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 21 May 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 19 March 2026	Kathy McLean	Decision	✓	✓	✓	✓	-
5.	Matters arising from the meetings in common, held on 19 March 2026	Kathy McLean	Discussion	✓	✓	✓	-	-
	Leadership and operating context							
6.	Citizen Story: Fighting Fit	Clair Raybould	Discussion	✓	-	-	✓	10:05
7.	Chair's Report	Kathy McLean	Information	✓	✓	✓	✓	10:20
8.	Chief Executive's Report	Amanda Sullivan	Information	✓	✓	✓	✓	10:30
	Strategy and partnerships							
9.	Neighbourhood Health Framework	Clair Raybould/ Maria Principe	Discussion	✓	✓	✓	✓	10:45
10.	Joint Capital Resource Use Plans 2026/27	Bill Shields	Decision	✓	✓	✓	✓	11:05
	Delivery assurance							
11.	Finance Report	Bill Shields	Assurance	✓	✓	✓	✓	11:20

Ref	Item	Presenter	Type	DD	L	NN	Enc	Time
12.	Commissioning Oversight Report	Maria Principe	Assurance	✓	✓	✓	✓	11:35
13.	Quality Report	Rosa Waddingham	Assurance	✓	✓	✓	✓	11:55
14.	Annual Equality Assurance Report	Rosa Waddingham	Assurance	✓	✓	✓	✓	12:10
	Governance							
15.	Senior Information Risk Owner Annual Report	Dave Briggs	Assurance	✓	✓	✓	✓	12:30
16.	Committee Highlight Reports	Committee Chairs	Assurance	✓	✓	✓	✓	12:45
	Closing items							
17.	Risks identified during the course of the meeting	Kathy McLean	Discussion	✓	✓	✓	-	12:55
18.	Questions from members of the public	Kathy McLean	-	✓	✓	✓	-	-
19.	Any other business	Kathy McLean	-	✓	✓	✓	-	-
	Meeting close							**13:00**

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

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:	21/05/2026
Paper title:	**Declaration and management of interests**
Paper reference:	ICB CIC 26 003
Paper author:	Committee Secretariat
Paper sponsor:	Kathy McLean, Chair
Presenter:	Kathy McLean, Chair

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.

Relevant statutory duties:

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

Appendices

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

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

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

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

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

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

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			NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB			Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
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.
Melbourne	Jon	NHS Trust/Foundation Trust Partner Member	–	–	✓	Chief Executive of Sherwood Forest Hospitals NHS Foundation Trust	Role within an NHS, local authority or provider organisation.	✓				TBC	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by Sherwood Forest Hospitals NHS Foundation Trust
Melbourne	Jon	NHS Trust/Foundation Trust Partner Member	–	–	✓	Director and Shareholder of Ten Five Four Homes Limited	Ownership and/or directorship of a private company	✓				01/08/2022	Present	This interest will be kept under review and specific actions determined as required.

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

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

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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	Present	This interest will be kept under review and specific actions determined as required.
Waddingham	Rosa	Director of Quality (Nursing)	✓	✓	✓	Member of the Advisory Board at NHS Professionals, an NHS staff bank, owned by the Department of Health and Social Care.	Role within an NHS, local authority or provider organisation.		✓			01/09/2023	Present	This interest will be kept under review and specific actions determined as required.
Waddingham	Rosa	Director of Quality (Nursing)	✓	✓	✓	Son is employed as a dispensing manager at Specsavers (Bingham)	Role within an NHS, local authority or provider organisation.				✓	01/02/2024	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be provided by Specsavers
Waddingham	Rosa	Director of Quality (Nursing)	✓	✓	✓	Honorary Professor at Nottingham Trent University	External role or association (non-NHS), declared for transparency.		✓			11/11/2024	Present	This interest will be kept under review and specific actions determined as required.
Waddingham	Rosa	Director of Quality (Nursing)	✓	✓	✓	Division Commissioner for Grantham and the villages / Charity Trustee of GirlGuiding Lincolnshire South	Trustee or leadership role in a voluntary, charitable or community organisation			✓		01/08/2025	Present	This interest will be kept under review and specific actions determined as required.
The following individual will be in attendance at the meeting but is not part of the Committee's membership:														
Branson	Lucy	Director of Corporate Governance and Assurance	✓	✓	✓	Registered patient at St George's Medical Practice	Use of NHS services commissioned by the ICB (registered patient).			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
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
Gurmail	Nizzer	Local Authority Representative	✓	-	-	Director for Commisisoning and Delvery at Derby City Council	Role within an NHS, local authority or provider organisation.	✓				15/05/2025	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 Derby City Council

Appendix B

Managing Conflicts of Interest at Meetings

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

    The above categories are not exhaustive, and each situation must be considered on a case-by-case basis.
4. In advance of any formal meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the

meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals.

5. At the beginning of each formal meeting, members and others attending the meeting will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting.

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

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

Minutes of the meetings in common of:

NHS Derby and Derbyshire ICB Board
NHS Lincolnshire ICB Board
NHS Nottingham and Nottinghamshire ICB Board

19 March 2026, 09:00-13:00

Derby City Council, Council House, Derby DE1 2FS

		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	-	-	✓
Stephen Posey	NHS Trust/ Foundation Trust Partner Member (up to and including item ICB CIC 25 050)	✓	-	-
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	✓	✓	✓
Paul Simpson	Local Authority Partner Member	✓	-	-
Amanda Sullivan	Chief Executive	✓	✓	✓
Dr Kevin Thomas	Primary Care Partner Member	-	✓	-
Jon Towler	Non-Executive Director	✓	✓	✓
Rosa Waddingham	Executive Director of Quality (Nursing)	✓	✓	✓
In attendance:				
Jude Boyle	Carer Commissioning Manager, Derbyshire County Council (for item ICB CIC 25 042)	-	-	-
Lucy Branson	Director of Corporate Governance and Assurance	✓	✓	✓
Jane Davis	Member of the Derbyshire Carers Association (for item ICB CIC 25 042)	-	-	-
Robyn Dewis	Director of Public Health, Derby City Council	✓	-	-
Helen Dillistone	Executive Director of Transition	✓	✓	✓
Wynne Garnett	Chair, Voluntary and Community Sector Alliance	✓	-	-

		NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB
Caroline Goulding	Director of Strategic and Specialised Commissioning (for item ICB CIC 25 046)	✓	✓	✓
Vivienne Robbins	Director of Public Health, Nottinghamshire County Council (deputising for Adrian Smith)	-	-	✓
Sue Wass	Corporate Governance Officer, NHS Nottingham and Nottinghamshire ICB (Minutes)	✓	✓	✓
Helen Weston	Chief Executive, Derbyshire Carers Association (for item ICB CIC 25 042)	-	-	-
Apologies:				
Karen Dunderdale	NHS Trust/ Foundation Trust Partner Member	-	✓	-
Dr Andrew Mott	Primary Care Partner Member	✓	-	-
Mark Powell	Ordinary Member – Mental Health	✓	✓	✓
Adrian Smith	Local Authority Partner Member	-	-	✓

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

Name	Possible	Actual	Name	Possible	Actual
Dr Kathy McLean	3	3	Maria Principe	3	3
Dr Dave Briggs	3	3	Clair Raybould	3	3
Karen Dunderdale	3	2	Sharon Robson	3	3
John Dunstan	3	3	Martin Samuels	3	2
Margaret Gildea	3	3	Bill Shields	3	2
Stephen Jackson	3	2	Paul Simpson	1	1
Mehrunnisa Lalani	3	2	Adrian Smith	3	1
Dr Kelvin Lim	3	2	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	3	Rosa Waddingham	3	2
Mark Powell	3	2	-	-	-

Introductory items

ICB CIC 25 037

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. It was noted that Vivienne Robbins was deputising for Adrian Smith.

Welcome was extended to Paul Simpson, who had recently been reappointed as Local Authority Partner Member of NHS Derby and Derbyshire ICB's Board; and as the Boards were meeting in Derby and Derbyshire a welcome was also extended to Robyn Dewis and Wynne Garnett.

ICB CIC 25 038 **Confirmation of quoracy**

The meetings were confirmed as quorate.

ICB CIC 25 039 **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 25 040 **Minutes of the meeting held on 15 January 2026**

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

ICB CIC 25 041 **Action log and matters arising from the meeting held on 15 January 2026**

All actions were agreed as completed and no other matters were raised.

Leadership and operating context

ICB CIC 25 042 **Citizen Story: Derbyshire Carers Association**

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

a) Carers played a vital role within health and social care services, a role that had been recognised within the ICBs' Five-Year Population Health Strategy. It was important for health and social care services to ensure that carers continued to be supported.

b) Jude Boyle and Helen Weston provided an overview of the services provided by the Derbyshire Carers Association, which supported unpaid carers across the county, providing practical, emotional and specialist help to people looking after a family member, partner, or friend. The organisation delivered a wide range of services for adult and young carers and had around 14,000 registered carers. Their value as a trusted 'expert' in the care of their charge was discussed. As was the value of the organisation to the wider economy as they supported carers to continue to work and study and fulfil their own potential.

c) Jane Davis, a member of the Association, gave a synopsis of the day to day practical and emotional strains of being a carer, asking members to note that good relationships with professionals were key to helping carers navigate services. Jane went on to highlight elements of the health system that she had found frustrating from her own experience, including NHS 111 services and Emergency Department services.

The following points were made in discussion:

d) After discussing elements of the services provided by the Association in further detail, there was agreement that support for carers needed to be an integral element in preventative health and personalised care strategies.

e) In response to a query on what further support could be provided by the ICBs, it was noted that carers should be considered expert and equal partners and their value to the delivery of the aims of NHS strategies should be more explicit.

f) Members asked how the Association raised awareness of its services within Derby and Derbyshire; and it was noted that this was an ongoing campaign, with communication within GP and hospital settings; however, of note, it often took a number of years for carers themselves to understand and identify themselves as carers.

g) In conclusion the Chair thanked Jude, Helen and Jane for their time and for their valuable work. There was agreement that there needed to be more explicit engagement with the sector across the ICBs' area going forward and further support in helping the Association to engage with GP practices was offered.

The Boards **noted** the Citizen Story.

At this point Jude Boyle, Jane Davis and Helen Weston left the meeting.

ICB CIC 25 043 **Chair's Report**

Kathy McLean introduced the item, highlighting the following points:

a) Gratitude was given to all ICB staff members who continued to work with professionalism under challenging circumstances, as the ICBs' management of change process to enact the nationally mandated cost reductions continued.

b) Kathy had taken part in a series of workshops to shape the forthcoming Health Bill, which would be published imminently. The publication of a national quality strategy was also awaited.

c) Attention was drawn to several other local and national meetings and visits, including an inspiring visit to the Pythian Club in Nottingham with the Mayor of the East Midlands to see how the organisation was helping to empower young people and support neighbourhood resilience.

The following points were made in discussion:

d) The Chair invited Robyn Dewis to provide an update on the recent outbreak of the Meningitis B virus in Kent. Members were asked to note that the rapid spread of this outbreak was highly unusual. Although to date there had been no further confirmed cases, communication had been made with schools and universities and guidance had been issued. It was further reported that an Emergency Preparedness, Response and Resilience exercise had taken place

to confirm that the necessary arrangements were in place to respond to an outbreak in the ICBs' areas and that there was a sufficient stock of vaccinations to target those most at risk.

e) There was further discussion of the importance of raising vaccination rates in the context of the future delegation of responsibility for vaccination services from NHS England to ICBs in 2027.

f) There was a query relating to an item in the report regarding the awarding of a Social Impact Supplier Badge to Age UK, specifically whether smaller charities, who may not have the capacity to undertake this process, would be at a disadvantage when bidding for future contracts. In response it was noted that voluntary and community sector forums could be used to support small charities. Moreover, it was anticipated that the majority of future commissioning activity would be through statutory providers, who would be expected to engage with and work with the voluntary and community sector on the development of bids and this would form part of the assessment process for all bids.

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

ICB CIC 25 044 **Chief Executive's Report**

Amanda Sullivan introduced the item, highlighting the following points:

a) Asking the Boards to note that the appointments process to the ICBs' senior leadership team was nearing completion, thanks were given to staff for their continued resilience. The final phase of the management of change process had now begun, which impacted on the majority of staff, and there had been some constructive feedback from the consultation, which had launched during February.

b) The results of the national NHS Staff Survey for 2025 had very recently been published. The breakdown of the results for the ICBs were being considered and an action plan to address areas for improvement would be presented at the April meeting of the Joint Remuneration and Human Resources Committee.

c) The public hearings for the Nottingham Inquiry were currently ongoing to provide a clear understanding of events that led to the brutal attacks on Ian Coates, Grace O'Malley-Kumar, Barnaby Webber, Wayne Birkett, Sharon Miller and Marcion Gawronski in 2023. The final report was scheduled for publication by April 2027. In the meantime, formal governance oversight arrangements to monitor quality and regulatory concerns at Nottinghamshire Healthcare NHS Foundation Trust remained in place to support the Trust to make sustained improvements in the delivery of safe services.

d) The Trust had announced a new leadership Team, with Tom Cahill recently assuming the Chair of the organisation and Mark Axcell joining in June 2026 as Chief Executive.

e) Two encouraging research initiatives were highlighted and welcomed: greater collaboration with Health Innovation East Midlands, with a view to aligning innovation support more deliberately to our priorities; and investment by the National Institute for Health and Care Research into a new Lincolnshire Unit for Mental Health Research.

f) Subject to Parliament's approval of changes in primary and secondary legislation, NHS England had now confirmed plans to transfer the majority of their remaining direct commissioning functions to ICBs by 2027. The report provided further detail of the services and planned governance arrangements, including the establishment of an Office for Pan ICB Commissioning in each NHS region.

The following points were made in discussion:

g) Following a query as to whether there were established collaboration channels between higher education institutes within the East Midlands, it was confirmed that there was. In response to a further query on visibility of the ICBs' research activities, it was noted that responsibility for oversight rested with the Joint Strategic Commissioning Committee, which would report progress to the Boards using agreed governance routes.

h) In relation to the ICBs' management of change process, queries on redundancy costs; assurance that there were 'claw back' clauses in redundancy settlements; and how the ICBs were supporting staff were raised. In response it was noted that there were national rules regarding the timeframes for staff returning to the NHS following redundancy, which differed according to grade; and staff were able to access a robust support package to help them find alternative employment. NHS England had provided the majority of funding to cover redundancy costs; however, it had left a small shortfall, which would be accounted for in the 2026/27 financial year.

i) Further to this point assurance was sought that the impact on joint posts with local authorities was being considered and it was noted that conversations with the local authorities were ongoing.

j) Discussing an item in the report regarding the Transformation Fund, assurance was sought that synergy with the recently released Neighbourhood Health Framework would be made and it was confirmed that the Fund responded to the direction of travel on neighbourhood health services. Further to this point Wynne Garnett noted that the short timescales for the submission of bids was challenging for the voluntary and community sector. It was acknowledged that, due to national deadlines, the timescales had been truncated and this would be taken into account for future bidding rounds.

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

	Strategy and partnerships

ICB CIC 25 045

Population Health Strategy and Strategic Commissioning Plan

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

a) The report provided an overview of the ICBs' Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan (2026/27–2030/31), both formally approved by the Boards in private session on 10 February 2026 and submitted to NHS England on 12 February 2026. It also outlined the immediate next steps for continued engagement with stakeholders and citizens.

b) The context for the development of the Strategy was provided. It responded to deepening deprivation, worsening health life expectancy, and rising multimorbidity statistics by identifying five 'population segment priorities' and three 'cross cutting priorities', aligned to the national Ten-Year Health Plan.

c) The Commissioning Plan translated the strategy into a framework for delivery, moving services towards prevention, proactive care and into a strengthened neighbourhood health offer.

d) Acknowledging the truncated timescale in which the documents were developed, next steps were noted as the development of public facing versions of the documents and a structured schedule of engagement. Programme Boards would be established to oversee operational delivery.

The following points were made in discussion:

e) There was a query regarding how activity would be moved from acute to community services, and it was noted that selected services or pathways would be identified and referral support services implemented to make the shift. Activity would be moved through contractual routes within the core neighbourhood health service specification.

f) In response to a follow-on question regarding whether acute trusts accepted this plan, the Chair invited Stephen Posey and Jon Melbourne to comment. Both were supportive of the direction of travel as the right thing to do for the patient population; however, there was a need to ensure that operational plans were aligned and it would be important to engage fully with staff.

g) Further to this point, the need to focus on the primary and secondary care interface was highlighted, noting the huge cultural shift it would take to enact. Members welcomed the development of a presentation that was being produced for leaders to use for engagement with staff.

h) There was a query as to whether there needed to be a greater focus on embedding the move from analogue to digital within the documents and whether the Boards could have visibility of progress in this area. It was noted that a report on the strategic direction for digital services was on the work programme of the Joint Strategic Commissioning Committee, and once received, would be highlighted to the Boards through the usual governance

channels. A focused update would also be scheduled within the Boards' work programme for 2026/27.

i) In response to a query regarding why commentary on prevention and wider determinants of health was not explicit in the documents, members were asked to note that the plan responded to NHS England guidance to detail how the ICBs would spend their allocations to meet their statutory requirements. There was now an opportunity to engage with Health and Wellbeing Boards and Integrated Care Partnerships on the alignment of strategic intent. The Strategy and Commissioning Plan were both considered to be 'live' documents and would be subject to further development following further engagement.

j) The Chair asked that members take back the messages from the discussion to their respective organisations and stated that updates on progress would be brought to future meetings of the Boards on a regular basis.

The Boards **noted** the report.

At this point Caroline Goulding joined the meeting.

Delivery assurance

ICB CIC 25 046

Dental Services: Strategic Overview and System Strategy

Maria Principe introduced the item, supported by Caroline Goulding, and highlighted the following points:

a) The report had been drafted within the context of oral health being a core component of overall health and wellbeing. Poor oral health was largely avoidable, yet it placed pressure on health services and remained a significant public health challenge.

b) Oral health outcomes tended to reflect wider inequalities, with tooth decay, gum disease and tooth loss disproportionately affecting people living in areas of higher deprivation, as well as vulnerable groups including children, older adults and those with complex health or social needs.

c) The current commissioning landscape was described, which had been shaped by the 2006 national dental contract, which limited flexibility to reallocate activity to changing population needs. Within the ICBs' areas Lincolnshire continued to experience the greatest access challenges due to its rurality, workforce recruitment difficulties, and historically lower levels of commissioned activity.

d) To support improved access and increase utilisation of commissioned activity, a number of initiatives had been implemented and urgent care provision had been expanded, alongside targeted awareness raising activity.

e) The forthcoming reform of the national dental contract from April 2026, which would place greater emphasis on improving access and management of patients with more complex oral health needs, provided an opportunity to align

and implement local commissioning approaches to strengthen pathways, increase flexibility within the system, and improve the targeting of services to areas with the greatest need.

The following points were made in discussion:

f) Chair of the Joint Strategic Commissioning Committee, Jon Towler, asked the Boards to note that on receiving the report, the Committee had not been assured that the drivers of activity levels were fully understood, nor whether the ICBs had the commissioning tools to address the gaps in provision. In response, it was noted that a key issue was the growing number of dentists that no longer wanted NHS contracts and it was hoped that the new contract would address this.

g) In response to a further question on whether the new contract would enable more of a focus on prevention, it was noted that the detail of the contract was as yet unknown. However, there would be an opportunity to align the ICBs' activities with the broader strategic approach of local authorities and bring dentistry into the development of neighbourhood health plans.

h) The Chair emphasised the need to ensure that outcome measures captured public satisfaction in dental services.

The Boards **noted** the report.

At this point Caroline Goulding left the meeting.

ICB CIC 25 047 **Finance Report**

Bill Shields introduced the item, highlighting the following points:

a) At month ten, the combined financial position of the ICBs and NHS providers was noted as an overall variance to plan of £165.5 million. This recognised that the large net risk reported in previous months was now being reported in the income and expenditure position following conversations to set year end forecast positions between individual organisations and NHS England.

b) Nottingham and Nottinghamshire providers remained the key driver of the position at £117.5 million adverse to plan, mainly due to staffing cost pressures.

c) This was a disappointing position and set a significant challenge for 2026/27. The robustness of providers' financial plans and management of their cost improvement plans would need to improve in order for financial balance to be achieved by the end of the next financial year.

d) The forecast for the ICBs was £6.2 million adverse to plan, recognising that deficit support funding would not be received by NHS Nottingham and Nottinghamshire ICB. Conversations were ongoing on the treatment of this issue from an audit perspective. NHS Derby and Derbyshire ICB and NHS

Lincolnshire ICB were both forecasting on plan outturns. Common pressure areas remained across the three ICBs, notably independent sector acute activity, prescribing charges, and mental health costs. Delivery of the full year efficiency plan was key to the delivery of the on-plan forecast.

e) The cash position remained challenging, particularly within providers, with Nottingham University Hospitals NHS Trust and Chesterfield Royal Hospital NHS Foundation Trust requesting support from NHS England and with United Lincolnshire Hospitals NHS Foundation Trust instigating a weekly cash committee.

f) As the scheduling of the Boards did not align to the deadline for submission of opening budget statements to NHS England, under the ICBs' Scheme of Reservation and Delegation the Boards were requested to delegate approval of the opening budgets to the Joint Finance and Performance Committee to take the decision at its meeting on 1 April 2026.

The following points were made in discussion:

g) Chair of the Joint Finance and Performance Committee, Stephen Jackson asked the Board to note that the Committee had been assured that the ICBs would achieve their stated forecast outturns.

h) Noting that NHS England had set clear expectations for the coming year, the Chair asked that lessons learnt from this year needed to be taken forward. The challenging environment in which systems continued to operate was acknowledged.

The Boards **noted** the report, having discussed its content for assurance purposes, and **delegated** approval of the ICBs' 2026/27 opening budgets to the Joint Finance and Performance Committee.

ICB CIC 25 048 **Quality Report**

Rosa Waddingham introduced the item, highlighting the following points:

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

b) Work continued to manage and understand the quality impacts on the sustained pressures within urgent and emergency care services. Following the publication of two Prevention of Future Deaths reports, a systemwide After Action Review had been undertaken to reduce the risk of re-occurrence. Planning had commenced for the coming winter, with a review of lessons learnt.

c) The NHS Derby and Derbyshire and Nottingham and Nottinghamshire ICBs continued to support the delivery of maternity improvement plans, as well as both the Ockenden Review at Nottingham University Hospitals NHS Trust and

the Government's national review into maternity services. Good progress was noted on the progress of improvement plans.

d) Collective focus remained on Special Educational Needs and Disabilities (SEND) services to ensure that strengthened partnership working would lead to stabilising leadership and workforce capacity and address ongoing pressures in high-demand pathways. The Department of Education's planned reform of SEND services was welcomed.

The following points were made in discussion:

e) Chair of the Joint Quality and Service Improvement Committee, Sharon Robson, asked the Boards to note that the Committee had held a productive development session to understand the ICBs' role in quality oversight as strategic commissioners and how the Committee could take assurance and escalate quality concerns to the Boards.

The Boards **noted** the report.

ICB CIC 25 049 **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 2025/26 for NHS Derby and Derbyshire, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire ICBs, as well as an update on the developing arrangements for commissioning leadership and oversight across the ICBs' areas, and the transitioning arrangements for provider oversight and delivery.

b) There continued to be sustained operational pressure in urgent and emergency care and continued challenge against elective, cancer, diagnostics performance trajectories. Both areas had an NHS England supported sprint approach through quarter four to improve the position at year end, focusing on improving ambulance handovers and urgent care waits, reducing waiting lists and long elective waits. In addition, there remained a focus on improving community waiting times and dental and Pharmacy First activity up-take.

c) Looking to 2026/27, work was being undertaken to translate strategic commissioning intentions into clear provider expectations, with measurable milestones and consistent escalation routes where delivery fell below expected levels. There was a need to tighten alignment between planning assumptions, commissioning activity, contractual levers and delivery expectations, which was being undertaken as the contract agreements were progressed.

d) The format of the report to the Boards had been refreshed to respond to the changing role of the ICBs regarding performance oversight and any feedback on how to improve the content of future reports would be welcomed.

There was no further discussion and the Boards **noted** the report.

	Governance
ICB CIC 050	**Updated Governance Framework for the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire Integrated Care Boards working in partnership**

Lucy Branson introduced the item, highlighting the following points:

a) Approval was sought for a small number of refinements to the Governance Handbooks for the NHS Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs, following a stock-take of the new cluster arrangements implemented in late 2025.

b) The proposed changes updated several committee terms of reference and aligned financial delegation arrangements to reflect the emerging single staffing structure, alongside preparations for the further transfer of NHS England commissioning functions.

c) The report also asked Boards to approve the 2026/27 Midlands ICB Specialised Services and NHS England Commissioning Services Collaboration Agreement, which established a new Midlands Joint and Collaborative Committee to support multi-ICB joint governance arrangements ahead of the anticipated 2027 statutory transfer.

The following points were made in discussion:

d) Supportive of the transfer of further NHS England commissioning functions, members sought to understand whether the ICBs would be able to influence decision making arrangements within the Office for Pan-ICB Commissioning.

e) A further point was raised on whether arrangements would allow for input from wider partners, such as Public Health. The Chair replied that she would be supportive of such input and urged the ICBs to ensure that arrangements could flex to meet the ICBs' populations' needs. It was noted that the Joint Strategic Commissioning Committee would be provided with regular updates on progress ahead of the transfer.

The Boards:

- **Approved** the proposed changes to the ICBs' Governance Handbooks.
- **Approved** the Midlands ICB Specialised Services and NHS England Commissioning Services Collaboration Agreement 2026/27, including the establishment of the Midlands Joint and Collaborative Committee.

At this point Stephen Posey left the meeting.

CB CIC 051 **Board Assurance Framework**

Lucy Branson introduced the item, highlighting the following points:

a) Following the Boards' approval of the joint strategic risks in November 2025, a comprehensive exercise had been undertaken to populate the Assurance Framework. This exercise had identified areas of duplication and overlap, as well as opportunities to strengthen clarity and alignment across the emerging cluster arrangements.

b) As a result, some risks had been consolidated where there was overlap, one risk had been disaggregated into two distinct risks, and one risk had been removed.

c) Controls and assurance mechanisms had now been developed. Many of the identified 'gaps' reflected the ongoing development and alignment of cluster-wide processes, rather than being weaknesses in control. Where there were genuine gaps, mitigations had been identified.

d) Where assurances were pending, they had been built into committee workplans for oversight or would be captured in 2026/27 Internal Audit Plans.

e) Further updates would be reported to the Boards on a bi-annual basis, following committee review and oversight, in line with the ICBs' Risk Management Policy.

The following points were made in discussion:

f) Following a query regarding whether the consolidation of the risks relating to the transformation of commissioned services, which included prevention, community care models, and digital enablement, would diminish focus on each of the three transformation areas, it was noted as a pragmatic solution, as the control environment was essentially the same for all three areas.

g) Members were asked to note that a session to review the ICBs' risk appetite was scheduled for June 2026.

The Boards reviewed the joint Board Assurance Framework and **approved** the revised joint strategic risks.

ICB CIC 25 052 **Committee Highlight Reports**

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

The Chair noted that updates from Committee Chairs had already been provided during related discussions under agenda items ICB CIC 25 047 and ICB CIC 25 048.

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

a) Chair of the Joint Finance and Performance Committee, Stephen Jackson, asked members to note the potential opportunities that a recent policy announcement on the transfer of NHS Property Services assets could bring to maximising the use of NHS estate in the ICBs' areas.

b) The Chair queried the limited assurance rating on several of the reports received by the Joint Quality and Service Improvement Committee. Chair of the Committee, Sharon Robson, clarified that the ratings were a reflection of the need to develop benchmarking data to support improvements.

c) Chair of the Joint Remuneration and Human Resource Committee, Margaret Gildea, asked members to note that the Committee continued to be assured of the robustness of the ICBs' management of change process and was very supportive of the ICBs' wellbeing offers.

d) John Dunstan, Chair of the Auditor Panels, drew members' attention to the Committees' recommendation to align external audit arrangements, which had subsequently been approved by the Boards in confidential session during February 2026.

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

Closing items

ICB CIC 25 053 **Risks identified during the course of the meeting**

No new risks were identified.

ICB CIC 25 054 **Questions from the public relating to items on the agenda**

The Chair drew the Board's attention to four questions, which had been received prior to the meeting, and summarised their content: the questions referenced the shift to prevention and proactive care in the strategy, queried recent decisions taken by NHS Lincolnshire ICB to cease funding of three projects relating to dementia care and the voluntary and community sectors. There was little mention in the strategy on the contribution of social care. How would ICBs assess parity of esteem for mental health care. There was no reference in the documentation on services for ex-prisoners, given the number of prisons in the ICBs areas.

Welcoming the questions, the Chair asked that a full response be sent to the member of the public at the earliest opportunity, which would then be appended to the minutes for completeness.

Post meeting note: The questions in full and the ICBs' response to them are appended below

ICB CIC 25 055 **Any other business**

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

ICB CIC 25 054: Questions from the public relating to items on the agenda

Question 1

Paper reference ICB CIC 045 page 5 (full document page 51)
In the summary of the Five-Year Population Health Strategy at paragraph 18:
18. A significant shift to prevention, proactive and community-based delivery is required, together with a shift in the pattern of healthcare spending so the share of expenditure on hospital care falls with proportionally greater investment in out of hospital care.

How does this objective of the health strategy align with the following recent decisions of Lincolnshire ICB (LICB) and Lincolnshire County Council (LCC):

a. *Refusal by the LICB of the business case from Lincolnshire Partnership NHS Foundation Trust (LPNFT) to fund a separate Dementia Memory Assessment service (MAS) for Lincolnshire (in order to bring Lincolnshire in line with the rest of England where a separate MAS is the norm);*

b. *Decision of Lincolnshire County Council to cease funding of the Dementia Memory Support service provided by LPNFT (£450,000);*

c. *Joint decision by LCC and LICB to cease joint funding of the Mental Health and Wellbeing Community Investment Fund (£1,000,000) administered by Shine Lincolnshire which supports the Voluntary, Community and Social Enterprise (VCSE) sector in Lincolnshire.*

Item c) will cause significant disruption to the VCSE sector in Lincolnshire and redundancies in charities currently engaged in this work.
How do these decisions align with the redirection of funding to preventative, community based initiatives from acute, tertiary services?

Answer provided

As we move toward more integrated neighbourhood working—with a stronger emphasis on prevention and community-based support—we expect new models of care to develop through our strategic commissioning approach. The examples referenced predate this strategy and are therefore not directly linked to it.

The strategy sets a long-term direction of travel: shifting support closer to communities, strengthening prevention, and building neighbourhood-based care over the next five years. This transition happens gradually and within finite resources.

A key part of this shift is reducing duplication and parallel services so that we can improve system efficiency. Population health approaches emphasise coordinated, integrated care, and reducing duplication allows us to redirect resources to other priority programmes, supporting system-wide efficiency goals.

The draft Lincolnshire Dementia Strategy also highlights the need for multi-agency care pathways from assessment through to ongoing support, rather than standalone

services. This aligns with the ICB's ambitions for integrated neighbourhood teams and joined-up management of long-term conditions.

The ICB recognises and deeply values the vital contribution of the VCFSE sector in supporting our population and the initiatives in place through the Mental Health and Wellbeing Community Investment Fund (MHWCIF) grant allocation funding. The ICB is committed to ensuring the mental health community assets grants that fall within their criteria, in year 2 of their current grant regime, are continued into 26/27, and LCC has committed to fund those existing schemes that had been promised LCC funding in 26/27.

Question 2

The Department of Health was renamed the Department of Health and Social Care in 2018, some 8 years ago. Yet the focus of the reports from the ICBs appears to be the acute sector, as does the funding priority. Little mention is made of the contribution to population health of Social Care. When will the public see a change in this focus in the deliberations of the ICBs to include discussion of the contribution to population health that Social Care contributes? Where is the plan?

Answer provided

Social care makes a significant contribution to population health, and this is recognised across the system. However, responsibility for commissioning and delivering social care sits with local authorities rather than the NHS, and therefore it will not always appear in detail within ICB reports, which focus primarily on NHS services and commissioning responsibilities.

That being said, the system benefits from strong existing partnerships with local authorities and social care providers, and these relationships are central to our approach to improving population health. Our 5 Year Population Health Strategy reflects this by categorising actions as NHS-led, NHS in partnership, and multi-agency led, recognising that many of the factors that influence health outcomes sit outside the NHS.

Integration with social care is particularly visible through our approach to neighbourhood working, one of our key priorities, where NHS services, local authority teams, and community organisations work together to support local populations. As neighbourhood delivery plans are implemented, this joint working will become increasingly visible in system planning and reporting.

In addition, the NHS contributes through its anchor institution role, supporting wider social and economic determinants of health through employment, procurement, and community investment.

Question 3

Parity of esteem for physical and mental health care. How does the ICBs assess the progress towards parity of esteem in terms of resource for physical and mental health

care funding? What progress has been made? What are the plans in the next 5 years to address the current imbalance of funding?
See, for example, The Centre for Mental Health Briefing 46 (April 2013)
https://www.centreformentalhealth.org.uk/wp-content/uploads/2018/09/briefing46_NHSmandate.pdf

Answer provided

Parity of esteem is central to the strategy, which treats physical and mental health as interconnected and prioritises both equally—particularly for children, young people and people with complex needs.

By framing priorities around population groups rather than service silos, and by shifting towards neighbourhood and community models, the strategy sets a clear direction for more balanced focus and investment. Over the next five years, it will guide commissioning, pathway redesign and resource allocation so that decisions increasingly align with population need and the agreed priority framework, improving outcomes, equity and value across mental and physical health together.

Question 4
There are a number of prisons within the catchment of the joint ICBs in the LDN cluster. Where in the strategic documents is there reference to this cohort of people who will be released back in their communities from those prisons, and who often have considerable health needs, both physical and mental?
See here for a map of prisons in England and Wales focused on East Midlands
https://tvcs.co.uk/googlemaps/mysql/prisons/prisons_map.php?area=eastmidlands

Answer provided

People leaving prison are included within the strategy's focus on inclusion health and high-need populations, as they often face significant physical and mental health issues, substance misuse, trauma and wider social vulnerability, making continuity of care at transition a high-risk point.

The neighbourhood approach is designed to provide more joined-up, coordinated support for these groups, and this cohort is reflected across the strategy's inclusion health, neighbourhood health and access priorities rather than as a standalone segment.

The 5 Year Population Health Strategy highlights homelessness, inclusion health, strong general practice, vaccinations, screening and neighbourhood-based care as core elements of the place-based model, all of which are directly relevant to people leaving prison, particularly in ensuring GP registration, continuity of treatment, proactive follow-up and coordinated community support.

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	21/05/2026
Paper title:	**Citizen's Story**
Paper reference:	ICB CIC 26 006
Paper author:	Abi Cuffling, Senior Communications Officer, NHS Lincolnshire ICB
Paper sponsor:	Clair Raybould, Executive Director for Strategy and Citizen Experience
Presenter:	Clair Raybould, Executive Director for Strategy and Citizen Experience

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

Report summary:

Fighting Fit is a Lincolnshire based initiative focused on improving health, wellbeing and physical activity levels across local communities, with a specialist focus on supporting people living with and beyond cancer. It is run by Lincoln City Foundation and was a finalist in the Health and Wellbeing category at the Lincolnshire Sport and Physical Activity Awards 2022 after the pilot programme was supported through a grant from the Tackling Inequalities Fund (now Together Fund) distributed through Active Lincolnshire. Developed to support individuals of all ages and abilities, the programme works closely with partners to create inclusive opportunities that help people become more active, build confidence and improve their overall quality of life.

Established with a clear emphasis on tackling inactivity and reducing health inequalities, Fighting Fit delivers a range of tailored sessions and support offers. A key part of its provision includes cancer-specific physical activity sessions, delivered by Level 4 Cancer Rehabilitation fitness instructors, designed to help individuals maintain or regain strength before, during and after treatment. These sessions are safe, supportive and adapted to meet the needs of those at different stages of their cancer journey.

Its approach is rooted in partnership working, collaborating with local organisations, healthcare providers and community groups, including the NHS, to ensure activities are accessible, clinically informed and responsive to local need. By embedding sessions within neighbourhoods and trusted settings, Fighting Fit helps remove common barriers such as cost, confidence and accessibility, particularly for those who may feel uncertain about returning to physical activity following diagnosis or treatment. Participants are supported to not just take part in physical activity, but to make sustainable lifestyle changes. Everyone is offered the opportunity to speak with a qualified professional before attending, helping to shape sessions around their diagnosis, goals and personal circumstances. The programme also fosters a welcoming, non-judgemental environment where people can progress at their own pace.

Alongside the physical benefits, Fighting Fit places strong emphasis on social connection and peer support. Cancer-focused sessions provide opportunities for individuals to meet others with shared experiences, helping to reduce isolation and build confidence through a sense of community. Through their work, Fighting Fit aims to ensure that no one in Lincolnshire navigates their diagnosis, treatment, or recovery journey alone, or without the benefits of physical activity.

Report summary:

'Fighting Fit' is directly aligned with, and will support delivery of, the ambitions set out in the Ten Year Health Plan for England and the National Cancer Plan for England. The programme contributes to wider system priorities by supporting the shift from hospital to community care through delivery across ten community localities in Lincolnshire, enabling participants to access Level 4 Cancer Rehabilitation closer to home. This approach reduces reliance on hospital-based services, strengthens prevention and recovery pathways, and aligns with emerging Neighbourhood Working Models.

The Fighting Fit programme aligns closely with Commitment 4 of the National Cancer Plan (2026): Designing cancer care around people's lives:

a) It provides an accessible, community-based intervention where physical activity has been identified as a need, helping individuals to act on their personalised care plans in a supportive and non-clinical environment. The programme's in person, group-based delivery model additionally fosters peer support, which can improve psychological wellbeing and reduce social isolation.
b) It delivers structured exercise, prehabilitation and rehabilitation support to help individuals prepare for treatment, improve treatment tolerance and support recovery outcomes following treatment.
c) It is focused on helping people stay in or return to work. By supporting individuals to rebuild physical fitness, resilience and confidence following cancer treatment, Fighting Fit can contribute to improved work readiness and support earlier reintegration into employment, in partnership with ICBs and local employers.

Recommendation(s):

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

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

Appendices

None.

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

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:	21/05/2026
Paper title:	**Chair's Report**
Paper reference:	ICB CIC 26 007
Paper author:	Dr Kathy McLean, Chair
Paper sponsor:	Dr Kathy McLean
Presenter:	Dr Kathy McLean

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

Report summary:

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

Recommendation(s):

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

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

Appendices

Appendix A: 2026/27 Board Work Programme.

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Chair's Report

Introduction

1. The ICBs continue to make progress in delivering the required cost reduction programme, seeking to reorganise and reduce operating costs by approximately half. I remain impressed that ICB colleagues have continued to deliver significant progress in challenging circumstances, for which I know the Boards are grateful. Many colleagues have already departed, having taken voluntary redundancy, with more due to leave through this route in the coming weeks. Significant levels of constructive and helpful feedback have been received from staff during our main consultation on organisational structures, and the outcome of the deliberations of our Executive Director and senior leadership teams is due to be published shortly. A linked consultation for our All-Age Continuing Care, Section 117 assessments and Acquired Brain Injury Teams was launched at the start of May.
2. The consultations on future structures need to fulfil a dual purpose to ensure we are fit for purpose as a strategic commissioner and achieve the immediate cost reductions required. This is a fine balancing act, and we must ensure that our priorities are clear as we seek to make improvements to local health services, with a refocused workforce. I would like to place on record my thanks to everyone who has continued to show significant resilience and commitment over the last 14 months since the national announcements of change were made.
3. We have had some positive news from across our ICB cluster since the last Board meeting. I am delighted that teams in both Derby and Derbyshire and Nottingham and Nottinghamshire have been recognised as regional champions in the first ever NHS Excellence Awards; successes that were complemented by a strong set of submissions from across our cluster. This is a real achievement and a strong reflection of the innovation and commitment we benefit from.
4. Specifically in this instance, Derby and Derbyshire’s Team Up team has been recognised as a regional champion for Neighbourhood Health. Their work brings together partners across health, care and communities to deliver more joined-up support closer to home, with a strong focus on prevention, proactive care and reducing inequalities. Meanwhile, Nottingham West Primary Care Network has been named a regional champion in the quality improvement category for its work on making equity a routine part of everyday clinical care and making practical changes that improve patient experience and outcomes.
5. As we continue to work through a challenging operating and financial environment, it is important to pause and recognise achievements like these. They demonstrate the impact of collaboration, neighbourhood working, and a

shared focus on improving outcomes for local populations, and they should give us confidence as we continue to deliver our priorities.

National matters

6. The Government's Health Bill, introduced to Parliament on 14 May 2026, sets out a major programme of legislative reform to modernise the NHS and wider health and care system. The Bill proposes the abolition of NHS England and a transfer of its functions to the Department of Health and Social Care; alongside wider structural changes intended to reduce national bureaucracy and strengthen local accountability. It reinforces the role of ICBs as strategic commissioners, introduces a national single patient record to support more integrated, proactive care, and includes measures to enhance patient safety, reform foundation trusts and streamline arm's-length bodies. Collectively, the reforms are intended to improve patient outcomes and experience, increase efficiency and innovation, and place greater flexibility and responsibility with local systems to design services around population need. We will have some time in the private session later in the meeting to discuss the Bill in more detail.

7. In addition to the Health Bill, there have been a number of further key national developments since the Boards' last meeting, including notification of priorities for 2026/27 by NHS England, guidance on the annual ICB assessment process, and guidance on the development of Neighbourhood Health Centres. These areas will also be covered in more detail as part of later agenda items at the meeting.

8. I continue to be outward facing, connecting with and understanding the needs of our local and national communities and stakeholders. In my role as Chair of the NHS Alliance's ICB Network, I wrote an editorial piece for the Health Service Journal on the future direction for ICBs. It was important to note that ICBs are ready to act as strategic commissioners, and have a clear role in improving population health, patient experience and NHS sustainability. Delivery of the Ten-Year Health Plan depends on ICB success, particularly around neighbourhood health, prevention and shifting care into the community; and despite major organisational change, ICBs have maintained delivery and supported recovery, including improvements in urgent and emergency care and dentistry. ICBs now have greater clarity, experience and strong local partnerships to lead long-term system change.

9. However, Government support is critical to make reform deliverable and not an uphill struggle. National action requires a focus on stronger commissioning leadership and capability development, a clear, consistent roadmap for ICB roles and operating models and recognising that ICBs will need to make difficult financial and commissioning decisions, including decommissioning and shifting funding away from acute care. To achieve this agenda, political backing and

policy reform, including payment reform, are essential to manage risk and enable change.

10. The NHS Alliance has also been convening engagement sessions in collaboration with NHS England and the Department of Health and Social Care to support the development of new Modern Service Frameworks. These are structured approaches designed to guide large-scale service improvement, align local and national priorities, and support long-term transformation across the NHS in line with the Ten-Year Health Plan. The next session on 20 May will focus on palliative care and end of life.

Local matters

11. There have been a number of positive announcements relating to local health service estate in recent weeks. Firstly, I was delighted to see that Long Eaton Health Centre was listed as one of the 27 areas to receive Government funding as a designated neighbourhood health centre. A range of services will be provided under one roof, including urgent treatment, GP and pharmacy services. The existing NHS estate will be repurposed, refurbished and transformed and the 27 centres will be open by 2027. We are also working towards an end of May deadline to submit our systems' recommendations for the future waves of neighbourhood health centre designations across our geography. For us, this work also links directly to our ambitions around neighbourhood care, strategic commissioning and closer collaboration with local authorities and providers to improve outcomes and tackle health inequalities.

12. In other estates-related news, a ground-breaking ceremony has officially marked the start of a significant construction project at the heart of Boston to create a new £24.9 million Community Diagnostic Centre (CDC). The Boston CDC is scheduled to open to patients in spring 2027. Once complete, it will provide two new MRI scanners, two new CT scanners, x-ray facilities, three ultrasound rooms, and a further eight consultation rooms, including dedicated space for audiology services. Across the patch in Mansfield, a new state-of-the-art CDC has now officially opened, marking a major step forward in improving access to vital health tests. The centre provides a one-stop shop for patients across Nottinghamshire to access the tests and investigations they need in a single visit, reducing the time it takes for patients to be referred to help them receive an ‘all clear’ or diagnosis sooner. In addition to these two centres, the Department of Health and Social Care recently announced a further national investment of £237 million to accelerate the expansion of CDCs in England. In the ICBs’ area this funding will also target sites in Nottingham, Grantham and Matlock.

13. The Nottingham Inquiry, which began on 23 February 2026, continues to seek to build a clear understanding of the events, acts and omissions that led to Valdo Calocane conducting brutal attacks in Nottingham on 13 June 2023. Our thoughts remain with the families of Ian, Grace and Barnaby who were killed and also with Wayne, Sharon and Marcion who were injured. NHS Nottingham and Nottinghamshire ICB will have representation at the Inquiry in the coming weeks. We will ensure we provide any information required accurately and with clarity to support these families and those undertaking the Inquiry as fully as possible. We are committed to safe and high-quality services for our communities and we will continue to provide support and challenge our providers and our partners to ensure sustained improvements in the delivery of safe services.

14. The East Midlands Combined County Authority, with the NHS Confederation, convened local partners for a highly interactive day-long workshop on the 22 October 2025. The primary objective of this workshop was not only to convene local partners to imagine what the future should be, but to outline how they could collectively get there. Attendees came from across the East Midlands, covering the full range of geographic footprints and included representatives from local authorities, the combined authority, the Voluntary, Community and Social Enterprise sector, higher education, and healthcare. The event set out a vision for the future, whereby people living in the East Midlands Combined County Authority area will live longer, happier lives in better health – nurtured by the places they live in and the communities they are part of. A series of headline actions were agreed by the attendees, and now relevant is the follow up event which takes place in May 2026 to do further work in setting the direction to achieve our shared ambition. We will support this fully, just as we did the October event.

15. I have continued with my series of podcasts with health and care leaders from across the system. We have now amalgamated this podcast series to cover the breadth of the ICBs' work. The latest episode discussed population health across our area and the importance of improving health outcomes. My guests were Emma Tatlow, CEO of Active Lincolnshire, Rima Chauhan, Head of Pharmacy, Integration and Place at Derby and Derbyshire ICB, and Vivienne Robbins, Director of Public Health and Communities at Nottinghamshire County Council. Subjects discussed included how to increase healthy life expectancy, the use of population health management, making the best use of our population data, and successful preventative interventions.

Board matters

16. Members are asked to note that following the resignation of Paul Simpson, the role of Local Authority Partner Member on NHS Derby and Derbyshire ICB's Board will remain vacant until Derby City Council has appointed a substantive

Chief Executive. In the meantime, the Council has been helpful in providing interim representation, which is most welcome.

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

18. An initial work programme for 2026/27 has been developed that aims to build on progress made by the Boards over the past six months. This is provided for information and feedback at Appendix A. The work programme will be used to steer agenda planning; however, we will keep this under review as the year progresses, and as ICB transition arrangements become clearer.

19. I have also continued my practice of observing our committees as they do the 'heavy lifting' of assuring and steering the work of the ICB. This has been one of the ways that I have been able to gather input into the appraisal and objective setting process for our Non-Executive Directors, which I have now completed.

20. On a related point, the annual Fit and Proper Person Test (FPPT) review process for all Board members is due to commence shortly, forming part of the ICBs' ongoing arrangements to support compliance with the NHS England FPPT Framework. This provides an important opportunity to confirm that Board member declarations, appraisals, training compliance and wider governance checks remain up to date, and to ensure that the Boards continue to meet the expected standards of competence, conduct and accountability. The final submission to NHS England is expected to be made by the end of June 2026.

Looking forward

21. It remains clear from this report and also the other items on today's agenda that a huge volume of activity is taking place across the ICBs' footprints to deliver high quality services for our populations, alongside the internal re-organisation. As ever, we must track progress on both fronts, to deliver our core aim of population health improvement, and finding stability following the period of significant change, and the organisational development that will support that, will be an important focus for the next few months.

22. Once again, I want to underline my empathy for colleagues undergoing a considerable period of change and thank them for their fortitude and resilience as we move forward.

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

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	-	-	-	-	-	✓	-	-

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
Improvement, learning and innovation Report (incorporating research)	-	-	-	✓	-	-	Strategic risks 1 and 9	See note 7
Commissioning oversight and delivery								
2027/28 Opening Budgets	-	-	-	-	-	✓	Strategic risks 7a and 7b	See note 8
Finance Report	✓	✓	✓	✓	✓	✓	Strategic risks 7a and 7b	See note 9
Commissioning Delivery Report	✓	✓	✓	✓	✓	✓	Strategic risk 10	See note 10
Quality Strategy	-	✓	-	-	-	-	Strategic risk 9	See note 11
Quality Report	✓	✓	✓	✓	✓	✓	Strategic risk 9	See note 12
Governance and compliance								
Transition Report	-	✓	-	✓	-	✓	Strategic risk 11	See note 13
Board Assurance Framework	-	-	✓	-	-	✓	All risks	See note 14
Annual Equality Assurance Report	✓	-	-	-	-	-	Strategic risks 2-5, 6, 9 and 10	See note 15
Senior Information Risk Owner (SIRO) Annual Report	✓	-	-	-	-	-	Strategic risk 12	See note 16
Annual Report on Working in Partnership with People and Communities	-	✓	-	-	-	-	Strategic risk 6	See note 17
Annual Statement on Health Inequalities	-	✓	-	-	-	-	Strategic risks 2-5, 6, 9 and 10	See note 18
Freedom to Speak Up Annual Report	-	-	-	✓	-	-	Strategic risk 11	See note 19
Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Report	-	-	-	-	✓	-	Strategic risk 12	See note 20
Committee Highlight Reports	✓	✓	✓	✓	✓	✓	All risks	See note 21
Closing items	✓	✓	✓	✓	✓	✓	Not applicable	See note 22

Board Seminars and Development Sessions:

Topic	16 Apr	18 Jun	15 Oct	17 Dec	18 Feb
• Development of ICBs' shared values and behaviours • 2026/27 priorities, planning and contracting update	✓	-	-	-	-
• Review of ICBs' shared risk appetite • Strategic Commissioning Capability Self-Assessment	-	✓	-	-	-
• Review of recent and upcoming legislative changes as appropriate to ICBs	-	-	✓	-	-
• National Cyber Security Centre (NCSC) NHS cyber security training	-	-	-	✓	-
• To be confirmed	-	-	-	-	✓

Annex 1: Purpose and content of agenda items

No.	Agenda item	Purpose
1.	**Introductory items**	This section of the meeting will include: • A copy of members' registered interests for consideration and agreement of how any real or perceived conflicts of interest are required to be managed. • The previous meeting's minutes for agreement (and any matters arising). • The Boards' Action Log for review.
2.	**Citizen Story**	To present a citizen story at the outset of each meeting of the Boards, with the purpose of grounding the following discussions at each meeting in the reality of patient care and putting citizens at the heart of Board decisions. The stories will demonstrate a range of examples of healthcare provision, what matters to people, their experience of healthcare services, learning points and improvement actions.
3.	**Chair's Report**	To present a summary briefing for Board members of the Chair's reflections, actions, and activities since the previous meeting of the Boards. As appropriate, this will include updates on key governance developments, and on an annual basis this will present the Boards' Annual Work Programme and include a review of the skills, knowledge, and experience of Board members (when taken together) to ensure the Boards can effectively carry out their functions.
4.	**Chief Executive's Report**	To present a summary briefing on recent local and national developments and areas of interest for Integrated Care Boards (ICB) and wider Integrated Care Systems (ICS), along with key updates from system partners and formal partnership arrangements, including Integrated Care Partnerships and Health and Wellbeing Boards. On a quarterly basis, the reports will include the latest segmentation ratings under the NHS Oversight Framework. The report will also include key updates regarding the ICBs' workforce on a periodic basis, including NHS staff survey results and wider workforce indicators. As appropriate, the report may also include specific items requiring approval or for noting by Board members.
5.	**Refresh of Five-Year Population Health Strategy, Five-Year Strategic Commissioning Plan, and Three-Year Operational Plan**	To present the annual refresh of the Five-Year Population Health Strategy, Five-Year Strategic Commissioning Plan, and Three-Year Operational Plan for approval. *Note: Development of the refreshed strategy and plans will be overseen by the Joint Strategic Commissioning Committee and Joint Finance and Performance Committee.*
6.	**Reports on Strategic Priorities**	To provide the Boards with a collective and integrated view of progress against delivery of the Population Health Strategy priorities and Neighbourhood Health Plan, bringing together contributions from across strategy, commissioning, finance, quality and outcomes. Reports will focus on the intended population outcomes, target cohorts and inequalities, and demonstrate how delivery activity is contributing to measurable improvement, supported by triangulated evidence including performance, financial, quality, safety, provider insight and citizen experience. The reports will be 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

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:	21/05/2026
Paper title:	**Chief Executive's Report**
Paper reference:	ICB CIC 26 008
Paper author:	Amanda Sullivan, Chief Executive
Paper sponsor:	Amanda Sullivan
Presenter:	Amanda Sullivan

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

Report summary:

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

Recommendation(s):

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

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

Appendices

Appendix A: Emergency Preparedness Resilience and Response (EPRR) and Business Continuity Policy.

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Chief Executive's Report

Letter from NHS England Chief Executive Sir James Mackey regarding collective priorities for 2026/27

1. NHS England has issued guidance for 2026/27 requiring ICBs to build on recent operational recovery and transition towards a more sustainable, system-led model of care. While performance has improved across key areas such as referral to treatment and urgent and emergency care, the focus now shifts to strengthening multi-year strategic commissioning, with particular emphasis on neighbourhood-based care, improved financial and payment mechanisms, and closer collaboration across system partners.
2. ICBs are required to submit a single, system-aligned narrative setting out how they will deliver this transformation over the next three years, including how commissioning will evolve, how neighbourhood models will address local challenges, and what national support or flexibilities are needed to enable delivery. This represents a significant step-up in expectations regarding system integration, clarity of strategic intent, and alignment between commissioners and providers.
3. Delivery will be underpinned by eight national priority areas, including outpatient transformation, reduction in hospital bed days for high-risk cohorts, urgent care access reform, technology-enabled productivity, expansion of the NHS App, payment reform, renewed focus on quality, and investment in workforce capability.
4. These areas are very much in keeping with our local priorities and we have been meeting with NHS partners in each of the three ICB areas to work through our collective approach to achieving our service ambitions. The ICBs are working with the NHS England regional team to submit a single document to summarise the above by Friday 15 May 2026.
5. The full letter can be found here: https://www.england.nhs.uk/long-read/1-april-2026-next-steps-on-planning-and-priorities-for-2026-27/.

Annual assessment of integrated care boards 2025/26

6. NHS England has released guidance describing the process for the annual assessments of ICBs for 2025/26. The guidance sets out the key lines of enquiry that NHS England will use to underpin its assessments. It recognises the significant organisational changes that are taking place within ICBs and their evolving responsibilities, so the process has been designed to be proportionate and minimise administrative impact on ICBs.

7. NHS England will draw on existing evidence and intelligence that includes, but is not limited to:

   a) ICB annual reports and accounts, which includes ICB self-assessments of how they have performed their duties.

   b) Feedback from system partners including Health and Wellbeing Boards and, where appropriate, Health Overview and Scrutiny Committees and Integrated Care Partnerships.

   c) Records of NHS England's performance and development discussions with ICBs throughout the year, including delivery of 2025/26 operating plans and progress towards agreed improvement goals.

8. The key lines of enquiry are grouped into three areas: performance; capability considerations; and support and intervention. Further detail can be found here: https://www.england.nhs.uk/long-read/annual-assessment-of-integrated-care-boards-2025-26-supporting-guidance/.

9. The outcomes of the assessments are expected by the end of July 2026.

Strategic Commissioning Framework update

10. In November 2025, NHS England published a Strategic Commissioning Framework setting out an approach for ICBs to follow in order to meet the ambitions of their strategic commissioning role. The need for ICBs to complete a baseline self-assessment against the framework was signalled, with a strategic commissioning development programme due to be made available in Spring 2026 to support ICBs with the key skills and experience required.

11. The self-assessment requirements are now anticipated to be published in June 2026, and once received, the ICBs' Executive Director of Transition will co-ordinate its completion and will share the output with the Boards, together with an outline plan as to how the organisational development programme will support the closure of any identified gaps in skills and capabilities.

12. ICB colleagues are participating in the development of the programme and in terms of Board development, sessions planned to be launched later in the year will include: core ICB Board capabilities aligned to strategic commissioning; good governance, assurance and insight; the strategic commissioning cycle, and alignment with the Ten-Year Health Plan; and financial stewardship and intelligent payer role, building capability in financial risk management, and contract oversight. Further information will be provided when available.

Neighbourhood health centres

13. NHS England has issued guidance and criteria for its Regional Teams and ICBs to support the development of Neighbourhood Health Centres, which are

a key tool in the Government's Ten-Year Health Plan to enable care to be delivered closer to home and be a 'one stop shop' for an increased range of healthcare services, including: mental health services; some clinics traditionally held within hospital settings; minor diagnostics and urgent treatment; and wellbeing services.

14. The investment is intended to support improved access to General Practice and reshape community and primary care estate that will be supported by a combination of new capital investment, estate disposals and repurposed estate.

15. ICBs are required to submit their initial proposed strategic pipeline of neighbourhood health centres by 28 May 2026; and working with ICBs, Regions will then set out their thinking on how they will define neighbourhoods geographically in their area, articulate the proposed neighbourhood health estate, and provide a list of disposals that will be enabled through investment and improved utilisation of existing estate.

16. Proposals approved by NHS England will then be subject to the development of more detailed business cases in order to approve funding. Both stages of approval will be taken through the Neighbourhood Estates Investment Committee, a new, nationally convened panel that will provide assurance in line with HM Treasury Green Book principles.

17. This work should build on existing local estates strategies, with any new build schemes expected to be funded through a combination of public capital and public private partnerships.

18. The ICBs' Joint Finance and Performance Committee will oversee estate developments within the ICBs' geographies. A wider and more detailed report on Neighbourhood Health can be found later on the agenda for this meeting, and the full guidance document from NHS England can be found here: https://www.england.nhs.uk/long-read/neighbourhood-health-centre-guidance-for-regions-and-integrated-care-boards/.

Future of Freedom to Speak Up

19. Following a recommendation by the Dash Review of patient safety across health and care, from 1 July 2026, NHS England will deliver some activities previously undertaken by the National Guardian's Office. Trusts, primary care organisations, ICBs and independent providers will be expected to take on greater responsibility and accountability for embedding effective Freedom to Speak Up arrangements within their own organisations.

20. Going forward NHS England will provide training, collect data and review policy at the national level. Healthcare providers and commissioners will have sole responsibility for ensuring that information about how to contact their Freedom to Speak Up Guardian is kept accurate and is accessible, ensure that any

guardian they appoint completes the mandatory guardian foundation training and ensure appropriate psychological support is available for their guardians once the nationally sourced independent Employee Assistance Programme ends in December 2026.

21. The ICBs are currently reviewing and aligning their Freedom to Speak Up arrangements across the cluster, which will include the involvement of Mehrunnisa Lalani, Non-Executive Lead for Freedom to Speak Up and oversight by the Audit Committees. A further update will be provided to a future Board meeting.

Modern Slavery and Human Trafficking Statements

22. The ICBs have recently published their 2025/26 Modern Slavery and Human Trafficking Statements in accordance with Section 54 of the Modern Slavery Act 2015. The statements reflect the organisations' joint commitment to preventing modern slavery and human trafficking within their corporate activities, workforce and supply chains.

23. The statements set out the ICBs' approach to safeguarding, employment checks, staff training, procurement and contract management arrangements, and outline expectations placed on commissioned providers and suppliers in relation to compliance with the Modern Slavery Act 2015. They also highlight the ICBs' arrangements for safeguarding oversight, workforce governance and partnership working with other agencies in responding to concerns relating to modern slavery and human trafficking.

24. In line with NHS England's request for NHS organisations to publicly demonstrate their support for the eradication of modern slavery and human trafficking, the ICBs' statements should be read alongside the NHS England Modern Slavery and Human Trafficking Statement, which outlines the wider NHS approach and expectations across the health system.

25. The ICBs' statements can be found here: https://joinedupcarederbyshire.co.uk/your-services/safeguarding/safeguarding-adults/, https://lincolnshire.icb.nhs.uk/about-us/safeguarding/modern-day-slavery-statement/, https://notts.icb.nhs.uk/about-us/safeguarding/equality-inclusion-and-human-rights/.

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

26. The ICBs have recently strengthened their emergency response processes to provide a more robust and consistent approach to managing EPRR incidents in their roles as Category 1 Responders under the requirements of the Civil Contingencies Act 2004.

27. At their May 2026 meeting, the ICBs' Audit Committees endorsed the development of a single approach for the management of incidents, which has necessitated the refreshing of a suite of documents that were presented to the Committees for approval. The ICBs' refreshed EPRR and Business Continuity Policy; Business Continuity Management System; Incident Response Plan; EPRR Steering Group Terms of Reference; and EPRR Communications and Media Handling Plan were subsequently approved following scrutiny by the Committees.

28. The ICB's refreshed EPRR and Business Continuity Policy is appended to this report for completeness. It sets out how the Derbyshire, Lincolnshire and Nottinghamshire ICBs will meet their statutory and regulatory duties to prepare for, respond to, and recover from emergencies and business continuity incidents. It establishes a single framework for governance, accountability, risk management, training, exercising, assurance and continuous improvement across the three ICBs, aligned to the Civil Contingencies Act, NHS EPRR Framework, NHS EPRR Core Standards, and ISO 22301 principles. The policy clarifies roles and requirements as well as EPRR resourcing across the ICBs to ensure effective delivery of the EPRR programme. In effect, it provides the overarching organisational and system-wide approach to maintaining resilient services and protecting patient safety, whilst making clear that incident-specific response plans must be used during an actual event.

29. This was a significant undertaking for the EPRR teams; nevertheless, it has proved to be a productive exercise, taking best practice from each of the ICBs in order to produce a more robust single approach to the management of incidents. A Steering Group has also been assembled to provide continued oversight of management processes.

30. The Audit Committees also received a mid-year progress update on compliance with 2026/27 NHS Core Standards, indicating that good progress was being made.

31. Reflecting heightened concerns about those motivated by Islamist or extreme right-wing ideologies, the UK's national terrorism threat level has been raised from 'substantial' to 'severe', indicating that an attack is considered highly likely. EPRR arrangements have been mobilised and messaging has been issued to all ICB and provider staff to inform them of the increased threat level and the ICBs have received confirmation from providers that plans and processes are in place to respond to all major incidents should they occur.

Hantavirus outbreak

32. Hantaviruses are a family of viruses primarily transmitted to humans through contact with infected rodents, their urine, droppings, or saliva, with very occasional person-to-person transmission reported in specific strains outside

Europe. Human infection remains rare in the UK, and the overall risk to the public is currently assessed as low. Clinical presentation can range from a mild flu-like illness to more severe disease, including haemorrhagic fever with renal syndrome (HFRS) or hantavirus pulmonary syndrome (HPS), depending on the viral strain involved.

33. The UK Health Security Agency (UKHSA) and international public health agencies continue to monitor the situation closely, with no evidence at present of sustained community transmission within the UK. NHS organisations are being reminded of the importance of maintaining vigilance for unusual febrile respiratory or renal presentations in patients with relevant travel, occupational, or environmental exposure histories. Standard infection prevention and control precautions remain appropriate in routine healthcare settings, with additional precautions applied where clinically indicated. Existing microbiology and infectious disease pathways are considered sufficient to manage suspected cases, and established escalation arrangements remain in place should the risk profile change.

34. The ICBs' Executive Director of Outcomes (Medical), Dave Briggs, is leading on oversight of the issue, and across the ICBs' systems, the current position does not require any change to operational posture. However, the situation reinforces the importance of preparedness arrangements, horizon scanning, and robust infection prevention capability across providers and community settings. These arrangements have been robustly tested to ensure preparedness and communications continue through regional resilience and public health networks to ensure timely dissemination of emerging intelligence. The NHS remains well-practised in managing rare infectious disease incidents, and partners across the cluster continue to work collaboratively to ensure an appropriate and proportionate response to any evolving risks.

Industrial action

35. NHS resident doctors who are members of the British Medical Association undertook a further period of industrial action from 7 to 13 April. As with previous rounds of industrial action, our priority was to maintain safe services, with a particular focus on urgent and emergency care and providing consistent messages to the public.

36. Our collective preparation for the action was thorough, and services were managed with minimal disruption. I wish to thank everyone who took part in the planning and delivery of services during this period, and we look forward to the earliest possible resolution to this national dispute.

Women's Health Strategy

37. During April, the Department of Health and Social Care renewed its Women's Health Strategy. Key reforms include:

    a) Redesigning clinical pathways for heavy periods, urogynaecology and menopause to speed up diagnosis and treatment.

    b) Funding a specialist centre in each region to introduce group-based approaches to care, helping women understand and manage their conditions better.

    c) Launching a new £1 million programme to improve menstrual education so girls are better equipped to recognise the signs and symptoms of unhealthy periods.

    d) Launching a £1.5 million Femtech challenge fund to accelerate adoption of innovations that could transform women's healthcare in the future.

    e) Establishing the women's voices partnership to bring organisations representing women together to help inform future policy and decision making.

    f) Providing better access to contraceptive and abortion care with continued support for protected spaces.

    g) Reviewing how different levels of support should work for families who experience repeated baby loss, and update the guidance based on that review.

38. The full strategy can be found here: https://www.gov.uk/government/publications/renewed-womens-health-strategy-for-england.

Announcement on addressing corridor care

39. The Department of Health and Social Care has announced plans to support hospital trusts with the highest rates of corridor care by deploying specialist teams to provide bespoke clinical support to significantly reduce or eradicate corridor care within these trusts.

40. This announcement is part of plans to expand urgent treatment centres and same day emergency care services to help ease the pressure in accident and emergency departments. Within the ICBs' area the Queen's Medical Centre has been targeted for expansion of their Urgent Treatment Centre.

Recent leadership appointments

41. Following the resignation from the Government of Wes Streeting earlier this week, the Rt Hon James Murray MP has been announced as Secretary of

State for Health and Social Care. James has previously served as Chief Secretary to the Treasury and Exchequer Secretary to the Treasury.

42. Derby City Council has announced Sam Dennis as their new Interim Chief Executive following the resignation of Chief Executive Paul Simpson. Sam joined the Council in November 2020 as Director of Communities and then became Strategic Director of Place in 2024.

43. Sherwood Forest Hospitals NHS Foundation Trust has recently announced the appointment of Rukshana Kapasi OBE as their new Chair. Rukshana has extensive experience from her 30-year career serving across the NHS and the charitable sectors, most recently having served as the Director of Health at the Barnardo's children's charity since 2020. She is also currently a non-executive director at Hertfordshire Community NHS Trust.

44. Sir Jim Mackey has announced the names of seven chairs for NHS regional teams, ahead of the service moving to its new operating model. All but one of the appointees will take up their post from April. They are:

    a) East: Nick Carver, currently chair of Nottingham University Hospitals NHS Trust, and previously CEO of East and North Hertfordshire NHS Trust for 19 years.

    b) London: Ian Peters, currently chair of the UK Health Security Agency, and previously of Barts Health NHS Trust.

    c) Midlands: Russell Hardy, chair of South Warwickshire University NHS Foundation Trust and three other trusts in the 'foundation group' established under Mr Hardy's chairmanship.

    d) North West (starting 1 May): Kathy Cowell, is chair of Manchester University NHS Foundation Trust.

    e) North East and Yorkshire: Bill McCarthy, most recently interim chair of Greater Manchester Mental Health NHS Foundation Trust, and previously a director at regional, national and trust levels.

    f) South East: Jonathan Montgomery, chair of Oxford University Hospitals NHS Foundation Trust, and professor of Health Care Law at University College London.

    g) South West: Dame Gill Morgan, most recently chair of Gloucestershire Integrated Care Board, formerly a CEO of local and national NHS organisations and of the NHS Confederation.

45. Several changes to the leadership team across the Department of Health and Social Care and NHS England have also been confirmed:

    a) David Probert will return to his full-time role at University College London Hospitals from 1 April 2026. The Department will shortly advertise for a permanent Performance and Delivery Director General, who will also

serve as Deputy NHS Chief Executive. In the interim, Glen Burley and Meghana Pandit will act as Deputy Chief Executives in a part time capacity alongside their trust roles.

b) Mark Cubbon, National Programme Director for Planned Care, will continue in his role part-time, before returning to his Trust full time in the summer.

c) Sarah-Jane Marsh, will take on the role of Chief Operating Officer for NHS England, with a focus on the organisation's internal operations, retaining responsibility for urgent and emergency care, operations, emergency preparedness, resilience and response (EPRR) and improvement until the new Performance and Delivery function is in place, which we expect ahead of winter 2026.

d) Elizabeth O'Mahony has been appointed as Director General for Finance, having carried out the role on an interim basis.

e) Rob Checketts will continue as Director of Corporate Affairs and Communications.

f) Matthew Style will take on the role of interim Second Permanent Secretary at the DHSC with immediate effect. The role of System Development Director General will be advertised shortly, with Glen Burley maintaining oversight in the interim.

g) Matthew Coats, Chief Executive of West Herts Teaching NHS Trust, will be joining NHS England as CEO Advisor to the New Hospitals Programme for a six-month period from 1 April.

h) Recruitment for the National Medical Director role has been completed and the Department will announce the successful candidate shortly.

i) A new Director of Patient Experience post has also been established within the Chief Nursing Officer's directorate that will have a direct reporting line to the NHS Chief Executive.

Health and Wellbeing Board updates

46. Derby City Health and Welling Board met on 8 May 2026 and received updates from the Child Poverty Action Group and update reports on action to reduce poverty in Derby, the Better Care Fund, and the pharmaceutical needs assessment. Papers for the meeting can be found here: Health and Wellbeing Board - Derby City Council.

47. Derbyshire Health and Wellbeing Board met on 26 March 2026. The agenda focussed on the Neighbourhood Health Model and the role of the Board, and the Derby and Derbyshire Oral Health Strategy. Papers for the meeting can be

found here: Browse meetings - Health and Wellbeing Board - Derbyshire County Council.

48. The Lincolnshire, Nottingham City and Nottingham County Health and Wellbeing Boards have not met since the last update.

Appendix A

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Policy

May 2026 - May 2029

PLEASE NOTE THIS IS A PLANNING DOCUMENT AND NOT A RESPONSE DOCUMENT, PLEASE REFER TO THE ICBs' RESPONSE PLANS DURING AN INCIDENT

Policy purpose and key messages
The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety. The ICBs have a responsibility to ensure that it is properly prepared to respond to and recover from an emergency. This policy indicates a programme of work pertaining to EPRR during 2026/27 to ensure the resilience of the organisation, and how the ICBs will ensure that partner agencies from across the NHS and wider organisations will provide holistic multi agency planning to protect the health and wellbeing of the community.

CONTROL RECORD	
Title	Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Policy
Reference number	DLN-EPRR-01
Version	1.0
Status	Final
Author	ICBs' EPRR Teams
Sponsor	Maria Principe, Accountable Emergency Officer (AEO)
Team	ICBs' EPRR Teams (Derbyshire, Lincolnshire and Nottinghamshire)
Amendments	Not applicable.
Superseded documents	• Derby and Derbyshire ICB EPRR and Business Continuity Policy • Lincolnshire ICB EPRR Policy and Framework • Lincolnshire ICB Business Continuity Management Policy • Nottingham and Nottinghamshire ICB EPRR Policy • Nottingham and Nottinghamshire ICB Business Continuity Management System Policy
Audience	Business Continuity Leads and Business Continuity Approvers ICB approved policies apply to all employees, contractors, volunteers, and others working with the ICB in any capacity.
Consulted with	• Internally with all EPRR team staff • Externally, providers of funded care DLN and NHS England Midlands EPRR Team
Equality Impact Assessment	March 2026
Approving body	Audit Committee
Date approved	5 May 2026
Date of issue	June 2026
Review date	May 2029
Policy retention period	Life of organisation plus 6 years
This is a controlled document and whilst this policy may be printed, the electronic version available on the ICBs' document management system is the only true copy. As a controlled document, this document should not be saved onto local or network drives.	

Contents

1. Introduction

1.1 This policy is applicable to NHS Derby and Derbyshire Integrated Care Board, NHS Lincolnshire Integrated Care Board and NHS Nottingham and Nottinghamshire Integrated Care Board collectively referred to in this policy as 'the ICBs.'

1.2 The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety. These can include anything from severe weather to an infectious disease outbreak, pandemic, cyber-attack, or a major transport accident.

1.3 The ICBs not only have a responsibility to ensure that the integrated care systems are resilient and prepared to respond to such incidents, but also to ensure its own internal resilience is in place.

1.4 This policy indicates the programme of EPRR work for 2026/27 to ensure that the ICBs and health systems are resilient and compliant with associated legislation and guidance.

1.5 The ICBs have a responsibility to ensure that it is properly prepared to respond to, and recover from, an emergency as defined by legislation and relevant guidance; this policy ensures compliance against relevant standards, including:

a) The Civil Contingencies Act 2004 (CCA 2004), which defines that as an ICB we are a Category 1 responder "an integrated care board established under section 14Z25 of the National Health Service act 2006", and thus that six core duties are required to be fulfilled:

- Risk Assessment
- Emergency Planning
- Business Continuity Management
- Communicating with the public
- Co-operation
- Information sharing

b) The Health and Social Care Act 2012, Section 46-47, and as amended 2022, which defines that the ICB must be prepared to deal with relevant emergencies, including monitoring of service arrangements compliance in relation to EPRR. The amendment details new responsibilities placed on the ICB following national changes to NHS structures.

c) The EPRR Framework 2022, which contains overarching principles required for the embedding of EPRR across NHS organisations.

d) The NHS Core Standards for EPRR, which is an annual self-assessment assurance process undertaken to demonstrate robust EPRR arrangements are in place.

e) ISO22301:2019, which is the International Standard for Business Continuity that the ICB is committed to ensuring alignment to.

f) The Minimum National Occupational Standards, which are minimum standards that all in positions of responsibility are expected to be trained upon in relation to EPRR, covered in section 9 (ICB Training Plan).

2. Purpose and Aim

2.1 Aim

2.1.1 Define the processes by which the ICBs ensure compliance against EPRR legislation, and the steps taken to ensure resilience across the systems, as well as providing the framework for planning for incidents including Business Continuity events.

2.1.2 Strategic Intent for Business Continuity

2.1.3 Our strategic intent is to ensure the uninterrupted delivery of safe, high-quality care across the Integrated Care System by embedding a resilient, proactive, and continually improving approach to business continuity.

2.1.4 We will safeguard critical services, protect our population's wellbeing, and maintain organisational stability by anticipating disruption, strengthening system-wide preparedness, and enabling rapid, coordinated recovery.

2.1.5 Through collaboration, clear governance, and a culture of resilience, we will ensure that essential health and care functions remain reliable and responsive in the face of any challenge.

2.2 Objectives

2.2.1 Ensure a planning process is in place with the full engagement of relevant internal/external stakeholders and multi-agency partners.

2.2.2 Indicate the governance arrangements for EPRR and Business Continuity.

2.2.3 Identify roles and responsibilities of individuals involved within the EPRR and Business Continuity planning process.

2.2.4 Indicate relevant risks and associated mitigations pertinent to the ICBs.

2.2.5 Indicate processes for raising risks and issues related to ICBs process.

2.2.6 Indicate the training needs analysis pertaining to ICBs.

2.2.7 Indicate the testing and exercising needs analysis pertaining to ICBs.

2.2.8 Indicate assurance process(es) for ICBs and systems.

2.2.9 Indicate the audit plan for EPRR arrangements within the ICBs.

3. Scope

3.1 This policy covers all employees, including Board Members, those appointed by the ICBs, and anyone working within the ICBs on a temporary basis or under a contract for services (either individually or through a third-party supplier), collectively referred to as 'individuals'

3.2 Out of Scope

3.3 This document covers the arrangements and processes that will be followed to ensure effective response processes are implemented at the ICB. This does not constitute a response document in itself, this is covered by the relevant response arrangements.

3.4 Detailed processes for the effective business continuity management at the ICB is covered within the ICB Business Continuity Management System (BCMS).

3.5 Detailed process around on call management is covered within the on-call policy for the ICB.

4. Definitions

4.1 Definitions of key terms referenced in this policy are described in Appendix A.

5. Roles and Responsibilities

5.1 Key responsibilities for specific roles and staff groups are described in the table below:

Role	Responsibilities
Chief Executive (or deputy)	The Chief Executive (or deputy) has overall responsibility for EPRR inc. Business Continuity and ensuring: a) The ICBs have required plans and arrangements in place. b) The Board receives regular updates on EPRR. c) The board ensures sign off of casualty numbers under the casualty regulations. d) That appropriate resources are made available to facilitate these responsibilities. e) That Board-level responsibility for EPRR is clearly defined and that there are clear lines of accountability throughout the organisation leading back to the Board. f) The Chief Executive may designate these responsibilities to an ICB Accountable Emergency Officer (AEO).

Role	Responsibilities
Accountable Emergency Officer (AEO) (or Deputy)	The NHS Act 2006 places a duty on ICBs to appoint an individual to be responsible for discharging the duties under section 252A (9). This individual is known as the Accountable Emergency Officer (AEO). The Executive Director of Commissioning is assigned as the AEO for all 3 ICBs covered by this policy. The AEO will be a Board-Level Director responsible for EPRR. They will have executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements. They will provide assurance to the Board that strategies, systems, training, policies, and procedures are in place to ensure their organisation responds appropriately in the event of an incident. AEOs will be aware of their legal duties to ensure preparedness to respond to an incident within their health community to maintain the public's protection and maximize the NHS response. Specifically, the AEO will be responsible for ensuring that their organisation: a) Itself and any sub-contractors are compliant with the EPRR requirements as set out in the CCA 2004, the 2005 Regulations, the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract, including this Framework and the Core Standards, as well as Business Continuity aligned to ISO 22301:2019. b) Is properly prepared and resourced to deal with an incident. c) Has robust surge capacity plans that provide an integrated organisational response and has been tested with other providers and partner organisations in the local area served. d) Complies with any requirements of NHS England in respect of monitoring compliance. e) Provides NHS England with such information as it may require for the purpose of discharging its EPRR functions. f) Is appropriately represented by director-level engagement with and effective contribution to any governance meetings, sub-groups or working groups of the LHRP and/or Local Resilience Forums (LRF), Derbyshire Resilience Partnership (DRP), as appropriate.

Role	Responsibilities
	The AEO also acts as the co-chair for the Local Health Resilience Partnership (LHRP). In the event of the absence of the AEO through sickness, annual leave or competing priorities the Deputy AEO is assigned to Director of Commissioning Nottinghamshire, they will provide the AEO role for the ICBs for any period of absence. The Deputy AEO will also have full designated approval powers for the purposes of deputising for the AEO at LHRP, Local Resilience Forum (LRF) and any other EPRR meetings that the AEO is unable to attend. This includes the power to approve and/or commit resources on behalf of the ICB.
Director of Commissioning Nottinghamshire	The Director of Commissioning Nottinghamshire holds the director level responsibility as designated by the AEO in relation to the effective delivery of EPRR within the DLN cluster, they line manage the EPRR Team and provide have the ability to deputise for the AEO at some meetings.
Non-Executive Director (NED)	The Non-Executive Director will be designated by the Board to have oversight via Audit Committee of all ICB EPRR arrangements and will represent EPRR from a non-executive director perspective assisting, where possible, to ensure that the ICBs are resilient.
EPRR Steering Group	Formal group established to provide steerage for the EPRR programme at the DLN Cluster of ICBs. A TOR is in place for this meeting detailing full roles and responsibilities.
EPRR Team	Responsible for: a) Ensuring the ICBs have appropriate response and recovery plans in place that are regularly reviewed, tested, and circulated to partners. b) Providing internal liaison and subject matter expertise in matters pertaining to EPRR and Business Continuity. c) Ensuring horizon scanning is conducted and relevant risks are placed onto relevant risk registers and processes are put in place where possible to mitigate against their effects. d) Ensuring system planning for EPRR is facilitated i.e., evacuation and shelter planning. e) Ensuring a robust training and exercising process is in place ensuring relevant roles are trained to fulfil roles when responding to emergencies.

Role	Responsibilities
	f) Facilitating any assurance processes pertaining to EPRR both for the ICBs and for the ICS' covered by this policy g) Providing recommendations and subject matter expertise to ICBs projects ensuring EPRR is considered within processes. h) Production of briefing document and papers for the relevant meetings i.e. EPRR Steering Group and Audit Committee i) Business Continuity Plans / processes to be checked for Provider organisations as part of the annual EPRR Core Standards assessment. j) Manage the ICB Learning Log
Directors/Heads of Service	Directors and Heads of Service are responsible for ensuring: a) That their departments/divisions have appropriate regularly updated EPRR arrangements (including local Business Continuity Plans and Business Impact Analysis) in place and that these complement the overall ICBs response to emergencies. b) To ensure full engagement/compliance with planning for EPRR processes and training and exercising to ensure preparedness across the ICBs. c) That any new services procured, planned works or critical assets are identified to the EPRR team, to ensure collation and risk assessment as part of the ICBs planning processes via the 3rd party business continuity process. d) That internal disaster/emergency alerts are maintained and tested regularly (six monthly) to communicate actions in the event of an incident. e) To ensure appropriate attendance and engagement with ICBs EPRR preparedness processes. f) That, in the event of local incidents, the departmental debriefs are conducted promptly utilising the ICBs `hot debrief` process and then sent onwards to EPRR to ensure collation in the ICBs Post Incident Debrief (PID) report.
Business Continuity Authoriser	Executive or Director lead for the service, responsible for oversight and sign off Business Continuity processes for the team, must retain oversight of the associated risks from business continuity processes and ensure mitigations are implemented and local capture of risks where required in local risk registers.

Role	Responsibilities
Business Continuity Lead	• Responsible for ensuring service level business continuity is delivered and embedded within own team. • Senior person within the team ensuring holistic oversight of the business continuity process responsible for leading on the writing and updates to service level business continuity planning. • Ensure identification and escalation to EPRR of any new services and/or risks associated with Business Continuity. • Ensure team members and new starters are aware of the requirements for business continuity and the steps to take in the event of an incident occurring and ensuring that the creation of new Business Continuity processes do not create any equality issues
All Staff	Familiarisation with all relevant EPRR arrangements and plans. Exercise, where possible, `self-resilience` to ensure minimal impacts on the ICBs operation during incident response. They regularly update their service contact lists to ensure they can be contacted in an emergency. Ensure their completion and compliance against all appropriate training. Engage within the ICBs exercising process.
Facilities Management (as per each ICB office location)	All contractors on site have in place robust EPRR and Business Continuity arrangements and that the ICB are informed of this. That these arrangements are created in conjunction with, and complement, the ICBs response to emergencies. That, where required, provide relevant subject matter expertise to the ICBs in relation to planning for, responding, and recovering from emergencies. Engagement and attendance within the ICB EPRR training and exercising processes. That the EPRR Team is informed of any planned works to ensure that EPRR and Business Continuity arrangements are considered
Digital Solutions Provider	That they have in place robust EPRR and Business Continuity arrangements and that the ICB is assured that these are in place. Engagement specifically in relation to the creation and maintenance of a Cyber Resilience Plan for the ICBs

Role	Responsibilities
	These arrangements are created in conjunction with and compliment the ICBs response to emergencies. That, where required, provide relevant subject matter expertise to the ICBs in relation to planning for, responding to, and recovering from emergencies. Engagement and attendance within the ICBs EPRR training and exercising processes.
Other 3rd party contractors	They have robust Business Continuity and EPRR response and recovery elements in place and that the ICBs are assured these are in place as part of the contracting process, managed via the contract oversight group. They engage fully with, as required, all EPRR processes as part of the ICBs EPRR arrangements. Where required, subject matter expertise is provided to the ICBs for the purposes of response and recovery. Ensure provision of assurance by circulation to the ICBs of individual Business Continuity Plan. Ensure business continuity is considered in relation to services/works provided to the ICBs and include question within BIA collection process.
On Call Staff (Strategic and Tactical)	These roles have been pre-identified as having key responsibilities in disaster/emergency response and are responsible for the Strategic and Tactical management of the system during a declared or standby incident: Strategic on call: will act as the ICBs Strategic Commander for the ICBs in incidents providing strategic direction and oversight for the Tactical Command Team. Tactical on call: will act as the ICBs Incident Manager for the relevant ICB in incidents providing tactical direction and coordination of front-line services to minimise disruption whilst providing patient care in incidents, and/or coordination of the ICBs, in the event of `internal` incidents. All the roles identified above are contactable 24/7 for the period of their on call for incidents affecting the ICBs, either internal or external
Integrated Care Board (ICB)	The ICBs have a variety of duties under the Civil Contingencies Act 2004 and the Health and Social Care Act 2022. This is supported by key definitions in the EPRR Framework 2022 including: a) Accountable Emergency Officer (AEO) to co-chair the LHRP

Role	Responsibilities
	b) Maintain involvement and support of LHRP partners at strategic and tactical level. c) Ensure appropriate director level representation at the LRF. d) Establish a mechanism to provide NHS strategic and tactical leadership and support structures to effectively manage and coordinate the NHS response to, and recovery from, incidents and emergencies 24/7. This will include representing the NHS at Strategic Coordinating Groups and Tactical Coordinating Groups. e) Support NHS England in discharging their EPRR functions and duties locally, including supporting ICS tactical coordination during incidents (EPRR level 2–4 incidents) f) Ensure robust escalation procedures are in place to respond to disruption to delivery of patient services. g) Provide a route of escalation for resilience planning issues to the LHRP in respect of commissioned provider EPRR preparedness. h) Develop and maintain incident response arrangements in collaboration with all NHS-funded organisations and partner organisations. i) Ensure that there is an effective process for the identification, recording, implementation and sharing of lessons identified through response to incidents and emergencies and participation in exercises and debrief events. j) Provide annual assurance against the NHS EPRR Core Standards, including by monitoring each commissioned provider's compliance with their contractual obligations in respect of EPRR and with applicable Core Standards. k) Ensure contracts with all commissioned providers (including independent and third sector) contain relevant EPRR elements, including business continuity.

3.6 Where the ICB or LRF covers more than one geographical location then agreement will be made locally in respect of assurance and commissioning management. For the DLN Cluster this includes

Organisation	Implications
University Hospitals Derby and Burton (UHDB)	UHDB will ensure attendance at relevant personnel levels to both Staffordshire and DLN LHRP(s). UHDB will ensure representation at suitable levels to both Staffordshire and Derbyshire LRF (DRP for Derbyshire). The DLN Cluster ICBs will lead on assurance in relation to EPRR Core Standards and other assurance processes as issued by the regulator. Incidents will be reported via the DLN Cluster ICBs who will lead on the response coordination for both the Royal Derby and Queens Hospital Burton sites. UHDB will ensure that information i.e. SBARs are shared with Staffordshire ICB System Coordination Centre (SCC) for coordination purposes.
DHU Healthcare	DHU Healthcare will ensure attendance at relevant personnel levels to all LHRPs covered by their geographical footprint. DLN Cluster ICBs will lead on assurance in relation to EPRR Core Standards and other assurance processes as issued by the regulator.
EMAS	EMAS will ensure attendance at relevant personnel levels to all LHRPs covered by their geographical footprint. DLN Cluster ICBs will lead on assurance in relation to EPRR Core Standards and other assurance processes as issued by the regulator. EMAS will ensure notification during incident response to the lead ICB for which the incident geographically occurs. EMAS will ensure at an appropriate time that DLN Cluster ICB Ambulance Commissioning Team are notified of any incidents that have been responded to as defined by the EPRR Framework 2022.

6. EPRR Process and Governance

6.1 Underpinning principles for NHS EPRR

6.2 The Cluster ICBs are committed to ensuring that the EPRR processes that it defines and embeds are aligned to best practice, as well as ensuring a holistic approach to the emergency preparedness processes throughout the cycle of preparedness. This shall be done by ensuring that the below aspects are considered within the EPRR cycle:

Principle	ICB Delivery process
Preparedness and anticipation	Ensuring that a complete, holistic, risk assessment process is conducted both locally (ICB) level and system wide (LHRP and Community Risk Register(s). The ICBs will also ensure a horizon scanning programme is conducted and any identified local, regional, or national risks will be considered within the ICB EPRR work programme.
Continuity	Ensuring that the response to incidents is grounded within the organisational functions; this will be considered within the plans formulated by the ICBs in relation to our role as system coordinator for EPRR incident response. The ICBs will also ensure system programmes of work are completed to develop joined up plans between partner organisations.
Subsidiarity	The ICBs will ensure that decision making with organisations stays within those organisations. The ICBs will act as a facilitator for system and joined up response to incidents. The ICBs internally will also ensure that staff are trained and equipped to respond to ensure decision making and response occurs at the correct level to ensure a consolidated response.
Communication	Ensuring effective communication is key during incident response. The ICBs will ensure that it has robust mechanisms for managing communications related to: • Public Communications • Communications with Partners • Incident Reporting processes (both to NHSE, regulators and providers within the cluster footprint as well as wider ICBs organisations and systems)
Cooperation and integration	The ICB will ensure that it cooperates in a variety of mechanisms to ensure joined up consolidated planning as well as transfer of knowledge and best practice learning both from the cluster footprint and wider afield, this will include: • Midlands Health Resilience Partnership Board (MHRPB)

	• Local Health Resilience Partnership (LHRP) • Health Emergency Planning Officers Group (HEPOG) • Emergency Preparedness ICB Leads Midlands (EPICBLM) • Local Resilience Forum (Lincolnshire and Nottinghamshire) • Derbyshire Resilience Partnership (DRP) • And other established and associated groups within the field of EPRR The ICB will also ensure appropriate mutual aid arrangements are in place both within the cluster footprint and with supporting bordering organisations/systems i.e. ICBs, NHSE, LRF/DRP Partners.
Direction	The ICBs will ensure that the aims and objectives of its EPRR Programme are delivered in line with Integrated Emergency Management The ICBs will also ensure work programmes established within the cluster have clear aims and objectives that are set and delivered with assurance via appropriate reporting mechanisms.

6.3 Integrated Emergency Management (IEM)

6.4 The ICBs follow Integrated Emergency management (IEM) to ensure that all aspects are considered within ICB Cluster EPRR arrangements:

Section	Detail
Anticipate	Horizon scanning processes are to be established within the ICBs ensuring link up with key departments i.e., System Coordination Centre (SCC) to ensure that potential hazards and risks are identified and assessed.

Assess	ICBs will utilise suitable risk assessment tools to assess the likelihood and impact that a potential or actual risk may have not only on the organisation but also on the DLN Cluster.
Prevent	The ICBs will ensure where possible that mitigations are put in place for identified risks and where possible to present the likelihood of that risk occurring, this will also extend to system preparedness processes.
Prepare	The ICBs will ensure internal planning processes are conducted for identified unmitigable risks, this will again extend to system preparedness, ensuring that the organisation and the cluster can respond effectively to identified risks.
Respond	The ICBs will ensure effective response mechanisms are in place for incidents that may occur within the system or those that affect the cluster. This will include effective command and control principles as well as key considerations during the breadth of identified incident types that may affect the ICBs/Cluster.
Recover	To ensure that all plans and processes consider recovery within their response aims and objectives. These processes will aim to return the organisation and/or cluster to a state of `normality` and to recover that which is affected by any declared incidents within the cluster or affecting it.

6.5 This cycle will be deployed in multiple ways but, as a minimum, the ICBs will consider this process annually via its annual refresh of emergency plans and arrangements. This will ensure the embedding of any changes to processes due to new guidance as well as any changes being identified as part of continual improvement processes covered later in this document.

6.6 Utilising this process, the EPRR Team will ensure that an EPRR Work Plan is developed detailing the delivery aspects required in relation to EPRR, this will extend into system working via an LHRP Work Plan that will be developed jointly by the Accountable Emergency Officers (AEO) and EPRR Leads for the organisations that comprise the cluster/system.

6.7 EPRR Work Planning

6.8 The EPRR Work Plan for the ICBs will be constructed by the EPRR Team upon the identification of key risks to the ICBs, the work plan will also consider the requirements set by the NHS Core Standards process.

6.9 The EPRR work plan will be reported on via the established Governance structure (EPRR Steering Group to Audit Committee). The EPRR Team will ensure that to each of these stages of reporting an update on progress of all actions is delivered along with any delayed actions and rationale for delay in delivery, along with any articulation of key risks to the operational delivery of the work plan.

6.10 The EPRR Work Plan will be updated as a minimum quarterly via the EPRR steering group and subsequently Audit Committee.

6.11 Each action/objective will have a clear delivery aim, scope, action owner and anticipated delivery date. These will be checked by the EPRR Team before to ensure they align with the established principles of EPRR (IEM)

6.12 The ICBs work plan will ensure that it considers any open actions/objectives linked to the ICBs contained within the LHRP work plan or wider i.e., MHRPB work plan.

6.13 Reporting for these will be via the relevant reporting body i.e., LHRP, MHRPB, the EPRR Team will ensure in line with ICB reporting that these are reported articulating progress made, risks to delivery etc. as detailed above under the ICBs EPRR Work Plan.

6.14 ICB EPRR Governance

6.15 DLN Cluster ICBs are committed to ensuring effective governance arrangements are in place for the delivery of its EPRR programme; these bodies will take direct oversight and management of actions pertaining to EPRR within the ICBs.

6.16 The EPRR Team will ensure as a minimum a quarterly EPRR Steering Group meeting that will oversee the EPRR work programme ensuring effective delivery, this will subsequently ensure a formal report to the ICB Audit Committee on the progress and any challenges to the EPRR work programme, as well as providing an approval route for BIAs and BCPs where required.

6.17 The Committee receives update reports at each meeting on developments in respect of emergency planning and business continuity including, but not limited to, incidents, training and exercising, policy development and progress made towards meeting the NHS Core Standards for EPRR.

6.18 The EPRR team conduct a monthly ICB Incident and Exercise Learning Review to evaluate all identified lessons from incidents and exercises. The group monitors the implementation of actions, ensuring continuous improvement in the ICBs EPRR arrangements.

6.19 Lessons remain open until fully implemented, at which point they are marked as ‘Pending’ and reviewed again after six months before their formal closure. Progress updates and assurance reports from this group will be in the highlight report to the Audit Committee, ensuring that learning is embedded across the ICBs.

6.20 The Committee ensures rigorous scrutiny and oversight and reports directly to the ICB Board (inc. Public Board), which is an open public meeting. A summary assurance report detailing the work it undertakes is provided to the ICB Board for assurance as part of the Audit Committee report.

6.21 As a minimum an annual report will be generated by the EPRR Team that will be presented to the various committees as detailed above before direct presentation to the ICB Board.

6.22 As a minimum a statement will also be included in the ICBs annual reports/accounts indicating the compliance of the ICBs against the EPRR core standards and overall statement and commitment to EPRR within the ICBs.

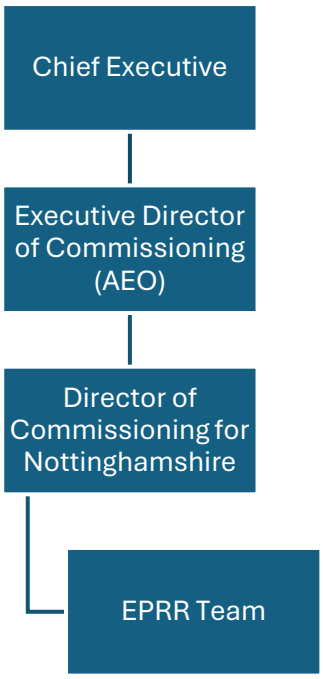
6.23 Workstreams external to the ICBs may also need to be factored into the ICBs EPRR workplan, these will be fed in via attendance at the variety of meetings attended (covered in relevant section). The EPRR Team will then ensure that relevant actions are captured onto the ICBs work plan and progressed and updated via the relevant assurance group internal to the ICBs

6.24 The EPRR Team/AEO will also ensure that the relevant workstream i.e., Midlands Health Resilience Partnership (MHRPB) etc. are also updated on progress of actions at the relevant meetings.

6.25 ICB EPRR Resourcing

6.26 The ICBs are committed to the effective resourcing of its EPRR function to ensure not only completion of internal planning but also in relation to cluster and system oversight, planning and assurance processes.

6.27 In consideration of the cluster and its unique risk profiles the team has been defined as below:



6.28 The Cluster Executive team and Cluster Board are assured and committed to ensuring suitable and effective resourcing of the EPRR Team to deliver the statutory and regulatory responsibilities of the ICB in relation to EPRR functions.

6.29 The EPRR Team has a budget assigned that sits within the Commissioning budget, this is assessed as suitable for the team's needs and requirements in line with the work programme that the team delivers. Larger projects are identified, and costs allocated to the relevant department, and/or business cases provided via the identified ICB channels to ensure appropriate funding to the EPRR services provided by the ICBs.

6.30 This resourcing also considers the need to provide duties such as the ICB on call functions for which appropriate people will be trained to deliver the function to ensure appropriate resourcing is provided.

6.31 The Director of Commissioning for Nottinghamshire oversees this budget (planned EPRR expenditure) and ensures it is effectively managed and where uplifts may be required are escalated to the ICBs Executive for decision on whether this can be done.

6.32 Costs are captured and reflected by finance and meet the requirements to ensure EPRR is appropriately funded by the ICBs.

7. Anticipate and Assess

7.1 Anticipate

7.2 The EPRR Team will ensure that it is engaged within relevant warning and informing and horizon scanning groups (please note some of these groups are also planning groups) these are fully defined and how they are engaged with in the LRF Cooperation Agreement.

7.3 If a risk is identified, it will be assessed by the EPRR Team using the mechanisms that form the ICBs risk assessment process detailed in the risk assessment section.

7.4 Assess

7.5 As a risk is identified it is key that the ICBs ensure it relates whether the risk is to the system of Derbyshire, Lincolnshire or Nottinghamshire or the ICBs as organisations, those that directly link to the organisation that pose a significant risk will be managed via the DLN Risk Management Policy (Available on the ICBs Intranet), this will enable risks to be raised onto the corporate risk register for management through the relevant reporting bodies. This also includes the need to continually assess risks to the organisation including the risk of climate change.

7.6 System Risks will also be managed via the LHRP Risk Register.

7.7 The EPRR Team will ensure that these risks are managed and reflected within the EPRR Work Plan, these will be updated no less than monthly and reported via the corporate risk reporting process as well as via the established EPRR governance reporting lines.

7.8 The ICB ensures that the National Risk Assessment for Emergencies and the Community Risk Registers (CRR) are factored into the local ICBs risk assessment process, this will ensure a holistic oversight of those risks identified as having a potential impact on the health and wellbeing of the population of the DLN Cluster footprint.

7.9 In additionality the below will be followed in relation to risk management and escalation:

	Very Low (1–3)	Low (4-6)	Medium (8–12)	High (15–20)	Extreme (25)
Level of risk	An acceptable level of risk that can be managed at directorate / team / project level (recorded in Risk Logs)	An acceptable level of risk that can be managed at directorate / team / project level (recorded in Risk Logs).	A generally acceptable level of risk. Corrective action needs to be taken	An unacceptable level of risk which requires senior management attention and immediate corrective action	An unacceptable level of risk which requires urgent Executive and senior management attention and immediate corrective action
Add to ICBs	No	No	Yes, with quarterly progress updates (as a minimum)	Yes, with bi- monthly progress updates (as a minimum)	Yes, with monthly progress updates (as a minimum)
Oversight and scrutiny	Risk Logs to be reviewed in relevant Team/Directorates Meetings	Risk Logs to be reviewed in relevant Team/Directorates Meetings	ICB Operational Risk Registers (full or relevant extracts) to be reviewed by the relevant committee(s) at each meeting.	ICB Operational Risk Registers (full or relevant extracts) to be reviewed by the relevant committee(s) at each meeting. Detail of the high risks to be included in main body of risk report.	ICB Operational Risk Registers (full or relevant extracts) to be reviewed by the relevant committee(s) at each meeting. Detail of the extreme risks to be included in main body of risk report.

7.10 The above is taken from the DLN Risk Management Policy and should be referred to when considering ICBs EPRR Risk Management.

7.11 Risks within the ICBs are identified and managed via the DLN ICB risk management policy, this is then subsequently fed into the ICB Operational Risk Registers when required.

7.12 The EPRR Team ensure alignment to the ICBs' joint risk management policy, this includes the articulation of risk appetite for the ICBs, this is transferable into the DLN ICB Risk Management process

Joint Risk Appetite Statement
The Boards of NHS Derby and Derbyshire, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire Integrated Care Boards (ICBs) recognise that achieving long-term sustainability and improving health outcomes for their populations requires a balanced and considered approach to risk-taking. The ICBs are committed to adopting a mature approach to risk, where potential long-

term benefits justify short-term risks, provided that appropriate and robust controls are in place.

The ICBs seek to minimise risks that could negatively affect patient safety, health outcomes, legal and statutory obligations, or the organisations' ability to demonstrate high standards of probity and accountability. While calculated risks may be accepted to achieve strategic objectives, particularly where innovation or improvement may be realised, such risks will only be taken when the level of control is sufficient to manage potential impacts effectively.

Reputational risks are approached with caution, favouring delivery options that are more predictable and likely to achieve successful outcomes while safeguarding the ICBs' reputation for providing high-quality, cost-effective services.

The ICBs' risk appetite is not static and will be reviewed regularly to ensure it remains appropriate to the changing environment and aligned with the strategic objectives of the organisations. This approach ensures a consistent, transparent, and accountable framework for decision-making across all areas of risk.

- *Good Governance Institute Risk Appetite for NHS Organisations – definition of 'mature' is confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.*
- *Good Governance Institute Risk Appetite for NHS Organisations – definition of 'minimal' is preference for ultra-safe delivery options that have a low degree of inherent risk.*

7.13 The ICBs ensure this is reflected within the ICB Operational Risk Registers that is accessible via request. Risks are reported to each meeting of the Audit Committee, this ensures that mitigations are current and managed appropriately.

7.14 Risks will be closed by agreement that actions have been completed at the EPRR Steering Group, with further seeking of approval from the Accountable Emergency Officer (AEO) these will then be placed on a 6-month review cycle to ensure lessons are suitably embedded.

7.15 The EPRR Team will ensure that risks that are identified are suitably escalated via reporting routes and then captured onto the corporate risk register and where required the LHRP and Midlands Health Resilience Preparedness Board (MHRPB).

7.16 The LHRP risk register is managed by the LHRP and administered by the ICB. Annually this risk register will be reviewed (Approx. November each year) considering the output from regional discussions and the MHRPB risk register as well as internal risk registers for each organisation and the Community Risk Registers for which the ICB represents health at the Risk Assessment Working Group (RAWG). These will be factored into a holistic risk assessment, ensuring an all-hazards approach to EPRR risks.

7.17 A localised risk assessment of the impacts of civil contingencies risk is managed by the EPRR Steering Group, demonstrating the ICBs capability and capacity against the range of risks identified in the National Security Risk Assessment (NSRA).

8. Prevent and Prepare

8.1 Prevent

8.2 The ICBs will be committed, where possible, to ensuring that risks identified are mitigated to their lowest level.

8.3 Where possible the ICB EPRR Team, in conjunction with other relevant departments will remove risk causes to reduce the impact of risks occurring, this will be done via:

8.3.1 Physical intervention (where required) i.e. Business Case, Contract variations

8.3.2 Plans, Policies and Procedures aligned to the identified risk profile for the ICB/ICS

8.3.3 Training Plan

8.3.4 Exercising Plan

8.4 Prepare

8.5 The ICBs will ensure it is fully prepared for incident response via a robust planning, training, and exercising programme. This will be supported by a system preparedness programme of work managed and maintained by the LHRP and HEPOG.

8.6 Emergency Plans

8.7 The ICBs ensure it has plans relevant to risks identified in the ICB risk assessment and/or those identified through assurance processes i.e., Core Standards. The ICBs will maintain plans which are required as identified by the annual and ongoing risk assessment process these include:

Plan/Policy	Review Schedule	Responsible Department
DLN Cluster EPRR and BC Policy	Every 3 years	EPRR Team
DLN Cluster Business Continuity Management System (BCMS)	Every 2 years	EPRR Team
DLN Cluster Incident Response Plan (IRP)	Annually	EPRR Team
DLN Cluster Business Impact Assessments (BIA)	Annually	EPRR Team
DLN Cluster Corporate BC Plan	Annually	EPRR Team

DLN Cluster Cyber Response Plan (ICB)	Annually	EPRR Team/Digital Team
DLN Cluster Emergency Communications Plan	Annually	ICB Communications Team

8.8 *These plans are reviewed in line with these timescales but are also change led as required (i.e. national guidance changes, learning from incidents)

8.9 Change led: Plans to be updated if changes are required because of audit's (internal and external), updates to partner agency plans and updates to associated legislation and/or guidance, also to include any internal changes to ICB structures and governance.

8.10 Post Exercise: Plans will be updated where lessons have been identified post exercise.

8.11 Post Incident: Plans will be updated where lessons have been identified post incident.

8.12 All changes will be discussed via the HEPOG and LHRP where required to ensure formal acknowledgement of changes to ICB plans.

8.13 These plans will be supported and complemented by relevant EPRR guidance, local plans, and Standard Operating Procedures

8.14 These documents will also be supported by other standing ICB arrangements and processes, and alongside operational arrangements detailed in the plans of providers of funded care.

8.15 Plans/Policies are stored as hard copies within the Incident Control Centres at each ICB Building these are updated as required by the EPRR Team, with an overview compliance tracker kept by the EPRR Team.

8.16 Business Continuity and Supplier Planning

8.17 The ICBs ensures it has in place a Business Continuity Management System (BCMS) which covers the arrangements for assurance of key suppliers and contractors (including audit) who provide services either directly or indirectly to the DLN Cluster ICBs.

8.18 These are identified during the contracting, commissioning, or business impact analysis processes. They are then assessed by the EPRR team to ensure suitable and effective arrangements are in place and then ensuring that internal ICBs plans are also updated and assessed to reflect these arrangements.

8.19 Consultation of Plans and Arrangements

8.20 The ICBs ensures that all its plans are consulted on with key partners to ensure shared learning and establishment of joint aims and objectives for EPRR arrangements.

8.21 Plans are shared as a minimum with:

8.21.1 On Call Team (Strategic and Tactical Commanders)

8.21.2 System Coordination Centre and Commanders (Operational Commanders)

8.22 System Partners:

8.22.1 Relevant Acute Hospital Trust

8.22.2 Relevant Community Hospital Trusts

8.22.3 Relevant Menal Health Provider Trusts

8.22.4 EMAS

8.22.5 DHU Healthcare

8.22.6 NHS England Midlands

8.22.7 UK Health Security Agency

8.22.8 The 3 Local Resilience Forums (LRF)

8.23 Other agencies may be added in dependant on the subject matter expertise.

8.24 All organisations will be consulted and given a specific timeframe in which to respond. To ensure full engagement plans / documents will also be placed on the agenda for ICB Board, Audit Committee, HEPOG, and LHRP where required and relevant.

8.25 Each set of comments will be considered as part of the wider planning and will be accepted or rejected, rejections will be discussed with the person raising the amendment to ensure understanding, consultation processes will be captured by the ICB Audit tool for amendments and consultation of plans (available via the EPRR Team).

8.26 Final Plans will then be shared as per arrangements in this document.

8.27 Availability of Plans

8.28 Plans will be made available to ensure full engagement by members of ICBs and/or contractors, as they are updated communication will be sent to identified service leads. As a minimum copy will be made available to:

8.28.1 Relevant responders/staff via email.

8.28.2 Located within the Incident Control Centres

8.28.3 Located on the ICB Microsoft Teams Channels

8.28.4 Locally (Lincolnshire L:// drive, Derbyshire T:// drive, Nottinghamshire G:// drive)

8.28.5 Located on Resilience Direct (Business Continuity location)

8.29 There is then an expectation that these updates will be cascaded down through all layers of staffing to ensure resilience.

8.30 These documents will also be shared with key external partners as required.

8.31 ICB and ICS Assurance

8.32 As the lead for commissioning within Lincolnshire, Nottinghamshire and Derbyshire and in line with the delegated responsibility from NHS England, DLN Clustered ICBs lead on the gathering, confirm, and challenge and submission of system's levels of assurance for the NHS EPRR Core Standards.

8.33 The Cluster ICB will receive a submission from providers monthly in relation to EPRR activity and progress against the previous year's EPRR Core Standards, this will be done via an MS Forms format.

8.34 The ICBs will ensure that confirm and challenge sessions are run as part of the annual process with each provider. This will encompass a check of the evidence and challenge of any areas of concern or requiring further clarity.

8.35 Any providers that are identified as non-compliant will be directly supported by the ICBs ensuring a robust work plan and individual support sessions are calendared to ensure effective management of the standards.

8.36 The ICBs are also responsible for its contracted and commissioned services, as a minimum the ICB EPRR team will work to support the delivery of assurance processes across these fields for example Primary Care services will be supported in relation to ensuring effective Business Continuity arrangements are in place.

9. Respond and Recover

9.1 Respond

9.2 Incident funding

9.3 In the event of the ICBs being required to respond to an incident, or an event, it is required that financial considerations/charging will not impact on the speed or scale of the response required.

9.4 All incident responses must ensure that the core priority of incident response is always considered as articulated in the incident response strategic aim.

9.5 The ICBs finance team will dedicate a cost code for usage in an incident response allowing the identification, allocation and tracking of expenditure linked to the EPRR Response, this will be created at the time of the incident activation in line with established ICB finance policies and procedures.

9.6 Each organisation has a requirement to commit to meeting the financial requirements of a response. However, the ICBs recognise that where an

incident escalates there may be releases of national or regional funding by the Department of Health and Social Care (DHSC), the ICB is prepared in this eventuality to receive and then allocate funding to its commissioned providers to support in an emergency response.

9.7 The ICBs will ensure all costs from incident response are captured (via the finance team) these will be factored into response and recovery considerations to ensure that incident response costs are reimbursed or recouped where required in a sufficient and timely manner, and in line with the incident response.

9.8 Mutual Aid

9.9 The ICBs can call on mutual aid as required, this will be coordinated with input from the Regional EPRR Team (L3-4 Incidents, please refer to ICB Incident Response Plan for details). The ICBs are also signed up to an ICB wide mutual aid agreement allowing the sharing of resources for EPRR response should the eventuality be required.

9.10 The process for commencement of a mutual aid request will be via the 1st On Call liaising with the 2nd on call for authorisation, contact will then be made with the Regional NHSE team requesting mutual aid, the mutual aid request form is located in the DLN Cluster Incident Response Plan, this must include the detail of:

9.10.1 What is required?

9.10.2 Why is it required?

9.10.3 When is it required?

9.10.4 Funding identification (If necessary)

9.11 NHSE will then support in the activation of the mutual aid response with the relevant ICB areas, a template will be within the rear of the IRP for staff to utilise.

9.12 Formal authority for mutual aid within the ICBs will sit with the Strategic Commander on call as the executive level responsible for incident response.

9.13 Information Sharing

9.14 When an emergency occurs a variety of agencies will respond, and others will support that response remotely. The emergency will place those affected at risk. People who are more vulnerable may be at a higher risk. It is in the interest of those affected people for personal data to be shared amongst emergency responders. Sharing personal data will assist in response and in the identification of those most likely to be adversely affected or vulnerable linked to an emergency response.

9.15 The Data to be shared will be dependent upon the nature of the emergency but will generally be limited in scope and volume. Due to the urgent nature of needing to share Data obtaining consent will usually be impractical but the agency holding the primary data will already have satisfied the consent requirements when they gathered the data before the emergency.

9.16 The ICBs have a responsibility to share relevant information with other responder agencies, this must be necessary and required for the response, all data requests should consider Information Governance (IG) processes and how that information is to be shared, and no data will be shared without following the information governance process for the ICBs.

9.17 The ICBs as a commissioner of the services provided across DLN Cluster have a responsibility to ensure that any information provided to them be that through planning or response is held securely and safely in line with standing IG arrangements.

9.18 The ICBs have access to Resilience Direct collaborate page that allows the data storage of key documents and processes in a secure, externally hosted system.

9.19 The ICBs also has access to NHS futures whereby EPRR information is stored, and incidents can be coordinated.

9.20 The ICBs and ICS within DLN are part of, and a signatory to, the

9.20.1 Derby and Derbyshire DRP Information Sharing agreement

9.20.2 Nottingham and Nottinghamshire LRF Information Sharing Agreement(Notts)

9.20.3 Lincolnshire LRF Information Sharing Agreement

9.21 In an emergency you should share information if necessary and proportionate. Not every urgent situation is an emergency, examples include:

9.21.1 Preventing serious physical harm to a person.

9.21.2 Preventing loss of human life.

9.21.3 Protection of public health.

9.21.4 Safeguarding vulnerable adults or children.

9.21.5 Responding to an emergency.

9.21.6 An immediate need to protect national security.

9.22 Further guidance can be obtained from the Cabinet Office Data Sharing Guidance 2019 and is available on the Civil Contingencies Secretariat page of: https://www.resilience.gov.uk/

10. ICBs Training Plan

10.1 To ensure EPRR is embedded across the ICBs, we are required to engage in training to ensure key roles and those identified by guidance and legislation are appropriately prepared to plan for and respond to an incident within the ICBs, these roles, numbers (these are indicative and do change through the year due to leavers and starters) and the types of training required are identified within the EPRR Training Needs Analysis below:

Role	Average Numbers requiring Training	Principles of Health Command (NHSE)	ICB On Call and EPRR Training	Loggist
CEO	1	Yes	Yes	No
AEO	1	Yes	Yes	No
Strategic Commander	40	Yes	Yes	No
Tactical Commander	75	Yes	Yes	No
Loggist	14	No	No	Yes

10.2 In addition, Cyber Resilience Responsibilities are identified under the Information Governance Training Needs Analysis available via request to the ICB Information Governance team.

10.3 National Occupational Standards (NOS):

10.4 National Occupational Standards for EPRR have been identified as a key requirement to ensure effective response. The table below identifies what is expected and against which role:

10.5 Key

M = Mandatory O = Optional

Skills for Justice NOS	Chief Executive Officer	Accountable Emergency Officer	Strategic Commander on call	Tactical Commander on call	SCC Led (Operational Commander)	EPRR
SFJ CCA A1 Work in cooperation with other organisations	O	O	M	M	M	M
SFJ CCA A2 Share information with other organisations	O	O	M	M	M	M
SFJ CCA A3 Manage information to support civil protection decision making			M	M	M	M
SFJ CCA B1 Anticipate and assess the risk of emergencies		O	M	M	M	M
SFJ CCA C1 Develop, maintain, and evaluate emergency plans and arrangements			O	O		M
SFJ CCA D1 Develop, maintain, and evaluate business continuity plans and arrangements		O	O	O	O	M
SFJ CCA D2 Promote business continuity management		M				M
SFJ CCA E1 Create exercises to practice or validate emergency or business continuity arrangements						M
SFJ CCA E2						M

Direct and facilitate exercises to practice or validate emergency or business continuity arrangements						
SFJ CCA E3 Conduct debriefing after an emergency, exercise or other activity	O	M	M	M	M	
SFJ CCA F1 Raise awareness of the risk, potential impact, and arrangements in place for emergencies		O	O		M	
SFJ CCA F2 Warn, inform, and advise the community in the event of emergencies	O		M	O	O	M
SFJ CCA G1 Respond to emergencies at the strategic level	O	O	M			M
SFJ CCA G2 Respond to emergencies at the tactical level				M		M
SFJ CCA G3 Respond to emergencies at the operational level					M	M
SFJ CCA G4 Address the needs of individuals during the initial response to emergencies			O	M	O	M
SFJ CCA H1 Provide on-going support to meet the needs of individuals affected by emergencies			M	M	O	M
SFJ CCA H2 Manage community recovery from emergencies	M	O	M	O	O	M

10.6 Responsibility for Training

10.7 All training is coordinated by the EPRR Team and is aligned to the National Occupational Standards for EPRR. A range of methods for delivery and a variety of dates will be offered; however others will be coordinated by EPRR some will be the responsibility of the service areas to plan.

10.8 Staff members are responsible for ensuring they attend training and keep up to date on EPRR developments.

10.9 This is monitored through PDP records (for those holding a commander or EPRR role) held on the EPRR online system (Inc. Certifications)

10.10 Types of Training

10.11 There are a variety of teaching methods that will be used by the EPRR Team to deliver training across the ICBs, these are:

10.11.1 Face to Face

10.11.2 E-Learning

10.11.3 Self-Learning

10.11.4 Exercise based.

10.12 Training dates can be made available through the EPRR Team at request.

10.13 Alternate training resources available to all staff

10.14 JESIP All staff awareness

10.15 IOR for the wider NHS

10.16 UKHSA E-learning system for EPRR

10.17 ICB EPRR e-learning platform (Derbyshire ICB)

11. ICBs Exercising Plan

11.1 As a Category 1 responder the ICBs are required to undertake, at a minimum, the following level of exercise:

11.1.1 Six-monthly communications cascade test requires x1 in hours and x1 out of hours test in a rolling 12-month period and will include internal and system-based cascade testing.

11.1.2 Annual tabletop exercise (TTX).

11.1.3 Three-yearly live exercise.

11.1.4 Three-yearly command post exercise (CPX).

11.1.5 Every 3 months, ICC Equipment testing.

11.2 Following each exercise, the EPRR Team will produce a post exercise report. This will include a series of recommendations and is shared with the EPRR Steering Group.

11.3 The cluster will hold a record of all lessons in a lessons learnt log, this will be managed as per details below.

11.4 DLN Cluster ICBs commit as part of its role as system coordinator to ensure that regular system exercises are held to ensure joined up response is assured.

11.5 Ad Hoc exercising

11.6 More exercises will be planned throughout the year to test new risks or to exercise new plans/documents/SOPs as required.

12. Continuous Improvement Process

12.1 EPRR is a continually evolving field that ensures effective update of processes via learning cycles to embed new and better ways of working, these can be from learning from exercises and/or incidents as well as changes in national, regional or LRF guidance.

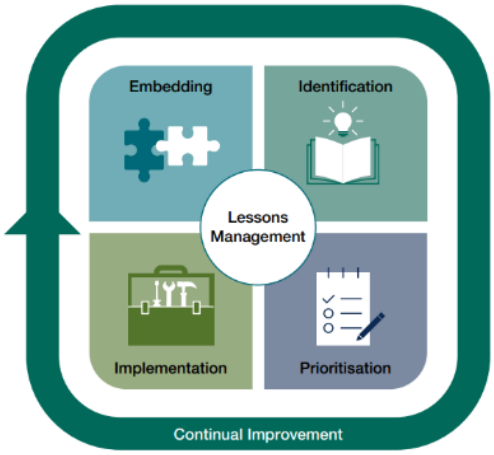
12.2 The ICBs are committed to three strategic principles in relation to continuous improvement, these are:

12.2.1 Shared and developed understanding of risk

12.2.2 Prevention over cure

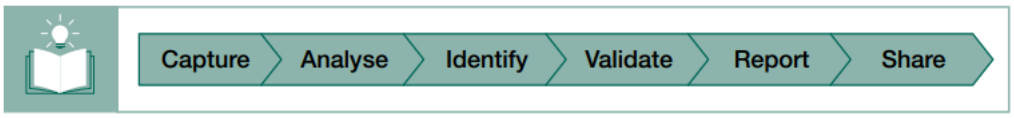
12.2.3 Whole NHS endeavour

12.3 The ICBs are committed to embedding the lessons management framework



12.4 Lessons will be identified by the six-step process, ensuring that lessons are SMART (Specific, measurable, achievable, relevant and time bound)

12.5



12.6 As soon as it is practicable following an exercise or incident debriefs will be conducted, this can take two main forms within the ICBs:

12.7 Hot Debrief:

12.8 Conducted immediately after the incident or period of duty, but within 48 hours of stand down. This allows responders, within the area for which the debrief is being conducted, to capture their immediate thoughts on areas of good practice and those that require improvement. This will be led by the most senior person within the area at the time and will utilise the ICB `hot debrief forms` within the relevant plans.

12.9 Structured Debrief:

12.10 This will be conducted within 28 days post incident, this will be conducted by the EPRR team (trained in performing structured debriefs) this will require representation from key `players` and individuals involved in the response as well as those that lead the hot debriefing process.

12.11 This debrief will ensure that full details of areas of good practice and those that require improvement are captured and then prioritised.

12.12 This includes multi agency debriefing for which the ICB will represent health partners.

12.13 Post Incident/Post Exercise Reporting:

12.14 These will be completed for any incidents that require the activation of an ICB EPRR plan. This process may also be followed for incidents where key learning is identified but activation of a document was not required. The report and actions will then be presented to the Audit Committee for sign off or LHRP if specific to a system level exercise.

12.15 Severe incidents with major impacts on patients/staff safety or the ability of the ICB to discharge its functions (HIGH RISK) will be presented to Audit Committee and the Board.

12.16 Incident and exercise learning is captured via a monthly meeting which will review the whole incident and exercise learning log to ensure progress against all actions. This is both for the ICBs and ICS where 2 separate meetings are held once a month led by the ICBs EPRR Team to review these actions.

12.17 All actions pertaining to the Post Incident Report (PIR) or Post Exercise Report (PXR) will be captured within the relevant action log that is shared routinely and managed by the EPRR Team. This will also apply to lessons identified by external incident and/or exercises whereby actions will be identified and then captured at the regional level and then fed into the ICBs.

12.18 The PIR and PXR will be produced within 4 weeks of the debrief being conducted and shared with relevant parties and on request NHS England.

12.19 Role in Regional Debriefing/Lessons Learnt

12.20 The ICBs have a duty to ensure engagement with and inclusion of lessons within the NHS England Midlands Regional process. This is key to ensuring any specific risks or lessons identified linked to healthcare can be seen by other providers and NHS partners to reduce the risk of similar issues occurring within their area.

12.21 The ICBs lessons learnt process will identify key areas of concern and if during this process learning is identified as pertinent or a key risk for the system/region the EPRR Team will ensure that this is raised with the NHS E Midlands EPRR Team, this will only be for those lessons identified as requiring immediate escalation.

12.22 The NHS England Midlands Team request quarterly the post incident and post exercise reports from the ICBs, within these are our identified lessons with actions and due dates. These will be submitted as requested for capture on the regional learning log.

12.23 The ICBs will also regularly assess this log that is on futures for any lessons that can be considered as part of the Audit Committee for internal risks and the Health Emergency Planning Officers Group (HEPOG) for system risks, both these meetings have a section given to learning and development and within this section would be discussed and then captured any regional lessons escalated for consideration.

12.24 Subsequent upward reporting to the LHRP will be conducted via the HEPOG Update report. It is expected then that this will be escalated in MHRPB for oversight and assurance around the regional lessons process.

12.25 Any lessons identified as for inclusion will then be captured on the relevant system or internal learning logs.

13. Key Performance Indicators

13.1 The ICBs have set several internal KPIs in relation to EPRR this ensures ongoing resilience within the ICBs in relation to EPRR matters and serves to support the identification of any risks, each is measured against an annual attainment of 80% unless otherwise indicated.

13.2 The year for EPRR is measured from the 1st of September to the 31st of August in line with the national EPRR Assurance process.

13.3 Updates against the KPIs will be provided quarterly to the EPRR Steering Group.

13.4 The ongoing recording of the KPIs will be captured by the EPRR team

KPI 1- There is an overall framework in place to ensure that appropriate Business Continuity arrangements are developed and maintained. (Min 90% achievement)	**Frequency**
In date plans (% of total)	Annual
In date BIAs (% of total)	Annual
Tested in the last 3 years (% of total)	Annual
Accessible to all members of staff? (Yes/No)	Annual
Number of depts internally audited (% of total)	Annual
Audit completed of relevant contracts and arrangements	3-year cycle
KPI 2- There are effective reporting arrangements in place to inform the Board of the adequacy of arrangements for EPRR within the ICB. (Yes/No within 12 month period)	
Annual report format to Board at least annually.	Annual
Ensure that an Audit review is carried out within the three-year audit plan	3-year cycle
KPI 3- Ensure effective training is in place across the ICB for roles identified within TNA. (min 80% achievement)	
ICB Incident Response Training	Annual
Loggists	3-year cycle
Principles of Health Command	3-year cycle
Business Continuity Awareness Training	Annual
EPRR Awareness Training	Annual
KPI 4- There is an overall framework in place to ensure that appropriate EPRR arrangements are developed and maintained. (min 80% achievement)	

In date plans (% of total)	Annual
Tested in the last 3 years (% of total)	3-year cycle
Accessible to all members of staff? (Yes/No)	Annual
KPI 5- There is an overall framework in place to ensure that appropriate system EPRR arrangements are developed and maintained. (min 80% achievement)	
In date plans (% of total)	Annual
Tested in the last 3 years (% of total)	3-year cycle
Accessible to all members of system and embedded in their own processes? (Yes/No)	Annual

14. Equality and Diversity Statement

14.1 The ICBs pay due to the requirements of the Public Sector Equality Duty (PSED) of the Equality Act 2010 in policy development and implementation, as commissioners and providers of services, as well as employers.

14.2 The ICBs are committed to ensuring that the way services are provided to the public and the experiences of staff does not discriminate against any individuals or groups based on their age, disability, gender identity (trans, non-binary) marriage or civil partnership status, pregnancy or maternity, race, religion or belief, gender or sexual orientation.

14.3 The ICBs are committed to ensuring that activities also consider the disadvantages that some people in the diverse population experience when accessing health services. Such disadvantaged groups include people experiencing economic and social deprivation, carers, refugees and asylum seekers, people who are homeless, workers in stigmatised occupations, people who are geographically isolated, Gypsies, Roma and Travellers.

14.4 To help ensure that these commitments are embedded in day-to-day working practices, an Equality Impact Assessment has been completed, and is included within this policy.

15. Communication, Monitoring and Review

15.1 This policy will be available to all ICB staff via the 3 ICB Intranet pages, there is an expectation that line managers indicate this policy to all staff

15.2 It will be reviewed initially annually in alignment with the ICB policy on policies, see version control at start of document.

15.3 Staff with an active role to play within this policy will be sent it by the ICB EPRR Team to ensure awareness, it will also be signed off at Public Board to ensure public awareness of the ICB commitment to EPRR.

15.4 This document will be overseen by the ICB Audit Committee ensuring compliance to relevant legislation and internal KPIs.

15.5 Any individual who has queries regarding the content of this policy, or has difficulty understanding how this policy relates to their role, should contact the ICB EPRR Team.

16. Confidentiality

16.1 This document can be shared but prior approval must be sought from the ICB EPRR Team before sharing, this document will be subject to ICB EPRR Document retention process as defined in appendix B.

16.2 This document should ensure compliance with the Data Protection legislations and also ICB Cluster IG policies and procedures.

17. Interaction with other Policies

17.1 This document should be read in conjunction with other EPRR document and plans including but not limited to:

17.1.1 Incident Response Plan

17.1.2 ICB Business Continuity Arrangements

17.1.3 ICB Business Continuity Management System

17.1.4 ICB Emergency Communications Plan

18. References

18.1 The following legislation and guidance have been taken into consideration in the development of this procedural document:

- Cabinet Office Civil Contingencies Act 2004
- Health and Social Care Act 2012
- The Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005
- Expectations and Indicators of Good Practice Set for Category 1 and 2 responders
- NHS EPRR Core Standards
- ISO 22301 Societal Security – Business Continuity Management Systems – Requirements
- ISO 22313 Societal Security – Business Continuity Management Systems – Guidance
- The Route Map to Business Continuity Management Meeting the Requirements of ISO 22301
- Business Continuity Institute Good Practice Guidelines (GPG) Edition 7.0

- NHS England Emergency Preparedness Framework 2022
- NHS Commissioning Board frequently asked questions (FAQs) on the future arrangements for health Emergency Preparedness, Resilience and Response (EPRR) (Jan2013)
- NHS England Business Continuity Toolkit and guidance
- Preparation and planning for emergencies: responsibilities of responder agencies and others
- Concept of Operations for Mass Casualty Incidents
- CBRN Incidents: A Guide to Clinical Management and Health Protection
- The United Kingdom's Strategy for Countering Chemical, Biological, Radiological and Nuclear (CBRN) Terrorism
- Arrangements for Health Emergency Preparedness, Resilience and Response From April 2013
- Chapters 5 to 7 Revision to Emergency Preparedness
- Minimum National Occupational Standards for EPRR, June 2022
- Management of Surge and Escalation in Critical Care Services Standard Operating Procedure for Adult & Paediatric Burns Care Services in England & Wales (2015)
- National Security Risk Assessment (2025)

19. Equality Impact Assessment

Date of assessment:	23 March 2026			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
Age[1]	Yes	Emergencies may impact on those with protected characteristics, the principle of ensuring inequality is addressed in all emergency response is considered within each ICB EPRR plan and process. Where required and appropriate further guidance will be sought by the EPRR Team to ensure effective planning and	No	No

[1] A person belonging to a particular age (for example 32 year olds) or range of ages (for example 18 to 30 year olds).

Date of assessment:	23 March 2026			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
		consideration of inequality within its processes		
Disability (Including: mental, physical, learning, intellectual and neurodivergent)[2]	Yes	Emergencies may impact on those with protected characteristics, the principle of ensuring inequality is addressed in all emergency response is considered within each ICB EPRR plan and process. Where required and appropriate further guidance will be sought by the EPRR Team to ensure effective planning and	No	No

[2] A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

Date of assessment:	23 March 2026			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
		consideration of inequality within its processes		
Gender (including trans, non-binary and gender reassignment)[3]	Yes	Emergencies may impact on those with protected characteristics, the principle of ensuring inequality is addressed in all emergency response is considered within each ICB EPRR plan and process. Where required and appropriate further guidance will be sought by the EPRR Team to ensure effective planning and	No	No

[3] The process of transitioning from one gender to another.

Date of assessment:	23 March 2026			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
		consideration of inequality within its processes		
Marriage and civil partnership[4]	Yes	Emergencies may impact on those with protected characteristics, the principle of ensuring inequality is addressed in all emergency response is considered within each ICB EPRR plan and process. Where required and appropriate further guidance will be sought by the EPRR Team to ensure effective	No	No

[4] Marriage is a union between a man and a woman or between a same-sex couple.
Same-sex couples can also have their relationships legally recognised as 'civil partnerships'.

Date of assessment:	23 March 2026			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
		planning and consideration of inequality within its processes		
Pregnancy and maternity[5]	Yes	Emergencies may impact on those with protected characteristics, the principle of ensuring inequality is addressed in all emergency response is considered within each ICB EPRR plan and process. Where required and appropriate further guidance will be sought by the EPRR Team to	No	No

[5] Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

Date of assessment:	23 March 2026			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
		ensure effective planning and consideration of inequality within its processes		
Race[6]	Yes	Emergencies may impact on those with protected characteristics, the principle of ensuring inequality is addressed in all emergency response is considered within each ICB EPRR plan and process. Where required and appropriate further guidance will be sought by the EPRR Team to	No	No

[6] Refers to the protected characteristic of race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.

Date of assessment:	23 March 2026			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
		ensure effective planning and consideration of inequality within its processes		
Religion or belief[7]	Yes	Emergencies may impact on those with protected characteristics, the principle of ensuring inequality is addressed in all emergency response is considered within each ICB EPRR plan and process. Where required and appropriate further guidance will be sought	No	No

[7] Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

Date of assessment:	23 March 2026			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
		by the EPRR Team to ensure effective planning and consideration of inequality within its processes		
Sex[8]	Yes	Emergencies may impact on those with protected characteristics, the principle of ensuring inequality is addressed in all emergency response is considered within each ICB EPRR plan and process. Where required and appropriate further guidance will be sought	No	No

[8] A man or a woman.

Date of assessment:	23 March 2026			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
		by the EPRR Team to ensure effective planning and consideration of inequality within its processes		
Sexual orientation[9]	Yes	Emergencies may impact on those with protected characteristics, the principle of ensuring inequality is addressed in all emergency response is considered within each ICB EPRR plan and process. Where required and appropriate further guidance will be sought	No	No

[9] Whether a person's sexual attraction is towards their own sex, the opposite sex, to both sexes or none. https://www.equalityhumanrights.com/en/equality-act/protected-characteristics

Date of assessment:	23 March 2026			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
		by the EPRR Team to ensure effective planning and consideration of inequality within its processes		
Carers[10]	Yes	Emergencies may impact on those with protected characteristics, the principle of ensuring inequality is addressed in all emergency response is considered within each ICB EPRR plan and process. Where required and appropriate further guidance will be sought	No	No

[10] Individuals within the ICB which may have carer responsibilities.

Date of assessment:	23 March 2026			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
		by the EPRR Team to ensure effective planning and consideration of inequality within its processes		

Appendix A: Definitions and Glossary of Terms

Definitions of key terms referenced in this policy are described in the table below:

Term	Definition
Business Continuity	The capability of an organisation to continue delivery of its critical services and activities at acceptable pre-defined levels following a disruptive incident.
Business Continuity Incident	A business continuity incident is any event that disrupts an organisation's normal service delivery, to below acceptable pre-defined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption, provider failure or cyber security incidents
Business Continuity Plan	A business continuity plan is documented information that guides an organisation to respond to a disruption and resume, recover and restore the delivery of its critical activities at an acceptable pre-defined level. The plan contains command and control principles for BC incidents to be utilised by command staff.
Business Impact Analysis	The process of analysing the impacts of disruption over time to determine the organisation's response, recovery priorities and resource requirements. This process is used to identify critical areas/functions within the ICB, available in support of this document.
Critical Incident	Any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions. A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services.
Command	The exercise of vested authority that is associated with a role or rank within an organisation (the NHS), to give direction to achieve defined objectives.
Control	The application of authority, combined with the capability to manage resources, to achieve defined objectives.

Term	Definition
Coordination	Integration of multi-agency efforts/capabilities to achieve pre-defined objectives.
Emergency	Defined by the Civil Contingencies Act 2004 as: an event or situation which threatens serious damage to human welfare in a place in the United Kingdom. an event or situation which threatens serious damage to the environment of a place in the United Kingdom. war, or terrorism, which threatens serious damage to the security of the United Kingdom.
Emergency Preparedness	The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of, and response to emergencies.
HEPOG	Health Emergency Planning Officers Group is the operational delivery group for system resilience and EPRR within the NHS, it covers a geographical area and reports to a Local Health Resilience Partnership (LHRP)
LHRP	The strategic oversight and leadership group for resilience and EPRR within a allocated area, this group reports to the relevant NHSE structures as well as providing a link between healthcare resilience and the Local Resilience Forum (LRF)
Major Incident	Defined by The Cabinet Office, and the JESIP, as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency. In the NHS this will cover any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties as to require special arrangements to be implemented. For the NHS, this will include any event defined as an emergency. A Major Incident may involve a single agency response, although it is more likely to require a multi-agency response, which may be in the form of multiagency support to a lead responder. The severity of the consequences associated with a Major Incident are likely to constrain or complicate the ability of responders to resource and manage the incident, although a Major Incident is unlikely to affect all responders equally. The decision to declare a Major Incident will always be made in a specific local and operational context. There are no precise, universal thresholds or triggers. Where Local Resilience Forums (LRFs) (Derbyshire Resilience

Term	Definition
	Partnership within Derbyshire) and responders have explored these criteria in the local context and ahead of time, decision makers will be better informed and more confident in making that judgement. Classifications of types of Major Incident are: Rapid onset: develops quickly, and usually with immediate effects, thereby limiting the time available to consider response options (in contrast to rising tide) e.g., a serious transport accident, explosion, or series of smaller incidents. Rising tide: a developing infectious disease epidemic or a capacity/staffing crisis or industrial action. Cloud on the horizon: a serious threat such as a significant chemical or “Emergency responder agency” includes any category 1 and category 2 responder as defined in the CCA 2004 and associated guidance. nuclear release developing elsewhere and needing preparatory action. Headline news: public or media alarm about an impending situation, significant reputation management issues, e.g., an unpopular patient treatment plan which gathers significant publicity. Chemical, biological, radiological, nuclear and explosives: CBRNe terrorism is the actual or threatened dispersal of CBRNe materials (one or several, or in combination with explosives), with deliberate criminal, malicious or murderous intent. Hazardous materials (HAZMAT): accidental incident involving hazardous materials. Cyber security incident: a breach of a system’s security policy to disrupt its integrity or availability or the unauthorised access or attempted access.
Mass Casualty	An incident (or series of incidents) causing casualties on a scale beyond normal resources of emergency and healthcare services’ ability to manage. It may involve hundreds or thousands of casualties with a range of injuries, the response to which will be beyond the capacity of normal major incident procedures to cope and requires further measures to appropriately deal with these numbers.
Maximum Tolerable Period of Disruption (MTPD)	The maximum amount of time that a service or function can be unavailable or undeliverable after an event that causes disruption.

Term	Definition
Recovery Time Objective (RTO)	The targeted duration of time within which a function must be restored after a disruption to avoid unacceptable consequences associated with a break in provision
Resilience	The ability of the community, services, area, or infrastructure to detect, prevent and, if necessary, withstand, handle and recover from disruptive challenges.
Response	Decisions and actions taken in accordance with the strategic, tactical, and operational objectives defined by emergency responders.
Recovery	The process of rebuilding, restoring, and rehabilitating the community following an emergency
Subsidiarity	Decisions relating to the management of an incident should be taken at the lowest appropriate level, with co-ordination and oversight at the highest necessary level. For the ICB, this means that while the ICB Strategic Commander retains overall responsibility for an incident, the Provider Strategic Commanders will continue command and control of their organisations at their local level.

Appendix B: EPRR Document Retention Process

In line with Information Governance processes, the Assistant Director of EPRR will ensure archiving of all relevant EPRR documents and processes in line with national NHS guidelines in relation to document retention, they will be stored as necessary in an online account or hard copies will be securely stored by the Assistant Director of EPRR, these are available for view through request via the Assistant Director of EPRR.

Document Type	Examples	Minimum Retention Period	Final Action
Incidents (declared)	Decision logbook, on call logbook, incident related documents including plans and organisational structures, paper and electronic records.	30 years	Review, archive or destroy under confidential conditions
Exercise	Paper and electronic records.	10 years	Review, archive or destroy under confidential conditions
On-call (routine – non-Major Incident)	Decision log, on-call log, handover records Paper and electronic records.	10 years	Review, archive or destroy under confidential conditions
EPRR	Incident response plans, guidance, standard operating procedures, core standards for assurance. Electronic records.	30 years	Review, archive or destroy under confidential conditions
EPRR	Information sharing protocols, memorandum of understanding, service-level agreements. Paper and electronic records.	10 years	Review, archive or destroy under confidential conditions
EPRR	LHRP and sub-group minutes, papers, action logs . ICB EPRR minutes, papers, action logs. Risk registers. Electronic records.	30 years	Review, archive or destroy under confidential conditions

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	21/05/2026
Paper title:	**Neighbourhood Health Framework**
Paper reference:	ICB CIC 26 009
Paper author:	Clair Raybould, Executive Director of Strategy and Citizen Experience Tom Diamond, Director of Population Health Strategy
Paper sponsor:	Clair Raybould, Executive Director of Strategy and Citizen Experience Maria Principe, Executive Director of Commissioning
Presenter:	Clair Raybould and Maria Principe

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

Report summary:

This paper briefs the Boards on the publication of the national Neighbourhood Health Framework and its implications for Integrated Care Boards (ICBs) as strategic commissioners. It sets out the expectations for 2026/27 and seeks endorsement for a pragmatic, phased approach to implementation across the Derbyshire, Lincolnshire and Nottinghamshire systems.

Recommendation(s):

The Boards are asked to:

- **Discuss** the content of the report, noting the role of Health and Wellbeing Boards as the principal partnership forums for neighbourhood health planning at place level.
- **Endorse** the proposed pragmatic phased approach to implementation during 2026/27, noting that the Joint Strategic Commissioning Committee will oversee delivery, with detailed implementation plans brought forward as the programme develops.

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

Appendices

Appendix 1: Neighbourhood Health Framework Presentation

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Neighbourhood Health Framework

National context

1. In March 2026, NHS England and the Department of Health and Social Care published the Neighbourhood Health Framework. This provides the delivery framework for the Government's wider NHS reform agenda and the ambitions within the Ten Year Health Plan for England. The framework supports the fundamental strategic shifts from hospital to community, from treatment to prevention, and towards more integrated neighbourhood-based delivery models.
2. The framework positions Health and Wellbeing Boards as the principal partnership forum through which local government, the NHS, and wider partners will align neighbourhood health planning and delivery arrangements at Place level.
3. Whilst statutory accountability for NHS commissioning remains with ICBs, the framework is explicit that neighbourhood health plans should be developed jointly through Health and Wellbeing Board-led partnership arrangements, involving local authorities, providers, primary care, voluntary, community and social enterprise organisations, and wider partners.
4. The framework is intended to be implemented in two phases:
    a) Stage 1 (2026/27): immediate operational and planning requirements (the minimum basic requirements ICBs need to ensure the NHS delivers).
    b) Stage 2 (2027–2029): development of longer-term neighbourhood health reform models and plans (the fundamental changes NHS and local authorities must work together with partners to deliver).
5. The strategic direction aligns with the ICBs' Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan.
6. The framework presents a significant opportunity to strengthen:
    a) Prevention and population health.
    b) Integrated neighbourhood delivery.
    c) Measuring improvements in health outcomes for high-priority cohorts.
    d) Partnership working across NHS, local government, and voluntary, community and social enterprise sectors.
    e) More proactive models of care.
7. However, it is recognised that implementation will need to be progressed during a period of significant NHS and local government reform and operational pressure.

Implications for ICBs as strategic commissioners

8. The framework establishes a significant role for ICBs as strategic commissioners, including responsibility for:
    a) Leading NHS neighbourhood health local prioritisation and investment decisions.
    b) Agreeing neighbourhood footprints for future development of Integrated Neighbourhood Teams.
    c) Commissioning NHS neighbourhood models.
    d) Ensuring delivery of nationally mandated NHS requirements from 2026/27 onwards.
9. The framework also introduces increasing expectations around:
    a) Neighbourhood-based commissioning.
    b) Integrated provider delivery arrangements.
    c) The progressive shift of activity and resource into community settings where clinically appropriate.
10. Whilst the national direction of travel is clear, some elements of governance, accountability and delivery expectations remain high level and continue to emerge nationally.

Delivery risks and mitigation

11. Key delivery risks will require active management throughout implementation. Capacity constraints necessitate a prioritised focus on delivering the nationally mandated minimum requirements of the Neighbourhood Health Framework during 2026/27.
12. System complexity will be mitigated through a strong partnership approach, with NHS delivery continuing to operate through existing Place and neighbourhood footprints, providing stability whilst enabling the progressive development of neighbourhood health models over time.
13. A pragmatic phased approach will be adopted during 2026/27 that:
    a) Builds on existing Place and neighbourhood arrangements.
    b) Avoids unnecessary structural disruption in-year.
    c) Aligns with Health and Wellbeing Board partnership arrangements.
    d) Focuses initially on the nationally mandated minimum requirements, which are heavily NHS focussed.

Strategic shift

14. This represents a shift from enabling neighbourhood working to actively commissioning and performance-managing neighbourhood outcomes at scale, reinforcing the ICBs' role as a strategic commissioner driving population health improvement.

The Neighbourhood Health Framework

A blueprint for accessing health and care as close to home as possible

The aims of the neighbourhood health approach

1 IMPROVE OUTCOMES AND REDUCE INEQUALITIES

Help people stay well through prevention, proactive care and strong local services.

2 ORGANISE CARE AROUND THE PERSON

More convenient, personalised and joined-up care.

NEIGHBOURHOOD HEALTH

Health, care and wider support working together around people, families and communities.

Not around organisational boundaries.

3 REDUCE PRESSURE ON ACUTE SERVICES

Fewer avoidable hospital visits and admissions; more care closer to home.

4 CUT WASTE AND DUPLICATION

Better use of resources through joined-up working and digital.

5 DELIVER BETTER NHS PERFORMANCE

Better access, planned care and urgent care, with improved experience for patients and staff.

The key challenge

Neighbourhood health will only work by combining the **NHS's responsibility** for health services with **local authorities' responsibility** for adult and children's social care services and public health, alongside wider partners.

The NHS and local authorities must **transform how they work together** – and with wider partners (such as the VCSE sector) – to improve planning and, in turn, health and care outcomes.

Similar proposals have been set out over the last **15 years...**

...and many other countries have moved to a **similar way of working.**

Yet, over the last **10 years**, the system has orientated **more to hospitals,**

...with significantly greater spend and investment in **hospitals** rather than in **primary and community care.**

The challenge is the ability of the system to **make the change.**

The key building blocks of neighbourhood health

ICBs and local authorities, working with other local partners, need to make changes to services to deliver 3 reforms:

1 Reform agenda 1

Improve services for people who need routine healthcare.

2 Reform agenda 2

Improve proactive care for people.

3 Reform agenda 3

Deliver better alternatives to hospital care.

ICBs are being asked to implement these minimum interventions in every community over the next 3 years.

These are not the ceiling of neighbourhood health, but the foundation upon which local priorities will be built.

Reform Agenda 1: Improving Routine Care

Ensuring general practice is the bedrock of neighbourhood health.

1 Improve access to same day care

People can get the right help, first time, when they need it – through easier access to appointments and services, including online.

2 Increase proactive care to prevent illness and address problems early

Identify people's needs early and support them to stay well.

3 Improve access to diagnostics, and OPs, out-of-hours care and pharmacy support

Make it easier to access diagnostics and OPs, get care when GP practices are closed, and strengthen pharmacist's role in delivering care.

Reform Agenda 2: Proactive Care via Integrated Neighbourhood Teams (INTs)

Focusing on those who need it most to prevent illness, improve outcomes and reduce inequalities.

1 What is an INT?

A locally defined, multidisciplinary team working side-by-side to deliver assessment, care planning, and follow-on support.

2 Focusing on those who need it most

INTs priorities proactive support for key population cohorts:

Children and young people (CYP)
Timely paediatric expertise in the community. Goal: Every child who needs an INT has access by 2028/29.

People with multiple long-term conditions (LTCs)
Focus on conditions with the highest impact (e.g. CVD, diabetes, COPD, dementia) to slow frailty onset.

People with frailty & end of life
Over 75s with frailty, care home residents, and end-of-life patients.

People with cancer
Improving quality of life for those living with cancer in their communities.

3 Working together for better outcomes

INTs work with health, care and wider partners and local people to deliver joined-up, person-centred support.

Reform Agenda 3: Shift Care from Hospital to Community

Delivering more care closer to home, improving outcomes and experience, and freeing up hospital capacity.

1 The NHS will expand urgent community response services

Prevent avoidable attendances, particularly for frailty and falls, by expanding urgent community response capacity.

2 The NHS will radically increase the capacity of virtual wards

So people don't have to attend hospital unnecessarily.

3 The NHS will work with local authorities and other partners to increase intermediate care capacity

Optimising the capacity of step-up and step-down intermediate care to help avoid admissions and attendances, improve discharge and support better recovery.

For the NHS, ICBs will set clear expectations and contract accordingly

In its initial stages neighbourhood health will be delivered through commisssoning reform.

1 Single-Neighbourhood Provider (SNP)

~50,000 population.

Delivers new services via INTs within a single defined neighbourhood.

Works directly with local GP practices.

2 Multi-Neighbourhood Provider (MNP)

~250,000+ population.

Coordinates consistent delivery across multiple neighbourhoods.

Designs services at scale and uses risk-sharing to incentivise preventative care.

Works with local GP practices across multiple neighbourhoods.

- **ICBs will work closely with both local authorities as commissioners of social care and public health services, and the providers of those services across civil society and the public, private and VCSE sectors.**

Neighbourhood health estates and locations

Neighbourhood health centres are a crucial part of the neighbourhood health model.

Neighbourhood health centres bring services together

They bring together GP services with a mix of community, local authority, civil society and VCSE sector services, allowing staff to join up care.

2035

Delivering 250 NHCs by 2035

- **120** NHCs by 2030
- A mixture of repurposed underused estate and new builds

Wave 1 pipeline: 2026 to 2027

Focus on repurposing
Will largely focus on repurposing existing NHS buildings.

Using existing NHS estates
Mostly NHS Property Services and LIFT (NHS Local Improvement Finance Trust) estates.

Targeting areas of greatest need
In areas with the highest deprivation.

Future waves: 2028 onwards

Continued use of repurposed estate
Further repurposed estate will be brought into use.

New builds
New NHCs will be delivered to meet growing need.

The wider ecosystem: Integrating health into civic life

Neighbourhood health is part of the government's wider agenda of local public service reform.

Best Start Family Hubs:

Streamlining early interventions and child health for 0–5 year olds (aligning with CYP INTs).

Pride in Place:

Aligning health investments with £5.8 billion in funding for 284 left-behind communities, guided by local neighbourhood boards.

Young Futures Hubs:

Targeted early mental health advice and opportunity access for vulnerable youth.

Neighbourhood Health

WorkWell & Pathways to Work:

Integrating health and employment support to help people with health conditions stay in or return to work.

Housing & Homelessness:

Connecting with the Decent Homes Standard (Awaab's Law) and the Changing Futures program for holistic support.

Who is accountable for delivering neighbourhood health?

Different partners are accountable for different parts of delivery — from national strategy to Implementation and frontline care.

Government (DHSC) and NHS England

- Set national policy and expectations for Neighbourhood Health
- Set national standards and guidance
- Track progress and remove barriers to reform

Health and Wellbeing Boards

- Provide strategic leadership for local health and wellbeing
- Bring partners and communities together to set priorities
- Align Neighbourhood Health Plans with wider plans and determinants
- Forum where HWB partners agree the Neighbourhood Plan

Integrated Care Boards (ICBs)

- Lead NHS neighbourhood health planning and identify funding
- Set priorities from needs assessments and joint strategies
- Deliver the minimum interventions over the next three years
- Embed Neighbourhood Health Plans in the 5-year strategic commissioning plan

Delivering Neighbourhood Health

Local authorities

- Accountable for public health, adult and children's social care, and wider local services
- Jointly plan and commission through Neighbourhood Health
- Align pooled budgets with wider local services
- Support integration and outcomes for communities

Providers and INTs

- Redesign pathways and deliver joined-up care
- Build multidisciplinary teams
- Shift more care closer to home
- Share learning and improve

VCSE, communities and residents

- Bring local insight and lived experience
- Co-produce neighbourhood solutions
- Connect people to community support
- Champion inclusion and reduce inequality

Summary of actions to deliver neighbourhood health

Two stages of action...

Stage 1 — Immediate changes in the 2026 to 2027 financial year

The minimum basic requirements ICBs need to ensure the NHS delivers.

1. Initial plan to reduce non-elective admissions
2. Agree a plan for improving access to general practice
3. Agree neighbourhood footprints for future development of INTs
4. Agree plans to establish INTs focussed on high priority cohorts
5. Start to plan for a new neighbourhood approach for elective pathways
6. Confirm how ICBs and local authorities intend to use pooled funding
7. Confirm organisational ownership of planned deliverables

Stage 2 — Longer-term reform (April 2027 to March 2029)

The fundamental changes the NHS and local authorities must work together with partners to deliver.

1. Set out how national NHS objectives will be delivered through the 3 reform agendas
2. Set out how neighbourhood health will support wider goals to improve health outcomes and reduce inequalities
3. Set out how local objectives are informed by the JSNA and any other local assessments
4. Confirm final geographies that partners will work within
5. Confirm which organisations are responsible for different elements of delivery
6. Confirm governance and operational partnership arrangements
7. Align other relevant initiatives e.g. Best Start Family Hubs

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:	21/05/2026
Paper title:	**Joint Capital Resource Use Plans 2026/27**
Paper reference:	ICB CIC 26 010
Paper author:	Cath Benfield, Strategic Finance Lead, Joined Up Care Derbyshire Provider Collaborative Luca Paderi, Head of Financial Planning, NHS Lincolnshire ICB Clare Hopewell, Assistant Director of Finance and System Efficiency, NHS Nottingham and Nottinghamshire ICB
Paper sponsor:	Bill Shields, Executive Director of Finance
Presenter:	Bill Shields, Executive Director of Finance

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

Report summary:

This report presents the 2026/27Joint Capital Resource Use Plans for Derbyshire, Lincolnshire and Nottinghamshire for review and approval.

The plans set out the proposed use of the capital funding allocated to the respective three ICB systems and demonstrates how resources have been prioritised in line with national guidance and local priorities.

The plans were endorsed by the ICBs' Joint Finance and Performance Committee at its May 2026 meeting.

Recommendation(s):

The Boards are asked to **approve** the Joint Capital Resource Use Plans for 2026/27 as presented in advance of publication in accordance with NHS England guidance.

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

Appendices

Appendix 1 – Summary of Capital Plans for 2026/27
Appendix 2 – NHS Derby and Derbyshire Joint Capital Resource Use Plan
Appendix 3 – NHS Lincolnshire ICB Joint Capital Resource Use Plan
Appendix 4 – NHS Nottingham and Nottinghamshire Joint Capital Resource Use Plan

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Joint Capital Resource Use Plans 2026/27

Background and national policy context

1. NHS England issues guidance setting out the requirements with regards to the development and publication of Joint Capital Resource Use Plans. The guidance states that ICBs and their partner trusts must:

    a) Prepare a plan setting out their planned capital resource use before the start of each financial year.

    b) Publish the plan and give a copy to the Integrated Care Partnership for the relevant ICB's area, any relevant Health and Wellbeing Boards, and NHS England.

2. The published plans aim to provide transparency for local residents, patients, NHS health workers, and other NHS stakeholders on the prioritisation and expenditure of capital funding by ICBs and their partner trusts to achieve their strategic aims. This supports both provider and ICB requirements to manage capital plans within allocated capital and meets ICB responsibilities to report annually on the use of resources.

3. The plans for 2026/27 as presented are aligned to final planning submissions made on 31 March 2026.

4. In addition to core system allocations, indicative national capital funding has been identified to support the delivery of constitutional standards and the aims of the Ten-Year Health Plan for England.

5. Each of our three NHS systems has developed plans against the relevant allocations across diagnostics, urgent and emergency care, mental health learning disabilities and autism, and community programme areas. Where appropriate, providers have included these schemes in their planning submissions, noting that the bids are still subject to a national approval process. Some schemes are still in development and therefore at the point of the planning submission, a provider has yet to be determined and therefore is not included in the plans submitted.

6. Each ICB has received initial feedback on the bids submitted and continues to work with NHS England to respond to any requests for further information or progress schemes to the next stage where approval has been granted.

7. ICB/primary care capital requirements are funded across three funding streams as detailed below:

    a) Business as usual/General Practice information technology capital – for routine primary care estates and information technology purchases.

    b) ICB strategic capital – to support system prioritised schemes.

c) Utilisation and modernisation fund – to support improvements in primary care estates, productivity and modernisation.

8. Whilst the capital regime for 2026/27 replaces system level operational capital allocations with provider level allocations, as set out above, the requirement to produce Joint Capital Resource Use Plans remains unchanged.

9. Once finalised, systems must publish their Joint Capital Resource Use Plans and share them with the relevant Integrated Care Partnerships, Health and Wellbeing Boards, and NHS England.

10. ICBs must share a copy of the final plan with NHS England once it is published, but this does not constitute a formal submission.

11. Appendix A provides a high-level overview of the proposed capital programmes across the three systems for 2026/27. It brings together the position across core capital allocations, national programme funding and indicative allocations in relation to constitutional standards and left shift.

12. Further details of the individual ICB plans are contained within the relevant Joint Capital Resource Use Plans, which are also appended to this report.

13. It is important to note that the values presented here may be subject to change pending confirmation of final allocations and any in-year adjustments.

Appendix 1 – Summary of Capital Plans 2026/27

Capital Departmental Expenditure Limit (CDEL) as of 31 March 2026	LICB	ULTH	LCHS	LPFT	NICB	NUH	SFH	NHT	DDICB	CRH	DCHS	DHcFT	EMAS	UHDB	Total full year plan £'000
Operational Capital – ICB	1.74				2.50				2.19						6.42
Strategic Capital – ICB	2.78				3.90				3.49						10.17
Utilisation and Modernisation Fund - ICB	0.75				1.00				1.00						2.75
Operational Capital – Provider		29.90	1.99	2.50		48.90	10.40	12.30		8.64	4.62	6.10	12.20	23.46	161.01
Sub Total System Operational Capital	**5.27**	**29.90**	**1.99**	**2.50**	**7.40**	**48.90**	**10.40**	**12.30**	**6.68**	**8.64**	**4.62**	**6.10**	**12.20**	**23.46**	**180.36**
Programme National Programme Spend															
Critical Infrastructure Risk		6.27		0.24		9.05		4.00		0.53	0.94	0.24	1.12	3.21	25.59
Mental health dormitories								2.30							2.30
Other Adjustments – Provider						0.05	6.00	0.70					11.44	3.50	21.69
Sub Total National Programmes	**0.00**	**6.27**	**0.00**	**0.24**	**0.00**	**9.10**	**6.00**	**7.00**	**0.00**	**0.53**	**0.94**	**0.24**	**12.56**	**6.71**	**49.58**
Return to Constitutional Standards: Diagnostics		17.73				5.50				4.55				2.65	30.43
Return to Constitutional Standards: Urgent and Emergency Care		7.00				12.90				3.64	4.63		15.33	6.90	50.40
Return to Constitutional Standards: Mental Health, Learning Disabilities and Autism				0.20		0.30		2.10		0.15		0.28			3.03
Return to Constitutional Standards: Community			1.75								2.00				3.75
Sub Total Return to Constitutional Standards	**0.00**	**24.73**	**1.75**	**0.20**	**0.00**	**18.70**	**0.00**	**2.10**	**0.00**	**8.34**	**6.63**	**0.28**	**15.33**	**9.55**	**87.61**
Other Adjustments – Provider		21.67	-0.41	0.02						0.31		0.96		7.81	30.36
TOTAL CDEL and ICB capital	**5.27**	**82.57**	**3.33**	**2.96**	**7.40**	**76.70**	**16.40**	**21.40**	**6.68**	**17.81**	**12.19**	**7.58**	**40.10**	**47.53**	**347.91**

Organisation Abbreviation	NHS Full Name
LICB	Lincolnshire Integrated Care Board
ULTH	United Lincolnshire Teaching Hospitals NHS Trust
LCHS	Lincolnshire Community Health Services NHS Trust
LPFT	Lincolnshire Partnership NHS Trust
NICB	Nottingham and Nottinghamshire Integrated Care Board
NUH	Nottingham University Hospitals NHS Trust
SFH	Sherwood Forest Hospitals NHS Foundation Trust
NHT	Nottinghamshire Healthcare NHS Foundation Trust
DDICB	Derby and Derbyshire Integrated Care Board
CRH	Chesterfield Royal Hospital NHS Foundation Trust
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DHcFT	Derbyshire Healthcare NHS Foundation Trust
EMAS	East Midlands Ambulance Service NHT Trust
UHDB	University Hospitals of Derby and Burton NHS Foundation Trust

Appendix 2: Derbyshire Joint capital resource use plan – 2026/27

Region	**Midlands**
ICB or system	**Derby and Derbyshire ICB**
Date published	**May 2026**
Version control	**5**

Version	Date issued	Who/Comment	Updated by	Sign off	Approvals
4	26 March 2026	n/a	n/a	01 April 2026	Finance and Performance Committee
5	13 May 2026	Accessibility and narrative checks for Board	n/a	21 May 2026	Board Meeting

Introduction

Derby and Derbyshire Integrated Care Board (ICB) is responsible for planning and buying NHS services for the 1.06 million people living in Derby and Derbyshire. Our ambition to work collaboratively across the NHS and wider health and care sector in Derbyshire is set out in the Joint Forward Plan, which describes our aim to provide joined up care and support to meet people's health and care needs. The effective use of capital resources is essential to delivering that ambition. The Derbyshire Integrated Care System (the Derbyshire ICS) includes six NHS organisations:

- Chesterfield Royal Hospital NHS Foundation Trust (CRH).
- Derbyshire Community Health Services NHS Foundation Trust (DCHS).
- Derbyshire HealthCare NHS Foundation Trust (DHcFT).
- East Midlands Ambulance Service NHS Trust (EMAS)*.
- University Hospitals of Derby and Burton NHS Foundation Trust (UHDB).
- Derby & Derbyshire Integrated Care Board (DDICB).

** EMAS is hosted by the Derbyshire Integrated Care System (the Derbyshire ICS) but provides ambulance services across the East Midlands.*

We serve more than 1 million people, including the populations of Derby city, Chesterfield, Ilkeston and Long Eaton, Amber Valley, the Derbyshire Dales, Bolsover District, High Peak, and Glossop. Our specialised services include treating cardiovascular, respiratory, and musculoskeletal diseases; strokes and cancers; and mental health problems. In addition, we have a core focus on preventative care, and work to ensure that factors contributing to poor health and health inequalities are addressed. We are passionate about our role in the local communities in which we serve and are keen to ensure that our impact on the environment is reduced.

We have a mixture of owned and leased estate across Derbyshire. The age and condition of the estate vary, ranging from older buildings with significant backlog maintenance requirements to newer estate in good condition.

The Derbyshire ICS developed a system-wide Infrastructure Strategy 2024 – 2040 that set out the longer-term vision of the infrastructure and estate requirements aligned to the Joint Forward View.

The Infrastructure Strategy provides an overview of our current estate and infrastructure, considers the changing demographics of our population and highlights some of the steps we can take to help meet our strategic aims of prioritising prevention, reducing inequalities, developing personalised care, and improving connectivity.

As a system, we will continue to face many challenges which will require increasing levels of integration and partnership working. Some areas are expected to experience significant population and housing growth, and our elderly population will continue to grow at an increasing rate. These changes will place new and increasing demands on our healthcare services and providers, and our ability to transform our estate and infrastructure will be key in meeting our system aims and ambitions and needs of our population.

NHS Derby and Derbyshire, NHS Lincolnshire and NHS Nottingham and Nottinghamshire ICBs (hereafter referred to as the ICBs) are working together under cluster arrangements. This plan is produced in line with Derby and Derbyshire ICB's arrangements for capital planning and oversight within Derbyshire, Lincolnshire, and Nottinghamshire (DLN) ICB cluster. Whilst Derby and Derbyshire ICB remain accountable for its statutory duties and for the delivery of its own joint capital resource use plan, the DLN cluster provides a consistent framework for assurance, decision making and escalation. This supports a coordinated approach to prioritisation, affordability, and deliverability of schemes, including where allocations and funding streams require cross-system alignment. Governance and oversight are provided through the Joint Finance and Performance Committee, supported by shared reporting arrangements that enable consistency of approach and learning across the three systems, while ensuring that Derbyshire's local system priorities and provider plans remain clearly reflected.

The ICB receives a ring-fenced capital allocation of c. £2.5m each year to invest in Information Technology (IT) replacement and small premises improvements in primary care (general practice). The Utilisation and Modernisation Fund (UMF) in 2026/27 is £1.0m and will be invested in appropriate primary care developments. In addition, Strategic Primary Care Capital, newly available in 2026/27, will fund prioritised strategic primary care schemes.

All financial information presented in this document is consistent with the integrated care system (ICS) financial and operational plan submission to NHS England on 12th February 2026.

Capital Departmental Expenditure Limit (CDEL) 2026/27

Where appropriate, providers have reflected schemes in their plan submissions that are included in the system's submission to NHS England in respect of the Constitutional Standards and left shift funding. This is discussed in more detail later in this report.

In overall terms the £131.88m is made up of the following:-
Strategic Capital £ 68.62m
BAU / Operational Capital £64.79m
Leases / PFI related costs £7.95m
Less Donations , Grants and Disposals £9.10m
Less Elimination of Inter-Group Leases £0.377m
Total £131.88m

		DDICB	CRH	DCHS	DHcFT	EMAS	UHDB	TOTAL	
		£ms	£ms	£ms	£ms	£ms	£ms	£ms	
Strategic Capital									
Acute Front Door							3.50	3.50	
2026/27 Ambulance Replacement						11.44		11.44	
2026:2030 Community Bids				2.00				2.00	
Decarbonisation							6.51	6.51	
2026:2030 Diagnostic Bids			4.55				2.65	7.20	
2026:2030 Estate Safety			0.53	0.94	0.24	1.12	3.21	6.04	
2026:2030 MHLD&A Bids			0.15		0.28			0.43	
2026:2030 UEC Bids			3.64	4.63		15.33	6.90	30.50	
Utilisation and Modernisation Fund		1.00						1.00	
BAU Capital									
Backlog Maintenance			3.07	2.97	1.36	1.64	2.90	11.94	
Routine Maintenance			0.50		0.81	1.57		2.88	
Estates(non-maintenance)		3.97	1.19	0.50	3.05	3.20	13.15	25.07	
Equipment (inc donated)			2.37	0.30	0.03		2.28	4.97	
Fleet, Vehicles & Transport			0.05			1.29	0.04	1.38	
IT -Software			1.00				6.21	7.21	
IT - Hardware		1.71	0.78	1.50	0.25	1.45	0.71	6.38	
Leases									
Building Lease					0.60	0.42		1.02	
Vehicle Lease						3.94		3.94	
Equipment Lease								0.00	

Other								0.00	
PFI Lifecycle / Capital Charges					0.96		6.98	7.95	
Total Capital Expenditure		6.68	17.81	12.84	7.58	41.41	55.03	141.36	
Less Donations, Disposals & Grants				-0.66		-0.94	-7.51	-9.10	
Elimination of Intra Group Leases						-0.38		-0.38	
Planned Capital Expenditure 26/27		**6.68**	**17.81**	**12.19**	**7.58**	**40.10**	**47.52**	**131.88**	

The values above include PFI lifecycle (capital) charges. This is a technical accounting entry relating to Private Finance Initiative (PFI) buildings: it reflects the value of the hospital buildings that the NHS will own when the PFI contracts end. It is required by national accounting rules and does not represent additional cash being diverted from patient care.

The values above reflect the capital plans submitted to NHS England on 12th February 2026. Any subsequent changes (including confirmation of additional funding for specific initiatives) are not reflected here. During 2026/27 there may also be in-year adjustments to provider capital allocations to honour prior-year system agreements (for example, where one provider supported another through brokerage). A national process allows capital funding to be transferred between providers in-year; this has a net zero impact on the overall capital available across Derbyshire.

Capital planning and prioritisation

The financial year 2026/27 sees a move away from system level capital allocations and a reversion back to provider level allocations.

Alongside this change, systems have been advised of capital allocations covering a 4 year period up to and including 2029/30. Having this clarity around funding over the medium term is welcomed and enables more longer term planning to be undertaken.

Individual organisations have therefore prioritised their investment plans for 2026/27 based on the following criteria:-

- Need to address key patient safety issues
- Address backlog maintenance and infrastructure risk
- Equipment replacement and investment in information management and technology (IM&T)
- Delivery of key strategic schemes and supplementing national funding

Plans are approved and signed off through each organisation's governance arrangements as part of the operational planning process.

The Derbyshire Capital Planning and Prioritisation Group continues to meet monthly and brings together all NHS partners in the Derbyshire ICS to ensure the overall system capital resource is effectively managed.

To effectively manage the capital resources in 2025/26 and to ensure a balanced capital plan could be delivered across Derbyshire in aggregate, agreement was reached to manage cost pressures in one provider with underspends in another provider. This was effectively a form of brokerage and will need to be repaid in 2026/27. With the move to provider level allocations, this will need to be transacted via an adjustment (increase or decrease) to the allocations already notified to providers. There is a national process to enable this to happen.

Overview of ongoing scheme progression

£2.953m in 2026/27 is included in the DHcFT plans to support the ongoing Mental Health Dormitory Eradication programme across Derbyshire. Named the "Making Room for Dignity" programme, this major investment into mental health inpatient facilities in Derbyshire forms part of the national eradication of dormitory programme.

£3.50m in 2026/27 has been provided from national Sustainability and Transformation Partnership (STP) funding to support the redesign of the Acute Front Door services at Derby Royal Hospital. This will facilitate the delivery of comprehensive patient assessment and ongoing high-quality urgent care to residents of South Derbyshire.

The development on the Outwoods site near Queens Hospital Burton is to build a nursery, GP surgery, and residential accommodation as part of the Healthcare Village plans, Medical Education Centre and newly built dementia centre. This scheme is an example of collaborative working across the Derbyshire and Staffordshire systems to deliver a new primary care centre for local GPs and to provide additional estate capacity for acute sector use.

New Business Cases within the 2026/27 Capital Plan

Return to Constitutional Standards / Left Shift Allocations

As part of national funding to support improvements in performance against NHS Constitutional Standards, and to enable the ‘left shift’ of care from hospital to community settings where appropriate, systems have been provided with an indicative allocation across Diagnostics, Elective, UEC, MHLD&A and Community programmes. The total indicative allocation for Derbyshire across these programme areas is £48.25m in 2026/27, with further indicative allocations provided up to 2029/30. The table above includes some provider-specific schemes included in the Derbyshire submission to NHS England and reflected within provider operational capital plans.

There are some schemes where the provider is yet to be confirmed, as the scheme is still in development.

The indicative allocations for Derbyshire in 2026/27 are as detailed below :-

- Diagnostics: £13.5m
- Urgent and Emergency Care (UEC): £31.0m
- Mental health, learning disabilities and autism (MHLD&A): £1.75m
- Community: £2.0m

It is important to note that Derbyshire’s Urgent and Emergency Care (UEC) allocation includes funding for East Midlands Ambulance Service, which operates across the East Midlands, because Derby and Derbyshire ICB is the host commissioner.

Bids have been submitted to NHS England in line with national timescales. Initial feedback was

received in March 2026 from the national panel. Some schemes are now progressing to business case development, while for other schemes further information is required to support a panel decision.

Cross-system and collaborative working

Derbyshire works collaboratively across NHS organisations and partners to ensure capital resources are used to deliver the best outcomes for patients and local communities. The Derbyshire ICS brings together capital planning across estates, digital and medical equipment to support prioritisation, affordability, and deliverability within the overall system resource envelope. As set out in the Derbyshire, Lincolnshire, and Nottinghamshire (DLN) ICB cluster arrangements, the three ICBs work together to provide a consistent framework for assurance, decision making and escalation for capital planning, while maintaining clear visibility of local priorities and provider plans.

In addition, some providers deliver services across ICB boundaries (for example, East Midlands Ambulance Service), and capital funding routes can differ. Where capital resources are routed through another ICB, Derby and Derbyshire ICB works through system and regional forums to ensure capital requirements that impact Derbyshire services are understood and reflected in planning and delivery.

Net zero carbon strategy

NHS England has made it mandatory for all trusts and integrated care systems (ICSs) to produce a board-approved Green Plan which sets out a sustainability strategy for the next three years. The Derbyshire ICS has a system-level sustainability strategy. It presents our carbon footprint data and outlines our commitment to sustainability, summarises our organisation-level Green Plans (including carbon hotspots and actions to address them), and sets out a programme of interventions to support delivery.

Lastly, we present a total of eleven interventions through which the strategies and priorities of the Derby and Derbyshire Integrated Care Partnership (ICP) will be coordinated and integrated. A separate document outlines the ways and timescales by which our organisations will be held to account for reducing carbon emissions and making progress toward net zero.

The system recognises a wider responsibility to support net zero ambitions and to make the most of digital advancements to provide more accessible and efficient services. Capital procurements consider environmental impacts when prioritising how we use limited resources. We have local targets and timelines to reduce carbon emissions, air pollution and waste, and we will work towards a net zero system by 2040.

The NHS estate and its supporting facilities services – including primary care, trust estates and private finance initiatives – comprises 15% of the total carbon emissions profile. There are opportunities for emissions reductions in the secondary and primary care estates respectively, with significant opportunities seen in energy use in buildings, waste and water, and new sources of heating and power generation.

Delivering a net zero health service will require work to ensure that new hospitals and buildings are net zero compatible, as well as improvements to the existing estate. The Derbyshire ICS approach supports the capital and estates elements of the net zero agenda in several ways. To help ensure that disadvantaged communities, staff, and patients can access NHS services equitably, the Derbyshire ICS will promote active travel (for example, through salary sacrifice

schemes) and other low-carbon alternatives where possible.

To improve access to a greener estate, the Derbyshire ICS will also ensure that opportunities to 'green' the estate are maximised, with a focus on areas within the most deprived communities. The Derbyshire ICS is planning for all major refurbishments and new builds to consider the need to reduce emissions and, wherever possible, to ensure maintenance and equipment replacement improves energy efficiency and reduces emissions. For example, the Making Room for Dignity programme includes greening and greenspace as part of its estate approach.

Our 2026/27 capital plan includes £6.511m Salix funded schemes for decarbonisation priorities along with core capital expectations of reducing emissions such as low or zero emission vehicles, lower power Estates schemes and sustainable supply chain.

Risks and contingencies

Risks in the delivery of capital plans include the risk of inflationary pressure on plan values and the ability to manage the over commitment in the system plan effectively. The system's capital planning and prioritisation group is responsible for overseeing the delivery of the capital programme, effectively identifying and managing in year risks and ensuring that the programme is delivered within the resources available to the system.

However, more specific risks to the Derbyshire ICS plan include:

The Making Room for Dignity program has previously received additional national allocation to support financial pressures. The scheme remains a live program and has been exposed to significant cost pressures which will need to continue to be proactively managed as the programme moves into the next phase. The Trust closely manages this scheme progress and provides assurance through system financial reporting. The success to this program will support a financially sustainable future by bringing out of area patient placement back within the system estate.

Trusts have highlighted critical infrastructure risks and the subsequent impact that this has on addressing ongoing backlog maintenance; this has in part been mitigated in the plan through the inclusion of additional national allocation for Estates Safety. The continued limited availability of system capital means that providers are often faced with challenging decisions about how best to spend their limited capital. It also means that some critical elements of buildings' infrastructure remain very fragile, which may impact on future service delivery

The system will continue to carefully monitor these risks throughout the year taking escalation for action through the Capital Planning and Prioritisation Group, system / cluster CFO meetings and onward through Finance Committee and Boards of partner organisations.

Joined Up Care Derbyshire

NHS Derby and Derbyshire Integrated Care Board

Appendix A – System CDEL template for allocation of capital resource 2026/27

CDEL	DDICB	CRH	DCHS	DHcFT	EMAS	UHDB	Total full year plan £'ms
Operational Capital – ICB	2.19						2.19
Strategic Capital – ICB	3.49						3.49
Utilisation & Modernisation Fund - ICB	1.00						1.00
Operational Capital – Provider		8.64	4.62	6.10	12.20	23.46	55.02
Sub Total System Operational Capital	**6.68**	**8.64**	**4.62**	**6.10**	**12.20**	**23.46**	**61.70**
Programme National Programme Spend							
Critical Infrastructure Risk		0.53	0.94	0.24	1.12	3.21	6.04
Mental health dormitories							0.00
Other Adjustments – Provider					11.44	3.50	14.94
Sub Total National Programmes	**0.00**	**0.53**	**0.94**	**0.24**	**12.56**	**6.71**	**20.98**
Return to Constitutional Standards: Diagnostics		4.55				2.65	7.20
Return to Constitutional Standards: Urgent & Emergency Care		3.64	4.63		15.33	6.90	30.50
Return to Constitutional Standards: Mental Health, Learning Disabilities & Autism		0.15		0.28			0.43
Return to Constitutional Standards: Community			2.00				2.00
Sub Total Return to Constitutional Standards	**0.00**	**8.34**	**6.63**	**0.28**	**15.33**	**9.55**	**40.13**
Other Adjustments – Provider		0.31		0.96		7.81	9.08
TOTAL CDEL and ICB capital	**6.68**	**17.81**	**12.19**	**7.58**	**40.10**	**47.53**	**131.88**

Other adjustments - Provider includes any over-programming factored into the capital plans, disposals and or capital grants and PFI related capital charges.

Appendix 3: Lincolnshire Joint Capital Resource Use Plan 2026//27

Region	**Midlands**
ICB or system	**NHS Lincolnshire ICB**
Date published	**May 2026**
Version control	**5**

Version	Date issued	Who/Comment	Updated by	Sign off	Approvals
4	26 March 2026	n/a	n/a	1 April 2026	Joint Finance and Performance Committee
5	13 May 2026	Accessibility and narrative checks /review/update final submissions 31 March for Board.	n/a	21 May 2026	Board Meeting

Introduction

Lincolnshire ICB and its partners Lincolnshire Community and Hospitals NHS Group and Lincolnshire Partnership NHS Foundation Trust, serve a population of 826 thousand people in Lincolnshire. The services provided are:

- planned care
- cancer care
- emergency care
- mental health
- learning disability and autism
- maternity services
- community and GP services

As set out in our Integrated Care Partnership (ICP) Strategy, our Joint Forward Plan (JFP) and our Lincolnshire Older People's Strategy, our Integrated Care System (ICS) ambitions and priorities have been developed by partners across the Lincolnshire health and care system and have been informed by understanding the needs of our population.

At its core, the 'Our Shared Agreement' describes the foundations of an evolving relationship between health, care, communities, and the people of Lincolnshire that is rooted in partnership, education, personalised care and making decisions together.

Our priorities are:

- A better relationship with the people of Lincolnshire
- Living well and staying well
- Improving access
- Integrated community care
- A happy and valued workforce

The ICS has a mixture of NHS-owned and leased estate. Within Lincolnshire, there remains limited opportunity for further development of our existing sites, and there are significant constraints both operationally and financially to the continued expansion of our existing estate.

This plan is produced in line with Lincolnshire ICB's arrangements for capital planning and oversight within the Derbyshire, Lincolnshire and Nottinghamshire (DLN) ICB cluster. Whilst Lincolnshire ICB remains accountable for its statutory duties and for the delivery of its own joint capital resource use plan, the DLN cluster arrangements provide a consistent framework for assurance, decision-making and escalation across ICBs. This supports a coordinated approach to prioritisation, affordability and deliverability of schemes, including where allocations and funding streams require cross-system alignment. Governance and oversight are provided through the cluster Joint Finance and Performance Committee, supported by shared reporting arrangements that enable consistency of approach and learning across the cluster, while ensuring that Lincolnshire's local system priorities and provider plans remain clearly reflected."

This capital resource plan provides transparency for local residents, patients, NHS health workers and other NHS stakeholders on the prioritisation and allocation of capital funding within the NHS bodies in Lincolnshire to achieve their strategic aims and ambitions. This aligns with the ICBs' financial duty to remain within the allocated capital funding levels and to report annually on their use of resources.

As set out in our Integrated Care Partnership (ICP) Strategy, our Joint Forward Plan (JFP) and our Lincolnshire Older People's Strategy, our Integrated Care System (ICS) ambitions and priorities have been developed by partners across the Lincolnshire health and care system and have been informed by understanding the needs of our population.

Recognising the ICS priorities and challenges, the capital investment strategy looks to ensure that Lincolnshire meets several requirements.

1. There should be a high-quality estate that supports the delivery of operational service developments and ongoing transformational projects and investments.

2. Lincolnshire ICS should have an affordable, well utilised and fit for purpose estate. This will be driven by information from a recent 6-facet survey that allows Lincolnshire to

take into consideration the level of risk and backlog maintenance that exists and plan accordingly.

3. The ICS should maximise digital and technology opportunities. Lincolnshire will look to have a digitally mature ICS supported by a smarter network of intelligent and connected systems to connect and transform.

4. This ICS is keen to Improve our energy efficiency and deliver estate which meets the NHS Green principles.

5. There should be an effective medical equipment replacement programme. This will ensure our patients are being treated with up-to-date equipment and advanced technologies that support patient care.

The ICS has been given a 1-year capital settlement covering 2025/26. The government has not yet awarded a capital settlement beyond 2025/26. However, we expect to receive a multi-year settlement as part of the 2025 Spending Review (Phase 2).

The government has agreed that systems can assume that they will receive at least 80% of their 2025/26 core operational capital allocation in each year of this Parliament. This assumption is intended to provide greater certainty, enabling providers and systems to plan with confidence, accelerate investment decisions, and focus on delivering maximum value for patients and the public

The funding is split into four elements:

Operational Capital £4.0bn (Lincolnshire £39.7m) for day-to-day investments, including depreciation and IFRS 16-related costs. System allocations subject to uplift / reduction dependent upon revenue performance.

National Programs: £5.6bn (Lincolnshire £33.2m) for national strategic priorities such as diagnostics, urgent and emergency care (UEC), technology transformation & net zero commitments. It also includes funded allocated for the New Hospital Program, reinforced autoclaved aerated concrete (RAAC) safety works, and other ongoing initiatives.

New Financial Freedoms & Flexibilities for Trusts / Systems in NOAF 1 / 2

The key system strategic capital projects for 2026/27 are:

Lincolnshire Community and Hospitals NHS Group

- Electronic Patient Record (ePR) part of the Front-Line Digitalisation Programme – Year 3 of the programme, completion scheduled for Q3 2027/28
- Endoscopy Unit, conclusion of the 4 year project with the new unit to open in early 2026/27.
- Boston Pilgrim Hospital Emergency Dept – the culmination of the seven year project is expected to in April 2026.

- Carbon reduction Project – Yr 2 of a three year project to address the Trusts energy infrastructure as part of the UK Government and NHS Carbon Commitments
- Critical Infrastructure and Estate Safety Works continuing the focussed upgrade of fire safety and electrical infrastructure.
- Boston Community Diagnostic Centre completion scheduled for March 2027
- Combined Same Day Emergency Care Centre (SDEC) at Lincoln County Hospital.Stroke Unit Modernisation & Centralisation. The Acute Services Review concluded in May 2022, with the decision to centralise stroke services to the Lincoln County Hospital (LCH) Site. Whilst the service centralised in September 2023 due to the fragility of the medical staffing, the ASR recommendations included an estates element to accommodate the increased stroke patients to Lincoln County Hospital.
- Skegness Community Estate development contributing to the shift of activity safely out of acute hospitals into the community whilst also addressing inequalities in service provision across coastal communities.

Lincolnshire Partnership NHS Foundation Trust

- The Trust has a smaller operational allocation and NHSE PDC Estates Safety allocation than previous years. Therefore, available funds will be utilised on backlog maintenance/estates safety schemes such as the Peter Hodgkinson Centre water infrastructure works and the Manthorpe Centre Priority structure and fabric works.
- There are currently no strategic capital projects in the 26/27 capital plan apart from £200k that is to be spent on digitising mental health pathways utilising the Constitutional Standards and Left Shift NHSE PDC allocation.

2026/27 CDEL allocations

This table details a summarised view of the capital plans for the providers across Lincolnshire and the ICB.

The constituent parts of the allocation include the following –

- Operational Capital across the ICB and the 3 NHS Provider organisations
- ICB Strategic Capital allocation
- ICB Utilisation & Modernisation Fund
- Specific Provider allocations resulting from successful bids for additional

capital

- Support for Schemes designed to address the Left Shift Programme and an improvement in Constitutional Standards performance
- Benefits from planned capital disposals

Lincolnshire ICB Joint Capital Resource Plan 2026/27	LICB	ULTH	LCHS	LPFT	Total
	£'m	£'m	£'m	£'m	£'m
Operational Capital allocation	1.7	29.9	2.0	2.5	**36.1**
ICB Strategic Capital allocation	2.8				2.8
ICB Utilisation and Modernisation Fund	0.7				0.7
Total System Operational Capital Allocation	**5.2**	**29.9**	**2.0**	**2.5**	**39.6**
Estates Safety: Targeted maintenance		5.3		0.2	5.5
Estates Safety: Strategic - LCH Maternity		1.0			1.0
Diagnostics Schemes		17.7			17.7
UEC Schemes		7.0			7.0
Mental Health, Learning Disability and Autism Schemes				0.2	0.2
Community Schemes			1.8		1.8
Total Allocations	**5.2**	**60.9**	**3.7**	**2.9**	**72.7**
Other resource: Salix Grant		10.5			10.5
Sub-total	**5.2**	**71.4**	**3.7**	**2.9**	**83.2**
Fair Shares / System bonus		10.3			10.3
Total Resources - excluding disposals	**5.2**	**81.7**	**3.7**	**2.9**	**93.6**
Planned disposals / Tfrs: ICT Infrastructure		0.9	(0.4)	0.0	0.5
Total Resources - inc disposals	**5.2**	**82.6**	**3.3**	**3.0**	**94.0**

Capital prioritisation

Lincolnshire is constantly reviewing the capital requirements to meet the needs of two key elements:

- 'Business as usual' investment required to 'keep the lights on', and;
- Transformational investment required to support continued improvements for the population of Lincolnshire.

Lincolnshire has implemented a System Investment Group that brings together all the requirements of the key groups at both a local provider level and also from a strategic perspective. This covers Digital, Estates and Medical Devices.

This group supports the prioritisation process of available resources to ensure that services continue to be provided but that funding is available to promote continuous improvement. This process often highlights need for further funding into Lincolnshire as supporting current services requires significant

Capital planning

The system capital expenditure plan is seeking to address both immediate pressures and backlog requirements through operational capital, while applications are made to national monies for innovations.

For 20 the providers' capital planning is largely managed by Finance and the technical sub-groups (Estates, Digital and Medical Devices) to ensure those areas most in need of investment are given priority.

Capital investment requirements are assessed against the following:

- Strategic fit
- Investment requirement (cost)
- Deliverability
- Risk

All capital plans are ratified within organisational governance structures comprising of Capital Investment Groups reporting upwards through the Executive Infrastructure Groups, Performance and Finance & Performance Committees and Trust Boards. These are then further assessed as part of the ICS approval processes in place.

All capital expenditure is managed by controls as set out in the Standing Financial Instructions.

Overview of ongoing scheme progression

Lincoln Endoscopy - Capacity within the existing Endoscopy Department at Lincoln County Hospital does not support the growth in endoscopy demand and new diagnostic procedures. Demand has increased with the age extension of the Bowel Cancer Screening Programme. The condition of the Lincoln Endoscopy Unit has serious outstanding building maintenance issues requiring urgent work to ensure compliance with requirements for infection prevention and control, health and safety, and also the Joint Advisory Group (JAG) for GI Endoscopy accreditation. This scheme, which is due to be completed in June 2026, delivers a new endoscopy unit at Lincoln County Hospital designed to current standards with additional rooms and facilities. This will provide the additional capacity to meet growing demand and age extension of the Bowel Cancer Screening Programme and retention of JAG accreditation. The benefits created will be numerous but most important are improvements to patient experience, increased early detection of pathology to improve the quality of life of our patients and an environment that supports our staff to do their work with pride.

Community Diagnostic Centre Boston (CDCs) – Lincolnshire has been successful in bidding for funding against the national Community Diagnostic Centre (CDC) Programme. Following approval of the business case in 2025/26 and the recent successful builds at Lincoln, Skegness and Grantham the CDC model is set to be replicated at Boston.
The new centre is scheduled to be fully open in March 2027 but with some services able to be delivered from December 2026. These centres offer patients a wide range of diagnostic tests closer to home and greater choice on where and how they are undertaken, reducing the need for hospital visits and potentially expediting the start of treatment. Key benefits are:

- Increased capacity for diagnostic tests while protecting the acute site capacity for UEC/IPD
- Improve the population's health by allowing quicker, more local access to a wider range of diagnostic tests and treatment.
- Improve productivity and efficiency by streamlining activity, remove duplication and redesign pathways to achieve optimal efficiency.
- Reduce health inequalities within the area through increased service provision, addressing unmet demand and encouraging patients to seek early treatment and reduce emergency presentations.

- Support integration of care and improve the personalisation of a patient's diagnostic experience.

Electronic Patient Record - The aim of this project is to replace outdated and unsuitable paper-based notes/records and multiple disparate systems. The proposal aligns to the national policy of ensuring digital transformation to improve digital maturity to HIMSS (Healthcare Information and Management Systems Society) level 5. Lincolnshire aspires to a transformational change rather than digitising its current processes. The largest investment will be in United Lincolnshire Hospitals NHS Trust (ULHT). Through procuring a high-functioning electronic patient record (ePR) system which will be implemented across ULHT, this scheme, whilst led by ULHT (the lead provider of acute care services in the county) will support both the Trust and the wider Integrated Care System (ICS) achieve its ambition of providing excellent patient care. Patients, visitors, and staff will gain a range of benefits from the proposal, not seen with the current arrangements.

The principal aim of a successful EPR deployment is to improve clinical outcomes and safety for patients. EPR technology provides clinicians with modern clinical decision support tools, based on well-managed data, at their fingertips reflecting best practice guidelines, recognised clinical standards and data insights drawn from across hospital operations. Powerful audit tools can monitor clinical practice and outcomes and therefore minimise variations in clinical care, while electronic data validation and predictive clinical algorithms based on high-quality real time data can reduce the number of clinical errors or alert staff to potential hazards or deterioration in a patient's condition.

An EPR also supports improved safety and outcomes by providing a comprehensive clinical record and a single aggregated view of a patient's data. It will also let multiple users view and update the patient's record at the same time from wherever they are on-site or remotely. This ensures that staff have access to the right information at the point when they need it, without logging into multiple systems, or requiring a complex paper chase and series of phone calls. There is an added benefit, when EPRs work well, of improving staff morale, retention and the working environment.
Funding of this project was approved at National Level early in 2025/26 and work is progressing at pace with the first in a series of 'go-live' dates due Oct 2026 with the final planned for Autumn 2027.

Boston Pilgrim Emergency Dept – Funded through the Health Infrastructure Plan this project's aims were to transform the provision of urgent and emergency care at the hospital. It was known that demand was outstripping capital with clinicians making difficult decisions as to which patients could go into resus. Too few majors' cubicles meant congestion in the department. The UTC was too small, and some patients had to be sent to ED. The department did not meet current HTM / HBN standards and was poor for patient confidentiality and experience.

Phase 1a / 1b were completed in 2025/26 and work is substantially completed on the refurbishment of the old ED. This is due to be completed with the opening of the new department early in 2026/27.

Carbon reduction Project – The Trust successfully bid for and was awarded a Grant of £23.3m through the Salix Public Sector Decarbonisation Scheme (PSDS) Phase 4. As a condition of this award, the Trust is committed to invest at least 12% (£2.8m) of its own resources to improve the carbon emissions at Pilgrim Hospital, Boston. This Investment into energy infrastructure will assist the Trust in achieving the targets set out in the Climate Change Act (Delivery of a Net Zero National Health Service).

This is year 2 of the project which will run over 3 years with our procured strategic delivery partner. The carbon saving of 79,789 tonnes of Co2 over 15 years has been identified as part of the PSDS submission.

The total scheme value is a capital investment of £28.91m including the trusts contribution which maximises the reduction of carbon emissions for this project at the Pilgrim Hospital, Boston.

Combined Same Day Emergency Care Centre (SDEC) at Lincoln County Hospital. -
Phase 1 of this project commenced in 2025/26 with the main build work scheduled in the latter half of the new financial year. This will increase capacity and patient flow within LCH – moving orthopaedic outpatient activity off site and developing the vacated area next to A&E. The project will generate 5 key benefits:

- Creation of a combined SDEC to ensure capacity is available to treat patients in a timely manner in the right place at the right time,
- Improving patient outcomes and reducing pressure on Urgent and Emergency services at LCH.
- Efficient use of staffing resources to create an integrated workforce team for SDEC services.
- Reduction of admissions as patients are managed in SDEC and community
- Streamlining activity, removing duplication and redesigning pathways/processes

Stroke –
The modernization and upgrade of Stroke Services was a key deliverable identified as part of the Acute Services Review in 2022. In 2025/26 – 2026/27 a total of £7.6m will have been invested.
The overall project aim is to implement a sustainable, efficient clinical service model, and

develop a fit for purpose centralised stroke centre of excellence on the Lincoln County Hospital site for the populations served and ensure:

- a coherent strategic vision to align our services with local and national policy.
- Delivery of excellent facilities for clinicians with improved patient safety and able to provide optimum care resulting in improved Key Performance Indicators (including SSNAP data, Thrombectomy referral rates and thrombolysis figures) working towards a Lincolnshire Stroke Service Model.
- a unit that will be responsive to the requirements of Hyper-Acute and acute Stroke Patients whilst ensuring capacity for future demographic changes over the next 30 years.
- a fit for purpose Stroke Unit to treat all Hyper-acute and Acute stroke patients on the Lincoln County Hospital site through the centralisation of Trustwide services.

Skegness Community Estate –

This project will focus on the development of Skegness, the community estate to enable shift of activity safely out of acute hospitals, provision of integrated services around communities working with all provider partners to develop better integrated services and address entrenched coastal inequalities.

A strengthened Skegness estate creates a local anchor for integrated care, reducing reliance on distant acute services and supporting:

- Urgent care – upgraded UTC estate and delivery of core standards.
- Delivery of planned community services – upgraded lymphoedema facilities (community waiting list delivery – core standards)
- ambulatory and day-case pathways
- urgent community response
- virtual ward step-up provision
- rehabilitation closer to home

A modern, flexible Skegness estate enables:

- A physical home for the INT (community nursing, ACT, mental health, social care, VCSE)
- Regular multidisciplinary working, shared information and coordinated care planning.
- Seamless “step-up” and “step-down” from hospital
- Co-location with mental health, diagnostics, and outpatient specialties
- A visible neighbourhood asset for residents

Eradication of Mental Health Dormitories –

This project was completed in 2025/26 with the formal opening of the facility on 11 March 2026.

Capital Departmental Expenditure Limit (CDEL)

Lincolnshire CDEL limit is significantly lower than the level of investment that is required. This is the biggest block to being able to deal with the key risks and developments that need to be resolved and/or invested in for the benefit of the Lincolnshire population

Business cases in 2026/27

The key Lincolnshire business cases that are likely to be submitted during 26/27 are:

- *Boston Maternity Services - £28m (ULTH)*
- *Lincoln Maternity Services - £48m (ULTH)*
- *Grantham Theatres - £38m (ULTH)*
- *SDEC (Phase 2) - £7m (ULTH)*
- *Skegness Community Estate £6.3m (LCHS)*
- *Acute Floor reconfiguration - £tbc (ULTH)*
- *R & I – NHIR Funding bid opportunity £1.5m (ULTH)*
- *Neighbourhood Health Hubs Boston & Grantham supporting the left shift agenda, working in partnerships with local councils in relation to levelling up funding support, value tbc (LCHS)*
- *Sterilisation Services – developing a new decontamination service to replace the Steris service at the end of contract (Jan 28) est £5m (ULTH)*

Cross-system and collaborative working

System collaboration is key to ensure capital expenditure is maximised to provide the optimum outcome for the patients we serve. This section provides evidence of the strong partnership working within schemes and across the wider system.

Lincolnshire has established a number of cross-system working groups or committees that seek to identify the capital investment requirements. The key groups cover Estates and Digital Technology. These groups/committees have representation from all key stakeholders to ensure collaborative working.

Further to this, Lincolnshire has established a system-wide finance capital group. All finance system partners are represented on the Group. The aim of this group is to ensure a collaborative approach to capital and to ensure capital investment is prioritised and used effectively.

Capital plans are agreed upon taking into account the information and outcomes from these groups/committees to ensure that financial resources are being invested in the best way.

Net zero carbon strategy

Our Trusts have made considerable progress in their net zero journeys over the years. The challenge now is to set a long-term vision for sustainability within the System and define the actions that the System and our stakeholders will take to achieve it.

The end goal of the NHS Green Plans is to reach net zero by 2045. This plan will take us through the next three years. As the System develops and matures as an organisation it will be possible to further develop our longer-term strategy and vision to get to 2045.

The pace of change within the system is beginning steadily, as there is new architecture around healthcare in Lincolnshire. However, as our relationships with stakeholders grow and develop, environmental progress is hoped to increase exponentially. This will also allow conversations around budgets funding to develop further. Some financial saving will be feasible by choosing a more sustainable approach, but in many cases, investment will be needed too. Funding should therefore be of focus in the delivery of this Green Plan.

The net zero journey will require changes to infrastructure, policies, practices, behaviours, values, and the alignments of activities with the green agenda. Therefore, it is important that a green thread persists throughout all our workstreams. Each area of focus details the actions NHS Lincolnshire will take to reach net zero within that workstream. The actions also need to ensure that the Green Plan will be rooted in the ‘place’ rather than the ‘provider’, meaning that it will bring a broader Lincolnshire focus.

Appendix 4:
Nottingham and Nottinghamshire ICB
Joint capital resource use plan – 2026/27

Region	**Midlands**
ICB or system	**NHS Nottingham and Nottinghamshire ICB**
Date published	**May 2026**
Version control	**5**

Version	Date issued Who/Comment	Updated by	Sign off		Approvals
4	26 March 2026	n/a	n/a	1 April 2026	Joint Finance and Performance Committee
5	13 May 2026	Accessibility and narrative checks /review/update final submissions 31st March for Board.	n/a	21 May 2026	Board Meeting

Introduction

NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) is a statutory body which brings together health and care organisations and partners to improve population health and establish shared priorities within the local health and care system.

The ICB has developed an Integrated Care Strategy to improve health and care outcomes and experiences for local people. The Strategy covers health and social care and addresses the wider determinants of health and wellbeing. It is based on three guiding principles:

- Prevention is better than cure.
- Integration by default.
- Equity in everything.

The Strategy builds on existing system strategies, including the Joint Local Health and Wellbeing Strategies for Nottingham and Nottinghamshire, and sets out the system's priorities to improve life expectancy and healthy life expectancy and to reduce health inequalities for the people of Nottingham and Nottinghamshire.

The ICB and its five NHS Trust and NHS Foundation Trust partners Sherwood Forest Hospitals NHS Foundation Trust (SFH), Nottingham University Hospitals NHS Trust (NUH), Nottinghamshire Healthcare NHS Foundation Trust (NHT), East Midlands Ambulance Services NHS Trust, and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust) have

developed a Joint Forward Plan that describes how the local NHS organisations will implement the NHS Mandate, tackle key issues and contribute to the delivery of the Integrated Care Strategy and the Joint Local Health and Wellbeing Strategies. The effective use of Capital Resource is essential to the ability to deliver on that ambition.

The ICB serves a population of approximately 1.2 million people and covers the city of Nottingham and the surrounding Nottinghamshire County, including urban, suburban and rural communities.

NHS Derby and Derbyshire, NHS Lincolnshire and NHS Nottingham and Nottinghamshire ICBs (hereafter referred to as the ICBs) are working together under cluster arrangements. This plan is produced in line with Nottinghamshire's ICB's arrangements for capital planning and oversight within the Derbyshire, Lincolnshire and Nottinghamshire (DLN) ICBs. Whilst Nottinghamshire ICB remains accountable for its statutory duties and for the delivery of its own joint capital resource use plan, the ICBs provide a consistent framework for assurance, decision-making and escalation. This supports a coordinated approach to prioritisation, affordability and deliverability of schemes, including where allocations and funding streams require cross-system alignment. Governance and oversight are provided through the Joint Finance and Performance Committee, supported by shared reporting arrangements that enable consistency of approach and learning across the three systems, while ensuring that Nottinghamshire's local system priorities and provider plans remain clearly reflected.

Since 2020/21, the system has been provided with an annual capital resource envelope for use across the 3 provider organisations (NUH, SFH and NHT) and the ICB and is expected to plan and deliver capital expenditure within available resources.

The Nottinghamshire estate contains a mixture of older poor condition building and newer estate. The older estate, notably at Queens Medical Centre (QMC), Nottingham City Hospital and Rampton Hospital, requires extensive maintenance and as such, the system is recognised as having one of the highest backlog maintenance requirements in the country.
Coupled with capital required to support service continuity pressures and strategic priorities the requirements for capital funds across our provider organisations are significantly higher than funding available.

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

2026/27 CDEL allocations and sources of funding

From 2026/27, operational capital allocations will flow directly to individual providers rather than through systems.

The summary table below (see more detailed table in Annex A) shows the expected sources of capital income for NHS partners in 2026/27 (based on the submission of capital plans to NHSE on the 31st of March 2026). The system has been successful in bidding for several funding sources from outside of the operational capital envelope.

Following publication of the planning guidance, it has been confirmed that resource will continue from 2025/26 and be made available nationally for 2026/27 to support the delivery of a return to constitutional performance standards. Systems have been provided with an indicative allocation across Diagnostics, Urgent and Emergency Care, Mental Health, Learning Disabilities and Autism and Community programmes.

The table above includes an indicative amount for some specific provider schemes for Return to Constitutional Standards as submitted in provider capital plans.

The total indicative capital allocation for Constitutional Standards for 2026/27, as advised by NHSE, is £25.5m, broken down as follows: -

- Diagnostics £5.5m
- Urgent & Emergency Care (UEC) £12.9m
- Mental Health, Learning Disabilities and Autism £4.8m
- Community £2.3m

This includes some schemes in the Mental Health, Learning Disabilities and Autism and Community Programmes for which the provider has not yet been agreed as schemes are still being developed or maybe a non-NHS provider.

Bids have been submitted to NHSE for the indicative amount will panels being held across NHS England (NHSE) Capital and Programme teams and regions to consider the system schemes. Initial feedback has been received from the NHSE national team in March 2026 with approval pending for some schemes ahead of queries requiring responses and agreement.

The ICB receives a ring-fenced capital allocation of c. £2.5m each year to invest in Information Technology (IT) replacement and small premises improvements in primary care (general practice). The Utilisation and Modernisation fund (UMF) in 2026/27 is £1.0m and will be invested in appropriate primary care developments. In addition, Strategic Primary Care Capital, newly available in 2026/27, will fund prioritised strategic primary care schemes.

Net CDEL 2026/27	Plan £m' s
Operational Capital – ICB	**2.5**
Strategic Capital – ICB	**3.9**
Utilisation & Modernisation Fund – ICB	**1.0**
Operational Capital – Provider	**71.7**
Sub Total System Operational Capital	**79.0**
Programme National Programme Spend	
Critical Infrastructure Risk (CIR)	**13.0**
Mental health dormitories	**2.3**
Other Adjustments – Provider	**6.7**
Sub Total National Programmes	**22.1**
Return to Constitutional Standards: Diagnostics	**5.5**
Return to Constitutional Standards: Urgent & Emergency Care	**12.9**
Return to Constitutional Standards: Mental Health, Learning Disabilities & Autism	**2.4**

Sub Total Return to Constitutional Standards	**20.8**
TOTAL CDEL and ICB capital	**121.9**

Risks and Contingencies

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

Nottingham University Hospitals (NUH)

- The Trust has c. £500m of critical infrastructure back log maintenance.
- The core allocation BAU funding has been significantly reduced across the 4 years when compared to previous years. Whilst CIR and Constitutional Standards are welcome separate funding streams, they come with conditional requirements which restricts the extent to which the Trust can address the increased number of high-risk capital priorities.
- Further slippage during 2025/26 leaves NUH with pre-commitments on several major projects going into 2026/27, these will need to be delivered alongside a range of BAU capital items against a reduced envelope of capital resources available.
- The Trust still has a significant level of red rated medical equipment replacement requirements.
- There is a significant level of expenditure urgently required to replace the digital network and end point devices which will need to be addressed from 2026/27 onwards. This is likely to require use of national digital funding given the scale required.
- The two main campuses, QMC and City, remain capacity constrained from an electricity perspective which may lead to a critical infrastructure failure.
- The Trust is having to review its commitment to previously approved multi-year schemes that support rolling replacement of clinical need due to insufficient funding availability.

Sherwood Forest Hospitals (SFH)

- Due to major commitments relating to completion of the new build Magnetic Resonance Imaging (MRI), Emergency Department refurbishment and implementation of the new electronic patients record system, there is limited business as usual capital in 2026/27.
- All risks are controlled and managed by Digital, Estates and operational teams and monitored via the Capital Resource Oversight Group.

Nottinghamshire Healthcare (NHT)

- Long Term Segregation (LTS) at Rampton Hospital and Arnold Lodge.
- Eradication of Dormitories with final phase of programme to be completed in 2027/28
- £24.5m of critical infrastructure backlog maintenance.
- Ageing estate of Secure Services.
- Health and Safety risks of the schemes are being controlled and managed by Digital, Estates and operational teams.

The Trust has developed a 5-year capital programme to address a proportion of the specific risks with its highest priorities being addressing LTS and the eradication of dormitories. The Trust is also finalising a Development Control Plan (DCP) for the Rampton Hospital estate which will

identify and prioritise currently unfunded works such as the replacement of the District Heating Main (£15m) which is critical infrastructure to maintain business continuity.

Capital planning and prioritisation

In prioritising operational capital, now issued directly to providers rather than through the system, providers will consider the following factors:

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

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

- Agree prior year precommitments are the first call on the capital envelope. This includes any slippage or unexpected cost increases.
- Additional provider capital envelopes to address operational priorities using an agreed assessment of priorities across the provider organisations.
- National funding to be used to support strategic priorities where possible.

In 2026/27, system partners have several pre-commitments that require funding from the operational capital envelope. Much of these pre-commitments arise from nationally funded schemes. Due to timing of available funds, inflation or changes in scope, local capital funding has been required to supplement the capital funds provided.

Overview of ongoing schemes progression

Nottingham University Hospitals

NUH have planned for a total £76.7m capital resource for 2026/27. This includes the core ICB envelope allocation of £48.9m, along with the specific allocations that cover Estates critical infrastructure £9.0m and Constitutional Standards £18.7m. There will in year confirmation of non CDEL spend relating to donations and grant funded spend including further stage of Public Sector Decarbonisation Scheme (PSDS).

Significant schemes in the 2026/27 plan include:

- The National Rehabilitation Centre (NRC) at Stanford Hall Rehabilitation Estate, a 70-bed clinical facility which will be a purpose-built rehabilitation centre anticipated to open Spring/Summer 2026.
- The completion of a Community Diagnostic Centre in Nottingham city centre. This is a Nationally approved scheme to now be completed early in 27/28 with significant spend in 26/27, including an expansion of the original scheme of which is funded by constitutional standards allocations.
- Completion of the second phase of development to create a Ring-fenced Elective Hub on the City Campus.

- Completion of the compliant inpatient and tertiary cancer Endoscopy facility on D floor at QMC, to support improvements to patient care, patient safety and the workforce in multiple parts of the current pathway.
- Same Day Elective Care project which has an overall aim to reduce patient length of stay and waiting times for patients who access urgent care across NUH. This investment ask also includes a Radiology Hub to support diagnostics across the UEC pathway, leading to further improvement in waiting times across the NUH emergency pathway.
- To replace and reconfigure two Interventional Radiology (IR) theatres at the City Campus. This is planned to open in Jan 2027 Ongoing BAU spend will need to be managed on Estates, medical equipment and ICT to facilitate the extent of pre-commitments going into 2026/27.

Sherwood Forest Hospitals

Significant schemes in the 2026/27 plan include:

- The completion of the Community Diagnostic Centre (CDC) in Mansfield. This is a Nationally approved scheme started in 2022/23 due to be completed in Q1 2026/27. The Nottingham and Nottinghamshire ICB programme seeks to reduce health inequalities as evidence has shown that residents who live in high areas of deprivation are more likely to experience poorer health outcomes. National funding received is £22.51m. and any costs above have, and this will be met through SFH capital envelope.
- Ongoing implementation of an Electronic Patient Record (EPR) system, expenditure of £3.6m planned in 2026/27 as part of the NHS Frontline Digitisation programme. This will be a key enabler of the ambition to develop the single summary health and care record across the system and will be a core data source for the development of the Population Health Management capability.
- Completion of the new build MRI facilities in Q2 2026/27.
- Upgrade works to the existing Central Sterile Services Departments (CSSD) facilities which are classed as a critical infrastructure risk.

Nottinghamshire Healthcare

Significant schemes in the 2026/27 plan include:

- Continuation of the Trust's frontline digitisation EPR programme (Digi-Care)
- Commencement of final phase of eradication of dormitories project that is scheduled to be finalised at the beginning of 2027/28.
- Estates safety funding at Rampton and Arnold Lodge – to address critical infrastructure risks.
- De-carbonisation of Wells Road Centre.
- Commencement of development of in-house provision for Psychiatric Intensive Care Unit patients.

Business Cases in 2026/27

Electronic Patient Record (EPR)

All three Providers have business cases approved and continue to implement and optimise their EPRs. This is a key element of the ICB frontline digitisation strategy as well as meeting the minimum national standards. The roll out of Nerve Centre commenced in Autumn 2025, NHT are currently working through a programme of enhancing and optimising the use of SystemOne and Rio and SFH started the implementation of Nervecentre with the Emergency Department the first

area to go live. This was paused briefly to ensure activity during winter pressures was not compromised.
The ICB will be looking to secure frontline productivity funding in future years to help optimise the use of EPRs.

Mental Health Dormitories
The system has had a particular focus on the eradication of mental health dormitories. The final phase is the redesign and improvement of Cherry Ward (Highbury Hospital) eradicating dormitory accommodation with inpatient wards with national funding to support the project.

In-house Female Psychiatric Intensive Care Unit (PICU)
An 8-bedded female PICU will be developed to provide this service through NHS provision across Nottinghamshire.

District Mains Heating at Rampton
This is currently at Strategic Outline Case (SOC) and will require funding over several years.

Community Diagnostic Centres (CDCs)
CDC schemes at Mansfield Community Hospital and in Nottingham City Centre remain in progress. The Mansfield scheme is set for completion in quarter 1 2026/27 with the Nottingham City Scheme likely to be completed in spring 2026/27. Once operational, the CDCs will provide additional capacity and greater access to key diagnostic services, aiding the delivery of elective performance.

Same Day Elective Care (SDEC) QMC
The overall aim to reduce patient length of stay and waiting times for patients who access urgent care across NUH. This investment ask also includes a Radiology Hub to support diagnostics across the UEC pathway, leading to further improvement in waiting times across the NUH emergency pathway. This is funded predominantly via Constitutional Standards but will require a full business case approval given the funding total is c. £19m.

Pharmacy Production Unit (NUH & SFH)
The Pharmacy Production Units at both Trusts are challenged with aging infrastructure, compliance with new regulatory requirements, and operational risks. Both organisations face significant risks (scoring 20 and 25), including potential regulatory action, service shutdowns, and patient safety concerns, necessitating a strategic and unified response to safeguard critical healthcare services. The "Preferred Way Forward" suggests constructing a joint facility to enhance efficiency, sustain patient care, and boost revenue margins. The SOC level expected capital cost of the Preferred Way Forward is projected to be £18.2m but consideration for any land purchase may also be required.

Outpatient Facility (City Hospital)
This scheme is more in the longer term, but it is likely that there may be some early business case feasibility being submitted for approval in 2026/27 or 2027/28, as part of the consideration by the wider regional and national process to utilise the Estates Safety Fund. This transformational opportunity of c.£60m to transform patient care, created a new identify for the site and reorientation of the site through a new main entrance that will remain a fixed point through the site consolidation and reconfiguration. This project will significantly address the poor patient experience across the City and NUH outpatient offering, provide a step

change in reduction to back log maintenance at the City campus, through the demolition of old building stock and enabling the estate consolidation, whilst championing the Left Shift, set out in the 10-year 'Fit for Future' health plan.

Wholly Owned Subsidiary WOS (NUH)
NUH is to rapidly assess the near-term opportunities open to the Trust to deliver financial and operational benefits from new ways of operating non-clinical services and purchasing functions and set the delivery plan for the larger distribution centre implementation plan.
The Trust has a multi-site operating model with an ageing estate, with the reprovision due through the NHP and Tomorrows NUH now within the back-end Wave 3 (2037 onwards). The condition of the estate along with growing demand and desire for clinical efficiency means that space on the Acute sites is at a premium and maintaining non-clinical function may be hampering the ability to deliver effectively. The end state business case via a WOS will consolidate a number of non-clinical functions at an off-site, purpose-built facility. It is anticipated that this consolidation can drive operational efficiencies in our procurement and supply functions, whilst freeing up clinical space on our acute sites.

Cross-system and collaborative working

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

In addition to this, East Midlands Ambulance Service and Doncaster and Bassetlaw Hospitals are key service providers within the system and require capital resources to support service pressures and operational priorities. The capital funds for these providers are routed through other ICBs. However, via system forums the ICB is party to decision making for capital funds. This is particularly true for capital required to support emergency care capacity and elective/diagnostic recovery.

Net Zero carbon strategy, approach and progress

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

Our Approach
The system's Green Plan has been recently refreshed through collaborative working between providers and the ICB. Each provider has an organisational green plan, and delivery is caried out at this level. Each provider has one or more sustainability lead who come together monthly alongside NHSE to identify and share best practice and work on cross organisational schemes.

Progress

Heat decarbonisation plans (HDP) are in place for NUH, SFH and NHT. The continuing challenge is finding and securing funding to deliver recommendations made within them.

NUH has previously received PSDS grants towards completion of the replacement of windows at QMC and removing steam as the main transfer of heat around the buildings. The new solution when complete will use a low temperature hot water system from both Combined Heat & Power (CHP) and ground source heat pumps. The new energy centre at QMC that is required to operate this will now complete during 2026/27, utilising the residual grant funding and the contribution required from the Trust.

With capacity provided by Clinical Sustainability fellows, good progress has been made in reducing waste on primary care prescribing and continue to, in line with the reduction trajectory for reducing carbon footprint of inhalers.

Priorities

The Green Plan prioritises several key areas, including estates and energy, procurement, travel, medicines and sustainability training across clinical specialities (also referred to within the NHS as Carbon Literacy).

Estates and energy initiatives focus on heat decarbonisation and energy efficiency improvements across NHS buildings. Procurement efforts are geared toward embedding sustainability into supply chains through the Net Zero Procurement Strategy, ensuring that goods and services align with environmental objectives. There are national clinical procurement schemes that we participate in.

Challenges

The system's approach to delivering a system-wide Green Plan has been commended by NHS England, particularly the co-working across organisations. However, recent carbon footprint quantification has indicated that, despite various initiatives, emissions reductions are not yet sufficient to align with the NHS set net zero trajectory. This highlights the need for further targeted interventions to accelerate progress. One of the key challenges faced is securing funding and resources for sustainability projects.

Annex A – Nottingham and Nottinghamshire System 2026/27 CAPITAL PLAN

2026/27 Capital Plan As of 31 March 2026	ICB £'m	NUH £'m	SFH £'m	NHT £'m	Total £'m	Narrative on the main categories of expenditure
ICB Core Allocation	2.5				**2.5**	The ICB capital plans relate to GP IT and primary care premises developments/improvements.
ICB Strategic Allocation	3.9				**3.9**	This resource is to be used to support primary care estates in response to capital requirements for future developments of Neighbourhood Health Hubs
ICB Utilisation & Modernisation Fund	1.0				**1.0**	The ICB Utilisation & Modernisation fund is for small premises improvements in general practice.
Operational Capital - Provider		48.9	10.4	12.3	**71.7**	This funding is to support business as usual e.g. backlog maintenance and supports several national schemes e.g. Community Diagnostic Schemes
Sub Total System Operational Capital	**7.4**	**48.9**	**10.4**	**12.3**	**79.0**	
Critical Infrastructure Risk (estates safety)		9.0		4.0	**13.0**	This funding is intended to mitigate critical infrastructure and safety risks, addressing the poorest quality estates and ensuring a safe, sustainable environment for healthcare delivery.
Mental health dormitories				2.3	**2.3**	This relates to the eradication of dormitories from mental health facilities.
Other Adjustments – Provider		0.0	6.0	0.7	**6.7**	This relates to the technical adjustment relating to PFI capital charges e.g. residual interest.
Sub Total National Programme Spend	**0.0**	**9.1**	**6.0**	**7.0**	**22.1**	
Return to Constitutional Standards: Diagnostics		5.5			**5.5**	This is for the completion of the Nottingham City CDC scheme.
Return to Constitutional Standards: Urgent & Emergency Care		12.9			**12.9**	This is for completion of the Elective Surgical Scheme at Nottingham City Hospital.
Return to Constitutional Standards: Mental Health, Learning Disabilities & Autism		0.3		2.1	**2.4**	This includes funding for a Psychiatric Intensive Care Unit and clinical digitalisation schemes.
Sub Total Return to Constitutional Standards	**0.0**	**18.7**	**0.0**	**2.1**	**20.8**	
Total System CDEL & ICB Capital	**7.4**	**76.7**	**16.4**	**21.4**	**121.9**	

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	21/05/2026
Paper title:	**Finance Report**
Paper reference:	ICB CIC 26 011
Paper author:	Rebecca McCauley, NHS Lincolnshire ICB Donna Johnson, Craig West, NHS Derby and Derbyshire ICB Clare Hopewell, Ian Livsey, NHS Nottingham and Nottinghamshire ICB
Paper sponsor:	Bill Shields, Executive Director of Finance
Presenter:	Bill Shields, Executive Director of Finance

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

Report summary:

The report outlines the financial positions of the three ICBs and local NHS providers for the financial year April 2025 to March 2026.

The overall financial position for 2025/26 was a £201.8 million adverse variance to plan position. Providers were £195.7 million adverse to plan and ICBs £6.1 million adverse to plan.

Nottingham and Nottinghamshire providers are the key driver of the overall deficit position, at £163.3 million adverse to plan. Derby and Derbyshire providers were £40.6 million adverse to plan, and NHS Nottingham and Nottinghamshire ICB posted a deficit position of £6.2 million.

Lincolnshire providers were £8.2 million above plan, NHS Derby and Derbyshire ICB posted a small £0.1 million favourable variance and NHS Lincolnshire ICB delivered to plan.

Key drivers of deficits in provider positions were pay (overspent by £100.3 million) and shortfalls in efficiency delivery (total £83.5 million). NHS Nottingham and Nottinghamshire ICB's deficit position was entirely due to the non-receipt of Deficit Support Funding for quarters three and four as a result of the Nottingham and Nottinghamshire provider financial positions.

All other key financial duties for the ICBs were delivered, with capital spending remaining within allocation, Mental Health Investment Standard spend targets achieved, cash balances delivered under maximum allowed, running costs delivered within target, and all Better Payment Practice Code targets met.

Recommendation(s):

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

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

Relevant statutory duties:	
☐ Promoting innovation	☐ Promoting research
☐ Patient choice	☐ Obtaining appropriate advice
☐ Promoting education/training	☐ Climate change

Appendices

None.

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 - Month 12

Contents

Systems Overview

Key Finance Metrics by System at Month 12

Key Finance Metric	Derby and Derbyshire ICS Full Year Variance £'m	Derby and Derbyshire ICS Full Year RAG Rating	Lincolnshire ICS Full Year Variance £'m	LIncolnshire ICS Full Year RAG Rating	Nottingham and Nottinghamshire ICS Full Year Variance £'m	Nottingham and Nottinghamshire ICS Full Year RAG Rating	Total Full Year Variance £'m	Total Full Year RAG Rating
Financial Performance (Note 1)	(40.6)	Red	8.2	Green	(169.5)	Red	(201.8)	Red
Efficiency	(18.7)	Red	(16.3)	Red	(57.7)	Red	(92.7)	Red
Capital - Charge Against Revised Plan	0.6	Green	(0.1)	Red	0.5	Green	1.0	Green
Pay Costs (Provider)	(6.1)	Red	(10.1)	Red	(84.1)	Red	(100.3)	Red
Mental Health Investment Standard (MHIS)	0.0	Green	0.2	Green	1.1	Green	1.3	Green
Underlying Position	(190.2)	Red	(114.8)	Red	(228.4)	Red	(533.4)	Red

Note 1. Financial Performance is inclusive of non-recurrent Deficit Support Funding (Derby and Derbyshire ICS £41.4m and Nottingham and Nottinghamshire ICS £39.3m). Of the £115m planned £34.3m of Deficit Support Funding is being held back by NHSE due to provider financial performance.

Overview of the Derbyshire, Lincolnshire, Nottinghamshire (DLN) position

The Month 12 position shows an adverse variance of £201.8m compared with the planned break-even position, including deficit support funding (DSF). Lincolnshire (L) ICS achieved a small surplus of £8.2m compared with plan, with Derby & Derbyshire (DD) ICS £40.6m deficit and Nottingham and Nottinghamshire (NN) ICS £169.5m deficit (84% of the total deficit). The position has deteriorated in month by £12.2m in total, with an adverse movement for NN ICS partly offset by favourable movements for DD ICS and L ICS.

The position reported for the year has been agreed with NHS England, recognising the System's financial pressures. This position includes the withholding of £34.3m of the original total £115m deficit support funding.

A key element of the adverse variance is the reduced level of efficiencies that have been delivered. All three systems are reporting adverse to plan on their efficiency schemes. NN ICS are reporting the highest variance due to their significant efficiency challenge in 2025/26. Tight grip and control will be required as we go into 2026/27 as plans continue to be challenging for all systems.

Pay costs are a major driver of the position, with a £100.3m adverse variance at Month 12, with the majority of this variance within the NN system. This pressure is experienced across both substantive and temporary staffing, with bank pay being the main contributor due to efficiencies not delivering as expected.

Cluster ICBs (1 of 2)

Key Finance Metrics for Cluster Integrated Care Boards (ICBs) at Month 12

ICB Key Metrics	Derby and Derbyshire ICB Full Year Variance £'m	Derby and Derbyshire ICB Full Year RAG Rating	Lincolnshire ICB Full Year Variance £'m	Lincolnshire ICB Full Year RAG Rating	Nottingham and Nottinghamshire ICB Full Year Variance £'m	Nottingham and Nottinghamshire ICB Full Year RAG Rating	Total Cluster Full Year Variance £'m	Total Cluster Full Year RAG Rating
Financial Performance	0.1	Green	0.0	Green	(6.2)	Red	(6.1)	Red
Efficiency	0.0	Green	(9.2)	Red	0.0	Green	(9.2)	Red
Spend of Capital Resource	0.5	Green	0.0	Green	0.0	Green	0.5	Green
Spend of Running Cost Allocation	5.2	Green	8.9	Green	3.7	Green	17.8	Green
Mental Health Investment Standard	0.0	Green	0.2	Green	1.1	Green	1.3	Green
Underlying Position	5.7	Green	(58.2)	Red	(26.5)	Red	(79.0)	Red
Better Payment Practice Code	>95%	Green	>95%	Green	>95%	Green	>95%	Green

Both DDICB and LICB delivered their full-year financial plans, with DDICB achieving a small surplus of £0.1m and LICB reporting a £3.7m surplus. NNICB reported a £6.2m deficit, having not received Q3–Q4 Deficit Support Funding (DSF) due to the Nottinghamshire system not achieving its financial plan.

Cluster ICBs (2 of 2)

Key Finance Metrics for Cluster Integrated Care Boards (ICBs) at Month 12 continued

Financial pressures persist, notably:

- £6.2m of deficit support funding for Nottingham and Nottinghamshire ICB has not been received in year due to the Nottinghamshire system not meeting its financial plan.
- Acute activity is £47.9m adverse to plan. This is mainly due to higher than planned elective activity in the Independent Sector and operational constraints and increasing activity pressures within NHS providers.
- Mental health and learning disabilities reported a £23.5m adverse variance to plan, driven by continued increased demand for ADHD/ASD assessments in the private sector, section 117 activity and costs and pressure in acute out of area bed costs.
- Prescribing services reported pressures in Lincolnshire LICB, predominately due to diabetes medicines and price/volume trends.
- Community services reported pressures from delayed efficiency schemes, particularly in DD ICB and NNICB.

Efficiency

Both DDICB and NNICB delivered their full-year efficiency targets, (DDICB £44.0m and NNICB £76.3m) LICB achieved efficiencies of £63.2m, £9.2m less than the full-year plan of £72.4m. The total efficiency delivery for 2025/26 was £183.5m, mainly driven by non-recurrent schemes, performance against recurrent efficiencies being below plan at adverse £48m creating financial pressure in future years.

Other Areas to Note

The DLN ICBs remained within the capital and running cost allocations, as per national directions and achieved the Mental Health Investment Standard (MHIS), with NNICB reporting an overperformance of £1.1m.

The Better Payment Practices Code (BPPC) target is consistently achieved across the Cluster ICBs. Nationally, ICBs went live with a new financial ledger on 1st October 2025. There have been several challenges following implementation of the new ledger, however, BPPC and month end cash targets have been achieved.

Actions

- Drive the delivery of recurrent efficiency schemes in 2026/27, mitigate any arising risks.
- Maintain grip and control on managing acute and prescribing pressures and manage the demand for mental health and learning disability services.

Cluster Providers (1 of 3)

Key Finance Metrics for Cluster Providers at Month 12

Provider	Financial Performance Full Year Variance £'m	Financial Performance Full Year RAG Rating	Efficiency Full Year £'m	Efficiency Full Year RAG Rating	Revised Capital Envelope Full Year Variance £'m	Revised Capital Envelope Full Year Variance RAG Rating	Underlying Position Full Year £'m	Underlying Position Full Year RAG Rating
Chesterfield Royal Hospital NHS Foundation Trust (Note 1)	(23.1)	Red	(3.7)	Red	(1.0)	Red	(34.5)	Red
Derbyshire Community Health Services NHS Foundation Trust	(0.0)	Red	0.1	Green	(0.8)	Red	(7.9)	Red
Derbyshire Healthcare NHS Foundation Trust	0.0	Green	0.0	Green	0.9	Green	(10.6)	Red
East Midlands Ambulance Service NHS Trust	0.0	Green	(0.0)	Red	1.5	Green	(6.4)	Red
University Hospitals Of Derby And Burton NHS Foundation Trust (Note 1)	(17.5)	Red	(15.1)	Red	(0.5)	Red	(136.6)	Red
Total Derby and Derbyshire Providers	(40.6)	Red	(18.7)	Red	0.1	Green	(195.9)	Red
Lincolnshire Community Health Services NHS Trust	1.6	Green	0.0	Green	(0.0)	Red	(8.1)	Red
Lincolnshire Partnership NHS Foundation Trust	1.6	Green	0.0	Green	0.5	Green	(12.4)	Red
United Lincolnshire Teaching Hospitals NHS Trust	4.9	Green	(7.1)	Red	(0.6)	Red	(36.1)	Red
Total Lincolnshire Providers	8.2	Green	(7.1)	Red	(0.1)	Red	(56.6)	Red
Nottingham University Hospitals NHS Trust (Note 1)	(80.6)	Red	(30.1)	Red	0.4	Green	(98.5)	Red
Sherwood Forest Hospitals NHS Foundation Trust (Note 1)	(29.0)	Red	(9.5)	Red	0.0	Green	(48.1)	Red
Nottinghamshire Healthcare NHS Foundation Trust (Note 1)	(53.7)	Red	(18.1)	Red	0.0	Green	(56.5)	Red
Total Nottingham and Nottinghamshire Providers	(163.3)	Red	(57.7)	Red	0.5	Green	(203.0)	Red
Grand Total Cluster Providers	(195.7)	Red	(83.5)	Red	0.5	Green	(455.5)	Red

At month 12, the adverse variance to plan is £195.7m, primarily due to pay overspends of £100.3m and a shortfall in planned efficiencies of £83.5m (of which a proportion is directly related to pay costs). Two providers in Derby and Derbyshire (DD) (Chesterfield Royal Hospital (CRH) and University Hospitals of Derby and Burton (UHDB)) and all providers in Nottingham and Nottinghamshire (NN) have not achieved the planned financial position for the year, and this is reported in line with agreement with NHSE. All other providers in DD have achieved their planned positions for the year, and Lincolnshire (L) providers have achieved a total surplus of £8.2m.

Efficiencies are off plan by £83.5m in total. Recurrent efficiencies are £118.3m behind plan, partially offset by non-recurrent schemes mitigating the shortfall.

Cluster Providers (2 of 3)

Key Drivers for Cluster Providers at Month 12

Provider	Total Pay Costs Full Year Variance £'m	Total Pay Costs Full Year RAG Rating	Substantive Pay Costs Full Year Variance £'m	Substantive Pay Costs Full Year RAG Rating	Bank Pay Costs Full Year Variance £'m	Bank Pay Costs Full Year RAG Rating	Agency Pay Costs Full Year Variance £'m	Agency Pay Costs Full Year RAG Rating
Chesterfield Royal Hospital NHS Foundation Trust	2.9	Green	16.4	Green	(9.8)	Red	(3.7)	Red
Derbyshire Community Health Services NHS Foundation Trust	3.0	Green	2.4	Green	0.5	Green	0.0	Green
Derbyshire Healthcare NHS Foundation Trust	2.7	Green	1.5	Green	0.3	Green	0.9	Green
East Midlands Ambulance Service NHS Trust	4.2	Green	3.9	Green	(0.0)	Red	0.3	Green
University Hospitals Of Derby And Burton NHS Foundation Trust	(18.9)	Red	(15.2)	Red	(1.6)	Red	(2.1)	Red
Total Derby & Derbyshire Providers	(6.1)	Red	9.1	Green	(10.6)	Red	(4.5)	Red
Lincolnshire Community Health Services NHS Trust	(2.9)	Red	(1.0)	Red	(2.9)	Red	1.0	Green
Lincolnshire Partnership NHS Foundation Trust	4.0	Green	3.5	Green	0.1	Green	0.5	Green
United Lincolnshire Teaching Hospitals NHS Trust	(11.3)	Red	(0.4)	Red	(8.6)	Red	(2.3)	Red
Total Lincolnshire Providers	(10.1)	Red	2.0	Green	(11.4)	Red	(0.8)	Red
Nottingham University Hospitals NHS Trust	(56.9)	Red	(52.6)	Red	(4.5)	Red	0.2	Green
Sherwood Forest Hospitals NHS Foundation Trust	(19.6)	Red	(24.1)	Red	3.8	Green	0.7	Green
Nottinghamshire Healthcare NHS Foundation Trust	(7.7)	Red	(2.0)	Red	(8.6)	Red	2.9	Green
Total Nottingham & Nottinghamshire Providers	(84.1)	Red	(78.7)	Red	(9.3)	Red	3.8	Green
Grand Total Cluster Providers	(100.3)	Red	(67.6)	Red	(31.2)	Red	(1.5)	Red

Pay expenditure is £100.3m adverse to plan with substantive and other pay (£67.6m), bank (£31.2m), and agency (£1.5m) all contributing to the variance. Bank costs are above the system ceiling at D&D, L and N&N, and agency costs are above the ceiling for D&D and L. Providers implemented vacancy controls, executive-led monitoring, and workforce transformation to manage costs. Whilst an impact was seen from these actions, this was still the main contributor to providers not delivering their 2025/26 plans.

Cluster Providers (3 of 3)

Key Drivers continued.

Derby and Derbyshire

Month 12 position is £40.6m adverse to the planned break-even position. CRH are £23.1m adverse to plan and UHDB is £17.5m adverse to plan. Key drivers include increased variable pay costs, under delivery of efficiencies and operational cost pressures. All other organisations have delivered the plan for 2025/26.

Lincolnshire

The system providers have delivered an £8.2m surplus to plan at month 12. United Lincolnshire Teaching Hospitals (ULTH) has delivered £4.9m surplus to plan, Lincolnshire Partnership (LPFT) £1.6m surplus to plan and Lincolnshire Community Health Services (LCHS) £1.6m surplus to plan. Pressures in year, including under-delivery of efficiencies, have been managed through controls on pay and discretionary spend, and non-recurrent actions.

Nottingham and Nottinghamshire

Month 12 position is £163.3m adverse variance to plan. All providers have an adverse position – Nottingham University Hospitals (NUH) £80.6m, Sherwood Forest Hospitals (SFH) £29.0m and Nottinghamshire Healthcare (NHT) £53.7m. Key drivers of the position are substantive and bank staffing, non-pay pressures, shortfalls in efficiency delivery and withheld deficit support funding (DSF).

Recovery Actions

Cluster wide actions include enhanced financial oversight, a turnaround approach, and the implementation of a cluster wide financial recovery group, chaired by the ICB CFO. Providers are focusing on reducing staff costs, improving efficiency delivery, and implementing workforce transformation. Whilst these cluster wide actions were in place, these did not bring systems back to their planned positions. To enable delivery of the 2026/27 plans, this rigour of grip and control must continue with the continuation of the financial recovery group and the link with the NHSE assurance process being discussed across the cluster to ensure this happens.

Appendix 1 – Cluster System Income and Expenditure

Total DLN Cluster	Full Year Plan	Full Year Actual	Full Year Variance	Full Year Variance2
	£m	£m	£m	%
System Revenue Resource Limit	**(8,885.0)**			
ICB Net Expenditure				
Acute Services	4,102.1	4,150.0	(47.9)	(1.2%)
Mental Health Services	904.3	927.9	(23.5)	(2.6%)
Community Health Services	689.0	693.9	(4.9)	(0.7%)
Continuing Care Services	388.5	379.1	9.4	2.4%
Primary Care Services	696.5	689.4	7.1	1.0%
Memo: Prescribing	568.6	570.7	(2.1)	(0.4%)
Other Commissioned Services	33.4	31.6	1.7	5.2%
Other Programme Services	70.4	78.4	(8.0)	(11.4%)
Reserves / Contingencies	86.4	59.5	26.9	31.2%
Delegated Specialised Commissioning	801.6	792.2	9.4	1.2%
Delegated Primary Care Commissioning	1,022.7	1,017.0	5.8	0.6%
ICB Running Costs	86.2	68.3	17.9	20.7%
Total ICB Net Expenditure	**8,881.2**	**8,887.4**	**(6.1)**	**(0.1%)**
ICS Providers I&E - Adjusted Financial Performance				
Income	(7,111.1)	(7,231.1)	120.0	(1.7%)
Pay	4,864.7	5,024.8	(160.0)	(3.3%)
Non-Pay	2,119.4	2,278.4	(159.0)	(7.5%)
Non Operating Items	130.7	127.4	3.3	2.5%
TOTAL Provider Surplus/(Deficit)	**(3.7)**	**(199.4)**	**(195.7)**	**2.8%**

Note, ICB position is shown gross, ie., includes intra system providers

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	21/05/2026
Paper title:	**Quality Report**
Paper reference:	ICB CIC 26 012
Paper author:	Quality Business Management Unit
Paper sponsor:	Rosa Waddingham, Executive Director of Quality (Nursing)
Presenter:	Rosa Waddingham

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

Report summary:

This report provides the Boards with assurance on the quality and safety of services across the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire Integrated Care Systems. It sets out the current position in relation to providers and system pathways subject to enhanced or escalated oversight, in line with the NHS Oversight Framework and National Quality Board guidance.

The report reflects the transition to a single cluster-wide System Quality Group, which from May 2026 will provide a consolidated forum for system-level quality oversight, intelligence sharing and escalation. 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. The reporting period covers 28 January to 26 March 2026.

Recommendation(s):

The Boards are asked to **receive** the report for assurance on the quality and safety position across the DLN system, including areas of enhanced or escalated oversight.

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

Appendices

Appendix 1: ICS Escalation Framework

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Quality Report

National Quality Board guidance

1. The ICBs' approach to quality remains aligned to the National Quality Board's single shared view of quality and its recent guidance reinforcing the importance of maintaining a focus on quality, safety and leadership during a period of system change and operational pressure.
2. The ICBs continue to discharge their statutory duty for quality through clear provider accountability, system oversight, and proportionate escalation arrangements in line with the NHS Oversight Framework.
3. This report provides assurance to the Boards on the current quality position across the three ICB systems, including areas subject to enhanced or escalated oversight and the actions in place to mitigate risk.

System Quality Group

4. From May 2026, system-level quality oversight across Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire will be delivered through a single System Quality Group. The first meeting of the Group will take place on 15 May 2026.
5. The System Quality Group provides a consolidated forum for system partners to routinely share and triangulate quality intelligence, identify emerging risks, and agree appropriate escalation and improvement actions. This transition supports a more consistent and proportionate approach to quality oversight across the ICBs' combined footprint, whist maintaining clear accountability within individual ICB governance and provider arrangements.
6. The intelligence and assurance generated through the System Quality Group will directly inform this Quality Report and support assurances provided to the Boards.

ICB approach to quality and 2025/26 commitments

7. Recognising the National Quality Board's planned review of its approach, a shared approach to quality has been developed for 2025/26, focused on maintaining robust quality governance, consistent oversight arrangements, and delivery of national quality and patient safety priorities.
8. This approach includes aligned ICB quality priorities, with further work underway to align these with provider quality priorities through the System Quality Group.
9. The quality priorities are:

a) Access and capacity: Ensuring timely, equitable access to services.

b) Patient safety and experience: Reducing harm, learning from incidents, and improving user experience. With a particular focus on maternity and mental health.

c) Reducing health inequalities: Targeted interventions for underserved groups, using population health management.

d) Workforce: Acknowledging the impact workforce has on quality ensuring a focus on this in quality including training, sickness, retention, and staff wellbeing.

e) Clinical effectiveness: Ensuring evidence-based care, pathway optimisation, and outcome measurement.

f) Digital maturity: Leveraging technology for safer, more effective care. With an internal focus on continuing healthcare transformation.

g) Safeguarding and health protection: Robust frameworks for vulnerable groups and infection prevention. With a particular focus on children and people with mental health and/or learning disabilities and autism.

10. For 2025/26, the ICBs remain committed to:

    a) Maintaining effective system oversight and escalation arrangements.

    b) Ensuring timely identification and management of quality and safety risks.

    c) Supporting improvement delivery in providers and pathways subject to enhanced or intensive oversight.

    d) Strengthening system learning and assurance.

11. Progress against these commitments will to be monitored through the System Quality Group, with assurance provided to the Joint Quality and Service Improvement Committee the Boards.

Acute and mental health providers under escalated oversight

12. Quality oversight continues for a number of NHS Trusts across the ICBs' geographies. During the reporting period, there were no new quality escalations; however, sustained system pressures and provider-specific risks continue to require close monitoring through established governance arrangements.

13. **Chesterfield Royal Hospital NHS Foundation Trust** remains under escalated oversight. Areas of focus include information governance performance and delivery of theatre improvement actions. The Trust has implemented a recovery plan supported by external expertise, with assurance provided through enhanced engagement and oversight.

14. **Derbyshire Healthcare NHS Foundation Trust** remains under oversight following recent regulatory activity. Care Quality Commission (CQC) inspections and Mental Health Act visits provided largely positive assurance, although areas for improvement were identified. A recent internal audit identified limited assurance against Patient Safety Incident Response Framework requirements; an improvement plan is in place and subject to ongoing monitoring with completion targeted by August 2026.
15. **University Hospitals of Derby and Burton NHS Foundation Trust:** CQC engagement continues, with maternity licence conditions now lifted. Harm review activity is progressing, with learning and assurance monitored through the Care Quality Review Group and system oversight arrangements. Further assurance is expected later in Q1 2026/27.
16. **North Lincolnshire and Goole NHS Trust** remains in intensive oversight under the NHS Oversight Framework. The provider continues to experience significant urgent and emergency care pressures. System-level oversight meetings chaired by NHS England Regional Directors remain in place, with strengthened ICB engagement following contractual changes from April 2026.
17. **United Lincolnshire Teaching Hospitals NHS Trust:** An unannounced CQC visit to Grantham and District Hospital in March 2026 did not identify any immediate safety concerns. Formal feedback and action plans will be reviewed through the Lincolnshire Care Group governance structures.
18. **Lincolnshire Partnership NHS Foundation Trust:** Recent CQC inspections rated services as ‘Good’. With improvement actions now embedded and regulatory assurance received, a recommendation has been made to stand down enhanced oversight and return to routine monitoring, subject to committee approval.
19. **Nottinghamshire Healthcare NHS Foundation Trust** remains under enhanced oversight. Pressures continue around mental health bed capacity, delayed admissions, and custody suite demand. The Nottingham Public Inquiry has commenced, with hearings continuing through summer 2026. A new Chief Executive has been appointed and will commence in June 2026.
20. **Nottingham University Hospitals NHS Trust** remains under enhanced quality oversight. Whilst no new quality risks were escalated during the period, ongoing concerns remain in urgent and emergency care, incident management, and recovery delivery. Additional oversight continues in relation to breast services and mortuary governance following regulatory inspection activity.
21. **Sherwood Forest Hospitals NHS Foundation Trust:** Performance indicators show improvement in emergency care flow, though operational pressures persist. The Electronic Patient Record programme remains a delivery risk, with mitigations in place and system oversight continuing.

System pathways under enhanced oversight

22. **Urgent and Emergency Care:** No new quality exceptions were identified during the reporting period. Operational pressures remain significant across the system, with continued focus on corridor care, infection-related bed closures, and demand management. System-wide learning activity has been undertaken following Coroner Regulation 28 reports, with further review planned.
23. **Learning Disabilities and Autism:** No new exceptions were reported. Risks continue to be managed through routine reporting and system governance. Additional focus has been applied in Derbyshire to support inpatient recovery trajectories.
24. **Children and Young People, including Special Educational Needs and Disabilities services:** Oversight arrangements remain in place across all three ICBs. While no new escalations were reported, risks relating to service continuity, capacity, and system readiness continue to be actively managed through safeguarding and partnership governance.
25. **Infection Prevention and Control:** System-wide pressures remain elevated, driven by operational crowding and Healthcare-associated infections performance challenges. Nottingham University Hospital NHS Trust continues to manage the impacts of norovirus and a Pseudomonas outbreak, with mitigating actions and enhanced surveillance in place.
26. **Primary Care:** A Regulation 28 Preventing Future Deaths report has been received relating to long-term opioid prescribing risks. A coordinated system response is being progressed. CQC inspection activity continues to focus on practices with historic or ‘Requires Improvement’ ratings.
27. **Independent Sector:** Enhanced oversight continues for a small number of independent sector providers where significant regulatory and safeguarding concerns have been identified. ICBs are working collaboratively with NHS England, host commissioners, and local authorities to ensure patient safety and appropriate placement review.
28. **Maternity:** Maternity services across Derby and Derbyshire and Nottingham and Nottinghamshire remain under active oversight. Providers continue to deliver improvement actions aligned to national safety programmes, with assurance supported through NHS England engagement and Local Maternity and Neonatal System governance.

Appendix 1. ICS Escalation Framework

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	21/05/2026
Paper title:	**Commissioning Delivery Report – May 2026**
Paper reference:	ICB CIC 26 013
Paper author:	Sarah Bray, Associate Director of System Performance and Assurance, NHS Nottingham and Nottinghamshire ICB
Paper sponsor:	Maria Principe, Executive Director of Commissioning
Presenter:	Maria Principe

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

Report summary:

This report provides an overview of delivery across the ICBs against the 2025/26 operational plan, based on February and March positions. Overall performance remains under sustained pressure across several programmes; however, the report highlights areas of progress alongside a strengthened commissioning oversight approach as the system transitions into 2026/27.

Planned Care remains off trajectory across all three ICBs, with Referral to Treatment performance below plan and ongoing long-wait pressures in high-risk specialties. While the longest waits continue to reduce, the pace of recovery is insufficient to fully mitigate delivery risk entering 2026/27.

Diagnostics remains a critical system constraint, with performance above plan for six-week waits across all systems. Capacity pressures in MRI, endoscopy and other key modalities continue to impact elective and cancer pathways. Additional capacity, including mobile provision and Community Diagnostic Centres, is supporting incremental improvement, but sustained recovery will require further gains in productivity and workforce.

Cancer performance remains materially below key national standards, including Faster Diagnosis and 62-day pathways. Rising referral demand, diagnostic constraints and workforce pressures are limiting the pace of recovery. Recovery remains fragile and heavily dependent on improvements in underlying system capacity, particularly diagnostics.

Urgent and Emergency Care continues to face sustained pressure, with four-hour performance, ambulance handovers and 12-hour waits below plan. Localised improvements have been delivered through front-door redesign, Same Day Emergency Care expansion and system control, but flow and discharge remain key constraints on performance.

Neighbourhood and Same Day Care continues to be a key strategic priority, supporting prevention, admission avoidance and care closer to home. Early progress is being made in developing integrated models and pathways; however, delivery remains dependent on workforce, operational maturity and consistent implementation across the cluster.

Mental Health and Learning Disabilities and Autism services continue to face demand, capacity and flow pressures, particularly in inpatient pathways and discharge, where community provision remains a key constraint.

Report summary:

Primary Care – Access, Workforce and Delivery remains a key system enabler, with high activity levels and increasing use of digital access and Pharmacy First services. However, GP appointment volumes are below the ambitious plans, workforce constraints remain significant, and NHS dentistry continues to present a persistent access challenge.

Community Services are in line with plan for adult waits. However, delivery risk is concentrated in Children and Young People's pathways, where long waits persist across Speech and Language therapy and Community Paediatrics services.

Children and Young People's services remain a significant cross-cutting risk, with long waits concentrated in community and neurodevelopmental pathways.

Overall, the report reflects a pressured system with clear areas of progress and a strengthened commissioning approach to support recovery and delivery.

Recommendation(s):

The Boards are asked to **receive** the paper for assurance in relation to service delivery against the operational plans submitted for 2025/26.

Relevant statutory duties:

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

Appendices

Appendix 1 - Commissioning Oversight Delivery Report for May 2026

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Commissioning Oversight Delivery Report

Introduction

1. This report provides an overview of current delivery across Derbyshire, Lincolnshire and Nottinghamshire against operational planning requirements for 2025/26, alongside emerging risks, mitigations and recovery actions for 2026/27. Appendices A and B provide an overview of the latest performance delivery.
2. The report also outlines the implementation of the strengthened commissioning oversight framework designed to improve commissioner grip, accountability, performance management and system recovery across operational performance, finance, quality and contracting arrangements.
3. The briefing highlights areas of improvement and success, current delivery challenges, recovery actions and the next steps associated with the rollout of the Commissioning Oversight Group and Programme Board governance arrangements during June 2026.

Commissioning Oversight Framework

4. A revised commissioning oversight approach is being implemented across the ICBs to strengthen commissioner-led oversight of performance, finance, quality, contracting and operational delivery. This represents a significant cultural shift towards a more proactive and co-ordinated commissioning model focused on delivery, escalation and system accountability.
5. The framework introduces:
    a) A strengthened Commissioning Oversight Group
    b) Cluster-wide Programme Boards
    c) Enhanced provider oversight arrangements
    d) Integrated performance, finance and quality triangulation
    e) Consistent contractual escalation processes
    f) Co-designed recovery and remedial action planning
6. Programme Boards are being established across:
    a) Planned Care (including Diagnostics and Cancer)
    b) Urgent and Emergency Care
    c) Neighbourhood and Same Day Care
    d) Primary Care
    e) Mental Health

f) Children and Young People and Women's Services

7. The full rollout of the governance structure and programme oversight arrangements will take place during June 2026.

Current Performance Overview

8. Performance across the ICB geographies remains mixed, with operational pressures continuing across planned care, diagnostics, cancer and urgent care pathways. However, there are also several areas of improvement and emerging best practice across prevention, frailty, pathway redesign and primary care transformation.

Areas of Improvement and Success

9. Significant progress has been achieved across proactive care programmes:

   a) 300 more care home residents died in their preferred place of death.

   b) 650 additional care home residents now have a Clinical Frailty Score.

   c) Over 30,000 additional people aged over 65 have a recorded Clinical Frailty Score.

   d) 2,600 additional frail older adults received falls risk assessments.

   e) 1,000 additional flu vaccinations delivered to patients with significant frailty.

10. Further improvements include:

   a) 1,200 additional referrals into the Diabetes Prevention Programme.

   b) Over 5,500 more people with Type 2 Diabetes achieving all three treatment targets.

   c) 1,700 additional Chronic Obstructive Pulmonary Disease self-management plans implemented.

   d) Improved end of life care planning and ReSPECT form completion.

   e) Nottingham's Dermatology left shift model has achieved a 17% reduction in acute activity and is now being rolled out into Derbyshire, with further alignment developing across Lincolnshire.

11. Primary care continues to remain a critical system enabler:

   a) Nottinghamshire and Lincolnshire continue to deliver strong Pharmacy First activity, with Derbyshire also showing improving utilisation and uptake.

   b) A productive meeting has taken place with the Local Pharmaceutical Committees, who are keen to work collaboratively with the ICBs to

strengthen the role of community pharmacy as a first line of defence within the wider urgent and primary care system.

c) Digital access and online consultation usage continues to increase significantly across all systems.

Planned Care, Diagnostics and Cancer

12. Planned care recovery remains one of the most significant delivery risks across the ICBs. All three ICBs remain below trajectory for Referral to Treatment performance, with persistent long-wait pressures across several specialties.

13. Key challenges include:

a) Significant pressures within Gynaecology, Ear, Nose and Throat, Dermatology, MRI and Endoscopy pathways.

b) Ongoing diagnostics constraints across Lincolnshire and Nottinghamshire.

c) Continued pressures across Breast, Gynaecology, Urology and Lower Gastrointestinal cancer pathways.

d) Workforce, outpatient and theatre capacity constraints.

e) Referral growth and increasing pathway complexity.

f) Data quality and reporting issues linked to pathway validation and Electronic Patient Record implementation.

14. Mitigations and recovery actions include:

a) Elective recovery sprint activity across providers.

b) Increased use of evenings, weekends and independent sector capacity.

c) Validation sprints to improve Patient Treatment List accuracy and waiting list control.

d) Mobile MRI capacity and expansion of Community Diagnostic Centres.

e) Increased insourcing and outsourcing activity.

f) Expansion of left shift models for Ophthalmology, Gynaecology and Dermatology.

g) Strengthened commissioner oversight through Programme Boards and escalation routes.

h) Cluster-wide outpatient improvement work focused on Advice and Guidance, Patient Initiated Follow-up, productivity and ‘did not attend’ reduction.

15. Positive improvements include improving Lower Gastrointestinal pathways at Sherwood Forest Hospitals NHS Foundation Trust through the Days Matter

Programme, pathway redesign work at CRH and increasing resilience through Community Diagnostic Centre rollout.

Urgent and Emergency Care

16. Performance remains under pressure across the ICBs, with continued challenges relating to four-hour performance, ambulance handovers, discharge and patient flow.

17. Mitigations and recovery actions include:

    a) Revised ambulance offload processes implemented with East Midlands Ambulance Service (EMAS).

    b) Release to Respond arrangements to improve handover flow.

    c) Increased Same Day Emergency Care capacity.

    d) Strengthened frailty pathways and front-door streaming models.

    e) Daily operational oversight and system control arrangements.

    f) Enhanced collaboration with EMAS, Clinical Assessment Service and Clinical Navigation Hub arrangements.

    g) The Urgent Treatment Centre in Nottingham has continued to increase and is operating at its highest levels to support system pressure.

    h) Additional workforce and expanded clinical space are planned following completion of Nottingham University Hospitals NHS Trust estate works later this year.

18. Several providers have also demonstrated local improvements in front-door flow, discharge arrangements and frailty pathway delivery.

Neighbourhood and Same Day Care

19. Neighbourhood and Same Day Care continue to be a major strategic priority across the ICBs and forms a core part of the wider prevention, admission avoidance and left shift agenda.

20. The ICBs are working closely with providers and system partners to develop the neighbourhood specification and establish a more consistent cluster-wide neighbourhood model aligned to the NHS Ten-Year Plan and Integrated Neighbourhood Team principles.

21. Current work includes:

    a) Development of the neighbourhood service specification.

    b) Mapping neighbourhood population cohorts and risk profiles.

c) Alignment of frailty, same day access, prevention and proactive care pathways.

d) Development of neighbourhood-based admission avoidance models.

e) Strengthening same day response and urgent community pathways.

f) Improved integration between primary care, community, social care and acute services.

22. The ICBs will also be hosting their first national neighbourhood visit in Derby on 1 June 2026 to support shared learning, showcase emerging delivery models and strengthen alignment with national neighbourhood priorities.

23. Neighbourhood development is expected to support:

a) Earlier intervention and proactive care.

b) Improved management of long-term conditions.

c) Reduced avoidable admissions and emergency department attendances.

d) Improved discharge and flow.

e) Greater care closer to home.

f) Reduced variation across places and providers.

24. Challenges remain around workforce, operational maturity and pathway consistency; however, strengthened governance and commissioner oversight arrangements are now being established to support delivery and long-term transformation.

Mental Health and Learning Disabilities and Autism

25. Mental Health and Learning Disabilities and Autism services continue to face demand and flow pressures across the ICB geographies.

26. Key challenges include:

a) Acute bed utilisation and out-of-area placements.

b) Workforce and demand pressures across several pathways.

c) Learning Disabilities and Autism inpatient trajectories requiring improvement.

27. Mitigations include strengthened commissioner oversight, continued focus on discharge and community alternatives, and improved governance arrangements across provider systems.

Primary Care Access, Workforce and Delivery Confidence

28. The immediate priority across primary care is improving access. The plan is focused on achieving 90% same day urgent access by March 2027 and tackling the 8am pressure point through total triage, digital access and improved demand management. The overall approach is clear and aligned nationally; however, successful delivery will depend on consistent implementation at practice level.

29. Workforce remains the key delivery constraint. There is strong utilisation of Additional Roles Reimbursement Scheme and GP capacity funding alongside a clear focus on multidisciplinary teams and neighbourhood working. However, recruitment, retention and estate limitations are likely to affect both the pace and scale of delivery.

30. Reducing variation across practices and providers remains a relative strength. Established contract management processes, quality oversight and targeted support arrangements provide a strong platform for improvement, although delivery remains dependent on sustained practice engagement and operational capacity.

31. Digital transformation continues to be a major enabler, particularly through the NHS App, online consultation models and digital access routes. The ambition is high and supports national priorities, although delivery risks remain around adoption, digital maturity and digital exclusion.

32. The longer-term strategic direction remains centred around neighbourhood teams and shifting care further into community settings. This is well aligned with system priorities and the wider prevention agenda, but delivery will depend on wider transformation programmes, workforce sustainability and investment.

33. There is also a clear intention to make greater use of community pharmacy, dentistry and optometry to help manage demand, particularly through the continued expansion of Pharmacy First and wider primary care integration.

34. Overall delivery confidence is assessed as medium. The strategy and direction of travel are strong; however, delivery risks remain around workforce availability, financial pressures, practice engagement and wider system operational pressures.

35. In summary, the strategic approach is robust and well aligned to national policy. The key challenge will be maintaining consistent execution across practices and providers, whilst continuing to address workforce, operational and capacity constraints.

Conclusion and Next Steps

36. The ICBs continue to face significant operational pressures across planned care, diagnostics, cancer and urgent care pathways. However, there are clear

areas of progress across proactive care, Pharmacy First, frailty, proactive care, pathway redesign and neighbourhood delivery models.

37. The strengthened commissioning oversight framework being rolled out during June 2026 will provide:

    a) Greater commissioner grip and accountability.

    b) Stronger provider oversight and escalation.

    c) Co-designed remedial action planning.

    d) Enhanced use of contractual levers.

    e) Improved data quality and intelligence oversight.

    f) Greater consistency across pathways and service specifications.

    g) Stronger alignment between operational, financial and quality delivery.

38. The Commissioning Oversight Group and Programme Boards will provide the core governance structure to support operational recovery, delivery assurance and sustainable improvement across the ICB geographies.

Appendix A: Performance Overview

Activity: February 2026 Year to Date (Apr-Feb 2025/26) & vs Last Year

February 2026 v Plan (YTD)
Above Plan ✔ | Below Plan ✖

YTD Variance v Prior Month
Increased ↗ | Decreased ↘

Current YTD v Last Year YTD
More Activity ↑ | Less Activity ↓

Key

Derby and Derbyshire

	Plan	Actual	YTD Var	vs LY
Outpatient 1st (Specific Acute)	373,853	**368,340**	✖ -1.5% ↗	-1.2% ↓
Outpatient F'Up (Specific Acute)	841,661	**824,416**	✖ -2.0% ↘	-1.6% ↓
Day Cases	136,232	**157,481**	✔ 15.6% ↗	-1.0% ↓
Elective (Ops)	21,207	**23,168**	✔ 9.2% ↗	-0.7% ↓
Diagnostics (9)	465,235	**474,812**	✔ 2.1% ↗	11.8% ↑

Summary: Outpatients under plan and lower than last year. Day case and electives increased over plan, but lower than previous year.

Lincolnshire

	Plan	Actual	YTD Var	vs LY
Outpatient 1st (Specific Acute)	273,577	**271,517**	✖ -0.8% ↘	-2.9% ↓
Outpatient F'Up (Specific Acute)	457,778	**475,154**	✔ 3.8% ↗	-1.5% ↓
Day Cases	105,478	**105,921**	✔ 0.4% ↘	-3.4% ↓
Elective (Ops)	16,553	**16,297**	✖ -1.5% ↘	-2.0% ↓
Diagnostics (9)	419,808	**410,602**	✖ -2.2% ↘	6.9% ↑

Summary: Outpatient Follow-ups over plan, however all electives are lower than last year. Strong growth in diagnostics however remains below planned level.

Nottingham and Nottinghamshire

	Plan	Actual	YTD Var	vs LY
Outpatient 1st (Specific Acute)	366,403	**324,862**	✖ -11.3% ↘	-4.1% ↓
Outpatient F'Up (Specific Acute)	758,316	**708,434**	✖ -6.6% ↘	-2.3% ↓
Day Cases	166,432	**163,038**	✖ -2.0% ↘	-1.7% ↓
Elective (Ops)	24,220	**24,764**	✔ 2.2% ↗	-0.1% ↓
Diagnostics (9)	473,927	**496,363**	✔ 4.7% ↗	-0.6% ↓

Summary: Outpatients and Day case are under plan and lower than last year. Elective and diagnostics over plan however remain slightly below last year levels.

Key Messages:

Clear focus is needed on increasing outpatient 1st appointments and ensuring follow up activity is delivered in line with clinical best practice to enable capacity for the increased 1st appointments needed. Additional activity is needed to improve elective performance.

NHS Operational Plan Delivery – Headline Overview

Actual v Plan (Latest Period)

Better than Plan | Worse than Plan

DLN Cluster Delivery

All Above Plan ☑ | Areas Under Plan ☒

Key

In Hospital Plan Delivery Headlines

Programme Area	Period	DDICB	LICB	NNICB	DLN
Electives					
<18w waits RTT (%)	Feb-26	59.8%	57.5%	58.8%	☒
>52 week waits (%)	Feb-26	2.2%	1.0%	2.0%	☒
>65 week waits	Feb-26	75	17	56	☒
Waiting List	Feb-26	114,938	109,009	129,673	☒
Cancer					
<28-day Faster Diagnosis	Feb-26	77.9%	74.3%	72.7%	☒
<62-day RTT	Feb-26	64.5%	59.2%	66.0%	☒
Diagnostics					
>6 week waits (9)	Feb-26	21.3%	40.2%	24.3%	☒
Urgent Care					
<4 hour wait ED	Mar-26	72.1%	81.3%	70.6%	☒
>12 hour wait from arrival ED	Mar-26	9.7%	11.3%	12.7%	☒
>45m ambulance Handovers	Mar-26	8.3%	16.3%	22.0%	☒
Ambulance Cat 2 Response	Mar-26	00:26:18	00:37:31	00:30:46	☒

Summary: The Cluster is worse than plan across all in-hospital performance measures. Some improvement across waiting lists.

Key Plan Delivery Headlines

Programme Area	Period	DDICB	LICB	NNICB	DLN
Primary Care					
GP Appointments	Feb-26	602,539	484,507	678,928	☒
Units of Dental Activity	Feb-26	116,596	68,192	147,353	☒
Pharmacy First Activity	Feb-26	7,566	7,849	10,064	☒
Community					
>52 week waits - Adult	Feb-26	48	0	0	☑
>52 week waits - CYP	Feb-26	2126	935	169	☒
Mental Health					
Inappropriate OAPs	Feb-26	3	0	10	☒
Inpatient Mean LOS	Feb-26	64	30	63	☒
Talking Therapy Reliable Recovery	Feb-26	50.3%	50.6%	50.9%	☑
Talking Therapy Reliable Improvement	Feb-26	70.6%	69.8%	70.1%	☒
CYP Access	Feb-26	14,770	10,740	21,435	☒
CYP ED Routine	Feb-26	100.0%	100.0%	81.0%	☒
Learning Disability and Autism					
Adult Inpatients	Mar-26	37	35	38	☒

Summary: Derby and Derbyshire are delivering to more plan areas than Lincolnshire and Nottingham and Nottinghamshire.

Key Messages:

Cluster focus is required across all in-hospital delivery, including understanding demand and commissioned capacity, as well as clear focus on increasing commissioned dental activity and patient uptake. Pharmacy first, adult community waits and areas of mental health are progressing positively.

NHS Oversight Framework – Provider Overview Q3 2025-26

Organisation	Type	Q3 25-26 NOF		NPIP	
Nottinghamshire Healthcare (NHT)	MH & Comm	4*	↔	Y	↔
Nottingham University Hospitals (NUH)	Acute	4	↑	N	↑
United Lincolnshire Hospitals (ULTH)	Acute	4	↔	N	↔
Chesterfield Royal Hospital (CRH)	Acute	4	↓	N	↔
University Hospitals of Derby and Burton (UHDB)	Acute	3	↔	N	↔
Sherwood Forest Hospitals (SFH)	Acute	3	↔	N	↔
Lincolnshire Partnership (LPFT)	MH	3	↔	N	↔
Derbyshire Healthcare (DHcFT)	MH	3	↔	N	↔
Lincolnshire Community Health Services (LCHS)	Comm	2	↑	N	↔
Derbyshire Community Health Services (DCHS)	Comm	1	↔	N	↔
East Midlands Ambulance Service	Amb	1	↔	N	↔

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

Key Messages:

Nottingham University Hospitals and Lincolnshire Community Hospitals segment have improved in Q3. Chesterfield Royal segmentation has deteriorated, and they have moved into NOF4.

NHS
Derby and Derbyshire
Integrated Care Board

NHS
Lincolnshire
Integrated Care Board

NHS
Nottingham and
Nottinghamshire
Integrated Care Board

Appendix B
Commissioning Delivery Report

May 2026 Board Report

Prepared By: **SAIU – Performance**
13.05.2026

DLN Commissioning Delivery Report - Contents

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

1.0 DLN Commissioning Delivery Report – Executive Summary

1. **2025-26 Performance Delivery** - This report presents an overview of delivery against the operational plan delivery requirements for 2025-26, as the data reporting delays for national published data mean that current reporting relates to February and March 2026. Some progress has been made across UEC and planned care in Q4 with the impact of the sprint activity. Validation is ongoing across these positions to ensure March year end positions are as accurate as possible for national reporting.

2. **2026-27 Plan** – As current reporting is in the transitional period between prior and current year; updates have been provided on areas of greatest risk to delivery for April 2026 against the submitted plans for 2026-27. The areas of greatest improvement needed are across the planned care programme, with all areas needing a marked improvement for April delivery.

3. **Commissioning Oversight Delivery Report** – a revised approach has been undertaken for the report this month as a move towards the focus being on the commissioning actions and responsibilities being taken to address the performance issues and improvements needed to deliver against the targets agreed for 2026/27. This will be a significant cultural change for key programme leads and will be underpinned by the development of the Cluster Programme arrangements which are being rolled out during May and June.

4. **Planned Care** continues to be off trajectory across all three ICBs. Long waits are reducing, but RTT performance remains below plan and recovery remains concentrated in high-risk specialties, underpinned by constrained capacity and diagnostics dependency. Diagnostics performance remains a critical system constraint, with all ICBs significantly above plan for the six-week wait standard and material pressure in MRI, endoscopy and audiology, limiting recovery across both elective and cancer pathways.

5. **Urgent and Emergency Care** performance remains significantly below plan, with continued pressure on four-hour performance, ambulance handovers and 12-hour waits. Flow constraints, high bed occupancy and delayed discharge continue to limit system resilience, although targeted front-door and system control measures have delivered some localised improvement.

6. **Community services** remain under pressure, with the most significant risks concentrated in Children and Young People's pathways. CYP services continue to hold the majority of >52-week waits, particularly in SLT, OT and community paediatrics, while adult community waits are largely in line with plan.

7. **Primary Care** GP appointment volumes were below plan in February across the cluster, NHS dentistry remains a persistent delivery challenge, and Pharmacy First performance is improving but variable, requiring continued focus to embed system impact.

8. **Mental Health and LD&A** services continue to face pressure from demand growth and inpatient flow challenges, with LD&A inpatient numbers above trajectory.

9. **Children and Young People's** services remain a significant delivery risk across the DLN Cluster, with the majority of >52-week waits concentrated in CYP community and neurodevelopmental pathways, particularly SLT, OT and community paediatrics, requiring sustained, coordinated system-wide action to reduce long waits and address inequalities.

2.1 Operational Plan: Delivery Risk Key Headlines 2025/26

DDICB	LICB	NICB	Programme Performance Headlines
			1. Elective Care & Waiting Times
			•**18-Week RTT**: All three ICBs are below plan in February 2026
			•**Long Waits (52+ Weeks)**: DDICB and NNICB are off plan for reducing long waits, with targeted actions underway. LICB are achieving the % of patients under 52 weeks. All ICBs are working to eradicate 65-week waits. NNICB risk due to PICS gynae patient transfers
			•**PTL (Patient Tracking List)**: LICB and DDICB are better than plan, NNICB is above plan. Waiting lists in local NHS Providers remain challenging, with some providers seeing increases due to referral growth and reporting changes. Validation sprints and productivity programs are in progress.
			2. Cancer Pathways
			•**28-Day Faster Diagnosis**: Performance is below the plan target for all three ICBs. There is variation across the Cluster tumour sites, some increased capacity in key specialties.
			•**62-Day Treatment**: Performance is below trajectory for all ICBs. NUH is under Tier 1 NHS oversight.
			3. Diagnostics
			•**6-Week Waits (DM01)**: Performance is significantly off plan in LICB, and static under plan for DDICB and NNICB. Audiology, ECHO, MRI, NOUS, and endoscopy are particularly challenging. Improvement plans include increasing capacity and insourcing.
			4. Urgent and Emergency Care
			•**4-Hour ED Waits**: System performance is below national plans for DDICB and NNICB, with acute trusts facing challenges, for ED performance, LICB are achieving the plan. Front-door performance, flow and discharge are still key issues. The 12-hour target was missed at all three ICBs.
			5. Primary, Community, and Mental Health Services
			•**Primary Care**: ICBs are under plan for urgent dental activity. Pharmacy first appointments are performing well in LICB and NNICB, however risk to year end due to stepped increase required. GP appointments are lower than plan in February in all three ICBs. DDICB are performance well on dental UDAs, LICB and NNICB are under plan
			•**Community Services**: All ICBs are achieving plan for 52ww Adults. DDICB are achieving the 52ww CYP plan. LICB has a risk in relation to ULTH Community Paediatrician services, as ICB business case has not been taken forward. NNICB risks relate to NHT Community Paediatrics OT and SLT services, due to staffing issues and whole service pathway redesign required for SLT, extended waits are increasing.
			•**Mental Health & LD&A**: Access targets are being met in several areas, but challenges persist in out-of-area placements and acute bed utilisation. LD&A inpatient numbers are behind trajectory, but health checks are ahead of plan.
			6. Vaccinations
			•**Vaccinations**: COVID spring campaign – commenced on 13th April 2026 and ends on 30th June 2026.
			7. NHS Oversight Framework Q3
			•**Q3 assessments** have led to NHT, NUH, ULH, and CRH being rated NOF 4. NUH and LCH have had improved ratings. Recovery support remains for NHT.

Forecast Delivery RAG

2.1 Operational Plan - Latest Delivery Position – May 2026 report

DLN Cluster Service Delivery Dashboard v Plan		Pop / Provider	% / Value	Period	Derby and Derbyshire ICB			Lincolnshire ICB			Nottingham and Nottinghamshire ICB		
Acute	Metric				Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Planned Care	<18 week wait for 1st OP	ICB Pop	%	Feb-26	70.2%	62.0%	-8.2% ✗	65.8%	56.9%	-8.9% ✗	73.2%	62.0%	-11.2% ✗
	<18w waits RTT	ICB Pop	%	Feb-26	62.5%	59.8%	-2.7% ✗	59.5%	57.5%	-1.9% ✗	62.7%	58.8%	-3.9% ✗
	>52 week waits	ICB Pop	%	Feb-26	1.0%	2.2%	1.2% ✗	1.1%	1.0%	-0.2% ✓	1.0%	2.0%	1.0% ✗
	>65 week wait	ICB Pop	Value	Feb-26	0	75	75 ✗	0	17	17 ✗	0	56	56 ✗
	PTL (Waiting List)	ICB Pop	Value	Feb-26	117,875	114,938	-2,937 ✓	111,219	109,009	-2,210 ✓	124,586	129,673	5,087 ✗
Cancer	<28 Day Faster Diagnosis	ICB Pop	%	Feb-26	78.7%	77.9%	-0.8% ✗	79.4%	74.3%	-5.1% ✗	78.9%	72.7%	-6.2% ✗
	<31 day	ICB Pop	%	Feb-26	93.0%	93.3%	0.3% ✓	94.7%	88.7%	-6.0% ✗	94.3%	94.7%	0.4% ✓
	<62 Day Referral to Treatment	ICB Pop	%	Feb-26	74.6%	64.5%	-10.1% ✗	73.9%	59.2%	-14.7% ✗	72.5%	66.0%	-6.5% ✗
	LGI Fit Test	ICB Pop	%	Feb-26	81.3%	83.1%	1.8% ✓	79.7%	88.6%	8.9% ✓	79.5%	80.7%	1.2% ✓
Diagnostics	Planning 9 Modalities > 6ww	ICB Pop	%	Feb-26	17.8%	21.3%	3.5% ✗	7.3%	40.2%	32.9% ✗	11.1%	24.3%	13.2% ✗
Urgent Care	<4 hour wait ED	ICB Prov	%	Mar-26	80.1%	72.1%	-8.1% ✗	78.0%	81.3%	3.3% ✓	78.0%	70.6%	-7.4% ✗
	>12 hour wait from arrival ED	ICB Prov	%	Mar-26	7.3%	9.7%	2.4% ✗	10.7%	11.3%	0.5% ✗	7.5%	12.7%	5.3% ✗
	>45m Ambulance Handovers	ICB Prov	%	Mar-26	0.0%	8.3%	8.3% ✗	0.0%	16.3%	16.3% ✗	0.0%	22.0%	22.0% ✗
	Cat 2 Mean Response Time	ICB Prov	Value	Mar-26	00:27:29	00:26:18	-00:01:11 ✓	00:30:00	00:37:31	00:07:31 ✗	00:27:29	00:30:46	00:03:17 ✗
Primary Care	GP Appointments	ICB Pop	Value	Feb-26	640,378	602,539	-37,839 ✗	514,849	484,507	-30,342 ✗	686,622	678,928	-7,694 ✗
	Units of Dental Activity (UDAs)	ICB Pop	Value	Feb-26	112,491	116,596	4105 ✓	73,000	68,192	-4808 ✗	150,273	147,353	-2,920 ✗
	Urgent Dental Activity	ICB Pop	Value	Feb-26	6,824	5,382	-1442 ✗	3,974	3,802	-172 ✗	8,464	6,429	-2,035 ✗
	Pharmacy First	ICB Pop	Value	Feb-26	7,891	7,566	-325 ✗	6,503	7,849	1346 ✓	9,185	10,064	879 ✓
Community	>52ww - Adult	ICB Pop	Value	Feb-26	487	48	-439 ✓	93	0	-93 ✓	0	0	0 ✓
	>52ww - CYP	ICB Pop	Value	Feb-26	2,503	2,126	-377 ✓	35	935	900 ✗	13	169	156 ✗
Mental Health	Inappropriate Out of Area Inpatients	ICB Pop	Value	Feb-26	5	3	-2 ✓	0	0	0 ✓	0	10	10 ✗
	Inpatient Mean Length Of Stay	ICB Pop	Value	Feb-26	42	64	22 ✗	54	30	-24 ✓	53	63	10 ✗
	Individual Placement Support	ICB Pop	Value	Feb-26	807	845	38 ✓	700	710	10 ✓	1300	1500	200 ✓
	Early Intervention Psychosis	ICB Pop	%	Feb-26	60.0%	75.0%	15.0% ✓	60.0%	70.0%	10.0% ✓	60%	70.0%	10.0% ✓
	Talking Therapy Reliable Recovery	ICB Pop	%	Feb-26	47.2%	50.3%	3.1% ✓	49.3%	50.6%	1.3% ✓	50%	50.9%	0.9% ✓
	Talking Therapy Reliable Improvement	ICB Pop	%	Feb-26	68.0%	70.6%	2.6% ✓	71.6%	69.8%	-1.9% ✗	68%	70.1%	2.1% ✓
	CYP Access	ICB Pop	Value	Feb-26	14,565	14,770	205 ✓	11,645	10,740	-905 ✗	20475	21435	960 ✓
	CYP ED Routine	ICB Pop	%	Feb-26	95%	100.0%	5.0% ✓	95%	100.0%	5.0% ✓	95%	81%	-14.0% ✗
LD&A	Adult Inpatients	ICB Pop	Value	Mar-26	28	37	9 ✗	25	35	10 ✗	32	38	6 ✗
	CYP Inpatients	ICB Pop	Value	Mar-26	3	5	2 ✗	1	2	1 ✗	2	0	-2 ✓
	Annual Health Checks	ICB Pop	Value	Mar-26	661	670	9 ✓	3,562	3,745	183 ✓	5,667	5,583	-84 ✗

All data is taken from National Published Data Sources except for LD&A

Key: Orange = plan has not been achieved / Blue = plan has been achieved

2.1 Operational Plan : Latest Activity Position – May 2026 Report

Derby and Derbyshire ICB Population	February 2026 Only				Feb26 v Feb25		April 2025 - February 2026				YTD 25/26 v YTD 24/25	
Metric Full Name	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance
A&E Attendances (All types: UHDB, CRH, DCHS, DUCC	47,166	49,463	2,297	4.9%	1,217	2.5%	536,948	608,859	71,911	13.4%	41,158	7.2%
Elective Ordinary	1,815	2,063	248	13.7%	60	3.0%	21,207	23,168	1,961	9.2%	-154	-0.7%
Day Cases	11,809	13,132	1,323	11.2%	-893	-6.4%	136,232	157,481	21,249	15.6%	-1,590	-1.0%
Diagnostics (9 key modalities)	41,009	41,996	987	2.4%	3,271	8.4%	465,235	474,812	9,577	2.1%	50,223	11.8%
Outpatients 1st (Spec Acute)	31,660	33,666	2,006	6.3%	1,378	4.3%	373,853	368,340	-5,513	-1.5%	-4,656	-1.2%
Outpatients Follow-ups (Spec Acute)	72,402	70,450	-1,952	-2.7%	-3,080	-4.2%	841,661	824,416	-17,245	-2.0%	-13,629	-1.6%

Lincolnshire ICB Population	February 2026 Only				Feb26 v Feb25		April 2025 - February 2026				YTD 25/26 v YTD 24/25	
Metric Full Name	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance
A&E Attendances (All types: ULTH, LCHS, SMG)	27,839	28,502	663	2.4%	2,612	10.1%	332,063	327,288	-4,775	-1.4%	10,380	3.3%
Elective Ordinary	1,483	1,434	-49	-3.3%	6	0.4%	16,553	16,297	-256	-1.5%	-328	-2.0%
Day Cases	9,081	8,620	-461	-5.1%	-861	-9.1%	105,478	105,921	443	0.4%	-3,685	-3.4%
Diagnostics (9 key modalities)	34,811	33,787	-1,024	-2.9%	-1,002	-2.9%	419,808	410,602	-9,206	-2.2%	26,625	6.9%
Outpatients 1st (Spec Acute)	23,689	23,186	-503	-2.1%	-1,311	-5.4%	273,577	271,517	-2,060	-0.8%	-8,212	-2.9%
Outpatients Follow-ups (Spec Acute)	39,266	40,735	1,469	3.7%	-993	-2.4%	457,778	475,154	17,376	3.8%	-7,264	-1.5%

Nottingham and Nottinghamshire ICB Population	February 2026 Only				Feb26 v Feb25		April 2025 - February 2026				YTD 25/26 v YTD 24/25	
Metric Full Name	Plan	Actual	Variance	% Variance	Variance	% Variance	Plan	Actual	Variance	% Variance	Variance	% Variance
A&E Attendances (All types: NUH+SFH)	39,974	37,359	-2,615	-6.5%	-280	-0.7%	456,940	448,922	-8,018	-1.8%	7,802	1.8%
Elective Ordinary	2,115	2,273	158	7.5%	43	1.9%	24,220	24,764	544	2.2%	-18	-0.1%
Day Cases	14,490	14,062	-428	-3.0%	-453	-3.1%	166,432	163,038	-3,394	-2.0%	-2,763	-1.7%
Diagnostics (9 key modalities)	40,479	45,090	4,611	11.4%	-415	-0.9%	473,927	496,363	22,436	4.7%	-3,122	-0.6%
Outpatients 1st (Spec Acute)	31,435	28,566	-2,869	-9.1%	1,336	4.9%	366,403	324,862	-41,541	-11.3%	-13,938	-4.1%
Outpatients Follow-ups (Spec Acute)	67,154	61,120	-6,034	-9.0%	2,710	4.6%	758,316	708,434	-49,882	-6.6%	-16,654	-2.3%

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

Delivery Summary:

1. Planned care recovery remains off trajectory across the DLN Cluster. All three ICBs are below plan for the 18-week RTT standard and continue to carry material long-wait backlogs; while the number of 65-week waits is reducing, the pace of improvement is not yet sufficient to fully eliminate long waits across the cluster.
2. Lincolnshire has recovered delivery of 52-week waits to plan and has achieved the <1% of waiting list ambition, however RTT performance remains below plan. Derbyshire and Nottinghamshire remain materially off plan for 52-week waits and continue to report residual 65-week breaches, with long waits concentrated in high-pressure specialties (including gynaecology, dermatology and ENT). Delivery of the 52-week wait plans is a significant risk for 26/27 for Derbyshire and Nottinghamshire. Nottinghamshire remains above plan for overall waiting list (PTL), reflecting demand pressure, pathway change and ongoing validation impacts.
3. Delivery at NUH is a concern where 52 week wait volumes were 2353 at 19/04/26 against a plan of 784 patients (2.6% of the total waiting list). The volume of long waiting patients is reducing, but the pace and magnitude of the reduction are of concern.
4. A significant increase in the pace of improvement is required in 2026/27 across the cluster due to the Non-recurrent element of the Elective Recovery Fund clawback being enacted should waiting lists not reduce in line with operational plans. This is risk of £5.8m in 26/27. However, risks increase in future years in line with growth in non-recurrent funding levels.

Key Programme Delivery Risks:

1. There exists a persistent gap between demand and capacity across planned care which affects RTT recovery. Constraints on capacity include staffing, theatres, out-patients and productivity which the providers will need to address. Commissioning plans will need to address the increasing demand and impacts of pathway changes due to provider service changes.
2. Diagnostics capacity remains a critical dependency for elective recovery across the cluster, with persistent constraints in key modalities which impact waiting list reduction and the ability to treat long-waiting patient cohorts. Diagnostic capacity will need to be addressed to underpin elective recovery.
3. Long waiting patient cohorts remain concentrated in high-pressure specialties including gynaecology, dermatology and ENT, which require additional capacity and productivity improvements to deliver improvements. These are areas for targeted service change reviews into community-based settings.
4. There is Inconsistent waiting list control and data quality across providers (including validation and partial booking/ASI backlogs) which reduces the assurance on the providers grip and control of the improvement actions required.

Commissioner Response and Mitigating Actions:

1. Planned care sprints in Q4 2025/26 have been undertaken across providers funded by non-recurrent funding from NHSE. Providers were expected to maximise their available capacity, including evenings and weekends, use the independent sector, and prioritise maximising completed treatments. This is needed to ensure a good start for 2026/27 delivery, which has trajectories which start from March 2026 plan positions being delivered.
2. A validation sprint is being undertaken by providers in Q1 2026/27 to ensure clear and accurate waits. The NUH performance position has been impacted by the EPR implementation, but the validation sprint work has assisted with cleansing and validating the transferred lists, which intended to provide a clear position from which to drive further improvement during the year.
3. Following from the 2026/27 planning model which determined levels of activity needed to deliver the performance requirements, the Cluster level commissioning arrangements will ensure additional elective capacity is secured for areas where delivery risk is highest and will ensure affordability and value for money through establishment of community models as appropriate, including Ophthalmology, gynaecology, dermatology.
4. The Planned Care programme will set consistent cluster-wide expectations for demand management and outpatient improvement, including improved use of Advice and Guidance, appropriate expansion of PIFU, reduced DNA, improved productivity and establish system wide triage and treatment models, for example for ophthalmology.
5. Cluster-level grip will be enhanced through programme board and commissioning oversight groups, and provider escalations through robust contract routes, which will ensure contractual levers and incentives are consistently applied across the cluster to ensure delivery of the operational plans for each ICB.

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

Delivery Summary:

1. Diagnostics performance remains significantly off plan across the DLN Cluster and continues to constrain both elective and cancer recovery. All three ICBs are above plan for the proportion of patients waiting >6 weeks, with Lincolnshire most challenged (40.2% in February 2026), and Derbyshire and Nottinghamshire also materially above trajectory. Key pressures persist in audiology, MRI, endoscopy and non-obstetric ultrasound, with notable concern regarding MRI long waits in Nottinghamshire and ongoing constraints affecting pathway progression.
2. Long-wait diagnostic backlogs remain a material risk but vary by system and modality. In Derbyshire, the total number of patients waiting >13 weeks is reported as low overall, whereas in Nottinghamshire MRI remains a key driver of 13-week waits, with the NUH MRI 13-week backlog continuing to grow and a mobile scanner in place as a temporary mitigation.
3. In Lincolnshire, ongoing pressures in MRI and NOUS are linked to booking and operational capacity constraints and transfer impacts, and recovery remains dependent on stabilising booking processes alongside additional capacity measures. Across the cluster, diagnostics remains a critical dependency for RTT and cancer pathways and requires sustained capacity and productivity improvement to support delivery of 2026/27 trajectories
4. There are known data quality issues related to NUH due to the migration to NerveCentre EPR in November 2025, which is impacting the reporting of patient pathways, particularly those waiting for endoscopy. There are also issues with reporting long waiting patients at ULH, which is artificially inflating the volume of 13-week waiters to very high levels.
5. There is significant concern around the future delivery of MRI by NUH where there is reliance upon high-cost temporary mobile capacity until the Nottingham City CDC opens in 2027.
6. A significant increase in the pace of improvement is required in 2026/27, as the March 2027 target requires improvements of between 18% and 25% from the current performance level. The most significant is Lincolnshire where an improvement from 40.2% to 14% of patients waiting over 6 weeks is required by March 2027.

Key Programme Delivery Risks:

1. A persistent gap between demand and capacity exists across diagnostics pathways. In addition, demand is expected to increase as part of the ambition for earlier diagnosis, for which NHS England provided an expected activity model at ICB level to deliver the increased activity levels required. The ICBs included these within the 2026/27 operational plans and in some areas, such as Nottingham and Nottinghamshire, planned for activity exceeding these levels to enable the steep increase in performance expected.
2. Diagnostics capacity remains a critical dependency for elective and cancer recovery, with persistent constraints in key modalities (notably MRI, audiology, endoscopy and non-obstetric ultrasound) impacting waiting list reduction and the ability to treat long-waiting patient cohorts. Balancing the capacity available across urgent and cancer requirements and planned care is key to the improvements needed, including capacity available across the NHS, Independent Sector and Community Diagnostic Centres.

Commissioner Response and Mitigating Actions:

1. Additional capacity has been commissioned in Lincoln for a new endoscopy unit in quarter 2 2026/27. A NUH mobile MRI scanner is in place and is reducing the 13ww backlog volume whilst contractual discussions are concluded.
2. The ICBs will ensure continued roll-out and effective utilisation of the Community Diagnostic Centres, to enhance capacity and improve diagnostic, elective and cancer performance. There are five CDCs across Derby and Derbyshire, while one is fully operational the other four will continue to increase capacity. Three CDCs are operational in Lincolnshire, with a further facility planned in Boston. In Nottingham and Nottinghamshire, Mansfield CDC became live in April 2026, whilst the Nottingham CDC has been delayed until April 2027.
3. The Diagnostic programme will set consistent cluster-wide expectations for demand management, identification of capacity availability, reductions in DNA, improved productivity and establish system wide referral management and pathway reviews.
4. Cluster-level grip will be enhanced through programme board and commissioning oversight groups, and provider escalations through robust contract routes, which will ensure contractual levers and incentives are consistently applied across the cluster to ensure delivery of the operational plans for each ICB.

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

Delivery Summary:

1. Rising 2-week-wait referral volumes and increased pathway conversion continue to add pressure across tumour sites, contributing to sustained delivery risk for 28-day FDS and 62-day performance. Recovery remains dependent on addressing diagnostic, histology and front-end pathway capacity constraints in the most challenged pathways.
2. Nottingham and Nottinghamshire remains significantly off trajectory and NUH is subject to Tier 1 NHSE oversight for cancer, with ongoing pathway challenges and diagnostic constraints affecting performance.
3. Cluster recovery actions continue to focus on high-impact tumour sites, increased diagnostic and treatment capacity (including insourcing/outsourcing where appropriate), and pathway redesign supported by EMCA and NHSE.
4. Cancer screening continues to present both an opportunity and a delivery risk across the DLN Cluster. Uptake remains variable across breast, bowel and cervical screening programmes, with lower participation in some population groups contributing to late presentation and increasing pressure on 2-week-wait referral volumes. Improving screening coverage is an important medium-term enabler of earlier diagnosis and pathway sustainability, but benefits will be realised over time rather than in-year.
5. Delivery of the 62-day cancer standards is a significant risk for 26/27 for all ICBs, with greater risk for Derbyshire and Nottinghamshire due to the difference between current performance and the plan start point in April 2026.

Key Programme Delivery Risks:

1. Sustained gap between demand and capacity across cancer pathways, exacerbated by increasing referrals and pathway complexity.
2. Diagnostics, radiology and histology constraints continue to delay pathway progression, directly impacting both FDS and 62-day performance.
3. Workforce fragility across key pathway components limits resilience and the ability to flex capacity at pace.
4. Backlog reduction activity may continue to create volatility in headline performance where clinical prioritisation focuses on treating the longest waiters.

Commissioner Response and Mitigating Actions:

1. Apply cluster-level commissioning grip to rising 2-week-wait referral volumes, including systematic review of growth drivers, assurance on referral quality and demand management, and alignment of capacity decisions to protect sustainable delivery of cancer standards
2. Work with Public Health, Primary Care and providers at cluster level to support improved cancer screening uptake in under-represented populations, ensuring commissioning decisions across screening, diagnostics and treatment are aligned to support earlier diagnosis and sustainable cancer pathway delivery.
3. Maintain cluster-level grip through commissioner-led cancer governance, including escalation through contract forums and alignment to NHSE tiering oversight where applicable.
4. Use shared DLN commissioning arrangements to prioritise interventions in the highest-risk tumour sites and pathway steps, including targeted use of additional diagnostic and treatment capacity.
5. Commission and assure delivery of EMCA/NHSE-supported pathway improvement programmes (including demand and pathway reviews where required) and monitor impact through agreed milestones.
6. Align diagnostics recovery decisions to cancer pathway priorities to reduce bottlenecks and support sustainable delivery of FDS, 31-day and 62-day standards.

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

Delivery Summary:

1. Urgent and Emergency Care performance remains below plan across the DLN Cluster, with continued pressure on four-hour ED performance, ambulance handovers and 12-hour waits. Performance against the four-hour standard remains weak across all three ICBs, with particularly significant challenge in Nottingham and Nottinghamshire.
2. Ambulance handover delays continue to present a material system risk, driven by flow constraints and high bed occupancy. Although some improvement has been seen through enhanced system grip and Release to Respond arrangements, sustained delivery of handover standards has not been achieved.
3. Nottingham and Nottinghamshire remains one of the most challenged systems nationally, including very low Type 3 performance and continued impact from demand timing and discharge pressures; Lincolnshire saw improvement in March following front door pathway redesign and improved streaming/SDEC utilisation, though 12-hour waits remain a challenge.
4. Ongoing demand pressure, workforce constraints and variability in front-door and discharge processes continue to limit system resilience, reinforcing the need for coordinated cluster-level action.
5. SFH went live with NerveCentre in ED during mid-April, which has impacted performance whilst the new clinical system is embedded. Additional validation processes have been implemented by the Trust to enable an accurate 4 hour wait position to be submitted for April.

Key Programme Delivery Risks:

1. The Cluster continues to under-deliver the four-hour ED standard, with limited resilience to demand surges and ongoing exposure to national and NHSE scrutiny. Despite the ICBs not submitting operational performance targets for 2026/27, the ICBs have been assigned performance targets as aggregate positions of the providers within their geographical boundaries.
2. High levels of ambulance handover delays are persistent, which are driven by hospital flow constraints, high bed occupancy and delayed discharge, increasing risks to patient safety and ambulance response times.
3. Variability in front-door models and streaming effectiveness across providers, including inconsistent performance in Type 3 and urgent treatment centres, limiting system-wide impact.
4. High system fragility arising from workforce pressures across acute, ambulance and community services, reducing the ability to flex capacity during periods of sustained operational pressure.
5. Strong interdependency between urgent care performance and wider system performance (including discharge, community capacity and elective pressure), increasing delivery risk if actions are not taken in a coordinated, system-wide manner.

Commissioner Response and Mitigating Actions:

1. Use shared DLN commissioning and management arrangements to maintain system-wide oversight of demand, flow and performance, including the operation of System Control Centres and daily operational intelligence to enable early intervention and escalation.
2. Set and enforce clear cluster-wide expectations for ambulance handover improvement, including continued implementation of the Release to Respond model, strengthened joint working with EMAS, and accountability for reducing internal delays that contribute to prolonged handovers
3. Drive consistent implementation of effective front-door and flow models across the cluster, including alignment to the national Model ED approach, expanded use of SDEC, improved streaming and prioritisation of Type 3 performance to reduce avoidable ED attendances.
4. Strengthen system-wide discharge and flow arrangements through coordinated commissioning of community, intermediate and frailty services, ensuring urgent care recovery actions are aligned with discharge capacity and avoid shifting pressure elsewhere in the system
5. Apply contractual and performance levers consistently across the cluster to reinforce delivery expectations ensuring improvements deliver sustainable system performance

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

Delivery Summary:

1. Community services performance across the DLN Cluster remains under pressure, with sustained challenges in eliminating the longest waits in children and young people (CYP) pathways, while adult >52-week waits are largely in line with plan.
2. In Lincolnshire and Nottinghamshire, all >52-week waits are concentrated in CYP services, with key pressure in ULTH community paediatrician services in Lincolnshire and SLT/OT pathways in Nottinghamshire.
3. In Nottinghamshire, pathway changes are delivering only modest improvement in SLT waits and OT recovery plans are being refreshed following advice that the previous recovery date is no longer achievable; this remains a material delivery risk and requires strengthened system oversight through SEND governance.
4. Delivery of the 52-week wait community plans is a significant risk for 26/27 for all ICBs. The risk is significant for Nottinghamshire as NHT has forecast continued growth in the volume of long waiters based on the current capacity levels for OT and SLT. This was reflected in operational plans and led to a non-compliant trajectory when internally assessed by the ICB against the requirement from NHSE to reduce waits towards elimination by March 2029.

Key Programme Delivery Risks:

1. Persistent pressure on community service waiting times across the cluster, driven by sustained demand growth and limited capacity to absorb additional referrals.
2. Workforce recruitment and retention challenges across community services, reducing resilience and limiting the ability to flex capacity to meet recovery trajectories.
3. Variation in service models, productivity and data quality across providers, limiting commissioner assurance and the pace of consistent improvement at cluster level.
4. Dependency on transformation and productivity assumptions to deliver recovery, with limited short-term mitigations available where staffing or capacity constraints persist.
5. Risk of knock-on impact to urgent care and acute performance if community capacity is unable to sustain flow and discharge support during periods of high demand.

Commissioner Response and Mitigating Actions:

1. Maintain strong cluster-level grip through commissioner-led community governance, which is being set up at present and is expected to be aligned to place arrangements. This will oversee delivery, assure recovery trajectories and escalate risk where required.
2. Use shared DLN commissioning arrangements to prioritise support and intervention in the most challenged community services, focusing on pathways with the longest waits and highest system impact.
3. Set and enforce consistent cluster-wide expectations for community service productivity and demand management, including improved caseload management, reduction in unwarranted variation and clearer referral and access criteria.
4. Align community commissioning decisions with system flow priorities, ensuring community capacity commissioned to support discharge and admission avoidance is balanced with delivery of access and waiting time standards.
5. Support delivery through coordinated workforce and capacity planning across the cluster, including the use of short-term mitigations (such as targeted insourcing or temporary capacity) where appropriate, alongside longer-term service transformation.
6. Apply contractual levers consistently across the cluster to reinforce delivery expectations, improve transparency of performance and ensure recovery actions deliver sustainable improvement rather than short-term stabilisation.

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

Delivery Summary:

1. GP appointment volumes were below plan in February across all three systems, reflecting continued high demand, workforce constraints and wider system pressures. While appointment delivery remains high in absolute terms, performance has not consistently met planned trajectories, reinforcing the need for ongoing access and demand management actions.
2. Access to general practice remains variable across the cluster and constrained by workforce availability, particularly GP and practice nurse capacity, resulting in reliance on non-recurrent mitigations to stabilise delivery. Digital and alternative access routes continue to expand but have not yet delivered consistent system-wide impact on access or demand pressures.
3. NHS dental services remain a significant and persistent delivery challenge, with under-delivery of commissioned activity and variation in access across the cluster continuing to limit improvement. Urgent dental activity remains below ambition overall despite commissioning interventions to stabilise and maximise existing capacity.
4. Pharmacy First delivery in February was above plan in Nottinghamshire and Lincolnshire, with Derbyshire below plan. While performance is improving, continued focus is required to sustain delivery, support consistent uptake across the cluster and maximise the system impact on primary care and urgent care demand.

Key Programme Delivery Risks:

1. GP contract changes: Implementation of GP contract changes may create short-term instability and divert focus from access and capacity improvement.
2. Digital roll-out issues: Variable uptake of digital access and triage, alongside integration and exclusion issues, limits impact on access and demand management.
3. Urgent dental uptake and awareness: Low public awareness of urgent dental pathways risks under-utilisation of capacity and continued avoidable urgent care demand.
4. Dental hand backs: Dental contract hand backs create access gaps across the DLN cluster, increasing unmet need and pressure on urgent care.
5. Community pharmacy ramp-up: The pace of pharmacy service expansion is constrained by workforce capacity, readiness and public awareness.

Commissioner Response and Mitigating Actions:

1. Maintain strong cluster-level oversight through commissioner-led primary care governance, ensuring delivery is aligned to system priorities, outcomes and population need, with clear escalation through established contract and performance forums where access or capacity risks emerge.
2. Use shared DLN commissioning arrangements to support delivery of GP contract changes in a consistent and coordinated way, providing clarity of expectations and assurance that contractual implementation supports improved access, workforce sustainability and system flow.
3. Drive delivery of sustainable access improvement through consistent cluster-wide expectations for digital and alternative access models, ensuring digital transformation delivers measurable benefit for patients while mitigating digital exclusion and protecting equitable access.
4. Apply a place-based and system-wide commissioning approach to urgent dental services, strengthening public understanding of access routes, improving utilisation of commissioned capacity and reducing avoidable demand on urgent and emergency care.
5. Act collectively across the DLN cluster to manage dental contract hand-backs, prioritising rapid re-commissioning and reallocation of capacity to minimise service gaps, protect population access and maintain system resilience.
6. Support the strategic expansion of community pharmacy services as part of the wider primary care transformation agenda, with commissioner assurance on readiness, workforce sustainability and impact on access, prevention and demand reduction.
7. Apply contractual, financial and assurance levers consistently across primary care, dental and pharmacy services to reinforce delivery against agreed outcomes, maximise value for money and ensure improvement actions contribute to long-term system sustainability rather than short-term mitigation.

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

Delivery Summary:

1. Mental health performance across the DLN Cluster remains under sustained pressure, with ongoing challenges in access, waiting times and service capacity across several core pathways. Demand for mental health services continues to increase, driven by population need, complexity and acuity, placing pressure on both community and inpatient provision and limiting the pace of recovery.
2. Access standards remain a key delivery risk across several pathways, including adults, children and young people's services, and urgent and crisis care. Variability in delivery across the cluster reflects capacity constraints, workforce challenges and differences in pathway maturity, with reliance on recovery trajectories and improvement actions continuing.
3. Learning Disability and Autism (LD&A) services remain under pressure, particularly in relation to inpatient care and timely discharge. Continued challenges in securing appropriate community placements and support contribute to prolonged inpatient stays and delayed progress against national ambitions to reduce inpatient numbers.

Key Programme Delivery Risks:

1. Nottinghamshire Healthcare NHS Trust is currently managing the ongoing Enquiry into the Nottingham Homicides (VC), which continues to require significant senior leadership focus. This has reduced the capacity of senior managers to engage fully in wider system initiatives and programmes and presents a short- to medium-term risk to pace of delivery and senior-level engagement.
2. Workforce recruitment and retention challenges across mental health services, reducing service resilience and constraining recovery and transformation delivery.
3. Sustained pressure on crisis and urgent mental health pathways, increasing the risk of missed access standards and knock-on impacts on urgent and emergency care.
4. Variability in pathway maturity and delivery across the cluster, limiting consistent performance improvement and commissioner assurance.
5. Ongoing challenges in LD&A inpatient flow, including delays in securing appropriate community provision, increasing the risk of prolonged inpatient stays and non-compliance with national expectations.

Commissioner Response and Mitigating Actions:

1. Maintain strong cluster-level strategic oversight through commissioner-led mental health and LD&A governance, ensuring delivery is aligned to population need, agreed outcomes and system priorities
2. Use shared DLN commissioning arrangements to target resources and intervention to the most pressured mental health pathways, focusing on improving access, capacity and equity of delivery across the cluster.
3. Drive sustainable improvement in access and waiting times through consistent cluster-wide commissioning expectations, supported by clear recovery trajectories, milestone monitoring and assurance that improvement is embedded rather than reliant on short-term mitigations.
4. Strengthen system-wide commissioning of crisis and urgent mental health services, ensuring pathways are integrated with urgent and emergency care and support admission avoidance, timely intervention and improved patient flow.
5. Act collectively to deliver the LD&A programme ambition, prioritising the commissioning of community-based support and housing solutions to reduce reliance on inpatient care, enable timely discharge and improve independence and outcomes for individuals.
6. Support long-term workforce sustainability through coordinated cluster-level planning and commissioning decisions, recognising workforce as a critical enabler of both recovery and transformation.
7. Apply contractual, financial and assurance levers consistently across the cluster to reinforce outcome-focused delivery, promote value for money and ensure mental health and LD&A services contribute to long-term system sustainability and prevention.

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

Delivery Summary:

1. The CYP Programme provides a coordinated, matrix-based approach across the DLN Cluster to strengthen oversight and delivery of services impacting children and young people. Performance remains under pressure across several CYP access and waiting time standards, with the most significant risks concentrated in community and neurodevelopmental pathways.
2. Community CYP services continue to carry the majority of >52-week waits across the cluster, particularly within Speech and Language Therapy (SLT), Occupational Therapy (OT) and community paediatrics, with improvement trajectories sensitive to workforce capacity and pathway redesign. While adult community waits are largely in line with plan, CYP recovery remains slower and more complex.
3. CYP mental health services continue to face sustained demand growth, particularly within neurodevelopmental pathways, contributing to extended waiting times and increasing pressure across assessment and intervention stages. These pressures exacerbate system-wide inequality risks and require coordinated commissioning action.
4. Overall, CYP performance remains a cross-cutting system challenge. Delivery risk reinforces the need for a joined-up cluster-level approach that aligns commissioning decisions, prioritises the most vulnerable cohorts and strengthens grip across pathways spanning health, social care and education interfaces.

Key Programme Delivery Risks:

1. Persistent long waits in CYP community services (notably SLT, OT and community paediatrics), driven by sustained demand growth, limited workforce capacity and complex pathway redesign requirements.
2. Continued pressure in CYP mental health and neurodevelopmental pathways, increasing risk to access standards and timely intervention.
3. Workforce recruitment and retention challenges across CYP services, reducing recovery pace and service resilience.
4. Strong interdependencies across community, mental health, acute and SEND systems, increasing delivery risk where capacity, pathway alignment or joint commissioning is insufficient.
5. Data maturity and pathway visibility limitations across CYP services which limit commissioner assurance
6. Risk of widening inequalities in access and outcomes for vulnerable CYP cohorts if recovery is uneven or further delayed.

Commissioner Response and Mitigating Actions:

1. Maintain strong cluster-level oversight through the CYP Programme using a matrix governance model, with escalation through contract and performance forums where delivery risk persists.
2. Use shared DLN commissioning arrangements to prioritise intervention in the most pressured CYP pathways, particularly community and neurodevelopmental services, with clear recovery trajectories, milestones and assurance of delivery.
3. Align commissioning decisions across CYP services to support pathway-based recovery, including coordination of capacity, workforce and transformation actions
4. Strengthen commissioner grip on CYP waiting times and access standards, improving data transparency, validation and reporting to support targeted action and system assurance.
5. Act collectively to address workforce constraints affecting CYP services, including consideration of targeted short-term mitigations alongside longer-term transformation and service redesign.
6. Work with system partners to reduce inequality of access and outcomes for CYP, ensuring commissioning decisions prioritise early intervention, timely support and the needs of the most vulnerable cohorts.

4.0 NHS Oversight Framework: ICB Delivery Overview

1. A summary of the NHS National Oversight Framework will be included once it has been finalised and published for ICBs.

2. NHS England are currently holding engagement events for provider and ICBs to outline the framework and approach for 2026-27 ahead of publications in May 2026. An ICB specific session is to be arranged as it will be the first year in which ICBs will be included in the segmentation.

3. Q1 2026/27 will be the first quarter assessed against the new framework, with segmentation expected to be published around August 2026.

ICB NOF is currently under consultation and engagement rollout with systems for publishing in Q1. Metric updates will be provided in due course.

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	21/05/2026
Paper title:	**Annual Equality Assurance Report**
Paper reference:	ICB CIC 26 014
Paper author:	Rebecca Neno, Director of Quality, Safety and Improvement Philippa Hunt, Director of Human Resources and Organisational Development (Transition) Lucy Branson, Director of Corporate Governance and Assurance
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 assurance that the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs have met their statutory obligations under the Public Sector Equality Duty during 2025/26.

Equality, diversity and inclusion (EDI) are embedded across commissioning, governance, workforce practices and organisational change, supporting equitable access, experience and outcomes for patients and staff.

The report sets out how a systematic approach to 'due regard' has been applied, including the routine use of equality impact assessments, targeted engagement with underserved groups, data-driven commissioning, and robust governance oversight. Equality considerations have also been integral to organisational change, supported by structured and transparent processes.

Key areas for further development in 2026/27 include developing joint equality objectives, improving the quality and consistency of impact assessments, strengthening the use of equality data, and the full implementation of the NHS Equality Delivery System.

Recommendation(s):

The Boards are asked to **receive** the paper for assurance that the ICBs are meeting their statutory equality duties, noting the need for a continued focus on strengthening measurable impact and delivery during 2026/27.

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

Appendices

None.

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

NHS
Derby and Derbyshire
Integrated Care Board

NHS
Lincolnshire
Integrated Care Board

NHS
Nottingham and
Nottinghamshire
Integrated Care Board

Annual Equality Assurance Report

May 2026

Contents

1. Introduction

The Ten-Year Health Plan for England reinforces the role of Integrated Care Boards (ICBs) as strategic commissioners. In response, NHS Derby and Derbyshire, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire ICBs have been operating formal partnership arrangements as an 'ICB cluster' since November 2025, aligning governance and leadership arrangements to improve efficiency and reduce duplication. A significant organisational change programme is underway to support this transition and reshape the ICBs as strategic commissioners with a reduced workforce, ahead of potential future merger (subject to legislative change).

The ICBs serve diverse populations and are committed to embedding equality, diversity and inclusion (EDI) across all functions, including policy development, commissioning processes, employment practices, and governance, with the aim of:

- Improving equality of access to health services and health outcomes for the diverse populations we serve.
- Building and maintaining a diverse, culturally competent workforce, supported by an inclusive leadership team.
- Creating and maintaining an environment in which dignity, understanding and mutual respect are experienced by all, free from prejudice and discrimination, and where patients and staff feel able to challenge discrimination and unacceptable behaviour.

This report provides assurance on how the ICBs have met their statutory obligations under the Public Sector Equality Duty, as set out in the Equality Act 2010. It summarises how due regard to equality has been embedded within decision-making, commissioning processes and organisational change during 2025/26, and sets out priorities for further improvement in 2026/27.

2. Our organisations

The ICBs were established by NHS England on 1 July 2022 and collectively serve a population of 3.25 million people across:

- NHS Derby and Derbyshire ICB – Derby City, Chesterfield, Ilkeston and Long Eaton, Amber Valley, Derbyshire Dales, Bolsover, High Peak and Glossop.
- NHS Lincolnshire ICB – Boston, East Lindsey, Lincoln City, North Kesteven, South Holland, South Kesteven, and West Lindsey.
- NHS Nottingham and Nottinghamshire – Ashfield, Bassetlaw, Broxtowe, Gedling, Mansfield, Newark, Rushcliffe, Sherwood, and the City of Nottingham.

The combined population is diverse and geographically dispersed, encompassing both densely populated urban areas and significantly rural and coastal communities.

Lincolnshire has a comparatively older population profile, with the highest proportion of residents aged 65 and over, while parts of Derbyshire and Nottinghamshire have younger and more economically active populations. All three ICBs experience significant inequalities in health outcomes, access and experience; however, the nature of these inequalities differs:

- Derbyshire and Nottinghamshire are more likely to experience inequalities linked to urban deprivation, ethnicity and social exclusion.
- Lincolnshire faces inequalities associated with rurality, digital exclusion and an ageing population.

There are shared priority cohorts across all areas, including people with multiple long-term conditions, severe mental illness, learning disabilities, and those experiencing severe and multiple disadvantage. However, the scale and underlying drivers vary, requiring locally tailored approaches. These differences require a balance between consistent cluster-wide approaches and place-based delivery to ensure services are responsive to local need.

The ICBs commission health services to meet population needs, including:

- Most planned hospital care for the diagnosis and treatment of illness (including responsibility for 59 specialised acute services and 12 specialised mental health and learning disabilities services delegated to us by NHS England since 1 April 2024 and 1 April 2025 respectively).
- Urgent and emergency care (including out of hours services, accident and emergency services, ambulance services and NHS 111 services).
- Mental health services (including psychological therapies).
- Services for people with learning disabilities and autism.
- Maternity and new-born services.
- Children's healthcare services (mental and physical health).
- Most community health services.
- Rehabilitative care.
- Palliative care.
- NHS continuing healthcare.
- GP services (responsibility delegated to us by NHS England since 1 July 2022).
- Pharmacy, optometry and dental services (responsibility delegated to us by NHS England since 1 April 2023).

The ICBs are also responsible for ensuring services are high quality, deliver value for money and improve outcomes. This includes safeguarding responsibilities and improving outcomes for children in care and those with special educational needs

and disabilities (SEND). Patients are central to all activity, and the ICBs actively involve local people in shaping services and transformation.

As of 31 March 2026, the combined workforce is approximately 1,600 staff, with further reductions expected through the organisational change programme.

3. Our equality duties

The Equality Act 2010 provides the legal framework for preventing discrimination and promoting equality of opportunity and good relations.

The Public Sector Equality Duty (PSED) requires public bodies to have due regard to three aims:

- To eliminate discrimination, harassment, victimisation and any other conduct prohibited by the Act.
- To advance equality of opportunity between people who share a relevant protected characteristic and those who do not.
- To foster good relations between people who share a relevant protected characteristic and those who do not.

The relevant protected characteristics for these purposes are: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Marriage and civil partnership are also a protected characteristic, but only in relation to eliminating unlawful discrimination in employment practices.

The purpose of the duty is to ensure equality considerations are integrated into day-to-day decision-making. Failure to consider differential impacts can lead to poorer outcomes and increased inequalities.

Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 require relevant public bodies to:

- Publish equality information annually to demonstrate compliance with the general equality duty.
- Prepare and publish one or more equality objectives at least every four years.
- Publish gender pay gap information annually (where employing 250 or more staff).

The ICBs also consider the needs of wider disadvantaged groups, including vulnerable migrants and people experiencing homelessness.

A summary of the legislative framework for equality is provided for information at **Appendix A**.

4. Governance and operational oversight

Board members are collectively accountable for ensuring compliance with statutory equality duties and embedding EDI across all functions. The Boards seek assurance that effective systems, processes and governance arrangements are in place, and promote an inclusive culture through leadership and oversight.

In exercising these responsibilities, the Boards ensure that equality considerations are integral to commissioning, service delivery and organisational performance, and seek assurance that appropriate systems, processes and governance arrangements are in place to support compliance with the PSED. Through their leadership, the Boards promote an inclusive culture, hold committees and executives to account for delivery, and ensure that the ICBs demonstrate transparency, fairness and continuous improvement in advancing EDI.

EDI responsibilities are embedded across a comprehensive committee structure:

- At a strategic level, the Joint Strategic Commissioning Committee provides primary oversight of EDI as part of its responsibility for delivering population health outcomes and addressing inequalities. The Committee oversees the development and delivery of strategic commissioning plans with an explicit focus on reducing health inequalities, and scrutinises the actions taken to identify and address disparities in access, experience and outcomes. It also oversees the ICB's arrangements for meeting its equality duties as a commissioner and ensures that public and patient involvement, particularly with underserved communities, is embedded in decision-making and service design.
- Supporting this, the Joint Quality and Service Improvement Committee provides assurance that EDI considerations are embedded within the quality and safety of care. The Committee is responsible for ensuring that services are safe, effective and equitable, with a clear focus on reducing inequalities in the quality and outcomes of care. This includes oversight of programmes such as vaccination and immunisation to ensure equitable access and uptake, as well as safeguarding arrangements for vulnerable groups, and the use of patient experience and feedback to drive inclusive service improvement.
- The Joint Finance and Performance Committee contributes to the delivery of EDI through its oversight of financial planning, performance and contracting arrangements. In particular, it scrutinises whether commissioning and contractual mechanisms incentivise equitable access to services and supports the delivery of operational plans that improve outcomes across the population.
- At an operational commissioning level, the Joint Commissioning Executive Group ensures that equality considerations are directly integrated into decision-making on resource allocation and contract awards. In doing so, the Group is required to demonstrate compliance with the PSED and wider statutory duties when making investment and disinvestment decisions, thereby embedding EDI within day-to-day commissioning practice.

- Specific oversight of primary care services is provided by the Joint Primary Care Commissioning Group, which ensures that services are planned, commissioned and reviewed in line with population needs. Through its responsibility for needs assessment and service configuration across primary medical, dental, ophthalmic and pharmaceutical services, the Group contributes to equitable access and the reduction of unwarranted variation in provision.
- Workforce equality is overseen by the Joint Remuneration and Human Resources Committee, which ensures that the ICBs meets their statutory equality duties as employers. The Committee provides assurance that recruitment, reward and organisational development arrangements are fair and transparent, and that policies and practices support an inclusive culture, staff engagement and a positive working environment. It also oversees workforce change and organisational development to ensure compliance with equality legislation and best practice.
- Finally, the Audit Committees provide independent assurance that the systems and processes underpinning EDI are effective. Through their oversight of governance, risk management and internal controls, the Committees ensure that statutory duties, including equality obligations, are being met, and that policies relating to areas such as standards of business conduct and freedom to speak up support an open, inclusive and accountable organisational culture.

Collectively, these arrangements ensure that responsibility for EDI is not confined to a single committee but is embedded across the ICBs' governance framework, with clear lines of accountability spanning strategy, commissioning, service quality, workforce and assurance.

During early 2026/27, the ICBs plan to establish a joint Equality, Diversity and Inclusion Steering Group to operationally drive the EDI agenda within the ICBs and to provide a focal point for the discussion, development and implementation of ways to improve the ICBs' equality performance. The Group will be chaired by the Executive Director of Quality (Nursing), as the ICBs' executive lead for EDI, with membership comprised of senior leaders from all directorates and representative from staff forums. The work of the Group will feed into the scrutiny, assurance and decision-making arrangements described above.

5. Having due regard to equality

The ICBs adopt a systematic, embedded approach to EDI, integrating compliance with statutory duties into day-to-day business as both commissioners and employers. Equality considerations are embedded within core governance and operational processes, informing decision-making, commissioning intentions, policy development and workforce practices, ensuring EDI is delivered as an integral component of effective, equitable services and a positive working environment. The following

paragraphs set out the key business activities where due regard to equality duties is required.

5.1 Assessing the health needs of our populations

It is essential for the ICBs to fully understand the health needs of their populations. This is done by producing Joint Strategic Needs Assessments (JSNA) in conjunction with Local Authorities. The JSNAs identify where inequalities exist and describe the future health and wellbeing needs of local populations. The ICBs work with Local Authority Public Health colleagues to ensure that JSNA chapters consider all protected characteristics and other disadvantaged groups to accurately inform equality considerations in the ICBs' commissioning strategies and plans.

During 2025/26, the ICBs have used the JSNAs, alongside population health data and equality intelligence to develop a joint Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan. Together, these set out how the ICBs will improve equity of outcomes, reduce inequalities, and deliver equitable access to care, while recognising the distinct needs and characteristics of each ICB's population and targeting improvement activity accordingly. Inequalities will be addressed through:

- Population health management and segmentation, identifying groups and communities with the greatest unmet need and poorest outcomes.
- A proportionate universalism model, ensuring a universal offer for all, with intensified action for the most disadvantaged populations and neighbourhoods.
- Targeted commissioning interventions, designed to address inequities in access, experience and outcomes across priority cohorts and pathways.
- Systematic measurement of outcomes and inequalities, including routine monitoring by deprivation and other characteristics where appropriate.

This approach supports the ICBs to demonstrate compliance with the PSED by systematically identifying inequalities, targeting action where it will have greatest impact, and tracking measurable reductions in outcome gaps over time.

5.2 Public engagement and communications

The ICBs place the voices of patients, carers and communities at the centre of commissioning and decision-making. This includes meaningful involvement in how services are designed, delivered and evaluated, alongside a continued focus on strengthening communication with local populations.

Engagement activity is designed to reach people from all protected characteristic groups, as well as wider underserved communities, with a particular focus on those whose views are less routinely heard. A range of methods is used, including formal

co-production structures, targeted outreach, patient groups, surveys and place-based engagement, to ensure that insight from lived experience is systematically captured and used to inform commissioning decisions and service improvement.

During 2025/26, each ICB has demonstrated a proactive and targeted approach to engagement and co-production, tailored to the needs of its population:

- NHS Derby and Derbyshire ICB has delivered community-based engagement with protected characteristic groups, including work through partnerships such as the Community Health Alliance to engage Black African and Caribbean communities. This has supported service development, including the co-production of care models such as sickle cell services. Co-production has also been embedded within maternity services through the Maternity and Neonatal Voices Partnership, alongside wider engagement with women, birthing people and seldom-heard communities to inform improvements in safety, experience and equity. The ICB has undertaken targeted action to address specific access barriers, including the development of British Sign Language provision within Talking Therapies, and initiatives to support women to influence the design of women's health services. In addition, place-based engagement has enabled communities experiencing deprivation to shape local service developments, such as health hubs.
- NHS Lincolnshire ICB has embedded co-production within formal structures, including the Maternity and Neonatal Voices Partnership and a frailty co-production group, ensuring that the perspectives of women, families and older people are directly reflected in service design and communication approaches. Targeted engagement has been undertaken with communities experiencing inequalities, including Black and Asian families, Eastern European communities and those living in areas of deprivation, to improve equity in maternity outcomes. The ICB has also undertaken engagement with people with specific health conditions, such as coeliac disease and Functional Neurological Disorder, ensuring that service changes are informed by lived experience. Wider engagement activity, including patient groups, surveys and outreach, has informed inclusive service redesign, for example within weight management services, and supported the development of the Inclusion Health Strategic Plan, reflecting the needs of underserved groups.
- NHS Nottingham and Nottinghamshire ICB has developed a mature, system-wide model for engagement and co-production, supported by structured mechanisms such as a Citizens' Panel, co-production networks and system-wide engagement forums. These arrangements ensure that patient and community insight is consistently embedded in service planning and transformation. Co-production has been particularly evident within programmes relating to mental health, learning disabilities and autism, ensuring that the needs of people with protected characteristics are reflected in service design.

The Maternity and Neonatal Voices Partnership continues to provide an established route for women and families to influence maternity services, supporting improvements in equity and experience. Engagement activity has also supported increased awareness and access to services, including targeted work to improve uptake of perinatal mental health services and ongoing involvement of underserved groups, such as LGBTQ+ communities and people with severe mental illness, in commissioning decisions.

Collectively, these approaches demonstrate that engagement and co-production are embedded as core components of commissioning practice across the ICBs. They provide evidence of a systematic approach to involving diverse communities in decision-making, supporting the advancement of equality of opportunity and ensuring that services are informed by a broad range of lived experiences and responsive to population need.

5.3 Equality impact assessments

Equality impact assessments (EIAs) are a central mechanism through which the ICBs demonstrate that they are acting transparently, consistently and in line with their statutory equality duties. EIAs support the identification and assessment of potential impacts on people with protected characteristics and other disadvantaged groups, ensuring that commissioning decisions, service changes and workforce practices do not result in unintended disadvantage. They also enable the ICBs to identify opportunities to advance equality and reduce inequalities.

EIAs are undertaken for all significant service, policy and workforce changes and are maintained as live documents to inform decision-making throughout the lifecycle of proposals. During 2025/26, there has been a specific focus on strengthening and aligning EIA processes across the ICBs, including the provision of targeted training to staff to improve the quality and consistency of impact assessments and to support their effective application within commissioning practice.

During the year, each ICB has demonstrated how equality analysis has informed commissioning decisions and service delivery, reflecting a systematic and evidence-led approach:

- NHS Derby and Derbyshire ICB has applied equality analysis alongside population health intelligence to inform commissioning decisions, with a particular focus on early intervention and addressing access barriers. This includes expansion of mental health support for children and young people and the development of neurodevelopmental pathways delivered through schools and early years settings. For people with disabilities, improvements in the delivery and timeliness of learning disability annual health checks and LeDeR (Learning from Lives and Deaths Review) processes have supported system learning and service improvement. Targeted commissioning has addressed specific barriers to access, including the continuation of British Sign Language

Talking Therapies provision through a regional model to ensure continuity of care for deaf residents. The ICB has also acted to address gender-specific need through contract modifications to maintain female Psychiatric Intensive Care Unit capacity. Wider commissioning activity has supported improvements in maternity and women's health services through pathway redesign, enhanced diagnostics and strengthened safety governance, alongside targeted interventions to improve access and uptake for racially diverse populations and recognition of LGBTQ+ needs within inclusive service design.

- NHS Lincolnshire ICB has demonstrated a structured and risk-informed approach to commissioning, underpinned by equality analysis and population need. Preventative activity has included expansion of early intervention services through Family Hubs and increased access to children's mental health and speech and language services. The ICB has taken responsive commissioning action to mitigate identified service risks, including the procurement of children and young people's continence services to maintain continuity of provision. For people with disabilities, high uptake of learning disability health checks, combined with action to reduce inpatient admissions and strengthen community provision, reflects progress in improving outcomes and quality of life. Commissioning decisions have also addressed barriers to access for diverse populations, including targeted procurement of GP translation and interpreting services to support non-English-speaking communities. Improvements within maternity and neonatal services have been supported through strengthened assurance and delivery of national programmes, contributing to improved quality, safety and patient experience.
- NHS Nottingham and Nottinghamshire ICB has demonstrated a mature, data-driven approach to commissioning, with equality analysis embedded within population health management and resource allocation. Investment in children and young people's services has included interim provision for Avoidant Restrictive Food Intake Disorder, addressing identified gaps and supporting early intervention, alongside continued investment in weight management services to improve long-term outcomes. For people with disabilities, strengthened learning disability health checks and use of Dynamic Support Registers have been complemented by proactive commissioning to reduce inpatient admissions and expand community-based care. Targeted commissioning for high-risk groups is further evidenced through the Severe Mental Illness health check programme, improving physical health outcomes. Population data has been used to inform investment in community-based mental health provision and step-down services in areas of highest need, reducing reliance on inpatient care. Preventative approaches are also reflected in investment in screening programmes, such as lung cancer screening, while improvements in maternity and women's health services have been supported through enhanced governance, digital systems and specialist networks.

Commissioning activity also recognises the needs of LGBTQ+ populations through inclusive service design.

In addition, the ICBs have applied equality analysis to the commissioning and delivery of immunisation and vaccination programmes. This has included the use of population health data and engagement insight to identify variations in uptake and to design targeted interventions for underserved groups. Actions have included tailored outreach, culturally appropriate communications and localised delivery models to reduce geographic, digital and socio-economic barriers. Ongoing monitoring of uptake by protected characteristic and deprivation enables responsive action where inequalities are identified.

Collectively, these approaches demonstrate that equality impact assessments are embedded within commissioning processes and are actively used to inform decisions, mitigate risks and target improvement activity. This provides clear evidence of a systematic approach to having due regard to equality, supporting improved access, experience and outcomes for diverse populations.

5.4 Procurement and contract management

The ICBs commission health services for their local populations from a range of NHS, independent and third sector providers, and it is important for all associated procurement and contract management arrangements to incorporate appropriate equality considerations. As such, the ICBs include an assessment of compliance with equality legislation requirements as a routine aspect of all procurement exercises. The ICBs also use the national NHS Standard Contract, which in its full-length version mandates providers of NHS services to implement:

- The NHS Equality Delivery System.
- The NHS Accessible Information Standard – an approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.
- The NHS Workforce Race Equality Standard (WRES) – which requires NHS organisations to assess and report annually on workforce race equality. It measures differences in experience and outcomes between White and ethnically diverse staff across nine indicators, including recruitment, career progression, disciplinary processes, staff experience, and Board representation.
- The NHS Workforce Disability Equality Standard (WDES) – which requires NHS organisations to assess and report annually on disability equality within the workforce. It compares the experiences of disabled and non-disabled staff across ten indicators, covering areas such as recruitment, career development,

workplace adjustments, bullying and harassment, staff engagement, and Board representation.

A range of assurances on compliance with the above requirements are incorporated within the ICBs' routine quality and performance monitoring processes, which will be further aligned and strengthened during 2026/27.

5.5 Recruitment, selection and the working environment

The ICBs are committed to developing a more representative workforce at all levels and to maintaining a working environment that promotes the health and wellbeing of ICB employees. The ICBs operate fair, inclusive and transparent recruitment and selection processes and we are committed to maintaining a working environment that promotes the health and wellbeing of the whole workforce. This is achieved through a suite of human resources policies, which have been assessed from an equality perspective, and the establishment of staff equality groups/networks.

The ICBs have established a range of inclusive workforce practices, which include:

- Implementing the Workforce Race Equality Standard (WRES) and working to the requirements of the Workforce Disability Equality Standard (WDES).
- Assessing the pay gap between male and female employees, taking action as required.
- Ensuring reasonable workplace adjustments and support plans are in place for staff with disabilities and that appropriate support is provided for staff with caring responsibilities.
- Establishing robust and inclusive Freedom to Speak Up arrangements.

During 2025/26, there has been a focus on the ICBs' organisational change programme, which has followed a structured and transparent methodology, with equality considerations embedded throughout design, consultation, selection, and implementation, supported by targeted training and staff development to promote fair and inclusive outcomes. The organisational change programme has included the implementation of three sequential consultation waves, covering Executive Directors (Wave One), Senior Leadership roles (Wave Two), and the wider staff group (Wave Three), ensuring a consistent and equitable approach for all staff groups affected by organisational change.

Across all phases, equality considerations have been embedded as a core principle of the process. The ICBs have undertaken equality impact assessments to identify potential impacts on protected characteristic groups, including risks associated with workforce reduction and changes to organisational structure. These assessments have informed mitigating actions, including the design of recruitment and selection processes, to ensure that outcomes are visibly fair, equitable and inclusive, and that the diversity of the workforce is maintained wherever possible.

The consultation approach has been deliberately designed to support inclusive engagement. Staff in scope have been provided with comprehensive information and sufficient time to participate meaningfully in consultation, supported by collective engagement with recognised Trade Unions and professional bodies. Individuals have been offered one-to-one discussions with Executive Directors or senior leaders, alongside access to human resources support, enabling consideration of individual circumstances and reducing the risk of disproportionate impacts. The process has also ensured that staff absent from work, including those on maternity leave or other forms of leave, are able to participate fully in consultation activity.

The ICBs have also ensured that staff are appropriately supported throughout the change process, recognising the potential equality impacts associated with organisational change. A comprehensive wellbeing and transition support offer has been made available to all affected staff, including career planning support, access to external advice, and targeted development such as interview skills training and CV preparation. This provision supports equal access to opportunities during redeployment and external employment and helps to mitigate any adverse impacts arising from the change process.

Throughout the year, the Joint Remuneration and Human Resources Committee has maintained a focus on ensuring that the organisational change programme is delivered in line with statutory equality duties, with ongoing monitoring through consultation feedback, and engagement with staff networks. This oversight will continue into 2026/27, including specific review of workforce impacts as the programme progresses.

Appendix B sets out the current demographics of the ICBs' combined workforce.

5.6 Cultural competence

All ICB staff are responsible for treating everyone with dignity and respect and must not discriminate or encourage others to discriminate. Consequently, it is a mandatory requirement for new staff to complete equality, diversity and human rights training as part of their induction and every three years subsequently.

To enhance the mandatory training requirements, the ICBs aim to provide relevant training and development opportunities to staff to improve their cultural competence and their understanding of the needs of our diverse population. This will form part of the work of the new joint Equality, Diversity and Inclusion Steering Group during 2026/27.

6. How we measure our equality performance

The NHS Equality Delivery System (EDS) is a national framework designed to support NHS organisations to assess and improve their performance in relation to EDI. It provides a structured, evidence-based approach to evaluating how effectively

organisations are meeting the needs of their local populations and workforce, and in doing so supports compliance with the PSED. The EDS enables organisations to measure equality performance across three core domains:

- **Commissioned services** – services are accessible, responsive, safe and shaped by patient voice, with a particular focus on reducing inequalities in access, care and outcomes.
- **Workforce health and wellbeing** – the organisation fosters a safe, inclusive and supportive workforce environment, promoting wellbeing, addressing inequalities, and improving staff experience and engagement.
- **Inclusive leadership** – leadership is visibly committed to equality, with strong governance, accountability and use of data to embed equality considerations into decision-making and performance management.

Organisations are required to undertake regular EDS assessments, assign performance ratings, and publish the outcomes alongside clear action plans. This promotes transparency and accountability, while supporting continuous improvement. The outputs of the EDS process are used to inform organisational equality objectives, service development, and workforce strategies, providing a systematic mechanism for identifying inequalities and targeting improvement activity. Through this structured and iterative process, the EDS provides a consistent framework for NHS organisations to track progress, demonstrate impact, and strengthen assurance to Boards that equality considerations are embedded in decision-making and service delivery.

The ICBs' EDS domain one outcomes for 2025/26 are summarised below:

ICB	Service assessed	Outcome
Derby and Derbyshire	Selected provider services, including Sickle Cell pathways	Developing – assessment demonstrated established processes and patient engagement, but overall evidence indicated further work is required to achieve consistent, system-wide impact.
Lincolnshire	Pregnancy smoking cessation – STAAR	Developing – some high scores achieved for individual outcomes, but the need for broader application across services noted.
Nottingham and Nottinghamshire	Lung Cancer Screening Programme	Excelling – strong performance across all outcomes, with comprehensive evidence of equitable access, tailored delivery, and positive patient experience.

Formal assessments against EDS domains two and three have not been completed for 2025/26, due to the ongoing organisational change programme. However, as detailed earlier in the report, the ICBs have maintained a strong equality focus to the associated processes during the year, with ongoing oversight through the Joint

Remuneration and Human Resources Committee. Despite this, it is evident that further work will be required across these domains during 2026/27. This will include confirmation of Board member equality objectives as part of annual appraisal processes.

While formal EDS assessments for domains two and three have not been completed, the ICBs did take part in the 2025 NHS Staff Survey, which measures EDI through a set of core questions focusing on respect, inclusion, fairness in career progression, and experiences of discrimination and harassment, with expanded coverage of protected characteristics.

The ICBs achieved overall response rates of 74% (Derby and Derbyshire), 71% (Lincolnshire), and 62% (Nottingham and Nottinghamshire), compared to an average national ICB response rate of 66%. Across the three ICBs, the staff survey results demonstrate consistently strong performance in diversity and equality, indicating positive perceptions of fairness and alignment with equality frameworks; however, this is not fully reflected in staff experience. Nottingham and Nottinghamshire shows solid equality foundations but comparatively weaker scores in inclusion, advocacy and voice, suggesting variability in how different staff groups experience psychological safety and involvement. Lincolnshire presents a more balanced position, with strong equality outcomes and engagement broadly in line with benchmarks, though emerging declines in raising concerns and morale highlight risks to sustained inclusivity. Derby and Derbyshire demonstrates the strongest overall performance, with above-average results across inclusive culture, leadership and flexible working, supporting equitable staff experience, albeit alongside shared declines in advocacy and morale. Overall, the findings indicate that while structural equality is well established across the ICBs, lived experience, particularly staff voice, psychological safety and confidence to speak up, remains variable and represents a key area for future focus.

7. Equality objectives

The ICBs are currently developing a new set of joint equality objectives. These will be directly derived from the shared population health priorities, commissioning ambitions and outcome measures set out within the Five-Year Population Health Strategy and Five-Year Strategic Commissioning Plan, ensuring that equality considerations are embedded within core business rather than treated as standalone activity. Equality objectives for the ICBs as employers will also be developed following completion of the organisational change programme.

While further work is needed during the early part of 2026/27 to finalise the ICBs' new joint equality objectives, the following high-level areas have been identified as the strongest and most consistent themes where equality objectives will have the greatest impact:

- **Reduce inequalities in prevention, early identification and uptake** – to be focused on vaccinations, screening, health checks and early diagnosis in deprived and underserved groups (directly linked to evidence of lower uptake and later presentation in higher-risk populations).
- **Improve equity of access and outcomes for people with multiple long-term conditions, severe mental illness, and learning disabilities** – to be focused on proactive care, physical health checks, and coordinated management (responding to poorer outcomes and higher system utilisation within these groups).
- **Reduce inequalities in children and young people's health and early life outcomes** – to be focused on mental health, obesity, early intervention and prevention (reflecting the clear emphasis on early years disadvantage shaping lifelong inequality).
- **Ensure equitable access, experience and communication across services** – to be focused on removing access barriers (digital, geographic, cultural), improving communication and co-production (aligned to citizen feedback on timely access, clear information and inclusive services).
- **Improve workforce diversity at all levels within the ICBs** – to better reflect the populations we serve.
- **Improve the cultural competence of our workforce** – to empower our staff to support us in improving equality, acceptance and inclusion within our organisations and commissioning functions.

8. Priority actions for 2026/27

Priority actions for 2026/27 will focus on strengthening the consistency, quality and impact of EDI across the ICBs' core functions. This includes:

- Improving the quality and consistency of equality impact assessments.
- Strengthening the use of equality data to support decision-making.
- Fully embedding the NHS Equality Delivery System to measure progress.

The ICBs will establish a joint Equality, Diversity and Inclusion Steering Group to drive delivery and oversight, alongside further alignment of governance, assurance and procurement processes. Delivery will also prioritise:

- The development and implementation of joint equality objectives.
- Strengthened workforce equality oversight.
- Improved equitable access, experience and outcomes for underserved groups through targeted commissioning, engagement and co-production.
- Improved workforce diversity and cultural competence.

Appendix A: Summary of the legislative framework for equality

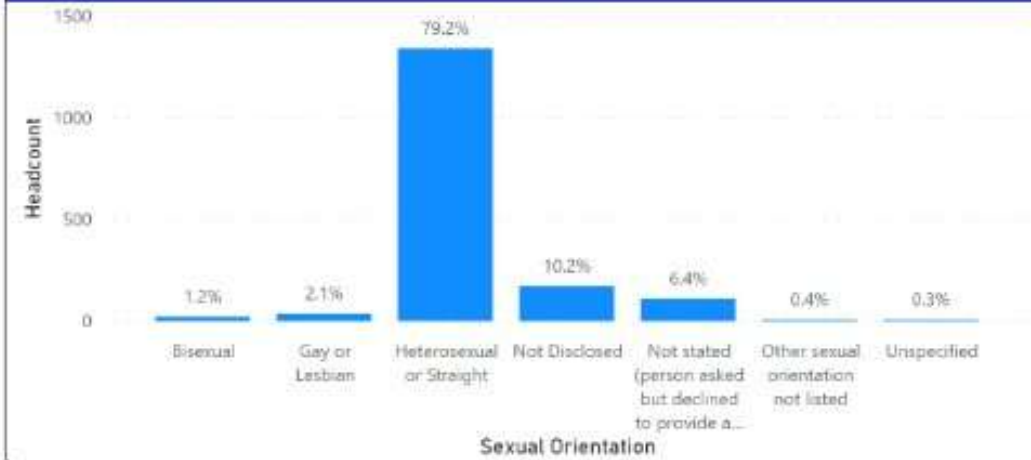
Equality Act 2010 – Nine protected characteristics:	Age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation
Equality Act 2010 – Types of discrimination:	**Direct discrimination** – treating someone with a protected characteristic less favourably than others **Indirect discrimination** – putting rules or arrangements in place that apply to everyone, but that put someone with a protected characteristic at an unfair disadvantage **Harassment** – unwanted behaviour linked to a protected characteristic that violates someone's dignity or creates an offensive environment for them **Victimisation** – treating someone unfairly because they have complained about discrimination or harassment
Equality Act 2010 – Further considerations:	Within each protected characteristic group, the **risk of discrimination** is greater for some people than others. **Intersectionality** – different types of 'identity' overlap for some people, which can shape unique experiences of discrimination. The protected characteristic of **disability** includes a wide range of physical and sensory impairments, learning disabilities, mental health conditions and long-term conditions. The needs of people from **other disadvantaged groups** (or 'Inclusion Health' groups) also need to be considered (e.g. vulnerable migrants, homeless people).
General Equality Duty – Requires public bodies to have 'due regard' to the following three aims:	To **eliminate discrimination**, harassment, victimisation and any other conduct prohibited by the Act. To **advance equality of opportunity** between people who share a relevant protected characteristic and those who do not. To **foster good relations** between people who share a relevant protected characteristic and those who do not.
Having '**due regard**' involves:	Removing or minimising disadvantages suffered by people due to their protected characteristics. Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
Fostering good relations is described as:	Tackling prejudice and promoting understanding between people from different groups.
Specific Equality Duties – Require public bodies to:	Publish information demonstrating compliance with the general equality duty – on an annual basis. Prepare and publish one or more equality objectives – at least every four years. Publish information to demonstrate how large the pay gap is between their male and female employees – on an annual basis.

Appendix B: Workforce demographics

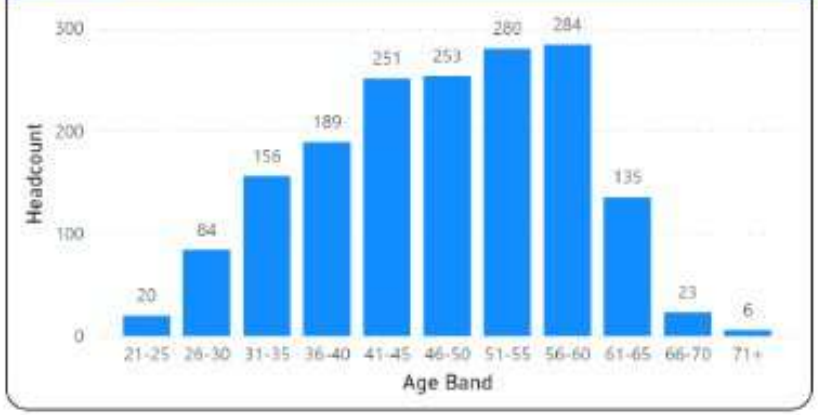
The following illustrates the demographics of the combined workforce of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB ('the DLN Cluster'):

DLN Cluster Workforce EDI metrics

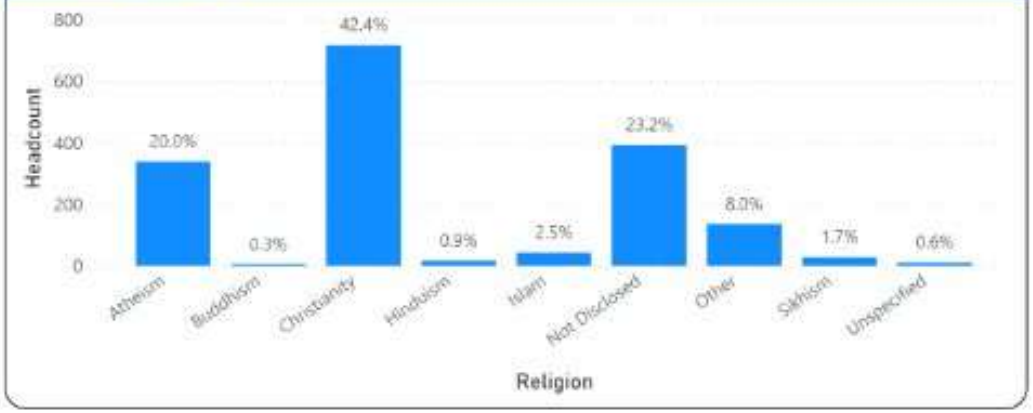
DLN Sexual Orientation



DLN Age Band



DLN Religious Belief



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:	21/05/2026
Paper title:	**2025/26 Senior Information Risk Owner Annual Report**
Paper reference:	ICB CIC 26 015
Paper author:	Lucy Branson, Director of Corporate Governance and Assurance Siân Gascoigne, Assistant Director of Corporate Affairs, and Bronwyn Jackson, Head of Information Governance and DPO (NHS Nottingham and Nottinghamshire ICB) Ged Connolly-Thompson, Head of Digital and Information Governance and DPO, and Emma Holt, Information Governance Officer (NHS Derby and Derbyshire ICB) Kelly Huckvale, Senior Information Governance Manager, and Judith Jordan, Associate Director of Integrated Governance and DPO, NHS Arden and Greater East Midlands Commissioning Support Unit (on behalf of NHS Lincolnshire ICB)
Paper sponsor:	Dr Dave Briggs, Executive Director of Outcomes (Medical) and Senior Information Risk Owner
Presenter:	Dr Dave Briggs

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

Report summary:

The purpose of the Senior Information Risk Owner (SIRO) Annual Report is to provide assurance to the Boards that information risks are being effectively managed across NHS Lincolnshire ICB, NHS Derby and Derbyshire ICB and NHS Nottingham and Nottinghamshire ICB. It summarises the key activities undertaken during 2025/26, including work completed to meet the requirements of the Data Security and Protection Toolkit, and provides assurance on the management of cyber security and information risks and incidents.

The report was reviewed and endorsed by the Audit Committees at their meeting in common during April 2026.

Recommendation(s):

The Boards are requested to **receive** the 2025/26 SIRO Annual Report for assurance that information risks are being managed appropriately and that the ICBs are complying with statutory, regulatory, and legal obligations.

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

Appendices

None.

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

2025/26 Senior Information Risk Owner Annual Report

Introduction and background

1. As the Senior Information Risk Owner (SIRO) for NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB, I am responsible for ensuring that each organisation has a robust approach to information governance, data security, and information risk management. This joint SIRO role provides executive oversight across the three statutory ICBs, ensuring consistent and coordinated management of information risks at Board level. I take overall accountability for managing information risks across the three organisations.
2. Each ICB has established information governance arrangements, underpinned by their respective information governance policy frameworks. These frameworks set out how information risks are managed, providing a structured approach to governance, assurance, and compliance with statutory and regulatory requirements. Over the course of 2026/27, these policy frameworks will be brought together and aligned as ICB Clustering arrangements embed, and preparations are made for potential future merger.
3. The Audit Committees of the three ICBs oversee compliance with regulatory requirements for information governance, including data protection and cyber security, and receive assurance updates at least twice yearly.
4. During 2025/26, a joint Information Governance, Data Protection and Cyber (IGDPC) Steering Group was established by the ICBs. This Steering Group has operational responsibility for developing, monitoring, and implementing effective information governance arrangements across the three ICBs, and will become fully embedded over the coming year. It replaces the previous operational information governance arrangements across the three ICBs and provides a single forum for managing information governance, data protection, and cyber security risks. As joint SIRO, I actively participate in the Steering Group alongside the joint Caldicott Guardian for the three ICBs, ensuring executive-level ownership of these agendas across the ICBs. In addition, joint appointments to the roles of Deputy SIRO and Deputy Caldicott Guardian have been made to further strengthen leadership capacity, oversight, and resilience across these agendas.
5. The purpose of this Annual Report is to provide assurance to the Boards that information risks are being effectively managed across the ICBs. It summarises key activities undertaken during 2025/26, including work to meet the requirements of the Data Security and Protection Toolkit, and provides assurance on the ICBs' management of cyber security and information risks and incidents.

Data Security and Protection Toolkit (DSPT)

6. The annual Data Security and Protection Toolkit (DSPT) self-assessment deadline is 30 June. Each ICB is required to submit a separate DSPT assessment.

7. The DSPT was updated in September 2024 to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and information governance assurance. This update was part of the Department of Health and Social Care's cyber security strategy to 2030. The DSPT requirements remain unchanged for 2025/26.

8. As a reminder, the CAF-aligned DSPT aims to:

   a) Emphasise good decision-making over compliance, focussing on better understanding and ownership of information risks at the local organisation level, where those risks can be most effectively managed.

   b) Support a culture of evaluation and improvement by encouraging processes that meet desired outcomes, focused on effective measures, rather than what ticks a compliance box.

   c) Create opportunities for better practice by ensuring processes remain current with new security measures to address emerging threats and risks.

9. The CAF-aligned DSPT consists of five objectives, 18 principles and 46 contributing outcomes (supported by 540 indicators of good practice). The five objectives are summarised in the table below:

Objective	Goal	Focus
A. **Managing Risk**	Enhance decision-making and ownership of information risks at the local level.	Encourage a proactive approach to identifying, assessing, and mitigating risks.
B. **Protecting Against Cyber Attacks**	Implement measures to safeguard against cyber threats and data breaches.	Strengthen defences to prevent unauthorised access and data loss.
C. **Detecting Cyber Security Events**	Improve the ability to detect and respond to cyber security incidents.	Develop robust monitoring and alerting systems to identify potential threats.
D. **Minimising the Impact of Incidents**	Reduce the impact of cyber security incidents on operations and data integrity.	Establish effective incident response and recovery plans.
E. **Using and Sharing Information Appropriately**	Ensure information is used and shared securely and in compliance with regulations.	Promote best practices for data handling and sharing within and between organisations

10. The CAF-aligned DSPT is outcome based and recognises differing levels of organisational maturity. Not all outcomes are expected to be fully achieved immediately, and ‘partially achieved’ is proportionate for many areas. Where expected achievement levels are not yet met, organisations are required to agree and deliver time bound improvement plans.

11. NHS England sets a minimum achievement level for each outcome, known as the ‘CAF profile’; this will need to be met to be graded ‘Standards Met’ on the DSPT. The CAF profiles will be made progressively more stringent over time; however, as the assessment framework will remain effectively constant, organisations will be able to forecast future expectations much further in advance, enabling better planning. It is important to note that the ‘CAF profile’ for 2025/26 remained the same as it was for 2024/25; however, there are some areas that will be more stringent for the ICBs’ submissions in 2026/27.

12. The scope of the CAF-aligned DSPT is centred on an organisation’s ‘essential functions’, which must be locally defined and approved. Since November 2025, I have overseen work to establish a consistent and aligned approach to defining these functions across the three ICBs. This builds on differing approaches taken in previous years and reflects the opportunity presented by the ICBs’ formal partnership as an ICB Cluster to review and standardise our methodology. This has resulted in a single, agreed set of essential functions being developed, alongside a consistent method for identifying the supporting information, systems and networks. This provides a clear and comparable basis for the CAF-aligned DSPT assessment across the ICB Cluster and strengthens the overall assurance position.

13. A baseline submission for the CAF-aligned DSPT was completed by each ICB in December 2025, in line with national requirements. As the CAF profile has remained consistent with 2024/25, this has provided a strong foundation for the current year’s assessment. The primary purpose of the baseline submission was to confirm that a full assessment had been undertaken and to identify the actions required to achieve ‘Standards Met’ by the final submission deadline in June 2026.

14. Across the ICBs, compliance positions vary. NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB achieved fully compliant submissions for 2024/25. NHS Derby and Derbyshire ICB initially reported a position of ‘standards not met’, primarily due to gaps in assurance evidence relating to information asset management, incident learning, cyber security controls, and training compliance. Since that time, a comprehensive improvement plan has been delivered in partnership with NHS England, resulting in an improved position of ‘approaching standards’ as of December 2025. The remaining actions are limited in number and are on track for completion, with achievement of ‘standards met’ anticipated by 30 June 2026.

15. For 2025/26, detailed DSPT action plans are in place for the three ICBs, with delivery monitored through established programme management arrangements and oversight provided by the joint Information Governance, Data Protection and Cyber Steering Group. While evidence to support full compliance is still being finalised in some areas, there is a clear understanding of the requirements and a high level of confidence that all actions will be delivered ahead of the 30 June 2026 submission deadline.

16. The clustering of the three ICBs has provided an opportunity to strengthen alignment and consistency in approach. The establishment of joint SIRO and Caldicott Guardian roles from November 2025 has enabled the use of shared evidence in a number of areas, including training, engagement, and governance oversight. Evidence relating to Board, committee and senior management arrangements is now consistent across the ICBs. A key consideration for the 2025/26 submission is the need to clearly distinguish between pre- and post-cluster arrangements when presenting evidence.

17. A small number of risks and challenges to delivery have been identified. These include capacity constraints within NHS Lincolnshire ICB's outsourced information governance function, following notice from the Commissioning Support Unit (CSU) that it ceased delivery of this service from 1 May 2026 due to capacity pressures. In addition, there are transitional impacts associated with the transfer of information technology services to Lincolnshire Community Health Services NHS Trust, which has continued to affect the timely availability of supporting evidence. Across the ICBs, the scale of organisational change continues to present challenges in maintaining training compliance, clarity of information asset ownership, and effective oversight of data flows.

18. These risks are being actively managed, with mitigating actions in place, and are subject to ongoing oversight through the Steering Group. At the time of writing, there are no significant concerns that would prevent the ICBs from achieving compliant DSPT submissions for 2025/26.

Cyber security

<u>NHS Nottingham and Nottinghamshire ICB</u>

19. Cyber security risk across the Nottingham and Nottinghamshire system is overseen through the Cyber Security Assurance Programme Board (CSAPB), which provides system-wide governance, challenge, and assurance on cyber security controls, compliance, and risk management.

20. During 2025, the CSAPB refreshed and formally ratified its terms of reference, strengthening clarity around SIRO-level oversight, reporting lines, and assurance responsibilities. This has further embedded the CSAPB as the primary mechanism for providing collective cyber assurance across

organisations supported by the Nottinghamshire Health Informatics Service (NHIS), which provides corporate information technology services to the ICB. AS SIRO, I continue to receive assurance through a comprehensive programme of cyber hygiene and monitoring activity, overseen by the CSAPB and reported to the ICBs' Steering Group.

21. Regular reporting covers patch compliance, unsupported operating systems and applications, anti-virus coverage, identity hygiene (including inactive and weak accounts), and Microsoft Defender for Endpoint benchmarking. These reports provide consistent, evidence-based assurance on the cyber posture of the estate and inform ongoing risk management decisions.

22. The CSAPB has highlighted the strategic and financial implications of the Windows 10 end-of-life timetable. Where migration to Windows 11 cannot be achieved within required timescales, extended security support has been implemented as a risk mitigation measure, incurring additional cost. This risk is monitored at system level and informs local decision-making on investment, risk acceptance, and prioritisation. Based on the assurance provided through the CSAPB, supported by DSPT compliance, cyber hygiene reporting, and active risk management, as SIRO, I am able to take reasonable assurance that appropriate cyber security controls are in place and operating effectively across NHIS-supported services.

23. Cyber risk remains dynamic and continues to be actively monitored, with clear governance routes in place to escalate, mitigate, or accept risk where required.

<u>NHS Derby and Derbyshire ICB</u>

24. Cyber security assurance in the Derby and Derbyshire system is provided through a combination of internal governance arrangements and system-wide reporting. NECS Commissioning Support Unit (CSU) provides corporate information technology services to the ICB, with cyber security reporting now received through the ICB's Steering Group. These reports provide assurance on key areas including security threat activity, endpoint protection, network access controls, and compliance with patching requirements and security vulnerability alerts.

25. The ICB also receives additional third-party assurance of cyber security posture through tools and reporting provided by the National Cyber Security Centre (NCSC) and NHS England, including Bitsight and the Vulnerability Monitoring System (VMS).

26. For information assets and systems not managed through NECS, assurance is provided through Information Asset Owners (IAOs), supported by quarterly reporting and review. These returns are collated by the Information Governance

team and form part of the assurance I receive as SIRO regarding the effective discharge of Information Asset Owner responsibilities.

27. Within Joined Up Care Derbyshire, cyber resilience is coordinated through the Cyber Resilience Group, led by EPRR and Digital teams. Operational oversight is provided through the Cyber Security Sub-Group, which reports into the Derbyshire Data and Digital Board (D3B). This supports system-wide coordination of cyber risk management and improvement activity.

NHS Lincolnshire ICB

28. Cyber security assurance across the Lincolnshire system is provided through Lincolnshire Community and Hospitals Group (LCHG), which delivers corporate information technology services to the ICB.

29. I receive assurance through LCHG governance arrangements into its Trust Board, supported by regular reporting on key cyber security indicators including patch compliance, legacy and unsupported systems, endpoint protection, identity management, and security monitoring outputs. This provides consistent evidence-based assurance of the cyber security posture of the environment.

30. At system level, Lincolnshire Integrated Care System (ICS) organisations work collaboratively through the Lincolnshire ICS Cyber Security Group, which provides strategic coordination of cyber resilience, risk management, and improvement activity across health and care partners. This group reports into the Lincolnshire System Digital Oversight Group and subsequently the Lincolnshire Neighbourhood Partnership Board.

31. In addition, LCHG provides cyber security assurance reports to the ICB Steering Group. Taken together with DSPT compliance and system governance arrangements, this provides me with reasonable assurance as SIRO regarding the effectiveness of cyber security controls in place.

Information assets and personal data flows

32. The effective management of information assets is essential to ensuring the organisation can manage information risks. The ICBs maintain Registers of Information Assets, and personal data flows, as part of the requirement to keep a Register of Processing Activities (RoPA) under data protection legislation.

33. Across the ICBs, Information Asset Owners and Information Asset Managers are in place and are responsible for maintaining oversight of their respective assets, including ensuring that entries remain accurate and up to date.

34. During 2025/26, a review of Information Asset Registers is underway across the ICBs as part of preparation for the DSPT submissions. Approaches to this

review have varied in line with local capacity, with some ICBs undertaking direct engagement with asset owners, while others have progressed updates through remote processes.

35. The ongoing management of Information Asset Registers represents a key area of focus given the scale of organisational change associated with the ICBs' Transition Programme. Work is being progressed as part of wider corporate records and knowledge preservation activity to ensure the appropriate handover and continuity of ownership for information assets. However, this remains a live risk across the three ICBs, particularly in relation to maintaining clear accountability and oversight during periods of change.

36. As we move into 2026/27, a key priority is the alignment of Information Asset Registers across the three ICBs, alongside strengthening role clarity and responsibilities for those accountable for information assets. This will support a more consistent and sustainable approach to managing information risk at an ICB Cluster level.

Information risks

37. Information and data security risks across the ICBs are identified through a range of sources, including risk assessments (such as Data Protection Impact Assessments), Information Asset Register reviews, DSPT compliance activity, incident reporting, business continuity exercises, audit findings, and external assessments. Risks are also informed through engagement with senior responsible officers, operational and clinical leads, and system-wide digital and cyber forums.

38. As the three ICBs have progressed through clustering arrangements, there has been a notable shift from risks impacting individual organisations to those affecting the ICBs collectively. A consistent approach has been established to identify and manage these as joint risks, where the cause, impact and required mitigating actions are shared across all ICBs.

39. All identified risks are assessed and managed in line with joint risk management arrangements, with mitigating actions agreed and actively progressed. At the time of writing, the overall risk profile is stable, with no information governance or cyber security risks currently exceeding the threshold for inclusion on the ICBs' joint Operational Risk Register.

40. The ICBs' most significant risks relate to the ongoing management of change, including potential capacity constraints within information governance functions and the need to maintain robust oversight of information assets, training compliance, and data protection processes during transition. In addition, as previously reported, cyber security remains an enduring and evolving threat, requiring continued system-wide focus and mitigation.

41. Cyber risk is recognised as a strategic risk and is captured on the ICBs' joint Board Assurance Framework, reflecting the fact that, despite robust controls, the likelihood of cyber incidents cannot be fully mitigated. Ongoing work to strengthen cyber resilience, including work with system partners and our supply chain, continues to support risk reduction in this area.

42. Overall, I am assured that information risks are being appropriately identified, managed and monitored across the ICBs, with effective oversight arrangements in place and no current risks that would prevent the ICBs from meeting their statutory data security and protection requirements.

Incidents and near misses

43. Information governance incidents or personal data breaches, including near misses, are reportable. Serious incidents must also be reported to the Information Commissioner's Office under the Data Protection Act 2018. Serious data breach incidents are reported through the DSPT and incidents meeting a specified threshold will trigger automatic notification to the Department of Health and Social Care and Information Commissioner's Office (ICO).

44. During the reporting period, the ICBs recorded a number of data breach incidents and near misses. The main causes of incidents were accidental disclosure, inappropriate access, and issues related to equipment or data handling. The table below summarises the number of incidents by ICB:

	Derby and Derbyshire ICB	Lincolnshire ICB	Nottingham and Nottinghamshire ICB
Number of ICB data breaches	43	8	26
Number of ICB near misses	3	4	3

45. While Derby and Derbyshire ICB reports a higher number of recorded incidents, this reflects differences in local reporting practices and awareness across the three ICBs rather than a material variation in underlying risk. Variation in how incidents and near misses are identified and recorded locally can influence reporting volumes, and this is not unusual across organisations with differing processes. These processes will be aligned as part of transition activity, supported by the establishment of a single information governance team structure across the cluster.

46. All reported information incidents across the three ICBs are received, reviewed and managed by information governance teams, with appropriate action taken and follow-up where required. Since 1 April 2025, no incidents within NHS Nottingham and Nottinghamshire ICB were assessed as significant enough to require reporting to the ICO. Within NHS Derby and Derbyshire ICB and NHS

Lincolnshire ICB, two incidents in each ICB met the threshold for reporting to the ICO; appropriate action was taken in each case, and actions have since been closed following review.

47. As highlighted previously, the predominant cause of information incidents continues to be human error, most commonly resulting in accidental disclosure (for example, emails sent to incorrect recipients). Root cause analysis is undertaken for all incidents, with lessons learned identified and shared across the organisations. Where themes or trends are identified, these are reflected in staff communications, training, and updates to relevant policies and procedures.

48. Overall, incident themes during the reporting period show that the majority relate to accidental disclosure, with a smaller number arising from loss, theft, or failure of data, equipment, or devices, and isolated instances linked to access control weaknesses. Cyber-related incidents remain rare; where they do occur, they have not related to core ICB-held data but instead involve external organisations handling related services.

Staff awareness (training and communication)

49. Across the three ICBs, mandatory information governance and data security training is in place for all staff, supported by role-specific training for key information governance and cyber security roles. This is underpinned by local Training Needs Analysis (TNA) arrangements which define additional training requirements based on role, responsibilities, and risk exposure.

50. TNAs and staff awareness activity across 2025/26 has been locally driven, reflecting differing organisational maturity and historical approaches across the three ICBs. While this has supported delivery of mandatory requirements, there has been limited alignment in approach across TNA frameworks, communication planning, and the application of consistent compliance targets to date.

51. While DSPT compliance has been achieved overall, there remain areas where further work is required to ensure consistent achievement of compliance levels across all organisations throughout the year. This is particularly relevant in the context of workforce change, including staff turnover, vacancy management and voluntary redundancy processes, which can impact on the timeliness and uptake of training.

52. During 2025/26, staff communications and awareness activity have been delivered across the ICBs through a combination of planned and reactive approaches, including cyber security messaging, policy updates, and learning from information governance incidents. Whilst the structure and maturity of

communications activity vary, all organisations continue to actively engage staff in relation to information governance and data protection responsibilities.

53. A key priority for 2026/27 is the development and implementation of a single, cluster-wide TNA, communications framework and compliance monitoring approach, supported by the new integrated staffing model. This will enable consistent application of training requirements and compliance targets across the ICBs, improving assurance, visibility and efficiency.

Conclusion

54. As SIRO, I am assured that the three ICBs have a strong and developing foundation for the effective management of information risk across the cluster. All three organisations have made significant progress in meeting the requirements of the DSPT, with a clear trajectory towards full compliance for 2025/26. This is supported by internal audit activity and a strengthening, shared approach to governance, risk management and oversight.

55. The establishment of joint roles and governance arrangements has provided an opportunity to improve consistency and alignment across the ICB Cluster. Progress has been made in standardising approaches to information asset management, risk identification, and staff training and awareness. While this work is ongoing, it is supporting the development of a more cohesive and resilient information governance framework across the ICBs.

56. The scale of organisational change presents inherent challenges, particularly in maintaining capacity, role clarity, and oversight during transition. These risks are recognised and are being actively managed as part of wider corporate transition and preservation activity. A continued focus on embedding roles and responsibilities, alongside aligning key processes such as Information Asset Registers, is critical as the ICB cluster moves forward.

57. Cyber security remains a significant and evolving strategic risk, and while robust controls and mitigating actions are in place, the threat landscape continues to develop, requiring ongoing vigilance and system-wide collaboration. Work is planned to deliver a comprehensive cyber and cyber security development session for the Boards during quarter three of 2026/27, to further strengthen strategic oversight, awareness, and organisational resilience across the ICB cluster. I am confident that the progress made to date, alongside the continued focus on strengthening cyber resilience, will support the ICBs in responding effectively to emerging risks and maintaining the security of information.

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	21/05/2026
Paper title:	**Committee Highlight Reports**
Paper reference:	ICB CIC 26 016
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 March 2026. The report is intended to provide assurance that the committees are discharging their delegated duties and to escalate any matters requiring the Boards' attention.

The report includes the committees' assessments of the levels of assurance they have gained from the items received and any actions instigated to address any areas where low levels of assurance have been provided.

Recommendation(s):

The Boards are asked to **receive** the paper for assurance in relation to the work of its committees.

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

Appendices

Appendix 1 – Joint Finance and Performance Committee Highlight Report
Appendix 2 – Joint Quality and Service Improvement Committee Highlight Report
Appendix 3 – Joint Strategic Commissioning Committee Highlight Report
Appendix 4 – Joint Remuneration and Human Resource Committee Highlight Report
Appendix 5 – Joint Transition Committee Highlight Report
Appendix 6 – Audit Committees' Highlight Report
Appendix 7 – Description of levels of assurance
Appendix 8 – Current high-level operational risks being overseen by the Boards' committees

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Appendix 1: Joint Finance and Performance Committee Highlight Report

Meeting Dates:	01 April 2026 06 May 2026
Committee Chair:	Stephen Jackson, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
2024/25 System and ICB Finance and Efficiency Report (Months 11 and 12)	The Committee received the unaudited year-end financial position following submission of outturn positions to NHS England. The three ICBs reported a combined position of £6.1 million adverse to plan, driven by NHS Nottingham and Nottinghamshire ICB due to the non-receipt of deficit support funding, as previously reported. All three ICBs remained within capital resource and running cost allocations and achieved the Mental Health Investment Standard and Better Payment Practice Code targets. Efficiency schemes delivered £183.5 million across the ICBs, although NHS Lincolnshire ICB delivered £9.2 million below plan. Across the three local NHS systems, the financial position was reported as £201.8 million adverse to plan, with Nottingham and Nottinghamshire providers remaining the key driver of the position. The Lincolnshire system reported an £8.2 million surplus. Members highlighted that although providers had largely delivered to their revised forecasts, a much more rigorous control environment needed to be in place within some providers to achieve 2026/27 financial plans.	**Full** (ICBs) **Adequate** (providers)	Full (ICBs) Partial (providers) *(awarded at the meeting held on 01 April 2026)*

Item	Summary	Level of Assurance	Previous Level of Assurance
Commissioning Delivery Report 2025/26	The Committee noted that most service areas remained under sustained pressure, although some areas of good performance were highlighted. Lincolnshire was above plan for 52-week waits and four-hour emergency department performance, Mental Health programmes continued to perform well across all ICB areas, and all three ICBs were achieving 52-week wait targets for adult community services. Key delivery risks remained workforce constraints, diagnostic capacity and increasing demand, with continued focus required on referral to treatment, Mental Health, Learning Disability and Autism services, and children and young people's community 52-week waits. The Committee asked for future reports to be reframed to provide clearer assurance on progress against key targets and the actions being taken in areas of persistent underperformance, noting that Programme Boards were due to begin meeting in June 2026.	**Partial**	Partial *(awarded at the meeting held on 01 April 2026)*

Other considerations:

Decisions made:
a) Following review of the 2026/27 Joint Capital Resource Use Plans for NHS Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire ICBs, which set out the proposed use of the capital funding allocated to the providers and ICBs, the Committee endorsed the plans and recommended them for approval by the Boards.

Information items and matters of interest:
a) The first of what will become a quarterly update on strategic estates matters was presented, covering a range of areas, including Neighbourhood Health Centres, corporate estates and plans for business-as-usual capital funds. The Committee noted that a Pan-ICB Capital and Estates Oversight Group had been established to provide co-ordinated governance, assurance, and oversight of all primary care and neighbourhood capital and estates programmes.
b) Members received an update on progress on the agreement of contracts, following the submission of the 2026/27 operating and financial plan to NHS England in February 2026.
c) The Committee reviewed the risks within its remit at both meetings. There were currently 17 risks on the Committee's risk register, four of which were rated as high, which related to financial stability and underlying deficit positions.

Appendix 2: Joint Quality and Service Improvement Committee Highlight Report

Meeting Dates:	08 April 2026 13 May 2026
Committee Chair:	Sharon Robson, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Quality Oversight Report	The Committee received an overview of the quality and safety position across the three ICBs at both meetings. Members agreed that the revised reporting format provided clearer visibility of provider quality concerns and helped distinguish these from wider national escalation factors, such as finance or performance. The format was considered to support a more rounded view of assurance, including clearer oversight of mitigations, actions and confidence levels. The Committee discussed the sustainability of improvement trajectories across a number of providers, particularly University Hospitals Derby and Burton NHS Foundation Trust (UHDB), Nottinghamshire Healthcare NHS Foundation Trust (NHFT), Nottingham University Hospitals NHS Trust (NUH) and Chesterfield Royal Hospital NHS Foundation Trust (CRHFT). Discussion focussed on provider capacity and capability to sustain improvement, alongside wider organisational pressures relating to workforce, governance,	**Partial**	Partial *(awarded at the meeting held on 08 April 2026)*

Item	Summary	Level of Assurance	Previous Level of Assurance
	urgent and emergency care, maternity services and infection prevention and control. The Committee noted variation in stroke rehabilitation pathways and quality oversight arrangements across the cluster footprint, highlighting the need for continued monitoring through commissioning and quality governance routes. In relation to Special Educational Needs and Disabilities (SEND), the Committee discussed the staffing impacts arising from the Voluntary Redundancy scheme and received reassurance that appropriate cover arrangements and sufficient skilled capacity were in place, including in the context of anticipated inspection activity in Nottingham City.		
Deep Dive Report into Quality Escalations: Maternity at Nottingham University Hospitals NHS Trust and University Hospitals Derby and Burton NHS Foundation Trust	The Committee received a deep dive into maternity quality escalations at NUH and UHDB, noting both Trusts as outliers on the regional maternity heatmap, with increasing regional and national focus. NUH was recognised as being on a sustained improvement trajectory, with strong governance, system-wide working and evidence of improving outcomes, despite wider Trust challenges and anticipated concerns emerging from the Ockenden Review. UHDB was noted to have a positive improvement narrative and increasing compliance with national schemes, though	**Partial**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
	challenges remained in workforce sustainability, data quality and embedding consistent improvements, with likely continued national and regional oversight. Members were assured that both Trusts were delivering safe maternity services, were compliant with key national requirements, and were at different, but positive, stages of their improvement journeys.		
The Patient Safety Incident Response Framework	The Committee received the Patient Safety Incident Response Framework (PSIRF), setting out ICB arrangements for learning and continuous improvement in patient safety, identified as a key quality priority for 2026/27. Assurance was provided that PSIRF was embedded across all three ICBs, with strong alignment and the opportunity to aggregate learning to support system-wide improvement through existing governance groups. Members discussed the need to strengthen the links between PSIRF, quality outcomes and improvement, including better triangulation of safety, effectiveness and patient experience, and clear evidence of co-production. It was noted that patient-reported outcome measures remained underdeveloped nationally, presenting an opportunity for the system to shape and influence future practice as part of an evolving journey.	**Full**	*Not applicable*

Item	Summary	Level of Assurance	Previous Level of Assurance
Health Protection Report	Members were assured that outbreak response arrangements were in place and had been tested in practice across all three ICBs, with recent incidents including Tuberculosis and blood-borne virus upticks, and further updates on screening improvements to be brought in future reports. Members noted that strong and consistent arrangements were in place with local authorities and public health partners across the patch, despite differing local clinical and operational challenges. Members also discussed the current Hantavirus outbreak response arrangements, receiving assurance regarding system preparedness and escalation arrangements.	**Full**	*Not applicable*

Other considerations:

Decisions made:
The Committee approved: a) The ICBs' 'DLN Approach to Quality', noting that it aligned quality delivery with the ICBs' strategic and commissioning priorities and supported a consistent, contract-driven and partnership-based approach to quality management. Members agreed that the approach would provide a shared framework for quality oversight, escalation, assurance and improvement across the three ICBs. b) The ICBs' corroborative statements for the Annual Quality Accounts of several NHS Trust providers. c) The annual Modern Slavery and Human Trafficking Statements for the three ICBs.

Information items and matters of interest:
The Committee also received: a) Assurance regarding progress against actions arising from a historic clinical pathway review within Derby and Derbyshire. Members noted that further improvement actions remained in progress and agreed an assurance level of adequate pending completion of outstanding actions and external review activity. b) Received an update on oversight of mortuary and after-death care in provider organisations following the David Fuller Inquiry. Members agreed that a more detailed assurance report should be provided at the next scheduled meeting. c) A thematic report on Learning Disabilities and Autism services, noting that transformation programmes were currently managed differently across the three ICBs and work was underway to align approaches. As this was programme area with significant specific challenges, members agreed that the Committee should have close and regular oversight on progress. d) An overview of Primary and Neighbourhood Care Quality and Improvement Plans, setting out quality assurance, governance and the quality management approach across the three ICBs. Members noted variation in provision and discussed the need to identify and apply best practice consistently across the footprint, while tailoring improvements to different population cohorts. e) An Education Quality Summary Report for NHS Trust providers for information, noting that whilst this did not sit within the ICBs' responsibilities, the information supported the triangulation of quality data. f) Updates on the risks within its remit at both meetings, noting live risks on the register with some movement but no new additions.

Appendix 3: Joint Strategic Commissioning Committee Highlight Report

Meeting Dates:	30 April 2026
Committee Chair:	Jon Towler, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Joint Commissioning Executive Group Assurance Report	Members received a report summarising the broad range of commissioning proposals considered by the Joint Commissioning Executive Group in March 2026. A number of decisions were taken during this meeting, supported by appropriate clinical, financial and equality assessments, with none requiring escalation to the Joint Strategic Commissioning Committee.	**Full**	Full *(26 February 2026)*

Other considerations:

Decisions made:
The Committee approved the publication of the Equality Delivery System Domain 1 reports on each individual ICB website, subject to confirmation of the accuracy of the information contained within one particular section of the NHS Nottingham and Nottinghamshire ICB report.

Information items and matters of interest:
The Committee:

Information items and matters of interest:	
a)	Noted an urgent decision made on its behalf during March 2026. The revised governance arrangements for delegated Pharmacy, Optometry and Dental functions were approved, ensuring they were operational from 1 April 2026. The arrangements would be reviewed after three to six months.
b)	Discussed the requirements for its 2026/27 Work Programme. The importance of aligning the work programme with Board and other committee work plans was highlighted and the need to focus on delivering the agreed priorities for the year was emphasised.
c)	Discussed the ICBs' Neighbourhood Health Delivery Plan and the responses received to date from each of the five Health and Wellbeing Boards across the ICBs' footprint to the Neighbourhood Health Framework. The complexity of the neighbourhood health development programme was acknowledged, particularly in relation to the governance arrangements, responding to local community needs, engaging stakeholders, and affordability. Members agreed to hold a focussed session on neighbourhood development at the May 2026 meeting.
d)	Discussed the emerging strategic approach to digital transformation across the ICBs, including the establishment of a formally constituted DLN Digital Collaborative to bring together digital, operational and clinical representation from across all Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire health and care providers to work collaboratively for mutual benefit. Members requested a further report be presented to a future meeting outlining the digital baseline, actions to build digital confidence and maximise the use of solutions, alignment with the Population Health Strategy, and links to key programmes, with a focus on delivery over the next 12 months.
e)	Discussed the delegated specialised commissioning arrangements affecting the ICBs within the Midlands collaborative commissioning model. The delegated arrangements were operating effectively, supported by well-established governance and strong engagement across all ICBs in the Midlands. Financial performance remained stable and aligned to plans, with risk-share arrangements in place. Consideration would be given to the way in which collective discussions and decisions made on behalf of the Midlands' ICBs were reported to the ICBs' Boards.
f)	Reviewed risks within its remit, noting 15 identified risks. This represented an increase of one since the previous report, reflecting ongoing review and active management of the Operational Risk Register. Work to review risk appetite was scheduled to take place with the ICBs' Boards in June 2026, following which it was anticipated that future reports would include quantitative analysis.

Appendix 4: Joint Remuneration and Human Resource Committee Highlight Report

Meeting Dates:	23 April 2026
Committee Chair:	Margaret Gildea, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Workforce Report	Members received a report that provided an overview of the March 2026 workforce metrics across the ICBs. This included data on whole time equivalent, head count, sickness, turnover (including aggregated reasons for leaving), mandatory training, appraisal and Equality, Diversity and Inclusion. Members emphasised the importance of gaining a clearer understanding of the reasons for the high number of staff reporting anxiety, stress and depression as the cause of sickness absence, highlighting the need to ensure appropriate support mechanisms were in place for staff, alongside support for line managers and senior managers to enable them to help their teams remain well at work. Importance was also placed on developing a consistent, best practice approach to appraisals across the ICBs to support staff development and progression, alongside regular staff touchpoints to foster an open and supportive organisational culture. In recognition of the current position in relation to the Management of Change process, an assurance rating of adequate was applied.	**Adequate**	**Adequate** *(22 January 2026)*

Item	Summary	Level of Assurance	Previous Level of Assurance
Senior Leadership Team – Equality Impact Assessment	Members received a report on the equality impact of appointments to the new Senior Leadership Team (SLT), following the Wave 2 Management of Change process. It was recognised that the SLT lacked diversity, and a further paper would be presented to a future meeting of the Committee on the development of a talent pipeline and associated development programmes aimed at improving representation. Actions to support inclusive recruitment practices throughout the Wave 3 Management of Change process were also noted.	**Limited**	Not applicable

Other considerations:

Decisions made:
The Committee approved the All Age Continuing Care/Continuing Health Care (Wave 3a) Consultation process.

Information items and matters of interest:
The Committee: a) Discussed the ICBs' NHS Annual Staff Survey results, noting common strengths and themes, shared structural risks, and potential actions to address these areas across the ICBs. Members recognised the need to bring together the various actions arising from the surveys to support the development of a healthy, high performing organisational culture. The need to promote a positive work–life balance, avoid inappropriate pressure on staff, reduce sickness absence, encourage staff to speak up and support career development was also emphasised.

Information items and matters of interest:
b) Received an update on the Wave 3 Consultation process, including key themes arising from the feedback received, proposed next steps and current risks.
c) Considered a small number of confidential workforce-related matters and received assurance that national guidance and internal governance routes were being followed.
d) Reviewed the risks within its remit, noting six medium ‘live’ risks, all of which were joint risks across the three ICBs. As all workforce and HR risks within the Committee’s remit were linked to the ICB transition programme and related to organisational change, the future ICB operating model and the impact on business-as-usual delivery, these risks were presented to both this Committee and the Joint Transition Committee.

Appendix 5: Joint Transition Committee Highlight Report

Meeting Dates:	07 May 2026
Committee Chair:	Jon Towler, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Transition Finance Update	The Committee received an update on the Transition Programme financial position, including workforce transition costs, CSU arrangements and associated risks. The Programme is required to deliver £52.9m annualised savings, with £43.3m pay-related savings forecast in-year for 2026/27 and full savings expected by 2027/28 due to phasing. A non-recurrent mitigation budget had been identified to manage the timing gap in 2026/27. CSU transfer expectations and potential stranded costs remained uncertain and continued to be monitored through the programme risk register. Corporate estates remained a key non-pay savings priority, with options for future estate configuration being explored to support rationalisation and deliver the required savings. The Committee was satisfied that appropriate oversight and controls were in place, noting continued dependency on national clarity to quantify and mitigate longer-term financial risk.	**Adequate**	**Full** *(Awarded at the meeting on 5 March 2026)*

Item	Summary	Level of Assurance	Previous Level of Assurance
Transition Programme Plan update a) Summary Transition Programme Plan b) Workstream Highlight Reports	The Committee received an update on the Transition Programme Plan, confirming that delivery remained on track against agreed milestones, with robust governance in place across workforce, finance, CSU and estates workstreams. The Programme continued to progress through the phased implementation of change, with dependencies and timing risks actively managed through established programme controls and mitigation plans. Financial delivery remained aligned to the agreed transition profile, supported by identified non-recurrent mitigations. No new programme-level risks requiring escalation were identified during the reporting period. The Committee was satisfied that the Transition Programme Plan remained credible, controlled and deliverable, with appropriate oversight arrangements supporting effective implementation.	**Full**	**Adequate** *(Awarded at the meeting on 5 March 2026)*

Other considerations:

Information items and matters of interest:
The Committee also: a) Received a verbal update from the Chief Executive on transition progress. Members noted the impact of Voluntary Redundancy exits on team capacity, with interim workforce gaps being managed through executive discussions ahead of Wave 3 implementation. Wave 3 consultation feedback was being reviewed and Wave 3a consultation had launched. The Committee also

Information items and matters of interest:
noted NHSE's ongoing restructure and the need for continued vigilance regarding potential impacts on capacity, experience and oversight arrangements. b) Received an update on progress against the Strategic Commissioning Framework, published by NHS England in November 2025, including completion of baseline self-assessment activity across the ICBs. Preparatory work was underway to support participation in the Strategic Commissioning Development Programme. Further detailed consideration would be undertaken by the Remuneration and Human Resources Committee, focusing on the key components and proposed approach. c) Discussed the Operational Risk Report, noting that operational risks arising from delivery of the Transition Programme and ongoing business-as-usual activity were being systematically identified, recorded and monitored through the joint Operational Risk Register, with appropriate mitigating actions in place. There were 12 risks within the Committee's remit, all of which were 'joint' risks across the three ICBs representing a decrease of three since the previous meeting. Two risks were rated high and ten as medium. Overall risk levels remained stable, with no new risks requiring escalation beyond existing governance arrangements.

Appendix 6: Audit Committees Highlight Report (meeting in common)

Meeting Dates:	09 April 2026 05 May 2026
Committees' Chair:	John Dunstan, Non-Executive Director

Item	Summary	Level of Assurance	Previous Level of Assurance
Emergency Preparedness, Resilience and Response and Business Continuity Report	The Committees received an update on progress against addressing the gaps in the ICBs' compliance with the Emergency Preparedness, Resilience and Response (EPRR) Core Standards national assurance process. Good progress had been made, with only one area of compliance outstanding; and work was on track to achieve full compliance for all three ICBs ahead of the submission deadline in August 2026. The Committees also acknowledged the work that had been undertaken in recent months to take best practice from each of the ICBs in order to produce a more robust and consistent approach to EPRR arrangements across the three ICBs. Key to strengthening these arrangements had been the development of a single approach to the management of incidents, which had necessitated the refreshing of a suite of documents that was presented to the Committee for approval, as noted below.	**Adequate**	Adequate for DDICB and LICB Partial for NNICB *(awarded at the meeting held on 17 December 2025)*

Item	Summary	Level of Assurance	Previous Level of Assurance
Risk management arrangements	The report provided a further update on the work being undertaken to embed joint strategic and operational risk management arrangements across the ICBs. The report also provided a detailed analysis of the ICBs' current operational risk profile; the processes in place for identifying and categorising risks; and provided an update on the development of the Boards' Assurance Framework. Noting the robustness of the processes in place for the management of risk within the ICBs, the Committees applied an assurance rating of adequate, reflecting the continued evolvement and embedment of processes.	**Adequate**	Full *(awarded at the meeting held on 17 December 2025)*
Health and safety report	The Committees received their first joint report on health and safety arrangements across the ICBs, confirming that each organisation continued to discharge its statutory duties as an employer to maintain safe working environments. Some variation in arrangements was identified, reflecting the ICBs' separate organisational arrangements, and improvement actions were agreed to support greater alignment, standardisation and continued compliance through transition.	**Adequate**	*Not applicable*
Draft 2025/26 Senior Information Risk Owner (SIRO) Annual Report	Members received the report, which provided assurance that information risks were being effectively managed across the three ICBs. It summarised key activities which had been undertaken during 2025/26, including work undertaken to meet the requirements of the ICBs' Data Security and Protection Toolkits, and provided assurance on arrangements to provide consistent management of cyber security and information risks and incidents. Following further work on aspects of the report, the Committees noted that a final version of the Annual Report will be presented to the Board at this meeting.	*Not applicable*	*Not applicable*

Other considerations:

Decisions made:
The Committees approved: a) The ICBs' 2026/27 joint Internal Audit Plan. b) The 2026/27 Counter Fraud Plans for the ICBs. c) The ICBs' EPRR and Business Continuity Policy; Business Continuity Management System, Incident Response Plan, Steering Group Terms of Reference and Communications and Media Handling Plan. d) The Accounting Policies for the three ICBs.

Information items and matters of interest:
The Committees received updates and reviewed progress on: a) The ICBs' unaudited draft annual reports and accounts and for 2025/26. b) The ICBs' Internal Audit Plans for 2025/26 and interim Head of Internal Audit Opinions, noting that good progress was being made against the agreed plans. c) The external audits of the ICBs, noting that no issues of significance had been raised to date. d) A report on the risks overseen by the Committees was discussed.

Appendix 7 - Description of levels of assurance

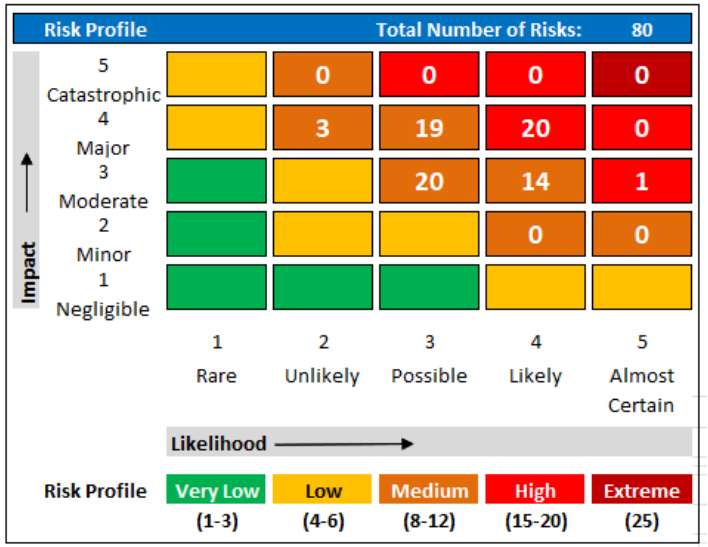
Levels of assurance:	The report demonstrates that:
Full Assurance	• Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required.
Adequate Assurance	• Desired outcomes are either being achieved or on track to be achieved; and/or • Required levels of compliance with duties will be achieved; and/or • There are minor weaknesses in control and risks identified can be managed effectively. Unlikely that the achievement of strategic objectives and system priorities will be impaired. Minor remedial and/or developmental action is required.
Partial Assurance	• Achievement of some outcomes are off-track or mechanisms for monitoring achievement in some areas have yet to be established/fully embedded; and/or • Compliance with duties will only be partially achieved; and/or • There are some moderate weaknesses that present risks requiring management. Possible that the achievement of strategic objectives and system priorities will be impaired. Some moderate remedial and/or developmental action is required.
Limited Assurance	• Achievement of outcomes will not be achieved or are significantly off-track for achievement; and/or • Compliance with duties will not be achieved; and/or • There are significant material weaknesses in control and/or material risks requiring management. Achievement of strategic objectives and system priorities will be impaired. Immediate and fundamental remedial and/or developmental action is required.

Appendix 8: Current high-level operational risks being overseen by the Boards' committees

Risk Profile

There are 80 risks within the Operational Risk Register. Of these 80 risks; 21 risks are scored at a high-level, accounting for 26% of the total risks. Seven of the high scoring risks originate from NHS Derby and Derbyshire ICB, two originate from NHS Lincolnshire ICB, and ten from NHS Nottingham and Nottinghamshire ICB. Two 'joint' high scoring risks have also been identified. The ICB's total risk profile is shown in figure 1 below.

Figure 1



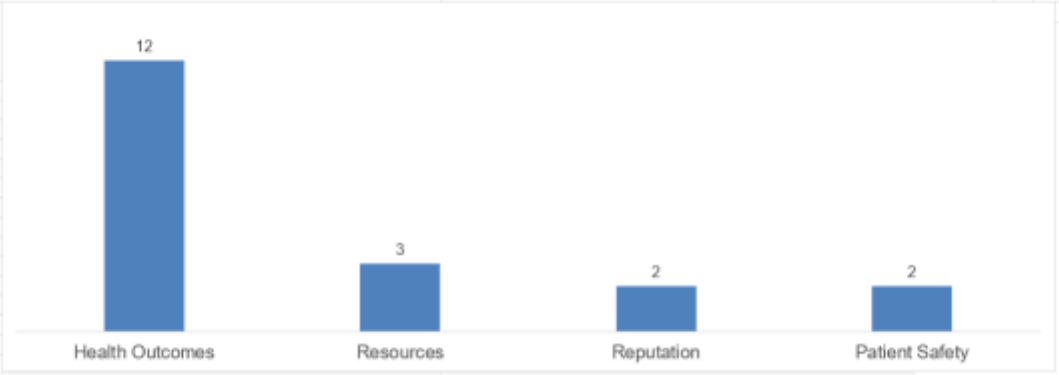
The 21 high-level operational risks include two risks classed as confidential. In rare circumstances, a risk may also be held confidential if it relates to sensitive topics, such as ongoing legal matters, contractual negotiations, or personnel issues, where early disclosure could be inappropriate or compromise effective management. The confidential risks are reported separately and excluded from the analysis and detail of this report.

The remaining 19 high-level operational risks included in this paper are detailed in the below table.

Risk Domains

As a reminder, there are ten risk domains used when classifying operational risks. Figure 2 shows the risk domains where the high-level risks sit.

Figure 2



Details of High-Scoring Risks

Operational risk reports continue to be routinely presented to the committees of the Boards, enabling the ongoing review and scrutiny of all risks, including those high-level risks.

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
RR036	NNICB	If NHS Nottingham and Nottinghamshire ICB is unable to implement sustainable recurrent financial efficiency solutions, there is a risk that the underlying deficit (UDL) will worsen, limiting the ICB's ability to meet population needs within available financial resources.	**High** 16 (I4 x L4)	Joint Finance and Performance Committee

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
RR047	NNICB	In pursuit of NHS financial efficiencies and operational delivery for 2025/26 for Nottingham and Nottinghamshire, there is a risk that ICB relationships may decline (with ICS partners and wider stakeholders). This may lead to deterioration in collaborative efforts, communication breakdowns and wider stakeholder dissatisfaction	**High** 16 (I4 x L4)	Joint Finance and Performance Committee
RR092	LICB	If NHS Lincolnshire ICB is unable to implement sustainable recurrent financial efficiency solutions, there is a risk that the underlying deficit (UDL) will worsen, limiting the ICB's ability to meet population needs within available financial resources.	**High** 16 (I4 x L4)	Joint Finance and Performance Committee
RR134 (NEW)	LICB	If NHS Lincolnshire ICB is unable to implement sustainable recurrent financial efficiency solutions, there is a risk that the underlying deficit (UDL) will worsen, limiting the ability of The ICBs to meet population needs within available financial resources.	**High** 16 (I4 x L4)	Joint Finance and Performance Committee
RR003 ↓	DDICB	If excessive handover delays in Derby and Derbyshire prevent timely ambulance responses, patients waiting in the community may experience significant delays in care, increasing the risk of clinical harm and compromising patient safety.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR016 (NEW)	NNICB	If discharges from Mental Health and Learning Disability and Autism inpatient settings are delayed due to lack of capacity in community-based settings, individuals may stay in inpatient settings longer than necessary or be cared for in a more restrictive environment. This may lead to poor experience and adverse health outcomes for adults in Nottingham and Nottinghamshire.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR022	NNICB	If ambulance handover times at acute trusts within Nottingham and Nottinghamshire increase and cause delayed ambulance arrival in the community, there is a risk of potential harm to citizens who are waiting for an ambulance, which may lead to further deterioration of their condition.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR023	NNICB	If there are ineffective discharge processes within Nottingham and Nottinghamshire, there is a risk of increased length of stay and potential for individuals to experience harm when leaving the hospital and returning home. This may lead to deconditioning and poor experience.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
RR029	NNICB	If Nottingham University Hospitals NHS Trust (NUH) fail to sustain improvements made to date following CQC and external recommendations, there is a risk quality of services may decline. This may lead to compromised safety and quality of care issues which could result in poor experience and adverse health outcomes for the population of Nottingham and Nottinghamshire.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR048	NNICB	If adverse media coverage relating to key health services commissioned by the Nottingham and Nottinghamshire ICB (e.g. maternity, mental health, primary care) persists, public confidence in the ICB may decline. This may lead to reduced trust, and impact on public confidence.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR049	NNICB	If cancer service demand continues to exceed available system capacity, the ICB may be unable to fulfil its statutory duty to commission timely and effective services that support the diagnosis and treatment of cancer across Nottingham and Nottinghamshire. This could result in non-compliance with national cancer standards, including the 62-day referral-to-treatment target and the 28-day Faster Diagnosis Standard, leading to poorer clinical outcomes and diminished experience for the population.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR051	NNICB	If operational performance pressures persist due to capacity constraints and rising demand, the ICB may be unable to fulfil its statutory duty to commission hospital and medical services across Nottingham and Nottinghamshire that meet the reasonable requirements of the population. This could result in Trusts being unable to deliver planned levels of elective activity, leading to missed waiting time targets, delayed treatment, poorer health outcomes, and increased reliance on urgent and emergency care pathways.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR083	DDICB	If improvements in urgent and emergency care access are not delivered by March 2026, there is a risk of delayed or unsafe care, poorer health outcomes, and reduced confidence in NHS services across Derby and Derbyshire.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR084	DDICB	If adult mental health bed use in Derby and Derbyshire is not reduced by March 2026, there is a risk of unsafe, delayed care, resulting in poorer outcomes and experience and greater system pressure.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee

Risk Ref.	ICB	Risk Description	Score	Responsible Committee
RR089 (NEW)	DDICB	If maternity services across Derby and Derbyshire do not sustain the quality improvements made to date, there is a risk that service standards could deteriorate. This may lead to compromised safety, reduced quality of care, and poor experiences for women, birthing people, their babies, and families.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR128 (NEW)	DDICB	If cancer service demand continues to exceed available system capacity, the ICB may be unable to fulfil its statutory duty to commission timely and effective services that support the diagnosis and treatment of cancer across Derby and Derbyshire. This could result in non-compliance with national cancer standards, including the 62-day referral-to-treatment target and the 28-day Faster Diagnosis Standard, leading to poorer clinical outcomes and diminished experience for the population.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR129 (NEW)	DDICB	If diagnostic service demand continues to exceed available capacity, the ICB may be unable to fulfil its statutory duty to commission timely and effective diagnostic services across Derby and Derbyshire. This could result in persistent backlogs and extended waiting times, particularly for individuals approaching 78 and 65-week thresholds, leading to poorer clinical outcomes diminished experience for the population and increased pressure across the health and care system.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR130 (NEW)	DDICB	If operational performance pressures persist due to capacity constraints and rising demand, the ICB may be unable to fulfil its statutory duty to commission hospital and medical services across Derby and Derbyshire that meet the reasonable requirements of the population. This could result in Trusts being unable to deliver planned levels of elective activity, leading to missed waiting time targets, delayed treatment, poorer health outcomes, and increased reliance on urgent and emergency care pathways.	**High** 16 (I4 x L4)	Joint Quality and Service Improvement Committee
RR072	NNICB	If NHCT lacks the capacity and capability to implement sustainable quality improvements identified through serious incidents, deaths, quality reviews, and broader performance concerns, then similar failures may recur, leading to harm and poor health outcomes for the population of Nottingham and Nottinghamshire.	**High** 15 (I3 x L5)	Joint Quality and Service Improvement Committee