical Services	352.0	350.9	1.0	0.3%	G	716.3	714.2	2.1	0.3%	G
Delegated Dental, Ophthalmic and Pharmacy	157.9	157.1	0.8	0.5%	G	343.8	342.9	0.9	0.3%	G
Dental Services	95.1	94.9	0.2	0.2%	G	212.5	212.5	0.0	0.0%	G
Ophthalmic Services	12.6	11.6	1.0	8.0%	G	30.6	29.3	1.3	4.2%	G
Pharmacy Services	50.2	50.7	(0.5)	(0.9%)	R	100.7	101.1	(0.3)	(0.3%)	R
Other Primary Care Services	48.1	46.8	1.2	2.6%	G	96.7	94.3	2.4	2.5%	G
Delegated Specialised Commissioning	447.4	442.2	5.2	1.2%	G	886.9	876.5	10.4	1.2%	G
Other Programme Services	43.8	33.4	10.4	23.8%	G	84.1	79.5	4.6	5.5%	G
Reserves/Contingencies	(22.8)	(28.4)	5.6	(24.4%)	R	(20.9)	(77.1)	56.1	(268.3%)	R
Total Programme	**4,416.7**	**4,416.6**	**0.0**	**0.0%**	G	**8,827.7**	**8,827.7**	**0.0**	**0.0%**	G
Running Costs	20.9	21.0	0.0	(0.2%)	R	42.4	42.5	0.0	(0.1%)	R
Grand Total	**4,437.6**	**4,437.6**	**0.0**	**0.0%**	G	**8,870.2**	**8,870.2**	**0.0**	**0.0%**	G
Surplus/(Deficit)	(4.8)	(4.8)	**0.0**	**0%**	G	**0.0**	**0.0**	**0.0**	**100%**	G
Less Non Recurrent Deficit Support Funding	(2.2)	(2.2)	**0.0**	**0%**	G	(4.3)	(4.3)	**0.0**	**0%**	G
Surplus/(Deficit) excluding Non-Recurrent Deficit Support Funding	(7.0)	(7.0)	**0.0**	**0%**	G	(4.3)	(4.3)	**0.0**	**0%**	G

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/11/2026
Paper title:	**Transition Programme Report**
Paper reference:	ICB CIC 26 074
Paper author:	Chrissy Tucker, Director of Programmes - Transition
Paper sponsor:	Clair Raybould, Executive Director of Strategy and Citizen Engagement Rosa Waddingham, Executive Director of Quality (Nursing)
Presenter:	Clair Raybould and Rosa Waddingham

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

Report summary:

This report provides an update on the ICBs' Transition Programme since the last substantive Board report in January 2026. It describes progress in implementing the cluster operating model and management of change process, and the implications of the national decision to defer ICB mergers.

It also sets out the next phase of transition, with increasing focus on embedding an effective and sustainable operating model and developing the organisational capacity, capability, culture and ways of working required to support effective strategic commissioning.

The Joint Transition Committee will continue to oversight the Transition Programme through established governance routes.

The Boards are asked to **receive** this report for assurance regarding progress of the ICBs' Transition Programme, noting the challenges associated with management of change process and the changing national context.

Board Assurance Framework

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

- Failure to develop and implement an effective operating model and workforce capability to support the transition to a merged ICB

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Transition Programme Report

Executive overview

1. Since January 2026, the ICBs' Transition Programme has moved from designing and planning new organisational arrangements into implementing the joint leadership structures, progressing management of change delivery, reducing corporate costs, and transferring functions previously provided by Commissioning Support Units. This has been delivered alongside the continued statutory responsibilities of the NHS Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs.
2. The recent national announcement to defer ICB mergers has materially changed the context for delivery. The ICBs will continue to develop shared leadership, teams and ways of working. However, the three ICBs remain separate statutory organisations, each with its own accountabilities. The transition plan is being reviewed to reflect that position, including the continuing governance requirements and possible additional non-recurrent costs.
3. As management of change progresses, the focus must move increasingly beyond establishing structures to ensuring that the operating model has the capacity, capabilities, culture and systems needed for effective strategic commissioning. The ICBs' Joint Transition Committee continues to oversee detailed milestones, dependencies and risks, with matters of strategic significance reported to the Boards.

Progress in delivering transition

People and structures

4. Waves one and two of the management of change programme, covering Executive and Director appointments, have completed, with Executives commencing in post from November 2025 and most Directors commencing in March 2026. Wave three, covering the remaining workforce, is progressing through the more complex stages of alignment, appointments, appeals and redundancy processes.
5. Progress with wave three has been slower than originally planned, reflecting both the scale and complexity of the process and challenges in the planning and sequencing of activity. In response, executive oversight and programme management arrangements have been strengthened, with a greater focus on delivery milestones, resolving issues and maintaining momentum, whilst ensuring that employment processes are undertaken fairly and consistently.
6. By the end of November, all staff are expected to have received formal notification of their position within the management of change process,

confirming whether they have been slotted into a role, placed within a ringfenced selection pool, or identified as requiring further assessment through the alignment process. The remaining assessments and competitive appointment processes will then continue, with appointments planned for completion before Christmas 2026.

7. As the programme progresses, some colleagues are now entering the formal at-risk stage. Our priority remains to minimise compulsory redundancies wherever possible, with a continued focus on securing suitable alternative employment opportunities for affected colleagues and providing appropriate support throughout the process. However, given the scale of the required workforce reductions and the number of roles available within the new structures, it is recognised that compulsory redundancies will be unavoidable in some cases. These processes will continue to be managed fairly, sensitively and in accordance with agreed policies, with appropriate oversight through the programme's governance arrangements.

8. The national voluntary redundancy scheme has concluded, with agreements for 404 members of staff to leave the ICBs voluntarily.

9. The revised timetable and associated workforce risks remain subject to close oversight through the Joint Transition Committee, with the joint remuneration and Human Resource Committee providing additional scrutiny of the people-related implications, including redundancy arrangements and compliance with agreed policies.

Financial delivery

10. The 2026/27 allocations included a 44% reduction in corporate costs. The Transition Programme is intended to deliver this reduction on an annualised basis, although consultation and notice periods mean that the full recurrent benefit could not be realised from 1 April 2026. The ICBs have identified funding to manage associated non-recurrent pressures, including through the national pause in system debt repayment under revised business rules.

Functional transfers and service continuity

11. National policy on the transfer of ICB functions has continued to evolve, with fewer functions now expected to transfer than originally anticipated. The ICBs' workforce model was developed recognising that some proposed transfers might not proceed and therefore made provision for the retention of certain functions.

12. Consequently, whilst the revised national position does not necessitate an immediate reconsideration of the agreed workforce model, it does create a potential capacity and capability trade-off. Within the reduced running-cost

envelope, retaining existing responsibilities may constrain opportunities to develop or strengthen capacity in other areas, particularly the strategic commissioning capabilities expected of the future ICB operating model.

13. This will need to be considered through the Strategic Commissioning Framework self-assessment and subsequent organisational development planning, ensuring that available resources are aligned as effectively as possible to the ICBs' statutory responsibilities and strategic priorities.

Responding to the changed national context

14. The national decision to defer ICB mergers has materially changed the context for the Transition Programme. Whilst NHS Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs will remain separate statutory organisations pending further national decisions on future ICB footprints, the ICBs have already established a single Executive Team, shared Non-Executive Director arrangements, Boards meeting in common and joint committees.

15. These arrangements provide a common leadership and governance framework, enabling the ICBs to operate collectively, develop shared approaches and make best use of available resources, whilst maintaining the individual statutory responsibilities and accountabilities of each ICB.

16. The deferral does, however, create additional complexity. The ICBs must continue to meet separate statutory, financial and reporting requirements within a significantly reduced running-cost envelope, whilst developing a shared operating model. The Transition Programme is therefore being reviewed to distinguish activities necessary to support effective cluster working from those specifically dependent on formal merger, including the sequencing of common policies, systems and processes.

17. The priority remains to embed an effective and sustainable operating model that enables the three ICBs to fulfil their statutory responsibilities whilst maximising the benefits of shared leadership, resources and expertise.

National Audit Office report – implications for the next phase of transition

18. As outlined in the Chief Executive's Report earlier on the agenda, the National Audit Office (NAO) published its report Restructuring of Integrated Care Boards on 4 November 2026. Its findings highlight the need to ensure that the pace of organisational restructuring is matched by development of the capacity, capability, relationships and measures of organisational effectiveness required for ICBs to operate successfully as strategic commissioners.

19. These findings are particularly relevant as our ICBs progress through the final stages of management of change and adapt to the deferral of formal ICB

mergers. While delivering the required financial reductions remains essential, equal attention must now be given to ensuring that the emerging operating model is effective, sustainable and capable of fulfilling the ICBs' statutory responsibilities and strategic commissioning ambitions.

20. The planned Strategic Commissioning Framework self-assessment, development of the Organisational Development Programme and continued oversight of organisational risks through the Joint Transition Committee will provide important mechanisms for identifying capability gaps and assessing the effectiveness of the emerging arrangements. This will require continued consideration of organisational capacity, leadership, workforce capability and the strength of partnerships across the cluster.

Building an effective strategic commissioning organisation

21. The Strategic Commissioning Framework provides the basis for assessing the capabilities expected of ICBs, including population health leadership, clinical and professional leadership, analytical capacity, citizen involvement, relationships with local government and commissioning expertise. An initial internal self-assessment is planned through the Senior Leadership Team, with Executive review and challenge. The findings will inform organisational development priorities ahead of a further national assessment in 2027.

22. The ICBs are actively engaging with NHS England's national Strategic Commissioning Development Programme, which brings together a range of initiatives to strengthen ICB strategic commissioning capability. The ICBs are also participating in the neighbourhood health commissioning network and work on intelligence, outcomes and evaluation, alongside the wider development opportunities available through the programme.

23. Building on this engagement, the ICBs intend to seek Wave One participation in the Population-Based Commissioning Programme, using frailty as a live commissioning challenge. This will provide an opportunity to develop practical capability in population-based commissioning, including analytical insight, service and market development, and contracting and payment approaches, whilst contributing learning from the ICBs' existing work.

24. Alongside this, the ICBs are developing an Organisational Development Framework and plan, with a focus on establishing a shared organisational culture, leadership expectations, team development and common ways of working. This recognises that, whilst new structures and leadership arrangements are being established, bringing teams together and developing a common sense of purpose will be equally important to the effectiveness of the future operating model.

25. A series of three all-staff events is being planned, with the same programme repeated to maximise opportunities for colleagues to attend whilst maintaining

business continuity and accommodating leave arrangements. These events will provide an opportunity to bring colleagues together, recognise the challenges and achievements of the transition period, and begin to turn the page towards the next phase of the organisational development. They will also help reinforce a shared purpose, engage staff in shaping how we work together and build a collective identity across the ICBs.

26. Together, these activities represent a shift in focus from implementing organisational change towards ensuring that the new operating model has the capacity, capability, culture and ways of working necessary to deliver effective strategic commissioning.

Summary and next steps

27. Significant progress has been made in establishing shared leadership and governance arrangements and implementing the new operating model. However, the remaining management of change activity, the deferral of formal ICB mergers and the evolving national policy context continue to present challenges that require active management.

28. The immediate priority remains completing the outstanding workforce processes, delivering the required financial reductions and maintaining effective arrangements across the three statutory ICBs.

29. Alongside this, attention is increasingly turning towards embedding the new operating model, developing strategic commissioning capabilities and establishing the culture and ways of working needed to support effective delivery.

30. The Joint Transition Committee will continue to oversee the remaining transition activity, with future assurance increasingly focused on the effectiveness, capacity and sustainability of the emerging operating model.

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/11/2026
Paper title:	**Committee Highlight Reports**
Paper reference:	ICB CIC 26 075
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 September 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. Details of all high-scoring risks being oversighted by the Boards' committees, where current exposure exceeds the agreed risk appetite and tolerance for the relevant risk domain, are also included.

Recommendation(s):

The Boards are asked to **receive** the paper for assurance in relation to the work of their committees.

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 – Audit Committees (meeting in common) Highlight Report
Appendix 7 – Description of levels of assurance
Appendix 8 – Operational risk report

Board Assurance Framework

Not appliable

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:	07 October and 04 November 2026
Committee Chair:	Stephen Jackson, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
ICB Finance and Efficiency Report (Months 5 and 6)	At month six, 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 £133 million, representing an adverse variance of £53 million. Providers in Nottingham and Nottinghamshire were the principal drivers of the adverse variance. The Committee discussed in detail the increasing risks to the ICBs' positions, notably acute activity, mental health and learning disability services, prescribing, continuing healthcare and community services; and welcomed the proactive steps taken to instigate a financial recovery framework. An assurance rating of partial was applied, taking into consideration that although robust plans and governance had been put in place, delivery of the financial recovery plans was not yet evidenced.	**Partial**	*Partial* *(awarded at the meeting held on 07 October 2026)*
Financial Recovery Framework and Progress Report	Presented at the October meeting, the Framework proposed a time-limited, organisation-wide approach to strengthen financial management across the ICBs and provided assurance on leadership, accountability, governance, financial controls and escalation routes.	**Partial**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
	Following a review of the month six financial position, £16.9 million of net risk had been identified within the reported position. In addition, further risks outside of the reported position increased the total financial risk across the ICBs to £116.5 million. Mental health, continuing healthcare, Section 117, and medicines optimisation programmes had been escalated for urgent action and further detailed reports on these programmes were presented for assurance at the November meeting. The Committee supported the process but noted that the pace of implementation would be key to the realisation of the plans by the end of the financial year. The Committee considered that although robust governance processes had been implemented, an assurance rating of partial was applied, pending progress being made on the delivery of the recovery plans.		
Commissioning Delivery Report 2026/27	Overall performance remained mixed, with continued pressures on urgent and emergency care, cancer care and diagnostics. Planned care remained a national focus. Referral to Treatment performance, 52-week waits and total waiting-list size performance targets were all adverse to plan across all three ICBs. Recovery action plans had been requested from providers but had not yet provided sufficient assurance that activity would reach the levels required to achieve performance targets. Members sought further detail on the options available to recover performance against the targets and were assured that the ICBs were taking all available action to address performance concerns. However, factors beyond the ICBs' control could affect delivery, and confidence remained low that some key targets would be met. Concerns were raised that data quality issues affecting some providers could compromise the ICBs' ability to make informed commissioning decisions.	**Partial**	*Partial* *(awarded at the meeting held on 07 October 2026)*

Item	Summary	Level of Assurance	Previous Level of Assurance
	Despite acknowledging that many targets were delivering to plan, the Committee applied an assurance rating level of partial, as under performance in key areas persisted.		

Other considerations:

Decisions made:
Not applicable.

Discussion and information items:
The Committee reviewed and discussed the six operational risks within its remit, ensuring that the risks reflected the increasing challenge of achieving financial and efficiency targets. Although the implementation of financial turnaround measures provided further mitigations to financial risks, the difficulty of implementing additional financial grip and control measures during a period of considerable structural change across the organisations was highlighted.

Appendix 2: Joint Quality and Service Improvement Committee Highlight Report

Meeting Dates:	14 October and 11 November 2026
Committee Chair:	Sharon Robson, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Delivery of 2026/27 Quality Improvement Priorities – general overview of progress	Significant progress was reported against the 2026/27 Quality Improvement Priorities, particularly in continuing healthcare, special educational needs and disabilities (SEND) and safeguarding, alongside greater clarity around cluster-wide governance, provider oversight, and the development of the Quality Management System. The overall position remained mixed, with assurance gaps around the impact of financial and workforce pressures on quality and patient safety. Members discussed winter and urgent and emergency care pressures and the ICBs' evolving workforce oversight responsibilities and agreed that partial assurance was appropriate pending completion of remedial actions.	Partial	*Not applicable*
Maternity and Neonatal Oversight and Assurance	All providers had completed baseline assessments against the NHS England 10-Point Plan, with strengths identified in governance, leadership and engagement; although further improvement was required in areas including maternity triage,	Partial	*Limited* *(awarded at the meeting held on 09 September 2026)*

Item	Summary	Level of Assurance	Previous Level of Assurance
	workforce assurance, inequalities oversight and board-level reporting. Members noted that the overall position was generally positive and discussed variation between providers, including the stronger governance and oversight arrangements evident in more challenged services and the sustained maternity focus in Nottinghamshire. Provider action plans would continue to be monitored through local and system governance, noting that current compliance levels remain provisional pending national or regional moderation.		
Thirlwall Inquiry: Key Findings, Immediate Requirements and Implications for Integrated Care Boards	The Thirlwall Inquiry had identified significant failures in governance, safeguarding, culture and responses to clinical concerns at Countess of Chester Hospital, which had been reviewed against existing quality, safeguarding and maternity arrangements across the ICBs' areas. The current arrangements provided a level of assurance whilst further testing and standardisation were undertaken. Members discussed the need for clear commissioning levers and robust challenge where quality concerns emerged, ensuring that patient safety took precedence over organisational or professional reputation. They also emphasised the importance of effective Freedom to Speak Up arrangements and assuring an open provider culture, drawing on lived experience, family feedback and broader	Adequate	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
	intelligence to strengthen learning and oversight across the system.		
Deep Dive into Quality Escalations	Under the ICBs' 2026/27 quality approach, this paper reviewed four providers in escalated assurance: University Hospitals of Derby and Burton NHS Foundation Trust maternity services; Chesterfield Royal Hospital NHS Foundation Trust; Nottingham University Hospitals NHS Trust; and Nottinghamshire Healthcare NHS Foundation Trust. Members discussed recurring themes around leadership, culture, workforce and psychological safety, emphasising the need to demonstrate that learning from recent reviews was translating into sustained improvement and better outcomes. Members recognised differing levels of assurance across the item, with limited assurance in relation to the provider positions, but greater confidence in the actions being taken by the ICBs. The Committee therefore agreed an overall rating of limited assurance, whilst acknowledging the positive assurance provided by the ICBs' actions.	Limited	*Not applicable*
Avoidable Mortality Reviews / Learning from Deaths	Progress was reported in reducing avoidable mortality, including improvements in areas of greatest deprivation, whilst Learning from Lives and Deaths (LeDeR) work had identified aspiration pneumonia as a key shared priority for people with learning disabilities across the three ICBs.	Partial	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
	Members discussed the continuing mortality gap for people with learning disabilities and the need for improved dashboards to track outcomes, inequalities and progress across the system. They emphasised the importance of targeted prevention and neighbourhood approaches, alongside effective use of commissioning levers and existing resources, recognising that avoidable mortality was also influenced by broader determinants beyond healthcare.		
Quality Oversight Report	Quality and regulatory concerns persisted across a number of providers, with two trusts entering escalated oversight and continued focus on urgent and emergency care, maternity, SEND, learning disabilities and autism, and infection prevention and control. Members discussed the pace of improvement in areas subject to prolonged oversight and the need to strengthen the levers available to commissioners, including clearer contractual expectations, whilst recognising the importance of maintaining effective provider relationships. Future reporting would need to provide clear, tangible evidence of progress and assurance that statutory responsibilities had been discharged, incorporating triangulation of quality outcomes, patient experience and meaningful engagement.	Partial	*Partial* *(awarded at the meeting held on 09 September 2026)*
Long Term Conditions: Outcomes, Health	The developing integrated Long Term Conditions Outcomes and Improvement Framework would provide a clearer line of	Partial	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
Inequalities and Improvement framework	sight from population need and health inequalities through to intervention, improvement and longer-term outcomes, with a particular focus on Core20PLUS5 and people with severe mental illness and learning disabilities. Members discussed the links with LeDeR learning and discussed how the developing dashboards could support more regular assessment of improvement across populations and neighbourhoods, alongside commissioning and primary care responsibilities. Members also discussed the importance of bringing together long-term conditions, inequalities, outcomes, risk and quality to provide a joined-up view of transformational and restorative quality.		
Thematic Quality Reports: General Practice	The Committee received assurance on current general practice quality arrangements across the three ICBs, noting that no practices were currently in quality escalation and that work was progressing towards a consistent, intelligence-led Quality Management System approach. Members discussed the need to extend this across broader primary care services and develop appropriate measures of quality, access, prevention and outcomes within emerging neighbourhood models, recognising that priorities would vary between localities.	Adequate	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
ICB Complaints and PALS service	The Committee recognised the significant progress made in stabilising complaints and PALS services following substantial workforce pressures, with a considerably reduced backlog and strengthened oversight and triage arrangements in place. Members emphasised the importance of maintaining momentum, embedding compassionate complaint handling and strengthening thematic learning to demonstrate how complaints would lead to service and quality improvement.	Partial	*Not applicable*
Clinical Leadership and Care Pathway Optimisation	Phase 1 of the Clinical and Professional Stewardship Model was substantially progressed and on track, with clinical leadership, neighbourhood arrangements and supporting governance continuing to be established across the ICBs. Members welcomed the multiprofessional approach and discussed the importance of securing broad clinical engagement and demonstrating, through subsequent phases, how clinical leadership would influence commissioning, pathway optimisation and measurable improvements in outcomes and variation.	Adequate	*Adequate (awarded at the meeting held on 10 June 2026)*

Other considerations:

Discussion and information items:
a) The Committee received an update on delivery of seasonal vaccination programmes, noting that overall uptake across the ICBs' areas remained above the regional and national position, alongside targeted work with primary care, community pharmacies and

Discussion and information items:
local partners to address variation and improve uptake in lower-performing communities. Members noted the developing emphasis on neighbourhood-based delivery and population health approaches, with future reporting to provide broader oversight of immunisation and screening programmes and associated outcomes. b) The Committee discussed the 25 operational risks within its remit, noting a net reduction of two risks overall alongside three new risks relating to provider quality and a consolidated maternity risk across the ICBs' areas. Members welcomed the increasingly integrated approach to identifying and refining risks, whilst highlighting the need for continued close oversight of areas of concern, where sustained evidence of improvement would be required before the risk position could be reconsidered. c) The Committee discussed concerns regarding corridor care across the ICBs' areas, emphasising that its use must not become normalised and should only occur as a last resort and following appropriate risk assessment. Members supported further cross-directorate scrutiny of urgent and emergency care, including patient flow, winter planning and provider actions, with a focus on securing robust and effective improvement plans. d) The Committee noted the planned discontinuation of Levemir insulin and the ongoing programme to transition remaining patients to suitable alternatives, with particular attention to individuals requiring specialist support. A risk and action plan were in place at directorate level, with escalation available through NHS England if required.

Appendix 3: Joint Strategic Commissioning Committee Highlight Report

Meeting Dates:	24 September and 29 October 2026
Committee Chair:	Jon Towler, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Delivery Plans: Approach, Oversight and Assurance	Members received an update on the development, monitoring and assurance of programme-specific delivery plans associated with the ICBs' Strategic Commissioning Plan. Programme Delivery Boards would provide the primary mechanism for oversight and delivery management, supported by standardised reporting and a single integrated dashboard covering the core elements of delivery. The importance of embedding equality and equity throughout delivery was highlighted. Members also discussed the delivery risks and Provider Selection Regime considerations associated with transferring activity from acute to community settings. Future reporting would provide greater visibility of actions to address health inequalities and adopt a standardised approach covering outcomes, benefits realisation, risks and escalations, resources, workforce, affordability, organisational capacity and transformation. The Committee agreed an assurance rating of 'partial', noting the current delivery risks, interdependencies and areas requiring further development.	**Partial**	*Not applicable*
Neighbourhood Health	The Committee received an update on progress of the Neighbourhood Health Programme as it moved from design into implementation, including the Core	**Partial**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
Programme – Current Position, Delivery Approach and Roadmap	Integrated Neighbourhood Team (INT) Specification, neighbourhood architecture, priority population cohorts, delivery plans, governance arrangements, outcomes development, the phased roadmap for 2026/27 to 2030/31, and the proposed funding approach. Members discussed the importance of maintaining a strong focus on reducing health inequalities, appropriately targeting investment and considering delivery through the patient lens. Workforce capacity, capability and leadership were highlighted as critical to successful implementation, alongside effective engagement with providers, local authorities, Health and Wellbeing Boards and the Voluntary, Community and Social Enterprise (VCSE) sector. A further update would be provided in November 2026, covering implementation and anticipated impact of the INT Specification, funding and contracting arrangements, delivery of the priority cohorts, workforce, and leadership and accountability. Members agreed an assurance rating of 'partial'.		
Mental Health Programme Update	The Committee received a deep dive report into the mental health delivery plan and outcomes. The cluster-wide Mental Health, Learning Disability and Autism Programme Board would oversee transformation, performance, finance, quality, inequalities, risk and benefits realisation, providing a formal route for escalation of cross-system issues. Areas of strong performance were noted alongside material challenges reflecting wider system pressures, with the 2026/27 delivery plan aligned to the identified risks. Members emphasised the importance of sufficient workforce capacity and capability, embedding cultural competence within delivery plans, addressing health inequalities, and strengthening VCSE and community-based approaches.	**Partial**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
	Future updates would focus on progress against the delivery plan and actions to address identified risks, including anticipated impact, affordability, workforce implications and provider engagement.		
NHS England delegated functions: Primary Care	The Committee received a report providing assurance on the actions being taken by the ICBs to discharge the primary care functions delegated by NHS England, in line with the relevant Delegation Agreements across the ICBs, including performance, quality, finance and key risks. Same-day urgent GP access remained strong across all three systems, Pharmacy First continued to perform positively, and primary care financial programmes remained on track to deliver planned efficiencies. Dental activity remained below plan, with improvement measures underway to increase activity and access, including for children and young people. Members highlighted the importance of making effective use of available funding to support sustainable service improvements.	**Adequate**	*Not applicable*
Approach to Equality, Diversity and Inclusion 2026/27	The Committee received a paper that provided assurance on the proposed equality approach for 2026/27, which established a consistent framework across the three ICBs and integrated statutory equality responsibilities with population health, commissioning, data, quality and governance. Members emphasised the importance of embedding equality considerations within strategic commissioning, procurement, contracts and service specifications, alongside meaningful engagement with providers and local populations. The proposed approach was considered appropriate for meeting the ICBs' equality responsibilities and provided assurance of continued	**Adequate**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
	compliance with statutory duties, with an expectation of demonstrating tangible progress in equality outcomes during 2027/28. The Committee noted that its focus related specifically to equality within commissioning, with workforce matters overseen separately through the Joint Remuneration and Human Resource Committee. An assurance rating of 'adequate' was agreed.		
Joint Commissioning Executive Group Assurance Report	Members received reports summarising the broad range of commissioning proposals considered by the Joint Commissioning Executive Group in August, September and October 2026. It detailed the number of decisions taken and confirmed that these were supported by appropriate clinical, financial and equality assessments. Members noted that although several recent matters had had the potential to be contentious, appropriate action had been taken to mitigate the associated risks.	**Full**	*Full (awarded at the meeting held on 24 September 2026)*
Planned Care, Cancer and Diagnostics Transformation Programme Update	The Committee received a paper that provided assurance on delivery of the Planned Care, Cancer and Diagnostics Transformation Programme across the three ICBs, noting that programme governance was established and delivery was moving from development into implementation. A credible cluster-wide programme was in place, with significant opportunities identified, although a number of changes remained dependent on provider agreement, approval, funding, legal resolution and capacity. Members discussed the importance of addressing unwarranted variation and maintaining effective provider and clinical engagement. Future reporting would clearly distinguish opportunities from agreed changes and demonstrate progress against milestones, implementation and impact on patient access, outcomes,	**Adequate**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
	experience, activity and capacity. Future transformation reports would also adopt a standardised approach, with greater visibility of digital, equity and health inequalities, patient involvement and benefits realisation. A more detailed update on cancer and diagnostics would be provided at a future meeting. The Committee agreed an assurance rating of 'adequate', reflecting progress against the Transformation Delivery Plan and the transition into implementation.		
Urgent and Emergency Care Transformation Programme Update	The Committee received a report that provided assurance on progress of the Urgent and Emergency Care Transformation Programme, which was moving towards a more consistent, needs-led and outcomes-based approach. Four priorities had been highlighted: navigation and access, Urgent Treatment Centres, community urgent care, and intermediate care and discharge. Delivery remained at varying stages of maturity, with key risks relating to commissioning capacity, workforce and financial constraints, contractual variation, provider pressures, and the need for agreed baselines and benefits reporting. Members welcomed the focus on standardisation and highlighted the importance of understanding and addressing the differential impact of transformation on local populations. Future reporting would provide clearer assurance on implementation, delivery against milestones, material risks and dependencies, health inequalities and evidenced benefits, including progress in delivering proactive support through INTs. The Committee agreed an assurance rating of 'partial', recognising the significant volume of work still to be delivered.	**Partial**	*Not applicable*
Provider Market Shaping and	The Committee received assurance on the development of a coherent Provider Market Shaping and Development approach across the ICBs, bringing existing	**Full**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
Development Approach	activity into a single pipeline supported by a proportionate five-stage process and governance arrangements for identifying, assessing and responding to emerging provider market issues. Members noted that delivery would be a shared responsibility across ICB directorates, drawing on existing capacity, intelligence and expertise, with external support considered for particularly complex or contentious areas. Periodic updates would be provided to the Committee as the approach developed. An assurance rating of 'full' was agreed.		

Other considerations:

Decisions made:
The Committee: a) **Approved** the Provider Accreditation Framework and associated Standard Operating Procedure, **approved** the transition of the 34 outstanding applications to the new cluster-wide process and **endorsed** the proposed 12-week assessment timeframe, subject to confirmation of the applicable statutory requirements and the operational capacity needed to deliver it. b) **Approved** a proposed non-material amendment to the Procurement and Provider Selection Policy.

Discussion and information items:
The Committee: a) Discussed a paper providing assurance on improvements in Intensive and Assertive Community Mental Health Services and noted ongoing work with local mental health trusts to develop Mental Health Personalised Care Framework Implementation Plans ahead of presentation to the ICBs' Boards in November. Members welcomed the progress update, sought assurance that associated risks

Discussion and information items:
were fully understood and appropriately reflected in the ICBs' Operational Risk Register, and identified areas for further strengthening the paper ahead of submission to the Boards. b) Discussed the proposed approach, governance arrangements and delivery plan for the alignment of commissioning policies across the three ICBs in support of cluster-wide working and the anticipated merger on 1 April 2028. c) Discussed proposed amendments to the Adult Continuing Healthcare and NHS Funded Nursing Care Commissioning Policy and Joint Funding to Adult Care Packages Commissioning Policy, noting that full Equality and Quality Impact Assessments would need to be undertaken before the policies could be considered for approval. d) Reviewed and discussed the 15 operational risks within its remit, comprising 13 joint risks and two risks specific to NHS Nottingham and Nottinghamshire ICB. The overall risk profile remained unchanged since the previous reporting period, with one high risk and 14 medium risks. Of the 15 risks, 11 were within the ICBs' agreed risk appetite and tolerance levels, with four below appetite. e) Received the Committee's Annual Work Programme for information, noting that it would be reviewed ahead of the next meeting to ensure that the proposed scheduling of items remained appropriate.

Appendix 4: Joint Transition Committee Highlight Report

Meeting Dates:	01 October 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 ICBs remained on track to achieve the revised national running cost target of £19.60 per head, supported by around £33 million in annualised workforce savings since May 2025. Transition plans remained financially viable within existing assumptions, although the outcome of the NHS England funding bid for transition and stranded costs remained outstanding. Members emphasised that future estate and agile working arrangements should balance affordability and capacity with workforce experience, accessibility and team cohesion, with further refinement through consultation and implementation planning.	**Full**	Full *(awarded at the meeting on 3 September 2026)*
Transition Programme Plan update	The Committee received an update on the Transition Programme Plan and noted good overall progress. Wave 3 remained broadly on track, with members emphasising the need to maintain momentum despite Human Resource	**Adequate**	Adequate *(awarded at the meeting on 3 September 2026)*

Item	Summary	Level of Assurance	Previous Level of Assurance
	capacity pressures, appeals and recruitment dependencies which could result in slippage into November 2026. Members noted the implications of continuing as three statutory ICBs, with further work underway to understand the financial, operational and capacity impacts whilst progressing the shared cluster operating model. The Midlands Procurement Hub remained on track to commence operation on 1 December 2026, with members noting initial staffing constraints and that hub capacity would be monitored through existing risk management arrangements. Members received assurance that the Information Sharing Framework was supporting effective cross-cluster working, with further function-specific data protection arrangements progressing alongside final team structures.		

Other considerations:

Discussion and information items:
The Committee also: a) Received a verbal update from the Chief Executive on transition progress. Current planning assumed the three ICBs would continue being separate statutory organisations for a further year, with capacity and resource requirements under review alongside ongoing Wave 3 activity. Updates were also provided on the Commissioning Academy and preparations for the NHS England

Discussion and information items:
strategic quarterly review. Members highlighted ongoing workforce capacity pressures and the likely need for interim support, alongside the importance of clear and timely communication with staff on the future direction of the cluster. b) Reviewed its 15 live joint transition risks, including increased risks relating to Wave 3 workforce pressures and residual recruitment, alongside emerging risks associated with estates, future merger arrangements and the East Midlands Procurement Hub. Members sought assurance on available mitigations and agreed that the scoring of Risk RR118 should be reviewed, while enhanced oversight and wellbeing support would continue to mitigate the increased impact of Risk RR144.

Appendix 5: Joint Remuneration and Human Resource Committee Highlight Report

Meeting Dates:	10 October (extraordinary), 22 October and 29 October (extraordinary) 2026
Committee Chair:	Margaret Gildea, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Workforce Report	The Committee received assurance on the workforce position across the three ICBs, noting the continuing impact of the Management of Change programme on capacity, turnover and organisational wellbeing. Sickness absence and appraisal compliance remained areas of focus, whilst statutory and mandatory training compliance remained comparatively strong. Members discussed progress with the Management of Change programme and the support available to affected staff. The importance of retaining corporate memory and ensuring effective handovers through the organisational transition was emphasised, with further detail requested in future reporting. Work also continued to align workforce systems and strengthen future reporting, including improved visibility of workforce diversity and training compliance. The Committee agreed an assurance rating of 'partial' and improving.	**Partial**	***Partial*** *(awarded at the meeting held on 23 July 2026)*
Equality, Diversity and Inclusion (EDI) Approach	The Committee received a report that provided assurance on the proposed shared EDI approach for 2026/27, focusing on the ICBs' responsibilities as employers, including inclusive leadership, workforce culture, equality data, staff experience and compliance with NHS workforce equality standards.	**Adequate**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
	Members supported the approach and emphasised the importance of translating it into measurable delivery, with future reporting incorporating clear metrics alongside qualitative staff feedback to demonstrate progress and impact. The Committee agreed an assurance rating of 'adequate', noting that the Joint Strategic Commissioning Committee had separately considered the approach in relation to equality in commissioning.		
HR Policy Alignment	The Committee received a paper that provided assurance on the approach to developing a single, aligned HR policy framework across the three ICBs, aimed at supporting consistent and effective workforce management whilst maintaining legislative compliance and alignment with emerging national NHS requirements. The transition would be carefully managed with ongoing Trade Union engagement. Further updates would be provided as the work progressed, including policy tranches for approval. The Committee agreed an assurance rating of 'adequate'.	**Adequate**	*Not applicable*

Other considerations

Decisions made:
The Committee: a) Approved the proposed cluster-wide Strategic Clinical Leadership arrangements, including recruitment and remuneration arrangements for key clinical leadership roles, with formal reviews at six and 12 months covering recruitment, equality, expenditure, market competitiveness and overall effectiveness. b) Approved the interim acting-up arrangements for the Executive Director of Finance role.

Discussion and information items:
The Committee: a) Considered a proposal in relation to interim Executive Team arrangements. b) Received a verbal update on the development of the Organisational Development (OD) Plan and highlighted the need to maintain focus and momentum in delivering the culture and OD agenda across the three ICBs. c) Reviewed the six operational risks within the Committee's remit, all of which were joint risks across the three ICBs and related to workforce and organisational risks associated with delivery of the transition programme. All remained within the Boards' approved risk appetite.

Appendix 6: Audit Committees' Highlight Report (meeting in common)

Meeting Dates:	08 October 2026
Committees' Chair:	John Dunstan, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Standards of Business Conduct Assurance Report	The report provided assurance on the operation of the joint Standards of Business Conduct Policy across the ICBs. The policy provided a framework for managing day-to-day arrangements regarding conflicts of interest, gifts, hospitality and sponsorship, in line with NHS England expectations. Consistent arrangements had been put in place across the ICBs for maintaining and publishing registers and managing conflicts of interest at meetings. No formal breaches of the Policy requiring escalation had been identified during the reporting period.	**Full**	*Not applicable*
Freedom To Speak Up Assurance Report	Members received an update on interim Freedom to Speak Up (FTSU) arrangements across the ICBs. It described current FTSU Guardian provision, staff engagement, activity reporting and priorities for further development. Members queried the low number of cases reported and discussion ensued as to whether this reflected the visibility of the Freedom to Speak Up arrangements or indicated that staff felt able to raise concerns through other means. Members were assured that pragmatic arrangements had been implemented to maintain continuity during the organisational transition. Nevertheless, members considered it important	**Adequate**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
	to triangulate intelligence from other sources to assess the organisations' speaking up culture and whether the arrangements were operating effectively.		
Information Governance Assurance Report	Members received an update on preparations for the 2026/27 Data Security and Protection Toolkit (DSPT); NHS Lincolnshire ICB's plan to address weaknesses identified in its 2025/26 DSPT assessment; and progress on the alignment of information governance arrangements. Members were assured that work was progressing in key areas of information governance. However, they questioned whether the national announcement that the ICB merger process had been paused, together with resource constraints within the ICBs, would materially affect progress in aligning arrangements. The Committees noted that consistent arrangements were being implemented incrementally through a risk-based approach, alongside work to promote a consistent information governance culture across the three ICBs. The Committees requested regular updates to enable the them to oversee continued progress.	**Partial**	*Adequate* *(awarded at the meeting held on 16 June 2026)*

Other considerations:

Decisions made:
The Committees approved: a) The Information Rights including Subject Access Requests Policy. b) The Freedom of Information and Environmental Information Regulations Policy. c) The Confidentiality and Data Protection Policy.

Information items and matters of interest:
The Committees received updates and reviewed progress on: a) The ICBs' Counter Fraud Plans for 2026/27, noting that good progress was being made overall. b) The ICBs' Internal Audit Plans for 2026/27, noting that good progress was being made against the agreed plans. c) A report on the risks overseen by the Committees was discussed.

Appendix 7 - 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 are 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 8: Operational Risk Report

Introduction

To strengthen alignment with the Boards' agreed risk appetite framework, the approach to operational risk reporting has changed. Previously, all operational risks with a current score of 15 or above were reported to the Boards. The revised approach continues to focus on high-scoring risks but only reports those where current exposure exceeds the agreed risk appetite and tolerance for the relevant risk domain.

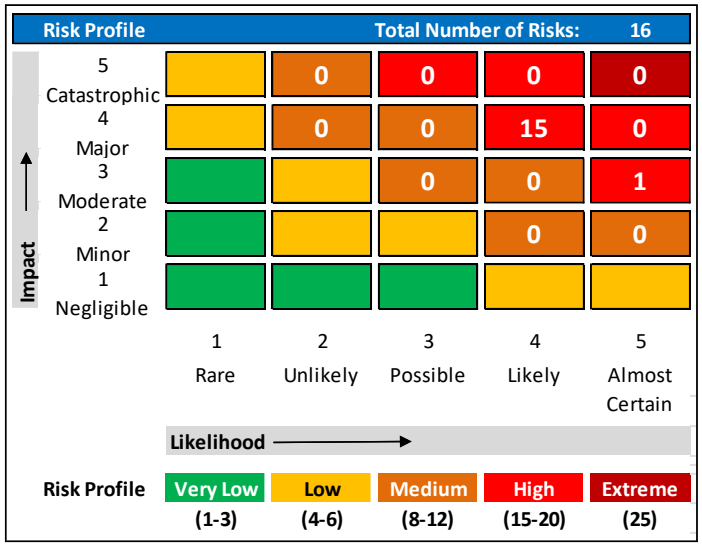
This recognises that a high risk score does not necessarily mean a risk is outside appetite, as the Boards may accept higher levels of risk in some areas, such as innovation and transformation.

Detailed oversight of individual risks, controls and mitigating actions remains with the relevant committees. This approach will continue to evolve as the risk appetite framework becomes further embedded.

Risk profile

There are currently 63 risks within the Operational Risk Register. Of these, 16 high-scoring risks are above the risk appetite and tolerance levels agreed by the Boards. The risks above appetite are predominantly concentrated around quality, patient safety and service delivery, including urgent and emergency care, planned care, mental health and neurodevelopmental services, cancer and diagnostics, discharge, maternity, and the delivery of sustainable quality improvements. There are also risks relating to financial sustainability and workforce capacity and resilience during organisational transition.

These are the high-scoring risks where current exposure exceeds the level the Boards have agreed they are prepared to accept. Other high-scoring risks may remain within the agreed tolerance for their risk domain and therefore do not require the same level of Board visibility. This reflects the risk appetite framework, which allows different levels of risk to be tolerated depending on the nature of the activity.



Operational risk reports continue to be routinely presented to the relevant committees of the Boards, providing ongoing oversight and scrutiny of risks within their respective remits, including the effectiveness of controls and progress of mitigating actions.

The profile of operational risks currently above appetite and tolerance is shown in Figure 1.

Details of risks above risk appetite

The table below identifies the high-scoring risks where current exposure exceeds the Boards' approved risk appetite. Detailed oversight and scrutiny of the controls and mitigating actions remain with the relevant committees of the Boards.

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
RR003	DD ICB	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	NN ICB	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
RR029	NN ICB	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
RR051	NN ICB	If capacity constraints and rising demand continue, the ICB may be unable to commission sufficient planned care across Nottingham and Nottinghamshire, resulting in reduced elective activity, longer waiting times, delayed treatment and poorer patient outcomes.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR130	DD ICB	If capacity constraints and rising demand continue, the ICB may be unable to commission sufficient planned care across Derby and Derbyshire, resulting in reduced elective activity, longer waiting times, delayed treatment and poorer patient outcomes.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee

Risk Ref.	ICB	Risk Description	Score	Responsible 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
RR159	Joint	If demand, capacity constraints and pathway inefficiencies continue to impact cancer service performance, the three ICBs may be unable to commission services that meet required cancer standards, resulting in delays to diagnosis and treatment, poorer clinical outcomes and diminished experience for the population.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR160	Joint	If diagnostic demand continues to exceed available capacity, the three ICBs may be unable to commission sufficient diagnostic services to meet population needs, resulting in longer waiting times, delays across treatment and cancer pathways, and poorer outcomes and experience for the population.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR161	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
RR173	Joint	If maternity transformation across the three ICBs does not maintain momentum and changes are not embedded across maternity services, there is a risk that progress in quality, safety and experience will not be maintained or advanced, resulting in poorer outcomes for women, birthing people, babies and families.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR119	Joint	If financial performance deviates from plan, particularly, there is a risk that the cluster ICBs will not achieve their 2026/27 year-end financial positions, potentially reducing stakeholder confidence and triggering increased external scrutiny or intervention.	**High** 16 (I4 x L4)	Joint Finance and Performance Committee
RR134	Lincs ICB	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)	**High** 16 (I4 x L4)	Joint Finance and Performance Committee

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
		position will not be achieved, impacting long-term financial resilience and the ability to operate within available resources.		
RR135	NN ICB	If NHS Nottingham and Nottinghamshire 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
RR144	Joint	If there is a prolonged gap between voluntary redundancy exits and the implementation of 'wave 3/3a/4' structures, there is a risk that roles cannot be confirmed or populated in a timely manner. This may reduce capacity to deliver business-as-usual (BAU) activity, operational resilience and increase workload pressures, anxiety, and stress for remaining staff.	**High** 16 (I4 x L4)	Joint ICB Transition Committee
RR072	NN ICB	If NHCT lacks the capacity and capability to implement sustainable quality improvements identified through serious incidents, deaths, quality reviews, and broader performance concerns, then similar failures may recur, leading to harm and poor health outcomes for the population of Nottingham and Nottinghamshire.	**High** 15 (I3 x L5)	Joint Quality and Service Improvement Committee

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	19/11/2026
Paper title:	**Joint Board Annual Work Programme**
Paper reference:	ICB CIC 26 076
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	✓	-	-	-	-

Topic	16 Apr	18 Jun	15 Oct	17 Dec	18 Feb
• Review of ICBs' shared risk appetite • Consultation on future footprint of merged ICB • ~~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	-	-	-	✓	-
• NHS England Board Development Programme: Session 1 • ~~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