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 20 November 2025 10:00-12:15

Boardroom, 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 meeting held on 10 September 2025	Kathy McLean	Decision	-	-	✓	✓	-
5.	Minutes of the meeting held on 18 September 2025	Kathy McLean	Decision	✓	-	-	✓	-
6.	Minutes of the meeting held on 30 September 2025	Kathy McLean	Decision	-	✓	-	✓	-
7.	Action log and matters arising	Kathy McLean	Discussion	✓	✓	✓	✓	-
	Leadership and operating context							
8.	Citizen Story: Functional Neurological Disorder – The power of working together	Clair Raybould	Discussion	-	✓	-	✓	10:05
9.	Chair's Report	Kathy McLean	Information	✓	✓	✓	✓	10:20
10.	Chief Executive's Report	Amanda Sullivan	Information	✓	✓	✓	✓	10:35
	Governance							
11.	Governance Framework for the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire Integrated Care Boards working in partnership	Lucy Branson	Decision	✓	✓	✓	✓	10:50

Ref	Item	Presenter	Type	DD	L	NN	Enc	Time
	Delivery and assurance							
12.	Finance Report	Bill Shields	Assurance	✓	✓	✓	✓	11:10
13.	Quality Report	Dave Briggs	Assurance	✓	✓	✓	✓	11:30
14.	Service Delivery Performance Report	Maria Principe	Assurance	✓	✓	✓	✓	11:50
	Items for information*							
15.	Committee Highlight Reports	-	Assurance	✓	✓	✓	✓	-
	Closing items							
16.	Risks identified during the course of the meeting	Kathy McLean	Discussion	✓	✓	✓	-	12:10
17.	Any other business	Kathy McLean	-	✓	✓	✓	-	-
	Meeting close							**12:15**

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)

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

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:	20/11/2025
Paper title:	**Declaration and management of interests**
Paper reference:	ICB CIC 25 003
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 2025/26

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.
Dillistone	Helen	Director of Transition	✓	✓	✓	No relevant interests declared	No interests declared.					_	_	Not applicable
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	✓	✓	✓	Non-executive director of Our Learning Cloud Limited, a tech services company in the education sector	Non-executive director role in a private or non-NHS company.	✓				01/04/2025	19/09/2025	This interest will be kept under review and specific actions determined as required.
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.
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.

NHS Derby and Derbyshire ICB
NHS Lincolnshire ICB
NHS Nottingham and Nottinghamshire ICB
Board Meetings in Common Register of Interests 2025/26

Surname	Forename	Position	Member of			Declared interest (name of organisation and nature of business)	Nature of interest	Type of Interest				Date of Interest		Action taken to mitigate risk
			NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB			Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Lalani	Mehrunnisa	Non-Executive Member	✓	✓	✓	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	John	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	TBC	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
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.

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Board Meetings in Common Register of Interests 2025/26

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			NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB			Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Mott	Andrew	Primary Medical Services Partner Member	✓	–	–	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.
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	Chief Delivery Officer (Interim)	✓	✓	✓	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.
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	✓	✓	✓	No relevant interests declared	No interests declared.							Not applicable
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 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 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.
Smith	Adrian	Local Authority Partner Member	–	–	✓	Chief Executive of Nottinghamshire County Council	Role within an NHS, local authority or provider organisation.	✓					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.

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Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	GP partner at Market Rasen Practice	Role within an NHS, local authority or provider organisation.	✓				01/08/2023	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Company Director of RCWT Property Ltd	Ownership and/or directorship of a private company	✓				01/11/2020	Present	This interest will be kept under review and specific actions determined as required.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Clinical Director of East Lindsey Primary Care Network	Role within an NHS, local authority or provider organisation.	✓				01/03/2022	Present	This interest will be kept under review and specific actions determined as required.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Workforce lead at the Lincolnshire Training Hub, which assists with workforce transformation in primary care	Role within an NHS, local authority or provider organisation.	✓				01/04/2021	Present	This interest will be kept under review and specific actions determined as required.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Deputy Chair of the Lincolnshire Primary Care Network Alliance	Role within an NHS, local authority or provider organisation.		✓			01/04/2022	Present	This interest will be kept under review and specific actions determined as required.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Director of East Lincolnshire Primary Care Limited	Role within an NHS, local authority or provider organisation.	✓				01/03/2022	Present	This interest will be kept under review and specific actions determined as required.
Thomas	Kevin	Primary Medical Services Partner Member	–	✓	–	Spouse is a salaried GP at Lincolnshire Practice and an employee of United Lincolnshire Hospitals NHS Trust	Role within an NHS, local authority or provider organisation.				✓	01/08/2018	Present	This interest will be kept under review and specific actions determined as required.
Towler	Jon	Non-Executive Member	✓	✓	✓	Registered patient at Sherwood Medical Practice	Use of NHS services commissioned by the ICB (registered patient).			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
Towler	Jon	Non-Executive Member	✓	✓	✓	Family members are registered patients at Major Oak Medical Practice, Edwinstowe	Use of NHS services commissioned by the ICB (registered patient).				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
Towler	Jon	Non-Executive Member	✓	✓	✓	Chair (Trustee and Director) of The Conservation Volunteers: a national charity bringing together people to create, improve and care for green spaces.	Trustee or leadership role in a voluntary, charitable or community organisation	✓				01/12/2022	Present	This interest will be kept under review and specific actions determined as required.
Waddingham	Rosa	Director of Quality (Nursing)	✓	✓	✓	Member of the Advisor 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)	✓	✓	✓	Chair of the Members' Advisory Group at Florence Nightingale Foundation, a charity supporting Nurses and Medwives to improve patient care.	Trustee or leadership role in a voluntary, charitable or community organisation		✓			01/09/2023	01/09/2025	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.

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

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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.

Integrated Care Board (Open Session)
Unratified minutes of the meeting held on
11/09/2025 09:00-12.00
Mansfield Civic Centre

Members present:

Dr Kathy McLean	Chair
Professor Marios Adamou	Non-Executive Director
Dr Dave Briggs	Medical Director
Stephen Jackson	Non-Executive Director
Mehrunnisa Lalani	Non-Executive Director
Dr Kelvin Lim	Primary Care Partner Member
Ifti Majid	NHS Trust/Foundation Trust Partner Member
Victoria McGregor-Riley	Acting Director of Strategy and System Development
Maria Principe	Acting Director of Delivery and Operations
Bill Shields	Director of Finance
Amanda Sullivan	Chief Executive
Jon Towler	Non-Executive Director
Rosa Waddingham	Director of Nursing

In attendance:

Lucy Branson	Director of Corporate Affairs
Lucy Hubber	Director of Public Health, Nottingham City Council
Philippa Hunt	Chief People Officer
Daniel King	Voluntary, Community and Social Enterprise Alliance Chair
Guy Van Dichele	Interim Executive Director of Adult Social Care and Health, Nottinghamshire County Council
Sue Wass	Corporate Governance Officer (minutes)

Apologies:

Gary Brown	Non-Executive Director
Vicky Murphy	Local Authority Partner Member

Cumulative Record of Members' Attendance (2025/26)

Name	Possible	Actual	Name	Possible	Actual
Kathy McLean	3	3	Victoria McGregor-Riley	3	3
Marios Adamou	3	3	Vicky Murphy	3	0
Dave Briggs	3	3	Maria Principe	3	3
Gary Brown	3	2	Bill Shields	3	3

Name	Possible	Actual	Name	Possible	Actual
Stephen Jackson	3	3	Amanda Sullivan	3	3
Mehrunnisa Lalani	3	3	Jon Towler	3	2
Kelvin Lim	3	1	Rosa Waddingham	3	3
Ifti Majid	3	2	Melanie Williams	2	2

Introductory items

ICB 25 048 Welcome, introductions and apologies

The Chair welcomed members to the meeting of the Board. A round of introductions was undertaken, and apologies noted as above.

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

ICB 25 049 Confirmation of quoracy

The meeting was confirmed as quorate.

ICB 25 050 Declaration and management of interests

It was noted that all members had an inherent interest in relation to the ICB transition process; however, due to the role of the Board in providing strategic direction and assuring delivery, it was noted that all members could participate in the discussions and any decisions.

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

ICB 25 051 Minutes from the meeting held on: 09 July 2025

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

ICB 25 052 Action log and matters arising from the meeting held on: 09 July 2025

Two actions remained open and on track for completion by their stated due dates. All other actions were confirmed as completed, and no other matters were raised.

Leadership and operating context

ICB 25 053 Citizen Story: Volunteering at Killisick Friendship Group

Board members were shown a short video that presented the citizen story that was the subject of the paper. Maria Principe went on to highlight the following points:

a) The paper set out a citizen's story demonstrating the positive impact of volunteering on both volunteers and the communities they supported. It focused on the experience of Julie, a volunteer at the Killisick Friendship Group in Arnold, Nottingham.

b) With the support of volunteers, the Group was helping to reduce health inequalities, reduce social isolation and improve health outcomes.

c) The paper also described the support provided to the voluntary, community and social enterprise sector to enable volunteer recruitment.

At this point Lucy Hubber and Dr Kelvin Lim joined the meeting.

The following points were made in discussion:

d) Discussing the huge contribution that the voluntary sector made to the Integrated Care Strategy's fourth aim to support broader social and economic development, members highlighted the need to take into consideration that volunteering opportunities required financial backing.

e) Members went on to discuss the various benefits of volunteering, both for individuals, with the promotion of wider health and wellbeing, and its contribution to realising the aims of the Integrated Care Strategy.

f) There was agreement that thought should be given as to how the voluntary, community and social enterprise sector could play a more prominent role within the future strategic commissioning landscape and to ensure that the ICB continued to hear from the sector at the strategic level.

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

ICB 25 054 Chair's Report

Kathy McLean highlighted the following points from her report:

a) The Government's reform of the NHS continued, and work to enable the clustering of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB from quarter three 2025/26 was progressing well. Kathy went on to put on record her thanks to Gerry McSorley, the outgoing Chair of NHS Lincolnshire ICB, for his support and collaborative approach to

working together over the past few months. On behalf of the Board, she wished him well in his retirement.

b) The last couple of months had seen a busy schedule of visits, which provided an opportunity to gain greater connections with staff at the front line. A meeting with the Regional Mayor had proved productive, and greater collaboration with regional authorities moving forward was welcomed.

c) As this would be the last formal meeting of the Board in its current format, Kathy thanked members for their hard work and support over the last few years and also gave thanks to staff, who continued to work extremely hard and with professionalism at a time of considerable uncertainty and ambiguity.

The Board **noted** the report.

ICB 25 055 Chief Executive's Report

Amanda Sullivan highlighted the following points from her report:

a) Over the summer NHS England had completed its narrative assessment of the ICB. It had concluded that the ICB had demonstrated effective leadership and a strong collaborative approach, having strengths in areas such as health inequalities, shared decision making, and prevention. It had noted challenges relating to several areas, including urgent and emergency care, the complexity of quality challenges facing the system, and the system's financial position. Overall, it was considered a fair assessment.

b) Also, during the summer, significant work had been undertaken on preparations for winter. Demand and capacity modelling had been undertaken and there had been a renewed focus on vaccinations to attempt to address the 'vaccine fatigue' experienced over the past few years. The initial plan had been scrutinised and endorsed by the Finance and Performance Committee in July ahead of its submission to NHS England and their feedback had since been incorporated. The plan had also been stress tested using three winter scenarios in an NHS England-hosted exercise during August and all NHS Boards were now required to submit a Board Assurance Statement to NHS England by the end of September 2025, which was appended to the report for endorsement.

c) Noting the good progress that had been made on the Integrated Care System (ICS) Green Plan, there was now a requirement to refresh the plan for the next three-year cycle. To ensure that the submission deadline of 31 October 2025 would be met, it was requested that

approval of the refreshed ICS Green Plan be delegated from the Board to the Finance and Performance Committee.

d) The Board was asked to note the areas of positive progress within the quarter one achievements report, and thanks were given to teams who continued to work hard to deliver these positive outcomes.

e) The news that Nottingham had been one of ten areas across the country set to benefit from better public services as part of a £100 million 'Test, Learn and Grow' programme was very much welcomed. In addition, congratulations were extended to Nottingham City Place Based Partnership, which had been selected as a pioneer neighbourhood development site.

f) Thanks were extended to David Selwyn for his support to the Nottinghamshire system as Acting Chief Executive of Sherwood Forest Hospitals NHS Foundation Trust (SFH), who had announced he would be stepping down from the role in November 2025. Jon Melbourne, currently Deputy Chief Executive and Chief Operating Officer at the University Hospitals of Leicester NHS Trust would join as the Trust's new Chief Executive in October.

The following points were made in discussion:

g) Members sought assurance that the winter plan could be delivered within the system's financial envelope. It was noted that this consideration had been factored into the plan and the exercise undertaken during August had demonstrated that the plan could be delivered by re-prioritisation of services if required.

h) Discussing several achievements from the quarter one report, increased GP practice engagement in integrated neighbourhood teams was noted as a positive step, the outcome of which would need to be built on in the future strategic commissioning landscape.

i) Noting the rise in units of dental activity, there was a query regarding whether there was capacity to further increase activity. In response it was noted that there was an expectation that it would continue to increase. On this point, the Chair emphasised the need to ensure that the Nottingham and Nottinghamshire patient population were experiencing the benefit of better access to dentistry. It was noted that outcome performance was being developed to capture, for example, information such as a decline in the number of complaints.

j) With reference to the summary of the latest meeting of the East Midlands Joint Committee within the report, there was a request for an update on the progress of the National Rehabilitation Centre; how aligned it was to its original business case; and its current financial model. An update on this important regional asset was welcomed and

it was agreed this should be received by the Strategic Planning and Integration Committee in the first instance.

The Board **noted** the Chief Executive's Report for information, **endorsed** the Board Assurance Statement regarding the 2025/26 Winter Plan and **delegated** approval of the ICS Green Plan to the Finance and Performance Committee.

Action: Lucy Branson to add an update report on the National Rehabilitation Centre to the work programme of the Strategic Planning and Integration Committee.

Strategy and partnerships

ICB 25 056 Response to the Ten-Year Plan and Joint Forward Plan Update

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

a) The paper provided a progress update on delivery of the 2025/26 NHS Joint Forward Plan (JFP) including a high-level assessment of risk to ongoing delivery and a specific update on the development of Integrated Neighbourhood Health Teams.

b) The refreshed JFP for 2025/26 reflected the establishment of eleven Transformation Programmes with the greatest opportunity to support improved care for people and cost-effective use of resources. These programmes were supported by 25 detailed delivery plans, structured around the four clinical priority areas originally defined in the JFP.

c) The JFP set out three transformational shifts in the way system partners worked collaboratively with changes beginning in 2025/26. The focus on these shifts would continue to evolve throughout the year, and sustained effort would be required by all partners to realise the anticipated benefits. Sustaining collaboration in the context of reducing management costs in NHS organisations was recognised as an issue which would be managed through the Programme Boards.

d) The risks and issues to JFP delivery were outlined along with the next steps. Whilst the JFP remained a statutory responsibility of the ICB, a five-year strategic commissioning plan was due by December 2025 and was expected to replace the JFP from 2027/28, subject to legislative changes. An update would be provided to the Strategic Planning and Integration Committee at its October meeting.

The following points were made in discussion:

e) Members discussed the opportunity to use the development of the strategic commissioning plan to progress greater collaborative working, with an opportunity to examine what initiatives were having the biggest impact by using outcomes driven data, given the limited resources of the NHS and local authority partners. Early diagnosis of cancer was noted as an area that would have a notably positive impact of life expectancy rates in the long term. Likewise, in areas demonstrating little progress, such as suicide rates, the data had been used by public health colleagues to draft a Joint Strategic Needs Assessment to inform a strategy.

f) As Chair of the Strategic Planning and Integration Committee, Jon Towler asked the Board to note that the Committee had concluded that there had been positive progress; however, given the breadth of the subject matter, it was difficult to assess the progress and recovery actions in some areas and further detail had been requested.

g) The Chair advised members that moving forward, the Board would need to be kept sighted on the development of Integrated Neighbourhood Teams and that updates in this area would be scheduled over the coming months.

The Board **noted** the progress with delivery of key milestones in the NHS Joint Forward Plan 2025/26.

ICB 25 057 Report from Nottingham and Nottinghamshire Voluntary, Community and Social Enterprise Alliance

Daniel King presented the item, highlighting the following points:

a) Since the last update to the Board in May 2024, the Nottinghamshire Voluntary, Community and Social Enterprise (VCSE) Alliance had continued to broaden its membership, and as evidenced at the Board's development session in June, had engaged with faith-based groups within Nottinghamshire, welcoming their inclusion into the Alliance.

b) The Alliance continued to feed citizens' voices into the Third Sector Commissioning Group and the Insights Hub, the latter of which had developed into a central resource for capturing and reporting community intelligence.

c) Contact with VCSE colleagues from Lincolnshire and Derbyshire had already been established and whilst arrangements across the three geographies were very different, all agreed with the importance of

using the Alliances to support neighbourhood working and the prevention agenda.

d) The challenge going forward was how to continue to engage over a larger geographical footprint once the ICBs had enacted their clustering arrangements; and to ensure that the patient and the lived experience voice was still able to be heard.

e) There was a need to understand whether the sector's primary role was to provide intelligence or provide services. For the latter, and referencing the discussion during item ICB 25 053, the need for sustainable investment and clear commissioning pathways was emphasised to enable the sector to contribute effectively and equitably.

The following points were made in discussion:

f) Welcoming the report, members supported the further development of both roles for the Alliance. Members discussed the key strengths of the sector and the challenge for the ICB to work through some of the current barriers to commissioning with the sector and how they could be addressed.

g) It was noted that engagement with the sector would be in the portfolio of one of the new Executive Director posts in the new ICB cluster arrangements.

The Board **noted** the progress made in establishing and embedding the VCSE Alliance within the Nottingham and Nottinghamshire Integrated Care System.

Delivery and system oversight

ICB 25 058 Finance Report

Bill Shields presented the item and highlighted the following points:

a) At month four, the NHS system was reporting a £13.3 million deficit position driven by the impact of the resident doctors' strike during July, mental health private bed costs, flexible staffing, and efficiency shortfalls.

b) Nottingham University Hospitals NHS Trust (NUH) had been disproportionally impacted by the industrial action, with over 90% of resident doctors taking action.

c) It was expected that the financial position of Nottinghamshire Healthcare NHS Foundation Trust (NHT) would improve from month six following the appointment of a Turnaround Director.

d) Shortfalls in the delivery of efficiency plans for all organisations continued to be a concern and there would need to be a significant improvement in the delivery of recurrent efficiencies and an intense focus on workforce costs if the financial plan for 2025/26 was to be achieved.

e) The overall ICB financial position remained on plan for both year-to-date and forecast outturn.

f) The Board was asked to note that all ICBs would be required to move to a new financial ledger from 1 October 2025. NHS England had provided an assurance statement, which was appended to the report, in response to several concerns raised by ICBs.

The following points were made in discussion:

g) In response a query regarding how a step change in delivery could be made to achieve the financial plan, it was noted that in addition to the appointment of a Turnaround Director at NHT, SFH had requested additional capacity to support the delivery of its financial plan and an escalation meeting had been arranged with NUH and NHS England to further understand the root causes of its financial position.

h) In response to a follow up query as to the likelihood of deficit support funding being withdrawn, it was noted that there had been no communication from NHS England on the issue to date.

i) Members sought to understand whether the ICB's strategic delivery partner was making progress. It was noted that whilst the delivery partner was supporting the Trusts to strengthen their governance around the delivery of their financial plans, it was critical for the Trusts themselves to understand the imperative of delivering their financial plans, as no additional funding would be available at year end. Key to turning around the position would be the delivery of workforce plans.

j) Ifti Majid asked the Board to note that whilst having the support of a Turnaround Director was making a positive difference at NHT, a tension between financial restraint and delivery had been noted during a recent well-led inspection by the Care Quality Commission. Its feedback had referenced an organisation overly focused on finances.

k) Members were assured that a risk had been added to the ICB's risk register regarding the transfer to the new ledger and the Finance and Performance Committee would have another opportunity to review preparations at its meeting later in the month.

l) In response to a query relating to mitigating actions and the detail that sat behind the other finance solutions heading, it was noted these were technical accounting arrangements.

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

ICB 25 059 Quality Report

Rosa Waddingham presented the item and highlighted the following points:

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

b) Positive progress was being demonstrated at NHT. Intense oversight to improve the overall quality of services continued, with 33 of the 34 recommendations from the Section 48 improvement action plan, overseen by the Improvement Oversight and Assurance Group, either completed or on track for completion by their due date. A well-attended Trust-wide ‘Learning from Incidents’ event had provided an opportunity for staff to reflect on the learning from the Independent Review into the care and treatment of Valdo Calocane, as well as wider learning nationally and from people with lived experience. In addition, the implementation of the ‘SafeNow’ process was allowing a more comprehensive overview of each service, their daily challenges, and the discussions taking place across teams to develop and implement improvements.

c) Pressure on emergency and urgent care services continued. Whilst the implementation of the 45-minute handover protocol had led to a reduction in handovers times, it had not reduced waiting times within emergency departments and work continued to address flow through hospital and care planning. It was, however, positive that there had been a continued reduction in the use of temporary escalation spaces.

d) Continuing high levels of bed occupancy was impacting on the challenge to meet healthcare-associated infection thresholds.

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

ICB 25 060 Service Delivery Report

Maria Principe presented the item and highlighted the following points:

a) The report provided a summary of compliance against targets required for 2025/26, and the actions and recovery timeframes for those targets currently off track.

b) As noted during the previous item, urgent and emergency care continued to encounter significant challenges, particularly in meeting the four- and twelve-hour performance targets, and the system remained under strain due to rising emergency department attendances and ongoing staffing shortages. Actions were being taken to improve hospital flow ahead of winter.

c) The system's focus on eradicating 65-week waiting times had shown a continued reduction, with only eight patients on the waiting list and a continued reduction in 52-week waiting patients.

d) Performance against cancer standards remained challenging, particularly at NUH. The Trust would present a detailed cancer recovery trajectory to the System Oversight Group later in the month.

e) Diagnostics remained a concern, with performance not yet fully returning to previous levels following the dip in performance due to capacity withdrawal in April. However, gradual improvements were being seen at both acute trusts.

f) The proportion of GP appointments offered within two weeks was now meeting planned targets for the first time this year.

The following points were made in discussion:

g) Board members noted the continuing tension between actions to improve services and their affordability, and the risk of focusing on one measure having unintended negative impacts on other areas of the system. This was acknowledged as a continuing challenge to balance and would need to be a focus of relevant committee discussions moving forward.

h) Concern was raised over the number of children and young people waiting over 52 weeks for occupational therapy, speech and language therapy and physiotherapy, and members requested that the Finance and Performance Committee focus on this area at a future meeting.

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

Action: Maria Principe to provide a further update on the actions being taken to address the number of children and young people waiting over 52 weeks for occupational therapy, speech and language therapy and physiotherapy to the next meeting.

ICB 25 061 Population Health Management Report: Special Educational Needs and Disabilities

Maria Principe presented the item, highlighting the following points:

a) The report discussed how population level data had shaped the approach to understanding the Special Educational Needs and Disabilities (SEND) system within Nottinghamshire and how this would translate into improving outcomes for SEND service users.

b) The 2023 inspection of Nottinghamshire SEND services by Ofsted and the Care Quality Commission had highlighted several concerns regarding the use of information and data. In response, the System Intelligence and Analytics Unit had led an innovative collaboration between health and social care to collate and display the health, social and education data of children with SEND in Nottinghamshire, creating a single platform for service managers, clinicians, education, and social care professionals to monitor service performance.

c) The dashboard would now enable the local area partnership to better monitor outcomes for children and young people with SEND, enabling partnership leaders to identify where gaps existed and whether actions taken to address these were effective.

d) This baseline picture, previously understood mostly through anecdote, would now enable partners to focus discussions on the review and redesign of neurodevelopmental services. It had also prompted exploration of different approaches to supporting families awaiting speech, communication, and language services.

The following points were made in discussion:

e) Rosa Waddingham asked the Board to note the challenging technical difficulties that had been overcome to enable the use of shared data and how this piece of work was a good example of how collaboration and the use data could inform commissioning decision-making.

f) Members commended the work that had been undertaken to date and discussed the further work that was planned to determine whether the use of the dashboard was having a positive impact on the experience of service users.

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

Governance

ICB 25 062 Committee Highlight Reports

The report presented an overview of the work of the Board's committees since its last meeting in July 2025; it aimed to provide assurance that the committees were effectively discharging their delegated duties and included assessments of the levels of assurance the committees had gained from their work during the period. The report also provided a summary of the high-level operational risks being oversighted by the committees.

The Chair noted that updates from Committee Chairs had already been provided during related discussions under agenda items ICB 25 058, ICB 25 059 and ICB 25 060. Further updates from the Committee Chairs were invited by exception and the following points were highlighted:

a) Chair of the Strategic Planning and Integration Committee, Jon Towler, asked the Board to note the positive progress made on the development of the Special Educational Needs or Disability joint delivery plans for 2025/26 and 2026/27 since the last update in May 2025.

b) As Chair of the Joint ICB Transition Committee, Jon also updated the Board on the most recent meeting held on 9 September 2025. Members had taken assurance in progress made in key areas of the alignment of functions in the operating model and around the developing governance framework.

The Board **noted** the reports.

Information items

ICB 25 063 Board Assurance Framework

The Board Assurance Framework had been included on the agenda in light of forthcoming changes to governance and accountability arrangements, ensuring appropriate Board-level visibility of strategic risks, assurance sources, and control mechanisms ahead of the move to a clustered operating model.

The item was received for information.

ICB 25 064 2025/26 Board Work Programme

This item was received for information.

Closing items

ICB 25 065 Risks identified during the course of the meeting

No new risks were highlighted.

ICB 25 066 Questions from the public relating to items on the agenda

No questions had been received.

ICB 25 067 Any other business

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

Date and time of next Board meeting held in public: 20 November 2025

Derby and Derbyshire
Integrated Care Board

NHS DERBY AND DERBYSHIRE ICB BOARD MEETING IN PUBLIC

Thursday, 18th September 2025

Hasland Village Hall, Eastwood Park, Hasland, Chesterfield S41 0AY

Unconfirmed Minutes

Present:		
Dr Kathy McLean	KM	ICB Chair (Meeting Chair)
Jim Austin	JA	Chief Executive Officer, DCHSFT (Participant Member to the Board for Place)
Michelle Arrowsmith	MA	ICB Chief Strategy and Delivery Officer / Deputy CEO
Dr Avi Bhatia	AB	Participant to the Board for the Clinical & Professional Leadership Group
Dr Chris Clayton	CC	ICB Chief Executive Officer
Jill Dentith	JED	ICB Non-Executive Member
Helen Dillistone	HD	ICB Chief of Staff
Margaret Gildea	MG	ICB Non-Executive Member / Senior Non-Executive Member
Ellie Houlston	EH	Director of Public Health – Derbyshire County Council (Local Authority Partner Member)
Prof Dean Howells	DH	ICB Chief Nurse
Dr Andrew Mott	AM	GP Amber Valley (Partner Member for Primary Care Services) / Medical Director of GP Provider Board
Stephen Posey	SPo	Chief Executive, UHDBFT / Chair of the Provider Collaborative Leadership Board (NHS Trust and FT Partner Member)
Lee Radford	LR	ICB Chief People Officer
Bill Shields	BS	ICB Joint Chief Finance Officer with NNICB
Nigel Smith	NS	ICB Non-Executive Member
Prof. Chris Weiner	CW	ICB Chief Medical Officer
In Attendance:		
Donna Booth	DB	Community Growth, Chesterfield
Nicki Doherty	ND	Director of Place and Partnerships
Kathryn Durrant	KD	ICB Executive Board Secretary
Scott Groom	SG	ICB Internal Communications Manager
Christina Jones	CJ	ICB Head of Communications
Sam Knight	SK	Sustainability Programme Manager
Dr Penny Blackwell	PB	Place Partnerships Clinical Chair
Fran Palmer	FP	ICB Corporate Governance Manager
Natalie Peace	NP	Community Growth, Chesterfield
Suzanne Pickering	SP	ICB Head of Governance
Apologies:		
Dr Deji Okubadejo	DO	ICB Clinical Lead Member
Mark Powell	MP	Chief Executive DHcFT (NHS Trust and FT Partner Member)
Paul Simpson	PS	Chief Executive, Derby City Council (Local Authority Partner Member)
Sue Sunderland	SS	ICB Non-Executive Member

Item No.	Item	Action
ICBP/2526/048	**Welcome, introductions and apologies:** The Chair, Dr Kathy McLean (KM) welcomed all Board Members and attendees to the Board Meeting in Public in Hasland. The Chair welcomed the colleagues attending to present the Citizens' Story and the item on neighbourhoods. Apologies for absence were received as noted above.	

	The Chair noted that a petition relating to Pilsley Surgery was received from District Cllr Kevin Gillott and Cllr Mike Shaw, Chair of Pilsley Parish Council. The petition has been passed to the ICB's Communications Team for respond via the usual process.	
ICBP/2526/049	**Confirmation of quoracy** It was confirmed that the meeting was quorate.	
ICBP/2526/050	**Declarations of Interest** The Chair reminded Committee Members of their obligation to declare any interests they may have on issues arising at Committee meetings which might conflict with the business of the ICB. Declarations made by members of the Board are listed in the ICB's Register of Interests and included with the meeting papers. The Register is also available either via the ICB Board Secretary or the ICB website, using the following link: https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/integrated-care-board-meetings/ It was noted that, other than the uncertainties of the current circumstances, there were no specific conflicts of interest.	
ICBP/2526/051	**Minutes of the meeting held on 17th July 2025** **The Board APPROVED the minutes of the above meeting as a true and accurate record of the discussions held.**	
ICBP/2526/052	**Action Log – July 2025** It was agreed that the open actions on the log must be rapidly closed or transitioned to the new cluster Board. **The Board NOTED the action log.**	
ICBP/2526/053	**Citizen Story: Community Growth** Helen Dillistone (HD) welcomed Donna Booth (DB) and Natalie Peace (NP) to the meeting to present the work of their company, Community Growth CIC. DB and NP gave an overview of their work. Community Growth supports clients in the community through a preventative and holistic approach, ensuring that clients, their families and networks are supported in the community before hospital admission becomes necessary; their work has saved a considerable amount of public money as inpatient care is substantially more expensive than community-based care. Their flagship project, Flourishing Females, offers a healing space for women to connect to themselves, others and the environment. The project has had a meaningful impact, providing foundational skills enabling clients to support themselves and each other, gain independence and find work. A typical week in the life of Community Growth was presented, including: • gathering local community insights, such as through community events, and collaborating with the ICB Engagement Team to strengthen networks, to identify gaps in the system and to establish strategies to most effectively work with communities; • using their networks across Chesterfield to actively identify swift, immediate solutions to client problems; • supporting clients to work with and present to clinical colleagues and increasing referrals into social and green prescribing; • working with partners, such as Occupational Therapists, social prescribers and the Derbyshire Wildlife Trust, to establish how to most effectively apply the limited resources available without any partners being in competition; • compiling data to demonstrate the value of the project and quantify savings of public funds; and • carrying out enjoyable creative projects to support clients, staff and children in deprived communities. Community Growth can support the system in exploring a new way to work, incorporating the lived experiences of staff and clients. The Community, Voluntary and Social Enterprise sector has strong, established community networks and	

	relationships, and the sector brings energy and passion to greatly support the work of the NHS. However resources are limited and the system must recognise the benefit and the impact that the third sector will have on preventative healthcare. Integrating this sector into the system will bring sustainable, long lasting benefits. The Board expressed their appreciation for the presentation, and the following comments were made: • The Chair highlighted the team's passion and strength and noted that she very much enjoyed visiting their site. Their work is very much aligned with the neighbourhood health item in the agenda. There is limited funding available, but the system will be focusing on shifting more into the community; • The team's work is aligned to the three shifts of the NHS, in particular the shift to community. The importance of keeping engagement linked in with infrastructure was stressed; • Community growth is a vital part of the secure services pathway and their preventative work is crucial in de-escalating clients, keeping them out of hospital and keeping families together; • The data arising from the team's work will be very useful in informing the Board about issues arising in the population and the impact the work has on them. The ICB will support the team to link in with Derby University; and • It may be useful for the team to link with DHCFT pathways as they also run services and carry out preventative work aimed at keeping mental health clients from being sectioned. In summary, the Chair commented that Community Growth is an example of the good work taking place across Derbyshire; the system needs to link in with these projects across all communities. The Chair thanked DB and NP for their inspirational presentation and any Board members who would like to know more about the team's work are welcome to get in touch. **The Board NOTED the Citizen Story.**	
ICBP/2526/ 054	**Chair's Report** The Chair highlighted the following from her report: • the NHS is in a period of great change and this is the last Board meeting in its current form. Since the previous Board meeting in July, at which time it was known that Derbyshire, Lincolnshire and Nottinghamshire ICBs would cluster, progress towards this has been made although some answers are still awaited such as around Chief Executive Designate and redundancy schemes. The Chair is happy to have been appointed as Chair Designate. The model region has been published and there will be a Chair but no Board at regional level. The three ICBs will remain separate statutory bodies until formal mergers take place and will need to create a Board in common. The Chair extended her thanks to Gerry McSorley, all colleagues around the table and their teams for their support during this time of great uncertainty and difficulty; • the Chair enjoyed her recent visit to the Neighbourhood Team in High Peak and commented on the coherence of the team despite members of staff being employed by different organisations. It is inspiring to see examples of teams like this working together to address problems quickly and effectively; and • the ICB's Annual General Meeting is being held today, providing a chance to share with the public the year's achievements and plans for the future. In summary the Chair thanked the Board for their hard work so far and as the ICB moves forward towards clustering. There were no questions or comments on the Chair's report. **The Board NOTED the Chair's report.**	
ICBP/2526/ 055	**Chief Executive's Report** The Chair introduced the Chief Executive's report and thanked Dr Chris Clayton (CC) for his leadership, support and hard work over the years. CC highlighted the following from his report, which was noted to be the last public Chief Executive's report in its current form:	

	• CC offered congratulations to the Chair in her appointment to the role of Chair Designate and to the cluster, which will have a very important and influential role as one of the largest clusters in the country. • CC thanked all ICB staff for managing the change in a calm, thoughtful and careful manner, observing that this is the latest of many changes and Derbyshire has always operated in this way. Particular appreciation was expressed for the Executive Team and their continued leadership and resilience throughout the process; • the Annual General Meeting will showcase the ICB's highlights of the year; • a formal response to councils around Local Government Reorganisation consultations has been submitted and thanks were offered to those colleagues who worked on the response; • the work of GP partners was highlighted, and their crucial and unique contributions which support the system; • the Community Transformation Project and its very important work was also highlighted; • CC was shocked by the sudden death of Rob Taylor, Chief Fire Officer and Chief Executive at Derbyshire Fire and Rescue Service. He expressed appreciation for all of Rob's work with the Fire Service in partnership with NHS and especially during the Covid pandemic; and • there are improvements taking place in the NHS; the number of available GP appointments across the country have risen by millions and Derbyshire has contributed to this progress. There were no questions or comments on the Chief Executive's report. **The Board NOTED the Chief Executive's report.**	
ICBP/2526/ 056	**Neighbourhood Health Update** Jim Austin (JA), Nicki Doherty (ND) and Dr Penny Blackwell (PB) gave an overview of the update, including highlighting examples of Neighbourhood Teams carrying out excellent work across the Derbyshire footprint in ways best suited to their own communities. It would not be appropriate to impose a neighbourhood model of care at the strategic level on these teams. The ICB have been working in partnership with the third sector, general practice and wider primary care partners to establish the best way to deliver improvements for communities. The GP Provider Board (GPPB) in Derbyshire is unique in that every Derbyshire GP practice contributes to the NHS linking successfully with the third sector. Governance will be required to allow the system to deliver neighbourhood working at all levels; the framework will be provided at the strategic level, along with the data infrastructure to evidence and demonstrate the work and its impact. The report was discussed, with the following comments: • clarity was sought on the structure of neighbourhoods in Derbyshire and the three layers of scale in the model, Integrated Neighbourhood Teams, Neighbourhood Health Alliances and the Integrated Health and Care Organisation, were clarified. Rather than an imposition, the strategic-level infrastructure will support Neighbourhood Teams to work in the way they have determined is best for their communities; • cities do not necessarily follow natural neighbourhood geographical communities, so Derby City may not comprise one neighbourhood in the future; • local neighbourhood teams have developed excellent existing relationships with their communities which must not be disrupted; • there will be an expectation of what a neighbourhood will deliver, which will align with system requirements. This has been driving early work such as Team Up, supporting urgent community response and discharge from hospitals and working to improve wellbeing and outcomes to reduce reliance on the healthcare sector; • the importance of system metrics being measured was stressed, to establish if the teams are having an impact or if an initiative is not working in a particular community. This can also function as a measure and early warning system for	

	the healthcare sector. Ultimately the goal is to equip neighbourhood leadership to identify where they can make the greatest impact, then bring this data to Board to demonstrate activity and inform commissioning decisions; • the Strategic Commissioning and Integration Committee (SCIC) have been able to inspect in detail the neighbourhood work, all of which is very positive. The governance arrangements and architecture behind the work is important, creating a strong, simple foundation to build on is crucial. The funding framework must be demonstrated but overall the model is excellent. Outputs will be expected and the ICB will be held to account; • the resources for this work will have to be accounted for, which has not taken place yet although work is ongoing to identify this. Derbyshire have so far used some national funding to support this work but this may not be able to continue in future. A profile of spend will be set out to establish if the initiatives are successful, which can be compared against other areas for mutual learning and improvement. The 10 year plan focuses on places that are performing better and demonstrating positive outcomes, and working together in the integrated space should maximise the benefit of this work; • from a provider perspective, it is vital to approach neighbourhood working in a joined up, professional and meticulous way across a range of specialties for the best possible patient experience. This work is to be welcomed as a positive use of time and resources; • absolute clarity will be needed as to the framework and the source of funding for this work; many projects need additional funding but all available ICB finance is allocated. The ICB will need to be increasingly discerning and challenging around its investments, ensuring all funded initiatives add value and deliver a positive impact; • while the initiatives are very highly spoke of, it is crucial to increase the gathering of data arising from them; for example, the work is not yet joined up with virtual wards. Tangible data will be required around numbers of patients in hospital and in virtual wards, as well as softer data around quality of life, patient experiences and the impact on others; • The ICB must communicate this good work, its successes and impact so that the system and the population are aware of it. The public need to know how best to contact and access the neighbourhood teams and effective communications will be able to ensure that they do. The Chair summarised that the Neighbourhood Teams report was very helpful and there is great work taking place that will be built on. **The ICB Board:** • **NOTED the progress to date as well as the strong position that we have achieved because of our collective work since the ICB began.** • **AGREED the next steps in progressing our Neighbourhood Model, as recommended by the Strategic Commissioning and Integration Committee**	
ICBP/2526/057	**JUCD Seasonal Plan – Winter 2025/26** Prof Chris Weiner (CW) gave an overview of the Plan and commented that the plan and associated statement have come to Board for assurance that the system will be able to deliver requirements for winter. CW also promoted the Flu immunisation plan for winter and stressed the importance of vaccination in protection of patients and communities, with high immunisation coverage in professional and hospital spaces leading to better outcomes. The plan and report were taken as read and CW highlighted the Technical Assurance Statement on Meeting Pack Page 42 which states that the system takes full assurance on the quality, breadth and depth of the plan however under the current pressures from the Urgent and Emergency Care System the plan can only provide limited assurance on service delivery during times of increased pressure. The Strategic Commissioning and Integration Committee (SCIC) have reviewed the plan in detail and concur with the issue around limited assurance. The plan was discussed, with the following comments:	

	• the statement around delivery assurance is alarming and the assessment is that the available beds will come under extreme pressure. It was queried if the plan can be amended to improve the position and give more assurance; • it was noted that immunisation for staff and the system population will help to relieve pressure in the system; • if the Board had received full assurance this would have been questioned; the position is realistic and this is the best position under the current plan. To reduce the risk the 2025/26 plan would need to be revisited and changes to the ICB's intent and primary care and community resources from the finite allocations available would be required. But it would be preferable to have additional winter capacity unnecessarily than be under-resourced for the seasonal pressures; • from a local authority perspective, public health directors are not assured in the public protection from the plan, in terms of community infection control, especially in care homes. This would comprise a small element overall, however blocking of care homes leads to problems in the acute sector, which is a key issue that must be resolved as a system; • the plan is robust but the reality on the frontline may be very different; the Board were assured that weekly data has informed the plan and the system command centre is being managed on an hourly basis with partners. Live operational updates are tracking and de-risking the plan; and • other stakeholders such as general practice can support this work within the cost envelope, such as by standing down unnecessary services over winter. General practice has increased capacity over winter and can support if thresholds are being crossed, however there must be a lead time for this to happen. It was stressed that urgent care does not happen in a bubble. The Chair thanked the team for the work that has taken place on the plan from April 2025 to now, and the areas in need of additional work have been highlighted. **ACTION: Prof. Chris Weiner to revisit the Seasonal Plan for 2025/26 with the Urgent and Emergency Care Board in light of the concerns at limited assurance around Urgent and Emergency Care, with a view to derisking the plan as far as possible. The revised plan will go to SCIC and the Board for review and this will need to take place quickly.** **The Board DID NOT APPROVE the:** • **JUCD Seasonal Plan for 2025/26** • **ICB Board Assurance Statement for submission to NHS England**	
ICBP/2516/ 058	**Integrated Performance Report** The report was taken as read by exception, with the following highlighted: **Quality** A full assessment around Mental Health improvement oversight has been carried out by NHSE and has had a strong outcome; thanks were expressed to Mark Powell and the DHCFT team for this very good result. The East Midlands are moving forward as the exemplar region in this area. CQC have been active in the patch, with a very strong outcome in forensic inpatient low secure services and a number of reports still awaited. The Chair noted that the ICB's approach to commissioning outcomes must change in order to get ahead. **Performance** Cancer performance has dropped and will need to be carefully monitored, however plans are in place to improve the position. Urgent and Emergency Care metrics are also behind, which is also concerning and will play into plans as above. However within this the picture is mixed; some improvements have been made with regards to handover times. **Finance** As at month 4 the system is £0.7m adverse to the plan, due to the impact of industrial action, but the system remains on track at month 4 to deliver the plan. There are some concerns around the level of cost improvement required to be delivered in the second half of the financial year. Cost improvement plans are backended and there will need to be a significant reduction in key spend to achieve	

	the plan. Capital spend is currently under plan and may be utilised; this is something to be worked through over the course of the year. The challenge faced by the system in the second half of the year was emphasised; there must be a reduction in the rate of spend in quarters 3 and 4 in order to meet the plan. The Chair noted that backended plans are not ideal and ultimately plans must match the system's actions and be delivered. **Workforce** The system is on plan in terms of Whole Time Equivalent, however there has been some increase in bank and agency spend. Some costs have been offset against the vacancy freeze in the substantive workforce. Work with regional team and acute Trusts is taking place to understand and reduce what is driving this increase. Safety Improvement Plans include the impact of industrial action and the importance of cohesion was stressed. The ICB are working with providers on pay and aggregation spend, and data is being collected around workforce costs around sickness, overtime and waiting list initiatives. It was noted that there was no August meeting of the Finance and Performance Committee. Progress is being made on training. Overall costs need to be reduced and pay is the most significant cost. **The ICB Board RECEIVED the Integrated Performance Report for assurance.**	
ICBP/2526/ 059	**Integrated Care Board Risk Register Report – as at 31st August 2025** Helen Dillistone (HD) gave an overview of the report, including the new risks, increases in risk scores and risk ownership transferral. The Chair invited comments from Committee chairs on their oversight of risks. It was clarified that the Board Assurance Framework (BAF) will have a closing down quarter 2 position for the new cluster Board; once the new Board membership has been established a joint cluster BAF will be created. **The ICB Board RECEIVED and NOTED:** • **Appendix 1, the Risk Register Report;** • **Appendix 2, which details the full ICB Corporate Risk Register;** • **Appendix 3, which summarises the movement of all risks in August 2025.** **The ICB Board APPROVED NEW RISKS:** • **Risk 43 relating to the continuation of CSU services to the ICB following the recent announcement regarding CSU abolition by the end of March 2027;** • **Risk 44 relating to System plans not aligning to activity, workforce and finance; and** • **Risk 45 relating to the new ledger/ISFE2 system not working fully on implementation.** **The ICB Board APPROVED INCREASE in risk scores for:** • **Risk 17 relating to sustaining communication and engagement pace of change during the significant change programme; and** • **Risk 19A relating to delivering a timely response to patients due to excessive handover delays.** **The ICB Board NOTED the TRANSFER OF RISK OWNERSHIP for:** • **Risk 1 relating to the Acute providers may not meet the new target in respect of 78% of patients being seen, treated, admitted or discharged from the Emergency Department within 4 hours; and** • **Risk 23 relating to RTT and cancer performance a result of increased demand and insufficient capacity.**	
ICBP/2526/ 060	**Committee Assurance Reports** The assurance reports were taken as read, with additional comments as below: **Audit and Governance Committee** The Committee has taken good levels of assurance on governance issues in general, which is reflected in this report. Overall the situation is positive and encouraging.	

	Remuneration Committee The most recent Committee meeting was held jointly with NNICB to review the new people and change policies and improving the management of change processes. **Transition Committee** The Committee has taken limited assurance so far in the transition process as there is a considerable amount that is currently unknown and the process is inherently risky. The Committee are considering the risks and how to mitigate them in a fair and compassionate way. Discussions with trade unions are going well under the circumstances. The Committee's work will continue for some time. KM offered thanks to the Committee members for their hard work. **The ICB Board RECEIVED the Committee Assurance Reports for assurance.**	
ICBP/2526/ 061	**For information: ICB Annual Assessment Outcome Letter 2024/25** The letter was taken as read and it was agreed that the letter gave a fair and depiction of the ICB's position. In the future it is likely that ICBs will be assessed and given a rating, with league tables created from the outcomes. **The ICB Board NOTED the proposed changes to the ICB Constitution.**	
ICBP/2526/ 062	**Risks identified during the course of the meeting** The Chair emphasised the risk around the seasonal plan and the Board recognised the current, continually changing risks.	
ICBP/2526/ 063	**Forward Planner** The forward planner was taken as read; it will be subject to change throughout the transition process. Some statutory items will be required against a set schedule; Governance Teams will work together to create a new cluster forward planner. **The Board NOTED the Annual Assessment Outcome of Derby and Derbyshire ICB's performance in 2024/25.**	
ICBP/2526/ 064	**Questions received from members of the public** No questions were received from members of the public.	
ICBP/2526/ 065	**Any Other Business** The Chair commented that this was the last time the Board would convene in its current form. She gave thanks to all and added that, whatever the future holds, the Board should be proud of what has been achieved around the table. All roles have been fulfilled to a greater degree than could have been expected.	

Subject to approval by the Board at its next meeting

MINUTES OF THE NHS LINCOLNSHIRE ICB MEETING HELD ON TUESDAY, 30th SEPTEMBER 2025 AT 9.30 AM AT BRIDGE HOUSE, THE POINT, SLEAFORD AND VIA MICROSOFT TEAMS

PRESENT:	Dr Gerry McSorley	ICB Chair
	Ms Anita Day	Non-Executive Member
	Professor Karen Dunderdale	Group Chief Executive, Partner Member, NHS and Foundation Trusts
	Mr John Dunstan	Non-Executive Member and Chair of the Audit and Risk Committee
	Dr Phillip Earnshaw	Non-Executive Director and Chair of the Primary Care Commissioning Committee
	Mr Martin Fahy	Director of Nursing (Chief Nurse)
	Mr Matt Gaunt	Director of Finance
	Dr Sunil Hindocha	Medical Director
	Mrs Dawn Kenson	Non-Executive Member and Chair of Service Delivery and Performance Committee
	Mrs Julie Pomeroy	Non-Executive Member and Chair of Finance and Resource Committee
	Mrs Clair Raybould	Chief Executive
	Mrs Sharon Robson	Non-Executive Member, ICB Deputy Chair and Chair of System Quality and Patient Experience Committee (Chair for this meeting)
	Mr Navaz Sutton	Chief Executive Officer, HWLincs
	Dr Kevin Thomas	Partner Member, Primary Medical Services
REGULAR PARTICIPANTS/ ATTENDEES	Ms Charley Blyth	Director of Communications and Engagement
	Councillor Steve Clegg	Chair, Health and Wellbeing Board
	Mrs Jules Ellis-Fenwick	ICB Board Secretary
	Mrs Anne Lloyd	Director of Workforce Transformation
	Ms Sarah-Jane Mills	Director for Primary Care and Community & Social Value
	Mrs Rebecca Neno	Deputy Director for System Delivery
	Professor Derek Ward	Public Health Representative (on behalf of Mr Samuels)
	Mrs Sandra Williamson	Director for Health Inequalities & Regional Collaboration
APOLOGIES:	Mrs Sarah Connery	Executive Board Mental Health Member
	Mrs Michele Jolly	Voluntary and Care Sector Representative
	Mr Martin Samuels	Partner Member, Local Authority (LCC)
	Mr Chris Wheway	Voluntary and Care Representative (due to attend on behalf of Mrs Jolly)

25/342 WELCOME AND INTRODUCTIONS

Dr McSorley welcomed all those present to the ICB Board and the member of the public sitting in on the meeting. It was emphasised that whilst the meeting was being held in public it was not a public meeting. These meetings were usually held both on a face to face basis and via Microsoft Teams but due to technical reasons outside of the ICB's control, it was not possible on this occasion to hold the meeting through the 'live event' facility. Dr McSorley apologised for any inconvenience caused.

Members of the public were provided with the opportunity to submit any questions to the Board prior to the meeting through a proforma as published on the website.

Any questions submitted would be responded to after the meeting subject to inclusion of name and contact details. Questions will be published on the ICB website in future along with the response in terms of being open and transparent.

The Board Members were asked to introduce themselves when presenting papers or asking questions/making comments both for the benefit of those in the room and also those people listening in.

25/343 CONFIRMATION OF QUORACY

Dr McSorley confirmed the meeting was quorate.

25/344 DECLARATIONS OF PECUNIARY AND NON-PECUNIARY INTERESTS AND CONFLICTS OF INTERESTS

Dr McSorley reminded the Board members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the ICB. Declarations made by members of the Board are listed in the ICB's Register of Interests. The Register is available either via the ICB Board Secretary or the ICB website.

Declaration of Interest from Committees:
No items declared.

Declarations of Interest from today's meeting:
No items declared.

The Board agreed to:

- **Note no interests were declared.**

25/345 MINUTES OF THE PREVIOUS MEETING

The Board considered the minutes of the previous meeting held on the 29th July 2025 and agreed to:

- **Approve the minutes as a true and accurate record of the meeting subject to inclusion of Mrs Rebecca Neno, Deputy Director for System Delivery as being in attendance.**
- **Page 12 – commended the achievement not commenced.**
- **Page 2 – in line with the plan and page 3 – fit and proper person.**
- **Dr McSorley handed over to Mr Odell should be Mrs Robson.**

25/346 MATTERS ARISING

Dr McSorley presented the Action Log as included in the pack of papers and confirmed that the two items included were identified as complete.

25/347 CHAIR AND CHIEF EXECUTIVE UPDATES

ICB Chair update

Dr McSorley advised that this meeting marked the final session of the Lincolnshire ICB in its current format. Members were reminded that, as part of the national NHS reorganisation, Lincolnshire ICB will join a new cluster with Derby and Derbyshire ICB and Nottingham and Nottinghamshire ICBs. The new cluster will operate with a Board in Common across all three ICBs with the first meeting to be held in November 2025. Dr Kathy McLean will Chair the cluster, and Dr Amanda Sullivan will serve as Chief Executive. The first joint meeting of the cluster will take place in November.

The Chair reflected on the achievements of the Lincolnshire ICB, noting its successful management of the consequences of the pandemic and its strong collaborative working across NHS providers, County and District Councils, the voluntary sector, general practice, and community services including pharmacy, optometry, and dentistry. The ICB has focused on addressing health inequalities and has worked closely with local universities on research, innovation, and the development of the Lincolnshire Medical School. The Chair also highlighted progress on dental and oral health facilities, which were recently visited by system leaders.

Expressing pride in the work undertaken, Dr McSorley emphasised confidence that the commitment and expertise of Lincolnshire colleagues will continue to influence the new cluster and that patients and citizens will remain at the heart of decision-making.

Dr McSorley concluded by thanking all colleagues for their dedication and service, acknowledging the challenges of transition, and wishing everyone the very best for the future.

Chief Executive update

Mrs Raybould advised that this was her last day in the role as Interim Chief Executive and as such her final report to the Lincolnshire ICB Board.

Mrs Raybould provided an update on recent national communications regarding NHS priorities and reform. She noted that a letter had been received from Sir Jim Mackey, Chief Executive of NHS England, expressing gratitude to NHS leaders and their teams for their continued dedication during this period of significant change. The letter, which will be shared with Board Members sets out key priorities for the remainder of the financial year and outlines alignment with the 10-year health plan and evolving NHS budget direction.

Action: Mrs Raybould/Mrs Ellis-Fenwick

The priorities highlighted include winter preparedness with a strong emphasis on operational resilience, financial discipline to ensure delivery within agreed budgets, and continued progress on performance, transformation goals, and leadership culture. The letter reinforces the importance of transparency, collaboration, and ambition, alongside medium-term planning and system-wide leadership.

Mrs Raybould confirmed that all systems will participate in a mid-year review led by regional colleagues, and potentially national representatives, in a cluster format. This review will assess current operational and financial plans and readiness for future requirements.

Mrs Raybould also provided feedback on the recent bid for the Neighbourhood Health Service pilot. Lincolnshire was not selected for the first wave, primarily due to size considerations, although feedback was positive and confirmed the strength of the proposal. Work will continue locally to develop neighbourhood health plans, led by the Health and Wellbeing Board, supported by a sub-working group and provider collaboration. Lincolnshire will also participate in the national Community of Practice Learning Network.

In terms of oversight and performance, the pack of papers for the meeting included the ICB Annual Assessment Letter for 2024/25 which provided a balanced and constructive review, recognising strong leadership, collaborative working, and progress on strategic priorities.

NHS England has also published the Oversight Framework for 2025/26. While ICBs will not be formally scored this year due to the scale of change, performance monitoring will continue across key metrics including leadership and statutory duties.

Mrs Raybould acknowledged the significant efforts of staff managing transition alongside day-to-day responsibilities and expressed appreciation for their commitment during this challenging period.

Winter planning is progressing well, and Mrs Raybould extended thanks to all partners for their collaborative approach in developing a robust plan to manage anticipated seasonal pressures. This would be covered further later in the meeting as the Winter Plan was a separate item on the agenda.

As per Dr McSorley, Mrs Raybould reflected on the achievements of the ICB over the past three years, highlighting improvements in performance, successful implementation of Core20PLUS5, progress on health inequalities, and securing significant resources on the back of good performance for areas such as Community Diagnostic Centres. These achievements were attributed to strong partnerships and collaboration across the system.

Finally, Mrs Raybould expressed gratitude to all colleagues for their contributions and offered particular thanks to Dr McSorley for his leadership and support. As the organisation transitions into the new cluster, Mrs Raybould emphasised the importance of carrying forward Lincolnshire's values and lessons, noting that the legacy of this work will continue to shape future developments.

Ms Day expressed her pride in the achievements of the ICB, echoing earlier reflections from Dr McSorley. She highlighted that, having worked across several ICSs nationally, the spirit of collaboration and cooperation within Lincolnshire is exceptional and something she has not experienced elsewhere. Ms Day attributed much of this success to the leadership of Dr McSorley , as well as previous Chairs and system leaders, and noted that this period will remain a particularly proud part of her career.

Ms Day raised a specific question regarding the recent Annual Assessment, asking which areas were of greatest concern to regional colleagues and what priorities should be carried forward into the new cluster. In response, Mrs Raybould explained that the Annual Assessment was not conducted through a face-to-face meeting but based on ongoing dialogue. She confirmed that financial performance had been the main area of concern last year, which was acknowledged and addressed through lessons learned and strengthened system working.

Mrs Raybould noted that the system is now in a much stronger position, supported by regular monthly executive meetings and an open, transparent approach. While challenges remain, the progress made, and external feedback provide confidence that Lincolnshire is well placed moving forward.

The Board considered the update and agreed to:

- **Note the Chair and Chief Executive updates.**

KEY UPDATES

25/348 **PUBLIC HEALTH**

Professor Ward provided a verbal update from Public Health and presented the annual Health Protection Board report, which had recently been considered by the Lincolnshire Health and Wellbeing Board. For noting he Chairs the Health Protection Board. The following points were highlighted:

- **Health Protection Board Activities:** Professor Ward outlined the dual focus of the Health Protection Board on proactive measures (e.g., vaccination, screening) and reactive responses (e.g., outbreak management), highlighting the annual self-assessment showing full assurance in most domains except for commissioning responsibilities in immunisation and screening.
- **Immunisation Strategy and Outcomes:** Professor Ward described targeted interventions to improve childhood and adult immunisation rates, such as community clinics and school-based programmes, resulting in significant increases in vaccine uptake for pertussis and MMR.

- **Infection Prevention in Care Settings:** The team conducted infection prevention and control assurance visits to 277 registered homes, maintaining named individuals trained in infection control, a practice not widely replicated in other regions.

Lincolnshire has a strong, effective and unique Health Protection model compared to other ICBs, and he stressed the importance of maintaining a Lincolnshire-specific focus within the cluster.

The report is available on the Lincolnshire County Council website, but he was happy to share this with Mrs Ellis-Fenwick after the meeting for onward circulation to the Board.

Action: Professor Ward/Mrs Ellis-Fenwick

The Board considered the update and referred to the uptake of flu. Mr Dunstan specifically asked what work/actions were being undertaken to increase uptake of the vaccination. Professor Ward and Mr Fahy briefed the Board on the various strategies to increase staff flu vaccination rates, including early promotion, multiple access points, and addressing vaccine fatigue, aiming for a 5% improvement over last year's uptake. The Board was assured that every action possible was being taken to encourage uptake.

Dr McSorley referred to the rise in the number of cases of Tuberculosis (TB) and invited Professor Ward to respond, who explained the complexities of TB management, particularly among vulnerable populations, emphasising the need for integrated support across clinical, housing, and social services to ensure treatment completion.

The Board considered the update and agreed to:

- **Note the Public Health update.**

25/349 HEALTHWATCH

Dr McSorley handed over to Mr Sutton to present the latest Healthwatch report.

Mr Sutton presented a comprehensive update on recent engagement activities, including decreased GP service enquiries, increased mental health and social care queries, and confusion around new eligibility criteria, as well as focused work on carers, sensory impairment. He highlighted concerns around access, communication, and awareness of services.

A major upcoming survey on health and care experiences was announced, with plans to launch at the "Your Voice" event on 30 October 2025.

Mr Sutton also addressed national changes to Healthwatch, including the proposed abolition of the brand and the campaign to protect independent voice. He assured the Board that Healthwatch Lincolnshire would continue its work as a standalone charity.

Mrs Robson raised a point regarding carers, noting that while the report references local authority involvement, many carers do not engage with local authority services and sought assurance on how traction is being achieved from a health perspective. Mr Sutton advised that this is reflected in the report and will be taken back for further consideration.

Mrs Kenson queried the existence of a cross-system carers strategy. Ms Mills confirmed that one is in place, though work is ongoing to ensure it is sufficiently specific and aligned with wider initiatives such as social finance.

Ms Day asked about accessibility of the online version and alternative formats; it was confirmed that the report is available through usual channels, including social media. It was hoped that partners will support that dissemination and Healthwatch were currently testing alternative response methods with a group of volunteers, the outcome of which would be collated through their central team.

Mrs Raybould highlighted ongoing work to improve identification and access to carer services across the sector, though acknowledged further work is needed.

Mrs Pomeroy raised a question on transitions between child and adult services and whether this was something to work with the providers on. Mr Fahy confirmed this is being addressed through the Children and Young People's Board.

Dr McSorley thanked Mr Sutton for his comprehensive run through of the report.

The Board agreed to:

- **Note the Healthwatch report.**

POPULATION HEALTH PLANNING

25/350 Mrs Williamson advised that under duty s.13SA of the National Health Service (NHS) Act 2006 NHS England published (27th November 2023) its first Statement on Information on Health Inequalities which sets out requirements for ICBs (and Trusts) to collect, analyse and publish information relating to health inequalities for the periods 2023/24 and 2024/25.

ICBs and Trusts are required, in their annual reports, to review the extent to which they have exercised their functions regarding the Statement and explain whether the information has been published, summarise the inequalities it reveals, and state how the information has been used in the relevant period to guide action.

Mrs Williamson presented the second ICB Annual Statement on Health Inequalities, which will sit alongside the Annual Report and Accounts 2024/25, outlining the system-wide approach to addressing health and healthcare inequalities.

The Statement emphasises the importance of collecting accurate and complete data to inform targeted actions and monitor progress. It aligns with statutory duties, compares 2023/24 and 2024/25 indicators, highlighting both progress and areas of deterioration, and is integrated with monthly performance reporting. It also identifies areas of focus to understand why those inequalities exist and what action is planned to address them in 2025/26.

- **Key Areas of Progress and Challenge:** Improvements were noted in waiting times, emergency admissions for under-19s, and mental health outcomes, while challenges remain in vaccination uptake in deprived areas and annual health checks for under-30s with disabilities.
- **Targeted Interventions and Data Quality:** The report emphasised the importance of granular data to target interventions by subgroup, ongoing work to improve data quality (especially ethnicity recording), and the launch of new initiatives such as lung cancer screening in high-risk areas.

While the work reported looks at the needs of many key groups it does not cover others which have been identified as Lincolnshire Core20PLUS groups such as people who are homeless, military personnel and their families, military veterans and those from Gypsy Roma Traveller backgrounds or who are refugees.

The Health Inequalities Team is working with the Business Intelligence Team and partners to further develop the Lincolnshire joint linked data set to include inclusion health in future statements on inequalities.

The Board considered the contents of the report and discussed the definition of "off target" within the Health Inequalities report. It was confirmed that "off target" indicates a deterioration compared to the 2023/24 baseline, meaning the inequality gap has widened rather than narrowed. This differs from "on target," which reflects progress in addressing the issue. Members suggested clearer language in future reports, such as noting where there is no significant difference between subgroups.

Mrs Raybould thanked Mrs Williamson for an excellent report, noting it as clear evidence of the progress made across the system in embedding health inequalities work. She reflected that, compared to a few years ago when this was challenging to integrate, the report demonstrates significant successes and ongoing efforts. Appreciation was expressed for the leadership shown and the commitment of all partners in driving this work forward.

Mr Fahy commended the report and highlighted the value of the granular detail provided, particularly around subgroups such as Children and Young People (CYP) males and access to therapy services, as well as annual health checks for people with learning disabilities under 30. Mr Fahy noted that this level of insight enables teams to target specific groups more effectively rather than applying a blanket approach. Reflecting Professor Ward's earlier point, he emphasised that while individuals cannot be compelled to take up services such as vaccinations, understanding which groups face barriers allows tailored communication and engagement to address those obstacles. Mr Fahy concluded that this represents significant progress and provides a strong foundation for future work.

Mrs Kenson advised that the report had been through the Service Delivery and Performance Committee and reviewed, noting that at nearly 100 pages it contains a vast amount of detailed information. The summary provided was highlighted as extremely helpful in drawing out the key points and making the content meaningful. Appreciation was expressed for the quality of the work and its relevance to the Board Assurance Framework risk relating to health inequalities.

The Board agreed to:

- **Approve the report to be published on the ICB website alongside the ICB Annual Report in September 2025.**
- **Note the priority actions for 2025/26 which will continue to be updated on as part of the operational plan delivery update.**

SYSTEM OVERSIGHT AND ASSURANCE

25/351 INTEGRATED PERFORMANCE, QUALITY AND FINANCE REPORT

Performance Section

Mrs Neno, Mr Fahy and Mr Gaunt presented updates on operational performance, quality improvement, and financial position, highlighting emergency department performance, cancer and mental health metrics, provider transitions, and financial risks related to independent sector activity and prescribing costs.

Specific areas highlighted:

- **Operational Performance Highlights:** Mrs Neno reported that emergency department four-hour performance exceeded planned trajectory, with improvements in 12-hour waits, while cancer 62-day standards were below target due to industrial action, and mental health talking therapies remained above plan.
- **Provider Transitions and Quality:** Mr Fahy noted the successful transition to a new community equipment and wheelchair provider, positive CQC reports for Lincoln County and Pilgrim Hospitals, and ongoing quality improvement initiatives, including a joint health and care careers event and targeted work in children's services.
- **Winter Vaccination Programme:** Mr Fahy highlighted the commencement of the winter vaccination programme, including flu and COVID boosters, with efforts to promote early uptake among eligible groups and support from rapid response teams.
- **Financial Position and Risks:** Mr Gaunt reported that the ICB is off plan by just under £4 million, driven by higher-than-planned independent sector activity and increased prescribing costs, particularly for weight management and diabetes drugs, with mitigation efforts underway and strong performance in other areas.

Dr McSorley requested an update on the position with Social Finance. Mr Gaunt and Ms Mills described the successful contractual agreement with MacMillan and social finance investors to fund four projects in Lincolnshire, including support for carers, high-intensity users, frailty, and third sector capacity building Lincolnshire is the first ICB to secure this type of investment, which will support neighbourhood health development and community capacity building.

- **Project Scope and Funding:** The agreement secures up to £6 million in principle, with an initial £2 million investment for projects supporting carers, high-intensity users, frailty, and an anchor offer to build third sector capacity, with contractual commitments in place and mobilisation planned for the next financial year.
- **Governance and Risk Management**: Mr Gaunt explained that the initiative has gone through all necessary approvals, presents no new risks beyond those already managed in similar schemes, and is designed to test the value of extending services beyond traditional health models.

The Board discussed the update on social finance and highlighted the potential for the initiative to support neighbourhood health development; shift focus in a constrained financial environment and serve as a model for future investment in social outcomes.

Dr McSorley expressed his appreciation to Mr Gaunt, Ms Mills and their teams for their work on this initiative; it was a really positive outcome.

The Board considered the contents of the report and agreed to:

- **Note the Integrated Performance, Quality and Finance Report.**

25/352 WINTER PLAN

Mrs Neno presented the system-wide winter plan, developed in collaboration with partners and clinical colleagues, outlining aims to avoid attendances, admissions, and reduce length of stay, with robust stress testing, risk assessment, and assurance processes in place.

Specific areas highlighted:

- **Plan Development and Testing:** The winter plan was developed early, underwent system stress testing and external review, and incorporates lessons from previous years, with minor adjustments made based on feedback and scenario planning for base, moderate, and surge levels.
- **Key Risks and Controls:** Risks such as demand outstripping capacity are acknowledged, with system controls and a coordination centre operating throughout the winter period, and assurance provided that all required statements and submissions are in place.
- **Vaccination and Prevention Focus:** Vaccination and prevention are emphasised as cornerstones of the plan, with all staff and public encouraged to participate in flu and COVID vaccination programmes to mitigate winter pressures.

The Winter Plan was presented to and considered by the Service Delivery and Performance Committee at its meeting last week, which was confirmed by Mrs Kenson who advised that some slight tweaks were identified but other than that the Committee was happy to recommend approval to the Board.

Mrs Raybould advised that Lincolnshire has strong winter planning arrangements, which resulted in the area not requiring an assurance visit - unlike other regions where visits were carried out.

The Board agreed to:

- **Note the work undertaken in preparation of Lincolnshire's winter plan for 2025/26.**

- **Approve the Board Assurance Statement for Winter in line with national requirements for submission on the 30th September 2025.**

25/353 STAMFORD ENGAGEMENT REPORT

Ms Blythe advised that the ICB has a statutory 'duty to involve' as outlined in section 14Z45 of the NHS Health and Care Act 2022. The duty requires the ICB to have in place provisions for involving the public in the planning of commissioned services; and the development and consideration of proposals for changes in the commissioning arrangements which would have an impact on service delivery; and decisions which would have an impact on services.

The report presented summarised engagement activities undertaken between November 2024 and January 2025, including 12 community events and an online survey with 726 responses. The purpose was to gather feedback and experiences from the residents of Stamford about their health and care services now and in the future as the population grows.

- **Engagement Approach and Response:** The exercise involved face-to-face events, outreach to underrepresented groups, and an online survey, achieving a 4% response rate from the local population, with support from local providers and community groups**.**
- **Key Findings and Service Access:** Respondents highlighted difficulties accessing GP, dental, and A&E services, with long waits and out-of-county care noted, particularly among those with long-term conditions.

Next steps/recommendations:

- Local providers have received the engagement findings; the report has been reviewed by the Executive Team and is now presented to the Board for assurance.
- The intention is to publish the report following Board receipt.

The Board considered the contents of the report.

Mr Dunstan queried the reason Stamford had been chosen for this engagement piece of work. Ms Blyth advised that Stamford was selected due to planned population growth and other strategic factors.

Mrs Robson noted that while the report highlights expressed need for out-of-hours services, this does not confirm actual demand. This was discussed and it was agreed that this insight should be triangulated with other data sources before informing service planning.

The Board discussed and acknowledged the inherent bias in self-selected surveys, overrepresentation of certain groups, and the need to triangulate findings with other data sources to avoid bias and ensure balanced insight. This information will also need to inform the ICB's strategy, transformation plans, and wider system assessment, including preventative care priorities.

Dr McSorley thanked Ms Blyth and the engagement team for their work.

The Board agreed to:

- **Note the feedback from the public captured in the Stamford Engagement Report; to be included in the strategic planning process by all system partners for the five-year plan, neighbourhood health, clinical strategies.**

GOVERNANCE

25/354 JOINT HIGHLIGHT COMMITTEE REPORT

Dr McSorley presented the latest report from the Joint Transition Committee Highlight Report from the meetings held on 11th July 2025, 21st July 2025, and 12th August 2025.

Subject to approval by the Board at its next meeting

The Joint ICB Transition Committee reported that work on the Management of Change Business Case and the ICB Cluster Operating Model is progressing, with emphasis on affordability, legal compliance, and staff wellbeing, though delays in national guidance and leadership appointments have impacted timelines. The Transition Programme Plan remains largely on track, and governance arrangements for clustering are now a focus. The Committee continues to review the Transition Risk Log, with key risks including operating model design, redundancy costs, staff perceptions, and delivery of priorities, alongside emerging risks around CSU service continuity and new financial ledger implementation.

The Board was assured that progress is being closely monitored, and appropriate mitigations are in place.

The Board agreed to:

- **Note the latest Joint Transition Committee Highlight Report.**

25/355 ICB ANNUAL REPORT AND ACCOUNTS 2024/25

The Board received the Lincolnshire ICB Annual Report and Accounts for 1 April 2024 – 31 March 2025, including the Annual Governance Statement and Remuneration Report. The document complies with DHSC Group Accounting Manual requirements and covers performance, accountability, and financial statements. The audited report was submitted to NHSE in June 2025 and is presented for publication on the ICB website by 30 September 2025. No conflicts or specific risks identified.

The Board considered the document and noted some minor inconsistencies in the terminology when referring to the Non-Executive Members.

The Board agreed to:

- **Approve the Annual Report and Accounts 2024/25.**

25/356 COMMITTEE HIGHLIGHT REPORTS

The Board received highlight reports from the latest meetings of the following Committees:

- System Quality and Patient Experience
- Service Delivery and Performance
- Audit and Risk

The Chairs of each Committee provided brief updates with specific mention of ongoing internal controls and risk management arrangements during the transition. Internal audit reports to date provide reasonable assurance on internal controls despite significant organisational change.

A previous high-risk issue regarding the finance system update has been mitigated; risks remain but are being managed appropriately.

The Committee Chairs thanked ICB and provider colleagues for their contributions and commitment, specifically noting the valuable discussions on service delivery.

The Board agreed to:

- **Note the Committee reports.**

INFORMATION/CLOSING ITEMS

25/357 ANY RISKS IDENTIFIED

The Board considered whether any specific risks had been identified during the meeting and confirmed that there were no additional risks beyond those already captured within the ICB Corporate Risk Register (CRR) and Board Assurance Framework (BAF).

Dr McSorley highlighted the importance of ensuring that the BAF and Board Committee Handover Reports are as comprehensive and robust as possible as part of the transition process.

25/358 DATE AND TIME OF THE NEXT MEETING

The first meeting of the ICBs meeting 'in common' was scheduled to take place on Thursday, 20th November 2025 at 10.00 am in the Boardroom, Bridge House, Unit 16, The Point, Sleaford, NG34 8GG

Dr McSorley reiterated his earlier comments expressing his appreciation to the Board and associated colleagues and closed the meeting.

The Board agreed the following resolution:

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 of which would be prejudicial to the public interest' - (Section 1(2) Public Bodies (Admission to Meetings) Act 1960). Items in the private part of the meeting are either commercial in confidence or relate to individual staff and patients.

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Chair Signature **Date**

Action Log from Board Meetings held on:

10 September 2025 (NHS Nottingham and Nottinghamshire ICB)
18 September 2025 (NHS Derby and Derbyshire ICB)
30 September 2025 (NHS Lincolnshire ICB)

NHS Nottingham and Nottinghamshire ICB:

Meeting date	Agenda item	Action	Lead	Due date	Updates	Status
09.07.25	ICB 25 035: Integrated Care System People and Workforce Plan	To provide further assurance to the Quality and People Committee regarding the validity of the workforce transformation timeline set out within the People and Workforce Plan.	Rosa Waddingham	17.09.25	Reported to the Quality and People Committee at its 17 September meeting.	**Closed – Action completed**
09.07.25	ICB 25 038: 2024/25 Statement on Health Inequalities	To reflect on whether a different model could be used in the presentation of the Primary Care Network data sets.	Maria Principe	12.11.25	After consultation with Public Health colleagues, changes to the Primary Care Network data sets have been implemented on the live SAIU Outcomes Dashboard and the new table will be included in future reports.	**Closed – Action completed**

Meeting date	Agenda item	Action	Lead	Due date	Updates	Status
10.09.25	ICB 25 055: Chief Executive's Report	To add an update report on the National Rehabilitation Centre to the work programme of the Strategic Planning and Integration Committee	Lucy Branson	15.01.26	The work programme for the proposed new joint Strategic Commissioning Committee is in development, pending approval of the Committee's terms of reference.	**Open – On track**
10.09.25	ICB 25 060: Service Delivery Report	To provide a further update on the actions being taken to address the number of children and young people waiting over 52 weeks for occupational therapy, speech and language therapy and physiotherapy to the next meeting.	Maria Principe	20.11.25	See shared agenda item 14.	**Closed – Action completed**

NHS Derby and Derbyshire ICB:

Meeting date	Agenda item	Action	Lead	Due date	Updates	Status
20.07.23	NHS Derby and Derbyshire One Workforce Strategy	To present a further update of the Plan to a future Board meeting for further discussion.	Lee Radford	January 2026	The workforce plan review is in progress. Reporting arrangements in line with the new Governance Framework to be determined in line with developing Board and committee work programmes.	**Open – On track**

Meeting date	Agenda item	Action	Lead	Due date	Updates	Status
16.01.25	Citizen's Story: Can community-based projects begin to reduce health inequalities?	It is recognised that the use of the data that supports community-based projects sits with the Integrated Place Executive (IPE) oversight and Place Alliances. The ability to collate, share and surface data is one that the ICB is leading on through the data teams. Jim Austin, Chris Weiner, Andrew Fearn to update Board on progress and barriers.	Jim Austin, Chris Weiner, Andrew Fearn	January 2026	The ICB has agreed a modified process with officials from the Confidentiality Advisory Group and the ICB has recently submitted its annual statement for the existing Section 251 for risk stratification only. A draft of the amendment incorporating population health management has been completed and is awaiting information on the planned communications campaign with citizens.	**Open – On track**
22.07.25	Board Assurance Framework Quarter 1 2025/26 position	To review the Finance and Performance Committee's Risk Register to understand the flow around Chesterfield Royal Hospital, to understand where the risk around accident and emergency capacity and performance is captured and if it needs to be strengthened.	Helen Dillistone	November 2025	This action will be taken forward as part of arrangements to establish a joint Board Assurance Framework and Operational Risk Register for the ICBs.	**Open – Off track**
22.07.25	Derby and Derbyshire ICB Seasonal Plan –	To revisit the Seasonal Plan with the Urgent and Emergency Care Board in light of the concerns at	Chris Weiner	September 2025	This action was completed in time for submission of the revised Seasonal Plan on 30	**Closed – Action completed**

Meeting date	Agenda item	Action	Lead	Due date	Updates	Status
	Winter 2025/26	limited assurance around Urgent and Emergency Care, with a view to derisking the plan as far as possible.			September 2025.	

NHS Lincolnshire ICB:

Meeting date	Agenda item	Action	Lead	Due date	Updates	Status
30.09.25	Chief Executive Update	To circulate letter from Sir Jim Mackey, Chief Executive of NHS England on NHS priorities and reform.	Mrs Raybould and Mrs Ellis-Fenwick	October 2025	The letter was circulated to all Board members in early October 2025.	**Closed – Action completed**
30.09.25	Public Health Update	To circulate the Annual Health Protection Report	Professor Ward and Mrs Ellis-Fenwick	October 2025	The Health Protection Annual Report was circulated to all Board members by Professor Ward.	**Closed – Action completed**

Key:

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

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:	20/11/2025
Paper title:	**Citizen Story: Functional Neurological Disorder – The power of working together**
Paper reference:	ICB CIC 25 008
Paper author:	Charley Blyth, Director of Communications and Engagement, NHS Lincolnshire ICB
Paper sponsor:	Clair Raybould, Executive Director of Strategy and Citizen Experience
Presenter:	Clair Raybould, Executive Director of Strategy and Citizen Experience

Paper type:

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

Report summary:

This report outlines the experiences of people across Lincolnshire who directly or know someone who suffers with Functional Neurological Disorder (FND). The report describes the current pathway and experience, and outlines community involvement and leadership, in conjunction with multiple partners across the county's health and care sector, as together they strive to develop better experiences and outcomes through a co-produced strategy.

Recommendation(s):

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

Relevant statutory duties:

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

Appendices

None.

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Citizen Story: Functional Neurological Disorder – The power of working together

Introduction and background

1. Across the Lincolnshire ICB's geography, a collaborative of people and partners have come together to consider how the experience of people who face the challenges of Functional Neurological Disorder (FND) can be improved.
2. FND is a condition where the brain and nervous system are not working properly, even though their structure is normal. The 'wiring' is fine, but the signals between the brain and body get mixed up. Because of this, the body does not work as it should. People often compare it to a computer with a software problem – not a broken machine, but a system that is not running smoothly. This can cause issues like problems with movement, concentration, seizures, or changes in sensation.
3. This programme of work was driven by FND Lincs, an informal community of almost 2,000 people who have lived experience of the condition, and the health services associated with it, or work or care with those who do. This group quickly attracted the support of a multitude of partners across the health and care system and beyond, who together have progressed an exploration of how to collectively improve lives for those diagnosed with FND.
4. This initiative was underpinned by Lincolnshire's 'Our Shared Agreement', which is a movement to create a better relationship between the people of Lincolnshire and health and care services, based on five foundations that were shaped both by people who deliver care in Lincolnshire and those who receive it:
    a) Foundation 1: Being prepared to do things differently.
    b) Foundation 2: Understanding what matters to ourselves and each other.
    c) Foundation 3: Working together for the wellbeing of everyone.
    d) Foundation 4: Conversations with and not about people.
    e) Foundation 5: Making the most of what we have available to us.
5. They offer new ways of thinking and working together and invite us to move beyond problems and processes, and instead focus on strengths, hopes, and what truly matters most to people
6. The full detail of this initiative is described in a PowerPoint presentation that will be presented during the meeting by our FND support group representative.

Objectives of the community

7. Early feedback from the group identified that for many people it was difficult to get the support, recognition or help they needed following an FND diagnosis in the county. FND Lincs was invited to share their experiences and mitigations with NHS Lincolnshire ICB and other representatives from the health and care system and collaboratively consider how best to use existing resources to bring about improvement, such as strengthened existing provision, myth busting, and earlier diagnosis.
8. The end objective of the collaboration is a co-designed FND strategy for Lincolnshire.

The strength in togetherness

9. Led by people with FND and their families, a system wide conversation has started and brings together people and services for a shared purpose:

This illustration displays the partners and people supporting the programme, wrapped around the community at the heart of it.

Activity to date

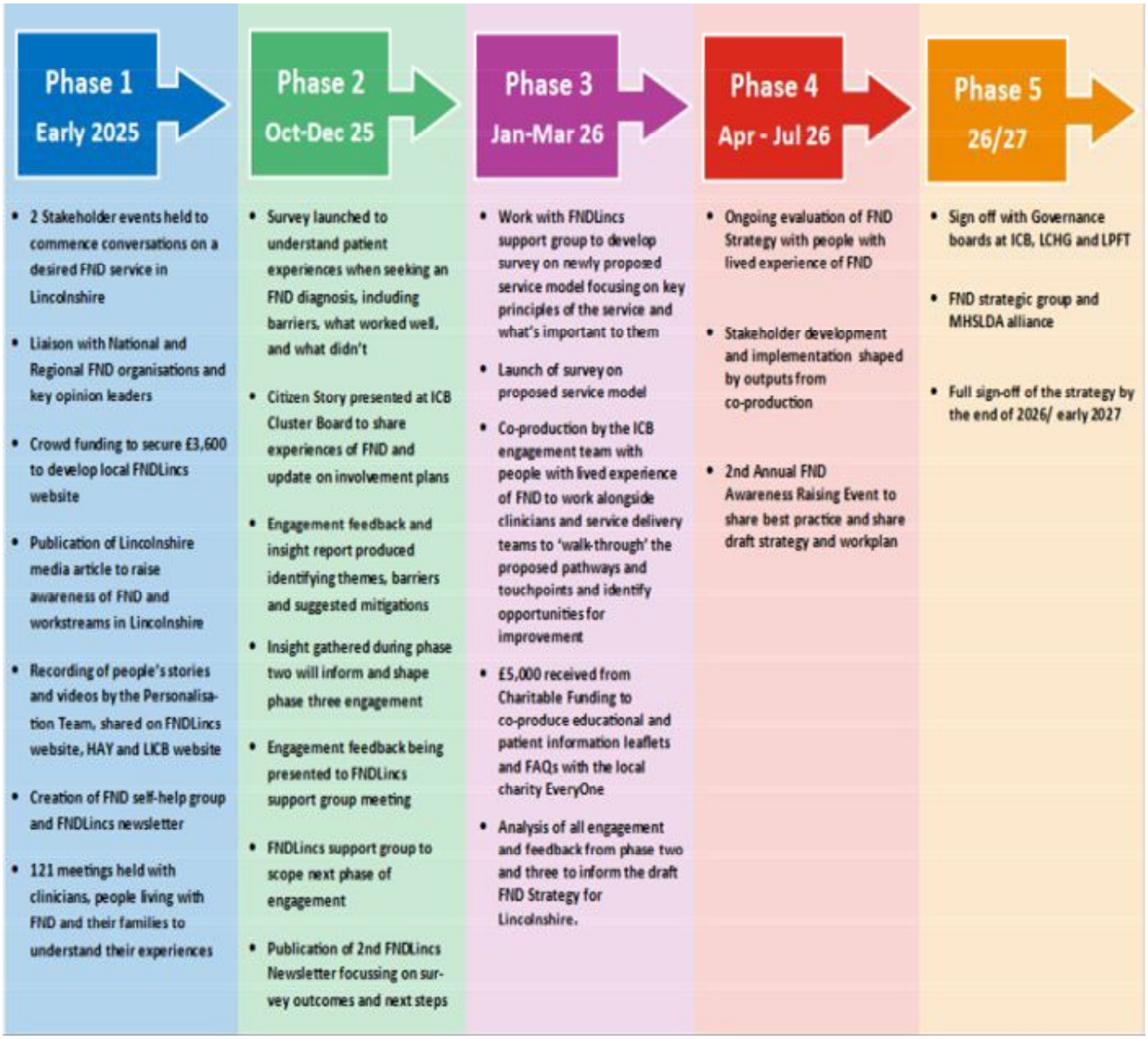
10. Momentum gathered from an initial awareness raising event in July 2025, led by a local charity, Stamford Health, Education and Awareness Charity, with over 220 people in attendance, including people with lived experience, clinicians, academics, public health, and NHS Lincolnshire ICB.

11. This truly system wide approach of valued, equal partners is now represented on a strategic steering group, established within the ICB and underpinned by task and finish groups to focus on areas including Living Well, Data, and Specialist Pathways. Self-help support groups have been established, an online information site developed, newsletters produced and circulated, and wider engagement started, with a survey to everyone in Lincolnshire and in particular to those living with FND and their families and friends.

12. This engagement approach will include co-production at every stage, with the ICB's engagement team weaving it into strategy development and eventual implementation, and a local charity, EveryOne, supporting the development of education materials and training with co-production through charitable funds.

13. The self-established support group remains integral to this and will be presented with the findings from the survey at its next meeting in December and will start scoping the next phase of engagement to develop the principles underpinning the strategy. All of this will be presented at a second FND Awareness Event in July 2026.

14. People's voices and sharing their stories ensures we do not lose sight of what is important and why we are all working together. Community reporting, led by the It's All About People team, is a grassroots media model that helps people share their stories and perspectives to drive change. Working with partners across the system to share skills in lived experience storytelling, creating a library of people's experience, and analysing themes to help inform the development of health and care in Lincolnshire.



This chart shows the schedule of activity happening in the programme. It is phased, with Phase 1 in early 2025 and concludes at Phase 5 in 2026/27. It notes engagement work which has happened with people and stakeholders, the meetings held by the FND group and the process which will happen to the findings from these.

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:	20/11/2025
Paper title:	**Chair's Report**
Paper reference:	ICB CIC 25 009
Paper author:	Dr Kathy McLean, Chair
Paper sponsor:	Dr Kathy McLean, Chair
Presenter:	Dr Kathy McLean, Chair

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

Report summary:

This report outlines my activities and actions in my role as Chair and provides a summary of the NHS Reform process, alongside a synopsis of some of the meetings I have attended on behalf of 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
☒ 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.

Chair’s Report

Introduction

1. I am delighted to welcome you all to this first meeting in common of the Boards of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB.
2. The three ICBs are now working in partnership as an 'ICB Cluster' and later on our shared agenda, we will be formally approving the ICBs' new governance framework that will be in operation moving forward. It is important to note that while we will be operating as an ICB Cluster, the three ICBs will remain as separate legal entities with distinct statutory duties. However, through our Boards meeting in common, we will be able to facilitate single discussions and provide a single strategic direction for the ICB Cluster, while retaining the ability for each Board to make its own decisions.
3. We have of course been working collaboratively over several months in preparation for these new arrangements, and I would like to personally thank all colleagues that have worked so hard to achieve the progress we have made to date. This includes the joint appointments we have made to our Boards, which has enabled the establishment of a single Executive Team for the ICBs. Work is now underway by Executive colleagues to establish interim delivery structures in each of their directorates, supported by the announcement of funding for a voluntary redundancy scheme from our colleagues in NHS England on 11 November.
4. While good progress has been made, there is still much to be done to fully transition to our new operating model and role as strategic commissioners. Continuation of this change process is now being led by our Executive Director of Transition, with continued oversight by our joint Transition Committee, ensuring that this complex programme of change retains the dedicated expertise and attention it requires.

NHS Reform

5. Outside of matters specific to our ICBs, more updates have been received from NHS England colleagues regarding the reform process as a whole.
6. The first ICB mergers have been confirmed. At the beginning of September this year, it was announced that seven new ICB footprints will come into effect in April 2026. None of these are in our Midlands region.
7. As well as the announcement regarding redundancy funding for ICBs, NHS England colleagues have also been notified of the same. This supports the movement towards the Department of Health and Social Care and NHS

England transitioning into one organisation, which we now know will be a more gradual process over the course of a couple of years.

8. Despite all these steps forward, it remains clear that this programme of reform continues to require a huge volume of resource and capacity across our workforce. In the most recent survey of Integrated Care System Leaders, this was cited as the biggest barrier against the four core purposes (to improve outcomes, equality, productivity and value, and social and economic development), more so than social care or financial positions. In a recent article published by the HSJ, I was asked to comment in my capacity as NHS Confederation ICS Network Chair, saying “ICB leaders have indicated through the survey that they are worried they could get left with the statutory responsibility and with the need to do these things but [not] the resources.”

National updates

9. NHS England has published the Medium Term Planning Framework for 2026/27 to 2028/29, in support of the delivery of the Ten-Year Health Plan for England. The Framework was released on 24 October and focuses on returning the NHS itself to better health in order to also drive the strategic shifts identified in the Ten-Year Health Plan. I know Amanda will provide more detail, but key ambitions in the Framework include:

    a) Dramatically reducing waiting times.

    b) Restoring access to local care at the level expected by patients and communities.

    c) Slashing unnecessary bureaucracy and pouring the resulting savings back into frontline services and staff.

10. I note also the publication of the Strategic Commissioning Framework by NHS England, which Executive colleagues will I am sure expand upon, but I welcome the additional detail that this provides us and note the ambitious and wide-reaching expectations that it places on ICBs to listen deeply to our population and be bold in changing commissioning arrangements in support of securing the best possible health outcomes. Again, I know Amanda will be providing more detail when she does her update.

Local updates

11. Alongside this national context, the great work and progress made across our ICBs is significant. Already taking advantage of the opportunity for shared learning and best practice, we are actively working through the appropriate processes to bring the Derby and Derbyshire all-age continuing healthcare services in-house. This in-housing process has already taken place in

Lincolnshire and Nottingham and Nottinghamshire, so allows for consistency and improved collaboration. Our Executive Director of Quality (Nursing) is leading this work.

12. We also made an important announcement regarding end of life care in Derby and Derbyshire earlier this month. Marie Curie nurses are now working closely with GP practices across Derby and Derbyshire as part of a new initiative to improve care across the county. Funded by the UK's leading end of life charity, the two-year scheme will help equip local teams with the skills and knowledge to support people with palliative and end of life care needs more effectively. The nurses are currently based in 23 GP practices in the area, with a further eight practices set to join the scheme in the coming months. They will work with staff to improve care in a range of ways including: identifying patients in need, supporting their families, and ensuring end of life care is embedded in clinical discussions. This is excellent news as we seek to further support patients and families during such challenging and emotional times.

13. Lincolnshire's Innovative Patient Safety Dashboard has gained HSJ Award attention. This new dashboard turns complex national data into clear, visual insights, helping teams spot patient safety trends and drive improvement, and is creating significant benefit for both staff and patients alike. Alongside this, Nottingham and Nottinghamshire's excellent work in developing a data dashboard for special educational needs and disabilities (SEND) has secured the top award at the HSJ Patient Safety Awards. The award for 'Care for Children and Young People Initiative of the Year' recognised work to develop a pioneering outcomes-based dashboard for children with SEND. The dashboard is believed to be the first of its kind to combine health, social care and education data to provide a comprehensive view of children with SEND in Nottinghamshire.

14. Lincolnshire is home to a great example of our important Neighbourhood health approaches. One of seven ICBs selected to take part in the Primary Care Network pilot to better understand demand and capacity, Lincolnshire was host to National Medical Director, Dr Claire Fuller and Professor Tim Briggs (National Director for Clinical Improvement and Elective Recovery) at the three PCNs participating on 31 October (Lincoln Healthcare Partnership, Apex, and IMP). The pilot undertakes data analysis to then inform interventions such as workforce design, new service models and innovations, which will in turn aid future national strategies and support the NHS Long Term Workforce Plan

15. I am pleased also to see the Citizens' Panel in Nottingham and Nottinghamshire continuing to recruit members. The Citizens' Panel is online and consists of surveys, polls and questionnaires throughout the year. The information collected helps the NHS to plan for future services. This is one of the many ways that we currently listen to our populations, all of which will need

to be strengthened and deepened as we move forward into our new strategic commissioning role.

16. I was delighted in September to visit Nottingham's Toy Library in Bulwell to find out about its innovative approach to supporting families. The Toy Library was founded 45 years ago and has evolved since then to offer family support services and child development through play. Community involvement, co-production and lived experience are at the heart of all Toy Library activities. It was impressive to see how the Toy Library is working with local families to offer them the services and support they need. They also demonstrate a commitment to inclusivity, with translators available on-site, strong partnerships with local primary schools, and dedicated sessions for children with special educational needs and disabilities. This is an excellent model for community-based support, which is helping to tackle this issue, and I can see the potential for inspiring similar initiatives in other areas of our ICBs.

17. Also this month, I published the fourth episode my *Healthy Conversations* podcast, which currently covers a range of topics that are contributing to our delivery of the Ten-Year Health Plan in Derby and Derbyshire. This episode is a deep dive into the neighbourhood health model, and I talk with Dr Penny Blackwell, GP and Chair and Clinical Director for Neighbourhood Health and Care, and Jim Austin, Chief Executive of Derbyshire Community Health Services, who is the programme's senior responsible officer. We discuss what a neighbourhood is, and how the Team Up model works, which was recently referenced in the Ten-Year Health Plan as a great example of integrated neighbourhood working. We also discuss other key parts of the neighbourhood model including urgent community response, severe frailty, falls, and the importance of creating the right culture.

18. Since taking on my joint role, I have continued with visits and meetings with partners across the three ICB geographies. It was very informative to spend time with Debbie Barnes and Martin Samuels, Chief Executive and Executive Director for Adult Care and Community Wellbeing at Lincolnshire County Council, and I am looking forward to doing the same with the Chairs and Chief Executives of Lincolnshire's NHS trusts and some charitable sector colleagues, which are arranged in the coming weeks. Amanda and I have been briefing our MPs on the changes taking place within the ICBs, and we have a further session with the Derby and Derbyshire MPs later in November to continue this conversation, as well as discussing the health issues affecting constituents.

Looking forward

19. It is apparent from this report alone the volume and quality of activity happening across our ICBs. It is imperative that we now focus on delivering the highest quality of service to communities across our vast geography, with the need to

progress and clarify our structures in support of our staff being crucial to our future success.

20. I would like to express my gratitude to my colleagues in attendance today, and our colleagues and communities across our ICBs and our health and care partners as a whole for their support and dedication in helping us work through this period of significant change. We remain ambitious and committed to collaboration in our approaches, and so I very much hope that this first coming together of our Boards signifies the start of an exciting, and successful journey together to improve the health and experiences of those we all serve.

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:	20/11/2025
Paper title:	**Chief Executive's Report**
Paper reference:	ICB CIC 25 010
Paper author:	Amanda Sullivan, Chief Executive
Paper sponsor:	Amanda Sullivan, Chief Executive
Presenter:	Amanda Sullivan, Chief Executive

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

Report summary:

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

Recommendation(s):

The Boards are asked to:

- **Note** this paper for information.
- **Adopt** the International Holocaust Remembrance Alliance working definition of antisemitism.

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 – Letter from Sir Jim McKay on antiracism

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Chief Executive's Report

Introduction

1. I am delighted to have been jointly appointed by the ICBs as Chief Executive, following agreement that the ICBs will work in partnership as an ICB Cluster. I am looking forward to continuing to work with colleagues across Derbyshire, Lincolnshire and Nottinghamshire as we take forward this ambitious programme of reform for the NHS. I would also like to thank everyone for their continued hard work and professionalism during this challenging stage of transition.

Letter from the Chief Executive of NHS England: Building on progress in the second half of 2025/26

2. The ICBs' new partnership working arrangements will be key to meeting the expectations detailed within Sir James Mackey's letter regarding his priorities for the second half of the year, which include the need to maintain focus on continuing to improve waiting times in electives, and for cancer and emergency care, whilst maintaining financial discipline. The full letter can be found here: https://www.england.nhs.uk/long-read/building-on-our-progress-in-the-second-half-of-2025-26/.

3. NHS England is currently undertaking mid-year reviews with all ICBs and providers to understand the risks to the delivery of operational performance targets and to seek assurance that steps are being taken to maintain financial discipline to the end of the financial year.

Medium Term Planning Framework

4. During October NHS England published its planning framework for 2026/27-2028/29. It aims to move towards medium-term financial and delivery planning cycles, breaking the cycle of 'short termism' and 'just about managing' in order to provide a stronger foundation for the strategic shifts required to deliver the Ten-Year Health Plan for England.

5. Within the detail of the Planning Framework there are some key changes relating to financial arrangements and ICB allocations, targeted actions on addressing productivity, a new operating model and a new approach to oversight.

6. The deadline for the first submission of plans for the three-year period is 24 December 2025, which will need to present three-year numerical plans covering workforce, finance and performance trajectories, as well as Board

assurance statements. Final plans will be expected in early February 2026, which will include a five-year narrative plan.

7. Board members will have the opportunity to discuss the ICBs' progress in meeting these requirements later in the meeting.

8. Further detail on the Planning Framework can be found here: https://www.england.nhs.uk/publication/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29/.

Strategic Commissioning Framework

9. NHS England has also published its direction of travel for this key role for ICBs going forward, as set out in the Medium-Term Planning Framework. The Strategic Commissioning Framework sets out the expectations of ICBs as strategic commissioners, and what ICBs and providers can expect from NHS England by way of support.

10. It describes strategic commissioning as a continuous evidence-based process to plan, purchase, monitor and evaluate services over a longer-term time framework in order to improve population health, reduce health inequalities and improve equitable access to consistently high-quality healthcare. ICBs, as strategic commissioners, will be accountable for creating the best value for the public from their NHS budget.

11. The expectation is that ICBs adopt the strategic commissioning approach outlined within the framework as part of the NHS planning process for the financial year 2026/27; and a strategic commissioning development programme will be in place from April 2026 to support this.

12. ICBs will need to undertake a baseline assessment against this framework in March 2026 to inform the development support they need. The ICBs' Transition Committee will oversee this work on behalf of the Boards.

13. Further information on the Framework can be found here: https://www.england.nhs.uk/long-read/strategic-commissioning-framework/

Action on racism including antisemitism

14. NHS England has published a letter highlighting the International Holocaust Remembrance Alliance working definition of antisemitism. The letter can be found at Appendix A.

15. We are proud of the diverse and multicultural team who make up our NHS. We are a team united by our care and support for other people and we are committed to inclusion and diversity, and I ask the Boards to formally adopt the definition alongside other NHS organisations.

16. Further equality, diversity and inclusion training is being developed nationally, and we will share details when it is available.

Primary Care Network Test Site Programme

17. Three Primary Care Networks (PCNs) in Lincolnshire were selected to be part of a national NHS England Pilot to understand capacity and demand in Primary Care and utilise additional funding to test out new models of delivery between 2024/25 and 2026/27. Each PCN receives additional funding, which is equivalent to 10% of their existing contract values, and has the flexibility to determine how to utilise the additional funding available. However, they are expected to be able to demonstrate a proportionate increase in capacity as a result of the funding.
18. Each PCN has taken a slightly different approach to their interventions and the utilisation of the funding. The PCNs have been supported by NHS Lincolnshire ICB's data analytics team to help them target interventions with specific population cohorts.
19. Assessments of the pilot to date show improved patient experience and staff satisfaction, improved access, including improved call waiting times and waits for on the day, urgent and routine appointments. The practices taking part have also seen improved Care Quality Commission metrics in relation to the management of patients with long term conditions and medicines management.

Neighbourhood health services pioneer site

20. Nottingham City is one of 43 areas to pilot a new neighbourhood health service, which aims to address health inequalities within areas with the lowest life expectancy and longest waits for treatment in England.
21. £10 million has been allocated to this initiative and each of the 43 areas will be allocated a programme lead who will work with existing local services to set up a new neighbourhood health service.
22. Using general practice as the cornerstone, they will draw together a range of professions to develop a neighbourhood health team consisting of community nurses, hospital doctors, social care workers, pharmacists, dentists, optometrists, paramedics, social prescribers, local government organisations and the voluntary sector, with the aim of giving people easier access to the right care and support closer to home. The initial focus will be on supporting people with long-term conditions such as diabetes, arthritis, angina, and high blood pressure.

Opening of the National Rehabilitation Centre

23. The formal opening of the National Rehabilitation Centre at Stanford Hall, near Loughborough, received favourable reports on local news outlets. Working in partnership with Nottingham University Hospitals NHS Trust over many years, the former NHS Nottingham and Nottinghamshire Clinical Commissioning Group approved the business case for the £105 million project in 2019 and construction commenced in 2023.

24. Combining patient care delivered by staff from Nottingham University Hospitals NHS Trust, with research, innovation and training via an academic partnership led by the University of Nottingham and Loughborough University, the centre will act as a national hub to transform how people recover and regain fitness and function following serious injury or illness, and to widen access to rehabilitation beds.

Industrial action

25. At the time of writing, resident doctors have rejected the latest pay and conditions offer from the Department of Health and Social Care and are set to take industrial action from 14 to 18 November 2025. As with previous periods of planned disruption, a warning of potential disruption has been issued to the public, asking for their support by using services appropriately. Our system response structures will be used to ensure that essential services are maintained.

Ashgate Hospice: response to recent statements

26. NHS Derby and Derbyshire ICB has responded to statements made by Ashgate Hospice to local media outlets regarding NHS funding. Whilst continuing to work closely with the hospice to understand its financial challenges, the ICB has reiterated its stance that funding is fair when benchmarked with the sector nationally and is in line with NHS England Guidance. The full response can be found here: https://joinedupcarederbyshire.co.uk/news/ashgate-hospice-response-statement/.

Care Quality Commission report into maternity services at University Hospitals of Derby and Burton NHS Foundation Trust

27. Maternity services at the Trust have been rated as ‘requires improvement’ by the Care Quality Commission following an inspection in December 2024. The report noted that whilst the Trust had made some progress since the last inspection, the risk to women’s safety was still a concern.

28. Since the inspection, the Trust has been progressing an action plan, which has resulted in increased staffing and improved compliance with national maternity standards and training. NHS Derby and Derbyshire ICB will continue to work alongside colleagues at the Trust to ensure that quality improvements are achieved and embedded, with ongoing oversight by the ICBs' Quality and Service Improvement Committee.

29. The Trust is not part of the national review of maternity services, announced by the Government in June, which is due to report by the end of 2025.

Critical Incident declared at Nottingham University Hospitals NHS Trust

30. Nottingham University Hospitals NHS Trust declared a critical incident on 4 November 2025, due to sustained pressures across all services, particularly in its Emergency Department, caused by challenges in staffing, flow and discharge within the hospital and technical issues with the roll out of the Electronic Patient Record System. NHS Nottingham and Nottinghamshire ICB's system response structure, which brings operational and emergency preparedness resilience and response leads together into a System Control Centre, was used to support the Trust in recovery operations and the incident was stood down two days later.

Jess's Rule

31. Following the tragic death of Jessica Brady, who had more than 20 appointments with her GP practice and was later diagnosed with stage four adenocarcinoma, a new initiative will ask GPs to think again if, after three appointments, they have been unable to offer a substantiated diagnosis, or the patient's symptoms have escalated.

32. Jessica's legacy will ensure that the patient voice is at the heart of healthcare, which is a key commitment in the Ten-Year Health Plan for England.

33. This initiative, targeting primary care, builds on the recent rollout of Martha's Rule to every acute hospital in England, which empowers patients, families and carers to request urgent clinical reviews if they are concerned about deteriorating conditions not being adequately addressed.

NHS online hospital

34. As part of the key aim of Ten-Year Health Plan to shift from analogue to digital, NHS England has announced the development of an 'online hospital', which will digitally connect patients to expert clinicians anywhere in England.

35. The initiative will go live from 2027. Patients will be able to book directly through the NHS App and have the ability to see specialists from anywhere in

the country online without leaving their home. If they need a scan, test or procedure, they will be able to book this at a time that suits them at Community Diagnostic Centres closer to home.

36. Initially the focus will be on a small number of planned treatment areas with the longest waits. Over time the intention is to expand it to more treatment areas. Treatment areas will only be offered if it is it is clinically safe to do so remotely.

37. Before NHS Online goes live, learning from existing research on patient experience of online care will be built into the programme as it develops. The programme is being developed with a commitment to patient partnership in design and delivery.

Review of GP funding formula

38. The current formula for distributing GP funding, the Carr-Hill formula, is based on data that is around 25 years old in some cases.

39. As part of the key aim in the Ten-Year Health Plan to strengthen the role of General Practice, a review is being undertaken by the National Institute for Health and Care Research to identify a new allocation formula and assess the feasibility of implementing it, with the review reporting by March 2026.

40. The review will be a key tool in helping to address healthcare inequalities, as people in more deprived areas and coastal towns often have the highest needs for the NHS, but the fewest GPs, the worst-performing services and the longest waits.

Nottingham and Nottinghamshire Healthwatch: GP Access Report

41. Earlier this year, Nottingham and Nottinghamshire Healthwatch undertook a desk-based review of 59 GP practices across Nottingham and Nottinghamshire, which covered two thirds of all registered patients in the area. The review sought to assess how local practices were progressing in implementing the aims of the NHS England Delivery Plan for Recovering Access to Primary Care, 2023. Key findings were:

    a) Telephone access varied widely: While 42% of practices answered within five minutes, 21% recorded a waiting time of over 30 minutes.

    b) Digital telephony inconsistencies: Call-back availability was not offered by more than 60% practices.

    c) Online request responsiveness is inconsistent: Around half the practices do not respond to online appointment requests on the same day.

    d) Patient choice in appointment format is limited in reality.

    e) Practice websites vary widely in clarity, content, and accessibility.

42. Several recommendations were made in the report in relation to improving telephone and digital access, responding to on-line requests more promptly and honouring patient preferences.

43. NHS Nottingham and Nottinghamshire ICB has provided Healthwatch Nottingham and Nottinghamshire with a comprehensive response to its findings, and since the report was published, progress continues to be made. This includes:

    a) A comprehensive website upgrade programme being rolled out across Nottingham and Nottinghamshire practices.

    b) All practices that were on analogue telephony have moved to cloud-based systems or are in the process of moving to one.

    c) From October 2025 practices have been contractually obliged to keep their on-line booking systems switched on for non-urgent clinical and admin requests during core opening hours.

Recent leadership updates

At the national level

44. A single joint executive team is being established at the Department of Health and Social Care (DHSC) and NHS England as part of the transition to one organisation. It will provide unified leadership across both organisations, bringing policy and delivery together. The single joint executive team will comprise:

    a) Samantha Jones, DHSC Permanent Secretary

    b) Jim Mackey, Chief Executive of NHS England

    c) Professor Chris Whitty, Chief Medical Officer

    d) Tom Riordan, Chief Operating Officer/Second Permanent Secretary

    e) Matthew Style, Director General, System Development

    f) Duncan Burton, Chief Nursing Officer for England

    g) Catherine Frances, Director General, Global, Public Health and Emergencies

    h) Professor Lucy Chappell, Chief Scientific Adviser and Director General, Science and Research

    i) Sally Warren, Interim Director General, Adult Social Care (recruitment to the permanent role began in July)

    j) Julian Hunt, Interim Director General, Technology and Data (recruitment to the permanent role will take place during autumn)

k) Elizabeth O'Mahony, Interim Director General, Finance (recruitment to the permanent role began in August)

l) David Probert, Interim Director General, Performance and Delivery (and continuing as NHS England's Interim Deputy Chief Executive)

m) Jo Lenaghan, Interim Director General, People (recruitment to the permanent role began in August)

n) Dr Claire Fuller and Professor Meghana Pandit, Interim Medical Directors (recruitment to the permanent role will take place during autumn)

o) Interim appointments to the roles of Director General, Strategy and Healthcare Policy and Director General, Commercial and Growth have yet to be confirmed.

45. Joint regional teams are also being established to serve as the delivery arm of the centre, driving improvement and performance locally. Dale Bywater will continue as Regional Director for the Midlands.

46. National Priority Programmes are led by:

a) Mark Cubbon, National Priority Programme Director for Planned Care.

b) Sarah-Jane Marsh, National Priority Programme Director for Urgent and Emergency Care.

c) Duncan Burton, Interim National Priority Programme Director for Maternity, Women's Health, Children and Young People.

d) Dr Claire Fuller, Interim National Priority Programme Director for Neighbourhood Health.

e) Dr Amanda Doyle will continue as NHS England's National Director of Primary Care and Community Services and Glen Burley will continue as NHS England's Financial Reset and Accountability Director, both reporting to the NHS England Chief Executive.

f) Recruitment to the role of National Priority Programme Director for Mental Health, Learning Disability and Autism will start shortly.

At the local level

47. Stephen Radford has recently been appointed as Non-Executive Director of the Board of Doncaster and Bassetlaw NHS Teaching Hospitals Foundation Trust. He replaces Hazel Brand, who has stepped down.

48. Gemma Poulter has been appointed as Interim Executive Director Adult Social Care and Health at Derbyshire County Council.

49. Richard Smith has joined Nottingham City Council as Interim Corporate Director for Adults and Health.

Appendix A

Classification: Official

NHS England

To: ICB, NHS Trust and Foundation Trust:
- Chairs
- Chief Executives
- Chief People Officers

cc. NHS England regional directors
Commissioning support units

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

16 October 2025

Dear colleagues,

Request for action on racism including antisemitism

We write to ask for your assistance in implementing important initiatives that support our shared commitment to fostering an inclusive, respectful, and professional environment – for colleagues, patients and visitors – across the NHS and assuring our communities of our commitment to tackling hatred in all its forms.

We want to reiterate our zero tolerance stance to all forms of hatred, antisemitism, Islamophobia, racism and to any form of discriminatory behaviour. We reiterate our commitment to creating workplaces and services where everyone feels safe, valued and supported, regardless of their background, faith or identity.

In line with this, NHS England is formally and actively adopting the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism.

Th UK Government adopted the definition in 2016 and the Secretary of State has today reaffirmed the Department of Health and Social Care's commitment to it. The Secretary of State has asked that other DHSC Executive Agencies and Arms-Length Bodies adopt this.

The definition includes illustrative examples of how antisemitism may manifest in contemporary settings, including but not limited to denial of the Holocaust, accusations of Jewish conspiracy, and the targeting of Israel as a proxy for Jewish people. Criticism of Israel similar to that levelled against any other country, however, cannot be regarded as anti-Semitic.

We strongly encourage all NHS organisations to adopt this definition and to note the associated commitments to free speech in order to reinforce our collective stance against antisemitism – whether experienced by our colleagues, our patients, our communities or partners.

We need to demonstrate equal rigour in tackling all other forms of hatred and racism. During the race riots of 2024, local NHS organisations acted as beacons of hope in their local communities – supporting staff in taking an active stance against racism, in particular at that time against Islamophobia.

The current climate in some of our communities means we need to redouble our efforts to create workplaces where our staff and patients alike feel safe and welcome.

The government is also reviewing the recommendations of the independent working group on Islamophobia.

Uniform and workwear guidance update

Ensuring everybody feels safe to present for care and treatment when they need it and in working environments for our colleagues is a patient safety matter.

Working with stakeholder groups, we will update our existing uniform and workwear guidance, drawing on the policies developed in Manchester, UCLH and other good practice. The guidance will continue to uphold the principles that underpinned its creation including freedom of religious expression, ensuring patients feel safe and respected at all times, and that staff political views do not impact on patients' care or comfort.

Antiracism including antisemitism training

We are also updating the existing NHS Core Skills Framework module on Equality, Diversity and Human Rights, extending the section on discrimination and content on antisemitism and Islamophobia, and including new questions on this in the assessment. We are working to ensure all NHS organisations are aligned to the Framework to ensure that all 1.5m NHS staff are required to complete this training as part of their mandatory training.

Working with Lord Mann, we will update the content developed with EDI, racism, antisemitism and Islamophobia subject matter experts and aligned to the core skills training framework.

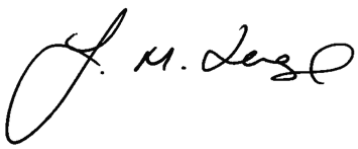
The existing training is completed by staff every three years, but we are asking for your help and support to ensure that all staff in your organisation refresh their EDI training as soon as this content is available rather than waiting for the prompt in the current three-year cycle.

Separately, work is underway to draft a new Statutory and Mandatory Training competency framework which will replace the Core Skills Training Framework (CSTF) – setting out all nationally recommended subjects to be mandated and is due to go live by April 2026.

We appreciate your leadership in implementing these changes and we ask you to support all staff in feeling safe and valued at work and also to support our communities accessing NHS services. We also recognise the importance of supporting NHS organisations in implementing these important initiatives and look forward to working with you to do this.

Yours sincerely,

Sir James Mackey
Chief Executive
NHS England



Jo Lenaghan
Chief Workforce Officer
NHS England

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:	20/11/2025
Paper title:	**Governance Framework for the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire Integrated Care Boards working in partnership**
Paper reference:	ICB CIC 25 011
Paper author:	Lucy Branson, Director of Corporate Affairs, NHS Nottingham and Nottinghamshire ICB
Paper sponsor:	Kathy McLean, ICB Chair Amanda Sullivan, Chief Executive
Presenter:	Lucy Branson, Director of Corporate Affairs, NHS Nottingham and Nottinghamshire ICB

Paper type:

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

Report summary:

This paper seeks Board approval for a new Governance Framework for the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire Integrated Care Boards ('the DLN ICBs') in line with a move to formal partnership working as an ICB cluster from November 2025. In response to the Ten-Year Health Plan for England and subsequent related publications, the framework aligns Board memberships, introduces joint leadership appointments, and establishes a revised committee structure to enable efficient, collaborative working while maintaining each ICB's statutory responsibilities. The framework includes updated Constitutions, Standing Orders, and aligned Standing Financial Instructions, alongside joint policies for business conduct and risk management. It sets out clear roles for Board members, committees, and management forums, and introduces a unified approach to strategic risk and assurance. The paper outlines next steps for implementation, including finalising Governance Handbooks, Board and committee work programmes, and further policy alignment, to support the transition to a single, effective operating model across the DLN ICBs.

Recommendation(s):

The Boards are asked to:

- **Note** the ICBs' amended Constitutions, as approved by NHS England.
- **Approve** the Boards' new committee structure and the associated committee terms of reference.
- **Approve** the appointment of Committee Chairs set out in paragraph 17 of the paper.
- **Approve** the appointments of non-executive lead roles set out in paragraph 20 of the paper.
- **Note** the appointments to Executive lead roles set out in paragraphs 21 to 24 of the paper.
- **Approve** the ICBs' revised Standing Financial Instructions.
- **Approve** the ICBs' new Standards of Business Conduct and Risk Management Policies.
- **Approve** the set of 12 joint strategic risks to form the basis of the Boards' new joint Board Assurance Framework.

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 – Combined memberships for DLN ICBs' Board meetings in common.
Appendix B – Proposed committee structure.
Appendix C – Proposed committee terms of reference.
Appendix D – Proposed joint strategic risks for development of joint Board Assurance Framework.
Appendix E – Standing Financial Instructions.
Appendix F – Standards of Business Conduct Policy.
Appendix G – Risk Management Policy.

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Governance Framework for the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire Integrated Care Boards working in partnership

Introduction and context

1. The Ten-Year Health Plan for England sets out a renewed focus for Integrated Care Boards (ICBs) as strategic commissioners of local health services and signals a significant reduction in the number of ICBs, with a requirement for ICBs to operate within a reduced running cost allowance of £19 per head of population.
2. In order to meet these requirements ahead of anticipated legislative changes, many ICBs are initially working in partnership as 'ICB clusters' in order to harness economies of scale. ICB clustering arrangements include the establishment of aligned governance arrangements and the introduction of joint leadership appointments where permissible, to enable more efficient delivery of functions and to reduce duplication. However, it is important to note that the ICBs involved in clustering arrangements will remain separate legal entities with distinct statutory duties until such time as any formal merger occurs.
3. Following national confirmation, NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB ('the DLN ICBs') will be formally operating as an ICB cluster from November 2025.
4. The purpose of this paper is to seek Board approval of the new Governance Framework for the DLN ICBs and to describe the further work required to ensure its successful implementation over the coming months.
5. Board members are asked to note that there are no changes to the existing delegation agreements in place between NHS England and the ICBs for primary care and specialised commissioning functions. However, arrangements for discharging the ICBs' delegated responsibilities are under review and the outcome of this work will be reported to a future meeting.

The Governance Framework

6. The proposed Governance Framework for the DLN ICBs was discussed with the Boards in September and has since been further reviewed in light of the Strategic Commissioning Framework published by NHS England in early November. The arrangements will consist of the following:
    a) **The ICBs' Boards** – memberships of the three Boards have been aligned, with joint appointments made wherever possible, while ensuring existing statutory requirements continue to be met. The three Boards will meet 'in common', facilitating single discussions and providing a single

strategic direction for the clustering DLN ICBs, while retaining the ability for each Board to make its own decisions.

b) **Board committees** – the three Boards will establish a revised non-executive-led committee structure, largely comprised of joint committees, while maintaining separate Audit Committees and Auditor Panels (in line with statutory requirements) that will meet 'in common'. The revised committee structure will enable effective oversight of ICB functions and duties, making recommendations and providing assurance to the Boards.

c) **Management-led forums** – a number of management-led forums will be established with responsibility for the ICB Cluster's operational decision-making and delivery oversight.

7. This framework will create a clear hierarchy of responsibility and decision-making authority; the Boards will set the direction, the committees will provide expert analysis and assurance oversight, and the management team will execute the plans.

ICB Constitutions and Board memberships

8. The Health and Care Act 2022 requires each ICB to have a Constitution, which must set out its name, area, Board membership and associated appointment requirements (including disqualification criteria), along with arrangements for discharging functions, demonstrating accountability, making decisions, managing conflicts of interests, and for public involvement. ICB Standing Orders are appended to the Constitutions, which set out the arrangements and procedures to be used at Board and committee meetings, including arrangements for deputies, quorum requirements and decision-making arrangements.

9. In September, the DLN ICBs' Boards endorsed a number of proposed amendments to the ICBs' Constitutions and Standing Orders to fully align Board memberships and appointment processes, and to enable the effective running of meetings in common. These amendments have now been approved by NHS England with effect from 1 November 2025, and in line with statutory requirements, the updated Constitutions have been published on the ICBs' websites here:

a) NHS Derby and Derbyshire ICB Constitution.

b) NHS Lincolnshire ICB Constitution.

c) NHS Nottingham and Nottinghamshire ICB Constitution.

10. Each of the three ICBs now has 17 Board members, comprised of:

a) Chair and six further non-executive members.

b) Chief Executive and five further executive members.

c) Three Partner Members.

d) One Ordinary Member for mental health

11. All Board members other than the Partner Members have now been jointly appointed by the DLN ICBs. The Partner Member roles are required to remain as individual ICB appointments in line with statutory requirements, and colleagues have either continued in these roles or been newly appointed, other than NHS Derby and Derbyshire ICB's Local Authority Partner Member role, for which a nomination is awaited. This means that for meetings in common of the Boards, there will be 23 members attending. The combined membership for the Boards' meetings in common has been illustrated for information at **Appendix A**.

12. A small number of regular participants will also attend meetings of the Boards:

    a) The ICBs' Executive Director of Transition, to ensure the Board retains appropriate oversight of the ICB transition process and to ensure the associated programme of work is effectively informed by Board discussions.

    b) Directors of Public Health, to ensure the Boards' discussions benefit from relevant public health insights. The five Directors of Public Health from across the DLN ICBs' geographies will attend meetings on a rotational basis.

    c) Chairs of Voluntary, Community, and Social Enterprise (VCSE) Alliances, to ensure Board discussions are informed by the perspectives of the VCSE sector. The three VCSE Alliance Chairs from across the DLN ICBs' geographies will attend meetings on a rotational basis.

Board committees and sub-committees

13. There are minimal statutory requirements placed on ICBs in terms of their Board committee structures. ICBs are required to establish an Audit Committee and a Remuneration Committee, plus the establishment of a separate remuneration panel for non-executive member remuneration. Also required is the establishment of an Auditor Panel to advise the Board on the selection and appointment of the external auditor. Otherwise, Boards have the freedom to determine their committee arrangements as they deem appropriate in line with ICB duties and responsibilities.

14. ICBs also have a number of flexibilities in how committees are established, including the ability to form joint committees with other ICBs, which is critical to establishing effective ICB clustering arrangements. The only limitation to this is that Audit Committees and Auditor Panels are required to be established per

statutory organisation (albeit that these are able to meet 'in common'), whereas all other ICB functions can be discharged via joint committee arrangements.

15. For clarity:

    a) Committees meeting 'in common' – this is where separate committees of each individual Board (with separate but aligned terms of reference) meet at the same time and place, with a common agenda. However, each individual committee retains the ability to make its own decisions. This approach is normally only utilised for time-limited periods, due to the complexities involved in operating 'in common' arrangements.

    b) Joint committees – this is where individual Boards establish formal joint committees (under section 65Z5 and 65Z6 of the NHS Act 2006, as amended) to operate under a single terms of reference to jointly discharge their delegated responsibilities and make joint decisions on behalf of all Boards.

16. The proposed committee structure for the DLN ICBs has been developed in line with the Model ICB Blueprint, the Model Region Blueprint and the Strategic Commissioning Framework, and meets all statutory requirements. The proposed committee arrangements are illustrated at **Appendix B**, with proposed terms of reference provided at **Appendix C**. It is anticipated that these will require further review and refinement as the new arrangements evolve and mature over the coming months.

17. The ICBs' Standing Orders require the Boards to appoint the Chairs of their committees, which are proposed as follows:

    a) Audit Committees and Auditor Panels – to be chaired by John Dunstan, Non-Executive Director.

    b) Finance and Performance Committee – to be chaired by Stephen Jackson, Non-Executive Director.

    c) Quality and Service Improvement Committee – to be chaired by Sharon Robson, Non-Executive Director.

    d) Remuneration and Human Resource Committee – to be chaired by Margaret Gildea, Non-Executive Director. The Non-Executive Director Remuneration Panel will be chaired by Kathy McLean, Chair of the ICBs.

    e) Strategic Commissioning Committee and Transition Committee – to be chaired by Jon Towler, Non-Executive Director. The Commissioning Executive Group, established as a sub-committee of the Strategic Commissioning Committee will be chaired by Amanda Sullivan, Chief Executive.

18. In line with statutory requirements, the ICBs' Chair is required to approve all individuals appointed as members of any committees or sub-committees that

exercise the ICBs' commissioning functions. This is line with the same responsibility placed on the Chair when appointing Board members in order to confirm that individuals could not be regarded as undermining the independence of the health service because of their involvement with the private healthcare sector or otherwise. This is relevant to the Strategic Commissioning Committee and the Commissioning Executive Group. A process to satisfy this requirement will be implemented following approval of the terms of reference.

19. Appropriate procedures have been followed to ensure the safe close down of existing ICB committees, which met for the final time in October. This has included the production of Committee Handover Reports, which will be received by the new committees at their first scheduled meetings in November and December.

Non-executive lead roles on the Boards

20. The ICBs' Constitutions and other national guidance stipulate a number of non-executive lead roles on the ICBs' Boards. The following proposals are presented in line with relevant Committee chairing responsibilities and non-executive portfolios:

    a) It is proposed that Jon Towler be appointed as the ICBs' Deputy-Chair and Senior Non-Executive Member. As the ICBs' Deputy Chair, Jon will be required to preside over any meetings of the Boards when the Chair is not available but is unable to exercise the statutory powers of the Chair[1]. As the ICBs' Senior Non-Executive Member, Jon will co-ordinate the annual appraisal process for the ICBs' Chair and take responsibility for ensuring the compliance of the ICBs' Chair with the fit and proper person test, in liaison with NHS England's Regional Director for the Midlands. Jon will also act as a sounding board for the Chair and, where necessary, mediate between the Chair and other Board members. In line with statutory guidance, there is no requirement for these roles to be held by separate individuals.

    b) It is proposed that John Dunstan be appointed as the ICBs' Conflicts of Interest Guardian. In this role, John will act as a safe and independent contact for Board members, staff, and the public to raise concerns about conflicts of interest, supporting the application of relevant ICB policies, providing impartial advice on how to manage potential conflicts, and helping to minimise risks.

[1] If the Chair post were to be vacant for a significant period, NHS England – with the approval of Secretary of State – may appoint an Interim Chair who would be able to exercise the statutory powers of the Chair.

c) It is proposed that Mehrunnisa Lalani be appointed as the ICBs' Non-Executive Lead for Freedom to Speak Up (FTSU). In this role, Mehrunnisa will champion the FTSU initiative, provide a credible, independent voice to support the ICBs' FTSU Guardians and ensure a safe FTSU culture is embedded across the ICBs.

d) It is proposed that Margaret Gildea be appointed as the ICBs' Health and Wellbeing Guardian. NHS England guidance[2] recommends that ICBs appoint to this role, which is an assurance role focussed on holding the executive and senior leadership teams to account to ensure they are prioritising the health and wellbeing of the ICBs' employees.

Executive Lead roles on the Boards

21. In line with a commitment to Parliament during consideration of the Health and Care Act 2022, NHS England statutory guidance[3] requires ICBs to identify lead executive members of their Boards with explicit responsibility for the following population groups:

    a) Children and young people (aged 0 to 25).

    b) Children and young people with special educational needs and disabilities (aged 0 to 25).

    c) Safeguarding (all-age), including looked after children and care leavers.

    d) Learning disability and autism (all-age).

    e) Down syndrome (all-age).

22. The intention of assigning these explicit executive responsibilities is to secure visible and effective Board-level leadership for addressing issues faced by the relevant population groups, and to ensure that statutory duties related to safeguarding and special educational needs and disabilities receive sufficient focus. For the DLN ICBs, Rosa Waddingham, Executive Director of Quality (Nursing), has been appointed as the Executive lead for the above-detailed population groups.

23. In line with their Category 1 status under the Civil Contingencies Act 2004, the ICBs' are required to appoint an executive lead with responsibility for ensuring that ICBs have robust plans and systems for Emergency Preparedness, Resilience, and Response (EPRR). Maria Principe, Interim Director of Commissioning, has been appointed as the Emergency Accountable Officer for the DLN ICBs.

[2] https://www.england.nhs.uk/long-read/health-and-wellbeing-guardian-guidance-appendix-2-guidance-for-implementing-in-integrated-care-boards/.
[3] https://www.england.nhs.uk/long-read/executive-lead-roles-within-integrated-care-boards/.

24. ICBs are also required to assign two executive lead roles related to information governance matters: a Senior Information Risk Owner with responsibility for overseeing and managing information security and data protection risk, and a Caldicott Guardian with responsibility for protecting patient confidentiality and ensuring that personal information is used lawfully, ethically, and appropriately. For the DLN ICBs, Dave Briggs, Executive Director of Outcomes (Medical), has been appointed as SIRO, and Rosa Waddingham, Executive Director of Quality (Nursing), has been appointed as Caldicott Guardian.
25. In line with the ICBs' Constitutions, the Chief Executive will formally appoint a Deputy Chief Executive in the coming weeks. The Boards will be advised of this appointment at the next meeting.

Standing Financial Instructions

26. Standing Financial Instructions (SFIs) are part of each ICB's control environment for managing the organisation's financial affairs and they contribute to good corporate governance, internal control and lessen the risk of irregularities.
27. A review of existing ICB SFIs has confirmed that there are no material differences in current requirements; however, they vary in terms of structure and level of detail. In order to provide a clear and consistent set of instructions for the ICBs, an aligned set of SFIs has been produced, which have also been updated to take account of the ICBs' new Governance Framework. These are provided at **Appendix E**.

Organisational policies

28. Corporate policies are an integral part of the ICBs' systems of internal control as they help to ensure compliance with relevant legislation and national guidance, as well as conveying other organisational standards, responsibilities and expectations.
29. A programme of work is underway in support of the ICB Transition Programme to review and align key ICB policy documents, and the first phase of this work has focused on aligning the policies that are required to facilitate the functioning of the DLN ICBs' Governance Framework, as follows:

Standards of Business Conduct Policy

30. A joint Standards of Business Conduct Policy for the DLN ICBs has been developed, which sets out the required standards of conduct and the framework for declaring and managing conflicts of interest, gifts, hospitality and sponsorship. As the ICBs' previous policies were already compliant with

national guidance, only minor amendments have been made to reflect the new clustering arrangements. Each ICB remains statutorily responsible for compliance with the requirements, which is clearly articulated in the policy. The new proposed policy is provided at **Appendix F**.

31. A joint Register of Declared Interests has also been established to facilitate the consideration of declared interests at meetings of the Boards and their committees from November onwards.

Risk Management Policy

32. A joint Risk Management Policy for the DLN ICBs has been developed to enable a consistent and collaborative approach to risk management across the ICBs. The policy development process has drawn together the best elements of each ICB's previous approach, ensuring consistency, clarity, and a shared understanding of risk across the ICBs. The new proposed policy is provided at **Appendix G**. Key points to note are as follows:

    a) A consistent risk matrix and scoring framework has been established, with standardised impact and likelihood definitions, to provide a single language for risk discussion and escalation, allowing the Boards and their committees to identify, assess and manage risks in a unified manner.

    b) A single, domain-based framework for risk classification has been established to improve clarity and provide consistency across the ICBs. The framework combines a high-level 'summary of impact' applicable to all risk classifications with domain-specific descriptors, enabling staff to assess risks consistently across programmes and geographies and enhancing the quality of information reported to the Boards and their committees.

    c) An overarching joint risk appetite statement has been developed as a holding position to enable the new Risk Management Policy to be approved and implemented. This reflects the ICBs' commitment to a mature approach, accepting short-term risks where long-term benefits are clear and robust controls are in place, while minimising risks that could impact safety, outcomes, or legal obligations. Further development work will be undertaken with the Boards to review and strengthen this position in the coming months.

33. In support of the new joint Risk Management Policy, a revised set of 12 strategic risks has been developed to form the basis of a new joint Board Assurance Framework (BAF). The strategic risks have been developed following a review and comparison of the three sets of existing strategic risks and consideration of the requirements of the Ten-Year Health Plan for England, the Model ICB Blueprint, and the recently published Strategic Commissioning Framework. The proposed strategic risks are provided at **Appendix D** for

consideration by the Boards. Subject to their approval, these will enable the new joint BAF to be fully populated alongside the development of the work programmes for each of the Boards' committees to ensure the required assurances are appropriately scheduled.

34. A joint Operational Risk Register is also currently being populated from the ICBs' previous registers, and this will form the basis of risk reporting to the Boards' new committees from November onwards.

Next steps

35. The governance workstream of the ICB Transition Programme will continue to finalise the remaining elements of the DLN ICBs' Governance Framework, as follows:

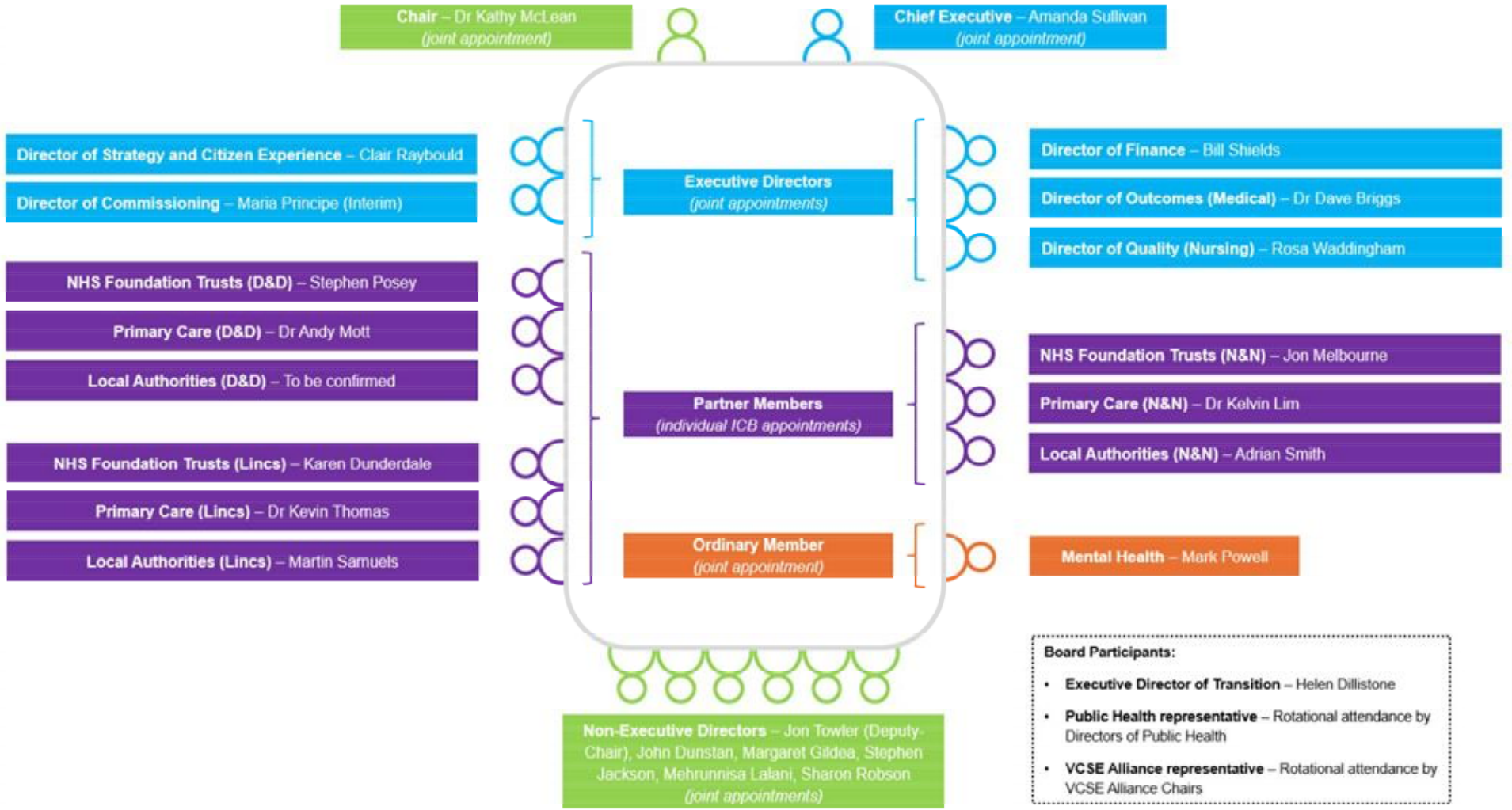
    a) The DLN ICBs' Governance Handbooks will be updated to include the new committee terms of reference and Standing Financial Instructions, and to reflect these approved changes within the ICBs' Schemes of Reservation and Delegation.

    b) Work Programmes for the Boards and their committees will be developed to ensure all responsibilities are able to be discharged effectively, and the handover process between the previous and new committees will be completed.

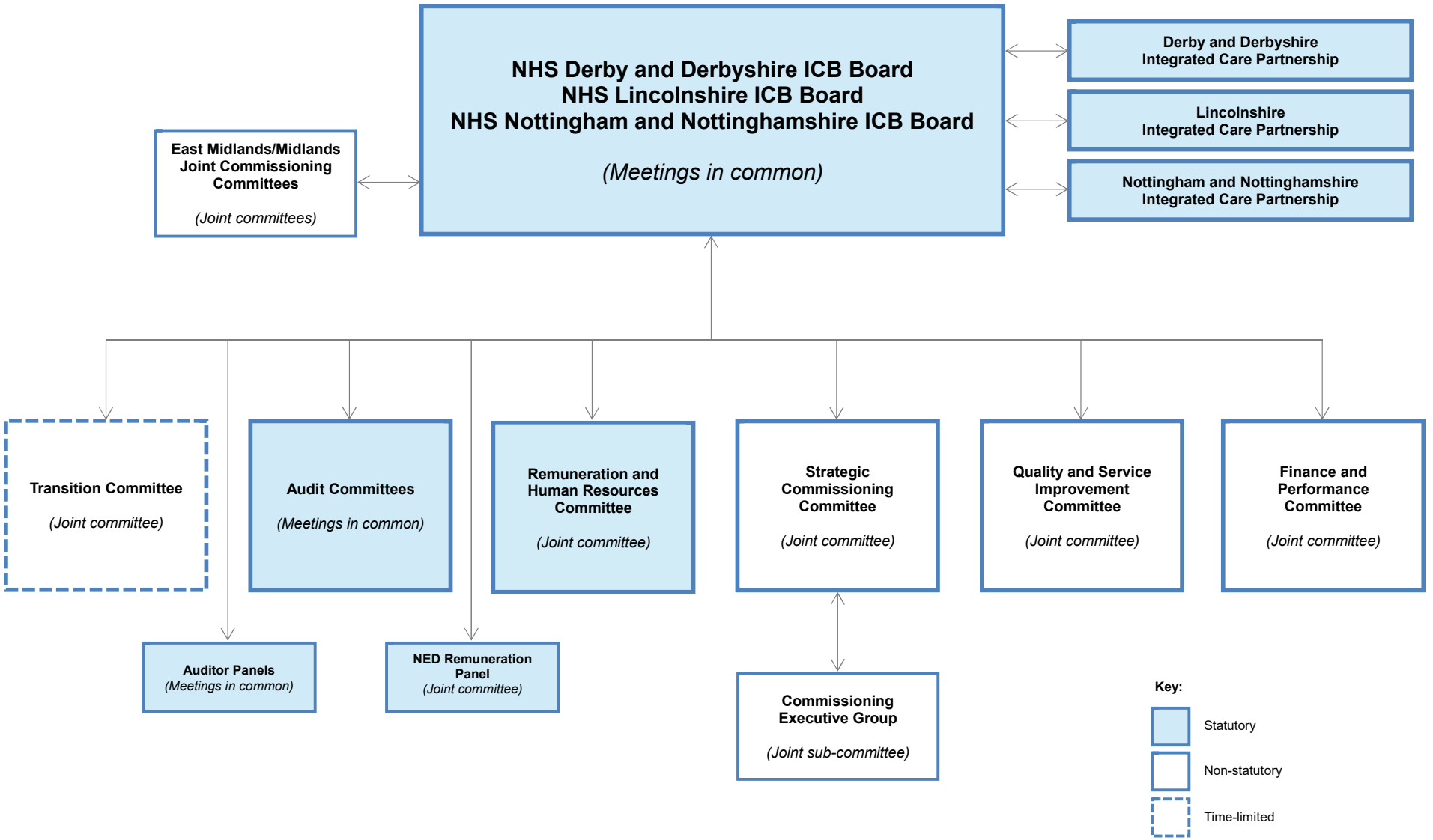
    c) ICB appointments to key statutory partnership forums, including Health and Wellbeing Boards, will be confirmed.

    d) The remaining work to align the ICBs' organisational policies will be completed. This work will be phased in line with the management of change timeframe to support colleagues as they move to working as part of a single staffing structure.

Appendix A: Combined memberships for DLN ICBs' Board meetings in common



Appendix B: Proposed committee structure



Appendix C: Proposed committee terms of reference

Audit Committee – Terms of Reference

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

3. Duties	*Integrated governance, risk management and internal control* a) The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the ICB's activities, which supports the achievement of its objectives. The Committee will: i) Review the adequacy and effectiveness of the ICB's risk management arrangements and all risk and control related disclosure statements (including the annual governance statement) together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances. ii) Review the adequacy and effectiveness of the underlying assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. This will include reviewing the outcome of the annual effectiveness assessment of all committees prior to consideration by the Board. iii) Review of all instances of non-compliance with Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation. iv) Review the reasonableness of the use of emergency powers for urgent decisions on behalf of the Board and its committees, and all instances where Standing Orders have been suspended. v) Approve and monitor compliance with standards of business conduct and freedom to speak up policies and any related reporting and self-certifications. vi) Monitor progress against the ICB's overarching Policy Work Programme. b) In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from Executive Directors and senior managers, as appropriate. c) The Committee will use the Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it. *Internal audit* d) The Committee will approve arrangements for the provision of internal audit services. e) The Committee will ensure that there is an effective internal audit function established by management that meets the Public Sector Internal Audit Standards and provides appropriate

	independent assurance to the Committee, ICB Chief Executive, ICB Chair and the Board. This will be achieved by: i) Considering the provision of the internal audit service and the costs involved; ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation. ii) Reviewing and approving of the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the ICB (as identified in the Board Assurance Framework). iii) Considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources. iv) Monitoring the effectiveness of internal audit and completing an annual review. *External audit* f) The Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by: i) Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan. ii) Discussing with the external auditors their local evaluation of audit risks and assessment of the organisation and the impact on the audit fee. iii) Reviewing all external audit reports, including the report to those charged with governance and any work undertaken outside of the audit plan, together with the appropriateness of management responses. g) The Committee will also ensure a cost-efficient external audit service. *Counter fraud* h) The Committee will approve arrangements for the provision of counter fraud, bribery and corruption services. i) The Committee will satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption (including cyber-crime) that meet NHS Counter Fraud Authority's standards and will review the outcomes of work in these areas. This will be achieved by: i) Reviewing, approving and monitoring counter fraud work plans; receiving regular updates on counter fraud activity and monitoring the implementation of action plans.

	ii) Ensuring that the counter fraud service submits an Annual Report, outlining key work undertaken during each financial year and progress in achieving the requirements of the Government Functional Standard 13 for counter fraud. j) The Committee will refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority. *Financial reporting and stewardship* k) The Committee will monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance. l) The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided. m) The Committee will scrutinise the outcome of the annual review of the Standing Financial Instructions, recommending any amendments to the Board for approval. n) The Committee will: i) Be notified of any new bank accounts or changes to existing bank accounts, and any arrangements made with the ICB's bankers for accounts to be overdrawn. ii) Approve the use of procurement or other card services by the ICB, including the types of card services that should be allowed, the types of transactions that should be permitted, the individuals who should be issued with a card, and the overall credit and individual transaction limits to be associated with each card. iii) Monitor the actual use of card services against authorised uses. iv) Review the extent to which debt is being managed effectively. v) Scrutinise any retrospective approvals to commit revenue expenditure. vi) Review all losses and special payments (including special severance payments). vii) Oversee compliance with the requirements of the NHS Provider Selection Regime (PSR). This will include oversight of annual reporting requirements (as set out in Regulation 25 of the PSR and associated statutory guidance) and oversight of the ICB's monitoring and publication arrangements (in line with Regulation 26 of the PSR), which will include retrospective reporting of all provider representations received in relation to procurement and contract award decisions for healthcare services.

	viii) Review all instances where competitive tendering requirements have been waived for non-healthcare services. *Annual report and accounts* o) The Committee will review and approve the annual report and accounts, focusing particularly on: i) The wording in the annual governance statement and other disclosures. ii) Changes in, and compliance with, accounting policies, practices and estimation techniques. iii) Unadjusted misstatements in the financial statements. iv) Significant judgements in preparation of the financial statements. v) Significant adjustments resulting from the audit. vi) Letters of representation. vii) Explanations for significant variances. *Information governance* p) The Committee will scrutinise compliance with legislative and regulatory requirements relating to information governance (including data protection and cyber security) and the extent to which associated systems and processes are effective and embedded within the ICB. This will include oversight of the ICB's performance against the Cyber Assessment Framework (CAF) aligned Data Security and Protection Toolkit (DSPT) standards. *Other regulatory and mandatory requirements* q) The Committee will also ensure the adequacy and effectiveness of the ICB's arrangements in relation to: i) The role of the ICB in respect of emergencies; overseeing the organisation's compliance against the requirements of the Civil Contingencies Act (2004) (CCA), NHS England's Emergency Preparedness, Resilience and Response (EPRR) Framework and any other mandated guidance pertaining to EPRR and business continuity. ii) The statutory and mandatory requirements for health, safety, security and fire. iii) The development and embedment of robust incident management processes, including ensuring that any 'lessons learnt' are routinely identified and appropriate actions are implemented to avoid reoccurrence. iv) Statutory and mandatory training requirements, ensuring that training plans and compliance align with the national Core Skills Training Framework requirements and providing

	assurance that outcomes are effective and meet NHS England expectations. v) The ICB's legal activity, receiving assurance on trends, outcomes and lessons learned. vi) National reviews and inquiries relevant to the ICB, seeking assurance that recommendations and learning are appropriately reflected in local systems and processes. r) The Committee will also review and approve policies specific to the Committee's remit. s) The Committee will monitor the quality of data that informs its work; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
4. Membership	The Committee's membership will be comprised of three Non-Executive Directors of the Board. Between them, the members will possess knowledge, skills and experience in accounting, risk management, internal, external audit, and technical or specialist issues pertinent to the ICB's business. The Chair of the ICB cannot be a member of the Committee. *Attendees* The following will be routine attendees at the Committee's meetings: a) Executive Director of Finance (or a suitable deputy, as appropriate) b) Senior leadership representative for governance and risk management (or a suitable deputy, as appropriate) c) Internal Auditors d) External Auditors Other officers may be invited to attend meetings when the Committee is discussing areas of risk or operation that fall within their areas of responsibility. This will include: e) The Chief Executive being invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the annual governance statement. f) The Local Counter Fraud Specialist being invited to attend at least twice per year. The Chair of the ICB will also be invited to attend one meeting each year to gain further assurance regarding the effectiveness of the ICB's governance arrangements.
5. Chair and deputy	The Board will appoint a Non-Executive Director who has qualifications, expertise or experience to enable them to lead on finance and audit matters to be Chair of the Committee. The Deputy-Chair of the ICB cannot be Chair of the Committee.

	In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's membership will be nominated to deputise for that meeting.
6. Quorum	The Committee will be quorate with a minimum of two members present. If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
7. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. If a consensus agreement cannot be reached, then the item will be escalated to the Board for a decision.
8. Meeting arrangements	The Committee will meet no less than six times per year at appropriate times in the reporting and audit cycle. Members of the Committee are expected to attend meetings wherever possible. The Head of Internal Audit and representatives from external audit have a right of direct access to the Chair of the Committee and may request a meeting if they consider that one is necessary. The Committee will meet privately with the internal and external auditors at least once during the year. Meetings of the Committee, other than those regularly scheduled above, shall be summoned by the secretary to the Committee at the request of the Chair. The Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including those relating to the quorum (as set out in section 6 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Committee to be open to the public. Secretariat support will be provided to the Committee to ensure the day-to-day work of the Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.

9. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Committee at the following meeting.
10. Conflicts of interest management	In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
11. Reporting responsibilities and review of effectiveness	The Committee will provide assurance to the Board that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing an assurance report to the Board following each of the Committee's meetings; summarising the items discussed, decisions made and any specific areas of concern that warrant immediate Board attention; and b) Providing an annual report to the Board, summarising how the Committee has discharged its duties across the year, key achievements and any identified areas of required committee development. This report will be informed by the Committee's annual review of its effectiveness.

	Any items of specific concern, or which require Board approval, will be the subject of a separate report.
12. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue date:	**Status:**	**Version:**	**Review date:**
November 2025	Draft	0.1	March 2026

Auditor Panel – Terms of Reference

1. Purpose and duties	The Auditor Panel ("the Panel") exists to advise the Board on the selection and appointment of the organisation's external auditor. This includes: a) Agreeing and overseeing a robust process for selecting the external auditor in line with the ICB's normal procurement rules. b) Making a recommendation to the Board as to who should be appointed. c) Ensuring that any conflicts of interest are dealt with effectively. d) Advising the Board on the maintenance of an independent relationship with the appointed external auditor. e) Advising the Board (if asked) on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable. f) Agreeing the ICB's position regarding the purchase of non-audit services from the appointed external auditor g) Advising the Board on any decision about the removal or resignation of the external auditor. The Panel will monitor the quality of data that informs its work; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
2. Status	The Panel has been established by the Board in accordance with The Local Audit and Accountability Act 2014 (the Act). The Board has authorised the Panel to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Panel. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. The Auditor Panel may meet 'in-common' with the Auditor Panels of NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB. [To be deleted as appropriate to the relevant ICB's terms of reference]
3. Membership	The Panel's membership will be comprised of three Non-Executive Directors of the Board. *Attendees* The Panel may invite a range of senior managers to attend meetings to support the Panel in discharging its responsibilities.

4. Chair and deputy	The Board will appoint a Non-Executive Director who has qualifications, expertise or experience to enable them to lead on finance and audit matters to be Chair of the Panel. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Panel's membership will be nominated to deputise for that meeting.
5. Quorum	The Panel will be quorate with a minimum of two members present. If any Panel member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
6. Decision-making arrangements	Panel members will seek to reach decisions by consensus where possible. If a consensus agreement cannot be reached, then the item will be escalated to the Board for a decision.
7. Meeting arrangements	The Panel shall agree the frequency and timing of meetings needed to allow it to discharge its responsibilities. Members of the Panel are expected to attend meetings wherever possible. The Panel may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Panel will apply, including those relating to the quorum (as set out in section 5 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Panel to be open to the public. Secretariat support will be provided to the Panel. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Panel. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
8. Minutes of meetings and reporting responsibilities	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Panel. The Panel will report in writing to the Board following each of its meetings in the form of a report from the Chair of the Panel.

9. Conflicts of interest management	In advance of any meeting of the Panel, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Panel will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Panel's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Panel's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
10. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Issue date:	Status:	Version:	Review date:
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Remuneration and Human Resource Committee – Terms of Reference

1. Introduction/ Purpose	The Remuneration and Human Resource Committee ("the Committee") is a joint committee of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB ("the ICBs"), established in accordance with section 65Z5 and 65Z6 of the National Health Service Act 2006 (as amended by the Health and Care Act 2022). The main purpose of the Committee is to jointly exercise the ICBs' functions as set out in paragraphs 18 to 20 of Schedule 1B to the NHS Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022). This includes: a) Ensuring that the ICBs have clear and transparent remuneration policies that enable the recruitment, motivation and retention of staff. b) Seeking assurance on all aspects of human resource management, workforce change, and organisational development, ensuring that the ICBs maintain an appropriate structure, size, and balance of skills to support strategic objectives. The remit of the Committee excludes the remuneration, fees, allowances and other terms of appointment for the jointly appointed Chair of the ICBs and for the jointly appointed non-executive members of the Boards. NHS England and the Non-Executive Director Remuneration Panel will set these, respectively. The Committee is authorised to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from employees of the ICBs, and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. d) Create sub-committees or task and finish groups to take forward specific duties or programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such sub-committees or task and finish group. Any sub-committee or task and finish group established may consist of or include persons who are not Board members or employees of the ICBs.

2. Duties	a) Determine the remuneration, fees, allowances and other terms of appointment for the ICBs' Executive Directors and all other Very Senior Manager (VSM) appointments (substantive and fixed term). Remuneration proposals will be guided by the relevant national pay frameworks, ensuring that VSMs are fairly rewarded for their individual contributions, while considering the broader performance and circumstances of the ICBs. b) Scrutinise and approve the joint VSM structure across the ICBs, ensuring clarity of roles in line with purpose, functions and affordability. c) Advise on recruitment and selection plans for all VSM roles to ensure integrity, rigour and fairness in the appointment process. d) Determine any allowances to be paid to Board, committee, joint committee and sub-committee members who are not employees of the ICBs (excluding Non-Executive Directors). e) Determine the remuneration, fees, allowances and other terms of appointment for any individuals engaged on a contract for service. f) Oversee workforce change arrangements and scrutinise and approve all associated exit payments, ensuring that appropriate ICB policies and national guidance have been followed, seeking NHS England or HM Treasury approval where required. g) Oversee human resource management and organisational development arrangements for all staff employed by the ICBs, with a view to: i) Ensuring that the ICBs' human resource and organisational development policies and ways of working are designed to ensure the workforce is appropriately engaged and motivated. ii) Ensuring the ICBs are meeting their equality duties as employers in line with relevant legislation and national guidance. iii) Ensuring the ICBs have effective succession planning and talent management arrangements in place. iv) Ensuring the ICBs are viewed as employers of choice, with a positive culture and working environment. h) Oversee the ICBs' response to feedback received through the annual NHS Staff Survey. i) Review and approve policies specific to the Committee's remit. j) Oversee the identification and management of risks relating to the Committee's remit. k) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.

3. Membership	The Committee's membership will be comprised of four jointly appointed Non-Executive Directors of the ICBs' Boards, which includes the jointly appointed Chair of the ICBs. Any Non-Executive Director appointed by the ICBs' Boards as Chair of an Audit Committee cannot be a member of the Committee. *Attendees* The Committee may invite a range of senior managers to attend meetings to support the Committee in discharging its responsibilities (providing their own remuneration is not being discussed). This will include expert human resource advisors.
4. Chair and deputy	The ICBs' Boards will appoint a Non-Executive Director to be Chair of the Committee. The jointly appointed Chair of the ICBs cannot be Chair of the Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's membership will be nominated to deputise for that meeting.
5. Quorum	The Committee will be quorate with a minimum of two members present. If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
6. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. Should this not be possible, then a vote of the Committee members will be required, the process for which will be, as follows: a) All members of the Committee who are present at the meeting will be eligible to cast one vote each. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote. b) A decision will be passed if more votes are cast for it than against it. c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the Committee will have a casting vote. Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting. In reaching its determinations, the Committee will take proper account of all relevant national guidance and agreements, for

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

	The Chair of the Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
10. Reporting responsibilities and review of committee effectiveness	The Committee will provide assurance to the ICBs' Boards that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing an assurance report to the Boards following each of the Committee's meetings; summarising the items discussed, decisions made and any specific areas of concern that warrant immediate Board attention. b) Providing an annual report to the Boards, summarising how the Committee has discharged its duties across the year, key achievements and any identified areas of required Committee development. This report will be informed by the Committee's annual review of its effectiveness. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
11. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the ICBs' Boards for approval.

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Non-Executive Director Remuneration Panel – Terms of Reference

1. Introduction/ Purpose	The Non-Executive Director Remuneration Panel ("the Panel") is a joint committee of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB ("the ICBs"), established in accordance with section 65Z5 and 65Z6 of the National Health Service Act 2006 (as amended by the Health and Care Act 2022). The Panel exists to set the remuneration, fees, allowances and other terms of appointment for the non-executive members of the ICBs' Boards. The remit of the Panel excludes the remuneration, fees, allowances and other terms of appointment for the jointly appointed Chair of the ICBs, which will be set by NHS England. The Panel will monitor the quality of data that informs its work; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data. The Boards have authorised the Panel to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Panel. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.
2. Membership	The Panel's membership will be comprised of the jointly appointed Chair of the ICBs, a non-remunerated Partner Member of one of the ICBs' Boards and the ICB's lead for governance. *Attendees* Senior Managers may be invited to attend meetings of the Panel to support the Panel in discharging its responsibilities.
3. Chair and deputy	The jointly appointed Chair of the ICBs will be the Chair of the Panel. Should the Chair be unable to attend all or part of the meeting, then a further non-remunerated Partner Member will be invited to join the Panel's membership and one of the non-remunerated Partner Members will be nominated to deputise for that meeting.
4. Quorum	The Panel will be quorate with a minimum of two members present. If any member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

	If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
5. Decision-making arrangements	Panel members will seek to reach decisions by consensus where possible. Should this not be possible, then a vote of the Panel members will be required, the process for which will be, as follows: a) All members of the Panel who are present at the meeting will be eligible to cast one vote each. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote. b) A decision will be passed if more votes are cast for it than against it. c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the Panel will have a casting vote. Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting. The Panel will take proper account of relevant guidance issued by the Government, the Department of Health and Social Care and NHS England in reaching its determinations.
6. Meeting arrangements	The Panel shall agree the frequency and timing of meetings needed to allow it to discharge its responsibilities. Members of the Panel are expected to attend meetings wherever possible. The Panel may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Panel will apply, including those relating to the quorum (as set out in section 5 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Panel to be open to the public. Secretariat support will be provided to the Panel to ensure its work is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Panel. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
7. Minutes of meetings and	Minutes will be taken at all meetings and presented according to the corporate style.

reporting responsibilities	The minutes will be ratified by agreement of the Panel (this may be performed virtually due to the timings between meetings). The Panel will report in writing to the Boards following each of its meetings in the form of a report from the Chair of the Panel.
8. Conflicts of interest management	In advance of any meeting of the Panel, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Panel will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
9. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the Boards for approval.

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Strategic Commissioning Committee – Terms of Reference

1. Introduction/ Purpose	The Strategic Commissioning Committee ("the Committee") is a joint committee of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB ("the ICBs"), established in accordance with section 65Z5 and 65Z6 of the National Health Service Act 2006 (as amended by the Health and Care Act 2022). The primary purpose of the Committee is to oversee the development and delivery of strategic commissioning plans across the ICBs, focused on improving population health and reducing inequalities. Its duties include guiding transformation programmes, promoting neighbourhood health models, prevention, and digital innovation, scrutinising actions to address health disparities, and determining decision-making frameworks for resource allocation and contract awards. The Committee also oversees primary medical services, market management, public and patient involvement, personalised care, and research strategies. The Boards have authorised the Committee to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee of the ICBs, and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. d) Create sub-committees or task and finish groups to take forward specific duties or programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such sub-committees or task and finish group. Any sub-committee or task and finish group established may consist of or include persons who are not Board members or employees of the ICBs. Individuals appointed as members of any sub-committee or task and finish group that is established to exercise the ICBs' commissioning functions will be subject to approval by the jointly appointed Chair of the ICBs (in line with the membership approval requirements set out in section 3 of these terms of reference).
2. Duties	a) Oversee development of the ICBs' strategic commissioning plans and recommend these for approval by the ICBs' Boards. This will include oversight of arrangements for developing and maintaining an evidence-based understanding of local population health needs, and the use of population health

	management approaches towards the achievement of improved health outcomes and reduced health inequalities. b) Oversee delivery of transformation programmes across ICB commissioned services, in line with the approved strategic commissioning plan. This will include, but is not limited to, specific oversight of: i) Delivery of neighbourhood health models, supporting the required shift from hospital-based care to community settings, making services more accessible in local areas and in people's homes. ii) Delivery of prevention and early intervention priorities, supporting the required shift from sickness to prevention. iii) Delivery of digital transformation, supporting the required shift from traditional analogue systems to digital systems, using new technology to improve efficiency and allowing people to manage their own health more easily. c) Scrutinise the actions being taken to identify and address health inequalities and reduce disparities in health outcomes, informed by the NHS Core20PLUS5 approach. This will include review the ICBs' Annual Health Inequalities Statements, recommending these for approval by the ICBs' Boards. d) Determine the ICBs' joint decision-making framework for resource allocations (investments and disinvestments) and contract awards, to ensure commissioning decisions are evidence-based, strategically aligned with the ICBs' commissioning plans, compliant with relevant statutory duties and affordable, aimed at delivering equitable health outcomes, reduced health inequalities, quality improvement and value for money. e) Oversee resource allocation and contract award decisions made by the Commissioning Executive Group. This will include making decisions on any proposals escalated to the Committee due to their novel, contentious or repercussive nature. f) Oversee the ICBs' joint commissioning arrangements, scrutinising new and existing agreements, whether with local authorities or other ICBs, and seeking assurance regarding the impact delivered. g) Oversee the ICBs' arrangements for shaping and managing the provider market. h) Oversee arrangements for evaluating the impact of commissioned services. i) Oversee the ICBs' arrangements for public and patient involvement, ensuring effective engagement in the development of commissioning plans and policies and the co-production and

	evaluation of services, with a particular focus on underserved communities. j) Oversee arrangements for meeting the ICBs' equality duties as strategic commissioners. k) Oversee the effective discharge of NHS England delegated Primary Medical Services functions, and decision-making arrangements for individual funding requests, mental health and learning disability funding requests, and packages of continuing healthcare and NHS-funded nursing care. l) Oversee personalised care arrangements, including patient choice, shared decision-making, supported self-management and self-care, social prescribing and community-based support, personalised care and support planning, personal health budgets and integrated personal budgets. m) Oversee the development of research strategies and recommend these for approval by the ICBs' Boards; subsequently scrutinising their delivery. n) Review and approve policies specific to the Committee's remit. o) Oversee the identification and management of risks relating to the Committee's remit. p) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
3. Membership	The Committee will have ten members, all of which have been jointly appointed by the ICBs. The Committee's membership is comprised as follows: a) Four Non-Executive Directors. b) Chief Executive. c) Executive Director of Strategy and Citizen Engagement. d) Executive Director of Commissioning. e) Executive Director of Outcomes (Medical). f) Senior leadership representative from the Finance Directorate. g) Senior leadership representative from the Quality (Nursing) Directorate. All individuals appointed as members of the Committee are required to be approved by the jointly appointed Chair of the ICBs due to the Committee's role in exercising the ICBs' commissioning functions. No individual will be approved as a member of the Committee if it is considered that their appointment could reasonably be regarded as undermining the independence of the health service because of their involvement with the private healthcare sector or otherwise. *Attendees*

	The Committee may invite a range of senior managers to attend meetings to support the Committee in discharging its responsibilities. The jointly appointed Chair of the ICBs will also be invited to attend one meeting each year to gain further assurance regarding the effectiveness of the ICBs' governance arrangements.
4. Chair and deputy	The ICBs' Boards will appoint a Non-Executive Director to be Chair of the Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's non-executive membership will be nominated to deputise for that meeting.
5. Quorum	The Committee will be quorate with a minimum of six members, to include two non-executive members and two executive members. To ensure that the quorum can be maintained, the Executive members of the Committee are able nominate a suitable deputy to attend a meeting of the Committee that they are unable to attend to speak and vote on their behalf. All nominated deputies must be approved by the jointly appointed Chair of the ICBs in advance of the meeting (in line with the membership approval requirements set out in section 3 of these terms of reference). Committee members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained. If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
6. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. Should this not be possible, then a vote of the Committee members will be required, the process for which will be, as follows: a) All members of the Committee who are present at the meeting will be eligible to cast one vote each. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote. b) A decision will be passed if more votes are cast for it than against it. c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the Committee will have a casting vote. Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting.

	On occasion, the Committee may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the scheduled meetings of the Committee and in relation to which a decision must be made prior to the next scheduled meeting. The powers that are delegated to the Committee, may for an urgent decision be exercised by the Chair of the Committee and the Chief Executive subject to every effort having been made to consult with as many members of the Committee as possible in the given circumstances. The exercise of such powers by the Chair of the Committee and the Chief Executive will be reported to the next formal meeting of the Committee for formal ratification and to the relevant ICBs' Audit Committees for review of the reasonableness of the decision to use emergency powers.
7. Meeting arrangements	Meetings of the Committee will be scheduled on a monthly basis and the Committee will meet, as a minimum, on a bi-monthly basis. Members of the Committee are expected to attend meetings wherever possible. Meetings of the Committee, other than those regularly scheduled above, shall be summoned by the secretary to the Committee at the request of the Chair. The Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including those relating to the quorum (as set out in section 5 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Committee to be open to the public. Secretariat support will be provided to the Committee to ensure the day-to-day work of the Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
8. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Committee at the following meeting.

9. Conflicts of interest management	In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
10. Reporting responsibilities and review of committee effectiveness	The Committee will provide assurance to the ICBs' Boards that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing an assurance report to the Boards following each of the Committee's meetings; summarising the items discussed, decisions made and any specific areas of concern that warrant immediate Board attention. b) Providing an annual report to the Boards, summarising how the Committee has discharged its duties across the year, key achievements and any identified areas of required Committee development. This report will be informed by the Committee's annual review of its effectiveness. Any items of specific concern, or which require Board approval, will be the subject of a separate report.

11. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the ICBs' Boards for approval.

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Commissioning Executive Group – Terms of Reference

1. Introduction/ Purpose	The Commissioning Executive Group ("the Group") has been established as a sub-committee of the joint Strategic Commissioning Committee established by NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB ("the ICBs"), in accordance with section 65Z5 and 65Z6 of the National Health Service Act 2006 (as amended by the Health and Care Act 2022). In line with the ICBs' duties and powers to commission certain health services, as set out in sections 3 and 3A of the National Health Service Act 2006 (as amended), the Group exists to make commissioning decisions to improve outcomes in population health and healthcare, tackle inequalities in outcomes, experience and access, enhance productivity and value for money, and help the NHS support broader social and economic development. See **schedule 1** attached to these terms of reference for further details of the relevant health services. The remit of the Group also incorporates relevant requirements set out within the Delegation Agreements between NHS England and the ICBs (Primary Medical Services). The Group is authorised to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee of the ICBs, and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.
2. Duties	a) Make resource allocation decisions (regarding investment and disinvestment business cases) in line with the decision-making framework established by the Strategic Commissioning Committee. When making decisions, the Group will ensure compliance with the general duties of ICBs as set out in sections 14Z32 to 14Z45 of the National Health Service Act 2006 (as amended), public sector equality duties, and social value duties. See **schedule 1** attached to these terms of reference for further details of the general duties. b) Make decisions in relation to the award of healthcare and non-healthcare contracts, ensuring compliance with the NHS Provider Selection Regime or Procurement Act 2023. Any decisions that are considered to set precedent, or are novel, contentious or repercussive in nature can be escalated to the Strategic Commissioning Committee.

3. Membership	The Group will have seven members, all of which have been jointly appointed by the ICBs. The Group's membership is comprised as follows: a) Chief Executive b) Executive Director of Commissioning c) Executive Director of Finance d) Executive Director of Outcomes (Medical) e) Executive Director of Quality (Nursing) f) Executive Director of Strategy and Citizen Experience g) Executive Director of Transition All individuals appointed as members of the Group are required to be approved by the jointly appointed Chair of the ICBs due to the Group's role in exercising the ICBs' commissioning functions. No individual will be approved as a member of the Group if it is considered that their appointment could reasonably be regarded as undermining the independence of the health service because of their involvement with the private healthcare sector or otherwise. *Attendees* The Group may invite a range of senior managers to attend meetings to support the Group in discharging its responsibilities.
4. Chair and deputy	The Chief Executive will be the Chair of the Group. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Group's membership will be nominated to deputise for that meeting.
5. Quorum	The Group will be quorate with a minimum of four members present. To ensure that the quorum can be maintained, the Executive members of the Group are able nominate a suitable deputy to attend a meeting of the Group that they are unable to attend to speak and vote on their behalf. All nominated deputies must be approved by the jointly appointed Chair of the ICBs in advance of the meeting. Group members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained. If any Group member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
6. Decision-making arrangements	Group members will seek to reach decisions by consensus where possible. Should this not be possible, then a vote of the Group members will be required, the process for which will be, as follows:

	a) All members of the Group who are present at the meeting will be eligible to cast one vote each. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote. b) A decision will be passed if more votes are cast for it than against it. c) Casting vote – If an equal number of votes are cast for and against a resolution, then the Chair of the Group will have a casting vote. Should a vote be taken, the outcome of the vote, and any dissenting views, will be recorded in the minutes of the meeting. On occasion, the Group may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between the scheduled meetings of the Group and in relation to which a decision must be made prior to the next scheduled meeting. The powers that are delegated to the Group, may for an urgent decision be exercised by the Chief Executive, subject to every effort having been made to consult with as many members of the Group as possible in the given circumstances. The exercise of such powers by the Chief Executive will be reported to the next formal meeting of the Group for formal ratification and to the Audit Committee for review of the reasonableness of the decision to use emergency powers.
7. Meeting arrangements	The Group will meet on a monthly basis and members of the Group are expected to attend meetings wherever possible. Meetings of the Group, other than those regularly scheduled above, shall be summoned by the secretary to the Group at the request of the Chair. The Group may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Group will apply, including those relating to the quorum (as set out in section 5 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Group to be open to the public. Secretariat support will be provided to the Group to ensure the day-to-day work of the Group is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Group. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.

8. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Group at the following meeting.
9. Conflicts of interest management	In advance of any meeting of the Group, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Group meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Group will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Group's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Group's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
10. Reporting responsibilities	The Group is accountable to the Strategic Commissioning Committee and will provide it with assurance regarding the effective discharge of its delegated responsibilities through routine reporting arrangements, summarising matters discussed, decisions made and any specific areas of concern that warrant attention.
11. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the ICBs' Boards for approval.

Schedule 1

Duties of Integrated Care Boards (ICBs) to commission certain health services

ICBs must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the people for whom it has responsibility:

a) Hospital accommodation.

b) Other accommodation for the purpose of any service provided under the NHS Act 2006 (as amended).

c) Medical services other than primary medical services.

d) Dental services other than primary dental services.

e) Ophthalmic services other than primary ophthalmic services.

f) Nursing and ambulance services.

g) Such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as the ICB considers are appropriate as part of the health service.

h) Such other services or facilities for palliative care as the ICB considers are appropriate as part of the health service.

i) Such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as the ICB considers are appropriate as part of the health service.

j) Such other services or facilities as are required for the diagnosis and treatment of illness.

Note: ICBs' duties to arrange for the provision of services or facilities does not apply to the extent that NHS England has a duty to arrange for their provision, or another ICB has a duty to arrange for their provision.

Power of Integrated Care Boards to commission certain services

ICBs may arrange for the provision of such services or facilities as it considers appropriate for the purposes of the health service that relate to securing improvement:

a) In the physical and mental health of the people for whom it has responsibility.

b) In the prevention, diagnosis and treatment of illness in those people.

Note: ICBs may not arrange for the provision of a service or facility if NHS England has a duty to arrange for its provision.

General duties of Integrated Care Boards

a) Duty to promote NHS Constitution (section 14Z32)

b) Duty as to effectiveness, efficiency and economy (section 14Z33)

c) Duty as to improvement in quality of services (section 14Z34)

d) Duties as to reducing inequalities (section 14Z35)

e) Duty to promote involvement of each patient (section 14Z36)

f) Duty as to patient choice (section 14Z37)

g) Duty to obtain appropriate advice (section 14Z38)

h) Duty to promote innovation (section 14Z39)

i) Duty in respect of research (section 14Z40)

j) Duty to promote education and training (section 14Z41)

k) Duty to promote integration (section 14Z42)

l) Duty to have regard to wider effect of decisions (section 14Z43)

m) Duties as to climate change (section 14Z44)

n) Public involvement and consultation by ICBs (section 14Z45)

Quality and Service Improvement Committee – Terms of Reference

1. Introduction/ purpose	The Quality and Service Improvement Committee ("the Committee") is a joint committee of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB ("the ICBs"), established in accordance with section 65Z5 and 65Z6 of the National Health Service Act 2006 (as amended by the Health and Care Act 2022). The main purpose of the Committee is to ensure the ICBs meet their statutory requirements with regard to continuous quality and service improvements and enabling a single understanding of and shared commitment to quality care across the system that is safe, effective, equitable, and that provides a personalised experience and improved outcomes with reduced health disparities. The remit of the Committee incorporates the relevant requirements set out within the Delegation Agreements between NHS England and the ICBs (Primary Medical Services), insofar as they relate to quality improvement. The Boards have authorised the Committee to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee of the ICBs, and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. d) Create sub-committees or task and finish groups to take forward specific duties or programmes of work as considered necessary by the Committee's membership. The Committee shall determine the membership and terms of reference of any such sub-committees or task and finish group. Any sub-committee or task and finish group established may consist of or include persons who are not Board members or employees of the ICBs.
2. Duties	a) Oversee the development of the ICBs' quality strategies and quality improvement priorities and plans, ensuring these are reflective of local quality challenges and focused on reducing inequalities in the quality of care, and recommend these for approval by the ICBs' Boards; subsequently scrutinising their delivery. b) Scrutinise arrangements for monitoring the quality of commissioned services, in line with contractual requirements and the NHS Oversight Framework. c) Oversee arrangements for learning and continuous improvement, including the management of patient safety

	incidents, mortality reviews, complaints, service user feedback and shared learning, to drive a culture of improvement and safety across commissioned services. d) Oversee care pathway optimisation arrangements, ensuring that pathways are designed for integrated, prevention-oriented and digitally enabled care, reducing unwarranted variation. e) Scrutinise arrangements for safeguarding vulnerable adults and children in line with the ICBs' statutory responsibilities. f) Scrutinise arrangements for ensuring the safe and effective management of medicines. g) Oversee the development and delivery of vaccination and immunisation programmes, ensuring equitable access and uptake across all population groups, with a particular focus on addressing health inequalities and supporting prevention at neighbourhood and system levels. h) Scrutinise health protection arrangements, including infection prevention and control and partnership arrangements to respond to public health incidents and outbreaks. i) Scrutinise arrangements for strategic workforce matters. j) Oversee arrangements for clinical and care professional leadership and engagement, ensuring that multi-professional voices inform decision-making, quality improvement, and service transformation. k) Review and approve policies specific to the Committee's remit. l) Oversee the identification and management of risks relating to the Committee's remit. m) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
3. Membership	The Committee will have eight members, all of which have been jointly appointed by the ICBs. The Committee's membership is comprised as follows: a) Three Non-Executive Directors. b) Executive Director of Quality (Nursing). c) Executive Director of Outcomes (Medical). d) Executive Director of Strategy and Citizen Experience. e) Senior leadership representative from the Commissioning Directorate. f) Senior leadership representative from the Finance Directorate. *Attendees* The Committee may invite a range of senior managers to attend meetings to support the Committee in discharging its responsibilities.

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

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

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

Issue date:	Status:	Version:	Review date:
November 2025	Draft	0.1	March 2026

Finance and Performance Committee – Terms of Reference

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

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

3. Membership	The Committee will have eight members, all of which have been jointly appointed by the ICBs. The Committee's membership is comprised as follows: a) Three Non-Executive Directors. b) Executive Director of Finance. c) Executive Director of Commissioning. d) Executive Director of Quality (Nursing). e) Senior leadership representative from the Outcomes (Medical) Directorate. f) Senior leadership representative from the Strategy and Citizen Experience Directorate. *Attendees* The Committee may invite a range of senior managers to attend meetings to support the Committee in discharging its responsibilities. The jointly appointed Chair of the ICBs will also be invited to attend one meeting each year to gain further assurance regarding the effectiveness of the ICBs' governance arrangements.
4. Chair and deputy	The ICBs' Boards will appoint a Non-Executive Director to be Chair of the Committee. In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's non-executive membership will be nominated to deputise for that meeting.
5. Quorum	The Committee will be quorate with a minimum of five members, to include at least one non-executive member and one executive member. To ensure that the quorum can be maintained, the Executive members of the Committee are able nominate a suitable deputy to attend a meeting of the Committee that they are unable to attend to speak and vote on their behalf. Committee members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained. If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
6. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. If a consensus agreement cannot be reached, then the item will be escalated to the ICBs' Boards for a decision.

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

	The Chair of the Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
10. Reporting responsibilities and review of committee effectiveness	The Committee will provide assurance to the ICBs' Boards that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing an assurance report to the Boards following each of the Committee's meetings; summarising the items discussed, decisions made and any specific areas of concern that warrant immediate Board attention. b) Providing an annual report to the Boards, summarising how the Committee has discharged its duties across the year, key achievements and any identified areas of required Committee development. This report will be informed by the Committee's annual review of its effectiveness. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
11. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the ICBs' Boards for approval.

Issue date:	Status:	Version:	Review date:
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Transition Committee – Terms of Reference

1. Introduction/ Purpose	The Transition Committee ("the Committee") is a joint committee of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB ("the ICBs"), established in accordance with section 65Z5 and 65Z6 of the National Health Service Act 2006 (as amended by the Health and Care Act 2022). The primary purpose of the Committee is to oversee and scrutinise arrangements for the transition of the ICBs into their future operating model, in line with national guidance. Due to the nature of the Committee's role, it will be time-limited in its establishment, with the ICBs' Boards determining the appropriate timeframe for the Committee to be dis-established. The Committee is authorised to: a) Investigate any activity within its terms of reference. b) Seek any information it requires from any employee of the ICBs, and all employees are directed to co-operate with any request made by the Committee. c) Obtain outside legal or other independent advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.
2. Duties	a) Oversee the establishment and maintenance of robust programme management arrangements to deliver ICB transition requirements within the prescribed timeframe. b) Oversee the development and implementation of a fit for purpose ICB operating model. This will include ensuring that the proposed new model: i) Is designed to effectively deliver revised ICB functions and responsibilities, in line with the Model ICB Blueprint and any applicable guidance published from time to time, based on a robust 'make, buy, share' assessment across relevant geographies, taking account of the future abolition of Commissioning Support Units. ii) Delivers required efficiencies and is affordable within the management cost allocation for the ICBs. iii) Enables compliance with applicable legal duties. iv) Is developed taking into account the feedback from the combined workforce of the ICBs, as appropriate. c) Oversee the development and implementation of fair and transparent exit and workforce change processes for ICB staff, in line with national guidance and local policy requirements (including those relating to equality legislation), working in conjunction with the Remuneration and Human Resource Committee, as appropriate. This will include oversight of

	appropriate training and development and health and wellbeing initiatives for ICB staff to ensure they are well supported throughout the transition process. d) Oversee the establishment of effective governance arrangements to support the period of transition the new ICB operating model, and to ensure its ongoing effectiveness. e) Oversee the delivery of timely, open, and transparent staff and stakeholder communications throughout the transition process. f) Oversee arrangements for the safe transition of any ICB functions identified for transfer elsewhere within the NHS infrastructure. g) Oversee arrangements for the ICBs' capability assessment in line with the new Strategic Commissioning Framework, working in conjunction with the Strategic Commissioning Committee, as appropriate. h) Oversee any potentially required preparations for ICB merger and/or boundary changes in line with national guidance, working in conjunction with the Audit Committees, as appropriate i) Oversee the identification and management of risks relating to the Committee's remit. j) Monitor the quality of data that informs the work of the Committee; this includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.
3. Membership	The Committee will have six members, all of which have been jointly appointed by the ICBs. The Committee's membership is comprised as follows: a) Three Non-Executive Directors. b) Chief Executive. c) Executive Director of Transition. d) Executive Director of Finance. *Attendees* The Committee may invite a range of senior managers to attend meetings to support the Committee in discharging its responsibilities. This will include the Senior Responsible Officers leading the Transition Programme Workstreams. The jointly appointed Chair of the ICBs will also be invited to attend one meeting each year to gain further assurance regarding the effectiveness of the ICBs' governance arrangements.
4. Chair and deputy	The ICBs' Boards will appoint a Non-Executive Director to be Chair of the Committee.

	In the event of the Chair being unable to attend all or part of the meeting, a replacement from within the Committee's non-executive membership will be nominated to deputise for that meeting.
5. Quorum	The Committee will be quorate with a minimum of four members, to include at least one non-executive member and one executive member. To ensure that the quorum can be maintained, the executive members of the Committee are able nominate a suitable deputy to attend a meeting of the Committee that they are unable to attend to speak and vote on their behalf. Committee members are responsible for fully briefing their nominated deputies and for informing the secretariat so that the quorum can be maintained. If any Committee member has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.
6. Decision-making arrangements	Committee members will seek to reach decisions by consensus where possible. If a consensus agreement cannot be reached, then the item will be escalated to the ICBs' Boards for a decision.
7. Meeting arrangements	Meetings of the Committee will be scheduled on a monthly basis and the Committee will meet no less than ten times per year. Members of the Committee are expected to attend meetings wherever possible. Meetings of the Committee, other than those regularly scheduled above, shall be summoned by the secretary to the Committee at the request of the Chair. The Committee may meet virtually using telephone, video and other electronic means. Where a virtual meeting is convened, the usual process for meetings of the Committee will apply, including those relating to the quorum (as set out in section 5 of these terms of reference). Virtual attendance at in-person meetings will be permitted at the discretion of the Chair. There is no requirement for meetings of the Committee to be open to the public. Secretariat support will be provided to the Committee to ensure the day-to-day work of the Committee is proceeding satisfactorily. Agendas and supporting papers will be circulated no later than five calendar days in advance of meetings and will be distributed by the secretary to the Committee. Any items to be placed on the agenda are to be sent to the secretary no later than seven calendar days in advance of the

	meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Agendas will be agreed with the Chair prior to the meeting.
8. Minutes of meetings	Minutes will be taken at all meetings and presented according to the corporate style. The minutes will be ratified by agreement of the Committee at the following meeting.
9. Conflicts of interest management	In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals. At the beginning of each Committee meeting, members and attendees will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declarations will be formally recorded in the minutes for the meeting. The Chair of the Committee will determine how declared interests should be managed, which is likely to involve one the following actions: a) Requiring the conflicted individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements. b) Allowing the conflicted individual to participate in the discussion, but not the decision-making process. c) Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements and where there is a clear benefit to the conflicted individual being included in both. d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.
10. Reporting responsibilities	The Committee will provide assurance to the ICBs' Boards that it is effectively discharging its delegated responsibilities, as set out in these terms of reference, by: a) Providing an assurance report to the Boards following each of the Committee's meetings; summarising the items discussed, decisions made and any specific areas of concern that warrant immediate Board attention. b) Providing an annual report to the Boards, summarising how the Committee has discharged its duties across the year, key

	achievements and any identified areas of required Committee development. This report will be informed by the Committee's annual review of its effectiveness. Any items of specific concern, or which require Board approval, will be the subject of a separate report.
11. Review of terms of reference	These terms of reference will be formally reviewed on an annual basis but may be amended at any time in order to adapt to any national guidance as and when issued. Any proposed amendments to the terms of reference will be submitted to the ICBs' Boards for approval.

Issue date:	Status:	Version:	Review date:
November 2025	Draft	0.1	March 2026

Appendix D: Proposed joint strategic risks for development of joint Board Assurance Framework

Risk No.	Strategic Risk Narrative	Executive Owner(s)
Risk 1	**Failure to develop and maintain a comprehensive, evidence-based understanding of local population health needs** (Risk that the ICBs do not use joined-up, person-level data and intelligence to identify current and future needs, drivers of risk, and underserved communities, leading to ineffective or inequitable commissioning decisions)	Director of Commissioning
Risk 2	**Failure to set and deliver a long-term, outcomes-focused commissioning strategy** (Risk that the ICBs do not establish a robust, evidence-based commissioning strategies and plans, or implement these using effective commissioning approaches, resulting in missed opportunities to improve health outcomes, reduce inequalities, and deliver system priorities)	Director of Strategy and Citizen Experience Director of Commissioning
Risk 3	**Failure to shift the system focus from sickness to prevention** (Risk that the ICBs do not prioritise or invest sufficiently in preventative approaches, resulting in continued high demand for reactive care, missed opportunities to improve population health, and inability to reduce long-term system pressures and health inequalities)	Director of Outcomes (Medical)
Risk 4	**Failure to transform care delivery from hospital to community settings** (Risk that the ICBs do not redesign pathways or commission integrated, community-based services, leading to over-reliance on hospital care, poor patient experience, and failure to deliver care closer to home or address the needs of people with long-term conditions)	Director of Commissioning Director of Strategy and Citizen Experience
Risk 5	**Failure to drive digital transformation and harness technology** (Risk that the ICB does not adopt or embed digital solutions, resulting in inefficiencies, limited access to innovation, and inability to improve outcomes, patient experience, or system productivity in line with national expectations)	Director of Finance
Risk 6	**Failure to involve people and communities meaningfully in commissioning and service design** (Risk that the ICBs do not systematically co-produce solutions with service users, carers, and communities, leading to services that do not meet local needs or legal requirements for engagement)	Director of Strategy and Citizen Experience

Risk No.	Strategic Risk Narrative	Executive Owner(s)
Risk 7	**Failure to allocate resources effectively and manage provider markets to achieve best value, increased productivity, and deliver financial sustainability** (Risk that the ICBs do not align funding to needs, shape provider markets, or use contracting and procurement mechanisms effectively, leading to poor value for money, inefficiencies, or inability to meet national and local priorities)	Director of Finance
Risk 8	**Failure to evaluate and respond to the impact of commissioned services** (Risk that the ICBs do not rigorously evaluate the outcomes of commissioned services, resulting in an inability to improve health outcomes and reduce health inequalities)	Director of Outcomes (Medical)
Risk 9	**Failure to systematically improve the quality of healthcare services** (Risk that the ICBs do not rigorously monitor, evaluate, and adapt services, resulting in persistent gaps in quality and safety and an inability to identify and act promptly on emerging quality concerns)	Director of Quality (Nursing)
Risk 10	**Failure to ensure timely and equitable access to healthcare services in line with national and local performance standards** (Risk that the ICBs do not rigorously monitor, evaluate, and adapt services, resulting in persistent non-delivery of access targets)	Director of Commissioning
Risk 11	**Failure to develop and deploy an effective ICB cluster operating model with the necessary workforce skills and capabilities for strategic commissioning** (Risk that the ICBs do not build or maintain the strategic commissioning skills required, while supporting the wellbeing of the ICBs' combined workforce, limiting their ability to deliver strategic commissioning effectively)	Director of Transition
Risk 12	**Failure to maintain cyber resilience** (Risk that the ICBs do not establish robust cyber security arrangements, which could compromise delivery of core functions and disrupt access to critical data and systems)	Director of Outcomes (Medical)/SIRO Director of Finance

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Standing Financial Instructions

Version	Effective Date	Changes
To be inserted	To be inserted	To be inserted

Contents

1. Introduction

1.1 General

1.1.1 These Standing Financial Instructions are part of the ICB's control environment for managing the organisation's financial affairs. They contribute to good corporate governance, internal control and managing risks. They enable sound administration; lessen the risk of irregularities, and support commissioning and delivery of effective, efficient and economical services. They also help the Chief Executive (as the ICB's Accountable Officer) and Executive Director of Finance to effectively perform their responsibilities. They should be used in conjunction with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation.

1.1.2 These Standing Financial Instructions identify the financial responsibilities which apply to members of the ICB's Board, its committees and sub-committees, and the ICB's employees and other workers. It is a duty of the Chief Executive to ensure that these individuals are notified of, and put in a position to understand, their responsibilities within these Standing Financial Instructions.

1.1.3 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions, then the advice of the Executive Director of Finance must be sought before acting.

1.2 Non-compliance with Standing Financial Instructions

1.2.1 Failure to comply with these Standing Financial Instructions may be regarded as a disciplinary matter that could result in dismissal.

1.2.2 If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All individuals as defined at SFI 1.1.2 have a duty to disclose any non-compliance with these Standing Financial Instructions to the Executive Director of Finance as soon as possible. If the Executive Director of Finance is responsible for the non-compliance, then this should instead be reported to the Chief Executive.

1.3 Review and amendment of Standing Financial Instructions

1.3.1 To ensure that these Standing Financial Instructions remain up-to-date and relevant, the Executive Director of Finance will review them at least annually, reporting the outcome of the review to the Audit Committee.

1.3.2 Following consultation with the Chief Executive and scrutiny by the Audit Committee, the Executive Director of Finance will recommend amendments, as necessary, to the Board for approval.

2. Roles and responsibilities

2.1 The Board

2.1.1 The Board exercises financial supervision and control by:

(a) Setting financial plans and budgets to meet its statutory responsibilities.

(b) Holding the executive to account for monitoring performance against core financial objectives.

(c) Setting these Standing Financial Instructions and defining specific responsibilities placed on members of the Board and other individuals as indicated in the Scheme of Reservation and Delegation.

(d) Establishing an Audit Committee to provide it with proactive support by:

(i) Advising on the effectiveness of risk management arrangements and systems of internal control.

(ii) Advising on the process for reviewing the accounts prior to submission for audit, management's letter of representation to the external auditors; and the planned activity and results of both internal and external audit.

(iii) Approving the accounting policies, the accounts, and the annual report of the ICB, including the governance statement.

(e) Establishing a Finance and Performance Committee to provide oversight and assurance on the discharge of the ICB's financial duties.

2.2 The Chief Executive

2.2.1 The Chief Executive (as Accountable Officer) is ultimately accountable to the Board and to the Secretary of State for Health and Social Care for ensuring that the ICB meets its obligation to perform its functions within the available financial resources.

2.2.2 The Chief Executive has overall executive responsibility for the ICB's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met; and has overall responsibility for the ICB's system of internal control.

2.3 The Executive Director of Finance

2.3.1 The Executive Director of Finance is responsible for ensuring that the ICB meets the financial targets set for it by NHS England, including living within the overall revenue and capital allocation, and the running costs limit.

2.3.2 Jointly with the ICB's NHS Trust and NHS Foundation Trust partners, the Executive Director of Finance has responsibility for ensuring that any joint financial objectives set by NHS England are achieved.

2.3.3 The Executive Director of Finance is also responsible for maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these Standing Financial Instructions.

2.4 Staff and individuals working on behalf of the ICB

2.4.1 All staff employed by the ICB and individuals working on behalf of the ICB are responsible for:

(a) Abiding by all conditions of any delegated authority.

(b) Ensuring integrity, accuracy, probity and value for money in the use of resources.

(c) The security of the ICB's property and avoiding all forms of loss.

(d) Conforming to the requirements of these SFIs.

2.5 Delegation and accountability

2.5.1 The Chief Executive and Executive Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

3. Internal and external audit

3.1 Internal audit

3.1.1 Internal audit is an independent and objective appraisal service within an organisation, which provides:

(a) An independent and objective opinion to the Chief Executive, the Board, and the Audit Committee on the degree to which risk management, control and governance, support the achievement of the organisation's agreed objectives.

(b) An independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

3.1.2 The Chief Executive, as the accountable officer, is responsible for ensuring there is appropriate internal audit provision for the ICB. For operational purposes, this responsibility is delegated to the Executive Director of Finance. All internal audit services are provided under arrangements proposed by the Executive Director of Finance and approved by the Audit Committee, on behalf of the Board.

3.1.3 Only the Executive Director of Finance may commission the procurement of internal audit services, having sought the approval of the Audit Committee.

3.1.4 The Executive Director of Finance is responsible for ensuring that the internal audit function complies with the Public Sector Internal Audit Standards and provides sufficient independent and objective assurance to the Audit Committee and the Chief Executive.

3.1.5 Internal audit will review, appraise and report upon policies, procedures and operations in place to:

(a) Establish and monitor the achievement of the organisation's objectives.

(b) Identify, assess and manage the risks to achieving the organisation's objectives.

(c) Ensure the economical, effective and efficient use of resources.

(d) Ensure compliance with established policies (including behavioural and ethical expectations), procedures, laws and regulations.

(e) Safeguard the organisation's assets and interests from losses of all kinds, including those arising from fraud, irregularity or corruption.

(f) Ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes.

3.1.6 The Head of Internal Audit will provide to the Audit Committee:

(a) A risk-based plan of internal audit work, agreed with management and approved by the Audit Committee, which will enable the internal auditors to collect sufficient evidence to give an opinion on the adequacy and effective operation of the organisation.

(b) Regular updates on the progress against plan.

(c) Reports of management's progress on the implementation of action agreed as a result of internal audit findings.

(d) An annual opinion based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). The Chief Executive uses this opinion to inform their annual Governance Statement and by NHS England as part of its performance management role.

(e) Additional reports as requested by the Audit Committee.

3.1.7 Whenever any matter arises during the course of internal audit work, which involves, or is thought to involve, irregularities in the exercise of any function of a pecuniary nature, the Executive Director of Finance must be notified immediately. If the Executive Director of Finance is thought to be involved in an irregularity, then this should instead be reported to the Chief Executive.

3.1.8 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to the Chair of the Audit Committee and the ICB Chair and Chief Executive.

3.1.9 The Head of Internal Audit reports to the Audit Committee and is accountable to the Executive Director of Finance. The reporting system for internal audit will be agreed between the Executive Director of Finance, the Audit Committee and the Head of Internal Audit and will comply with the guidance on reporting contained in the Public Sector Internal Audit Standards.

3.2 External audit

3.2.1 The ICB must comply with the Local Audit and Accountability Act 2014 when procuring an external audit service. The Executive Director of Finance is responsible for ensuring that the ICB procures external audit services in accordance with this legislation and relevant national guidance.

3.2.2 The Board is ultimately responsible for appointing the ICB's external auditor, but it will establish an Auditor Panel to advise on the selection and appointment process.

3.2.3 The Auditor Panel will:

(a) Provide assurance that procurement and contracting arrangements are appropriate and that any conflicts of interests have been effectively dealt with.

(b) Consider how the quality of the external audit service will be measured and monitored, and how that will be incorporated in the service requirements.

(c) Advise on an appropriate length of contract, noting that the ICB must appoint an external auditor at least once every five years.

(d) Advise on the maintenance of an independent relationship with the appointed external auditor.

3.2.4 The ICB must appoint an external auditor to audit its accounts for a financial year not later than 31 December in the preceding financial year

3.2.5 Within 28 days of an appointment being made, the ICB must publish a notice to name its external auditor and the length of the appointment.

3.2.6 The statutory responsibilities and powers of appointed auditors are set out in the Local Audit and Accountability Act 2014. The main responsibility of the ICB's appointed auditors is to meet the requirements of the National Audit Office's Code of Audit Practice.

3.2.7 The external auditors are required to provide an opinion on the ICB's financial statements. This confirms whether the Auditors believe the financial statements give a true and fair view of the financial affairs of the ICB and the income and expenditure recorded during the year.

3.2.8 The External Auditors are also required to:

(a) Form a view on the regularity of the ICB's income and expenditure i.e. that the expenditure and income included in the ICB's financial statements has been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

(b) Report by exception if the ICB has not complied with the requirements of NHS England in the preparation of its Governance Statement.

(c) Examine and report on the consistency of the schedules or returns prepared by the ICB for consolidation into the Whole of Government Accounts.

3.2.9 The External Auditors will also consider the arrangements in place for securing economy, efficiency and effectiveness (value for money) in the ICB's use of resources.

3.2.10 The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the external auditor these should be raised with the external auditor and referred to the Audit Committee if they cannot be resolved.

3.2.11 The External Auditor will normally attend Audit Committee meetings and has a right of access to the Chair of the Audit Committee and the ICB Chair and Chief Executive.

4. Fraud, bribery and corruption (economic crime)

4.1 General

4.1.1 The ICB is committed to identifying, investigating and preventing economic crime.

4.1.2 The Executive Director of Finance is responsible for ensuring appropriate arrangements are in place to provide adequate counter fraud provision which should include reporting requirements to the Audit Committee. These arrangements should comply with the NHS Requirements the Government Functional Standard 013 Counter Fraud as issued by NHS Counter Fraud Authority and any guidance issued by NHS England.

4.1.3 Only the Executive Director of Finance may commission the procurement of counter fraud, bribery and corruption services, having sought the approval of the Audit Committee.

4.1.4 All members of the ICB's Board, its committees and sub-committees, and the ICB's employees and other workers, severally and collectively, are responsible for ensuring ICB resources are appropriately protected from fraud, bribery and corruption.

4.1.5 Any individual that has evidence of, or reason to suspect, fraud, bribery or corruption has a duty to report these suspicions to the ICB's nominated Counter Fraud Specialist or via the NHS Counter Fraud Authority's confidential fraud, bribery and corruption reporting line.

4.1.6 Under no circumstances should any individual commence an investigation into suspected or alleged crime, as this may compromise any further investigation.

4.1.7 The ICB's policy on fraud, bribery and corruption sets out arrangements for eliminating fraud, bribery and corruption and provides a framework for responding to suspicions of fraud.

5. Resource limits and allocations, financial planning, budgetary control and grants

5.1 Funding allocations and resource limits

5.1.1 NHS England will make funding allocations to the ICB to support the delivery of its functions. Allocations will be based on a national needs-based formula and national policy on target allocations, which reflects the 'fair share' of NHS resources for the ICB. Allocations will:

(a) Include funding for acute, ambulance, community and mental health services.

(b) Include funding for the delivery of any functions delegated to the ICB by NHS England.

(c) Include a running cost allowance to cover management costs and costs of commissioning support.

5.1.2 The Executive Director of Finance will:

(a) Periodically review the basis and assumptions used by NHS England for distributing allocations to the ICB and ensure that these are reasonable and realistic and secure the ICB's entitlement to funds.

(b) Regularly update the Board on significant changes to any initial allocations and the uses of such funds.

5.1.3 The Chief Executive has overall responsibility for ensuring that the ICB complies with its statutory obligations, including its financial and accounting obligations, and that it exercises its functions effectively, efficiently and economically and in a way which provides good value for money.

5.1.4 The Executive Director of Finance is responsible for ensuring appropriate arrangements are in place to enable the ICB to meet the following statutory financial duties:

(a) Ensuring that the ICB's expenditure in each financial year does not exceed the aggregate of any sums received within that financial year, and that the ICB complies with any descriptions set out by NHS England of income and expenditure that should or should not be counted for the purposes of reaching financial balance, or the financial year in which they are to be counted.

(b) Ensuring that monies designated for integration are used for that purpose (e.g. Better Care Fund).

(c) Ensuring that the ICB exercises its functions with a view to ensuring that, in respect of each financial year:

(i) Local capital resource use does not exceed the limit specified in a direction by NHS England.

(ii) Local revenue resource use does not exceed the limit specified in a direction by NHS England.

(iii) Any joint financial objectives set by NHS England for the ICB and its partner NHS trusts and NHS foundation trusts are achieved.

5.2 Preparation and approval of financial plans

5.2.1 Before the start of each financial year, the ICB will produce financial plans in line with any directions or guidance issued by NHS England.

5.2.2 The financial plans, which will include any productivity and efficiency requirements, will be approved by the Board and must be published.

5.2.3 The plans can be revised, subject to approval by the Board. Any revised plans must be published.

5.2.4 The Executive Director of Finance will provide regular reports to the Board and the Finance and Performance Committee regarding delivery of the plans.

5.3 Preparation and approval of budgets

5.3.1 Before the start of each financial year, the Executive Director of Finance will, on behalf of the Chief Executive, prepare and submit annual budgets for approval by the Board. The annual budgets will be prepared within the limits of available funds and will identify any sums to be held in reserve and any potential risks.

5.4 Budgetary delegation

5.4.1 The Chief Executive may delegate the management of individual budgets to designated Budget Holders to enable the delivery of a defined range of activities.

5.4.2 Budget Holders may onward delegate the management of budgets within their areas of responsibility to designated Budget Managers.

5.4.3 A list of Budget Holder and Budget Manager designations is maintained by the ICB's Finance Directorate.

5.4.4 All Budget Holders and Budget Managers will be required to agree their allocated budgets at the commencement of each financial year.

5.4.5 The Executive Director of Finance is responsible for ensuring that adequate training is delivered to Budget Holders and Budget Managers to support the successful management of their budgets.

5.5 Budgetary control and reporting

5.5.1 The Executive Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) The issue of timely, accurate and comprehensible advice and financial reports to each Budget Holder and Budget Manager, covering the areas for which they are responsible.

(b) Investigation and reporting of variances from budgets and monitoring of management action to correct variances.

(c) Arrangements for the approval of budget virements.

(d) Regular budgetary reports to the Board and the Finance and Performance Committee detailing:

(i) Income and expenditure, showing the year to date actual and forecast positions.

(ii) Explanations of any material variances from budget.

(iii) Details of any corrective action where necessary and whether such actions are sufficient to correct the variance.

5.5.2 Each Budget Holder and Budget Manager is responsible for ensuring that:

(a) Any likely overspend or reduction of income which cannot be met by virement is not incurred without the prior consent of the Executive Director of Finance or nominated officer.

(b) They review their budget reports on a monthly basis and report any anomalies.

(c) The amount provided in the agreed budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement.

5.5.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.5.4 Non-recurring budgets should not be used to finance recurring expenditure without approval from the Chief Executive or Executive Director of Finance.

5.6 Capital expenditure

5.6.1 The general rules applying to budget preparation, delegation, control and reporting will also apply to capital expenditure.

5.7 Joint finance arrangements

5.7.1 Payments to local authorities or other specified bodies made under sections 75, 256 and 257 of the NHS Act 2006 shall comply with procedures established by the Executive Director of Finance, which shall be in accordance with the Act.

5.8 Grants

5.8.1 The Executive Director of Finance is responsible for providing robust management, governance and assurance to the ICB with regards to the use of specific powers under which it can make capital or revenue grants available to:

(a) Any of its partner NHS trusts or NHS foundation trusts.

(b) A voluntary organisation, by way of a grant or loan.

5.8.2 All revenue grant applications should be regarded as competed as a default position unless there are justifiable reasons why the classification should be amended to non-competed.

6. Banking arrangements and cash management

6.1 General

6.1.1 The Executive Director of Finance will approve the ICB's banking arrangements and is responsible for advising the Audit Committee on the provision of banking services and operation of accounts, including the provision and use of procurement or other card services. This advice will consider any guidance and/or directions issued by NHS England on the use of specified banking facilities for any specified purposes.

6.1.2 The ICB will use the Government Banking Service as its supplier for all banking services.

6.1.3 The ICB will hold the minimum number of bank accounts required to run the organisation effectively.

6.1.4 The Executive Director of Finance will report any new bank accounts or changes to existing bank accounts to the next meeting of the Audit Committee.

6.1.5 The Executive Director of Finance will approve all designated bank account signatories, and a list of approved signatories will be maintained by the ICB's Finance Directorate.

6.1.6 The Executive Director of Finance will ensure that the ICB has effective cash management procedures in place. This will include:

(a) Ensuring money drawn from NHS England against cash forecasts is required for approved expenditure only, and is drawn only at the time of need, following best practice as set out in Managing Public Money.

(b) Ensuring payments made from the ICB's bank accounts do not exceed the amount credited to the account except where arrangements have been made.

(c) Reporting to the Audit Committee all arrangements made with the ICB's bankers for accounts to be overdrawn.

(d) Monitoring of compliance with NHS England guidance on the level of funds held at the end of each month.

6.2 Procurement and other card services

6.2.1 The Executive Director of Finance is responsible for recommending to the Audit Committee, for approval:

(a) Whether procurement or other card services should be allowed.

(b) The types of card services that should be allowed on each account (debit, procurement, etc.).

(c) The types of transactions that should be permitted on each card.

(d) The individuals who should be issued with a card.

(e) The overall credit and individual transaction limits to be associated with each card.

6.2.2 The Executive Director of Finance will report on the actual use of card services against authorised uses to the Audit Committee.

6.3 Payable orders, petty cash and other negotiable instruments

6.3.1 The Executive Director of Finance is responsible for prescribing systems and procedures for the secure handling of payable orders, petty cash and other negotiable instruments should these be used or received by the ICB.

7. Income and debt recovery

7.1 Income

7.1.1 The ICB will utilise its relevant statutory powers to maximise its potential to make additional income available for improving the health service only to the extent that it does not interfere with the performance of the ICB or its functions.

7.1.2 The Executive Director of Finance is responsible for ensuring systems are in place for the proper recording, invoicing, and collection and coding of all monies due.

7.1.3 All employees and other workers must inform the Finance Team, in accordance with notified procedures, promptly of money due arising from transactions that they initiate/deal with, including all contracts, leases, tenancy agreements and other transactions.

7.1.4 The Executive Director of Finance will arrange to register with HM Revenue and Customs if required under money laundering legislation.

7.2 Debt management

7.2.1 The Executive Director of Finance is responsible for ensuring systems are in place for the timely recovery of all outstanding debts. This will include:

(a) Ensuring that arrangements cover end-to-end debt management from debt creation to collection or write-off in accordance with the losses and special payment procedures.

(b) Assigning responsibility to a senior officer within the Finance Team for the operational management of debt.

(c) Reporting to the Audit Committee that debt is being managed effectively.

7.2.2 Where it is necessary to use the services of a professional debt recovery agency and/or the courts to recover an outstanding debt, the ICB will seek to recover the associated costs from the debtor concerned.

7.2.3 Income not received should be dealt with in accordance with losses procedures.

7.2.4 Overpayments should be detected (or preferably prevented) and recovery initiated.

8. Terms of service and payment of senior managers and employees

8.1 Board and very senior manager remuneration and terms of service

8.1.1 The Board has established a Remuneration and Human Resource Committee to determine the remuneration and allowances for:

(a) Members of the Board, except for the Chair and non-executive members.

(b) Any members of the Board's committees and sub-committees that are not members of the Board or employees.

(c) Other very senior managers.

8.1.2 The Board has established a Non-Executive Director Remuneration Panel to determine the remuneration and allowances for non-executive members of the Board.

8.1.3 The Remuneration and Human Resource Committee and Non-Executive Director Remuneration Panel have clearly defined terms of reference approved by the Board, specifying which roles fall within their areas of responsibility.

8.1.4 Remuneration and allowances for the ICB's Chair are determined by NHS England.

8.2 Funded establishment

8.2.1 The workforce plan incorporated within the annual budget will form the funded establishment.

8.2.2 The funded establishment of any Directorate may not be varied without the approval of the relevant Budget Holder.

8.3 Staff appointments and contracts of employment

8.3.1 No Executive Director or employee may appoint employees, either on a permanent or temporary basis, or agree to changes to any aspect of remuneration, unless within the limit of their approved budget and funded establishment.

8.3.2 The NHS Agenda for Change terms and conditions of service will apply in full to all staff directly employed by the ICB, except for Executive Directors and other very senior managers.

8.3.3 All employees will be issued with contracts of employment in a form and timeframe that complies with employment legislation.

8.3.4 All requests for evaluations of pay bandings for new or existing posts must be approved by the relevant Budget Holder.

8.4 Processing of payroll

8.4.1 The Executive Director of Finance is responsible for ensuring appropriate arrangements are established for:

(a) Submission of properly authorised payroll records and notifications in line with agreed timetables.

(b) Making payments on agreed dates and agreeing methods of payments.

(c) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay.

(d) Checks to be applied to completed payroll before and after payment.

(e) Procedures for the recall of bank credits.

(f) Pay advances and their recovery.

(g) Recovery of overpayments or sums of money owed by employees or individuals leaving the employment of the ICB.

8.4.2 Officers authorised to approve payroll transactions, including new starters (and salary justifications where relevant), changes in circumstances and terminations, are set out in the Scheme of Reservation and Delegation.

8.4.3 Regardless of the arrangements for providing the payroll service, the Executive Director of Finance will ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.5 Consultancy spend and off-payroll and agency workers

8.5.1 It is recognised that there may be a business need to engage with specialist skills and knowledge for temporary or substantive posts. The need for specialist knowledge and skills varies dependent upon the work and focus of the ICB at any given time, and there are a range of different types of individuals that the ICB may wish to engage with.

8.5.2 All recruiting managers will give due consideration to the costs associated with the use of consultancy, agency or off-payroll workers.

8.5.3 Appropriate business cases must be completed by the recruiting manager prior to any decision being made. Approval requirements for consultancy spend and appointment of off-payroll and agency workers are set out in the ICB's Scheme of Reservation and Delegation.

8.5.4 The ICB's Human Resources function will be responsible for providing support and advice to recruiting managers to ensure the appropriate checks are completed for all off-payroll and agency engagements. This will include, but is not limited to, the HM Revenue and Customs (HMRC) employment status test and Status Determination Statement.

8.5.5 The ICB's Finance Directorate will be responsible for providing support and advice to recruiting managers to determine whether off-payroll working rules apply and to ensure compliance with IR35 legislation and guidance, including Understanding off-payroll working (IR35) - GOV.UK (www.gov.uk). The person providing services through their own intermediary will need to provide information to the ICB to help make this decision. If the rules apply, the ICB must deduct tax and Class 1 NICs and pay and report them to HMRC.

8.5.6 The ICB's Human Resources function will be responsible for issuing contracts in line with the outcome of the HMRC employment status test and maintaining a record of all completed employment status tests.

8.5.7 Business cases for consultancy spend and off-payroll/agency workers require prospective approval. The national business case template should be used in all instances, which will set out the:

(a) Explanation of the business need.

(b) Demonstration of the value for money of proposed engagement.

(c) Rationale for the proposed engagement.

(d) Reason for use of an off-payroll appointment as opposed to employment status.

(e) Framework compliance (i.e. the recruitment route).

(f) Recruitment strategy.

(g) Anticipated delivery.

8.5.8 Consultancy spend is defined as where an individual or team of consultants are appointed by the ICB to deliver a pre-defined project or output.

8.5.9 Off-payroll and agency workers are individuals engaged by the ICB to deliver time inputs (e.g. to cover a vacant post or a fixed term role) but not a defined output.

8.5.10 The ICB's human resources policies will be applied, as relevant, when an off-payroll or agency appointment is made. This includes, but is not limited to, policies relating to mandatory training and acceptable behaviours.

8.5.11 Where off-payroll workers are engaged through agencies, recruiting managers will seek to utilise agencies which are approved through a procurement framework and have adopted terms and conditions approved by NHS organisations.

8.5.12 The Executive Director of Finance will be responsible for ensuring appropriate processes are in place to respond to any disagreements, or complaints, which are raised by off-payroll workers or agencies. Records should be maintained by the ICB of any such instances.

9. Revenue expenditure and payment of accounts

9.1 Revenue expenditure

9.1.1 For all revenue expenditure, Budget Holders and Budget Managers must ensure that they have approval to commit ICB resources before undertaking procurement. The approval routes differ according to the value and type of expenditure and the relevant delegated financial limits are set out in the Scheme of Reservation and Delegation.

9.1.2 Retrospective approval to commit revenue expenditure is not permitted, and any such breaches must be reported to the Audit Committee.

9.2 Procurement and provider selection requirements

9.2.1 The ICB's policy on procurement and provider selection sets out requirements for ensuring that the ICB has a legally compliant, consistent, transparent and effective approach to the procurement, commissioning and contract management of goods, services and works.

9.2.2 The required approach to the selection of providers of healthcare services is set out in the ICB's policy on procurement and provider selection, which complies with the Health Care Services (Provider Selection Regime) Regulations 2023 and associated statutory guidance. The Audit Committee will oversee compliance with the ICB's annual reporting requirements (as set out in regulation 25 of the Prover Selection regime) and the ICB's monitoring and publication arrangements (in line with Regulation 26 of the Provider Selection Regime). This will include retrospective reporting of all provider representations received in relation to procurement and contract award decisions for healthcare services.

9.2.3 Quotation and tendering limits for non-healthcare goods, services and works are set out in the ICB's policy on procurement and provider selection, which complies with the Procurement Act 2023.

9.2.4 The waiving of competitive tendering procedures for non-healthcare goods, services and works should be avoided and only utilised in line with the exemptions provided for in the ICB's policy on procurement and provider selection. Approval of requests for competition waivers for non-healthcare goods, services and works shall be in accordance with the Scheme of Reservation and Delegation. All competition waivers are required to be reported retrospectively to the Audit Committee for review.

9.3 Contract modifications

9.3.1 Service continuations and contract modifications for healthcare services must comply with the ICB's Procurement and Provider Selection Policy.

9.3.2 All extensions and variations to existing non-healthcare contracts must be reviewed to confirm that they are legally possible they represent best value for money, including financial and non-financial aspects, and they are not being instigated solely to avoid or delay the requirement to conduct procurement.

9.3.3 Extensions to existing non-healthcare contracts can only be approved where the terms and conditions of the contract make provision for an extension and contract performance is satisfactory.

9.4 Payment of accounts

9.4.1 The Executive Director of Finance is responsible for ensuring systems are in place for the verification, recording and payment of all accounts payable by the ICB. Systems will provide for certification that:

(a) Goods have been duly received, examined, are in accordance with specification and order, are satisfactory and that the prices are correct.

(b) Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used were of the requisite standard and that the charges are correct.

(c) In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, that the rates of labour are in accordance with appropriate rates, and that the materials have been checked regarding quantity, quality and price.

(d) Where appropriate, the expenditure is in accordance with regulations and that all necessary authorisations have been obtained.

(e) The account is arithmetically correct.

9.4.2 The Executive Director of Finance will ensure that appropriate segregation of duties controls are established in relation to revenue and non-pay expenditure.

9.4.3 Officers authorised to approve requisitions and invoices are set out in the Scheme of Reservation and Delegation.

9.4.4 Payments should normally be made by bank credit transfer. Payment by other methods should only occur with the approval of the Executive Director of Finance or nominated officer.

9.4.5 Payment of contract invoices should be in accordance with contract terms. All payments should comply with the Government's policy on prompt payment.

9.5 Prepayments

9.5.1 Prepayments which fall outside of normal business practice (advance payments) are only permitted in exceptional circumstances and require the approval of the Executive Director of Finance. In such instances:

(a) The financial advantages must outweigh the disadvantages.

(b) The appropriate Budget Holder must provide a case setting out all relevant circumstances of the purchase. This must set out the effects on the ICB if the supplier is, at some time during the course of the advance payment agreement, unable to meet their commitments.

(c) The Executive Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed.

(d) The Budget Holder is responsible for ensuring that all items due under an advance payment contract are received and must immediately inform the Executive Director of Finance if problems are encountered.

10. Capital investments, asset management and property leases

10.1 Capital investment

10.1.1 For any capital investments made by the ICB, the Executive Director of Finance is responsible for:

(a) Ensuring that there is an effective appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans.

(b) Ensuring that processes require a business case to be produced for every capital expenditure proposal, which includes evidence of availability of resources to finance all revenue consequences.

(c) Ensuring that there are processes in place for the management of all stages of capital schemes to ensure that schemes are delivered on time and to cost.

10.1.2 Capital commitments typically cover land, buildings, equipment, capital grants to third parties and IT, including:

(a) Authority to spend capital or make a capital grant.

(b) Authority to enter leasing arrangements.

10.1.3 Advice should be sought from the Executive Director of Finance or nominated officer if there is any doubt as to whether any proposal is a capital commitment requiring formal approval.

10.1.4 Approval requirements regarding capital investments are set out within the ICB's Scheme of Reservation and Delegation.

10.2 Asset management

10.2.1 The Executive Director of Finance is responsible for ensuring the ICB has effective procedures in place regarding the management of assets.

10.2.2 Any capital assets held by the ICB will be recorded on an asset register, with physical checks of assets against the register to be conducted periodically.

10.2.3 Disposals of any surplus assets should be:

(a) Supported by an appraisal of the options and benefits of the disposal in the context of the wider public sector and to secure value for money.

(b) Made in line with any relevant published guidance.

10.3 Property leases

10.3.1 The Executive Director of Finance is responsible for ensuring that the ICB has effective procedures in place regarding property leases.

10.3.2 Approval requirements regarding lease matters are set out within the ICB's Scheme of Reservation and Delegation.

11. Financial systems

11.1 General

11.1.1 The Executive Director of Finance will ensure the ICB has suitable financial and other software to enable the production of management and financial accounts and to meet the consolidation requirements of NHS England.

11.1.2 NHS Shared Business Services provides and operates the ICB's financial ledger, known as the Integrated Single Financial Environment (ISFE). This is the required accounting system for use by ICBs. Access is based on single access log on to enable users to perform core accounting functions such as to transacting and coding of expenditure/income in fulfilment of their roles.

11.1.3 The Executive Director of Finance will:

(a) Satisfy themselves that access to financial systems is strictly controlled and delegated authorities within system approved limits are appropriately assigned.

(b) Ensure that transacting is carried out efficiently in line with current best practice (e.g. e-invoicing).

(c) Ensure that contracts for computer services for financial applications with another health organisation or any other agency clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. Contracts will also ensure rights of access for audit purposes.

(d) Periodically seek assurances that adequate controls are in operation where another health organisation or any other agency provides a computer service for financial applications.

12. Losses and special payments

12.1 General

12.1.1 The requirements set out within these Standing Financial Instructions reflect ICB Losses and Special Payments Guidance issued by NHS England, which contains further detailed operational guidance on losses and special payments.

12.1.2 Losses and special payments are items that parliament would not have contemplated when it agreed funds for NHS bodies or passed legislation. By their nature, they are items that ideally should not arise. They are, therefore, subject to special control procedures compared to the generality of payments and require special notation in the accounts to bring them to the attention of parliament.

12.1.3 HM Treasury retains the authority to approve losses and special payments which are classified as being either:

(a) Novel or contentious.

(b) Contains lessons that could be of interest to the wider community.

(c) Involves important questions of principle.

(d) Might create a precedent.

(e) Highlights the ineffectiveness of the existing control systems.

12.1.4 Therefore, HM Treasury approval is required if a transaction exceeds the delegated authority, or if transactions will set a precedent, are novel, contentious or could cause repercussions elsewhere in the public sector.

12.1.5 Therefore, all cases relating to ICB losses and special payments must be submitted to NHS England for approval if the proposed transaction values exceed the delegated limits set out below or satisfy the conditions in section 12.1.2:

Expenditure type	ICB delegated limit
All losses	Up to £300,000
Special payments, including extra contractual / statutory / regulatory / compensation and ex-gratia	Up to £95,000
Special severance and retention payments	£0
Consolatory payments	£500

12.1.6 NHS England has the statutory power to require an ICB to provide NHS England with information. The information, is not limited to losses and special payments, must be provided in such form, and at such time or within such period, as NHS England may require.

12.1.7 The Executive Director of Finance will support a strong culture of public accountability, probity, and governance, ensuring that appropriate and compliant structures, systems, and processes are in place to minimise risks from losses and special payments. All losses and special payments should be reported to the Executive Director of Finance.

12.2 Losses

12.2.1 Losses refer to any case where full value has not been obtained for money spent or committed. Managing Public Money defines losses as including, but not limited to:

(a) Cash losses (physical loss of cash and its equivalents, e.g. credit cards, electronic transfers).

(b) Bookkeeping losses (including missing items or inexplicable or erroneous debit balances).

(c) Exchange rate fluctuations.

(d) Losses of pay, allowances and superannuation benefits paid to employees (including overpayments due to miscalculation, misinterpretation or missing information; unauthorised issue; and other causes).

(e) Losses arising from overpayments.

(f) Losses from failure to make adequate charges.

(g) Losses of accountable stores (through fraud, theft, arson, other deliberate act or other cause).

(h) Fruitless payments and constructive losses.

(i) Claims waived or abandoned (including bad debts).

12.2.2 Losses that are subject to insurance cover should be accounted for on a net basis (i.e. after any insurance pay out).

12.2.3 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their director, who must immediately inform the Executive Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Executive Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Executive Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies, which may indicate fraud or corruption, the Executive Director of Finance must inform the ICB's Local Counter Fraud Specialist.

12.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Executive Director of Finance must immediately notify the Board and the external auditor.

12.2.5 The Executive Director of Finance is authorised to take any necessary steps to safeguard the ICB's interests in bankruptcies and company liquidations.

12.2.6 For any loss, the Executive Director of Finance should consider whether any insurance claim could be made.

12.3 Special payments

12.3.1 Managing Public Money defines special payments as:

(a) Extra-contractual payments: payments which, though not legally due under contract, appear to place an obligation on a public sector organisation which the courts might uphold. Typically, these arise from the organisation's action or inaction in relation to a contract. Payments may be extra-contractual even where there is some doubt about the organisation's liability to pay, e.g. where the contract provides for arbitration, but a settlement is reached without it. A payment made as a result of an arbitration award is contractual.

(b) Extra-statutory and extra-regulatory payments: are within the broad intention of the statute or regulation, respectively, but go beyond a strict interpretation of its terms.

(c) Compensation payments: are made to provide redress for personal injuries (except for payments under the Civil Service Injury Benefits Scheme), traffic accidents, and damage to property etc. They include other payments to those in the public service outside statutory schemes or outside contracts.

(d) Special severance payments: are paid to employees, contractors and others outside of normal statutory or contractual requirements when leaving employment in public service whether they resign, are dismissed or reach an agreed termination of contract.

(e) Ex gratia payments: go beyond statutory cover, legal liability, or administrative rules, including payments made to meet hardship caused by official failure or delay; out of court settlements to avoid legal action on grounds of official inadequacy; and payments to contractors outside a binding contract, e.g. on grounds of hardship.

12.3.2 The ICB will work with NHS England to ensure there is assurance over all exit packages, which may include special severance payments.

12.3.3 The ICB has no delegated authority for special severance payments and will refer to the guidance on that to obtain the approval of such payments. All other types of

special payments require approval from the Chief Executive or Executive Director of Finance, in line with the ICB's delegated limits.

12.3.4 All special severance payments must be reported to the Remuneration and Human Resource Committee.

12.3.5 The Executive Director of Finance is responsible for ensuring an annual assurance statement is submitted to NHS England that confirms:

(a) Details of all exit packages (including special severance payments) that have been agreed and/or made during the year.

(b) That NHS England and HM Treasury approvals have been obtained (in relation to non-contractual pay elements or amounts that exceed the ICB delegated limits) before any offers, whether verbally or in writing, are made.

(c) Adherence to the special severance payments guidance as published by NHS England.

12.4 Losses and special payments register

12.4.1 The Executive Director of Finance is responsible for ensuring that a losses and special payments register is maintained.

12.4.2 All losses and special payments (including special severance payments) must be reported to the Audit Committee.

12.4.3 Where write-off action is deemed necessary, this will be approved by the Audit Committee and recorded in the losses and special payments register.

13. Annual reporting and accounts

13.1 Accounts

13.1.1 The ICB must keep proper records in relation to its accounts.

13.1.2 The Executive Director of Finance, on behalf of the Chief Executive and the Board, will ensure that:

(a) Annual accounts are prepared in respect of each financial year (or for such periods as may be set out in directions issued by NHS England).

(b) The form and content of the annual accounts and the methods and principles for preparing them comply with any directions issued by NHS England.

(c) The unaudited and audited annual accounts are sent to NHS England by the date specified in any directions issued by NHS England.

13.2 Annual report

13.2.1 The ICB must prepare an annual report that describes how it has discharged its functions in the previous financial year. NHS England may give directions to the ICB as to the form and content of the annual report.

13.2.2 The annual report must explain how the ICB has:

(a) Discharged its general duties in relation to improving the quality of services, reducing inequalities, promoting the involvement of patients, enabling patient choice, obtaining appropriate advice, promoting innovation, research, education and training and integration, having regard to the wider effect of decisions and to climate change, public involvement and consultation, and keeping the experience of Board members under review.

(b) Exercised its functions in accordance with its published five-year forward plan and capital resource use plan.

(c) Exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised).

(d) Taken steps to implement its joint local health and wellbeing strategies. In producing this section of the annual report, the ICB must consult each relevant Health and Wellbeing Board.

13.2.3 The annual report must also include:

(a) A statement of the amount of expenditure incurred by the ICB during the financial year in relation to mental health.

(b) A calculation of the proportion of the expenditure incurred by the ICB during the financial year that relates to mental health.

(c) An explanation of the statement and calculation.

13.2.4 The ICB must give a copy of its annual report to NHS England by the date specified in a direction by NHS England.

13.3 Approval and publication

13.3.1 The Audit Committee will approve the annual report and accounts, on behalf of the Board.

13.3.2 The ICB must publish a copy of its annual report and accounts.

14. Legal and insurance

14.1 Legal

14.1.1 The Chief Executive is responsible for ensuring appropriate arrangements are in place for accessing external legal advice on matters relating to the delivery of the organisation's functions and duties or potential litigations.

14.1.2 A procedure will be established to control access to and expenditure on external legal advice, and to ensure that advice is centrally held to ensure its ongoing availability and benefit to the ICB.

14.1.3 Only the Chief Executive and Executive Director of Finance are authorised to commit or spend ICB revenue resources in relation to settling legal matters.

14.1.4 Arrangements regarding the execution of legal documents by signature are set out in the ICB's Standing Orders.

14.2 Insurance

14.2.1 Where the ICB uses the risk pooling schemes administered by NHS Resolution (for clinical, property and/or employers/third party liability), the Executive Director of Finance is responsible for ensuring that the arrangements entered into are appropriate and that appropriate systems are in place regarding the management of claims.

14.2.2 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when ICBs may enter into insurance arrangements with commercial insurers. The exceptions are:

(a) Commercial arrangements for insuring motor vehicles owned or leased by the ICB including insuring third party liability arising from their use.

(b) Where the ICB is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into.

(c) Where income generation activities take place, these should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the ICB for NHS purposes, the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution. In any case of doubt concerning the ICB's powers to enter into commercial insurance arrangements, the Executive Director of Finance should consult NHS England.

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Standards of Business Conduct Policy

November 2025 – November 2027

Policy purpose and key messages
This policy sets out the standards of business conduct required across the three ICBs, providing a clear framework for declaring and managing conflicts of interest, and for handling gifts, hospitality and sponsorship. Its purpose is to ensure decisions are taken with integrity, transparency and impartiality, safeguarding public funds and upholding the Nolan Principles and wider NHS governance requirements.

CONTROL RECORD	
Title	Standards of Business Conduct Policy
Reference number	*To be inserted*
Version	*To be inserted*
Status	Draft
Author	ICB Governance Leads
Sponsor	Amanda Sullivan, Chief Executive
Team	Corporate Governance
Amendments	Not applicable
Superseded documents	• NHS Derby and Derbyshire ICB Standards of Business Conduct Policy; Managing Conflicts of Interest Policy; and Gifts, Hospitality & Sponsorship Policy • NHS Lincolnshire ICB Standards of Business Conduct and Conflicts of Interest Policy (including hospitality, gifts and sponsorship) • NHS Nottingham and Nottinghamshire ICB Standards of Business Conduct Policy
Audience	All individuals employed by or appointed to the ICB, including those working for or with the ICB in a temporary capacity.
Consulted with	Not applicable.
Equality Impact Assessment	October 2025
Approving body	Boards of NHS Derby and Derbyshire Integrated Care Board, NHS Lincolnshire Integrated Care Board and NHS Nottingham and Nottinghamshire Integrated Care Board
Date approved	*To be inserted*
Date of issue	*To be inserted*
Review date	*To be inserted*
Policy retention period	*To be inserted*
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 applies to NHS Derby and Derbyshire Integrated Care Board (ICB), NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB, hereafter referred to as 'the ICBs'.

1.2 As publicly funded organisations, the ICBs have a duty to set and maintain the highest standards of conduct and integrity. We expect the highest standards of corporate behaviour and responsibility from the members of our Boards and their committees and sub-committees and all others working for, with, or on behalf of the ICBs.

1.3 Ensuring that decisions are taken transparently and clearly is a key principle in the NHS Constitution. All individuals working within the ICBs, regardless of their role, are expected to act in the spirit set out in the seven principles of public life: the 'Nolan Principles' (Appendix 1).

1.4 In how they conduct their business, the ICBs are required to adhere to the National guidance on managing conflicts of interest in the NHS. The ICBs also observe the principles of good governance described in:

a) The Good Governance Standards for Public Services (2004), Office for Public Management and the Chartered Institute of Public Finance and Accountancy.

b) The seven key principles of the NHS Constitution.

c) The Equality Act 2010.

d) The UK Corporate Governance Code.

1.5 Whilst this policy has been developed for implementation across the ICBs to ensure a consistent approach and aligned working practices, it is important to remember that the legal requirement for the management of conflicts of interest remains the responsibility of each individual organisation. As such, each ICB will need to continue to be able to demonstrate its own compliance with the national guidance on managing conflicts of interests.

2. Scope

2.1 The ICBs require this policy to be followed by:

a) All employees – this includes all individuals working for the ICBs in a temporary capacity, including agency staff, seconded staff, students and trainees, and any self-employed consultants or other individuals working for the ICBs under a contract for services. Where relevant, it also includes prospective employees who have commenced the recruitment process.

b) Members of the ICBs' Boards and joint committees and committees of the Boards.

c) Any other individual directly involved with the business or decision-making of the ICBs.

2.2 Hereafter, the above are referred to throughout this policy as 'individuals'.

3. Purpose and Values

3.1 The purpose of this policy is to:

a) Safeguard the ICBs' decision-making arrangements and protect the integrity of their workforce by ensuring that robust arrangements are in place for declaring and managing conflicts of interest.

b) Ensure that all individuals are aware of their own responsibilities with regard to standards of business conduct.

c) Support the ability of individuals to apply good judgement across the topics included in this policy; understanding when further guidance and support in meeting the requirements of this policy may be needed and where to obtain it.

3.2 This policy supports the ICBs' Constitutions, Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation, which set out the statutory and governance framework in which the ICBs operate. All individuals are required to comply with the requirements of the ICBs' Constitutions, Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation when carrying out their duties and these shall prevail over the requirements of this policy where conflicting advice is given.

3.3 All clinically qualified individuals employed by or working with or on behalf of the ICBs must also refer to their respective codes of conduct relating to the areas included in this policy.

4. Definitions

4.1 Definitions of key terms referenced in this policy are as follows:

Term	Definition
Bribery	Giving or receiving a financial or other advantage in connection with the 'improper performance' of a position of trust, or a function that is expected to be performed impartially or in good faith (Bribery Act, 2010).

Term	Definition
Conflict of Interest	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 (NHS England, 2024).
Actual Conflict of Interest	A material conflict between one or more interests.
Potential Conflict of Interest	The possibility of a material conflict between one or more interests in the future.
Perceived Conflict of Interest	An individual could be incorrectly seen to have a conflict of interest, due to false perceptions about their responsibilities, their interests or their relationships.
Gift	Any item of cash or goods, or any service, which is provided for personal benefit, free of charge or at less than its commercial value.
Hospitality	Offers of meals, refreshments, travel, accommodation and other expenses in relation to attendance at meetings, conferences, education and training events.
Sponsorship	Support (financial or otherwise) of ICB activities by an external body.
Procurement	The process of finding and agreeing to terms, and acquiring goods, services, or works from an external source, often via a tendering or competitive bidding process.

5. Roles and Responsibilities

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

Role	Responsibilities
ICB Boards, Committees and Decision-making Groups	The ICBs' Boards, their committees and decision-making groups are responsible for upholding the principles of good corporate governance and ensuring that the ICBs are acting in the best interests of stakeholders at all times. In particular, the Chairs of these fora are responsible for ensuring that any declared interests in relation to agenda items at meetings are managed in accordance with this policy.
Audit Committees	The Audit Committees are responsible for reviewing the establishment and maintenance of an effective system of integrated governance and internal control. In particular, the Committees are responsible for monitoring compliance with this policy and the organisation's established probity arrangements.
Chief Executive Officer	The Chief Executive has overall accountability for the ICBs' management of conflicts of interest, which includes the requirements for the management of gifts, hospitality and sponsorship.
Director of Finance	The Director of Finance is responsible for ensuring the adequacy of the ICBs' counter fraud arrangements.
ICB Governance Leads	Governance Leads are responsible for: • The day-to-day management of matters and queries relating to the application of this policy. • Maintaining the Registers of Interests. • Providing advice, support, and guidance on how conflicts of interest should be managed. • Ensuring that appropriate administrative processes are put in place.

Role	Responsibilities
	• Supporting the Conflicts of Interest Guardian in carrying out their roles effectively.
Conflicts of Interest Guardian	The Conflicts of Interest Guardian is in place to further strengthen the scrutiny and transparency of the ICBs' decision-making processes. This role will also: • Act as a conduit for anyone with concerns relating to conflicts of interest. • Be a safe point of contact for individuals to raise concerns in relation to conflicts of interest. • Support the rigorous application of the principles and policies for managing conflicts of interest. • Provide independent advice and judgment where there is any doubt about how to apply this policy and principles in individual situations in regard to conflicts of interest. • Provide advice on minimising the risks of conflicts of interest.
Freedom to Speak Up Guardian	The Freedom to Speak Up Guardian is in place to provide an independent and impartial source of advice to individuals at any stage of raising a concern. This can include concerns relating to standards of business conduct.
Executive Management and Senior Leadership Team	Members of the Executive Management Team and Senior Leadership Team have an ongoing responsibility for ensuring the application of this policy within the ICBs.
Individuals	All individuals are responsible for complying with this policy and for seeking advice if unsure how it applies to them.

6. Decision-Making Officers

6.1 Some individuals are more likely than others to have a decision-making role or influence on the use of public money because of the requirements of their role. In the context of this policy 'decision-making officers' are defined as members of the ICBs' Boards, joint committees and committees of the Boards, members of formal decision-making groups and ICB Officers with individual decision-making authority. Delegated decision-making arrangements are set out specifically in the ICBs' Schemes of Reservation and Delegation (SoRD).

6.2 The interests of all decision-makers, which includes the acceptance of gifts and hospitality, will be published on the ICBs' websites.

7. Conflicts of Interest

7.1 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.

7.2 Interests fall into the following categories:

Term	Definition
Financial interests	Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.
Non-financial professional interests	Where an individual may obtain a non-financial benefit from the consequences of a decision, they are involved in making, such as increasing their professional reputation 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

[1] This may be a financial gain, or avoidance of a loss.

Term	Definition
	because of decisions they are involved in making in their professional career.
Indirect interests	Where an individual has a close association[2] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making. Indirect interests can also arise through relationships with colleagues from other organisations – *see 'loyalty interests' in section below.*

Loyalty Interests

7.3 As part of their jobs, staff need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define as they may often fall in the category of indirect interests. They are unlikely to be directed by any formal process or managed via any contractual means - it can be as simple as having informal access to people in senior positions.

7.4 However, loyalty interests can influence (or be seen to influence) decision making. Conflicts of interest can arise when 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 scope of loyalty interests is potentially huge, so judgement is required for making declarations.

7.5 The above categories are not exhaustive, and each situation must be considered on a case-by-case basis. Where individuals are unsure whether a situation falling outside of the above categories may give potential for a conflict of interest, they should seek advice from the ICBs' Governance Leads or the ICBs' Conflicts of Interest Guardian. If in doubt, the individual concerned should assume the existence of a conflict of interest and ensure that it is managed appropriately, rather than ignore it.

7.6 Examples of each of the above categories of interest are provided at Appendix 2.

[2] A common-sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

8. Principles

8.1 In discharging their functions, the ICBs will abide by the following principles for managing conflicts of interest to ensure they are handled with integrity and probity, in an open and transparent way:

(a) All decisions will be made in the best interests of the ICB's population, consistent with the ICBs' statutory duties and responsibilities.

(b) Conflicts of interest will be identified and declared as early as possible, with clear and specific disclosures.

(c) Decision-making will be inclusive, ethical, and based on professional advice, with all participants acting with integrity, avoiding undue influence from personal, financial, or organisational interests.

(d) Conflicts of interest will be managed in a balanced and proportionate way, preserving collective decision-making wherever possible; mitigations will consider both actual and perceived conflicts, and the risks and benefits of individual involvement.

(e) Clear records will be maintained of declared interests and actions taken, fostering a culture of openness and accountability.

(f) All Board members and decision-makers will receive appropriate support and guidance to ensure compliance with relevant ICB policies, including procedures for managing breaches.

9. Partner Members

9.1 Individuals from partner organisations who have a role in the ICBs' decision-making will be expected to act in accordance with principles set out in section 8. Whilst it will not be assumed that they are personally or professionally conflicted, the possibility of actual and perceived conflicts of interest will remain. For all decisions, the ICBs will need to consider whether an individual's role in another organisation could result in actual or perceived conflicts of interest and whether or not these outweigh the value and knowledge they bring to the process.

10. Declaring and Registering Interests

10.1 All individuals must declare any interests as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days.

10.2 Processes are in place to support individuals in the declaration of new interests or to amend any existing interests at the following points:

a) On appointment - for new starters to the organisation, the completion of the 'Declarations of Interest Form' (provided at Appendix 3) is required prior to commencing in post. Individuals will also be asked about any relevant interests as part of the mandatory questions asked during job interviews. In the event that there are no interests to declare, a 'nil declaration' must be submitted.

b) On significantly changing role and/or responsibilities within the organisation.

c) At each meeting of the ICBs' Boards or their joint committees and committees and other decision-making groups (as described in the section 'Managing Conflicts of Interest at Meetings' in this policy).

d) Through the annual assurance exercise detailed in section 10.8 of this policy.

10.3 If individuals are in any doubt as to whether they have an interest or whether it is declarable, they should consult their line manager and/or the ICBs' Governance Leads.

10.4 In order to promote confidence in the probity of commissioning decisions and the integrity of those involved, the ICBs will maintain and make publicly available registers that detail the interests of all individuals as defined in section 3.1.

10.5 The ICBs' Governance Leads, supported by the Corporate Governance Teams, will maintain a register of declared interests for each ICB, which will include the following information:

a) Name of the person declaring the interest.

b) Position within, or relationship with, the ICB.

c) Type of interest.

d) Nature of the interest.

e) The dates to which the interest relates.

f) The actions to be taken to mitigate risk.

10.6 The Registers of Declared Interests for decision-makers will be published on the ICBs' websites at least annually. A copy can also be obtained directly from the relevant ICB.

10.7 The Registers of Declared Interests will be updated whenever a new or revised interest is declared. NB: This means that the versions published on the ICBs' websites will not always be the most up-to date.

10.8 The ICBs will assure themselves on an annual basis that their registers of declared interests are accurate and up to date. A request will be sent to all

individuals, on behalf of the ICBs' Governance Leads, asking them to check their entry on the registers. Where an individual has no interest to declare, or no interest in addition to those already declared, they must confirm this by way of 'nil return'. The request is designed to prompt individuals and does not negate the responsibility of individuals to proactively declare, as stipulated within this policy.

10.9 Offers/receipt of gifts and hospitality of decision-making staff will remain on the published registers for a minimum of six months. In addition, the ICBs will retain a record of historic interests (including offers/receipt of gifts and hospitality) for a minimum of six years after the date on which it expired. The ICBs' published registers of interests state that historic interests are retained by the ICBs for the specified timeframe and details of whom to contact to submit a request for this information.

10.10 Where an individual has substantial grounds for believing that publication of their interests should not occur, they may request in writing that the information is not published, explaining the reasons why. In exceptional circumstances, the information may be withheld on the public registers. However, this would be the exception, and information will not be withheld or redacted merely because of a personal preference.

10.11 The decision as to whether or not to publish information will be made by the Conflicts of Interest Guardian, in consultation with the ICBs' Governance Leads.

11. Management of Declared Interests

11.1 The ICBs' Governance Leads (supported by the Corporate Governance Teams) are responsible for ensuring that for every interest declared, arrangements are in place to manage the conflict of interests or potential conflict of interests following an assessment of the:

a) **Materiality of the interest**: in particular whether the individual (or family member, close friend or business associate) could be advantaged or disadvantaged from the individual's involvement in a decision.

b) **Extent of the interest**: in particular, whether it is related to a business area significant enough that would impact on the individual's ability to make a full and proper contribution to relevant commissioning activities.

11.2 These arrangements will confirm the following:

a) When an individual should withdraw from a specified activity, on a temporary or permanent basis.

b) Monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

11.3 All individuals that have declared interests are responsible for ensuring that they understand any requirements for managing their declared interests before participating in any decision-making activities.

11.4 There will be occasions where an individual declares an interest in good faith but upon closer consideration, it is clear that this does not constitute a genuine conflict of interest. The ICBs' Governance Leads will provide advice on this and decide whether it is necessary for the interest to be added to the Registers of Declared Interests.

12. Managing Conflicts of Interest at Meetings

12.1 All formal meetings, including the ICBs' Boards and their joint committees and committees, must have a standing agenda item at the beginning of each meeting to determine whether anyone has any conflicts of interest to declare in relation to the business to be transacted at the meeting. The ICBs' Standing Orders and all Committee terms of reference will incorporate this requirement. Any new interests declared at the meeting should be included in the ICBs' Registers of Declared Interests as soon as practicable after the meeting.

12.2 Actions to mitigate conflicts of interest should be proportionate and should seek to preserve the spirit of collective decision-making wherever possible. Mitigation should take account of a range of factors including the perception of any conflicts and how a decision may be received if an individual with a perceived conflict is involved in that decision, and the risks and benefits of having a particular individual involved in making the decision.

12.3 If an interest is declared but there is no risk of a conflict arising, then no further action need be taken (although the interest will still need to be recorded). However, if a material interest is declared, then it should be considered to what extent it affects the balance of the discussion and decision-making process. In doing so the ICBs should ensure conflicts of interest (and potential conflicts of interest) do not, and do not appear to, affect the integrity of the ICBs' decision-making processes

12.4 In the event that the chair of the meeting has a conflict of interest, the deputy chair is responsible for deciding the appropriate course of action to manage conflicts of interests. If the deputy chair is also conflicted, then the remaining non-conflicted voting members of the meeting should unanimously agree how to manage the conflict(s).

12.5 When a member of the meeting (including the chair or deputy chair) has a conflict of interest in relation to one or more items of business to be transacted at the meeting, the chair (or deputy chair or remaining non-conflicted members where relevant as described above) must decide how to manage the conflict. The appropriate course of action will depend on the particular circumstances, but could include one or more of the following:

a) Including a conflicted person in the discussion but not in decision-making.

b) Excluding a conflicted person from both the discussion and the decision-making.

c) Including a conflicted person in the discussion and decision where there is a clear benefit to them being included in both – however, including the conflicted person in the actual decision should be done after careful consideration of the risk and with proper mitigation in place.

d) Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.

12.6 The rationale for the agreed course of action should be properly documented and included in the minutes of the meeting. This should include:

a) Who has the interest.

b) The nature and extent of the conflict.

c) An outline of the discussion.

d) The actions taken to manage the conflict; and

e) Evidence that the conflict was managed as intended.

12.7 In all cases, a quorum must be present for the discussion and decision.

13. Conflicts of Interest in Procurement Activities and the Provider Selection Regime (PSR)

13.1 The appropriate management of conflicts of interest extends to any situation where an individual has, directly or indirectly, an interest which might be perceived to compromise their impartiality and independence in the context of a procurement process.

13.2 At the outset of any process, the relevant interests of individuals involved should be identified and clear arrangements put in place to manage any conflicts. This includes consideration as to which stages of the process a conflicted individual should not participate in, and in some circumstances, whether the individual should be involved in the process at all.

13.3 Decision-making processes with regard to procurement and the PSR are subject to the principles described in section 8 and the arrangements detailed in sections 11 ‘Management of Declared Interests’ and 12 ‘Managing Conflicts of Interest at Meetings’.

13.4 The ICBs’ Procurement Policy describes the ICBs’ arrangements for procurement and applying the PSR. This includes where there is a requirement to publish any declared or potential conflicts of interest of individuals, groups or committees making the decision and how these were managed.

14. Outside Employment

14.1 All employees are required to seek approval from their line manager if they are engaged in or wish to engage in outside employment in addition to their work with the ICBs.

14.2 Outside employment or private practice must neither conflict with nor be detrimental to the NHS work of the officer in question. Examples of outside employment or private practice which may give rise to a conflict of interest includes, but is not limited to:

a) Employment with another NHS body or any organisation which might be in a position to supply goods/services to the ICBs; or

b) Self-employment, including private practice, in a capacity which might conflict with the work of the ICBs, or which might be in a position to supply goods/services to the ICBs.

14.3 Where a risk of conflict of interest is identified, these should be managed in accordance with the guidance provided in this policy. The ICBs reserve the right to refuse permission where we reasonably believe a conflict will arise or that approval would be detrimental to the work of the officer in question.

14.4 In undertaking any outside employment, employees should have regard to the section ‘Trading on NHS premises’ in this policy.

14.5 The ICBs may have legitimate reasons within employment law for knowing about outside employment of employees, even where this does not give rise to the risk of a conflict of interest. Nothing in this policy prevents such enquiries being made.

14.6 Where an individual is approached to speak at an externally sponsored event, the individual should ensure that the provisions in the sponsorship section of this policy are observed.

14.7 All employees must declare any relevant outside employment or private practice on appointment, and when any new employment arises, in accordance with the guidance above.

14.8 Declarations will be documented on the ICBs' Registers of Declared Interests.

15. Patents and Intellectual Property

15.1 Individuals should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.

15.2 Individuals should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.

15.3 Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

16. Gifts, Hospitality and Sponsorship

Gifts

16.1 Individuals should not accept gifts that may affect, or be seen to affect, their professional judgement. This overarching principle should apply in all circumstances.

16.2 Gifts from suppliers or contractors:

a) Gifts from suppliers or contractors doing business (or likely to do business) with the ICBs should be politely declined. Low cost promotional aids (under the value of £6[3] in total) can be accepted and do not need to be declared.

b) If a gift from a supplier or contractor (with an estimated value in excess of the £6 limit) arrives without warning, it must be handed over to the ICBs' Governance Leads who will decide whether the gift should be returned (or passed on to a charity or good cause). In such

[3] The £6 value has been selected with reference to existing industry guidance issued by the Association of the British Pharmaceutical Industry.

circumstances, action will be taken to ensure that the donor is informed of what has happened.

16.3 Gifts from other sources (e.g. patients, families, service users):

a) Individuals should not ask for gifts.

b) Gifts of cash and vouchers should always be politely declined.

c) Modest gifts under a value of £50 may be accepted and do not need to be declared.

d) Gifts at a value of £50 or over should be treated with caution and only be accepted on behalf of the ICBs and not in a personal capacity. Such gifts should be declared.

e) A common-sense approach should be applied to the valuing of gifts – if the actual value is unknown, this should be based on an estimate that a reasonable person would make as to its value.

16.4 Multiple gifts from the same source over a 12-month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

Hospitality

16.5 Individuals should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.

16.6 Hospitality must only be accepted when there is a legitimate business reason, and it is proportionate to the nature and purpose of the event.

16.7 Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. These offers can be accepted if modest and reasonable, but individuals should always obtain approval from a member of the Executive Management and Senior Leadership Team.

16.8 Individuals should never put themselves in a position where there could be any suspicion that their business decisions could have been influenced by accepting hospitality from others. With this in mind, individuals should ask themselves what a member of the public, who may be critical or suspicious, might think.

16.9 Individuals are advised to consult with the ICBs' Governance Leads if they are unsure as to whether to accept any offers of hospitality.

Meals and refreshments:

a) Under a value of £25 may be accepted and need not be declared.

b) Of a value between £25 and £75 may be accepted and must be declared.

c) Over a value of £75[4] should be refused unless (in exceptional circumstances) approval from a member of the Executive Management and Senior Leadership Team is given. A clear reason for the approval should be recorded on the Register of Interests.

16.10 Individuals should take a common-sense approach to the valuing of meals and refreshments (if actual value is not known) and always adhere to the principles set out in this policy.

Travel and Accommodation

16.11 Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.

16.12 Offers which go beyond modest or are of a type that the ICBs themselves would not usually offer (e.g. business class or first class travel, offers of foreign travel, etc) need approval from a member of the Executive Management Team and should only be accepted in exceptional circumstances. A clear reason for the approval should be recorded on the Register.

16.13 Where a declaration is required, the following information should be provided:

a) The staff member/individual's name and their role within the ICBs.

b) A description of the nature and value of the gift/hospitality, including its source.

c) Date of offer and receipt of the gift or hospitality.

d) Any other relevant information (e.g. circumstances surrounding the offer, action taken to mitigate any conflict of interest, details of any approvals given that may conflict with this policy).

Sponsored Events

16.14 Sponsorship of NHS events by external parties is valued, as such offers can secure their ability to take place and ultimately benefit patients, as well as

[4] The £75 value has been selected with reference to existing industry guidance issued by the Association of the British Pharmaceutical Industry.

NHS staff. Without this funding, there may be fewer opportunities for learning, development and partnership working.

16.15 Sponsorship of the ICBs' events by appropriate external bodies should only be approved if a reasonable person would conclude that the event will result in clear benefits for the ICBs.

16.16 Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit the organisations and the NHS.

16.17 During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.

16.18 No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.

16.19 At the organisations' discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event.

16.20 The involvement of a sponsor in an event should always be clearly identified.

16.21 Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.

16.22 Staff arranging sponsored events must declare this to the organisation. The organisation will maintain records regarding sponsored events in line with the above principles and rules.

Sponsored Research

16.23 Funding sources for research purposes must be transparent and any proposed research must go through the relevant health research authority or other approvals process.

16.24 There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.

16.25 The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.

16.26 Staff should declare involvement with sponsored research to the organisation. The Corporate Governance Teams will maintain records of:

a) Their name and their role with the organisation.

b) Nature of their involvement in the sponsored research.

c) Relevant dates.

d) Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Sponsored Posts

16.27 External sponsorship of a post requires prior approval from the organisation.

16.28 Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.

16.29 Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.

16.30 Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.

16.31 Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

16.32 The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.

16.33 Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

17. Hospitality provided by the ICBs

17.1 Care should also be taken when providing hospitality from ICBs' funds. Individuals must be able to demonstrate that the hospitality is being provided for a legitimate business reason and is subject to senior manager approval.

18. Working with the Pharmaceutical Industry

18.1 It is recognised that cross-sector working can accelerate improvements in patient care, with pharmaceutical companies able to bring expertise, skills

and resources to complement the expertise of healthcare organisations. Types of cross-sector working that might be taken by the ICBs include:

a) **Joint Working** – this is defined by the Department of Health and Social Care as situations where, for the benefit of the patients, pharmaceutical companies and the NHS pool skills, experience and/or resources for the joint development and implementation of patient-centred projects and share a commitment to successful delivery; and

b) **Collaborative Working** – this is a new and broader category of cross-sector working and is wider than joint working, in that project outcomes can be for patient and/or healthcare centred projects.

18.2 Whilst the ICBs are generally supportive of working with the pharmaceutical industry, it has a duty to ensure any involvement is transparent and ethical. In summary, Individuals are responsible for ensuring that:

a) The interests and integrity of the ICBs are safeguarded at all times and pharmaceutical companies should not use any aspect of the ICBs to infer its endorsement of products. Explicit agreement from the ICBs' Executive Team should be sought if use of the ICBs' name and/or branding is deemed necessary.

b) Where individuals are approached by pharmaceutical industry representatives with requests for meetings to promote products or services, the decision to meet with a representative is in line with the ICBs' priorities.

c) Engagement with any pharmaceutical company (or its representatives) does not occur without approval from an individual's line manager.

d) Any conflicts of interest are identified at the project outset, and management actions agreed in line with the requirements of this policy.

e) Ensuring engagement with the appropriate ICB team takes place at the earliest stage of any discussions with pharmaceutical companies. This team will be able to provide the correct guidance and advice, and ensure the ICBs are working in line with The Association of the British Pharmaceutical Industry's Guidance on Cross-Sector Working (2024).

18.3 Agreement to proceed with cross-sector working must be authorised by the relevant ICB Executive Director.

18.4 The ICBs' Confidentiality and Data Protection Policy must be always followed during any joint working or collaborative working projects.

19. Corporate Responsibilities

Charitable Collections

19.1 Whilst the ICBs wish to support individuals who want to undertake charitable collections amongst immediate colleagues, no reference or implication should be drawn to suggest that the ICBs are supporting the charity. Permission is not required for informal collections amongst immediate colleagues on an occasion like retirement, marriage, birthday or a new job.

19.2 Charitable collections which reference the ICBs must be authorised by a member of the Executive Management Team and reported to the Corporate Governance Teams.

Political Activities

19.3 Any political activity should not identify an individual as an officer of the ICBs. Conferences or functions run by a party-political organisation should not be attended in an official capacity, except with prior written permission from a member of the ICBs' Executive Management Team.

Personal Conduct

19.4 All individuals have a responsibility to respect and promote the corporate or collective decision of the ICBs, even though this may conflict with their personal views. This applies particularly if we are yet to decide on an issue or has decided in a way with which they personally disagree. Individuals may comment as they wish; however, if they decide to do so, they should make it clear that they are expressing their personal view and not the view of the ICBs.

19.5 When speaking as a member of the ICBs, whether to the media, in a public forum or in a private or informal discussion, individuals should ensure that they reflect the current policies or view of the organisations. For any public forum or media interview, approval should be sought in advance:

a) In the case of the Boards, from the Chair and/or Chief Executive or their nominated deputies. Advice should also be sought from the ICBs' Communications Teams.

b) In the case of all other individuals, advice should be sought from the ICBs' Communications Teams.

19.6 When this is not practicable, they should report their action to the Chair or Chief Executive or their nominated deputies, as soon as possible.

19.7 Individuals must ensure their comments are well considered, sensible, well informed, made in good faith, in the public interest and without malice and that they enhance the reputation and status of the ICBs.

19.8 Individuals must follow the guidance for communication with the media; disciplinary action may be taken if this is not followed.

Use of Social Media

19.9 Individuals should be aware that social networking websites are public forums and should not assume that their entries will remain private. Individuals communicating via social media must comply with the ICBs' Internet and Email Policy.

19.10 Individuals must not:

a) Conduct themselves in a way that brings the ICBs into disrepute.

b) Disclose any ICB information that is or may be sensitive, confidential and person-identifiable, or subject to a non-disclosure contract or agreement.

c) Divulge details of their NHS employer on their personal profile pages. If this information is divulged staff must state that they are communication in a personal capacity.

Confidentiality

19.11 Individuals must, at all times, operate in accordance with the UK General Data Protection Regulation and Data Protection Act 2018, and maintain the confidentiality of information of any type, including but not restricted to patient information; personal information relating to individuals; commercial information.

19.12 This duty of confidence remains after individuals (however employed) leave the ICBs.

19.13 For the avoidance of doubt, this does not prevent the disclosure or information where there is a lawful basis for doing so (e.g. consent). Staff should refer to the ICBs' Confidentiality and Data Protection Policy for more detailed information.

Gambling

19.14 No officer may bet or gamble when on duty or on ICBs' premises. The exception is small lottery syndicates or sweepstakes related to national events such as the World Cup or Grand National, where no profits are made, or the lottery is wholly for purposes that are not for private or commercial gain (e.g. to raise funds to support a charity).

Lending and Borrowing

19.15 The lending or borrowing of money between individuals should be avoided, whether informally or as a business, particularly where the amounts are significant.

19.16 It is a particularly serious breach of discipline for any officer to use their position to place pressure on someone in a lower pay band, a business contact, or a member of the public to loan them money.

Individual Voluntary Arrangements, County Court Judgment (CCJ), Bankruptcy or Insolvency

19.17 Any individual who becomes bankrupt, insolvent, has active CCJs, or made individual voluntary arrangements with organisations must inform their line manager and the ICBs' HR Team as soon as possible. Officers who are bankrupt or insolvent cannot be employed, or otherwise engaged, in posts that involve duties which might permit the misappropriation of public funds or involve the approval of orders or handling of money.

Arrest or Conviction

19.18 An individual who is arrested, subject to continuing criminal proceedings, or convicted of any criminal offence must inform their line manager and the ICBs' HR Team as soon as is practicably possible. Further information can be found within the ICBs' Disciplinary Policy.

20. Breaches of this Policy

20.1 Failure by an individual to comply with the requirements set out in this policy may result in action being taken in accordance with the relevant organisational disciplinary procedure. Such disciplinary action may include termination of employment (where applicable).

20.2 Where the failure to comply relates to an individual that is not a direct employee of the ICBs, this may result in action being taken in accordance with the relevant engagement procedures (e.g. termination of a secondment agreement).

20.3 Any financial or other irregularities or impropriety which involve evidence or suspicion of fraud, bribery or corruption by any officer, will be reported to the ICBs' Counter Fraud Specialist, with a view to an appropriate investigation being conducted and potential prosecution being sought.

20.4 Individuals who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to the ICBs' Governance Leads or ICBs' Conflicts of Interest Guardian.

20.5 Each ICB will investigate breaches relating to its own staff, decision-making groups and activities, according to its own specific facts and merits and give relevant parties the opportunity to explain and clarify any relevant circumstances.

20.6 Following investigation the relevant organisation will:

a) Decide if there has been or is potential for a breach and if so, what the severity of the breach is.

b) Assess whether further action is required in response – this is likely to involve any individual involved and their line manager, as a minimum.

c) Consider who else inside and outside the organisation should be made aware.

d) Take appropriate action (as set out in the next section).

20.7 Breaches could require action in one or more of the following ways:

a) Clarification or strengthening of existing policy, process and procedures.

b) Consideration as to whether HR/employment law/contractual action should be taken against staff or others.

c) Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Protect, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

d) Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.

e) Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

20.8 These actions will not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisations can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach.

20.9 Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. In extreme cases, individuals could face personal civil liability.

20.10 To aid transparency, the ICBs will consider whether anonymised information on the breach and the actions taken should be published on the ICBs' website.

21. Equality and Diversity Statement

21.1 The ICBs pay due regard to the requirements of the Public Sector Equality Duty (PSED) of the Equality Act (2010) in policy development and implementation, as a commissioner and provider of services, as well as an employer.

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

21.3 The ICBs are committed to ensuring that their activities also consider the disadvantages that some people in the ICBs' 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.

21.4 To help ensure that these commitments are embedded in our day-to-day working practices, an Equality Impact Assessment has been completed, and is included within this policy at Appendix 4.

22. Communication, Monitoring and Review

22.1 The ICBs will establish effective arrangements for communicating the requirements of this policy, to include:

a) Communicating the publication of this policy at the time of issue.

b) Ensuring that the existence of this policy, and the requirements, are highlighted to new starters as part of the local induction process.

c) As a minimum, bi-annual reminders of the existence and importance of this policy will be sent out via established staff communication methods.

22.2 The implementation of this policy, and the effectiveness of the arrangements detailed within it, will be monitored by the ICBs' Audit Committees on a bi-annual basis.

22.3 This policy will be reviewed by the ICBs' Boards every three years or in light of any legislative changes or best practice guidance.

22.4 Any individual who has queries regarding the content of this policy or has difficulty understanding how this policy relates to their role, should contact the ICBs' Governance Leads.

23. Training

23.1 Individuals will be made aware of this policy at induction and through regular reminders via the ICBs' staff communication channels.

23.2 Advice, training and support for staff on how interests should be managed will be available to individuals via the ICBs Governance Leads.

24. Interaction with other policies

24.1 This policy should be read in conjunction with the following ICB policies:

- Fraud, Corruption and Bribery Policy
- Procurement Policy
- Raising Concerns at Work (Freedom to Speak Up) Policy
- Secondary Employment Policy
- Disciplinary Policy
- Confidentiality and Data Protection Policy

Appendix 1: The Seven Principles of Public Life set out by the Committee on Standards in Public Life (The Nolan Principles)

Selflessness	Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
Integrity	Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
Objectivity	In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
Accountability	Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
Openness	Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
Honesty	Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
Leadership	Holders of public office should promote and support these principles by leadership and example.

Appendix 2: Categories of Interests

Type of Interest	Description
Financial	Where an individual may get direct financial benefits* from the consequences of a decision their organisation makes. This could include: • A director (including a non-executive director) or senior employee in another organisation which is doing or is likely to do business with an organisation in receipt of NHS funding. • A shareholder, partner or owner of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding. • Someone in outside employment. • Someone in receipt of secondary income. • Someone in receipt of a grant. • Someone in receipt of other payments (e.g. honoraria, day allowances, travel or subsistence). • Someone in receipt of sponsored research.
Non-financial professional interests	Where an individual may obtain a non-financial professional benefit* from the consequences of a decision their organisation makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where the individual is: • An advocate for a particular group of patients. • A clinician with a special interest. • An active member of a particular specialist body. • An advisor for the Care Quality Commission or National Institute of Health and Care Excellence. • A research role.
Non-financial personal interests	This is where an individual may benefit* personally from a decision their organisation makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • A member of a voluntary sector board or has a position of authority within a voluntary sector organisation. • A member of a lobbying or pressure group with an interest in health and care.
Indirect interests	This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who

Type of Interest	Description
	would stand to benefit* from a decision they are involved in making. This would include**: • Close family members and relatives. • Close friends and associates. • Business partners.
Loyalty interests	This is 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. This would include: • Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role: • Sit on advisory groups or other paid or unpaid decision making forums that can influence how their organisation spends taxpayers' money. • Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners. • Are aware that their organisation does business with an organisation with whom close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

Appendix 3: Declaration of Interest Form

Declaration of Interest Form

This declaration form is used across NHS Derby and Derbyshire, NHS Lincolnshire and NHS Nottingham and Nottinghamshire Integrated Care Boards (ICBs). Each ICB remains a separate statutory body and must individually demonstrate compliance with NHS England's 'Managing Conflicts of Interest in the NHS' guidance.

A conflict of interest can be described 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."*

Declarations of interest should be made as soon as reasonably practicable and by law; within 28 days after the interest arises (this could include an interest an individual is pursuing).

Further details on conflicts of interest management can be found in the ICB's Standards of Business Conduct Policy or NHS England's Managing Conflicts of Interest in the NHS: Guidance for Staff and Organisations.

Please complete the following:

Full Name:		**Role:**	
Start Date of current post:		**Directorate:**	

Please complete:

Section A and **Section C** if you have interests to declare.

Section B and **Section C** if you have no interests to declare.

Section A

Description of Interest - please include all relevant details, e.g.: - Nature of interest - Name of the organisation and the nature of business - Details of relationship for indirect interests	Type of Interest (See section D)				Date of Interest		How is the interest relevant to your ICB role and which ICB does it relate to? *Please explain how this interest could affect (or appear to affect) your ICB responsibilities and tick which ICB(s) it applies to.*
	Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect Interest	Date From:	Date To: (leave blank if end date is unknown)	
	☐	☐	☐	☐	Click or tap to enter a date.	Click or tap to enter a date.	Relevant ICB area(s):

Description of Interest - please include all relevant details, e.g.: **- Nature of interest** **- Name of the organisation and the nature of business** **- Details of relationship for indirect interests**	**Type of Interest (See section D)**				**Date of Interest**		**How is the interest relevant to your ICB role and which ICB does it relate to?** *Please explain how this interest could affect (or appear to affect) your ICB responsibilities and tick which ICB(s) it applies to.*
	Financial Interests	**Non-Financial Professional Interests**	**Non-Financial Personal Interests**	**Indirect Interest**	**Date From:**	**Date To:** **(leave blank if end date is unknown)**	
							D&D ☐ Lincs ☐N&N ☐ All ☐
	☐	☐	☐	☐	Click or tap to enter a date.	Click or tap to enter a date.	Relevant ICB area(s): D&D ☐ Lincs ☐N&N ☐ All ☐
	☐	☐	☐	☐	Click or tap to enter a date.	Click or tap to enter a date.	

Description of Interest - please include all relevant details, e.g.: - Nature of interest - Name of the organisation and the nature of business - Details of relationship for indirect interests	Type of Interest (See section D)				Date of Interest		How is the interest relevant to your ICB role and which ICB does it relate to? *Please explain how this interest could affect (or appear to affect) your ICB responsibilities and tick which ICB(s) it applies to.*
	Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect Interest	Date From:	Date To: (leave blank if end date is unknown)	
							Relevant ICB area(s): D&D ☐ Lincs ☐N&N ☐ All ☐
	☐	☐	☐	☐	Click or tap to enter a date.	Click or tap to enter a date.	Relevant ICB area(s): D&D ☐ Lincs ☐N&N ☐ All ☐

Section B

Please tick the box ☐ to confirm that you have **no relevant interests** to declare.

Section C

Please tick the box ☐ to confirm the following statement: The information I have provided above is complete and correct. I acknowledge that any changes to my declaration must be notified to the ICB as soon as practicable, and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, professional regulatory or internal disciplinary action may result.

The information submitted will be held by the ICBs for personnel or other reasons specified in this email and to comply with the ICB's policies. This information will be held in electronic form in accordance with the Data Protection Act 2018 and may be disclosed to third parties in accordance with the Freedom of Information Act 2000.

The ICB is obliged to publish the interests of decision making staff on its website. If you have any concerns about this, please raise these in your response and explain why you consider that the information you supply should not be made publicly available.

Signed:

Date: Click or tap to enter a date.

Appendix 4: Equality Impact Assessment

Name of Policy	Standards of Business Conduct Policy
Date of Completion	7th October 2025
EIA Responsible Person	ICB Governance Leads

For the policy, please answer the following questions against each of the protected characteristics, human rights and health groups:	What are **the actual, expected or potential positive impacts** of the policy, process, strategy or service change?	What are the **actual, expected or potential negative impacts** of the policy, process, strategy or service change?	What **actions have been taken** to address the actual or potential **positive and negative impacts** of the policy, process, strategy or service change?
Age	There are no actual or expected positive impacts on the characteristic of Age.	There are no actual or expected positive impacts on the characteristic of Age.	None.
Disability[1] (including: mental, physical, learning, intellectual and neurodivergent)	There are no actual or expected positive impacts on the characteristic of Disability.	There are no actual or expected positive impacts on the characteristic of Disability.	Mechanisms are in place via the Communications and Engagement Teams to receive the policy in a range of large print, Braille, audio, electronic and other accessible formats.
Gender[2](Including: trans, non-binary and gender reassignment)	There are no actual or expected positive impacts on the characteristic of Gender.	There are no actual or expected positive impacts on the characteristic of Gender.	None.
Marriage and Civil Partnership	There are no actual or expected positive impacts on the characteristic of Marriage or Civil Partnership.	There are no actual or expected positive impacts on the characteristic of Marriage or Civil Partnership.	None.

For the policy, please answer the following questions against each of the protected characteristics, human rights and health groups:	What are **the actual, expected or potential positive impacts** of the policy, process, strategy or service change?	What are the **actual, expected or potential negative impacts** of the policy, process, strategy or service change?	What **actions have been taken** to address the actual or potential **positive and negative impacts** of the policy, process, strategy or service change?
Pregnancy and Maternity	There are no actual or expected positive impacts on the characteristic of Pregnancy and Maternity.	There are no actual or expected positive impacts on the characteristic of Pregnancy and Maternity.	None.
Race[3]	There are no actual or expected positive impacts on the characteristic of Race.	There are no actual or expected positive impacts on the characteristic of Race.	Mechanisms are in place via the Communications and Engagement Team to receive the policy in a range of languages.
Religion and Belief[4]	There are no actual or expected positive impacts on the characteristic of Religion and Belief.	There are no actual or expected positive impacts on the characteristic of Religion and Belief.	None.
Sex[5]	There are no actual or expected positive impacts on the characteristic of Sex.	There are no actual or expected positive impacts on the characteristic of Sex.	None.
Sexual Orientation[6]	There are no actual or expected positive impacts on the characteristic of Sexual Orientation.	There are no actual or expected positive impacts on the characteristic of Sexual Orientation.	None.
Human Rights[7]	There are no actual or expected positive impacts on the characteristic of Human Rights.	There are no actual or expected positive impacts on the characteristic of Human Rights.	None.

For the policy, please answer the following questions against each of the protected characteristics, human rights and health groups:	What are **the actual, expected or potential positive impacts** of the policy, process, strategy or service change?	What are the **actual, expected or potential negative impacts** of the policy, process, strategy or service change?	What **actions have been taken** to address the actual or potential **positive and negative impacts** of the policy, process, strategy or service change?
Community Cohesion and Social Inclusion[8]	There are no actual or expected positive impacts on the characteristic of Community Cohesion and Social Inclusion.	There are no actual or expected positive impacts on the characteristic of Community Cohesion and Social Inclusion.	None.
Safeguarding[9]	There are no actual or expected positive impacts on the characteristic of Safeguarding.	There are no actual or expected positive impacts on the characteristic of Safeguarding.	None.
Socioeconomic and other 'at risk' groups[10] (Including carers, homeless, Looked After Children, living in poverty, asylum seekers, rural communities, victims of abuse, ex-offenders)	There are no actual or expected positive impacts on the characteristic of other 'at risk' groups.	There are no actual or expected positive impacts on the characteristic of other 'at risk' groups.	None.

[1]**Disability** refers to anyone who has: "…a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities…" (Equality Act 2010 definition). This includes, but is not limited to: mental health conditions, learning disabilities, intellectual disabilities, neurodivergent conditions (such as dyslexia, dyspraxia and dyscalculia), autism, many physical conditions (including HIV, AIDS and cancer), and communication difficulties (including d/Deaf and blind people).

[2]**Gender**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: "A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex."

[3]**Race**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: A person's colour, nationality, or ethnic or national origins. This also includes people whose first spoken language is not English, and/or those who have a limited understanding of written and spoken English due to English not being their first language.

[4]**Religion and Belief**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: Religion means any religion and a reference to religion includes a reference to a lack of religion. Belief means any religious or philosophical belief and a reference to belief includes a reference to a lack of belief.

[5]**Sex**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: A reference to a person who has a particular protected characteristic and is a reference to a man or to a woman.

[6]**Sexual Orientation**, in terms of a Protected Characteristic within the Equality Act 2010, refers to: Sexual orientation means a person's sexual orientation towards persons of the same sex, persons of the opposite sex or persons of either sex.

[7]**The Human Rights Act 1998** sets out the fundamental areas that everyone and every organisation must adhere to. In relation to health and care, the most commonly applicable of the Articles within the Human Rights Act 1998 include: Article 2 Right to Life, Article 5 Right to Liberty and Security, Article 8 Right to Respect of Private and Family Life, and Article 9 Freedom of Thought, Conscience and Religion.

[8]**Community Cohesion** is having a shared sense of belonging for all groups in society. It relies on criteria such as: the presence of a shared vision, inclusion of those with diverse backgrounds, equal opportunity, and supportive relationships between individuals. **Social Inclusion** is defined as the process of improving the terms of participation in society, particularly for people who are disadvantaged, through enhancing opportunities, access to resources, voice and respect for rights (United Nations definition). For the EQIA process, we should note any positive or negative impacts on certain groups being excluded or not included within a community or societal area. For example, people who are homeless, those from different socioeconomic groups, people of colour or those from certain age groups.

[9]**Safeguarding** means: "…protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility" (NHS England definition). Those most in need of protection are children, looked after children, and adults at risk (such as those receiving care, those under a DoLS or LPS Order, and those with a mental, intellectual or physical disability). In addition to the ten types of abuse set out in the Health and Care Act 2022, this section of the EQIA should also consider PREVENT, radicalisation and counterterrorism.

[10]**Other Groups** refers to anyone else that could be positively or negatively impacted by the policy, process, strategy or service change. This could include, but is not limited to: carers, refugees and asylum seekers, people who are homeless, gypsy, Roma and traveller communities, people living with an addiction (e.g., alcohol, drugs or gambling), people experiencing social or economic deprivation, and people in stigmatised occupations (e.g., sex workers).

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Risk Management Policy

November 2025 – November 2028

Policy purpose and key messages
The purpose of this policy is to set out how NHS Derby and Derbyshire Integrated Care Board, NHS Lincolnshire Integrated Care Board and NHS Nottingham and Nottinghamshire Integrated Care Board (ICBs) will manage both strategic and operational risks. It seeks to ensure alignment of working practices during the ICB transition programme, in accordance with the NHS 10-year plan. This policy aims to ensure that risk management is viewed as an essential process within the ICBs and provides assurance to the public, patients, and partner organisations that risks are being managed appropriately. It sets out the risk architecture of the ICBs (roles, responsibilities, communication and reporting arrangements) and describes how risk management is integrated into governance arrangements, key business activities and culture.

CONTROL RECORD	
Title	Risk Management Policy
Reference number	*To be inserted*
Version	*To be inserted*
Status	Draft
Author	ICB Risk Management Leads
Sponsor	Amanda Sullivan, Chief Executive
Team	Corporate Governance
Amendments	Not applicable
Superseded documents	NHS Derby and Derbyshire ICB Risk Management Policy v3.0 NHS Lincolnshire ICB Risk Management Strategy (ICB Corporate 013) NHS Nottingham and Nottinghamshire ICB Risk Management Policy GOV-001 v.2.5
Audience	All staff within NHS Derby and Derbyshire Integrated Care Board, NHS Lincolnshire Integrated Care Board and NHS Nottingham and Nottinghamshire Integrated Care Board.
Consulted with	Not applicable.
Equality Impact Assessment	September 2025
Approving body	Boards of NHS Derby and Derbyshire Integrated Care Board, NHS Lincolnshire Integrated Care Board and NHS Nottingham and Nottinghamshire Integrated Care Board
Date approved	*To be inserted*
Date of issue	*To be inserted*
Review date	*To be inserted*
Policy retention period	*To be inserted*
This is a controlled document and whilst this policy may be printed, the electronic version available on the ICB's document management system is the only true copy. As	

a controlled document, this document should not be saved onto local or network drives.

Table of Contents

1. Introduction

1.1 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 ICBs are statutory organisations which form part of the wider Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire Integrated Care Systems (ICS). While this policy specifies risk management arrangements for the statutory ICBs, it is essential that these arrangements operate collaboratively with other key components of the respective ICS families.

Figure 1 – Key parts of the Integrated Care System (ICS)

1.3 The management of risk across organisational boundaries is complex. Governance models should allow sovereign organisations to manage their own risks independently, whilst enabling a strong and holistic partnership approach to risk management to support the delivery of system priorities.

1.4 The ICBs recognise that risk management is an essential business activity that underpins the achievement of an organisation's objectives. A proactive and robust approach to risk management can:

- Reduce risk exposure through the development of a 'lessons learnt' environment and more effective targeting of resources.
- Support informed decision-making to allow for innovation and opportunity.
- Enhance compliance with applicable laws, regulations and national guidance.
- Increase stakeholder confidence in corporate governance and ability to deliver.

1.5 Risk is accepted as an inherent part of health care. Likewise, uncertainty and change in the evolving healthcare landscape may require innovative approaches that bring with them more risk. Therefore, it is not practical to aim for a risk-free or risk-averse environment; rather one where risks are considered as a matter of course and identified and managed appropriately.

1.6 This policy has been developed to ensure that risk management is fundamental to all activities of the ICBs and is understood as the business of everyone. The policy has adopted the following principles of risk management as set out in the ISO 31000: 2018 standard[1].

Principle	Description
Integrated	Risk management is an integral part of all organisational activities.
Inclusive	Appropriate and timely involvement of stakeholders enables their knowledge, views and perceptions to be considered. This results in improved awareness and informed risk management.
Structured and comprehensive	A structured and comprehensive approach to risk management contributes to consistent and comparable results.
Customised	The risk management framework and process are customised and proportionate to the organisation's external and internal context related to its objectives.
Dynamic	Risks can emerge, change or disappear as an organisation's external and internal context changes. Risk management anticipates, detects, acknowledges and responds to those changes and events in an appropriate and timely manner.
Best available information	The inputs to risk management are based on historical and current information, as well as on future expectations. Risk management explicitly considers any limitations and uncertainties associated with such information and expectations. Information should be timely, clear and available to relevant stakeholders.
Human and cultural factors	Human behaviour and culture significantly influence all aspects of risk management.
Continual improvement	Risk management is continually improved through learning and experience.

Table 1 – ISO 31000 principles of risk management

[1] ISO 31000 helps organisations develop a risk management approach to effectively identify and mitigate risks, thereby enhancing the likelihood of achieving their objectives and increasing the protection of their assets. https://www.iso.org/iso-31000-risk-management.html

1.7 This policy demonstrates the commitment of the ICBs to a total risk management function. It sets out the risk architecture of the ICBs (roles, responsibilities, communication and reporting arrangements) and describes how risk management is integrated into governance arrangements, key business activities and culture.

2. Purpose

2.1 This policy describes the approach of the ICBs to the management of strategic and operational risks across the respective statutory organisations.

2.2 The purpose of this policy is to encourage a culture where risk management is viewed as an essential process of the activities of the ICBs. It provides assurance to the public and partner organisations that the ICBs are committed to managing risk appropriately.

2.3 This policy aims to achieve several key objectives, including:

- Outline the benefits of risk management.
- Explain the risk appetite and approach to tolerance within the ICBs.
- Set out the ambition of the ICBs to continuously improve risk management arrangements.
- Outline the approach to implementation and monitoring.
- Describe the relevant compliance and assurance arrangements regarding risk management within the ICBs.
- Ensure there is a robust system in place to manage risk effectively.

3. Scope

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

4. Definitions

4.1 Definitions and a glossary of terms referenced in this policy are described in Appendix A.

4.2 The diagram below summarises the differences between strategic and operational risks. Further detail is provided at Appendix B.

Figure 2 – The two types of risks

5. Roles and Responsibilities

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

Role	Responsibilities
Forums	
Integrated Care Boards	The Boards have overall accountability for risk management and, as such, need to be satisfied that appropriate arrangements are in place and that internal control systems are functioning effectively. The Boards determine the ICBs' joint risk appetite and risk tolerance levels and are also responsible for establishing the joint risk culture.
Audit Committees	The Audit and Risk Committees provide the Boards with assurance on the effectiveness of the Board Assurance Framework and the robustness of the ICBs' operational risk management processes. The role is not to 'manage risks' but to ensure that the approach to risks is effective and meaningful. In particular, the Committees support the Boards by obtaining assurances that controls are working as they should, seeking assurance about the underlying data upon which assurances are based and challenging relevant managers when controls are not working, or data is unreliable.
ICB Committees	Committees are responsible for monitoring operational risks related to their delegated duties* as outlined within their respective Terms of Reference. This will

Role	Responsibilities
	include monitoring the progress of actions, robustness of controls and timeliness of mitigations. They are also responsible for identifying risks that arise during meeting discussions and ensuring that these are captured on the Operational Risk Register.
Operational groups with oversight of Information Governance	Data protection and information security risks identified through operational activities, DPIAs, or the DSPT are recorded in a combined IG, IT, and cyber risk log. This log includes tailored mitigations for each risk and is regularly updated and reviewed to ensure all risks are current and effectively managed.
Executive Management Team	The Executive Management Team (EMT) provides oversight of the organisations' approach to risk management. It ensures risks are appropriately owned, assessed, and mitigated, and that controls are effective. The EMT reviews escalated risks, determines whether further action or escalation to the Boards is required, and monitors trends to support proactive risk management and continuous improvement.
Individuals	
Chief Executive	The Chief Executive has responsibility for maintaining a sound system of internal control that supports the achievement of the ICB's policies, aims and objectives, whilst safeguarding public funds and assets. As part of the BAF, the Chief Executive on behalf of the Boards, will publish statements on internal control known as the Annual Governance Statements. These will give stakeholders confidence that the ICBs can demonstrate they are adequately informed about the totality of their risks.
ICB Non-Executive and Partner Members	As members of the Boards and committees, Non-Executive Members will ensure an impartial approach to risk management activities and should satisfy themselves that systems of risk management are robust and defensible.
Senior Leadership Team member with oversight of risk management	This individual leads on the implementation of corporate governance and risk and assurance systems across the ICBs. This includes the development, implementation and co-ordination of the risk

Role	Responsibilities
(supported by the Risk Management Team)	management activities and provision of training and advice in relation to all aspects of this policy.
Risk Management Team	The Risk Management Team is responsible for consolidating, reviewing, and reporting risk management information, and for providing guidance and support to ensure the Risk Management Policy is applied consistently across the ICBs. This includes supporting the implementation of risk management arrangements, maintaining the operational risk register and Board Assurance Framework, providing guidance and training to staff on risk management processes, and monitoring the application of the policy in practice to ensure operational and strategic risks are appropriately identified, assessed, mitigated, and escalated. The Risk Management Team work with subject matter experts to identify risks and articulate control and mitigation strategies.
Executive Directors	Executive Directors are responsible for ensuring effective systems of risk management are in place, and commensurate with this policy, within their respective Directorates. This includes promoting the risk culture and ensuring all senior leaders, within their respective Directorates, have a robust understanding of risk management arrangements.
Senior Leadership Team *(including Associate/Deputy Directors)*	Members of the Senior Leadership Team are responsible for leading risk management arrangements within their Teams, which includes, but is not limited to, ensuring that: • Risk Logs are in place, as appropriate, to support delivery of team, place and project/programme objectives. • Operational risks are appropriately escalated from Risk Logs to the Operational Risk Register. • Mitigating actions are in place to manage risks in line with the risk appetite statement; and • Staff are suitably trained in relation to risk management.

Role	Responsibilities
Senior Information Risk Owner (SIRO)	The SIRO takes ownership of the ICBs' information risks. The SIRO operates at Board level and is responsible for ensuring that organisational information risk is properly identified and managed, and that appropriate assurance mechanisms exist to support effective information risk management.
Risk Owners	Risk owners are responsible for the effective management of the risks assigned to them. This includes ensuring that appropriate mitigating actions are identified, implemented, and monitored to reduce the risk to an acceptable level. Risk owners are also responsible for providing timely and accurate updates on their risks as part of the regular risk review process coordinated by the Risk Management Team.
Information Asset Owners (IAOs) ***(Executive/ Senior Leadership Level)***	Information Asset Owners (IAOs) are responsible for ensuring risks relating to information assets under their control are managed securely, in compliance with data protection and information governance policies. They oversee the use, protection and retention of data, ensuring that risks are mitigated, and access is appropriately controlled. This role is supported by the Information Asset Managers, see the Information Governance Management Framework for further detail.
Individuals	All individuals are required to comply with this policy and are expected to consider risks in all activities, including business planning, procurement, and project delivery. This includes identifying risks at the outset of projects or activities, conducting risk assessments where necessary, and continuously reviewing risks throughout the lifecycle. Individuals must integrate risk considerations into planning, procurement, and operational decisions, and ensure that any operational risks they identify are appropriately recorded on local risk logs or the ICB's Operational Risk Register in line with the assessed risk score.

Table 2 – Roles and responsibilities

6. Risk Appetite

6.1 Good risk management is not about being risk averse, it is also about recognising the potential for events and outcomes that may result in opportunities for improvement, as well as threats to success.

6.2 A 'risk aware' organisation encourages innovation to achieve its objectives and exploit opportunities and can do so in confidence that risks are being identified and controlled by senior managers.

6.3 The sovereign ICB Boards have previously approved individual risk appetites, which have now been aligned to create a joint risk appetite statement as follows:

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. 1 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. 2 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.

6.4 The above is further supplemented with a risk appetite matrix, which will describe the organisation's approach to risk taking across five levels, from averse (taking little or no risk) to significant (taking higher levels of risk). *NB: The development and implementation of the risk appetite narrative and matrix will be undertaken during late 2025/26, in line with the clustering of ICBs and associated management of change processes.*

7. Risk Tolerance

7.1 Whilst risk appetite is about the pursuit of risk, risk tolerance is concerned with the level of risk that can be accepted (e.g. it is the minimum and maximum level of risk the ICBs are willing to accept reflective of the risk appetite statement above).

7.2 A target risk score range is applied to each of the ten risk domains: the target risk score being the acceptable level of risk able to be tolerated by the ICBs. A target risk score will be agreed for each risk and mitigating actions identified as appropriate. *NB: The development and implementation of a target risk score range, and the associated risk appetite matrix, will be deferred until late 2025/26, as highlighted at 6.4 above.*

7.3 It is recognised that some risks are unavoidable and will be out of the ability of the ICBs to mitigate to a tolerable level. Where this is the case, the focus will move to the controls in place to manage the risks and the contingencies planned should the risks materialise.

8. Strategic Risk Management

8.1 Strategic risks are high-level risks that are pro-actively identified and threaten the achievement of the ICB's strategic objectives and key statutory duties. Strategic risks are owned by members of the Executive Management Team and are outlined within the **(Board Assurance Frameworks (BAF))** of the ICBs.

8.2 The Assurance Framework provides the Boards with confidence strategic risks have been identified and there are robust systems, policies and processes in place (*controls*) that are effective and driving the delivery of their objectives (*assurances*). It provides confidence and evidence to management that 'what needs to be happening is actually happening in practice.

8.3 The Assurance Framework also provides a structured approach for the Boards to gain assurance that key strategic risks are being effectively managed. It aligns with the three lines of defence model, where operational management (first line) manages risks day-to-day, oversight functions such as risk and governance teams (second line) provide monitoring and challenge,

and internal audit (third line) provides independent assurance. This alignment ensures clear accountability and supports the Board in making informed decisions on the management of strategic risks (see Figure 3).

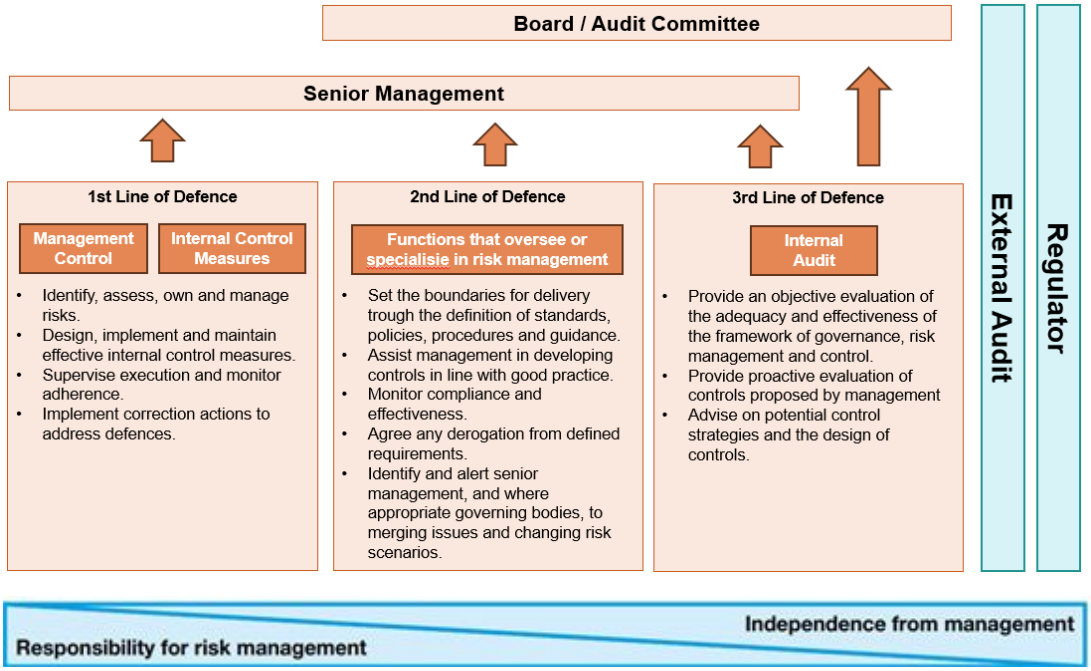

Figure 3 – Three lines of defence model [2]

8.4 The Assurance Framework plays a key role in informing the production of the Annual Governance Statements and is the main tool that the Boards should use in discharging overall responsibility for ensuring that an effective system of internal control is in place.

8.5 The Boards approve the strategic risks (opening position) during the first quarter of the financial year, following agreement of the strategic objectives. The Boards review the fully populated Assurance Framework bi-annually to affirm that sufficient levels of controls and assurances are in place in relation to the organisation's strategic risks.

8.6 The Assurance Framework is reviewed and updated by Executive Directors throughout the year. This involves a review of the effectiveness of controls and what evidence (internal or external) is available to demonstrate that they are

[2] Adapted from HM Treasury Orange Book - More information is available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/866117/6.6266_HMT_Orange_Book_Update_v6_WEB.PDF

working as they should (assurances). Any gaps in controls or assurances will be highlighted at this point and actions identified.

8.7 The Audit Committees receive a rolling programme of targeted assurance reports which, over a 12-month period, covers all the ICB's strategic objectives (the full Assurance Framework). This enables a focussed review on specific sections of the Assurance Framework and allows for robust discussions on the actions in place to remedy any identified gaps in controls and assurances. *NB: These reports will be implemented from 2026/27, allowing for a full-year cycle following the clustering of the three ICBs.*

8.8 Assurance provides evidence that risks to objectives are being appropriately managed and controlled. Its purpose is to give confidence that risks are effectively mitigated, with higher levels of assurance reflecting greater confidence in risk management. Risk owners and leads achieve this by conducting in-depth assessments of the evidence supporting risk controls. While it is not possible to provide complete or absolute assurance, the concept of positive and negative assurance is applied: positive assurance (+) indicates that controls are effective and risks are being managed as intended, whereas negative assurance (–) indicates that controls are not effective, and risks may not be adequately mitigated.

9. Operational Risk Register

9.1 Operational risks are 'live' risks the ICBs are currently facing which are by-products of day-to-day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives.

9.2 Operational risk management relies upon reactive identification of risks, which are 'dynamic' in nature. Operational risks are managed via additional mitigations and are captured on the **Operational Risk Register**.

9.3 The Operational Risk Register is the central repository for all the three ICBs operational risks. Whilst risks will feature across several processes, it is important that these are captured centrally to provide a comprehensive log of prioritised risks that accurately reflect the risk profiles of the ICBs.

9.4 The Operational Risk Register contains details of the risk, the current controls in place and an overview of the actions required to mitigate the risk to the desired level. A named individual (risk owner) is given responsibility for ensuring the action is completed by the specified due date.

10. Risk Logs

10.1 Risk logs are used to record operational risks at **individual team, directorate and programme/project-level.**

10.2 Risk logs provide a means to record operational risks at team, directorate, or programme/project level. During the current clustering and transition period, their use is optional and may be adopted where helpful to support local risk management. Risks not significant enough for the Operational Risk Register can be captured in risk logs, aligned with team or programme objectives.

10.3 Oversight of risk logs is the responsibility of the relevant senior manager, who may choose to review them within project or team meetings. Risks that could impact the achievement of ICB priorities must be escalated to the Operational Risk Register. As risk logs are maintained at team or project level, a risk reaching a medium or high score should prompt review and discussion but will not necessarily result in automatic escalation. This reflects the distinction between risks assessed against team-level objectives and those affecting ICB-wide objectives recorded on the Operational Risk Register. Guidance and support on risk logs and escalation are available from the Risk Management Team. Their use and governance will be reviewed and strengthened once leadership and management arrangements are fully established.

11. Risk Management Processes

11.1 Risk management is a multi-faceted process of continuous improvement; the main elements are described below.

Risk Assessments

11.2 Risk assessments can be undertaken at the start of any activity and provide a helpful means of anticipating ‘what could go wrong’ and deciding on preventative actions. For specific risk assessments relating to workplace safety (e.g. use of display screen equipment, lone working, maternity, etc.), please refer to the health and safety policies.

11.3 When identified risks are considered to have the potential to directly impact the achievement of the ICBs’ priorities, these must be captured on the Operational Risk Register. The ICBs’ Risk Management Team can offer support and guidance regarding risk escalation.

Objectives Framework

11.4 Objectives define the scope, context, and criteria or risk appetite that are used to identify and manage risks. If objectives are not established or are unclear, risks cannot be determined. Understanding the context is essential because risk management occurs within the framework of the objectives and activities of the ICBs. Further details are provided in the table below.

Objective	Oversight	Recording	Risk Management Role
Strategic	ICB Board	Board Assurance Framework	Risks are linked to the agreed strategic objectives of the ICBs. Updates and assurance are provided by executives to the Board to support oversight and decision-making.
Operational	ICB Committees	Operational Risk Register	Managed by the Risk Management Team, operational risks relate to high-level corporate priorities and statutory functions. Risk owners provide updates and assurance on mitigation and control measures
Local	Teams (ICB Directorate / team / programme)	Risk Log	Managed locally within teams in line with their directorate, team, or programme objectives. Teams identify and monitor risks to achieving these priorities/objectives. Risks may be escalated to the Operational Risk Register through review discussions with the Risk Management Team and relevant senior managers.

Table 3 – Risk log and operational risk register process

Risk Identification

11.5 Operational risks (those which require adding to the Operational Risk Register) may be identified through an assortment of means, including but not limited to:

- horizon-scanning for external and internal environmental factors that might threaten the achievement of priorities/objectives.
- formal risk assessment exercises.
- lessons learnt following an incident or a complaint.
- discussion at a meeting (e.g. a Board, Committee, Transformation Board or Team meeting).
- completion / review of a project business case or associated Equality Impact Assessment (EQIA).

- discussions with providers.
- external assessments.
- audits (internal / external) - any medium (or higher) risks identified within internal or external audit reports are captured within the Operational Risk Register.

11.6 Factors to be considered when identifying a risk include:

- tangible and intangible sources of risk.
- causes and events, threats and opportunities.
- vulnerabilities and capabilities.
- changes in the external and internal context.
- indicators of merging risks.
- the nature and value of assets and resources.
- consequences and their impact on objectives.
- limitations of knowledge and reliability of information.
- time related factors / likelihood of risk materialising over the next 12 to 18 months.

11.7 The committees of the ICBs all have a key role in the identification of risks in response to information presented to, and discussions held, at each meeting. A standing agenda item is included for every meeting to determine if there are any new risks that need to be considered for the Operational Risk Register.

11.8 Regular meetings are held with Executive Directors and members of the Senior Leadership Team to discuss new or evolving risks within their respective portfolios/teams.

Risk Articulation

11.9 It is good practice to articulate risks using the 'cause, event and effect framework' as outlined in the table below.

Risk element	Question	Consideration	Wording
CAUSE	**What will cause the risk to occur?)**	Operational risks arise from definite events or circumstances linked to the day-to-day running of the organisation.	Where the cause is known, use: "**As a result of**…". If the cause is uncertain, hypothetical, or conditional, it may be appropriate to use: "**If…**".

EVENT	**What can go wrong?)**	The risk event is the specific thing that could go wrong, potentially disrupting operations or objectives.	**There is a risk ….**
EFFECT	**What will be the consequence/ effect if the risk were to materialise?)**	Risks may negatively impact the organisation and its ability to achieve objectives. The specific objective at risk should be reflected in the wording.	**Which may lead to ….**

Table 4 – Cause, event and effect framework

11.10 Training on writing risk statements is available from ICB's Risk Management Team, and you can find guidance documents along with Risk Log templates on the intranet page.

Risk Evaluation

11.11 Risks are evaluated by defining qualitative measures of impact and likelihood, as shown in the risk scoring matrix, shown in Appendix C, to determine the risk's RAG rating. Risk scores can be subjective; therefore, the scores will be subject to review by senior managers and/or the responsible committee.

11.12 When scoring the likelihood of a risk this should be assessed in the context of the likelihood of the risk materialising within the next 12 to 18 months.

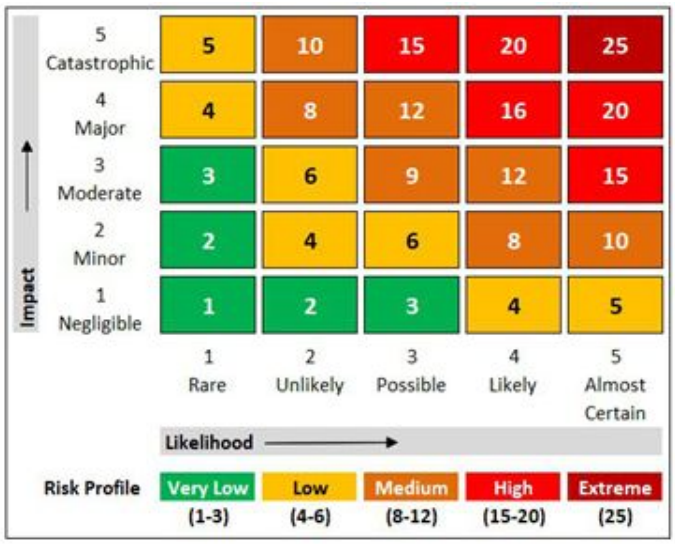

Figure 4 – 5x5 risk matrix

Risk Treatment

11.13 Risk treatment (also known as risk control) is the process of selecting and implementing measures to mitigate the risk to an acceptable level. Once risks have been evaluated, a decision should be made as to whether they need to be mitigated or managed through the application of controls (as described using the 'four T' risk treatment model below).

Treatment	Description
Terminate	Opt not to take the risk by terminating the activities that will cause it (more applicable to project risks).
Treat	Take mitigating actions that will minimise the impact of the risk prior to its occurrence and/or reduce the likelihood of the risk occurring.
Transfer	Transfer the risk, or part of the risk, to a third party.
Tolerate	Accept the risk and take no further actions. This may be due to the cost of risk mitigation activity not being cost effective or the impact is so low it is deemed acceptable to the organisation. Risks which are tolerated should continue to be monitored as future changes may make the risk no longer tolerable.

Table 5 – The 4T model (Risk treatment options)

11.14 Most operational risks should have the ability to reduce in impact and/or likelihood, and the relevant risk treatment must be performed to mitigate risks to an acceptable level in line with the risk appetite of the ICBs. High and extreme operational risks (those scoring 15 or above) which are not deemed to be treatable will be highlighted to the Board as part of routine risk reporting.

11.15 For operational risks scored below 12, the responsible committee may agree that they can be tolerated. However, this would be subject to the committee being satisfied that no other actions can be undertaken.

Management and Reporting of Risks

11.16 The reporting of risk is the process of communicating real time risks. Monitoring risk is a continuous activity that results in the awareness of what is happening across the organisation. Reports should help the ICBs to:

- Monitor agreed risk response plans/actions.
- Track key milestones.
- Evaluate the impact of controls and actions on the risk.
- Identify new or unexpected risks.

11.17 Reports should focus on what has changed to allow Executives and other decision makers to make informed decisions.

11.18 Updates to risks are to be obtained via risk review meetings held with Risk Management Team and the risk owner / executive leads. The table below describes the minimum frequency for updates based on the level of risk.

11.19 The following categories of risk grading provide a high-level view of management and reporting requirements. Expected management of risks at each grading has been designed in consideration of the ICB's risk appetite.

- The **ICB Boards** will oversee all risks with an overall score of 15 or above (e.g. any high and/or extreme operational risks from the Operational Risk Register) at each of its meetings.
- **Committees** will oversee all risks relevant to their remit with an overall score of 8 or above (e.g. medium rating and upwards) from the Operational Risk Register at each of their meetings.
- The **Audit Committees** will receive bi-annual risk management updates, including the full Operational Risk Register, which will enable any risk themes and trends to be reviewed; ensuring any multiple, similar risks of a minimal impact and likelihood are not ignored. This will support their duty to provide the Boards with assurance on the robustness and effectiveness of the ICB's risk management processes.

	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 Operational Risk Register?	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).

	Very Low (1-3)	Low (4-6)	Medium (8-12)	High (15-20)	Extreme (25)
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.

Table 6 – Reporting requirements

Archiving of Risks

11.20 Archiving risks within the ICBs is a structured process designed to ensure that the risk register remains current, relevant, and aligned with the evolving operational landscape. The decision to archive a risk typically follows a review with the risk owner.

11.21 Risks may be archived when they meet one of the following triggers:

- **Cause updated or no longer valid:** If the original cause of the risk has changed significantly or is no longer applicable, the risk may be archived. This ensures that the register does not retain outdated entries that no longer reflect the current operating environment.
- **Risk no longer reflects current challenge:** Risks that were once relevant but no longer pose a threat due to changes in service delivery, policy, or external conditions are candidates for archiving. This helps maintain a focused and actionable risk profile.
- **Risk fully mitigated, tolerated (at target risk score) or transferred**: Where controls have been successfully implemented and assurance is strong, the risk may be closed and archived. In some cases, risks may be transferred to another team or escalated to a different register (e.g. operational risk register to local risk log when the risk no longer meets the threshold for reporting on the operational risk register).

11.22 The rationale for archiving is documented, including any changes to the cause, context, or objective.

11.23 Updates are reflected in the Operational Risk Register or local risk logs, and archived risks are retained for audit purposes. Archiving is not deletion. Archived risks remain accessible for reference and audit.

12. Fraud Risks

12.1 The Government Functional Standard 013: Counter Fraud “Management of counter fraud, bribery and corruption activity” has applied to NHS organisations since April 2021. The standard is part of a suite of standards that promotes consistent and coherent ways of working across government, and provides a stable basis for assurance, risk management and capability improvement.

12.2 The NHS Counter Fraud Authority (NHSCFA) is a health authority charged with identifying, investigating and preventing fraud and other economic crime within the NHS. The NHSCFA requires the organisation to undertake a local risk assessment to identify fraud, bribery and corruption risks and to ensure these are recorded and managed in line with its risk management policy.

12.3 A separate joint fraud risk register will be maintained by the ICBs and reported to the Audit Committees once a year (as a minimum), to coincide with the Counter Fraud annual planning process.

13. Information Risks

13.1 Information risk management is led by the Senior Information Risk Owner (SIRO) who is responsible for ensuring that information risks are effectively identified, assessed, and managed. The SIRO also ensures the organisation maintains compliance with all relevant legislation, including the Data Protection Act 2018, UK General Data Protection Regulation (UK GDPR), the Human Rights Act 1998, and other applicable information security and cybersecurity requirements.

13.2 The organisations recognise that information risks can arise from the loss, misuse, unauthorised access, or failure to protect information, whether in digital or physical form. These risks can impact the confidentiality, integrity, and availability of information, and must be managed through appropriate controls. Several arrangements are in place to support, manage and mitigate information risks which include, but are not limited to, the Information Asset and Data Flow Mapping registers, IG incident management arrangements and Data Protection Impact Assessments (DPIAs).

14. Performance Risks

14.1 The ICBs monitor performance against key delivery priorities via a separate, but parallel, process to the risk management arrangements.

14.2 To minimise duplication, failures to achieve performance standards are not routinely identified as specific risks on the Operational Risk Register. This should not indicate its absence from the organisation's overall risk profile and poor performance from a risk perspective will be referenced as necessary when reporting externally on risks (e.g., in the Annual Governance Statements).

14.3 The consistent non-delivery of performance standards will be assessed to ensure that any specific risks this poses to the functions of the ICBs (e.g., a detrimental impact on health outcomes, patient safety or experience) are identified and captured on the Operational Risk Register.

15. Management of Issues

15.1 An issue is a current problem, concern, or event that has already materialised and is impacting the organisations. Unlike a risk, which refers to a potential future event with uncertain outcomes, an issue represents something that is happening now and requires immediate attention or resolution.

15.2 Issues are not routinely recorded on the Operational Risk Register as they are managed via the performance management framework. However, senior leads/managers may use discretion as to whether local issues are captured on individual risk logs.

15.3 Known issues are an important mechanism to determine if there are any new risks needed to be identified, and captured, within the risk management arrangements. The Risk Management Team can provide further support and guidance on the management of issues.

16. Equality and Diversity Statement

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

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

16.3 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.

16.4 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.

17. Communication, Monitoring and Review

17.1 The policy will be published and maintained in line with the Policy Management Framework.

17.2 The policy will be highlighted to new staff as part of the local induction process and made available to all staff through internal communication procedures (and internet/intranet sites).

17.3 The Audit Committees will review the effectiveness of this policy, and its implementation, via bi-annual risk management update reports and targeted assurance reports.

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

18. Confidentiality

18.1 Confidential information related to risk management will be handled in accordance with the organisation's Information Governance policies and relevant data protection legislation. Access to such information will be restricted to authorised individuals on a need-to-know basis and stored securely using approved systems.

18.2 All staff have a responsibility to maintain the confidentiality of sensitive information, including risk registers, incident reports, and assurance documentation. This responsibility is underpinned by the UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018, and the Code of Conduct of the organisation.

18.3 Where risk-related information includes personal, clinical, or commercially sensitive data, additional safeguards, such as restricted access permissions, anonymisation, or redaction, will be applied. Any sharing of such information must be justified, proportionate, and documented in line with organisational procedures.

18.4 Where risks score 15 or above, are not deemed to be in the public interest, they will be clearly marked 'confidential' on the Operational Risk Register and reported to the Boards during the closed session. This should be for a time-limited period only and risk owners and committees are responsible for agreeing when confidentiality no longer applies.

19. Staff Training

19.1 The ICBs will proactively raise awareness of the risk management policy and provide ongoing support to committees and individuals to enable them to discharge their responsibilities effectively. Formal training sessions can be arranged through team meetings or other forums by contacting the designated risk management function.

19.2 The intranet will include accessible, bite-sized training materials on key risk management topics to support continuous learning.

19.3 Any individual with queries regarding the content of the policy or its relevance to their role should initially discuss these with their line manager. Further support can be sought from the Risk Management Team.

20. Interaction with other Policies

- Standard of Business Conduct Policy
- Health and Safety Policies
- Information Governance Policies

21. References

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- Financial Reporting Council. (2024). *UK Corporate Governance Code*. London: FRC.

22. Equality Impact Assessment

Date of assessment:	October 2025			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
Age[3]	There are no actual or expected impacts on the characteristic of age.	Not applicable.	Not applicable.	Not applicable.
Disability (Including: mental, physical, learning, intellectual and neurodivergent)[4]	There are no actual or expected impacts on the characteristic of disability.	Not applicable.	Not applicable.	Not applicable.
Gender (including trans, non-binary and gender reassignment)[5]	There are no actual or expected impacts on	Not applicable.	Not applicable.	Not applicable.

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

[4] 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.

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

Date of assessment:	October 2025			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
	the characteristic of gender.			
Marriage and civil partnership[6]	There are no actual or expected impacts on the characteristic of marriage and civil partnership	Not applicable.	Not applicable.	Not applicable.
Pregnancy and maternity[7]	There are no actual or expected impacts on the characteristic of pregnancy and maternity Status.	Not applicable.	Not applicable.	Not applicable.

[6] 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'.

[7] 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:	October 2025			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
Race[8]	There are no actual or expected impacts on the characteristic of race.	Not applicable.	Not applicable.	Not applicable.
Religion or belief[9]	There are no actual or expected impacts on the characteristic of religion or belief	Not applicable.	Not applicable.	Not applicable.
Sex[10]	There are no actual or expected impacts on the characteristic of sex.	Not applicable.	Not applicable.	Not applicable.

[8] 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.

[9] 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.

[10] A man or a woman.

Date of assessment:	October 2025			
For the policy, and its implementation, please answer the questions against each of the protected characteristic and inclusion health groups:	Has the risk of any potential adverse impact on people in this protected characteristic group been identified, such as barriers to access or inequality of opportunity?	If yes, are there any mechanisms already in place to mitigate the adverse impacts identified?	Are there any remaining adverse impacts that need to be addressed? If so, please state any mitigating actions planned.	Are there any positive impacts identified for people within this protected characteristic group? If yes, please briefly describe.
Sexual orientation[11]	There are no actual or expected impacts on the characteristic of sexual orientation.	Not applicable.	Not applicable.	Not applicable.
Carers[12]	There are no actual or expected impacts on the characteristic of carers.	Not applicable.	Not applicable.	Not applicable.

[11] 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

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

Appendix A: Definitions and Glossary of Terms

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

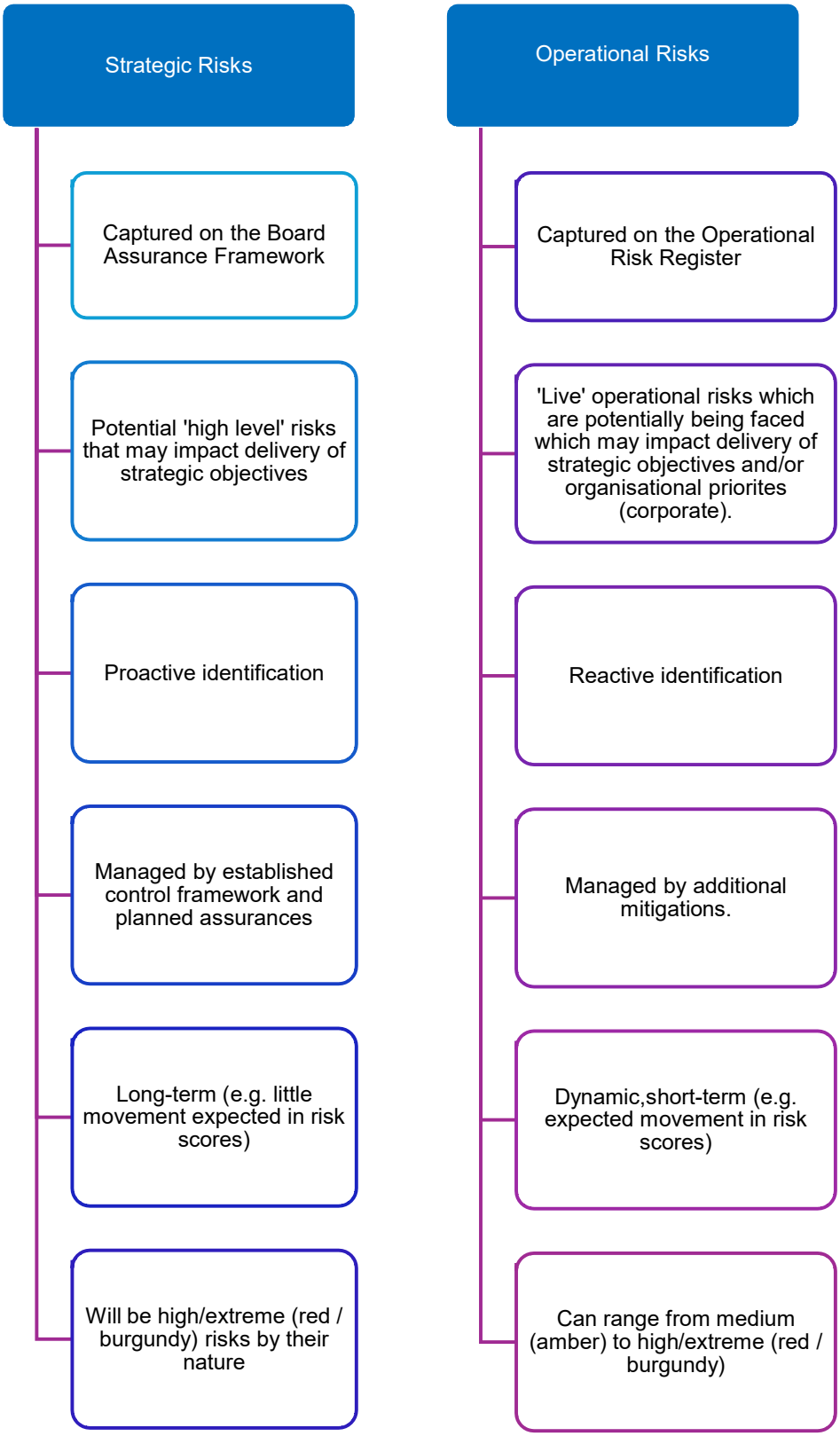
Term	Definition
Assurance	Evidence that controls are working effectively. Assurance can be internal (e.g. committee oversight) or external (e.g. internal audit reports).
Assurance Framework	A (Board) Assurance Framework is a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect. The Assurance Framework document is the key source of evidence that links an organisation's strategic objectives to risk, controls and assurances and the main tool a Board should use in discharging its responsibility for internal control.[13]
Controls	The measures in place to control risks and reduce the impact or likelihood of them occurring. • Internal controls include policies, procedures, practices, behaviours and organisations structures to manage risks and achieve objectives. • External controls may include oversight by regulatory bodies, external audits, independent reviews, or accreditation processes that provide additional assurance beyond the organisation itself.
Corporate risks	Operational risks which relate to the delivery of the statutory duties, functions and/or priorities/objectives of an organisation.
Current (or residual) risk score	The numerical assessment of the risk (impact vs. likelihood) after taking into consideration any mitigating controls and/or actions.
Information Asset	An information asset is a body of information, which can be as small as a single document, defined and managed as a single unit so it can be understood, shared, protected, and exploited efficiently. Information assets have recognisable and manageable value, lifecycles, and risks that could impact the confidentiality, integrity and availability of the information.
Initial risk (or inherent) risk score	The numerical assessment of the risk (impact vs. likelihood) prior to considering any additional mitigating controls and/or actions.

[13] NHS Governance, Fourth Edition 2017 (HfMA)

Term	Definition
Integrated Care Board (ICB)	An ICB is the statutory NHS organisation within the ICS which holds responsibility for NHS functions and budgets.
Integrated Care Partnership (ICP)	An ICP is a statutory committee which brings together all ICS system partners to produce a health and care strategy.
Integrated Care System (ICS)	An ICS is a partnership that brings together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of the population.
Operational Risk Register (ORR)	A tool for recording identified 'live' operational risks and monitoring actions to mitigate them.
Operational risk management	Risk management processes which focus on 'live' operational risks which an organisation is potentially facing. It relies upon the identification of risks, which are 'dynamic' in nature and are managed via additional mitigations. Operational risk management processes are centred around the Operational Risk Register.
Operational risks	These risks are by-products of day-to-day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on an organisation and its priorities/objectives. Operational risks include corporate risks (those which directly relate to the priorities/objectives/duties of an organisation).
Place-Based Partnerships (PBPs)	Place-based partnerships are collaborative arrangements formed by the organisations responsible for arranging and delivering health and care services in a locality or community.
Risk	There are many definitions of risk, but this policy has adopted the definition set out in ISO 31000 in that a risk is the 'effect of uncertainty on objectives'. The effects can be negative, positive or both. It is measured in terms of impact and likelihood.
Risk appetite	The total amount and type of risk that an organisation is willing to take to meet its strategic objectives. A range of appetites exist for different risk domains, and these may change over time.
Risk assessment	An examination of the possible risks that could occur during an activity.

Term	Definition
Risk culture	The values, beliefs, knowledge and understanding of risk, shared by a group of people with a common intended purpose.
Risk logs	Risk logs are a tool for capturing operational level risks at team/directorate/place/project level which may impact on the delivery of local objectives. Examples of risk logs may include directorate/team specific risk logs, project risk logs and transformation programme risk logs.
Risk management	The arrangements and activities in place that direct and control an organisation regarding risk.
Risk mitigation	How risks are going to be controlled to reduce the impact on an organisation and/or likelihood of their occurrence.
Risk profile	The nature and level of the threats faced by an organisation.
Risk treatment	The process of selecting and implementing suitable measures to modify the risk.
Strategic objectives	Strategic objectives describe a set of clear organisational goals that help establish priority areas of focus. Whilst broad and directional in nature, they need to be specific enough that their achievement can be assured, and progress measured. They should have direct alignment with the (Board) Assurance Framework and an organisation's performance management processes.
Strategic risk management	Risk management processes which support the achievement of the organisation's strategic objectives. It focuses on the proactive identification of 'high level' risks which are managed by an established control framework and planned assurances. Strategic risk management processes are centred around the (Board) Assurance Framework.
Strategic risks	Potential, significant risks that are pro-actively identified and threaten the achievement of strategic objectives.
Target risk score	The numerical level of risk exposure that an organisation is prepared to tolerate following completion of all the mitigating actions.
Three lines of defence model	A risk governance framework that splits responsibility for operational risk management across three functions, where operational management (first line) manages risks day-to-day, oversight functions such as risk and governance teams (second line) provide monitoring and challenge, and internal audit (third line) provides independent assurance.

Appendix B: Characteristics of Strategic and Operational Risks



Appendix C: Risk Scoring Matrix

Table 1A: Impact Score (I) Guidance

Impact Score	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Guidance	Negligible impact on objective/s. Day to day operational challenges.	Minor impact on objective/s. Temporary restriction to service delivery with limited impact on stakeholder confidence.	Moderate impact on objective/s. Short term failure to deliver key objectives with temporary adverse local publicity.	Major impact on objective/s. Medium term failure to deliver key objectives with ongoing adverse publicity or negative impact on stakeholder confidence.	Catastrophic impact on objective/s. Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of stakeholder confidence.

Table 1B: Impact Score (I) Further Guidance broken by Risk Domain

Risk Domain	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Health Inequalities Risks that may result in unfair or unavoidable differences in health across different groups within society.	• Minor risk to individuals or communities, with limited impact on health inequalities or disparities.	• Moderate risk which may lead to noticeable effects on certain populations, leading to moderate disparities in access to healthcare services or health outcomes across different groups within society.	• Serious risk which may significantly affect certain populations, resulting in substantial disparities in health status, access to care, or health-related quality of life among affected groups.	• Major risk which may have a profound impact on certain populations, exacerbating disparities in morbidity, mortality, and overall well-being, with far-reaching consequences for affected communities.	• Catastrophic threats to individuals or populations, leading to widespread and severe health crises, overwhelming healthcare systems, and causing significant loss of life and societal disruption.

Risk Domain	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Health Outcomes Risks that may result in poor or worsening health outcomes for individuals or populations.	• Health outcomes for individuals are minimally affected, with only minor variations to care or health status observed.	• Moderate risk which may lead to noticeable effects on health outcomes, leading to moderate disparities in disease management, treatment outcomes, or overall well-being.	• Serious risk which may lead to significant impacts to health outcomes, resulting in disease progression, functional impairment, and health-related quality of life.	• Major risk which may lead to profound impact on health outcomes, exacerbating disparities in morbidity, mortality, and life expectancy, with significant implications for health trajectories and long-term prognoses.	• Catastrophic threats to health outcomes, leading to severe and potentially life-threatening consequences, overwhelming individuals' ability to cope, and causing significant harm to their physical and mental well-being.
Legal Risks that may result in successful legal challenge and/or non-compliance with regulatory requirements. [May include, but not limited to, risks linked to statutory duties, inspections, Information Governance, general governance / probity, compliance, safeguarding and Emergency Preparedness, Resilience and Response (EPRR)]	• No impact or minimal impact or breach of guidance / statutory duty.	• Breach of statutory legislation. • Reduced performance rating if unresolved.	• Single breach in statutory duty. • Challenging external recommendations / improvement notice.	• Enforcement action. • Multiple breaches in statutory duty. • Improvement notices. • Low performance rating. • Critical report.	• Multiple breaches in statutory duty. • Prosecution. • Complete systems change required. • Zero performance rating. • Severely critical report.

Risk Domain	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Patient Safety Risks that may result in unintended or unexpected harm occurring. [May include, but not limited to, risks associated with harm, quality, medicines and pharmacy and patient Experience]	• Minor adverse events or safety incidents identified, and appropriate safeguards in place to mitigate any risks. • Peripheral element of treatment or service suboptimal. • Informal complaint/ Inquiry.	• Moderate level of safety incidents or adverse events occurring, but generally manageable with existing protocols and interventions. • Overall treatment or service suboptimal. • Formal complaint stage 1. • Local resolution. • Single failure to meet internal standards. • Minor implications for patient safety if unresolved. • Reduced performance rating if unresolved.	• Serious safety concerns or adverse events occurring sporadically, indicating the need for heightened vigilance and targeted interventions to address underlying factors contributing to patient safety risks. • Treatment or service has significantly reduced effectiveness. • Formal complaint stage 2. • Local resolution (with potential to go to independent review). • Repeated failure to meet internal standards. • Major patient safety implications if findings are not acted on.	• Frequent safety incidents or adverse events occurring with major impacts, indicating systemic weaknesses in care delivery and patient safety protocols requiring urgent attention and comprehensive improvement efforts. • Non-compliance with national standards with significant risk to patients if unresolved. • Multiple complaints/ independent review. • Low performance rating. • Critical report.	• The risk of harm to patients is severe, with widespread and persistent safety failures posing a significant threat to patient well-being, necessitating immediate and decisive action to prevent further harm and restore trust in the healthcare system • Unacceptable level or quality of treatment/ service. • Gross failure of patient safety if findings not acted on. • Inquest / ombudsman inquiry. • Gross failure to meet national standards.

Risk Domain	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
People Risks that may result in damage to staff morale, well-being and/or adversely impact workforce collaboration and integration. [May include, but not limited to, risks linked to human resource issues, organisational development, skills mix and staff experience]	• Short-term low staffing level that temporarily reduces service quality (< 1 day).	• Low staffing level that reduces the service quality.	• Late delivery of key objective / service due to lack of staff. • Unsafe staffing level or competence (>1 day). • Low staff morale. • Poor staff attendance for mandatory training.	• Uncertain delivery of key objective / service due to lack of staff. • Unsafe staffing level or competence (>5 days). • Loss of key staff. • Very low staff morale. • No staff attending mandatory training.	• Non-delivery of key objective / service due to lack of staff. • Ongoing unsafe staffing levels or competence. • Loss of several key staff. • Staff unable to attend mandatory training on ongoing basis.
Reputation Risks that may result in damage to reputation, poor experience and/or destruction of trust and relations. [May include, but not limited to, risks linked to adverse publicity and engagement]	• Rumours. • Potential for public concern.	• Local media coverage – short-term reduction in public confidence. • Elements of public expectation not being met.	• Local media coverage – long-term reduction in public confidence.	• National media coverage with <3 days service well below reasonable public expectation.	• National media coverage with >3 days service well below reasonable public expectation. • MP concerned (questions in the House). • Total loss of public confidence.

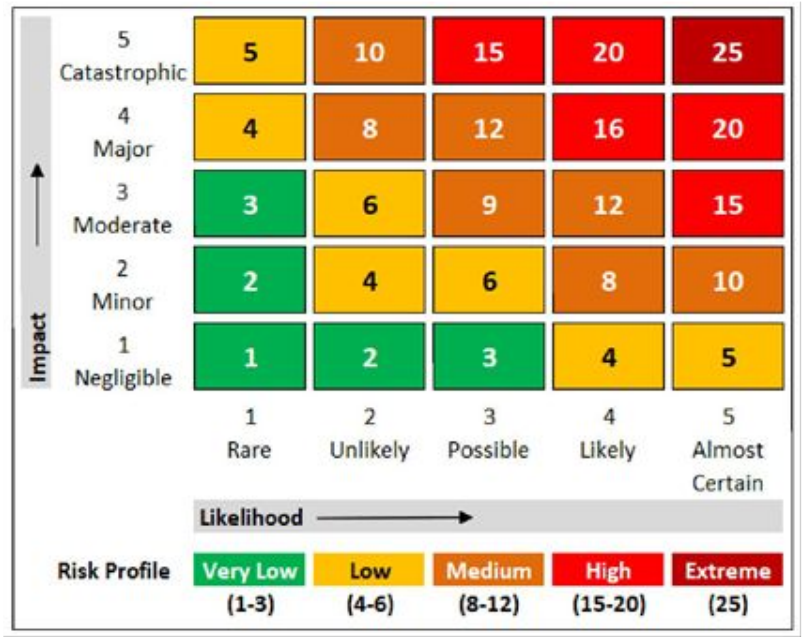
Risk Domain	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Resources Risks that may result in the organisation operating outside its resource or capital allocations, poor productivity, inefficiencies, or no return on investment. [May include, but not limited to, risks linked to workforce, finance, procurement and claims]	• Small loss. • Risk of claim remote.	• Loss of 0.1–0.25 per cent of budget. • Claim less than £10,000.	• Loss of 0.25–0.5 per cent of budget. • Claim(s) between £10,000 and £100,000.	• Uncertain delivery of key objective. • Loss of 0.5–1.0 per cent of budget. • Purchasers failing to pay on time. • Claim(s) between £100,000 and £1 million.	• Non-delivery of key objective • Loss of >1 per cent of budget. • Failure to meet specification • Slippage. • Loss of contract/ payment by results. • Claim(s) >£1 million.
Social and Economic Development Risks relating to decisions or events which may have favourable social, ethical and/or environmental outcomes.	• Minimal or no impact on the environment.	• Minor impact on environment.	• Moderate impact on environment.	• Major impact on environment.	• Catastrophic impact on environment.
Strategic Commissioning Risks associated with potential threats or uncertainties that may impact the ICB's ability to plan, procure, and deliver services that meet population needs, improve outcomes, and ensure value for money. Strategic commissioning risks emerge when this process is	• Negligible disruption to commissioning activities with no impact on service delivery or population outcomes. • Temporary delay in pathway design or contract negotiation.	• Minor impact on commissioning capacity or service planning. • Delays in procurement or pathway redesign affecting a small population group.	• Moderate disruption to commissioning functions. • Inability to deliver planned service changes or meet transformation targets.	• Major failure in commissioning processes. • Inability to deliver key services or meet statutory duties. • Major impact on population health outcomes, equity, or	• Catastrophic failure / systemic breakdown in commissioning capability. • Widespread service failure or collapse of strategic programmes. • Catastrophic impact on population health,

Risk Domain	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
disrupted or compromised. These risks may affect the ICB's ability to ensure person-centred, equitable, and sustainable care.		• Minor misalignment with strategic objectives.	• Moderate impact on access, equity, or quality of care.	financial sustainability.	legal compliance, and organisational viability.
Strategy and Operations Risks associated with identifying and pursuing strategies/plans (including risks associated with the establishment of innovative systems and processes to deliver the strategies/plans), which could lead to improvements, opportunities for growth or may contribute positively to the achievement of aims and objectives. [May include, but not limited to, risks linked to capacity, demand, Primary Care, service/ business interruption, digital, projects, planning, delivery, commissioning, partnership working and transformation]	• Day to day operational challenges. • Loss/ interruption of >1 hour. • Insignificant cost increase / schedule slippage. • Key 'political' target is being achieved and impact prevents improvement.	• Temporary restriction to service delivery with limited impact on stakeholder confidence. • Loss/ interruption of >8 hours. • <5 per cent over project budget. • Schedule slippage. • Key 'political' target is being achieved but impact reduces performance marginally below target in the near future or performance currently on target, but there is no agreed plan to meet	• Short term failure to deliver key objectives with temporary adverse local publicity. • Loss/ interruption of >1 day. • 5–10 per cent over project budget. • Schedule slippage. • Key 'political' goal is marginally below target or is soon projected to deteriorate beyond acceptable limits or there is an agreed plan, but it does not yet meet the rising target.	• Medium term failure to deliver key objectives with ongoing adverse publicity or negative impact on stakeholder confidence. • Loss/ interruption of >1 week. • Non-compliance with national 10–25 per cent over project budget. • Schedule slippage. • Key 'political' target not being achieved, and impact prevents improvement, or substantial decline in performance trend.	• Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of stakeholder confidence. • Permanent loss of service or facility. • Incident leading >25 per cent over project budget. • Schedule slippage. • Key objectives not met. • Key 'political' target is not being achieved and the impact further deteriorates the position.

Table 2: Likelihood Score (L)

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	Probably never happen / recur only in very exceptional circumstances.	Do not expect it to happen / recur but is possible it may do so.	Might happen / recur occasionally.	Will probably happen / recur but is not a persisting issue.	Will undoubtedly happen / recur, expected to occur in most circumstances.
How likely is it to happen?	**Less than 1% chance of event happening.**	**1% - 30% chance of event happening.**	**31% - 60% chance of event happening.**	**61% - 95% chance of event happening.**	**96% to 99% of chance of this occurring.**

Table 3: Impact (I) x Likelihood (L) Risk Matrix



Appendix D: Risk Review Checklist

Element	Guidance	Findings (with prompts)
Risk Description	Think about the reader when formulating the description, a clear and concise description helps the reader to understand what the risk is. A description includes: **CAUSE:** 'As a result of ….' (what will cause the risk to occur?) or if the cause is uncertain, hypothetical, or conditional, it may be appropriate to use: 'If ….' **EVENT: '**There is a risk ….' (what can go wrong?) **EFFECT: '**Which may lead to ….' (what will be the consequence/effect if the risk were to materialise?)	Q: Does the description follow the above format?
Objective	Objectives define the purpose and context within which risks are identified, assessed, and managed. They should be clearly stated and aligned with one of the three recognised levels within the organisation: **strategic**, **corporate (operational)**, or **local**. Each risk must be linked to a relevant priority/objective to ensure it is meaningful and appropriately contextualised. When recording a risk, ensure the associated objective is specific, current, and reflects the organisational level at which the risk is being managed.	Q: Is the priority/objective clearly stated and relevant to the risk? Q: Is the priority/objective aligned with the ICB's statutory functions, team goals, or strategic priorities? Q: Is the priority/objective specific enough to guide the identification and evaluation of the risk?
Controls	A control is a process, policy, device, or action that acts to minimise risk and describes what is in place to reduce or manage the risk. **PLANNED ACTIONS ARE NOT CONTROLS**	Q: Are any controls identified? Q: Are your controls up to date?
Gaps in Control	It is essential you consider what controls may be missing (not recorded) that would help to manage the risk.	Q: For all instances of negative assurance, do you have a corresponding ACTION to close the gap in control.
Actions	An action will exist where you have a gap in control and completion of actions should provide assurance, strengthen existing controls, or add new controls. **All gaps in control and gaps in assurance require an ACTION to close the gap.**	Q: Are you confident the actions will be delivered and on time? Q: Is the action owner the right action owner? Q: Is the action owner aware they have this action assigned to them?

Initial Risk Score	This was the score evaluated when the risk was first recorded.	Q: Are you confident the initial risk score was reflective of the risk when recorded?
Current Risk Score	It is essential to consider the likelihood of the impact being realised (see risk description - **EFFECT: '***Which may lead to ….*') considering the existing controls and assurances.	Q: Does the current score consider all the controls and assurances? Q: Have you used the risk scoring guidance? Q: Have you evaluated the evidence to quantify the risk?
Likelihood Score	Score your risk on the potential of the risk occurring in the next 12 - 18 months.	Q: Have you assessed the probability of this risk materialising within the next 12-18 months?
Impact Score	Score your risk on the impact the risk materialising would have on the priority/objective the risk is being scored against.	Q: Have you assessed the potential impact on the priority/objective?

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	20/11/2025
Paper title:	**Finance Report**
Paper reference:	ICB CIC 25 010
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 presents the financial position of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICBs (the ICBs), including both the ICBs' and relevant providers' financial positions, for the six month period, April to September 2025.

The overall year to date financial position is a £42.1 million adverse variance to plan. For the full year, the ICBs are forecasting to be on plan. These positions include non-recurrent deficit support funding of £115 million (full year).

Nottingham and Nottinghamshire providers are the key driver of the year to date position (£32.2 million), mainly due to staffing cost pressures. NHS Lincolnshire ICB is £8.8 million adverse to plan for the year to date, with acute independent sector activity and prescribing pressures.

Efficiency delivery across the ICBs is £20 million behind the year to date target of £257 million. The full year target is £624 million and delivery of this target, whilst forecast to be delivered in full, is the ICBs' largest financial risk.

Capital expenditure is forecast to be delivered within allocation.

Cash is a risk within providers, with Nottingham University Hospitals NHS Trust and United Lincolnshire Teaching Hospitals NHS Trust both requesting support from NHS England.

The ICB specific position is a year to date adverse variance to plan of £8.7 million, with NHS Lincolnshire ICB the main driver as above. The forecast remains on plan, albeit with significant efficiency risk. Efficiency plans delivering to plan, whether new schemes or accelerated delivery, are key in delivery of the on plan forecast outturn.

Recommendation(s):

The Boards are asked to **receive** the paper for assurance.

Relevant statutory duties:

☐ Quality improvement	☐ Public involvement and consultation

Relevant statutory duties:	
☐ 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

Finance Report - Month Six

Cluster Systems Overview

Key Finance Metrics by System at Month Six

Key Finance Metric	Surplus / (Deficit) - Variance to Plan															
	Year To Date								Full Year Forecast							
	Derby & Derbyshire ICS		Lincolnshire ICS		Nottingham & Nottinghamshire ICS		DLN Total		Derby & Derbyshire ICS		Lincolnshire ICS		Nottingham & Nottinghamshire ICS		DLN Total	
	£m		£m		£m		£m		£m		£m		£m		£m	
Financial Performance [1]	(1.4)	R	(8.7)	R	(32.2)	R	(42.1)	R	0.0	G	0.0	G	0.0	G	0.0	G
Efficiency	(0.1)	R	0.2	G	(20.1)	R	(20.0)	R	0.0	G	0.0	G	0.0	G	0.0	G
Capital - Charge against allocation [2]	8.5	G	4.8	G	7.3	G	20.6	G	0.9	G	(5.0)	R	0.0	G	(4.1)	R
Pay Costs (Provider)	(0.4)	R	2.7	G	(32.5)	R	(30.1)	R	2.3	G	3.5	G	(7.1)	R	(1.3)	R
Mental Health Investment Standard (MHIS)									0.0	G	0.0	G	0.0	G	0.0	G
Risk (Net Position)									0.5	G	(31.7)	R	(44.8)	R	(76.0)	R
Underlying Position									(150.1)	R	(70.7)	R	(191.5)	R	(412.3)	R

1. Financial Performance is inclusive of non-recurrent Deficit Support Funding (Derby and Derbyshire ICS £22.5 million and Nottingham and Nottinghamshire ICS £39.3 million year to date)
2. The overspend in Lincolnshire ICS is due to a provider notified capital allocation not yet received

Overview of the Derbyshire, Lincolnshire, Nottinghamshire Systems

The Month six year-to-date (YTD) position across the three ICBs shows an adverse variance of £42 million. The largest contributors are within the Nottingham and Nottinghamshire (N&N) system, specifically Nottinghamshire Healthcare NHS Foundation Trust, driven by flexible staffing, private sector bed usage, and under-delivery of efficiency plans. Nottingham University Hospitals NHS Trust (NUH) is also a key driver, impacted by industrial action, contract and income pressures, deterioration in substantive pay run rates, non-pay cost pressures, and shortfalls in efficiency delivery.

The forecast remains on plan, supported by £115 million of deficit funding (£45 million in the Derby and Derbyshire (D&D) system and £70 million in the N&N system). There are significant risks that need to be managed to deliver the forecast position, including efficiencies and pay costs.

Efficiency plans for 2025/26 total £624 million, with £237 million achieved YTD, resulting in a £20 million adverse variance against target. Efficiency delivery remains the most significant financial risk this year, with the current NHS England calculated risk-adjusted assessment at 79% of the annual target.

Pay costs are a major driver of the YTD position, with a £30 million adverse variance at Month six, almost entirely within the N&N 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.

Cash is significantly constrained in some providers, with NUH having requested support from NHS England. Whilst cash-releasing savings are the primary mitigation, further cash escalations are likely, particularly among acute providers, as we progress through the second half of the year. United Lincolnshire Hospitals NHS Trust (ULTH) also has cash pressures and is likely to request additional cash support from NHS England but are managing it within their Integrated Care System (ICS) for now.

Cluster ICBs (1 of 2)

Key Finance Metrics by ICB at month six

Key Finance Metric	Surplus / (Deficit) - Variance to Plan															
	Year To Date								Full Year Forecast							
	Derby & Derbyshire ICB		Lincolnshire ICB		Nottingham & Nottinghamshire ICB		DLN ICBs' Total		Derby & Derbyshire ICB		Lincolnshire ICB		Nottingham & Nottinghamshire ICB		DLN ICBs' Total	
	£m		£m		£m		£m		£m		£m		£m		£m	
Financial Performance	0.1	G	(8.8)	R	0.0	G	(8.7)	R	0.0	G	0.0	G	0.0	G	0.0	G
Efficiency	0.0	G	0.3	G	9.8	G	10.1	G	0.0	G	0.0	G	0.0	G	0.0	G
Spend of Capital Resource Allocation	0.0	G	0.4	G	0.0	G	0.4	G	0.0	G	0.0	G	0.0	G	0.0	G
Spend of Running Cost Allocation									0.8	G	0.9	G	0.2	G	1.8	G
Mental Health Investment Standard (MHIS)									0.0	G	0.0	G	0.0	G	0.0	G
Risk (Net Position)									0.0	G	(16.8)	R	0.0	G	(16.8)	R
Underlying Position									7.4	G	(36.0)	R	(27.3)	R	(55.9)	R
Better Payment Practice Code - against 95% target	>95%	G	>95%	G	>95%	G										

Financial Performance and Key Drivers of the Position

Derby and Derbyshire ICB - A £0.1 million favourable variance year-to-date and a forecast break-even position. The year-to-date favourable variance is driven by lower than planned spend in Continuing Healthcare and slightly reduced prescribing costs. These benefits are offsetting pressures in Mental Health and Learning Disabilities and Planned and Urgent Care due to increased activity at Independent Sector providers.

Lincolnshire ICB - A year-to-date £8.8 million adverse variance with a forecast break-even position with £16.8 million unmitigated net risk position reported at month six. Year-to-date overspend principally relates to acute independent sector provider activity exceeding plan, prescribing overperformance, higher than planned expenditure on drugs and devices and the outcomes of contract agreements and contract escalations. These pressures have been partially offset by forecast underspends on Continuing Healthcare costs.

Nottingham and Nottinghamshire ICB - A break-even position against plan year-to-date and forecast. Overspends have been reported in acute commissioning, primarily relating to acute Independent Sector providers, prescribing costs with volume and price pressures, and community costs due to non-NHS contracts over delivery of activity. These pressures have been offset by forecast underspends on GP contracting, Continuing Healthcare, and due to non-recurrent finance solutions that have been identified e.g. balance sheet releases and reserve slippage.

Efficiency

At month six efficiency delivery is reported as on plan for the cluster. However, there is a £34.4 million risk to delivery of the efficiency plan based upon an NHS England calculated risk-adjusted assessment at 82%. ICBs estimate risks to efficiency to be less than the NHS England calculated risk. Of the reported efficiencies, non-recurrent savings account for 52% (£48 million) year-to-date and 43% (£83 million) expected outturn.

Cluster ICBs (2 of 2)

Financial Performance and Key Drivers of the Position continued

Underlying Position
The cluster ICB reported underlying position at month six was a deficit of £55.9 million principally due to non-recurrent efficiencies and prescribing and acute commissioning pressures.

Better Payment Practice Code (BPPC)
The BPPC target has been consistently achieved across the three ICBs to month six. Nationally, ICBs went live with a new financial ledger on 1st October 2025. There have been several challenges following implementation of the new ledger, with a resultant risk to the ICBs' BPPC and month end cash target.

Recovery Actions

As the ICBs move to joint system leadership, there will be shared accountability. This will support the ongoing work to understand core drivers of performance and inform recovery strategies. This will include the pressures from the independent sector, which are experienced by each of the ICBs.

To date, independent sector acute contracts have been agreed with the aim of managing activity levels. Working groups will continue to assess levers for managing in line with overall planned activity levels. Phased activity plans are being aligned to trends alongside the activity controls.

In addition to acute commissioning pressures, the independent sector is also resulting in financial challenges for the Mental Health and Learning Disabilities portfolio through the national Right to Choose programme. Whilst longer-term solutions have been identified, immediate actions are insufficient. Learning from other ICBs is being considered, which includes indicative activity agreements and changes to the access criteria.

Given the significant risk surrounding efficiencies, actions will need to include the acceleration of in-year efficiency programmes as well as identifying additional efficiency schemes to support slippage or non-delivery of planned schemes. An approach to the governance surrounding efficiencies is to be aligned across the ICBs to ensure continued oversight of this critical target.

The ICBs will need to ensure strong financial governance to provide an understanding of the challenges and actions required to deliver the financial plans in-year but also to move to a position of financial sustainability.

The ICBs will be required to develop a realistic, recurrent financial plan for 2026/27 with early agreement on baselines, efficiency schemes, and investment priorities, aligned across the system.

Cluster Providers (1 of 3)

Provider	Surplus / (Deficit) - Variance to Plan						Workforce - Surplus / (Deficit) - Variance to Plan								Forecast	
	Financial Performance		Efficiency		Capital		Pay Costs		Substantive Pay Costs		Bank Costs		Agency Costs		Underlying Position	
	£m		£m		£m		£m		£m		£m		£m		£m	
Chesterfield Royal Hospital NHS Foundation Trust *	(1.0)	R	(0.2)	R	1.1	G	1.1	G	7.9	G	(5.1)	R	(1.4)	R	(31.5)	R
Derbyshire Community Health Services NHS Foundation Trust	0.0	G	0.0	G	0.0	G	(1.2)	R	(1.1)	R	(0.1)	R	0.0	G	(8.3)	R
Derbyshire Healthcare NHS Foundation Trust	0.2	G	0.2	G	1.3	G	3.9	G	3.2	G	0.3	G	0.3	G	(8.1)	R
East Midlands Ambulance Service NHS Trust	0.0	G	0.0	G	(0.8)	G	2.5	G	2.6	G	(0.1)	R	0.1	G	(9.9)	R
University Hospitals Of Derby And Burton NHS Foundation Trust *	(0.6)	R	(0.0)	R	6.9	G	(6.8)	R	(2.7)	R	(2.4)	R	(1.7)	R	(99.7)	R
Total Derby and Derbyshire Providers	**(1.4)**	R	**(0.1)**	R	**8.5**	G	**(0.4)**	R	**9.9**	G	**(7.4)**	R	**(2.7)**	R	**(157.5)**	R
Lincolnshire Community Health Services NHS Trust	0.1	G	0.4	G	0.4	G	(0.6)	R	0.3	G	(1.3)	R	0.4	G	(7.3)	R
Lincolnshire Partnership NHS Foundation Trust	0.0	G	0.0	G	0.6	G	2.5	G	1.5	G	0.5	G	0.5	G	(12.3)	R
United Lincolnshire Teaching Hospitals NHS Trust	0.0	G	(0.5)	R	3.3	G	0.8	G	(0.2)	R	1.9	G	(1.2)	R	(15.1)	R
Total Lincolnshire Providers	**0.1**	G	**(0.2)**	R	**4.3**	G	**2.7**	G	**1.6**	G	**1.1**	G	**(0.3)**	R	**(34.8)**	R
Nottingham University Hospitals NHS Trust *	(16.2)	R	(10.4)	R	3.8	G	(16.5)	R	(15.0)	R	(0.8)	R	(0.7)	R	(96.5)	R
Nottinghamshire Healthcare NHS Foundation Trust *	(12.9)	R	(12.6)	R	1.0	G	(8.2)	R	(2.0)	R	(6.5)	R	0.3	G	(47.7)	R
Sherwood Forest Hospitals NHS Foundation Trust *	(3.1)	R	(6.9)	R	2.5	G	(7.7)	R	(9.0)	R	1.5	G	(0.2)	R	(20.1)	R
Total Nottingham and Nottinghamshire Providers	**(32.2)**	R	**(30.0)**	R	**7.3**	G	**(32.5)**	R	**(26.1)**	R	**(5.9)**	R	**(0.5)**	R	**(164.3)**	R
Grand Total DLN Providers	**(33.4)**	R	**(30.2)**	R	**20.1**	G	**(30.1)**	R	**(14.6)**	R	**(12.2)**	R	**(3.6)**	R	**(356.6)**	R

Key Drivers

The year to date adverse variance of £33.4 million to plan is mainly driven by pay overspends of £30.1 million, which has impacted the ability to deliver planned efficiencies resulting in a year to date shortfall of £30.2 million. The pay overspends follow July's industrial action and ongoing operational pressures, with Nottingham and Nottinghamshire (N&N) most affected. See next page for further details.

Efficiencies are off plan by £30.2 million year to date. There is significant risk in this area of £102. 7million (NHS England weighted) across the three systems' financial plans, with N&N making up the majority with £54.9 million (27% of efficiency plan), Derby and Derbyshire representing £27.7 million (21% of efficiency plan) and Lincolnshire representing £19.1 million (21% of efficiency plan).

Other risks to delivery of the reported forecast position include increased pay costs, impact of further industrial action, delivery of elective activity, non-pay inflationary pressures and risks to provider income.

Cluster Providers (2 of 3)

Key Drivers (Continued from Slide 5)

The year to date adverse variance of £33.4 million to plan is mainly driven by pay overspends of £30.1 million, which has impacted the ability to deliver planned efficiencies resulting in a year to date shortfall of £30.2 million. The pay overspends follow July's industrial action and ongoing operational pressures, with Nottingham and Nottinghamshire most affected.

Provider organisations are reviewing risks to ensure there are sufficient mitigations for the remainder of the financial year.

Derby and Derbyshire

Chesterfield Royal Hospital is £1 million adverse to plan year to date, which is driven by the impact of industrial action, non-pay operational costs and a small shortfall in efficiency delivery. University Hospitals of Derby and Burton (UHDB) is also adverse to plan year to date by £0.6 million, which is because of the industrial action. UHDB is £6.8 million overspent on pay costs which is mainly mitigated through non recurrent benefits. Derbyshire community Health Services is adverse to plan on pay year to date due to increased pay costs for bank and agency staff at urgent treatment centres. Provider organisations are reviewing their risks on delivery for the rest of the year and identifying mitigations to deliver the plan.

Lincolnshire

United Lincolnshire Hospitals NHS Trust is reporting on plan for both year-to-date and forecast outturn. The year-to-date position has been supported by technical efficiencies. There are significant risks to the delivery of full year plan (driven by capacity and cost pressures, impacts of industrial action, and risks to income). Mitigations are mainly unidentified to offset potential risks.

Lincolnshire Partnership NHS Trust is also reporting on plan both year-to-date and forecast outturn. Risks to this include efficiency delivery and income assumptions.

Nottingham and Nottinghamshire

The largest adverse variance year-to-date is Nottingham University Hospitals Trust which is reporting a £16.2 million variance being driven by the impact of industrial action, contract and income pressures, deterioration in substantive pay run rates, non-pay cost pressures, and shortfalls in efficiency delivery. Nottinghamshire Healthcare NHS Foundation Trust is reporting a year-to-date adverse £12.9 million variance driven by flexible staffing, private sector bed usage, and under-delivery of efficiency plans. Sherwood Forest NHS Foundation Trust is £3.1 million year-to-date adverse to plan which is driven by the impact of industrial action, adverse cost Improvement Programme performance and adverse variable income performance.

Cluster Providers (3 of 3)

Provider Recovery Actions

Cluster-Wide Key Actions include:

- Cluster financial oversight arrangements under review to focus on high financial risk organisations.
- Turnaround approach from November, targeting weekly metrics, efficiency delivery, and grip and control.
- Joint Cluster Chief Finance Officer Group appointed to lead this work.
- NHS England Strengthening Financial Management Toolkit supports remedial action in deficit organisations.
- Financial delivery partner engaged to drive in-year efficiency and transformational opportunities.
- Financial Recovery Groups provide oversight and support.

Derby and Derbyshire

Derbyshire Community Health Services is maintaining focus on identifying remedies for urgent treatment centre staffing, as well as increasing internal controls for pay. University Hospitals of Derby and Burton has introduced executive-led measures to help reduce levels of variable pay and Chesterfield Royal Hospital has identified the top three divisions that are now having weekly meetings with the Chief Finance Officer on recovery actions. Both organisations have amended bank rates that they expect to start to take effect from month seven. Work is continuing to fully develop efficiency plans and gain assurance on scheme delivery and work is being carried out to improve flow/discharge to reduce mental health out of area placements.

Lincolnshire

United Lincolnshire Hospitals NHS Trust has vacancy control measures through executive-led processes and are also targeting their non-pay discretionary spend with enhanced approval processes. A Mutually Agreed Resignation (MARS) has been run within the year, and actions are in place to improve productivity. Some efficiency schemes have not delivered as intended - additional assurance meetings have taken place with care groups to understand risk and develop mitigations. The Group is also focusing on supporting its revenue position with variable income delivery. Lincolnshire Partnership NHS Foundation Trust has also undertaken a MARS scheme in year and are running a Living Within Our Means programme with the aim of recurrent break-even.

Nottingham and Nottinghamshire

Nottingham University Hospitals NHS Trust are developing a financial recovery plan focussing on grip and control arrangements and strengthening Cost Improvement Programme delivery. The plan is expected to be completed during month seven and the Trust is required to share this with the ICB and NHS England. Nottinghamshire Healthcare NHS Foundation Trust shared a detailed recovery plan with the ICB and NHS England in September with a Director of Financial Recovery appointed to oversee delivery. The Trust is implementing a rapid action plan to address the year-to-date deficit drivers, which include a suite of measures. Sherwood Forest NHS Foundation Trust is currently developing a financial recovery plan enhancing grip and control across the Trust and a focus on six key work programmes within divisions.

All providers are taking actions to reduce staff costs with a range of approaches being taken that support the reduction of temporary staffing and premium pay. Additional controls are in place to maintain grip on recruitment and there has been a reduction in advertised posts at the end of month six that is expected to continue into month seven. A MARS scheme has been run in-year by all organisations, and actions are in place to deliver workforce transformation and to improve productivity.

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	20/11/2025
Paper title:	**Quality Report**
Paper reference:	ICB CIC 25 013
Paper author:	Jo Hunter, Deputy Chief Nurse, NHS Derby and Derbyshire ICB Vanessa Wort, Associate Chief Nurse, NHS Lincolnshire ICB Diane-Kareen Charles, Deputy Chief Nurse, NHS Nottingham and Nottinghamshire ICB Nicola Ryan, Deputy Chief Nurse, NHS Nottingham and Nottinghamshire ICB
Paper sponsor:	Rosa Waddingham, Executive Director of Quality (Nursing)
Presenter:	Dr Dave Briggs, Executive Director of Outcomes (Medical)

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

Report summary:

This report provides updates on quality and safety matters relating to the following NHS Trusts for which the ICBs have responsibility, and where there are escalations based on the NHS Oversight Framework:

- Nottinghamshire Healthcare NHS Foundation Trust
- Nottingham University Hospitals NHS Trust
- University Hospitals Derby and Burton NHS Foundation Trust
- Lincolnshire Partnership NHS Foundation Trust

The report also provides exception reporting for areas of enhanced oversight, as per the ICBs' escalation framework (included for information at Appendix 1):

- Learning Disabilities and Autism
- Urgent and Emergency Care
- Maternity
- Special Educational Needs and Disabilities
- Infection Prevention Control

Recommendation(s):

The Boards are asked to **receive** the paper for assurance in relation to areas of quality and safety.

Relevant statutory duties:	
☒ Quality improvement	☐ Public involvement and consultation
☐ Reducing inequalities	☐ Equality and diversity
☐ Financial limits/ breakeven	☐ Effectiveness, efficiency and economy

Relevant statutory duties:	
☐ 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: Escalation Framework

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Quality Report

Nottinghamshire Healthcare NHS Foundation Trust – NHS Oversight Framework Segment Four

1. In 2019 and 2022, the Care Quality Commission (CQC) undertook an inspection of Nottinghamshire Healthcare NHS Foundation Trust's (NHT) services. The Trust was rated as requires improvement. Further CQC inspections took place throughout 2024, which resulted in a number of 'inadequate' findings and the Trust was issued with warning notices to improve safety and conditions imposed on their registration for two of their services.
2. Rampton Hospital was rated as 'inadequate' and had conditions on registration and re-licensing restrictions; and following the tragic killings in Nottingham in June 2023, the Secretary of State mandated a Section 48 Review under the Health and Social Care Act. The collective size and scale of concerns against a backdrop of internal risks resulted in NHT being placed into segment four of the NHS Oversight Framework in February 2024.
3. Furthermore, following publication of an Independent Homicide Review in January 2025, the Government announced that a Judge led inquiry would be held, and media attention in response to this has been significant.
4. The Trust remains in NHS Oversight Framework Segment Four, with a Well-Led Assessment by the CQC having been undertaken in September 2025: the full draft report is awaited. The Trust has started internal discussions on the findings to support next steps and appropriate actions.
5. The Safe Now meetings continue to identify challenges regarding data quality and coding, which affects many metrics. There is limited assurance that some metrics accurately reflect overall performance. The Trust is working to address data challenges, and the Safe Now meetings provide a forum for in-depth rationale on metric challenges.
6. Progress against the actions from the Independent Homicide Review continues; and the impact of these actions and next steps are currently being planned in conjunction with the Trust.
7. No additional risks have been identified; however, ongoing scrutiny and media attention related to the public inquiry persist. The impact on staff wellbeing has been recognised, and measures are actively being implemented to maintain a comprehensive support offer to all employees.

Nottingham University Hospitals NHS Trust – NHS Oversight Framework Segment Four

8. In October 2019, the CQC undertook an inspection of Nottingham University NHS Hospitals Trust's (NUH) Maternity Services. The Trust was rated 'inadequate' overall and the CQC issued an urgent enforcement action notice under Section 31 of the Health and Care Act, which imposed conditions on the registration as a service provider in respect of regulated activities for Maternity and Midwifery Services.

9. Following an inspection in July 2021, the Trust received an 'inadequate' rating for well-led and a 'requires improvement' rating overall. The CQC issued a further Section 29a warning notice in relation to well-led, specifically relating to Board effectiveness and the disconnect between the senior leadership and the wider organisation.

10. NUH was placed into segment four of the National Oversight Framework in September 2021 due to concerns identified by NHS England relating to a lack of pace and a scale of improvement due to quality concerns around maternity care and Board leadership, including governance and culture.

11. The Trust remains in NHS Oversight Framework Segment Four, with the Nottingham and Nottinghamshire ICB's Quality Team continuing to maintain relationships and plan periodic visits to the Urgent and Emergency Care pathway and Maternity Services.

12. The Breast Screening programme remains under a contract performance notice and is receiving additional support. Following a Rapid Quality Review in July 2025, a follow-up meeting is planned for 25 November to address ongoing leadership and cultural issues.

13. NUH is experiencing a backlog in Structured Judgement Reviews due to consultant capacity restraints, and a recovery plan has been initiated to address this challenge. Structures Judgement Reviews are clinician-led reviews of a patient's case notes following death, utilising explicit judgements and quality scoring across defined phases of care to evaluate the safety and quality of treatment, identify learning opportunities, and support continuous improvement in clinical practice.

University Hospitals Derby and Burton NHS Foundation Trust – NHS Oversight Framework Segment Four

14. University Hospitals Derby and Burton (UHDB) currently has an 'inadequate' rating for safe and well led maternity services following a CQC inspection in November 2023. A Section 31 notice for Royal Derby Hospital; and Section 29a warning notice for both Royal Derby Hospital and Queens Hospital Burton were

imposed. There were eight conditions to be met for the Section 31 notice and six have been removed to date.

15. In December 2024. a reinspection visit resulted in the identification of five additional conditions under the Section 31 notice. The Inspection report from December 2024 was published on 07 November 2025 with an inspection rating of ‘requires improvement’ for both UHDB sites.
16. UHDB has been in additional local enhanced oversight due to a number of extreme risks, which includes risks tied to:
    a) Meeting CQC and NHS England standards
    b) Breaching of professional body guidelines
    c) Emergency Department pressures
    d) Sexual safety incidents in emergency departments
    e) Safeguarding and vulnerable patient risks.
17. 97 live extreme risks remain on the Trust’s register, with 17 new risks added since the last review. Only a small number have been reduced or closed, indicating persistent risk exposure. Equipment-related risks are significant: 32 extreme risks are linked to ageing, failing, or insufficient medical devices. These issues impact diagnostics, surgery, and patient care, and are a recurring theme in risk escalation and mitigation discussions.
18. Non-equipment risks (65 in total) include staff shortages, process inefficiencies, and regulatory breaches, potentially contributing to delayed care.
19. Key risk themes relate to funding for equipment and delays in equipment replacement, leading to delays in diagnosis, treatment, referrals, imaging, and service delivery, and reputational damage due to service failures, regulatory breaches, and poor patient outcomes.

Lincolnshire Partnership NHS Foundation Trust – NHS National Oversight Framework Segment Three

20. Lincolnshire Partnership NHS Foundation Trust (LPT) is rated ‘good ‘overall with ‘outstanding’ for Well Led, following publication of a CQC inspection in June 2020.
21. An unannounced CQC inspection to adult mental health wards in June 2025 highlighted concerns in relation to compliance with Trust policies on rapid tranquilisation and restraint.
22. Quality Review meetings were established to support the development of and challenge to an improvement plan. These have taken place in July and October

2025 and are ongoing and will support the further improvement required. The CQC's formal findings are awaited

Learning Disability and Autism – Enhanced Oversight

23. There is a focus by all three ICBs on addressing long stays in secure settings and improving discharge pathways for people with learning disabilities and/or autism in secure settings.

24. There also continues to be long waits for attention deficit hyperactivity disorder (ADHD) and autism assessments and diagnosis for adults and children in all ICBs.

Derby and Derbyshire

25. The current adult inpatient number is 34, although this is currently being reviewed. There are 17 individuals in secure settings and 17 in non-secure settings. There were zero in-patient admissions, and zero discharges declared across all beds during October.

Lincolnshire

26. The current total adult inpatient number is 35, which is five above the combined learning disability and autism trajectory. There are 24 inpatient individuals with autism only, four above trajectory. There have been five discharges and four admissions. There are three children and young people inpatients against a trajectory of two. No admissions or discharges took place during September.

Nottingham and Nottinghamshire

27. The current adult inpatient number is 36, which is one above the combined secure/non-secure trajectory. There were zero admissions in October and two discharges from adult secure beds. There are two children and young people inpatients one below trajectory, with one admission and one discharges during October.

Urgent and Emergency Care – Enhanced Oversight

28. Across the three ICBs quality concerns are reported to the Urgent and Emergency Care Programme Boards and have broadly similar themes:

    a) Not achieving the average 30-minute target for category two ambulance call outs or the 45-minute handover target of 99% at emergency departments. These targets ensure that ambulances can be dispatched quickly and freed up so that they can respond to new emergencies, reduce delays and prevent potential harm to patients that may be waiting for long periods.

b) Not achieving the four-hour target set out in the Urgent and Emergency Care Plan for 2025/26 of a minimum of 78% of patients to be admitted into hospital, transferred or discharged; and for 12-hour breaches above the planned level. Delays in admission are linked to delays in receiving treatment, and worsening patient conditions leading to potential harm, a higher overall mortality rate and poor experience for both patients, their families/carers and staff.

29. CQC reports published in September 2025 to Lincoln and Pilgrim hospitals focused in this area and both received a 'requires improvement' rating.

30. The process to support NHS England's request for After Action Reviews for individuals experiencing prolonged delays in the urgent and emergency care pathway remains in place.

31. 2025/26 Winter Preparedness Plans are focussing on system wide consideration of risk and shared action with a focus on infection, prevention and control, on discharge and flow through hospital, mental health services and virtual ward usage.

Maternity

32. There is a focus across all three ICBs on ensuring improvements in perinatal outcomes, compliance with national initiatives, and ongoing CQC and Maternity Safety Support Programme oversight in UHDB and NUH.

Derby and Derbyshire

42. The UHDB Maternity Safety Support Programme remains an area of concern; however, there is improved assurance that the key objectives are being addressed and met. The Maternity Safety Support Programme will remain in place until January 2026.

43. Quarter four has seen improvements in perinatal mortality at both Chesterfield Royal Hospital and UHDB. The external review of stillbirths at Chesterfield Royal completed by Nottinghamshire Local Maternity and Neonatal System did not identify any safety themes.

44. Both Trusts are on track to meet 8 out of 10 safety actions the Maternity Incentive Scheme. UHDB has improved compliance with the Saving Babies Lives Care Bundle to meet safety action six; however, safety actions one and eight remain at risk. Chesterfield Royal Hospital's evidence for safety action six and for safety action eight will be updated following the next assessment during November.

45. Concerns remain at UHDB around third- and fourth-degree tear rates with a review requested by the Local Maternity and Neonatal System. Following the Section 29a and Section 31 CQC enforcement notices a Perinatal Pelvic Health

Service has been introduced; and recruitment has now been undertaken for a project manager and a midwife. A Lead Physiotherapist role will be interviewed this month.

46. Progress has been seen at both Trusts with the Three-Year Delivery Plan objectives. However, areas for improvement include personalised care, cultural safety for staff and workforce inequalities. Both Trusts have implemented transitional care and Chesterfield Royal has introduced a second enhanced midwifery continuity of carer team. The Maternity and Neonatal Voices Partnerships has increased the hours for the leads to improve engagement with service users and co-production with the Trusts.

Lincolnshire

47. In February 2022, the CQC published a report from their inspection of maternity services and both Lincoln County and Pilgrim Hospitals, and both were rated as ‘good’ overall.

48. This shows consistency for Lincoln County, which had previously been rated ‘good’ in 2019 and an improvement for Pilgrim Hospital that was previously rated as ‘requires Improvement’ in 2019.

49. There has been significant improvement in smoking at time of delivery rates; and for information regarding perinatal mental health services and for the military liaison co-ordinator role.

Nottingham and Nottinghamshire

50. NUH entered the Maternity Safety Support Programme in October 2020 following a CQC inspection, resulting in a rating of ‘inadequate’. Following a review and reset meeting in January 2025, it was agreed that the Trust will remain in the improvement phase of the Maternity Safety Support Programme until a further review and reset meeting has been completed in 9-12 months.

51. NUH continues to make positive progress with the three-year delivery plan, having previously being outliers in seven areas, they have reduced this to five in the most recent reporting period. Of the 11 active deliverables in the maternity improvement programme, six are on track, one requires attention and four are off track but are expected to close next month after experiencing time slippages.

52. A comprehensive Saving Babies Lives Care Bundle quarterly review of evidence was completed at both Trusts in September. SFH increased compliance from 90% to 94%, and NUH from 87% to 88%.

53. Escalation of non-compliance with minimum evidence requirements for Safety Action seven of the Maternity Incentive Scheme has commenced. Whilst the local Maternity and Neonatal Voices Partnership model in Nottingham and

Nottinghamshire is currently well-funded, it is undergoing a pilot phase with the intention to transition to a fully commissioned model from April 2026.

54. Media scrutiny persists due to the Independent Maternity Review and corporate manslaughter investigation announcement at NUH. The Nottingham and Nottinghamshire ICB continues to engage with the Independent Maternity Review and affected families.

Special Educational Needs and Disabilities (SEND) – Enhanced Oversight

55. There remains significant demand across all three ICBs for specialist assessments, particularly for Neurodevelopmental diagnosis and mental health services, leading to long waiting times, requiring whole SEND system multi-agency partnership to address.

56. There are SEND local area improvement plans in place across all three ICBs following CQC/Ofsted inspections. Local area partnerships are graded:

    a) Typically lead to positive outcomes.

    b) Inconsistent experiences and outcomes.

    c) Widespread and/or systemic failings leading to significant concerns about outcomes.

Derby City (graded 3) and Derbyshire (graded 3)

57. Derby City SEND Partnership is preparing for a joint Ofsted/CQC inspection imminently. The Self-evaluation, Local Area Improvement Plan, Joint Commissioning Plan and Joint Strategic Needs Assessment having been reviewed and refreshed. Strategic outcomes have been co-produced with children and young people. The partnership undertook a two day ‘mocksted’ inspection activity in October as part of knowing ourselves.

58. Post their inspection the Derbyshire County SEND Partnership will work to the Partnership Priority Impact plan for six priority areas and five areas for improvement. Derby and Derbyshire ICB is leading on three priorities: long waiting times for some NHS services, communications and joint commissioning.

Lincolnshire (graded 2)

59. The Lincolnshire Ofsted and CQC SEND inspection was undertaken in February 2025. A local area partnership improvement plan is in place and through a post inspection review in June 2025 by the department for Education and NHS England, it was confirmed the no additional support was required. A follow up meeting to review progress is due in February 2026.

Nottingham City (not inspected) and Nottinghamshire (graded 3)

60. The SEND Joint Commissioning Strategy annual delivery plan has been finalised, identifying three priority areas: support and waiting times for diagnostic pathways, speech, language, and communication needs, and complex health needs in education and transport settings. These priorities address findings from the recent monitoring inspection, which noted slow improvement in therapy pathways.

61. There has been significant progress within Nottinghamshire, with a successful progress visit and national recognition for work being on the SEND children and young people's Data Dashboard. In Nottingham City leadership and governance remain fragile, with Nottingham City operating with interim SEND leadership.

Infection Prevention Control (IPC) – Enhanced Oversight

Derby and Derbyshire

62. The ICB faces ongoing challenges with Healthcare Associated Infections (HCAIs) and is unlikely to meet all national 2025/26 thresholds. Whilst MRSA rates are well below average, infections from Clostridioides difficile (CDI), MSSA, E. coli, Klebsiella, and Pseudomonas exceed peers. Actions include enhanced surveillance, strengthened governance, cross-organisation collaboration, innovations like the 'HOUDINI' catheter protocol, and expanded IPC training. Despite improvement efforts, there are persistent threshold breaches, and an August 2025 CDI spike emphasised the need for ongoing monitoring and strategic adaptation, particularly in the community.

Lincolnshire

63. A system wide enhanced IPC consideration framework has been developed to apply evidence-based IPC precautions proportionate to the assessed risk; and real time data and will include using a proactive approach utilising primary care level Acute Respiratory Infection and Viral gastroenteritis presentation data to track case trajectories. This will give early evidence of possible case surges and will allow acute services more time to make any necessary adjustments.

Nottingham and Nottinghamshire

64. HCAI targets for 2025-26 are challenging to meet due to significant reductions in thresholds for Gram-negative bloodstream infections and with continued boarding and overcrowding, which impacts on the ability to undertake cleaning and is a factor with outbreaks and onward transmission. IPC teams continue to monitor standards, including environmental audits following outbreaks of infection. Audits are highlighting areas for improvement that include hand hygiene, cleaning of shared equipment and environmental cleanliness, and

areas of estate improvement. Actions are taken to address areas of improvement but sustaining improvement remains challenging across pressurised services.

Appendix 1. Escalation Framework

The ICS developed an Escalation Framework, to provide structure and consistency across all areas of oversight for escalation of concern through the governance routes of the system, and which then feed into the formal governance of the ICB. The framework has been created based upon work undertaken through the quality route building upon previous National Quality Board (NQB) guidance.

Monitoring level	**Routine**	**Further Information Required**	**Enhanced**	**Escalated Risk**
What does this mean?				
	No specific areas of concern identified	Potential for concern. Key milestones not achieved. More information required to determine level of risk	Delivery or quality concerns identified.	Serious specific risk to delivery or quality identified, including where there is a need to act rapidly to protect patients or staff.
What action should be taken?				
	Actions to be taken by relevant operational oversight group	Agree route to follow up to gain necessary information to assess risk and agree who will lead.	Agree actions and schedule for discussion at each Operational oversight Group until concerns resolved.	Trigger escalation single subject review /deep dive / risk summit.

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	20/11/2025
Paper title:	**Service Delivery Performance Report**
Paper reference:	ICB CIC 25 014
Paper author:	Sarah Bray, Associate Director of System Performance and Assurance, NHS Nottingham and Nottinghamshire ICB
Paper sponsor:	Maria Principe, Interim Director of Commissioning
Presenter:	Maria Principe, Interim Director of Commissioning

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

Report summary:

The purpose of this report is to present progress against compliance and commitment targets as required for 2025/26. The report describes the key drivers behind performance and actions being taken to address areas of concern in all service delivery performance areas. This report should be read in conjunction with the full Performance Reports, which are provided for Board members separately.

Mid-Year recovery plans have been submitted by providers to demonstrate recovery back to December 2025 planned levels across urgent care, planned care and cancer.

One provider is currently under Tier 1 enhanced oversight with the NHS England National Team: Nottingham University Hospitals for urgent care and cancer.

All systems are actively preparing for winter, reviewing their service capacity, pathways, and operational arrangements to ensure effective delivery throughout the season. Despite this proactive planning, pressures across the urgent and emergency care system are already increasing. There has been a noticeable rise in higher-acuity attendances, alongside growing numbers of respiratory and frailty-related admissions. Ongoing discharge challenges, both within hospitals and across wider system pathways, are impacting patient flow and contributing to bottlenecks at emergency department front doors. These issues are resulting in extended ambulance handover delays and, consequently, longer response and wait times within the community, highlighting the need for continued system coordination and escalation of winter resilience measures.

The systems are also required to focus on delivering to the planned care waiting list measures before the Christmas break, with zero tolerance of waits over 65 weeks after 21 December 2025. The position is progressing for those providers within our geographical footprint, however out of area providers are proving challenging.

Despite additional treatments compared to prior year, cancer performance is not achieving across the ICBs' area and recovery plans are in place to deliver back to plan by March 2026, with the challenging balance of reducing backlogs whilst improving monthly performance.

Urgent dental appointments continue to be below plan across all areas, and targeted actions are being undertaken to improve to national expected levels. Pharmacy First is delivering well across all ICBs.

Report summary:

The seasonal vaccination programme is progressing for both covid and flu vaccinations. All systems have been required to submit plans to increase take up across patient cohorts and improve delivery of staff vaccinations. Targeted actions are being taken on low uptake areas.

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
☐ 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 – Service Delivery Performance
Appendix 2 – Activity versus Plan August 2025
Appendix 3 – ICBs Seasonal Vaccination Performance
Appendix 4 – Revised Trajectories for Mid-Year Plan and Tiering
Appendix 5 – NHS Trust NHS Oversight Framework Ratings

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Service Delivery Performance Report

Introduction

1. There is mixed performance across the service delivery areas of the ICBs. A key focus is on the consolidation and enactment of plans to enable a sustainable urgent and emergency care system leading into the winter months, which includes undertaking immediate actions to improve current performance across Emergency Departments, with a focus on improved flow and internal efficiency measures. Recovery of planned care and cancer performance back to planned levels by December 2025 is another key priority, through improving efficiency and undertaking more activity in line with plans. There is also continued focus on timely access to mental health and community services and enhancing the take up of seasonal vaccinations across low uptake areas.
2. The ability to manage demand into winter and improve discharges and generate the additional activity required to improve planned care performance, whilst delivering the requirement to reduce spend run rate over the winter period will be extremely challenging for all systems and is likely to impact the ability to deliver the performance improvements needed in the second half of the year.
3. An overview of key priority system delivery metrics is provided at Appendix 1, an overview of system activity against the operational plans submitted is provided at Appendix 2, and an overview of delivery against seasonal vaccinations is included at Appendix 3.
4. Enhanced oversight arrangements are in place with Nottingham University Hospitals NHS Trust (NUH) and United Lincolnshire Teaching Hospitals NHS Trust (ULHT) for 4-hour and 12 hour waits in Emergency Departments and cancer waits at NUH through Tier One oversight arrangements with NHS England.
5. NHS England issued a mid-year review letter that required providers to submit recovery trajectories back to planned levels in December 2025 for areas of concern, a summary of which is provided at Appendix 4.

Urgent care and winter preparations

6. All three systems continue to face sustained operational pressures with all systems below urgent care trajectories for September 2025. Lincolnshire is closer to the 4-hour target; however, Nottingham and Nottinghamshire, and Derby and Derbyshire are reporting significant under performance. All systems are reporting high levels of ambulance handovers over 45 minutes and increased ambulance response times.

7. There remain persistent challenges relating to patient flow, both through the hospital and out of hospital, delayed discharges and high bed occupancy.

8. Winter preparedness and governance structures are relatively strong across all systems, with seasonal plans having been finalised and reviewed through all system governance routes and approved by respective provider partnership boards and progressing through relevant Health Overview and Scrutiny Committees. The suite of documents sets out the system approach to management of winter and mitigation of increased pressures and surge.

9. Capacity constraints and increased demand continues to pose risks to delivery during peak demand periods and will need to be targeted over the coming weeks for responsive surge planning through the winter period.

10. **NHS Derby and Derbyshire ICB**: Flow through the hospital is the key area of focus, including responding to differential demand profiles across the two main hospitals, addressing increased attendances by patients over 65 years of age, focus on reducing excess waits over 12 hours and long lengths of stay. Weekly winter monitoring is in place involving senior representatives from all system partners and led by the ICB, overseeing delivery of identified initiatives, oversight of urgent care metrics and mitigation of demand and capacity risk.

11. **NHS Lincolnshire ICB**: A winter delivery group and Urgent and Emergency Care Leaders group (both led by the ICB) are ensuring delivery of the winter plan and will have continued oversight of the winter performance metrics, the delivery of all winter initiatives and quantification of impact to support a clear understanding of the mitigation of the risk of demand outstripping capacity. A winter risk register has also been developed.

12. **NHS Nottingham and Nottinghamshire ICB**: Urgent care faces persistent pressures, with the Nottingham and Nottinghamshire position being at the bottom of national benchmark at 40 out of 42 systems for 4-hour performance. This has resulted in NUH being escalated to Tier One National oversight processes in November. Weekly Urgent Care Operational meetings are in place that monitor delivery of the winter plan actions, which include increased capacity, discharge marshals, and expanded urgent treatment centre slots. Areas of focus continue on addressing key risk areas, including increased demand, non-elective admissions conversion rates, high lengths of stay, and discharge delays, which have increased due to infection control and repatriation issues.

Planned care

13. Performance across the ICBs is variable for August 2025; however, continues to improve against the planned trajectories, with progress being made on long waits and Referral to Treatment (RTT) metrics. Derby and Derbyshire are delivering against RTT 18 week waits and 52 week wait trajectories.

Lincolnshire is delivering against first outpatient within 18 weeks metrics and total waiting list trajectories. Nottingham and Nottinghamshire are delivering against RTT 18 week waits and waiting lists.

14. All systems remain focused on recovery back to planned levels for all targets, and to deliver against the national requirement for zero waits over 65 weeks from the 21 December 2025.

15. Transformational work continues to be undertaken across all areas of the planned care systems to deliver sustainable services and improve operational efficiency through boosting outpatient efficiency, optimisation of theatres, demand management through advice and guidance, referral support services, community pathway and digital services.

16. **NHS Derby and Derbyshire ICB**: Despite positive progress against planning trajectories, the system is in the second to lowest quartile for national benchmarking, with a material productivity gap. Actions being targeted by the system include reviewing outpatient care to assess activity per consultant, focus on ‘did not attend’ rates, use of virtual appointments, uptake of specialist advice and guidance; improving theatre utilisation rates and reducing areas of non-compliance with evidence based intervention thresholds at University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and progressing shifts from day case/admitted electives to outpatient settings.

17. **NHS Lincolnshire ICB**: The system is focusing on productivity and demand management initiatives to deliver further performance improvements. Priority improvement plans across partners include outpatient and theatre improvement plans encompassing theatre scheduling, standardisation of clinic templates, clinic slot utilisation, ‘straight to test’ assessment pathways and targeting ‘did not attend’ rates. Referral Optimisation and Demand management plans include advice and guidance roll-out.

18. **NHS Nottingham and Nottinghamshire ICB**: Performance is differential across the two acute trusts, with NUH focusing on reducing long waits, and Sherwood Forest Hospitals NHS Foundation Trust (SFH) increasing activity to progress with waits within 18 weeks. Actions include pathway recovery of dermatology through insourcing, establishing referral support services, expanding community dermatology and progressing tele-dermatology, new group clinics for sleep services, and increased validation activity at both trusts. The transfer of gynaecology patients to various providers following the hand back of the contract has created backlogs, however robust tracking and booking systems are in place to ensure timely treatment.

Cancer

19. Across Derbyshire, Lincolnshire, and Nottinghamshire ICBs, progress against national cancer treatment standards remains mixed, with ongoing challenges in

meeting 62-day, 31-day, and Faster Diagnosis Standards targets. In August 2025, all ICBs were failing to deliver to the operational planning trajectories, however performance by individual provider is varied.

20. **NHS Derby and Derbyshire ICB**: UHDB continues to improve year-on-year but remains 5–6% below its 62-day trajectory. Chesterfield Royal Hospital NHS Foundation Trust (CRH) has performed above plan overall despite recent pressures on the breast cancer pathway. Treatment performance benchmarks well nationally, though significant variation persists across tumour sites, particularly in lower gastrointestinal, gynaecological, and urological cancers, which are areas of priority for sustained performance improvement.

21. **NHS Lincolnshire ICB**: ULHT continues to face underperformance across all three constitutional standards, with August's 62-day target falling below trajectory. Colorectal and head and neck pathways are key constraints for 31-day performance, whilst additional capacity is being introduced in breast and skin services to support recovery.

22. **NHS Nottingham and Nottinghamshire ICB**: NUH is the area of most challenge, and due to the distance from planned trajectories and low national benchmark performance, the Trust has been moved into Tier One oversight arrangements with NHS England. Causal factors are related to increasing referral volumes higher than national growth and growth in cancer backlogs. Recovery plans are in place, focusing on workforce expansion, pathway optimisation, and diagnostic capacity improvements, with a goal of achieving a material backlog reduction and performance improvement by March 2026. SFH has delivered to plan for 62-day and faster diagnosis standards, with focus needed on 31-day waits. The system is working with regional partners to address diagnostic delays and improve treatment capacity to further support improvement of the cancer pathway.

Diagnostics

23. All three systems were not achieving the six-week wait trajectories in August 2025 despite having undertaken more activity to August than in the same period last year. Diagnostic capacity constraints are impacting not only recovery of the diagnostic performance but also directly impact upon the delivery of cancer and elective performance. ICB-wide collaborations, targeted investment in diagnostic infrastructure (Community Diagnostic Centres and imaging), and sustained focus on pathway efficiency and modality productivity are essential to achieving year-end and medium-term performance targets.

24. **NHS Derby and Derbyshire ICB**: both trusts are delivering performance below their respective peers, and whilst CRH had been delivering to plan, their performance deteriorated in August. UHDB is further off plan and requires significant focus to improve in the second half of the year. The most challenging

tumour sites across both trusts are suspected gynaecological, gastrointestinal and urological cancers. In addition, CRH's dermatology service lacks sufficient capacity to meet both general and two-week wait demand. Cross cutting areas of focus for improvement are access to imaging and endoscopy and histopathology.

25. **NHS Lincolnshire ICB**: The six-week wait position is significantly under plan, with further deterioration in the August position. Immediate priority improvement plans across partners include an audiology improvement plan at ULHT, a recovery plan for imaging aligned to workforce and the development of a sustained cardiac MRI service at North West Anglia NHS Foundation Trust. Medium term actions for sustained diagnostic improvement are focused on the Community Diagnostic Centres, with a site at Boston having been approved with provisional opening at the end of 2026/27 and a new endoscopy unit in opening in Lincoln in quarter two 2026/27.

26. **NHS Nottingham and Nottinghamshire ICB**: Performance on six-week waits benchmarks relatively well for the Nottingham and Nottinghamshire system; however, the position is varied across the two main acute providers. SFH is gradually improving, with focus on echocardiology capacity improvements. The position at NUH continues to deteriorate, particularly in relation MRI activity. A comprehensive system-wide discussion regarding MRI services, funding and capacity is required to determine impact on performance in the second half of the year.

Acute activity

27. Performance is varied across the three ICBs, as are the types of activity being undertaken. First outpatients are under plan across all ICBs, however there is year on year growth at Derbyshire and Nottinghamshire. There has been year on year growth in electives at Derbyshire and Nottinghamshire, but only Derbyshire has seen year on year growth for day case activity. Out-patient follow ups have increased significantly at Derbyshire and Nottinghamshire, with only Lincolnshire seeing a small year on year reduction. NHS England is monitoring closely the delivery of activity to plan as a measure of productivity and efficiency, but also as a key element in the recovery of performance for the NHS.

28. **NHS Derby and Derbyshire ICB**: There has been less activity than planned across all areas, but all areas have increased year on year.

29. **NHS Lincolnshire ICB**: Day case and outpatient follow-ups are over planned levels, but all areas are lower than prior years. ULHT has developed a new Productivity and Planned Care Programme, which will focus on eight delivery pillars. The outpatient clinic utilisation workstream will include areas of focus such maximising patient initiated follow ups and reducing 'did not attends', clinic

template standardisation and slot utilisation reviews, including short notice cancelations and weekly meetings to challenge business units. These areas also remain a priority as part of the North West Anglia NHS Foundation Trust's Out-Patient Improvement Programme.

30. **NHS Nottingham and Nottinghamshire ICB**: Elective ordinary and outpatient follow-ups are over planned levels; day cases are below plan and lower than previous year and first outpatient appointments is below plan but higher than previous year. The systemwide 'Get It Right First Time' Board meets regularly to review efficiency opportunities, such as expanding advice and guidance, lowering 'did not attend' rates, and optimising patient initiated follow up use where appropriate.

Primary care

31. Across all three ICBs primary care access remains stable, with a slight deterioration in August. GP appointments are expected to increase over the winter period to meet demand. Focus remains on the national priority areas for increasing urgent dental appointments. Pharmacy First activities are delivering above planned activity levels across all three systems.

32. **NHS Derby and Derbyshire ICB**: GP appointments are subject to some variation throughout the year, with work continuing with practices and Primary Care Networks on the Primary Care Access Recovery Plan. Actions are on track and the position will continue to be monitored through the remainder of the year.

33. **NHS Lincolnshire ICB**: GP Appointments dropped slightly in August; however, 86% of GP appointments were within two weeks of contact. Work to support GP practices with capacity and demand management is underway, with seven priority practices engaged with the Practice Level Support Programme. Urgent dental appointments were below plan in September, which is due to service mobilisation and initial demand being lower than expected, and work is underway with East Midlands ICBs and locally to promote the services and increase utilisation. Pharmacy First consultations are currently above the planned levels.

34. **NHS Nottingham and Nottinghamshire ICB**: GP appointments were slightly below plan in August; however, appointments within two weeks stood at 85.3%. System support to practices continues to be provided to further improve appointment mapping and urgent access reporting. System support is also provided for improving dental activity with focus on delivering high levels of timely appointments and increasing and re-focusing dental activity to meet targets. Actions to improve urgent dental activity include agreeing extensions to contracts for core providers, developing a proposal to source a Bassetlaw provider and expanding communications with the public on appointment

availability. The Pharmacy First task force is actively collaborating with general practitioners and community pharmacies to further enhance utilisation of the Pharmacy First service.

Community services

35. The three ICBs continue to strive to reduce waits of over 52 weeks for therapeutic community waits and to enable a return to delivery focused on 18 week waits; however, the position is mixed across the ICBs.

36. **NHS Derby and Derbyshire ICB**: Children and Young People's community waits predominantly relate to Community Paediatrics Neurodevelopmental waits, for autism spectrum disorder assessments. The waits have increased in line with national position. (To note, the other ICBs do not report their neurodevelopmental pathways through community waits). A review of the full pathway for autism spectrum disorder and attention deficit hyperactivity disorder is underway, with opportunities across the ICBs to be undertaken to support improvement. The adult waits have improved in month.

37. **NHS Lincolnshire ICB**: 21 adult waits relate to the Lymphoedema service, and whilst the position is ahead of plan, a service expansion has been approved for a full-time Lymphoedema service in Sleaford to drive further improvements. In addition, a collaborative pathway is being developed with the Lower Limb Service. All 392 children and young people long waiters are within the ULHT Community Paediatrician service, which has significant waiting times for new and follow up appointments. Service change options appraisals to reduce waiting times are awaiting approval for additional funds.

38. **NHS Nottingham and Nottinghamshire ICB**: There has been a reduction in children and young people waiting over 52 weeks, primarily among children for occupational therapy and speech and language therapy. Recovery for occupational therapy waits has slipped from November 2025 to March 2026 due to staffing shortages and case complexity. System-wide workshops and task groups are developing sustainable pathways for speech and language therapy from 2026/27, with progress monitored through oversight boards. Adult breaches were due to data errors and have now been corrected by the provider.

Mental health, learning disabilities and autism

39. Across the ICBs there is progress on reducing out-of-area placements and improving access to community services. However, continued challenges remain in relation to demand, acute bed utilisation, inpatient lengths of stay, private bed dependence and reductions in learning disability and autism inpatients.

40. **NHS Derby and Derbyshire ICB**: areas of system focus include a significant reduction in out of area placements, achieved by targeted actions and new accommodation. Adult acute bed utilisation remains a critical issue, with focus on reducing average length of stay, which is currently 60 days, six days above trajectory as of August 2025, to 47 days by March 2026. Current priorities are delivering the national ten high-impact interventions for mental health discharges and maximising community resources to close the gap and manage Section 117 aftercare spend.

41. **NHS Lincolnshire ICB**: Areas of ICB focus and areas below plan include recruitment for Individual Placement Support services following an expansion in funding received; and mitigating inappropriate out of area placements using repatriation, rehabilitation beds, discharge planning, and partnership work, including social care improvements. Ashley House Residential Home in Grantham opened in October 2025, with a new pathway in development.

42. A recovery plan is in place to improve access for children and young people, with the continued rollout of Mental Health Support Teams for schools and a digital pilot. Data flow improvements are underway for the children and young people Complex Needs Service. The Perinatal Maternity Mental Health Service is being remodelled to strengthen staffing levels and increase access.

43. Lincolnshire is experiencing an increase in adult autism only short-term admissions previously not known to services and presenting in crisis. An admission / discharge approach is being developed for these individuals to aid prompt discharge.

44. **NHS Nottingham and Nottinghamshire ICB**: Areas of ICB focus and areas below plan include addressing inappropriate out of area placements. Current levels are above plan and private bed usage remains at high levels. Improvement plans are in place to reduce reliance on independent sector beds, with a focus on reducing lengths of stay to national ambition and managing demand through enhanced community support, aligned to the national ten high-impact interventions for mental health discharges. Further cross-system work is required to ensure that sustainable and aligned actions are being carefully balanced with wider system delivery risk.

45. The Crisis Advice Line faces ongoing quality and capacity issues, including data flows, and a spike in mental health presentations at accident and emergency departments, and is under review. The provider is developing targeted recovery plans for crisis services and data quality.

46. The Talking Therapies service is achieving most metrics, although reliable recovery rates are below target. A recovery plan is being developed with the provider to achieve the increased target for 2025/26.

47. There were no learning disability and autism adult admissions in September which was positive, however inpatient numbers remain above plan. Data

cleansing and pathway reviews are underway, with admission avoidance strategies and discharge panels in place to expedite progress. Long waits for attention deficit hyperactivity disorder and autism assessments persist, delaying access to support.

Seasonal vaccination

48. Across all three ICBs, vaccination uptake is broadly positive but uneven, and detailed information is provided in Appendix 3. Covid-19 vaccination update is strong in Derbyshire, with a steady rollout in Lincolnshire. However, there is a lower-than-expected uptake in Nottinghamshire. Flu vaccinations reports good overall system performance, with greater uptake currently for healthcare workers and children aged 2-3 than in the same period last year. However, children, school and maternity vaccination rates remain weak points across all three systems. Flu and RSV vaccination in pregnancy uptake is affected by issues at Derby and Burton sites and local actions are ongoing to stabilise access and uptake. National campaigns to improve flu uptake are being rolled out, as well as collaboration locally with voluntary sector organisations and targeted communications in lower uptake communities.

49. **NHS Derby and Derbyshire ICB**: Flu vaccination rates are performing well across several cohorts, with health care worker uptake above the November local trajectory. Key areas of concern are primary and secondary school uptake. There have been a number of changes in staffing with the provider, which has impacted on uptake. An action plan to increase vaccination uptake among pregnant women is in place and this issue has been escalated through Urgent Emergency Care Delivery Board and Health Protection Board. There have been a number of flu outbreaks in care homes. CRH has advised that they are unable to vaccinate patients on discharge to care homes, the impact of which on the urgent and emergency care resilience plan needs to be assessed.

50. **NHS Lincolnshire ICB**: Flu performance is ahead of national delivery across all cohorts. All long stay inpatients and patients being discharged from hospital into care homes will be offered a vaccine. Areas of focus include system wide communications and training with healthcare workers, with focus on leadership in relation to vaccine hesitancy; piloting GP delivery of flu vaccinations in nursery and early years settings in areas of low uptake, promotion of materials focused on nasal spray offer; and a focus on low uptake areas. The east coast communities will be supported by the Lincolnshire Community Health Services Vaccination and Rapid Response Team.

51. **NHS Nottingham and Nottinghamshire ICB**: Compared to last year, uptake is slightly down for the over 65-year eligible cohort and primary school children, but uptake is higher for healthcare workers, secondary school children, and children aged between 2-3. The low regional benchmark position for children

relates in part to the scheduling of the school vaccination service. For Covid-19 vaccinations, all cohorts are lower than at the same point last year, are below regional ambitions, and lower in more deprived areas and among Black, Pakistani, and other minority ethnic groups.

52. Targeted actions include additional school mop up clinics and expanded pharmacy provision being established for 2-3 year olds. Additional resources are supporting Nottingham City GP practices, and additional Primary Care Network wide clinics are planned, with targeted support for practices in areas with lower coverage and communities with lower uptake.

Provider oversight

53. NHS England is revising its oversight arrangements with providers as part of transition arrangements to the NHS new operating model. Monthly Provider Review Meetings will be held by NHS England with each of the providers as direct performance management is migrated to NHS England from quarter three onwards.

54. NHS England also undertake enhanced oversight in relation to specific national priority metrics. This is determined through national benchmarking of metrics for the delivery against the operational plan position, and assigning providers to tiering levels, with Tier One being the most intensive level of oversight. An overview of current tiering arrangements across the ICBs is provided at Appendix 4. One provider is under Tier One enhanced oversight, which consist of formal weekly or fortnightly meetings led by the NHS England National team, including the provider and the ICB. NUH is in Tier One for their 4-hour waits in the emergency department and their cancer performance. ULHT is in Tier One for 4-hour and 12 hour waits in Emergency Departments.

55. The NHS Oversight Framework has now been published, and Appendix 5 provides an overview summary of the provider position. There are two providers that are under enhanced oversight arrangements and within Recovery Support Programme arrangements, NUH and NHT. The ICBs are involved in the monitoring arrangements with NHS England.

Appendix 1 - Service Delivery Performance

DLN ICBs Service Delivery Dashboard v Plan					Derby and Derbyshire ICB				Lincolnshire ICB				Nottingham and Nottinghamshire ICB			
Acute	Metric	Pop / Provider	% / Value	Period	Plan	Actual	Variance		Plan	Actual	Variance		Plan	Actual	Variance	
Planned Care	<18 week wait for 1st OP	ICB Pop	%	Aug-25	65.1%	65.0%	-0.1%	✗	57.2%	60.1%	2.9%	✓	71.5%	68.8%	-2.7%	✗
	<18w waits RTT	ICB Pop	%	Aug-25	59.2%	60.9%	1.7%	✓	56.1%	55.9%	-0.2%	✗	60.3%	62.6%	2.3%	✓
	>52 week waits	ICB Pop	%	Aug-25	2.1%	2.1%	0.0%	✓	1.9%	2.6%	0.6%	✗	1.6%	2.0%	0.4%	✗
	>65 week wait	ICB Pop	Value	Aug-25	0	63	63	✗	0	82	82	✗	0	96	96	✗
	PTL (Waiting List)	ICB Pop	Value	Aug-25	121,473	123,084	1,611	✗	113,343	109,480	-3,863	✓	126,882	126,114	-768	✓
Cancer	<28 Day Faster Diagnosis	ICB Pop	%	Aug-25	77.0%	73.5%	-3.5%	✗	79.1%	74.1%	-5.0%	✗	79.8%	71.7%	-8.1%	✗
	<31 day	ICB Pop	%	Aug-25	92.0%	90.1%	-1.9%	✗	93.3%	87.6%	-5.7%	✗	93.2%	88.5%	-4.7%	✗
	<62 Day Referral to Treatment	ICB Pop	%	Aug-25	72.7%	67.4%	-5.3%	✗	70.1%	62.1%	-7.9%	✗	66.6%	59.1%	-7.5%	✗
	LGI Fit Test	ICB Pop	%	Aug-25	80.9%	82.0%	1.1%	✓	78.3%	87.3%	9.1%	✓	78.0%	65.0%	-13.0%	✗
Diagnostics	Planning 9 Modalities > 6ww	ICB Pop	%	Aug-25	22.3%	29.4%	7.1%	✗	17.3%	30.8%	13.5%	✗	12.6%	18.8%	6.2%	✗
Urgent Care	<4 hour wait ED	ICB Prov	%	Sep-25	76.9%	71.9%	-5.0%	✗	76.5%	74.9%	-1.6%	✗	71.8%	63.2%	-8.6%	✗
	>12 hour wait from arrival ED	ICB Prov	%	Sep-25	6.2%	11.3%	5.1%	✗	9.0%	11.6%	2.5%	✗	8.0%	10.1%	2.1%	✗
	>45m Ambulance Handovers	ICB Prov	%	Sep-25	0.0%	17.6%	17.6%	✗	0.0%	15.8%	15.8%	✗	0.0%	19.6%	19.6%	✗
	Cat 2 Mean Response Time	ICB Prov	Value	Sep-25	00:33:04	00:39:05	0:06:01	✗	00:30:00	00:38:09	00:08:09	✗	0:33:04	0:35:16	0:02:12	✗
Primary Care	GP Appointments	ICB Pop	Value	Aug-25	607,450	532,858	-74,592	✗	463,798	493,244	29,446	✓	585,573	580,890	-4,683	✗
	Units of Dental Activity (UDAs)	ICB Pop	Value	Sep-25	108,862	108,513	-349	✗	68,226	70,086	1860	✓	150,273	131,531	-18,742	✗
	Urgent Dental Activity	ICB Pop	Value	Sep-25	6,674	4,723	-1951	✗	3,972	2,768	-1204	✗	8,322	5,645	-2,677	✗
	Pharmacy First	ICB Pop	Value	Aug-25	7,891	8,119	228	✓	5,474	6,055	581	✓	10,169	14,363	4194	✓
Community	>52ww - Adult	ICB Pop	Value	Aug-25	788	112	-676	✓	23	21	-2	✓	0	4	4	✗
	>52ww - CYP	ICB Pop	Value	Aug-25	2,107	2,200	93	✗	10	392	382	✗	11	68	57	✗
Mental Health	Inappropriate Out of Area Inpatients	ICB Pop	Value	Aug-25	7	11	4	✗	7	1	-6	✓	0	10	10	✗
	Inpatient Mean Length Of Stay	ICB Pop	Value	Aug-25	48	61	13	✗	63	21	-42	✓	58	54	-4.2	✓
	Individual Placement Support	ICB Pop	Value	Aug-25	738	770	32	✓	683	635	-48	✗	1300	1195	-105	✗
	Early Intervention Psychosis	ICB Pop	%	Aug-25	60%	43%	-17.0%	✗	60.0%	61.0%	1.0%	✓	60%	78.0%	18.0%	✓
	Talking Therapy Reliable Recovery	ICB Pop	%	Aug-25	47%	39%	-8.2%	✗	46.6%	47.0%	0.4%	✓	50%	46.3%	-3.7%	✗
	Talking Therapy Reliable Improvement	ICB Pop	%	Aug-25	68%	62%	-6.0%	✗	67.0%	71.4%	4.4%	✓	68%	68.5%	0.5%	✓
	CYP Access	ICB Pop	Value	Aug-25	14,244	14,490	246	✓	10,541	10,075	-466	✗	20475	21770	1295	✓
	CYP ED Routine	ICB Pop	%	Aug-25	95%	100%	5.0%	✓	95.0%	63.0%	-32.0%	✗	95%	78%	-17.0%	✗
LD&A	Adult Inpatients	ICB Pop	Value	Aug-25	34	35	1	✗	29	35	6	✗	35	38	3	✗
	CYP Inpatients	ICB Pop	Value	Aug-25	3	5	2	✗	2	3	1	✗	3	2	-1	✓
	Annual Health Checks	ICB Pop	Value	Sep-25	361	343	-18	✗	1,216	1,351	135	✓	2,125	2,091	-34	✓

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

Appendix 2 – Activity v Plan August 2025

Derby and Derbyshire ICB Population	August 2025 Only				Aug 25 v Aug 24		April 2025 - August 2025				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)	47,958	47,892	-66	-0.1%	3,744	8.5%	242,632	249,485	6,853	2.8%	14,594	6.2%
Elective Ordinary	1,861	1,810	-51	-2.7%	131	7.8%	9,660	9,306	-354	-3.7%	1,307	16.3%
Day Cases	11,719	10,956	-763	-6.5%	71	0.7%	61,691	60,344	-1,347	-2.2%	4,408	7.9%
Diagnostics (9 key modalities)	40,860	41,898	1,038	2.5%	4,853	13.1%	209,940	214,528	4,588	2.2%	24,592	12.9%
Outpatients 1st (Spec Acute)	31,935	27,919	-4,016	-12.6%	-881	-3.1%	169,799	158,864	-10,935	-6.4%	7,688	5.1%
Outpatients Follow-ups (Spec Acute)	70,615	62,387	-8,228	-11.7%	4,139	7.1%	379,921	354,540	-25,381	-6.7%	45,045	14.6%

Lincolnshire ICB Population	August 2025 Only				Aug 25 v Aug 24		April 2025 - August 2025				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)	30,820	30,358	-462	-1.5%	2,105	7.5%	152,112	150,333	-1,779	-1.2%	2,969	2.0%
Elective Ordinary	1,451	1,409	-42	-2.9%	-121	-7.9%	7,513	7,346	-167	-2.2%	-354	-4.6%
Day Cases	9,103	9,157	54	0.6%	-880	-8.8%	47,969	49,122	1,153	2.4%	-560	-1.1%
Diagnostics (9 key modalities)	38,013	36,880	-1,133	-3.0%	3,662	11.0%	191,430	189,882	-1,548	-0.8%	19,707	11.6%
Outpatients 1st (Spec Acute)	23,088	22,037	-1,051	-4.6%	-1,384	-5.9%	124,962	122,898	-2,064	-1.7%	-1,913	-1.5%
Outpatients Follow-ups (Spec Acute)	38,459	37,583	-876	-2.3%	-3,411	-8.3%	207,819	214,790	6,971	3.4%	-2,328	-1.1%

Nottingham and Nottinghamshire ICB Population	August 2025 Only				Aug 25 v Aug 24		April 2025 - August 2025				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: DBTH, CRTH, DCHS)	34,376	30,625	-3,751	-10.9%	-1,706	-5.3%	181,213	175,288	-5,925	-3.3%	166	0.1%
Elective Ordinary	2,225	2,210	-15	-0.7%	13	0.6%	11,337	11,338	1	0.0%	119	1.1%
Day Cases	15,373	13,790	-1,583	-10.3%	-1,240	-8.3%	76,501	72,930	-3,571	-4.7%	-873	-1.2%
Diagnostics (9 key modalities)	41,465	40,585	-880	-2.1%	-6,113	-13.1%	212,014	225,693	13,679	6.5%	6,823	3.1%
Outpatients 1st (Spec Acute)	31,517	29,357	-2,160	-6.9%	258	0.9%	164,920	163,550	-1,370	-0.8%	13,120	8.7%
Outpatients Follow-ups (Spec Acute)	64,807	67,512	2,705	4.2%	4,434	7.0%	343,728	368,103	24,375	7.1%	36,595	11.0%

Appendix 3 – ICBs Seasonal Vaccination Performance

Flu Vaccine uptake (as of 03/11/2025) Based on National Reporting

	65+			<65 AR			Preg			Age 2/3			Primary School Children			Secondary School Children			HCWs			ALL
Area	Current	Ambition	Gap	Current	Ambition	Gap	Current	Ambition	Gap	Current	Ambition	Gap	Current	Ambition	Gap	Current	Ambition	Gap	Current	Ambition	Gap	Current
England	59.90%	75.00%	-15.10%	31.40%	45.00%	-13.60%	33.70%	31.10%	2.60%	34.70%	50.00%	-15.30%	26.80%	60.00%	-33.20%	17.60%	50.00%	-32.40%	30.10%	45.60%	-15.50%	38.30%
Midlands	61.30%	75.70%	-14.50%	31.10%	47.20%	-16.10%	33.30%	32.00%	1.30%	31.90%	46.70%	-14.80%	21.40%	53.30%	-31.90%	16.90%	44.10%	-27.20%	26.70%	42.40%	-15.70%	38.00%
Derbyshire	65.10%	79.70%	-14.50%	34.60%	50.60%	-16.00%	37.20%	35.00%	2.20%	37.50%	54.90%	-17.40%	25.40%	59.40%	-34.00%	9.20%	52.50%	-43.30%	33.30%	52.30%	-19.00%	41.90%
Lincs	63.90%	78.80%	-15.00%	34.20%	51.20%	-17.00%	39.60%	37.70%	1.90%	35.90%	52.30%	-16.40%	33.30%	61.50%	-28.20%	29.70%	53.60%	-23.90%	37.80%	52.00%	-14.10%	46.20%
Notts	63.00%	77.40%	-14.50%	31.90%	48.30%	-16.40%	31.70%	31.50%	0.30%	33.30%	49.00%	-15.70%	21.00%	56.20%	-35.20%	19.50%	48.50%	-28.90%	31.00%	46.60%	-15.50%	39.30%

Flu Vaccine uptake compared to same time last year

Area	65+	<65AR	Age 2/3	Primary School Children	Secondary School Children	HCWs	ALL
England Average	-2.3%	-0.1%	1.2%	-1.0%	1.5%	4.5%	0.2%
Midlands Average	-2.6%	-0.3%	1.8%	-4.8%	2.5%	3.5%	-0.4%
DDICB	-2.9%	-0.6%	1.0%	-6.2%	0.0%	2.9%	1.8%
Lincs ICB	-0.9%	0.8%	2.1%	1.4%	-1.6%	8.8%	2.6%
NNICB	-3.3%	-0.9%	1.3%	-1.8%	3.7%	7.9%	1.8%

	Covid						RSV					
	Care Home		75+		IS		Age 75		75 - 79		Preg	
Area	Current	Ambition	Current	Ambition	Current	Ambition	Current	Ambition	Current	Ambition	Current	Ambition
England	54.80%	66.20%	52.80%	59.90%	24.20%	25.00%	37.00%	60.00%	66.00%	70.00%	46.40%	50%/60%
Midlands	52.90%	66.00%	51.70%	58.70%	22.40%	24.10%	37.20%	65.00%	67.00%	70.40%	43.10%	50%/60%
Derbyshire	63.20%	69.60%	56.40%	63.90%	26.80%	28.80%	40.20%	68.20%	70.10%	73.90%	44.40%	50%/60%
Lincs	56.40%	69.20%	53.70%	64.90%	27.40%	30.60%	43.10%	71.00%	72.80%	75.60%	49.60%	50%/60%
Notts	39.20%	66.70%	50.20%	90.20%	22.30%	25.00%	39.20%	65.00%	69.50%	72.40%	42.20%	50%/60%

Key
Ahead of national and England average
Ahead of Midlands but not England average
Below both Midlands and England average

Appendix 4 –Revised Trajectories for Mid-Year Plan and Tiering

Derby and Derbyshire ICB	Lincolnshire ICB	Nottingham and Nottinghamshire ICB
Chesterfield Royal Hospital Total Waiting Lists RTT 18 week %	**United Lincolnshire Teaching Hospitals:** ***Recovery Plans:*** 4 hour waits in ED 12 hour waits in ED Total Waiting Lists RTT 18 week % 52 week waits volume and % **Tiering:** Tier 2 for UEC	**Sherwood Forest Hospitals:** ***Recovery Plans:*** 4 hour waits in ED % Total Waiting Lists RTT 18 week % **Tiering:** Tier 2 Elective
University Hospitals of Derby and Burton Not required to resubmit H2 trajectories		**Nottingham University Hospitals:** ***Recovery Plans:*** 4 hour waits in ED % Total Waiting Lists 52 week waits volumes and % Cancer 62 Day % **Tiering:** Tier 1 Cancer and UEC

Appendix 5 – NHS Trust NHS Oversight Framework Ratings

			DD ICB				Lincs ICB			NN ICB			
NOF Domain	**Area**	**Metric Name**	**UHDB**	**CRFT**	**DHFT**	**DCHS**	**ULTH**	**LPFT**	**LCHS**	**NUH**	**SFH**	**NHCT**	**EMAS**
			Acute	*Acute*	*MH*	*Comm*	*Acute*	*MH*	*Comm*	*Acute*	*Acute*	*MH&Com*	*Amb*
Rating Summary	Average Metric	Average Metrics Score	2.64	2.03	2.67	2.16	2.88	2.25	2.54	2.6	2.1	2.92	1.84
	Pre-Adjustment Segment	Pre-Adjustment Segment	4	1	4	2	4	2	3	3	1	4	1
	Group Ranking	League Table from Metrics Ranking (Acute 132 / Non-Acute 71 / Amb 10)	108	41	46	17	122	31	41	100	48	57	2
	Financial Downgrade	Financial Over-ride - downgrade due to finance planned/surplus deficit rating	Y	Y	N	N	N	Y	N	Y	Y	Y	N
	OF Segment	Oversight Framework Segment (Latest distribution)	4	3	4	2	4	3	3	3	3	4	1
	Provider Improvement Programme / Recovery Support Programme	Entry into Provider Improvement Programme (National Oversight Framework 5	N	N	N	N	N	N	N	Y	N	Y	N

The Nottingham and Nottinghamshire system has two providers within Provider Improvement Programme arrangements, Nottingham University Hospitals NHS Trust and Nottinghamshire Healthcare NHS Foundation Trust.

The ICBs have six Providers who have had the Financial Downgrade applied:

1. Nottingham University Hospitals NHS Trust,
2. Sherwood Forest Hospitals NHS Foundation Trust,
3. Nottinghamshire Healthcare NHS Foundation Trust,
4. University Hospitals Derby and Burton NHS Foundation Trust
5. Chesterfield Royal Hospital NHS Foundation Trust
6. Lincolnshire Partnership NHS Foundation Trust

There are four Providers in the with the lowest quartile ranking in the metrics league tables:

1. Nottingham University Hospitals NHS Trust,
2. Nottinghamshire Healthcare NHS Foundation Trust,
3. University Hospitals Derby and Burton NHS Foundation Trust
4. Lincolnshire Partnership NHS Foundation Trust

There are two organisations with the highest quartile ranking in the metrics league tables: Derbyshire Community Healthcare Services NHS foundation Trust and Lincolnshire Partnership NHS Foundation Trust.

NHS England » Segmentation and league tables

Nottingham University Hospitals NHS Trust is under NHS England Tier One oversight arrangements for urgent and emergency care and cancer.

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:	20/11/2025
Paper title:	**Committee Highlight Reports**
Paper reference:	ICB CIC 25 015
Paper author:	Committee Secretariat
Paper sponsor:	ICB Committee Chairs
Presenter:	-

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

Report summary:

This report provides an overview of the work of the NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB committees prior to the implementation of the new governance arrangements. At their final meetings, all committees approved handover reports to ensure key issues and ongoing actions are appropriately transferred into the new structure. The report provides assurance that the committees have effectively discharged their delegated duties and highlights key messages for the Boards' attention.

Recommendation(s):

Boards are asked to **receive** the report for assurance.

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: Highlight reports from NHS Derby and Derbyshire ICB committees
Appendix B: Highlight reports from NHS Lincolnshire ICB committees
Appendix C: Highlight reports from NHS Nottingham and Nottinghamshire ICB committees

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Committee Highlight Reports

Appendix A

Derby and Derbyshire Integrated Care Board

Audit & Governance Committee Highlight Report

Meeting Date(s):	9 October 2025
Committee Chair:	Sue Sunderland, Chair

Assurances Received:

Item	Summary	Previous Level of Assurance	Current Level of Assurance
Internal Audit Progress Report including counter fraud progress	Took reasonable assurance from Internal Audit's Progress report which summarised the current position including the completion of 3 audits since the last committee: 2024/25 plan – now complete • Elective recovery fund – advisory review • Provider selection regime – significant assurance 2025/26 • Business continuity – significant assurance A few changes were agreed to the Internal Audit plan (see below) but it was stressed that it is important that Internal Audit's work continues to ensure that sufficient work is completed to enable them to give their Head of Internal Audit Opinion. Progress around the implementation of Internal Audit recommendations shows that current performance has dropped to 56% first follow up for high and medium risks and it is important that this does not become the norm. A separate stocktake report on Internal Audit Actions provided a clear way forward with regard to all outstanding actions as the ICB moves into cluster arrangements. However, the Committee were concerned at the lack of progress around two key recommendations from the Quality Governance report and these have been escalated to the Quality Committee to obtain further details as to the delays (see below) No counter fraud update at this meeting	**Adequate**	**Adequate**

Derby and Derbyshire Integrated Care Board

Item	Summary	Previous Level of Assurance	Current Level of Assurance
Procurement Highlight Report	Took reasonable assurance around the ICB procurement arrangements from the report. We noted that the 111 contract still hasn't been signed off by all parties (confirmed 1 still outstanding) and reiterated the need to look at more efficient mechanisms for sign off of multiparty contracts going forward.	**Adequate**	**Adequate**
Board Assurance Framework	The BAF was reviewed and in particular the reduced risk score for SR8 linked to business intelligence was queried given the potentially conflicting evidence from the outstanding Internal Audit recommendations. This will be considered further during the cluster risk alignment process.	**Partial**	**Partial**
Risk Register Report	Reviewed the risks for which the committee is responsible' Approved with no changes	**Adequate**	**Adequate**
Risk management deep dive	SR10 digital risk deep dive demonstrated the progress being made in key project areas many of which will be ongoing in nature. This led to the question as to whether further work was needed to identify specific gaps or determine what would be needed to improve the current 'limited' assurance level. Again this will be considered further during the cluster risk alignment process.	**N/A**	**Partial**
Regular reports on key corporate issues	Took reasonable assurance from the regular reports on: • Conflicts of interest – high compliance • Appraisal monitoring – reasonable compliance but stressed need to prioritise appraisals with staff to ensure they feel supported during this period of uncertainty • Equality, diversity & inclusion – improving position but more to do	**Adequate**	**Adequate**
Regular reports on key control areas	Took reasonable assurance on the ICB's controls through the regular reports on: • Debt management review – noting improving position on old local authority debts	**Adequate**	**Adequate**

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Item	Summary	Previous Level of Assurance	Current Level of Assurance

New financial ledger	Took weak assurance from the update outlining the significant issues being encountered since the 1 October go live date. Noting that despite staff working above and beyond there are particular concerns regarding:
	• Functionality of the system causing problems with:
	  ○ User access
	  ○ Processing of invoices
	  ○ Reporting
	• Training which was insufficient to prepare for the live system
	• The promised hypercare package of support not delivering
	These issues are shared nationally and are being escalated but there are real risks around
	• Paying suppliers
	• Month 7 & 8 financially reporting – a critical time for ensuring that the ICB's finances remain on track.
	Flagged need to ensure that these risks are adequately documented within the risk register.
		Adequate	**Weak**

Other consideration:

Decisions made:
Approved the following changes to the Internal Audit plan • The planned full assurance review of data quality and performance management arrangements will be replaced by a follow up review on actions recommended by the original audit • Delegated commissioning audit removed from the plan as 3rd party assurance can be taken from the audit taking place through Northamptonshire ICB of the management and oversight arrangements of the East Midlands Primary Care Team and East Midlands working group • A delay to the start of Q4 for the Mental Health/Learning Disabilities and Autism review – this was approved reluctantly by Committee who were concerned that this audit needs to progress as soon as possible. Approved deadline extensions for the outstanding recommendation from the IA review of appraisals Approved the Audit & Governance Committee Closure and Handover Report subject to inclusion of a copy of this highlight report and a paragraph within the body of the report on the risks arising from the new ledger implementation.

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Information items and matters of interest:
The Audit and Governance Committee received the following items for information: • External Audit client technical update – specifically noting the change in reporting requirements around MHIS which will be incorporated as a disclosure within the financial statements from 2025/26. • Progress regarding the in-housing of the Continuing Healthcare Service • Progress regarding the ICB management of change process – noting the need to ensure that changes to the timing of committees are shared with external participants as soon as possible • Details of proposed early adoption of NHSE finance grip and control process across the system

Matters of concern or key areas to escalate:

Escalation to Quality, Safety and Improvement Committee
• The Committee were concerned about the lack of progress around two medium priority recommendations which were due in September but which have been put on hold and a requested deadline extension to April 26 – the Audit Committee requests that the Quality Committee receives further details on what progress if any has been made to date and the reasons for the requested extension.
Escalation to Board
• Concerns regarding the potential impact of the issues around the implementation of the new ledger on the ICB's ability to:
  ○ Pay suppliers
  ○ Accurately report the month 7 & 8 financial position
There is a need to ensure that concerns continue to be escalated to the highest level to ensure action is taken to rectify the situation as quickly as possible.

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Committee Highlight Reports

Finance & Performance Committee Assurance Report

Meeting Dates:	28 October 2025
Committee Chair:	Nigel Smith

Assurances Received:

Item	Summary	Previous Level of Assurance	Current Level of Assurance
DDICB Financial Position	The ICB reported a £0.1m favourable variance year-to-date at month 6 and a breakeven forecast outturn (in line with the submitted plan). The year-to-date favourable variance was attributed to lower-than-expected Continuing Healthcare expenditure, Specialised Commissioning & other delegated underspends, and reduced drug costs. These gains offset pressures in Mental Health, Learning Disabilities, and Planned/Urgent Care. The report emphasised the need for continued action to contain future costs. Achieving the £44m efficiency target stays central to delivering the financial plan. Statutory duties and supporting metrics have been achieved to date and are expected to be met at year-end. The Committee was assured that all statutory duties and financial metrics were being met, and that the ICB remained committed to delivering its financial plan despite ongoing challenges. Risks were being actively managed, particularly around efficiency delivery and aged debt with local authority partners. The Committee was asked to note the financial position, the distribution/retention of allocations, and the ongoing actions to address financial risks and efficiency targets. The level of assurance provided was considered **adequate**, with a clear commitment to ongoing monitoring and mitigation of emerging risks.	**Adequate**	**Adequate**
System Financial Position	The M6 System Finance Report summarised the financial position for the JUCD system as at 30 September 2025. The system reported a year-to-date deficit of £22.9m against a planned deficit of £21.7m, with the adverse variance mainly due to industrial action and other operational cost pressures. All organisations are forecasting to achieve a breakeven position for the year, after receipt of the planned £45m Deficit Support Funding. Pay costs were slightly below plan, with overspends in bank and agency offset by underspends in substantive staff. Efficiency delivery was marginally behind plan, but all organisations forecast full delivery of the £181.7m target. Capital expenditure was £21m below plan year-to-date. However, the year-end forecast remained in line with plan. A review of the capital programme is on-going and will report to system CFOs in early November.	**Partial**	**Partial**

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Item	Summary	Previous Level of Assurance	Current Level of Assurance
	The Committee was assured that, the ICB understand the risks and is actively managing the system position. Although the system is still on track to deliver the planned financial position, increased clarity and assurance is needed on detailed efficiency plans, especially within acute provider organisations. The level of financial risk identified by acute providers is being reviewed. The level of assurance was considered **partial**, reflecting the ongoing need for robust monitoring and risk mitigation.		
Performance Report	The Operational Performance Report focused on key priorities within planned care, urgent and emergency care, and mental health. Both acute trusts remained on their planned trajectories for Referral to Treatment (RTT), with CRH continuing stronger improvement than UHDB. Progress is encouraging. However, both trusts are in the second to lowest quartile when performance is benchmarked nationally and a material productivity gap persists, with further gains still to be realised. Outpatient productivity, theatre and bed utilisation, and compliance with Evidence Based Interventions were highlighted as areas for improvement. Cancer Performance - UHDB is still behind plan and there and a performance gap of 5-6% needs to be closed in the second half of the year to achieve the year-end target of 80%. At the CRH, the Trust has exceeded its planned trajectory, and performance is broadly in line with last year's level. Overall, both Trusts are delivering outcomes around 3% below their respective peer groups. Both acute trusts are behind their 4-hour trajectory, though to different degrees. UHDB is 1 point adverse to plan year to date, while the CRH is 7 percentage points adverse to plan and 9 points worse than last year's performance. The Committee was provided with **partial** assurance, noting that while progress had been made, key challenges persisted, including reducing waiting times, improving productivity, and managing demand and capacity. The report highlighted the need for continued focus on purposeful admission and discharge in mental health, and on addressing bottlenecks in urgent and emergency care.	**Partial**	**Partial**
Risk Report and BAF	The Risk Register Report presented the operational risks owned by the Finance and Performance Committee. The Committee reviewed the current risks. Two performance risks from the previous	**Adequate**	**Adequate**

Committee Highlight Reports

Item	Summary	Previous Level of Assurance	Current Level of Assurance
	committee structure were closed and replaced with three new risks. The finance ledger/ISFE2 risk was discussed and the members' concerns noted in respect of the challenging implementation and risk associated with reporting. The committee discussed the BAF risks. It was agreed to keep the BAF score for all risks.		

Other considerations:

Decisions made:
No key decisions were made.

Information items and matters of interest:
The Committee received an update report in respect of the system's digital programmes.

Matters of concern or key areas to escalate:
No matters of concern or key areas to escalate to the Board.

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Committee Highlight Reports
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Derby and Derbyshire Integrated Care Board

People and Culture Committee Highlight Report

Meeting Date(s):	21 October 2025
Committee Chair:	Margaret Gildea, Chair

Assurances Received:

Item	Summary	Previous Level of Assurance	Current Level of Assurance
Committee Closedown and Handover Report	The Report provides the Committee with the Handover Report. serves as a formal record of the People and Culture Committee's activities, decisions, and outstanding matters as the committee transitions to the new cluster arrangements. The report ensures continuity, captures legacy issues, and provides clear guidance for the incoming committee and future governance structure. It is recommended that the One Workforce strategy, widening participation and apprenticeship strategy, NHS Staff and Pulse Survey, EDI and Oliver McGowan mandatory training programmes of work be moved into the Director of Strategy and Citizen Engagement portfolio to be reviewed and a decision made on future reporting mechanisms in order to ensure that these important pieces of work continue. The report will be presented to the cluster Boards in Common on 20th November.	**Not applicable**	**Adequate**
Board Assurance Framework Quarter 2	The Report provides the Committee with the BAF position as at quarter 2 for Strategic risk 5, The risk score remains at a very high 16. The Committee believed that there were still significant gaps in social care and the voluntary sector which was enough to warrant a risk and felt it was important that this risk was carried over into the new cluster arrangement with a view to looking at affordability and gaps in affordability, this was the view from a Derbyshire perspective.	**Partial**	**Partial**

Committee Highlight Reports

Derby and Derbyshire Integrated Care Board

Quality, Safety and Improvement Committee Highlight Report

Meeting Date(s):	October 2025
Committee Chair:	Margaret Gildea, Vice Chair and Non-Executive Member

Assurances Received:

Item	Summary	Previous Level of Assurance	Current Level of Assurance
QSI/2526/061: LMNS Update	The Report provides the Committee with a Local Maternity and Neonatal System (LMNS) Update for assurance. The focus of the report were: • Improved assurance in maternity and neonatal services, with perinatal mortality stabilising below the national average and compliance improvements at both CRH (91%) and UHDB (86%) for Saving Babies Lives initiative. CRH introduced a second continuity of care team and a perinatal pelvic health service, with similar plans at UHDB by year-end. • Both trusts improved translation and interpretation services for Southeast Asian and non-English speaking communities. • Ongoing work is needed on personalised care and cultural strategy at both trusts. Perineal trauma remains a focus, especially at UHDB, with quality improvement and deep dives underway. • UHDB still awaits a CQC re-inspection report from the visit in December 2024 but has had six of eight Section 31 conditions removed and is seeking removal of the rest. The MSSP remains in place, with the next review in January 2026.	**Adequate**	**Adequate**

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Item	Summary	Previous Level of Assurance	Current Level of Assurance
QSI/2526/062 National Patient Safety Strategy and Learning – Derbyshire Position	The Report provides the Committee with National Patient Safety Strategy and Learning – Derbyshire Position - October 2025 for assurance. The focus of the report were: • Patient safety online training for levels 1 and 2 was introduced in June via the ESR system, with good and improving uptake. • Patient Safety Partners (PSP) were introduced as a team within the ICB, but providers sometimes were unaware of their availability; plans are in place to transition PSPs into provider organisations for better integration and earlier involvement in workstreams. PSPs have added significant value to system workstreams, and the aim is to maintain this momentum through the transition. • National Never Events remain a focus, with ongoing efforts to identify and address key themes in collaboration with providers.	N/A – paper not previously presented to the committee	**Adequate**
QSI/2526/063 SEND Annual Report	The Committee received the Special Educational Needs and Disabilities (SEND) Annual Report. The Annual Report highlighted the following key points • The report covers the annual SEND (Special Educational Needs and Disabilities) activity for children and young people aged 0-25, outlining ICB statutory duties and the structure of the virtual team, which works in partnership with local authorities and providers. • Focus this year has been on responding to the joint Ofsted and CQC inspection from September 2024, which identified significant weaknesses and required an improvement plan and board. The ICB and providers have been actively involved in addressing these weaknesses identified in the inspection. • Key areas of responsibility include long waits for neurodevelopmental (ND) assessments, mental health services, and some smaller services. • Performance on EHC (Education, Health, and Care) plan assessments and annual reviews remains strong, with Derbyshire meeting the six-week standard despite rising demand, making it an outlier in the East Midlands. The quality of reports is also high. • Derby City has not yet been inspected, but preparations are underway, including self-evaluation, strategy development, and a mock inspection.	N/A – paper not previously presented to the committee	**Adequate**

Committee Highlight Reports

Committee Highlight Reports

Derby and Derbyshire Integrated Care Board

Item	Summary	Previous Level of Assurance	Current Level of Assurance
	• Ongoing challenges include increasing demand for EHC needs assessments and ND assessments, and the need to better capture and use the voice of children, young people, and families in service improvement and development.		
QSI/2526/064: Quality Framework	A verbal update was received on the quality framework, a paper will be presented to the System Quality Group with a six-month update. Quality Improvement (QI) schemes for the year have been sourced from JUCD Delivery Boards. The framework also now captures PCN QI programmes and provider quality account improvements, offering a comprehensive view of QI work across Derbyshire. The update was noted for the Audit Committee, with no further action requested.	Presented for update and discussion only	**N/A**
QSI/2526/065: Board Assurance Framework	The Committee received the Board Assurance Framework update as at Quarter 2 for Strategic risk 1. The risk score remains high at 16 (probability 4, impact 4). One action (1.6) was completed: integration of the quality strategy with the 10-year plan, previously approved by the committee. The BAF will be merged into a single framework and risk register across Derbyshire, Lincolnshire, and Nottinghamshire as part of governance transition work.	Presented for update and discussion only	**N/A**
QSI/2526/067: Quality, Safety and Improvement Committee Handover Report	The Committee agreed the Committee Handover Report, the report is intended as a corporate memory, ensuring Derby and Derbyshire's key areas for oversight and follow-up are clearly handed over to the new governance structure. Outstanding matters to be emphasised in the handover include Local Maternity and Neonatal System (LMNS), the quality framework, and SEND (Special Educational Needs and Disabilities). Additional narrative will be added to the report to ensure these areas are not lost in transition. The committee confirmed that responsibilities have been discharged in line with terms of reference, and the handover report reflects all key focus areas and outstanding matters for effective transition. All Committee handover reports from Derbyshire, Lincolnshire, and Nottinghamshire will be presented to the DLN cluster boards in common at their first meeting.	Presented for update and discussion only	N/A

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Derby and Derbyshire Integrated Care Board

Other considerations:

Decisions made:
Not applicable

Information items and matters of interest:
• ICB Risk register – Nil return • System Quality Group Update Report

Matters of concern or key areas to escalate:
None identified in the meeting

Committee Highlight Reports

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Remuneration Committee Highlight Report

Meeting Date(s):	22nd September 2025, 6th October 2025, 23rd October 2025, 28th October 2025
Committee Chair:	Margaret Gildea

To Note: The Remuneration Committee meetings on 28th October 2025 comprised an extraordinary meeting in common with the Remuneration Committees of Lincolnshire ICB and Nottingham and Nottinghamshire ICB, followed by a meeting of the Derbyshire ICB Remuneration Committee.

Item	Summary
Redundancy notice	The Remuneration Committee APPROVED the serving of formal notice of termination of employment, due to redundancy, to a senior employee at NHS Derby and Derbyshire ICB.
Executive Director Secondment	The Remuneration Committee APPROVED the secondment of a senior employee to another NHS organisation.
Secondment to another NHS organisation	The Remuneration Committee: 1. APPROVED the secondment of the senior employee to another NHS organisation; and 2. CONSIDERED and DECIDED on the request for pay protection submitted by the senior employee.
Remuneration Committee Handover Report	The Remuneration Committee REVIEWED and APPROVED the Remuneration Committee draft handover report.
Confirmation of Executive Director joint appointments and proposed remuneration	The Committee APPROVED the proposed remuneration for the jointly appointed Executive Directors of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB.
Proposal to create an interim senior leadership team	The Committee APPROVED the proposed approach to establishing interim arrangements for the Senior Leadership Team.

Derby and Derbyshire Integrated Care Board

Item	Summary
Approval to Issue Notice of Redundancy and Payment of Contractual Redundancy to those ICB Executives that have been displaced as a result of the Cluster ICBs Executive Director Appointments	The Remuneration Committee APPROVED the issuing of notice of redundancy and the payment of contractual redundancy in compensation for loss of employment for those ICB Executive Directors who are “At Risk” of redundancy following the cluster Executive Team appointments. The Remuneration Committee NOTED the process for making exit payments as set out by NHS England.

Committee Highlight Reports
Sleaford, 10.00-20/11/25

Committee Highlight Reports

NHS
Derby and Derbyshire
Integrated Care Board

Strategic Commissioning and Integration Committee Highlight Report

Meeting Date(s):	October 2025
Committee Chair:	Jill Dentith, Non-Executive Member

Assurances Received:

Item	Summary	Previous Level of Assurance	Current Level of Assurance
SCIC/2526/059 Board Assurance Framework	The Report provides the Committee with the final Board Assurance Framework Quarter 2 Position as at 30 September 2025. • Strategic Risk 2 the score remains at a very high 16 with no completed actions during Q2. • Strategic Risk 3 the score remains high 12. Action 3.1 completed – implementation of the Engagement Strategy Framework, however, evaluation and embedding of the framework is on hold due to clustering. • Strategic Risk 7 the score remans high 12. Action 7.6 completed – relates to Delivery Board Plans and submission of the Operational plan. • Strategic Risk 8 – The Committee approved the recommendation to reduce the risk score from 12 to 9. The justification for the reduction related to the strengthened analytical capacity across the ICB. Visual Intelligence functions are now embedded, reliable and responsive. Primary Care and GP data still need further development. The Committee raised concern in relation to the impact of the transition and restructuring of the organisation, the strategic risk was updated to include this.	**Partial**	**Partial**
SCIC/2526/061 SCIC Closedown and handover Report	The Report provides the Committee with the Handover Report. serves as a formal record of the Strategic Commissioning and Integration Committee's activities, decisions, and outstanding matters as the committee transitions to the new cluster arrangements. The report ensures continuity, captures legacy issues, and provides clear guidance for the incoming committee and future governance structure. The report will be presented to the cluster Boards in Common on 20th November, alongside the other ICB Committee reports.	**Not applicable**	**Adequate**

Sleaford, 10.00-20/11/25

Derby and Derbyshire Integrated Care Board

Other considerations:

Decisions made:
N/A

Information items and matters of interest:
SCIC/2526/062 - Clinical Policy Advisory Group Updates - The Committee received the CPAG Bulletin for July and August 2025 and the CPAG Decisions and Justification Log for July and August 2025.

Matters of concern or key areas to escalate:
None identified in the meeting

NHS Lincolnshire Integrated Care Board

AUDIT AND RISK COMMITTEE

Meeting Date(s):	28th October 2025
Committee Chair:	John Dunstan, Non-Executive Member

Item	Summary	For Escalation to the Board (Yes or No)
ICB Risk Management Arrangements, Including The Latest Versions Of The Corporate Risk Register And BAF	• Updated and scored; minor changes pending. • Snapshot view as risks may change due to transition and staff changes. • Internal audit - reasonable assurance maintained despite resource constraints. • Risk transfer underway; new strategies to be approved at Board in Common. • Key risks: senior staff departures and ISFE2 financial system transition.	**Yes re ISFE2**
Governance	• Hospitality & Sponsorship Register - Nil return. • Losses & Compensations - No items to report. • Waivers - None for consideration. • Declaration of Interest - Updated following September meeting observations.	**No**
Audit And Risk Committee Interim Report For The Period 1st April 2025 To 31st October 2025	• Interim annual report (1 Apr–31 Oct) prepared early for handover; shared with Chair for review. • Proposed acceptance subject to minor amendments (e.g., attendance updates). • Legacy folder created with all key documents, including annual report, for transfer to new committee. • Interim report will feed into full annual report and year-end accounts.	**No**

Audit And Risk Committee Handover Report	• Interim report (1 Apr–31 Oct) prepared early; follows established format. • Legacy folder created with all relevant documents, including annual report, for new committee. • Interim report will feed into year-end accounts.	**No**
TIAA Summary of Internal Controls Assurance (SICA) Report	• Limited assurance review highlighted system-wide risks and benefits of cross-organisation audits; further discussion planned for next meeting. • Committee stressed importance of maintaining focus on property services in new governance structure, especially KPIs, utilisation, and cost savings; agreed to keep on future agendas.	**Yes**
Overdue IA Actions	• Most outstanding audit recommendations near completion; one review date extended to **June 2026** (approved). • Four of five Q2 audits complete, planning underway for remaining audits. • Committee agreed to update action tracker with new review date for collaboration/partnership recommendation. • Progress considered satisfactory given current circumstances.	**No**
Counter Fraud Progress Report	• PHB investigation progressed to interview under caution; all relevant files gathered. Committee to be kept informed. • Ongoing fraud monitoring activities: master classes, newsletters, alerts, benchmarking. • Strategic intelligence assessment confirms fraud risks remain consistent with previous reports. • No issues raised by the Committee.	**No**
Information Governance Quarterly Report Q1 25-26	• IG team undergoing transition due to NHS changes; regular meetings maintained. • No issues flagged for committee attention. • Committee noted IG report and confirmed compliance assurance; no further discussion required.	**No**
ISFE2 Update	• Extensive preparation completed, but national issues prevent invoice access, causing cash balances to exceed limits and delays in supplier payments. • BPPC compliance impacted; team prioritising contractual payments to main providers and CHC suppliers to minimise risk. • Risks - supply chain disruption, gaps in care, and lack of live financial data (control lapse). • Team facing burnout risk due to extended hours; collaborating across DLN cluster to resolve issues. • Committee advised strengthening handover report wording to reflect severity and impact on financial control, reporting, and decision-making.	**Yes**

NHS Lincolnshire Integrated Care Board

FINANCE AND RESOURCE COMMITTEE

Meeting Date(s):	21 October 2025
Committee Chair:	Julie Pomeroy, Non-Executive Member

Item	Summary	For Escalation to the Board (Yes or No)
System Financial Position Month Six	**Financial Position** £8.5m adverse variance from allocations, which equated to a £8.8m adverse variance from the planned £0.4m surplus. This compares to an adverse variance from plan of £3.9m reported in month five indicating a deterioration of £4.9m in-month. System year-to-date plan was to deliver a £16.2m deficit in month six. The ICS reported a deficit of £24.9m resulting in an adverse variance against plan of £8.7m. This compares to a £3.8m adverse variance from plan reported in month five, reflecting a further deterioration of £4.9m in the current month. A financial recovery plan for the ICB and system providers, will be developed. This will highlight the need for external support, identification of cost improvement schemes, and the establishment of governance structures to oversee delivery and risk mitigation. The ICB is off track financially and is rapidly building a recovery plan, with similar efforts underway at ULTH and other system executives, and external support being sought to achieve break-even. **Provider Overperformance Management** • Ongoing monitoring of overactivity using AQNS process.	**Yes**

	• Recovery plan development underway with input from system executives and external support. **AQNS and Contractual Compliance** • AQNS raised per contract for overperforming providers. • Expectation for providers to reduce activity later in the year to offset earlier excess. **Payment Withholding:** • Payments for overactivity currently withheld pending determination of payability. • Legal right to withhold payment under review, aligned with NHS England guidance. **Financial Risk and Accruals:** • Year-to-date position reflects unpaid overactivity. • Risks remain if overperformance persists; potential benefit if settlements are lower than forecast. **National Funding and Clawback:** • Current data suggests system is not at risk of national clawback. • Additional funding likely to remain within regional allocation. **Financial Recovery Planning:** • ICB off track financially; urgent recovery plan being built. • External support sought; governance structures established (DLN Cluster Recovery Board). **Key Financial Pressures:** • Winter bed delays, guidance changes, and industrial action (no relief provided). • £7m improvement required through internal actions. **Risk Position:** • Net risk deteriorated by £4.1m in-month. • ICB: £12m cost improvement schemes need to be identified as included in forecast; target £30m total to deliver plan.	

	Required Action: • Executive review and approval of recovery plan. • Continued engagement with providers to enforce AQNS compliance and manage overactivity. • Monitoring of governance board outputs and risk mitigation progress.	
System CIP Position Month Six	**CIP Delivery Challenges:** • Slight overperformance year-to-date, but significant risks in the second half of the year. • High-risk schemes and unidentified mitigations threaten achievement of targets. **High-Risk Schemes & Unidentified Mitigations:** • 14.5% of the CIP plan classified as high risk. • System: £22.5m (£14m Group, £8.5m ICB) in unidentified schemes requiring urgent identification of mitigations. **Technical Adjustments & Non-Recurrent Measures:** • Non-recurrent income and technical adjustments used to offset underperformance. • These measures are one-off and unsustainable for future years. **Lessons Learned & Future Planning:** • Need for earlier risk identification and clearer reporting. • Focus on transformation and sustainable solutions. • Two-week timeline set for identifying new schemes. • Financial Recovery Board established for ongoing oversight. **Required Action:** • Immediate identification of £8.5m in mitigations and new schemes within two weeks. • Strengthen governance and reporting through Financial Recovery Board. • Develop sustainable plans to reduce reliance on non-recurrent measures.	**Yes**
System Workforce Position	**Substantive Recruitment & Temporary Staffing:** • Ongoing recruitment reducing reliance on temporary staff. • Recent ward closure enabled redistribution of staff to support stroke services.	**Yes**

	MARS Scheme Implementation: • 13 whole-time equivalent exits achieved, delivering cost savings. • Up to 60 further exits anticipated within the next two months. **Vacancy Controls & Redundancy Management:** • Enhanced vacancy controls in place to avoid compulsory redundancies. • Redeployment hub established to manage suitable alternative roles. • Ongoing monitoring of impact on service delivery. **Agency and Bank Spend Monitoring:** • Agency spend must remain within cap limits, particularly during winter pressures. • Medical recruitment has reduced agency spend; system expected to remain under plan by year-end. **Required Actions:** • Continue monitoring MARS scheme impact and confirm projected savings. • Maintain strict vacancy controls and redeployment processes to minimize redundancy risk. • Ensure agency spend remains within cap limits through proactive workforce planning. • Report progress to Financial Recovery Board and escalate any risks to service delivery.	
DLN Turnaround Approach Update on Planning	**RONDA Risk Assessment:** • NHS England developed RONDA tool to assess financial risk across 14 organisations in the cluster. • Top seven high-risk organisations identified for focused recovery efforts. **Cluster Recovery Group Formation:** • New Cluster Recovery Group established, chaired by Bill Shields. • Fortnightly meetings scheduled; director-level participation required. • Organisations expected to implement grip and control checklists. **Resource Constraints:** • Concerns raised about additional resource demands during transition. • Current workload includes finalising year-end plans and developing next year's plans.	**No**

	• Operational detail required for self-assessment adds complexity. **Transition and Oversight Challenges:** • Need to stratify risk and focus oversight on highest-risk organisations. • Complexity in managing performance management and strategic commissioning roles simultaneously. **Next Steps:** • Organisations in top risk tier reviewing grip and control checklist. • Discussion planned with Bill Shields on rationale for inclusion in recovery group and resource implications. **Required Actions:** • Complete grip and control checklist for high-risk organisations. • Confirm meeting schedule and resource requirements with Cluster Recovery Group. • Ensure clarity on rationale for inclusion and expectations for compliance. • Monitor impact of resource constraints on delivery of year-end and future plans.	
Planning Update	**Scenario Modelling:** • Four financial scenarios developed based on varying assumptions for efficiency requirements, inflation, and funding growth. • Scenarios show differing impacts on deficits and surpluses across the ICB and providers over a five-year period. **Block Contract Deconstruction:** • Analysis underway on moving from block contracts to activity-based payments. • Potential risk that some providers may receive less funding under new arrangements. • Opportunities and risks identified for future financial model. **Consistency and Transparency in Planning:** • Emphasis on consistent assumptions and clear understanding of underlying positions. • Need for open communication across organisations to ensure aligned planning and avoid destabilisation. **Transition to Strategic Commissioning:** • Challenge of moving from system convener role to strategic commissioner.	**No**

	• Oversight complexity during prolonged transition, balancing contractual and system roles. **Required Actions:** • Validate assumptions across all four scenarios and communicate implications to stakeholders. • Complete impact analysis of block contract deconstruction and identify mitigation strategies. • Establish clear governance for transition to strategic commissioning. • Maintain transparency and alignment across organisations to prevent financial destabilisation.	
ICB Board Assurance Framework (BAF)	**Narrative Refresh:** • Committee requested an updated narrative for the section *"Mitigating Actions to Address Gaps"*. • Revised narrative presented in the paper. **Risk Score:** • Current risk score remains unchanged. • JP noted the score may need to increase if mitigations are not identified within the next month. **Risk Stratification & Reporting:** • Emphasis on clear risk stratification for effective oversight. • Importance of robust handover process for committee reporting highlighted.	**No – update actioned with amendments made to Lincolnshire ICB BAF.**

NHS Lincolnshire Integrated Care Board

PRIMARY CARE COMMISSIONING COMMITTEE

Meeting Date(s):	20th October 2025
Committee Chair:	Dr Phillip Earnshaw, Non-Executive Member

Item	Summary	For Escalation to the Board (Yes or No)
Integration Report on Primary Care, Pharmacy, Optometry and Dental	**Key Points:** • Slight delays on the Community Pharmacy Strategy and Eye Health Needs Assessment but work is progressing, with completion expected later this year. • The strategy will adopt a consistent regional approach while allowing flexibility for local needs. • Once finalised, the strategy will be shared with relevant stakeholders. **Dental Update:** • Dental commissioning arrangements have been updated to support service delivery and workforce sustainability in line with regional standards. **Annual Delegation Checklist Review:** • NHS England's annual delegation requirements for primary care services are being met, with processes in place for pharmacy, optometry, dental, and general practice commissioning. • Outstanding governance actions will be completed and shared as part of the transition to new committee structures.	
Finance Update	**Month 6 Financial Position** • Primary care budgets are being managed in line with national guidance, with assurance that reporting meets NHS England and audit standards. **Primary Care Investment Reporting**	

	• Investment plans remain on track, with adjustments being made to support service priorities and pilot initiatives.	
Committee Handover Report	• All committee documents (legacy files, strategies, operational records) will be stored in a dedicated folder on the corporate admin system until new Cluster governance is established. Detailed update of folders shared. • Documentation will be maintained via the Primary Care Business Management Group following the closure of the Private Primary Care Commissioning Committee. **Local Practice Services** • Following removal of CQC registration, a local practice has reopened and is now providing full services • Primary Care Resilient Assessment is maintained by the Primary Care Team. The Committee considered the four practices identified with the highest risk of resilience and plans are in place to support those practices.	

NHS Lincolnshire Integrated Care Board

REMUNERATION COMMITTEE

Meeting Date(s):	28th October 2025
Committee Chair:	Mrs Julie Pomeroy, Non-Executive Member

Item	Summary	For Escalation to the Board (Yes or No)
Redundancy Approvals	Agreed to issue redundancy notices and contractual payments for NHS Lincolnshire Executive Directors identified as "At Risk" following the new cluster structure. Payments will comply with NHS England guidance.	**No**
Remuneration Committee Handover Report	Approved the Committee's handover report confirming closure of current arrangements and transition to the new cluster governance structure from November 2025. Risks noted include governance gaps and financial implications during transition.	**No**

NHS Lincolnshire Integrated Care Board

SERVICE DELIVERY & PERFORMANCE COMMITTEE

Meeting Date(s):	29th October 2025
Committee Chair:	Mrs Dawn Kenson, Non-Executive Member

Item	Summary	For Escalation to the Board (Yes or No)
25/64 Performance Report	**Performance Report Overview** Noted a broadly challenging position across several domains, particularly finance, workforce, and elective recovery. While a number of areas remained on or close to plan, others required intensified recovery action. The ICB and partner organisations continued to focus on system-wide improvement through cluster-level financial and operational recovery planning. **Financial Performance** The Committee was informed that the financial position had deteriorated over the previous month, prompting targeted recovery work across both the ICB and provider organisations. These activities were being consolidated into cluster-level financial recovery plans to ensure alignment of local and system-wide actions. The Committee noted that financial pressures remained a potential key area of risk to operational delivery, with continued emphasis on cost control, productivity improvements, and alignment with national expectations for in-year financial recovery.	**No items for escalation to the Board.**

	Workforce Overall staffing levels remained marginally below plan, largely due to lower than planned workforce numbers within Lincolnshire Partnership NHS Foundation Trust (LPFT) and Lincolnshire Community Health Services (LCHS). United Lincolnshire Hospitals NHS Trust (ULHT) had reduced their level of over-establishment since the previous month, and the use of bank and agency staff remained in line with planned trajectories. The Committee recognised that workforce constraints continued to impact delivery in several operational areas, including elements of the diabetes programme and elective recovery. **Elective, Cancer and Diagnostic Performance** Most elective, cancer and diagnostic indicators remained off plan. However, ULHT has now agreed recovery trajectories with NHS England from Month 7 onwards. The Committee acknowledged that while improvement was anticipated over the remainder of the year, delivery risk remained elevated pending evidence of sustained progress against the revised trajectories. **Primary Care** High confidence was reported that general practice appointment volumes would return to plan by year-end. Dental performance remained below plan, particularly in adult and urgent appointments, though recovery to trajectory was still expected. Patient experience was assessed as medium confidence overall, reflecting some month-on-month variability. **Mental Health, Learning Disability and Autism (MHLDA)** Performance across talking therapies and learning disability (LD) health checks remained on track, supported by reductions in average length of stay.	

	Areas off plan were assessed as recoverable with trajectories in place. **Neighbourhood Health and Digital Programmes** Most transformational programmes remained on plan. Two initiatives—personalised care planning and parts of the diabetes programme were currently off target, primarily due to workforce limitations. Digital programmes were largely progressing as planned, though two initiatives had been paused due to capacity and strategic prioritisation decisions. The delay in the electronic bed and flow management system at ULTH was due to the prioritisation of the Optica national discharge system, which had been implemented in three months, significantly ahead of the nine-month national expectation. This work was now being referenced nationally as best practice. The completion of the bed and flow management system was imminent. Within neighbourhood health there was the establishment of a Neighbourhood Provider Board and an associated Health and Wellbeing Board-sponsored workshop to define required outcomes and system expectations. Early progress was reported, alongside recognition of the need to strengthen balance and parity of esteem between NHS organisations and the third sector. **Health Inequalities and Prevention** Over half of the key indicators were on target. Off-track areas included serious mental illness (SMI) health checks, smoking cessation and obesity. These were subject to enhanced local interventions, including targeted work in Boston and the expansion of Tier 3 weight management support.	
25/65 Programme Lead Reports	**Urgent and Emergency Care (UEC) Programme** **UEC priorities** - Attendance avoidance, Admission avoidance, Length of stay reduction - Performance for September showed mixed progress.	

	- System partners have now finalised three core improvement plans aligned to these priorities - Front Door Model, Discharge and Flow and Community Integration. Each plan was underpinned by detailed workstreams with clear metrics, accountability, and monitoring through the established governance framework. - The System Winter Plan has been approved through all governance routes and was scheduled for Health Scrutiny in November following Board approvals. A Winter Delivery Group, led by the ICB and compliant with national requirements, would oversee delivery of winter initiatives, review performance metrics, and assess system capacity and risk. ***Planned Care and Diagnostics*** **Elective Recovery** - Performance against 52 and 65-week RTT targets remains challenged. This was being driven by non-admitted pathways. - Outpatient productivity constraints limit overall recovery; surgical capacity remains strong. - November 65-week cohort expected to clear to zero. December cohort challenging; additional sessions under discussion. **Diagnostics** - Strong regional benchmarking post-COVID. - Principal challenges: audiology, echocardiography, and non-obstetric ultrasound. - Positive developments: DEXA compliance 12.5% → 100%, CDC programme progress (three operational, one near completion). **Elective Activity Coordination Hub (EACH)** - Effective in managing waiting lists, optimising independent sector use, supporting data quality, and patient choice. - Ensures system-wide coordination critical for elective recovery. **CDC** - Boston CDC approved (fourth centre), pivotal in backlog recovery and left-shift strategies. - Skegness CDC recognised for improving access for coastal populations; benefits case in development including experiential and health inequality metrics.	

	- - Planned Patient Support Hub (Jan 2026) to reduce DNAs and improve access. ***Cancer Programme*** - Performance below standard but improving: Past diagnosis: ~70% → 74% 62-day standard: ~60% → 64%, 31-day standard stable at 88% - Workforce and pathology delays impacting performance. **Cancer Programme key achievements:** - End-to-end pathway reviews (gynaecology, lung, urology, colorectal) - Lung cancer screening programme procurement (Q4 2025/26) - Living with Cancer programme recognised nationally/internationally (Eric Watts Award) ***Mental Health, Learning Disability and Autism (MHDLDA)*** - Talking Therapies and IPS: Recovery and improvement targets above plan; treatment course completion slightly below plan. - Children & Young People Access: Notable improvements, supported by digital tools (Luminova); some data flow issues remain. - Out-of-Area Admissions: Increase to ~8, mitigated by step-down accommodation and local support. - Inpatient Quality Improvement: Year 1 of three-year programme positively reviewed by NHS England. - Crisis & UEC Pathways: Stakeholder engagement conducted with police, voluntary sector, and local authorities. - Dementia & Neurodiversity: Strategies progressing; co-production embedded. - Adult Community Transformation: Left shift towards prevention; outcome indicators demonstrating patient well-being impact.	

NHS Lincolnshire Integrated Care Board

SYSTEM QUALITY & PATIENT EXPERIENCE COMMITTEE

HIGHLIGHT REPORT

Meeting Date(s):	22 October 2025
Committee Chair:	Sharon Robson, Non-Executive Member

Item	Summary	For Escalation to the Board (Yes or No)
Lincolnshire System Priorities Quality Register Update	Focus areas: • **12-hour waits** – Disproportionate impact on elderly/frail patients; audits completed; quality improvement plan in place; monitored weekly by Clinical Reference Group. • **Discharge delays** – Thematic review conducted with partners; actions identified to minimise delays; Trust reviews and documents harm related to delays. • **Rapid tranquilisation concerns (LPFT)** – CQC raised issues; action plans implemented; ICB-led quality review meetings ongoing; progress being made oversight still required. • **Community equipment and wheelchair service** – Provider change noted; oversight continues to ensure responsiveness and issue resolution. **Assurance Provided:-** • Recovery plans are in place and monitored. • Quality review meetings support improvements and oversight.	**No**

Item	Summary	For Escalation to the Board (Yes or No)
Updated Quality Strategy	• Emphasis on alignment with system priorities and inclusion of the patient voice. • Integrated with ICB/ICS priorities and the 10-year health plan. • Focus areas: patient safety, experience, clinical effectiveness and clinical outcomes. **Key Highlights** • Outlined quality challenges and success measures. • Need for improved data analysis, promote patient voice & inclusion, organisational accountability, and technology investment. • Defined success measures to track and plot progress. **Approval** • Committee unanimously approved the Strategy, recognising its relevance and adaptability to the evolving healthcare landscape.	**No**
Lincolnshire Voices Report	• Report covers patient engagement findings, complaints analysis, and Healthwatch updates. • Emphasis on linking patient voice to quality priorities and using feedback for service improvement. **Key Themes Identified** • Recurring issues: access to services, communication problems, and barriers for vulnerable groups. • Action plans published online to show responses to feedback. **Complaints Analysis** • Breakdown by theme: long waits and communication issues. • Future focus suggested on upheld complaints as opposed to all complaints received as many are not upheld, this will allow for targeted learning. **HealthWatch and GP Access** • Similar themes echoed in Healthwatch report. • GP access survey discussed; pilots underway to address 8:00 am appointment scramble across three Lincolnshire PCNs. • Importance of triangulating data for improvement noted.	**No**

	Next Steps • Further work to take place to formalise integration of patient voice into quality priorities, collaborating with the relevant colleagues.	
Patient Safety Incident Pregnancy Documentation in Pharmacy IT Systems	**Update on National IT System Error** • Issue: Incorrect pregnancy coding in the outcomes IT system. • Impact: Affected ten Lincolnshire Pharmacies and 13 GP Practices. • Actions: Ongoing checks and deadlines for corrections; additional communications issued to address DHSC miscommunication during phase two of review. **Risks & Escalation** • Concerns: Patient safety, reputational risk, and assurance implications. • Agreed actions: Add issue to risk register and escalate to Regional Quality Committee for oversight. **Next Steps** • Continued efforts to contact non-responding Pharmacies. • Use of local levers to ensure compliance, with further escalation if required.	**No**
Respiratory Pathway Deep Dive Review	• Data presented on prevalence, service challenges, patient survey findings, and improvement recommendations. • Review process included scoping, pathway analysis, and engagement with an expert reference group (people with lived experience). **Key Findings** • High prevalence of asthma and COPD in Lincolnshire. • Issues: increasing A&E presentations, long waits for pulmonary rehab, incomplete spirometry services, and multifactorial causes of breathlessness. • Patient survey: long waits for diagnosis/treatment, lack of treatment plans, poor communication and empathy; specialist care praised once accessed. **Recommendations** • Improve information provision, holistic support, localised clinics, inter-service communication, and reduce waiting times. **Respiratory Transformation Programme** • High-level recommendations:-	

	- Better diagnostic testing availability. - Proactive care model to reduce urgent/emergency demand. - Workforce development and move to seven-day working. - Technology enablement and improved partner integration. **Programme Actions** • Respiratory Leadership Group established; metrics dashboard created. • Clarifying GP pathways, transferring oxygen assessments to community, discussions with NHSE for localised care. • Pilot MDT launched; county-wide spirometry service in development. **Proactive Winter Care Model** • £225,000 funding secured for COPD patients (3,750 targeted) for proactive reviews, care plans, escalation plans, and vaccination optimisation. • Limited to COPD due to resource constraints and higher emergency activity. **Integration & Challenges** • Ongoing collaboration with pharmacy and secondary care; need for further integration. • Implementation challenges include resource limitations and need for strategic alignment with neighbourhood health models.	
EMAS Highlight Report	**Winter Planning Update** • Staff flu vaccination delivery and completion of staff survey. **Prevention of Future Deaths report** • Responding to a second from Nottinghamshire Coroner. • Improvement measures being developed; full response to be shared at a future meeting.	**No**
System Partners – Lincolnshire County Council Report	**Winter Planning & Health Protection Update** • Covered winter planning, vaccination, and health protection frameworks. • Development of an IPC RAG rating framework to coordinate system-wide outbreak responses. **IPC RAG Framework** • Uses red, amber, green status based on indicators. • Ensures consistent, proportional responses across NHS and social care (e.g., mask-wearing only when appropriate).	**No**

Item	Summary	For Escalation to the Board (Yes or No)
Operational Quality Assurance Group Update	• Covered CQC activity, transition of community equipment services, learning exercises, and provider-specific developments. • High level of CQC activity across providers noted. • Transition from NRS to Millbrook for community equipment and wheelchair services; recovery group stood down but operational oversight continues. • Gap in assurance on potential harm being addressed with the Trust; lessons-learned exercise planned via Partnership Board. **Provider Monitoring** • Ongoing quality monitoring across providers, including EMAS's response to Coroner's Report. • Update on Queen Elizabeth Hospital (King's Lynn) is part of the National Maternity Review – no local quality concerns identified.	**No**
Quality Committee Transition	• Discussion took place on formal disbanding of Lincolnshire ICB Quality Committee and transition to new ICB cluster structure from November 2025. • Handover Report reviewed; minor wording changes suggested (meeting quoracy, alignment to quality priorities, patient engagement/co-production, job title updates). Subject to amendments, members approved the report.	**No**

NHS Nottingham and Nottinghamshire

Appendix C: Nottingham and Nottinghamshire ICB Committee Highlight Reports

Strategic Planning and Integration Committee Highlight Report

Meeting Date(s):	**02 October 2025 and 27 October 2025 (Extraordinary Meeting)**
Committee Chair:	**Jon Towler, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. Primary Care Strategy – Mid Year Update	Members received a progress update on delivery of the Primary Care Strategy including key achievements, challenges and mitigations to date and the current risks and issues across all primary care providers. Extensive engagement had been carried out with primary care colleagues, and there was growing interest in provision at scale. A positive shift in attitudes and culture had been observed alongside delivery of the strategy. Members noted that alignment with Derby and Derbyshire, and Lincolnshire was being explored to support a more strategic approach. However, it was recognised that population needs differed and places were at varying stages of development.	**Adequate**	**Partial** *Awarded at the meeting held on 6 February 2025.*
2. Primary Medical Services Contracting Panel Assurance Report	Members received a report that provided a summary of the discussions, decisions, challenges, and risks considered by the Primary Medical Services Contracting Panel since April 2025.	**Full**	**Adequate** *Awarded at the meeting*

Item	Summary	Level of assurance	Previous level of assurance
	The requirement for all GP practices to keep their online consultation tool open for the duration of core hours from 1 October 2025 was an area of focus. Members discussed the associated risks, patient expectations around access and the importance of adopting a proactive approach. It was noted that further guidance was expected and the ICB was working with the Local Medical Committee to develop a framework to support practices to meet this contract requirement. Discussions were also taking place with colleagues in Derby and Derbyshire and Lincolnshire to ensure consistency in messaging. The overall assurance rating related to the work of the panel. The risks and mitigations associated with the online consultation tool were acknowledged.		*held on 3 April 2025.*

Other considerations:

Decisions made:
The Committee received a number of decision-making papers and approved proposals relating to: a) The Integration of Fast Track Services into North Nottinghamshire End of Life Care Together Alliance b) Community Crisis Support Service Review c) Mental Health Support Teams in Schools Expansion – 2026/27 d) Bassetlaw Voluntary, Community and Social Enterprise Investment Model 2026/27 The Committee also approved the: a) ICB Policy for Payment of Section 12 Mental Health Act Assessments. b) Strategic Planning and Integration Committee Handover Report.

NHS Nottingham and Nottinghamshire

Information items and matters of interest:
a) The Committee received and discussed the ICB's draft commissioning intentions for 2026, which set the direction for how system priorities would be delivered, grounded in the principles of prevention, equity, and integration, and framed to meet the four statutory purposes of Integrated Care Systems. The next steps were noted and included collating provider feedback and identifying any areas requiring additional clarity and aligning intentions with the contracting round for 2026/27.
b) The Committee received and discussed the operational risks relating to the Committee's responsibilities. There were currently 13 risks relating to the Committee's responsibilities, one of which was categorised as a high scoring risk. A focussed review of the primary care risks would be undertaken prior to the transition to the new cluster risk management arrangements, to ensure that they were clearly articulated and that the associated mitigations were appropriate.
c) The Committee received the Log of Investment, Disinvestment, Procurement and Contract Award Decisions (Healthcare) 2025/26 for information, which provided details of all such decisions made outside of the Committee's meetings.

NHS Nottingham and Nottinghamshire

Quality and People Committee Highlight Report

Meeting Dates:	**17 September 2025 and 15 October 2025**
Committee Chair:	**Marios Adamou, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. Quality Oversight Report	Members received the Quality Oversight Report at both meetings and concluded on each occasion that the assurance provided was limited due to the inherent challenges within these areas. It was noted that winter plans had been developed collaboratively, with equal focus on quality, performance and safety and there was a level of confidence around delivery of these plans, supported by appropriate mitigations and escalations. In addition, a clinical leadership engagement process was ongoing, supported by PA Consulting, to identify the key actions required to support winter pressures. With the shift towards cluster arrangements involving Derby, Derbyshire, and Lincolnshire, members noted that there were common issues across the broader footprint in urgent and emergency care, special educational needs and disabilities and maternity services, with infection prevention and control also recognised as a national challenge. Members acknowledged that significant cultural change within large and complex organisations would take time. However, rapid safety improvements continued to be prioritised through focussed clinical interventions.	**Limited**	**Limited** *Awarded at the meeting held on 17 September 2025.*

Item	Summary	Level of assurance	Previous level of assurance
2. Medicines Optimisation - Safe Management of Controlled Drugs Annual Report 2024/25	Members received the Safe Management of Controlled Drugs Annual Report 2024/25, which detailed how the ICB fulfilled its statutory duties related to Controlled Drugs (CDs) through the work of the ICB Medicines Optimisation team. It also outlined how support for prescribers in localities and wider organisations regarding CDs had been provided through a number of routes. Key messages included the promotion of incident reporting and the sharing of lessons learned.	**Full**	**Full** *Awarded at the meeting held on 18 September 2024.*
3. Adult Safeguarding Team Assurance and Annual Report	Members received a report which provided an overview and summary of assurance against the ICB's statutory responsibilities to safeguard adults at risk. Additional detail was included within the Safeguarding Adults Annual Report 2024/25, which was appended to the report. The support provided to statutory reviews was outlined within the report and it was noted that learning identified through these reviews was shared across key partnerships and included in GP Leads sessions annually. Consideration would be given to strengthening communication with dentists and pharmacists to enhance the dissemination of safeguarding shared learning.	**Full**	**Full** *Awarded at the meeting held on 18 September 2024.*
4. Review of organisational staff surveys and actions	Members received a report which provided an overview of the 2024/25 NHS staff survey results of the Nottingham and Nottinghamshire main providers and the actions they were undertaking in response. The strong correlation between the staff survey results and the intense media scrutiny surrounding some providers was acknowledged. Whilst all organisations were progressing actions in response to the staff survey results, the potential for a positive increase in both participation and staff experience	**Adequate**	*Not applicable*

Item	Summary	Level of assurance	Previous level of assurance
	would be influenced by the challenges faced at organisational, system and wider NHS levels. The overall assurance rating of 'adequate' reflected that, although provider organisations had action plans in place, the effectiveness of these plans in delivering the intended outcomes remained unclear.		
5. Equality Delivery System Improvement Plan	Members received the Equality Delivery System Action Plan, which had been updated, as requested by the Committee in April 2025, to provide greater clarity on the actions, action owners, and delivery timescales. The action plan would be reviewed in the context of the transition to cluster arrangements and revised Executive Director portfolios. The overall assurance rating of 'adequate' reflected that the report was not intended to provide an update on the progress of action plan delivery.	**Adequate**	*Not applicable*
6. Focussed Quality Oversight Report – Providers in National Oversight Framework Segment Three and National Oversight Framework Segment Four	At the October 2025 meeting, members received a focussed update on the position and next step plans for Nottingham University Hospitals NHS Trust and Nottinghamshire Healthcare NHS Foundation Trust. Both providers were in National Oversight Framework segment four. Members noted the Recovery Support Programme (RSP) criteria and current RSP position and discussed the ongoing challenges alongside the actions being implemented to address them. Although an overall assurance rating of 'limited' was awarded, members recognised that the Bellwether metrics for Nottingham University Hospitals NHS Trust appeared more sustainable, providing a greater level of assurance, particularly in relation to maternity services.	**Limited**	**Partial** *Awarded at the meeting held on 19 March 2025.*

Item	Summary	Level of assurance	Previous level of assurance
7. Nottinghamshire Healthcare NHS Foundation Trust: Comprehensive Review of Risks and Assurance	Members received a report on the Nottinghamshire Healthcare NHS Foundation Trust Key Lines of Enquiry (KLOEs), developed to support ongoing oversight and assurance processes with NHS England and regulators. A full risk and assurance review, conducted in quarter two of 2025/26, identified five areas of concern. These informed the KLOEs, which integrated concerns and priorities, focusing on assurance, transparency, financial and quality interdependencies, and reinforced the need for robust, evidence-based plans and cultural change. Members noted that whilst some positive progress had been made, the Trust's strategic approach and alignment of actions required further development. The appointment of a Turnaround Director had increased capacity, with early signs of positive impact.	**Limited**	*Not applicable*
8. Nottingham and Nottinghamshire Local Maternity and Neonatal System Assurance Report	The report aimed to provide assurance that the Nottingham and Nottinghamshire Local Maternity and Neonatal System (LMNS) was working effectively to improve the safety and quality of maternity and neonatal care. It was noted that Sherwood Forest Hospitals NHS Foundation Trust and Nottingham University Hospitals NHS Trust had achieved full compliance with the NHS Resolution Maternity Incentive Scheme Year Six and were progressing towards compliance with the Saving Babies' Lives Care Bundle Version Three. The LMNS also demonstrated growing areas of excellence in relation to the NHS England's three-year delivery plan for maternity and neonatal services. Whilst the overall assurance rating acknowledged that the report was comprehensive and demonstrated continuing improvement, members	**Adequate**	**Partial** *Awarded at the meeting held on 16 October 2024.*

Item	Summary	Level of assurance	Previous level of assurance
	suggested that it would be helpful to include demographic data in future iterations.		
9. 2025/26 Winter Plan	The report aimed to provide assurance that considerations around quality and people were embedded throughout the planning process for the 2025/26 Winter Plan, which had been developed in partnership with all system partners. It was noted that lessons learned from the previous two winter periods had informed planning, proactive rota planning had been undertaken for high-risk, high-demand areas to ensure that staffing capacity was effectively targeted where it was most needed and the ICB had stress-tested the plan against surge and super-surge scenarios, with consideration given to mutual aid arrangements across the system. Members acknowledged the exceptional level of stakeholder engagement in the development of the plan, noting that this collaborative approach had enabled the creation of a system-wide solution to a complex challenge.	**Adequate**	**Adequate** *Awarded at the meeting held on 16 October 2024.*
10. Health Protection, Immunisation and Vaccination Programmes	Members received a report that provided an overview of the delivery and assurance arrangements for both the ICB's Health Protection Programme and Immunisation and Vaccination Programme. The ICB had strengthened its structures and capabilities to enhance its ability to plan for and respond to incidents effectively, whilst ensuring the successful delivery of its programmes of work. Robust arrangements for health protection had been established, and health inequalities remained central to all planning activities in order to protect local communities.	**Adequate**	*Not applicable*

Item	Summary	Level of assurance	Previous level of assurance
	Recognising that there was vaccine hesitancy within some communities, members discussed the levers being utilised by the ICB to engage effectively with these populations, including working closely with local authorities to build trust and strengthen relationships. Learning from the recent Tuberculosis programme was also being applied to support delivery of the vaccination and immunisation programme, and the 'Making Every Contact Count' initiative would be revisited, with a targeted focus on smaller cohorts, including religious and faith communities.		

Other considerations:

Decisions made:
a) Approved the ICBs corroborative statement for inclusion in NEMS Community Benefit Services Annual Quality Account and publication in line with the ICB's responsibility for review and scrutiny of Quality Accounts.
b) Approved the Quality and People Committee Handover Report, to be updated with key discussion points, particularly on provider-related issues. Emphasis would be placed on sustaining progress in health inequalities reporting, aligning ethnicity data with incident reporting, and clarifying workforce responsibilities.
Information Items and Matters of interest:
The Committee also:
a) Discussed examples of how the collaboratively developed outcomes-based dashboard designed to support children and young people with Special Educational Needs and Disabilities would inform ongoing improvements and support the ICB in fulfilling its role as a strategic commissioner, with a targeted focus on population health needs. The dashboard was recently recognised at a national level, receiving the Health Service Journal Care Award for Children and Young People Initiative of the Year.

b)	Reviewed identified risks relating to its areas of responsibility. There were currently 36 risks relating to the Committee's responsibilities, seven of which was categorised as a high scoring risks. The current live risks were reflective of the discussions that had taken place throughout the meeting and would be transferred to the relevant new committees as part of the handover process.
c)	Received the Quality Integrated Performance Report for information.
d)	Received the NEMS Community Benefit Services Quality Account for information.
e)	Received the 2025/26 Committee Annual Work Programme for information.

NHS Nottingham and Nottinghamshire

Finance and Performance Committee Highlight Report

Meeting Date(s):	**24 September and 29 October 2025**
Committee Chair:	**Stephen Jackson, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
a) 2024/25 System and ICB Finance and Workforce Report (Month 6)	At the end of month six the system was reporting a £32.4 million deficit but continued to forecast a year-end break-even position; and the ICB was on plan for both year-to-date and full year forecast outturn. However, there remained significant risk to achieving the Financial Plan. Increasing pressures in the management of the cash flow position for all providers was also highlighted as a growing concern. The Committee discussed the current drivers of the deficit and the proactive actions that were being taken to address shortfalls. Members noted that although the ICB had positioned two turnaround directors in the system and had enlisted the help of a strategic delivery partner, confidence that the financial plan would be delivered was low and challenged the ICB on what additional support could be given to ensure that the plan was delivered in full.	**Limited**	**Limited** *(awarded at the meeting held on 24 July 2025)*
b) 2025/26 System Financial and Workforce Efficiency Update	The report provided an update on progress towards developing plans to meet the £279 million efficiency target, as detailed in the 2025/26 Operational Plan. At month six, 80% of financial efficiencies had been delivered against plan, representing a £24.6 million underperformance. Although this was an	**Limited**	**Limited** *(awarded at the meeting*

Item	Summary	Level of assurance	Previous level of assurance
	improvement in delivery from previous months, the risk adjusted shortfall against the efficiency requirement currently stood at £74.4 million. Whilst some transformation programmes continued to progress well, including Estates and Facilities, Digital Transformation and Medicines Optimisation, there were other transformation programmes that continued to present a significant risk, including Workforce, Planned Care, and Urgent and Emergency Care. Moving forward into ICB cluster arrangements, the Committee endorsed a proposed approach to system financial governance to move away from system transformation and to instead focus on the financial recovery of individual organisations at high risk of not achieving their financial plans. There was also growing concern regarding the deteriorating performance in the delivery of providers' workforce plans.		*held on 24 July 2025)*
c) Operational Plan 2025/26 Delivery and Service Delivery report	Members received reports highlighting areas of improvement and challenges, noting that increased grip and control by both the programme boards and the Performance Oversight Group was resulting in improvements to several performance metrics. Although the summer had seen an improvement in urgent and emergency care performance, going into autumn this had not been maintained, and members sought assurance of the efficacy of the actions that were being put in place to address the rising demand. The performance of planned care was being maintained; however, as cancer and diagnostic performance remained a challenge, the overall assurance	**Partial**	**Partial** *(awarded at the meeting held on 24 July 2025)*

Item	Summary	Level of assurance	Previous level of assurance
	rating remained at partial, recognising the significant risks and challenges to achieving the operational plan.		
d) Thematic Service Review: Reducing the time people wait for elective care (RTT and cancer)	Members received a deep dive review of the current performance and system wide actions to improve elective care key metrics such as route to treatment (RTT) and cancer waiting time performance. The report found that overall, referrals and waiting lists were lower than the previous year and the system continued to make positive progress to reduce the number of patients waiting over 65 and 52 weeks. Historically cancer performance within the ICS had benchmarked at the national and regional average, however, this position had changed since the start of the financial year, with a reduction in performance against two specific targets and an increase in the cancer backlog. The Committee discussed the factors behind the deteriorating performance and asked the ICB to challenge whether the trusts' action plans would fully address the issues within the report.	**Partial**	*Not applicable*
e) 2025/26 Winter Plan	Following the Committee's review of the Winter Plan in July 2025, the report provided an update on actions to close the forecast bed gap, which had stood at 191 before mitigations. Following intense work over the intervening months, the forecast gap now stood at 46. Despite the mitigations in place, the Committee noted that within these forecasts there were a number of assumptions regarding the operation of the urgent and emergency care system, and performance was already starting to deteriorate ahead of the peak winter period.	**Partial**	*Not applicable*

Item	Summary	Level of assurance	Previous level of assurance
f) Joint Capital Resource Use Plan – mid-year update	The Committee received a report that presented the quarter two position of the annual Joint Capital Resource Use Plan, noting that at this stage there was a low risk of over commitment of the financial envelope; and requests to NHS England had been made to defer spend relating to several large national schemes in order to prevent the risk of underspend.	**Partial**	*Not applicable*
g) Corporate Services Optimisation Programme	As previously noted by the Committee, the development of this programme had been slower than expected. A confirm and challenge session held earlier in the year had not provided assurance that there was sufficient willingness and capacity to drive forward the programme in its current form. The proposed revised approach to taking this piece of work forward was debated and the Committee concluded that, as this was a concept that had been proposed for a number of years and had not progressed in any significant way, it was considered too ambitious and resource intensive for the estimated return on investment and that consideration should be given to undertaking a smaller scale exercise in an area where there was already good working relationships between teams.	*Not applicable*	-
h) Implementation of the IFSE2 Financial Ledger (pre transfer)	Due to the timing of the implementation of the IFSE2 financial ledger, oversight of which sat within the remit of the Audit and Risk Committee, a report was brought to this Committee to provide assurance that the ICB was prepared for the transfer. The Committee heard that as an organisation the ICB had done everything required and had provided a 'green' readiness assessment rating to NHS England. However, the confidence assessment in the new system had been rated as 'amber', due, in the main, to concerns around training and hyper	*Not applicable*	-

Item	Summary	Level of assurance	Previous level of assurance
	care. NHS England had provided an assurance statement in response to several concerns raised by ICBs		

Other considerations:

Decisions made:
a) Following delegation from the Board, the Committee approved the refreshed Green Plan ahead of its submission to NHS England by the stated deadline of 31 October 2025. b) The Committee's handover report was approved, with a request to update it in line with key discussion points; particularly to include narrative relating to the need to ensure that Trust Boards were receiving consistent information going forward

Information items and matters of interest:
An extract from the Operational Risk Register relevant to the Committee's remit was reviewed, which included 13 risks, with six rated as high risks.

Audit and Risk Committee Highlight Report

Meeting Dates:	**16 October 2025**
Committee Chair:	**Gary Brown, Non-Executive Director**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. Bi-annual Risk Management Arrangement Update	The report had provided an update on the work being undertaken to embed strategic and operational risk management arrangements within the ICB. The report had also provided a detailed analysis of the ICB's current operational risk profile; the processes in place for identifying and categorising risks; and provided an update on the development of system risk management arrangements. The Committee also received an update on the development of joint risk management arrangements as part of a wider programme to establish cluster governance arrangements across the three organisations. This would also include a full review of system risk management arrangements, as they were found to be very different among the three ICBs. Going forward existing system risks will be reframed to focus on risks to the ICB as a commissioning organisation.	**Full**	**Adequate** *Awarded at the meeting held on 20 May 2025.*
2. Statutory and Mandatory Training Compliance	The Committee reviewed the ICB's current statutory and mandatory training compliance figures and the processes in place to monitor and improve compliance rates. Overall, compliance rates remained high.	**Full**	**Full** *Awarded at the meeting held on 20 May 2025*
3. Financial Stewardship Assurance Report	The report provided an update on the ICB's key financial arrangements. The Committee noted that procurement card usage and agency spend continued to be	**Full**	**Adequate**

Item	Summary	Level of assurance	Previous level of assurance
	proactively managed. The Committee was also provided with details of the two instances where competitive tendering requirements had been waived during the financial year to date and considered the decisions to be appropriate.		*Awarded at the meeting held on 20 May 2025*
4. Implementation of the IFSE2 Financial Ledger (post transfer)	Members received an update on the outcome of the implementation of the new financial ledger (ISFE2) on 1 October 2025, noting that there had been a significant number of issues primarily around functionality. However, they had been escalated and were being proactively managed. Members noted the potential risk of it adversely impacting the ICB's Better Payment Practice Code and a potential impact on the execution of the external audit and asked that this continued to be monitored.	*Not applicable*	-

Other considerations:

Decisions made:
a) Members received an update on the progress of the 2024/25 Internal Audit Plan and approved the reallocation of the days set aside for the system wide review to support attendance at the ISFE2 project board; and to postpone the audit related to quality oversight arrangements until 2026/27 due to the delay in the publication of National Quality Board guidance. b) The Committee's handover report was approved, with a request to update it in line with key discussion points; particularly to include narrative relating to the need to ensure that the Internal Audit action rate remained high; for there to be a continued focus on risk management arrangements in relation to developing cluster arrangements; and an on-going scrutiny of the implementation of the new financial ledger, both in relation to the potential risk of it adversely impacting the Better Payment Practice Code and any potential impact on the execution of the external audit.

Matters of interest:
a) An update on the 2024/25 Counter Fraud Plan was received.

Remuneration and Human Resources Committee Highlight Report

Meeting Date(s):	**18 August 2025 (extraordinary meeting held in common with the NHS Derby and Derbyshire ICB Remuneration Committee)**
Committee Chair:	**Mehrunnisa Lalani, Non-Executive Director (18 August 2025)** **Jon Towler, Non-Executive Director (28 October 2025)**

Assurances received:

Item	Summary	Level of assurance	Previous level of assurance
1. ICB Workforce Report	Members received a report which provided a summary of the key information discussed by the ICB's executive-led Human Resources Steering Group relating to performance against a range of workforce metrics, including whole time equivalent, head count, rolling sickness absence and turnover. The report also provided an update on progress with the 2024 Staff Survey Action Plan and presented the ICB's Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports, including associated actions plans, for consideration prior to publication. Members discussed the actions that had contributed to a reduction in sickness absence rates and the rigorous controls that were in place around agency usage. Several improvements were proposed for the WRES and WDES reports. Members recognised that diversity at Board and very senior manager levels was declining and was not reflective of the population served. This would inform future considerations around culture, succession planning, and talent management.	*Not applicable*	**Partial** *Awarded at the meeting held on 21 Julu 2025*

Other considerations:

Decisions made:
The Committee approved: a) The proposed remuneration for the Chief Executive designate of the ICB Cluster, comprised of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB. b) The Management of Change and Pay Protection Policy. c) The Executive Director Consultation process, subject to the ICBs' Boards approval of the Management of Change Business Case. d) The WRES and WDES Reports for publication subject to the points raised during the meeting being addressed. e) The Remuneration and Human Resources Committee Handover Report.

Joint ICB Transition Committee Highlight Report

Meeting Date(s):	**9 September 2025, 10 October 2025 and 13 November 2025**
Committee Chair:	**Jon Towler, Non-Executive Director, NHS Nottingham and Nottinghamshire ICB**

Item	Summary
1. **ICB Cluster Operating Model: Functions Confirm and Challenge Update**	The Joint Committee received an update on progress with the development of the ICB Cluster Operating Model, including outputs from a comprehensive review of functions and activities and recommendations on the appropriate scale for delivery. Most functions in the Model ICB Blueprint were deemed viable at cluster level, with a high level of alignment to initial considerations; however, there was a clear need to retain sensitivity to local knowledge and relationships in order to fulfil commissioning responsibilities for some activities. Members acknowledged that the comprehensive work to date had resulted in a strong sense of clarity and alignment around the functions to be delivered at cluster level.
2. **Proposed Governance Framework for the DLN ICB Cluster**	The Joint Committee received a report which outlined the proposed Governance Framework for the DLN ICB Cluster and described the work underway to enable its implementation during quarter three of 2025/26. The proposed framework would be submitted to the three ICBs' Boards in September 2025 for consideration, along with a request for the Boards to endorse proposed changes to each ICB's Constitution, for onward submission to NHS England for formal approval. Members agreed the proposed framework was clear and provided a good level of assurance regarding the work underway to establish the revised governance arrangements.
3. **ICB Operating Model: Financial model for the allocation of running cost allowance**	The Joint Committee received a report outlining principles for allocating running cost allowances across the ICBs' functions and activities to meet the £19 per head of population target by 2026/27, ensuring a sustainable and highly capable workforce with diverse skills and capabilities to deliver the ICBs' strategic commissioning responsibilities. The revised Financial Framework recognised that transition planning was evolving and would remain under review to achieve the allowance.

Item	Summary
	Members acknowledged the need for assurance on the affordability and deliverability of the wave two management of change process. Although the process was considered clear, some human resources considerations still had to be worked through, and independent support had been secured. The proposed methodology for allocating running cost allowances to functions within agreed Executive portfolios was endorsed.
4. **Preparation for Management of Change process for Wave Two**	Members received an update on the developing plans to implement the Board approved Management of Change Business Case and the recently announced model voluntary redundancy scheme which NHS England had agreed with Government. The Joint Committee would continue to oversight the process in accordance with national policy.
5. **Transition Programme Plan Progress**	The Joint Committee received routine updates at all meetings regarding progress against the ICB Transition Programme Plan and was assured that the plan remained largely on track. Upcoming priorities included confirming the timelines for the wave two management of change process and voluntary redundancy scheme, as well as clarifying the work programme associated with the closure of Commissioning Support Units. The format of the Transition Programme Plan report would be revised to include greater detail on action owners, the current status of actions, and clearly defined timelines. Members highlighted the importance of ensuring clear communication and visible leadership throughout the transition process.
4. **Transition Risk Log**	The Transition Risk Log was reviewed by the Joint Committee at each meeting. Ownership of the transition risks had now transferred to Helen Dillistone, Executive Director of Transition. The two highest-rated risks related to the affordability of redundancy costs and the abolition of Commissioning Support Units. Members requested a new risk be added to reflect the potential for distraction and reduced capacity to deliver priorities following the launch of the voluntary redundancy scheme.