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 15 January 2026 10:00-13:00

Rushcliffe Arena, Rugby Road, West Bridgford, NG2 7YG

Ref	Item	Presenter	Type	DD	L	NN	Enc	Time
	Introductory items							
1.	Welcome, introductions and apologies	Kathy McLean	-	✓	✓	✓	-	10:00
2.	Confirmation of quoracy	Kathy McLean	-	✓	✓	✓	-	-
3.	Declarations and management of interests	Kathy McLean	Information	✓	✓	✓	✓	-
4.	Minutes of the meetings in common, held on 20 November 2025	Kathy McLean	Decision	✓	✓	✓	✓	-
5.	Action log and matters arising from the meetings in common, held on 20 November 2025	Kathy McLean	Discussion	✓	✓	✓	✓	-
	Leadership and operating context							
6.	Citizen Story: Children's Bereavement Centre	Alex Ball	Discussion	-	-	✓	✓	10:05
7.	Chair's Report	Kathy McLean	Information	✓	✓	✓	✓	10:20
8.	Chief Executive's Report	Amanda Sullivan	Information/ Decision	✓	✓	✓	✓	10:35
9.	ICB Transition Programme update	Helen Dillistone	Discussion	✓	✓	✓	✓	10:55
	Strategy and partnerships							
10.	Medium Term Planning update	Clair Raybould, Maria Principe, Marcus Pratt	Discussion	✓	✓	✓	✓	11:15

Ref	Item	Presenter	Type	DD	L	NN	Enc	Time
	Delivery assurance							
11.	Finance Report	Marcus Pratt	Assurance	✓	✓	✓	✓	11:40
12.	Quality Report	Rosa Waddingham	Assurance	✓	✓	✓	✓	11:55
13.	Service Delivery Performance Report	Maria Principe	Assurance	✓	✓	✓	✓	12:10
14.	Emergency Preparedness, Resilience and Response Annual Reports	Maria Principe	Assurance	✓	✓	✓	✓	12:25
	Governance							
15.	Committee Highlight Reports: • Joint Finance and Performance Committee • Joint Quality and Service Improvement Committee • Joint Strategic Commissioning Committee • Joint Remuneration and Human Resource Committee • Joint Transition Committee • Audit Committees	Committee Chairs	Assurance	✓	✓	✓	✓	12:40
	Closing items							
16.	Risks identified during the course of the meeting	Kathy McLean	Discussion	✓	✓	✓	-	12:55
17.	Any other business	Kathy McLean	-	✓	✓	✓	-	-
	Meeting close							**13:00**

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

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	15/01/2026
Paper title:	**Declaration and management of interests**
Paper reference:	ICB CIC 25 020
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.
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.

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	✓	✓	✓	Director of Sara (Leicester) LTD, consultancy and advisory services	Ownership and/or directorship of a private company	✓				01/01/2025	Present	This interest will be kept under review and specific actions determined as required.
Lalani	Mehrunnisa	Non-Executive Member	✓	✓	✓	Brother is employed by iBC Healthcare, which provides specialist support and bespoke accomodation to adults with complex care needs	Role within an NHS, local authority or provider organisation.				✓	01/01/2025	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by iBC Healthcare LTD.
Lim	Kelvin	Primary Medical Services Partner Member	–	–	✓	Registered patient at Eastwood Primary Care Centre	Use of NHS services commissioned by the ICB (registered patient).			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
Lim	Kelvin	Primary Medical Services Partner Member	–	–	✓	Clinical lead for various projects at Primary Integrated Community Service (PICS), a provider of local health services in the Nottinghamshire area	Role within an NHS, local authority or provider organisation.	✓				01/07/2022	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by Primary Integrated Community Services.
McLean	Kathy	Chair	✓	✓	✓	Director of Kathy McLean Limited, a private limited company offering health related advice	Ownership and/or directorship of a private company	✓				01/07/2022	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Kathy McLean Limited.
McLean	Kathy	Chair	✓	✓	✓	Member of the Workforce Policy Board at NHS Employers, an organisation which supports workforce leaders and represents employers in the NHS	Role within an NHS, local authority or provider organisation.		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
McLean	Kathy	Chair	✓	✓	✓	Chair of National Negotiation Committee for staff and associate specialists on behalf of NHS Employers, an organisation which supports workforce leaders and represents employers in the NHS	Role within an NHS, local authority or provider organisation.		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
McLean	Kathy	Chair	✓	✓	✓	Occasional Advisor to the Care Quality Commission, the Independent regulator of health and social care services in England	External role or association (non-NHS), declared for transparency.	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
McLean	Kathy	Chair	✓	✓	✓	Chair of The Public Service Consultants Ltd, a public sector consultancy business	External role or association (non-NHS), declared for transparency.	✓				01/07/2022	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by The Public Service Consultants Ltd.
McLean	Kathy	Chair	✓	✓	✓	Advisor at Lio (formerly Oxehealth) Ltd, a health-tech company that develops digital monitoring and operational platforms focussed on inpatient mental health care.	External role or association (non-NHS), declared for transparency.	✓				01/11/2024	Present	To be excluded from all commissioning discussions and decisions (including procurement activities) relating to services that could be provided by Lio Ltd.
McLean	Kathy	Chair	✓	✓	✓	Chair of the ICS Network Board at NHS Confederation, a membership organisation for the whole healthcare system in England, Wales and Northern Ireland.	Role within an NHS, local authority or provider organisation.	✓				01/04/2024	Present	This interest will be kept under review and specific actions determined as required.
McLean	Kathy	Chair	✓	✓	✓	Trustee of the NHS Confederation, a membership organisation for the whole healthcare system in England, Wales and Northern Ireland.	Trustee or leadership role in a voluntary, charitable or community organisation		✓			01/06/2025	Present	This interest will be kept under review and specific actions determined as required.
Melbourne	Jon	NHS Trust/Foundation Trust Partner Member	–	–	✓	Chief Executive of Sherwood Forest Hospitals NHS Foundation Trust	Role within an NHS, local authority or provider organisation.	✓				TBC	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) relating to services that are currently, or could be, provided by Sherwood Forest Hospitals NHS Foundation Trust
Melbourne	Jon	NHS Trust/Foundation Trust Partner Member	–	–	✓	Director and Shareholder of Ten Five Four Homes Limited	Ownership and/or directorship of a private company	✓				01/08/2022	Present	This interest will be kept under review and specific actions determined as required.
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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			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	Director of Commissioning	✓	✓	✓	Director of Boho Beauty - Aesthetics and Beauty	Ownership and/or directorship of a private company	✓				01/10/2024	Present	This interest will be kept under review and specific actions determined as required.
Principe	Maria	Director of Commissioning	✓	✓	✓	Registered patient at Bilsthorpe Surgery	Use of NHS services commissioned by the ICB (registered patient).			✓		05/01/2026	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
Principe	Maria	Director of Commissioning	✓	✓	✓	Son is employed as a helpdesk technician at Sherwood Forest Hospitals NHS Foundation Trust	Role within an NHS, local authority or provider organisation.				✓	05/01/2026	Present	This interest will be kept under review and specific actions determined as required.
Raybould	Clair	Director of Strategy & Citizen Experience	✓	✓	✓	Registered patient at Tasburgh Lodge Practice	Use of NHS services commissioned by the ICB (registered patient).			✓		01/11/2025	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
Robson	Sharon	Non-Executive Member	✓	✓	✓	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.
Shields	Bill	Director Finance	✓	✓	✓	Chair of the 360 Assurance Management Board	Role within an NHS, local authority or provider organisation.		✓			01/12/2025	Present	This interest will be kept under review and specific actions determined as required.
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

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

NHS Nottingham and Nottinghamshire Integrated Care Board

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.

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Minutes of the meetings in common of:

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

20 November 2025, 09:00-12:15

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

		NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB
Members present:				
Dr Kathy McLean	Chair	✓	✓	✓
Dr Dave Briggs	Executive Director of Outcomes (Medical)	✓	✓	✓
Karen Dunderdale	NHS Trust/ Foundation Trust Partner Member	-	✓	-
John Dunstan	Non-Executive Director	✓	✓	✓
Margaret Gildea	Non-Executive Director	✓	✓	✓
Stephen Jackson	Non-Executive Director	✓	✓	✓
Jon Melbourne	NHS Trust/ Foundation Trust Partner Member	-	-	✓
Dr Andrew Mott	Primary Care Partner Member	✓	-	-
Stephen Posey	NHS Trust/ Foundation Trust Partner Member	✓	-	-
Mark Powell	Ordinary Member – Mental Health	✓	✓	✓
Maria Principe	Interim Executive Director of Commissioning	✓	✓	✓
Clair Raybould	Executive Director of Strategy and Citizen Experience	✓	✓	✓
Sharon Robson	Non-Executive Director	✓	✓	✓
Martin Samuels	Local Authority Partner Member	-	✓	-
Bill Shields	Executive Director of Finance	✓	✓	✓
Amanda Sullivan	Chief Executive	✓	✓	✓
Dr Kevin Thomas	Primary Care Partner Member	-	✓	-
Jon Towler	Non-Executive Director	✓	✓	✓
In attendance:				
Lucy Branson	Director of Corporate Affairs, NHS Nottingham and Nottinghamshire ICB	✓	✓	✓
Helen Dillistone	Executive Director of Transition	✓	✓	✓
Paul Gutherson	Chair, Lincolnshire Voluntary and Community Sector Alliance	✓	✓	✓
Derek Ward	Director of Public Health, Lincolnshire County Council	✓	✓	✓
Sue Wass	Corporate Governance Officer, NHS Nottingham and Nottinghamshire ICB (Minutes)	✓	✓	✓
Apologies:				
Mehrunnisa Lalani	Non-Executive Director	✓	✓	✓
Dr Kelvin Lim	Primary Care Partner Member	-	-	✓

		NHS Derby and Derbyshire ICB	NHS Lincolnshire ICB	NHS Nottingham and Nottinghamshire ICB
Adrian Smith	Local Authority Partner Member	-	-	✓
Rosa Waddingham	Executive Director of Quality (Nursing)	✓	✓	✓

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

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

Introductory items

ICB CIC 25 001

Welcome, introductions and apologies

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

The Chair explained that the Boards were meeting in common in line with the agreement that three ICBs would be working in partnership as an 'ICB cluster', which would enable the ICBs to harness economies of scale, enable more efficient delivery of functions, and reduce duplication, with joint leadership appointments having been made where permissible. The meetings in common provided the opportunity to facilitate single discussions and provide a single strategic direction for the three ICBs. However, it was important to note that the ICBs remained separate legal entities with distinct statutory duties and each Board retained the ability to make its own decisions.

While there would be a large number of Board members present at the meetings in common, it was nevertheless considered important for there to be additional subject matter experts in attendance from public health and the voluntary and community sector to advise the Boards. The subject matter experts would attend on a rotational basis and liaise with their counterparts in each geographical area ahead of meetings.

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

ICB CIC 25 002 **Confirmation of quoracy**

The meetings were confirmed as quorate.

ICB CIC 25 003 **Declarations and management of interests**

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

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

ICB CIC 25 004 **Minutes of the NHS Nottingham and Nottinghamshire Board meeting held on 10 September 2025**

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

ICB CIC 25 005 **Minutes of the NHS Derby and Derbyshire Board meeting held on 18 September 2025**

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

ICB CIC 25 006 **Minutes of the NHS Lincolnshire Board meeting held on 30 September 2025**

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

ICB CIC 25 007 **Action log and matters arising**

Noting that there were several ongoing actions from the previous ICB Board meetings, the Chair noted that the actions would be assigned new named leads, and their resolution expedited, likely through inclusion on the relevant committees' forward work programmes. This work be undertaken prior to the next meeting in January 2026.

Leadership and operating context

ICB CIC 25 008 **Citizen Story: Functional Neurological Disorder – The power of working together**

The Chair invited Charley Blyth, Director of Communications and Engagement at NHS Lincolnshire ICB and John Smith to introduce the item. John then proceeded to present a PowerPoint presentation, highlighting the following points:

a) The presentation described John's experience of bringing together an informal community of almost 2,000 people to provide a supportive environment for people suffering from Functional Neurological Disorder (FND).

b) John described his own experiences and frustrations of accessing healthcare systems with a condition that was not fully or widely understood in mainstream services and how he, and many people in the support group, had found it difficult to access support following diagnosis.

c) The support group, FND Lincs, had been invited to share their experiences with NHS Lincolnshire ICB and other representatives from the health and care system to collaboratively consider how best to use existing resources to bring about improvement, such as strengthened existing provision, myth busting, and earlier diagnosis. The group had found this to be an extremely positive step forward.

d) John went on to discuss several ideas about how services could be improved, such as better coding for patients with FND; greater awareness of the condition; and how to promote the work undertaken by the group across a much wider geographical footprint.

The following points were made in discussion:

e) Commenting on the positive engagement that the group had had with the Lincolnshire system, members queried what feedback John would give on how other ICBs could learn from the engagement. It was noted that citizens often found organisations to be overly bureaucratic and it was helpful that Lincolnshire ICB had been willing to listen to what the group had achieved to date and make connections with other organisations. There was also a great benefit of the promotion of what could often be seen as a 'hidden' condition.

f) Members agreed that awareness raising among health and care staff was an important point that could benefit both the patients and NHS efficiency, and went on to note how the condition fell in between physical and mental health, with a need to explore further the concept of 'social health'.

g) Furthermore, it was noted that the presentation had demonstrated the benefits of what could be achieved by a relatively low level of support and cross-organisational working; and how, by working at a neighbourhood level, public health, the NHS and the voluntary and community sector could make a tangible difference. An offer was made for the ICBs to partner in any future bids.

h) Noting that learning from the presentation should be used to focus on wider support for other neurological conditions, as well as FND, the Chair noted that further work in this area would need to be taken forward as part of the prevention agenda.

i) On behalf of the Boards, the Chair thanked John for sharing his powerful story.

The Boards **noted** the Citizen Story.

ICB CIC 25 009 **Chair's Report**

Kathy McLean introduced the item, highlighting the following points:

a) Board members were asked to embrace the new ICB clustering arrangement and use it as an opportunity to build on the excellent work that had been undertaken to date in areas such as neighbourhood health and population health management; and to use this foundation to guide the organisations into

becoming strategic commissioners. This would entail a sharp focus on outcomes, ensuring value for money and making brave decisions on behalf of the ICBs' constituent populations. The publication of the Strategic Commissioning Framework by NHS England was a welcome document that would be used to guide this change.

b) There had been several recent announcements from NHS England regarding planning requirements for future years, with challenging timescales attached. Gratitude was given to staff that continued to work extremely hard and with professionalism at a time of great personal uncertainty.

c) Attention was drawn to several visits undertaken over recent months and a commitment to continuing with a programme of visits over the wider geographical footprint was reiterated, noting the importance and immense value of continuing to hear from staff on the front line and from people using the services.

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

ICB CIC 25 010 **Chief Executive's Report**

Amanda Sullivan introduced the item, highlighting the following points:

a) Reiterating the Chair's thanks to all staff for their continuing hard work under difficult circumstances, the Boards were asked to note the acceleration of the ICBs' management of change process following recent communication clarifying the national funding arrangements for redundancy costs.

b) Nevertheless, it was important to also maintain focus on addressing current winter pressures following the earlier than expected outbreak of influenza and the undertaking of industrial action by resident doctors. The requirement to also retain a focus on achieving elective care targets and to address the challenging financial position were also highlighted.

c) Further to the discussion under item ICB CIC 25 009 regarding planning for future years, initial draft plans would be required by NHS England ahead of the end of the calendar year. The intention of the new planning framework was to move ICBs towards medium-term financial and delivery planning cycles in order to provide a stronger foundation for the strategic shifts required to deliver the Ten-Year Health Plan.

d) Linked to this was the intention for ICBs to adopt the strategic commissioning approach outlined within the framework as part of the NHS planning process, which was welcomed as a key tool to enable ICBs to plan, purchase, monitor and evaluate services over a longer-term timeframe in order to improve population health.

e) A letter published by NHS England regarding a renewed commitment on zero tolerance of all forms of hatred, antisemitism, Islamophobia and racism was welcomed and members were asked to formally adopt the International Holocaust Remembrance Alliance's working definition of antisemitism.

f) Discussing a recent visit to Primary Care Network test sites in Lincolnshire, the Boards were asked to note the encouraging results for what would prove to be a useful pilot on which to build upon.

g) Noting recent reports on local news outlets regarding the financial issues experienced by Ashgate Hospice in Chesterfield, the Boards were asked to note that NHS Derby and Derbyshire ICB had been in dialogue with the organisation to understand their financial challenges and the ICBs' Executive Director of Finance would meet with them early in December with a view to helping them mitigate any cuts to services. However, it was emphasised that the funding provided to the Hospice was commensurate when benchmarked with the sector nationally and was in line with NHS England guidance.

The following points were made in discussion:

h) With reference to the national initiative for 'online' hospitals, there was a query whether this would need referencing in the Medium-Term Plan. In response it was noted that work was already underway on building IT system capacity on an East Midlands footprint.

i) A query was raised regarding how the benefits of the Primary Care Test Site initiative would be captured and rolled out to all areas. It was noted that if common critical success factors could be identified through the process, ICBs would use commissioning levers to enact change. It was noted that there was also a plan to examine best practice across all geographical areas. However, before enacting any changes to pathways, ICBs would also need to consider feedback from service users and demonstrate best value. To ensure more rigour was put into this process the Chair stated that a mechanism should be put in place to capture and monitor how learning from pilots was being utilised and for Committee Chairs to continue to seek assurance in this area.

j) The Boards welcomed the International Holocaust Remembrance Alliance's working definition of antisemitism, and the Chair noted the alignment with the ICBs' values and behaviours.

The Boards **noted** the Chief Executive's Report and **endorsed** the adoption of the International Holocaust Remembrance Alliance's working definition of antisemitism.

	Governance
ICB CIC 25 011	**Governance Framework for the Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire Integrated Care Boards working in partnership**

Lucy Branson introduced the item, highlighting the following points:

a) The report proposed a new governance framework for the NHS Derby and Derbyshire, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire ICBs in line with a move to formal partnership working as an ICB cluster from November 2025.

b) Following the report on the proposed joint arrangements discussed at the September Board meetings of the ICBs, work had been undertaken to align Board memberships, progress joint leadership appointments and develop a revised committee structure to enable efficient, collaborative working, whilst maintaining each ICB's statutory responsibilities.

c) The paper confirmed that NHS England approval of the ICBs' updated Constitutions had been received and included the proposed terms of reference for the Boards' new committee structure, along with aligned Standing Financial Instructions and two key joint policies for business conduct and risk management. In line with the requirements of the ICBs' Constitutions, the paper also set out the proposed Chairs for each of the new committees.

d) A number of appointments to specific non-executive and executive leads roles on the ICBs' Boards were also proposed.

e) In support of the new joint Risk Management Policy, a revised set of 12 strategic risks had been developed to form the basis of a new joint Board Assurance Framework. Subject to approval, these would enable a new Board Assurance Framework to be fully populated. A full review of the Board's risk appetite was scheduled for discussion at a future Board development session.

f) Subject to Board approval of the proposals set out within the paper, next steps would include reflecting the changes within the ICBs' Governance Handbooks, agreeing Board and committee work programmes for the forthcoming year, and further policy alignments to support the transition to a single, effective operating model across the ICBs.

The following points were made in discussion:

g) On behalf of the Board, the Chair thanked the ICBs' teams for the hard work that had been undertaken in a very short period of time to progress and produce the documents presented for approval.

h) Board members welcomed the new arrangements, and there was a request for members to be able to explore in greater detail the role of the ICBs as strategic commissioners and it was noted that this would be a focus of the Boards' upcoming development sessions.

i) On behalf of colleagues within public health, Derek Ward offered support for the input of a wider range of views into the committee structure that sat under the Boards. Thanking Derek for this offer, it was noted that terms of reference would be kept under review as arrangements evolved.

j) Further to this point, it was noted that governance arrangements at system and pan-system level also needed to be considered; however, there was still some uncertainty as to the future role of the ICBs within system oversight and regulation arrangements. Revised arrangements would be progressed over the next few months.

The Boards:

- **Noted** the ICBs' amended Constitutions, as approved by NHS England and the appointments to Executive lead roles on the Boards.
- **Approved** the Boards' new committee structure, the associated committee terms of reference, and the appointment of Committee Chairs.
- **Approved** the appointments of non-executive lead roles on the Boards.
- **Approved** the ICBs' revised Standing Financial Instructions.
- **Approved** the ICBs' new Standards of Business Conduct and Risk Management Policies.
- **Approved** the set of 12 joint strategic risks to form the basis of the Boards' new joint Board Assurance Framework.

Delivery and assurance

ICB CIC 25 012

Finance Report

Bill Shields introduced the item, highlighting the following points:

a) At month six all systems within the Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire ICBs' footprints had demonstrated a deteriorating financial position. The overall year to date financial position for the three systems was a £42.1 million adverse variance to plan.

b) Nottingham and Nottinghamshire providers were the key driver of the position, at £32.2 million. As a consequence, NHS England had confirmed that quarter three deficit support funding would be withheld from the Nottingham and Nottinghamshire system. Cash flow was also an increasing issue for two Nottinghamshire providers.

c) Although the reasons for the deteriorating positions varied, common themes were the non-delivery of both cost improvement plans and workforce plans.

d) The ICBs' year to date positions were noted as a variance to plan of £8.7 million. NHS Lincolnshire ICB was the main driver, with acute independent sector activity and prescribing pressures given as the main cause of the deficit position; a deep dive review of the position would be undertaken over the coming week. The loss of deficit support funding would also put increased pressure on NHS Nottingham and Nottinghamshire ICB's financial position. The continued delivery of efficiency plans was key ensuring that the ICBs remained on forecast.

The following points were made in discussion:

e) Discussing whether the providers' deteriorating financial positions could be turned around in the second half of the financial year, Board members understood that there would be little to gain in the identification of additional savings as the main issue lay in the execution of the providers' original financial plans. A key learning point for future years would be a close monitoring of run rates and for immediate action to be taken if any provider was veering off plan.

f) It was noted that there was little national flexibility if financial plans were not met, and non-delivery would be met with rigid spending controls and significant restrictions. All systems were expected to operate within their financial envelopes and the ICBs continued to provide support.

g) Regarding the ICBs' positions, there was a query on the impact of redundancy costs, and it was noted that although there continued to be significant risks to the ICBs' financial positions, there was an expectation that the ICBs would be able to deliver their financial plans in full.

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

ICB CIC 25 013 **Quality Report**

Dave Briggs introduced the item, highlighting the following points:

a) Members were asked to note that this report provided a summary of the quality issues affecting services across all three ICB areas; therefore, the report was for information rather than assurance. A programme of focused thematic reports was being developed that would inform future quality reports to the Boards.

b) Currently there were three providers in the highest level of NHS England's National Oversight Framework for escalated risk: Nottinghamshire Healthcare NHS Foundation Trust; Nottingham University Hospitals NHS Trust; and University Hospitals Derby and Burton NHS Foundation Trust. The status and progress of their respective improvement programmes was provided within the report.

c) The report also provided an overview of quality concerns in areas of enhanced oversight, including learning disabilities and autism services; urgent and emergency care; maternity services; special educational needs and disabilities services; and infection prevention control.

The following points were made in discussion:

d) Members discussed the need for a more systematic approach to addressing quality issues, with a more strategic outcomes-based approach towards improvements in safety and quality without replicating the mechanisms used by provider Boards to monitor quality concerns. It was noted that the ICBs' Executive Director of Quality was developing a data driven risk-based approach across the ICBs.

e) Members also noted the need to ensure that any oversight mechanism was able to recognise deterioration in the quality of services at an earlier stage.

f) The need to take learning from areas of best practice from across the three ICB areas was also highlighted, for example in the differential models in urgent and emergency care across the acute providers.

g) Discussing the need for population health management information at the neighbourhood level across all thee ICB areas, it was noted that the ambition

was to achieve this by May 2026, although it would require the positive engagement and willingness of all organisations to share their data.

The Boards **noted** the report.

ICB CIC 25 014 **Service Delivery Performance Report**

Maria Principe introduced the item, highlighting the following points:

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

b) All emergency and urgent care systems were under significant pressure and the ICBs continued to support acute trusts to optimise flow with a continued focus on admission avoidance and discharge pathways.

c) Continued focus was also required to meet the national target of zero patients waiting over 65 weeks for treatment by 21 December 2025. Meeting this target may prove challenging in out of area providers.

d) Despite additional treatments compared to previous years, cancer targets were not being achieving across the ICBs' areas and recovery plans were in place to deliver back to plan by March 2026, with the challenging balance of reducing backlogs whilst improving monthly performance. Due to the distance from planned trajectories and low national benchmark performance, Nottingham University Hospitals NHS Trust has been moved into Tier One oversight arrangements with NHS England.

e) Across the ICBs there had been progress on reducing mental health services out-of-area placements and improving access to community services. However, continued challenges remained in relation to demand, acute bed utilisation, inpatient lengths of stay and private bed dependence.

f) Looking ahead, it was anticipated that the ICBs' key role as strategic commissioners would provide a platform on which to improve performance.

The following points were made in discussion:

g) In discussion members noted that it was helpful to see the variations in performance across the wider geography and there was an opportunity to learn quickly from good practice in other areas.

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

Items for information

ICB CIC 25 015 **Committee Highlight Reports**

The Chair noted that these reports were presented for information; however, wished to put on record her thanks to all outgoing Non-Executive Director colleagues for engaging with new committee chairs in a robust handover process.

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

Closing items

ICB CIC 25 016 **Risks identified during the course of the meeting**

No new risks were identified.

ICB CIC 25 017 **Questions from the public relating to items on the agenda**

The Chair advised members that a question had been received regarding the closure of beds at Ashgate Hospice in Chesterfield, Derbyshire. Specifically:

"Ashgate Hospice was part of national news reports this Tuesday (18th November) highlighting how hospice beds are closing all around the country due to inadequate funding including reports by BBC Health Editor Hugh Pym on BBC Breakfast and BBC One O Clock news.

Given the closure of hospice beds is a problem receiving national media attention and the continued progress of the Assisted Dying Bill in Parliament how can it be acceptable for DDICB to refuse to provide additional funding for Ashgate's specialist end of life care beds, which will further increase inequity of specialist end of life care across Derbyshire and add to the seasonal pressures which the system are already experiencing?"

Amanda Sullivan asked the Boards to note that the ICBs valued greatly the work of the sector and had offered to support Ashgate Hospice. She and Kathy had met with their Chair and Chief Executive and the ICBs' Executive Director of Finance would meet with his counterpart over the next few weeks. However, NHS Derby and Derbyshire ICB did not support the Hospice's stance that there was differential funding for the area, as there had been significant uplifts in funding over previous years.

It was confirmed that a full response in writing would be provided to the requester.

ICB CIC 25 018 **Any other business**

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

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Action Log from Board meetings in common, held on 20 November 2025

Meeting date	Agenda item	Action	Lead	Due date	Updates	Status
20.07.23 *(NHS Derby and Derbyshire ICB)*	NHS Derby and Derbyshire One Workforce Strategy	To present a further update of the Plan to a future Board meeting for further discussion.	Clair Raybould *(reassigned lead)*	January 2026	Strategic Workforce Capability Reports included within the work programme for the Joint Quality and Service Improvement Committee.	**Closed – Action completed**
16.01.25 *(NHS Derby and Derbyshire ICB)*	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. Board to be updated on progress and barriers.	Maria Principe *(reassigned lead)*	January 2026	Reports on population health management and transformation programme delivery included within the work programme for the Joint Strategic Commissioning Committee.	**Closed – Action completed**
22.07.25 *(NHS Derby and Derbyshire ICB)*	Board Assurance Framework Quarter 1	To review the Finance and Performance Committee's Risk Register to understand the flow around Chesterfield Royal	Lucy Branson *(reassigned lead)*	November 2025	New set of joint strategic risks approved by the Boards to form the basis of a new joint Board Assurance Framework.	**Closed – Action completed**

Meeting date	Agenda item	Action	Lead	Due date	Updates	Status
	2025/26 position	Hospital, to understand where the risk around accident and emergency capacity and performance is captured and if it needs to be strengthened.			A joint Operational Risk Register also now established from review of the ICBs' existing registered risks.	
10.09.25 *(NHS Nottingham and Nottinghamshire ICB)*	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	Report on the National Rehabilitation Centre included within the work programme for the Joint Strategic Commissioning Committee.	**Closed – Action completed**

Key:

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

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	15/01/2026
Paper title:	**Citizen story: Children's Bereavement Centre**
Paper reference:	ICB CIC 25 023
Paper author:	Julie Cuthbert, Head of Communications, NHS Nottingham and Nottinghamshire ICB
Paper sponsor:	Clair Raybould, Executive Director of Strategy and Citizen Experience
Presenter:	Alex Ball, Director of Communications and Engagement, NHS Nottingham and Nottinghamshire ICB

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

Report summary:

This report outlines the impact bereavement can have on the mental health of children and young people, alongside other factors such as social isolation and school exclusions. The report includes the experiences of children and young people from Nottingham and Nottinghamshire who have received support from the Children's Bereavement Centre. The Centre is a member of the Voluntary Community Social Enterprise Alliance, which is administered by the ICB. The report demonstrates how timely support can empower children and young people to manage their feelings and reduce the effects of trauma and anxiety.

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: Children's Bereavement Centre

Introduction

1. The Children's Bereavement Centre, based in Newark-on-Trent in Nottinghamshire, was formed in 2003 and supports children and young people who are experiencing trauma or grief due to the death or terminal-illness of someone important to them.
2. The charity supports children and young people aged three to 18 years old and their parents and carers, from Nottinghamshire and some areas of Lincolnshire, including South Kesteven, North Kesteven and Lincoln.
3. The charity is an early intervention service that seeks to improve children and young people's health by supporting them to understand the feelings and anxieties created by the trauma of losing a loved one.
4. They are the only dedicated children's bereavement charity providing a range of therapeutic support in individual and group setting in Nottingham and Nottinghamshire.
5. Support is delivered by a mixture of paid staff and volunteers who are all trained and from a wide range of backgrounds including counselling, social work, psychology and play therapy.

The impact of bereavement

6. Children who experience bereavement are extremely vulnerable to mental health disorders and are more likely to have problems with anxiety, drinking and other substance abuse. Compared to their non-bereaved peers, children whose mother or father has died are around 1.5 times more likely as non-bereaved children to have a mental disorder; three times more likely to develop new-onset depression if bereaved suddenly; 1.7 times more likely to attempt suicide in young adulthood, and more likely to be hospitalised for a psychiatric disorder[1].
7. Other impacts of bereavement include behavioural problems, which can lead to changing schools or exclusion, lack of concentration and increased social isolation. Approximately one third of bereaved children reach clinical levels of emotional and behavioural difficulties in the two years following a parent's death[2].

[1] Written evidence to the Health and Social Care Committee's "Children and young people's mental health - role of education inquiry", https://committees.parliament.uk/writtenevidence/76937/pdf/

[2] Written evidence to the Health and Social Care Committee's "Children and young people's mental health - role of education inquiry", https://committees.parliament.uk/writtenevidence/76937/pdf/

8. A child is bereaved of a parent every 20 minutes in the UK, which means the scale of potential support needed is extensive. It is estimated that 3.5 percent, or approximately one in 29 children in that age group, are bereaved of a parent or sibling each year. This is roughly 3,600 children in Nottingham and Nottinghamshire who experience such loss each year.
9. Parents and carers can often be coping with their own grief and may not have the knowledge or understanding of how to support their bereaved child or children effectively.

Support offered by the Children's Bereavement Service

10. The Children's Bereavement Centre provides free specialist emotional support to children and young people and their parents/carers. This includes:
    a) Family assessments.
    b) Individual bereavement support.
    c) Counselling.
    d) Play therapy.
    e) Filial therapy – based on developing relationships between the parent or carer and child to improve understanding of a child's grief and their feelings and behaviours.
    f) Pre-bereavement service – when there is an expected death in a family.
11. The charity also offers training and advice to professionals to help build a network of effective support around every bereaved child.

Funding

12. The Children's Bereavement Centre is funded primarily through fundraising, local donations and grant income, with a small contribution from statutory sources. Whilst it operates outside core NHS commissioning arrangements, it represents an effective example of voluntary, community, social enterprise and faith sector partnership working to support children and families.

Voluntary Community and Social Enterprise Alliance

13. The Centre is a member of the Voluntary Community and Social Enterprise (VCSE) Alliance, which is administered by the ICB. The VCSE Alliance acts as a single point of contact to enable the generation of citizen intelligence from the groups and communities that the VCSE sector works with in Nottingham and

Nottinghamshire. This intelligence and insight are shared by the ICB to ensure that the experiences and views of citizens are considered in the design and delivery of health and care services, enabling a two-way flow of information. The VCSE Alliance also provides a forum for the sector to be involved in system-level discussions around governance structures and system workforce, population health management and service redesign work, leadership and organisational development plans.

How the service is making a difference

14. In 2025, Abigail[3] (aged 10) experienced the loss of her maternal grandmother due to terminal illness. Abigail was extremely close to her grandmother and found the decline in her health distressing. Abigail had also experienced several other significant losses in recent years. Abigail is awaiting an assessment for a possible neurodivergent disorder. Mum reported that Abigail found it difficult to talk about her feelings, often internalising her emotions. Her school attendance had become inconsistent, and she was described as withdrawn and increasingly anxious at home. Abigail received eight one to one bereavement support sessions, which incorporated creative activities and safe ways for Abigail to express thoughts she found difficult to verbalise. Mum was provided with guidance on supporting a neurodivergent young person through grief with emotional regulation strategies. Abigail's progress was monitored at session one and session eight. The results demonstrated improvements in Abigail's emotional regulation, anxiety levels, and overall wellbeing. She began attending school more consistently, her mood improved, and she appeared more settled and less overwhelmed. Abigail became more open at home, meltdowns reduced, and Abigail was better able to regulate her emotions.

15. Kirsten and Leanna are sisters who used the service after their baby sister sadly passed away following cot death. Kirsten said: "I had such low self-esteem afterwards and could not really talk to people. I developed anxiety and had to move schools because I was in such a bad place. The support worker really helped me to develop that confidence back. I am happy to talk to people about it now and I do not get upset now when I talk about my sister, and I have really developed as a person. I went to the bereavement camp which was really beneficial because it helped me make friends and then I went on to go to the Saturday support group. It has continued help and we still go there even though our sister passed away five years ago. This is an amazing service to use. It is one of the best things you can do, and it will make you feel so much better as a person – they are like family."

16. Kenny Stevenson is one of the Centre's young ambassadors. He said: "I received help from the Children's Bereavement Centre in 2016 after a very

[3] Name adjusted so the child remains anonymous.

difficult time in my life. The service I received was amazing and helped me understand I was not alone and there are many other children and young people going through similar situations. I had some one-to-one counselling sessions and attended the two day bereavement camp in summer 2016. I came back with new understandings and wanting to give back to this worthwhile charity. I am now one of the young ambassadors. The thing I gain most from volunteering is the knowledge of knowing I can help make a difference to a child/young person and their family at what is one of the most emotional and vulnerable times of their lives. Knowing from past experience how they changed my future is something that makes me feel proud to support the Centre. Kids are the future and deserve the help now."

17. Other testimonials from children, young people and parents and carers include:

    a) “I thought I was alone and then I met the amazing people at the bereavement centre.” (Nine year old boy)

    b) “You took a child who did not know how to cope and who was talking about self-harming back to a child who enjoys life.”

    c) “They have been supportive, always at the end of the phone, never judged us, been a friend and a whole lot more.”

18. These examples demonstrate how providing appropriate timely support can empower children and young people to manage their feelings and reduce the effects of trauma and anxiety, increase emotional wellbeing and stop or reduce mental health issues.

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:	15/01/2026
Paper title:	**Chair's Report**
Paper reference:	ICB CIC 25 024
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 of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB, and NHS Nottingham and Nottinghamshire ICB, and provides an update on the NHS Reform process, alongside a synopsis of some of the meetings I have attended on behalf of the ICBs.

Recommendation(s):

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

Relevant statutory duties:	
☒ Quality improvement	☒ Public involvement and consultation
☐ Reducing inequalities	☐ Equality and diversity
☒ 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 want to start my update by thanking all health and care staff from across the three Integrated Care Systems for their hard work in 2025 and throughout the festive period and into the new year. This year in particular the run-up to Christmas was made even more challenging by a further round of strikes by Resident Doctors and an early and widespread peak of ‘flu infections, resulting in a considerable number of hospitalisations.
2. We anticipate that the remainder of the winter period will be extremely challenging, but I am confident that by working together we will deliver the very best possible care for our populations.
3. The Chief Executive and I made sure that we expressed our thanks to ICB staff for all their hard work just before Christmas. Colleagues from across the ICBs have had a very challenging year in terms of changes to organisational form and structure, and whilst this is likely to continue for some time into 2026, it does feel like we are now making progress in establishing some certainty about what the future looks like.
4. With this certainty, however, will come changes for many individuals, with the ICBs needing to achieve the reduction in running costs mandated by the Government and NHS England. Some colleagues will move forward through a voluntary exit from the organisation, whilst for others there will be different conversation.
5. In that context, I am nevertheless pleased to welcome the Board back from the Christmas break and hope that everyone found some time for rest and relaxation. There is much to be done in 2026, but I am proud of the work that the Board has led over recent months to support the organisations to navigate change together.
6. At the final Staff Briefing of the year, teams from across the ICBs shared some of their proudest achievements and these were a clear reminder of what we are capable of and our shared enthusiasm for what more we can achieve on behalf of the people we serve.

NHS reform and national updates

7. Since the Boards met last, there has been some stability in terms of national announcements and updates which, alongside the early publication of the Medium-Term Planning Framework, means that ICB colleagues have been able to focus on developing plans against those known objectives.

8. Just before Christmas I joined a meeting with Penny Dash, Chair of NHS England, alongside other ICB Chairs from across the country. It was helpful at that session to hear about the national focus on reform of both the outpatient pathway with an emphasis on the role of neighbourhoods and also the urgent and emergency care pathway. It was also clear that continuing to bear down on the variation in productivity levels between Trusts, as well as the overall gap when compared to pre-Covid data, will be important for us all.

9. We also heard updates on the planned reform of NHS payment mechanisms and the forthcoming Quality Strategy – both of which will be materially important for our strategic planning.

Local updates

10. I am pleased that work is progressing well on the ICBs' five-year Population Health Strategy and associated Population Health Plan. Both of these will be supported by the excellent discussions the Board held in late December at our Development session – my thanks to Executive colleagues for leading the session so well and for the helpful and incisive contributions from Non-Executive and Partner Members.

11. I have continued to be outward facing, promoting our ICBs and wider health and care services and engaging with local and national stakeholders. This included giving evidence to the Independent Commission on Adult Social Care, Chaired by Baroness Casey of Blackstock at the request of the Prime Minister. At the session in late November, I highlighted the many examples of collaborative and positive working between the NHS and social care teams. These included the 'Team Up' approach in Derby and Derbyshire, the development of a new Intermediate Care Model in Lincolnshire and the rapid roll-out of Integrated Neighbourhood Teams focussed on frailty in Nottingham and Nottinghamshire.

12. I also took the opportunity in early December to speak at 'The Future NHS Summit' hosted by the Institute of Government and Public Policy. In my presentation I talked in particular about the need to both work across our entire 3.3 million population, securing the economies of scale and experience that presents us, but also respecting the diversities and differences within our area, meaning that our neighbourhood and place approach will need to be carefully tailored. For me, this clearly underlines the importance of the role of ICBs through our strategic planning function – understanding our population and their needs and working out when we need one single set of provision and when we need locally nuanced offers will be a critical success factor.

13. In late November I was pleased to be able to join the Chief Executive's briefing meeting with the Derby and Derbyshire MPs where we covered a number of topics most important to their constituents. Executive colleagues are currently

developing a cluster-wide approach to how we will be continuing our positive work with all MPs in all three ICB areas.

14. Early in December I was joined by the Chief Executive and other colleagues at a meeting with East Midlands Mayor, Claire Ward, and other members of her team. We covered a number of topics including how we can align our strategic approach to best effect including across transport, housing and employment.

15. I was pleased therefore to see the Mayor's launch of the 'Get East Midlands Working' plan that same week in December, which Clair Raybould, Executive Director for Strategy and Citizen Experience, was able to attend on my behalf. The partnership working between the ICBs, the East Midlands Combined County Authority and the Department of Work and Pensions in producing this plan is a really good example of how we can deliver on the expectations of the 'Fourth Aim' to help the NHS support broader social and economic development and develop stronger links with our Mayoral authorities.

16. I have continued my programme of visits to health and care services across the ICBs' areas, including at the St James Centre in Derby. The Centre has 34 adults receiving day opportunities support five days a week, many of whom have been there since they were children. Caring for vulnerable people in society when they really need us is one of the most important jobs of the health and care service. The last thing people need when they are already struggling with a disabled child or adult is a complicated system making it even harder to get support. It was a really inspiring visit, and there were so many smiles on the residents faces as they went about their daily life – a hive of activity, buzzing with energy. The NHS pound is constantly stretched but it is important that as commissioners we keep an eye on the groups of vulnerable people we know need us the most, and ensure the best decisions are made by us and our partners to support them however we can.

17. Congratulations to Nottingham City Place Based Partnership for winning a Health Service Journal Award. The Partnership won the Integrated Care Initiative of the Year Award for its programme to support people experiencing severe and multiple disadvantage (SMD), which is a service I have visited a number of times. This is recognition of the exceptional work and innovation demonstrated by all partners to support people experiencing SMD. Their partnership approach continues to grow from strength to strength, now with 15 statutory and voluntary sector organisations across primary, secondary, community and mental health NHS services, adult social care, housing and criminal justice involved in the place-based delivery model.

18. Congratulations also to Lincolnshire ICB colleagues on the recent news of their shortlisting success for the 2026 Health Service Journal Partnership Awards. Alongside colleagues they have worked with in NHS Humber and North Yorkshire ICB and Teesside University, the ICB are shortlisted in the Best Educational Programme for the NHS category for their 'Flippin' Pain' initiative.

'Pain: Do You Get It?' is a Professional Education programme blending science, lived experience, and storytelling to change the way whole healthcare systems support people affected by chronic pain. We wish them all the best for the finalists judging process.

19. During this time of considerable change for ICBs, it feels important to make sure that media outlets are fully informed on our decisions and emerging thinking in order to ensure that their reporting is as accurate as possible. I was pleased therefore in early December to have a conversation with a journalist from the Health Service Journal. We covered a number of topics including the establishment and development of our Board arrangements and our approach to strategic commissioning.

20. Congratulations to all recipients of Honours in the New Year list, particularly those that live in the ICBs' areas and whose work supports the improvement of health and wellbeing for our residents. I would like to especially celebrate Dr Stephen Shortt, Deputy Medical Director for NHS Nottingham and Nottinghamshire ICB on his receipt of an OBE. Responding to the announcement, Stephen said, "I am very grateful, humbled and chuffed to be awarded an OBE in the New Year's Honours. Healthcare is, as we all know, a team game, and the NHS is perhaps the greatest team of all. That I have been able to take some responsibility for taking care of it, trying, and in parts actually succeeding, to make it better makes me happy and proud. However, there is nothing that I have achieved that has not been owed to a professional lifetime of collaboration with wonderful colleagues. I have learned the essential importance of having an occupation you feel enthusiastic and passionate about, so that work does not feel like work or a job. I think the key to this is never to think of patients as our problem but rather that they are our purpose, and indeed our teammates."

Board matters

21. I am pleased to confirm that Maria Principe has now been substantively appointed as Executive Director of Commissioning for the ICBs, following an external recruitment process. I am also pleased to welcome Adrian Smith, Chief Executive of Nottinghamshire County Council, to his first formal meeting since his appointment to the role of Local Authority Partner Member for NHS Nottingham and Nottinghamshire ICB. We await nominations from Derby City Council and Derbyshire County Council for the role of Local Authority Partner Member for NHS Derby and Derbyshire ICB, and following completion of this process all Boards' memberships will be fully appointed.

22. Following approval of the ICBs' new governance arrangements at the last meeting, the relevant amendments to reflect these changes have been made to the ICBs' Governance Handbooks, which are published on the organisations'

websites. The new committee arrangements have started well, and we will hear from the Committee Chairs later in the meeting when they present their Highlight Reports from the first meetings. As Chair of the Boards, I have responsibility for ensuring that the Boards' committees are operating effectively and supported by appropriate governance arrangements. As such, I will be observing meetings of all committees over the coming months.

Looking forward

23. It is clear from this report and also the other items on today's agenda that a huge volume of activity is taking place across the ICBs' footprints to deliver high quality services for our populations – alongside the internal re-organisation.
24. Making sure that both of those workstreams continue at the required pace will be the challenge of the next few months and I then look forward to, I hope, a period of stability as we enter the spring and summer.
25. Once again, I want to underline my empathy for colleagues undergoing a considerable period of change and thank them for their fortitude and resilience as we move forward.

NHS Derby and Derbyshire Integrated Care Board

NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	15/01/2026
Paper title:	**Chief Executive's Report**
Paper reference:	ICB CIC 25 025
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.
- **Approve** the Counter Fraud Statement for inclusion on the ICBs' websites.

The NHS Derby and Derbyshire ICB Board is asked to:

- **Endorse** the Smokefree Derby and Derbyshire Pledge.

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 – Smokefree Derby and Derbyshire Pledge on Tobacco Control.
Appendix B – Counter Fraud Statement for inclusion on the ICBs' websites.

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Chief Executive's Report

Introduction

1. I would like to wish colleagues a happy new year and I hope that everyone had the opportunity to take a few days of rest and relaxation ahead of what is set to be another busy year. We are continuing to progress the development of our new organisational structure to achieve the required running cost reductions, whilst also developing a five-year Population Health Strategy and Improvement Plan and three-year Operational Plan that will put into action the aims of the Government's Ten-Year Health Plan. Together, these developments will set the foundations for a stronger health and care service for the future. These next few months will be a period of considerable challenge for us all and I would like to put on record my thanks for the hard work and resilience of the ICBs' staff.
2. The first stage of the ICBs' management of change process is nearing completion with the conclusion of the appointments to the Executive Team. We are now into the next stage of the process, with a consultation on the structure of the senior leadership team being launched in December and due to end on 22 January 2026. At the same time, a voluntary redundancy scheme has also been launched for all staff. We continue to support staff at this difficult time and to engage with Trade Union representatives.
3. These internal processes cannot be allowed to distract us from our focus on delivering a safe winter. The expected wave of influenza and covid came earlier than predicted, and although infection rates are now falling, concern remains high. Therefore, it is important for all eligible cohorts to receive a vaccination, and the campaign will continue until March 2026.
4. The high numbers of patients being admitted into emergency departments with influenza, coupled with the industrial action undertaken by resident doctors between 17 and 22 December did put considerable strain on health services. However, our systems responded well, not only to ensure that essential services were maintained, but also to ensure that there was minimal disruption to planned care services. I would like to acknowledge and thank the continuing efforts of all staff to manage the winter pressures.

New year message from Sir Jame Mackey, NHS England Chief Executive

5. Sir James Mackey has written a letter to all NHS trust and ICB leaders thanking colleagues for their continuing hard work and effort, recognising the robust management of the latest round of industrial action by resident doctors, alongside the preparations that have been implemented to address winter challenges that resulted in strong performance during December. In the letter he asks for his thanks to be extended to all teams. The full letter can be found

here: https://www.england.nhs.uk/long-read/new-year-letter-from-nhs-england-chief-executive/.

Smokefree Derby and Derbyshire Pledge

6. The Smokefree Derby and Derbyshire Pledge is a commitment by local authorities, health services, and other partner organisations across Derby and Derbyshire to reduce smoking prevalence in the area to less than 5% by 2030.

7. As part of this campaign, public health colleagues in Derby and Derbyshire have developed a pledge for organisations to sign and commit to creating healthier environments for staff and the public.

8. The Board of NHS Derby and Derbyshire ICB is asked to endorse the pledge, which can be found at Appendix A.

Failure to Prevent Fraud – Chief Executive Statement

9. A new 'failure to prevent fraud' offence under the Economic Crime and Corporate Transparency Act 2023 came into force in September 2025. It applies to large organisations, including NHS bodies, charities and partnerships with over 250 employees or over a £36 million turnover. The NHS Counter Fraud Authority has provided specific guidance for NHS bodies, which includes reviewing current fraud prevention measures in light of the new legislation and ensuring systems and training are robust enough to meet 'reasonable procedures' standards.

10. One of the actions required to comply with the NHS Counter Fraud Authority guidance is for the chief executive officer (or equivalent) to publish a statement on the organisation's website about its fraud prevention approach and measures. My proposed statement is provided at Appendix B, for Board consideration and approval. Following approval by the Boards it will be published on the ICBs' websites.

11. A detailed report on any further actions required to ensure compliance with the guidance will be presented to the Audit Committees in due course.

Mental Health Act 2025

12. The Mental Health Act has now received Royal Assent. The Act implements reforms proposed by Sir Simon Wessely in his 2018 Independent Review of the 1983 Mental Health Act.

13. Key changes to legislation will ensure that patients have stronger rights and greater control over their treatment through statutory care and treatment plans; families and carers will have more involvement in decisions around treatment;

and racial disparities in treatment will be addressed through clearer guidance for mental health professionals. The Act will also strengthen the rights of children and young people, ensuring that they are consulted and involved where appropriate with decisions around their care and treatment.

14. The Government is now starting to develop the detailed guidance on the new Act before it comes into force. The ICBs will respond to this guidance as appropriate once published.

Independent review into mental health conditions, attention deficit hyperactivity disorder (ADHD) and autism

15. On 4 December 2025, the Secretary of State for Health and Social Care announced an independent review into the prevalence, trends and inequalities associated with mental health conditions, ADHD and autism in children, young people and adults.

16. The review will seek to understand:

    a) The factors behind trends in prevalence.

    b) The impact of clinical practice, including social and cultural factors and the risks and benefits of medicalisation.

    c) Ways to promote the prevention of mental ill health.

    d) Ways to create resilience and improve early intervention.

17. Professor Peter Fonagy will chair this review, supported by Professor Sir Simon Wessely and Professor Gillian Baird as vice-chairs. There will also be a multidisciplinary advisory working group to directly shape the recommendations and scrutinise the evidence.

18. The review is expected to take up to six months and will provide a short report setting out conclusions and recommendations. This will include recommendations for responding to rising need, both across the health system and wider public services. These recommendations will consider the diversity, inclusivity and accessibility of interventions required for different groups.

19. The terms of reference can be found here: https://www.gov.uk/government/publications/independent-review-into-mental-health-conditions-adhd-and-autism-terms-of-reference/independent-review-into-mental-health-conditions-adhd-and-autism-terms-of-reference.

Independent investigation into maternity and neonatal care in England

20. Following the request from the Secretary of State for Health and Social Care to conduct a rapid investigation into maternity and neonatal services in England, on 9 December 2025, Baroness Amos published a report setting out her

reflections and initial impressions from what she has heard to date from engagement with families, staff, community organisations and MPs. This includes consistently raised issues relating to communication and informed choices, emotional support and empathy, holistic and integrated care, equity and inclusion, accountability and governance, and operational failures. Full details can be found here: Independent Investigation into Maternity and Neonatal Services in England - Reflections and Initial Impressions - National Maternity and Neonatal Investigation.

21. The report also sets out the approach to setting up and delivering the investigation and summarises the published terms of reference, which are structured around five different areas of work:

    a) Local investigation phase.

    b) System wide review – including evidence from families, staff, previous reviews, academic experts, national healthcare leaders and other community engagement.

    c) Inequalities – specifically developing an understanding of the experience of women, families and non-birthing partners from Black, Asian and other seldom heard communities.

    d) A review of the legal framework regarding the role of Coroners in relation to stillbirths and compensation following harm caused by clinical negligence.

    e) The development of one set of national recommendations.

22. The independent investigation will launch a call for evidence soon. The original plan was to investigate 14 Trusts; however, in light of new developments, Baroness Amos has removed Leeds Teaching Hospitals NHS Trust and Shrewsbury and Telford Hospital NHS Trust from the investigations list.

23. The final investigation report with recommendations is expected to be published in Spring 2026.

University Hospitals of Derby and Burton NHS Foundation Trust awarded £2 million for cutting patient waiting times

24. University Hospitals of Derby and Burton NHS Foundation Trust has been awarded £2 million by NHS England for making significant improvements in reducing waiting times for planned care and is one of just eight trusts across England to receive this recognition and financial award.

25. The additional funding comes through the Elective Capital Incentive Scheme. The Trust achieved a 5.35% improvement in its performance against the national 18-week referral-to-treatment standard, an increase of nearly 2,000 surgeries compared to the same timeframe in 2024.

National award for Skegness and Lincoln community diagnostic centres

24. Skegness and Lincoln community diagnostic centres have been recognised at the Building Better Healthcare Awards 2025, with a ‘gold’ win for the Community Diagnostic Centre of the Year. The Building Better Healthcare Awards celebrates the most innovative projects and products shaping the future of healthcare design, technology, and delivery nationally. This was an ambitious £38 million project to deliver two modern NHS facilities at the same time, approximately 40 miles apart in less than 40 weeks. The feedback from those who have attended continues to be overwhelmingly positive.

Recent leadership updates

25. Neil Crittenden has now been officially appointed as Derbyshire County Council’s new permanent Chief Executive and Head of Paid Service. Neil will officially take up his post on 19 January 2026 following approval by Full Council. Gemma Poulter has also been appointed as Interim Executive Director Adult Social Care and Health at Derbyshire County Council.

26. Mark Bailey has begun his tenure as Chair of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. Mark has been a Non-Executive Director at the Trust since 2020 and also serves as a Non-Executive at the Derbyshire Community Health Services NHS Foundation Trust.

27. Elaine Baylis, Chair of Lincolnshire Community and Hospitals NHS Group will be leaving her role at the end of March 2026, as she reaches the end of her appointment, having served the maximum term permitted. To ensure continuity, Group Deputy Chair, Rebecca Brown will step into the role as Acting Group Chair for a six-month period, beginning in April 2026, which will provide the opportunity to conduct a thorough recruitment process to appoint a new substantive Group Chair later in the year.

Appendix A

Smokefree Derby and Derbyshire Pledge on Tobacco Control

As local leaders, we acknowledge:

- Smoking is a leading cause of premature death, disease, and disability in our county, with over 1300 deaths each year across Derby and Derbyshire.
- Smoking is an epidemic created and sustained by the tobacco industry.
- Smoking is an addiction, which often starts in childhood.
- The illicit tobacco trade is linked to criminal gangs and gives access to cheap and often contaminated tobacco.
- Smoking places a significant burden on all health and care services, and emergency response services.
- Reducing smoking will help the local economy and will put money back into families in greatest need with the average smoker saving £2,500 per year.
- All staff in contact with our citizens have a role to play in helping people to stop smoking.

We welcome:

- The ambition to make Derby and Derbyshire smokefree by 2030.
- The commitment to tackle inequalities in smoking prevalence across our county.
- The commitment by the NHS to provide support to help our citizens to quit.
- The commitment by the government to provide legislative support for our ambition and to protect public health policy from vested tobacco industry interests.

In support of a smoke-free ambition, together we commit to:

1. Do all we can to protect everyone from the harms of tobacco smoke and stopping the start by:
    - De-normalise smoking by making our business/sites smoke-free and supporting our staff to stop smoking.
2. Support every smoker to quit and stay smokefree by:
    - Ensuring that all our staff can refer citizens to free support to quit smoking.
    - Ensuring citizens using our NHS services have access to services to quit smoking.
3. Helping our citizens understand the harm smoking causes to them and the opportunities and support to stop smoking by:
    - Sharing and promoting Smokefree Derby and Derbyshire messages through our staff and public facing communication channels.

Signed [Add position]

Appendix B: Counter Fraud Statement for inclusion on the ICBs' websites

As Chief Executive of [NHS Derby and Derbyshire ICB / NHS Lincolnshire ICB / NHS Nottingham and Nottinghamshire ICB], I am pleased to set out our commitment to remaining transparent, ethical and accountable in all that we do. In line with our overall mission to commission safe, high-quality care for patients and communities, we also recognise our responsibility to maintain the highest standards of integrity, including preventing and detecting fraud.

On 1 September 2025, a new fraud offence came into force. This is a corporate offence of *'failure to prevent fraud'*, which is part of the Economic Crime and Corporate Transparency Act 2023.

Under the failure to prevent fraud offence, organisations may be held criminally liable when a person associated with the organisation (for example an employee, agent or subsidiary) commits a specified fraud offence for the benefit of the organisation, and the organisation did not have reasonable procedures in place to prevent that fraud.

In that context, I confirm that [NHS Derby and Derbyshire ICB / NHS Lincolnshire ICB / NHS Nottingham and Nottinghamshire ICB] has in place, and will maintain, procedures which we believe to be reasonable and proportionate in preventing fraud, consistent with the guidance issued by government. Specifically:

1. **Leadership and culture**
   We are committed to fostering a culture of honesty and transparency across the ICB. I personally endorse the principle that any suspected fraudulent or dishonest behaviour should be reported, investigated and addressed appropriately.

2. **Risk assessment**
   We undertake regular assessments of the fraud risk profile facing the ICB, considering where and how fraudulent activity might arise within our operations, including the supply chain, agency arrangements and other partnerships. These assessments are reviewed and updated periodically.

3. **Prevention procedures**
   We have implemented proportionate, risk-based procedures designed to prevent fraud. These include, but are not limited to, due diligence checks, financial controls, procurement oversight, contract monitoring, segregation of duties, clear scheme of delegations, and a whistle-blowing mechanism. Where appropriate, we provide fraud-awareness training to our staff, contractors and partners.

4. **Communication and training**
   We communicate clearly to all staff and partners that fraud is unacceptable and that we expect conduct in line with the ICB's values and standards of behaviour. We provide guidance, policies and training to support staff in identifying and reporting concerns.

5. **Monitoring, review and continuous improvement**
   We monitor our procedures and controls to ensure they remain effective and relevant. Where weaknesses or control gaps are identified, we act promptly to remediate them. We review our policy and governance framework to ensure alignment with evolving risks and external guidance.

6. **Whistle-blowing and speaking up**
   We have in place mechanisms for staff, contractors, agency workers and others to raise concerns without fear of reprisal. We encourage openness and will treat as a priority any reports suggesting potential fraud or misconduct, investigating them thoroughly and impartially.

7. **Governance and accountability**
   The ICB's Board has established an Audit Committee that receives assurance on fraud risk, prevention activity and control effectiveness, with regular reporting between the Committee and the Board. I, as Chief Executive, take ultimate responsibility for the arrangements and for embedding the anti-fraud culture within the organisation.

I believe the procedures set out above reflect our commitment to acting ethically, lawfully and using public funds in the best interests of patients, staff, and the public we serve. We will continue to review and refine our approach to ensure that we remain vigilant and compliant with the requirements of the Act and the associated guidance.

This statement has been approved by the Board of [NHS Derby and Derbyshire ICB / NHS Lincolnshire ICB / NHS Nottingham and Nottinghamshire ICB].

Reporting concerns

If you have any concerns or suspicions regarding bribery, corruption, or fraud, please contact:

[360assurance.counterfraud@nhs.net / yhs-tr.counterfraudyork@nhs.net]

Or alternatively please contact:

NHS Fraud and Corruption Reporting Line

Telephone – 0800 028 4060

https://cfa.nhs.uk/report-fraud

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:	15/01/2026
Paper title:	**ICB Transition Programme update**
Paper reference:	ICB CIC 25 026
Paper author:	Chrissy Tucker, Director of Corporate Governance and Assurance, NHS Derby and Derbyshire ICB
Paper sponsor:	Helen Dillistone, Executive Director of Transition
Presenter:	Helen Dillistone, Executive Director of Transition

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

Report summary:

This paper provides an update and overview on the progress of the ICB Transition Programme to date. The programme involves several complex workstreams, and progress including delivery of the detailed programme plan and associated risks are overseen by the Joint Transition Committee each month. This paper provides an overview of the current key areas that form the programme. It includes the current position on:

- Creating the new operating environment.
- Management of change.
- Functions designated for transfer.
- Functions designated for delegation.
- Abolition of Commissioning Support Units.
- Quarter four priorities.

Recommendation(s):

The Boards are asked to **discuss** the progress of the ICB Transition Programme.

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

Appendices

Appendix A – Functions Designated for Transfer.

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

ICB Transition Programme update

Creating the new operating environment

1. Following the publication of the ICB Operating Model Blueprint, published last spring, a Strategic Commissioning Framework was subsequently published in November 2025, which sets out an approach to support ICBs in their core role as strategic commissioners. This Framework stipulates that ICBs must ensure that population health is improved, health inequalities are reduced, and that consistently high-quality and accessible health care is provided within budget.
2. By the end of March 2026, ICBs will have submitted a baseline assessment against the requirements of the Framework. ICBs are likely to be assessed against the following areas:
    a) System leadership for population health.
    b) Clinical and care professional leadership.
    c) Data analytics and technology.
    d) Intelligent payor function.
    e) User involvement and co-design.
    f) Strong relationships with local government.
    g) Competency and capability development within ICBs.
3. The ICBs' Boards will have oversight of the self-assessment; however, timescales for publication and completion are not yet confirmed. The assessment results will help to inform the ICBs' Organisational Development Plan, and also the development of the new national Strategic Commissioning Development Programme, which will build organisational and individual capabilities from April 2026. Elements of the Framework will also be used in NHS England's annual assessment of ICBs from 2026/27.
4. In March 2025, it was also announced that NHS England would be abolished and would be combined with the Department of Health and Social Care to form a smaller central organisation, whilst still retaining their regional model. Guidance on the Model Region was published in September 2025, setting out the core functions and responsibilities of the new central and regional teams against those of the ICBs. Work is in progress nationally to develop this further and to begin to set out the likely structures of that new organisation.
5. The ongoing developments at NHS England will also continue to inform the development of ICBs, and the transition programme will therefore take into account these changes, with the ICBs continuing to work closely with the regional and national NHS England teams as part of this local ICB transition.

Management of change – people and structures

6. Wave one of the ICBs' management of change process for appointments to the ICBs' Executive Team is nearing conclusion. Redundancy and notice approvals are awaited from NHS England, which will finalise the transaction of this wave.

7. The wave two process for the appointment of the ICBs' senior leadership team has commenced, with consultation with affected staff due to close on 22 January 2026. The proposed changes to the senior leadership structure and the proposed portfolios have been shared and those affected. The recruitment process will commence in mid-February with the aim of posts being filled by mid-March 2026.

8. The wave three process for the remaining ICB staff is in the planning stage, with proposals scheduled to be presented to the Joint Remuneration and Human Resource Committee meeting on 5 February 2026. Executive Directors have been developing their draft structures, taking into account the requirements of the Strategic Commissioning Framework, the voluntary redundancy process and the anticipated directorate budgets. It is anticipated that consultation will take place between early February and the end of March. Feedback and review will take place during April and recruitment to posts will commence from May onwards.

9. A voluntary redundancy scheme developed by NHS England was agreed by HM Treasury and launched to staff on 9 December 2025. The scheme will pay staff under the same principles as compulsory redundancy, in accordance with Section 16 of Agenda for Change Terms and Conditions of Employment. A Panel has been established to review all applications, with the aim of ensuring that the ICBs retain the appropriate staff for the appropriate period of time to support functions and developing structures.

10. NHS England has identified funding to support redundancy costs. This is anticipated to cover the cost of waves one and two and voluntary redundancy costs. The ICBs remain in dialogue with NHS England in relation to wave three redundancy costs.

11. 2026/27 financial allocations have been received, which include a 44% reduction in corporate costs in 2026/27. The transition programme will deliver annualised cost reductions of this value. However, given consultation and notice periods, the ICBs will not be able to release the full value of savings from 1 April 2026. A non-recurrent mitigation has been identified, and system debt repayment has been paused nationally for a period of two years under revised NHS England business rules.

12. In order to support staff through this extensive period of change and uncertainty, a wellbeing offer has been developed and made available. This includes:

a) Training and development on CV writing, interview skills, and career planning, as well as wider training via the NHS Leadership Academy.

b) Financial planning, including for retirement and early retirement.

c) Health and social wellbeing sessions and promotion of the Employee Access Programme, which includes physical and mental health, nutrition, exercise and counselling support.

Functions designated for transfer

13. The Model ICB Blueprint published in May 2025 listed a number of ICB functions that were planned to transfer out of ICBs and into NHS providers or NHS England. National policy has since been updated, and fewer functions are now expected to transfer. The latest plan is described at Appendix A, which is informing the work on the design of ICB staffing structures.

14. The latest guidance states that ICBs should now expect to retain:

a) Emergency preparedness, resilience and response and system co-ordination centres.

b) Green Plan and environmental sustainability.

c) Infection prevention and control.

d) Safeguarding.

e) Special Educational Needs and Disabilities.

f) Development of neighbourhood and place-based partnerships – further guidance anticipated on developing neighbourhood health services.

g) Medicines optimisation.

h) Continuing healthcare.

15. ICBs should also expect to retain the following functions until legislation may be passed or transfer is possible:

a) Research, development and innovation – statutory responsibility remains, working with health innovation networks, NHS England will be responsible for oversight and co-ordination of health innovation networks.

b) High level strategic workforce planning, development, education and training will move to NHS England during 2026/27, with the exception of workforce leadership, subject matter expertise, commissioning multi-partner workforce strategy and plans to support neighbourhood health models and commissioning for reductions in health inequalities through work and workforce.

c) Primary care operations and transformation – ICBs will retain until legislation is passed to allow transfer and delegation to providers.

d) Pathway and service development programmes – ICBs retain until transfer to providers who will be expected to take on greater responsibility for outcomes.

e) General Practice Information Technology – ICBs retain under current delegation arrangements until formally changed.

f) Digital and technology leadership and transformation – ICBs to provide digital strategic oversight, with providers ensuring local operational delivery capacity.

Functions designated for delegation and transfer to ICBs

16. Since the establishment of ICBs in 2022, NHS England and ICBs have worked together on the delegation or the transfer of some functions from NHS England to ICBs, specifically primary medical services, pharmacy, optometry and dental commissioning and acute specialised commissioning. Collaboration Agreements and Memoranda of Understanding are in place for these arrangements, which have been overseen by the East Midlands Joint Committee. In light of the changes to ICB responsibilities, a proposal has been made that recommends the establishment of an Office of Pan ICB Commissioning in each region, and for additional functions to be delegated or transferred. These functions include Health and Justice, vaccinations, immunisations and screening, and some mental health and learning disability and autism services.

17. A formal Delegation Agreement will come to the Boards for approval in due course.

Abolition of Commissioning Support Units

18. Commissioning Support Unit (CSU) services have been included in discussions since the announcement of running costs reductions in March 2025 and the announcement of the abolition of Commissioning Support Units by March 2027. Due to the combined size of the ICBs, it is anticipated that the majority of functions can be covered by existing ICB staff, with external recruitment only taking place where capacity or competency gaps emerge following the design of structures. However, in the absence of any national policy or direction regarding potential transfers of staff, discussions are ongoing locally between the ICBs and CSUs.

19. HM Treasury also agreed the voluntary redundancy scheme for use by CSUs, and the ICBs are expecting an update in late January as to how this may affect resources for CSU services provided to the ICBs during 2026/27.

Quarter four priorities

20. The transition priorities for the remainder of quarter four are:

    a) Conclusion of the wave 2 management of change process, and finalisation of planning for the launch of staff consultation for wave 3.

    b) Completion of the voluntary redundancy application and approval process.

    c) Identification and mitigation of impacts from CSU voluntary redundancies and abolition.

    d) Development and agreement of a plan for the reduction of corporate estate costs.

    e) Completion of the Strategic Commissioning Framework Self-Assessment, to start to inform and plan for the ICBs' Organisational Development Programme.

    f) Continuation of communications and engagement activities and staff support and wellbeing offers.

Appendix A: Functions ICBs should plan to retain through 26/27 and possibly beyond

	Functions in scope	Model ICB guidance- May 2025	National Policy (Dec 25)	Guidance notes
1.	**Emergency Preparedness, Resilience & Response (EPRR) and system coordination centre**	Region	ICB retain	ICBs should plan on the basis that their EPRR statutory duties will remain unchanged. ICBs should retain responsibility to provide or commission an operational system co-ordination function.
2.	**Research development and innovation**	Region	• ICB retain statutory duties and work with health innovation networks. • Region responsible for coord, oversight and assurance of health innovation networks.	National policy leads have recommended that the majority of elements of the function (oversight and assurance of research activities across ICBs and providers) transfer out of ICBs to regions. ICBs retain statutory duties to facilitate, promote and to take account of research and innovation as part of their core commissioning role. ICBs should explore how they work closely with health innovation networks as crucial links between the NHS, academia, industry and the Voluntary Community and Social Enterprise sector. Regions retain responsibility for the coordination, oversight and assurance of the health innovation networks .
3.	**High level strategic workforce planning, development, education and training**	Region (or National)	Region - strategic workforce, planning, development, education and training will move in 26/27 except for the 3 areas being retained by ICBs.	**High level strategic workforce, planning, development, education and training will move to regions during 2026/27** except for: • Strategic workforce planning: workforce leadership, subject matter expertise and insights to enable outcomes-based commissioning of new care and service models, and contract management. • System development: commissioning multi-partner workforce strategy and plans (NHS, primary care, social care and VCSFE employers), to support Neighbourhood Health models, and associated strategic risk management. • Socio-economic and anchor impact: commissioning for reductions in health inequalities through work and workforce including local skills supply, apprenticeships, and routes into employment, health and care careers. Shared training hubs are being developed.
4.	**Green plan and sustainability**	Providers	ICB retain	ICBs should retain responsibility for discharging their statutory duties, working efficiently through partnerships.
5.	**Infection prevention and control (IPC)**	Not specified	ICB retain	The current focus is spreading IPC best practice amongst ICBs (a good practice guide has been shared – see Model ICB good practice documents - Integrated Care Learning Network - Futures), rather than delegating the function.
6.	**Safeguarding**	Not specified	ICB retain	The current focus is spreading Safeguarding best practice amongst ICBs (a good practice guide has been shared – see Model ICB good practice documents - Integrated Care Learning Network - Futures), avoiding unnecessarily duplicative activities with providers and partners.
7.	**Special Educational Needs and Disabilities (SEND)**	Not specified	ICB retain (SEND policy subject to national review)	SEND policy is currently subject to a national review. ICBs are focusing on adopting best practice (a good practice guide has been shared – see Model ICB good practice documents - Integrated Care Learning Network - Futures).

Functions ICBs should plan to retain through 26/27 and possibly beyond

	Functions in scope	Model ICB guidance- May 2025	National Policy (Dec 25)	Guidance notes
8.	**Development of neighbourhood and place-based partnerships**	Neighbourhood health providers	ICB retain	Before delegation is likely, further development work would be required in light of forthcoming guidance on developing neighbourhood health services.
9.	**Primary care operations and transformation (including primary care, medicines management, estates and workforce support)**	Neighbourhood health providers	ICB retain until legislation is passed to allow transfer and delegation to providers.	It is expected that the forthcoming legislation will transfer currently delegated primary care functions from NHS England to ICBs. Once this transfer has taken place, the ICB could onward delegate some primary care functions to providers and this may be a good option as and when that new legislation comes into effect. Until the legislation takes effect and any onward delegation occurs, all functions currently delegated to ICBs under the delegation agreement remain the responsibility of ICBs.
10.	**Medicines optimisation**	Providers	ICB retain	The current focus is spreading Medicines Optimisation best practice amongst ICBs (a good practice guide has been shared – see Model ICB good practice documents - Integrated Care Learning Network - Futures).
11.	**Pathway and service development programmes**	Providers	ICB retain until transfer to providers	As providers are asked to take on greater responsibility for outcomes – not only delivering specific services – pathway and service development is expected to be increasingly undertaken by those providers.
12.	**NHS Continuing Healthcare**	Not specified	ICB retain whilst current legislation prohibits delegation	Secondary legislation currently prohibits the delegation of the decision-making itself but there is long established practice of supporting activities being delivered by third parties. ICBs are focusing on adopting best practice (a good practice guide has been shared – see Model ICB good practice documents - Integrated Care Learning Network - Futures) in this area of significant cost pressure.
13.	**General Practice Information Technology (IT)**	Not specified	ICB retain under current delegation arrangements – until formally changed.	Under current delegated commissioning arrangements, ICBs remain responsible for GP IT leadership, commissioning, delivery oversight, and assurance. These arrangements remain in place, and obligations within the GP Contract, the ICB Practice Agreement, and the GP IT Operating Model must continue to be met unless and until delegation is formally changed.
14.	**Digital and technology leadership and transformation**	Providers	ICB – digital leadership/strategic oversight. Providers – local operational delivery capacity.	ICBs are expected to provide digital leadership in the form of strategic oversight. Local operational delivery capacity should reside with providers (n.b. this refers to secondary care providers/trusts).

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:	15/01/2026
Paper title:	**Medium Term Planning update**
Paper reference:	ICB CIC 25 027
Paper author:	Tom Diamond, Associate Director of Strategy and Integration, NHS Lincolnshire LICB Craig Cook, Director of Strategy and Planning, NHS Derby and Derbyshire ICB Marcus Pratt, Interim Joint System Director of Finance, NHS Derby and Derbyshire and Nottingham and Nottinghamshire ICBs
Paper sponsor:	Clair Raybould, Executive Director for Strategy and Citizen Experience Maria Principe, Executive Director of Commissioning Bill Shields, Executive Director of Finance
Presenter:	Clair Raybould, Executive Director for Strategy and Citizen Experience Maria Principe, Executive Director of Commissioning Marcus Pratt, Interim Joint System Director of Finance, NHS Derby and Derbyshire and Nottingham and Nottinghamshire ICBs

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

Report summary:

The purpose of this report is to set out the requirements, progress and next steps in relation to the development of the ICBs' Medium-Term Planning Framework.

Recommendation(s):

The Boards are asked to **discuss** this update on the ICBs' Medium-Term Planning.

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

Medium Term Planning update

Planning requirements

1. The table below highlights the specific deliverables of ICBs and NHS providers, as set out in the Medium-Term Planning Framework and Strategic Commissioning Framework.

ICBs	Providers
• 5-Year Population Health Strategy • 5-Year Population Health Improvement Plan • 3-Year Operational Plan	• 5-Year Integrated Delivery Plan • 3-Year Operational Plan

2. In light of the published guidance the ICBs have developed a five-year strategic planning output framework, which is set out below.

Output	Purpose
Five-Year Population Health Strategy Public Facing	Communicates the ICBs' long-term vision and ambitions for improving health and access to high quality care and addressing inequalities.
Five-Year Population Health Strategy Board / NHSE Technical	Provides formal evidence that the strategy is data-led, outcomes-based, inequalities focussed and deliverable, meeting national assurance requirements.
Five-Year Population Health Improvement Plan	Translates the strategy into actionable, resourced, measurable commissioning programmes that will deliver impact over the next five years.
Three-Year Operational Plan	Three-year revenue, workforce and operational performance and activity return and four-year capital plan - integrated planning template showing triangulation/alignment of plans.

3. The NHS Finance Business Rules for ICBs and NHS Trusts have recently been updated for 2026/27. These describe the relevant statutory financial duties and other financial policy requirements set by NHS England and the Department of Health and Social Care (DHSC) that apply to ICBs and NHS Trusts, as well as setting out how the impact of surpluses and deficits are managed in future years.

4. The key change from prior years is that ICBs and NHS Trusts no longer have a joint financial objective to deliver a system-wide breakeven position. From

2026/27, ICBs and NHS Trusts only have a requirement to deliver a breakeven revenue position as individual bodies.

5. To support the transition to the updated business rules, ICB repayments of cumulative system deficits will be paused in 2026/27 and 2027/28. Where the ICB delivers a breakeven revenue position in both 2026/27 and 2027/28, NHS England will consider writing off the historic system cumulative deficit (up to and including 2025/26).

6. A summary of ICB financial duties can be found in the table below.

Duty or requirement	Summary	Further information
ICB breakeven duty	Statutory duty to act with a view to ensuring expenditure does not exceed funding received.	-
ICB revenue resource use limit	Statutory duty to comply with the limit set by NHS England.	Set by NHS England in financial directions with reference to closing ICB allocations.
ICB administration limit	Statutory duty to comply with the limit set by NHS England (referred to as ICB running cost allowance).	Set by NHS England in financial directions with reference to closing ICB running cost allowance.
Better Care Fund (BCF)	Requirement to comply with the ICB funding conditions set by DHSC.	Set by DHSC in the BCF policy framework.
Mental Health Investment Standard (MHIS)	Requirement to comply with the ICB MHIS values set by NHS England.	Set by NHS England as part of planning information shared with ICBs.
Dental services ringfence	Requirement to comply with the ICB dental services ringfence values set by NHS England.	Set by NHS England as part of planning information shared with ICBs.

7. A link to the full NHS England document can be found here: NHS England » NHS finance business rules from 2026/27: guidance for integrated care boards and NHS trusts.

Progress

8. The table below sets out the progress to date of each of the planning outputs that the ICBs are required to submit on 12 February 2026.

Output	Progress
Five-Year Population Health Strategy – Public Facing	*This is not a national submission requirement and will be developed once the NHS England technical version of the Five-Year Population Strategy has been completed and approved.*
Five-Year Population Health Strategy – Board / NHS England Technical	• Case for change developed. • Five Year ICB 'Strategy Map' and Outcomes Framework drafted. • Board Strategy Development Session held in December 2025. • Emerging priorities identified: children and young people obesity and mental health, multimorbidity and frailty, end of life care, a strong General Practice, vaccinations and immunisations, outpatient redesign.
Five-Year Population Health Improvement Plan / Commissioning Plan	• Commissioning intentions from across the three ICBs have been reviewed. • Commissioning leads from across the three ICBs have developed initial plans and assumptions. • Plans developed by commissioning leads have been reviewed and amalgamated into an initial Commissioning Plan for further engagement, testing and refining.
Three-Year Operational Plan	First submission was made to NHS England on 17 December 2025. Finance key headlines: • Break-even plans submitted by all three ICBs Efficiency requirements inclusive of corporate reductions (2026/27): - Derbyshire: £44.4 million (4.6%) - Lincolnshire: £64.8 million (7.6%) - Nottinghamshire: £49.0 million (5.0%) • Commissioning running cost reductions: £51.4 million. Quality key headlines: • Operational trajectories compliant with national standards. • Planned improvements include significant increases in referral to treatment performance, reduction in long waits for mental health and community services, expansion of mental health support teams in schools, and reductions in inpatient reliance for learning disabilities and autism.

9. As part of the first submission of the Medium-Term Plan, the Board Assurance Statements were used to provide structured oversight of the planning process and the level of assurance currently available. This is designed to support the Boards in assessing progress against national planning requirements, understanding areas of emerging assurance and identifying where further work is required as plans are refined through subsequent phases.

10. For the first submission, assurance is based primarily on the Boards' engagement in the planning process and confirmation that the required planning activities have been initiated and are progressing. It is recognised that full assurance of outcomes will only be achievable at later stages of the planning cycle, with further development of the five-year population health strategy and commissioning plan. As such, all areas of the assurance statement are currently assessed as being in a developing or maturing state.

Next steps

11. The next phase of work will focus on ensuring alignment across each of the ICBs planning outputs whilst:

    a) Finalising the strategy, including confirming the priorities and defining the actions and key performance indicators for them.

    b) Finalising the commissioning plan, including milestones, delivery timescales and delivery scale.

    c) Establishing deliverable, contractually underpinned plans, centred on securing detailed provider delivery plans for all priority access standards, particularly referral to treatment, cancer, diagnostics, community services and mental health.

12. A key priority will be aligning commissioning ambitions with contract baselines, especially for urgent and emergency care in the context of the proposed blended payment model. Planned reductions in activity and demand will need to be explicitly reflected in contracts and supported by credible system readiness, underpinned by the five-year commissioning programme as the primary mechanism for reducing avoidable demand and shifting care out of hospital.

13. Further work will be undertaken to reconcile financial assumptions, assess affordability and prioritise investment decisions within the available funding envelope. This will include tighter governance over transformation funding, clearer prioritisation of initiatives with the greatest impact, and active management of financial risk, including provider sustainability and the implications of payment reform.

14. The next phase of planning will also place a strong focus on contracting as the primary mechanism for converting planning assumptions into deliverable

operational and financial commitments. The Boards will ensure that sufficient levels of activity are commissioned from providers to support the agreed performance trajectories, with particular focus on referral to treatment, cancer, diagnostics, urgent and emergency care and mental health constitutional standards. Planned activity levels will be explicitly tested through the contracting process to confirm they are credible, and affordable.

15. The immediate focus after the first submission will be on achieving internal alignment within each ICB. By mid-January 2026, service development and improvement priorities, activity assumptions, financial offers and negotiation strategies will be aligned and agreed internally. This will ensure that a clear, consistent and robust commissioner position is taken into formal negotiations with providers, reducing the risk of late changes and misalignment between activity, finance and performance expectations.

16. From mid-January to early February 2026, up to four structured rounds of contract negotiations will be undertaken with providers to agree activity plans, contract values and performance expectations. The objective of this phase will be to reach agreement on the final commissioning and contracting position required to support submission of the refreshed plan to NHS England by 12 February 2026.

Risks and mitigations

17. Five key risks have been identified that could impact on the quality and alignment of the required planning deliverables requiring management and mitigation. These are set out in the table below together with mitigations.

Risk	Mitigation
Alignment of Core Content Across ICB Planning Outputs There is a risk of misalignment of assumptions across the planning outputs for the three ICBs, particularly in relation to the scale of ambition in terms of the shift in activity from hospital to community.	The Executive led Strategy and Planning Coordination Group which has senior ICB leadership representative from strategy, commissioning, planning, performance and finance has the responsibility to ensure alignment across the ICBs' planning outputs.
Dependency on Provider Delivery Plans for Access Performance The proposed access performance trajectories are dependent on effective provider delivery plans. While all providers have indicated compliance with national standards, detailed delivery plans are not yet available, creating a	Accelerating engagement with providers during the contract negotiation phase to secure detailed, credible delivery plans that underpin the proposed access trajectories. These plans will be tested for realism and phasing, with clear milestones and performance monitoring arrangements put in place. Where

Risk	Mitigation
high degree of uncertainty—particularly for referral to treatment, cancer, diagnostics and the reduction in the use of mental health inpatient beds.	delivery risks cannot be sufficiently mitigated, the ICB will retain flexibility to revisit trajectories and apply appropriate escalation and support mechanisms.
Uncertainty Around Expenditure and Affordability The full exposure of commissioner expenditure risk over the next two years is not yet fully understood, with further work to do to assess the affordability of the activity required to support performance improvement, what is already assumed within existing contracts, the potential risk of a new blended payment arrangement for urgent and emergency care and the scale and phasing of transformation initiatives.	Further detailed affordability analysis in quarter four to fully understand the cost of planned activity and transformation initiatives. Clear prioritisation criteria will be applied to manage inevitable trade-offs within the available funding envelope. Investment decisions, particularly for transformation funding, will be subject to robust business cases and phased implementation to manage financial risk and retain flexibility.
Misalignment of Financial Assumptions There is a risk of misalignment between ICBs' and providers' financial assumptions, particularly in relation to the treatment of non-recurrent income, growth assumptions, and the recurrent baseline. This could result in inconsistencies between planning submissions and final contract positions.	Reconciling key financial assumptions with providers as part of the contracting process, ensuring a consistent understanding of recurrent and non-recurrent income and growth assumptions. Formal governance will be used to agree and lock down these assumptions ahead of final plan submission, reducing the risk of divergence between planning returns and final contract positions.
Provider Financial Sustainability and Delivery Capacity Provider financial positions remain uncertain, with Cost Improvement Programme (CIP) requirements currently in the region of 5–6%. There is significant uncertainty around deliverability, which may impact providers' ability to deliver the required operational performance improvements and influence ICBs' funding decisions.	Scrutiny of provider financial plans and CIP deliverability through the contract negotiation and assurance process. Operational performance expectations will be aligned with realistic assessments of provider financial capacity, supported by ongoing financial and performance oversight. The ICBs will retain flexibility in commissioning and funding decisions to respond to emerging risks in provider financial positions.

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:	15/01/2026
Paper title:	**Finance Report - Month 8**
Paper reference:	ICB CIC 25 028
Paper author:	Rebecca McCauley, NHS Lincolnshire ICB Donna Johnson and Craig West, NHS Derby and Derbyshire ICB Clare Hopewell and Ian Livsey, NHS Nottingham and Nottinghamshire ICB
Paper sponsor:	Bill Shields, Executive Director of Finance
Presenter:	Marcus Pratt, Interim Joint System Director of Finance, NHS Derby and Derbyshire and Nottingham and Nottinghamshire ICBs

Paper type:

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

Report summary:

The paper sets out the financial position of NHS Derby and Derbyshire ICB, NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB (the ICBs), including both the ICBs' and providers' financial positions, for the period April to November 2025.

The overall year to date financial position is a £95.0 million adverse variance to plan. For the full year, the ICBs are forecasting to be on plan. These positions include receipt of non-recurrent deficit support funding of £115 million (full year). In month, the position is £27.9 million adverse to plan.

Nottingham and Nottinghamshire providers remain the key driver of the year-to-date position at £66.7 million adverse to plan (£18.6 million adverse in month) mainly due to staffing cost pressures. NHS Lincolnshire ICB is £8.1 million adverse to plan year to date (a £0.3 million improvement in month) with acute independent sector activity and prescribing pressures being the key drivers.

The overall net risk identified is £116.7 million, £103.9 million within providers and £12.8 million within ICBs. Key drivers of the risk remain the delivery of efficiency plans, receipt of full deficit support funding, industrial action costs, provider pay costs and income risks. A turnaround approach has been put in place from November, targeting weekly metrics, efficiency delivery and grip and control.

Whilst the forecast for the ICBs is on plan, there are significant risks in this forecast. The ICB specific position is a year-to-date adverse variance to plan of £10.1 million, with NHS Lincolnshire ICB the main driver as above. NHS Nottingham and Nottinghamshire ICB has a year-to-date adverse variance of £2.1 million, representing the deficit support funding that has been withheld by NHS England for October and November. The forecast remains on plan, albeit with significant risk. There are common pressure areas across the three ICBs, notably independent sector acute activity, prescribing charges and mental health costs. Delivery of the full year efficiency plan is key in delivery of the on plan forecast.

Report summary:

Efficiency delivery across the ICBs is £36.8 million behind the year-to-date target of £363.1 million. The full year target is £623.8 million with delivery forecast marginally below at £623.3 million. Delivery of this target remains a significant risk as noted above.

Capital expenditure is forecast to be delivered within allocation.

Cash is a risk within providers, with Nottingham University Hospitals NHS Trust requesting support from NHS England with other providers expected to follow.

Recommendation(s):

The Boards are asked to **receive** the paper 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

None.

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Joined Up Care Derbyshire

NHS Lincolnshire

Integrated Care System
Nottingham & Nottinghamshire

Finance Report - Month 8

15 January 2026

Systems Overview

Key Finance Metrics by System at Month 8

Key Finance Metric	Surplus / (Deficit) - Variance to Plan															
	Year To Date								Full Year Forecast							
	Derby and Derbyshire ICS £m		Lincolnshire ICS £m		Nottingham and Nottinghamshire ICS £m		DLN Total £m		Derby and Derbyshire ICS £m		Lincolnshire ICS £m		Nottingham and Nottinghamshire ICS £m		DLN Total £m	
Financial Performance 1	(15.7)	R	(10.5)	R	(68.8)	R	(95.0)	R	0.0	G	0.0	G	0.0	G	0.0	G
Efficiency	(7.2)	R	(1.9)	R	(27.6)	R	(36.8)	R	(0.5)	G	0.0	G	(0.0)	G	(0.5)	G
Capital - Charge against allocation 2	12.7	G	8.4	G	12.3	G	33.4	G	0.0	G	(5.1)	R	0.0	G	(5.1)	R
Pay Costs (Provider)	1.9	G	(3.2)	G	(51.6)	R	(52.9)	R	7.5	G	(4.0)	G	(7.8)	R	(4.2)	G
Mental Health Investment Standard (MHIS)									0.0	G	0.0	G	0.0	G	0.0	G
Risk (Net Position)									(39.1)	R	(29.6)	R	(48.3)	R	(117.1)	R
Underlying Position									(167.0)	R	(116.5)	R	(175.4)	R	(458.9)	R

1. *Financial Performance is inclusive of non-recurrent Deficit Support Funding (Derby and Derbyshire Integrated Care System £30 million and Nottingham and Nottinghamshire Integrated Care System £49.5m year to date)*
2. *The overspend in Lincolnshire Integrated Care System is due to a provider notified capital allocation not yet received*

Overview of the Derbyshire, Lincolnshire, Nottinghamshire Systems

The month 8 year-to-date position across the three systems show an adverse variance of £95m (Month 7 £66 million). The largest contributors are within the Nottingham and Nottinghamshire system, specifically Nottinghamshire Healthcare NHS Foundation Trust (NHT) (£22.7 million adverse to plan), 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 (£35.5 million adverse to plan), impacted by industrial action, contract and income pressures, deterioration in substantive pay run rates, non-pay cost pressures, and shortfalls in efficiency delivery. Appendix 1 shows the consolidated income and expenditure position of the systems.

The forecast remains on plan, supported by £115 million of deficit funding (£45 million in the Derby and Derbyshire system and £70 million in the Nottingham and Nottinghamshire 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 £326 million achieved year-to-date, resulting in a £37 million adverse variance against target, an adverse movement of £9 million from month 7. Efficiency delivery remains the most significant financial risk this year, with the current NHS England calculated risk-adjusted assessment at 82% of the annual target, a gap of £109 million.

Pay costs are a major driver of the position, with a £53 million adverse variance at month 8 (£39 million at month 7), almost entirely within the Nottingham and Nottinghamshire 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 constrained in some providers, with NUH having met with NHS England national colleagues in respect of their cash situation and requested quarter four cash support. Both United Lincolnshire Teaching Hospitals NHS Trust (ULTH) and Chesterfield Royal Hospital NHS Foundation Trust (CRH) are likely to request additional support.

ICBs (1 of 2)

Key Finance Metrics for ICBs at M8

ICB Key Metrics - Variance to Plan Surplus / (Deficit)	Year To Date								Full Year Forecast							
	DDICB		LICB		NNICB		DLN ICB Total		DDICB		LICB		NNICB		DLN ICB Total	
	£m		£m		£m		£m		£m		£m		£m		£m	
Financial Performance	0.1	G	(8.1)	R	(2.1)	R	(10.1)	R	0.0	G	0.0	G	0.0	G	0.0	G
Efficiency	0.0	G	(1.2)	R	11.8	G	10.6	G	0.0	G	0.0	G	0.0	G	0.0	G
Spend of Capital Resource	0.0	G	6.0	G	0.0	G	6.0	G	0.0	G	0.6	G	0.0	G	0.6	G
Spend of Running Cost Allocation	0.8	G	0.0	G	0.0	G	0.8	G	0.9	G	0.0	G	0.2	G	1.1	G
Mental Health Investment Standard	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0	G	0.0	G	0.0	G	0.0	G
Risk (Net Position)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0	G	(12.8)	R	0.0	G	(12.8)	R
Underlying Position	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	10.3	G	(56.9)	R	(19.1)	R	(65.7)	R
Better Payment Practice Code	>95%	G	>95%	G	>95%	G	>95%	G	>95%	G	>95%	G	>95%	G	>95%	G

Financial Performance and Key Drivers of the Position

The ICBs are forecasting to achieve their submitted financial plans for the year, including breakeven positions for NHS Derby and Derbyshire ICB (DDICB) and NHS Nottingham and Nottinghamshire ICB (NNICB), and a £3.7 million surplus for NHS Lincolnshire ICB (LICB). This is supported by £12.5 million deficit support funding for NNICB. There are risks in delivering the position, with LICB reporting a £8.1 million adverse variance to plan year to date (£8.4 million adverse at month 7). Within the forecasts, there is a net risk of £12.8 million, with a Financial Recovery Plan in place to address this and an underlying deficit of £65.7 million, primarily due to non-recurrent efficiencies and pressures in prescribing and acute commissioning.

Financial pressures persist, notably:

- Acute activity mainly due to higher than planned elective activity in the Independent Sector and operational constraints within NHS providers.
- Mental health and learning disabilities, driven by increased demand for Attention-Deficit/Hyperactivity Disorder and Autism Spectrum Disorder assessments in the private sector and pressure in acute out of area bed costs.
- Prescribing costs, mainly in LICB and NNICB, due to diabetes medicines and price/volume trends.
- Community services are under pressure from delayed efficiency schemes, particularly in DDICB and NNICB.

Underspends in Continuing Healthcare, Primary Care, and Delegated Pharmacy, Ophthalmic, and Dental Services are helping to offset pressures elsewhere.

Efficiency

At month 8, the ICBs are £10.6 million ahead of the year-to-date efficiency plan, but this is due to non-recurrent efficiencies. Recurrent efficiencies are behind plan, which may create future financial challenges. The ICBs' ability to deliver the efficiency target is a key risk, with £27.4 million of schemes assessed as high or medium risk (£34.2 million at month 7). Additional efficiency schemes are being sought, further efficiency governance is being developed to support intelligence into the Financial Recovery Meeting.

ICBs (2 of 2)

Financial Performance and Key Drivers of the Position continued

Other Areas to Note

The ICBs are anticipating to remain within the capital and running cost allocations, as per national directions.

The Better Practice Payment Code (BPPC) target is consistently achieved across the ICBs to month 8. Nationally, ICBs went live with a new financial ledger on 1 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

LICB Performance: A recovery plan of £28.8 million has been developed, with a plan to deliver £3.1 million in month 8. The Financial Improvement Director for the ICB, with the Deputy Director of Finance, have led on the plan and on gaining assurances on delivery. Further opportunities are being explored to provide further stretch to cover any slippage on the plan or further risks that may occur in the remaining months of the year. Full details are discussed at the ICBs' Financial Recovery Meeting and further detailed review is undertaken at the Provider Recovery Assurance Group. As one of the seven highest risk organisations in the three systems, LICB also attend the Financial Recovery Group to provide progress updates and assurances. The financial recovery plan delivered as planned during month 8, however other movements in acute, independent sector and prescribing worsened the ICB's position.

Acute Activity Pressures: Activity Query Notices have been issued to several independent sector and NHS providers, and revised activity plans for the remainder of the financial year are being agreed with the intention to bring activity back to plan by the year end. To manage flows from NHS providers, activity levels are being reviewed to ensure appropriate subcontracting arrangements are in place.

Mental Health and Learning Disabilities Pressures: Longer term strategic approaches to Attention-Deficit/Hyperactivity Disorder and Autism Spectrum Disorder assessments in the private sector are being considered to manage rising demand and capacity constraints. In parallel, Finance, Contracting and Commissioning colleagues are meeting to explore the feasibility of establishing Indicative Activity Plans with key providers; introducing clearer activity parameters, strengthening financial oversight, and limit unmanaged growth.

LICB has commissioned the opening of an in-county bed provision with Lincolnshire Partnership NHS Foundation Trust (LPFT). This facility (Ashley House) opened mid-October and is expected to vastly reduce acute out of area placements. The ICB is working in close partnership with LPFT to maximise this opportunity and reduce acute out-of-area expenditure over the remaining months of the financial year. LICB is monitoring activity with the Trust, and impact will be assessed as data matures.

Prescribing Pressures: In LICB, detailed analysis of the cause of high growth in endocrine prescribing is also underway. Similarly, NNICB's medicines optimisation team has undertaken practice visits to discuss the position of high growth. Further efficiency and saving opportunities are being sought across the ICBs

Risk to Efficiency Delivery: Key actions to support full delivery of the efficiency requirements include the maximising of potential opportunities, replacement initiatives and/or full development of high risk schemes, and oversight by the Financial Recovery Meeting . This meeting provides oversight of the ICBs' budget management and savings and efficiency processes, receiving information from efficiency delivery groups and reporting up to Finance and Performance Committee. The Financial Recovery Meeting is chaired by the Chief Executive, and attended by Executive Directors; demonstrating the importance of efficiency delivery to the ICBs.

Other: 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.

Providers (1 of 3)

Provider	Surplus / (Deficit) - Var to Plan				Forecast Var		YTD Workforce - Surplus / (Deficit) - Var to Plan								Forecast	
	YTD Financial Performance		YTD 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 *	(6.4)	R	(1.7)	R	0.0	G	1.7	G	11.1	G	(6.6)	R	(2.7)	R	(31.2)	R
Derbyshire Community Health Services NHS Foundation Trust	0.0	G	0.0	G	(2.8)	R	1.8	G	1.6	G	0.2	G	0.0	G	(8.2)	R
Derbyshire Healthcare NHS Foundation Trust	0.0	G	0.2	G	1.1	G	3.8	G	3.0	G	0.3	G	0.5	G	(4.5)	R
East Midlands Ambulance Service NHS Trust	0.0	G	0.0	G	1.8	G	3.5	G	3.5	G	(0.1)	R	0.1	G	(6.4)	R
University Hospitals Of Derby And Burton NHS Foundation Trust *	(9.4)	R	(5.7)	R	0.0	G	(9.0)	R	(5.0)	R	(2.0)	R	(1.9)	R	(127.0)	R
Total Derby & Derbyshire Providers	**(15.8)**	R	**(7.2)**	R	**0.0**	G	**1.9**	G	**14.1**	G	**(8.3)**	R	**(3.9)**	R	**(177.3)**	R
Lincolnshire Community Health Services NHS Trust	0.7	G	0.9	G	0.0	G	(0.9)	R	0.2	G	(1.6)	R	0.5	G	(8.1)	R
Lincolnshire Partnership NHS Foundation Trust	0.0	G	0.0	G	0.5	G	2.8	G	1.8	G	0.5	G	0.5	G	(12.4)	R
United Lincolnshire Teaching Hospitals NHS Trust	(3.0)	R	(1.6)	R	(5.6)	R	(5.1)	R	(1.9)	R	(1.4)	R	(1.9)	R	(39.0)	R
Total Lincolnshire Providers	**(2.4)**	R	**(0.7)**	R	**(5.1)**	R	**(3.2)**	R	**0.1**	G	**(2.5)**	R	**(0.8)**	R	**(59.6)**	R
Nottingham University Hospitals NHS Trust *	(35.5)	R	(16.7)	R	0.0	G	(30.6)	R	(28.1)	R	(1.9)	R	(0.6)	R	(96.4)	R
Sherwood Forest Hospitals NHS Foundation Trust *	(8.5)	R	(9.7)	R	0.0	G	(11.6)	R	(14.8)	R	3.0	G	0.2	G	(20.1)	R
Nottinghamshire Healthcare NHS Foundation Trust *	(22.7)	R	(12.9)	R	0.0	G	(9.4)	R	(2.4)	R	(7.8)	R	0.9	G	(39.8)	R
Total Nottingham & Nottinghamshire Providers	**(66.7)**	R	**(39.3)**	R	**0.0**	G	**(51.6)**	R	**(45.4)**	R	**(6.7)**	R	**0.5**	G	**(156.3)**	R
Grand Total DLN Providers	**(84.8)**	R	**(47.2)**	R	**(5.1)**	R	**(52.9)**	R	**(31.2)**	R	**(17.5)**	R	**(4.2)**	R	**(393.1)**	R

** These providers are in receipt of Deficit Support Funding (DSF) and are assuming full year receipt of the DSF funds*

Key Drivers

The year-to-date adverse variance of £84.8 million to plan (month 7 £57.9 million) is mainly driven by pay overspends of £52.9 million (month 7 £39.3 million), which has impacted the ability to deliver planned efficiencies resulting in a year-to-date shortfall of £47.2 million. The pay overspends follow July's and November's industrial action and ongoing operational pressures, with Nottingham and Nottinghamshire providers most affected.

Efficiencies are off plan by £47.2 million year-to-date (an adverse movement of £9.9 million from month 7). There is significant risk in this area of £81.9 million (NHS England weighted) across the efficiency plans with Nottingham and Nottinghamshire providers making up the majority with £51.3 million (25.3% of efficiency plan), Derby and Derbyshire providers representing £21.1 million (15.4% of efficiency plan) and Lincolnshire providers representing £9.6m (10.6% 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.

Providers (2 of 3)

Key Drivers (Continued from Slide 5)

Derby and Derbyshire

The Month 8 year to date position is £15.7 million adverse to the planned deficit of £20.1 milion, an adverse movement of £6.9 million in month. Chesterfield Royal Hospital NHS Foundation Trust (CRH) is £6.4 million adverse to plan compared to £2.9 million adverse at Month 7. Key drivers include under delivery of efficiencies, industrial action costs and operational cost pressures.

University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) is £9.4 million adverse to plan compared to £6.0m adverse at month 7. Key drivers are increased variable pay costs, including higher costs in nonelective care due to increased activity levels, industrial action, care for complex behaviour patients and income shortfalls. UHDB is also reporting an underlying position of £127 million deficit. Further work is required to align the UHDB underlying position to the guidance shared by NHS England.

Both CRH and UHDB have developed financial recovery plans; however, further work is required to identify further work is required to gain assurance that the financial plans for the year will be achieved.

Lincolnshire

United Lincolnshire Teaching Hospitals NHS Trust is reporting £3 million adverse to plan year-to-date with a forecast in line with plan. The year-to-date position has been supported by technical efficiencies. There are risks to the delivery of full year plan (driven by capacity and cost pressures, impacts of industrial action, and risks to income). The position is anticipated to be recovered through the impact of our productivity work and work is ongoing to close the gap in efficiency delivery. Some mitigations are unidentified to offset potential risks.

Lincolnshire Partnership NHS Foundation Trust is reporting on plan both year-to-date and forecast outturn. Risks to this include efficiency delivery and income assumptions.

Lincolnshire Community Health Services NHS Trust is reporting on plan both year-to-date and forecast outturn.

Nottingham and Nottinghamshire

The month 8 year to date position is a £66.7 million adverse variance to the planned surplus of £0.2 million, with an adverse in-month actual movement of £18.6 million. All providers have seen an in-month actual adverse impact – NUH £10.5m, Sherwood Forest Hospitals NHS Foundation Trust (SFH) £2.5 million and NHT £5.7m. Key drivers of the in-month position are substantive and bank staffing, withheld deficit support funding and efficiency delivery.

The largest adverse variance year-to-date is NUH who are reporting a £35.5 million variance being driven by the impact of industrial action, contract and income pressures (including month 7 & 8 deficit support funding), shortfalls in efficiency delivery, substantive pay run rate deterioration and non-pay pressures. For NHT (£22.7 million adverse year-to-date variance to plan), the main drivers are bank staffing, private sector beds, month 7 and 8 deficit support funding and delivery of efficiency plans. SFH is £8.5 million year-to-date adverse to plan which is driven by the impact of industrial action, adverse efficiency performance, month 7 and 8 deficit support funding and variable income performance.

Providers (3 of 3) **Provider Recovery Actions**

Financial recovery key actions include:

Establishing strengthened DLN System Financial Recovery Governance Arrangements from November, focussing on high-financial risk organisations:

- This aims to strengthen grip and control within organisations to support successful (2025 26) financial delivery, and to provide assurance to Boards, ICBs and NHS England.
- It targets efficiency delivery, financial recovery plans, grip and control, underpinned by weekly lead metrics.
- A Financial Recovery Group, chaired by the ICB s' Executive Director of Finance provides oversight and support.
- External financial delivery partner engaged to drive in-year efficiency and transformational opportunities.
- NHS England Strengthening Financial Management Toolkit supports remedial action in deficit organisations.

All high-risk providers are taking actions to deliver financial recovery plans, with a focus on enhanced grip and control, delivery of major interventions to address cost drivers at divisional/care group level, and increased control of substantive and temporary staffing and premium pay. Additional controls are in place to maintain grip on recruitment and there has been a reduction in advertised posts since the end of month 6, which is expected to continue. Mutually Agreed Resignation Schemes have been run in-year by all organisations, and actions are in place to deliver workforce transformation and to improve productivity.

Latest position of High Financial Risk Organisations is summarised below:

The **NUH** financial recovery plan is focussed on grip and control (pay/non-pay), cost improvement plan delivery and care optimisation. The best case aims to deliver a £39 million deficit but there is significant risk. There is Board / Executive ownership, a Turnaround Director, weekly delivery assurance through Care Groups and assertive pay controls.

The **UHDB** financial recovery plan is focussed on improving run rates, variable pay and enhanced pay/non-pay controls. The current financial recovery plan is forecast to achieve a £28.4 million deficit position at year end and therefore, further mitigations are urgently required to close the gap. Further assurance is required to illustrate that clear action plans are in place at divisional level and that those plans are being delivered. Enhanced vacancy control is in place and focussed action required to reduce variable pay. UHDB is strengthening their Programme Management Office. In view of the significant challenges it faces, UHDB have been advised to review its current financial recovery governance arrangements – particularly the frequency of associated meetings.

The **NHT** financial recovery plan is focussed on pay, independent sector beds and discretionary spend. There is Board / Executive and Care Group ownership and a Director of Financial Recovery to oversee delivery. The workforce optimisation programme includes a vacancy freeze and significant controls on bank and agency are in place. Daily interface takes place to ensure patients are discharged to plan.

CRH has a full financial recovery plan in place that achieves breakeven, however, there are significant risks. The financial recovery plan focusses on accelerating transformation, divisional major interventions, clinical variable pay, corporate cost control, income/contracts, non-pay and trade-offs (e.g. performance). Enhanced workforce controls are in place with a focus on medical agency. Three divisions are in 'special measures' with weekly progress reviews with the Chief Finance Officer. Executive-wide ownership is evidenced.

The **SFH** financial recovery plan is focussed on enhanced grip and control across the Trust and six key work programmes within divisions. The latest internal full year forecast at M8 is a £10.2 million deficit, with further mitigations required. Robust pay / non-pay controls are in place and whilst pay costs are reducing, these are not at the required rate which is a risk. There is strong Board, Executive and Divisional ownership.

ULTH has a comprehensive cost improvement plan. Major interventions include temporary pay, vacancy control, discretionary spend controls and other areas where help is required to resolve external factors outsides ULTH's control (e.g. VAT treatment issues). There are local targets and enhanced emphasis on temporary medical spend and weekly scrutiny of bank nursing. There is enhanced executive led vacancy control which is currently subject to a 3-month started date pause. There is Board / Executive and Care Group ownership with additional internal assurance to expand / expedite plan delivery, with additional internal assurance to expand / expedite plan delivery.

Appendix 1 –Systems' Income and Expenditure

TOTAL CLUSTER	Plan YTD £m	Actual YTD £m	Variance YTD £m	Variance YTD %	Plan Year Ending £m	Forecast Year Ending £m	Variance Year Ending £m	Variance Year Ending %
System Revenue Resource Limit	-5,738.20				-8,610.10			
ICB Net Expenditure								
Acute Services	2,672.30	2,702.20	-29.9	-1.12%	3,968.80	4,002.20	-33.4	-0.84%
Mental Health Services	596.2	602	-5.8	-0.97%	901	911.6	-10.5	-1.17%
Community Health Services	454.1	453.8	0.4	0.09%	673.1	671.2	1.8	0.27%
Continuing Care Services	256.3	249.5	6.8	2.65%	389.6	380.2	9.3	2.39%
Primary Care Services	452.9	449.4	3.4	0.75%	673.1	666.7	6.4	0.95%
Memo: Prescribing	381.7	381.9	-0.2	-0.05%	572.2	570.8	1.4	0.24%
Other Commissioned Services	21.4	21.6	-0.3	-1.40%	31.9	31.3	0.7	2.19%
Other Programme Services	25	22.7	2.2	8.80%	35.9	35	0.9	2.51%
Reserves / Contingencies	28	29.1	-1.2	-4.29%	50.4	40.8	9.6	19.05%
Delegated Specialised Commissioning	525.1	520	5.1	0.97%	804.7	797.1	7.6	0.94%
Delegated Primary Care Commissioning	665.8	657.9	7.9	1.19%	1016.5	1008.1	8.4	0.83%
ICB Running Costs	43.2	42.2	1	2.31%	61.4	62.1	-0.8	-1.30%
Total ICB Net Expenditure	5,740.30	5,750.50	-10.1	-0.18%	8,606.40	8,606.40	0	0.00%
ICS Providers I&E - Adjusted Financial Performance								
Income	-4,575.10	-4,608.10	33	-0.72%	-6,861.80	-6,886.80	25	-0.36%
Pay	3,100.50	3,153.40	-52.9	-1.71%	4,627.00	4,631.40	-4.3	-0.09%
Non-Pay	1420.3	1487.7	-67.3	-4.74%	2,107.80	2,133.70	-25.8	-1.22%
Non Operating Items	86.7	84.1	2.4	2.77%	130.7	125.5	5.2	3.98%
TOTAL Provider Surplus/(Deficit)	-32.5	-117.3	-84.9	261.23%	-3.7	-3.7	0	0.00%
Note, ICB position is shown gross, ie., includes intra system providers								

Derby and Derbyshire Integrated Care Board

Lincolnshire Integrated Care Board

Nottingham and Nottinghamshire Integrated Care Board

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	15/01/2026
Paper title:	**Quality Report**
Paper reference:	ICB CIC 25 029
Paper author:	Nursing and Quality Business Management Unit, NHS Nottingham and Nottinghamshire ICB
Paper sponsor:	Rosa Waddingham, Executive Director of Quality (Nursing)
Presenter:	Rosa Waddingham, Executive Director of Quality (Nursing)

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
- Derbyshire Healthcare NHS Foundation Trust
- University Hospitals Derby and Burton NHS Foundation Trust
- United Lincolnshire Teaching Hospitals NHS 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.

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

Appendices

Appendix 1: 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. Recent Care Quality Commission (CQC) Reports rated the Trust as ‘requires improvement’ for long-stay/rehabilitation mental health wards and wards for people with learning disabilities or autism.
2. Lings Bar Hospital remains under scrutiny due to cultural and operational challenges, with leadership and staffing reviews in progress. The latest CQC review rated the unit ‘requires improvement’ overall and rated ‘good’ for safe and caring.
3. Staff Wellbeing is recognised as a risk due to ongoing regulatory, public inquiry scrutiny and media attention; support measures are in place.

Nottingham University Hospitals NHS Trust – NHS Oversight Framework Segment Four

4. There are operational pressures around ambulance delays, abandoned discharges, and a Structured Judgement Review backlog. Quality insight visits and leadership/culture reviews are ongoing.
5. A Prevention of Future Deaths order was issued in September 2025, and actions are being taken to address coroner’s concerns.

Derbyshire Healthcare NHS Foundation Trust – NHS Oversight Framework Segment Four

6. Infrastructure challenges persist regarding the design and build of the Enhanced Care/Paediatric Intensive Care Unit (PICU) wards and seclusion rooms, including incidents of severe damage, prompting an independent review of specifications.
7. Out of Area placements remain above target due to delays in opening the male PICU ward and bed availability issues. A recovery plan has been requested, with additional beds commissioned from April 2026.
8. The Rapid Improvement Plan for the Mental Health crisis line continues, alongside transition to NHS 111 Mental Health access point, with further equality impact work underway to ensure patient safety.

University Hospitals Derby and Burton NHS Foundation Trust – NHS Oversight Framework Segment Four.

9. Ophthalmology services are addressing long waits and overdue follow-ups through risk stratification and harm review processes.
10. Targeted divisional action is underway to improve Local Safety Standards for Invasive Procedures compliance and reduce procedural variation.

United Lincolnshire Teaching Hospitals NHS Trust – NHS Oversight Framework Segment Four

11. Recent CQC visits to Lincoln County Hospital and Pilgrim Hospitals rated Urgent and Emergency Care as 'requires improvement.'
12. Key concerns are around Children and Young People congenital heart disease waiting times; epilepsy pathway risks; ophthalmology capacity; and Infection, Prevention and Control accountability and ownership. Improvements have resulted in a step-down from enhanced oversight for congenital heart disease waiting times.

Lincolnshire Partnership NHS Foundation Trust – NHS Oversight Framework Segment Three

13. Recent CQC unannounced visits have triggered an escalation of concerns regarding rapid tranquilisation, restraint practices, care planning, and risk assessments. Published reports are awaited, but immediate improvement actions have been initiated to address identified risks and strengthen clinical governance.
14. The system is responding proactively with targeted improvement measures and strengthened governance. Whilst immediate actions demonstrate commitment to safety and compliance, sustained focus on workforce capacity and embedding learning will be critical to achieving long-term assurance and restoring confidence ahead of the forthcoming CQC reports.

Learning Disability and Autism – Enhanced Oversight

15. Across the three ICBs, there is a clear and shared commitment to reducing prolonged stays in secure settings and improving discharge pathways for individuals with learning disabilities and/or autism. Whilst progress is evident in some areas, significant challenges remain.
16. Adult inpatient performance remains above planned trajectories across the three ICBs, with Derby and Derbyshire ICB and Lincolnshire ICB showing the

greatest variance. Nottingham and Nottinghamshire ICB is only slightly above trajectory.

Urgent and Emergency Care – Enhanced Oversight

17. Across the three ICBs, Urgent and Emergency Care services are under sustained pressure, driven by high demand, patient flow challenges, and winter resilience concerns. Whilst improvement initiatives are underway, performance against key operational and quality standards remains variable.
18. Persistent high demand, delayed ambulance handover times and long waiting times in Emergency Departments continue to impact service quality and performance across the three ICB areas. Targeted interventions are being implemented to manage flow and resilience, but all areas require continued focus on winter preparedness, patient flow optimisation, and reducing escalation space dependency to maintain safe and effective care.

Maternity – Enhanced Oversight

19. Maternity services across the three ICBs show varying levels of progress, with strong compliance in some areas and ongoing challenges in others. Improvement programmes and national initiatives are supporting safety and quality, but scrutiny and workforce-related actions remain key priorities.
20. Lincolnshire ICB is performing strongly, and Derby and Derbyshire ICB is showing positive movement under the Safety Support Programme. Nottingham and Nottinghamshire ICB is progressing but remains under heightened external scrutiny, requiring robust communication and governance. Continued focus on completing safety actions, sustaining compliance, and managing reputational risk is essential to maintain momentum and public confidence.

Special Educational Needs and Disabilities (SEND) – Enhanced Oversight

21. SEND services across the three ICBs are under significant pressure, with common themes of high demand, long waits, and statutory compliance challenges. Improvement plans and governance frameworks are in place, but delivery remains variable, and resource constraints continue to impact performance.
22. Sustained operational and compliance pressures are compounded by rising demand and complexity. Lincolnshire ICB presents the most acute challenges with rapid Education, Health and Care Plan growth and tribunal activity, while Derby and Derbyshire ICB and Nottingham and Nottinghamshire ICB are focused on readiness and governance improvements. Continued emphasis on

capacity planning, statutory compliance, and collaborative improvement is essential to deliver consistent outcomes and meet inspection standards.

Infection Prevention Control (IPC) – Enhanced Oversight

23. IPC remains a critical focus across all three ICBs, with varying levels of assurance and persistent challenges linked to healthcare-associated infections (HCAIs) and system pressures.
24. Significant strain remains across the three ICB areas, driven by high demand and workforce pressures. Lincolnshire ICB demonstrates strong assurance in some areas but faces elevated HCAI rates, while Nottingham and Nottinghamshire ICB is contending with persistent outbreaks and capacity challenges. Derby and Derbyshire ICB requires continued oversight to address provider-level pressures. Sustained focus on improvement plans, outbreak management, and resilience measures is essential to mitigate risk and maintain patient safety.

Appendix 1. Escalation Framework

The below Escalation Framework has been developed to provide structure and consistency across all areas of oversight for escalation of concerns. 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:	15/01/2026
Paper title:	**Service Delivery Report**
Paper reference:	ICB CIC 25 030
Paper author:	Sarah Bray, Associate Director of System Performance and Assurance, NHS Nottingham and Nottinghamshire ICB
Paper sponsor:	Maria Principe, Executive Director of Commissioning
Presenter:	Maria Principe, Executive 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.

Two providers remain under Tier One enhanced oversight with NHS England National teams: Nottingham University Hospitals NHS Trust for urgent care and cancer, and United Lincolnshire Teaching Hospitals NHS Trust for urgent care.

All three systems continue to experience significant urgent care pressures, including persistent ambulance handover delays and challenges with patient flow, despite robust winter plans and daily operational oversight. Lincolnshire achieved its four-hour emergency department target in November, but Derbyshire and Nottinghamshire fell short of their plans. High levels of ambulance handovers over 45 minutes and increased ambulance response times are being reported across all systems. Delayed discharges and high bed occupancy remain key risks, with ongoing system-wide governance and daily oversight supporting winter delivery.

Planned care recovery is progressing, but risks remain around 65-week wait breaches and specialty backlogs. Lincolnshire is broadly on track for year-end compliance, whilst Nottinghamshire and Derbyshire face greater challenges. All systems are focused on eliminating waits over 65 weeks, but each has risks to delivery. Additional sessions, workforce flexibility, and pathway redesign are being used to mitigate risks, but productivity gaps and the impact of seasonal and industrial action continue to present challenges.

Although more treatments have been given than last year, cancer performance across the three systems is still not meeting targets. Recovery plans are set to bring performance back on track by March 2026, aiming to reduce backlogs and improve monthly performance. However, confidence in achieving the March goal remains low at present.

Urgent dental appointments continue to be below the planned volume 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 plans to increase take up across patient cohorts and improve delivery of staff vaccinations. Targeted actions are being taken on low uptake areas.

The report includes a summary of the evolving arrangements for performance oversight which describe how the ICBs are transitioning to a strategic commissioning and system stewardship role, prioritising outcomes, value for money, and transformation delivery through an integrated performance and assurance framework. Providers will retain operational responsibility, whilst the ICBs set clear expectations and applies intelligence-led oversight to enable proactive risk management, improvement, and long-term sustainability.

The appendices include the Cluster Performance Report as well as individual ICB reports for Nottinghamshire, and Derbyshire. However, a report for Lincolnshire has not been produced for January 2026.

Recommendation(s):

The Boards are asked to **receive** the paper 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 1 – Service Delivery Performance – January 2026
Appendix 2 – Activity versus Plan – October 2025
Appendix 3 – ICBs' Seasonal Vaccination Performance
Appendix 4 – NHS Provider Oversight Arrangements
Appendix 5 – NHS Trust NHS Oversight Framework Ratings – Q2 2025-26

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Service Delivery Performance Report

Introduction

1. Ongoing urgent care pressures continue, including ambulance handover delays and difficulties with patient flow, despite the ICBs having strong winter plans and daily operational monitoring. Notwithstanding those pressures, Lincolnshire met its four-hour target during November, but both Derbyshire and Nottinghamshire fell significantly short of their plans.
2. Planned care recovery continues but risks remain around 65-week breaches and specialty backlogs. Lincolnshire is broadly on track for year-end compliance, with Nottinghamshire and Derbyshire facing greater challenges to return to planned levels. Transformation programmes across all systems focus on outpatient optimisation, theatre efficiency, and demand management.
3. Cancer and diagnostics performance remain below trajectory, with Nottingham University Hospitals NHS trust (NUH) under NHS England Tier 1 National Oversight Framework arrangements for emergency care and cancer standards. Diagnostic capacity constraints are impacting elective and cancer recovery, with investment in Community Diagnostic Centres critical to improvement.
4. Primary care access is stable, with Pharmacy First performing strongly, and vaccination uptake generally positive, although uneven across cohorts. Mental health and community services continue to experience long waits and capacity issues, with recovery plans in place.
5. An overview of key priority system delivery metrics is provided in 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 in Appendix 3.
6. Enhanced oversight arrangements are in place with NUH and United Lincolnshire Teaching Hospitals NHS Trust (ULTH) for 4-hour and 12 hour waiting times in the Emergency Department.

Evolving arrangements for performance oversight

7. The ICBs' approach to performance oversight continues to evolve in line with the NHS Commissioning Framework and Model ICB Blueprint. The ICBs' role has moved away from direct operational management towards a clearer strategic commissioning and system stewardship function, with a stronger emphasis on outcomes, value for money and delivery of agreed transformation.
8. The ICBs retain system accountability for delivery of constitutional standards, financial balance, quality and population health outcomes. Oversight is exercised through a strengthened performance and assurance framework that

brings together finance, activity, quality, workforce and delivery milestones, providing a coherent view of system performance rather than siloed reporting. This enables earlier identification of risk, clearer prioritisation of support, and more timely intervention where delivery is off-track.

9. Operational responsibility for day-to-day performance sits with providers, operating at neighbourhood, place and ICB levels as appropriate. The ICBs' role is to set clear expectations, agree trajectories, hold providers to account through contracts and formal oversight forums, and intervene proportionately where required. This includes escalation where performance, quality or financial risk cannot be mitigated through routine management, and de-escalation where delivery is stable, and improvement is embedded.

10. Performance oversight will increasingly focus on delivery against agreed outcomes and benefits realisation, including reduction in avoidable demand, unwarranted variation and low-value activity, alongside improvement in access, experience and equity. This reflects a deliberate move from retrospective assurance to forward-looking, intelligence-led oversight that supports system learning, improvement and sustainability over the medium term.

Urgent care and winter preparation

11. Despite significant urgent care pressures, the Lincolnshire system achieved the urgent care four-hour performance trajectory in November. However, Nottingham and Nottinghamshire, and Derby and Derbyshire are reporting significant under performance for the month. All systems are reporting high levels of ambulance handovers over 45 minutes and increased ambulance response times.

12. There remain persistent challenges relating to patient flow, both through the hospital and out of the hospital, delayed discharges and high bed occupancy.

13. Winter preparedness is established across all systems, with seasonal plans finalised, approved by provider partner board, and reviewed through governance channels. Documents outline strategies for managing winter pressures, although capacity limitations and rising demand remain risks during peak periods. Ongoing system-wide governance and daily oversight supports effective delivery throughout winter.

14. **Derbyshire ICB:** Persistent pressure continues across Derby and Derbyshire, with a clear focus on front-door performance, hospital flow, and system-wide discharge processes. Challenges remain around patient transport capacity for outflow and the need for acute sites to prioritise earlier discharges, alongside reducing 12-hour waits and long lengths of stay. Weekly winter monitoring, led by the ICB and involving senior system partners, provides oversight of initiatives, urgent care metrics, and demand–capacity risks.

15. **Lincolnshire ICB:** The system ambition remains to deliver 78% 4-hour performance in March 2026, and delivery is currently on track. Demand has been under plan for the year to date, although in recent weeks the system has been over plan at its front doors. This has now returned to plan but continues to experience peaks at certain times of the day or days of the week causing operational pressures. 12-hour performance remains a challenge; and with recent performance around 16% it is unlikely that the system can deliver the plan for 10% across the year. Whilst the 45minute handover process is now embedded as business as usual, there is not any consistency currently in delivery of the 95% ambition, and the Boston site generally performs much better than the Lincoln site. East Midlands Ambulance Service has enacted a weekly 'breaking the cycle' process every Monday, including the 'release to respond' model. 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 and is routinely reviewed and updated with escalation and assurance provided to the Urgent and Emergency Care Partnership Board. Winter initiatives are now all mobilised and the system has partially mitigated a recent risk around reduced home based reablement capacity.

16. **Nottingham and Nottinghamshire ICB**: Urgent care faces persistent pressures, with the Nottingham and Nottinghamshire position being low within the national peer organisations at 40 out of 42 systems for 4-hour performance in November. In combination with below planned performance, this has resulted in NUH being escalated into Tier 1 national oversight processes in November. Weekly Urgent Care Operational meetings are in place, which monitor delivery of the winter plan actions, which include increased capacity, discharge marshals, and expanded urgent treatment centre slots. Focus continues on efforts to reduce demand, non-elective admissions conversion rates, high lengths of stay, and discharge delays. Ambulance handover times remain challenging, with 45-minute handover protocols now established at each provider location.

Planned care

17. Across the ICBs, systems are implementing targeted productivity and demand management initiatives to address long waits and optimise patient flow. Risks remain around 65-week breaches and specialty-specific pressures, but mitigations include additional sessions, workforce flexibility, and pathway redesign. Delivery against national standards is challenging but broadly on trajectory, with Lincolnshire and Nottinghamshire forecasting compliance by

year-end and Derbyshire accelerating recovery actions. The three systems are progressing recovery plans but remain under pressure due to productivity gaps, and seasonal and industrial action risks.

18. 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. However, each system has risks to delivery of this standard.

19. Transformational work continues to be undertaken 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.

20. **Derbyshire ICB:** Despite positive progress against planned trajectories, the system is in the second to lowest quartile for national benchmarking, with a material productivity gap. Actions being prioritised by the system include reviewing outpatient care to assess activity per consultant, ‘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 Derby and Burton NHS Foundation Trust (UHDB) and progressing shifts from day case/ admitted electives to outpatient settings. In parallel, the system is accelerating demand management initiatives, including rapid expansion of Advice and Guidance to support clinical decision-making. These measures aim to reduce unnecessary referrals, optimise patient flow, and ensure timely access to specialist input while maintaining quality of care.

21. The system faces significant risk of breaches beyond 65 weeks, particularly for complex orthopaedic and robotic cases, compounded by seasonal flu pressures and confirmed industrial action impacting elective capacity. To mitigate these risks, demand management initiatives are being accelerated, including expansion of Advice and Guidance to reduce unnecessary referrals and optimise patient flow. Additional Waiting List Initiative sessions are being deployed to clear long waiters, whilst teams validate lists to confirm ongoing need. Workforce actions, including flexible staffing and cross-site collaboration, aim to maintain trajectory and ensure timely access to specialist care.

22. **Lincolnshire ICB:** The system is forecasting achievement of the requirement to reduce 52-week waits (all ages) to below 1% of the total waiting list by March 2026, although this remains challenging for United Lincolnshire Teaching Hospitals NHS Trust (ULTH). ULTH’s 52-week waits are currently off plan, primarily within gynaecology, neurology and ear, nose and throat/audiology. A revised trajectory has been agreed to return performance to plan by the end of December. Recovery is dependent on increased activity through additional sessions, alongside productivity improvements delivered via outpatient and theatre improvement programmes. These measures are also expected to support improvements in performance against the 18-week referral to treatment

standard and the Time to First Appointment metric. North West Anglia NHS Foundation Trust has implemented a comparable outpatient improvement programme and is now ahead of plan in delivering reductions in 52-week waits.

23. **Nottinghamshire ICB**: Both providers are focusing on eliminating waits of 65 weeks and reducing the volume of patients waiting over 18 weeks for treatment. Dermatology is a specialty within the system where demand exceeds available capacity. Initiatives include pathway recovery for dermatology via insourcing, development of referral support services, expansion of community dermatology provisions, implementation of tele-dermatology, introduction of group clinics for sleep services, and enhanced validation processes at both trusts. The transfer of gynaecology patients to multiple providers following the contract hand back from Primary Integrated Community Services has resulted in backlogs, which are closely monitored to ensure timely treatment. All patients selected their choice of provider by the end of November, which met the ICB ambition.

Cancer

24. Across Derbyshire, Lincolnshire, and Nottinghamshire ICBs, progress against national cancer treatment standards remains mixed, with ongoing challenges in routinely meeting 62-day, 31-day, and Faster Diagnosis Standard targets. In October 2025, all ICBs failed to deliver to the operational planning trajectories except for the 28-day and 31-day standards being met by Nottinghamshire. However, performance by individual provider is varied.

25. **Derbyshire ICB:** UHDB continues to improve year-on-year but remains 5–6% below its 62-day trajectory, whilst 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.

26. Performance against cancer standards remains below ambition across the system. Neither Trust has achieved the 80% Faster Diagnosis Standard target this year, with CRH showing early gains in quarter one but declining in quarter two and further in September and October. UHDB has consistently underperformed by around 4% against plan. For the 31-day standard (96%), both Trusts averaged 90% early in the year, but CRH dropped to 86.6% in September and 82.7% in October, whilst UHDB achieved 94.1% in October—the best system performance to date.

27. The 62-day standard (85%) remains the most challenged, with both Trusts significantly below target in recent months. Close working is taking place with the East Midlands Cancer Alliance through the ‘Days Matter’ initiative and

leveraging additional funding to prioritise delivery and achieve overperformance by the end of quarter four, improving the year-end position. Both Trusts have cancer recovery plans in place.

28. **Lincolnshire ICB:** ULHT continued to show improvement across all three constitutional standards in November, although performance remains off the planned trajectory; and the backlog declined further to 350 patients as of 16/12/2025, with a low of 328 reached last week, driven by activity in colorectal pathways, which remains the area of greatest concern due to a high volume of patients waiting over 62 days (100 patients). Whilst the 28-day FDS and 31-day performance are improving but are still below plan and 62-day continues to be the most challenging yet showing modest gains; colorectal meetings are ongoing, and early front-end improvements can be evidenced on the 28 Day FDS. Breast cancer services remain a current concern though there is confidence in recovery to the expected position before the end of the financial year. In summary, improvements across all constitutional standards are progressing but not yet meeting trajectories, and governance remains focused on sustaining momentum through targeted pathway improvements and close monitoring of 62-day timelines to prevent deterioration, whilst aiming to meet all standards in the medium term.

29. **Nottinghamshire ICB**: NUH faces the greatest performance challenges. Due to significant deviations from planned trajectories and performance metrics having low national benchmarks, the Trust has been placed under Tier 1 oversight arrangements by NHS England. Referral volumes have risen at a rate exceeding national growth and have contributed to growth in cancer backlogs, particularly at NUH. Trust recovery strategies are currently being implemented, with an emphasis on expanding the workforce, optimising care pathways, and enhancing diagnostic capacity. These initiatives aim to achieve significant backlog reduction and improved performance by March 2026. Sherwood Forest Hospitals NHS Foundation Trust (SFH) delivered to plan for 62-day and 28 faster diagnosis metrics, but additional focus is required on 31-day diagnosis to treatment, which was below plan in October. The system is working with regional partners to address diagnostic delays and improve treatment capacity to further support improvement of the cancer pathway.

Diagnostics

30. Two of the three ICBs did not meet their 6-week wait trajectories in October 2025. Derbyshire were marginally ahead of plan with Lincolnshire and Nottinghamshire behind their plans. Diagnostic capacity limitations are affecting both the recovery of diagnostic performance and the delivery of cancer and elective services. Achieving year-end and medium-term targets requires ICB-wide collaboration, strategic investment in diagnostic infrastructure (including

community diagnostic centres and imaging). There is ongoing focus on pathway efficiency and modality productivity.

31. **Derbyshire:** both Trusts are delivering performance below their respective peers, and whilst CRH had been delivering to plan, their performance deteriorated from August. UHDB are further off plan and require 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. Cross cutting areas of focus for improvement are access to imaging and endoscopy and histopathology reporting improvements. Diagnostics remains a critical priority. As of October 2025, the diagnostic waiting list stands at 29,439, almost 6,000 above plan. Planned reductions in waiting times have not been achieved by either Trust this year. In October, 6,649 patients were waiting over 6 weeks, and 2,329 over 13 weeks. Recruitment freezes, withdrawal of Waiting List Initiatives and enhanced rates have contributed to poor performance. Significant investment in diagnostic capital through Community Diagnostic Centres and the Neighbourhood Health Centre approach aims to expand capacity and improve resilience.

32. **Lincolnshire**: The 6-week wait position is significantly under plan, with performance increasing by 1.9% in October and now sitting at 34%. The main pressures remain in audiology, NOUS and ECHO. Immediate priority improvement plans across partners include audiology improvement plan at ULHT. Medium term actions for sustained diagnostic improvement are focused on the Community Diagnostic Centres, and a new endoscopy unit in Lincoln in quarter two of 2026/27.

33. **Nottinghamshire**: Performance on 6-week waits benchmarks relatively well for the Nottingham and Nottinghamshire system within the Midlands; however, the position is varied across the two main acute providers. SHH is demonstrating steady progress, particularly with enhancements in echocardiology capacity. In contrast, NUH is experiencing ongoing challenges, especially concerning MRI capacity and related 6-week and 13-week waiting times. The challenges associated with MRI are largely attributable to reconciling the need to achieve the required financial targets with operational plan delivery. However, the decision has been made to keep the Nottinghamshire emergency Medical Services MRI scanner online and to extend scanner hours at the Nottingham Treatment Centre, which will add a further 45 scans per day. Other mechanisms to increase capacity are being considered by the Trust, which will form the basis of a backlog recovery plan.

Acute activity

34. Activity delivery is varied across the ICBs. First outpatients are under plan across all ICBs. Day Case volumes are above plan for Derbyshire and

Lincolnshire, and marginally below plan for Nottinghamshire. Complex Elective Ordinary activity is above plan for Derbyshire and Nottinghamshire. NHS England is closely monitoring 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.

35. **Derbyshire ICB:** There has been strong delivery of admitted activity, with Day Case and Elective Ordinary being significantly above planned levels for the year to date. However, Outpatient First and Follow Up activity is below planned levels by 2.2% and 1.4% respectively for the year to date.

36. **Lincolnshire ICB**: Consultant led out-patient follow-ups are off-plan and have not reduced to planned levels, in addition out-patient firsts have not increased to planned levels. To support the drive in activity and productivity across planned care pathways, ULTH has implemented a productivity programme focussing on out-patients and theatres. The out-patient clinic utilisation workstream includes maximising patient initiated follow up and reducing 'did not attends', clinic template and slot utilisation reviews and weekly meetings to challenge business units. Additional capacity (insourcing and waiting list initiatives) has been approved by the ULTH Board for November and December to support the national performance requirements for the end of December.

37. **Nottinghamshire ICB:** Elective Ordinary activity is above planned levels and day cases are marginally below plan by 0.2% for the year to date but above last year's volume by 0.8%. Outpatient first and follow up volumes are below plan and the volume delivered in the equivalent period of last year. The systemwide Get It Right First Time (GIRFT) 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 clinically appropriate.

Primary care

38. Primary care access has remained consistent across all three ICBs. Each ICB met its planned volume of GP appointments delivered in October. The ICBs continue to concentrate on national priority areas, including increasing units of dental activity and urgent dental appointments. Pharmacy First initiatives are performing above expected activity levels in all three systems.

39. **Derbyshire ICB:** Primary Care GP appointments increased in October and are back on plan following the dip in activity in the last two months. Work is ongoing with those GP practices in the bottom decile of the national dashboard and good progress is being made. Urgent Dental appointment take up remains a challenge and work is underway to promote services and increase take up.

40. **Lincolnshire ICB:** GP Appointments increased in October in part due to seasonal vaccination campaigns. 85.3% 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 October, which is due to service mobilisation and initial demand being lower than expected, work is underway to promote the services and increase utilisation. Pharmacy First consultations and units of dental activity are currently above the planned levels year to date.

41. **Nottinghamshire ICB:** GP appointments surpassed planned numbers in October. 86.9% of GP appointments were delivered within two weeks, exceeding NHS England's target of 85%. There are ongoing discussions with several practices to improve appointment book mappings for greater accuracy and consistency in recording. Support is being given to enhance dental activity by prioritising timely appointments, as well as re-focusing efforts to meet targets. Measures to boost urgent dental services include extending contracts with core providers, developing a proposal for securing a Bassetlaw provider, and expanding public communications about appointment availability. The Pharmacy First task force continues to work closely with general practitioners and community pharmacies to optimise the use of the Pharmacy First service.

Community services

42. The ICBs remain committed to reducing therapeutic community waits that exceed 52 weeks and aim to re-establish service delivery centred on the 18-week wait standard; however, performance varies across the ICB areas.

43. **Derbyshire ICB:** Children and young people’s community waits predominantly relate to Community Paediatrics Neurodevelopmental services. Autism Spectrum Disorder (ASD) assessment waits have increased in line with national position. (To note, Nottinghamshire and Lincolnshire do not report their neurodevelopmental pathways through community waits). A review of the full pathway for ASD and Attention-Deficit/Hyperactivity Disorder (ADHD) continues, with opportunities across the three ICBs to support improvement to be explored. 477 vasectomy patients were still waiting more than 52 weeks by month seven and conversations are ongoing on addressing the underlying problem of demand exceeding capacity in Derbyshire. Three Podiatry patients were waiting over 52 weeks at month seven, however this was not reflective of waiting times in general and these cases were related to patient choice, as 81.4% of patients were waiting less than 18 weeks.

44. **Lincolnshire ICB:** Five adults are waiting above 52 weeks for the Lymphoedema service, which is below plan. Funding has been approved for the Lymphoedema Service to establish a full-time clinic in Sleaford. This expansion will enable an additional 20–25 appointments per week, helping to reduce current waiting times. Following a review of the contract and service

specification, patients with Lipoedema will now be redirected to their GP Practice, along with appropriate treatment advice. Work has also commenced on developing a pathway in collaboration with the Lower Limb Service. This aims to support the assessment and garment fitting for patients with mild to moderate lower limb lymphoedema following triage. All 525 children and young people long waiters are within the ULTH Community Paediatrician service, which has significant waiting times for new and follow up appointments. The ICB business case to reduce wating times has not been taken forward as many stakeholders no longer have capacity.

45. **Nottinghamshire ICB**: The 52-week waiting position for the ICB remains over plan, with 114 patients against a plan of 12, of which all are children and young people. The key drivers are challenges in Speech and Language Therapy and Occupational Therapy services at Nottinghamshire Healthcare NHS Foundation Trust (NHT). A programme of work for Speech and Language Therapy began with a service-mapping workshop in September, followed by a second workshop in November to inform an options appraisal. NHT expects to clear all 52-week Occupational Therapy waits by the end of August 2026, which has been revised from the end of March. The service is moving to an “assess to treat” model, reducing hidden waits and treatment blocks.

Mental health and learning disabilities and autism

46. Progress has been made in lowering out-of-area placements and enhancing access to community services. Nonetheless, persistent difficulties continue with demand, use of acute beds, lengths of inpatient stays, reliance on private beds, and reductions in Learning Disabilities and Autism inpatients.

47. **Derbyshire ICB**: A Significant reduction has been achieved in Out of Area Placements due to targeted actions and new accommodation, although numbers have increased over the last two months. The focus remains on maintaining flow.

48. Adult Acute Bed Utilisation remains a critical issue, with focus on reducing average length of stay to 47 days by March 2026. It remains around 61 days and therefore still above trajectory as of October 2025.

49. Priorities are to deliver the 10 high-impact interventions and maximise community resources to close to manage Section 117 aftercare spend.

50. **LincoInshire ICB:** Talking Therapies is below plan with a Reliable Recovery rate of 47.7% and a Reliable Improvement rate of 69.8%, with some treatments continuing to be outsourced to provide additional capacity. A recent deep dive identified the need for staff to maintain greater awareness of the points reduction required to meet Reliable Recovery targets, which is now being addressed through enhanced staff supervision.

51. Access to Children and Young People's services continues to improve as of the end of September 2025, the median wait for a mental health assessment was eight weeks and 14.5 weeks for treatment. To support further reductions in waiting times, a Child and Adolescent Mental Health Services Action Recovery Plan and demand and capacity modelling have been completed and will be refreshed quarterly from September to ensure team capacity is aligned with demand and emerging data trends.

52. Within Individual Placement Support, one post has been successfully recruited to, with a start date of 27 January 2026, although long-term sickness within the team since October has delayed the realisation of benefits from new staff.

53. Bed occupancy within Lincolnshire Partnership NHS Foundation Trust (LPFT) remains high at 95% for acute beds, leaving the service vulnerable during periods of increased demand. A Rapid Action Plan is in place to address issues that can be managed internally, including a renewed focus on timely discharge, improved reporting, and closer collaboration with system partners to improve accommodation and social care pathways.

54. **Nottinghamshire ICB**: Current levels of inappropriate out of area placements are above plan and private bed usage remains at high levels, although reducing. Improvement plans are in place to reduce reliance on independent sector beds, with a focus on reducing lengths of stay to the national ambition and managing demand through enhanced community support, aligned to the 10-high impact changes. Further cross-system work is required to ensure that sustainable and aligned actions are being carefully balanced with wider system delivery risk, this is being supported by ICB colleagues.

55. The Crisis Advice Line faces ongoing quality and capacity issues, including data flows, and a spike in mental health presentations at accident and emergency units is under review. The provider is developing targeted recovery plans for crisis services and data quality. Early improvements are reported on improved call response rates following additional staff commencing with the service.

56. The Talking Therapies service is achieving most metrics, though reliable recovery rates are below target. A recovery plan is in place and being monitored through the Mental Health Programme Board with the provider to achieve the increased target for 2025/26.

57. There were two Learning Disabilities and Autism Inpatient adult admissions in November, and inpatient numbers remain above plan. Data cleansing and pathway reviews are underway, with admission avoidance strategies and discharge panels in place to expedite progress. Discussions are underway with the Local Authority regarding additional unplanned care beds to prevent inpatient admissions. Long waits for ADHD and autism assessments persist, delaying access to support.

Seasonal vaccination

58. Across all three ICBs vaccination uptake is broadly positive but uneven and detailed information is provided on Appendix 3. Covid vaccination rates show has strong performance in Derbyshire and Lincolnshire however there is a lower-than-expected uptake in Nottinghamshire. Flu 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, school children and maternity vaccinations remain weak points across all systems. Flu and RSV vaccination in pregnancy uptake is affected by issues at hospital sites in Derby and Nottinghamshire and national and local actions are ongoing to stabilise access and uptake. National campaigns to improve flu uptake continue, as well as collaboration locally with voluntary sector organisations and targeted communications in lower uptake communities.

59. Some providers are reporting discrepancies data matching for some staff cohort vaccinations, which could mean that the performance data is under-reported, and this is being investigated.

60. **Derbyshire ICB:** Seasonal performance is ahead of national delivery for most cohorts, with Flu school vaccinations and RSV vaccinations in pregnancy being the main areas of focus. The team continues to support care home outbreaks with regards to vaccination information.

61. All Primary and secondary schools were visited in December; however, all consenting children could not be vaccinated due to provider capacity and mop ups are scheduled during January.

62. A formal contractual letter was issued by NHS England to UHDB in relation to Vaccination in Pregnancy (RSV) uptake at the Royal Derby Site. Early indications are that the Trust is making process changes positively.

63. **Lincolnshire ICB:** Flu performance is ahead of national delivery across all cohorts. There are no specific areas of concern, but ongoing work will be focussed on healthcare workers, childhood flu vaccinations and in low uptake areas for the 65+ cohort supported by the Lincolnshire Community Health Services Vaccination and Rapid Response Team.

64. **Nottinghamshire ICB**: Flu vaccination uptake is above the Midlands and national average for over 65s, under 65s at risk, 2-3 year olds and healthcare workers. However, uptake remains lower for pregnant women, and primary and secondary school-aged children. The low uptake among school children relates in part to the scheduling of the school vaccination service and some capacity issues. For the Covid-19 vaccine, all cohorts are lower than at the same point last year and below regional ambitions, and lower in more deprived areas and among Black, Pakistani, and other minority ethnic groups. Targeted actions include:

    a) Additional school mop up clinics including weekends and school holidays.

b) The successful resolution of staffing issues relating to delivery of pregnancy vaccinations at both acute hospitals.

c) Additional resources are supporting Nottingham City practices in low uptake areas

d) Ongoing local communication and community engagement campaigns, press release, bulletins, newsletters across the system to promote all vaccinations.

Provider oversight

65. NHS England is revising their oversight arrangements with providers as part of the transition to the new operating model of the NHS. Monthly Provider Review Meetings will be held by NHS England with each provider as direct performance management is migrated to NHS England from quarter four onwards.

66. NHS England also undertakes enhanced oversight in relation to specific national priority metrics. This is determined through national benchmarking of metrics for delivery against the operational plan position, and assigning providers to tiering levels, with Tier 1 being the most intensive level of oversight. An overview of current tiering arrangements is provided in Appendix 4. The ICBs have two providers under Tier 1 enhanced oversight, which consist of formal weekly or fortnightly meetings led by the NHS England National Team and include the provider and the ICB. NUH is in Tier 1 for their four-hour wait emergency department performance and their cancer performance. ULTH is in Tier 1 for their four-hour and 12 hour waiting performance in Emergency Departments.

67. The NHS Oversight Framework has now been published, and Appendix 5 provides an overview summary of the provider position for quarter two. There are two providers that are under enhanced oversight arrangements and within Recovery Support Programme arrangements, these are NUH and NHT. ICB Executives are involved in the monitoring arrangements with NHS England.

Appendix 1 - Service Delivery Performance - January 2026

Service Delivery Dashboard v Plan		Pop / Provider	% / Value	Period	Derby and Derbyshire ICB				Lincolnshire ICB				Nottingham and Nottinghamshire ICB			
Acute	Metric				Plan	Actual	Variance		Plan	Actual	Variance		Plan	Actual	Variance	
Planned Care	<18 week wait for 1st OP	ICB Pop	%	Nov-25	68.0%	62.4%	-5.6%	✗	61.5%	60.7%	-0.8%	✗	72.4%	66.6%	-5.7%	✗
	<18w waits RTT	ICB Pop	%	Oct-25	60.6%	60.6%	0.0%	✓	57.2%	56.3%	-0.9%	✗	61.9%	61.2%	-0.7%	✗
	>52 week waits	ICB Pop	%	Oct-25	1.7%	2.3%	0.6%	✗	1.7%	2.6%	0.9%	✗	1.4%	2.3%	0.9%	✗
	>65 week wait	ICB Pop	Value	Oct-25	0	72	72	✗	0	73	73	✗	0	104	104	✗
	PTL (Waiting List)	ICB Pop	Value	Oct-25	119,842	118,090	-1,752	✓	112,524	108,645	-3,879	✓	126,069	128,712	2,643	✗
Cancer	<28 Day Faster Diagnosis	ICB Pop	%	Oct-25	76.9%	72.6%	-4.3%	✗	78.7%	76.1%	-2.6%	✗	77.3%	72.1%	-5.2%	✗
	<31 day	ICB Pop	%	Oct-25	92.0%	89.7%	-2.3%	✗	93.9%	89.0%	-4.9%	✗	90.4%	93.0%	2.6%	✓
	<62 Day Referral to Treatment	ICB Pop	%	Oct-25	73.5%	63.1%	-10.4%	✗	70.2%	66.0%	-4.3%	✗	65.5%	65.6%	0.1%	✓
	LGI Fit Test	ICB Pop	%	Oct-25	81.1%	82.6%	1.5%	✓	78.6%	87.2%	8.7%	✓	78.2%	76.1%	-2.1%	✗
Diagnostics	Planning 9 Modalities > 6ww	ICB Pop	%	Oct-25	20.5%	20.1%	-0.4%	✓	16.0%	33.2%	17.2%	✗	15.0%	18.7%	3.7%	✗
Urgent Care	<4 hour wait ED	ICB Prov	%	Nov-25	77.1%	68.9%	-8.2%	✗	73.0%	76.3%	3.3%	✓	72.4%	65.5%	-6.9%	✗
	>12 hour wait from arrival ED	ICB Prov	%	Nov-25	6.5%	13.4%	6.9%	✗	9.3%	12.3%	3.0%	✗	10.1%	11.4%	1.3%	✗
	>45m Ambulance Handovers	ICB Prov	%	Nov-25	0.0%	20.9%	20.9%	✗	0.0%	18.6%	18.6%	✗	0.0%	21.8%	21.8%	✗
	Cat 2 Mean Response Time	ICB Prov	Value	Nov-25	00:26:09	00:51:00	00:24:51	✗	00:30:00	00:47:45	00:17:45	✗	00:26:09	00:46:07	00:19:58	✗
Primary Care	GP Appointments	ICB Pop	Value	Oct-25	771,108	793,070	21,962	✓	628,969	631,557	2,588	✓	832,204	857,793	25,589	✓
	Units of Dental Activity (UDAs)	ICB Pop	Value	Nov-25	108,862	86,919	-21943	✗	68,588	54,598	-13990	✗	150,273	106,131	-44,142	✗
	Urgent Dental Activity	ICB Pop	Value	Nov-25	6,674	3,291	-3383	✗	3,973	2,391	-1582	✗	8,322	4,857	-3,465	✗
	Pharmacy First	ICB Pop	Value	Oct-25	7,891	9,070	1179	✓	6,306	7,900	1594	✓	10,169	13,850	3681	✓
Community	>52ww - Adult	ICB Pop	Value	Oct-25	687	4	-683	✓	37	5	-32	✓	0	0	0	✓
	>52ww - CYP	ICB Pop	Value	Oct-25	2,239	2,288	49	✗	15	525	510	✗	12	114	102	✗
Mental Health	Inappropriate Out of Area Inpatients	ICB Pop	Value	Oct-25	5	11	6	✗	7	0	-7	✓	0	5	5	✗
	Inpatient Mean Length of Stay	ICB Pop	Value	Oct-25	46	61	15	✗	61	29	-32	✓	56	56	0	✗
	Individual Placement Support	ICB Pop	Value	Oct-25	762	785	23	✓	689	655	-34	✗	1300	1140	-160	✗
	Early Intervention Psychosis	ICB Pop	%	Oct-25	60.0%	56.6%	-3.4%	✗	60.0%	66.0%	6.0%	✓	60%	84.0%	24.0%	✓
	Talking Therapy Reliable Recovery	ICB Pop	%	Oct-25	47.2%	46.0%	-1.2%	✗	48.8%	45.4%	-3.4%	✗	50%	49.5%	-0.5%	✗
	Talking Therapy Reliable Improvement	ICB Pop	%	Oct-25	68.0%	69.0%	1.0%	✓	68.5%	66.9%	-1.6%	✗	68%	69.3%	1.3%	✓
	CYP Access	ICB Pop	Value	Oct-25	14,494	14,655	161	✓	10,909	10,360	-549	✗	20475	21855	1380	✓
	CYP ED Routine	ICB Pop	%	Oct-25	95%	100.0%	5.0%	✓	95.0%	75.0%	-20.0%	✗	95%	87%	-8.0%	✗
LD&A	Adult Inpatients	ICB Pop	Value	Nov-25	31	41	10	✗	27	29	2	✗	33	37	4	✗

CYP Inpatients	ICB Pop	Value	Nov-25	3	7	4	✗	2	0	-2	✓	3	2	-1 ✓
Annual Health Checks	ICB Pop	Value	Nov-25	454	461	7	✓	1,883	2,043	160	✓	1,346	3,110	1,764 ✓

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 October 2025

Latest Month	Oct-25
Previous Year	Oct-24
YTD Period	Apr - Oct

Derby and Derbyshire ICB Population	October 2025 Only				Oct25 v Oct24		April 2025 - October 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)	50,942	48,808	-2,134	-4.2%	552	1.1%	342,372	347,502	5,130	1.5%	19,548	6.0%
Elective Ordinary	2,110	2,273	163	7.7%	-75	-3.2%	13,739	14,945	1,206	8.8%	-125	-0.8%
Day Cases	13,454	15,280	1,826	13.6%	-11	-0.1%	87,690	104,318	16,628	19.0%	2,486	2.4%
Diagnostics (9 key modalities)	44,994	45,546	552	1.2%	5,329	13.3%	297,949	303,452	5,503	1.8%	35,284	13.2%
Outpatients 1st (Spec Acute)	37,157	34,664	-2,493	-6.7%	-1,682	-4.6%	242,263	236,933	-5,330	-2.2%	-3,767	-1.6%
Outpatients Follow-ups (Spec Acute)	84,554	81,165	-3,389	-4.0%	-1,625	-2.0%	543,642	535,852	-7,790	-1.4%	85	0.0%

Lincolnshire ICB Population	October 2025 Only				Oct25 v Oct24		April 2025 - October 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	30,160	-660	-2.1%	1,120	3.9%	212,758	209,761	-2,997	-1.4%	5,675	2.8%
Elective Ordinary	1,627	1,623	-4	-0.2%	37	2.3%	10,749	10,450	-299	-2.8%	-403	-3.7%
Day Cases	10,397	10,226	-171	-1.6%	-363	-3.4%	68,303	69,695	1,392	2.0%	-451	-0.6%
Diagnostics (9 key modalities)	41,573	38,912	-2,661	-6.4%	1,644	4.4%	271,503	267,123	-4,380	-1.6%	25,350	10.5%
Outpatients 1st (Spec Acute)	26,640	26,449	-191	-0.7%	-1,774	-6.3%	177,387	175,794	-1,593	-0.9%	-3,313	-1.8%
Outpatients Follow-ups (Spec Acute)	45,446	46,317	871	1.9%	-2,423	-5.0%	296,246	306,538	10,292	3.5%	-2,272	-0.7%

Nottingham and Nottinghamshire ICB Population	October 2025 Only				Oct25 v Oct24		April 2025 - October 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: NUH+SFH)	43,116	47,490	4,374	10.1%	6,695	16.4%	292,670	299,060	6,390	2.2%	18,121	6.5%
Elective Ordinary	2,303	2,499	196	8.5%	291	13.2%	15,885	16,023	138	0.9%	190	1.2%
Day Cases	16,153	16,304	151	0.9%	229	1.4%	107,521	107,265	-256	-0.2%	859	0.8%
Diagnostics (9 key modalities)	46,197	47,748	1,551	3.4%	-1,939	-3.9%	302,348	316,387	14,039	4.6%	1,479	0.5%
Outpatients 1st (Spec Acute)	36,289	32,484	-3,805	-10.5%	-1,739	-5.1%	236,174	213,348	-22,826	-9.7%	-9,170	-4.1%

Outpatients Follow-ups (Spec Acute)	74,427	69,219	-5,208	-7.0%	-3,435	-4.7%	487,083	459,002	-28,081	-5.8%	-16,460	-3.5%

Data Source:
Elective, Day Case, Outpatients - Futures: Joint Activity Report
Diagnostics - Statistical Work Area: Monthly Diagnostic Waiting Times and Activity Report
A&E Attendances - Statistical Work Area: A&E Attendances and Emergency Admissions Report

Appendix 3 – ICBs' Seasonal Vaccination Performance

Flu Vaccine uptake based on National Reporting

Flu Vaccine Uptake (as of 15/12/2025) 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	70.60%	75.00%	-4.40%	40.50%	45.00%	-4.50%	40.90%	31.10%	9.90%	43.20%	50.00%	-6.80%	50.60%	60.00%	-9.40%	41.10%	50.00%	-8.90%	44.10%	45.60%	-1.50%	51.30%
Midlands	72.40%	75.70%	-3.30%	40.00%	47.20%	-7.20%	39.80%	32.00%	7.80%	40.00%	46.70%	-6.70%	45.50%	53.30%	-7.80%	38.20%	44.10%	-5.80%	39.40%	42.40%	-3.10%	51.10%
Derbyshire	76.60%	79.70%	-3.10%	43.80%	50.60%	-6.80%	45.00%	35.00%	10.00%	47.60%	54.90%	-7.30%	47.70%	59.40%	-11.70%	38.30%	52.50%	-14.20%	49.10%	52.30%	-3.20%	55.80%
Lincs	75.70%	78.80%	-3.20%	44.60%	51.20%	-6.50%	45.50%	37.70%	7.80%	46.20%	52.30%	-6.10%	54.70%	61.50%	-6.80%	47.20%	53.60%	-6.30%	51.90%	52.00%	0.00%	59.10%
Notts	74.00%	77.40%	-3.50%	41.30%	48.30%	-7.00%	38.70%	31.50%	7.20%	42.00%	49.00%	-7.00%	44.20%	56.20%	-12.00%	37.40%	48.50%	-11.00%	44.90%	46.60%	-1.70%	52.10%

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	-0.90%	0.60%	1.80%	-0.10%	1.00%	7.30%	0.80%
Midlands Average	-0.90%	0.30%	2.30%	-1.50%	2.10%	5.80%	0.70%
DDICB	-0.80%	0.40%	2.00%	-5.10%	-3.80%	5.70%	-0.20%
Lincs ICB	-1.00%	1.20%	3.50%	-0.90%	-0.20%	10.40%	0.80%
NNICB	-1.20%	0.40%	2.00%	-3.70%	-0.80%	8.70%	0.10%

	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	66.60%	66.20%	63.20%	59.90%	29.00%	25.00%	42.10%	60.00%	66.60%	70.00%	45.60%	50%/60%
Midlands	66.80%	66.00%	62.70%	58.70%	27.00%	24.10%	42.10%	65.00%	67.50%	70.40%	41.70%	50%/60%
Derbyshire	69.90%	69.60%	68.00%	63.90%	32.20%	28.80%	45.50%	68.20%	70.60%	73.90%	42.20%	50%/60%
Lincs	71.80%	69.20%	68.60%	64.90%	33.80%	30.60%	47.50%	71.00%	73.30%	75.60%	46.40%	50%/60%
Notts	62.4%*	66.70%	62.90%	60.20%	27.10%	25.00%	43.90%	65.00%	70.00%	72.40%	44.20%	50%/60%

Key
Ahead of national and England average
Ahead of Midlands but not England average
Below both Midlands and England average

*Uptake may be understated due to vaccination not flowing into FDP

Appendix 4 – NHS Provider Oversight Arrangements

Derby and Derbyshire ICB	Lincolnshire ICB	Nottingham and Nottinghamshire ICB
Chesterfield Royal Hospital Total Waiting Lists Referral to Treatment (RTT) 18 week % **Tiering:** Tier 2 Elective, Cancer and Diagnostics	**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 1 for UEC	**Sherwood Forest Hospitals:** ***Recovery Plans:*** 4 hour waits in ED % Total Waiting Lists RTT 18 week % **Tiering:** Tier 2 Elective (1st OP 18w)
University Hospitals of Derby and Burton Not required to resubmit H2 trajectories **Tiering:** Tier 2 Elective, Cancer and Diagnostics		**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 Tier 2 Elective (52ww)

Appendix 5 – NHS Trust NHS Oversight Framework Ratings – Q2 2025-26

The Nottingham and Nottinghamshire system has two providers within Provider Improvement Programme arrangements:

1. Nottingham University Hospitals NHS Trust
2. 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:

1. Derbyshire Community Healthcare Services NHS Foundation Trust
2. East Midlands Ambulance Service NHS Trust

Q2 2025-26												
Provider Name	**Type**	**Access to Services**	**Finance & Productivity**	**Effectiveness & Experience**	**Patient Safety**	**People & Workforce**	**Org Delivery Score**	**Average Score**	**Org Rank**	**Finance override**	**Trust in RSP**	**Final Segment**
University Hospitals of Derby and Burton NHS Foundation Trust	Acute	2	3	3	3	3	3	2.54	89	Yes	No	3
Chesterfield Royal Hospital NHS Foundation Trust	Acute	3	4	2	1	3	3	2.53	87	Yes	No	3
Derbyshire Healthcare NHS Foundation Trust	MH	4	1	4	3	3	3	2.55	41	No	No	3
Derbyshire Community Health Services NHS Foundation Trust	Comm	2	2	3	1	2	1	2.02	13	No	No	1
United Lincolnshire Hospitals NHS Trust	Acute	4	1	3	4	3	4	2.9	124	No	No	4
Lincolnshire Partnership NHS Foundation Trust	MH	2	3	1	2	2	2	2.2	30	Yes	No	3
Lincolnshire Community Health Services NHS Trust	Comm	2	3	4	2	3	4	2.7	46	No	No	4
Nottingham University Hospitals NHS Trust	Acute	4	4	2	4	3	4	2.84	113	Yes	No	4
Sherwood Forest Hospitals NHS Foundation Trust	Acute	2	4	3	1	2	2	2.26	56	Yes	No	3
Nottinghamshire Healthcare NHS Foundation Trust	MH&Comm	3	4	1	4	4	4	2.85	56	Yes	Yes	4*
East Midlands Ambulance Service NHS Trust	Amb	4	1	1	1	2	1	1.86	2	No	No	1

Key:
Lowest Quartile
Highest Quartile

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:	15/01/2026
Paper title:	**EPRR Annual Reports and Core Standards 2024-25**
Paper reference:	ICB CIC 25 031
Paper author:	Rebecca Neno, Deputy Director for System Delivery and Deputy Accountable Emergency Officer, NHS Lincolnshire ICB
Paper sponsor:	Maria Principe, Executive Director for Commissioning and Accountable Emergency Officer
Presenter:	Maria Principe, Executive Director for Commissioning and Accountable Emergency Officer

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

Report summary:

The annual reports provide assurance on the ICB Emergency Preparedness, Resilience and Response (EPRR) activities undertaken by each ICB to be adequately prepared to respond to major and/or business continuity incidents. The reports outline the following:

- ICB Compliance against the 2024/25 Core Standards.
- Oversight of the EPRR programmes of work.
- Delivery against the annual Training and Exercise programme.
- Summary of business continuity, critical and major incidents experienced by the organisations and wider system during the year.
- Learning identified through incidents and exercises.

The reports were endorsed by the ICBs' respective Audit Committees at their meeting on 17 December 2025.

Recommendation(s):

The Boards are asked to **receive** the reports for assurance regarding the ICBs' current level compliance.

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 – NHS Derby and Derbyshire ICB Emergency Preparedness, Resilience and Response Annual Report 2024-25
Appendix 2 – NHS Lincolnshire ICB Emergency Preparedness, Resilience and Response Annual Report 2024-25

Appendices

Appendix 3 – NHS Nottingham and Nottinghamshire ICB Emergency Preparedness, Resilience and Response Annual Report 2024-25

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Derby and Derbyshire Integrated Care Board

Preparing for Emergencies in the NHS in England

NHS Derby and Derbyshire ICB Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2024-25

1. EXECUTIVE SUMMARY

This annual report provides assurance regarding the system-wide and organisational activities related to Emergency Preparedness, Resilience, and Response (EPRR) undertaken during the reporting period from 31 August 2024 to 31 August 2025.

2. BACKGROUND

As a Category 1 responder, the Integrated Care Board (ICB) is mandated to deliver eight key resilience objectives:

- Assess the risk of emergencies occurring and incorporate this assessment into planning.
- Establish comprehensive emergency plans.
- Develop and maintain business continuity plans to ensure the continuation of critical functions during emergencies.
- Provide timely warnings, information, and advice to the public in the event of an emergency.
- Share information with other local responders to enhance coordination.
- Cooperate with local responders to improve coordination and efficiency.

This programme is collectively referred to as Emergency Preparedness, Resilience, and Response (EPRR). In addition, NHS organisations are required to comply with relevant legislation and guidance, including:

- Health and Social Care Act 2022
- NHS EPRR Core Standards (annual assurance process)
- EPRR Framework 2022
- ISO 22301 (Business Continuity)

3. DELIVERY OF THE EPRR WORK PROGRAMME 2024

A workplan/objectives were set in 2023-24 outlined below with progress made:

Objective	Detail	Status
CS 12	Infectious Disease- inclusion of HCID process	**COMPLETED**
CS 14	Countermeasures- Countermeasures system response	**COMPLETED**
CS 16	Evacuation and Shelter- System understanding of capability to respond	**COMPLETED**
CS 25	Staff Awareness and training- All staff training programme for awareness	**COMPLETED**

Objective	Detail	Status
CS 29	Decision Logging- Adequately trained Loggists for the ICB	COMPLETED
CS 50	Business Continuity Management System (BCMS) Monitoring and evaluation- No clear KPIs established	COMPLETED
CS 51	Business Continuity Audit- no clear evidence of internal auditing	COMPLETED
CS 52	BCMS continuous improvement- No clear links to improvement cycle	COMPLETED
CS 53	Assurance of commissioned providers/Suppliers Business Continuity Plans (BCPS)- lack of audit of commissioned providers	COMPLETED

4. EMERGENCY PLANS COMPLIANCE

During 2024-25 the EPRR team updated all EPRR documentation as below:

Plan	Purpose
EPRR Policy	Strategic oversight document for EPRR delivery within the ICB
Incident Response Plan	Regulatory required plan to respond to Major, Business Continuity and Critical Incidents affecting the ICB Inclusion of other key risk elements was also completed to reduce numbers of plans within DDICB.
Emergency Communications Plan	This plan details how the ICB will ensure delivery of its legal responsibility to warn and inform the system of Derbyshire and partner responders during an emergency
Business Continuity Management System	This details how the ICB will ensure the delivery of Business Continuity processes for itself as an organisation in alignment with ISO 22301.
Service level Business Continuity Plans	These plans detail the local arrangements for each service area within the ICB and how each department will respond to any Business Continuity Incidents.

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4.1 Business Continuity Compliance 2024-25

Business Continuity KPIs demonstrate compliance as below:

KPI 1 - Overall framework to ensure that Business Continuity arrangements are developed and maintained.	**80%**
In date plans (% of total)	100%
In date BIAs (% of total)	100%
Tested in the last 3 years (% of total) (Exercise Domino) *	67%
Accessible to all members of staff? (Yes/No)	Yes
Number of depts internally audited (% of total)	100%

Testing over 3 years- 100% to be achieved by end of year 2025-26

5. TRAINING COMPLIANCE

The KPI performance for last 12 months is as below:

KPI 3 - Effective training is in place for roles identified within TNA.	**80%**
ICB Incident Response Training	100%
Loggists	100%
Principles of Health Command*	13%
Business Continuity Awareness Training	100%
EPRR Awareness Training	85%

**** Limited PoHC courses have been given to DDICB in past 12 months.***

6. EXERCISING COMPLIANCE

Exercising as a core component of EPRR has been a focus for the past 12 months the details below show the engagement across DDICB in this programme:

- Exercise Cyber Response (ICS Cyber Resilience)
- Exercise Tangra (NHS Pandemic Exercise)
- Exercise Pegasus (National Pandemic Exercise)
- Exercise COMAH Response (multiple LRF support)
- Exercise Domino CPO (Local Business Continuity TTX)
- Exercise Domino COS (Local Business Continuity TTX)
- Exercise Hermes V (Communications Exercise)
- Exercise Hermes VI (Communications Exercise)

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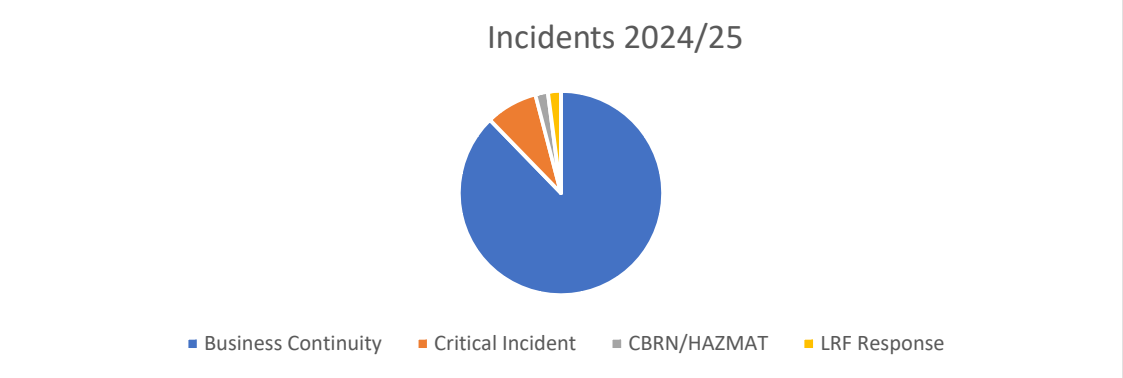
7. INCIDENTS EXPERIENCED

The ICB has been alerted or responded to incidents during past 12 months, including:

Year	Major Incidents	Business Continuity Incident	Critical Incident	CBRN/HAZMAT
2024-25	0 ↓	43↑	4↑	1 ↓
2023-24	2 ↔	29 ↑	3 ↑	10↔
2022-23	4	21	5	1



8. LESSONS AND LEARNING FROM INCIDENTS AND EXERCISES

The ICB continues to learn from incidents and exercises, with numbers detailed below:

Total number learning points	Number Closed	Number pending closure (6-month review*)	Number open
41	25	11	5

9. COMPLIANCE WITH THE EPRR CORE STANDARDS PROCESS 2024-25

Core Standards have been approved by NHS England and DDICB has attained a status of Substantial Compliance, this is achieved by an 99% compliance against the Core Standards (2024-25 was 96%). Areas of work identified are:

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Title	Gaps	Action Plan	Due Date
CS 49- DSPT Toolkit	DSPT Toolkit marked as working towards during this year's assessment	DSPT Toolkit submission managed by ICB Digital Team, EPRR Team will support to develop arrangements in relation to Cyber Resilience	31/08/2026

NHS Lincolnshire Integrated Care Board

Preparing for Emergencies in the NHS in England

NHS Lincolnshire ICB Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2024 – 2025

1. EXECUTIVE SUMMARY

This annual report provides assurance regarding the system-wide and organisational activities related to Emergency Preparedness, Resilience, and Response (EPRR) undertaken during the reporting period from 31 August 2024 to 31 August 2025.

2. BACKGROUND

As a Category 1 responder, the Integrated Care Board (ICB) is mandated to deliver eight key resilience objectives:

- Assess the risk of emergencies occurring and incorporate this assessment into planning.
- Establish comprehensive emergency plans.
- Develop and maintain business continuity plans to ensure the continuation of critical functions during emergencies.
- Provide timely warnings, information, and advice to the public in the event of an emergency.
- Share information with other local responders to enhance coordination.
- Cooperate with local responders to improve coordination and efficiency.

This programme is collectively referred to as Emergency Preparedness, Resilience, and Response (EPRR). In addition, NHS organisations are required to comply with relevant legislation and guidance, including:

- Health and Social Care Act 2022
- NHS EPRR Core Standards (annual assurance process)
- EPRR Framework 2022
- ISO 22301 (Business Continuity)

3. EPRR ASSURANCE

As a system, substantial compliance has been reported to and agreed at LHRP. This is a significant improvement with two trusts moving from overall partial to substantial compliance this year.

Good practice and compliance continue to be present within the domain of Chemical, Biological, Radiological and Nuclear (CBRN) response. Comprehensive training and

specialist resource is available across a spectrum of capability. This includes Initial Operational Response (IOR) and full decontamination of self-presenting casualties.

Lincolnshire ICB is reporting a substantial compliance position with two standards challenged by NHS England.

Core Standard	Detail
44 – Business Continuity Policy Statement	Observation required policy to be presented to board
53 – Assurance of commissioned suppliers / providers (Business Continuity Plans)	Management process of providers / suppliers who do not provide assurance, should be included within the Business Continuity Management System

4. TRAINING & EXERCISING

The training mandate remains as follows for all ICB commanders.

LRF Multi Agency Training

Compliance remains high with commanders attending the county emergency centre to undertake multi agency training alongside other Category 1 & 2 responder agencies. Strong availability of courses contributes to compliance.

NHS England Principles in Health Command

Course availability remains poor and the main contributor to low compliance. Escalation continues to take place through both LHRP and Regional Emergency Planning Leads group.

Lincolnshire ICB Command Training

At the time of reporting, the ICB is halfway through its internal training cycle. It is expected that 100% compliance will be achieved in the new year period.

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Strategic Commanders

Tactical Commanders

Lincolnshire ICB continues to maintain a robust exercising schedule which tests the catalogue of EPRR capabilities. We remain compliant with the EPRR framework

3

exercise schedule and have been identified as good practice by continuing to exercise during challenging periods of demand and response.

Exercise debriefs take place following all exercises and learning is shared with LHRP organisations and LRF partners where applicable. Lessons identified are subsequently managed by the ICB EPRR team.

The detail below shows engagement across Lincolnshire:

- Exercise Tangra (NHS Pandemic Exercise)
- Exercise Pegasus (National Pandemic Exercise)
- Exercise COMAH Response (multiple LRF support)
- Exercise Aegis (Cold Weather Preparedness)
- Exercise Agnew (Multi Agency Resilient Telecoms)
- Exercise Blue Snapper (Situation Reporting)
- Exercise Cinder Rose (Hot Weather Preparedness)
- Exercise Orange Signal (Alerting Cascade)
- Exercise Solaris (Pandemic Preparedness)
- Exercise Blue Coral (Business Continuity)
- Exercise Toucan (National Alerting Cascade)

5. INCIDENTS

So far in 2025, there has been 23 declared incidents by NHS funded organisations who provide services to Lincolnshire. All incidents have been classified as Business Continuity.

Several multi-agency incidents have been supported, although no declaration made by an NHS funded organisation. Evacuation & Shelter due to adverse weather or threat has required health organisations to rapidly identify vulnerable persons and support where required. This is often resource intensive in a sudden impact context.

6. LESSONS AND LEARNING FROM INCIDENTS AND EXERCISES

The ICB continues to learn from incidents and exercises. Lessons are identified nationally, regionally and through local resilience forum organisations.

Lessons are assessed for applicability by the EPRR team and shared with other relevant teams for assessment.

Significant numbers of lessons are received via the regional process, and not all are pertinent to EPRR. This has been escalated through LHRP.

Regional Lessons Learned

Total number lessons identified	Number Closed	Not Applicable	Amber	Red
696	446	234	16	0

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LRF Lessons Learned

Total number lessons identified	Number Closed	Not Applicable	Amber	Red
35	12	23	0	0

Organisational Lessons Learned

Total number lessons identified	Number Closed	Not Applicable	Amber	Red
93	60	21	12	0

NHS Nottingham and Nottinghamshire ICB Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2024-2025

1. Executive Summary

This annual report provides assurance regarding the system-wide and organisational activities related to Emergency Preparedness, Resilience, and Response (EPRR) undertaken during the reporting period from 31 August 2024 to 31 August 2025.

2. Introduction

The Integrated Care Board (ICB) as a Category 1 Responder under the requirements of the Civil Contingencies Act 2004 (CCA) is subject to the full set of civil protection duties:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place business continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance coordination
- Co-operate with other local responders to enhance coordination and efficiency

3. ICB Annual assessment against EPRR Core Standards

Following a self-assessment with NHS England, the ICB has been rated as **partially compliant**. Whilst this remains the same compliance level as last year it should be noted that significant progress has been made across the partially compliant domains.

The ICB achieved full compliance with 38 out of the 47 core standards. Nine standards were assessed as partially compliant, and there were no non-compliance ratings for the ICB.

All areas of partial compliance for the ICB have a clear action plan to ensure full compliance in next year's assessment.

Actions are summarised below and are also incorporated in the EPRR work programme for 25/26.

Ref	Standard	Standard detail	ICB specific Action	Timeframe
13	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic.	Development of an ICB Pandemic Plan will be based on the findings from the 2025 pandemic exercises (Tangra, Solaris and Pegasus). These findings will be used to produce an ICB plan aligned with the LRF Pandemic Plan	April 2026
25	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Continue to progress training programme to deliver the EPRR awareness training to all ICB teams	June 2026
29	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24-hour access to a trained Loggist(s) to ensure support to the decision maker	Undertake a modelling review of the ICB's loggist requirements to establish a clear 24/7 call-out process and determine the staffing and shift requirements needed to maintain coverage during extended incidents. Increase the number of trained ICB loggists in line with modelling outcomes.	March 2026 July 2026
34	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Review and align the ICB's communications plans and action cards to ensure consistency across the IRP and Comms Emergency Plan, including staffing arrangements for extended and out-of-hours coverage. Test the plan in and out of hours	March 2026 July 2026

Ref	Standard	Standard detail	ICB specific Action	Timeframe
46	Business Impact Analysis / Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Review and update the ICB's Business Continuity arrangements to clarify policies, standardise BIA processes across departments, and strengthen service-level continuity planning.	March 2026
47	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover, and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Review and update the ICB's Business Continuity arrangements to clarify policies, standardise BIA processes across departments, and strengthen service-level continuity planning.	March 2026
48	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Following an update of the BIAs and wider Business Continuity arrangements continue to undertake a tabletop exercise with Departments	March 2026
50	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured, and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Undertake an internal assessment against the KPIs and present the results to the ICB Audit and Risk Committee and Board	June 2026
53	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these	Agree a three-year programme with procurement to undertake a risk-based audit of suppliers	February 2026

Ref	Standard	Standard detail	ICB specific Action	Timeframe
		providers business continuity arrangements align and are interoperable with their own.	Undertake & complete 3-year programme	March 2029

4. ICB Training and Exercising

This year, the SCC and EPRR Team has developed joint on-call incident response and operational pressures training to ICB on-call staff. All ICB staff roles and colleagues with a role in incident response are now included in the Training Needs Analysis to ensure they receive suitable and effective training.

The annual Training Prospectus' includes a programme of live, table-top, command post and communication exercises. The exercises are designed to test and develop the ICB's plans and procedures and are a requirement of both the Civil Contingencies Act (2004) and NHS EPRR Core Standards. The ICB is required to hold the following:

- Communication exercises – minimum frequency – every six months
- Table-top exercise – minimum frequency – every 12 months
- Live play exercise – minimum frequency – every three years
- Command post exercise – minimum frequency - every three year

In May 2025, the ICB undertook a Business Continuity exercise (Exercise Troy) to test the response of the ICB System Coordination Centre (SCC) as an essential operational service to a cyber outage. The outcomes were used to update the SCC's Business Continuity Plan.

In June 2025, the ICB undertook an in hours test (Exercise Parakeet) of the ability to contact provider and ICB first points of contact. Overall, the ICB was able to promptly contact the first points of contact.

In August 2025, the ICB SCC & EPRR Team delivered a system-wide tabletop exercise (Exercise A Winter's Tale) to stress test the resilience of the urgent and emergency care system winter plans and OPEL escalation cards.

This year the ICB EPRR Manager was responsible for leading the planning on a series of pandemic exercises:

- Exercise Tangra (Apr 2025): System wide tabletop exercise designed to provide NHS and health organisations with an opportunity to explore their response to a pandemic

- Exercise Solaris (Apr 2025): The tabletop exercise was developed to provide Local Resilience Forum (LRF) partners with an opportunity to explore their response to a pandemic. This was held as preparation for a national pandemic exercise (Exercise Pegasus).

- Exercise Pegasus (Sep to Nov 2025). The exercise was run at a national and local level, with the outcome from national play being fed into the local play.

Apart from Principles of Health Command, there is strong compliance with on-call training within the ICB.

Training	Compliant	Non-compliant
Tactical Oncall (Urgent Care Operational Pressures & Incident Response) (19 On-call)	18	1
Strategic Oncall (Urgent Care Operational Pressures & Incident Response) (18 On-call)	18	0
Principles of Health Command (All On-call)	6	31
Loggist	10	0

5. Incidents Over the Past 12 Months

The ICB has oversight of incidents across the system and has been alerted to the number of following incidents (1st Sept 2024 to 1st Sept 2025).

Year	Major Incidents	Business Continuity Incident	Critical Incident	CBRN / HAZMAT	Other
2024-25	3*	13	1	0	12**

* These Major Incident were Police declared non-health related incidents

** Two Major Incident Stand Bys; four periods of Industrial Action; and six miscellaneous

Meeting title:	Integrated Care Boards: Open Session (meeting in common)
Meeting date:	15/01/2026
Paper title:	**Committee Highlight Reports**
Paper reference:	ICB CIC 25 032
Paper author:	Committee Secretariat
Paper sponsor:	Committee Chairs
Presenter:	Committee Chairs

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

Report summary:

This report provides an overview of the work undertaken by the Boards' committees since the last meeting in November 2025. Following the Boards' agreement to implement aligned governance arrangements across the three ICBs, all committees have now convened, adopted their terms of reference and draft work programmes, and received handover reports from their predecessor ICB committees to support continuity through the transition.

The Human Resource and Remuneration Committee has met on an extraordinary basis to progress urgent business and will hold its first formal meeting on 22 January 2026. At that meeting, it will receive its terms of reference, draft work programme, handover report and the relevant operational risks, in line with the other committees.

All committees have received the operational risks relevant to their remit following work to align risks across the three ICBs. Work is currently underway to review and refine the aligned risk entries, including executive oversight, to ensure consistency in grading and narrative. Major risks will be provided in the next Committee Highlight Report for the Boards' information.

This report is intended to provide assurance that the committees are discharging their delegated duties and to escalate any matters requiring the Boards' attention. It summarises the assurance levels determined for the items considered and any actions initiated in response to areas of limited assurance.

Recommendation(s):

The Boards are asked to **receive** the paper for assurance in relation to the work of its committees.

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

Relevant statutory duties:	
☒ Promoting innovation	☒ Promoting research
☒ Patient choice	☒ Obtaining appropriate advice
☒ Promoting education/training	☒ Climate change

Appendices

Appendix 1 – Joint Finance and Performance Committee Highlight Report
Appendix 2 – Joint Quality and Service Improvement Committee Highlight Report
Appendix 3 – Joint Strategic Commissioning Committee Highlight Report
Appendix 4 – Joint Remuneration and Human Resources Committee Highlight Report
Appendix 5 – Joint Transition Committee Highlight Report
Appendix 6 – Audit Committees' Highlight Report
Appendix 7 – Description of levels of assurance

Are there any conflicts of interest requiring management?

No.

Is this paper confidential?

No.

Appendix 1: Joint Finance and Performance Committee Highlight Report

Meeting Dates:	03 December 2025 16 December 2025 (extraordinary meeting) 07 January 2025
Committee Chair:	Stephen Jackson, Non-Executive Director

Item	Summary	Level of Assurance
2024/25 System and ICB Finance and Efficiency Report (Months 7 and 8)	At the end of month eight the systems were reporting a £130 million deficit but continued to forecast a year-end break-even position, which was £95 million adverse to plan and demonstrated a deteriorating position. Within the ICBs, a year-to-date variance of £10 million was being reported, with NHS Lincolnshire ICB being the main driver. In line with the NHS England reporting protocol, all providers and ICBs continued to forecast a break-even position at year end and for efficiency plans to be delivered in full, although there was considerable risk to this position. The Committee discussed the current drivers of the deficit and the proactive actions that were being taken to address shortfalls. Members noted that the key generic issue driving the deficit position within providers was non delivery of cost improvement and workforce plans. All providers with a deficit position had been requested to produce plans to recover to their original planned positions and within these recovery plans the providers were expected to highlight any risks to quality and performance. Only then could a realistic year end forecast position be provided.	**Limited**
Operational Plan 2025/26 Delivery	Members received reports highlighting areas of improvement and challenges, noting that all systems continued to experience significant urgent care pressures, including persistent ambulance handover delays and challenges with patient flow, despite robust winter plans and	**Partial**

Item	Summary	Level of Assurance
and Service Delivery report	daily operational oversight. Delayed discharges and high bed occupancy remain key risks, with ongoing system-wide governance and daily oversight supporting winter delivery. Frailty was highlighted as a common theme among the rising number of emergency department presentations. Planned care recovery was progressing, but risks remained around 65-week breaches and specialty backlogs. Lincolnshire was broadly on track for year-end compliance, while Nottinghamshire and Derbyshire faced greater challenges. Despite additional treatments compared to prior years, cancer performance was not achieving across the cluster area and recovery plans were in place to deliver back to plan by March 2026.	
NHS Lincolnshire ICB recovery plan	The Committee received details of the key drivers behind the ICB's adverse position, which provided assurance on the development and implementation of a financial recovery plan to address the deficit position. Querying whether the recovery plan would result in a break-even position for the ICB, the Committee was informed that although several actions were already in train that would reduce the deficit position, at this time assurance could not be given that the full position would be recovered.	**Partial**

Other considerations

Decisions made:
a) In line with NHS Nottingham and Nottinghamshire ICB's Scheme of Reservation and Delegation, the Committee approved for the expansion of the Radcliffe-on-Trent Health Centre located in Rushcliffe Primary Care Network in South Nottinghamshire, utilising Community Infrastructure Levy and Section 106 contributions totalling up to £1,250,000 secured by Rushcliffe Borough Council from residential developers.

Decisions made:
b) An extraordinary meeting of the Committee was convened to approve the first submission of the ICBs' Medium-Term Plan 2026/27-2027-28 ahead of the national deadline. The plan, as presented, set out compliant trajectories across all national priority areas including elective care, cancer, diagnostics, community services, mental health, and learning disabilities and autism. The first submission was approved, following examination of several assumptions within the plan regarding the feasibility of re-allocating resource at scale and how performance in key constitutional standards would be improved. The Committee noted the next steps following this submission and an update on progress was received at the January meeting.

Information items and matters of interest:
The Committee: a) Noted the work underway to develop the ICBs' performance monitoring arrangements. b) Welcomed a revised approach to financial oversight across all three systems, focussed on high financial risk organisations and the use of a new System Grip and Control Framework to seek assurance on workforce, cost improvement plan delivery and on the culture, ownership and accountability for the reported financial position within those organisations. c) Received an overview of the National Medium-Term Planning Framework for 2026/27–2028/29 and outlined how the ICBs were organising the operational planning process to develop a three-year plan ahead of the extraordinary meeting to review the plan's first submission.

Appendix 2 - Joint Quality and Service Improvement Committee Highlight Report

Meeting Date(s):	10 December 2025
Committee Chair:	Sharon Robson, Non-Executive Director

Item	Summary	Level of Assurance
Quality Report	The Committee received the Quality Report for assurance, which provided a system-wide overview of quality, safety and performance across all provider Trusts within the ICBs' footprints. This included current National Oversight Framework and Care Quality Commission positions, thematic issues across the system, and emerging areas of concern, including those relating to smaller commissioners and primary care. The Committee explored its role in supporting the ICBs as strategic commissioners and sought clarity on quality responsibilities across the ICBs and NHS England, noting that any future transfer of functions remains subject to national policy direction. Future iterations of the report will highlight where the ICBs' statutory duties to secure quality services is most at risk. Assurance from the report was assessed as limited due to the breadth of challenges identified; however, the contextual narrative provided a meaningful level of assurance that improvements are being made across the three ICBs' systems.	**Limited**

Information items and matters of interest:
The Committee also discussed its new remit, noting potential overlaps with other committees. The ICBs' operating model was discussed in the context of ICBs' future roles in strategic workforce functions, and it was agreed that a clear understanding of the role of ICBs in this area was essential to ensure effective oversight.

Appendix 3 - Joint Strategic Commissioning Committee Highlight Report

Meeting Date:	27 November 2025
Committee Chair:	Jon Towler, Non-Executive Director

Decisions made:
The Committee **approved**: a) The Joint ICB Procurement and Provider Selection Policy, noting that an updated process for managing Provider Selection Regime representations would be submitted for approval in due course. The Policy may be subject to minor amendments, and any proposals for significant changes would be brought back to the Committee for approval. b) Publication of the Nottingham City Special Educational Needs and Disabilities Inclusion and Alternative Provision Strategy 2025–2028.

Information items and matters of interest:
The Committee: a) Noted the work underway to develop the ICBs' joint Decision-Making Framework and supporting working arrangements. b) Discussed the proposed approach to developing the initial population health outcomes for the ICBs, building citizen insights into the ICBs' initial Population Health Strategy and the proposed use of the ICBs' joint Board Development Session on 18 December 2025 in relation to the Five-Year Population Health Strategy.

Appendix 4 – Joint Remuneration and Human Resources Committee Highlight Report

Meeting Date:	04 December 2025 (Extraordinary meeting)
Committee Chair:	Margaret Gildea, Non-Executive Director

Decisions made:
The Committee **approved**: a) The Senior Leaders Consultation process subject to the amendments put forward throughout the discussion. b) The proposed pay framework for senior leadership team appointments. c) The approach and timeline for the launch of the voluntary redundancy scheme across the ICBs.

Appendix 5 – Joint Transition Committee Highlight Report

Meeting Date(s):	04 December 2025 08 January 2026
Committee Chair:	Jon Towler, Non-Executive Director

Item	Summary	Level of Assurance
Update on Redundancy – Plan and Approach	Members received an update on the Redundancy Plan and overall approach, which included an overview of the centrally available funding to support the process and the whole-time equivalent reduction required. The Committee discussed how the available funding would be accessed, and how the shortfall between available and required funding to deliver the management of change process might be addressed. Concerns were raised about the potential impact on remaining staff, who may be required to absorb responsibilities from those exiting the organisation, as well as tasks previously undertaken by the Commissioning Support Units (CSU). Members stressed the importance of accurately tracking staff numbers, activity, and associated financial data, and requested a progress update on these metrics to support effective oversight.	**Adequate**
Transition Programme Plan update	The Committee received an update on progress against the ICB Transition Programme Plan and was assured that delivery remained largely on track. Upcoming priorities included the continued provision of support to colleagues affected by redundancies arising from Wave One of the management of change process, and the development of a robust support package for those impacted by Waves Two and Three.	**Adequate**

Item	Summary	Level of Assurance
	The Committee also discussed the legal guidance received regarding Transfer of Undertakings (Protection of Employment) (TUPE) arrangements for CSU staff.	
Management of Change Process - Update	The Committee received assurance on the continued development of the new operating model, alongside a progress update covering Wave One, preparations for Waves Two and Three, and the implementation of the Voluntary Redundancy programme. Members were assured that the impact of the Voluntary Redundancy scheme on the workforce across the three ICBs would be fully assessed by the end of January 2026. Plans for broader organisational development, including the potential future merger of the ICBs, were also noted to be in progress. Despite delays in the publication of national guidance by the Pensions Agency, the Committee was assured that staff have access to the necessary information to support informed decision-making. Members also considered potential mitigations for the funding shortfall associated with Waves Two and Three, and the likely immediate and longer-term implications of these.	**Adequate**
Corporate Non-Pay Reductions	The Committee received a paper outlining plans to reduce corporate non-pay expenditure alongside pay-related savings. It was noted that a significant proportion of non-pay costs relate to CSU contracts, estates, and audit fees, with remaining areas such as software, training and travel expected to reduce in line with workforce changes. A reduction target of 55% has been set for non-pay expenditure, a higher rate than for pay, to help protect workforce capacity and support financial	**Adequate**

Item	Summary	Level of Assurance
	sustainability. The Committee discussed the implications of estate provision changes on staff decisions regarding voluntary redundancy and identified potential opportunities for long-term savings, including in external audit arrangements.	

Other considerations

Information items and matters of interest:
The Committee also received a verbal update from Amanda Sullivan, Chief Executive, for information. Key points included the completion of Wave One and the launch of Waves Two and Three of the Management of Change process, alongside the rollout of the Voluntary Redundancy Scheme. The Committee discussed staff responses to the launch of the process and the continued uncertainty surrounding the functions to be transferred from ICBs. Members acknowledged the need to manage this uncertainty proactively and agreed that planning should be based on the best information currently available, while remaining flexible to national developments.

Appendix 6 - Audit Committees' Highlight Report (meeting in common)

Meeting Date:	17 December 2025
Committees' Chair:	John Dunstan, Non-Executive Director

Item	Summary	Level of Assurance
EPRR Annual Assessment Reports	The Committee received the 2024/25 Emergency Preparedness, Resilience and Response (EPRR) annual assurance reports for each ICB. These reports are part of a national process led by NHS England to assess compliance with core EPRR standards. Individual reports were discussed as follows:	
	NHS Derby and Derbyshire ICB: The ICB was rated substantially compliant by NHS England and the annual assurance report was endorsed for Board approval. The Committee applied an assurance rating of adequate, noting that common areas of continued focus were required for all three ICBs and further assurance would be received following a review of progress in six months' time.	**Adequate**
	NHS Lincolnshire ICB: Lincolnshire ICB also achieved a substantially compliant rating from NHS England and its annual assurance report was endorsed for Board approval. The Committee applied an assurance rating of adequate, for the reasons stated above.	**Adequate**
	NHS Nottingham and Nottinghamshire: The ICB was rated partially compliant, reflecting that some core standards were not fully met. The Committee reviewed the specific areas of partial compliance, which included documentation of command and control procedures, business continuity plans, and internal assurance processes. Robust action plans are in place to address	**Partial**

Item	Summary	Level of Assurance
	these gaps. The Committee endorsed the report for Board approval and applied a partial assurance rating, with further assurance to be gained through monitoring of implementation.	
Risk management arrangements update	The report had provided an update on the work being undertaken to embed joint strategic and operational risk management arrangements within the ICBs. The report also provided a detailed analysis of the ICBs' current operational risk profile; the processes in place for identifying and categorising risks; and provided an update on the development of the Boards' Assurance Framework.	**Full**

Other considerations

Decisions made:
The Committee approved the Nottingham and Nottinghamshire ICB's External Audit Plan for 2024/25.

Information items and matters of interest:
The Committee: a) Received an update on the continuing issues following 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. Issues continued to be escalated and proactively managed. However, concern was noted around the additional time being taken to undertake checks on the accuracy of financial payments and reporting. b) Reviewed progress of the ICBs' 2024/25 Internal Audit Plans and sought confirmation that the plans could be delivered by the end of the financial year. c) Received an update on the internal and external audit arrangements across the three ICBs.

Appendix 7 - Description of levels of assurance

Levels of assurance:	The report demonstrates that:
Full Assurance	• Desired outcomes are being achieved; and/or • Required levels of compliance with duties is in place; and/or • Robust controls are in place, which are being consistently applied. Highly unlikely that the achievement of strategic objectives and system priorities will be impaired. No action is required.
Adequate Assurance	• Desired outcomes are either being achieved or on track to be achieved; and/or • Required levels of compliance with duties will be achieved; and/or • There are minor weaknesses in control and risks identified can be managed effectively. Unlikely that the achievement of strategic objectives and system priorities will be impaired. Minor remedial and/or developmental action is required.
Partial Assurance	• Achievement of some outcomes are off-track or mechanisms for monitoring achievement in some areas have yet to be established/fully embedded; and/or • Compliance with duties will only be partially achieved; and/or • There are some moderate weaknesses that present risks requiring management. Possible that the achievement of strategic objectives and system priorities will be impaired. Some moderate remedial and/or developmental action is required.
Limited Assurance	• Achievement of outcomes will not be achieved or are significantly off-track for achievement; and/or • Compliance with duties will not be achieved; and/or • There are significant material weaknesses in control and/or material risks requiring management. Achievement of strategic objectives and system priorities will be impaired. Immediate and fundamental remedial and/or developmental action is required.